

GEORGIA STATE HEALTH PLAN

COMPONENT PLAN

RADIATION THERAPY SERVICES

**HEALTH STRATEGIES COUNCIL
AND
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH PLANNING**

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FEBRUARY 2001

Planning area map has been changed effective April 1, 2003

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PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Department of Community Health/Division of State Health Planning, pursuant to the provisions of O.C.G.A. 31-5A-1, et seq., and 31-6-1, et seq. The purpose of the Plan is to identify and address health issues and recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, public participatory process developed and monitored by Health Strategies Council appointed by the Governor. The Plan is effective upon approval by the Council and the Board of Community Health and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) Program, criteria and standards for review (as stated in the Rules, Chapter 272-1, 272-2 and 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the review function has the legal authority to implement. The Rules are reviewed by the Health Strategies Council, prior to their adoption by the Board of Community Health, for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

Any questions or comments on this Component Plan should be directed to:

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I. INTRODUCTION

A. PLANNING PROCESS

Georgia's original Cancer Plan was developed in 1981 and last updated in 1983. In 1991, the Georgia General Assembly passed legislation to regulate diagnostic, treatment, and rehabilitation centers including physician offices that offer radiation therapy, cardiac catheterization, biliary lithotripsy, and surgical procedures outside of the hospital setting. Prior to the passage of this bill, health planning review and certificate-of-need approval were required for these services only if they were offered by and performed in a hospital setting. This legislation was intended to control expenditures for this highly technologically advanced equipment, and to level the playing field by ensuring that the same rules applied to the provision of radiation therapy services, regardless of setting or ownership.

Coupled with the change in regulatory expectations, the treatment modalities for cancer illnesses have changed dramatically giving rise to a range of sophisticated technologies and changes in the delivery of care. Today, nearly twenty years after Georgia's last Cancer Plan, radiation therapy facilities are no longer only hospital-based and high energy linear accelerator units provide routine treatment for thousands of individuals every year. Changes in industry practices and other advances in technology created the need to evaluate and update the regulatory guidelines for radiation therapy services.

At its November 1999 meeting, the Health Strategies Council voted to convene a Technical Advisory Committee (TAC) to evaluate and make recommendations to develop a Component Plan and Certificate of Need Rules for Radiation Therapy Services. The membership of the TAC represented radiation therapy providers and other interested parties and experts. TAC members are listed in Appendix A. The TAC held an initial meeting in March 2000. However, organizational changes and the development of the Governor's Cancer Initiative required the group to pause for several months before proceeding with their work. The TAC reconvened in August 2000 and met through December 2000.

The plan which follows has been developed based on the deliberation of the TAC and the work of the Department of Community Health, Division of Health Planning. The goals of the revised plan are to update the antiquated regulatory guidelines while promoting the goals and visions of the newly announced Georgia Cancer Initiative.

B. GEORGIA'S CANCER INITIATIVE

On Wednesday, November 29, 2000, following nearly six (6) months of study and development, Governor Roy E. Barnes announced the framework of Georgia's Cancer Initiative. The program seeks to turn Georgia into a national leader in cancer treatment and research by accelerating research, prevention, early detection and treatment. The Governor's initiative will align public education, cancer screening, and the care of cancer

patients with cutting-edge new treatment options in clinical trials and the use of new and innovative technologies to seek breakthroughs in understanding cancer and to reduce the number of cancer deaths. This initiative is expected to be one of the most comprehensive attacks on cancer in the United States. The Georgia Cancer Alliance, a public/private partnership, will coordinate development of this comprehensive cancer control program for the benefit of all Georgians.

