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# Letting the Future In

**by Donald Jewler**

Perhaps the small earthquake that greeted meeting attendees on the opening day of ACCC's 12th Annual National Economics Conference, held September 20-23, 1995, in southern California, was the perfect metaphor. Powerful forces beyond our control are shifting the ground on which we work. Stand-alone hospitals are transitioning into integrated delivery systems. Managed care is threatening the viability of some oncology practices. Discounted fee-for-service is giving way to capitated reimbursement. Pressures for cost containment are conflicting with patient access to quality cancer care. Not all hospitals will survive; nor will many specialist physicians be able to adapt to the new health care environment.

There is reason for optimism, however. The tremors of change, according to many presenters at ACCC's conference, offer enormous opportunities for those with vision, the willingness to learn and take risks, and a strategy for tomorrow.

## SURVIVAL TIPS FOR HOSPITALS

"By the year 2000," said presenter Richard B. Oths, M.B.A., "a multispecialty group of 40 physicians will be capable of performing in its offices 80 to 90 percent of the procedures currently performed in a 300-bed community hospital." Oths, who is president and chief executive officer of Morristown Memorial Hospital in Morristown, N.J., was recounting the projections of several key futurists.

The bottom line for hospitals as we approach the new century, according to Oths, is that a 50 to 60 percent excess capacity in many markets is leading to brutal, unrelenting price competition and the necessity for massive downsizing.

"Many hospitals will survive," said Oths, "albeit in a new integrated form, and in some cases thrive when their new role and relationship to the community, the corporation, the insurer, and to the physician is understood and, most importantly, 'lived.' "

Living that new role means:

- shifting from inpatient to outpatient care
- streamlining the management system and support structure
- implementing an information and decision system that comprehensively interprets clinical and management data
- increasing value in the form of better patient access, cost, measurable quality, and customer satisfaction.

Integrating physicians into a leadership position within an integrated delivery system is central for hospitals to succeed in the 1990s, according to Oths. Hospitals bring value to their physician partners, including capital access, management and information system expertise, care continuity components, and education.

Maintaining and increasing market share are also critical for hospital survival. The first steps in any marketing strategy are to define your market and quantify how you compare with the competition, according to Patti Jamieson, M.S.S.W., M.B.A.

"More than ever before, we are having to look at market research and analysis," said Jamieson, who is senior associate and project manager for ELM Services, Inc., in Rockville, Md. "Hospitals need a complete, competitive SWOT analysis that details the Strengths, Weaknesses, Opportunities, and Threats posed by the competition. This knowledge will help hospitals develop a niche market, whether it be development of a multidisciplinary breast center, a women's health/cancer program, a pain management center, or a prostate center."

To market themselves effectively, hospitals must find out how much of their geographic area is managed health care and how much is private indemnity, according to Jamieson. In the past broad-marketed, glitzy ads have sparked consumer interest. Today, managed care requires more targeted approaches. "If you do a radio ad," asked Jamieson, "and 80 percent of the people who respond do *not* have a contract with your center, is that really cost-effective?"

Jamieson reviewed a long list of marketing tips that include:

- visiting major insurers in your area to find out what they want from a cancer program before they go to sign a contract
- visiting major corporations in your area to set up cardiac and/or cancer corporate screenings
- keeping employees informed about the services you provide, such as cancer screenings and wellness programs
- developing alliances and collabo-

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ration with local physicians via discussions about joint ventures and business development issues and/or a quarterly newsletter that details new developments in cancer and activities of your cancer program.
- establishing a close working relationship with local TV stations and newspapers.

Increasingly, hospitals are turning again to focus groups in order to assess how the community, hospital and office staff, and physicians perceive their services. "They may say things you don't want to hear," said Jamieson. "However, to position yourself for the future, you must know their perceptions, expectations, and needs so you can prove you are the best. No longer will blanket statements about the value of a cancer program be accepted."

## MSOS, CARVE-OUTS, AND CARVE-INS

In a demanding and competitive managed care environment, organizations are actively seeking oncology practices. "Most oncologists, while flattered with all the new attention, are confused and deficient in their understanding of the legal and tax consequences as well as the long-term effects of these deals," said Kim R. Johnson, R.N., principal, KRJohnson & Associates, Coeur d'Alene, Idaho.

