Practice-hospital partnerships: a marriage made for patients

By Leah and Patrick Young

Can community oncologists merge with a comprehensive cancer center without getting swallowed up? When a New Hampshire practice partnered with Dana-Farber Cancer Institute, the result was a strengthened private practice able to offer more to its patients while retaining its grass-roots culture.

A pioneering effort is taking place to marry community oncology practices to major academic cancer research centers. In the forefront of this new trend is New Hampshire Oncology Hematology (NHOH)—a community practice for more than 30 years with five New Hampshire locations—and Boston's Dana-Farber Cancer Institute, a National Cancer Institute (NCI)-designated comprehensive cancer center. The partnership culminates a 20-year relationship between the two.

"This is a unique opportunity to do something different and new with a partner that is unparalleled," said Frederick M. Briccetti, MD, medical oncologist, vice president of NHOH, and one of two NHOH physicians on the steering committee that engineered the planned new facility in Londonderry, New Hampshire. Dr. Briccetti explained that oncologists at NHOH hope that creating this joint site, planned to open in December 2008, "will improve actual outcomes." The merged site will bring, on a regular basis, specialists in particular cancers from Dana-Farber to Londonderry and provide second opinions in the community.

The partnership, which will be Dana-Farber's first foray outside Massachusetts, will preserve the community oncology culture and bring resources to it, says Lawrence N. Shulman, MD, chief medical officer and senior vice president for medical affairs and chief of the division of general oncology, at Dana-Farber. "This is not the big fish eating the little fish."

Dr. Shulman explains that the new facility will benefit both sides. It will enhance patient care by providing to the New Hampshire unit high-risk genetic counseling, the Dana-Farber cancer survivorship program, and pain and palliative care specialists. The facility, which will be managed by Dana-Farber, will also bring "a robust clinical trials infrastructure in the Londonderry office," he says. Specialists from Dana-Farber will work there as well.

Partnering with NHOH is one of Dana-Farber's responses to a longstanding NCI initiative designed to encourage the transfer of knowledge, resources, and care from the academic medical centers into community practices. This becomes especially important as the pace of research and new treatment options accelerates.

Dr. Shulman notes that expanding outside Boston will help ease Dana-Farber's space constraints. "If we can move some of our care to communities, we will benefit the communities and ease our space problems at the same time," he said.

Innovation plus

"It's very impressive that both sides were able to get to the table," says Teri U. Guidi, president and CEO of Oncology Management Consulting Group. "This is an innovative move and it's remarkable that they pulled it off." Ms. Guidi indicated she was not aware of similar arrangements being negotiated. There may be practices and large medical institutions having in-house conversations, she added, but they are not at a stage where they would go public. This sort of partnership "holds tremendous promise," she says.

Ronald Barkley, an attorney and healthcare administrator who was executive director of NHOH during the formation of the partnership, explained that the practice could obtain management resources from the joint site appli-

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cable to its other sites. "The practice does not have electronic medical records, but this new site will open with paperless records. This provides an opportunity to have an operational infrastructure from day one." Once the staff is comfortable with the new technology, he said, NHOH may want to "backfill system-wide using Dana-Farber's electronic medical records or some commercial application that might be out there. This is a chance to see what will work for us."

Mr. Barkley pointed out that an earlier collaboration with Dana-Farber to create educational programs for primary care physicians and spiritual advisors and to work together on some cancer trials put NHOH in a position to be one of few community test sites for the Lance Armstrong Foundation survivorship program. It would be difficult for a community oncology practice to bear the expense of this program on its own and to launch other programs such as educating primary care physicians to monitor patients who are no longer in cancer treatment, he added. "Better follow-up for survivorship is costly to develop, define, and implement," Dr. Briccetti explained. But at the joint site, such post-treatment care will be integrated into the process and later extended to NHOH's other sites, he said.

Dr. Briccetti noted that NHOH's past collaborations with Dana-Farber included bringing genetic counseling to two of their five sites, and NHOH is hoping that other programs developed by Dana-Farber will also "overflow to our other clinics." He emphasized that "no community oncology center has the depth of a major medical center like Dana-Farber."

