



# **Changes in Oncology Practices in the First Quarter of 2005**

## **Survey of Oncology Nursing Society Members:**

### **Are Changes In Medicare Reimbursement For Drugs Implemented In 2005 Influencing Oncology Practice?**

Prepared for:

**The Global Access Project**  
in collaboration with  
**The Oncology Nursing Society**

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**THE MORAN COMPANY**

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This project could not have been carried out without the support and assistance of ONS staff and members. While ONS made critical contributions to the survey process and the content of the survey instrument, the final instrument, the data analysis and conclusions are the sole responsibility of The Moran Company. The authors would also like to thank: the Global Access Project and its contractor, The Lewin Group, for their guidance and assistance in obtaining comments on draft reports; and the National Patient Advocate Foundation for funding the study.

## EXECUTIVE SUMMARY

In January 2005, the Centers for Medicare and Medicaid Services (CMS) implemented changes to the Medicare program contained in the Medicare Modernization Act (MMA) that reduced reimbursement for drugs and increased reimbursement for drug administration in physician offices and certain other health care settings. The Global Access Project (GAP) has been concerned about how these changes in economic incentives are influencing provider behavior in offering drugs and related care to patients. Patients undergoing chemotherapy represent a group likely to experience the immediate impact of these policy changes. Acting as an agent for the Global Access Project, the National Patient Advocate Foundation (NPAF) retained The Moran Company to conduct a study with the cooperation of the Oncology Nursing Society (ONS) to examine the experience of oncology practices across the country by surveying oncology nurses in both inpatient and outpatient settings.

The study is based on a survey that was conducted during April, 2005, and inquired about changes seen by oncology nurses in their practice settings during the first quarter of 2005, compared to experience in 2004. Questions explored changes in each practice's:

- Scheduling of treatment and prescribing of drugs;
- Purchase and storage of drugs;
- Referrals for chemotherapy to hospitals;
- Personnel and practice structure;
- Patient volume and payer mix,
- Relationship to research and clinical trials;
- Policies related to insurance and accepting new patients;
- Perceptions about the financial impact of reimbursement changes; and
- Other aspects of change in nurses' jobs and practice operations.

In addition, the survey queried nurse opinions on patient concerns about these processes and any changes that have taken place.

The findings in this survey of oncology nurses across the United States suggest that some level of change in oncology practices is occurring and may be attributable to the 2005 Medicare drug reimbursement rule changes. All conclusions must be understood as tentative because this is the first time this survey has been conducted and no baseline exists as a basis for comparison. Clearly, at the front lines of clinical practice where oncology nurses work with patients they report heightened sensitivities to reimbursement for drugs and administration of drugs. Respondents articulate increased attention to the role of reimbursement in decisions about where patients are treated and what drugs they receive. Many nurses, particularly those in office based settings, perceive their involvement in financial matters as increasing. In interpreting these survey results, it is important to remember that oncology practice changes are presented through the perspective of nurses, and so operations that may have been handled without nurse involvement in the past may present themselves as changes now, due to the integration of nurses into those operations.

In designing the survey, the authors hypothesized that decreases in payment levels for drugs and increases in drug administration payments in the Medicare program would create economic incentives to encourage oncology practices to make changes in the use of certain drugs. Based on economic hypotheses alone, we would expect practices to decrease the use of drugs for which substantial payment decreases are not offset by increases in drug administration payments, and

possibly to increase use of drugs that result in larger drug administration payments. Of course, we recognize that the practice of medicine is complex and that provider behavior does not respond solely or primarily to economic incentives. However, the types of increases in infusions, patient visits, and staff time, and changes in scheduling reported in this survey tend to confirm these hypotheses, at least in part. Office based practices are reporting increased financial screening of patients and the influence of reimbursement levels on the choice of drug. They are also reporting increased referrals to hospitals for both outpatient and inpatient chemotherapy when reimbursement, including specifically Medicare reimbursement, is inadequate. Hospital based respondents confirm that these referrals from office settings are increasing, particularly for uninsured and Medicaid patients, but also for patients with Medicare only coverage. Anecdotally, inadequate reimbursement is identified in private insurance and HMOs as well as in public programs. Half of the office based nurse respondents report having been informed by their practice management that private insurers are aligning payment policies with Medicare. These reports appear to be consistent enough that they cannot be disregarded as entirely based upon changes in the perceptions of nurses due to shifting of responsibilities.

Patient concerns, as reported by nurses, are consistent with increased referrals to hospitals for chemotherapy and more frequent physician office visits. The associated waiting time, increased travel and changes in providers are perceived as disrupting optimal care and inconveniencing seriously ill patients. Office based respondents also report many types of “staffing up” to adapt to changes in reimbursement and related documentation requirements. These reports suggest incremental cost increases to practices associated with staff time to:

- Offer financial counseling and assist in applying for financial aide for patients;
- Gain authorizations for drugs and treatment;
- Arrange/schedule treatment regimens taking reimbursement as well as clinical concerns into account;
- Mix, transport, store, purchase and account for drugs; and
- Handle additional paperwork to support claims, billing audits, and other associated tasks.

The survey does not indicate that reimbursement rule changes have had much, if any, influence on clinical trials or research. It provides little evidence to suggest that Medicare patients are being turned away or refused care in oncology practices. More increases and expansions in practices are reported than closures or financial distress and there is no evidence to suggest that the mix of growing and troubled practices is substantially influenced at this time by changes in Medicare reimbursement for drugs

Many practices only began to see the effects of the Medicare drug reimbursement rule changes as their January and February claims were processed. Lags in reimbursement and claims processing may have delayed awareness in some settings of the full impact of the rule changes. Other respondents reported that their practices anticipated the rule changes by adding staff, increasing infusion capacity, putting patient screening practices into place, and otherwise making adaptations based on what they believed would happen when the rules were implemented. Whether or not what the managers of these practices believed would happen actually did transpire is masked by the fact that these practices already modified various procedures to be consistent with those beliefs.

The survey findings indicate that some reported changes—particularly increasing referrals for chemotherapy to both inpatient and outpatient hospital settings for Medicare patients and selecting drugs based on reimbursement—are probably real responses by oncology practices to reimbursement policy changes. It is not clear the extent to which these changes cause disruptions to access, quality, or continuity of care. This study only examines the perceptions of change on oncology practices where chemotherapy represents a course of treatment highly dependent upon drug administration. We cannot extrapolate from these findings to other health care settings in which affected drugs may have a different role in the delivery of care.

## **INTRODUCTION**

In January 2005, the Centers for Medicare and Medicaid Services (CMS) implemented changes to the Medicare program contained in the Medicare Modernization Act (MMA) that reduced reimbursement for drugs and increased reimbursement for drug administration in physician offices and certain other health care settings. The Global Access Project (GAP) has been concerned about how these changes in economic incentives are influencing provider behavior in offering drugs and related care to patients. Patients undergoing chemotherapy represent a group likely to experience the immediate impact of these policy changes. Acting as an agent for the GAP, the National Patient Advocate Foundation (NPAF) retained The Moran Company to conduct a survey to examine the experience of oncology practices across the country as these policy changes are implemented.

The Oncology Nursing Society (ONS) agreed to provide access to its members as a group of survey respondents working at the front lines of oncology practice across the United States. Oncology nurses interact closely with both physicians and patients, and in most instances are responsible for providing drug administration and documentation. Therefore, the GAP study sponsors agreed that these individuals would be well positioned to report on the decision making about drugs and related health care occurring in oncology practices in both office and hospital based settings. Working closely with ONS staff and advisors, The Moran Company developed a detailed survey which was sent to a random sample of ONS members.

The survey indicates in its introduction that its purpose is to examine the effects on oncology practices of changes in Medicare payment policy. However, the text of most questions inquires about a variety of specific changes in oncology practices without implying a specific causal relationship to changes in Medicare. Respondents are asked to compare experience during the first few months of 2005 to experience in 2004. Respondents were assured anonymity at both the individual and practice level. The intent was that nurses would represent oncology practices in both hospital based and non-hospital based settings and that the oncology practice is the unit of analysis.

