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## How to Position Your Program for Success

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# 1994 Strategic Imperatives for Community Cancer Programs and Providers

## How to position your program for success

by Thomas L. Cureton, P.A.-C., M.P.A., and Lee E. Mortenson, D.P.A.

The year 1994 is the 11th hour for some cancer programs. Pressures from health care reform are creating a number of challenges, and not all cancer programs will survive. With capitated payment systems, institutional downsizing, mergers, acquisitions, and vertical and horizontal integration, the environment in which oncology programs and practices must survive is changing...and changing rapidly. Many hospital CEOs are making live-or-die decisions about which of their clinical programs they will sustain and which they will discard.

To strengthen your hand in the oncology game of the 1990s, focus attention on six central areas.

*Information.* Develop a responsive base that provides data for critical decision making. Armed with a full complement of critical data, physicians and cancer program administrators will be better able to anticipate the needs of the community, assess program strengths and weaknesses, and position the program for future success.

*Investment.* If your oncology program is going to capture the higher ground, major investments need to be made now.

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*Affiliation.* Integrate, affiliate, bond, link, and collaborate. Take action now to strengthen the relationships between the cancer program and the medical staff.

*Cost consciousness.* Target efficiency and cost-effectiveness with clinical pathways, outcomes, and complete financial data.

*Managed Care: Comparison.* Consider how you compare with your neighbors. What in your program is likely to be evaluated and what is likely to "sell"?

*Positioning.* Decide whether you are going to be the tertiary-level biotech center in your network or whether you are going to be a clinical service organization.

### INFORMATION: ARM YOURSELF WITH DATA

For many cancer programs, truly usable management information is a scarce commodity. Historically, cancer centers have had access only to data for a superficial level of critical management information. To be successful in 1994 and beyond, programs will need readily accessible information about a broad range of data involving the institution, region, and nation. They will need to know real costs, from where revenues are coming, and what margins are realized for each diagnosis. In addition, programs will need to know which physicians are performing, which are coding correctly, and which need help.

Physicians and cancer program administrators preparing for health care reform have some important questions to ask themselves and each other. Key physician considerations include:

- Who are my hospital partners going to be in health care reform?
- How viable are these partners financially?
- With whom are they going to affiliate?
- How are they going to position the hospital's cancer program? As the leader? As a service center? As a feeder program?
- Is the hospital's cancer program going to be a cost-effective one?
- Is the hospital going to be able to compete effectively for health care alliance contracts?
- Are there other oncology groups or practices that will be able to bid for the hospital's business in a more cost-effective way?

These are serious questions, important to determining which way you should position your practice. Obviously, it will be important to consider your real costs and what you have to offer hospital partners. You will have to figure out a way to capitate your practice or prepare to lose significant client bases.

You can find out about your hospital's viability in a variety of ways, from looking at its annual report to discussions with the CEO and medical staff leadership. Don't be shy. Some hospitals are not going to make it in the health care reform run-off.

Calculation of a capitated rate is no easy matter, but consider as one piece of the puzzle categorizing your office patient load by site and stage. Insurers are already profiling physicians by cancer site. You should know as much about your

own practice patterns as they do.

Hospitals have their own set of key considerations, which include:

- Who are the physician partners?
- Are they cost conscious or high-profile physicians?
- What is the total cost of the product line, and what margins are generated?
- Are the physician affiliates billing appropriately?
- Are they practicing in a way that is cost effective to the hospital?
- What is the hospital's strategy versus other partners in a health alliance? Is it high-tech, a service center, or a feeder program?
- Can the hospital generate a profile of current cancer program financials sufficient to generate a capitated total program rate?

In summary, physicians and cancer program administrators need accurate financial data *now*, and they need to track it constantly. Moreover, they must identify physicians who may be willing to partner with them to develop a single, global cancer program data pool, sufficient to bid the entire program accurately.

## INVEST NOW, AND MARKET YOUR PROGRAM

Identification of oncology as an important product or service line—one that requires attention and investment—may be crucial to getting the attention you need now to pay dividends later. Administrators should consider the role of oncology in the hospital's total mix of services. If the program seeks to be a leader in oncology, major investments must be made, including a medical director with vision and insight into oncology's opportunities and a cancer program administrative staff that is top-notch and well acquainted with the issues affecting oncology (inpatient and outpatient coding, biotechnology, off-label drug issues, clinical trials). If you are not in a position to make the major required investments, lobby those who are.

