A Roundtable Discussion with Cancer Program Administrators

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MODERATOR: Welcome. Let's begin by finding out some of the challenges that you, as program administrators, are having.

PARTICIPANT 1: I'm director for oncology services. We're going through uncharted waters by moving from a non-profit to a for-profit hospital. I'm also involved with a joint venture. Part of the oncology program has spun off into joint ventures, and I'm on the managing board.

PARTICIPANT 2: I'm the oncology administrator and the director of pharmacy. I became the oncology administrator a few months ago, although I have 15 years of experience as a pharmacy director. As with most community hospitals, our biggest challenge right now is how to manage the tremendous growth [patient volume] we're seeing in our area.

PARTICIPANT 3: We are an NCI-designated hospital with a very comprehensive research program. I'm the senior administrator for surgical services. My focus, though, is on the clinical side, and primarily surgical services. We are, as everyone is, looking to continue to maintain and grow our market. I'm focused on recruitment of several surgical subspecialties.

MODERATOR: Surgery is certainly an important part in any hospital oncology program going forward.

PARTICIPANT 4: I'm the cancer center director for a small community hospital. My biggest challenge is our size—it's growing like crazy. We need to provide services and programs to meet the community's growing needs. How do we do that? Do we add surgical services as part of a core program?

PARTICIPANT 5: I'm the director of a small community hospital. I joined a year ago. Now I'm just trying to learn what it is I need to know. One challenge I'm wrestling with is how to best utilize our three surgical oncologists.

MODERATOR: Three surgical oncologists in a community hospital?

PARTICIPANT 5: And they're very busy. One is also board certified in nuclear medicine.

PARTICIPANT 6: Our health system is still relatively small, a 110-bed hospital, physician network. The challenge is how do we get out into neighboring communities with two relatively large health systems surrounding us? We're looking at ways to increase our staffing model and our oncology area, and find ways to utilize the services we do have and tout regionally, rather than just locally in our community.

PARTICIPANT 7: We are engaged in a number of joint venture discussions. I think the struggle is to forge agreements where everyone is truly on the same page and is committed to quality service. We are trying to develop models.

We are also concerned about reimbursement, what is going to happen in 2006 and beyond, particularly on the chemotherapy side. If the reimbursement rates that we're looking at now stay in place, it's going to be a big challenge for us all.

MODERATOR: Reimbursement is an issue, of course. As a

consultant, one thing I find fascinating is the number of hospitals I go into where they haven't revised their chargemaster in the last three to six months. For some, it's been a year or two, or they haven't looked at it at all! That to me is just amazing. When I say, "How long has it been since you've looked at your chargemaster?" if they say, "More than three months," I'm worried from a medical oncology standpoint. An active involvement in financials in a hospital-based setting, I think, is key to our survival.

Most of the progressive programs I'm working with now have a financial person dedicated to the program. No matter the size of the program, someone from that division is actively involved in financials and keeping ahead of the curve.

Participant 8: I'm the vice-president of cancer services. Our challenge is: How do you go from physicians as customers to physicians as partners? That's very difficult. We're looking for ways to find relationships with physicians that are a win-win for both them and us. We recognize and realize physicians need the incomes to keep them involved and excited about their business, as we do. Finding the best way to optimize that, as everyone knows, is very difficult.

Participant 9: I manage oncology at a rural community hospital. We're going through recruitment problems for medical and GYN oncologists. In our area, the pay is not as good as it is across the rest of the country, and recruiting is very difficult. We've actually been recruiting for a GYN oncologist for almost two years now. We're contracting with another group until we can provide the service ourselves. But it's just not the same.

As far as radiation oncology goes, the major issue for us right now is the development of freestanding centers—particularly centers specializing in prostate cancer—that are going to compete with our hospital right in our community. For us, that [competition] is a major problem because about 45 percent of our patients are prostate patients.

Participant 10: I'm the chief therapist at a community cancer. Our focus is on getting reimbursed with the changes we've made with our radiation oncology equipment. We've put in new linear accelerators and upgraded our equipment.

Long-term, our issues are joint ventures with physicians and looking at more of a patient-centered clinic rather than having our patients going over to pharmacy and then over to us.

Participant 11: I'm the director of outpatient cancer care. I was hired to bring together the four providers in our community in a joint venture. We have two medical oncology groups—separate groups—who will be coming together in the cancer center. We have four radiation oncologists and three surgical oncologists, and we will all move into our new building together, somehow, some way. We are building a new cancer center.

We are doing some joint venturing, and we have a model that we have completed called an equipment leasing joint venture. Our physicians came together, formed an equipment leasing company.

Moderator: Can you expand on your equipment leasing agreement?

Participant 11: The three physician groups came together as the organizations forming this equipment leasing company. They will purchase from the hospital two existing linear accelerators. They will then lease that back to the hospital at a per-click basis. Attorneys figured out the fair market value.

It is important that the physicians become investors in the program. With two competing medical groups in town, how do you get the Hatfields and McCoys to come together? We found that where you can come together is around the care of the patient.

Hospitals have a tough time with capital these days. As a cancer program, you are competing with radiology needs, cardiac, and surgery. Hospitals need a pathology lab. At our hospital we had $35 million requested for capital last year—only $10 million was approved.

