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Keeping Your Balance in Changing Times

by Donald Jewler

To learn more about how the rapidly changing oncology scenarios are affecting their livelihood and the delivery of quality patient care, nearly 400 cancer care professionals traveled to Washington, D.C., March 13-16, 1996, to attend ACCC's 22nd Annual National Meeting: *Balancing Costs, Competition, Consolidation, and Caring*.

Meeting attendees were treated to presentations by a host of cancer care notables, including Richard D. Klausner, M.D., director of the National Cancer Institute; Allen S. Lichter, M.D., internationally known for his research in the treatment of breast cancer; and Pearl Moore, R.N., M.N., F.A.A.N., a leader in oncology nursing for more than twenty years.

A theme present in many conference sessions was that to remain competitive, hospitals and oncology practices must be prepared to launch a four-pronged attack by 1) integrating and managing clinical service components, 2) understanding costs and efficiencies, 3) implementing sophisticated information systems, and 4) differentiating the hospital or practice network from others through demonstrated high-quality, cost-effective services to payers.

ALLIANCES AND NETWORKS

"Today, we are dealing with a whole new model of cancer care." said presenter Albert B. Einstein, Jr., M.D. "Just three to four years ago, we were discussing the hospital-based cancer program and the multidisciplinary medical staff associated with that hospital. The cancer unit was in that hospital, as was radiation therapy.... Everything was centered around a single institution.

"Today, that is not the case. The new cancer model is 'cancer care management,' meaning coordination of the utilization of resources across the entire health care delivery system throughout the continuum of cancer care—from screening and diagnosis to cure or death. And that is not institutional based," said Einstein, who is associate center director for clinical affairs at H. Lee Moffitt Cancer Center and Research Institute in Tampa, Fla.

The new cancer model, according to Einstein, features awareness of cost efficiency and cost competitiveness in the community. Providers must think in terms of utilization of services, drugs, tests, and procedures. In addition, patient populations, not just individual patients, are now important. Risk sharing with third-party payers becomes critical in order to gain control of how services are used to ultimately deliver quality patient care.

To provide care under the new model, according to Einstein, "we have to devise new systems and new relations," which include:

- hospital alliances, mergers, and buy-outs to consolidate services and make the hospital systems run more efficiently
- integrated delivery systems, which are not buy-outs but are cooperative agreements among various hospitals and other institutions to cover a large geographic area and attract managed care contracts
- PHOs, relationships between the physicians and hospitals
- IPAs, in which physicians take control and create their own groups
- carve-out networks, which attempt to take all the services related to cancer and manage them independently and separately from the rest of the health care continuum.

"When providers come together, they bring increased value," noted Einstein.

A checklist of activities applicable to the formation of most networking or partnership ventures was outlined in a presentation about academic/community hospital alliances by David A. Gift of Michigan State University. He urged would-be partners to:

- make sure they know why they want to enter into a relationship
- relate fairly at a fair market value
- create a definite business plan
- plan ahead for flexibility and termination of that venture
- involve competent legal counsel early.

"One of the greatest reasons for failure," said Gift, who is executive administrator in Michigan State University's Department of Radiology, "is that the partners do not know why they want to join the alliance in the first place."

NCI: MORE RESPONSIVE TO THE COMMUNITY

While the health care marketplace is in a period of major transition, and while cancer programs and physician practices learn to adapt to a new environment, the National Cancer Institute is undergoing dramatic

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Donald Jewler is managing editor of Oncology Issues.

changes of its own. NCI's director, Richard D. Klausner, M.D., provided meeting attendees with a detailed look at the "new" NCI.

"The NCI has changed," said Klausner. "Over the past eight months much has happened. But the fundamental identity of the NCI not only has not changed but has been dusted off and reaffirmed. NCI is an institution of discovery. It is this nation's primary investment in the discoveries that we all are going to need if we are to reduce the burden of cancer. It is an institution of science—science that takes place in the community, in the clinic, and in the laboratory. Science that knows no bounds among those areas.

"While we reaffirm what the NCI is and has been, we have to recognize that almost everything about the world in which it operates has been changing, changing in terms of new opportunities, new challenges, new needs, and new threats.

"On the positive side the science is extraordinary. We are in a period of history of a level and degree of fundamental discovery that—even for those of us who spend our time in discovering things like genes—is amazing.

"Change is happening extremely fast in ways we can begin to imagine, in ways we hope for, and in ways (as happens in times throughout history of intellectual revolution) we cannot yet imagine. We are going to move from a time of empiricism and groping with diseases that we do not really understand to a time when we are dealing with diseases we begin to unravel and whose nature will finally be understood.

