Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: Patricia A. Soenksen & Joseph R. Halperin (1999) Creating Collaborative Oncology Partnerships, Oncology Issues, 14:6, 23-26, DOI: 10.1080/10463356.1999.11905271

To link to this article: https://doi.org/10.1080/10463356.1999.11905271

Creating Collaborative Oncology Partnerships

by Patricia A. Soenksen, C.H.E., M.B.A., and Joseph R. Halperin, M.D.

Comprehensive cancer care includes distinctive features that make the development of collaborative service models attractive for both providers and patients.

- Cancer care providers—ranging from physician groups to community hospitals, academic medical centers, and freestanding cancer centers—are all struggling to differentiate themselves in an intensely competitive marketplace.
- Providers must deal with the realities of reduced Medicare and managed care reimbursement, as well as rising costs due to expensive technology and, in some cases, labor shortages.
- A certain volume of service delivery is needed to sustain complex programs and to support expensive technology.
- Expanding physician manpower requires on-call and vacation coverage. Program development necessitates additional resources.

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- The approval process of the American College of Surgeons' (ACoS) Commission on Cancer (CoC) is becoming increasingly critical. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the CoC recently agreed that the JCAHO will accept CoC accreditation decisions for cancer treatment facilities and cancer hospitals affiliated with health plans and health systems applying for accreditation under the JCAHO's Network Program. It is expected that the JCAHO recognition of CoC-approved cancer programs will be expanded to include all JCAHO accreditation programs during the year 2000.[1]
- Cancer patients and their families have become more informed and better educated through the vast amount of information available from print media, television, and the Internet. Patients are now more aware of cutting-edge treatments and clinical trials. Often, the patient and family are proactive about seeking access to new cancer services, although many still prefer convenient care that is provided locally or regionally. In other words, a wealth of information and technology has raised patients' expectations. For an individual provider to meet the public's rising expectations, it no longer suffices merely to project an image of expertise. Rather, providers must tangibly demonstrate better customer service, lower cost, and superior clinical outcomes.

Because an individual provider who seeks to provide better, more comprehensive cancer care faces significant programmatic, management, human resource, technological, and economic barriers, the only solution may be the development of a collaborative partnership.

MODELS OF ONCOLOGY PARTNERSHIPS

Over the past ten years, there has been an explosion in the number and types of models for collaborative oncology ventures. Representative models include:

- a large community hospital or tertiary "hub" affiliated with one or more smaller community hospitals and/or satellites
- an academic medical center (AMC) or NCI-designated center with satellite programs operating under a positive "brand" name, such as Johns Hopkins Oncology, Duke Oncology Consortium, or the Dana Farber Cancer Center
- large, regional, even international, oncology alliances or networks, such as the Fox Chase Network, the Memorial Sloan-Kettering Network, and the Cancer Care Alliance in the Northwest
- for-profit physician practice management groups, such as U.S. Oncology, which was recently formed through the merger of American Oncology Resources (AOR) and Physicians Reliance Network (PRN), or cancer centers such as Salick Health Care, Inc., (AstraZeneca) and privately owned Cancer Treatment Centers of America.

While there are many different ways oncology providers can partner with other providers, we will limit ourselves to issues pertinent to health system-related (tertiary hub) and community hospital/cancer center-related ventures.

STRATEGIC AND ECONOMIC MOTIVES FOR DIFFERENT PARTIES

In any collaborative venture, each party seeks to maximize strengths and minimize vulnerabilities. The collaborative venture should create new operating syn-

ergies and demonstrate outcomes that meet or exceed those previously provided by the individual parties. For example, patient satisfaction may increase due to the patient's reduced driving time to radiation therapy treatment when a joint venture satellite is created in a rural community. Or, pain management may improve as venture partners use standardized treatment protocols.

Table 1 illustrates how different parties in a partnership (e.g., a community hospital and tertiary hub or AMC) may have different but sometimes complementary motives for collaboration.

OPTIONS FOR ORGANIZATIONAL STRUCTURE

Early in the process of exploring a partnership, providers should seek qualified legal advice. Different state laws regarding the corporate practice of medicine, federal and state antitrust regulations, Stark regulations, and IRS rulings all necessitate thorough legal review and approval of any proposed organizational structures.

