Providing High Quality Care in Community Oncology Practices /

An Assessment of Infusion Services and Their Associated Costs

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Avalere®

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Executive Summary

Community oncologists, like other physicians, are experiencing an increasingly challenging environment in which to maintain a practice. Increases in operating costs, particularly for clinical support staff, coupled with decreases in Medicare reimbursement rates make it difficult for physicians to deliver comprehensive services in their communities. The impact of these divergent trends can be problematic for communities that rely on accessing care from local oncology practices. Clearly defining the services and the resources involved in delivering high quality care to cancer patients and their families is a necessary first step to appropriately valuing the services that oncology practices routinely provide.

To study this complex issue, the Community Oncology Alliance (COA) worked collaboratively with Avalere Health to design and administer a survey to identify the complete suite of services performed by community oncology practices and to capture detailed costs associated with all aspects of delivering high quality cancer care.

The survey results suggest that the cost of providing infusion services in community oncology practices may be higher than 2009 Medicare reimbursement rates. Specific activities related to infusion services provided in community oncology practices, which are identified in this survey, are not currently explicitly reimbursed by Medicare. The activities oncologists identify as being integral to furnishing infusion services include treatment planning, treatment counseling, care coordination, supportive care, palliative and end of life care, telephone support, and financial counseling. The study methodology allocates practice costs for all activities performed on the same day as infusion services into categories that are distinct from evaluation and management services.

To date, no studies have examined the breadth of services and associated costs as comprehensively as this study. With these data in hand, the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and other policymakers could address the issue of adequate reimbursement to providers for the cost of rendering high quality cancer care.

Background and Study Purpose

Medical care in the United States has become increasingly complex with the implementation of new technologies and treatment options. Equally challenging is devising payment systems that keep pace with these new treatments so providers receive fair and appropriate payment for the services they deliver to patients. Medical oncology practices are a prime example of this trend because they offer patients a wide range of services in conjunction with chemotherapy treatments. These include what many would consider to be “routine” services that are ineligible currently for separate reimbursement from third-party payers. Clearly defining the services and the resources

involved in offering high quality care to cancer patients and their families is a necessary first step to valuing the services that oncology practices routinely provide.

To investigate these challenges, the Community Oncology Alliance (COA) worked collaboratively with Avalere Health to design and administer a survey different from others conducted to date. The COA Components of Care Survey is a comprehensive study designed to identify the complete suite of services performed by community oncology practices and to capture detailed costs associated with all aspects of delivering high quality cancer care. A COA Components of Care Committee—comprised of medical oncologists, mid-level providers (e.g., Nurse Practitioner, Physician Assistant), nurses, pharmacists, and practice administrators—was engaged to define both the clinical and operational components of care furnished in community oncology practices. This committee provided input for the 15 clinical and 6 operational components of care descriptors, and vetted the final list of community oncology services to ensure their accuracy. Avalere also used input from this committee to design a survey of all activities performed in community oncology practices and to isolate the costs of providing infusion services from others within the total suite of services involved in the delivery of high quality cancer care. A copy of the survey instrument can be found in Appendix A.

Methods

Avalere obtained a list of practicing oncology physicians from COA and assigned all physicians to unique practices to avoid duplication. We excluded academic medical center and university practices to create a mailing list that would target community oncology practices. We sought to distribute surveys to small (1-2 physicians), medium (3-5 physicians), and large (6 or more physicians) practices in each of the 4 US census regions (Northeast, Midwest, South, and West). We distributed surveys to all 2,922 practices on the list. The distribution of intended-to-survey practices by geographic area and survey type is shown below in Table 1.

Table 1. Distribution of Practices by Geographic Location and Survey Type

		By Region			
Method	**Total**	**Northeast**	**South**	**Midwest**	**West**
Email	1,668	327	653	366	322
Paper	1,254	272	495	281	206
TOTAL	***2,922***	***599***	***1,148***	***647***	***528***

We mailed a PDF file and MS Excel document to all 2,922 practices on the list supplied by COA in April, 2009. Due to incorrect email addresses, 1,254 emails were not delivered. For these practices, we sent hard copy printouts of the survey via the US mail in late April 2009; 63 of these paper surveys were subsequently returned as undeliverable. For

purposes of our analysis, we assumed a total of 2,859 surveys were successfully distributed.

We collected and tabulated surveys between April and August 2009. We received a total of 91 survey responses: 18 paper and 73 electronic. We attempted to resolve any missing or inaccurate data by following up with practices via telephone and email. If data were missing, we excluded the survey submission from our analysis. We excluded 15 of the 91 surveys from our analysis due to missing data, making a usable yield of 76.

Survey Design

The Components of Care Survey was broken into three main sections.

1. Practice Information
   This section collected full-time equivalent (FTE) staff and salary information. Staff members were divided into five categories: Administrative, Medical Oncologist/ Hematologist, Mid-level Provider (e.g., Nurse Practitioner, Physician Assistant), Medical Oncology Clinical Staff, and Ancillary Clinical Staff (e.g., clinical staff that do not directly contribute to the delivery of medical oncology services).

2. Support Services
   This section gathered data on the average percentage of time each of the five staff categories above spent on the clinical and operational components of providing comprehensive oncology care. These components were developed with extensive review and input from the COA Components of Care Committee.

3. Practice Volume and Financials
   The final section collected financial and productivity information. Respondents were asked to submit data directly from 2008 year-end financial reports that were audited by a certified public accountant. Billing data with all Current Procedural Terminology (CPT) codes submitted for payment from all third-party payers in calendar year 2008 were also collected.

Data Analytics

We analyzed Components of Care Survey data compiled from survey responses using Statistical Analysis System (SAS) software. We developed algorithms within SAS to identify and allocate total salary and other financial data for each practice to infusion services as distinct from all other services performed in community oncology practices. These calculations used survey participants' responses for staff time spent on specific components of care from Section II (Support Services), and actual third-party payer claims data with utilization by CPT code from Section III, Question 12. The survey

requested calendar year 2008 utilization data, so we cross-walked the 2008 infusion CPT codes 90760-90779 that were deleted on January 1, 2009 to the 2009 infusion CPT codes 96360-96542.

We modeled Medicare infusion service payments in 2009 using Relative Value Units (RVUs) for this year for the three components in the American Medical Association (AMA)/Centers for Medicare & Medicaid Services (CMS) process translating each CPT code into payment under the Medicare Physician Fee Schedule (MPFS). These include: Physician Work (W), Practice Expense (PE), and Professional Liability/ Malpractice Insurance (MP). Our computation of infusion service costs by RVU type used both reported allocations of provider time and RVU volume related to infusions versus other aspects of oncology practice. The sum of W, PE, and MP components yielded total infusion services-related costs.