## **HYPOTHESES GUIDING THE ANALYSIS**

The GAP is generally concerned that changes in reimbursement may alter economic incentives in a manner that has the potential to create disruptions in access, continuity, and/or quality of care. The survey was designed to inquire about changes in oncology practices during the first three months of implementation of the reimbursement changes. The Medicare reimbursement changes that provide the focus for this survey decrease the reimbursement rates for certain drugs that are administered to patients in physician offices, clinics, or other ambulatory care settings. At the same time reimbursement rates are increased for certain types of drug administration.

The study was designed based upon the hypothesis that healthcare providers will examine the costs of purchasing drugs and compare those costs to reimbursement levels in making a variety of decisions. If the decreases in reimbursement are large enough for certain drugs:

- Some providers might discontinue offering those drugs to patients;
- Some providers might consider the adequacy of reimbursement levels in prescribing certain drugs for patients;

- Some providers might refer patients to other settings where the preferred drug is available and covered by the patient's insurance; or
- Some providers may adapt their purchasing, storage, staffing, scheduling and other practices to become more efficient or offset losses in revenue due to changes in drug reimbursement. Some of these changes in practice may have a variety of effects on patients.

Since reimbursement levels were increased for some drug administration services, we would also hypothesize that:

- Some providers might increase their capacity to administer certain drugs (e.g., infusions); or
- Some providers might consider reimbursement levels for drug administration services in prescribing certain drugs for patients.

These hypotheses are purely based upon assumptions that provider behavior is influenced by reimbursement levels. Clearly many other factors have considerable influence upon provider behavior and decision making regarding patient care.

## **THE SURVEY**

The survey was sent to 4000 ONS members in early April 2005, and responses were accepted through the middle of May. Respondents are registered nurses employed full time in oncology practices in office based and hospital based settings. Because certain questions require a comparison between responses of hospital based and office based respondents, the ONS drew separate random samples for each group. The random samples drawn included 1625 hospital based nurses and 2375 office based nurses. A detailed description of survey development and methodology is included in Appendix A. The survey instrument itself is provided in Appendix C.

A total of 924 responses (23 percent of total mailing) were received and entered into a database. Forty-six responses were deleted from the database for various reasons. The final database used for the analyses in this report included 878 surveys: 303 hospital based nurse respondents and 575 office (non-hospital) based nurse respondents. These response numbers are statistically representative of the universe of ONS members and support generalization of results with the following qualifications:

- Nurses were selected to report actual changes in practice and may not have complete information for all questions;
- Responses may include some duplication of practices, particularly with respect to very large practices;
- We have no way of knowing the extent to which ONS membership represents the breadth of oncology practices in the United States.

## RESPONDENT AND PRACTICE CHARACTERISTICS

Office based (non-hospital) nurses provided a somewhat higher response rate than hospital based nurses. Respondents identified their primary role in the oncology setting as shown in Table 1 and their practice site as shown in Table 2. The roles of nurses responding to the survey are nearly the same in both respondent groups.

**Table 1. Role of Respondent in Practice Setting**

Role of Respondent	Total Sample		Hospital Based		Office Based	
Staff Nurse	569	65%	191	63%	375	65%
Manager/Administrator	191	22%	65	21%	127	22%
Research	19	2%	12	4%	8	2%
Nurse Practitioner	96	11%	33	11%	64	11%
Unidentified	3	<1%	2	1%	1	<1%
Total Sample	878		303		575	

**Table 2. Practice Settings Represented by Respondents**

Practice Setting	Hospital Based		Office Based	
Private Practice			297	52%
Private clinic/infusion center			269	47%
Free standing public/govt. clinic			9	1%
Private for-profit hospital	42	14%		
Academic medical center	98	32%		
Govt. operated hospital	21	7%		
Non-profit community hospital	142	47%		
Total Sample	303		575	

Respondents were asked to characterize the structure of the organizations within which they practice in terms of the spread of sites. When organizations have multiple sites, the respondents were directed to report answers to questions in the survey only for the site they work in most of the time or know best. The information on organizational structure is shown in Table 3. Respondents were also asked to indicate whether or not their practices participated in clinical trials. That information is shown in Table 4.

**Table 3. Organizational Structure**

Organizational Structure	Hospital Based		Office Based	
Single Location	175	58%	241	42%
Multiple locations in same metro area	64	21%	165	29%
Multiple locations in state or multi-state	55	18%	162	28%
Not identified	9	3%	7	1%

**Table 4. Clinical Trials at Practice Site**

Clinical Trials at Site	Hospital Based		Office Based	
Yes	240	79%	476	83%

The geographic distribution of respondent oncology practice sites is shown in Table 5.

**Table 5. Geographic Distribution**

State	Total Sample	Hospital Based	Office Based
AK	0	0	0
AL	9	2	7
AR	9	2	7
AZ	11	4	7
CA	67	23	44
CO	10	5	5
CT	19	4	15
DC	1	1	0
DE	0	0	0
FL	57	9	48
GA	26	6	20
HI	2	1	1
IA	14	3	11
ID	4	3	1
IL	41	14	27
IN	30	8	22
KS	17	5	12
KY	11	3	8
LA	15	7	8
MA	18	13	5
MD	18	11	7

<b>State</b>	<b>Total Sample</b>	<b>Hospital Based</b>	<b>Office Based</b>
ME	6	4	2
MI	27	12	15
MN	14	6	8
MO	24	5	19
MS	4	0	4
MT	3	1	2
NC	28	15	13
ND	2	1	1
NE	10	4	6
NH	6	4	2
NJ	27	9	18
NM	4	2	2
NV	5	0	5
NY	49	20	29
OH	40	23	17
OK	5	1	4
OR	12	3	9
PA	52	22	30
RI	0	0	0
SC	13	2	11
SD	0	0	0
TN	39	9	30
TX	42	9	33
UT	5	1	4
VA	24	4	20
VT	2	2	0
WA	17	10	7
WI	29	8	21
WV	3	1	2
WY	2	1	1
Unidentified	5		
Rural	134	62	72
Urban	679	224	455
Not Specified	65		

## CHANGE REPORTED IN SCHEDULING, REFERRAL AND PATIENT FLOW IN 2005

In oncology care settings, patient visits may be complex, involving a combination of assessment by physician or nurse, infusion or other administration of medications, patient education and interaction with clinicians related to management of the side effects of treatment. Different medication regimens require appointments of different lengths, so changes in medications may require the practice to make adaptations in scheduling. Respondents report a variety of changes made in their practice settings either since January 1, 2005, or late in 2004, in anticipation of changes in Medicare drug reimbursements. The changes reported are shown on Table 6. Respondents may have checked more than one response for items b-h.

**Table 6. Scheduling Changes in Oncology Practice Settings since January 2005**

Has your practice made changes in scheduling patients?	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware of any changes.	114	38%	156	27%
b) Consolidating days on which chemotherapy is given	21	7%	54	9%
c) Using drug regimens with weekly administration schedules more frequently	73	24%	128	22%
d) Increase in number of visits scheduled per patient	49	16%	101	18%
e) Separating physician visits from chemotherapy visits	70	23%	136	24%
f) Treatments delayed due to waiting for authorization from insurers	51	17%	247	43%
g) Longer treatment appointments due to drugs that require longer administration times	114	38%	246	43%
h) Other—describe	46	15%	110	19%
Respondents reporting one or more types of change	185	61%	420	73%

Office based practices reported a somewhat higher level of change than hospital based informants. Well over half of each group reported changes in scheduling for patient visits. Responses to “d” and “e” suggest that changes in scheduling will lead to increases in the volume of visits per patient. Scheduling changes appear to focus on ensuring that all reimbursements can be captured by the practice.

When reimbursement policies differ in different sites of care, providers may change referral practices to ensure patients get optimal treatment at locations that accept the coverage and payments for needed care. Changes in site of care can raise a variety of concerns for patients. The survey asked hospital based and office based nurses to comment on any changes they observed in referral policies. Respondents were to check all answers that apply and some may have checked more than one between b and g. Respondent observations about changes in referral practices are summarized in Table 7.

Office based respondents indicated greater awareness of change than hospital based respondents, with more than half reporting some sort of changes in referral practices. However, both groups’ descriptions of change were consistent with each other and suggest some increase in referrals to hospitals for both outpatient and inpatient chemotherapy. This finding is consistent with the

hypothesis that changes in reimbursement levels for drugs could result in providers referring more patients to hospital settings to achieve optimal treatment.

