How to Create A Successful Joint Venture

by Linda L. Weller-Ferris, Ed.D.

ILLUSTRATION BY NEIL BRENNAN

Oncology patients and their families expect quality, state-of-the-art cancer care in modern facilities that have access to integrated ancillary services and clinical trials. Unfortunately, cancer programs are facing an increasing number of challenges as they endeavor to meet these expectations. New payment systems from the Centers for Medicare and Medicaid Services (CMS) are reducing hospital and physician reimbursement. Critical shortages of nurses, radiation therapists, dosimetrists, and medical physicists are straining human resources to the limit; and high-priced radiation technology and aging physical plants are putting great stress on institutional budgets.

As the baby boomers age, hospital oncology units are preparing for an increased demand for cancer care services and are fighting for their share of the limited resources within their institutions. The statistics are grim. By the year 2013, 65-year olds will increase by 37 percent, and for every American under the age of 18, there will be one over the age of 65.[1] Statistics tell us that 50 percent of the males and 33.3 percent of the females who live to age 80 will develop some form of invasive cancer over their lifetime.[2]

Regulatory pressures also continue to mount. This year was marked by the first compliance deadline for the Health Insurance Portability and Accountability Act (HIPAA) and an intense focus on the Medication Error Reduction Team (MERT). In addition, cancer program administrators are facing increasing competition from the cancer programs of nearby hospitals and are being forced to spend significant amounts of money on marketing.

To meet these numerous challenges, cancer programs must create improvements within their organization.[3] One option is a joint venture cancer center, which has a number of advantages. To make such a partnership work, however, each participating cancer center must first conduct a careful, independent analysis of what it will win and/or lose by taking such a step.

A joint venture cancer center can offer participating institutions increased purchasing power, lower costs, and enhanced program effectiveness. Human resources are maximized, and the quality and coordination of care usually improve as physicians adjust and commit to the new regime. Successful joint ventures can also lower administrative overhead costs, reduce duplication of services, and increase market share, bringing different geographic penetrations to the partnership. However, without shared values and goals, partnerships will not be successful.

A Case in Point

The Genesys Hurley Cancer Institute (GHCI) was created out of a shared vision of excellence in oncology care on the part of the two hospitals that formed the joint venture, Genesys Regional Medical Center and Hurley Medical Center. These goals were 1) improved patient care, 2) creating a comprehensive, multidisciplinary approach to cancer treatment, 3) updating aging physical

plants, 4) offering state-of-the-art technology in the community setting, and 5) increasing the number of patients participating in clinical trials.

Change is difficult and challenging. This joint venture made changes in the organizational leadership, corporate structure, work team members, daily work patterns, and physical environment of both member institutions over 18 months.

The journey has been long and hard, and many lessons have been learned along the way. At the groundbreaking ceremony, a board member of one of the hospitals remarked that the idea of a joint venture was hatched at his kitchen table with a prominent physician and administrator some seven years ago. The two hospital presidents/CEOs and a dedicated team of administrators from both hospitals "stayed the course" and kept the vision alive. They formed an Administrative Steering Committee composed of key leaders from both hospitals, articulated their ideas repeatedly, built acceptance among the key stakeholders of both hospitals, and brought the project to fruition.

Genesys Regional Medical Center (GRMC) is a 410-bed hospital located in Grand Blanc, Mich. GRMC has annual revenues of more than $300 million with a staff of more than 2,600 FTEs and more than 700 affiliated physicians. The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), and the American College of Surgeons (ACoS). Its physician hospital organization (PHO) network is large geographically, and is composed of more than 127 primary care physicians and 200 specialists.

Hurley Medical Center (HMC) is a 466-bed charter hospital of the City of Flint, Mich. A Board of Managers appointed by the mayor of Flint governs HMC. HMC's PHO network has 54 primary care physicians and more than 200 specialists located in Flint and the surrounding areas.

After both parties exercised their due diligence, the Articles of Incorporation were filed in December 1999 and both hospital boards passed the agreement for the joint venture in October 2000. The medical director was hired from the University of Michigan in August 1999, the second executive director was hired in June 2000, and the GHCI Board of Directors was established in February 2001. The certificate of need name change on four linear accelerators was issued by the state in March 2001. Freestanding, independent financial and corporate status was achieved in May 2001. Assets were transferred into the joint venture with each hospital contributing 50 percent, and a $12.8 million bond was issued through the Economic Development Corporation of the City of Flint to finance the expansion and renovation of the radiation oncology facility that was purchased by the GHCI from GRMC.

