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INSIDE

President's Message	2
Educational Opportunities	2
PSONS Member Profile	12
Treasurer's Report	15

Oncology Nursing Society

Vol. 37, No. 1 Spring 2014

The Oncology Medical Home: An Oncology Nurse's Dream

*Ted Okon, MBA, Executive Director,
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Before I get into the meat of this article, you should know I have a bias about oncology nurses: I'm married to one. I see first-hand the hours my wife Susan puts in and the investment she has in her patients. So, with all due respect to my oncologist colleagues, I believe that oncology nurses are the heart and soul of cancer care. And I believe that there is an especially key role for oncology nurses in the *Oncology Medical Home*.

The cost of health care has become part of the national dialogue on the fiscal health of the United States. Regardless of political ideology, there is a common belief that the federal government — the single largest purchaser of health care — needs to accomplish two things concurrently: purchase quality and efficient health care. The two operative words are 'quality' and 'efficient', the later referring specifically to cost. And private payers have adopted a similar quest in terms of ensuring quality health care delivery in a cost-contained environment.

This is certainly true of cancer care, where costs

have increased substantially with new therapies. Attempts by Medicare and private payers to contain costs by cutting provider reimbursement have had the unintended consequence of consolidating the cancer care delivery market. This consolidation is creating patient access issues, and is increasing costs for both patients and payers. We also believe that reimbursement changes are the root cause of the shortages of low-

cost injectable cancer drugs.

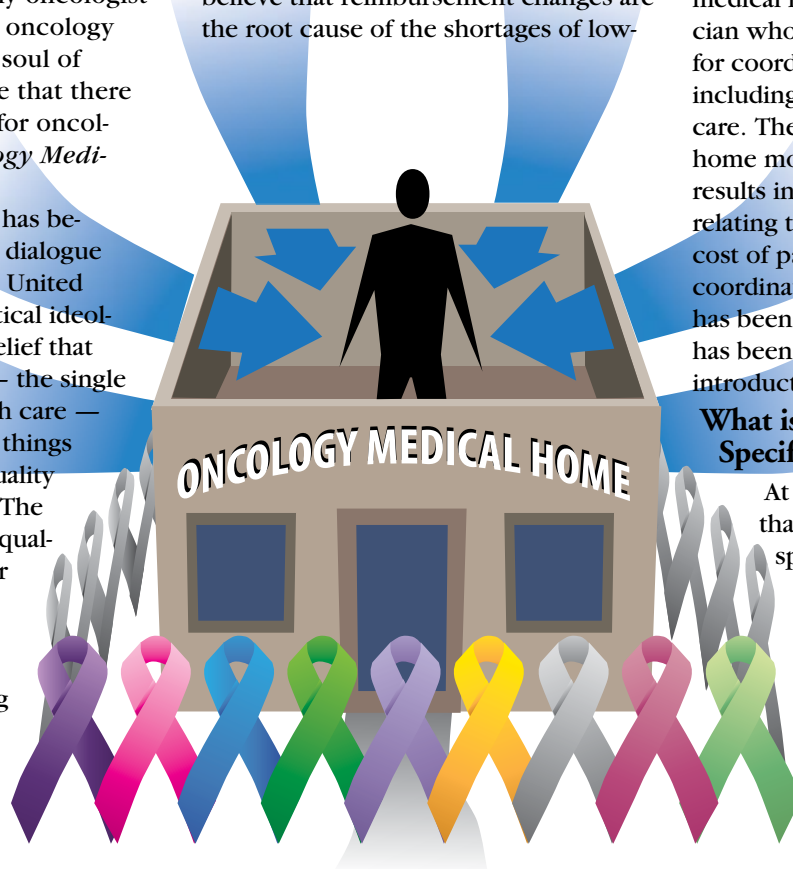
The medical home model of cancer care that the Community Oncology Alliance (COA) is pursuing provides elements that all primary stakeholders — patients, payers (both primary and secondary), and providers — want in ensuring quality, efficient cancer care delivery. We know this because that is exactly what the stakeholders have communicated to us.

What is a 'Medical Home?'

In basic terms, the patient has a 'medical home' that is the central 'coordinator' or 'gatekeeper' of their medical care, and as importantly becomes a source of hope and comfort. Typically, the medical home is a primary care physician who becomes the point person for coordinating the patient's total care, including both primary and specialty care. The theory is that the medical home model of patient-centered care results in important positive outcomes relating to the quality, efficiency, and cost of patient care by optimizing care coordination. The medical home model has been around for over 40 years and has been evolved and piloted since its introduction.

