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Cancer Program Development in the 1990s: Elements for Success

Part two in a six-part series that explores the future of multidisciplinary delivery of cancer care

by Lloyd K. Everson, M.D.

As structural and strategic changes evolve in our health care system over the next few years, not all cancer programs will survive—no matter their dimension, level of sophistication, or location at a community hospital or a university. The programs that do survive will be the ones that pay close attention to the key components that form the foundation for development of a successful cancer program.

There are five essential components for developing a successful cancer center, whether it be "freestanding," hospital based, or university based. The basic, programmatic and operational issues that require attention include vision, organization, funding, hospital and physician relationships, and programs.

- Vision is a clear idea that the key/core leaders of the administrative and medical staff have bought into.
- Organization involves a clearly defined administrative, organizational, and medical staff authority for the cancer center, including an experienced and strong medical director and administrative director.
- Funding includes a strong financial commitment during the initial capitalization/investment stages, i.e., facilities, equipment, personnel, and program support, and during ongoing operational program development.
- Hospital and physician relationships include a cooperative and sharing relationship between hospital and physicians in the planning and administration of the cancer center.
- Programs encompass a comprehensive programmatic development of initiatives in screening, early detection, treatment, rehabilitation, palliative and terminal care, clinical research, and outreach development.

The absence of any one of these key elements can severely delay continued development of a center or, at the very worst, prevent the realization of a true cancer center altogether.

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VISION AND STRATEGIC PLANNING

A clear vision for the cancer center is a fundamental requirement for a successful program in this turbulent health care environment of hospital system mergers, networking, and alliances. In this milieu, it is best to consider strategies that will position the cancer program for the long-term future.

The strategic planning process involves three fundamental steps: 1) assessment of strengths and weaknesses of the current program, 2) strategic planning for the future of the cancer program, and 3) identification of the resources required to implement the strategic plan.

The first step is to identify where the program is by analyzing the strengths and weaknesses of the cancer program, with special attention to clinical services, educational and teaching programs, marketing, and financial analysis.

Strengths and weaknesses can best be evaluated within the construct that groups cancer programs into three levels, each defined by the mission that underpins its breadth of services. Level I includes basic level services. The main mission is in delivery of clinical oncology services. Level II includes secondary level services. The main mission is evolving to encompass clinical services and a developing mission in education and research. Level III includes tertiary level services. The main mission is delivering tertiary level clinical services and an established mission in education and research.

The next step in strategic planning is to evaluate where the cancer program should be in the future and how the program relates to the overall strategic planning of its parent hospital system and its oncologists. It may be decided, for example, that the program may eventually become a tertiary cancer care center. Market, financial, legal, and program implications must be

considered—whatever the goal.

In this era of health care reform, cancer program planning must be an integral part of hospital and physician planning. Carrying forward the message of integrated and comprehensive cancer care during the planning process will be especially important as primary care in the managed competition models of health care reform becomes of increasing emphasis and as specialty services are viewed as cost centers—not revenue producers.

The third step in strategic planning is to find how to arrive at one's goals. Assuming that the cancer program is supported in its quest by the hospital and physician strategic plan, it is a relatively simple task to identify what program, financial, personnel, legal, and administrative resources are required for implementation—and then act! For instance, to achieve tertiary level care, one must first enhance and expand secondary level services. Programs that are now struggling to encompass the basic and secondary level of cancer program services will find it challenging to gather the commitment and resources for tertiary level development.

The future of medicine and certainly of cancer prevention, diagnosis, and treatment lies in the newer technologies of fourth modality—biotechnology—that will exploit the revolution in genetic medicine. Oncology is at the forefront of these rapidly expanding technologies. Health care institutions that survive over the next 15 years and remain at the cutting edge of technology will have to develop those resources and services by themselves or in partnership with others, such as universities and other established tertiary-care level providers.

A SOLID ORGANIZATION

A clear administrative organization with true budget and resource allocation authority is critical to the ultimate success of a program. In addition, the support of the oncologists and the commitment of the hospital CEO and COO are absolute requirements.

Equally important is the multidisciplinary team of personnel that constitutes the organization. The key person within that structure is the medical director, who must provide leadership, vision, and focus for the program. Likewise, an administrative director, who works closely with the medical director, is an important individual in the program's ultimate success. An executive committee or steering committee for the center's development is a key initial and ongoing piece of organizational commitment, because it can help build the buy-in to the vision and deal with the myriad implementation issues.

A solid functional organization and structure that deals with the multiple and parallel programmatic, academic, scientific, operational, and financial issues of the cancer center is a basic need. Regardless of whether the thrust of the organization of the cancer center is product line or matrix oriented, key ingredients to success include a strong relationship between 1) the medical director and administrative director, 2) the medical director and administrative director and the oncologists, and 3) the medical director and administrative director and the hospital CEO and COO.

As hospital systems grow, merge, and form alliances once thought to be nearly impossible and as oncologists jockey to position themselves in the environment of a primary care dominated managed care, cancer programs that can transcend these structural changes and seize the opportunities inherent in an expanded market will survive and flourish. Indeed, these types of cancer programs will begin to realize the advantages by showing increased market share, decreased and shared overhead expenses, and decreased rates of discounting, which larger groups of health care organization can provide.

SECURING FUNDING

A truly tertiary level and even a secondary level cancer program that strives to integrate its multidisciplinary cancer services (clinical services, research, and education) require funding from other sources for many of its nonclinical service/revenue producing programs. Net margins from operations will be difficult to maintain in an increasing competitive market, especially one in which specialty services such as cancer are viewed as cost centers and called on to cut costs while maintaining or enhancing quality. A strong foundation, with an endowment fund, is critically important to support the program's ability to compete in future cancer care delivery—whether that market be in secondary or in tertiary care level services. Those universities and community health systems that have such a strong foundation will have a major strategic advantage over the next few years.