Physician Work (W) Component

We calculated community oncology practice costs for the W component using physician and mid-level provider responses to Section II of the survey, which detailed how their time is spent in a typical day. In our calculations, we made the assumption that most services rendered by mid-level providers (physician assistants and nurse practitioners) are performed incident-to physician services, so mid-level provider salaries and benefits are included with physician labor costs.

We used two methods to allocate time to infusion services. In the first, we used providers' responses to Section II, Question 6. In our opinion, and per discussions with COA and practice representatives, these responses reflect a more literal interpretation of the time that providers spent physically in the infusion area of their practices and/or actually performing the infusion.[1] Table 2 shows the applicable responses of providers to Section II, Question 6.

[1] Note that we used information from Question 6 to estimate the relationship between physician and midlevel provider work costs and Medicare payment and arrived at similar numbers, supporting the present Medicare definition of activities included in payment.

Table 2. Survey Respondents' Allocation of Time to Infusion Services – Narrow Definition (Taken from Section II, Question 6)

	Mean Percent of Time Spent On*:					
Category of Staff	**Infusion Room Related Services**	**Other Services Performed in the Office**	**Hospital Services**	**Ancillary Services**	**All Other Activities**	**Total**
MEDICAL ONCOLOGISTS, HEMATOLOGISTS						
Total	13.37%	58.44%	16.59%	2.20%	9.40%	100.00%
MID-LEVEL PROVIDERS						
Physician Assistant	10.22%	62.88%	17.31%	2.53%	1.56%	100.00%
Nurse Practitioner	13.47%	66.30%	6.24%	1.06%	2.19%	99.70% **

* Figures are weighted by numbers of FTE staff in each category
**Does not equal 100% due to rounding.

In the second approach, we used the answers to Section II, Question 7, in which the providers indicated the percentage of time spent performing a wider array of activities related to infusion services. Services were included regardless of the physical location within the office in which they are performed and inclusive of, but not limited to, the act of infusion. It is our opinion that this second method, to the point of the survey, more appropriately captures all effort related to infusion services. The responses to this question are shown in Table 3.

We used the data taken from Section II, either Question 6 or 7, to quantify the W cost of providing both infusion services and evaluation and management (E&M) services performed in oncology practices. We multiplied the percentage of time spent on each by the physician and mid-level provider salary and benefit information reported in Section I, Question 6.[2] All procedures apart from infusions, services performed in the hospital, and clinical trials were omitted from these time allocations. To calculate the cost for infusion-related services only, we used the utilization data supplied by survey respondents in Section III, Question 12 of the survey. We multiplied the volume of CPT codes 96360 - 96542 ("infusion codes") and E&M codes 99201-99215 and 99241-99245 by their respective RVUs. The total RVUs for these two categories were then added together. The final step of the calculation was to divide this total RVU allocation by the percentage of infusion-related services to determine the W component of the cost of providing infusion services.

[2] A separate section of Question 6 asks for base (unallocated to activity) salary and benefit costs and number of personnel.

Table 3. Survey Respondents' Allocation of Time to Infusion Services – Broader Definition (Taken from Section II, Question 7)

	Mean Percent of Time Spent, by Staff Category*:	
Components of Care Category	**Medical Oncologists / Hematologists**	**Mid-Level Providers**
Treatment Management		
Patient Check-in	0.01%	0.29%
Treatment Planning	15.86%	5.49%
Treatment Response Assessment & Modification	16.34%	16.60%
Treatment Counseling	8.41%	12.81%
Testing and Analysis	6.52%	7.53%
Care Coordination	7.32%	10.33%
Disease Surveillance & Cancer Survivorship	7.48%	7.55%
Office Procedures	7.81%	9.02%
Hospital Care and Procedures	11.74%	6.68%
Provision of Therapeutics		
Drug Preparation	0.05%	0.12%
Drug Administration	0.35%	0.17%
Supportive Care	4.55%	7.21%
Palliative and End of Life Care	4.14%	5.25%
Telephone Support	3.49%	5.18%
Clinical Trials and Miscellaneous Services	3.07%	1.83%
Scheduling, Billing and Collections	0.26%	0.41%
Preauthorization	0.15%	0.19%
Financial Counseling	0.13%	0.07%
Pharmacy Operations	0.05%	0.04%
Oral Therapeutics	1.16%	1.49%
General Practice Management and Payer Contracting	1.08%	0.46%
TOTAL	**100.00%**	**100.00%**

* Figures are weighted by numbers of FTE staff in each category
Note: Highlighted rows indicate activity directly related to infusion services

Practice Expense (PE) Component

We calculated clinical and administrative staff costs for the PE component of infusion services using a parallel methodology to that outlined above for the W component. This time, we used salary and benefit responses for categories of staff other than physicians and midlevel providers from Section II. To determine the remaining PE overhead costs for infusion services, we used a two-step calculation. First, we calculated a grand total of practice RVUs based on all CPT code utilization submitted in Section III, Question 12. We divided total infusion RVUs, calculated previously, by the grand total of all practice RVUs to compute the percentage of infusion RVUs relative to all other services. The final step of the calculation was to multiply this infusion RVU percentage by the practice cost data (Rent & Building Expenses and All Other Expenses) collected in Section III, Question 11 of the survey. We added these costs to staff costs to provide total PE costs.

Malpractice Insurance (MP) Component

We calculated MP costs by multiplying the percentage of infusion RVUs relative to all other services, referenced above, by MP costs reported in Section III, Question 11.

The sum of W, PE, and MP components yielded total infusion services-related costs.

Results

The survey results suggest that the cost of providing infusion services in community oncology practices may be higher than 2009 Medicare reimbursement rates. When comparing the difference in current Medicare payments to practice costs collected in this survey, we found that the practices sampled would receive payment equivalent to 56.53[3] percent of the costs they incurred to provide infusion services. The payment-to-cost ratios by practice size and geographic location are shown below in Tables 4 and 5.

Table 4. Medicare Payment-to-Cost Ratios for Infusion Services in Community Oncology Practices by Size

Practice Size	Number of Practices	Number of Providers	2009 Medicare Payment-to-Cost Ratio
Small	20	42	73.69%
Medium	22	125	71.21%
Large	34	513	52.63%
All	*76*	*680*	*56.53%*

Table 5. Medicare Payment-to-Cost Ratios for Infusion Services in Community Oncology Practices by Geographic Region

Region	Number of Practices	Number of Providers	2009 Medicare Payment-to-Cost Ratio
Northeast	12	80	66.53%
South	38	350	55.09%
Midwest	16	155	59.30%
West	10	95	52.78%
All	*76*	*680*	*56.53%*

Upon further analysis, we noted differences in the payment-to-cost ratios by RVU type. Using the broader definition of infusion-related activities from survey Section II, Question 7 (summarized in Table 3 of this report) W payments comprised 35.10 percent of

[3] Note that this number is somewhat overstated, as no inflation was added to 2008 costs to when compared to 2009 Medicare payment rates.

related costs. This finding was consistent across all practice sizes: small, medium, and large.

