An Employer's Guide to
Cancer & Treatment Prevention

Tool 5:
Vendor Contracting and Administration

Background

This tool can be used to help develop the metrics and reporting components of an employer's contracts with medical and pharmacy vendors and, if applicable, the Centers of Excellence (COE) program, and clinical support and condition management program vendors.

This tool also includes information for developing metrics and reporting components of contracts with short-term disability (STD), family medical leave (FML), employee assistance program (EAP) and health improvement program (HIP) vendors.

Suggested metrics are included for most of the recommendations found in the *Plan Design & Assessment* tool and the *Vendor and Program Management* tools. In addition, employers may receive request reporting on general cancer-related incidence and costs; for example, number of claimants with a cancer diagnosis; gross, billed and paid charges for cancer; details on high-cost cases with a cancer diagnosis, hospital admissions, etc. Note that ICD-9 neoplasm diagnosis coding includes malignant neoplasms (cancer), diagnosis codes 140.0 through 209.69, plus carcinoma in situ, diagnosis codes 230.0 – 234.9, and benign neoplasms (not cancer), diagnosis codes 210.0 through 229.9.

Cancer is a relatively infrequent diagnosis—only about 2.4% of beneficiaries under the age of 65 will have a new diagnosis of cancer during any one year.[1] However, approximately 6.6 % of short-term disability cases and 15% of long-term disability cases are related to cancer.[2] Therefore, it is clear that cancer is a major cost that needs tracking and reporting.

