

# FREESTANDING CANCER CENTERS: The Changing Course of Cancer Care Delivery

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One of the most controversial issues in recent cancer program development is the emergence of the freestanding cancer center (FCC). Like any controversial issue, it has its ardent skeptics, proponents, and detractors.

The core of the FCC controversy surrounds the concept itself. Skeptics say FCCs are a fad or a marketing scam. Proponents suggest FCCs are a better way to bring together cancer resources. Detractors assert that FCCs are a retreat from multidisciplinary cancer patient management, lowering the quality of care.

While it may only seem to be a recent flurry of interest in FCCs, one analyst points out that they have been around since the mid-1970's. "Freestanding cancer centers initially began with radiation therapists. Since most radiation therapy patients are outpatients, it made sense to develop ambulatory care facilities. Later, freestanding cancer centers were a fallout of the training programs that began in academic centers in the 1970's. That's when hospitals began to build separate wings, separate buildings, or totally freestanding centers to facilitate multidisciplinary ambulatory cancer care," says Kathie Bowling, general manager and vice president of Salick Health Care, Inc., and a former employee of CDP, Inc., two of the firms involved in FCC development.

However, the 1980s brought new interests in and reasons for developing an FCC. The impact of DRGs 409 (radiotherapy) and 410 (chemotherapy) on hospital reimbursement has fostered the potential value of outpatient care under a separate (non-hospital) provider number. Thus, the need to move radiation therapy and chemotherapy treatment outside hospital walls has not been lost on most administrators.

"We started trying to establish an FCC as early as 1972," says Dr. Simeon Cantril, a San Francisco radiation

therapist, "but those were the days of cost reimbursement. Hospitals had no incentive to joint venture. When cost containment and DRGs showed up in the 1980's, so did the administrators' attention." Today, Cantril faces the challenge of putting together the first hospital joint venture in San Francisco, a task complicated by the usual planning problems and some unusual licensing problems (see p. 16).

## IDENTIFYING THE COMPONENTS OF AN FCC

Identifying the appropriate cancer services of a freestanding cancer center is often a fundamental problem. Since no standard model exists for an FCC, different cancer care facilities with different components are commonly lumped under the term of 'freestanding cancer center.'

The various program configurations make it difficult to establish an exact count of existing FCCs. Programs are referred to as a "freestanding cancer center" when, in fact, only radiation therapy services are provided. In which cases, it may be more appropriate to define the programs as 'freestanding radiation therapy centers.'

According to Dr. James Diamond, director of Research for the American College of Radiology, there are 216 freestanding radiation therapy centers -- a 50%

increase since 1980. "Based on our January 1986 statistics, the College identified 1,144 radiation therapy facilities in the United States," says Diamond. "Two hundred sixteen (216) are freestanding, 890 are physically attached to a hospital, and 38 are federally-owned."

While radiation therapy may be one of the economic strongholds for any cancer program, integrating all the components of cancer care frequently becomes the subject of much debate, and further complicates the definitional problem.

If multiple oncology disciplines are involved, the FCCs are often said to be multidisciplinary or a true freestanding cancer center. The same confusion of terms applies to the actual facility. Some FCCs are referred to as hospital-affiliated freestanding cancer centers, or if the FCC is a joint venture with non-hospital ownership, as a truly freestanding cancer center or a freestanding freestanding cancer center. This problem of definition can get quite complicated with no standard definitions in the offing.

When the Association of Community Cancer Centers (ACCC) developed standards for cancer programs, the membership struggled with the programmatic concept. "We designed standards to meet the changes in cancer program configurations -- standards that would cover all physical

sites of care," says Dr. Robert Enck, president of ACCC. "We developed *generic* cancer care standards that could be applied to the different configurations."

Since ACCC promotes the multidisciplinary approach to cancer care, the membership could hardly ignore the coordinated effort it has long sought. "The critical piece in the standards says that an institution or organization must have access to whatever services it doesn't have in-house. We demand some type of documentation that indicates that referral lines have been established or that services have been contracted," Enck says.

The ACCC, the Joint Commission on Accreditation of Hospitals, and the American College of Surgeons are all deliberating the problems of accrediting FCCs, while the American College of Radiology is attempting to accredit freestanding radiation therapy centers. Yet, none of these accreditation programs impact FCC reimbursement.

At present, the American College of Radiology has a voluntary program to accredit radiation therapy facilities, including those they identify as freestanding. "A freestanding radiation therapy center is a facility that is not physically attached to a hospital," says Diamond. "However, all radiation facilities go through the same accrediting process: We send a review team to the facility that randomly selects several patient charts. The data from these charts are compared with national data and statistics. We also conduct interviews with personnel and look at the facility's policy and procedures."

All outpatient cancer care like inpatient cancer care needs to be measured for quality. Yet, outcome of care is difficult to measure, and it is matter that each accrediting organization will need to study.

#### **THE PLANNING STAGE -- FEASIBILITY, POLITICS, PATIENT LOAD, AND LOCATION**

Building a freestanding cancer center can be risky. Investing \$2 to \$10 million with a five to ten year payout requires more than casual guess work. Usually, hospital and FCC planners rely on feasibility studies for the answers.