PE payments comprised 60.25 percent of practice costs in aggregate. We noted differences between large practices (55.03 percent) and small and medium practices (81.10 and 83.38 percent, respectively). Anecdotal evidence tends to support the fact that larger practices may have disproportionately greater PE costs than smaller ones as a result of their desire to, and belief that they can, offer more services integrally related to infusions (e.g., in-house care coordination).

Finally, our survey results found that reported malpractice insurance expenses were less than MP payment received from Medicare for infusion services. Upon further review of MP costs, it appears that outliers included two practices from California with low MP costs compared to the average.

We completed additional analyses to allocate infusion services-related costs incurred by practices for each of the relevant components of care. Consistent with the methodologies outlined above, we allocated practice costs for all relevant activities performed on the same day as infusion services into categories that are distinct from E&M services. On average, practices that submitted data to survey Question 7 reported infusion services-related costs of $3,186,607, or $485,335 per medical oncology/hematology physician. The detailed list of infusion services-related costs by Components of Care Category is shown below in Table 6.

Table 6. Infusion Services-Related Costs

Components of Care Category	Average Reported Costs Per Practice	Average Reported Costs Per Medical Oncologist/ Hematologist	Percentage of Total Infusion Services-Related Costs
Treatment Management			
Patient Check-in	$294,687	$44,882	9.2%
Treatment Planning	$164,122	$24,996	5.2%
Treatment Response Assessment & Modification	$172,836	$26,324	5.4%
Treatment Counseling	$150,908	$22,984	4.7%
Testing and Analysis	$131,160	$19,976	4.1%
Care Coordination	$190,081	$28,950	6.0%
Disease Surveillance & Cancer Survivorship	$68,045	$10,364	2.1%
Office Procedures	-	-	-
Hospital Care and Procedures	-	-	-
Provision of Therapeutics			
Drug Preparation	$133,113	$20,274	4.2%
Drug Administration	$297,530	$45,315	9.3%
Supportive Care	$111,553	$16,990	3.5%
Palliative and End of Life Care	$59,710	$9,094	1.9%
Telephone Support	$178,602	$27,202	5.6%
Clinical Trials and Miscellaneous Services	-	-	-
Scheduling, Billing and Collections*	$408,307	$62,187	12.8%
Preauthorization	$310,270	$47,256	9.7%
Financial Counseling	$169,987	$25,890	5.3%
Pharmacy Operations	$133,500	$20,333	4.2%
Oral Therapeutics	$40,617	$6,186	1.3%
General Practice Management and Payer Contracting*	$171,577	$26,132	5.4%
TOTAL**	***$3,186,607***	***$485,335***	***100%***

* Costs for these rows are based on infusion services allocations of total practice overhead expenses reported in survey question 11.
** Total costs exclude one practice that did not provide Component of Care allocations for all staff.

In addition to other uncompensated services reported in the survey, the average reported annual bad debt per practice that participated in this survey was $500,178, or $76,241 per medical oncology/hematology physician.

A total of 76 community oncology practices, representing 499 medical oncology and hematology physicians completed the Components of Care Survey (a 2.7% response rate). This response rate does not comprise a statistically significant sample, meaning that it is not possible to draw firm conclusions from answers to individual survey questions. However, the total number of respondents is comparable to, and in some cases exceeds, other surveys of oncology practices, including the AMA's 2007 – 2008 Physician Practice Information Survey (PPIS), which collected usable data results from 50 physicians. The AMA developed a weighting methodology to report results from its 2007 – 2008 PPIS. The AMA's methodology was based on previous physician data collection efforts and attempted to adjust for bias resulting from the receipt of information from a

non-representative sample of practices. CMS uses the AMA PPIS data when calculating the payment rates for different specialties, including oncology, in the MPFS.

Avalere was also able to make limited comparisons between selected survey results and those from other organizations such as the Medical Group Management Association and Onmark. We found aggregate similarities in practice composition between this and other studies performed by these organizations despite variances in responses to individual questions.

Avalere's analysts noted a "wide" variance in practice response rates.[4] As an example, the responses we received showed wide variation in staff time spent on infusion-related services. Some physicians and nurses reported zero time spent on infusion-related services; others reported 50 to 60 percent of their time on these services. It was not possible for us to analyze the variance in a meaningful way without detailed comparative information on all community oncology practices.

Discussion

Community oncologists, like other physicians, are experiencing an increasingly challenging environment in which to maintain a practice. Increases in operating costs, particularly for clinical support staff, coupled with decreases in Medicare reimbursement rates make it difficult for physicians to deliver comprehensive services in their communities. The impact of these divergent trends can be problematic for communities that rely on accessing high quality cancer care from local oncologists and their support staff.

The COA Components of Care study was unique in its ability to identify and quantify the complete suite of services performed by these practices. The results suggest that the costs of providing infusion and related support services in community oncology practices are not adequately reimbursed by Medicare.

The data collected in this study identified the broad range of services that community oncology practices offer to their patients, beyond the act of administering chemotherapy and other medications and counseling patients during E&M office visits. As noted in the **Data Analytics** section, we started our analyses by allocating practice costs using survey responses to staff time spent on infusion services defined narrowly (i.e., using the time allocation answers to Section II, Question 6, as summarized in Table 2 of this document). However, our final analysis incorporated both services currently reimbursed and not reimbursed under existing definitions of infusion-related services (we used the responses to Section II, Question 7, summarized in Table 3 of this document.)

The specific activities related to infusion services performed in community oncology practices appear to vary; however, all practices report spending time on activities that

[4] As measured by standard deviations exceeding means and/or medians in question results.

oncologists argue are critical to delivering high quality cancer care. The activities oncologists identify as being integral to providing infusion services include treatment planning, treatment counseling, care coordination, supportive care, palliative and end of life care, telephone support, and financial counseling. None of these practice activities are currently specified explicitly in existing CPT code descriptors or associated Medicare payments for infusion services. Furthermore, CMS does not allow physicians to bill and receive separate payment for E&M services (possibly inclusive of some the services noted above) on the same day as infusion services.

The methodology we used to allocate practice costs attempted to account for additional activities performed on the same day as infusion services by separating them from E&M services. Table 6 of this document (Infusion Services-Related Costs) includes detailed cost data for all activities included to render infusion services in community oncology practices. These costs include those currently reimbursed by Medicare and those identified by oncologists as integral to delivering high-quality infusion services but not identified in current reimbursement methodologies.

