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Models for Oncology Within Hospital Alliances

by Lee E. Mortenson, D.P.A.

Overwhelmingly, individual community hospitals have been the "home base" for development of cancer programs outside of university settings. The National Cancer Institute spurred the development of individual community hospital oncology programs in the mid-1970s with its Community Oncology Program (COP) and Community Hospital Oncology Program (CHOP) initiatives.

In the past five years, however, a number of freestanding facilities and medical oncology offices have added significantly to the locations for cancer patient management. By 1994, more than 1,300 hospitals had programs approved by the American College of Surgeons, and nearly 500 institutions had active member status in the Association of Community Cancer Centers (ACCC).

Needless to say, the majority of experience in cancer program development is based in single institution activities, although there are a few exceptions, notably the CHOP program and its successor, the Community Clinical Oncology Program (CCOP). These programs have often included rival institutions within a local community jointly involved in the collective development of community clinical research efforts. While many of these multi-institutional programs still exist, they do not provide us much of a basis for development of the new, multi-institutional alliance cancer programs.

Today, voluntary hospital alliances are in a rapid growth stage. While some hospitals have had a loose-knit affiliation or a management contract with other hospitals in their region for some time, the last few years have seen significant consolidation of facilities.

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Increasingly, hospitals are aligning with other hospitals, and the configuration of cancer programs is shifting from single institution initiatives to coordinated, multi-institutional ventures.

For purposes of discussion, I propose four different models of oncology programs within hospital alliances:

- the *distributed model*, which builds upon existing cancer programs at alliance institutions
- the *feeder system model*, in which an alliance plays a much stronger centralized management role in system planning, monitoring, and development
- the *consolidation model*, in which a number of poorly organized cancer programs decide to consolidate all programs at a single facility
- the *carve-out model*, in which an oncology "carve-out" organization (a commercial firm or a joint venture between several hospitals) takes charge of all care provided to alliance members.

Each model has its benefits and downsides; each works best in differing settings. Although each model exists in its stated form, there are many hybrids.

THE DISTRIBUTED MODEL

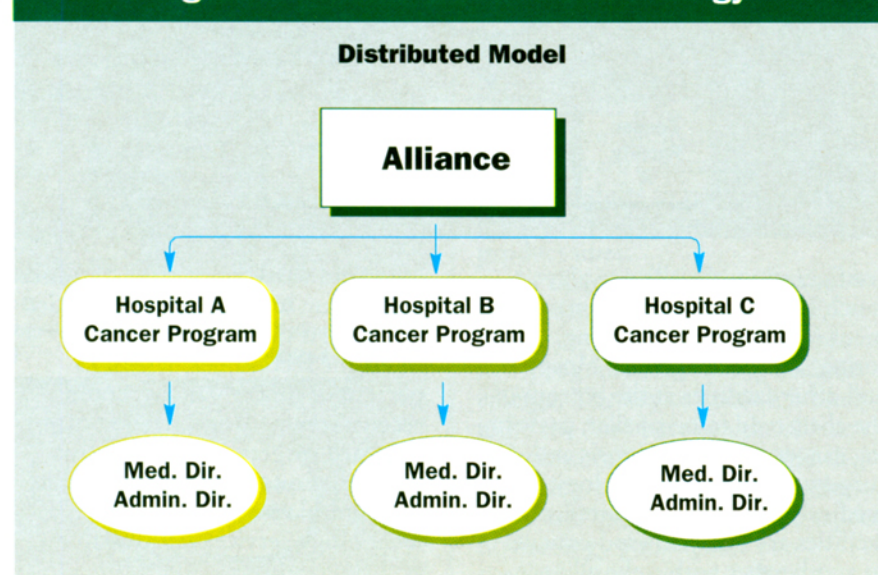
Perhaps the simplest alliance model, the distributed model, builds upon existing cancer programs at alliance institutions. The alliance includes cancer programs at separate hospitals, which support separate administrative and medical staff directors of the cancer program (Figure 1). Usually this type of structure is found in alliances where central control is low. The hospitals themselves may be fairly comparable in size, with independent corporate status and a high degree of hospital autonomy.

Day-to-day management of the cancer program is a hospital function in this configuration. Financial monitoring, program development, physician contracting, and recruiting all take place at the hospital level.

In these types of alliances, only a few functions tend to be centralized. These functions include some central purchasing, cancer education activities, some planning activities, and perhaps development of a global research function or alliance-wide guidelines/critical path development.

One benefit of this configuration is that cancer program managers are at the hospital level, where day-to-

Figure 1. Alliance Models for Oncology



day program decisions are made. The alliance centralizes only those functions that are not involved in direct patient care or program development, such as planning and developmental activities. Joint purchasing, fewer personnel making management decisions, and having one versus several administrative directors/medical directors help to better the bottom line.