National Business Group on Health

NCCN National Comprehensive Cancer Network®

1.0: General Medical & Behavioral Health

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.1	Does the medical plan offer a network that includes access to a wide range of cancer care providers, including medical oncologists, pediatric hematologist-oncologists, radiation oncologists, surgeons who specialize in cancer, palliative care specialists and pathologists, both in the community setting and in large, academic cancer centers, including National Cancer Institute (NCI)-designated Comprehensive Cancer Centers and Cancer Centers? If the medical plan requires employees and their dependents to obtain prior authorization to receive services at academic medical centers/cancer centers and NCI-designated cancer centers outside the region in order to obtain network benefits, what is the actual average turnaround time to respond to requests?	1. Any changes to the network that materially increase or decrease access to listed categories of providers. 2. Any changes in practices that affect prior approval requirements. 3. Actual average turnaround time on requests for access to non-network providers. 4. Total number of requests for out-of-network access for cancer care: requests approved, requests denied and reasons for denial.	1 & 2: Prior to making the change. 3 & 4: At end of first year and annually thereafter.
	Does the medical plan utilize a restrictive pathway program that limits and/or favors cancer treatment options and includes financial incentives for physicians to choose pathway options for the majority of patients? If so, is the program offered by an external vendor or was it developed internally? OR Does the medical plan preferentially contract with physicians who have adopted a restrictive pathway program?	1. Any changes to the medical plan's use of pathway programs or to the number of physicians who have adopted a restrictive pathway program. 2. If medical plan operates the pathway program, any substantive changes to program design, incentives and/or availability of information about the program.	Prior to making the change.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.2 Medical plan or transplant Center of Excellence (COE) program vendor report on this topic.	Does the transplant Centers of Excellence (COE) program vendor or medical plan: • Employ a rigorous qualification process using transplant-specific criteria for transplants, including bone marrow/stem cell transplants (SCT)? • Reevaluate transplant centers at least every two years? • Have criteria and a process in place to remove a transplant center that no longer meets criteria?	Any material changes to network, network criteria, evaluation requirements or frequency.	Prior to making the change.
	Are transplant COE contracts all-inclusive of hospital services and all applicable physicians, ancillary and other medical care professionals (including behavioral medical specialists) who provide care during the transplant period?	Any material changes to contracting structure or rates.	Prior to making the change.
	Does the transplant COE program provide access to nurses to guide patients in understanding their condition and choosing an appropriate transplant center?	1. Any material changes to clinical guidance practices. 2. Number of stem cell transplant candidates assisted, number that proceeded to transplant (by type of transplant, transplant center, diagnosis). 3. Number of patients going to a non-network transplant center. 4. Data on billed charges, paid and saved, by patient and total. 5. Trend data from prior periods (if applicable).	1: Prior to making the change. 2-5: At end of first year and annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.3 Medical plan or cancer Center of Excellence (COE) program vendor report on this topic.	Does the cancer COE program vendor or medical plan that offers the program: • Employ a rigorous qualification process using appropriate criteria? • Reevaluate cancer centers at least every two years? • Have criteria and a process in place to remove a cancer center that no longer meets criteria?	Any material changes to network, network criteria, evaluation requirements or frequency.	Prior to making the change.
	If applicable, are the cancer COE contracts all-inclusive of hospital services and all applicable physicians, ancillary and other medical care professionals (including behavioral medical specialists) who provide care?	Any material changes to contracting structure or rates.	Prior to making the change.
	Does the cancer COE program vendor or medical plan offer access to clinical staff to guide patients in understanding their diagnosis and treatment options and choosing an appropriate cancer center?	1. Any material changes to clinical guidance practices. 2. Number of cancer patients assisted (by type of cancer and COE). 3. Types of services provided to employees and their dependents; that is, number of referrals to COEs, topics discussed (e.g., education on a cancer diagnosis, symptom management, advance directive, other topics that are tracked). 4. Data on billed charges, paid and saved, by patient and total (if cancer COE network contracts are used). 5. Trend data from prior periods (if applicable).	1: Prior to making the change. 2-5: At end of first year and annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.4 Medical plan or Center of Excellence (COE) program vendor report on this topic.	Does the medical plan or COE program vendor administer a travel and lodging assistance program for patients accessing a transplant COE, cancer COE or both?	1. Number of employees and their dependents who received travel and lodging assistance, by transplant vs. cancer COE program (if both programs are offered). 2. Average payment, per transplant or cancer patient, for transportation and for lodging. 3. Total payments for transplant patients and cancer patients.	At end of first year and annually thereafter.
1.5	Does the medical plan pay for services that are components of a second opinion (for review of the diagnosis, review of the treatment plan or both) at standard reimbursement levels for employees and their dependents with a diagnosis or suspected diagnosis of cancer? If prior authorization (PA) is required, what is the actual average turnaround time to respond to requests?	1. Any changes in practices that affect coverage of PA requirements for second opinion services. 2. Actual average turnaround time on requests for access to second opinion services for network and non-network providers. 3. Total number of PA requests received, number of requests approved, number of requests denied and reasons for denial.	1: Prior to making the change. 2 & 3: At end of first year and annually thereafter.
1.6	Does the medical plan cover routine costs of care when the patient is enrolled in an approved cancer clinical trial that is comparable to coverage for services provided outside of a clinical trial?	1. Any material changes to policies regarding clinical trials. 2. Number of employees and their dependents known to have participated in clinical trials.	1: Prior to making the change. 2: At end of first year and annually thereafter.
	Is prior notification to the medical plan required by the treating physician, who indicates a patient's intent to participate in a clinical trial and confirms that it is an approved clinical trial?	1. Total number of requests received, number of requests approved, number of requests denied and reasons for denial. 2. Actual average turnaround time on requests for access to clinical trials.	At end of first year and annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.7	Can the medical plan implement the hospice benefit as described in the RFP for employees and their dependents with an estimated life expectancy of 12 months or less, including up to five days of inpatient respite care?	1. Any material changes in hospice coverage or criteria for hospice enrollment. 2. Number of employees and their dependents enrolled in hospice during the reporting period; range and average length of stay in hospice. 3. Number of employees and their dependents utilizing respite care option. 4. Trend data from prior periods (if applicable).	1: Prior to making the change. 2-4: At end of first year and annually thereafter.
