Making the Move to a Multispecialty Oncology Practice

Developments in cancer diagnosis and treatment have led many medical oncology groups to consider adding radiation oncologists and other specialists to their practices, either as individuals or by way of merging with another group. For example, chemotherapy and radiation therapy are often carried out concurrently. The availability of both modalities in one location or through one group can improve communication between the two specialist disciplines, enhance patient convenience, and better facilitate treatment planning.

Successfully adding other specialists is a process that takes time. It starts with carefully evaluating the feasibility, followed by identifying suitable candidates, and finally managing group needs.

Making the Multispecialty Decision

The process starts with clearly defining the goals of the project. Having multiple specialties in one group can improve patient

care in several ways. Before forming Integrated Community Oncology Network, based in Jacksonville, FL, through a merger of Florida Radiation Oncology Group and Florida Oncology Associates, Thomas A. Marsland, MD, and his medical oncology colleagues sent their patients to an insurance-preferred diagnostic imaging facility. “The reports we received often lacked information we would have found meaningful in planning therapy,” says Marsland. “Having radiation oncology in the group and

our own equipment improves the quality because the same radiologists, who know what we need, are carrying out the imaging with the same equipment for every patient.”

Patient access to care and coordination of that care can be improved as well. At Greenebaum Cancer Center, University of Maryland, Baltimore, MD, oncologist Naimish Pandya, MD, is a member of the multidisciplinary gastrointestinal team. “If a gastroenterologist performs a colonoscopy and finds a malignancy,” says Pandya, “the patient can immediately be scheduled to see a surgeon.” All team members are involved in planning the patient’s care, which speeds communication and gives patients the benefit of the group’s collective wisdom.

For the medical oncologists at Albuquerque, NM-based New Mexico Oncology Hematology Consultants Ltd (NMOHC), the primary goal was to improve the quality of patient care. About a decade ago, the group was dissatisfied

with the providers of radiation medicine in their market. “Other institutions were content to send their patients to these existing facilities with old equipment,” says Barbara L. McAneny, MD, CEO. “We talked with them about upgrading their equipment, but they weren’t interested. We then started looking at providing radiation medicine services through our group.”

Many medical oncology groups also have financial goals for the addition, which can bring new revenue streams into a practice. In the case of a merger between two or more groups, the new group may have a major portion of market share, giving it a stronger negotiating position with health plans and ancillary service providers.

With its goals defined, the group needs to turn its attention to the impact of the addition on the practice. McAneny suggests visiting an existing multispecialty practice outside the group’s market to gain a deeper understanding of just what to expect. Among the issues to consider are:

Facilities. Is the current office space large enough and appropriate for the new specialist and any additional staff? NMOHC’s decision to add computed tomography and positron emission tomography necessitated building a new office that met the demands of radiation medicine. Also consider whether the existing waiting room and parking lot can accommodate increased numbers of patients.

Equipment. Will the specialist need equipment not currently available in the practice? Can major capital items such as positron emission tomography scanners be shared? How will computers and information technology be provided? If a merger is being planned, how will ownership of equipment and other assets be transferred?

Referral patterns. How will the addition affect current and future referral patterns? “If you recruit an individual specialist,” Marsland notes, “will your competitors get ticked off and not refer patients to you? If you have a significant share of the market, this is less of an issue.”

Staffing. What level and type of staff will another specialist need? Many mergers are driven by the desire to reduce duplicate staff, through consolidation of common functions—billing, human resources, and reception staff—that may be able to be shared or cross-trained. Cross-training

isn't an option, for example, between an oncology nurse and a radiation technologist. In mergers, some realignment of responsibilities and downsizing may occur, but reductions are not inevitable. If the merger is successful, and results in increased business, any excess staff is likely to be absorbed by the increased business.

Governance and management. In a merger, the two groups need to reach consensus about very basic issues, such as: What will the new group be called? Is this a merger of one group into the other or will an entirely new entity (with a new tax identification number) be formed? Will physicians be partners, independent contractors, or employees? How is the group to be governed and by whom? If a group is adding an individual specialist, how will the on-call schedule be handled? Will the new physician have a role in governance and setting policies and procedures?

Legal pitfalls. The Stark law governing referrals, noncompete and antitrust regulations, licensing, and even health plan credentialing all have potential to penalize groups that fail to carry out due diligence, so good legal advice is essential. Practices wanting to add radiation or other capital-intensive equipment may also need to comply with certificate-of-need laws.¹

Finally, the evaluation process should include a strategic plan. As Marsland notes, the groups in a merger "won't be integrated on day 1. Everyone needs to be able to envision what the group will be like in 6 months, 1 year, and longer." The strategic plan of one successfully merged group included the following items²:

- Mission statement and goals
- Market analysis and growth potential
- Cash-flow requirements for the first 18 months
- Five-year financial forecast under various scenarios
- Consolidation plan, including timetable, system integration plans, and contract review
- Committee and governance structures
- Compensation plan during transition period

Finding a Match

Once the decision is made, the task becomes one of finding the best match. Many issues are the same as for adding another medical oncologist. Whether it's a merger partner or an individual physician, sharing common values and goals is essential to long-term success. Among physicians who leave a group, 47% do so within the first 3 years, and cultural fit is a major reason.³ It can take 18 to 24 months for a new physician's total income to equal the expense of hiring him or her,⁴ so a lot is riding on getting a good fit.