In addition to the physical challenges of battling cancer, patients and their caregivers face many unique stresses that affect quality of life. The support services documented by oncology practices involved in this study can greatly improve the quality of life for cancer patients and their families throughout the care experience. Particularly in larger oncology practices, there may be office staff and other resources dedicated to providing the additional services critical to the delivery of high quality cancer care on the same day that an infusion is performed. Community oncology practices also report bad debt for services rendered that are not compensated by third-party payers or patients that have exhausted their financial resources in the battle with cancer. Recognition of, and adequate reimbursement for, the challenges faced in operating a physician practice is critical so that comprehensive cancer care can be delivered in community settings to patients and their caregivers.

The Components of Care study has identified and quantified a full range of infusion-related services provided by oncology practices and their related costs. No other studies to date have examined the breadth of services and associated costs as comprehensively as this study. With these data in hand, the AMA, CMS, and other policymakers could address the issue of adequate reimbursement to providers for the cost of rendering high quality cancer care.

APPENDIX: COMPONENTS OF CARE SURVEY INSTRUMENT

I. Practice Information

1. Which of the following best describes the ownership structure of your practice? (Please select only one.)

Physician-owned

Joint venture of several organizations (e.g., physicians, hospital, health system, etc.)

Owned by hospital or health system

Other. Please specify_____

2. Is your practice affiliated with an oncology network, such as U.S. Oncology or Cancer Treatment Centers of America (excludes GPO relationships)?

Yes

No

3. How many practice locations do you have?

_____

4. What is the total square footage for **ALL** of your practice locations, including all satellite offices? (Refer to your lease agreements, as necessary, to assist with this calculation.)

_____ square feet

5. Please provide the square footage of office space assigned to ancillary services for **ALL** of your practice locations (e.g., retail pharmacy, imaging, lab, radiation).

_____ square feet

6. For each staff category listed in the tables below, please provide the total number of full-time equivalent (FTE) staff, the total annual salary including bonuses, and percentage of time spent on various activities.

FTE: with some exceptions, a full-time equivalent equals a 40-hour week. To calculate FTE based on a 40-hour per week basis, take total hours worked in 2008 and divide by 2080 (40 hours * 52 weeks). Include all contract and temporary staff, *locum tenens* physicians, transcriptionists, etc.

Please apportion FTE values to the role that best describes the staff member's primary responsibilities. If a staff member has more than one clearly defined role in the practice, or if they share responsibilities between the practice and an affiliated medical practice or hospital, apportion their FTE value appropriately.

When apportioning FTE values for physicians and midlevel providers, please use your practice's definition for FTE as the expected work hours for a physician or midlevel provider FTE can vary from one practice to another. Please report all data to one decimal place.

Examples:

1. Employee works 40-hours per week splitting their time evenly among two roles (medical secretary and transcriptionist). The calculation is as follows:

   (20*52) ÷ 2080 = .5 FTE medical secretary and
   (20*52) ÷ 2080 = .5 FTE transcriptionist

2. Employee works 60-hours per week as a registered nurse. The calculation is as follows:

   (60*52) ÷ 2080 = 1.5 FTE

Total annual salary: include any bonuses paid in 2008. Do not include benefits (e.g., medical/dental, life insurance, etc).

Percentage of Time Spent on:

Infusion Room Related Services: include the percent of time spent on any services performed in an infusion or injection room, as well as time spent on work that supports services performed in an infusion room such as scheduling infusions, mixing drugs, etc.

Other Services Performed in the Office: include the percent of time spent on all other services performed in the office (e.g., evaluation and management services, procedures, treatment planning, etc.) that were not performed in an infusion or injection room. (Include care delivery as well as all work that supports care delivery such as scheduling non-infusion room appointments, patient check-in, preparing lab specimens and paperwork, etc.)

Hospital Services: include the percent of time spent on services performed in the hospital setting of care.

Ancillary Services: include the percent of time spent on any ancillary services performed in the practice (e.g., retail pharmacy, imaging, lab, radiation).

All Other Activities: include the percent of time spent on all other activities (e.g., administrative activities, general practice management, etc.).

Question 6, continued

6A.

			% of Time Spent on:					
Administrative Staff	**# of FTE Staff**	**Total Annual Salary (including bonuses)**	**Infusion Room Related Services**	**Other Services Performed in the Office**	**Hospital Services**	**Ancillary Services**	**All Other Activities**	**Total**
TOTAL	**____._**	**$_____**	**_____%**	**_____%**	**_____%**	**_____%**	**_____%**	**100%**

Administrative staff includes: administrators, chief executive officer, chief financial officer, medical director, human resources, marketing, purchasing, business office manager, office manager, billing manager, charge entry, billing, collection, credentialing, payment and posting, controller, accounting manager, accounts payable, payroll accounting, budget, bookkeeping, medical secretaries, registration, schedulers, clinical manager, clinical operations manager, medical records/transcription (transcribers, medical records), information technology staff, and other administrative staff.

6B.

			% of Time Spent on:					
Medical Oncologists, Hematologists	**# of FTE Staff**	**Total Annual Salary (including bonuses)**	**Infusion Room Related Services**	**Other Services Performed in the Office**	**Hospital Services**	**Ancillary Services**	**All Other Activities**	**Total**
TOTAL	**____._**	**$_____**	**_____%**	**_____%**	**_____%**	**_____%**	**_____%**	**100%**

6C.

			% of Time Spent on:					
Mid-Level Providers	**# of FTE Staff**	**Total Annual Salary (including bonuses)**	**Infusion Room Related Services**	**Other Services Performed in the Office**	**Hospital Services**	**Ancillary Services**	**All Other Activities**	**Total**
Physician Assistant	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Nurse Practitioner	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
TOTAL	**____._**	$_____						

6D.

			% of Time Spent on:					
Medical Oncology Clinical Staff	# of FTE Staff	Total Annual Salary (including bonuses)	Infusion Room Related Services	Other Services Performed in the Office	Hospital Services	Ancillary Services	All Other Activities	Total
Registered Nurse (includes triage nurses and nurse managers)	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Licensed Practical Nurse	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Medical assistant/Nurse's aide	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Nutritionist/Dietician	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Social Worker/Patient Navigator	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Other medical support staff	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Phlebotomist	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Pharmacist	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
Pharmacy technician/ Admixture technician	____._	$_____	_____%	_____%	_____%	_____%	_____%	100%
TOTAL	____._	$_____						

Other medical oncology support staff includes: clinical research staff (nurses, coordinators, data managers, medical assistants, and managers), lab manager, lab technician, and other medical oncology clinical staff.