	Can the medical plan cover routine costs of care, paid separately from the hospice per diem, for employees and their dependents enrolled in a qualified clinical trial while also enrolled in hospice?	Number of employees and their dependents known to have enrolled in a clinical trial while in hospice.	At end of first year and annually thereafter.
	Can the medical plan reimburse for residential services (in a residential hospice, skilled nursing or assisted living facility or when provided by in-home aides) when an employee or dependent is eligible for and enrolled in a hospice program and meets other criteria described in the RFP?	1. Number of employees and their dependents who were approved for residential services, by setting (residential hospice, skilled nursing facility, assisted living facility, in-home). 2. Range, average and total days in residential care. 3. Average cost per person receiving residential care; total costs of residential care.	At end of first year and annually thereafter.
	Does the medical plan provide care management support for individuals who have a diagnosis of cancer, an advanced illness and/or who are terminally ill?	1. Number of employees and their dependents assisted by care management nurses related to discussion of end-of-life options and hospice. 2. Number and percent of those assisted who elected to enroll in hospice. 3. Average days in hospice for those assisted by care managers compared to those known to have enrolled in hospice who were not assisted by care managers.	At end of first year and annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.7 *(continued)*	Does the medical plan use a qualification process for hospice programs to ensure they have appropriate certification and meet quality standards?	Any material changes to qualification criteria and hospice network.	Prior to making the change.
1.8	Can the medical plan ensure reimbursement at standard rates for consultation by a network physician with patients and family members about options for care?	Number of employees and their dependents known to have requested coverage for consultation.	At end of first year and annually thereafter.
1.9	Can the medical plan ensure reimbursement for nutrition counseling and medical nutrition therapy in conjunction with a diagnosis of cancer?	1. Any material changes in policy related to medical nutrition therapy and nutrition counseling. 2. Number of employees and their dependents known to have received these services.	1: Prior to making the change. 2: At end of first year and annually thereafter.
	Does the medical plan network include registered dietitians, including dietitians who are Board-certified in oncology (CSO)?	Any material changes to network of registered dietitians and dietitians who are Board-certified in oncology (CSOs).	Prior to making the change.
1.10	Does the medical plan ensure reimbursement of dental preventive services and treatments when required prior to, during and after cancer treatment or stem cell transplant and when not otherwise covered by dental benefits, consistent with specifications in the RFP?	1. Any material changes in policy related to coverage of dental services. 2. Number of employees and their dependents receiving these services under the medical plan. 3. Total and average charges and paid amount for dental services under the medical plan.	1: Prior to making the change. 2 & 3: At end of first year and annually.
	Does the provider network include dentists and oral surgeons, including maxillofacial surgeons (MD/DDS or DDS), on faculty at academic medical centers and cancer centers?	Any material changes to network providers in these categories.	Prior to making the change.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.11	Does the medical plan reimburse for molecular/ biomarker testing based on recommendations in NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)?	Any material changes in monitoring, management or reimbursement of these services.	Prior to making the change.
1.12	Does the medical plan reimburse for genetic testing and counseling for risk assessment of employees and their dependents with significant family or personal cancer history based on recommendations in NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)?	1. Any material changes in policy related to genetic testing and counseling, including process for ensuring appropriateness of services. 2. Total number of employees and their dependents receiving these services. 3. Total and average charges and amount paid for genetic testing and counseling services.	1: Prior to making the change. 2 & 3: At end of first year and annually thereafter.
	Does the medical plan reimburse for genetic counseling services only when provided by professionals certified to provide genetic counseling and medical genetic services; that is, Board-certified or Board-eligible genetic counselors or medical geneticists (physicians)?	Any material changes to policy related to appropriately qualified genetic counselors and medical geneticists.	Prior to making the change.
	Does the medical plan network provide access to Board-certified or Board-eligible genetic counselors and medical geneticists?	Any material changes to network providers in these categories.	Prior to making the change.
1.13	Does the medical plan reimburse for standard fertility preservation treatments for iatrogenic infertility (infertility caused by medically necessary cancer treatment) when treatments have been identified as appropriate by applicable professional societies and any requirement to demonstrate attempts to conceive before infertility benefits become available have been waived?	1. Any material changes in policy regarding coverage for iatrogenic infertility. 2. Number of employees and their dependents known to have requested coverage for fertility preservation treatments for iatrogenic infertility.	1: Prior to making the change. 2: At end of first year and annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.14	Does the medical benefit plan reimburse for home health visits consistent with standards described in the RFP?	1. Any material changes in policy regarding home health services. 2. Number of employees and their dependents with cancer who received home health services (excluding home hospice visits). 3. Average per recipient and total number of home health visits.	1: Prior to making the change. 2 & 3: At end of first year and annually thereafter.
1.16	Does the medical plan reimburse for depression screening (performed by oncologists and other covered providers) for all cancer patients and other employees/dependents?	Any material changes in policy regarding reimbursement for depression screening.	Prior to making the change.
	Does the medical plan reimburse for depression screening procedures as a unique lab test?	Any material changes in policy regarding reimbursement for depression screening when a standardized screening instrument is used.	Prior to making the change.
1.17	Does the medical plan reimburse approved providers, including oncologists, for screening, assessing and diagnosing behavioral medical conditions as a primary or secondary medical condition?	Any material changes in policy regarding reimbursement for screening, assessing and diagnosing behavioral health conditions.	Prior to making the change.
1.18	Does the medical plan reimburse for consultation between an approved provider, a behavioral medical specialist and/or a condition management specialist to provide collaborative care for patients with cancer who are diagnosed with a behavioral medical disorder but are principally treated in a medical setting?	Any material changes in policy regarding reimbursement for collaborative care.	Prior to making the change.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
1.19	Does the medical plan credential and contract with behavioral health providers at network cancer centers and children's hospitals?	Any material changes in network behavioral health providers in cancer centers and children's hospitals.	Prior to making the change.

