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A Not-for-Profit Game Plan: How One Not-for-Profit Community Cancer Center Competes

by Bruce Feldman

The Sanford R. Nalitt Institute for Cancer and Blood-Related Diseases at Staten Island University Hospital is one of four hospitals in the highly competitive health care market of Staten Island, N.Y. Currently Staten Island University Hospital is the only facility on Staten Island offering comprehensive oncology services. However, the steady rise of managed care penetration and the recent entry of Salick Health Care into the New York City market have forced the hospital's administration to re-examine its strategies for providing quality care to patients with cancer.

Salick Health Care, the largest chain of for-profit cancer centers in the United States, is known for its ability to provide hospitals with capital to build state-of-the-art cancer centers. The company has been successful in recruiting leaders in oncology to staff its cancer centers. One of the first companies to "carve out" oncology services with HMOs, Salick Health Care is also rich in managed care expertise.

Salick recently entered into a joint venture with St. Vincent's Hospital in Manhattan and has initiated discussions with Bayley Seton Hospital, a direct competitor of Staten Island University Hospital. In the not-too-distant future Salick Health Care or another large cancer entity will probably move into the Staten Island market. However, Staten Island University Hospital cannot afford to wait and see what develops. As a not-for-profit institution, it cannot compete head-to-head against the almost inexhaustible resources of these larger companies. Instead, for the past several years the hospital has used creative, cost-effective approaches to expand its outpatient services and broaden its market share to include residents of Staten Island and the neighboring boroughs as well.

Since 1991 Staten Island University Hospital has offered ambulatory oncology services in a freestanding state-of-the-art cancer center located immediately adjacent to the main hospital building on its north campus. The center's opening was part of an aggressive attempt to bring outpatient care on site, concentrating all aspects of oncology care, including inpatient and outpatient medical oncology, radiation oncology, and surgical oncology, at the hospital. Other driving forces included the shifting demand to move oncology care from the inpatient to the outpatient setting and the need to attract patients who were traveling to larger academic medical centers in Manhattan.

That same year a thriving medical hematology/oncology practice in the community moved on site to the Nalitt Institute. This practice had already established strong medical and administrative ties with the hospital; this close relationship facilitated a smooth transition. Several factors contributed to the practice's decision to move on site:

- the need to decrease the fragmentation of care that had been present prior to the establishment of the cancer facility.
- the desire to expand access to resources that were not available in the physician group's private office
- anticipation of the potential impact of managed care and future health care trends, such as declining physician reimbursement and an increase in chemotherapy drug costs. The oncologists' on-site location has since allowed the physicians more time to participate

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in clinical research trials and to better organize their teaching and administrative roles.

FACING UP TO THE CHALLENGES

Expanding outpatient oncology treatment services, as well as establishing an autologous bone marrow transplant program, was only the first step in creating a more dominant presence in the region. To more effectively compete with the larger surrounding New York City hospitals, the hospital's administration had to develop a model for operating at optimum convenience and efficiency.

A freestanding cancer center by definition affords certain economies of scale that any hospital or other twenty-four-hour care facility cannot. The Sanford R. Nalitt Institute for Cancer and Blood-Related Diseases is open five days a week, with extended evening hours available three nights a week. The hours of operation facilitate patient convenience, but also contribute to decreased overhead costs, such as electricity and staff hours. The campus location allows the center to immediately transport patients with complications and who require admission to the hospital's twenty-five-bed inpatient oncology unit.

Previously, patients requiring continuous or long-term infusions had to be admitted to the hospital for the duration of their treatment. However, the availability of portable chemotherapy pumps that patients can use at home and the ability to administer six- to eight-hour infusions have helped dramatically reduce inpatient admissions for chemotherapy infusion.

Continuous infusion chemotherapy is performed in the following manner. On the first day of treatment, a patient requiring continuous infusion comes to the center for an assessment by an oncology nurse and a medical oncologist. The patient is then con-

For-Profits: Are Patients Paying More, Getting Less?

An inherent conflict of interest exists in for-profit medicine and is undermining the community roots and samaritan traditions of medicine, according to Stephanie Woolhandler, M.D., M.P.H., F.A.C.P., associate professor of medicine at Harvard Medical School in Cambridge, Mass. Dr. Woolhandler spoke at ACCC's 1997 Annual Meeting in Washington, D.C., last March.

Today's giant for-profit health care chains operate with centralized corporate boards that are cut off from the communities their hospitals serve, Woolhandler said in a recent interview. As a result, the charitable tradition within American medicine and nursing suffers. "With for-profits, board officers are legally required to put the interests of the hospital's shareholders above the interests of patients," said Woolhandler.

For Woolhandler, the only conceivable justification for for-profit health care would be if it offered quality care at an affordable price. But in fact, a recent study published by Woolhandler and Harvard Medical School colleague David U. Himmelstein, M.D., in the March 13, 1997, issue of the *New England Journal of Medicine* found that care provided by for-profit hospitals is more expensive.

Woolhandler and Himmelstein calculated administrative costs for 6,227 nonfederal hospitals and the total costs of inpatient care for 5,201 acute care hospitals in the United States for fiscal year 1994 on the basis of data the hospitals submitted to Medicare.[1] The study found that administrative costs per discharge were 23 percent higher at for-profit hospitals than at corresponding not-for-profit institutions.

