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Merging Hospital Cancer Programs: Easing the Transition

by Ronald D. Deisher, M.P.A.H.

Mergers and consolidations of hospital cancer programs in today's health care market continue. Such major changes to cancer programs generally take place within the organizational context and cultures of hospital mergers and involve major organizational and financial components of hospitals.

The merger and consolidation experiences of The Cancer Institute of Health Midwest (TCI/HM) may help other institutions involved in merging divergent organizational and professional cultures. TCI/HM has grown from three separate competing hospitals and cancer programs in 1989 to include the cancer programs and services at 12 Health Midwest hospitals throughout the 10-county Kansas City metropolitan area of approximately 1.7 million people. More than 4,400 new cancer cases are diagnosed and treated annually within TCI/HM.

OBSTACLES TO SUCCESSFUL MERGERS

Some of the major problems and issues that are often encountered in merging or consolidating hospital cancer programs evolve from the established cultures, relationships, and attitudes of physicians, nurses, and other professional staff. Blending divergent organizational and professional cultures and attitudes is often a major stumbling block to successful mergers. This can be especially difficult if the previous relationship between merging programs has been one of competition and suspicion.

A competitive environment can breed staff attitudes and actions that convey obvious feelings of superiority and antagonism toward the merger as well as toward the merging programs and staffs. Often heard are such statements as: "Our programs and ways of doing things are clearly better than those of the organizations with which we are merging. They should do things our way. As the biggest hospital cancer program in the system, major new services should always be provided through our program. After all, we have the most patients and revenue and are obviously supporting the other programs." Or conversely, remarks such as this may be said: "The only reason that we're developing this service, or providing services at this location, is to benefit the mother ship. It's always to support that program or their interests at our expense."

Fear of the unknown and suspicions about the motives and intent of others can also be major obstacles to successful cancer program mergers. Concerns about losing patients, resources, revenue, and jobs to the hospital or program initiating the merger help promote these attitudes. Again, such feelings can be even more entrenched and difficult to overcome if they have evolved from a competitive background. In meeting with physician groups, cancer committees, or other professional groups for the first time at a merging hospital, staff from The Cancer Institute of Health Midwest has been asked many times in different ways, "Are you here to steal our patients? Are you here to undermine our practices and programs?"

It is important to deal with these negative feelings and concerns in a positive manner as soon as possible. Left alone to fester and grow, these attitudes can become in time either very difficult issues to overcome or insurmountable obstacles to successful mergers.

In the organizational model with a centralized staff working with all of the merged cancer programs, the additional tasks required of a centralized staff in supporting the additional cancer programs may complicate the merger process. The additional time, travel, and demand for resources, often without significant increases in central staff personnel or resources, contribute to the stress and antagonism sometimes felt by a centralized staff.

PRACTICAL APPROACHES

Staff of The Cancer Institute of Health Midwest has been involved in merging and assisting in the coordination of cancer activities and services at 12 geographically dispersed hospital cancer programs. As a result, they have learned, often with some difficulty, a number of practical approaches to resolving many of the key issues and problems in achieving successful cancer program mergers.

In dealing effectively with some of the fears and suspicions of new relationships and coordinated activities, our staff has learned and practices a three-phase approach. First, meet early and as often as possible with merging hospital cancer program staffs. Second, listen carefully to what they are *really* saying. Third, focus your efforts on strengthening patient care services and support.

Nothing dispels suspicions faster than finding a common agenda around improved patient care. Bringing in or developing services that help the merging cancer pro-

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grams and their professional staffs take better care of their patients goes a long way toward breaking down suspicions and improving working relationships.

Take advantage of existing hospital forums, such as cancer committee meetings, cancer patient conferences, department as well as team meetings, whenever possible, to listen and promote new services and opportunities. As soon as practical, involve key physicians and other staff from merging hospitals in screening, outreach, supportive care, and education programs. Feature them and take every opportunity to acknowledge their contributions.

Central staff should work on developing expanded "team" efforts that include newly merged physicians and other professionals. Emphasize the "team" approach as well as inclusiveness, not exclusiveness, in the planning and development of new or expanded programs and services.

One of the major strengths of a merged and coordinated system of hospital cancer programs can be their geographic dispersion and the location of individual programs throughout a given area or market. This then makes expanded services and resources more readily available and more accessible to greater numbers of cancer patients.

Most new programs and services should *not* be reserved or located only at the largest or flagship hospital cancer program(s) in a system. Spreading most of these services, except for a few highly specialized and costly resources, throughout the system is more responsive to the needs of most cancer patients and communities. Such dispersion usually results in greater patient volumes and activities for all physicians and programs involved in the merger, which further serves to lessen suspicions and reluctance to participate.

Bringing in cancer physicians and other professional staff from existing cancer programs in a system to do special professional and public education programs for and with newly merged physicians and program staffs can help to break down suspicions and hasten cooperation toward successful mergers.

VALUE OF INVOLVING KEY PROFESSIONAL GROUPS

Cancer registrars and cancer registries help coordinate most hospital cancer programs and have worked with and know the key oncology and other medical staff at newly acquired hospital cancer programs. Central program staff should make the cancer registrars and registries one of the first areas to be integrated into an expanded system. Their knowledge and contacts can be very helpful for introductions and making the right contacts as well as for information about professional attitudes, relationships, and potential issues.

Another key professional group and resource to bring into an expanded system early in the merger process is the oncology nurse, clinicians/specialists. One of the ways to involve them at the onset is to develop and bring additional training resources and programs to them and through them to the other nursing staff working with cancer patients. Additional training and competency in the oncology nursing staffs also helps build rapport and support from key physicians.

These key oncology nurses can be brought together as a working advisory group for team building and for developing new ideas for patient care and support. This advisory group can also help in getting to know the new oncologists and other physicians, and serve as system resources for public and professional education and certification.

A Steering Committee or advisory board made up of key oncology physicians, other oncology professionals, and administrative representatives from each hospital cancer program can help in promoting the "team" approach. The growing familiarity and working relationships developed among oncology professionals on a Steering Committee can also help to reduce suspicions and reluctance to be active participants in a merged system of cancer programs and services.

LOOKING AHEAD

During the merger process, and as an ongoing activity to strengthen the merged hospital cancer programs, central program staff should always look for ways to share resources and services. They should also look for opportunities to reduce the unnecessary duplication of expensive technologies and equipment.

As much as possible, all newly merged cancer programs should be invited to participate in systemwide marketing and promotion activities. The new physicians and program staffs should be involved, whenever possible, in helping to identify, design, and carry out these expanded system marketing efforts. Finally, as soon as politically and administratively possible, all cancer programs in a merged system should adopt a common name. Although this might seem easy, it is no small task. Developing and growing consensus on the name itself can be very difficult. However, having a common name helps begin the process of building a consistent and stronger, more recognized public image, as well as a more common agenda and stronger ties among merged cancer programs and professional staff.