What is the Logic of an Oncology-Specific Medical Home?

At first glance, it would appear that the concept of an oncology-specific medical home flies in the face of reason by defeating the purpose of a medical home managed by the primary care physician. However, the rationale is seen in the complexity and severity of cancer treatment. As all oncology nurses well under-



Continued on page 3

Measuring Quality and Value in Cancer Care

Bo Gamble

Director of Strategic Practice Initiatives,
Community Oncology Alliance

The Affordable Health Care for America Act (ACA), which passed November 7, 2009, was the first official legislative attempt to increase the quality of health care while also reducing the expense. (Translation = “value”.) This represents a radical change in thinking from the traditional approach of a health care delivery system that was based simply on “utilization”. If you got sick or had an accident, you went to a health care provider/facility and they would address the problem – as they thought best. There has been minimal accountability in this model and the services were paid for with no regard to quality, value or outcomes. The ACA brought the concept of measurable quality and value to the forefront of negotiations between provider and payer, provider networks and general payment reform. (One Hundredth Eleventh Congress, 2010)

This has also been true for cancer care but with far less visibility than other aspects of healthcare. This is primarily due to the lack of understanding of the uniqueness of cancer care by our decision makers or legislatures. The March 23, 2010 public ACA law mentions “cancer” 14 times within the 906 pages. The references included six references to cancer hospitals, six references to cancer screening, and one reference to the importance of cancer assays. There was only reference to cancer with regards to payment reform and that was in reference to evidence-based medicine (only).

The community of cancer care

providers took this as a wakeup call to organize as well as educate and propose practical solutions for all of cancer care. This new perspective includes a focus on quality, value and outcomes in cancer care and how payment can be wrapped into the equation for demonstrated achievement.

This process started with the collaboration and establishment of 19 measures

very specific to cancer care. These measures, along with standardized patient satisfaction survey for cancer care represent a comprehensive view of what is important in cancer care and from key stakeholders. This 18 member team includes a mid-level provider, pharmacist, patient (and a patient focus group), 2 practice administrators, 4 nationally recognized oncologist, 5 medical directors from national and regional payers, and representation from ASCO, NCCN, NPAF, McKesson and International Oncology Network. Together they have reached consensus on a set of measures that is...

- Stakeholder driven – This team narrowed the selection of key measures

from a starting list of over 200 to 40 to the initial list of 16. 3 additional measures have been subsequently added. (See <http://www.medicalhomeoncology.org/coa/benchmarking.htm> for a complete list and details of these measures.) All of these measures were endorsed with the understanding that they are important to providers, payers and most importantly...patients. (OMH Steering Committee, 2013)

- Cancer specific – These measures are specific to key attributes and deliverables in cancer care. And they are measures that can be used in any site of care or any cancer care delivery model. Unlike some of the general or oncology measures within the Physician Quality Reporting System (PQRS), all of these measures are relevant, practical

and important to any cancer care model.

- Balanced – The entire continuum of cancer care is reflected in the set. Measure categories are specific to patient care, resource utilization, survivorship and end of life care. The patient satisfaction survey compliments these measurements with summary and detail scores of how the patient and family perceive their cancer care throughout their journey.

- Ongoing – The work of this team and this effort is not complete. As the understanding of true quality and value continues to evolve, this team will continue to evaluate and endorse mea-

asures that will benefit all aspects and stakeholders in cancer care.

The drivers and motivation for these measures is a new payment model for all of cancer care. We continue to see samplings of this reform through the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) projects, evolution and maturing of ACA models, and pilot programs from regional and national insurance carriers. The days of getting reimbursed simply for providing care are disappearing. It is as if everyone has taken lessons from the grand state of Missouri

Continued on next page

and is saying "Show me." Patients are demanding quantifiable quality, value, and outcomes in cancer care. Payers, including Medicare and Medicaid, are demonstrating that they are willing to pay for these distinctions.

These concepts, the recommended changes to the care process, measurement, benchmarking, and payment reform are all part of establishing your team as "medical home" for your patients and their families. There are many cancer centers/practices leading this effort and they are being noticed by employers, payers and other entities. You can be champion within your own team by accepting the challenge of:

a) Transitioning your thoughts and deeds to those based on quantifiable improvement in quality, value and outcomes.

b) Promote your measurable differences so that your cancer care team is

adequately recognized and rewarded by national and regional payers and employers.

c) Continue to make measurable improvements to that your patients receive the best cancer care available.