The success of for-profits in decreasing inpatient length of stay has not translated into lower patient care costs. Average inpatient costs per discharge at for-profit institutions in 1994 were $8,115 compared to $7,490 at nonprofit hospitals. Costs per inpatient day at for-profit hospitals averaged $1,403, about $400 more than at not-for-profit hospitals.

The study found that a higher percentage of for-profit hospital resources are allotted to administration, with fewer resources allocated to clinical staffing. Administrative costs averaged 34 percent of total costs in 1994 at for-profit hospitals, where equivalent costs at not-for-profits averaged 25 percent. Not-for-profits generally contribute a higher percentage of total costs to wage and salary costs than for-profits (48 percent of total costs vs. 41 percent). "Patients are paying more and getting less in return" at for-profit hospitals, said Woolhandler.

Woolhandler reports growing rebellion among physicians and nurses in the state of Massachusetts against for-profit takeovers. Woolhandler, Himmelstein, and more than thirty physician colleagues founded the Ad Hoc Committee to Defend Health Care. The Committee recently circulated *Call to Action*, a statement against for-profit takeovers and in support of universal access to care that has been endorsed by 1,200 Massachusetts physicians. The group is calling on the state's attorney general, governor, and legislators to place a moratorium on for-profit conversions, pending the development of national and state policies to govern their growth.

A half dozen states have enacted laws in the last year to create more government oversight of the conversion of hospitals to for-profit business. Two dozen additional states are considering similar measures.

REFERENCE

[1] Woolhandler S, Himmelstein DU. Costs of care and administration at for-profit and other hospitals in the United States. *N Engl J Med* 336(11):769. March 13, 1997.

nected to an ambulatory pump via a vascular access device. Once the pump is started, the physician and oncology nurse review the pump's operation with the patient and any family members, and the patient is sent home. The pump is small enough to fit into either the patient's pocket or a small carrying case.

The patient is instructed to call the center's number if any problems arise. An oncologist is on call during those evening hours when the center is closed and on weekends and can be easily reached to assist patients if necessary. The patient will travel to the center for several consecutive days to have the status of the portable infusion monitored and his or her medical condition evaluated. The nurse ensures that the pump is working properly and that the patient is receiving the appropriate infusion rate and not experiencing any complications or nausea. Patient satisfaction with this cost-effective approach to long-term infusions has been high. Very few quality of care issues have been reported.

Infusional chemotherapy that is not continuous is prepared for patients in a similar manner.

The September/October 1997 *Oncology Issues* looks at more face-offs in managed care. In a heavily managed care market, one Arizona oncology practice decides to just say "no" to a capitated contract. When the oncologists explained the situation to their patients, a majority stayed with their physician and not with the insurance plan. Revenues went up, and the competition was quite unhappy.

"The most difficult challenge in competing with any for-profit health care company has been in the area of outcomes data."

Patients remain in comfortable reclining chairs within the center's infusion area for their entire treatment under the supervision of an oncology nurse. A support staff team, including dedicated oncology social workers, a nutritionist, a data manager, a patient educator, and volunteers, helps foster a relaxed environment and assists patients with specific problems that may arise. Activities such as bingo and special nutritional luncheons or seminars are offered for patients receiving treatment.

Plasmapheresis, blood transfusions, phlebotomies, diagnostic bone marrow biopsies, intrathecal chemotherapy, and administration of biologicals are also performed at the center. Patients have access to consultations and follow-up visits by hematologists and a wide range of oncology specialists, including medical, radiation, pediatric, and neurosurgical oncologists.

The most difficult challenge in competing with any for-profit health care company has been in the area of outcomes data. For-profit entities, equipped with top-of-the-line cost accounting systems, have the ability to accurately assess the exact costs of treating a given patient. This ability puts them at an advantage when negotiating contracts with managed care companies.

Like many community hospitals, Staten Island University Hospital must transition to a cost accounting system that will enable it to perform more sophisticated analyses of data to determine true costs and identify areas where cost savings can be realized without jeopardizing quality. For example, many for-profit competitors have the ability and appropriate resources to study the outcomes of two particular drug regimens that may vary widely in price yet may offer similar results in terms of long-term success and remission rate. If an outcomes study shows that the less expensive regimen produces quality outcomes equal to the more expensive regimen, the hospital can save costs by purchasing the less expensive drug and maintain quality patient care simultaneously. Unfortunately, most community hospitals lack the appropriate resources to devote to such studies.

Despite these challenges, the Staten Island University Hospital network continues to grow. In October 1996 oncology services were expanded into Brooklyn, and aggressive plans are underway to open a satellite cancer facility there within the next few months. To build physician referrals, the hospital has also opened multiple primary care physician offices throughout neighboring and outlying communities. As part of an extensive marketing effort, the cancer center sponsors comprehensive patient education and free cancer screenings throughout the area and conducts a wide variety of support groups.

Cost competitiveness remains only one facet of Staten Island University Hospital's operation. As a not-for-profit institution, our greatest advantage must lie in our ability to provide comprehensive quality oncology services to patients with cancer.