Hospitals, physicians, and entrepreneurs have learned that, despite a real interest in establishing FCCs, the project can fold before it ever gets off the drawing board. When confronting the challenges of developing a freestanding cancer center, the biggest obstacles often cited by FCC developers are feasibility, politics, patient load, and location.

#### **Feasibility Studies -- Should You Buy Help?**

"At least 80% of the problems we hear about with FCCs stem from the planning process," says ACCC Executive Director Lee E. Mortenson. "Hospitals complain that consultants don't always disclose their assumptions, and when they do, they are sometimes based on old data or national norms that have no application to a local area. Planners are nervous

## **FEASIBILITY STUDIES...**

### **WHAT THEY SHOULD CONTAIN**

There are a few key ingredients to any feasibility study. If you are thinking of developing a freestanding cancer center and may hire an outside firm to assist you, know what to look for:

#### **Measuring Medical Politics and Support**

Consultants say this is the toughest part, and one of the most essential roles they play. Someone from the outside -- without turf -- can frequently help bring together factions in ways that are self-evident but are hard to do with local leadership.

Individual and informal interviews with key leadership of 30 to 60 minutes can help determine the "oncopolitics." Generally, group meetings follow to clarify priorities and to define goals.

#### **Running the Numbers -- Estimating Patient Load**

Several consulting firms consider their formulas for estimating patient load to be highly proprietary. Yet, you have paid for that information, so demand to know how they arrived at their conclusions.

Look at the assumptions. Make sure that incidence is not overstated, particularly as it relates to the use of radiation therapy treatment. Also, make sure that regional variations in patterns of care are factored. *Always* plan for competition.

SEER incidence rates provide baseline information along with hospital, regional, and state tumor registry information.

However, be cautious of medical records data. Just looking at ICD9-CM codes for malignancies may seriously understate your cancer patient load or admission.

#### **Financial Payoff and Business Plan**

You will invest a lot of money in an FCC. Project a financial break-even point. Based upon realistic estimates of patient load, in-house financial experts or consultants should develop a business plan that projects construction, equipment, operation, and maintenance costs to determine the expected financial payoff.

#### **Joint Venture Arrangements -- Who Controls? Who Profits?**

Capitalizing an FCC may involve a joint venture arrangement with general and limited partners. A feasibility study should determine who has the capital, resolve the various alternative ownership and control configurations, and propose how profits might be distributed.

#### **How Much Do They Cost?**

Consulting firms vary in costs and timetables. At the low end, firms charge as little as \$15,000 with a three to four week turnaround. On the top end, some firms demand fees of \$50,000 and still want ownership, leaving some FCC planners with the feeling they have paid for the consulting firm's investment research. ■



*Greg Lewis of Cancer CarePoint suggests that "oncopolitics" play a key role in determining the feasibility of an FCC.*

enough about the dollars involved that some have told me they are simultaneously hiring two consulting firms to study FCC feasibility."

And so, the first planning decision is whether to study FCC feasibility on your own or with the assistance of an outside consultant; however, consultants are not without their detractors.

Says one FCC planner and medical director: "I've talked with some independent FCC consultants and investors and rejected that approach. It was not so much the concept, but the individuals I ran into. I was not at all sure that the interest of the hospitals were protected. I do think an outside consultant could be useful. Like a broker...someone who whistles into town, asks the dirty questions, and then goes home. It probably could speed everything up."

To be effective, a feasibility study should include a few key ingredients: measures of medical and community support, estimates of the patient load, projections of developmental and building costs, assessments of joint venture arrangements, and approximations of financial payoff. (See p. 12).

Three of the firms developing FCCs today are Comprehensive Cancer Care, Inc., a subsidiary of Salick Health Care, Inc., Cancer CarePoint, Inc., and CDP Associates, Inc.

Kathie Bowing of Salick sees the consulting firms as having different approaches. "We have different niches," she says. "For instance, CDP gained its reputation in developing radiation therapy centers in the community and has stayed in that specialized niche. The Salick philosophy is to develop a large network of outpatient comprehensive clinical cancer care centers that are open 24 hours a day, seven days a week."

Cancer CarePoint also develops multidisciplinary cancer centers. "We advocate the Salick concept: A center should be open longer than 7 or 8 hours a day. Sometimes it may take 4 hours for a chemotherapy infusion, and a patient should be stabilized before they have to leave," says Gregory W. Lewis, executive vice president of Cancer CarePoint, Inc.

Although Salick and Cancer CarePoint advocate the multidisciplinary approach to cancer patient management, their operational approach differs. Salick jointly owns and operates the FCCs they develop, while Cancer CarePoint provides consultation services only.

"Salick jointly develops cancer centers with hospitals and physicians since we strongly believe in the integration of cancer inpatient and outpatient services. Salick usually puts up most of the capital for the project," says Bowing. Salick capital funds were raised on the stock market through publicly-held stock and convertible bonds. The first year \$50 million was raised.