The Georgia Cancer Alliance has been charged with building a coordinated statewide network of cancer care. Public and private hospitals, private physicians and other health care providers will deliver most of the screening and treatment. The initiative calls for non-profit organizations, civic groups and private businesses to participate in prevention programs. Clinical research will involve public and private academic institutions. Public agencies such as the Department of Community Health, which insures almost two million Georgians through Medicaid, the State Health Benefit Plan and PeachCare for Kids, and the Department of Human Resources, which directs the state's cancer control program and supports health departments in every Georgia county, will be involved in prevention and screening. The specific objectives of this initiative are as follows:

- **Prevent cancer and detect existing cancers earlier.**
The initiative will work to reduce the number of cancer deaths through a focused education and screening effort, with particular emphasis on the cancers that are the major causes of death. Development of a statewide network of public and private providers will give Georgians greater access to screenings.
- **Improve access to quality care for all Georgians with cancer.**
A network of hospitals will ensure that basic cancer care is available close to home anywhere in the state. More advanced treatment will be available at several medical centers throughout the state and at three cancer centers of excellence, enabling Georgians to get world-class medical care and participate in clinical trials without leaving the state. All Georgia cancer providers will be part of the initiative. Georgia will undergo an extensive process to earn designation from the National Cancer Institute (NCI) for a comprehensive cancer center, the highest designation offered.
- **Save more lives in the future.**
The initiative will recruit 150 eminent scientists and clinicians to Georgia universities and medical centers and coordinate clinical research efforts. New detection and treatment methods and technology will contribute to the ultimate eradication of cancer. The initiative will support a bioinformatics program, using biology, mathematics and computers to predict predisposition for specific cancers. The program will be one of the few in the nation specializing in cancer.
- **Train future cancer researchers and caregivers.**
The initiative will develop curriculum standards for training of future clinicians and continuing education for practicing clinicians.
- **Realize economic benefits from eradicating cancer.**
Building partnerships with pharmaceutical and biotechnology companies will provide quality jobs to Georgians and environmentally clean additions to the economy. Private funding will help support research and launch new developments with commercial potential.

Through the Georgia Cancer Initiative, Governor Barnes and the Georgia Cancer Alliance have mapped out the state's strategic plan for comprehensive cancer services and treatment. The regulatory guidelines put forth by this component plan are designed to support this vision for improved and expanded services and fulfill the review process required by law and regulation.

II. OVERVIEW

A. CANCER AND ITS INCIDENCE IN GEORGIA

Cancer is a group of diseases characterized by uncontrolled growth and the spread of abnormal cells. If this spread is not controlled, the disease can result in death. Treatment of cancer consists mostly of three types: surgery, chemotherapy, and radiation therapy. For most cancers, the initial approach to treatment has been surgery. However, over the last 50 years great strides in chemotherapy and radiation therapy have made cancers that were not treatable with surgery potentially curable. These techniques also have been used in conjunction with resection for those lesions that could not be completely removed.

The Georgia Department of Human Resources, Division of Public Health and the American Cancer Society recently issued a joint report entitled Georgia Cancer Data Report 2000. The report indicates that more than 32,900 Georgians will develop cancer in 2000, and 13,700 Georgians will die from this disease. Additional information from the Data Report 2000 highlights the anticipated demand for and potential benefit from an expanded, quality-driven cancer services network throughout the state.

Cancer is the second leading cause of death in Georgia, accounting for 1 of every 4 deaths from cancer. This disease most often affects adults in mid-life or older. Data Report 2000 indicates that between 2000-2015, the number of Georgians over the age of 65 will increase by 51% to 1.2 million. Since the risk of developing cancer increases with age, this aging of the population will increase the burden of cancer in Georgia. Between 1994-1998, there was an average of 12,714 cancer deaths in Georgia per year; 6,818 males and 5,896 females. Four cancer sites, lung, colorectal, breast and prostate accounted for 54% of those cancers.

Predictably, there are a large number of counties in rural south and east Georgia where mortality rates are significantly higher than the state average. All counties in the Metropolitan Atlanta area, with the exception of Fulton County, have significantly lower cancer mortality rates than the state average. This documented disparity between rural and urban communities should be considered in developing any regulatory guidelines for radiation therapy services.