2.0: Pharmacy Benefits

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
2.1 Medical and pharmacy plan vendors report on this topic where applicable.	Does the pharmacy benefit plan include a reasonable out-of-pocket threshold, consistent with the limits described in the RFP?	Any material changes in out-of-pocket requirements, or implementation of customer's out-of-pocket requirements.	Prior to making the change.
	Do pharmacy and medical benefit plan administrators work together to implement a single out-of-pocket maximum for medical and pharmacy expenditures?	Any material changes in the working relationship between medical and pharmacy administrators to implement a single out-of-pocket maximum.	Prior to making the change.
	Does the Specialty Pharmacy (SP) program provide counseling services to employees and their dependents obtaining oncology medications?	Any material changes to the counseling services (e.g., conditions addressed, drugs included, and qualifications of counselors) for employees and their dependents obtaining oncology-related medications through the SP program.	Prior to making the change.
	Does the SP program provide access to information about programs to assist patients with the costs of prescription drugs?	Number of employees and their dependents provided with information about financial assistance programs.	At end of first year and annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
2.2 Medical and pharmacy plan vendors report on this topic.	Do administrators of medical plans, pharmacy benefit management (PBM) programs, SP plans and any other relevant organizations ensure that plans cover evidence-based cancer treatment, whether paid under the medical or pharmacy benefit, based on treatment recommendations in NCCN Guidelines® and NCCN Drugs & Biologics Compendium (NCCN Compendium®) with Category 1 and 2A level of evidence and consensus, and/or as included in ASCO Guidelines? Do plans have policies or provisions for determining coverage decisions for treatment recommendations included in the NCCN Compendium® Category 2B level of evidence and consensus?	Any changes to criteria used to determine coverage of on-label or off-label drugs and biologics for cancer care.	Prior to making the change.
2.3 Medical and pharmacy plan vendors report on this topic.	Do medical and pharmacy benefit plan administrators have a process to work together to establish parity of patient cost sharing, consistent with specifications in the RFP?	Any changes in vendors' ability to ensure parity.	Prior to making the change.