Some office based respondents provided additional information about increased referrals to hospital outpatient clinics. The numbers of respondents who specifically identified the insurance status of the patients being referred to hospitals more often in 2005 are shown below:

- Medicare in general: 29
- Medicare without supplement: 81
- Medicare & Medicaid: 17
- Medicaid: 41
- Various private insurers: 11
- Various HMOs: 8
- Military health plans (CHAMPUS or Tricare): 4

Twenty respondents also indicated that referrals to hospital clinics were being made in 2005 for specific drugs and quite a few noted that referrals to the hospital depended on adequate coverage of the drug needed. Of the 83 respondents indicating that referrals for inpatient chemotherapy had increased in 2005, 19 reported that these referrals were primarily for Medicare patients with no supplemental insurance. Many of these respondents noted that uninsured and Medicaid patients are increasingly referred for inpatient chemotherapy.

**Table 7. Changes in Referral Practices or Policies**

Changes in referral practices or policies	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware of any changes in 2005 compared to 2004.	167	55%	252	44%
b) Referrals to hospital clinics for chemotherapy increased.	73	24%	223	39%
c) Referrals to hospital clinics for chemotherapy decreased.	7	2%	15	3%
d) Referrals for inpatient chemotherapy increased.	28	9%	83	14%
e) Referrals for inpatient chemotherapy decreased.	12	4%	16	3%
f) Referrals of un-/under-insured patients to government operated hospitals increased <sup>1</sup>	n/a		184	32%
g) Other—describe	28	9%	37	6%
Respondents reporting one or more types of change	108	36%	321	56%

<sup>1</sup> This question was not asked of hospital based respondents. Analysis of other questions that address patient mix in hospital based clinics, however, shows that hospital based oncology nurses are seeing more un-/under-insured patients in government hospitals or are seeing fewer of these patients in private hospitals.

## CHANGE IN ADMINISTRATION OF CHEMOTHERAPY & RELATED DRUGS

Comments written on many surveys indicate that oncology practices are paying increasingly close attention to the adequacy of payment for drugs and their administration, both in terms of insurance reimbursement rates and patient ability to manage out-of-pocket expenses. Respondents were asked if their practices had made any changes in 2005 in the acquisition of chemotherapy and/or therapeutic drugs. Responses are summarized in Table 8.

Office based respondents reported many more changes than hospital based respondents. In quite a few cases, hospital based staff indicated in comments that they were not familiar with acquisition practices in their hospitals as these were handled in separate pharmacy departments.

Recall that 42 percent of office based respondents were single-office practices. Small practices may have more limited options in purchasing drugs than larger practices.

**Table 8. Changes in Acquisition of Chemotherapy & Other Therapeutic Drugs**

Type of change in acquisition of drugs in 2005	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware of any changes.	153	50%	88	15%
b) Selection of one drug over another based on cost to practice and reimbursement level	98	32%	322	56%
c) Selection of one drug over another based on out-of-pocket cost to patient	41	14%	131	23%
d) Patients are asked to fill some prescriptions for supportive management and bring drug with them to be administered in office/clinic.	36	12%	96	17%
e) Patients are asked to fill some prescriptions for chemotherapy and bring the drug with them to be administered in the office/clinic.	5	2%	48	8%
f) Increase in practice acquisition of generic drugs	32	11%	172	30%
g) Practice is negotiating with suppliers to obtain better prices	64	21%	396	69%
h) Practice stopped offering selected drugs due to inadequate reimbursement	18	6%	122	21%
i) Practice keeps less stock on hand and orders more frequently	54	18%	317	55%
j) Other—describe	22	7%	62	11%
Respondents reporting one or more type of change	148	49%	485	84%

More than half of the office based respondents indicated that their practices were making choices of drugs based upon cost and reimbursement rates to the practice. The survey asked respondents answering this question to explain their answers. Of the 322 office based respondents reporting this type of change, 20 percent explained an increasing frequency in selecting certain drugs and 14 percent indicated a decreased use in selecting certain drugs due to reimbursement levels. The specific drugs mentioned in order of frequency mentioned are: Aranesp (17), Procrit (12), Aredia (11), Anzemet and Taxol (10), Taxotere (9), Aloxi and Zofran(8), Neulasta and IVIG (5). Other drugs mentioned more than once include: Zoladex, Folfox 4, Zometa, Carbo, Kytril, Cisplatin,

Neupogen, Herceptin, Taxanes, Sandostatin, Gemzar, and antiemetics. A description of these drugs and the conditions for which they are prescribed is provided in Appendix B. Not all respondents reporting selection of drugs based upon reimbursement provided this detailed information. About 10 percent of respondents indicated that these selections were made primarily for Medicare patients. A few indicated Medicaid, selected HMOs and a few specific insurers as reasons for choosing one drug over another based on reimbursement.

Respondents reporting selecting drugs based on out-of-pocket cost to patients described many of the same drugs noted above and indicated that patients with Medicare, Medicare HMOs, and Medicaid were most often subject to these choices of drugs. Hospital respondents also reported choosing drugs based on reimbursement or patient out-of-pocket costs involving the same drugs mentioned above.

Respondents were then asked whether or not changes in drug acquisition contributed to changing other aspects of oncology practice. Office based respondents reported change twice as often compared to hospital based respondents. Office based respondents reported a greater impact on resources for authorizing/documenting treatments related to reimbursement, and delays in scheduling related to stocking/ordering drugs. Office based respondents (41 percent) also reinforce the data that suggest that changes in reimbursement for drugs result in increased referrals from office based settings to hospitals for treatment. Paraphrased comments written several times in relation to this question include: *patients get treatments that are reimbursed; requires additional staff time in pharmacy, for documentation, or for transporting drugs; delays in treatment and rescheduling due to availability of drugs; and, we try to get patients into drug trials where that is possible.* Responses are summarized in Table 9.

**Table 9. Changes in Oncology Practice Based on Changes in Acquisition of Drugs**

Changes in Oncology Practice in 2005, if changes in drug acquisition practices were described.	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware of changes in oncology practice or staffing related to changes in drug acquisition.	127	42%	144	25%
b) Cannot offer patients most effective treatment options	10	3%	34	6%
c) Can offer new more effective treatment options	11	4%	22	4%
d) Increased staff time needed for authorizations and claims documentation for reimbursement.	59	19%	255	44%
e) Some patients are referred to hospitals if the insurer does not provide adequate reimbursement.	n/a		237	41%
f) Low stock leads to changes in scheduling treatments and some treatment delays	34	11%	158	27%
g) Other—describe	8	3%	32	6%
Respondents reporting one or more types of change	99	33%	388	67%

Respondents were also asked about the influence of any changes in drug reimbursement on their practice's participation in clinical trials or research protocols. Few respondents reported significant changes. Of those who supplied written comments, some office based practices indicated increased staffing and plans to participate in clinical trials. Other comments described

increased time required of research staff to find financial assistance for patients participating in research. These responses are summarized in Table 10.

**Table 10. Influence of Change in Drug Reimbursement on Participation in Clinical Trials**

Do changes in drug reimbursement in 2005 influence participation in clinical trials or research protocols?	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware of changes in practice or staffing.	221	73%	416	72%
b) My practice does not participate in clinical trials or research protocols.	35	12%	61	11%
c) Research staff were decreased	9	3%	24	8%
d) Other impact	21	7%	57	10%

### CHANGES IN PATIENT PERCEPTIONS IN 2005

Respondents were asked if the questions and concerns articulated by patients in their practice settings had changed in 2005 compared to 2004. Office based respondents report slightly more concerns expressed by patients, particularly about Medicare reimbursement, increased expectations related to financial counseling, and concerns about having to change provider due to coverage issues. Respondents writing comments to explain patient concerns repeatedly indicated that (paraphrased):

- *Patients are unaware of changes in reimbursement until they receive bills, are advised of higher co-payment, or are referred elsewhere for care;*
- *Patients are upset about high co-payments and in some cases do not fill prescriptions for drugs for supportive therapies;*
- *Patients are upset by having to go to another setting for part of their treatment.*

Responses related to changes in patient concerns in 2005 are summarized in Table 11.