With the exception of physicians, everyone hired to staff a Salick-owned comprehensive cancer center is a Salick employee. Physicians are recruited to bring their private practice into the center. The physicians bill separately for their patients and pay Salick a minimal overhead fee.

According to Bowing, the Salick firm is developing a national network of hospital-affiliated freestanding cancer centers, whose members will benefit both clinically and administratively from a large, interactive base.

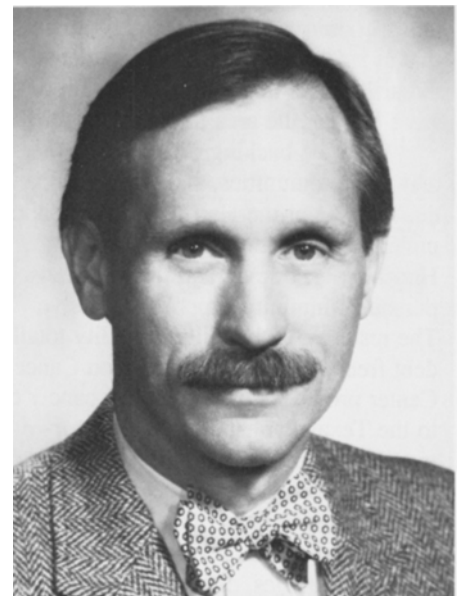
Greg Lewis says that Cancer CarePoint was formed as an alternative to other firms, and that it does not just develop FCCs. "We do not wish to be owner/operators of FCCs. It is not a foregone conclusion that when we are approached by a hospital that we will develop an FCC. We recognize a substantial need by

hospitals, medical schools, and private physician groups for a resource to help them improve and develop their existing cancer care programs," he says.

Using a consulting firm is not the only available course when deciding to build an FCC. Phil Periman, medical director of The Don and Sybil Harrington Cancer Center in Amarillo, Texas, hired three independent *physician* consultants. "Each of the consultants advised against building a freestanding radiation therapy center only. They supported a comprehensive cancer center, and that's just what we did," states Periman.

Periman and his colleagues also travelled to other centers and gathered ideas of what they wanted and didn't want from seeing these operations. Explains Periman, "We went to two particular centers to look at their supportive care departments. What we saw were individual departments fighting each other for limited dollars. So, when we planned our center, we decided to integrate all support services into one division."

Whether you decide to buy help or execute your own plan, much is at risk. If you choose a consulting firm, experienced FCC planners recommend you check references extensively. If you take the alternative and "do-it-yourself," consider seeking as much advice as possible from those who have already built an FCC.



*Phil Periman serves as physician leader in the development of the Harrington Cancer Center.*

### Politics, Ownership, and Control

Politics play a key role in planning a freestanding cancer center. Political complications can range from poor cooperation of participating hospitals to Certificate of Need and reimbursement problems to just plain physician jealousy.

The central concerns are easy to understand: ownership and control. Who will be involved? Will the hospital be in partnership? Will primary care physicians be partners? Will the consulting firm

demand partnership? Who will dominate? Who will profit?

Sim Cantril knows "oncopolitics" when he sees them. He spent time at the National Cancer Institute managing the NCI's comprehensive cancer center program, and he has been a principal investigator on several cancer control grants. To be sure, oncopolitics are at the heart of every FCC planning process.

"At first, it was horrendously difficult to get the three participating hospitals to move," says Cantril who is also a

founding member of ACCC. "There has been no prior time in which any joint *anything* has been done in San Francisco. I don't even know if we can get beyond the planning stage here. If we can, it will clearly provide a new level of coordinated cancer care to the citizens of San Francisco, and it will be a major achievement."

The first step in any planning process, according to Greg Lewis, is finding out what the key principals think. "We interview clinicians and allied health

## SUPPORTING AN FCC:

While most centers struggle for funds from hospital and banking sources to build and operate a freestanding cancer center, at least one oncologist turned to his community for support.

When Phil Periman, medical director of The Don and Sybil Harrington Cancer Center in Amarillo, Texas, came to Amarillo in 1976, he was determined to see that all the appropriate programs and facilities became available for a comprehensive cancer center. "Amarillo in 1976 was definitely behind the times," says Periman. "There were no full-time radiation oncologists in town, no physicists, no certified radiation technologists, no simulators. There was only one cobalt unit. I could tell from hospital statistics that at least half of the cancer patients in Amarillo were not getting treatment or were leaving the area to get it."

With the backing of interested medical and lay communities, and with the financial support of the Harrington Foundation under the direction of Mrs. Sybil Harrington, Periman and his staff chose to pursue community support aggressively. The result? A \$10 million facility totally debt free. Today, the Harrington Cancer Center provides comprehensive cancer care to the Texas Panhandle and four surrounding states.

But more money is needed as reimbursement decreases. "Our goal is to raise one million dollars a year," declares Charlotte Rhodes, director of Development. "We do this in two ways: \$500,000 is earned from the interest of the Harrington Cancer Center Endowment

Fund, which now has an excess of \$7 million from over a five year period. The other half is new money that we go out and raise with the help of our three member staff and volunteer committee of 12."