Please join us in this national effort to reshape how cancer care is viewed and rewarded. Visit www.medicalhomeoncology.org to learn more.

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COME HOME Implementation

Continued from page 7

(PMPY), which represents a savings rate of approximately 6.276%. Based on a Medicare enrollment of 8,022 patients over 3 years, the projected Medicare savings are \$33.5 million and net savings of \$13.76 million (after budget costs). The University of Tennessee Health Science Center will also be a partner for evaluation and cost analysis.

The results of Dr. McAneny's project could redefine the delivery of cancer care. This is one of the first projects that could pave the way towards a bundled payment model. If her hypothesis is correct, and community oncology practices provide quality care at a lower cost, that is more convenient for patients, the model could be exported to other practices and payers.

<http://www.comehomeprogram.com/index.php/come-home-practices/>



Medical Home Pilot: Significant Training Given to Triage Staff

Continued from page 5

practice staff, and recruited volunteers to take part in medical home activities including working extended hours and staffing the telephone triage lines. Significant training was given to the triage staff to use the newly developed triage pathways. Physician extenders were hired by the practices to increase the available same day appointment slots so that patients who needed them could be offered same day appointments for symptom management.

The enhanced access, enhanced care and active disease management portions of the grant have been implemented. This includes the use of triage pathways for symptom management, extended hours in the evenings and weekends and patient education. The final two phases of implementation will include roll out of the clinical (diagnostic and therapeutic) pathways, and application for Oncology Medical Home certification. For all phases of implementation, we have leveraged information technology to aggregate data across all practices and conduct monthly data reviews to identify trends, monitor process mea-

asures and evaluate outcomes, allowing for rapid cycle feedback on the effectiveness of the model.

Because inpatient and ED care is extremely expensive and, many times, unnecessary for our patients, we believe that the cost savings associated with utilization reductions in these areas will be sufficient to more than offset the cost of this OMH infrastructure. Only looking at the Medicare patients, the net savings from COME HOME are projected to be \$4,178/patient per six month episode of care. These savings reflect reduced hospitalizations (\$3619), reduced ED visits (\$593) and reduced pharmacy costs (\$450). They also reflect increased physician outpatient costs (\$484) which are attributed to additional visits to the oncology practice for acute symptom management. Total savings for the three year period of the grant are predicted to be approximately \$33 Million.

Our final analyses will include ED visit rate, inpatient hospitalization rate, all-cause mortality and total cost of care, both longitudinally for the COME HOME practices and in comparison with patients treated at non-COME HOME

practices.

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The Oncology Medical Home: What Patients Want Remains No Surprise to the Oncology Nurse

Scott Parker, Executive Director
Northwest Georgia Oncology Centers, P.C.

When the Community Oncology Alliance (COA) established a Steering Committee in late 2011 comprised of patients, payers and providers, the intent was to develop a blueprint for a model of care that would demonstrate quality of care for our patients, value and adherence to evidence based guidelines for payers, and a reduction in bureaucratic hurdles along with a sustainable reimbursement model for our providers and staff.

The patient is obviously the cornerstone for the COA Oncology Medical Home and was our initial focus. Shortly after Dr. Bruce Gould was appointed Chairman of the Steering Committee Northwest Georgia Oncology Centers (NGOC) began engaging its patients. NGOC was fortunate enough to have been an early partner in COA's Patient Advocacy Network (CPAN). As a result of our CPAN participation we were able to solicit feedback from a group of twenty patients who were active CPAN participants. NGOC paid an outside consultant to interview these patients, and ask one question. "As a cancer patient what's most important regarding your interaction with your physician and our office staff?"

Below is a summary of the responses we received:

- Best Possible Outcome
- Best Quality of Life
- Doctors Ability (education), Availability and Friendliness/Caring
- Timely Communication of Test Results
- Friendly, Compassionate, Competent Staff

- Easy/Timely Access to Staff and Office
- Honesty about Diagnosis and Prognosis
- Education and Engagement in their Care Plan
- Coordination of Care/Communication with Other Providers & Facilities
- Least Amount of Pain, ER Visits & Hospitalizations

Home incorporates processes of care that if implemented are designed to meet the expectations that our patients are telling us are important to them.

As the adoption of the Oncology Medical Home evolves, the idea of "patient centered" care is certainly not a new concept for the oncology nurse. In my seventeen plus years at NGOC, I am always humbled by the never ending level of care and compassion displayed by our nursing staff. Whenever I have the pleasure of interacting with patients there are always unsolicited compliments regarding the kindness, personal touch, and level of support provided by our nursing staff.

