



Opportunities and New Realities in Cancer Care

A White Paper on Oncologist/Hospital Integration
in the ACA Era

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Executive Summary

A new reality is changing the delivery of cancer care. Well apart from exciting technological, pharmacological, and biomedical advances, this new reality features strategic alignments of hospitals, physicians, and related cancer services. Mergers, acquisitions, and affiliations among cancer care providers are already widespread and expected to continue in the near future.

In cancer care, as increased integration between oncologists and hospitals becomes the new reality, questions arise as to how these alignments are affecting cancer care providers, hospitals, cancer programs, and the patients they serve. What are the opportunities and challenges? What impact does oncologist/hospital integration have on the cost and quality of cancer care?

On June 27, 2013, the Association of Community Cancer Centers (ACCC) Institute for the Future of Oncology held its first forum in Chicago, Illinois, to explore these questions as well as key issues that are affecting community cancer centers today and those anticipated in the future. Forty participants comprising oncologists and cancer program executives from hospitals, practices, and healthcare systems across the country provided insight and solutions to help better understand the challenges of oncologist/hospital integration. This white paper captures their discussions.

Stakeholders at the ACCC Institute for the Future of Oncology 2013 forum recognized a clear national trend: practices and hospitals across the country are consolidating and integrating their cancer programs in response to a variety of economic and market forces. At the same time, the Affordable Care Act (ACA) offers significant incentives to provide integrated oncology services and is driving payment reform initiatives to reduce costs.

Stakeholders agreed that:

- Cancer care providers continue to emphasize clinical integration and coordination (management of patient care across conditions, providers, and settings) with a focus on care that is effective, efficient, and patient-centered.
- Integration of oncologists within hospitals has not impinged on physicians' clinical decision-making. Still, physicians have concerns that their ability to tailor treatments may erode over time, particularly in light of the possibility that system-wide hospital committees may make decisions that impact physician autonomy.

- Quality, cost-effective cancer care requires active physician leaders to become advocates within the hospital and/or healthcare system. Oncologists must be engaged with hospital leadership through open communication between both parties. Hospital leadership would be well served to include oncologists as partners and stewards of resource utilization in light of their expertise in enhancing coordination of care.
- While the forces driving integration are often similar across settings, oncologist/hospital integration models vary across the country and from market to market. Since each community has different characteristics, one size does not fit all. Many options are available to physicians, hospitals, and healthcare systems.
- Under the Affordable Care Act (ACA) and healthcare reform, considerable challenges and opportunities exist. An area of challenge may be patient access to cutting-edge clinical trials. Oncologists will need to advocate for clear language protecting patients' rights concerning clinical trials under this statute. New models, such as accountable care organizations (ACOs) and the oncology medical home, may offer opportunities to ensure high-quality care while reducing costs. As the payment and reimbursement system changes from volume-based to value-based cancer care, the challenge will be to protect patients' interests both clinically and financially. Methods for measuring and ensuring quality must be implemented simultaneously.

I. How is Consolidation of Cancer Programs Taking Shape?

“A continuing shift in delivering cancer care through oncologist/hospital integration models is inevitable.”

According to a recent survey by the Association of Community Cancer Centers, one out of three oncology programs was involved in a merger, acquisition, or affiliation in 2012.¹ When asked if they expect consolidation in the next one or two years, 40 percent of survey respondents answered that they expect consolidation of cancer programs in their geographic area and 46 percent expect consolidation of physician practices.²

In general, *consolidation* brings cancer physicians together under a single tax ID number. *Integration* refers to a hospital or health system employing providers and buying their practices. *Affiliation* refers to a partnership that offers the right balance of structure to assist in improving oncology care delivery without sacrificing independence, for example, academic medical center-to-community cancer center affiliation or clinical research and pharmacy affiliation. However, these terms are often used broadly to describe the evolving landscape.