**Table 11. Changes in Patient Questions & Concerns**

Change in patient questions/concerns	Hospital Based (n=303)		Office Based (n=575)	
a) Patient concerns have not really changed since last year.	138	46%	172	30%
b) Patients are asking more questions about how changes in Medicare will affect their chemotherapy treatment.	69	23%	241	42%
c) Patients report waiting longer for appointments for chemotherapy treatment.	39	13%	91	16%
d) Patients report traveling further for chemotherapy treatment.	32	11%	66	11%
e) Patients report concern about quality of treatment because of private insurance coverage or reimbursement.	25	8%	75	13%
f) Patients report concerns about possible changes in provider related to reimbursement.	58	19%	150	26%
g) Patients expect more financial counseling and advice from staff in the practice.	72	24%	224	39%
h) Other—describe	23	8%	59	10%
Respondents reporting one or more type of change	156	51%	396	69%

More than half of all respondents indicate patient concerns regarding changes in Medicare and the impact of those changes on their care. Expectations for financial counseling and advice from staff likely increase the demands upon staff time and practice resources. Concerns about changing provider, traveling longer distances for treatment and longer waits for treatment may have some relationship to the noted increase in referrals to hospitals to ensure coverage of the drugs optimal for treatment.

## CHANGES IN PRACTICE SIZE & STRUCTURE

The survey asked a number of questions to gauge changes in oncology practice operations during the first quarter of 2005. Respondents were not asked to attribute reasons for changes to payment policy, but simply to report them in some detail. Respondents reported changes in the number of patients seen in their practice settings in 2005 compared to 2004 (Table 12). They also reported changes in the mix of patients based on insurance status, and noted changes observed in age mix, cancer diagnoses, and acuity/stage of patients seen (Table 13). They reported any changes in policy related to accepting new patients based on insurance coverage (Table 14). Changes in staffing are described (Table 15) as are changes in the structure of the practice (Table 16).

**Table 12. Number of Patients Seen in the Practice: 2005 Compared to 2004.**

Has there been any change in the number of patients seen in your practice since January 2005	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware of any change	50	17%	137	24%
b) No significant change.	60	20%	161	28%
c) Increase in patients.	167	55%	221	38%
d) Decrease in patients.	18	6%	46	8%
Missing Data	8	3%	10	2%

Hospital based practices report a larger increase in numbers of patients relative to office based practices, though both report increases. Relatively few respondents reported decreases in numbers of patients during the first quarter of 2005. No government operated hospitals reported decreases in patients. Smaller office based practices (single site) reported decreased numbers of patients somewhat more frequently than did larger multi-site practices.

Approximately 70 percent of both hospital and office based practices reported either lack of awareness of change or no change in patient mix based on type of insurance. Hospital respondents reporting changes in mix indicate increases in the insurance types for which office based practices reported increased referrals to hospitals in earlier questions: Medicare only, Medicare with supplement, Medicare & Medicaid, Medicaid, and uninsured patients. The number of respondents reporting change is small. The largest number of respondents reporting change in patient mix—14 percent increase in Medicare patients at hospital based settings—includes all types of hospitals. Office based practices report a mix of increases and decreases in all insurance types and for the uninsured. Reported changes in age mix, cancer diagnosis, and stage/acuity do not suggest any pattern and are reported by relatively few respondents.

The survey inquires about changes in policies regarding accepting new patients based on insurance coverage or lack of such coverage. Few changes in policy regarding new patients were reported by hospital based respondents. Written comments by hospital based respondents indicated some patients are not accepted with specific private insurance and HMOs. Several

hospital based respondents also describe increased efforts to help patients apply for Medicaid or obtain financial assistance to cover drugs.

About 13 percent of office based respondents reported screening new patients based on insurance, 6 percent stopped accepting uninsured patients, and 6 percent stopped accepting Medicaid. In the written comments of office based respondents, the following paraphrased comments appeared repeatedly (more than 10 times):

- *Patients get financial counseling before any treatment is provided.*
- *Patients pay co-pays before treatment, or agree to payment plans.*
- *More effort put into collection of co-pays.*
- *Patients who cannot pay co-pays are sent to the hospital.*
- *The practice has dropped HMOs and private insurance plans that don't have adequate reimbursement.*

**Table 13. Change in Patient Mix**

Type of change in patient mix	Hospital Based (n=303)			Office Based (n=575)		
	#	%	↑↓*	#	%	↑↓*
a) I am not aware of any change.	161	53%		291	51%	
b) No significant change.	49	16%		116	20%	
c) Medicare only	41	14%	↑	39	7%	↑
	1	<1%	↓	36	6%	↓
d) Medicare + Supplement/Medi-Gap				12	2%	*
	22	7%	↑	36	6%	↑
	0		↓	6	1%	↓
e) Medicare + Medicaid				1		*
	38	13%	↑	33	6%	↑
f) Medicaid only				21	4%	↓
	0		↓	7	1%	*
g) Uninsured	28	9%	↑	25	4%	↑
	1	<1%	↓	19	3%	↓
	1		*	30	5%	*
h) Private insurance				48	8%	↑
	43	14%	↑	18	3%	↓
	3	1%	*	37	6%	*
i) Change in age mix				31	5%	↑
	15	5%	↑	12	2%	↓
j) Change in cancer diagnoses seen	12	4%	↓	18	3%	
k) Change in disease stage or acuity	11	4%		26	5%	
Respondents reporting one or more types of change	17	6%		29	5%	
Respondents reporting one or more types of change	90	30%		155	27%	

\* means the practice does not accept these patients. ↓↑ mean decrease and increase respectively.

**Table 14. Changes in Policies about Accepting New Patients**

Has your practice changed policies about accepting new patients since January 1, 2005?	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware that the practice stopped accepting new patients based on insurance coverage since January 2005.	261	86%	425	74%
b) The practice stopped accepting new Medicare patients (with or without supplemental insurance).	0		4	<1%
c) The practice stopped accepting new dually eligible Medicare & Medicaid patients.	0		7	1%
d) The practice stopped accepting new Medicaid patients.	2	<1%	33	6%
e) The practice stopped accepting uninsured patients.	6	2%	34	6%
f) The practice began screening new patients based on insurance coverage.	19	6%	76	13%
g) Other—describe	17	6%	54	9%
Respondents reporting one or more types of change	37	12%	143	25%

More than half of all respondents in both settings reported some kind of change in staffing since January 2005. These changes are summarized in Table 15. Overall, in both groups, more respondents reported staff increases rather than staff decreases. A number of comments were repeated among office based respondents reporting decreases in staffing including, as paraphrased: *hiring freezes, difficulty hiring nurses, not filling positions when people leave, no raises or bonuses recently, more hours not compensated, losses in benefits including vacation and compensatory time*. In office based settings adding staff, many comments referred to the use of various categories of staff to handle patients' insurance, payment, and collection issues. The addition of pharmacists and pharmacy technicians to work with chemotherapy drugs was noted on a write-in basis.

Respondents were asked about specific types of changes in the structure of their practices. Among those reporting some sort of organizational change, the office based respondents reported more “negative” change (e.g., fewer infusions, cut clinic hours, closed sites) than the hospital based respondents. Six hospital respondents noted expansions of current services due to enlarged space, new facilities, and adding chemo chairs. Several hospital respondents indicated moving non-chemotherapy infusion services to another source to expand capacity for chemotherapy in their facilities. Among office based respondents: 11 wrote about plans for expanding facilities and adding services, including pharmacy services; 6 indicated plans for downsizing and cost cutting; 5 indicated exploring or planning mergers; and several indicated beginning or expanding research. Changes in organizational structure are summarized in Table 16.