One of the first tasks was to develop a governing structure for the joint venture. The GHCI Board of Directors has eight members: four from GRMC and four from HMC. The board has executive, finance, medical quality, and strategic planning subcommittees and an ad hoc governance effectiveness committee. The president/CEO and medical director of GHCI report to the GHCI board, and GHCI's president/CEO and medical director serve on the cancer committees of both Genesys and Hurley Hospitals. Each institution has kept its own tumor registry.

All clinical trial activities are funded by GHCI. Genesys uses a central institutional review board (IRB) from its CCOP, while HMC uses a hospital-based IRB. To date, GHCI has participated in one JCAHO survey and two ACoS/Commission on Cancer (CoC) surveys on behalf of the Genesys and Hurley oncology inpatient programs.

What the Joint Venture Achieved

The joint venture created a third institution, the Genesys Hurley Cancer Institute, whose mission is "care, quality, research, and life." GHCI is a new, two-story, 32,000-square-foot facility that was added to the existing 17,000-square-foot combined radiation oncology center. The first floor is for ancillary services (nutrition, pastoral counseling, psychological counseling, social work), the clinical trials department, public health programs, a laboratory, and a patient resource center. The second floor houses a medical oncology center that has 24 infusion chairs, four private rooms, a patient and family nourishment room, a procedure suite, a pharmacy, 14 examination rooms, and two multidisciplinary staff work rooms.

…the joint venture reduced program duplications and lowered administrative overhead costs…

The total cost of the new facility was $9.6 million. The project was funded from the issuance of a $12.8 million bond and from combined operating dollars.

The estimated cost of creating new cancer centers for each hospital was a minimum of $7.9 million in building costs alone, excluding the cost of land, architectural fees, and capital equipment. The joint venture allowed the hospitals to merge their purchasing power. This savings allowed the purchase of state-of-the-art equipment and technology, including a linear accelerator, CT simulator, treatment planning software for IMRT, and the equipment necessary to perform high-dose brachytherapy. (With the money saved, both hospitals were also able to address problems in their aging physical plants.)

The Radiation Oncology Department was renovated to change and improve work areas and update lighting and flooring. Additions included an ornamental waterfall, a vault to house a newly purchased linear accelerator, a separate ambulance entrance, a high-dose rate (HDR) brachytherapy room, a multidisciplinary workroom, and a staff break room.

GHCI is in the process of implementing an oncology software package for electronic charting in both radiation oncology and medical oncology. Chemotherapy protocols have been loaded to support the medical oncologists' computerized order entry.

The total cost for new equipment and software was $3.3 million. These improvements will help GHCI upgrade the quality of care, measure outcomes, increase the timeliness of communication, reduce the probability

of medical errors, and improve charge capture.

Lowered costs and enhanced program effectiveness. Total savings were about $11 million. At the same time the joint venture reduced program duplications and lowered administrative overhead costs, it improved services. The Genesys Hurley Cancer Institute can provide a full array of ancillary services for patients and families, including nutritional, financial, psychological, social work, and pastoral care. These services are offered on both the center's inpatient and outpatient units and have been streamlined and improved since the merger. For example, support groups are now more accessible and effective and more patients are participating in clinical trials. The number of dedicated oncology research nurses has also increased.

Maximized human resources. Both entities suffered from shortages of radiation therapists, dosimetrists, and/or physicists. Building the new cancer center and purchasing new equipment appear to have slightly lessened the difficulties of recruiting staff, although bidding wars for staff members continue. Other support positions, such as medical assistants, billing staff, and receptionists, have also become easier to recruit.

Improved medical quality. All GHCI's medical and radiation oncologists are private practice physicians who provide services within the cancer center on a contract basis. Their contractual duties include participating in multidisciplinary clinics (See "The Joint Venture and Physician Relations" by Paul T. Adams, M.D., on page 24), which the GHCI staff believes will produce the most integrated and effective patient care possible.

Chemotherapy is now mixed and administered by a pharmacist and a pharmacy technician to reduce the probability of medication errors. Both hospitals have Medication Error Reduction Teams that do everything possible to eliminate this life-threatening problem.[4]

Increased reimbursement. Since GHCI is a joint venture, it falls under Section 413.65(e) of a HCFA (now CMS) regulation that states: "Provider-based status is not applicable to joint ventures. A facility cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created freestanding facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the freestanding facility as a provider-based entity."