This trend toward consolidation and integration has been on the rise even before implementation of the Affordable Care Act (ACA). Over the past 4.5 years, 241 oncology clinics have closed, 392 oncology practices entered into purchase or management services agreements with hospitals, and 132 practices have merged or been acquired.³

As drug reimbursement and professional fees experience downward pressure from Medicare, many independent practices have struggled to remain economically viable. Hospitals are motivated to integrate with physician practices to add value to the cancer service line.⁴

Today, facets of the ACA and new payment models require a high degree of coordination and continue to propel the trend. Growing demands for cost containment and value-based healthcare under the ACA are pushing the creation of new approaches to manage the cost and delivery of cancer care.

Other significant drivers of increased integration include:

- A large and growing demand for cancer services, pointing to physician practice acquisitions as a logical expansion strategy for hospitals
- The need for hospitals to attract and retain a dedicated group of oncology providers or risk losing them to a rival hospital or system

- An evolving landscape that demands greater clinical coordination among the various oncology service providers
- Increased competition for high-reimbursement ambulatory services, such as imaging and radiation oncology.⁵

The message is that most hospitals and oncologists have very good reasons for considering consolidation and integration. Increased patient volumes and resources coupled with additional revenue are some of the obvious benefits.

The consensus among participants at the ACCC Institute for the Future of Oncology 2013 forum is that a variety of models for integration are available to oncologists, hospitals, and healthcare systems. One integration model does not fit all. Market dynamics vary from state to state and community to community. However, the new reality is that solo or smaller independent oncology practices may not be viable. The recent American Society of Clinical Oncology *National Census of Oncology Practices: Preliminary Report Census* found that the likelihood of reporting the purchasing of another practice and the closing of the practice in the next 12 months was related to practice size. Larger practices reported greater likelihood of purchasing other practices in the next 12 months. Smaller practices reported greater likelihood of closing their practices in the next 12 months. Geographic location was also related to differences in the reported likelihood of closing and selling practices.⁶

Smaller practices that seek to preserve the status quo may quickly find themselves at a disadvantage in recruiting and retaining providers, attracting patients with a broad scope of services, and meeting increased regulatory and quality reporting requirements.

Forum participants described varying oncologist/hospital integration models in different geographic areas. “You live in your market,” said one oncologist.

In one Southeastern city, for example, one large health system had the stated desire to become the dominant cancer care provider in the region. This same market included one large, diversified, independent practice with a large market share. Though consideration was given to remaining independent, ultimately, the practice agreed to employment and to lead and participate in hybrid cancer institute planning and future leadership.

Different employment models offer varying degrees of integration. These can range from medical staff affiliation to direct hospital employment. (See Appendix A on page 17 for information on the new range of physician/hospital integration models.)

Although multiple integration models are available, each requires commitment and focus to coordinate care and work through differences between the hospital and private practice cultures.

In some regions, strong independent private practices may be best positioned to deliver efficient, cost-effective, state-of-the-art cancer care. One stakeholder described a large practice in the Northeast that is financially stable and committed to being independent. It has the largest research program in the state and has taken on many projects that hospitals could not fund. The independent practice continues to maintain good relationships with payers.

Still, in the words of one oncologist from the South, “A continuing shift in delivering cancer care through oncologist/hospital integration models is inevitable.” This trend likely means that larger entities—whether practices or cancer programs—have a greater chance to survive and thrive in the new cancer care reality.

II. How is consolidation affecting physicians?

“The relationships are evolving. We are just in the second inning.”

Forum participants expressed differing opinions as to their satisfaction with the increased integration and consolidation occurring in their marketplaces. Many were satisfied with the additional resources and improved operational efficiencies that they experienced within the hospital or health system; others adopted a wait-and-see attitude.

Although a few participants at the ACCC forum were long-time hospital employees, many were new to hospital and health system employment. Many had been independent practitioners for many years, if not decades, but market forces such as decreased compensation, growing demands for cost containment, and payment reform initiatives suddenly forced them to reconsider the mature private practice model they had grown accustomed to. This is in keeping with the broader trend. Between 2008 and 2010, for example, studies show that the median oncologist collections for professional charges declined 30 percent, making it increasingly difficult for practices to operate. During the same time frame, compensation for hospital-employed medical oncologists increased by more than 12 percent.⁷ Hospitals are able to provide attractive compensation and

stability. In increasing numbers, oncologists have been migrating to a hospital-centric model.

