

Oncology Issues

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Physician Alignment

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Time to Align!

by Mark J. Dubow, MSPH, MBA

IN BRIEF

For hospital-based oncology programs, a well-crafted approach to physician alignment is the most significant contributor to achieving profitable growth and protecting market share. Generally, such physician alignment efforts are more profound than investing in clinical technology, consolidating services into a comprehensive cancer center, and/or participating in clinical trials. Physician alignment efforts establish common goals and strategies that enhance the operational relationship between the hospital and the physicians. Successful alignment strategies enable both parties (hospital and physicians) to achieve the value they seek. Keep in mind, the “value” sought is situation-specific.

Numerous catalysts might initiate discussion of physician alignment at a hospital-based cancer program (see “Why Align” on page 28). Common catalysts include: an opportunity to collaborate with physicians to achieve competitive differentiation; a chance to partner with physicians to penetrate target markets in a secondary service area; and a need to prevent staff physicians from forming a competing entity or from being recruited away by a competing entity.

Physician-hospital alignment can be beneficial in a broad array of situations, including the development and implementation of tools used in evidence-based medicine; recruitment and retention of physicians; shared funding of new clinical technology; collaboration in operational management of the program; and the design of cancer center facilities. Whatever the catalyst, hospitals must first understand four key concepts:

1. Which physicians make good candidates for alignment
2. Strategies for physician alignment
3. Criteria for selecting the best strategy
4. Critical success factors in physician alignment.

Identifying Alignment Candidates

Most often physician alignment specific to oncology programs focuses on medical oncologists and/or radiation oncologists. These specialists are an important starting point; however, an alignment strategy that stops here will likely fall short of its goals. Instead, take a comprehensive

approach to identifying potential candidates for alignment. Create a diagram of all the pathways and the associated medical specialties through which a patient may be referred to and guided through your program’s diagnostic and therapeutic cancer services (see Figure 1).

Each specialty pictured in Figure 1 is either a potential “channel” facilitating the flow of patients and thus revenue, or a barrier to that flow. Thus, formation of alignments between and among each of these specialties is crucial to the success of a hospital’s oncology program. Figure 1 shows several specialties that are often overlooked as alignment candidates, including internal medicine, family practice, and gynecology, among others. Bottom line: alignment is important not only with hospital staff but with specialists affiliated with other providers in targeted outlying communities.

Does this imply that representatives of these specialties (including those at other hospitals) should be contacted every time an oncology program embarks on a physician alignment strategy? Should your hospital try for alignment with the majority of physicians in each specialty area identified? The answer to both questions is—*it all depends*. Advance “profiling” of these channels provides valuable information that you can use to best answer these two questions. Be sure to include the following information in your potential alignment prospect “profile”:

- The volume of patients that currently flow through the channel—*Is this likely to increase or decrease during the next three to five years?*
- The payer mix
- The degree of vulnerability the hospital has due to the physicians’ level of satisfaction with the hospital and/or the extent to which they are being recruited by competitors
- Physicians in the channel that practice in a group versus those who are independent
- Regulatory/legal issues that may affect hospital-physician relationships (i.e., Stark law).

Another important factor is your hospital’s organizational culture. Some hospitals include all interested physicians in alignment activities. Other hospitals are more selective. A good rule of thumb is to first include all physicians that have the potential to significantly affect the long-term success of the cancer program. Most likely these candidates will include physicians with mature practices at their peak level of production, as well as younger members of the medical community around whom the future of the program will be built. You should also consider asking multiple groups in a specialty to participate in alignment activities. Such an offer will minimize the chance of animosity and the associated downside consequences.

**PHYSICIAN ALIGNMENT
SHOULD BE A TOP PRIORITY
FOR BUILDING PROFITABLE
GROWTH AND PROTECTING
MARKET POSITION**

Strategies for Physician Alignment

There are a variety of alignment approaches. All possible hybrids should be considered to create a customized approach that best meets the specific needs and interests of all parties—hospitals and physicians.

Below are five approaches to alignment starting with the fastest and easiest strategy and ending with the most difficult and time consuming one. These options are the more formal techniques for achieving alignment. Hospitals can take a wide variety of additional actions to enhance their relationship with targeted physicians. For example: joint marketing activities, (i.e., speakers’ bureaus, screening programs, websites), collaboration in payer contracting, and recruitment.