As a joint venture, GHCI is not under the ambulatory payment classification (APC) reimbursement structure for provider-based institutions, but is paid on the resource-based relative value scale (RBRVS). A nine-month analysis comparing revenues reimbursed under RBRVS methodology vs. APCs shows minimal differences between the two. On the average, APCs would have paid $446 over an RBRVS method of calculation each month. Considering GHCI's patient and payer mix, the cancer center has benefited under the RBRVS methodology.

Patients served by the joint venture bear a maximum 20 percent co-pay under global billing in the freestanding center. Co-pays are higher under APCs and can reach as high as 48 percent of a procedure charge.

Increased market share. Analysis of the market share numbers revealed that GRMC and HMC are perfect complementary partners, bringing different geographic

TAKE THE TEST

Is A Joint Venture Right for You?

- ✔ Can you articulate why this partnership makes sense?
- ✔ Can you articulate the joint venture's mission and goals?
- ✔ Do both parties share these goals?
- ✔ Do the hospital organizations share the same values?
- ✔ Are both hospital entities equally committed?
- ✔ Are there administrative leaders in both hospitals who can champion the cause in their institutions and to their boards?
- ✔ Do the administrative leaders in both organizations work well together?
- ✔ Are your physicians committed to the joint venture?
- ✔ Are you flexible enough to address the needs of affiliating physicians?
- ✔ Do you have physician support in the community for the joint venture?
- ✔ Are your physicians committed to participating in medical quality improvements?
- ✔ Do you have a business plan that truthfully and openly explores the strengths and weaknesses of both partners' oncology programs?
- ✔ Do you know your primary and secondary markets?
- ✔ Do you have the potential to capture market share?
- ✔ Do you know your fiscals, including the current performance of the parties, payer mixes, procedure mixes, and co-pay analyses? Do the numbers work?
- ✔ Will your partnership truly lower costs and enhance program effectiveness?
- ✔ Can your employees cope with a merger?
- ✔ Do you have union support for the merger?
- ✔ Can you create an interactive and supportive governing board for the new entity?
- ✔ Are you ready for a challenge?

penetrations to their collaboration. HMC dominated in the primary service area, while GRMC had significant and far-reaching penetration in secondary or outlying service areas.

In addition, GRMC and HMC have a nearby, competing hospital that spends significant dollars marketing its cancer center through billboards, radio advertising, and mass mailings. Before the merger, GRMC and HMC were also competitors, but the joint venture brought their forces together and allowed them to dominate this overly saturated oncology market. GHCI now has the potential to capture 66 percent of the primary market and almost 60 percent of the secondary market. Although 10 percent of the primary market and 19 percent of the secondary market still seek some aspect of oncology care elsewhere (particularly at an academic medical center 30 miles away), GRMC and HMC combined treated more than 1,550 analytic cases in the year 2000. An educational program to tell primary care physicians, general surgeons, specialists, the PHO, risk bearers, and the public what GHCI has to offer has begun to reduce these out-migrations.

The Genesys Hurley Cancer Institute in Flint, Mich., is a 49,000 square-foot facility.

First-year goals for GHCI centered on marketing, finances, quality, program, and access. The marketing goal was to have GHCI be recognized as the premier provider of cancer care in the region. The financial goal was to use resources wisely to ensure the institute's continued ability to serve those who choose GHCI for care. Quality goals included measuring quality indicators that emphasize clinical excellence, quality of life, and patients' hopes for the future. The program and access goals were to provide access to interdisciplinary cancer care—using the most current guidelines and protocols—to all patients regardless of their ability to pay.

PHOTOGRAPH BY PHOTODISC

Union Concerns

Both GRMC and HMC employees had union representation that complicated the staffing process for GHCI. All parties wanted to protect the retirement earnings and benefit packages of employees from Genesys and Hurley who worked at the freestanding cancer center. To do this, GHCI now leases many employees (such as nurses, administrative assistants, physicists, dosimetrists, radiation therapists, and research nurses) from both hospitals. Despite a highly complex array of work rules and salary/benefit packages, employees, hospital administrators, and union leaders know that this joint venture is best for both the patients and the community. There has been and continues to be incredible support and understanding about the unique aspects of this project, and everyone has displayed tolerance and openness in their dealings with GHCI.