Many types of deals include total buy-out with stock and/or cash followed by a guaranteed salary for a period of time. Another popular structure is a joint venture arrangement. The most popular arrangement, according to Johnson, is a management services organization (MSO), in which a company provides a list of services, including necessary capital, staffing, accounts receivable management, marketing, planning, and research in return for a percentage of the collected receivables.

"Oncologists—most often novices in bidding on contracts—are surprised at the competitiveness of the bidding for patient care and most often do not have useful data available to them in understanding the intricate details of their business," said Johnson. Information about cost and revenue per patient and profit per treatment in current oncology practices is critical when negotiating for patients and their health care dollars.

"It is also crucial to sit down with your current physician partners and discuss why you want a capital partner and agree to time limits in evaluating options," said Johnson. "Know your practice philosophy. Ask specifically about the philosophy of the company courting your practice. Insist on site visits. Ask questions!"

Johnson focused her presentation on how to appraise the value of a practice and stressed the need for a competent, independent appraiser with a medical/oncology background.

In certain market areas, oncologists are becoming "tied in" to oncology carve-outs, which are evolving to meet the needs of patients, providers, and payers. In a carve-out entire segments of the health care plan's benefits—such as oncology—are "carved out" and placed in separate programs. A cancer carve-out organization, for example, goes directly to an HMO and negotiates a contract under which it would receive capitation payments directly from the HMO for a set of cancer services, such as radiation and surgical oncology.

Substantial capital-rich cancer carve-out organizations include American Oncology Resources, Inc.; Physician Reliance Network; and Salick Health Care, Inc. Oncologists within these cancer carve-outs are usually paid through a capitated pool and may receive bonuses or incentives for quality of service, quality of care, comprehensiveness of services, etc. Representatives from the major oncology carve-outs presented conference attendees with overviews of their services and outlined the tremendous growth taking place within these organizations.

A recent variation of the carve-out is the City of Hope Oncology Network in Duarte, Calif. It was created by the City of Hope National Medical Center and affiliated oncologists to offer patients comprehensive cancer care and advanced oncology treatment options locally on a capitated, fixed-rate basis.

"This is the first community-based, national specialty network of its kind," said Andrew B. Leeka, M.P.H., M.B.A., chief operating officer, City of Hope National Medical Center. "It represents a unique alliance between the City of Hope and preeminent community oncologists who will work together to ensure patients access to state-of-the-art cancer care while assuring the payer community of competitive rates."

Leeka calls his model a "carve-in," or "augmenter" system. Unlike a carve-out, the City of Hope Oncology Network does not go directly to an HMO. "Instead, we work with the IPA, medical group, or staff model HMO, which is a step down the food chain from the oncology carve-out organization," said Leeka.

The Network "augments" services by adding value to the oncology services the medical group already has, according to Leeka. For example, if an IPA already includes a network of radiation oncologists, that network is left in place, instead of City of Hope going in and competing with it. That IPA is offered a flexible menu of additional comprehensive cancer services.

The advantage over the traditional carve-out model, according to Leeka, is that oncologists maintain their autonomy. Physicians can continue with their independent practice, yet be a part of the oncology IPA that deals strictly with capitated arrangements. "Moreover,

> "We have an obligation as cancer care specialists to educate and engage our primary care colleagues."
> —*Lloyd K. Everson, M.D.*

> "The core business of insurers, physicians, and hospitals is being redefined with Darwinian force and at a pace difficult to manage and govern given the reluctance of most hospital leadership to apply the principles of fundamental and radical change."
> —*Richard B. Oths, M.B.A.*

physicians gain access to patients through a large managed care organization," said Leeka, "and their management and administrative duties are lessened."

The City of Hope Oncology Network provides cancer care for patients at FHP Health Care medical centers in Orange County and southeast Los Angeles County, serving more than 725,000 covered lives.

## PATIENT ACCESS AND CONTROL

As pressures for cost containment impact the quantity and quality of care, cancer patients will need strong advocates. All participants in a panel addressing patient management agreed that the medical oncologist, by virtue of his or her primary care background and specialty expertise, is best suited to act on the cancer patient's behalf.