Rest assured the team at COA is working hard to ensure that the Oncol-

What Patients Want

Process	Expectations
<p>Evidence Based Medicine</p> <ul style="list-style-type: none"> • Adherence to nationally recognized guidelines • Access to clinical trials <p>Access</p> <ul style="list-style-type: none"> • Urgent appointments available for new patients • Same day appointment available • Structured telephone triage <p>Patient Engagement</p> <ul style="list-style-type: none"> • New patient orientation • Financial counseling • Chemotherapy education • Patient portal <p>Team Based Care</p> <ul style="list-style-type: none"> • Ensure that other providers are informed • Referrals and appointments arranged <p>Patient Satisfaction Survey</p> <ul style="list-style-type: none"> • Survey used to monitor/improve patient experience 	<p>Evidence Based Medicine</p> <ul style="list-style-type: none"> • Best quality outcome • Best quality of life • Least amount of pain, hospitalizations <p>Access</p> <ul style="list-style-type: none"> • Doctor availability • Easy/timely access to staff and office • Coordination of care with other provider's facilities • Reduced ER visits and hospitalizations • Timely communication of test results <p>Patient Engagement</p> <ul style="list-style-type: none"> • Education and engagement in care planning • Honesty about diagnosis and prognosis • Easy/timely access to staff and office <p>Team Based Care</p> <ul style="list-style-type: none"> • Coordination of care with other provider's facilities • Easy/timely access to staff and office • Timely communication of test results <p>Patient Satisfaction Survey</p> <ul style="list-style-type: none"> • Doctor's ability, availability and friendliness/caring • Friendly, compassionate, competent staff • Easy/timely access to staff and office

I'm sure most of you are not surprised by these responses and if faced in a similar situation might respond in a similar manner.

A well-constructed Oncology Medical

ogy Medical Home model succeeds in meeting all stakeholders' expectations and helps to maintain the viability of Community Oncology.

Patient Satisfaction Survey

Journey to Patient-Centered Care

Marsha DeVita, RN, NP, AOCN
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Hematology Oncology Associates of Central
New York*

Patient engagement is considered a cornerstone of High Quality Cancer Care. Measurement of patient satisfaction with CAHPS based survey questions focused on patient centered care is an important step on the journey to become an Oncology Medical Home. Hematology Oncology Associates of Central New York administered the Oncology Medical Home survey to their patients in 2012 and 2013 and used the results to examine and change practice process and improve care

There are many reasons why oncologists should be using a patient satisfaction survey. Patients desire a better healthcare experience and a greater level of participation in healthcare decisions. Cancer care is complex. Engaging patients in their care requires good communication skills. Providers need to understand patients' values and preferences as they discuss the diagnosis, prognosis and treatment options. Measurement of patient satisfaction gives us the feedback we need to ensure that we are meeting our patients needs and serves as a useful quality improvement tool. Favorable patient satisfaction scores can differentiate one healthcare facility from another.

There is a trend toward increasing transparency of quality and patient satisfaction scores in healthcare. The Center for Medicare and Medicaid (CMS) publishes hospital quality measure scores and patient satisfaction survey results on their Hospital Compare website. It is likely that the Physician Compare website will follow the same path. Patient experience surveys will gain importance in our increasingly transparent, competitive marketplace where patients

seek quality, value and a satisfying experience.

Hematology Oncology Associates of Central New York (HOACNY) is a comprehensive private ambulatory oncology practice with five office locations serving a six county area in Central New York. We have fourteen medical oncologists, three radiation oncologists 18 non-physician providers with a total staff of 260. Treatment modalities available within our organization include; medical oncology, radiation oncology, cyber knife, CT imaging, laboratory, infusion, dispensing pharmacy, psychosocial care, registered dietician consultation, cancer rehabilitation, integrative oncology and wellness.

We began to obtain patient experience data with the use of suggestion boxes several years ago. In 2008 we initiated a monthly patient satisfaction survey with approximately 60-70 responses each month. We added Consumer Assessment of Healthcare Providers and Systems (CAHPS) based survey questions to the monthly survey in 2011 as a preparation for anticipated CMS patient satisfaction reporting requirements.

We administered the Community Oncology Alliance (COA) Oncology Medical Home (OMH) Patient Satisfaction Survey for the first time in September 2012. The OMH survey is made up of 40 CAHPS based questions, divided among four categories: Timeliness, Thoroughness, Communications, and Friendliness-Helpful. Surveys were mailed to 3023 patients who were seen by a provider for an office visit during a 30-day period. Our response rate was 46% with 1307 responses.