Creating a New Organization

Every organization has its own culture that develops over time. The merger of our two organizations brought employees together who often had strong, compelling identifications with their mother organization's culture and values. People considering joint ventures must not underestimate the difficulty and time required to successfully merge two different cultures, work patterns, reporting relationships, and clinical orientations. Revising even a chart structure or a daily treatment sheet can be a trying experience.

Change is difficult and challenging. The multiple technological advances associated with the new equipment, for instance, forced employees to become accelerated learners on the job. This was extremely stressful for individuals who had enjoyed decades of routine calm and predictability in their daily work. Author Warren Bennis once remarked, "An organization's culture dictates the kinds of mechanisms that are needed to resolve conflicts and determines how costly, humane, fair, and reasonable the outcomes will be."[5]

People need a reason for change. If they understand why the upheavals in their lives are necessary, they will be more flexible and more successful in surmounting the difficulties involved. Administrators must communicate the reasons behind the changes they want to make and emphasize how important employee and union support is to the institution's success and survival. Underestimating the stress associated with change in a competitive, resource-limited market can be a critical miscalculation.

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The Joint Venture & Physician Relations

by Paul T. Adams, M.D.

When oncology care providers create joint ventures, the process produces more interaction between oncology treatment disciplines and makes a difference in the way cancer care is delivered. Joint ventures bring together the principal cancer care providers in the community—despite the competition between oncologists and the strong referral preferences of primary care physicians—and more integrated, comprehensive treatment programs are the result.

An integrated program of cancer care was the goal of Hurley Medical Center and Genesys Regional Medical Center in Flint, Mich. The community had cancer care providers spread throughout its environs, primarily in solo practice and two-person groups. Both Hurley and Genesys had radiation oncology facilities with radiation oncologists on staff, but interactions between the staff radiation specialists and cancer surgeons and medical oncologists were typically limited to weekly tumor boards, which were mainly retrospective.

Genesys and Hurley had employed medical oncologists in the past, and private practice physicians in the community perceived the arrangement as competitive. Adding to the complexity was the fact that referrals in the community tended to be made according to medical tradition (allopathic vs. osteopathic) and ethnic affiliation. The challenge was to bring these practitioners together.

Requirements of Affiliated Physicians

As described on pages 20–23, the Genesys Hurley Cancer Institute (GHCI) in Flint, Mich. was created out of a vision of excellence in oncology care. Two hospitals—Genesys Regional Medical Center and Hurley Medical Center—formed the joint venture and shared core values and goals, including preventing the GHCI cancer center under construction from becoming merely an office complex that housed competing private cancer care providers. To ensure that this would not take place, the GHCI Board of Directors and the participating private practice physicians crafted the following operational rules for affiliation with the cancer center.

1. The Genesys Hurley Cancer Institute will provide oncology services through not more than two radiation oncology groups and two medical oncology groups that are legally bound by identical contractual agreements.

2. Affiliates will provide on-site supervision of patient care 100 percent of the time when they are on call in the Cancer Institute. The contracts specify that a qualified radiation oncologist or medical oncologist must be physically present at the GHCI when patients are being treated in their specialty, and be substantially involved in the oversight of each procedure performed, whether that involves the delivery of chemotherapy agents or the administration of radiation treatment.

3. Physician practitioners must minimize the competition between the two institutions and promote the name and identity of the Genesys Hurley Cancer Institute.

4. All participating physicians are under the authority of GHCI's medical director.

5. The radiation oncology and medical oncology groups will provide all physician staffing for the delivery of radiation oncology and medical oncology care, medically supervise technicians and support staff, and comply with the treatment parameters that are developed by physicians affiliated with the Cancer Institute. All physicians must provide documented explanations of their care plans.

6. The oncologist will promptly inform each patient's referring primary care physician of the treatment plan and recommendations.

7. All affiliated oncologists must agree to use common software for patient registration, scheduling, billing, chemotherapy ordering, and complete medical charting at GHCI. This directive also includes use of the information system at the GHCI facility and the oncology inpatient units at Hurley and Genesys.

8. The Cancer Institute will have unlimited access to necessary patient records at all three facilities, as permitted by a confidentiality agreement.

9. GHCI is a charitable, tax-exempt institution and all oncologists working at GHCI must agree to treat patients, regardless of their ability to pay, in accordance with GHCI's Charity Care Policy.

10. The medical oncologists agree that a registered GHCI pharmacist will mix and dispense the chemotherapy agents they order. The oncologists will pay the salaries of the pharmacy staff.