Rhodes' involvement with the center began with its inception five years ago. Starting as a volunteer in the clinics, she became active in the Development Committee, the volunteer arm of the center. The Development Committee consists of 12 volunteers appointed by the center's Board of Directors. Since the center treats patients from a large geographical area, the 12 volunteers -- who are professional and business leaders -- represent many communities.

The philosophy of the Harrington Cancer Center is to promote it as a community resource, and Rhodes goes right to the heart of the community to get money: area banks. One of Rhodes more successful fundraising projects is the Area Bank Endowment Fund. "Over 70 banks participate in this project. The banks raise money within their own communities. The principal money stays at the bank, and the Harrington Cancer Center receives the interest earned. This is a great way for people to invest in their own communities and to help the center at the same time," declares Rhodes. Recently, the Harrington Cancer Center began a Matching Funds Program, which matches every dollar raised through local banks.

If that sounds easy, it's not. "We work very hard to develop and maintain relationships with these banks. Initially,

we promoted the idea through fliers, but now we personally go to every bank and talk with their staff. Also, we work with them on fundraising techniques by sponsoring seminars," Rhodes adds.

Although the Development Committee assists Rhodes in her daily activities, there are several subcommittees known collectively as Partners in Progress. One subcommittee is the Annual Giving Committee that works in several different areas. Each November, the Annual Giving Committee solicits donations through direct mail. The committee also coordinates special projects and events. "This past year, we had a 'Harrington Chamber Music Series,'" says Rhodes. "It was both a public relations and a fundraising effort for us. This was handled much like a community concert series. The concerts were held at the center, so our contributors could see the facility. We sold tickets, had a reception, and raised money at the same time."

Recognizing benefactors is another important public relations necessity. The Annual Giving Committee recently sponsored a five-year birthday party for the center and invited every donor. "The party was a big success and everyone had a good time," Rhodes states. The committee is already planning next year's party for benefactors. In May 1988, the Annual Giving Committee will hold a huge gala that will involve a New York production company, the American Ballet Company, and the fashions of ten international designers. "This event will be both a fashion show and a ballet. We will have a

professionals such as oncology nurses, social workers, and administrators to determine where they think their cancer program should be heading over a short and mid-term future. It is important to the planning process to know what the oncopolitics are within the hospital and in the entire competitive area."

Support of the medical community is critical. This is especially true if the physicians are being asked to make a financial investment in the freestanding cancer center. Joint venture arrangements in-

volving physicians, hospitals, and corporations can be a sensitive subject. Physicians investing in for-profit centers are not viewed favorably by some, including Arnold S. Relman, M.D., editor of the New England Journal of Medicine. Relman asserts that physicians should earn income from their professional services only.

Referring patients to one's own center raises similar ethical questions: If a physician is an investor in his own center, where is his responsibility? To the

business or to the patient? Or, should the patient choose his own treatment site?

One thing is certain: Joint venture arrangements are subject to both federal and state laws. Hiring an attorney familiar with joint venture laws is vital to the planning process.

"With any cancer program planning effort, you need to resolve the turf issues at the outset, or they come back to haunt you later," says ACCC's Mortenson speaking of his own experiences.

## UNIQUE WAYS TO RAISE MONEY

wine and cheese reception, followed by an elegant dinner. We also hope to have a national celebrity who has actively supported cancer programs," says Rhodes. "We already have reserved the local civic center and have begun selling advertising."

Another subcommittee -- the Circle of Friends -- has 1,000 members. Each member pays annual dues. "It is a support group that not only helps in fundraising, but also helps in getting the message out that the Circle of Friends supports education and cancer control programs in the community," explains Rhodes.

The Circle of Friends biggest fundraising project is a Christmas card enterprise that involves the entire Texas Panhandle community. Each year, public school children are asked to compete in a Christmas card drawing contest. Five winners are selected. Each winning child receives \$100, and their cards are printed and sold publicly. Another 50 cards become 'Exclusive Cards'. Printed in a limited supply, this series of cards is sold exclusively to 50 different buyers.

"When we are ready to sell the Christmas cards, we contact other community groups to help us," Rhodes says. "This includes church choirs, schools, business clubs -- whoever is interested. They get a commission on the number of cards they sell. It helps them, and it helps us. It becomes a total community fundraising effort."

The money raised from the Christmas card project goes solely to cancer patients, and their families, who are in need of financial assistance. Although the cancer

patient does not necessarily have to be treated at the Harrington Cancer Center, the financial aid is restricted to cancer patients living in the Texas Panhandle. "For instance, a physician may need to refer a patient to M.D. Anderson for a particular protocol. We can help by paying the family's airfare to Houston," Rhodes explains.

Today, uniqueness is the edge in fundraising. It is no longer enough just to ask for charitable donations. Contributors look for a return on their investment. "There is so much competition for the dollar that you have to be willing to give something back," says Rhodes. "We continually work with the many communities to make them feel a part of all that we do. Everything we do in fundraising we do in partnership with the community."