We were pleased with our overall results and the ability to benchmark. The OMH survey reporting allowed us to compare our results to other practices within our state and nation. We were able to study the survey results by ques-

tion, category, location and provider. The ability to sort by question, provider, and location is helpful in the evaluation process for quality improvement.

Communication is at the heart of patient centered care. The Institute of Medicine lists six components of high quality cancer care and ranks patient engagement first (2013). We decided to focus on a question related to communication and patient engagement for our quality improvement project. We selected the following question. "In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this providers office follow up to give you those results?" The patient is asked to select one of the following answers: never, sometimes, usually or always. 88.1% of responders reported that they were usually or always given the results of labs and other tests.

As we began to look at process we discovered variation in satisfaction scores by location and individual providers. We determined that variation was likely related to several factors including: scheduling practices, availability of testing and turnaround time for results by location, the importance providers placed on relaying normal results, and concerns about the amount of staff time it would take to call patients with normal lab results.

Notification of lab test results was primarily done on a "need to know" basis. The definition of "need to know" includes results that are abnormal, have some effect on the disease, treatment, or health and wellness of a patient. This did not necessarily include normal results. The satisfaction survey results prompted us to examine our attitudes, patient preferences and best practices. Studies have shown that the majority of patients want all test results, including normal results. Providing all test results improves satisfaction and enlists patients in a safety net for missing tests. (Baldwin et al 2005)

Access to laboratory testing with rapid turnaround time varies by office location. Our largest site typically produces a chemistry panel result within an hour while the other locations send results to a central office for process-

Continued on page 13

PSONS MEMBER PROFILE

Kari Ann Felzer, RN, BSN

Infusion Nurse, Seattle Cancer Care Alliance

Jody Stroh, MBA

In the years I have been writing these profiles, we have never featured a nurse fresh out of school. For the most part we have featured tenured, well known nurses and even a few advance practice nurses. Needless to say, I was tickled when a request went out to the Board for profile suggestions and Kari Ann's name came back with a great deal of enthusiasm.

Kari Ann was born into a close family in Everett. The only other individual in health care was Mom who worked in medical insurance and billing. Growing up, Kari Ann, like so many children, was definitely afraid of needles. So one might wonder how she got over that and selected nursing as a career. Kari Ann was exposed to cancer at an early age. When she was 9, her father was diagnosed with a brain tumor. It was a blessing for the family that he was able to survive his cancer for 10 years. Sadly, when Kari Ann was 19, her father lost his decade long battle with cancer.

During the 10 years Kari Ann and her family dealt with brain cancer, she was a first hand witness to the incredible nursing care her father received. It was an observation that would steer her into nursing. She worried that oncology nursing might hit too close to home and considered pediatric nursing as she started her education. Her first step was completing her Associate degree in nursing at Edmonds Community College in 2009. Kari Ann then completed her BSN in August 2012 at Seattle University.

The selection of Seattle University for nursing school would end up being serendipity for Kari Ann. Unbeknownst to Kari Ann, the SCCA had been reaching out to the University of WA with the idea of creating an out-patient clinical rotation. When that could not be realized, the SCCA turned to Seattle University who agreed the out-patient clinical rotation would be a wonderful oppor-

tunity for their nursing students. The SCCA created only 8 spots for this inaugural opportunity. Kari Ann applied and was accepted into the pilot program. She loved the experience and knew she was onto something inspirational at the Seattle Cancer Care Alliance!

Meanwhile, Kathleen Shannon-Dorcy, RN, PhD was spearheading a new opportunity at the SCCA. Kathleen was working to create a new graduate nursing residency program that would be split half time in transplant (at the SCCA) and half time in infusion (at the SCCA). Kathleen did get the program up and running just in time for Kari Ann to be among the first participants in this unique opportunity. Kari Ann spent eight months in the residency program and three months before it was completed, she accepted a position at the SCCA as an infusion nurse.

I asked Kari Ann about mentors she remembers as being particularly influential. It is an easy question for her to answer. At Seattle University, Karla Mather, RN, was a first time Clinical Leader and Instructor. "She really stepped up to the plate!" says Kari Ann. "Karla worked part time at Virginia Mason, juggled a family with kids, commuted from Bainbridge Island to work in Seattle, and ran the SCCA clinical rotations for Seattle U!" The admiration from Kari Ann is readily apparent.

