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Cancer Care in Transition

Highlights of ACCC's 20th Annual National Meeting

by Donald Jewler

The delivery of cancer care in the United States is in dramatic transition.

That was the message heard by more than 300 participants who gathered in Washington, D.C., March 23–27, 1994, for the Association of Community Cancer Centers' (ACCC) 20th Annual National Meeting. The focus of four days of presentations and panel discussions centered on preparing for and surviving health care reform.

"Although the rapidly evolving changes in delivery of health care in general, and cancer care in particular, are creating tremendous chaos, at the same time there is much opportunity," said ACCC Executive Director Lee E. Mortenson, D.P.A.

The challenge for medical oncologists is to recognize the speed of change and the market dynamics taking place.

"Solo practice—going it alone from either a clinical or financial perspective—is not a good idea," said Mortenson. "As competition grows, hospital linkages will also grow. And as hospital CEOs, administrators, and physicians struggle to lower overheads, linkages, purchases, and downsizing will increase."

In the changing dynamics of oncology practice, physicians are already becoming strategists much more than hands-on practitioners. Physicians are finding they must learn to deal with cost accounting, marketing, and the rising interest of venture capitalists to buy physician practices, as well as free-standing facilities.

Donald Jewler is Managing Editor of Oncology Issues.

TRACKING COSTS AND MARGINS

Part of the new health care environment is characterized by intense price competition and demand for documented value and quality outcomes.

"The future of health care includes lower reimbursements, global fees, capitated rates (fixed payments per month), unit prices, and global DRGs. Quality and outcomes assessment will become critical," said Kent Giles, M.P.P.M., West Paces Medical Center, Atlanta, Ga. The goal is to improve quality, reduce cost, and gain market share. (See "Capitating Cancer," pages 10–13.)

The key to success will be data collection and analysis, for example, knowing cost per case, cost per year of life, and procedures per physician.

"I can foresee a day when there is a *Consumer Report* on every hospital and every physician," said Giles.

Cost accounting must include actual costs for all aspects of a patient's care, actual collections (lag time) rather than estimates of collections by payor class, and direct and indirect costs by item of charge, procedure, case, and patient.

What will be done with all this data? Treatment plans will be compared for cost and efficacy. And reimbursement strategies will be developed, including global fees, capitated rates, and per diems.

PICK YOUR PARTNERS

Health care reform capitation strategies are forcing many hospitals and physicians to explore approaches to integrate vertically and to consolidate their services by forming multispecialty groups. An important emerging strategy for many hospitals and physician systems is to focus on primary care-based integrated health care delivery systems as the preferred approach to health care delivery. The goal underlying this primary care strategy is to control and decrease costs.

These integrated health care delivery systems offer the potential for delivery of a full continuum of care, said Lloyd K. Everson, M.D., president of American Oncology Resources, Inc., in Houston, Tex. Hospitals are redefining their vision of health delivery systems and are rethinking their role within those systems. Many hospitals are moving toward integrated network models to achieve the level of physician/hospital collaboration that will allow hospitals and physicians to be successful in this new era.

"The challenge is to identify and control risk when we consolidate and integrate services in our cancer program or in our network," said Everson.

Important questions for physicians to ask are: Is there any equity ownership or physician control in the business? Is there financial security and access to capital to build facilities? What is the compensation?

In the Minneapolis/St. Paul, Minn., area, there are three integrated service networks: the Allina Organization, made up of a health care system and an HMO; Health Partners, which is a staff model HMO in conjunction with a hospital system; and a network formed by the Blues that links a hospital system, a primary group, and possibly a specialty care group and the University of Minnesota.

According to Burton S. Schwartz, M.D., president of the Minnesota Society of Clinical Oncology, physicians are responding by selling practices to these systems. Some specialty physicians are joining physician/hospital organizations. Others are forming clinics without walls, a network of medical oncologists whose goals are to decrease cost by centralizing billing,

marketing, use of employees, and buying, especially drugs.

Schwartz and 10 other oncologists have joined with Minnesota specialists to form a multispecialty group without walls. The Minnesota Specialty Physicians (MSP) is made up of 12 different specialties, including cardiology, neurology, digestive and kidney diseases, and oncology. The organization plans to become a part of all three major integrated service networks. Through the development of practice guidelines, integrated systems, and effective working relationships with primary care physicians and hospitals, MSP will manage specialty medical costs to achieve optimum values for patients, buyers, and the larger community.