Participants described a number of challenges as they adjust to the new reality of integration with hospitals and health systems. “The relationships are evolving. We are just in the second inning,” said one oncologist from the Midwest. He and other forum participants expressed fears about lack of day-to-day control over administrative matters, such as staff and scheduling. Others voiced concerns that with consolidation, integration, and the looming oncologist workforce shortage they would spend less time as oncologists and more time as supervisors of mid-level providers, such as nurse practitioners and physician assistants.

Many oncologists noted challenges in adjusting to differences between the practice’s culture and the hospital’s culture. Physicians that may have had more freedom in the practice setting are now held accountable to institutional policies and procedures. Federal, state, and local hospital regulations and policies, as well as accrediting organizations, bring immediate changes to some of the processes that were long-standing in the physician office setting. Physicians unaware of program accreditation requirements for The Joint Commission and the American College of Surgeons, for example, may be challenged to participate in quality studies, cancer committee, chart reviews, and many other initiatives within the hospital.⁸

Participants also voiced concerns about the challenges of adopting information technology (IT) systems. Merging or migrating IT from the physician office setting to the hospital can be an enormous task. Further, hospitals’ systems are rarely oncology specific, and decisions have to be made about the trade-off between decreased functionality and increased cost to run multiple systems.⁹

Despite the many challenges of integration, the consensus of participants at this forum was that new relationships have the potential to benefit all parties involved, including providers, hospitals, and cancer patients. Among the many possible benefits are increased physician and patient resources, a diversified staff, improved operational efficiencies, and increased standardization of cancer care.

Are hospital bureaucracy, policies, and compliance regulations limiting clinical decision-making by physicians? Most participants reported no interference from the hospital or healthcare system in this regard. The consensus was that physicians are allowed leeway in making clinical decisions and in following clinical pathways in their treatment of patients with cancer.

“These pathways should *not* be followed 100 percent of the time,” said one participant, an oncologist/hematologist at a large academic medical center. “They should be followed 80 percent of the time. If you’re getting much above 80 percent, you’re probably not thinking enough....Our patients have to be thought of as individuals. Even more importantly, patients may not want, for example, to have adjuvant chemotherapy. That’s not a negative mark. A discussion happened, and you and the patient made a decision.”

Most physicians follow National Comprehensive Cancer Network (NCCN) *Clinical Practice Guidelines in Oncology* as their first choice. They also follow oncology clinical pathways, which are decision-making tools that help physicians select evidence-based treatment options, based on patient-specific data entries at the site of care.¹⁰

“We have to emphasize that we’re not talking about prescriptive medicine,” said another oncologist, also from a large academic medical center. “Too often, where pathways have recommended one regimen per situation, that gives little room for assessing the patient more appropriately. We need to emphasize that we are dealing with individual people. There will be variability—and there will be patient choice.”

To maintain quality of care and efficiency, participants at the forum stressed the need for oncologist leadership in integrated delivery models. Physician leaders are in a strong position to enhance coordination of care within the hospital or health system because of their expertise in supervision and management of chemotherapy services, clinical pathways implementation and compliance, and cancer services program development.

Participants advised their colleagues to stick up for the cancer service line. Although they may have independence in following clinical pathways today, there is concern that oncologists may lose their autonomy in the future. There is also concern that the cancer service line could be swallowed up in the larger system-wide perspective.

“Hospitals have no malice or direct intent to take away physician autonomy,” one participant noted, “but things crop up from a system level that could have unintended consequences on the cancer center. Always be attentive.” Although an Oncology Pharmacy and Therapeutics (P&T) Committee approves new therapeutics and meets monthly, his health system also has a system-wide P&T Committee, which engaged in discussions about oncologics—discussions that could have severely and negatively impacted treatment decisions if they had been conducted without the input of oncologists. “You have to ... keep your elbows out,” and speak up, he said. As part of the integration process, it is important to clearly define the oncologist’s role, participants said. Contract negotiations, which are a key component of integration

between physicians and hospitals, must spell out how physician leadership will function and provide oncologists a seat at the table.