The other mentor Kari Ann quickly mentions is Kathleen Shannon-Dorcy, RN, PhD. During Kari Ann's residency at the SCCA, she had monthly 1 to 1 meetings with Kathleen as she rolled out the new program. "We were building it as we went along. Because she was so experienced, Kathleen was like a mother figure to me. She always knew what I was coming up against next, and could draw me out and help put things back into perspective."

The mutual admiration between Kari



Kari Ann Felzer

Ann and Kathleen goes both ways so I gave Kathleen the opportunity to include some thoughts on Kari Ann: "Kari Ann has been a dedicated young woman to learning about oncology and implementing her knowledge into clinical practice since we first met. Kari Ann volunteered to be a participant in the pilot project between Seattle University and Seattle Cancer Care Alliance where senior Medical/Surgical clinical rotations could be completed in the Outpatient Clinic. Kari Ann was a pioneer in that program which has become a tremendously successful collaboration between SU and SCCA. Kari Ann then opted to do her senior practicum with SCCA in the summer term of her senior year. At that time SCCA had formulated the first residency program for our clinical site and Kari Ann was hired into that role. Throughout all the complex orientations and multiple areas of learning, Kari Ann was a steady committed nurse who always seized all opportunities to enhance her professional growth. Following her time in residency, she was then hired into a position within the Infusion Room at SCCA. It has been a privilege to have Kari Ann as a partner in this new adventure into working with nursing students, developing a residency program, and now hiring a talented young dedicated professional nurse."

Kari Ann, a PSONS scholarship re-

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PSONS Member Profile

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ipient for Symposium 2013, says she wasn't as familiar with ovarian cancer and she wanted to try to incorporate as many extra educational opportunities as possible. "Ovarian cancer was an area I wasn't as exposed to so I really learned a lot at Symposium and I felt way more prepared to care for that patient population" says Kari Ann. She also says now that school is over and she has a great new job (and a great new husband!) that she will definitely be joining ONS/PSONS.

I asked Kari Ann about advice she might give to other new nurses and she offered something I had not heard before: "Most nursing students tend to go to the hospital and start in med/surg for a year to get experience but I broke

the mold and went into out-patient and directly into oncology. If you know what you want to do, go for it!" Clearly it paid off for Kari Ann.

Our Editor, Bob Chapman, RN, posed a question for Kari Ann: "How do you promote evidence-based practice as a way to improve quality patient outcomes or improve a quality patient experience?" She responded, "During my time at the SCCA, I have never been told "We do things this way, because it is the way it has always been done." Whenever I have inquired why something is done in a particular way, the answer has always been based on science, research, and/or best practice standards. Throughout the residency program, I was taught how to care for our patients based on the policy and procedures of the SCCA, which have all been created and implemented based on science, research studies, and/

or best practice standards. Evidence-based practice guides the way I care for our patients every day, and is what allows me to provide the best quality of care for our patients."

Kari Ann and her new husband (an Environmental Studies grad "out to save the world!") have two sweet dogs, a lab Sadie and a puggle Gaje whom they love to treat to parks and hikes on the weekends. The new couple is also recent homeowners and busy themselves with lots of yard work and home projects in their spare time. Something you might not know about Kari Ann but won't be surprised to know either is that she graduated Summa Cum Laude from Nursing School. "It was really hard work" she says, "but it really paid off". Well I know a whole group of nurses and patients who would agree to that!

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Patient Satisfaction Survey: Secure Patient Online Portal Saves Staff Time

Continued from page 11

ing. When test results take longer, more patients leave our office without their result. This creates additional work and translates into more staff time to call patients and follow up on results. It also leads to a greater opportunity for lab result communication failure.

We explored several options to ensure that normal lab results and abnormal results are communicated. We ruled out mailing and calling normal results because of the volume and related staff time. We decided to use our secure patient portal to deliver lab results to patients. The process of uploading the results was automated to save on staff time. We encourage every patient who comes into our office to join the portal. The secure portal is a great tool to deliver labs and improves access in other areas.

We examined our process of sharing imaging results with patients.

Imaging tests are routinely scheduled so that a provider will see the patients the same day with a stat imaging result or within one or two days following a test. This enables the provider to have ample time to discuss the result with the patient. We have rare occasions when a patient has a test scheduled without a follow up appointment

within a day or two. When this occurs, it is up to the physician and care team to notify the patient of the results via telephone.

After review of our processes we were able to use our electronic medical record to develop a tracking system to ensure that we relay results to patients. The imaging test order is linked to an imaging results quality checklist. All imaging is tracked and remains on the check list until the patient is given the result. This tracking system is beneficial from a quality standpoint and a satisfaction standpoint.