6E.

			% of Time Spent on:					
Ancillary Clinical Staff	**# of FTE Staff**	**Total Annual Salary (including bonuses)**	**Infusion Room Related Services**	**Other Services Performed in the Office**	**Hospital Services**	**Ancillary Services**	**All Other Activities**	**Total**
TOTAL	**____._**	**$_____**	**_____%**	**_____%**	**_____%**	**_____%**	**_____%**	**100%**

Ancillary clinical staff includes: radiation oncologist, radiation manager, radiology technologist (generalist), bone densitometry technologist, cardiovascular interventional technologist, CT technologist, MRI technologist, mammography technologist, nuclear medicine technologist, quality management technologist, sonographer, technical aides, radiation nurse, medical physicist, medical dosimetrist, and other physicians, radiology staff, and pharmacy staff.

Do not report ancillary clinical staff on question 7.

II. Support Services

7. The COA Components of Care (CoC) Subcommittee developed a list of all activities furnished in community oncology practices and formulated a list of clinical and operational CoC categories. Clinical components are services: (1) typically furnished by a physician, midlevel provider, or other clinical staff member, and (2) involve direct patient interaction (i.e., "touching the patient"). Other practice activities and overhead not directly related to a patient are operational components.

   To complete this section, please input percentages for medical oncology/hematology services only. Please exclude staff time spent on radiation oncology or any ancillary services (e.g., retail pharmacy, imaging, lab, radiation).

   For each staff category (Administrative Staff, Medical Oncologists/Hematologists, Mid-level Providers, and Other Clinical Staff) please provide your best estimate of the percentage time spent on each of the CoC activities during an average workday. The total for activities for each staff category will add up to 100 percent. If multiple staff members within a CoC activity provide a service to varying degrees, please provide an average percentage across personnel within the staff category. If no time is spent on an activity, leave the box blank. Please refer to the "Definition of Services" list beginning on page 10 to allocate the percentage of time that in your opinion best represents the activities performed by staff at your practice.

   (Please note: Administrative Staff job descriptions may include both clinical and operational components of care. Allocate the percentage of time for each activity based on the personnel that you assigned to each staff category in Questions 6A through 6D.)

Question 7, continued SEE PAGES 10-24 FOR COMPONENTS OF CARE DESCRIPTIONS

	Components of Care Category	Administrative Staff	Medical Oncologists/ Hematologists	Mid-Level Providers	Medical Oncology Clinical Staff
Clinical	Treatment Management				
	Patient Check-in	%	%	%	%
	Treatment Planning	%	%	%	%
	Treatment Response Assessment & Modification	%	%	%	%
	Treatment Counseling	%	%	%	%
	Testing & Analysis	%	%	%	%
	Care Coordination	%	%	%	%
	Disease Surveillance & Cancer Survivorship	%	%	%	%
	Office Procedures	%	%	%	%
	Hospital Care & Procedures	%	%	%	%
	Provision of Therapeutics				
	Drug Preparation	%	%	%	%
	Drug Administration	%	%	%	%
	Supportive Care	%	%	%	%
	Palliative & End of Life Care	%	%	%	%
	Telephone Support	%	%	%	%
	Clinical Trials & Miscellaneous Services	%	%	%	%
Operational	Scheduling, Billing, & Collections	%	%	%	%
	Preauthorization	%	%	%	%
	Financial Counseling	%	%	%	%
	Pharmacy Operations	%	%	%	%
	Oral Therapeutics	%	%	%	%
	General Practice Management & Payer Contracting	%	%	%	%
	TOTAL	**100%**	**100%**	**100%**	**100%**

III. Practice Volume and Financials

8. The financial information that you submit to Avalere Health in this section will be aggregated with all other COA member surveys to determine the average cost of operating a community oncology practice. All submissions are confidential and not reportable at the individual practice level.

Please estimate your practice's payer mix.

Payer	Percent
Medicare	_____ %
Medicaid	_____ %
Private*	_____ %
Self-pay	_____ %
Miscellaneous**	_____ %
TOTAL	**100%**

*Includes private health insurance as well as medical coverage by life insurance companies, independent plans (employer/union sponsored and/or self-funded plans).
**Miscellaneous includes charity care, worker's compensation, no other (nonprofit sources of payment), and not stated cases.

9. What was your practice's total bad debt for 2008?

$_____

10. What percentages of your patients receive their treatment outside of your office (i.e., hospital, infusion center)?

_____%

Does your clinic receive a management fee for patients treated outside your office?

Yes
No

11. Please complete the financial information below based on your 2008 tax return or nearest fiscal year financial statement:

Expenses	
Salaries (Total from Questions 6A – 6E)	$_____
Employee Benefits (e.g., health, dental, life, and disability insurance, retirement plan/401k, state and federal payroll taxes, professional/continuing medical education, car, travel, meals, lodging)	$_____
Malpractice Insurance	$_____
Drug Purchase Costs (less rebates and discounts)	$_____
Rent & Building Expenses (e.g., utilities such as electric, gas, and water, building management fees, building repairs/maintenance, security)	$_____
Direct Expenses for Ancillary Services*	$_____
All Other Expenses	$_____
TOTAL	**$_____**

*Includes all direct ancillary expenses contained on your income statement. Do not include laboratory expenses that may be under general supply expenses.

12. Please attach or fax (202.459.6286) a printout from your practice management software that shows how many times you billed each CPT code in your practice for 2008. In most practice management software (i.e., Medical Manager, Centricity, Mysis, etc.), the report will be called the "Practice Productivity Report."

Thank you for your time.

Definition of Services

Clinical Components of Care

Treatment Management

Please include all evaluation and management services (e.g., new and established patient office visits, office consults) provided in your office in this category.

Patient Check-in: Preparing patient for physician or mid-level provider office visit by checking vital signs and documenting all pertinent information into the patient's record.

Patient Check-in
Assess a patient's vital signs, weight, allergies, etc.
Prepare patient's chart and confirm that all test results or other paperwork is properly documented
Assess patient's general condition and document it for physician or mid-level provider to evaluate

Treatment Planning: Developing an action plan to treat the cancer based on the patient's type of cancer, stage, comorbidities, and preferences.