11. To deliver integrated patient care, the affiliated physicians in the oncology groups agree to participate in multidisciplinary clinics for cancers of the breast, lung, GI tract, and other sites.

12. Affiliated physicians will carry out educational, research, and publication activities, including in-service programs for the staff. CME efforts will relate to specific oncology disciplines and sites of disease.

13. Affiliated physicians agree to participate in the development of critical pathways, treatment guidelines, and quality initiatives, and subsequently use the pathways and treatment guidelines that are developed. Deviation from approved pathways, guidelines, and regimens is grounds for the termination of GHCI affiliation.

14. Affiliated physicians will help perform medical care audits designed to promote continuous quality improvement and risk management.

15. Affiliated physicians agree to participate in Medicare, Medicaid, Blue Cross & Blue Shield of Michigan (BCBSM), and managed care programs as mutually agreed.

Behavioral Requirements

GHCI has a number of other behavioral requirements for its affiliating physicians. First and foremost, physicians must be courteous and respectful to all patients, family members, and GHCI staff members. Physicians are expected to support the medical staff and employees and not disclose confidential information regarding the activities of the Cancer Institute while employed and for one year following termination of affiliation. In addition, affiliating physicians must:

- participate in GHCI meetings, identify patterns of utilization, and address the quality management concerns of physicians outside of the company
- help the CEO market GHCI oncology services on a "single-entity basis by specialty." (The specific outpatient services GHCI offers to each specialty group should be presented as a unified entity to the public and medical community. Medical oncology and radiation oncology services are marketed as GHCI-based and not by private practice corporate names.)
- participate in meetings with the medical director and the CEO of GHCI to discuss quality, clinical practice, utilization patterns, and related issues on a mutually established schedule
- verify attendance at and completion of the same CMEs required by accrediting hospitals
- report any disciplinary action from licensing boards of the medical staffs to GHCI administration
- have medical staff privileges in good standing at both Hurley Medical Center and Genesys Regional Medical Center
- follow Genesys Regional Medical Center and Hurley Medical Center patient consultative guidelines.

In the fourth quarter of the first year of a physician's affiliation, the CEO and medical director will meet with the new affiliated physician to discuss the performance of GHCI and the physician groups.

The physician groups lease private office and treatment space for their doctors and staff, and bill for the professional services they provide. Physicians give GHCI a fee schedule, but must maintain that schedule in a stable manner. GHCI does not prohibit further professional income so long as it does not interfere with the requirements of the contract.

Satellite locations, if needed, are established by GHCI through a strategic planning process involving physicians.

Progress to Date

In June 2001 GHCI's radiation oncologists all moved into one facility in the new cancer center, which was being renovated, expanded, and furnished with new equipment. GHCI's radiation oncologists practice as two separate groups but have integrated charts and systems.

Efforts to combine the medical oncologists into one group proved impossible. GHCI presented the physicians with many possible practice configurations and economic models in an attempt to facilitate a merger. In the end, the principals, who had consciously made the decision to remain separate over the years, decided to remain apart. Not only did they want to remain apart, they also wanted to define separate office spaces. GHCI made two slight architectural changes to partition the clinics, but moved the chemotherapy administration area and support functions (such as a family refreshment room, cleaning supplies, medical waste storage, and nursing stations) into a large open space of 24 infusion bays and four private rooms.

> We still grapple with the persistent issues of competition…

The challenges we now face include the development of treatment guidelines for the cancer center and the establishment of multidisciplinary clinics. After the physical relocation of the medical oncology practices into the center, we will convene the committees that will develop these treatment guidelines. The physicians will try to develop treatment regimens that give the patients the best possible care but will also be accepted and implemented by all GHCI's practitioners to create uniformity of practice.

The establishment of multidisciplinary clinics becomes much more problematic when you have competing radiation and medical oncologists in private practices. Our radiation and medical oncologists will cooperate in this venture, and the surgical oncologists in the community have indicated a willingness to staff multidisciplinary clinics so long as there are enough patients to warrant their time. Our two major challenges are 1) to find an acceptable way of scheduling the various physician practitioners to staff the clinics, and 2) to convince primary care physicians to refer patients to GHCI without regard to the specific physician staffing the multidisciplinary clinic that day since they are used to referring their patients to a specific physician and these referral patterns are difficult to alter.