"The medical oncologist is trained to deal with the whole patient and provide the continuum of care from the time of diagnosis through treatment until recovery or death," said Robert J. Brooks, M.D., of Tucson, Ariz. "The medical oncologist is uniquely qualified to provide follow-up care, detect long-term sequelae of therapy, and counsel regarding new developments and interventions."

Unfortunately, under managed care the health care decision process may be changing. The primary care physician as gatekeeper for a capitated plan or administrators of the insurance plan itself may become the ones to manage the cancer patient. And this shift may be quite costly in dollars *and* in patient lives.

> "There always comes a moment in time when a door opens and lets the future in."
>
> —*Graham Greene, as quoted by Richard B. Oths, M.B.A.*

James L. Wade III, M.D., of Decatur, Ill., related the story of one of his patients, a 45-year old male, whose primary care physician recommended hospice care for his abdominal pain and liver masses. "The patient wanted another opinion. We did a biopsy and found stage IV lymphoma involving the liver. He was treated and is in complete remission," said Wade, who related other anecdotes about insurance company refusals to pay for selected treatments that were medically appropriate.

ACCC President-Elect John E. Feldmann, M.D., (left) presents ACCC's award for Outstanding Achievement in Clinical Research to Rodger J. Winn, M.D. Dr. Winn was recognized for his significant contributions to cancer patients and their families through the development of community-based clinical trials, cancer control and prevention trials, and cooperative research groups involving community providers. Dr. Winn is a medical oncologist whose career includes both community and academic tenures. In 1985 he moved to M.D. Anderson Cancer Center where he directs the Section of Community Oncology. This section has been involved in the development of research networks for performance of clinical trials and chemoprevention studies.

"It is scary to return to a primary care physician who often knows very little about the consequences of surviving cancer," said Susan Leigh, R.N., B.S.N., president of the National Coalition for Cancer Survivorship. "Oncology specialists need to be making decisions as opposed to payers or financial regulators who have no knowledge about long-term care," said Leigh.

She outlined a patient's perspective of treatment management throughout the continuum of survival. In the age of managed care patients must be listened to, taken seriously, and referred to specialists in a timely manner, according to Leigh, who is a cancer survivor.

Leigh also called for a stronger patient voice in the public policy arena to counter possible constraints placed on treatments in a managed care system. "Our voices add a different perspective to cancer care. As economics becomes the bottom line, we must make sure the quality of our lives is not jeopardized by misplaced priorities."

## TRANSPLANTS, CHEMOTHERAPY, AND COST

The direct cost of cancer care has risen steeply, up 62 percent from 1985 to 1990. That same time period saw an explosion in the number of bone marrow transplant units and transplant patients.

"Due to the high cost of the technology surrounding bone marrow transplantation, high-dose chemotherapy with autologous or allogeneic bone marrow transplantation has often become a focal point for the controversy about the cost of cancer care," said Glenn S. Harman, M.D., associate professor of medicine, University of Iowa College of Medicine, Iowa City, Iowa.

Harman outlined the growing evidence that certain diseases can be cured by high-dose chemotherapy followed by transplantation. Cure is a realistic goal of autologous transplantation in patients with acute leukemias, Hodgkin's disease, neuroblastoma, and non-Hodgkin's

lymphoma. It is also possible that patients with metastatic breast cancer, high-risk stage II/III breast cancer, or germ cell tumors *may* be curable with transplantation. Allogeneic bone marrow transplantation can potentially cure patients with acute leukemias, aplastic anemia, chronic myelogenous leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, myelodysplastic or myeloproliferative syndromes, and certain inherited diseases.

> "If we cut off the supply of new physicians right now, we would still have ample physicians to supply us to the year 2025—except for one specialty, thoracic surgery."
>
> —*Andrew Leeka*

Cure may also be possible with allogeneic transplantation with chronic lymphocytic leukemia and multiple myeloma.

As the list of indications grows, so does the overall cost of transplants to society. A variety of other reasons are also leading to an increase in overall cost, according to Harman.

- The length of hospitalization (although decreasing) in specialized units with specialized physician and nursing care is expensive.
- The cost of obtaining the stem cell product, the cost of chemotherapy and radiation, and the cost of many supportive care products are expensive.
- More and more patients, including those well over age 45, are opting for transplantation.