While well-known, joint ventures (see page 27) are merely one form of alignment. Before assuming that a joint venture is the preferred (or only) option that physicians will embrace, take time to carefully identify the “value” sought by both the hospital and the physicians. Face-to-face discussions are often the best way to achieve this outcome. Holding several of these discussions allows time to reveal underlying objectives and circumstances that can make or break the desired relationship. These open meetings increase the likelihood that the form of alignment ultimately selected will be successful.

Strategy 1: Improve Operational Efficiency

This alignment strategy is directed at making the cancer program “easier” for physicians and their patients to use. Enhancing the operational efficiency of the associated services is the most direct approach to creating alignment between a hospital and the physicians supporting its oncology program. Further, operational efficiency is highly-valued by physicians (see “What Do Oncologists Want?” on page 26).

Strategy 2: Facilitate Participation in Clinical Trials

While some oncologists are interested in direct participation, others would rather refer appropriate patients to other clinicians and programs. Usually clinicians eager to participate in clinical trials do so to bring new therapeutic techniques and better clinical outcomes to their patients—not for monetary compensation. To enhance physician alignment, the hospital can assist interested physicians to evaluate

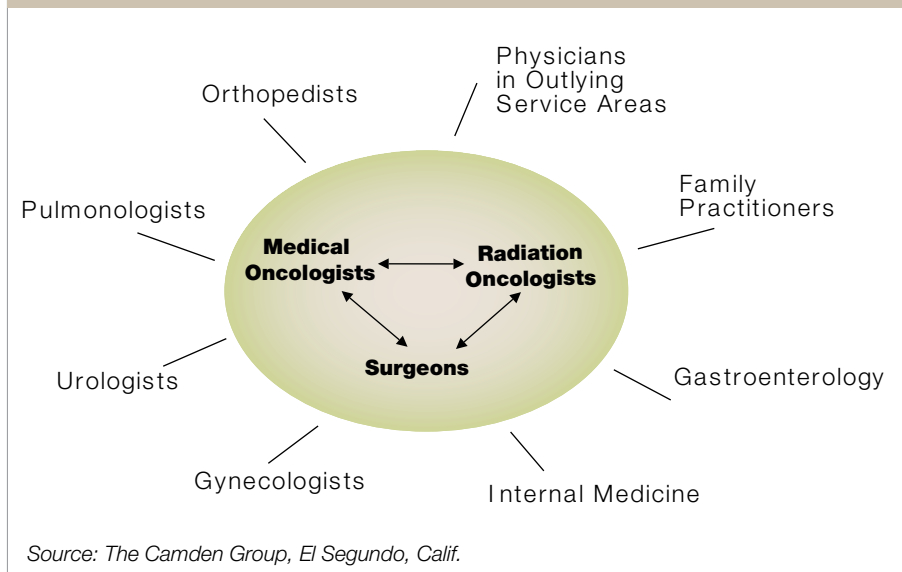
potential trials, enroll in a trial, and track and report findings. Community cancer centers that participate in large-scale clinical trials dedicate staff and information systems resources to managing the trials and supporting the physicians. Programs with a limited scope of clinical trial participation tend to use staff responsible for other functions (i.e., tumor board) to support clinical trials activity.

Strategy 3: Provide a Stipend for Key Medical Directorship Activities

Your hospital may want to enter into a medical directorship agreement with a key physician. With this strategy, hospitals can offer a leadership role and increased responsibility to a designated oncologist. The medical director might then be responsible for developing service-line strategy; overseeing daily operations and performance of a program or a cancer center; and/or managing the integration of the medical, radiation, and surgical oncologists with each other and the rest of the medical community. Establishing a medical directorship can enhance alignment between the director and the hospital. Indirectly—through the activities noted above—a medical directorship may also enhance alignment of other staff oncologists.

Physicians in directorship roles are most often compensated for these positions; however, the compensation must be at a market rate. To ensure that the rate paid to the medical director will pass legal scrutiny, the hospital should conduct an independent fair market analysis

Figure 1: A diagram of potential oncology service referral relationships and a cue for alignment participants



Source: The Camden Group, El Segundo, Calif.

What Do Oncologists Want?

What often sets successful organizations apart is a clear institutional objective to meet the characteristics valued by oncologists, and to meet these needs more effectively than the competition. Below are some “wished for” characteristics frequently identified by oncologists. A successful physician alignment strategy should address most of these issues:

Maximize the ease of patient scheduling. Possible steps include establishing centralized (one-stop) scheduling for all services a patient uses; offering physicians the option of scheduling a patient’s cancer center services online from their office or another remote location; or offering patients the option of online appointment scheduling.