For my program, the equipment leasing company allows the physicians to be the capital source…and it's a way for the physicians to literally be partnered in the organization.

Moderator: So the hospital is not a partner?

Participant 11: The hospital is *not* a partner. Basically, it came down to legal questions.

Participant 8: Our cancer center is looking at the same situation. Plus, if the hospital is a partner, you can't do the per-click model under the leasing agreement. But I was wondering: what's the benefit for the hospital?

Participant 11: The benefit for the hospital is to be able to pull providers together in town, to be able to run a cancer center together, and to raise our market share for our county from 30 percent, which is where it is today. So, if we can pull back market share, all of us win. The hospital will be doing the billing. To me, that was another advantage, as well.

Moderator: So the three partners were medical oncology, radiation oncology, and who?

Participant 11: Two medical oncology groups and radiology.

Moderator: You're also in the process of building a center?

Participant 11: The hospital is building a cancer center. We will be licensed under the hospital. The hospital has approved $4 million for a cancer center. The two medical oncology groups and the surgical oncologists will come into the center, yet to be determined how.

Moderator: And are these competing medical oncology groups?

Participant 11: They are and they aren't. Our region is big enough for both, and they clinically have some of the same standards. In that structure your surgical oncology can refer to your medical and your medical can refer to your radiation.

Participant 8: Actually, this is a real common model that we're seeing, because it does allow the medical oncologist to be part of radiation therapy without a violation of Stark. So, really, anybody can be in an equipment leasing company, because if you are leasing it, it gets

away from the referral to something you own.

Moderator: Let's switch tracks a little bit and just talk for a few minutes about surgical oncology.

Participant 3: First, can we ask how you define "surgical oncology"?

Participant 5: Fellowship trained?

Moderator: And a lot of breast surgeons call themselves—which I think was your point—surgical oncologists. But I'm talking about fellowship trained where the numbers are small and where you probably have a program objective that you're trying to accomplish.

Participant 3: In surgical oncology, you go through a five-year general surgery residency. You graduate from that program, and you then go into a Society for Surgical Oncology fellowship program, which has historically encompassed breast surgery, colorectal surgery, and thoracic surgery. Thoracic is sort of going off on its own now, but breast and colorectal are the two main tenets of surgical oncology. So it's a two-year fellowship.

Participant 5: The lower GI market is huge compared to the upper GI market. And some of the surgical oncologists also do esophagus work, and then you're sort of in with the thoracic surgeons. Where the market begins and ends sort of depends on the individual market.

Participant 3: What about thoracic surgeons? That's an issue in our community between cardio surgeons and the general surgeons. There's a bit of a tug-of-war between cardio and general surgeons.

Participant 1: I have a question for the sites that have surgical oncologists from a tumor board perspective, because the model that I'm used to is we have 10 tumor boards a week, and they're attended by radiology and pathology and then the surgical subspecialties. So do the various surgical oncologists go to multiple tumor boards? How does that work?

Participant 5: Right now we have about four tumor boards. One is a general with everybody—I even attend—in the inpatient site. Every new patient case is discussed. Next is GI. Right after that is a tumor board for all the docs, including MDs, and radiology. And then on Tuesdays there's a breast clinic. We get people in and out and actually do it in probably four hours or less.

Our challenge is:
How do you go from physicians as customers to physicians as partners?

Participant 1: And do you know, based upon what you pay your physicians, if your surgical oncologist practice is breaking even in terms of what you're doing?

Participant 5: Oh, it's profitable. We're doing well with it.

Moderator: And I think that's an argument that most of us can make to our financial departments. If you look at the data from The Advisory Board Company and ACCC on where the biggest consistent contribution margin is—it's surgery. So if you can get beyond the politics, you can make the financial argument.

Let's change topics. Why are you moving from non-profit to profit?

Participant 1: Well, one very obvious reason for the hospital is that it was losing a lot of money. And a group of 110 physicians from the cardiac group decided to get together and make a go of it. So that's where we are.

Moderator: So the cancer group is rolled into the larger hospital?

Participant 1: Yes.

Moderator: Okay. Can you tell us what the advantages are?

Participant 1: Part of the issue is physicians that move from hospital to hospital. We don't capture any of our physicians at all. The physicians have been playing one hospital against another. They're all within a hundred mile radius. So, it's getting commitments on the part of physicians to come together for a common cause.

Moderator: So, we're back once again to joint ventures.

Participant 7: Well, I'm sort of puzzled by it. We go out and look to physicians as part of joint ventures to invest some of their own capital. And we're not finding as many physicians who actually have capital available. Bluntly put, we're not finding as many [physician] investors with a pot full of money.

And more and more I hear physicians saying: "You know, this joint venture stuff is neat, and sure I'd like to make more money, but I'm really worried about what happens to me if I get myself tangled into some venture and all of a sudden Medicare changes the rules.

Participant 8: But we're seeing a large number of physicians that *are* buying into joint ventures, they're doing the due diligence and buying into the idea. It's a matter of gaining some control over their environment.

Participant 1: It's also about having some control over patient care.

Participant 8: But the group in our town, they are seeing it [joint venturing] more as a way to self-determine how they can improve the care in their particular world and make it better. I think you just have to bring it down to that: the care for cancer patients in our community is going to be better if everybody gets together.

Moderator: I appreciate getting to know you and hearing your thoughts. Thanks a lot.