We saw a modest improvement in our score on this question when we repeated the survey in 2013. Initially 88.1% of 1307 responders stated they usually or always received their test results and this increased to 91.4% of 1430 responders in April 2013.

We will continue to follow the satisfaction survey results, evaluate, and look for opportunities to improve. Our next survey will be administered in the first quarter of 2014. We believe that our tracking system for imaging results and utilization of the patient portal to relay lab test results will continue to improve our satisfaction score and patient experience.

Many physicians, nurses and other healthcare workers are drawn to cancer care in part because of a desire to improve the patient's journey. This is a great time to be a part of patient centered changes that will positively affect satisfaction, outcomes and the success of your organization. Measuring the patient experience is an ongoing commitment to review process, practice style and beliefs about what patients want and need. The COA OMH survey is a powerful tool when used to examine your patient experience and ensure that you can set yourself apart from your competition by meeting your patient's needs.

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Radiation Safety for Nurses in Medical Imaging and Radiation Therapy

Trang Marquez CNMI, PET, ARRT (CT)

Radiation is everywhere. It is naturally found in our environment. It comes from outer space through cosmic rays and the ground through soil. It is in our food we eat, the water we drink as well as building materials used to build homes. In fact, most of our natural exposure comes from radon; a gas released from the earth's crust into the air we breathe in. All this natural radiation is called background levels. No adverse health effects have been found from these levels of natural radiation exposure.

The average annual exposure from natural radioactive sources is 310 millirem or mrem in the US¹. A millirem is a unit used to measure doses of radiation. Radiations from man-made sources contribute another 310 mrem to our annual average radiation exposure through medical, commercial, and industrial events¹. Consumer products such as tobacco, fertilizer, exit signs, and smoke detectors add more than 10 mrem to our annual radiation exposure¹. For radiation exposures from occupational source of radiation the US Nuclear Regulatory Committee (NRC) and State Radiation protection officers require that all licensed medical facilities that use radioactive materials or machine generated radiation to limit occupational nurse radiation exposure to 5,000 mrem (50 mSv) per year¹. For more information regarding state and federal regulations and radiation exposure limits can be found on the NRC website in Title 10 of the Code of Federal Regulations, Part 20 or Washington State Office of Radiation Protection's website.

Natural and man-made radiation exposure affects us all in the same way, causing ions to be formed in cells. The human body has mechanisms to repair damage to living cells caused by radiation. The biological effects of radia-

tion affect cells in three ways¹. One outcome occurs when damaged cells repair themselves, causing no further biological effects to the person. Second, the cell dies and is replaced through normal biological processes. Lastly, the cells do not repair the damage or repair themselves incorrectly which leads to potential negative outcomes. Radiation risk is then based on the amount of radiation encountered, the area of the body exposed and the amount of time over which the exposure happened.

The relationship between radiation exposure and the cause of cancer are mostly based on populations that have received high levels of ionizing radiation such as the Japanese atomic bomb survivors. A high-dose exposure of greater than 50,000 mrem show cancer development for leukemia, breast, bladder, colon, liver, lung, esophagus, ovarian, multiple myeloma, and stomach cancers¹. According to the National Cancer Institute, lifestyle factors such as smoking, alcohol consumption, and diet, contribute largely too many of these same diseases¹. National Academy of Sciences is asked every 10-15 years to evaluate the risks of radiation at low levels because there is no scientific evidence to show the occurrence of cancer resulting from exposure to low dose of 10,000 mrem¹, which is double the occupational dose limit for workers.

What is the benefit of using radiation in medical imaging and therapy? Medical imaging and radiation therapy is needed for screening, diagnosing, and treating cancer. It's a set of important tools in diagnosing and treating cancer and other human health problems. Radioactive materials and x-ray radiation are commonly used in medical imaging and cancer therapy procedures, with more than 20 million nuclear medicine studies and 300 million x-rays given each year in the US⁴. While it's very easy to measure or estimate the amount

of radiation workers are exposed to, it's not always as easy for workers to see the benefits that are derived from the radiation exposure, and compare that to the risk. Federal law requires all workers to be trained in radiation safety if their annual occupational exposure is more than 100 mrem and monitored if their exposure will be more than 500 mrem per year⁴.

To minimize radiation exposure to all employees, the "As Low As Reasonably Achievable" (ALARA) principle is applied according to state regulations. This principle means that a reasonable effort is made to maintain exposures to ionizing radiation as far below the dose limit as possible. In addition, our goal is to keep the annual radiation dose to nurses below one-tenth the Federal occupational limit of 5,000 mrem per year. One-tenth of the Federal occupational limit is 500 mrem^{2&3}. This allows lifetime occupational exposure to be kept low. To date, we have never had one nurse have more than 500 mrem in a year (nor do we ever expect anyone to)! Well done!