**Table 15. Practices Reporting Changes in Staffing Since January 2005**

Type of change in staffing. (Arrows indicate increases and decreases reported)	Hospital Based (n=303)			Office Based (n=575)		
	#	%	↑↓	#	%	↑↓
I am not aware of any changes in staffing since January 2005.	137	45%		244	42%	
Change in physicians	41 12	14% 4%	↑ ↓	71 17	12% 3%	↑ ↓
Change in masters prepared nurses/NP/CNS	36 6	12% 2%	↑ ↓	44 16	8% 3%	↑ ↓
Change in RNs	73 6	24% 2%	↑ ↓	84 47	15% 8%	↑ ↓
Change in LPN/LVN	7 1	2% <1%	↑ ↓	16 10	3% 2%	↑ ↓
Change in physician assistants	9 1	3% <1%	↑ ↓	30 2	5% <1%	↑ ↓
Change in nursing assistants	5	2%	↑ ↓	4	<1%	↑
Change in lab/technician staff	20 5	7% 2%	↑ ↓	39 14	7% 2%	↑ ↓
Change in reception/administration	24 3	8% 1%	↑ ↓	50 24	9% 4%	↑ ↓
Change in managers	2 1	<1% <1%	↑ ↓	1 1	<1% <1%	↑ ↓
Change in pharmacy staff				10	2%	↑
Change in hours	30 2	10% <1%	↑ ↓	35 27	6% 5%	↑ ↓
Change in overtime	56 16	18% 5%	↑ ↓	62 75	11% 13%	↑ ↓
Respondents reporting one or more types of change	161	53%		327	57%	

**Table 16. Reported Changes in Practice Structure**

What, if any, changes have occurred in your practice structure in the last 6 months?	Hospital Based (n=303)		Office Based (n=575)	
a) I am not aware of any recent changes in practice structure.	130	43%	268	47%
b) Added clinic hours	47	16%	34	6%
c) Cut clinic hours	1	<1%	20	3%
d) Opened new office/clinic site	21	7%	51	9%
e) Closed satellite office/clinic	2	<1%	28	5%
f) Doing more infusions	114	38%	139	24%
g) Doing fewer infusions	15	5%	40	7%
h) Merged with other practice	6	2%	23	4%
i) Other—describe	28	9%	50	9%
Respondents reporting one or more types of change	168	55%	293	51%

## PERCEIVED FINANCIAL IMPACT OF CHANGE IN MEDICARE REIMBURSEMENT

The survey asked respondents about the extent to which they had been informed by practice managers and others about the impact of Medicare on their practices. Hospital based respondents had received less information than office based respondents, more than half of whom indicated that their practices' finances were negatively affected by changes in Medicare reimbursement. About half the office based respondents indicated they had been informed that private insurers were aligning their payment policies with Medicare, and that this too had a negative financial impact on their practices. Responses are summarized in Table 17.

**Table 17. Perceptions about Changes in Medicare Reimbursement Affecting Practice Finances**

Informed about Medicare and its impact on our Practice's finances	Hospital Based (n=303)					Office Based (n=575)				
			Changes result in <sup>2</sup>					Changes result in <sup>2</sup>		
	Informed #	%	Finan. Stress	Improve	No effect	Informed #	%	Finan. Stress	Improve	No effect
But not about how changes affect finances of practice.	147	49%				109	19%			
Medicare affects acquisition of drugs	64	21%	53	3	5	373	65%	360	3	9
Medicare affects reimbursement for procedures	61	20%	50	3	7	351	61%	324	15	5
Private insurers (not supplement or Medi-Gap) align payments with Medicare	48	16%	45	0	1	290	50%	278	4	5
Respondents reporting one or more type of impact.	93	31%				440	70%			

## RESPONDENT COMMENTARY

The survey provided several places for respondents to elaborate on their answers and provide additional information. For the most part, these comments have been included in the analyses in the body of this report where they are most relevant. In this section, comments that are relevant to understanding the perceived changes in oncology practices are discussed. Comments are paraphrased and reported only when several respondents offer similar information. In both hospital based and office based practices more than half the respondents indicated no substantial change in their jobs since January 2005, and made no additional comments about changes in their practices. The remainder of this discussion summarizes the comments made by approximately one third of all respondents.

Among hospital based respondents, the most common concerns expressed about how nurses' jobs have changed since January 2005 and how reimbursement changes are affecting practice include:

<sup>2</sup> Many respondents did not provide this information. Those that provided the information often checked more than one response. Due to inconsistent response patterns, percentages are not provided.

- *We have less time to spend with patients, less time to provide patient education..*
- *We are spending much more time learning about and managing tasks related to billing and reimbursement.*
- *Private practices in our area are sending more patients to the hospital for infusions and when they cannot afford co-payments. We are seeing more un/under-insured patients.*
- *We are doing more infusions related to other diseases than cancer.*

Office based respondents commented more often than hospital based respondents about changes in their work environment since January 2005. In many of the comments noted below, the change reflected may be that nurses historically were not as involved with administrative and financial matters as is currently required. The most frequent comments included:

- *Major increases in time involved in completing paperwork to justify treatment and billing.*
- *Major increases in time for nurses in obtaining authorizations for treatment.*
- *Major increases in time spent by nurses in researching insurance in relation to deciding whether the patient can be treated at the site or must be referred elsewhere, and in deciding which treatments will be covered.*
- *Increased time spent in training about coding, changes in Medicare reimbursement for drugs, and documentation.*
- *Time spent on reimbursement and documentation takes away from patient care.*
- *Increased time spent by nurses in financial counseling of patients, helping them apply for financial assistance and dealing with their concerns about payment for care.*
- *Increased time spent on cost containment activity.*
- *Increased time spent on audits of billing accuracy.*
- *Increased time spent mixing drugs.*
- *Poor morale, concern about job security, no raises for years, cuts in hours, short staffed, hiring freezes, new staff hired at lower pay, increased responsibility without increased pay, more hours for same pay, etc.*
- *Concerns about quality of care and direction of cancer care in future. Observation that patients are being treated in hospital when they could be at home because of reimbursement rules.*
- *Concerns that non-clinical people (financial staff in practices) are determining whether patients can be treated and how they can be treated based on reimbursement rather than clinical criteria.*
- *Concerns that patients are delaying care, choosing less effective treatments and forgoing treatment due to out-of-pocket costs.*
- *Concerns that nurses are now being held responsible for practice income.*

A number of respondents indicated that they were just beginning to see the impact of reimbursement changes at the time they submitted the survey. They expect to have a better understanding of the real impact in a few more months.

## CONCLUSIONS

The findings in this survey of oncology nurses in outpatient settings across the United States suggest that some level of change in oncology practices is occurring and may be attributable to the 2005 Medicare drug reimbursement rule changes. All conclusions must be understood as tentative because this is the first time this survey has been conducted and no baseline exists as a basis for comparison. Clearly, at the front lines of clinical practice where oncology nurses provide care to patients, sensitivities are heightened in relation to reimbursement for drugs and administration of drugs. Respondents articulate increased attention to the role of reimbursement in decisions about where patients are treated and what drugs they receive. Many nurses, particularly those in office based settings, perceive their involvement in financial matters as increasing. In interpreting these survey results, it is important to remember that oncology practice changes are presented through the perspective of nurses, and so operations that may have been handled without nurse involvement in the past may present themselves as changes now, due to the integration of nurses into those operations.

As noted at the beginning of this report, we hypothesized that decreases in payment levels for drugs and increases in drug administration payments in the Medicare program would create economic incentives to encourage oncology practices to make changes in the use of certain drugs. Based on economic hypotheses alone, we would expect practices to decrease the use of drugs for which substantial payment decreases are not offset by increases in drug administration payments, and possibly to increase use of drugs that result in higher drug administration payments. Of course, we recognize that the practice of medicine is complex and that provider behavior does not respond solely or primarily to economic incentives. However, the types of increases in infusions, patient visits, and staff time, and changes in scheduling reported in this survey tend to confirm these hypotheses. Office based respondents are reporting increased financial screening of patients and the influence of reimbursement levels on the choice of drug. They are also reporting increased referrals to hospitals for both outpatient and inpatient chemotherapy when reimbursement, including specifically Medicare reimbursement, is inadequate. Hospital based respondents confirm that these referrals from office settings are increasing, particularly for uninsured and Medicaid patients, but also for patients with Medicare only coverage. Anecdotally, inadequate reimbursement is identified in private insurance and HMOs as well as in public programs. Half of the office based nurse respondents report having been informed by their practice management that private insurers are aligning payment policies with Medicare. These reports appear to be consistent enough that they cannot be disregarded as based entirely upon changes in the perceptions of nurses due to shifting of responsibilities.

Patient concerns, as reported by nurses, are consistent with increased referrals to hospitals for chemotherapy and more frequent physician office visits. The associated waiting time, increased travel and changes in providers are perceived as disrupting care and inconveniencing seriously ill patients. Office based respondents also report many types of “staffing up” to adapt to changes in reimbursement and related documentation requirements. These reports suggest incremental cost increases to practices associated with staff time to:

- Offer financial counseling and assist patients in applying for financial aide;
- Gain authorizations for drugs and treatment;

- Arrange/schedule treatment regimens taking reimbursement as well as clinical concerns into account;
- Mix, transport, store, purchase and account for drugs;
- Handle additional paperwork to support claims, billing audits, and other associated tasks.