Treatment Planning
Assess cancer staging (involves measuring the severity and progression)
Assess predictive and prognostic markers (certain cancers need to be tested for tumor receptors in order to identify the most effective combination of drugs to be used in treatment)
Conduct a pathology review and consult with pathologists
Assess a patient's comorbidities (i.e., other medical conditions such as cardiovascular disease, which will likely impact treatment decisions)
Research best treatment options for rare or special cases
Research clinical trials available and assess patient's candidacy in program
Establish goals for therapy intervention with patient and family members
Develop specific chemotherapy regimen and administration protocol
Assess and discuss patient's needs for medical, psychosocial, social, spiritual, and financial support throughout the cancer experience
Complete original treatment plan

Components of Care Survey – Definitions

Clinical Components of Care

Treatment Management

Including all evaluation and management services (e.g., new and established patient office visits, office consults) provided in a practice.

Patient Check-in: Preparing patient for physician or mid-level provider office visit by checking vital signs and documenting all pertinent information into the patient's record.

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Develop specific chemotherapy regimen and administration protocol
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Complete original treatment plan

Treatment Response Assessment and Modification: Modifying the treatment plan during the course of care based on patient's tolerance and outcomes.

Treatment Response Assessment and Modification
Assess response and tolerance of treatment
Continue, discontinue, or modify treatment plan based on assessment
Review further treatment alternatives
Change to alternative treatment, other standard therapies, or clinical trial alternatives
Plan and coordinate appropriate laboratory, medical, and imaging evaluations to assess treatment response and tolerance
Review and assess clinical, laboratory, and medical imaging data
Review and assess interval history, catalogue, and grade toxicities and interventions
Review and assess interval quality of life, disease-related symptoms, and external psychosocial changes
Transition to survivorship follow-up
Formulate and discuss supportive care or hospice recommendations

Treatment Counseling: Working closely with patients and their families to teach them about cancer, its treatment (including the financial impact of oncology drugs and services), and coping with and managing treatment side effects.

Treatment Counseling
Counsel the patient and family/friend caregivers on the treatment plan
Discuss clinical trials available to patient
Provide a formal, face-to-face education session covering drugs, symptoms, side effects, diagnostic tools, and resources available at the practice and in the community
Discuss, as needed, details of the patient's condition and treatment plan (e.g., test results, chemotherapy regimen including oral therapeutic management, treatment progress, pain management, nutrition, and avenues of support)
Provide information packages that contain educational materials on topics such as coping with cancer and its side effects, information on the specific disease, treatment protocols, managing treatment-related fatigue, nutrition, choosing alternative therapies, paying for treatment, and available services at the facility and in the community
Provide a full-service resource library with books, pamphlets, journal articles, videos, and audiotapes that can be used during chemotherapy sessions or taken home
Recommend websites with information on state and local cancer resources, including patient and caregiver support groups
Provide Internet access for patients who would like to perform independent research

Testing and Analysis: Conducting certain lab testing in-house on the day of drug administration to determine if patient can receive chemotherapy drugs.

Testing and Analysis
Order and assess clinical, laboratory, and radiographic tests/studies
Complete lab testing (e.g., complete blood count)
Complete radiology tests/studies

Care Coordination: Interacting with other physician specialties and facilities to deliver care that is consistent with the nature of the cancer and the patient's needs.

Care Coordination
Coordinate other treatments, such as radiation
Monitor supportive care therapy
Obtain referrals from primary care physicians for office visits and procedures performed at the practice, as well as referrals for office visits and procedures performed by other providers
Provide diagnosis and treatment documentation to other facilities providing care to patients (e.g., reference labs or radiation oncology facilities)
Communicate with other service providers (current or former) with whom the patient has contact to discuss developments affecting that patient, answer questions, and incorporate feedback from other providers into the treatment plan
Make referrals for additional professional intervention if the level and nature of the patient's distress are more complex than can be addressed through support given by facility staff
Collect pathology, radiology, and clinical records from locations outside the practice

Disease Surveillance and Cancer Survivorship: Examining patients for recurrent disease after completion of therapy or for new primary tumors, and analyzing risk of malignancy in patient family members.

Disease Surveillance and Cancer Survivorship
Clinical, laboratory, and radiographic surveillance for recurrent disease after completion of therapy
Screen for new primary tumors
Management of chronic or delayed treatment induced symptoms or conditions
Analyze risk of malignancy in patient family members and recommend appropriate modification of screening procedures

Office Procedures

Office Procedures: Furnishing procedures, other than chemotherapy administration, during the patient's visit to the oncology office.

Office Procedures
Donation of patient's own blood for later use on self
Perform bone marrow biopsy
Aspiration
Thoracentesis
Paracentesis
Apheresis or leukapheresis
Ommaya reservoirs

Hospital Care and Procedures

Hospital Care: Managing patient in hospital setting of care including hospital consults.

Hospital Care
Admit patient
Evaluate and manage patient's condition
Conduct hospital evaluation and management consultation visits requested by other providers
Conduct follow-up visits to assess progress
Provide discharge instructions, write and review prescriptions, and provide instruction on administering shots and changing dressings

Hospital Procedures: Furnishing procedures, other than chemotherapy administration, during the patient's visit to the hospital.

Hospital Procedures
Donation of patient's own blood for later use on self
Perform bone marrow biopsy
Aspiration
Thoracentesis
Paracentesis
Apheresis or leukapheresis
Ommaya reservoirs

Provision of Therapeutics

Drug Preparation: Setting up drugs for administration and completing steps to prepare the patient to receive the drug.

Drug Preparation
Obtain patient consent
Administer local anesthesia
Access the intravenous line
Prepare the drug
Place and ready routine tubing and supplies

Drug Administration: Starting drug infusion, monitoring patients to assess adverse reactions from the medication, and completing infusion.

Drug Administration
Monitor patient, intra-service supervision of staff, and safety oversight
Complete the intravenous infusion of chemotherapy
Flush of the intravenous line at completion
Direct physician supervision for patient assessment
Conduct dye study when medical port does not yield blood
Document infusion information into medical record

Supportive Care

Dietician and Nutrition Support: Evaluating patient's nutritional status, providing information about diet and cancer, helping individual patients develop meal plans to meet their own needs, and helping them manage nutrition therapy.

Dietician and Nutrition Support
Provide nutrition supplements
Provide access to a nutritionist and/or dietician
Provide nutrition counseling to help patients maintain a healthy food regimen while on chemotherapy

Social Work and Other Supportive Care Services: Furnishing psychosocial support, including activities such as informal counseling sessions, support groups, and grief counseling. Transportation assistance also is provided for patients who need help getting to and from treatment facilities.