3.0: Clinical Support & Condition Management

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
3.1 Medical plan or care management vendor report on this topic.	Does the medical plan or a separate vendor provide assistance related to a cancer diagnosis via a nurseline service that offers information on cancer-related clinical issues and community resources?	1. Any material changes to nurseline services. 2. Number of employees and their dependents assisted, by cancer-related topic.	At end of first year and annually thereafter.
	Are appropriately trained nurses and/or others employed to staff the nurseline program?	Any changes to required qualifications of nurses or others who staff the nurseline program.	Prior to making the change.
3.2 Medical plan or care management vendor report on this topic.	Does the medical plan or a separate vendor offer a cancer care management/disease management program?	1. Any material changes to the cancer care management/disease management program (scope and focus of program, resources used, required qualifications of nurses and/or medical director). 2. Number of employees and their dependents assisted by topic: a) referral to COE (by cancer center); b) issues addressed (i.e., education about cancer diagnosis, symptom management, discussion of advance directives, hospice); and c) other topics that are tracked. 3. Trend data if employer has had the program for more than one year (number of employees and their dependents assisted, duration of engagement, hospice enrollment, etc.)	At end of first year and annually thereafter.
	Does the program include social workers with oncology experience to support patients and their families?	Any change regarding access to social workers.	Prior to making the change.

4.0: Short-Term Disability (STD)

For all disability contracts, the following information should be tracked:

The number of individuals assisted, including:

1. Disability referrals received and cases opened, organized by approved applications for STD and by type of cancer;
2. Average disability leave duration approved; and
3. Average disability leave duration used.

This information should be reported at the end of the first year and at least annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
4.1	Do the STD vendor's policies and practices require coordination with the EAP?	Number of STD cases in which coordination with the employer's EAP vendor occurred.	At end of first year and at least annually thereafter.
4.2	Does the STD vendor utilize cancer-specific protocols, based on clinically validated information, for guidance in certifying and managing cancer-related disability cases?	Any material change in cancer-specific disability protocols used.	Prior to making the change.
4.3	Do STD program case managers have working knowledge of evidence-based cancer treatment guidelines (e.g., NCCN Clinical Practice Guidelines in Oncology)?	Any material changes in requirements and training from what was included in the RFP response.	Prior to making the change.
	Do STD program case managers have access to an oncologist as needed for consultation?	Any change in access from what was included in the RFP response.	Prior to the change in access.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
4.4	Do STD program case managers actively manage each case, gather treatment data and information from the employee, the employee's treating physician/the physician's staff and others involved in the employee's care in order to certify and determine the length of the employee's STD leave?	1. Any material changes to policies and practices included in the RFP response. 2. Number of documented consultations with treating physician or physician's staff.	Prior to making the change.
4.5	When STD program case managers identify employees with behavioral issues or disorders, do they have access to health psychology and behavioral medicine specialists or health coaches trained to work with employees with serious and/or chronic illnesses such as cancer?	Any change in access to health psychology and behavioral medicine specialists or health coaches from what was included in the RFP response.	Prior to making the change.
4.6	Do STD program case managers consult with the employee's treating physicians to encourage collaborative care when an employee's treatment adherence and/or recovery are negatively affected by behavioral health issues?	1. Any changes in policies or practices included in the RFP response. 2. Number and percent of STD cases in which consultation with the employee's treating physician occurred related to behavioral health issues and collaborative care.	1: Prior to making the change. 2: At end of first year and at least annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
4.7	Do STD program case managers have the requisite training to: • Evaluate employee impairment and level of functioning (based on job requirements and demands)? • Understand the employee's return-to-work requirements? • Judge the intensity level of treatment and constellation of care needed to assist the employee? • Recognize and manage comorbidity and the overall health status of the employee?	Any material changes in requirements and training from what was included in the RFP response.	Prior to making the change.
4.8	Do STD program case managers, in coordination with the employee's supervisor, human resource (HR) representatives and, when appropriate, the legal department and EAP staff, establish criteria for determining reasonable accommodations for employees with cancer?	1. Any material changes in requirements and training from what was included in the RFP response. 2. Number and percent of STD cases in which consultation about accommodation occurred. 3. Number and percent, by type of accommodations recommended.	1: Prior to making the change. 2: At end of first year and at least annually thereafter. 3: At end of first year and at least annually thereafter.
4.9	Do STD program case managers ensure that an employee who has returned to work from STD as either a full- or part-time employee and then needs to take a second STD leave will not begin a new benefit period or be subjected to a new elimination period if the second disability is the same as the first? Is the entire period of absence considered as one continuous period resulting from the disability?	1. Number of employees who returned to work and remained on STD for ongoing treatment. 2. Average length of STD cases for employees who returned to work and remained on STD.	At end of first year and at least annually thereafter.