Although most of the money raised by Partners in Progress buys new equipment and sustains projects at the center, Rhodes has three new challenges. One is to raise a \$2 million endowment to begin a pediatric oncology department. The second is to put together an endowment program for the center's Supportive Care Division, the umbrella that covers nursing, social work, nutrition, and pastoral services. "These services are not reimbursed. Since our philosophy is that we treat the whole person and not just the cancer, we have to find ways to keep these services going," says Rhodes. The third major project area is to raise money for clinical services, including education and research. An optimistic Rhodes adds: "Currently, the center has about

\$6 million from the Harrington Cancer Center Endowment Fund for clinical services. But to do all the projects we want, we estimate that we will need \$30 million."

The unique fundraising efforts by the staff of the Harrington Cancer Center show the potential for community support to supplement dwindling reimbursement and to bring new resources to cancer care. ■



*Charlotte Rhodes' unique fundraising techniques bring new financial resources to her FCC.*

**Patient Load Studies -- Is The Volume Really There?**

While muddling through the politics, the feasibility study should also address whether there is a sufficient patient load to sustain the investment of capital required by an FCC. An error in projections might cause repercussions that can quickly accelerate to financial disaster. To avoid such a calamity, a survey of the catchment area demographics and market share helps assess patient load.

Tom Sawyer, chief of Radiation Oncology at Orlando Regional Medical Center (ORMC) and a part-owner of three freestanding radiation therapy facilities, agrees that predicting patient load is pivotal.

When developing his first radiation therapy center in Sanford, Florida, Sawyer not only had to make sure the statistics were good for developing a private center, but he also had to prove to the ORMC administration that he was not invading their turf. "I couldn't afford to alienate ORMC. We were able to prove that we were not cutting into ORMC's patient load by looking at projected patient volume by zip code, which showed that only a small percentage of the Sanford population was from the ORMC area," explains Sawyer.

Sawyer suggests that you do not forget regional business considerations in a patient load study. "First, always plan for competition," advises Sawyer. "Know who your competition is, and know what referral practice patterns exist. Secondly, consider the patient reimbursement mix. Know what percentage of your patients will be Medicare, Medicaid, indigent, and those patients that have prepaid plans."

Most patient load studies begin with information on incidence from NCI's Surveillance, Epidemiology and End Results (SEER) program and then build in a variety of assumptions about use of various cancer care resources by age, sex, race, and cancer site. Some include assumptions about competition, number and types of patient visits, and average payments per course of therapy.

"In many cases these are loosely knit, rule-of-thumb assumptions based upon data from 10 years ago that has never been validated anywhere," says ACCC's Mortenson. "We know there are regional

*An ACCC "founding father" fights for an FCC in San Francisco...*

**TRYING TO OPEN THE GOLDEN GATES FOR AN FCC**

For 50 years, the Golden Gate Bridge has linked San Francisco to its surrounding communities.

Today, Dr. Simeon Cantril is trying to link cancer resources within the San Francisco community by developing a freestanding cancer center. Little did he know what a time-consuming and frustrating experience it would be.

"When I first started working on this project, I kept a log of what I did, and the numbers of hours I spent. After 2,000 hours, I quit the log. It was too depressing," says Sim Cantril, executive director of the West Coast Cancer Foundation.

Some of the frustrations that Cantril faces come from trying to meet the challenges of starting the first hospital joint venture project in San Francisco. He had to convince administrations from three hospitals of the mutual benefits that an FCC can bring.

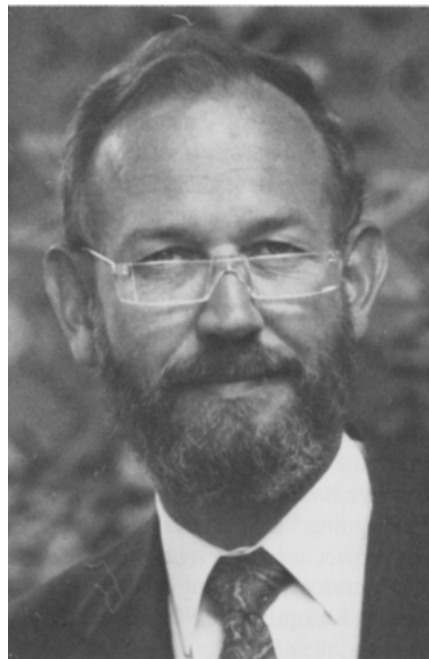
"San Francisco is a very unique town, very small. Only 600,000 people live in this city," says Cantril, who is also the chief of Radiation Therapy at Children's Hospital in San Francisco. "And, since there is plenty of sophisticated cancer care in surrounding communities, there are no major referrals to the city anymore. When I first came here, the norm was to refer to San Francisco. That's not so anymore, which is why San Francisco would do better with several large facilities instead of the numerous small ones we now have."