Social Work and Other Supportive Care Services
Order supportive care therapy
Provide emotional support and formal and informal counseling sessions in which patients are encouraged to talk freely about the social difficulties and emotional anxieties that may arise during the care process
Provide advice and information on local and national cancer support groups that are available within the community, including support groups for children and grief recovery programs designed for those who have lost loved ones.
Conduct "whole person" assessments to determine support services required by patients and their families
Provide access to prayer lists, spiritual support groups, and religious caregivers of various denominations and faiths for patients and families who request spiritual guidance and support
Facilitate patient-driven support groups for patients and their families
Provide special classes for patients such as "Journaling Group" and "Mind-Body Skills Group"
Respond to patient requests for information on complementary services, such as herbal therapies, including an evaluation of the pros and cons of therapies being considered
Provide complementary services, including massage therapy, yoga therapy, and art therapy
Meet with families to provide counseling with patient present or independently

Palliative and End of Life Care

Home Health Setup: Planning for home care, long-term care, community agency referrals, and other resources.

Home Health Setup
Coordinate and help patients plan for home health services and extended care placements
Identify and coordinate community-based resources that can provide assistance with transportation, housing, personal care, cleaning, shopping, and nutrition needs
Provide access to loaned medical equipment such as hospital beds and wheelchairs
Review and sign orders related to home health plan
Order approval and care modification

Hospice and End of Life Care/Symptom Relief: Planning for hospice care, working with a patient with an advanced stage cancer or one that has not responded to treatments to ensure patient is free of pain and other symptoms.

Hospice and End of Life Care/Symptom Relief
Assess and discuss patient's needs for physical, psychosocial, and spiritual support
Establish a palliative care program focused on pain and symptom management
Coordinate and help patients plan for hospice services
Review and sign orders related to hospice care
Communicate with multi-disciplinary team and other service providers involved in patient care

Telephone Support

Side Effect Management: Monitoring, informing, and aiding patients post-treatment for any side effects.

Side Effect Management
Monitor treatment side effects
Discuss side effects of chemotherapy and management of these conditions
Follow-up via telephone with patients to discuss any side effects or adverse reactions
Discuss and educate family members on management of patient's side effects
Evaluate and manage physical and emotional symptoms associated with the disease and its treatment, both in-person and by telephone
Evaluate, monitor, and ease patient's pain

Telephone Triage: Responding to patient and provider inquiries between in-person visits, by telephone, for any issues that the patient may encounter.

Telephone Triage
Provide a telephone number that patients can call at any time with questions or to report symptoms
Triage phone calls from patients and their families regarding medication changes, prescription refills, symptom management, lab results, and other concerns
Follow-up with patients using oral chemotherapy treatments

Clinical Trials and Miscellaneous Services

Clinical Trials and Miscellaneous Services: Enrolling, documenting, and complying with clinical trial procedures and completing any necessary ancillary services.

Clinical Trials and Miscellaneous Services
Train physician and staff regarding clinical trial
Screen patients for enrollment
Obtain informed consent
Obtain initial and annual renewal of institutional review board (IRB) regulatory approval
Coordinate patient visits
Schedule scans, visits (including post-visit follow-up appointments), and administration of study drug
Complete all case report forms (CRFs) and related documentation
Monitor visits
Communicate with sponsor and respond to queries
Attend sponsor meetings and study conference calls
Provide additional miscellaneous services in the practice

Operational Components of Care

Scheduling, Billing, and Collections

Patient Registration and Scheduling: Registering new patients, verifying insurance coverage, and scheduling appointments for office visits for all services furnished within the practice, including diagnostic/imaging services, laboratory tests, and chemotherapy treatments.

Patient Registration and Scheduling
Schedule appointment for new patient
Confirm referral is received from primary care physician (PCP)
Complete new patient registration
Verify insurance in practice management system for new and established patients
Schedule appointment for established patient
Schedule patient appointment for treatment, diagnostic/imaging service, or laboratory test
Confirm appointments with patients
Reschedule missed or cancelled appointments
Collect patient copays and deductibles from patients
Obtain records and scans from other providers prior to initial visit

Other Scheduling: Scheduling all appointments external to the practice for office visits with other physician providers, diagnostic/imaging services, laboratory tests, and any other services furnished outside of the practice. Other scheduling also includes hospital scheduling.

Other Scheduling
Schedule patient appointment for diagnostic/imaging service
Schedule patient appointment for laboratory test
Schedule patient appointment for other procedures
Supply preauthorization numbers to providers external to the practice
Obtain documentation (e.g., clinical notes, test results) from providers external to the practice

Disability Letters and Form Completion: Filling out forms that patients need to submit to federal and state government agencies, insurers, and employers.

Disability Letters and Form Completion
Complete form for Social Security benefits
Complete form for Medicare coverage
Complete form for handicap license plate or placard
Complete letter for patient's employer regarding missed work
Complete form for disability insurance
Complete Family and Medical Leave Act (FMLA) forms

Coding, Documentation, and Billing (Including Payer Denial Management): Completing all billing, coding, and documentation procedures to ensure proper payment from payers. In order to facilitate this process, staff must be educated about pertinent coding changes, claims requirements, and practice management system functionality.

Coding, Documentation, and Billing (Including Payer Denial Management)
Maintain and update an accurate and responsive billing department
Maintain day-to-day operability of practice management computer system
Input demographic, insurance, and patient encounter data into practice management system
Train end users and super users of practice management system
Educate staff about coding changes (particularly J and G codes)
Submit initial claims to payers
Post remittance advice from payers
Post payments from payers
Submit claims to secondary payers
Supervise denials management process by resubmitting claims to primary and secondary payers
Coordinate claims appeal process with clinical staff and payers
Transcribe clinical notes for patient medical record and documentation for claims submission
Maintain state and federal regulatory compliance (Health Insurance Portability and Accountability Act (HIPAA), ePrescribing, Physician Quality Reporting Initiative (PQRI) and other quality reporting)

Collections and Patient Bad Debt Issues/Resolution: Following-up with patient, collection agency, or other entity for reimbursement in situations where full payment is not received for services rendered.

Collections and Patient Bad Debt Issues/Resolution
Follow-up and maintenance of payment collection process from patients
Manage payment plans with patients
Maintain relationship and refer accounts to collection agency

Preauthorization

Preauthorization for Practice-Provided Diagnostic Services: Obtaining prior authorization from payers for all diagnostic services furnished within the practice, including time spent on hold waiting for preauthorization.

Preauthorization for Practice-Provided Diagnostic Services
Call primary payer for preauthorization for diagnostic/imaging test
Call secondary payer for preauthorization for diagnostic/imaging test
Obtain preauthorization for imaging test from radiology management vendors
Coordinate preauthorization with clinical staff

Preauthorization for Practice-Provided Treatment Services: Obtaining prior authorization from payers for all treatments furnished within the practice.