GHCI holds the ideal that multidisciplinary clinics are the best way to evaluate new patients with breast, lung, colon, and prostate cancer, and provide the fastest, most comprehensive approach to care. We still grapple with the persistent issues of competition and the strong preferences of referring primary care physicians, but draw strength from the fact that the affiliating physicians are totally committed to their patients, the community, and the cancer center.

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Accreditation for Health Care Networks

by Richard B. Reiling, M.D.

As an increasing number of hospitals merge and form networks, the American College of Surgeons' (ACoS) Commission on Cancer (CoC) is working to provide meaningful accreditation for these networks at a reasonable cost. The CoC's accreditation process focuses on community-wide delivery of quality cancer care through diagnosis, treatment, and prevention. Overall, the requirements of network accreditation are not burdensome and reflect CoC's commitment to the community.

Accreditation is more than "pro-forma" compliance to established standards. It must be compliance to established standards directed at quality outcomes that can be uniformly applied to all institutions seeking the accreditation. The task of the CoC is to develop these standards and make them measurable and appropriate to a cancer program. Without metrics, compliance cannot be documented.

As the CoC restructures itself, its standards (which are under review and are expected to be extensively revised) will be based on evidence of quality outcomes. Although the CoC Standards Committee has been disbanded, it is being replaced by site-specific committees. To date these committees are only in their organizational stage and not yet operational. They will, however, reflect the multidisciplinary approach to cancer care.

The CoC is an outgrowth of the ACoS, which was also the spark for what eventually became the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The CoC was never intended to be a tool solely for surgeons, but as a means to deliver quality cancer care. To date, there is multidisciplinary involvement.

The CoC is working with the JCAHO to avoid duplication of standards and the survey process. The quality issues required by the JCAHO and the CoC will be complementary and will encourage cooperation between the management of a hospital or network and its cancer committee.

In order to avoid duplicating effort and costs, the CoC will accredit a network of separate facilities as a whole, instead of certifying each separate institution, if the network has a unified management structure. The CoC maintains that the purpose of network accreditation is "to help participants use resources more effectively and efficiently, help participants eliminate duplication of administrative functions, and help participants take advantage of their size."

What Exactly Is a Network?

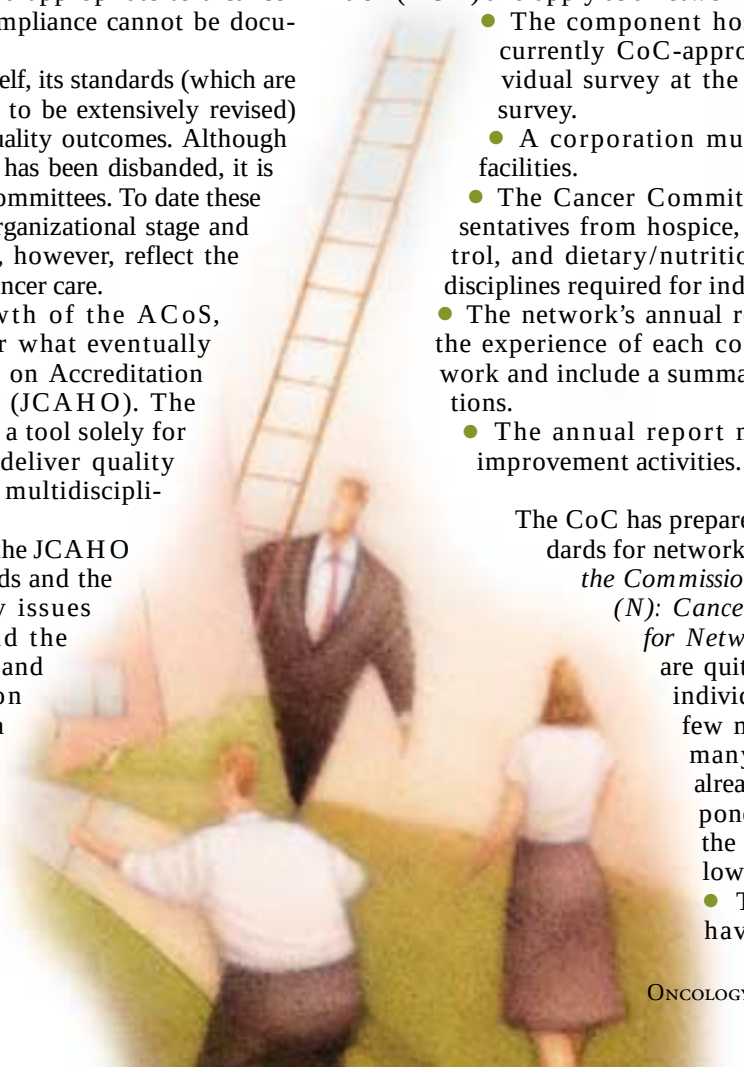
The CoC defines a network as "an entity that provides integrated cancer care and offers comprehensive services. Generally, networks are characterized by a network-wide Cancer Committee or its functional equivalent, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners."