In addition to appropriate legal factors, other aspects that must be considered when selecting the type of organizational structure include the number of parties involved, the degree of autonomy and/or control desired, and the amount of financial capital and/or financial risk each party is willing to bear. Potential venture partners must openly share their organizational needs, motives, and expected outcomes for the proposed venture in a face-to-face meeting and in writing. This early, critical step sets the stage for the development of trust or, conversely, the erosion of trust if the parties do not disclose their true motives and expected outcomes for the venture.

Therefore, the best way to achieve this information exchange and collaborative decision making is for the parties to participate in joint strategic planning. Not only will strategic planning help in assessing each party's SWOT (strengths, weaknesses, opportunities, and threats), but the process will also reveal if there are distinctive operating synergies between the parties. Ideally, the strategic planning process leads to the creation of collaborative program goals, strategies, and outcome measures. When the strategic planning process is avoided or shortchanged, problems frequently occur in implementation, harming the venture's long-term success.

Another key consideration when developing any joint arrangement between two entities is the potential reimbursement impact of the proposed organizational structure of the venture. Medicare's proposed Ambulatory Payment Classification (APC) regulations include provisions dictating human resources, facility location, and control requirements. These proposed requirements also preclude hospitals from venturing into collaboration with any party, including another hospital, and billing for services as a hospital-based outpatient service. If a key consideration is billing for services as a hospital-based department, then review of the final Medicare regulations for APCs is essential when developing joint venture arrangements.

Partnerships can vary by ease of integration. According to Pavia and Berry, "affiliation models of collaboration are usually most successful between organizations that are in limited competition and see some real opportunities to address health care needs of the community. Hospitals or systems that have been direct competitors often require a stronger structure in order to achieve any significant level of success."[2]

A less restrictive arrangement to consider is the *planning council.* A planning council operates like a joint planning committee or task force. Assets are not merged, and there is no sharing of risk.[2] The planning council might explore possible areas for oncology collaboration, such as joint cancer screening initiatives between a brand-name cancer center and a smaller community hospital. While Pavia and Berry warn that there are some antitrust implications for planning councils that must be explored,[2] the advantages are a lower level of financial commitment and the ability to disband the council easily if the arrangement proves unsuccessful. Potential drawbacks of the planning council arrangement include a lower level of commitment to any projects and less control over outcomes.

Another flexible arrangement is the *master affiliation agreement,* which allows the parties to test out their relationship on a shorter-term project, such as a joint cancer marketing program or shared clinical guidelines or protocols. This type of arrangement can be a helpful test when the parties are not certain they want to be economically linked for the long term.[3]

Along the continuum toward more restrictive arrangements is a *management agreement.* In this venture, one of the providers typically owns the equipment and the facilities, while the other partner may provide clinical and administrative services.[3] For example, a group of radiation oncologists may provide radiotherapy, physics, and staffing for a freestanding radiation therapy center that is owned by a community hospital. A fixed management fee may be paid.

In a *partnership franchise agreement,* a community hospital and a leading cancer center may enter into a financial agreement to create

a franchise of the cancer center at the community hospital. The agreement typically specifies the levels of investment and profit sharing between the specialty care organization and the local hospital. The franchise agreement may also involve employment of physicians in the local franchise by the specialty cancer center. It requires significant financial investment by both parties and marketing campaigns that promote and link the two parties in the venture.[4]

By contrast, in a *network franchise model,* the leading cancer center and the community hospital usually do not share the investment costs or profits of the local franchise. Both organizations use standardized protocols and streamline operations to facilitate care, such as through a phone triage system. In this model, the local hospital retains ownership of franchise oncology space, equipment, and physicians. There could be, however, sharing of educational programs for physicians and staff such as nurses.[4]

Models that offer the most enduring opportunity for collaboration require strong mutual obligation and commitment but offer the greatest potential rewards. These models include *joint ventures,* which typically involve the creation of a distinct corporate entity with a separate governing board and some shared management responsibilities. These structures may be for-profit or not-for-profit. The partners share in some of the risks and rewards of the joint venture.[5] Legal advice should be sought early in the process of considering the development of an oncology joint venture to avoid state or federal antitrust or other relevant legal concerns.

Finally, many states offer the *limited liability corporation* (LLC), which provides another alternative for partnerships between taxable and tax-exempt entities. According to Gift and colleagues,[6] the net earnings of the LLC are tax free as long as they remain within the LLC. When net earnings are disbursed to the partners from the LLC, they are taxed only at each partner's own tax structure and rate.