Program leaders must be more effective in marketing the importance of the cancer program within the organization. A focused marketing effort promoting cancer's clear importance to the community, coupled with institution-specific data about the program's direct and indirect contribution to the hospital, will strengthen the strategic importance of the cancer program.

## BUILD RELATIONSHIPS

Hospitals and physicians are increasingly linking their futures. This is particularly true in oncology, as more oncologists "bond" themselves to hospital cancer programs. Bonding between physicians and hospitals does more than just increase a physician's involvement at the hospital; it prepares the way for both to effectively link services in negotiating with managed care plans and group purchasing alliances.

> Physicians and cancer program administrators need accurate financial data *now*.

The reality is that size will equate with clout in the years ahead. This is true for solo physicians and solo hospitals. Both need to recognize the importance of their position within a larger framework.

There have been all sorts of responses to the need for size. Some physicians are developing larger oncology groups; some are contractually allying with hospitals; others are forming large multispecialty groups. Although any of these responses may be legitimate for the immediate future, keep in mind that in a few years we will be talking about only a few health care alliances competing for the overwhelming majority of care in your state. These will be conglomerations of a single insurer, many hospitals, and the physicians associated with those hospitals. These large systems will have cost as a major imperative, and every hospital and physician will be a cost item. As these systems develop, some hospitals will be viewed as the oncology advanced technology centers, while others will be merely service centers or feeder hospitals.

As you look at your plans, consider how you will stake out your role and how you stack up against other allies within your alliance. Will all the bone marrow transplants and gene therapy go to another hospital? Will your hospital be a feeder hospital, with only modest chemotherapy and surgery? As an oncologist, will you be working in a hospital facility with a number of oncology physician assistants and clinical nurse specialists and a large patient population? The program that you are developing now is likely to be frozen in its relative stage of development as the alliances are formed, so make sure it is everything you want it to be.

If the program is not complete, then find out what other programs you will be working with that will have the missing elements of oncology service. Will you be sending your patients to a university-based cancer center? If a university is included in your health care alliance, will it be too costly to compete? If a university is excluded from your alliance, find out if there will be a source for additional medical oncologists, physician assistants, or clinical nurse specialists to take on the additional cancer patients that ***will*** show up as incidence increases and the number of available oncologists levels off or decreases.

## GET A HANDLE ON COSTS

Most administrators are trying to turn the practice patterns of oncologists around before they hit the approaching iceberg. Forward looking administrators are targeting efficiency and cost effectiveness with clinical pathways, outcomes, and complete financial data.

Within the next two to three years, insurers will issue "guidelines" for cancer patient management. These guidelines may or may not be accurate, but they are going to restrict the therapies that are used, the tests that are administered, the frequency of follow-up visits, and the availability of high cost, supportive care. Within two years, several large national insurers will begin to credential physicians and facilities on the basis of cost by cancer site (i.e., the cost for management of breast cancer patients, lung cancer patients, etc.) as well as other credentials, such as American College of Surgeons approval, Association of Community Cancer Centers (ACCC) delegate membership, and board certification.

Within the next three years, managed care plans and insurers will have access to computer neural networks. These on-line terminals will predict (as they currently do for worker's compensation) the shortest path to patient discharge with the highest probability of successful treatment. These neural networks aren't science fiction. Using hard data, these networks will replace the panels of experts who are trying to steer insurers toward a preferred outcome without objective details.

Oncologists and hospitals must get a handle on their costs and their inefficiencies. Insurers are making the attempt, although they may not be savvy enough to understand the importance of staging breast patients when they look at their comparative costs of care. They soon will understand and *will* figure out a way to incorporate comparative cost information into their databases. The software to do this with your practice information and with your hospital information does exist. This is information that you are going to need as soon as possible.

## MANAGED CARE: FIND OUT HOW YOU COMPARE

Consider what is likely to be evaluated and what is likely to "sell." Does the hospital know what kind of program it wants to develop—and where it will fit with other hospital partners in the alliances now being formed?