5.0: Family Medical Leave (FML)

For all FML applications, the following information should be tracked by the FML vendor or employer:

The number of individuals assisted in the following ways:

1. By having their inquiries about FML addressed.
2. By having applications for FML processed for:
   - The applicant's cancer; and
   - Caregiver leave to assist someone else with cancer.

This information should be reported at the end of the first year and at least annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
5.2	When accepting inquiries about FML or applications for it, does the FML vendor provide information about other employer-sponsored benefits, such as EAPs and work/life programs, medical benefits and care management programs, that may be helpful for individuals with a serious and/or chronic illness or who are providing caregiver services for a loved one with a serious and/or chronic illness?	Number of individuals with cancer or providing caregiver services for someone with cancer who were provided with information about employer-sponsored benefits.	At end of first year and at least annually thereafter.
5.3	When accepting inquiries about FML or applications for it, does the FML vendor provide information about caregiver stress and depression and tell employees about resources (such as EAP) that may be able to assist them?	1. Number and percent of individuals with cancer or providing caregiver services for someone with cancer who were given information about caregiver stress and depression. 2. Number and percent referred to EAP or other resource.	At end of first year and at least annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
5.3 *(continued)*	Does the vendor consistently screen individuals applying for FML for depression using a standardized instrument?	1. Number of individuals with cancer or providing caregiver services for someone with cancer who were screened for depression. 2. Percent of all applicants who were screened for depression.	At end of first year and at least annually thereafter.
5.4	When accepting inquiries about FML or applications for it, does the FML vendor provide information about financial counseling and assistance that is available through the employer's EAP and/or other resources?	Number and percent of individuals with cancer or providing caregiver services for someone with cancer who were given information about financial counseling and assistance resources.	At end of first year and at least annually thereafter.

6.0: Employee Assistance Programs (EAPs)

For all participants in the EAP, the following information should be tracked:

1. The number of individuals assisted in the following ways:
   - Having their inquiries about cancer-related issues received and handled by category (e.g., clinical information requested, workplace issues, depression/other behavioral health issues, support services requested and financial issues).
   - Receiving workplace contacts from the applicant's supervisor, manager or the HR department.
2. Number of workplace interventions provided.

This information should be reported at the end of the first year and at least annually thereafter.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
6.1	Do EAP policies and practices require coordination with the STD vendor?	1. Number of referrals received from employer's STD vendor. 2. Number of referrals made to STD vendor.	At end of first year and at least annually thereafter.
6.2	Do EAP professional staff have a basic understanding of the cognitive, emotional and physical issues associated with serious and/or chronic illnesses, including cancer?	Any material changes to requirements and training from what was included in the RFP response.	Prior to making the change.
6.3	Are EAP professional staff capable of providing consultation to supervisors and HR professionals and working effectively with employees who are coping with serious and/or chronic illnesses, including cancer?	Any material changes to requirements and training from what was included in the RFP response.	Prior to making the change.
6.4	The EAP should include information in employee handouts and supervisor training materials that specifically address serious and/or chronic illnesses and how the program can be utilized for consultation and referral of employees coping with serious illnesses, including cancer.	Any material changes to information made available in employee handouts or supervisor training materials.	Prior to making the change.