INVESTING IN ONCOLOGY'S FUTURE

"You are all entrepreneurs," said Walter Drimer, president of Genesis Development Group in Jupiter Florida. "Whether you work for a profit or a not-for-profit institution, you have to create an excess of income over expenses, and you have to invest that income in growing your organization. If you don't, you die."

Drimer represents three health care companies that have purchased numerous practices, clinics, and facilities, including ambulatory services and pain management clinics. In small communities underserved by the oncology market, Drimer has worked to create a series of vertically integrated networks. "We are starting at the local level, moving to a regional level, and finally to a national level."

What does it mean to you when one organization, whether it is the Columbia Hospital Systems or Texas Oncology, controls a large number of institutions in your neighborhood? According to Drimer, it becomes extremely difficult to obtain a piece of the marketplace unless you find a way to cooperate with that organization.

Although the rapid increase in affiliations and linkages among practices and institutions appears frightening, mergers are normal in many industries. "These changes are cyclical. They occur about every seven to ten years," said Drimer. "For example, IBM dominated the computer industry 10 years ago. Today it finds itself scrambling to protect and maintain its market-share. Ten years from now the picture in our industry will be entirely different," said Drimer.

"In the meantime, each of you has to decide how you want to participate in a network and what are the advantages and disadvantages," Drimer added. "What do you have to give up? Do you want to give up what you have created and developed over a period of time?

"Although we are fearful that somebody else will come in and give us less, remember that venture capitalists, private investors, or companies that come to acquire or manage what you are doing all want to have a successful venture," said Drimer. "Without you in that equation there is no venture. You are the local organization, and they need your input."

Another entrepreneurial venture is Texas Oncology, which did its first practice merger in 1975. Throughout the 1980s, it expanded markets within the Dallas/Ft. Worth area as well as throughout the state. By the end of 1994, the organization expects to employ 94 physicians: 68 medical oncologists, 20 radiation oncologists, and 6 gynecologic oncologists. Today, it operates five major cancer centers and employs 26 people in full-time clinical research.

Merrick Reese, M.D., president of Texas Oncology, outlined past growth and future plans of his organization. "We feel that we must be able to provide all the professional services for our cancer patients, including very high-tech experimental therapy. We are developing relationships with hospitals to provide hospital inpatient, home care, and hospice services. By the end of 1995, we will operate 14 free-standing cancer centers," he said.

Although the financial value of Texas Oncology is growing by leaps and bounds, "the value of patient care is what we will really be measured on," concluded Reese.

UNIVERSITY AFFILIATIONS

Traditionally, community cancer centers have focused on patient care, whereas university academic cancer centers have focused their resources on clinical research and education. With increasing competition among institutions, academic centers are placing greater emphasis on clinical practice, and some community cancer programs are considering university affiliation. These new cooperative clinical relationships are technology oriented, disease specific (oncology), and supplement existing relationships.

According to Ron W. Gilden of Advanced Cancer Technologies, Inc. in Atlanta, Ga., affiliation with an academic cancer center can:

- create a physician-friendly clinical research environment
- allow greater access to emerging technologies of interest to local medical staff, patients, and families
- differentiate the local institution through regional recognition as a leader in current technologies
- increase patient accruals to clinical trials
- provide financial benefit to the local institution.

Affiliation offers numerous benefits to physicians, said Gilden. These benefits include: 1) being able to offer additional treatment options to patients; 2) differentiating participating physicians from their competition; 3) supplementing existing clinical research relationships; and 4) allowing access to a physician-friendly research environment that reduces data management and other administrative functions involved with clinical trials.

According to Gilden, the best relationship is one that includes a network of academic centers, which allows community cancer programs to pick and choose and have access to emerging technologies. It becomes critical to work with the academic centers to assure that the network has developed and continues to operate a respected on-site clinical research program to deliver clinical trials. The program should have some type of exclusive market area around the institution.

Promotion of the affiliation is also important. "You can have the greatest program in the world, but if you don't create awareness in the physician community and among your medical staff employees and the public now that you have access to new technologies, it will not work," said Gilden.

Of course, other speakers noted, all may not be perfect in such a relationship. One disadvantage of university affiliation is that you may never get your patients back.

"Community hospitals have big fears of cultivating too tight a relationship with large academic teaching hospitals. The fear is that once a

patient is referred to the academic hospital, which offers all the services and specialties the patient may need, he or she may never return," said Christopher D. Spinella, vice president of development, Salick Health Care, Inc., Los Angeles, Calif.

Although it is valuable to have a "brand name" associated with a community hospital, affiliation makes it more difficult to create a separate identity, according to Spinella. If a community hospital is using the leverage of a university name, it is not focusing energy on promoting its own name.