PROGRAM AND OPERATIONAL CONSIDERATIONS

Just as the legal structures vary, so too do the types of oncology services that might be "partnered," depending on the goals of the respective organizations. The goals can range from the development of joint cancer centers and provision of radiation oncology or

Table 1: Possible Strategic and Economic Motives for a Collaborative Partnership

For the Community Hospital	For the Tertiary Hub or Academic Medical Center
Enable patients to stay in local community for care, avoiding discomfort for patients and inconvenience for families.	Expand tertiary referrals for more "high-end," atypical care, such as bone marrow transplant.
Maintain autonomy and enhance identity as key community resource for cancer care.	Gain additional sites for teaching and research endeavors.
Defend current market share or grow market share.	Defend current market share or grow market share.
Gain access to new technology, expertise, professional education, specialized staffing, resources/capital, and research protocols.	Gain access to outreach opportunities for oncology and other medical/surgical specialties, such as infectious diseases or surgical consult clinics.
Reduce duplication of resources.	Reduce duplication of resources.
Associate with a "brand name" in oncology care and/or NCI-designated site.	Develop "community" presence or image as opposed to more typical image as a large, remote, imposing medical center.
Retain less complicated cancer cases in the community—those that now may be migrating out to tertiary hubs or AMCs.	Better utilize cancer specialists, such as a breast cancer surgeon or GYN oncologist.
Enhance managed care contracting.	Enhance managed care contracting.
Gain potential to share expenses related to capital intensive services.	Gain potential to share expenses related to capital intensive services.

chemotherapy services in satellite centers to sharing clinical guidelines, case management, staff, and cancer registry services.

Depending on the structure selected and the scope of services offered in the partnership venture, there are programmatic and operational issues that must be addressed. These include, but are not limited to:

Programs
- ACoS approvals (separate or joint), including registry linkages and common cancer conferences (tumor boards)
- Development and implementation of strategic and marketing plans
- Type and scope of services to be provided and by whom

Operations
- Governance and structure
- Administrative and medical leadership
- Professional services, such as physician coverage and staff job-sharing
- Process of managing and expediting patient referrals
- Compliance with applicable reimbursement regulations
- Development of the budget, including capitalization
- Information systems (separate or linked) and the role of telemedicine
- Process of partnership dissolution, if objectives of the parties are not met.

LESSONS LEARNED

Anyone who has ever undertaken an oncology partnership knows that there are a multitude of challenges to overcome and hard lessons to learn from the process. While each situation generates unique opportunities and challenges, the following are lessons we have learned from developing and observing successful oncology partnerships over the past ten years.

- While it may sound obvious, trust is the cornerstone of all collaborative relationships. Such arrangements will not long survive unless the parties work diligently to cultivate trust in all negotiations and interactions.
- Any partnership will take much longer to develop and to achieve outcomes than originally expected.
- A shared vision must be crafted early in the process and be supported by a joint strategic planning process, business plan, and financial proformas.
- Organizational cultures of the partners will not be the same or even similar, nor will they change in the short run. Constantly seek ways to build upon and promote the best attributes of each party. For example, if one party demonstrates an efficient decision-making style, try to model that behavior for the new venture.
- Never underestimate the importance of regular communication (oral and written) about the venture to the medical staff of the respective organizations. Communication must be ongoing.
- Recognize the power of internal champions in the process. For example, there may be well-respected primary care physicians or surgeons who have significant informal power in the organization and are anxious to participate in and make the venture successful.
- Develop mutual benchmarks and regularly monitor outcomes. Report outcomes quarterly to all parties and to the board of directors of the respective organizations. Quarterly reporting will help the process stay on track and promote accountability to the venture.

The delivery of oncology care in the next century will require providers to demonstrate that partnerships tangibly improve both cancer care in the community and the individual parties' financial and market status. There are different models, legal structures, operational/program issues, and reimbursement concerns inherent in any partnership decision. The array of models and structures available for collaborative partnerships means providers must be careful to seek arrangements that meet strict legal requirements, address financial and/or reimbursement changes and constraints, and satisfy each party's organizational goals. Providers will learn critical lessons along the way; however, being aware of what has and has not worked in other collaborations can serve to enlighten and improve the process for providers who contemplate partnerships in the future.

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