Two downsides of this type of arrangement are its expensive and redundant overhead and the duplication of some services.

THE FEEDER SYSTEM MODEL

Another type of alliance structure with a very different range of service components can be characterized as the feeder system (Figure 2). In this

First tier. First-tier facilities are likely to be small hospitals, outreach clinics, and screening and prevention clinics. In this situation with central financial control, there are more incentives to refer patients to other facilities for additional therapy.

Second tier. This tier of feeder system facilities is likely to include hospitals and freestanding cancer facilities that offer more specialized care. A freestanding radiation oncology center, an affiliated medical oncology clinic, or a hospital with a solid cancer program (absent some of the tertiary care features discussed below) are likely to be representative of this tier. Of course, many cancer patients within the alliance are also likely to receive their initial treat-

Third tier. The third tier in this alliance model includes those tertiary care hospital programs with a full range of services. Unlike the distributed alliance system, these tertiary care facilities have only part-time oncology program medical and administrative directors. On this tier, 95 percent of cancer patients could receive some portion of their care. The entire spectrum of standard cancer care—from prevention to terminal care—is available. These portions of the organization are more likely to represent “one-stop shopping” because there is an integrated cancer care team at the same facility. Tumor boards, tumor conferences, and clinical trials are all part of the standard features of the organization. Some of these high-tech facilities within the alliance are likely to provide specialized services, such as bone marrow transplantation, gynecologic oncology, head and neck specialties, and/or pediatric oncology.

Fourth tier. At the alliance level, or fourth tier, full-time oncology program administrative and physician leadership play a large, alliance-wide role in program development and management. At this level there is also likely to be a relationship with a quaternary research center. This relationship may be contractual, so the system is not put in a position of covering the heavy overhead of an academic institution, thus lowering its competitive position.

Quaternary care alliance contracts are likely to see the small segment of cancer patients that cannot be managed successfully in lower cost environments. These medical school environments can supply hospital alliances with access to research, new trials and drugs, and some prestige. Perhaps of greater interest to the hospitals, they can provide access to a steady supply of new physicians and other members of the health care team.

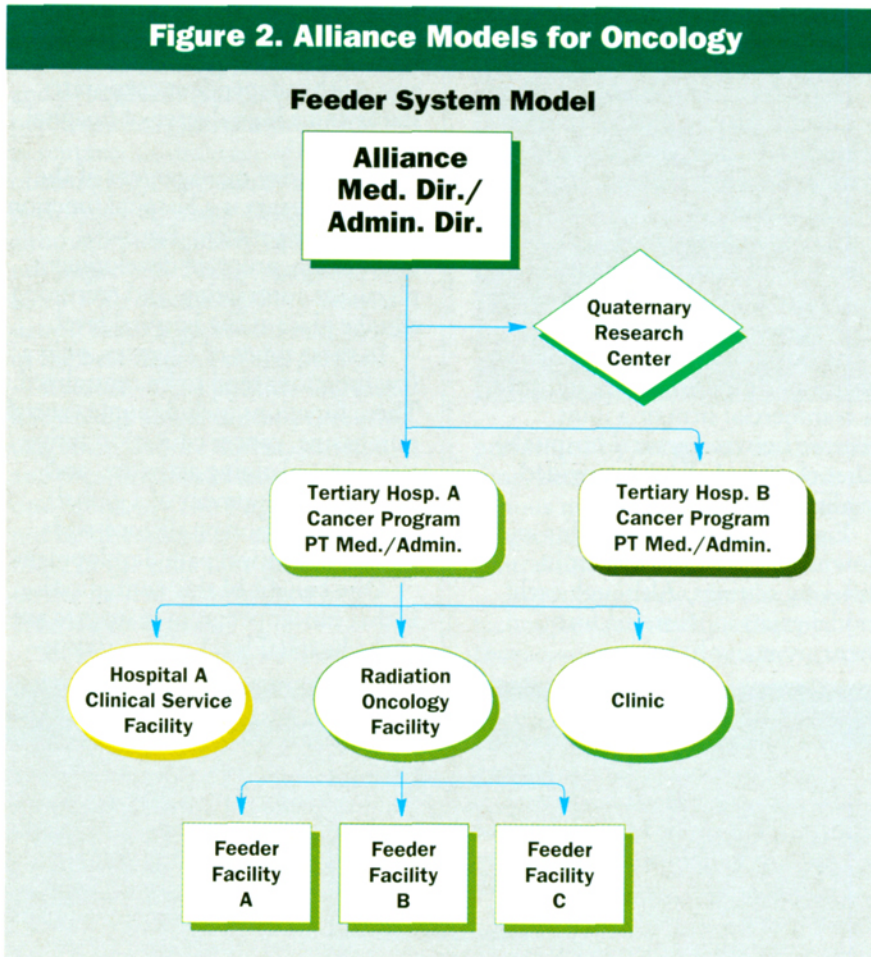
configuration, the alliance plays a much stronger centralized management role in system planning, monitoring, and development. Hospitals and other facilities at the bottom of the chart tend to be smaller, performing cancer patient diagnosis and surgery. If radiation oncology or medical oncology is required, these facilities are likely to send patients to another tier within the alliance.

ment and work-up at these facilities in addition to those feeder facilities on the first tier.