The survey does not indicate that reimbursement rule changes have had much, if any, influence on clinical trials or research. It provides little evidence to suggest that Medicare patients are being turned away or refused care in physician offices. More increases and expansions in practices are reported than closures or financial distress, and there is no evidence to suggest that the mix of growing and troubled practices is substantially influenced by changes in Medicare reimbursement for drugs.

As quite a few respondents note, just as many patients do not experience the effects of changes in reimbursement until they receive bills or referrals to alternate providers, many practices only began to see the effects of the Medicare drug reimbursement rule changes as their January and February claims were processed. Lags in reimbursement and claims processing may have delayed awareness in some settings of the full impact of the rule changes. Other respondents reported that their practices anticipated the reimbursement changes by adding staff, increasing infusion capacity, putting patient screening practices into place, and otherwise making adaptations based on what they believed would happen when the rules were implemented. Whether or not what they believed would happen, actually transpired, is masked by their having already modified practice to be consistent with those beliefs.

The survey findings indicate that some reported changes—particularly increasing referrals for chemotherapy to both inpatient and outpatient hospital settings for Medicare patients and selecting drugs based on reimbursement—are probably real responses by oncology practices to reimbursement policy changes. It is not clear the extent to which these changes cause disruptions to access, quality, or continuity of care. This study only examines the perceptions of change on oncology practices where chemotherapy represents a course of treatment highly dependent upon drug administration. We cannot extrapolate from these findings to other health care settings in which affected drugs may have a different role in the delivery of care.

## APPENDIX A

### SURVEY METHODOLOGY

Prior to the Global Access Project's (GAP) decision to sponsor this study, the Oncology Nursing Society (ONS) had conducted an email survey of its members inquiring directly about the impact of changes in Medicare rules in 2004. When the National Patient Advocate Foundation (NPAF) retained The Moran Company to conduct this survey for GAP, the ONS provided The Moran Company with the results of its 2004 survey. This information, particularly the narrative comments by nurses, was used as a reference in developing the current survey, primarily to determine an appropriate level of detail and language for framing questions about operational change in an oncology practice environment. The Moran Company developed several drafts of the survey, responding to comments from a number of reviewers, including ONS staff. The survey was pre-tested with an advisory group of ten ONS members, and a final revision was made based on pre-test experience.

The Moran Company retained The Resource Group as a subcontractor to handle survey logistics (production, mailing, database development, statistical power analysis). The ONS identified 6932 members in its database that profiled themselves as registered nurses working full time in primary work settings in hospital outpatient clinics and physician (non-hospital) offices. Because it had other member surveys scheduled through the year, ONS restricted the survey sample to 4000 members (58 percent of the possible respondent universe). Because certain questions require a comparison between responses of hospital based and office based respondents, The Moran Company instructed the ONS to draw separate random samples for these groups. The ONS respondent universe was 2816 for hospital based nurses, and 4116 for office based nurses. The random samples drawn included 1625 hospital based nurses and 2375 office based nurses.

Surveys were printed as a four page folded instrument. They were mailed first class with a letter from the ONS leadership and a first class stamped self-addressed return envelope in early April. Respondents were asked to return surveys by the end of April. Surveys were assigned a number for tracking purposes in case follow-up was required to increase the response rate. The numbers were detached from any respondent identification in the database to preserve respondent anonymity.

Survey responses were accepted until May 19, 2005. A total of 924 responses (23 percent of total mailing) were received and entered into a database. Forty-six responses were deleted from the database because they were: blank, new to job and not able to make comparisons between 2005 and 2004, retired or unemployed, or changed jobs and currently not working in an oncology setting. The final database used for the analyses in this report included 878 surveys (22 percent of mailing and 13 percent of ONS respondent universe). Surveys from 303 hospital based nurses are included (19 percent of the mailing and 11 percent of the ONS respondent universe). Surveys from 575 office (non-hospital) based nurses are included (24 percent of the mailing and 14 percent of the ONS respondent universe). These response numbers are statistically representative of the universe of ONS members and support generalization of results with the following qualifications:

- Nurses were selected to report actual changes in practice and may not have complete information for all questions;
- Respondents were asked to consolidate responses when multiple nurses received the survey in the same practice—only a very few did this—so some duplication may be present related to larger practices;

- We have no way of knowing the extent to which ONS membership represents the breadth of oncology practices in the United States.

The Resource Group developed a database in Microsoft Access that replicates the survey instrument, including fields to preserve all text data from written comments. The surveys were entered into the database as they were received. The completed database, including all open-ended comments, was then reviewed and “cleaned” by The Moran Company. Written comments that were difficult to understand due to legibility problems or those not clearly related to the purpose of the survey were deleted. Consistency in data entry was checked and respondents that did not fit the parameters for the survey (e.g., out of work, not working in oncology setting, new to job) were removed from the database. The database was then transferred to Excel and SAS for analysis.

## APPENDIX B

## CHEMOTHERAPY &amp; RELATED DRUGS REFERENCED IN THIS REPORT

Drug or Therapy	Generic Name	Classification	Indication
Aloxi	Palonosetron	Antiemetic	Nausea and vomiting due to chemotherapy
Anzemet	Dolasetron Mesylate	Antiemetic	Nausea and vomiting due to chemotherapy
Aranesp	Darbepoetin	Hematopoietic Growth Factor	Anemia due to chemotherapy, malignancy, end stage renal disease, chronic renal failure, and myelodysplasia
Aredia	Pamidronate Disodium	Inhibition of bone resorption	Hypercalcemia of malignancy, bone metastasis secondary to malignancy, multiple myeloma, Paget's bone disease
Carboplatin (Paraplatin)	Carboplatin	Chemotherapy	Ovarian, testicular, head and neck, cervical, bladder, and lung cancers; brain tumors, BMT (Bone Marrow Transplant), unknown primary, endometrial, esophageal, fallopian tube cancers, melanoma, neuroblastoma, lymphoma, Hodgkin's disease, peritoneal tumors, retinoblastoma and Wilms' tumor
Cisplatin (Platinol)	Cisplatin		Ovarian, testicular, bladder, cervical, breast, lung, prostate, and head and neck cancers, multiple myeloma; Hodgkin's disease, non-Hodgkin's lymphoma, leukemias, Wilms' tumor, brain tumors, tumors of the adrenal cortex, anal cancer, carcinoma of unknown primary, endometrial, esophageal, fallopian tube, and vulvar cancers, Kaposi's sarcoma, cancer of the kidney, skin, liver, penis, stomach, and thyroid, melanoma, neuroblastoma, osteosarcoma, soft-tissue sarcoma, peritoneal tumors, thymoma, and trophoblastic neoplasms
Folfox	Combination chemotherapy regimen consisting of oxaliplatin, folinic acid and 5-fluorouracil (FOLFOX-4)	Chemotherapy regimen	Advanced colorectal cancer Adjuvant therapy for colorectal cancer
Gemzar	Gemcitabine	Chemotherapy	Pancreatic, breast, ovarian, gallbladder, germ cell and bladder cancers; small cell and non-small cell lung cancer in conjunction with carboplatin, paclitaxel, or cisplatin; Hodgkin's lymphoma
Herceptin	Trastuzumab	Monoclonal Antibody	Metastatic breast cancer that over expresses the HER2/neu protein
IVIG	Intravenous Immuno-globulin	Immune globulin	Hypogammaglobulinemia Bacterial infections associated with B-cell chronic lymphocytic leukemia