Provide up-to-date, well-maintained medical equipment. Both physicians and patients are aware of the rapid evolution of oncology-related imaging, infusion, radiation therapy, and minimally-invasive surgery. To meet patient expectations and enhance clinical outcomes, oncologists want access to these new clinical tools. Shrinking reimbursement and pressure to cap soaring healthcare costs mean that few organizations have unlimited funds to invest in new technology. To meet this challenge, cancer programs may want to consider innovative sources of capital, including partnerships with equipment vendors.

Ensure that nurses and technicians have up-to-date training and minimal turnover. Physicians frequently remember times when a nurse or a technician fumbled with a new piece of equipment, a clinical procedure, or the care of a patient. The responsiveness of staff

to the physicians is also a point of focus. While it is unreasonable to expect all staff to be up-to-date on each stage of clinical evolution, physician perception that “gaffs” are routine is a sure-fire catalyst to frustration and ultimately a deteriorating relationship. Savvy cancer centers invest resources in enhancing staff training in clinical skills and physician relations. The end result not only benefits the physician-staff working relationship, it helps support quality care for patients and also fosters staff satisfaction. Together these factors can serve to minimize staff turnover.

Enhance timely access to clinical care data and patient medical records. Cancer centers are working with hospital management to extend picture archival communication systems (PACS) and electronic medical records (EMRs) to their service line. Putting healthcare IT advances to work allows physicians to access the data they need from a patient care delivery point within the cancer center, their office, or via remote connection (i.e., another hospital, home computer, PDA).

Provide sufficient capacity to deliver patient care. As the incidence of cancer and the volume of cases detected at earlier stages increases, demands on imaging and therapeutic equipment may rapidly near the “breaking point.” In these circumstances physicians consider referring patients to other sites and/or moving their practice to organizations that offer greater capacity. The obvious alignment strategy would seem to be: add new equipment—another stereotactic needle biopsy machine, another CT scanner, additional infusion chairs, or a second IMRT machine. In some cases, this decision may be correct. In other circumstances, the solution may lie in enhancing patient throughput and/or expanding capacity by extending the days per week or hours per day in which care is provided. 📌

of compensation. Additionally, the hospital must define explicit job responsibilities in conjunction with the compensation. Generally, these responsibilities include:

- Participation in setting the oncology service strategy
- A role in guiding the development of operational protocols and evidence-based medicine guidelines
- Leadership in physician recruitment and retention activities
- Acting as a “driving force” for physician leadership training
- A proactive role in patient referral network development and maintenance.

When defined in this manner, a medical directorship is not only an alignment strategy, but also a key element to effectively manage and lead the oncology service line.

A variety of approaches are used to select a medical director. Some organizations favor “rewarding” a physician who has been very active in patient care or who is the “senior statesperson” among peers. While this approach has benefits, hospitals may want to consider offering a direc-

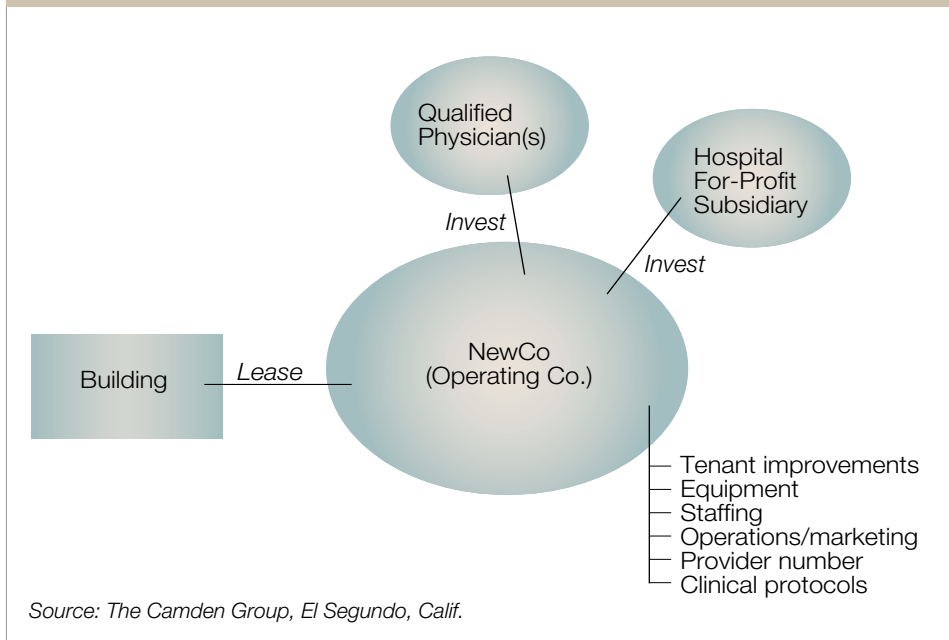
torship to a younger physician that represents one of the “up-and-coming leaders of the future.” When selecting a medical director, look for individuals who are respected by the other oncologists, politically astute, well organized, effective communicators, and team builders.