Racial differences exist in cancer mortality in Georgia. According to Data Report 2000, African-Americans in Georgia were 27% more likely to die of cancer than whites. During 1994-1998, overall cancer mortality rates were 205.1 per 100,000 among African-Americans and 161.1 per 100,000 among whites. During this same time, lung, prostate, colorectal, and pancreatic cancer mortality rates were higher 17%, 162%, 41%, and 50% respectively, among African-American males in Georgia compared to white males. The same report noted that African-American males are more than twice as likely to die of prostate cancer than white males. Unlike many other types of cancers, lung and ovarian cancer mortality rates during 1994-1998 were lower, 33% and 17% respectively, among African-American females in Georgia as compared to white females. Conversely, breast, colorectal, and pancreatic cancer mortality rates were higher, 36%, 54%, and 48% respectively among African-American females in Georgia as compared to white females. These data highlight the importance of promoting geographic, racial and financial access to radiation therapy services throughout

Georgia.

Data Report 2000 indicates that prostate cancer is the second leading cause of cancer death among Georgia males. During 1980-1992, prostate cancer mortality rates in Georgia increased 29% followed by a 20% decline between 1992-1998. The report indicates that breast cancer is the second leading cause of cancer death among Georgia females. During 1980-1987, breast cancer mortality rates in Georgia increased 25% followed by a 14% decline between 1987-1998.

Lung and colorectal cancers were rated as the first and third leading causes of death for both males and females in Georgia. The mortality rates for lung cancer of males in Georgia are two times higher than rates of any other cancer and the rate for women has doubled since 1980. More females have died each year of lung cancer than breast cancer, which, for over 40 years, had been the major cause of cancer death among females. Additionally, colorectal cancer is the third leading cause of cancer death among Georgia males and females. During 1980-1990 colorectal cancer mortality rates, for men, increased 12% followed by a 20% decline between 1990-1998; while for women, colorectal cancer mortality rates have declined 16%.

While cancer incidence seems to be growing, mortality rates have been decreasing or stabilizing. The overall cancer mortality rates among Georgia males declined by 9%. Unlike males, overall cancer mortality rates among females have been steadily increasing over the past two decades. The increase appears to be slowing in recent years. Prevention is the key to decreasing incidence. Screening and successful treatment can play a significant role in decreasing mortality once cancer is diagnosed.

To summarize key points of Data Report 2000:

- Cancer is the second leading cause of death in Georgia, causing almost a quarter of all deaths in the state.
- This year, a projected 13,700 Georgians will die of cancer and almost 33,000 will develop the disease.
- Cancers of the lung, breast, prostate, and colorectum account for more than half of Georgia's cancer deaths.
- Under current trends, 1 in 2 men and 1 in 3 women in Georgia will develop cancer sometime during their lifetime.
- Only about half of Georgia women 40 and older are screened for breast cancer and about half the adults in the state are screened for colorectal cancer. Early detection can affect survival rates for these cancers.
- Areas with high cancer death rates include Rome, Augusta, Fulton County and many counties in rural south and east Georgia.

B. THE ROLE OF RADIATION THERAPY IN TREATING CANCER

Data from the United States Department of Health and Human Services (HHS) indicates that cancer is commonly treated by surgery, radiation, chemotherapy, hormones, and immunotherapy or a combination of two or more of these methods. Radiation therapy is a clinical specialty in which ionizing radiation is used to

treat cancer. The predominant form of radiation therapy uses an external force of radiation, which is focused on the diseased area. Radiation therapy is an effective way to treat many kinds of cancer in almost any part of the body. For many cancer patients, it may be the only treatment needed. For others, radiation therapy may be used in combination with other cancer treatments like chemotherapy and surgery.