Today, less than 50 institutions qualify for network certification, and only a very few have been so surveyed. No doubt, however, more programs will seek this level of certification in the future.

Some programs—such as the Genesys Hurley Cancer Institute in Flint, Mich.—do not currently qualify for a network survey because they have a multiple governance structure. The CoC only surveys networks with single governance and will need to deal with this issue since its policy seems too restrictive. In the case of Genesys, for example, there is a unity of the cancer program despite the multiple governance structure.

The CoC has six criteria for qualification as a network:

- The program should be accredited by the JCAHO as a network. Alternatively, each program can be accredited by the JCAHO or the American Osteopathic Association (AOA) and apply as a network.
- The component hospitals must each be currently CoC-approved or have an individual survey at the time of the network survey.
- A corporation must own the multiple facilities.
- The Cancer Committee must have representatives from hospice, pharmacy, pain control, and dietary/nutrition in addition to the disciplines required for individual institutions.
- The network's annual report must represent the experience of each component of the network and include a summary of all service locations.
- The annual report must review quality improvement activities.



The CoC has prepared a manual with standards for networks entitled *Standards of the Commission on Cancer Volume I (N): Cancer Program Standards for Networks*. These standards are quite similar to those for individual programs with a few modifications. In fact, many network programs already have all these components in place. Among the standards are the following requirements:

- The network must have a Medical Ethics

Committee. (This requirement is the same as JCAHO's.)
- Ambulatory oncology services must be available within the network or through a documented referral process.
- The network must complete at least two network-wide improvement studies, one of which must incorporate oncology care given in the ambulatory setting.
- Registry functions must be in a uniform data repository to help eliminate duplicate case reports.
- A quality review must be conducted of the annual analytic accession for both inpatient and outpatient cases by at least 10 percent of the network's participating physicians.
- At least two network-wide community screening programs must be available.

In reality, the above-mentioned requirements are not radically different from the individual program requirements. What is different is the emphasis on the integrated nature of the network.

In Conclusion

The accreditation process should include a time of introspection and be a refreshing look at the current state of affairs. As a surveyor, I am greatly interested in the "spirit of the program"—the aura of commitment that is evident during a survey—as well as the nuts-and-bolts of standards compliance. I insist on compliance with the standards but am also critically aware of the energy that the cancer team puts into its compliance efforts. Unfortunately, this "spirit" cannot be put into words on the application. Clearly, some institutions satisfy the criteria but not the spirit of the standard. Good standards will measure attributes of a program that indicate true commitment.

Reviewing and revising standards are necessary for the CoC to remain current. While the CoC will survey more programs in the near future, it will also maintain an ongoing analysis of the process of network accreditation and standards compliance to ensure that its requirements are relevant to the realities of cancer care today.

The views expressed in this article are the author's and not necessarily those of the ACoS Commission on Cancer.

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Tuality/OHSU Cancer Center

The Oregon Health & Science University (OHSU) in Portland and Tuality Healthcare, a community hospital system in Hillsboro, Oreg., have entered into a joint venture to build a cancer center in Tuality, which should be completed in October 2002. The project will deliver significant benefits to both entities.

The new cancer center will enhance the OHSU Cancer Institute's reputation as a provider of integrated cancer services in the metropolitan Portland area and may be a clinical trials accrual site. On the local side, the new center will be the only radiation treatment facility in Washington county, which lies west of Portland, and will greatly simplify the lives of people with cancer who live in that area. The project will also give Tuality Healthcare the opportunity to capture a larger share of local cancer business.

The 5,000-square-foot, single-story facility will have office and exam space and house a linear accelerator and CT simulator. Its physicians and physicists will come from OHSU, but the support staff will be Tuality Healthcare employees. Environmental and security services, telecommunication technicians, information systems, and purchasing employees will be provided through negotiated contracts between the joint venture and one of the entities. While the joint venture owns the major equipment and will run the business, Tuality owns the building. The first phase of the project involves only radiation therapy services, but plans for the second phase include a 3,500-square-foot addition that will provide space for a second accelerator, more exam rooms, and a chemotherapy infusion center.