Strategy 4: Create an Oncology Services Operating Company

The operating company concept gives oncologists a significant role in managing a cancer center—without the hospital having to give up ownership of a building or requiring the physicians to invest large sums. Here’s how it works.

Qualified physicians (the oncologists) and a for-profit subsidiary of the hospital invest in the formation of a new company (“New Co.”). New Co. is an operating company that leases space at a market rate from the hospital in which it will provide and manage oncology services. The space can be in an existing building or in a to-be-constructed facility. The leased space could include the entire facility or a part of that space (i.e., one floor or suite). A portion of the investment made by the physicians and hospital in New Co. is

Figure 2: A physician alignment strategy using a cancer center operating company

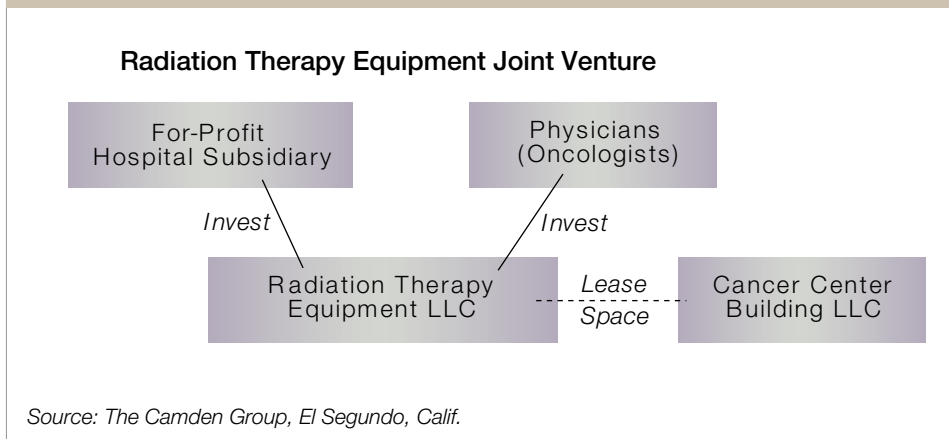


mine the use of the land, which tenants occupy the building, and the use of signage.

This physician alignment model is useful for integrating oncologists in multiple practice configurations, including solo practice and small or large groups. The physicians can elect to maintain their existing practice structure or—through their experience with New Co.—may decide to consolidate their practices. New Co. can use the physicians to manage the daily activity of the organization or hire an experienced administrator or cancer center management company. The latter could also be included as one of the initial investors in New Co.

On the basis of the physicians' financial investment in New Co. and involvement in the management of daily operations, physicians are highly motivated to work to achieve the success of the cancer center. This strategy successfully aligns physician activity with the hospital's objectives, as they relate to oncology services.

Figure 3: A physician alignment strategy involving a single joint venture



Strategy 5: Form an Equipment or Facility Joint Venture

Joint ventures form a significant economic bond between oncologists and the hospital because the parties jointly invest in one or more assets. Often, joint ventures occur when the cost of the asset (and thus the size of the investment) is notably larger than in the operating company model. The investors in the joint venture typically include qualified physicians (oncologists) and a for-profit subsidiary of the hospital. The investor pool could be expanded to include a third-party management company.

The parties may form a single joint venture by investing in a single asset, for example, a building or piece of equipment (see Figure 3), or a bundle of assets (the cancer center as a whole). Alternatively, a series of separate joint ventures could be bundled together into a “medical mall” (i.e., an infusion venture, a linear accelerator venture, a PET/CT scanner venture, and a building venture). Figure 4 provides an example of a “medical mall” joint venture.