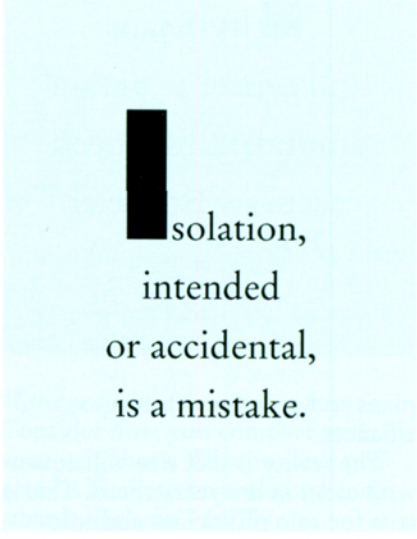
To put it plainly, think about what in your cancer program will be compared in a few years with your neighbors' program. You can make some educated guesses and then begin to work backwards. For example, it is likely that your survival statistics (from breast, lung, prostate, colorectal, or ovarian cancers) will be compared with the big and provocative cancer sites. The providers who are working with you are generating the survival curves that will be one of the primary ways that your program will be evaluated in a few years. If you think that some of your colleagues are "bad actors," now is the time to act. Their costly actions today will produce the blips in tomorrow's bar charts.

You can also guess that the availability of screening and prevention programs is going to be important. Is your institution active in the breast cancer prevention or prostate cancer prevention trials? Is your competitor? What about your proportion of radical mastectomy versus breast conservation therapy? What is your total package cost for breast cancer patient management?

There will be only a few key measures. You are going to need to think about what these measures will be and begin to take some steps to prepare for the obvious.

## FIND YOUR NICHE

Decide whether you are going to be a "feeder" hospital, a clinical service organization, or the tertiary-level biotech center in your network.




It's going to be hard to be at a feeder hospital. If you are, you are going to diagnose the patient and get them back for some chemotherapy and supportive care. Perhaps the surgery will be done at your hospital, perhaps not.

The majority of hospitals will be in the second category, that of a clinical service organization. Given the way health care reform is being discussed, there are some important characteristics you need to consider now if your facility is going to be a clinical service organization. For example, you can expect that the organization is going to be very cost conscious. There are likely to be a number of oncologists working together in a facility adjoining the hospital in some way, preferably close to radiation oncology in a patient service-oriented configuration. Relatively standard chemotherapy will be delivered at these hospital facilities within the network. There will be significant surgery and radiation oncology patient loads to deal with.

Depending on the way the contracts develop, the oncologists at the service center may go out to feeder hospitals to provide care in rural areas, or the patients may need to come to the service center. In either case, with a plethora of patients and limited physician resources, the oncologist will serve as a strategist, with other members of the health care team doing the implementation. In many cases, standardized protocols may be used for standard cases.

Of course, a number of physicians will resist working closely with hospitals, and some will be successful. The key issues for those outside the hospital's direct control will be their cost effectiveness and their attention to the conservative use of hospital resources. If there is no restraint, hospitals may opt to undercut freestanding physician practices by bringing in their own oncologists, which has already happened in more than one instance. Moreover, if the hospital controls the primary care physician base, the old "we'll get all of the referrals" leverage will disappear.

The third type of center will have all of the characteristics of the service center, but will also be involved in the new gateway, fourth modality technologies—bone marrow transplantation now, gene therapy in the near future. Don't bet on this fourth modality being high cost either. While some insurer profiles show medical school cancer providers to be the high cost providers, this behavior won't last. Nor will all the advanced technology stay at the medical schools. More than 70 ACCC institutions have indicated that they have developed or are planning to develop an autologous or allogeneic BMT unit. Many more than have been reported are in the planning stages. Hospital networks are looking for access to advanced technology at low cost.

These developments may sound like science fiction, but all of them are happening now—if not in your town, then in the next town over. Perhaps the most important advice is *not* to assume that things are going slowly because they have not imposed themselves upon you. Isolation, intended or accidental, is a mistake. These are turbulent times—times that require a great deal of information gathering, constant assessment, and repositioning of the program for future success. ■