At the second tier, where 75 percent of cancer patients could receive some portion of their care, standard surgery, chemotherapy, and radiation therapy are available. No clinical research or high-technology services are available at these locations.

In this model, the feeder facilities have responsibility for primary detection, diagnosis, and surgery. The facilities may be an outlet for prevention program activities at the community level. In some cases, depending on the geography of the region, these facilities may include low-energy radiation therapy units. In general, the facilities have the capability to handle in some way

Figure 2. Alliance Models for Oncology



perhaps 40 to 60 percent of all cancer patients.

At the alliance level, the corporation acts like one. It conducts corporate-wide planning, financing, and recruiting; it decides where high-tech facilities should be located; and it centralizes data management and quality control.

This alliance structure minimizes duplication of expensive overhead. It allows for coordinated planning and offers the potential for a large-scale, integrated oncology organization attractive to physicians and purchasers of health care.

On the downside, most facilities in this alliance structure will take on a role that will not change in the future, since they will be locked in by the corporate strategy dictated by the alliance. Moreover, some facilities will get negligible attention, because their role will be peripheral in the total alliance's cancer plan.

THE CONSOLIDATION MODEL

Another type of alliance model, the consolidation model, features a strong, centralized ownership of facilities (Figure 3). In this scenario, an alliance with a number of poorly organized cancer programs decides to consolidate all of its programs at a single facility or at a few of its facilities. In this case, one hospital may be given the "ball" to develop a strong program, or leadership at the corporate level may develop and support the program.

The benefits of this type of scenario are the elimination of redundant resources (i.e., three poor cancer programs may be "traded" for one good one) and the consolidation

of the best staff, physicians, and facilities at a central location. The downside includes fewer points of service and, in the wrong market, an opportunity for some referrals to "leak" to competitive alliances.

In this model, the alliance is likely to manage the financing, planning, and investment. Clearly, alliance senior management must play a major role in deciding which facilities will close and work to bring the "cream of the crop" at the original facilities to the new consolidated facility and program.

THE CARVE-OUT MODEL

The fourth model is one that we have yet to see in full bloom. It posits a relationship with an oncology "carve-out" organization. This carve-out may be a commercial firm, such as Caremark, American Oncology Resources, Salick Health Care, Inc., or Texas Oncology. Or, it may be a joint venture between several hospitals. In effect, the carve-out takes charge of all care provided to alliance members.

In this model, the carve-out organization capitates oncology patients, providing medical oncology and radiation oncology, and, perhaps, contracts for hospital beds and facilities as needed, or enters into a contractual relationship with an alliance. Hospital functions include analyzing competitive carve-out organizations and selecting the best of the alternatives for contracting. Of course, it is important to note that most carve-outs are developed in geographic regions where they can command a near-monopoly situation, making competitive

bidding difficult for hospitals.

The benefits of this model, from the hospital's perspective, are that the oncology carve-out organization assumes all the risks for patient care. This may mean low risk, low maintenance, and low investment costs for the hospital or alliance. It may also mean lower returns.

The downside of this situation is that the carve-out sets the quality for the hospital alliance. There may be no cost controls in this model and, of course, it would be possible for competitors to undercut the pricing of the carve-out if the carve-out is passing along high margins for supplies, ancillaries, and other overhead.

Finally, a near-monopoly carve-out puts hospitals and alliances in a difficult position if the carve-out organization does not opt to contract with the hospital or alliance in the future.

SETTINGS FOR SUCCESS

The four models best exist in different settings. The distributed model works best with a number of similar, strong institutions that work together under a loose-knit organizational structure. The feeder system is most likely to succeed when there are a large number of facilities and a broad geographic region. The consolidated model is most likely to emerge where there are a number of facilities under strong, central management and where the point of service issues are small, perhaps because the hospital facilities are not far from each other. The carve-out situation appears to appeal most to those administrators who do not have investment resources for oncology.

At the outset of these growing alliances and new relationships, much attention is placed on broad facility issues (i.e., who will stay open, executive staffing, overhead, managed care contracting). Later, attention shifts to issues such as the system-wide coordination of product lines.

As alliances develop over the next weeks, months, and years, we are certain to see a variety of new programmatic configurations emerge. The key to success is likely to be the "fit" between the alliance and the component pieces and the capability of the alliance to understand and manage the unique aspects of oncology patient care in a cost-effective manner. ■

Figure 3. Alliance Models for Oncology