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used to fund working capital that supports tenant improvements, purchase of furnishings and equipment, hiring of staff, and the initial marketing activities.

Once patient care activity has commenced, New Co. has responsibility for the following cancer center activities: setting and implementing strategy, determining clinical protocols and oversight of clinical care, managing the day-to-day activities, billing and collections, maintaining the center (housekeeping, supplies, etc.), marketing, and staff employment (see Figure 2).

The hospital retains ownership of the cancer center building or the portion of the building in which the New Co. services are located. Generally, the hospital retains responsibility for maintenance of the building as a whole, security for the building, and for providing parking. Because the hospital retains ownership of the building and the land on which it is located, it has full authority to deter-



...the “medical mall” joint venture approach enables a hospital to extend alignment activity to the broadest number of physicians.

In all forms of joint ventures, the investment must be structured to comply with Section 1877 of the Social Security Act (Stark II). Further, investment would have to be restricted to those physicians who would treat their own patients using the equipment in which they have an ownership interest. For example, in a joint venture specific to a linear accelerator, the hospital could invest but physician ownership would be limited to radiation oncologists and could not include medical oncologists or other specialists.

In a “medical mall” joint venture, however, radiation oncologists could invest in the linear accelerator, medical oncologists could invest in infusion equipment, radiologists could invest in a PET/CT scanner, and any of those physicians as well as individuals in other specialties could invest in the building itself. Thus, the “medical mall” joint venture

approach enables a hospital to extend alignment activity to the broadest number of physicians.

Using the single joint venture as an example, investors would typically form a limited liability company, which would lease space in the hospital (or other building) at a market rate. The physician investors would 1) provide the diagnostic or therapeutic service in the cancer center, 2) be responsible for the full clinical management of the patients, 3) provide the staff and supplies necessary for their care, and 4) conduct the associated billing and collections activity. Typically, the physicians would also be responsible for any marketing-related activities.

By virtue of their investment in the asset, the obligation of the lease, and occupation of the center, physicians would be fully immersed in the activity of the cancer center and have

Why Align?

Many circumstances make alignment attractive. Below are five common catalysts for physician alignment, including real-life case studies:

CASE STUDY 1—Collaborating with physicians to achieve competitive differentiation. In one southern Florida community, a significant number of hospital- and community-based cancer centers competed to serve cancer patients. The clinical outcomes of the programs were roughly equivalent and most provided a similar continuum of care using common clinical technology.

One cancer center in this community designed a growth strategy based on differentiation. The strategy emphasized patient access, efficient care delivery, and extraordinary service. The strategy’s success would largely depend on aligning the cancer center staff with the oncologists, radiologists, and general surgeons to bring concept to practice.

This program achieved alignment through collaborating on the development of the broad-based vision for differentiation, sharing decision-making on operating protocols and performance monitoring techniques, and using incentive systems that ensured that the daily activity was consistent with the objectives.

CASE STUDY 2—Partnering with oncologists to achieve “push/pull” strategies to penetrate target markets in secondary service areas. Through its strategic planning process, a hospital in a suburban area of northern California identified an opportunity to achieve profitable patient-volume growth in its oncol-

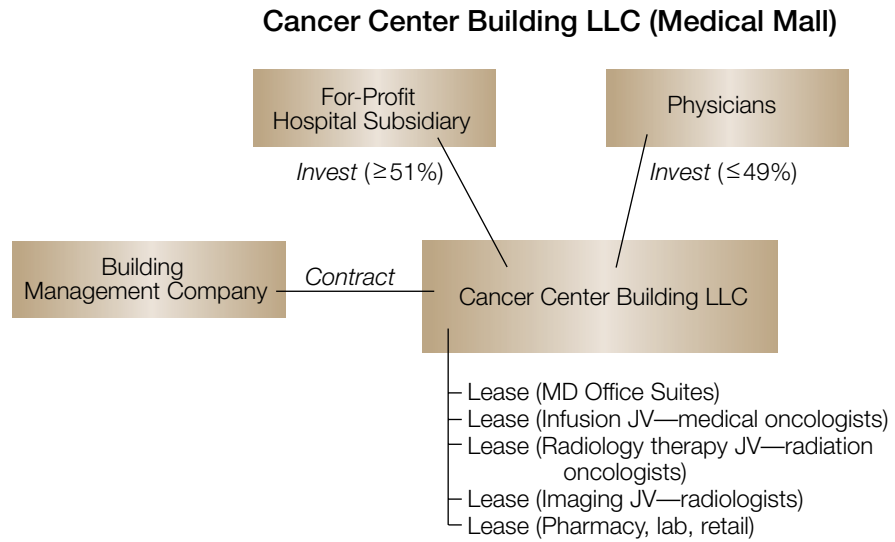
ogy program by serving the residents of communities outside its primary service area. This program set an objective to position itself as a regional leader in selected tumor-site diagnostic and treatment programs and develop both patient demand for its services (“pull” strategy), as well as have its oncologists rotate through the physician offices and smaller hospitals in the target communities to build referral networks (“push” strategy).