Decision-making requires alignment of expectations, and physicians must be involved in the decision-making for the cancer program. A partnership with engaged physicians and physician leaders can help deliver a high-quality cancer program integrated within a hospital or health system.¹¹ Unfortunately, some forum participants noted that there is a tendency for hospital systems to believe that physician leaders should be in charge of the clinical side and not necessarily be involved with discussions on policies, strategy, or institutional vision.

Since physician leadership is so critical to the success of a cancer program, some participants suggested that physician leaders should be compensated for their time overseeing policies and strategy. “Many oncologists do not have the time or interest to assume a leadership role,” said an oncologist from the South. He argued that practices must delineate an oncologist who is “good at business” and has a political sense to be that leader, even if it means paying him or her for that time.

III. How is consolidation affecting patients and the delivery of care?

“I’ve never seen so many patients asking to be seen less often or declining to get tests that are due for follow-up.”

Often the transitions related to increased consolidation of cancer programs and integration of oncologists within hospitals are seamless from the patient perspective, but not always.

A few forum participants noted longer patient wait times and fewer FTEs within their hospital compared to their former independent private practices. One participant observed that consolidation had actually resulted in less convenience for patients as some offices closed and patients had to drive farther for care.

In addition, participants expressed concern about the burden of costs of care on patients. As patients transition to care in the hospital setting, they may pay more for their care.

“I’ve never seen so many patients asking to be seen less often or declining to get tests that are due for follow-up,” said an oncologist from the Midwest. He noted also that some patients complain about hospital facility fees—fees they did not have to pay previously when they went to the independent private practice. (Hospital facility fees cover operating and overhead costs and other care not covered by insurance.)

In this shifting environment, the good news is that the emphasis remains on high-quality, individualized care. The addition of new technology and new service lines continues to be part of most cancer programs’ strategies. According to ACCC’s 2013 *Trends in Community Cancer Centers* survey, 61 percent of institutions report introducing new technologies and service lines—up from 51 percent in 2011. Cancer programs are, on average, anticipating increased capital equipment purchases, such as linear accelerators, computed tomography, and ultrasound imaging, in the next fiscal year.¹² In addition, hospital cancer programs continue to offer patients access to additional support services, such as patient navigation, psychological and nutrition counseling, social work, and palliative care, some of which may not have been available within the private practice, and some of which are non-billable—at no cost to the patient.

As forum participants expressed concern about the impact of the high costs of cancer care on patients, they also recognized the more active role that physicians can play to help lower costs.

“Oncologists are stewards of resource utilization,” said one participant. He urged physicians to play a more active leadership role as advocates to protect patients both clinically and financially.

Oncologists are capable of reining in costs for the health system, but in any value-based model they cannot do treatment planning piecemeal, noted the same oncologist, who said that his program is developing its pathways with cost-effectiveness and value in mind.

Participants in the forum also noted that integration with a hospital or healthcare system may have the potential to increase clinical trial availability as these institutions may provide the extra staff and resources needed to streamline the administrative process of accruing patients to studies and overcome burdensome regulatory hurdles.

IV. ACA and the New Reality

“I would hope ... we become more quality-centric and we do a better job of taking care of patients. My hope is that we are not incentivized to do more, but to do more with less.”

With implementation of the Affordable Care Act and its profound effects on healthcare delivery and reimbursement, considerable challenges exist to ensure community access for cancer patients to high-quality, affordable care, as well as to cutting-edge clinical trials.

Potential impact of the ACA on clinical trials

Forum participants agreed that integrating clinical research into routine cancer care at the community level is vital to expanding access to quality care for patients close to home and necessary to deliver high-quality treatment and attract and retain patients. What’s more, community-based oncologists are integral to the cancer clinical trial process. Those community-based oncologists who participate in clinical trials not only extend quality care and trial access to the patients they serve, they gain the experience and expertise needed to provide state-of-the-art, personalized care.¹³

In general, forum participants voiced concerns about shrinking funding for oncology clinical research. Out of a \$6 billion budget, the National Cancer Institute (NCI) allocates only \$150 million to the cooperative groups. (NCI’s Clinical Trials Cooperative Group Program is designed to promote and support clinical trials of new cancer treatments, explore methods of cancer prevention and early detection, and study quality-of-life issues and rehabilitation during and after treatment. Cooperative groups include researchers, cancer centers, and community physicians throughout the United States, Canada, and Europe.) Those dollars have not increased and are shrinking. Moreover, conservative estimates are that \$100 million of other resource monies, time, and personnel are donated to the cooperative groups. Some institutions rely on philanthropy to pay clinical research office bills.