Adequate funding is an obvious requirement for initial capitalization of facility construction and renovation and for program expansion and staff additions. With changing and declining reimbursement for patient care services, cancer program development and growth require foundation support and other sources of funding. This is especially true in the start-up phases.

For long-term operation and program development within the cancer center, a solid continuing revenue base is essential. Requirements include accounting and data system methodologies that enable an accurate tracking of revenues and expenses derived from cancer services and cancer diagnosis-related services in medicine, surgery, radiation therapy, pathology, pharmacy, and diagnostic radiology.

As hospitals and physicians seek to consolidate "the group" and look for outside funding sources, additional sources of capital are emerging. Many of these sources are investor originated. Although investor-originated sources deserve careful scrutiny with regard to ethical and financial considerations, many physician groups and hospitals are seriously entertaining these options as they search for their particular niche and vision of the future.

PHYSICIAN AND HOSPITAL RELATIONSHIPS

A cancer program cannot exist without the physician manpower to do the job clinically, programmatically, and scientifically. Strategies to involve physicians can take a "soft" approach or a "hard" approach. The soft approach uses a marketing strategy in which physicians participate in planning, educational symposia, speakers bureaus, and outreach sales development. The hard approach, which is more challenging from a regulatory, legal, and financial perspective, involves hospital/physician financial and contractual arrangements. If one embraces the concept that state-of-the-art cancer care is multidiscipli-

nary, integrated with physician and hospital, and comprehensive in nature, then a strong argument can be made for pursuing hard approaches.

From a broad perspective, it is best to consider the regulatory, legal, political, and ethical issues that bear on different models of physician and hospital relationships as ultimately adaptable to all potential oncology physician services. These services include not only medical oncology, but also surgery, radiation therapy, and other subspecialists. Whether the final model embraced is derived from "clinic without walls," PPO, contract, employee, lease, or private practice arrangements, the model should ultimately enhance and become an advantage to the patients served, the physicians, and the hospital.

Strategies that involve physicians and hospitals have become of increasing concern and are receiving intense interest across the United States. This interest is from the oncologists and hospitals involved as well as from state and federal authorities. As a cancer center program (one aimed at evolving a true competitive advantage and perceived superior service) develops, the relationship between the physician and the hospital/health system, as well as the degree of success that the system enjoys, will be critical issues to be considered.

The exact model that fits the local health care milieu, the hospital board, the medical staff, and, perhaps most importantly, the legal staff will depend on a number of factors, including:

1) a definite ownership of the vision for the cancer center (Is it to ultimately develop a tertiary center, for example?),
2) a clear understanding of the legal and regulatory guidelines that are permitted for the different models (for example, to provide a market-competitive and incentive-based arrangement between hospital and physicians in an ethical and legal way), and
3) an acknowledgment by both hospital and physicians to share administratively in the center's program planning.

DEVELOPING THE PROGRAM

Physicians, nurses, radiation technologists, administrators, social workers, and counselors can and must play a role in developing the true multidisciplinary team approach for each segment of the comprehensive spectrum of cancer care.

The nuts and bolts of most cancer centers have developed around the clinical services of medical and radiation oncology. However strong these key services are, the challenge is to build upon these strengths the supportive services, clinical research, counseling, cancer control, and fourth modality/biotherapy initiatives.

A clear administrative organization with true budget and resource allocation authority is critical to the ultimate success of a program.

The goal is to develop programs that affect patients and families in a direct way. Starting with cancer prevention and evolving through the entire spectrum of screening (early detection, treatment, rehabilitation, palliative care, terminal care, clinical research, and outreach), there are multiple approaches to making it easier for our patients and families to address their concerns about cancer and allied diseases.

As programs change their focus from a basic- or secondary-level program to one of true tertiary stature, their mission and program emphasis will evolve toward programmatic development in professional and public education and in expanded clinical and basic research.

As health systems form alliances or outright merge, opportunities for collaborative sharing of planning and resources will present themselves. An example is the collaborative consortia in which hospitals and health systems, physician groups, and universities arrange clinical, research, and education partnerships. As the high-tech approaches to cancer therapy and genetic engineering evolve, these expensive technologies will lend themselves to increasing collaborative arrangement.

SUMMING UP

The formula for success in building a cancer center is straightforward. A vision of what the cancer center should and can become is the most critical and fundamental starting point for consideration. The cancer center's vision must be congruent with that of the parent hospital system and of its physicians.

The organization of the key staff of the cancer center is fundamental to delivery of integrated and comprehensive services. Accountability and resource allocation authority both are prime concerns for the cancer center's leadership, which includes the medical director and the administrative director.

Funding support is of critical concern. Sources from operations, foundations, and others will need to be carefully reviewed. Without additional nonoperational-based revenue support, much of the glue of integrated and comprehensive cancer care will be difficult to support in the emerging cost-containment world of managed care.

Physician and hospital/health system relationships are and will be increasingly critical for success in the managed care future. Models of these interactions need to address multiple political, ethical, clinical, and financial concerns. How well a specific group of physicians/hospitals addresses these issues will in large measure determine their future success in cancer center development.

As we navigate the turbulent health care reform waters of the future, program growth will be a challenge. Enlarging the multidisciplinary and comprehensive thrust of cancer program development in a managed care environment will test physicians, nurses, and all personnel in the cancer center. ■