7.0: Health Improvement Programs (HIPs)

For health improvement programs, the following metrics should be reported at the end of the first year and at least annually thereafter:

1. Number of eligible employees and dependents.
2. Number of participants enrolled.
3. Number of health assessments administered.
4. Number of preventive service programs offered, including number of participants by service type.
5. Number of participants receiving coaching:
   - Average number of coaching sessions per participant.
6. Number of participants with cancer receiving coaching:
   - Average number of coaching sessions per participant with cancer.
   - Number of participants referred by EAP, STD, FML and workers' compensation (WC) for coaching.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
7.1	Do policies, practices and scope of services, including staff competencies, provide evidence of a comprehensive health improvement program that can be tailored to the needs of the organization and its employees and their dependents?	Any material changes to policies, practices and staffing requirements from what was included in the RFP response.	Prior to making the change.
7.2	Does the vendor operationally integrate the health improvement program with STD, FML, EAP and WC in terms of policies, practices and scope of services?	Any material changes to integration of the health improvement program with STD, FML, EAP and WC in terms of policies, practices and scope of services from what was included in the RFP response.	Prior to making the change.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
7.3	Does the health improvement staff have a basic understanding of the cognitive, emotional and physical issues associated with serious and/or chronic illnesses, including cancer?	Any material changes to staffing requirements and training from what was included in the RFP response.	Prior to making the change.
7.4	Does the vendor have clear goals and objectives for conducting health assessments, including biometrics, to identify and manage those at risk for developing serious and/or chronic illnesses, including cancer?	1. Any material changes to goals and objectives for conducing health assessments. 2. Number of health assessments conducted: a) Number of participants identified as at risk for developing cancer. b) Number of participants for whom interventions to mitigate risk were recommended. c) Number of participants for whom interventions were recommended who enrolled in the program.	1: Prior to making the change. 2: At the end of the first year and annually thereafter.
7.6	Does the vendor's health improvement program provide education, programs and services to manage cancer risks for those currently being treated for cancer and for those who have been treated for cancer in the past, as well as for healthy individuals?	Any material changes to programs and services from what was included in the RFP response.	Prior to making the change.

Benefit Recommendation	RFP Questions/Benefit Requirement	Metrics	Frequency of Reporting
7.9	Does your vendor's health improvement program coordinate with you to train staff about resources made available by the employer, including but not limited to the *Cancer Benefits and Resource Guide* and cancer-related fact sheets, which provide accurate information about cancer, health care benefits, cancer treatment, recovery and survivorship, support and advocacy groups and other topics?	Any material changes to cancer-related materials that are offered from what was included in the RFP response.	Prior to making the change.
7.10	Does the vendor describe how it coordinates with the employer to provide orientation and training for supervisors and managers about the health improvement program? Does the vendor provide information and resources to supervisors and managers working with employees and their dependents with serious and/or chronic illnesses, including cancer?	1. The health improvement program vendor should include information in employee handouts and supervisor training materials that specifically address serious and/or chronic illnesses, including cancer, and how the program can be utilized for consultation and referral of employees coping with such illnesses. 2. Number of supervisor and manager training sessions held. 3. Number of managers and supervisors attending training.	1: Prior to making the change. 2 & 3: At the end of the first year and annually thereafter.

References

[1] Barlow R, Schaper J. Actuarial analysis of the recommendations from *An Employer's Guide to Cancer Treatment and Prevention*. PricewaterhouseCoopers Actuarial Analysis. 2013:15.

[2] Unum. Cancer, pregnancy continue to lead disability causes for Unum. *Press Release.* http://www.investors.unum.com/phoenix.zhtml?c=112190&p=irol-newsArticle&ID=1693311&highlight. Accessed November 14, 2012.

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A *National Business Group on Health*[SM] Toolkit

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NCCN National Comprehensive Cancer Network®

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About the National Advisory Committee on Employer Services for the Cancer Continuum of Care

The National Advisory Committee on Employer Services for the Cancer Continuum of Care serves as the expert advisory body for the *Employer's Guide*, ensuring that all information and recommendations are relevant to employers and their partners.

The Committee helps develop recommendations for the design, quality assurance, structure, and integration of resources, programs and services around the full spectrum of employer benefits and programs. This includes the health plan, health and productivity programs and health improvement programs. The Committee consists of benefit managers, clinical cancer experts, medical directors, health plan representatives, pharmaceutical representatives, health care consultants, disability managers, EAP professionals and health improvement program professionals.

An Employer's Guide to
Cancer Treatment & Prevention

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