When the addition involves another specialty, a complex activity becomes even more complex. Differing specialties often have differing expense and revenue profiles. When NMOHC decided to add radiation oncology, much of the

medical oncologists' initial apprehension centered on finances, admits McAneny. "Radiation medicine has very high expenses, but the revenues from Medicare and other payers are much higher than for medical oncology." The group decided to share expenses and revenues among all the physicians and set up a base salary plus a productivity bonus compensation plan.

Practices that want to add an individual specialist can identify candidates by asking colleagues, telling local hospital administrators and in-house physician recruiters, and contacting residency programs. The specialty's professional association may offer member placement services, publication advertising, and conferences that provide opportunities to meet potential candidates. For a fee, the position can be listed on online physician job sites such as ASCO's JCO Career Center (www.careers.jco.org/ASCO/career_center.html) and PracticeLink (www.practicelink.com). Merger partners are likely to come from within the group's current colleagues—a group to which the group is currently referring patients, for example, or with whom partners have served on hospital committees.

All parties should take enough time to clarify their expectations. During the many months needed to complete a merger, for example, all physicians should meet frequently to discuss everything from committee structure to dissolution procedures. The strategic plan should be discussed in detail, consensus reached among all physicians, and revisions made, if necessary. Individual candidates should undergo an equally rigorous interview process, as with any new associate.^{3,5} Both parties should understand what is needed and expected, what both bring to the relationship, and what each party values in medicine.

Making It Work

Creating a multispecialty group has substantial rewards . . . and challenges. One challenge is finding ways for all physicians to have a voice in practice governance. With 56 physicians, for example, Integrated Community Oncology Network board meetings simply cannot be open as they once were, an issue "we are always struggling with," admits Marsland. Three medical oncologists and three radiation oncologists comprise the board, and major decisions require their unanimous support. Junior-level physicians are encouraged to approach the senior partners on the board with concerns and opinions. The group also holds regular meetings at each site with all doctors and keeps everyone informed with frequent e-mails.

Another challenge is to achieve true integration into one practice. Physicians must focus on the interests of the group, not of their specialty. Staff must be kept fully informed when additions are being planned, must be involved in operational decision making on an ongoing basis, and when necessary, should be reminded of the patient benefits

of multispecialization. “We work hard at getting everyone—staff and physicians—to think of this as one practice,” says McAneny. “We want camaraderie, not competition. Everyone does a specialized job in this practice, but no one feels more special than the others.”

When individual specialists are added, they may not have much experience working in a group. They should be assigned a mentor to explain how the practice operates and to model the desired group behavior, including showing respect for all practice members, accepting and supporting group decisions, and avoiding public criticism of the group.⁶ As with any new associate, they should be introduced to staff and colleagues and assisted with administrative tasks (eg, applying for licensing and hospital privileges). Assistance to locate housing, to register children in schools, and to introduce the family to the community should be offered. Performance feedback should occur within the first couple of months and often for the first year, with opportunities for the associate also to provide feedback.

The more experience everyone has working in a group, the more effective decision making is. “When a case is discussed, everyone has input and then collectively comes to a decision,” says Pandya. In addition, in a university setting such as that

of Greenebaum Cancer Center, learning is an ever-present element, so when multiple recommendations for a patient’s care are being discussed, a common question is “What is the evidence in support of the recommendation?” If the evidence supports two or more treatments equally, the care plan may incorporate a long-term strategy that applies first one therapy, then, if necessary, the second one.

A similar strategy can be applied even to decisions about costly practice purchases. When the radiation oncologists with NMOHC disagreed over which of two expensive new devices to recommend, the physicians were asked to present to the medical oncologists, describing how each device worked, what the outcome data indicated, and how patients would benefit. McAneny compiled relevant financial data and merged it with the clinical data, enabling the board to make a fully informed decision everyone could support.

For those who have successfully built multispecialty practices, these and other challenges are more than offset by the benefits to patients.

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References

1. Diagnostic imaging in community practice. *J Oncol Pract* 2:113–115, 2006
2. Wilkins HJ, Pierotti RJ, Motley RJ, et al: Developing a successful medical group. *Fam Pract Manag* 6:27–31, 1999
3. Valancy J: Recruiting and retaining the right physicians. *Fam Pract Manag* 14:28–33, 2007
4. Weiss GG: Group practice: How to keep the new guy. *Med Econ* 83:36–38, 40, 2006
5. The interview: Make it work for you. *J Oncol Pract* 2:252–254, 2006
6. Cincotta JA: Developing “groupthink” in a multispecialty group. *Fam Pract Manag* 6:45–47, 1999

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