Preauthorization for Practice-Provided Treatment Services
Call payer for preauthorization for chemotherapy treatment
Call payer for preauthorization for other treatment/medical procedure
Call payer for preauthorization for supportive care
Call payer for any other service needing preauthorization
Coordinate preauthorization with clinical staff
Enroll patients in reimbursement assurance programs for off-label uses

Preauthorization for External-Provided Diagnostics and Treatment Services: Obtaining prior authorization from payers for all diagnostic and treatment services completed outside of the practice.

Preauthorization for External-Provided Diagnostics and Treatment Services
Call primary payer for preauthorization for diagnostic/imaging test
Call secondary payer for preauthorization for diagnostic/imaging test
Obtain preauthorization for imaging test from radiology management vendors
Call payer for preauthorization for laboratory test
Call payer for preauthorization for chemotherapy treatment
Call payer for preauthorization for supportive care
Call payer for any other service needing preauthorization
Coordinate preauthorization with clinical staff

Financial Counseling

Patient Financial Counseling: Discussing services covered by a patient's insurance plan, including potential deductibles or other out-of-pocket costs. Discussions can include services the payer will not cover and the method of collecting payment from patient by the practice.

Patient Financial Counseling
Fully evaluate patient's insurance coverage and available financial resources before initiating therapy
Educate patients on various aspects of health insurance, such as deductibles, copays, coinsurance, and benefit limitations
Educate patients on method of payment or payment schedule for practice
Develop customized payment plans for individual patients
Discuss options for treatment by setting of care and financial implications
Assist patient with financial form completion

Patient Advocacy and Assistance: Advocating for the patient with the payer to acquire coverage for treatment, or identifying other methods of payment by patient assistance programs (PAPs), free drug programs, or copay relief.

Patient Advocacy and Assistance
Advocate with payer to gain coverage for patient's treatment
Maintain records of PAPs available to patients
Maintain records of free drug programs
Maintain records of copay relief agencies
Contact PAPs on behalf of patient to assist with payment for treatment
Contact free drug program on behalf of patient to assist with payment for treatment
Contact copay relief agencies on behalf of patient to assist with payment for treatment

Pharmacy Operations

Pharmacy (Non-Retail) Facility Management: Maintaining pharmacy facility (non-retail), including components such as drug mixing, ordering, and billing. Pharmacy facilities do not include retail pharmacy facilities that may also be within the practice.

Pharmacy Facility (Non-Retail) Management
Calculate drug order from physician
Prepare and mix drugs
Document drug order
Capture charges in billing system to bill payer for drug
Process drug waste
Comply with USP 797 (hood certifications, personnel compound validation, closed system transfer devices)
Maintain stock of drugs in appropriate area (just-in-time (JIT) management for chemotherapy drugs, intravenous fluids and infusion-related supplies in appropriate area)
Oversee pharmacy personnel
Repackage and return defective drugs

Drug Purchasing, Contracting, Negotiation, Price Monitoring, and Ordering: Monitoring of prices and contacting pharmaceutical representatives and specialty pharmacy providers to obtain the best price for the drugs used in the practice. Maintaining accurate records of drugs used to achieve any targets required by contract.

Drug Purchasing, Contracting, Negotiation, Price Monitoring, and Ordering
Discuss drug pricing with pharmaceutical representative/group purchasing organization (GPO)
Call distributors to discuss pricing and contract terms
Negotiate and monitor individual and GPO contracts for compliance
Monitor prices of other sources for drugs
Maintain records for all drugs
Procure drugs that are on national backorder (e.g., vinblastine, leucovorin)
Track drug replacement from manufacturer for select patients
Reconcile drug purchases and utilization monthly
Review drug charges to ensure drug charge capture
Review single dose vial billing
Compare targets for drug use with contracts
Conduct quarterly meetings with distributors

Oral Therapeutics

Oral Therapeutics: Writing prescriptions for oral oncolytics and supportive therapy, ordering and maintaining supplies of oral therapeutics, and completing specialty pharmacy forms.

Oral Therapeutics
Write prescriptions for oral oncolytics and supportive therapy
Order and maintain adequate supply of oral therapeutics
Complete specialty pharmacy forms
Interview prospective specialty pharmacies (dictated by payer)
Manage between specialty pharmacies

General Practice Management and Payer Contracting

Human Resources Management – Operational: Performing key functions such as hiring, training, career development, employee relations, and payroll for all administrative, information technology (IT), and building staff. Also involves monitoring efficiencies in the practice, as well as problems with patient flow.

Human Resources Management – Operational
Supervise day-to-day activities for administrative, IT, maintenance, and other operational staff
Manage all hiring, employee benefits, annual reviews, disciplinary, or other human resources activities for operational staff
Monitor practice efficiency and patient flow using patient satisfaction surveys
Mediate clinical staff conflicts

Human Resources Management – Clinical: Performing key functions such as hiring, training, career development, employee relations, and payroll for all clinical staff. Also involves monitoring efficiencies in the practice, as well as problems with patient flow.

Human Resources Management - Clinical
Supervise day-to-day activities of clinical staff
Manage all hiring, employee benefits, annual reviews, disciplinary actions, or other human resources activities for clinical staff
Monitor practice efficiency and patient flow using patient satisfaction surveys
Mediate clinical staff conflicts

Facilities Management (Excludes Pharmacy): Maintaining overall operations of the facility by ensuring that the building is cleaned properly, monitoring the performance of contractors, and responding to maintenance issues.

Facilities Management (Excludes Pharmacy)
Manage overall building maintenance and upkeep
Coordinate office cleaning and appropriate disposal of waste

Electronic Medical Record (EMR) Management: Training staff on the EMR system to maximize functionality and value of EMR system, entering clinical information into the system, remaining abreast of EMR updates, and providing IT support to ensure system is properly working.

EMR Management
Maintain day-to-day operability of EMR system
Input patient information into the EMR system
Train end users and super users of EMR system
Maintain IT support for EMR system
Scan hard copy documents into the EMR system from labs and other outside materials
Conduct chart audits

General Financial Management: General management of an oncology practice that includes financial reporting, and practice leadership meetings.

General Financial Management
Complete and analyze financial statements and other financial reports
Validate all reports used for tax and other business-related activities
Coordinate meetings with practice leadership and/or partners

Business and Strategic Planning: Projecting expansion, exploring opportunities, and conducting market analysis, referral networks, and clinic design.

Business and Strategic Planning
Perform market analysis of regional oncology environment
Coordinate expansions with hospital executives and other representatives
Develop new physician referral network
Plan new clinic design and logistics to move to new space

Payer Contracting: Negotiating with payers to secure fair and reasonable reimbursement terms for services rendered and drugs administered to patients.

Payer Contracting
Negotiate favorable terms with private payers for professional services
Negotiate single case agreements with non-contracted payers
Secure separate payment terms for drugs
Remain educated about quarterly average selling price changes and other drug pricing issues

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