The success of the “push/pull” strategies was contingent on the oncologists working closely with the cancer center to agree on the tumor-site focus, design an integrated program of care around each of the selected types of cancer, and then implement a structured outreach program in which the physicians were supported by representatives of the hospital.

CASE STUDY 3—Bringing technology to target communities and increasing market penetration. A Mississippi medical center with IMRT and PACS wanted to apply these technologies to a larger base of patients than it currently served. The center’s oncologists had identified an underserved population in an adjoining county where the local physicians provided infusion, a prior generation of radiation therapy, and general surgery but did not have the capital to invest in the technology upgrades available at the medical center.

The medical center and its oncologists decided that they could pursue their shared objective of building profitable patient volume by collaborating to serve the patients in the nearby county. They established a tactical plan through which oncologists and medical center staff would work together to meet with physicians in the tar-

Figure 4: A physician alignment strategy using a “Medical Mall” option



Source: The Camden Group, El Segundo, Calif.

a strong incentive to achieve success. This foundation for alignment is further strengthened by working with the hospital to jointly set the strategy for and build referral networks supporting the center.

A full discussion of joint ventures as a strategy necessitates a more in-depth dialogue about the legal structures, funds flow, and tax implications, which is beyond the scope of this article.

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geted communities, provide mobile screening and education services to residents, and ultimately build a referral network for IMRT services. In addition, they identified ways to extend the medical center’s PACS to providers in the outlying communities.

CASE STUDY 4—Preventing staff oncologists from forming a competing entity. Perhaps the most prominent “trigger” for pursuing alignment is to build loyalty with key oncologists and reduce the likelihood that they will opt to form their own outpatient cancer center that would draw patients and revenue away from the hospital.

One Ohio hospital faced just this threat. While the hospital was providing a full continuum of cancer services and achieving strong recognition for clinical outcomes and research, the components of the oncology program were fragmented. Multiple groups of medical and radiation oncologists competed with each other for patients and perceived that the hospital was not responding in a timely manner to their requests for aggregating the physically dispersed services into a comprehensive outpatient cancer center. In addition, the groups did not routinely interact with management or each other to foster clinical enhancement or referral network development. The frustrated physicians notified management that they intended to build their own comprehensive cancer center in the community.

A brief assessment of the circumstance underscored both that the physicians were highly motivated to do so and that if they proceeded the hospital would lose a significant amount of revenue, not only in infusion and radiation therapy services but also in related

imaging and lab tests. Ultimately, the hospital and the oncologists agreed to collaborate in preparing an oncology business plan. Among the strategies developed were the construction of a freestanding cancer center on the hospital campus and implementation of a series of equipment and facility joint ventures.

CASE STUDY 5—Preventing predatory staff recruitment efforts by competitors. A not-for-profit tertiary care hospital in an urban and highly competitive portion of southern California was confronted with this situation. Here too, the oncologists on staff included multiple small groups of physicians, as well as independent practitioners. Several of the physicians had been effective in developing a regional reputation and geographically broad patient referral networks. Those physicians were responsible for a significant proportion of the revenue flowing through the hospital’s oncology services. An academic medical center and a for-profit hospital in the local market initiated efforts to recruit several of those high profile physicians.

The hospital responded by forming a working committee that included all of the staff oncologists. The committee was then asked to develop solutions to a series of issues that were important to physicians, including: design of a virtual comprehensive cancer center; selection of new clinical technology that anticipated future trends in care; development of a centralized scheduling process; and identification of potential approaches to forming joint ventures specific to the purchase of new equipment. By directly involving the physicians in the resolution of these and other issues, the hospital diffused and deflected the competitors’ appeal. 📌



Even physician-hospital alignment strategies that seem well-attuned to the special circumstances of the environment can fall short of their objectives or fail.