And more specifically, under the ACA, access to clinical trials for patients with cancer may be in jeopardy, participants said.

“We assumed that, at least for Medicare patients, the costs of clinical trials would be paid for by the government. There is no such language in the Affordable Care Act,” said one forum participant.

Oncologists voiced concerns that the key words “standards of care” are not defined within the ACA. The ACA states that the insurer “is not required under federal law to pay for... the cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.”

Since the ACA does not define the actual components of “standards of care,” the door is left open for less coverage for trial participants. Trial participation may become more costly and possibly unaffordable for some patients with cancer. For example, as clinical trials increasingly look for molecular signatures to identify treatments tailored to a patient’s specific needs, routine biopsies are required. If these routine biopsies are not included as a component of “standards of care,” trial participants would be responsible for these costs.

Although current regulations call for tests and procedures that monitor potential complications of experimental drugs to be covered, the ACA does not. In addition, the ACA does not require insurers to pay nursing fees and the IV equipment needed to deliver the experimental drug.

On the one hand, physician integration with hospitals may bolster community access to clinical trials, if there is commitment to engaging in clinical research on the institution’s part. On the other hand, it’s possible that consolidation of hospitals and health systems may negatively affect participation in clinical trials. Many forum participants questioned whether health systems would make a commitment to oncology clinical research, which is typically run on extremely tight margins and even at financial loss to the provider.

“Some have done [clinical research] and done it really well,” said an oncologist. “But chief financial officers of health systems will not take their capital and invest in a loss leader.”

Participants urged hospitals and health systems to make a commitment to oncology clinical research, which is critical to the continued advancement of cancer diagnosis and treatment.

“The landscape is daunting for clinical research under the ACA,” concluded one forum participant. The consensus was that the oncology community will have to advocate and hold the ACA to its word that the rights given to patients under this statute are protected.

Potential impact of health insurance exchanges on access to care

Under the ACA health insurance exchanges will provide quality affordable choices for those who currently have none. By law, insurance plans will not be able to deny coverage to people because of pre-existing or chronic conditions like cancer.

However, participants at the forum expressed concerns that access to cancer care may be affected as health insurance exchanges under the ACA are implemented and as insurers in general seek to restrain costs and limit options. In some states health insurance exchanges are already excluding certain providers, so patients will not have access to some of the leading cancer programs.

Recently, for example, California revealed the bids from the 13 insurance companies participating in its state exchanges, where people without employer-provided insurance will be able to buy coverage from competing insurers. Premiums average just \$321 per month, though prices would vary significantly by age and income level.¹⁴ But there's a catch—under the new state exchange there may be fewer physicians and hospitals to choose from.

One participant noted that while the California exchange offered 13 plans, none in LA County [as of June 2013] included Cedars-Sinai, and that those who wanted to have UCLA Medical Center and its doctors in their health plan might have only one choice in California's exchange.

Participants expressed concerns over the potential impact of narrow network-type plans on health insurance exchanges and that these might lead to less access to care for patients, especially those patients needing specialized providers.

During the forum, participants noted that in the state of Maine some hospitals have been excluded from state exchanges, and some are threatening to file suit.

While state health insurance exchanges are still evolving, participants were concerned that access to some of the leading programs for cancer research might only be available to participants in higher-cost plans.

“There are two kinds of people: people who have cancer and people who do not,” said one Midwestern oncologist. “If you have cancer, you will pick the [plan offering leading centers for cancer research]. If you do not have cancer, you'll save 25 percent, go somewhere else, and panic when you [develop cancer and] don't have them in the

network.” He worried that denying access would lead to “haves and have nots” with regard to access to leading centers for cancer research.