<b>Drug or Therapy</b>	<b>Generic Name</b>	<b>Classification</b>	<b>Indication</b>
Kytril	Granisetron	Antiemetic	Nausea and vomiting due to chemotherapy
Neulasta	Pegfilgrastim	Granulocyte-colony-stimulating factor (G-CSF)	Maintain white blood cell (neutrophil) levels in patients with cancer and receiving chemotherapy
Neupogen	Filgrastim	Granulocyte-colony-stimulating factor (G-CSF)	Maintain white blood cell (neutrophil) levels in patients with cancer and receiving chemotherapy
Procrit	Erythropoetin	Hematopoietic Growth Factor	Anemia due to chemotherapy, malignancy, end stage renal disease, chronic renal failure, and myelodysplasia
Sandostatin	Octreotide	Antidiarrheal	Diarrhea due to chemotherapy, carcinoid tumors
Taxol	Paclitaxel	Chemotherapy	Ovarian cancer, breast cancer, non-small cell lung cancer, bladder cancer, AIDS-related Kaposi's sarcoma, metastatic melanoma, gastric cancer, acute leukemia, carcinoma of unknown primary, cervical, endometrial, esophageal, fallopian tube, head and neck, peritoneal, prostate, stomach and testicular cancers
Taxotere	Docetaxel	Chemotherapy	Breast, non-small cell lung, head and neck, bladder, esophageal, prostate, stomach and metastatic ovarian cancers.
Zofran	Ondansetron Hydrochloride	Antiemetic	Prevention of nausea and vomiting
Zometa	Zoledronic Acid	Inhibition of bone resorption	Hypercalcemia of malignancy, bone metastasis secondary to malignancy, multiple myeloma, Paget's bone disease

### Sources

Polovich, M., White, J.M., Kelleher, L.O. (Eds.) Chemotherapy and Biotherapy Guidelines and Recommendations for Practice, Second Edition. Oncology Nursing Society, Pittsburgh, PA, 2005

Association of Community Cancer Centers (ACCC) Compendia-Based Drug Bulletin, [http://www.accc-cancer.org/pubs/pubs\\_drugbul.asp](http://www.accc-cancer.org/pubs/pubs_drugbul.asp), August 3, 2005

This Appendix was developed by the Oncology Nursing Society to provide descriptive information about drugs identified in this report.

## APPENDIX C

The survey that follows was formatted and printed as a 4-page folded document.

**ONCOLOGY NURSING SOCIETY  
SURVEY ON CHANGE IN ONCOLOGY PRACTICES BETWEEN 2004 and 2005**

This survey is designed to collect information about changes that may be occurring in oncology practices as a possible result of recent changes in Medicare reimbursement. Your help in providing this information is critical to the ability of ONS and other organizations to advocate based on accurate information. The survey may be repeated in the future. The survey will take 15-20 minutes to complete. You may not have all the information to answer all questions. Answer as many questions as you can. If you can get specific information to answer questions from others, we appreciate that information. Not all changes in your practice will be due to Medicare reimbursement. If you have explanations, please feel free to **print** your comments in space provided. The survey envelope is coded for the purpose of conducting follow-up to increase the response rate. Codes will not be used in the database for analysis and **no responses will be identifiable to individual or practice**. The survey, follow-up, and analysis are conducted by an independent firm (The Moran Company). Only aggregate responses will be reported to ONS. Thank you for your generosity in taking time to complete the survey. Please return the completed survey in the enclosed envelope by 4/29/2005.

**SECTION I. Your Current Situation (April 1, 2005). If you are responsible for more than one setting, select one site (the largest or the one you know the best) for all responses after #2 below.**

1. **You are:** a)  Staff Nurse b)  Nurse Manager/Administrator  
c.)  Other: \_\_\_\_\_
2. **Number of months you have worked in/had responsibility for this location.**  
a)  Less than 6 months b)  6 months to 15 months  
c)  More than 15 months
3. **Practice Setting (check one that most closely describes your setting—if more than one setting, select the largest)**

<u>Physician Office/Clinic Non-hospital</u>	<u>Hospital Based Outpatient/Infusion Center</u>
a) <input type="checkbox"/> Private practice	d) <input type="checkbox"/> Private for-profit hospital
b) <input type="checkbox"/> Private clinic/infusion center	e) <input type="checkbox"/> Academic medical center
c) <input type="checkbox"/> Free standing public or government funded clinic	f) <input type="checkbox"/> Government operated hospital
	g) <input type="checkbox"/> Non-profit community hospital
4. a) **State:** \_\_\_\_\_ b) **Zip Code:** \_\_\_\_\_ c)  **Urban/suburban** d)  **Rural**
5. **Organizational Structure (check one)**  
a)  Single Location b)  Multiple sites same metro area only c)  Multiple sites in state or multi-state
6. **Practice Size (April 2005)**  
a) Number of oncologists in your practice (outpatient): \_\_\_\_\_  
b) Number of patients receiving chemotherapy per day: \_\_\_\_\_ per day  
c) Infusion beds/chairs available per day: \_\_\_\_\_ per day

7. **Staffing (in full time equivalents "FTE") April 2005**
- a) Number masters prepared/NP/CNS nurses: \_\_\_\_\_ d) Number administrative staff (not clinical): \_\_\_\_\_
- b) Number staff RNs \_\_\_\_\_ e) Lab/tech & other clinical: \_\_\_\_\_
- c) Number LVN/LPNs \_\_\_\_\_ f) Physician Assistants: \_\_\_\_\_
8. **Does your practice participate in any clinical trials or research protocols?**
- a)  No
- b)  Yes:

Describe: \_\_\_\_\_

**SECTION II. We are interested in changes in how your practice is managing patient flow and referrals from your practice to other providers since January 1, 2005 (or late in 2004 specifically anticipating changes expected in 2005) compared to most of 2004. You may add any explanatory comments at the end of this section.**

9. **Has your practice made changes in scheduling patients? Check all that apply.**
- a)  I am not aware of any changes.
- b)  Consolidating days on which chemotherapy is given.
- c)  Using drug regimens with weekly administration schedules more frequently.
- d)  Increase in number of visits scheduled per patient.
- e)  Separating MD visits from chemotherapy visits.
- f)  Treatments delayed due to waiting for authorizations from insurers.
- g)  Longer treatment appointments are required due to drugs that require longer administration times.
- h)  Other(s)

Describe: \_\_\_\_\_

10. **OFFICE and NON-HOSPITAL based nurses ONLY. Hospital nurses skip to #11. Has your outpatient practice changed referral policies (from your practice to other providers)? Check all that apply.**

- a)  I am not aware of any changes in 2005 compared to 2004
- b)  Increase in patients referred to hospital clinics for chemotherapy.  
Type of patients (specify the particular insurances and diagnoses/clinical status of patients affected) \_\_\_\_\_
- c)  Decrease in patients referred to hospital clinics for chemotherapy.  
Type of patients (specify the particular insurances and diagnoses/clinical status of patients affected) \_\_\_\_\_
- d)  Increase in patients referred for inpatient hospital chemotherapy.  
Type of patients (specify the particular insurances and diagnoses/clinical status of patients affected) \_\_\_\_\_
- e)  Decrease in patients referred for inpatient hospital chemotherapy.  
Type of patients (specify the particular insurances and diagnoses/clinical status of patients affected) \_\_\_\_\_
- f)  Patients who cannot afford co-payments are referred to city/county/government hospitals for treatment.
- g)  Increase in referral of patients to city/county/government hospitals for evaluation or treatment.
- h)  Other changes in referral policy? Describe:  
\_\_\_\_\_

11. **HOSPITAL based nurses ONLY. Office and non-hospital based nurses skip to #12. Have you seen changes in referrals to your hospital or in your hospital policies related to oncology referrals from office/non-hospital infusion center practices? Check all that apply.**
- a)  I am not aware of changes in referrals to my hospital in 2005 compared to 2004 from other outpatient settings.
  - b)  Referrals from non-hospital settings increased
  - c)  Non-hospital referrals decreased
  - d)  Inpatient. chemotherapy referrals increased
  - e)  Inpatient chemotherapy referrals decreased
  - f)  Policies have changed to address referrals for chemotherapy
- Explain: \_\_\_\_\_
12. **Comments or explanations on #9-11 in this section. Other changes in patient flow or referral in 2005 compared to 2004.**

**SECTION III We are interested in changes in administration of chemotherapy and related therapeutic drugs used in your practice in 2005 as compared to 2004. You may describe changes made late in 2004 in anticipation of expected reimbursement changes in 2005.**