Not only has the physician referral pattern changed, so has the delivery of cancer care. Cantril says: "Primary treatment of breast cancer has become an important part of our practice. We estimate 100 new breast cancer patients a year for primary radiation therapy. It was only four or five patients a few years ago. This is because women are more knowledgeable about their options now. Also, the surgical community is beginning to accept radiation therapy as a good alternative method. In fact, most of my patients are referrals from surgeons."

Jim Hochstadt, administrator of the West Coast Cancer Foundation, found his efforts in assisting Cantril with the FCC planning equally frustrating. "When we first approached the three hospitals about developing an FCC a few years ago, they weren't interested. Each hospital wanted to do their own thing. As long as they were on cost reimbursement, there was no economic incentive to do otherwise. Now, however, it just so happens that two of the three hospitals are in desperate need of new radiation equipment," says Hochstadt.

To them, Cantril's idea now makes sense, partly because if each hospital went alone, it would have to invest a considerable amount of money to upgrade its department. According to Hochstadt, new equipment and relocation costs are hard to justify considering the patient loads of the individual hospitals.

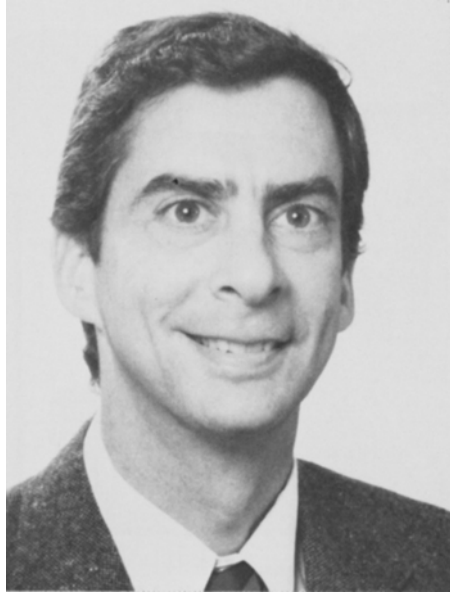
"Our experience was that the hospitals didn't know what their write-offs were. Sim had accurate statistics on the patient load and the write-off that his physician group



*Sim Cantril has been struggling with political and legal complications in his efforts to develop an FCC in San Francisco.*



*Jim Hochstadt has experienced a variety of political obstacles while assisting Sim Cantril in the development of an FCC in San Francisco.*



experienced," relates Hochstadt. "This enabled us to come to the three administrations with a viable plan.

"And, the business is easy enough to forecast. Each of the three hospitals would close their outpatient departments. The very day the center opens its doors, we would have patients from the three hospitals. We budgeted very conservatively based on two scenarios: One scenario is based exactly on the existing patient load of the three hospitals; the other scenario is with a relatively minor increase in patient load."

Along with administration, Cantril had to convince the medical community. Many of the 2,000 hours that Cantril initially spent on the project was going after physician support. Says Cantril, "You have to be able to listen to your medical colleagues. But when they say it can't be done, you have to ask: Why can't it be done, and why don't you want it done?"

This negativism, Cantril feels, stems from general paranoia in medicine. When people hear about such ventures, they fear they will be left out or not have any control. While there is no formula for dealing with medical politics, these concerns can be addressed within each community.

The freestanding cancer center that Sim Cantril wants to build is an ambulatory facility dedicated to cancer care. Although radiation therapy would be its economic base (approximately 80 - 85%), Cantril sees the center as a community resource. He wants the center to provide clinical care but also serve as an educational resource for both medical and public use.

"The center will be multidisciplinary. In addition to radiation and oncology services, we will have support services, including psychosocial, nutrition, and risk-factor counselling. We will also house a melanoma clinic that now operates out of Children's Hospital. At present, it is the only melanoma clinic in northern California that has treatment protocols," says Cantril.

Some services would be more cost efficient to contract out to existing companies says Cantril. "For instance, we want a boutique for cancer patients. Rather than us trying to hire someone to make wigs, why not hire a company that already does this and does it well?" Negotiations are underway to bring into the center a for-profit home health agency and a pharmacy company, too.

Cantril also wants to implement a computerized tumor registry system that will track the center's patients. He hopes to offer registry services to the smaller area hospitals.

Perhaps if hospital and medical politics had been his only problem, Cantril would have had an easier time developing the FCC concept. However, California laws are also complicating the process. "Although nothing seems to preclude a specialty clinic, our attorneys tell us there is a licensing problem for a non-hospital outpatient facility. Certainly, no one is crazy about hooking into one single hospital as an outpatient department. It is a matter of legal and financial control. All three hospitals will want equal control of their cash, which I understand," explains Cantril.

What odds does Cantril give the San Francisco project? "Today? About 50/50. Not because of the unwillingness of the hospitals, but because of the licensing issue. Two of these hospitals urgently need to upgrade their departments, and they can't wait years if legislative action is required."

Cantril is not giving up hope, though. He has put too much of himself into this project, and as he says, "Our lawyers are logging in the hours now." ■

variations in resource utilization and patterns of care, but many consultants do not adjust their assumptions to the region, the hospital's experience, or the decade."

