The Dinosaur Lives: How a Solo Medical Oncology Practice Survives

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I have had a solo medical oncology and hematology practice in Chico, California since 1992. Chico is 120 miles north of San Francisco in a hot, dry valley, and the surrounding area is semi-rural. The medical service area population is 250,000. The community has a nonprofit 225-bed acute-care hospital. Chico has

one other medical oncology/hematology practice composed of two doctors. We all share call.

Three years ago, in collaboration with our radiation oncologists and the hospital, we built a 40,000 square-foot free-standing comprehensive cancer center located three blocks from the hospital campus. The center contains radiation oncology, the hospital's outpatient infusion center, and both of the area's medical oncology practices. It also contains a patient resource library, a retail shop for patients, and social support services. The other practice uses the hospital infusion center for the majority of their infusion therapies. Our office provides comprehensive care including a hematology laboratory and an infusion center with six chairs. We employ four infusion nurses.

By offering extensive patient education, preemptive intervention, support, follow-up, and proactive management of treatment-related toxicities, I have effectively eliminated the inpatient hospital portion of my practice. My time is most efficiently spent in the office. Patients starting on new treatment plans undergo in-depth education by the nursing staff. Patients are given individual binders containing detailed information about their disease and treatments. They keep logs of their treatments, laboratory tests, side effects, etc. They are instructed in ways to manage side effects of treatments, including when it is essential for them to call us. Our staff regularly calls any at-risk patients so that we can intervene as problems develop. Patients requiring antiemetic therapy and IV fluid support are treated in the office, on a daily basis if need be. Antibiotics are often administered in the office. Growth factors are given pursuant to established guidelines and treatment protocols. All of this minimizes calls in to the office and maximizes efficient use of nursing time.

My charge nurse is responsible for ordering drugs, and we use the Lynx system. Most of our drugs come from a major national vendor, but we are members of several group purchasing organizations, and at least once a month we review acquisition pricing for most, if not all, high-volume drugs and

supplies. We also monitor inventory control at least monthly. We practice therapeutic interchange where it is appropriate and is clinically inconsequential. The nurses prepare the drugs for their own patients on treatment days after blood counts have been checked and patients are cleared to be treated. The nurses schedule the patients for treatments.

We have created a unique printed order sheet for every treatment regimen that we use. That sheet includes pertinent laboratory data, the treatment prescription with a cross-check to confirm proper drug dosing, post-treatment prescriptions, and subsequent scheduling of appointments, tests, etc. Each component of the treatment regimen has columns in which the start and stop times of infusion are noted, and this is cross-walked to the corresponding G-code for the type and mode of therapy administered.

Our full-time front office staff comprises four people. My wife is my practice manager, and she employs a primary billing person who is also responsible for payment posting. An administrative assistant, the primary receptionist, is responsible for all insurance authorizations prior to any treatment. This assistant is also primarily responsible for patient scheduling, testing, and consultative referrals. A medical assistant is responsible for the clinical laboratory, and the medical assistant also prepares patients for me to see. She triages clinical calls to the nurses and to me, handles a variety of non-clinical or administrative tasks, and is a flex front-office staffer. A part-time file clerk ensures that all pertinent chart documentation is up to date daily. Transcription is done off site. I dictate a clinical note on every patient immediately upon completion of the visit, and that note serves as a communication tool to referring physicians as well as intra-office staff. It is also the basis for service documentation for billing.

We have one general office staff meeting every month. Our approach is very much collaborative to find ways to increase everyone's efficiency. With the advent of the G-codes this year, we initially had weekly meetings with the nurses, manager, biller, and me to be sure that we all understood the proper way to code our services. The manager, biller, and I performed chart audits weekly to ensure compliance. Now, those meetings are on an as-needed basis, although we still do random chart audits every week or two. We are finding few if any errors.

Under the current reimbursement system, it is essential for us to collect the Medicare 20% co-pay for drugs and services. The capture rate for the 2005 Medicare Demonstration Project for chemotherapy treatments is 100%. Medicare comprises 50% of my practice; MediCal (California's name for the Medicaid program) is 5%, and the remainder is commercial. We currently have no HMOs in our area. In the event that a

patient has neither coverage nor funds for the co-pay, treatment is moved to the hospital infusion center. I still provide the physician evaluation and management services in the office, and oversee their treatments at the hospital infusion center next door. Thankfully, our hospital has a foundation that is well endowed and has funds available to help patients who are uninsured or underinsured.

Unfortunately, we have had to suspend our relationship with two cooperative groups for clinical trials. The cost of providing data management simply became prohibitive. For the future, I am anxious to see the evolution of electronic medical record systems for medical oncology. An EMR would be enormously cost saving in terms of the direct costs of RN salaries for time spent in chart documentation. When linked to laboratory and radiology services, it would improve charting efficiency. Improvement in communications among providers and the ability to retrieve data are other obvious benefits.

In the ideal world, if there were a universal competitive acquisition program (CAP) that completely addressed all of the concerns noted in the recent ASCO comments, that actually worked, I would strongly consider participation. Clearly, the CAP will impose an administrative burden significantly in excess of our current method of drug procurement and disbursement. As a solo practitioner, my biggest financial concern is my personal liability for under-reimbursed drug costs. If all drugs used in my clinic were provided by a perfectly functioning CAP system, my total liability would not be greater than my cost for an employee to administer the program in my office. I could budget for that. However, I cannot imagine that such will be the case, and I suspect that it will be quite some time of trial and error

before this system is even reasonably functional, if indeed that ever occurs. Thus, we need to look at ways to maintain access to drugs under the current system in the most cost-efficient way possible. This may involve new business relationships with larger partners in which volume discounting makes drugs affordable, so that we can continue to serve our patients.

It is essential for every practitioner to be personally engaged as a patient advocate at the every level. Even while managing this busy practice, I have had the honor to serve as the immediate past president of the Association of California Oncologists, and I remain on the Board of Directors. I am immediate past chair of the ASCO Clinical Practice Committee (CPC), and I remain a member of the CPC and the CPC Steering Committee. I have been our Medicare CAC representative for several years. I sit on several hospital committees. I have engaged in advocacy with our local Congressional representative on a number of occasions in terms of personal visits to his office here in Chico and in Washington; he and his wife and his staff have visited my office and our cancer center; and we have organized town hall meetings with him.

We all face serious challenges in our ongoing ability to provide the level of care for our patients that we've come to expect over the years. In addition to the funding cuts for cancer care specifically, all of medicine in the country now faces potential draconian cuts in Medicare reimbursement on the basis of the sustainable growth rate formula. It is imperative that each and every one of us remain or become involved in advocating at our local level and through our state and national professional societies, for our ability to continue to provide the finest health care in the world for our patients.