The ALARA may be achieved by nurses practicing several simple work practices, namely controlling one's time and distance. Time: A nurse can keep his or her exposure as low as possible by limiting the time they spend in an area where radiation is present when performing their duties. These areas usually include rooms marked with radiation warning signs, and lights that indicate when x-ray equipment is in use. Materials that emit ionizing radiation are kept in areas that are marked with warning signs, and the time in those areas should be limited. Patients receiving known doses of radioactive materials that emit radiation are considered safe by regulatory agencies however you can still minimize time spent close to radioactive patients. Distance: Exposure to ionizing radiation can be minimized by keeping some distance between oneself and the source of the radiation, except as needed to provide the appropriate level of care. In fact, doubling the distance between yourself and a source of radiation reduces your exposure to one quarter of its original rate. Casual social contact with our patients will not expose employees to unsafe levels of

Continued on next page

radiation. Other methods of minimizing radiation exposure include wearing protective gloves when working with radioactive patients and washing hands immediately after leaving the room if handling bodily fluids such as blood and urine.

Each licensed facility has an assigned Radiation Safety Officer that evaluates the Radiation Safety Program and to ensure that all occupational staff members adhere to the State and Federal guidelines with keeping radiation exposure levels below the set allowed annual limit. Devices used to measure radiation exposure for nurses are dosimeter badges. The Radiation Safety Officer provides dosimeter badges when working with x-ray equipment, radioactive patients, and radioactive materials to

measure occupational radiation exposure. Dosimeter badges are not to be worn if one needs an x-ray for medical or dental reasons. Medical doses resulting from necessary medical and dental procedures do not need to be included in the documentation of the radiation exposure of the wearer. It is important to review the dosimetry report when available to help monitor and minimize radiation exposure. The Radiation Safety Office will contact any person whose dose exceeds acceptable levels. And every facility is inspected, either by a State Office of radiation protection as in Washington, or by the Federal Nuclear Regulatory Commission. The inspections are to evaluate the program, and judge whether the facility is operating in compliance with all regulations and safety practices.

Trang Marquez has worked in the Medical Imaging Department at Seattle Cancer Care Alliance for 7 years. She is the lead technologist for Nuclear Medicine, Position Emission Tomography (PET), and Computed Tomography (CT) and is currently completing her master's in Health Physics.

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1. U.S. Nuclear Regulatory committee. (n.d.). Fact Sheet on Biological Effects of Radiation. Retrieved from <http://www.nrc.gov/reading-rm/doc-collections/fact-sheets/bio-effects-radiation.html>.
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TREASURER'S REPORT

Income	2013	2014 Budget
Service Project	\$235	\$250
Advertising	\$400	\$400
Fundamentals	\$30,332	\$38,000
Membership	\$4,858	\$6,600
Monthly Educational Programs	\$6,991	\$7,000
OCN Review	\$1,954	\$2,500
Symposium	\$58,514	\$60,000
Total Income	\$103,284	\$114,750
Expenses		
Board Meetings	\$1,590	\$1,590
Chapter Fees	\$558	\$558
Donation ONS Foundation	\$1,000	\$1,000
Fundamentals	\$33,826	\$38,000
Scholarships	\$3,886	\$7,800
Monthly Educational Programs	\$12,747	\$13,000
OCN Review	\$1,078	\$1,500
Newsletter	\$10,068	\$10,000
Office Supplies	\$250	\$250
Postage & Mailing	\$255	\$250
Symposium	\$46,141	\$46,000
Vendor Relations Mailing	---	\$110
Service Project	\$1,568	\$1,000
Nominating Committee Mailing	\$14	\$14
Travel to Leadership Weekend	\$790	\$800
Operations - Other	\$507	---
Bank Fees	\$12	---
Website	\$383	\$1,500
President Travel to ONS	---	\$2,200
Total Expenses	\$114,675	\$125,572



Puget Sound Chapter of the Oncology Nursing Society

Contact Information for PSONS Board, Committees, and Project Teams

Please utilize the following email addresses for contact. We want your input and would love to hear from our members!

All board meetings are open to the membership.

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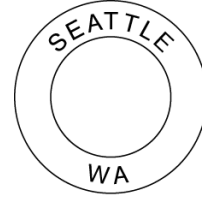
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