Selecting the Best Physician Alignment Strategy

With regards to physician alignment strategies, one size does *not* fit all. The “best fit” alignment strategy is the one that most effectively addresses the unique characteristics of *your* cancer program. With this in mind, your cancer program will need to follow several steps before settling on the “best-fit” strategy.

First, identify which physicians are targeted for alignment (i.e., radiation oncologists vs. other physicians).

Second, outline the benefits of aligning and determine the “opportunity cost” of *not* aligning? Opportunity cost is the strategic and/or economic shortfall that can be anticipated if the organization elects not to pursue a specific action or take advantage of a particular alignment strategy. For example, if a hospital does not enter into a joint venture with a group of oncologists and they subsequently shift their practices to a competitor, the opportunity cost to the hospital includes the loss in patient volume and revenue, as well as diminished patient care capacity.

Your cancer program must also decide how broad or narrow your alignment will be. For example, narrow alignment might be a shared approach to clinical trials. A broad application might include setting the oncology service line strategy and constructing a freestanding cancer center.

Next, identify the specific physician interests and concerns that must be addressed by the alignment strategy. Examples might include improved operational efficiency; access to new clinical tools/resources; new income streams and/or sought after return on investment; degree of physician control; and physician autonomy, among others.

The specific interests and needs of the hospital must also be taken into consideration. These might include: control over hospital assets, restricting the competition’s ability to gain leverage over key assets, protecting the hospital’s image, a return on investment, and the degree of control required by the hospital, among others.

The final determinations that must be made hinge on the willingness of the two parties. For example, how able and willing are the physicians to invest? How able and willing is the hospital to invest? Finally, how quickly or slowly are the parties ready to move?

In Sync: Critical Success Factors

Even physician-hospital alignment strategies that seem well-attuned to the special circumstances of the environment can fall short of their objectives or fail. Identifying and planning around critical success factors can help minimize the downside risks. Here are 10 common critical success factors, which should be tailored to meet the unique circumstances of each organization.

1. Common Vision: Physicians and hospital must have a shared understanding of objectives. Among other objec-

tives, the two parties must know how enhanced alignment will be mutually beneficial, as well as the “opportunity cost” of not aligning.

2. Clear Goals: Before formulating an alignment strategy or drawing joint venture diagrams, both hospitals and physicians need to set a clear goal for the actual alignment—whether that goal is as narrow as improved access to clinical trials or as broad as the building of a new cancer center.

3. Tailored to Fit: If you opt for a hybrid or new strategy, focus on creating a “win-win” alignment for the targeted physicians and the hospital and avoid using an “as-is” approach by merely adopting a plan that was successful for another organization.

4. Clear Structure: Be certain that the alignment plan outlines a clear structure—including responsibilities and the flow of funds—that all of the participants understand.

5. Accountability: Incorporate a mechanism for accountability related to financial performance, clinical quality, productivity, customer service, and other criteria, as appropriate.

6. Flexibility: Include the option to expand participants and change (unwind or revise) the structure of the alignment at a later point.

7. Legal and Regulatory Issues: The alignment approach should be consistent with Stark, Medicare Fraud and Abuse, and all other regulatory guidelines.

8. Designated Physician Leader: Identify a designated physician leader for alignment activities. The hospital can assist with training as needed.

9. Specific Performance Outcomes: Identify specific performance outcomes (i.e., clinical, operational, financial) for both parties—physicians and hospital.

10. Management Talent: Ensure that individuals who have a successful track record designing and implementing physician alignment are part of the team addressing the strategy. This could be an individual within the hospital’s management team or an outside consultant.

Whether a cancer center is freestanding or affiliated with a hospital, effective alignment of the physicians and the hospital is a necessity for optimizing the oncology program’s operating performance and profitable growth. While a multitude of operational steps are part of selecting the best approach and designing and implementing the tactics, successful alignment begins with a careful consideration of how physician alignment fits with and supports the broader strategy of the hospital and all of its constituents. ■

Mark J. Dubow, MSPH, MBA, is a vice president with The Camden Group, El Segundo, Calif., a national healthcare consulting company that provides strategic, operational, financial and other services to hospitals, physician organizations, and health plans.