Potential impact of the ACA on payment reform

The ACA and healthcare reform are creating opportunities for providers to assume risk as accountable care organizations (ACOs) and earn bonuses as medical homes. ACOs agree to manage all of the healthcare needs for a defined population in a specific period; they are required to report on utilization, cost, and quality of care. In this new milieu, the concept of payer begins to shift away from traditional commercial health plans to the providers.¹⁵

“We already have two shared savings contracts on total cost per cancer patient per year and it’s working for us and for our patients,” said one oncologist. “If you have a paradigm in place where you deliver high-quality care in a cost-effective manner, basically an oncology medical home, many managed care organizations will take note and send patients with cancer over to you. You’ll become a sustainable center of care for a growing number of patients.”

Participants in the forum said they expect that there will be financial sacrifices on the part of the health system and the oncologist as they transition to these new models of shared savings, such as oncology medical home, which may include care coordination with primary care physicians. Nevertheless, as oncology care providers transition to new shared savings contracts, they can meet these financial challenges through careful consideration, planning, and negotiation.

Within these new payment models, forum participants raised concerns about challenges to the delivery of cancer care. They questioned how health systems with some patients in an ACO and some not in an ACO could standardize care across the system.

If, for example, a health system has 15 percent of patients in an ACO and the other 85 percent are not in an ACO, how can cancer care be standardized in the two populations, asked one participant. “Oncologists cannot take care of patients with two or three standards of care. They cannot, for example, cut down on radiation treatments for some breast cancer patients to three weeks and not for others,” he noted. The challenge for oncologists will be to deliver cancer care based upon evidence-based medicine, not based upon the payer.

As providers and payers move to maximize both quality and cost effectiveness while driving standardization and equity of care, the consensus was that methods for measuring and ensuring quality must simultaneously be implemented. Failure to do so will invite the types of care rationing long associated with socialized medicine in other countries. While the ultimate outcome that matters most to patients is survival, this metric is difficult to measure with statistical accuracy for all but the largest programs. Existing quality reporting programs, such as ASCO’s Quality Oncology Practice Initiative (QOPI), provide an excellent foundation of both process and outcomes measures that are timely and relevant.¹⁶

“I would hope as we enter into different alignments and different consolidation models, we become more quality-centric and we do a better job of taking care of patients,” noted one oncologist from the South. “My hope is that we are not incentivized to do more, but to do more with less.”

Summary and a Look to the Future

An understanding of where cancer care delivery is headed in the next five years and beyond is critical to ensuring patient access both clinically and financially. The emphasis will likely be on clinical integration and coordination—management of patient care across conditions, providers, and settings, over time, with a focus on care that is effective, efficient, and patient-centered.

The trend toward new integration models is too new to measure the actual extent of greater efficiencies and improved care. We can say that innovative, high-quality care is alive and well; cancer programs are investing in capital equipment and new technologies. Most oncologists at this forum report no interference by the hospital with their clinical decision making. Yet at the same time, forum participants are concerned for the future, particularly in light of the possibility that system-wide hospital committees may make decisions that may inadvertently affect clinical decision-making and impact cancer patient access to high-quality treatment options. The message is that oncologists must remain engaged with hospital leadership. A sustainable relationship needs to have open communication and participation from both parties. Oncologist leadership is required to ensure that physicians’ voices are heard within the hospital or health system. To help

maintain quality and efficiency, integration agreements must clearly spell out leadership opportunities that offer oncologists a seat at the table with hospital executives.

As the payment and reimbursement system changes from volume-based to value-based cancer care, the challenge will be to protect patients' interests both clinically and financially. As stewards of resource utilization, oncologists can help rein in costs of care while protecting patient access to high-quality cancer care. Methods for measuring and ensuring quality must be implemented simultaneously.

As integration increases, hospitals and health systems must be encouraged to make a commitment to cancer clinical research, despite the fact that these trials are typically run on very tight margins or even at financial loss. Clinical research is critical to the continued advancement of cancer diagnosis and treatment and supportive care of patients with cancer. In support of patient access to clinical trials, oncologists will need to advocate for a clear definition of "standards of care" within the ACA.

In the new reality of increased integration, oncologists have an opportunity to ensure continued access to the highest value care for their patients and advance delivery of comprehensive, economically integrated cancer services.