"We have to make sure that this engine of discovery continues to be successful. We have to make sure that the opportunities for discovery continue, and that the possibility of young people to commit their lives to advancements for all of us is not viewed as professional suicide, but as an opportunity to participate in an extraordinary venture. We must, as well, make sure we deal with not only the rapid translation of those discoveries that benefit patients but also much more profoundly the direct and palpable transformation of the practice of medicine, the practice of oncology, and the practice of public health. We must make sure we deal with the barriers, the challenges, and the threats to that translation directly.

"Change is happening extremely fast in ways we can begin to imagine, in ways we hope for, and in ways (as happens in times throughout history of intellectual revolution) we cannot yet imagine."

"It is important that this institution of science recognize that science does not take place in a vacuum but takes place in terms of society as a whole, which supports this venture.

"We changed the NCI so that its structure is realigned with the new opportunities and challenges and reflects the fact that the science that underlies what we do does not look like it did 25 years ago. We changed NCI so there are decision-making processes that clearly and ultimately articulate priorities and that look for fiscal efficiencies and indeed 'debureaucritization' to make sure that what we do we do well, effectively, and efficiently.

"How have we done this?

"We have opened up the institution. We have brought in individuals from the outside world to sit on all of our councils of advice, on the very governance of the daily and weekly decision making at the institution. We have created a new set of advisory boards, not to rubber stamp what we have decided but to create an open and ongoing communication.

"We now have an advisory board for our relationships with the intramural community and have established a series of working groups that have been asked to create landmark reports within about nine months on: cancer centers, clinical trials system, prevention research, developmental therapeutics, and cancer control. We need to take a clean look at all of these, not simply to critique the programs but to ask the simple questions: What do we want to achieve? Where do we want to get to? How do we most simply, efficiently, and easily distribute our funds to accomplish our goals?

"We need to reach out and make sure to a larger extent that the practice of oncology is integrated with the national enterprise of discovery and research. We need to re-examine our clinical trials system to look

at disincentives for both providers and patients for entering and staying on clinical trials. We need to take a fresh look at different models for large-scale, simple clinical trials.

"The changes in the health care system will continue to place challenges, barriers, and problems for the conduct of clinical research, prevention, and treatment trials in all forms of clinical research. The patient is moving away from sites of clinical research because of the issue of what payers will pay. While we are not a medical practice institution, we must address the infrastructure that allows our discoveries to benefit patents."

Klausner next outlined NCI's aggressive set of negotiations with the major payers in the United States for the express purpose of setting up a partnership between the Institute and these organizations to allow patients throughout the country access to clinical research and clinical trials. "The payers must step up to their responsibility as members of this society and members of the world community to contribute to the advancement of oncology," he said.

"NCI has successfully completed the first of what it hopes to be many such agreements with major payers," Klausner continued. "It recently signed with the Department of Defense, an 8.3 million member, participant health care system, to form an active partnership allowing and encouraging the participation by their providers and for their participants in clinical cancer trials throughout this country.

"We need to learn how to partner with provider/payer systems," said Klausner. "The assumption that accruing and maintaining individuals on clinical trials will increase the clinical costs associated with cancer treatment has not been shown.

"We are also taking this agreement on the road. This agreement has been a wake-up call to a large number of payers that we are actively negotiating with that such agreements can be made."

PHOTO BY JIM TKATCH

ACCC's National Achievement Award for Outstanding Contributions to Cancer Care was presented to Pearl Moore, R.N., M.N., F.A.A.N., (at left) executive director of the Oncology Nursing Society. For more than twenty years, Pearl Moore has been a guiding force within oncology nursing, developing the emerging specialty and expanding the global influence of nursing. She accepted the award in the name of all nurses and called upon her colleagues to remember that, as they work together to establish guidelines, standards, and policies, they must keep the "caring" in cancer care. Ms. Moore poses with friends and colleagues: ACCC Board Member Margaret A. Riley, M.N., R.N., C.N.A.A. (second from left); ACCC Immediate Past-President Diane Van Ostenberg, B.S., R.N.; and ONS Immediate Past-President Sandra L. Schafer, R.N., M.N., A.O.C.N.

Again and again, Klausner stressed that at all levels NCI plans to work at partnership with the community and the institutions that it serves. "We can no longer be the Bethesda bureaucracy... . We will be seeking advice, recognizing that it is fine, necessary, and essential to listen to those who need to speak to us, because all have something to contribute. We will use that principle of science that says: You don't listen to people because of who they are. You listen to people because of what they have to say."

WHAT THE CARDS HOLD FOR THE FUTURE

"Technology in radiation oncology is advancing so rapidly that soon the traditional simulator will become obsolete," said Allen S. Lichter, M.D., Isadore Lamp Professor and Chair, University of Michigan Medical Center in Ann Arbor. "The simulator of the future will be a computer-driven linear accelerator connected to an automated treatment planning system... . Treatment planning will become automated...and incredibly cheap. I am looking to a day when we can do better therapy and we can do it cheaper than we are doing it now," said Lichter, who was upbeat about the future of radiation oncology. He remarked that radiation oncology is clearly more integrated into the fabric of oncology than ever before.