Not knowing the patient numbers can get an FCC off to a shaky start. "I have heard of one freestanding cancer center on the West Coast that was built utilizing patient numbers whose source no one seems to know!" says Marsha Fountain, administrative director of the Comprehensive Cancer System at Memorial Medical Center in Springfield, Illinois. "This is not an exception. Other facilities have been built with a similar lack of knowledge. I think it is necessary to have a tumor registry with solid data to help determine patient load projections."

Thus, when devising a patient load estimate or buying a consultant's study, it is important to know up front what variables will be examined, and how the data will be adjusted to reflect regional patterns of care, reimbursement and case mix, and historic hospital trends.

#### **Choosing a Location -- Does It Work for the Patient?**

Selecting a suitable facility location can be a delicate matter especially if more than one hospital is involved.

Jim Hochstadt, who has been working closely with Sim Cantril in the planning of a freestanding cancer center in San Francisco, relates that their site problems have been both political and financial. "We have identified three sites," Hochstadt says. "One site is owned by one of the three participating hospitals, which is not the preferred site because of its proximity. The other two sites are more desirable, yet we are competing against a foreign developer. We don't know if we can match the offer. San Francisco is a relatively small city, and our options are limited."

Location is not just a political and financial issue. It is an ease of access and quality of care issue, too. Since most FCCs plan to better utilize cancer resources and to make it a "one-stop shopping place" for the cancer patient, the center's accessibility for the cancer patient and family must be considered. This includes a convenient drop-off area for the patient and parking for the family.



*The \$12 million, 50,000 square foot Cedars-Sinai Comprehensive Cancer Center in Los Angeles, California, was jointly developed with Salick and Cedars-Sinai Medical Center.*

Another factor when choosing location is visibility. Developers suggest that you look for pleasant surroundings, and one that can be readily seen. If the center is affiliated with a hospital, location may be an important identification asset, enhancing the hospital's image within the community.

If not handled properly, location may draw more fire than it will head-off any competition. So while certain business elements need to be considered when selecting the location, so must cancer patients and families' needs.

**WHAT TO LOOK OUT FOR -- THE RISKS!**

The ability to provide state-of-the-art cancer treatment will determine whether an FCC remains open. "Doc-in-the-box" and other facsimiles that only serve to generate self-profiting revenues do not benefit the cancer patient or the community. "Quality of care is what makes an FCC viable," says Salick's Kathie Bowling. "It doesn't make sense to do otherwise. Physicians will just go elsewhere if quality is not there."

Thus, the impetus behind any freestanding cancer center should be a strong commitment to quality patient care.

Realistically, though, if you have decided to build a freestanding cancer center, be aware of the risks. Specifically, FCC developers warn that you need to

look out for competition and changes in reimbursement.

Competition will surely follow success. Not only should you anticipate a cut in the patient load, FCC developers advocate implementation of a center marketing campaign the very day an agreement is reached. Letting the community know that a cancer center is coming, and what kinds of treatment and programs it will provide, gives you name recognition and "position" in the mind of patients and physicians.

A major portion of the marketing campaign should be directed to physicians, according to Cancer CarePoint's Greg Lewis. "By and large, it is the physician that determines where the cancer patient will ultimately wind-up being treated. Yet, media is expensive and can be a sink hole. It would be easy to drop about \$500,000 over 8 to 12 months, and the advertising may or may not be effective. So be prudent."

Competition makes it hard not to be commercial, though. While health care professionals may still be uneasy with advertising care, educating the public to the FCC's treatment and prevention programs is a community service. As Phil Periman of the Harrington Cancer Center explains, "Although I am personally uncomfortable with marketing and promotion, we aren't purists. I am not so naive to think we can survive without it. We sure like to let people know we are here."

Inadequate and erratic reimbursement policies are cited by FCC developers as a major concern that may impact the FCC viability. Policies of federal and state governments and third party payers still effect where cancer care is delivered. Certain cancer treatments are not getting reimbursed because they are regarded as "experimental." And, there are certain treatments that are reimbursed at higher amounts in some settings than in others. Until consistency is demanded of the payers, the best you can do for right now is establish strong working relationships with them and work through troublesome problems.

**THE DEVELOPMENTAL PROCESS -- DESIGN/ CONSTRUCTION AND EQUIPMENT SELECTION/ INSTALLATION**

Beyond the planning stage is the actual development of the freestanding cancer center. Ideally, an architect should be chosen before the site is selected. "Any special site considerations, such as poor soil conditions or inaccess to a sewage facility, are factors that effect construction costs," says Patrick B. Davis, Jr., AIA, vice president for The Ritchie Organization, an architecture firm specializing in health care facility design.

The Ritchie Organization has designed 14 hospital-based freestanding radiation therapy centers, mostly along the eastern seaboard. Davis estimates that a small radiation therapy center needs about 7,000 square feet, and a comprehensive cancer center requires about 20,000 square feet.

Construction costs vary from region to region. "Based on our experiences regionally, costs per square foot can range from \$165 to \$200 depending on geographical location and how nice they want the facility. A radiation treatment facility in Florida, or the southeast, will be approximately \$175 per square foot. This includes material and labor costs for building only. The architect's fee is generally 7% of the construction costs," says Davis.