Harman compared the use of peripheral blood stem cells to the use of bone marrow in the autologous setting. Peripheral blood stem cells have led to decreased hospital stays and lower costs. The use of total parenteral nutrition, antibiotics, and blood products have also decreased considerably, according to Harman.

"However, peripheral blood stem cells have not yet gained the same popularity in allogeneic transplants," said Harman. "There are a

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## SPECIAL INTEREST GROUP (SIG) ROUND-UP

*Nursing SIG.* A session entitled "Managing Nursing Care Across the Continuum" was led by Peg Albrets, R.N., oncology/hematology/AIDS manager, and Teresa R. Donohoe, R.N., gyn-oncology case manager. Both are with Stanford Health Services, Stanford University Medical Center in Stanford, Calif. The presenters described patient, physician, and institutional benefits of case management, explored various models for case management, and discussed ways to evaluate the benefits of the role.

*Medical Director SIG.* SIG Chair Gordon R. Klatt, M.D., led more than 50 attendees in a discussion of a multidisciplinary approach to treatment plans.

*Radiation Oncology SIG.* Michael Steinberg, M.D., Santa Monica Cancer Treatment Center, Santa Monica, Calif., presented a session entitled "Outcomes Research: The Marriage of Clinical Medicine and Operations Research." According to Steinberg, variation in practice is a natural phenomenon affected by differences in the care-seeking process, choosing a course of treatment, execution of treatment, and the social, cultural, and economic environment.

"Medical care is an ongoing natural experiment whose results await measurement and interpretation. [We must] distinguish variation that is of value from variation that is valueless," said Steinberg. "We must develop understanding of variation to protect patient interests and our own."

In a separate presentation Ron Conheim, chief operating officer, Oncology Therapies, Inc., Timonium, Md., discussed "How the Medical Business World Sees an Investment in Radiation Oncology."

*Administrator SIG.* Four sessions were offered.

- "Marketing Your Cancer Program." This session was presented by Patti Jamieson, M.S.S.W., M.B.A., senior associate and project manager for ELM Services, Inc., Rockville, Md. See details within this article.
- "The Future of Mid-Level Providers in the Care of Oncology Patients." The presenter was Thomas L. Cureton, P.A.-C., M.P.A., administrator for clinical services, Georgetown University Medical Center, Lombardi Cancer Center, Washington, D.C.
- "The Cost of Chemotherapy Administration: Outpatient vs. Home Care." This session was presented by Patrick A. Grusenmeyer, M.P.A., financial administrator, Ochsner Cancer Institute, New Orleans, La. (See article for details.)
- "Customer Satisfaction in a Hospital Setting." The presenter was Cynthia Bucur, quality management leader, Ritz-Carlton Hotel, Marina del Rey, Calif. This presentation was well-received by attendees, who learned the Ritz-Carlton's methods for assuring customer satisfaction.

*CCOP SIG.* Cary A. Presant, M.D., F.A.C.P., president, California Medical Center, West Covina, Calif., presented a session entitled "Clinical Research Programs in a Managed Care Environment."

## SIGN UP NOW!

The Association of Community Cancer Centers currently recognizes five Special Interest Groups (SIGs): Administrator, CCOP, Medical Director, Nursing, and Radiation Oncology. The SIGs provide a forum for members to discuss ongoing ACCC activities, including the annual meetings, *Oncology Issues*, strategic planning, and other critical issues. Increased SIG participation by the membership will continue to strengthen the Association's ability to be a national leader on issues of importance to all cancer care disciplines. For a SIG membership form or more information, please contact Kathleen Young, ACCC SIG Membership, 301-984-9496.

few reasons for this. The advantage of allogeneic bone marrow is that a fresh product can be available on day zero with no need to freeze a product. A healthy allogeneic donor would require priming with colony stimulating factors and several days of harvesting to donate peripheral blood stem cells. The argument in favor of using peripheral blood stem cells for allogeneic transplants includes the facts that the procedure would be less painful and that no anesthesia would be required."

Harman closed with an appeal for managed care payers to promote patient access to transplantation, to support the concept of research protocols in transplantation, and to expand definitions of indications for transplantation.