Currently, radiation therapy is used to manage 50% to 60% of all patients with cancer (U.S. HHS, 1992). When radiation is used at high levels, it kills cancer cells or keeps them from growing and dividing more rapidly. Doctors use radiation therapy before surgery to shrink tumors and after surgery to stop the growth of cancer cells that may remain. Even when cancer cannot be cured, radiation therapy is an effective palliative treatment bringing relief to patients by shrinking tumors and reducing pressure, bleeding, pain or other symptoms. Radiation Therapy can be in either of two forms: external or internal. Some patients have both forms, one after the other. Presently, the predominant type of equipment that is used for radiation therapy is called a linear accelerator. The component plan guidelines focus on regulation of those most commonly used machines without restricting development of certain costly and scientifically specialized equipment. Data from the Department of Community Health, Division of Health Planning, indicates that there were 77 linear accelerators in the State of Georgia in 1999. The map, which follows, depicts the geographic distribution of radiation therapy services throughout the state. The vast majority of these sites use either high or low voltage linear accelerators.

III. GUIDELINES

A. USE OF GUIDELINES

The following criteria and standards outline the guidelines for the development and delivery of Radiation Therapy Services in the State of Georgia as recommended by the Health Strategies Council. The planning horizon for radiation therapy services should be five (5) years; comparable to the planning period for other specialty acute care services. Planning for radiation therapy services should be based on twelve fixed geographic regions. (See Appendix B.)

B. DEFINITIONS FOR GUIDELINES

1. "Planning area" means the geographic regions (state service delivery regions) in Georgia as defined in the official State Health Plan for use in planning for radiation therapy services (See Appendix B).
2. "Horizon Year" means the last year of a five-year projection period for need determinations for radiation therapy services.
3. "Most recent two years" means the twenty-four month period immediately prior to the month of application, in the case of data submitted by the applicant, or the twenty-four month period documented in the agency annual or ad-hoc survey process provided that the most recent such survey covers a period of time ending not more than six (6) months prior to the month of application.
4. "Optimal Utilization" refers to patient treatment visits and shall be defined as 6,000 treatment visits per year per radiation therapy unit.
5. "Radiation Therapy" means the use of penetrating rays, including to linear accelerators, x-rays and other sources of radiation, or subatomic particles to destroy cancer cells or treat medical conditions.
6. "Unit" means a single machine used for radiation therapy, generally a linear accelerator.
7. "Urban County" means a county with a projected population for the horizon year of 100,000 or more and a population density for that year of 200 or more people per square mile. All other counties are "rural."

C. STANDARDS FOR GUIDELINES

APPLICABILITY

A Certificate of Need will be required for the establishment of any new or expanded Radiation Therapy service.

AVAILABILITY

STANDARD 1: NEED

The need for a new or expanded radiation therapy service shall be determined through the application of a Numerical Need method and an assessment of the aggregate utilization rate of existing services.

(i) The numerical need for a new or expanded radiation therapy service in a planning area shall be determined through the application of a demand-based forecasting model. The model is outlined in the steps listed below, and all data elements relate to each planning area:

- A. Calculate the projected incidence of cancer for each county by multiplying the most recent Cancer Incidence Rate, as published by the State Cancer Registry, for each county by the horizon year population for the county;
- B. Multiply the projected incidence of cancer by 50% to determine the number of projected cancer cases in each county which could be treated with radiation therapy;
- C. Add the number of treatable cases for each county within a Planning area to determine the need for radiation therapy services within the Planning area for the horizon year.
- D. Calculate the number of needed radiation therapy service units by dividing the number of treatable cases by 250, which represents the optimal number of unduplicated patients to be served by a radiation therapy unit within a given year.
- E. Determine the net numerical unmet need for radiation therapy services by subtracting the total number of radiation therapy units currently existing or approved for use from the number of needed radiation therapy units.

(ii) Prior to approval of a new or expanded radiation therapy service in a planning area, the aggregate utilization rate for all radiation therapy services in that planning area shall equal or exceed 80% of optimal utilization for the most recent survey year.