At a recent jointly sponsored meeting by ACCC and the American Hospital Association targeting the development of freestanding cancer centers, Davis presented a case study of a 12,500 square



foot freestanding radiation therapy center affiliated with a hospital in Greensboro, North Carolina. The total project cost was \$4.5 million. Of the \$4.5 million, \$1.5 was actual construction costs, the other \$3 million included equipment, design, interior furnishings, legal counsel, and other miscellaneous costs.

Speaking at the same conference, Martha Wangenstein, administrative director of the Good Samaritan Comprehensive Cancer Center in Portland, Oregon, stated that their new FCC cost \$10 million. The center is housed in a four story building that is attached to the main hospital by a sky bridge, and operates three of the four stories with 25,000 assignable square feet to the center. The fourth story is leased for office practices.

"The actual cost of the building itself was \$7 million, and the additional \$3 million was for furnishing and equipment for the cancer center," says Wangenstein. "Ninety-five percent (95%) of the furnishings and equipment were new, including a Varian Clinac 1800 linear accelerator, a new simulator, diagnostic equipment, an ADAC treatment computer, and two film processing rooms. We did move the cobalt and hyperthermia equipment."

When the planning committee for the Harrington Cancer Center began a search for an architect, one factor was crucial: "We wanted an architect who could design an aesthetically pleasing facility. We did not want a hospital atmosphere," says



*This view of the Harrington Cancer Center's waiting area exemplifies the "patient-oriented" architectural design.*

Periman. "We contacted two dozen architects before finally choosing one from New York."

The Harrington planning committee also wanted a first-class, urban look for the center. Traditionally, Amarillo, Texas, has been the tertiary setting for about 600,000 people. According to Periman, a certain segment of that population used to believe they had to go to Houston or Dallas to get good cancer care. "The atmosphere of a facility can influence the way you think of yourself," says Periman. "If the facility doesn't work for

the patient, it can be a *perceived* negative impact on the quality of care."

Periman and his colleagues also wanted to make the facility function for the physicians. Thus, the facility was designed to foster informal relationships by clustering certain departments. "For instance, medical and radiation oncology departments are side-by-side," says Periman. "It makes it easy for the physicians to wander down the hall to see each other. Although we still need to integrate the surgeon's role a little bit better, we have found that the facility design has definitely nurtured informal relationship with physicians."

The cost for the Harrington Cancer Center was \$8 million for construction and design and another \$1.6 million for equipment.

Before hiring an architect, know what your equipment needs will be and the time frame involved. "Basically, in a freestanding radiation therapy center, plan to build around large pieces of equipment," says Davis. "It takes approximately 6 to 8 months to design an average facility of 10,000 to 12,000 square feet. It takes roughly an average of 20 months from when we are hired until the client actually moves into the facility. This includes planning, construction, and equipment placement."

Although equipment preference is a physician prerogative, purchasing the



*The Harrington Cancer Center rests on 3 acres of land. It is physically connected to two hospitals -- one by an underground tunnel, the other by a sky bridge -- and to the Texas Tech University Health Science Center by a sky bridge.*

equipment for the facility is an ownership responsibility. According to Davis, allow 4 to 8 weeks for the equipment to be installed, calibrated, and operational.

"When purchasing the equipment," says Davis, "it is critical that the owner directly asks the vendor how long it will take to install the equipment. Get references on that, too. Because the owner will start paying for that building as soon as the contract work is completed. The equipment vendor doesn't begin a major part of the installment until that building is virtually complete. You don't want to be left with an empty building."

Because medical technology rapidly changes, plan for frequent equipment upgrade. An FCC can not be viable, nor can it remain competitive, if the latest access to technology is not available.

#### THE FUTURE -- SHOULD YOU JOIN THE BATTLE?

Freestanding cancer centers are changing the course of cancer care delivery. And, while the economic climate for an FCC may be profitable today, it is difficult to predict tomorrow. Increased competition may alter a present vantage point. Out-patient reimbursement systems, such as Ambulatory Visit Groups (AVGs) or some other variant, may be on the horizon.

Moreover, the controversy surrounding freestanding cancer centers will not end until it can be substantiated that FCCs can provide quality, unfragmented, comprehensive cancer care. So for now, the skeptics, the proponents, and the detractors will continue to debate how FCCs should be assessed, accredited, and, eventually, reimbursed.

Should you join the battle? That depends on the estimated time of payoff,

changes in reimbursement, and projected competition.

Greg Lewis of Cancer CarePoint notes that most of his FCC studies use a 5 year payoff plan. ACCC's Mortenson says, "It seems likely that there will be major changes in outpatient reimbursement in the next five years that will parallel those we have seen on the in-patient side." And competition? As Tom Sawyer says, "Always plan for it!"

Joining the fray may depend on your feasibility analyses, your competition... and your level of risk-taking. ■

*In an upcoming issue...FCC  
Operational Issues*



**CANCER CAREPOINT**

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*For information about our services or our  
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