13. **Has your practice made changes in its acquisition of chemotherapy and/or therapeutic drugs? Please check all that apply.**
- a)  I am not aware of any changes.
  - b)  Selection of one drug over another based on cost to practice and reimbursement.
    - c)  Increased frequency? Specify drugs? \_\_\_\_\_ Specify insurers? \_\_\_\_\_
    - d)  Decreased frequency? ? Specify drugs? \_\_\_\_\_ Specify insurers? \_\_\_\_\_
  - e)  Selection of one drug over another based on out-of-pocket cost to patient.
    - f)  Increased frequency? Specify drugs? \_\_\_\_\_ Specify insurers? \_\_\_\_\_
    - g)  Decreased frequency? ? Specify drugs? \_\_\_\_\_ Specify insurers? \_\_\_\_\_
  - h)  Patients are asked to fill some prescriptions for supportive management and bring the drug with them to be administered in the office/clinic. This is a new procedure in 2005, or new for some drugs.
  - i)  Patients are asked to fill some prescriptions for chemotherapy and bring the drug with them to be administered in the office/clinic. This is a new procedure in 2005, or new for some drugs.
  - j)  Increase in practice acquisition of generic drugs in 2005 compared to 2004.
  - k)  Practice is negotiating with suppliers to obtain better prices.
  - l)  Practice stopped offering selected drugs due to inadequate reimbursement. Specify drugs: \_\_\_\_\_
  - m)  Practice keeps less stock on hand and orders more frequently.
  - n)  Other changes. Please describe : \_\_\_\_\_
14. **If you noted changes in #13, have any changes in drug acquisition, inventory, or selection influenced practice and staffing so far in 2005? Please check all that apply.**
- a)  I am not aware of changes in drug acquisition leading to other changes in practice or staffing.
  - b)  Cannot offer patients most effective treatment options.
  - c)  Can offer patients new more effective treatment options. Specify: \_\_\_\_\_
  - d)  Increased staff time needed for authorizations and claims documentation.
  - e)  Some patients are referred to hospitals if insurer does not provide adequate reimbursement. How often does this happen?

- i)  several/week ii)  weekly iii)  monthly iv)  rarely  
 f)  Low stock leads to changes in scheduling treatments and some treatment delays.  
 g)  Others. Please Describe: \_\_\_\_\_

**15. Do changes in reimbursement for drugs impact your practice's participation in clinical trials or research protocols? Please check all that apply.**

- a)  I am not aware of changes in our participation in clinical trials or research protocols so far in 2005.  
 b)  My practice does not participate in clinical trials or research protocols.  
 c)  Research staff were decreased. Explain: \_\_\_\_\_  
 c)  Some impact: Please explain: \_\_\_\_\_

**SECTION IV Patient Concerns**

**16. Please share your perceptions of any changes in patient concerns in 2005 compared to 2004. Please report only concerns coming from multiple patients rather than noting individual complaints.**

- a)  Patient concerns have not really changed since last year.  
 b)  Patients are asking more questions about how changes in Medicare will affect their chemotherapy treatment.  
 c)  Patients report waiting longer for appointments for chemotherapy treatment.  
 d)  Patients report traveling further for chemotherapy treatment.  
 e)  Patients report concern about quality of treatment because of private insurance coverage or reimbursement.  
 f)  Patients report concerns about possible changes in provider related to reimbursement.  
 g)  Patients expect more financial counseling and advice from staff in the practice.  
 h)  Other: Please describe: \_\_\_\_\_

**SECTION V We are interested in recent changes in the size and structure of your practice. For most questions below, compare the first quarter of 2005 to last year's experience. We understand that you may not know some of the information we are asking about.**

**17. Has there been any change in the number of patients seen by your practice since January 2005?**

- a)  I am not aware of any change. b)  There has not been any significant change.  
 c)  Increase in patients. d)  Decrease in patients.

**18. Has there been any change in the mix of patients seen in your practice? Please check all that apply.**

- a)  I am not aware of any change. b)  There have not been any significant changes.  
 c)  Medicare only patients i)  Increase ii)  Decrease iii)  Do not accept  
 d)  Medicare + Supplemental/Medigap. Insurance i)  Increase ii)  Decrease iii)  Do not accept  
 e)  Medicare + Medicaid i)  Increase ii)  Decrease iii)  Do not accept  
 f)  Medicaid only patients i)  Increase ii)  Decrease iii)  Do not accept  
 g)  Uninsured i)  Increase ii)  Decrease iii)  Do not accept  
 h)  Private Insurance i)  Increase ii)  Decrease  
 j)  Change in age mix. Please Describe: \_\_\_\_\_  
 k)  Changes in cancer diagnoses seen. Please describe: \_\_\_\_\_  
 l)  Change in disease stage or acuity. Please describe: \_\_\_\_\_

**19. Has your practice changed any policies regarding accepting new patients since January 2005 or late in 2004 in anticipation of changes in reimbursement expected in 2005?**

- a)  I am not aware that the practice stopped accepting new patients based on any payer since January 2005.
- b)  The practice stopped accepting new Medicare patients (with or without supplemental or MediGap insurance).
- c)  The practice stopped accepting new dually eligible Medicare & Medicaid patients.
- d)  The practice stopped accepting new Medicaid patients.
- e)  The practice stopped accepting new uninsured patients.
- f)  The practice began screening new patients based on insurance coverage.
- g)  Other changes in policy related to new patients: Please describe: \_\_\_\_\_

**20. Have any changes in staffing been made in your practice since January 1, 2005? (or were changes made late in 2004 anticipating changes in revenues expected as a result of changes in reimbursement?) Note: FTE means "full time equivalents" so use fractions if additions or decreases have reduced hours or changes are from full to part time or vice versa.**

- a)  I am not aware of any changes in staffing during this period.
- b)  Added physician(s) (#\_\_\_\_) to the practice
- c)  Physician(s) (#\_\_\_\_) left the practice.
- d)  Added masters prepared nurse/NP/CNS (#\_\_\_\_ FTE)
- e)  Decreased (#\_\_\_\_)masters prepared nurse/NP/CNS
- f)  Added staff RN(s) (#\_\_\_\_ FTE)
- g)  Decreased (#\_\_\_\_ FTE) staff RN(s)
- h)  Added LPN/LVN(s)(#\_\_\_\_ FTE)
- i)  Decreased (#\_\_\_\_ FTE) LPN/LVN(s)
- j)  Added lab/technician staff (#\_\_\_\_ FTE)
- k)  Decreased (#\_\_\_\_ FTE) lab/technician staff
- l)  Added physicians assistant (#\_\_\_\_ FTE)
- m)  Decreased (#\_\_\_\_ FTE) physicians assistant
- n)  Added reception/administrative staff (#\_\_\_\_ FTE)
- o)  Decreased (#\_\_\_\_ FTE) reception/admin. staff
- p)  Added staff hours
- q)  Decreased staff hours
- r)  Increased overtime
- s)  Decreased or eliminated overtime
- t)  Others. Please describe: \_\_\_\_\_

**21. What, if any, changes have occurred in your practice structure in the last 6 months?**

- a)  I am not aware of any recent changes in practice structure.
- b)  Added clinic/office hours
- c)  Cut clinic hours
- d)  Opened new office/clinic site(s)
- e)  Closed satellite offices or clinics
- f)  Doing more infusions
- g)  Doing fewer infusions
- h)  Merged with other practice
- i)  Other organizational structural changes: Please describe: \_\_\_\_\_

**22. Has your job changed in the last 3 months? Please explain.**

**23. Have your practice administrators informed you about the financial impact of recent changes in Medicare reimbursement on your practice? Please check only statements that are true for you.**

- a)  I have been informed of changes in Medicare regulations but not about how those changes affect our practice's financial performance.

- b)  I have been told that the Medicare reimbursement regulations affect our acquisition of drugs by: i)  causing financial stress ii)  having no significant effect  
iii)  improving our financial situation
- c)  I have been told the Medicare regulations affect reimbursement for certain procedures in a way that: i)  causes financial stress ii)  has no significant effect  
iii)  improves our financial situation
- d)  I have been told that private insurers (not Medicare supplement or MediGap) are changing their reimbursement to align payment with Medicare, and that this will:  
i)  cause financial stress ii)  have no significant effect iii)  improve our financial situation

**24. Please add any comments that will help us understand how your practice has changed in recent months. You may also note any changes that are planned based on expectations about how Medicare reimbursement will affect the practice's financial performance.**

**Do you know if more than one ONS member from your practice location is responding to this survey:  yes  no. If yes, please coordinate your responses by sealing each completed survey in its separate envelope and placing all envelopes in one package for mailing.**