Rationale for Standard 1: TAC members agreed that a formula which encapsulated both the projected need for services (supply, as measured by incidence and optional patient treatment volume) and the recent utilization of existing services (demand, as measured by treatment visits) would be appropriate and would provide the best indicator of need for radiation therapy services. Furthermore, TAC members agreed that

data used to estimate cancer incidence rates should be derived from the Georgia Comprehensive Cancer Registry (GCCR). The GCCR collects statewide data on new cases of cancer and these data are used to estimate cancer incidence rates within Georgia, monitor cancer trends, evaluate possible clusters of cancer, respond to inquiries about cancer from the public, and conduct research.

TAC members agreed that the number of cancer cases that could be treated with RT should be incorporated into the need formula. Members examined the percentage that other states used to make this determination, but felt that the national guidelines, as they appear in Radiation Oncology in Integrated Cancer Management, A Report of the Inter-Society Council for Radiation Oncology, 1991 ("the Blue Book") would be the most appropriate measure to adopt. The national guidelines indicate that the number of cancer cases that could be treated with radiation therapy is between 50%-60%. TAC members recommended that this percentage (50%) be revisited periodically, given the constant technological changes that continue to impact treatment modalities. The group derived the optimal number of patients (250) and the optimal number of treatment visits (6,000) per radiation therapy unit from documentation in "the Blue Book," and expert input.

STANDARD 2: EXCEPTION TO NEED

Exceptions to the need standard referenced in (c) (1) may be granted for applicants proposing any of the following:

- (i) To assure geographic access to a new radiation therapy service in rural areas when the proposed service is:
 - A. to be located in a rural county;
 - B. to be located a minimum of 45 miles away from any existing radiation therapy service; and
 - C. projected to serve a minimum of 200 patients per year. For purposes of this requirement, service projections must be submitted by the applicant using, at a minimum, state cancer registry data and documented cancer treatments within the service area.
- (ii) To allow expansion of an existing service, if the actual utilization of each radiation therapy unit within that service has exceeded 90 % of optimal utilization over the most recent two years.
- (iii) To allow expansion of an existing service, if the applicant has a substantial out-of-state patient base. 'Substantial out of state patient base' shall be defined as using at least 33% of optimal utilization for each radiation therapy unit over the most recent two years to treat patients who reside outside of the State of Georgia.
- (iv) To remedy an atypical barrier to radiation therapy services based on cost, quality, financial access and geographic accessibility.

Rationale for Standard 2: The TAC unanimously recommended the inclusion of an 'Exception to Need' standard to assure geographic access to services in rural counties and to allow for the development of or expanded services when special utilization factors or atypical barriers seem to warrant. The first standard recognizes that rural communities may need special dispensation to promote accessible services around the state. TAC members also agreed that providers whose units have reached optimal utilization of 90% for each unit over a two-year period should be allowed to seek an expansion of the service. This level of utilization suggests a growing demand for these particular services, even if the overall need has not been identified. The third exception standard recognizes the role of radiation therapy providers who, given the uniqueness of their program, attract a substantial out-of-state patient base. This exception may be particularly important as the Governor's Cancer Initiative is fully developed. For the fourth exception, the TAC unanimously agreed that an exception to need would be warranted if an unusual circumstance such as cost, quality, financial and geographic access is proven to exist. The burden to substantiate any of these circumstances rests on the applicant.

STANDARD 3: ADVERSE IMPACT

An applicant for a new or expanded radiation therapy service shall document the impact on existing and approved services which already provide radiation therapy to the residents of the planning area with the goal of minimizing adverse impact on the delivery system and shall document that the new or expanded service would not result in an existing service falling below 80% of optimal utilization. For those existing services in the applicant's proposed planning area already performing below 80% of optimal utilization, the application shall document that it will not cause such existing service to fall more than 10% below its current utilization. An applicant proposing a service pursuant to the exceptions to need standards referenced in (c) (2) (ii) and (iii) shall not be required to document impact on existing and approved services as required by this paragraph.