"As technology continues to improve, it is quite obvious that factors will occur that may lead to increasing costs of cancer care in the arena of high-dose chemotherapy," said Harman. "Other improved technologies are clearly leading to decreases in costs. These issues are going to require very aggressive negotiations between health care providers and managed care payers to result in the best possible access to curative therapies for the patient population."

Another conference session focused attention on the costs of chemotherapy both within and outside the hospital setting. "Administration of chemotherapy outside a hospital setting can provide greater patient and family satisfaction and the potential for major cost savings," said Patrick A. Grusenmeyer, M.P.A., financial administrator, Ochsner Cancer Institute, New Orleans, La.

While both clinic and home care are alternatives to inpatient treatment, an efficient outpatient clinic setting is associated with greater cost savings than home care. That was the conclusion of a study recently completed by Grusenmeyer and colleagues at Ochsner Cancer Institute, who compared outpatient with home care costs of personnel (treating and support staff), drugs and supplies, and overhead (rental costs and utilities). Grusenmeyer and colleagues looked at three supportive care measures (blood transfusion, hydration, and amphotericin) and five chemotherapy treatments (of short, medium, and long durations) given in three common malignancies (colon, breast, and lung cancers).

In each treatment type, the outpatient clinic was less expensive than home care. Average costs were two and one-half times more expensive in home care. Treatment with 5-FU/Leucovorin in a five-day regimen, for example, was significantly more expensive: $799 in home care versus $151 in the clinic. To control for the lower drug acquisition costs found in the clinic setting, costs were also examined independent of pharmaceuticals. The clinic setting remained less expensive.

> "Hospitals still don't get it. There is a fundamental need for a lot less hospital capacity. If the American Hospital Association were doing its job, it would be helping hospitals make graceful exits, consolidate services, and eliminate excess capacity while maintaining and preserving health in the community."
>
> —*Robert Mittman*

**MEETING THE FUTURE HEAD ON**

In the 1980s the private sector started the trend toward reorganization, downsizing, cost cutting, and reengineering. Today the health care industry is wending its way down its own path of dramatic change.

"Change implies breakdown," said Alan Gilburg. "And breakdown requires leadership. Leaders provide vision for the future, set direction, and take risks. Management is not enough." Gilburg, along with his partner Martha Spice, founded and directs The Leadership Laboratory, a program for senior executives, based in Bethesda, Md.

Three keys to developing personal leadership, according to Gilburg and Spice, are to:

- build an environment of trust and safety in which people are willing to work with and for you
- develop a vision that is simple, focused, clear, compelling, and energizing, one that sees beyond the present crises
- be willing to live with not knowing.

Although the health care delivery system may be changing rapidly in some areas of the country, several presenters cautioned that the pace of consolidation is on different tracks—or at least on different time frames—depending on location. What is happening in southern California, for example, is quite different from what is happening in Tupelo, Miss.

Timing is all important, according to Robert Mittman, director of health care programs with the Institute for the Future in Menlo Park, Calif. "Don't live in the future," said Mittman. "But when the future comes knocking at your door, be ready for it."

If managed care is moving aggressively into your area, don't be the last one in your community to get the contract, Mittman advised physicians. "Go for it, but focus carefully on understanding the terms of the contract," said Mittman.

As he crystal-balled the near future of managed care, Mittman believes there will be a growing backlash. He expects a move toward full disclosure in provider plans, more attention to and regulation of health care plan profits, and investigation of managed care organizations by consumer advocates, such as Ralph Nader, and by the American Medical Association. "Physicians have taken managed care a little bit lying down or at least have not gotten organized to fight it. Patients and consumers have not really understood it... . If managed care is just about rearranging income and ownership, what is the benefit?"

The consensus of ACCC's 12th Annual National Oncology Economics Conference was that managed care, capitated reimbursement, strategic alliances, and downsizing will continue to put increasing pressure on the entire multidisciplinary cancer care team. For those willing to take risks and learn new strategies, the tremors of change offer new opportunities for growth.

"In times of change," concluded Gilburg, quoting author Eric Hoffer, "learners inherit the world, while the learned remain beautifully equipped to deal with a world that no longer exists."