The bottom line is that in a managed care environment "your goals should be to broaden your service area," according to Spinella. "If that means affiliation with an academic cancer center, great. It could also mean affiliating with another hospital or aligning with an organization that will develop the network for you."

Whether or not a community cancer program should affiliate with another depends on the competitive market.

EXPANDING THE TEAM

"With the anticipated decline in the number of practicing medical oncologists and the ever-more cost-conscious environment, mid-level providers are finding an expanded role in clinical oncology practice," said Tom Cureton, P.A.-C., M.P.A., senior project manager of ELM Services, Inc. in Rockville, Md. Cureton was chairman of a panel that explored the use of mid-level providers by hospitals and oncologists.

The panel's consensus was that physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) will be joining the oncology team in increasing numbers over the next few years, in part driven by health care reform and by the realization that the complexities of oncology care require a team approach.

According to panel member Rebecca Hawkins, M.S.N., A.S.P., O.C.N., of Pendleton, Oreg., mid-level providers should be able to 1) obtain a patient history and physical; 2) dictate or prepare progress notes; 3) delineate physical findings; 4) order further diagnostic studies; and 5) in conjunction with the physician, diagnose clinical problems and determine the appropriate course of treatment. Furthermore, they can educate patients and families and refer to other specialists when problems fall outside the oncology realm. It is common for NPs and PAs to perform procedures, including bone marrow aspiration, thoracentesis, and lumbar puncture, according to the scope of practice per state. In some major bone marrow transplantation centers, PAs are acting in almost house-staff roles.

"NPs and PAs provide great continuity of care," said Hawkins. "They become very skilled in their areas and are more accessible to nursing and physician staff than residents. Plus, they maintain a high quality of care that we haven't been able to appreciate with residents, who are continually leaving the institution." According to Hawkins, NPs and PAs can provide quality care to patients undergoing treatment with chemotherapy, radiation, and biotherapy, as well as provide long-term follow-up.

NPs have authorized prescription privileges in 43 states, although each of these states has differing regulations. Forty states allow PAs to prescribe medications, while few states allow the CNS to prescribe.

NPs can attain some third-party reimbursement in 34 states, Medicare reimbursement in 42 states (from 60 to 100 percent of physician fees), and Medicaid reimbursement in 49 states (80 to 100 percent of physician fees). PAs can attain Medicare reimbursement under Part B in 41 states. Third parties usually cover PA services as long as they are performed within the care of physician services. "Although the CNS is instrumental in decreasing length of stay, keeping patients from accessing the physician's office, and decreasing costs, few states will reimburse for their services," said Hawkins.

The panel consensus was that although medical oncologists should be in charge of assigning treatment, the mid-level provider can help support them in that process. "I look to the nurse practitioner for a great deal of the education, communication, and arrangement of financing, all of which allow me to broaden my activities," said panel member and ACCC Immediate Past President Albert B. Einstein, Jr., M.D. "I would never practice without one."

However, hiring a mid-level provider may not be in the best interest of every oncologist and every institution. "Giving up control is a painful process for many of us," said Gordon R. Klatt, M.D., of Multicare Health Systems in Tacoma, Wash. "Many physicians will never be able to work with a PA or NP."

The panel agreed that letting go and developing trust in the mid-level provider are critical if the hiring process is to succeed. In addition, the physician or administrator must take time to research state regulations about mid-level providers and clarify what is expected of this person. Equally important is the orientation process and how the mid-level provider is presented to patients, family, and staff—particularly nursing staff.

THE ROCKY ROAD AHEAD

The grim statistics of cancer assure its place as a growth industry in the 1990s: One in three Americans alive today will develop cancer, and cancer incidence will continue to increase in an aging population.

With increasing costs and decreasing reimbursements there will be a greater shift to alternate site care, for example home care and outpatient care.

As health care moves toward a capitated system, the ability to participate in such a system becomes difficult for the small player because of the risks involved. In this environment of decreasing reimbursements and higher fixed costs, the focus becomes one of acquiring increased volume share through linkages, affiliations, and mergers. Consolidation, however, is replete with challenges and risks.

While Congress struggles with numerous versions of health care reform, state legislatures are passing their own widely varying reform bills. What's going on in Oregon, for example, is different from what's happening in Florida.

Surviving the changes that are rapidly taking place at the local, state, and national levels means remaining profitable by reducing costs and providing products that are differentiated from the competition. Patients are looking for quality service, including the availability of treatment protocols; payors are looking for cost-effective treatment. In the short term, cost may well overshadow quality.