Appendix A

Employment structures can offer varying degrees of integration both among oncologists and between the hospital and physicians. Broadly speaking, however, **hospital direct employment** of a physician is about as straightforward as it gets. The physician provides medical services to hospital patients, and in return, the physician receives a paycheck.¹⁷

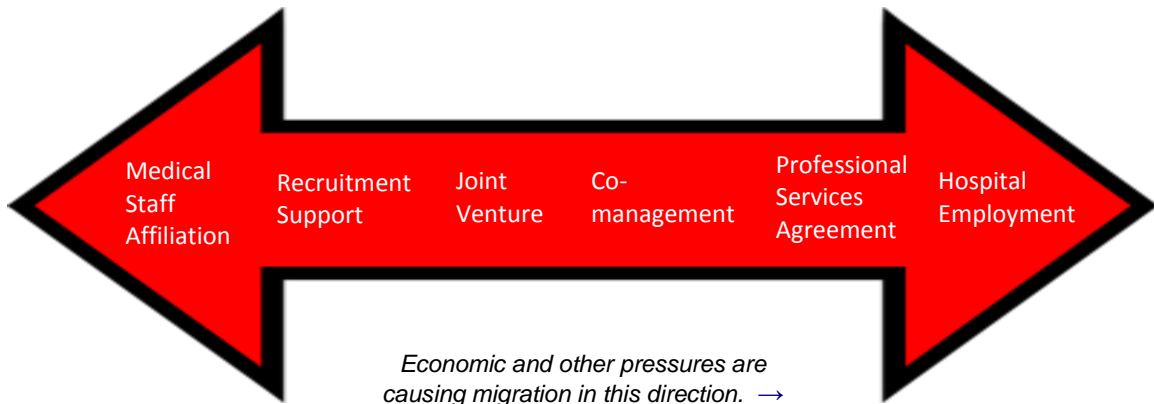
Some practices prefer not to become hospital employees, but instead enter into a **professional services agreement (PSA)** with a hospital. A PSA is one step removed from direct employment and preserves at least a modicum of private practice.¹⁸ A group of oncologists is linked to a separately incorporated hospital through a professional services agreement in which the hospital generally employs all staff, provides all support services, and negotiates managed care contracts. PSAs allow physicians to remain relatively independent. The services covered and the terms involved can be tailored to fit the circumstances.¹⁹

Other practices choose a **co-management arrangement**, in which oncologists and the hospital form a joint venture management company for the purpose of providing management services for cancer services or specific elements of cancer services, such as the infusion center. The management company works with hospital administration to lead the services and implement strategies to standardize the governance and operations of the physician practice. The management company, through its designated physician leaders, provides administrative, medical director, and quality improvement services, as negotiated by the management company. A major advantage: physicians become partners with the hospital in driving programmatic development and are in a strong position to enhance coordination of care.²⁰

Furthermore, many community cancer centers are aligning with National Cancer Institute-designated cancer centers and academic medical centers to expand the scope and quality of care they offer.

Although multiple integration models are available, each requires commitment and focus to coordinate care and work through differences between the hospital and private practice cultures.

Range of New Cancer Care Delivery Models²¹



Loose; little inter-relationship
More individual physician autonomy
Hospital financial support is limited

Tight, integrated relationship
Less individual physician autonomy
Hospital financial support is possible

End Notes

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²⁰ Sturm M and Turgon J;35.

²¹ Adapted from Sturm M and Turgon J; 35.

About the Association of Community Cancer Centers

The Association of Community Cancer Centers (ACCC) serves as the leading advocacy and education organization for the multidisciplinary cancer care team. More than 18,000 cancer care professionals from approximately 900 hospitals and more than 1,200 private practices are affiliated with ACCC. Providing a national forum for addressing issues that affect community cancer programs, ACCC is recognized as the premier provider of resources for the entire oncology care team. Our members include medical and radiation oncologists, surgeons, cancer program administrators and medical directors, senior hospital executives, practice managers, pharmacists, oncology nurses, radiation therapists, social workers, and cancer program data managers. For more information, visit ACCC's website at www.accc-cancer.org. Follow us on Face book, Twitter, LinkedIn, and read our blog, ACCCBuzz.

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