Rationale for Standard 3: The TAC unanimously recommended the inclusion of an Adverse Impact Statement, which states that the applicant has to document the impact on existing and approved services in the planning area with the goal of minimizing the impact on existing service(s) to less than desirable capacity levels. An existing facility should not fall below 80% of optimal utilization; an existing service that is already performing below 80% should not fall more than 10%. The TAC felt that a decrease in the volume of patients would impact the quality of the service.

The TAC recommended that facilities that fall under (C)(2) ii & iii of the Radiation Therapy Services Rules be exempted from addressing adverse impact in their Certificate of Need applications. The TAC contended that to allow an existing facility with a high utilization (= 90%) to expand, permits that facility to better serve new or existing patients. Likewise, a facility with a substantial out-of-state patient base does not adversely impact existing providers since it attracts a substantial portion of its patients from outside of the planning area and the state and is less likely to adversely impact another provider.

STANDARD 4: FAVORABLE CONSIDERATION

An applicant for a new or expanded radiation therapy service, whether applying under the need standard referenced in (c) (1) or any of the exceptions referenced in (c) (2), shall receive favorable consideration if the applicant is a designated participant in the Georgia Cancer Coalition.

Rationale for Standard 4: Following the announcement of the Georgia Cancer Coalition and the broad-based initiatives of Governor Roy Barnes relative thereto, the executive committee of the Health Strategies Council at the recommendation of the Department unanimously proposed the inclusion of this favorable consideration statement. The intent of this provision is to ensure that designated participants in the Georgia Cancer Coalition are afforded every possible consideration in the certificate of need review process, authorizing the Division to approve any Coalition-designated application submitted in accordance with either the need or exception provisions. Any such application would not be required to mitigate any potential adverse impact but would be required to address access, quality, continuity of care, and reporting requirements in keeping with the goals of the Coalition. In the case of competing but equal applications, a designated participant in the Coalition would be awarded the approval.

STANDARD 5: ACCESS TO CARE

An applicant for a new or expanded radiation therapy service shall foster an environment, which assures access to individuals unable to pay, regardless of payment source or circumstances, by the following:

- (i) providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, race, or ability to pay;
- (ii) providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent of annual, adjusted gross revenues for the radiation therapy services program or, in the case of an applicant providing other health care services, the commitment to services for indigent and charity patients may at the discretion of the applicant be applied to the entire facility;
- (iii) providing a written commitment to participate in the Medicaid and PeachCare programs;
- (iv) providing a written commitment to participate in any other state health benefits insurance programs for which the radiation therapy service is eligible; and
- (v) providing documentation of the past record of performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, and indigent and charity patients.

Rationale for Standard 5: Providing full access, free from financial or any other discrimination, is central to Georgia's health care purchasing and regulatory mission. Providers should be expected to adhere to these standards as a criterion for receiving any business or operational approval from the state. The TAC has endorsed the Department's mission of improving the health status and health outcomes for all Georgians by continuing to require providers to minimize barriers to the accessibility of health care services. TAC members unanimously recommended the inclusion of accessibility as a standard. Applicants for new or expanded services would be required to provide evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis, including providing services to individuals

regardless of race, sex, ability to pay. Applicants also must provide full access to services, regardless of ability to pay or payment source, and are required to agree to participate in any state sponsored or operated health insurance program. In evaluating the past record of performance of the applicant, the Division should consider the record of the applicant and any affiliates. Failure to meet an existing or previous indigent care commitment and/or failure to serve the Medicaid or indigent population at or above a level commensurate with the community served by the applicant and/or its affiliates may be grounds for denial of an application.