Although access to the new technology can be a source of financial concern for many community cancers centers, Lichter offered a possible solution: a joint university/community venture. He provided details of how the University of Michigan provides technical radiologic services backed up by a strong and sophisticated academic program to multiple community sites. The result is a more cost-effective use of resources for all involved.

The biggest challenge facing health

Special Interest Group (SIG) Round-Up

Nursing SIG. "A Discussion of Care Coordination and Quality Outcomes" was led by Teresa D. Smith, R.N., M.S.N., of Memorial Health System in Springfield, Ill., and Marija Bjegovich, M.S.N., of St. Luke's Medical Center in Milwaukee, Wisc. The presenters looked at designing programs that decrease the fragmentation of care, maximize patient self-care capabilities, optimize the impact of health services for patients, and provide patient advocacy.

Medical Director SIG. Charles H. Nash III, M.D., F.A.C.P., of Harrington Cancer Center in Amarillo, Tex., discussed "The Changing Role of the Oncology Physician Executive." Rosemarie E. Clive of the American College of Surgeons reviewed the new ACoS guidelines and their financial implications. It was a spirited discussion. Look for an article on the impact of the new guidelines in an upcoming *Oncology Issues*.

Radiation Oncology SIG. Allen S. Lichter, M.D., Isadore Lamp Professor and Chair, University of Michigan Medical Center in Ann Arbor, gave his views on "Radiation Oncology: Its Position in the Greater Oncology Community." (See article for details.) More than 150 people were in attendance.

Administrator SIG. Four sessions were offered.

- "Cancer Program Fundraising." This session was presented by Charlotte S. Rhodes, A.C.F.R.E, C.A.H.P., of the Harrington Cancer Center in Amarillo, Tex.
- "A Rational Approach to Career Change." The presenter was Diane M. Otte, R.N., M.S., O.C.N., of the Immanuel Cancer Center in Omaha, Nebr.
- "How to Build Your Own Customer Service/Satisfaction Program." This session was presented by B. Susan McJunkin, director of radiology services, at St. Joseph's Hospital in Atlanta.
- "Marketing Your Cancer Program in a Managed Care Environment." The presenter was Allan Fine, M.B.A., Ernst & Young, LLP, in Chicago, Ill.

CCOP SIG. An update on clinical research was presented by Leslie G. Ford, M.D., and Otis W. Brawley, M.D., both of the Division of Cancer Prevention and Control at the National Cancer Institute.

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.

care organizations is information systems, according to Eric N. Berkowitz, Ph.D.

"I am going to come to you as a buyer and say, 'Here is x amount of money to take care of a covered life per year. What would you bid?' Hospital chief financial officers simply do not know these costs," said Berkowitz, who is professor and head of the Department of Marketing at the University of Massachusetts at Amherst.

In addition to understanding service costs, explained Berkowitz, hospitals must establish an effective sales force (yes! sales people) to solicit oncology referrals, conduct market research, and recognize the growing importance of advertising in a health care world in which buyers have gained control over the suppliers. "Only those hospitals and practices that are most responsive to both buyers and patients will be able to maintain market share. Buyers and patients must be viewed as strategic partners," said Berkowitz.

Noted futurist Leland R. Kaiser, Ph.D., cited four "trump cards" that hospitals and physician practices will have to play to win.

- Be the least expensive in town. Cost efficiencies and cost reductions will be achieved by, among other things, use of physician extenders and new ways of thinking about how services are provided.
- Offer the highest quality.
- Provide a better patient experience, a nurturing, loving intervention at all levels—physical, emotional, mental, and spiritual.
- Have less disease, less morbidity, in the insured population. Early detection and disease prevention are key. "If you can change the lifestyle of one out of ten people, that creates all the reserves you need to survive in this new marketplace, which will have a profit margin of somewhere between 1 and 1.5 percent," said Kaiser.

Kaiser spoke of two futures. The high probability future is one of cut-throat competition, deep discounting, and compromised quality to meet the demands of the marketplace. The preferred future features almost the opposite: a health care environment that is collaborative, nurturing, and socially responsible.

"Let's share, collaborate, integrate, and nurture. Let's reframe the system to do things we have never been able to do before. That is the preferable future. Achieving that preferable future requires corporate social responsibility and a commitment to the community and to building a just, healthy society.

"The future of health care is dependent on our creativity," said Kaiser. "Our challenge is not to adapt, but to reshape, to evolve, to invent new selves for ourselves and for our patients."