OHSU lists as risks the investment of scarce capital off-campus and the need to redirect physician referrals for adjuvant radiotherapy. It will benefit from the new market for referrals, the potential for new clinical trial accruals, and the well-reimbursed revenue flow for its doctors. Tuality also has significant capital invested in the building, which will be lost if the project fails, and will need to redirect physician referrals as well. Tuality Healthcare's concern about whether the community would support the center has been proven groundless. The city of Tuality is 100 percent behind the new venture and is helping in any way it can. The center means that all three major cancer treatment modalities will be available close to home, and the hospital will benefit from being identified with the larger OHSU. Tuality Healthcare also foresees that the center and the new professional connection will make attracting other medical specialists to the Tuality area easier.

The joint venture will have its own governing structure, making it easier to change subcontractors than if the project had been hospital-based. At the same time, both entities incur the risk that the joint venture will limit potential philanthropic support and must cope with the fact that they will not be able to bill for essential support services such as nursing, social work, and nutrition. The partners also worry that Medicare reimbursement levels for chemotherapy will prohibit future expansion and that new targeted molecular therapies will reduce the need for radiation treatment and chemotherapy in the future. Nevertheless, the project is moving forward with confidence.

The Cancer Institute
A Kansas City Merger
"Together for a cure"

by Ron Deisher, M.P.A.H., and Doug Lawson, M.H.A.

After more than a year of feasibility studies and discussions, the two major health care systems in the Kansas City metropolitan area—Health Midwest and Saint Luke's-Shawnee Mission Health System—are merging major components of their cancer programs and services to form a new 501.c.3 nonprofit corporation called The Cancer Institute. Together, these two systems diagnose and treat more than 5,100 new cancer cases per year. The new corporation will be jointly owned by the two health systems and will be licensed as a hospital by the state of Missouri.

A number of factors played a role in the formation of this new partnership, including the rapid advances in expensive cancer treatments and technology over the past several years, the growing constraints on reimbursement, the lack of availability of capital financing, and the need to reduce unnecessary duplication of expensive technologies. Coordinated services will include:

- Two dedicated inpatient cancer care units at Research Medical Center (the Meyer campus) and Saint Luke's Hospital (the Wornall campus) with more than 80 licensed beds
- A blood and marrow transplant inpatient program/unit
- A gynecologic oncology practice
- Two comprehensive breast centers
- The region's only gamma knife radiosurgery center
- Four outpatient radiation therapy units offering state-of-the-art radiotherapy services, including stereotactic radiosurgery, 3-D treatment planning, and IMRT services
- A mobile PET imaging unit that provides services to several hospital sites throughout the Kansas City metropolitan area.

Staff of the former Cancer Institute of Health Midwest in Kansas City joined the new corporation in January 2002 to become the Division of Cancer Control and Community Outreach (DCC). Professional and volunteer staff of DCC will continue to provide critical and expanded patient and community support services, including:

- The Cancer Prevention Program, which includes risk assessment and genetic counseling for individuals and families at high risk for developing cancer
- Community screening and early detection programs and clinics
- Second opinion, physician review conferences, and consultations
- Lymphedema intake, assessment, referrals, and treatment at seven clinics
- Public and professional education programs
- Classes and supervised skill development labs for oncology nurses
- Multiple monthly patient support groups
- Extensive patient support services involving more than 200 specially trained volunteers.

Some immediate and short-term benefits for patients with cancer and the community will include improved access to expanded and strengthened cancer care services, better coordination and continuity of care for patients across multiple campuses and centers of excellence, and increased detection of early-stage disease. In addition, patients will gain greater access to National Cancer Institute and pharmaceutical clinical and prevention trials. The ultimate goal of these efforts is improved patient outcomes and survival.

Hospitals within the two health systems will continue to have cancer programs approved by the American College of Surgeons, multidisciplinary physician patient care review conferences, and cancer registries for clinical data management, patient follow-up support, and clinical outcomes research. The Cancer Institute and its staff will support these important hospital-based activities.

When the clinical infrastructure of The Cancer Institute is fully operational, the long-term goal will be to create an organized consortium of cancer care organizations throughout the Kansas City area, which will hopefully lead to the designation of a comprehensive cancer center by the National Cancer Institute. Such a designation would bring additional research opportunities and cancer care resources into the Kansas City community.

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