STANDARD 6: CONTINUITY OF CARE

An applicant for a new or expanded radiation therapy service shall provide evidence of ability to meet the following continuity of care standards:

- (i) Document a plan whereby the facility and its medical staff agree to provide or, in the case of a free-standing facility, agree to participate in a full array of cancer services to the community, including, but not limited to, community education and outreach, prevention, screening, diagnosis, and treatment.
- (ii) Document current and ongoing participation in the State Cancer Registry Program; and
- (iii) Document, where appropriate, participation in and referral to services and programs supported by the Georgia Cancer Alliance.

Rationale for Standard 6: The Department of Community Health, as part of its mission statement, is committed to forging partnerships with a goal of impacting health status in Georgia's local communities. The TAC recommended that an applicant be required to document commitment to the full continuum of care services and ongoing participation in the Georgia Comprehensive Cancer Registry. Appropriately, the TAC proposed that any applicant should have to document its participation with the Governor's Cancer Initiative. It is anticipated that this requirement will expand as the Initiative moves forward. The TAC unanimously agreed that other Quality/Continuity of Care Standards should be addressed through General Considerations.

STANDARD 7: DATA & INFORMATION REQUIREMENTS

An applicant for a new or expanded radiation therapy service shall agree to provide the department with all requested information and statistical data related to the operation and provision of services and to report that data to the department in the time frame and format requested by the Department.

Rationale for Standard 7: The TAC unanimously recommended the inclusion of Data and Reporting Requirements criterion into the Need standards. The proposed need methodology will require provider data for certain components. Further, uniform data is essential to assess changing patterns and projected service needs relevant to the provision of cancer services. As additional emphasis is placed on managed care, quality, patient outcomes, cost and other efficiency indicators, collection of data will allow more precise assessment of these factors as well as others which are important to health planning. Applicants will be

required to provide data related to the operation and provision of services to the Department of Health Planning by the requested time.

IV. GOALS, OBJECTIVES AND RECOMMENDED ACTIONS

GOAL:

- To support the Department of Community Health/Division of Health Planning in their efforts to produce a Radiation Therapy Services plan, which addresses regulatory mandates, changing treatment patterns and the state's vision for cancer services.

OBJECTIVES

- To reflect the rapid technological advances in the treatment of cancer
- To support the Georgia Cancer Alliance.

RECOMMENDED ACTIONS

- The Health Strategies Council should adopt this component plan for Radiation Therapy Services. This component plan is expected to be incorporated into a comprehensive State Health Plan.
- The Board of Community Health should adopt the component plan and rules consistent with the plan.
- The Division should approve Certificate-of-Need applications accordingly;
- The Health Strategies Council should repeal the outdated cancer plan;
- The state's strategic plan for cancer services should be that document or series of documents issued by Governor Roy E. Barnes and the Georgia Cancer Alliance.
- The state should consider providing additional resources to the state cancer aid programs such as the one operated by Department of Human Resources, Division of Public Health, to assist more people in accessing high cost treatment services.

REFERENCES

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Radiation Oncology In Integrated Cancer Management, Report of the Inter-Society Council for Radiation Oncology, 1991 (Blue Book 1991)

Georgia Cancer Coalition: Mobilizing Georgia. Immobilizing Cancer. Fact Sheet, 11/29/2000

Georgia State Health Plan
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APPENDIX A

- MEMBERS -
RADIATION THERAPY SERVICES TECHNICAL
ADVISORY COMMITTEE

Kay Wetherbee, R.N., Chairperson & Member, Health Strategies Council

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Athon, Troy, Starcrest Inc., Caremore Management Co., Inc. & Member, Health Strategies Council

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Cook, Henry, D.D.S., Member, Health Strategies Council

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Carpenter, Larry, Diversified Imaging Services, Inc.

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Hershatter, Bruce W., M.D. Georgia Baptist Medical Center/Medical Association of Georgia

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Georgia State Health Plan
Radiation Therapy Services Component Plan

APPENDIX B

- MAP -

STATE SERVICE DELIVERY REGIONS

GEORGIA

STATE SERVICE DELIVERY REGIONS