With the Dana-Farber presence, there will also be a mental health counselor on site as well as end-of-life care, Reiki (a Japanese stress reduction and healing technique), and massage therapy to address the mind and spirit of the patient. It would be costly for a community oncology practice to offer these complementary therapies on its own, he added. The Londonderry site will also offer the services of nutritionists, social workers, and patient advocates, among others.

Culture clashes and other negotiating pitfalls

NEGOTIATING A PARTNERSHIP with a hospital or academic cancer center requires more than due diligence by a community practice. Several people who have participated in the process recommend that a practice look carefully before it leaps.

Before negotiations begin, the physician partners need a clear vision for the practice's future and a strategic plan to achieve it. Moreover, all partners need to fully accept teaming up with a larger institution.

Negotiations require someone on the practice's team with experience in complex medical business transactions, typically a lawyer or consultant. Equally vital is the active participation of practice members. "You really need one or two committed physicians who are going to lead the process," said Frederick M. Briccetti, MD, medical oncologist, vice president of New Hampshire Oncology Hematology (NHOH).

With potential partners identified, the practice needs to explore which one it finds most acceptable. "Interview to the point where you understand culturally and clinically that this is someone you want as your partner," says Ronald Barkley, an attorney and healthcare administrator, and former executive director of NHOH. "Then lock in an arrangement—a letter of intent or some understanding—to explore the partnership in depth."

Failing to successfully mesh two different management and operational cultures can harm an organization. Sorting out differences in style requires detailed but friendly and empathetic discussions about such topics as business goals, personnel policies, and dealing with payer conflicts.

Once negotiations begin, the issues may appear endless. Nonetheless, "it really has to be very clear what each side expects and will, in turn, give to the partnership. And it all needs to be in writing," said practice consultant Teri U. Guidi.

Several broad questions need resolution:

- What does each party expect from the partnership?
- Is the arrangement reasonable for both parties?
- How will it affect each partner overall and various parts of each organization's internal operations?
- Can the partnership deliver an attractive service that fills a need and attracts people from the community?
- Are there some things either side refuses to accept?

"You have to think critically," Dr. Briccetti said, "and get inside the mind of the other party when you are negotiating."

Finally, "there has to be what amounts to a pre-nup," says Ms. Guidi. "If something goes wrong, the parties need to end the partnership without causing collateral damage to the community."

Commuting for care

This collaboration worked for NHOH and Dana-Farber, Mr. Barkley explained, because many patients in southern New Hampshire drive 50 miles to Boston to reach Dana-Farber or other sites for care. But because Dana-Farber is at full capacity in Boston, "we invited Dana-Farber to consider a satellite operation in our market," he said.

The goal for Dana-Farber, Dr. Shulman said, was to open additional centers in cooperation with existing groups of oncologists, not to enter new areas and compete with established practices. At the Londonderry site, Dana-Farber will have the ultimate oversight authority, but it will also be an NHOH facility.

"Physicians in our group will be assigned to the clinic," Dr. Briccetti said, "and we will offer care under the aegis of Dana-Farber." He explained that the new facility will be staffed by employees of both Dana-Farber and NHOH, mostly the latter. The clinic will be governed by a clinical management committee made up of three representatives of NHOH and three from Dana-Farber. But as chief medical officer, Dr. Shulman of Dana-Farber will have ultimate clinical control.

"Our trustees are protective of the Dana-Farber name and reputation," Dr. Shulman said, "so we only partner with oncology centers we feel are excellent and NHOH is an outstanding group." What Dana-Farber wants to do, he said, is to "bring in programs that make care in a center special. We are trying to enhance community oncology treatment."

Making it work

Negotiations to create this partnership took more than 2 years and there are still areas that need to be settled. Dr. Shulman said the two groups started with a general outline. Together they explored how to fund activities, deal with the legal and regulatory issues (since Dana-Farber is an out-of-state medical center), compensate physicians working in the unit, and finance the leasing and capitalization of equipment for the new site. There were also billing and insurance issues; insurance contractual relations are still being worked out.

Along with determining that the joint project would be financially supportable, NHOH and Dana-Farber had to develop a governing system for working together. "We shared risk as well as new responsibilities and duties," Mr. Barkley said.

To make this type of relationship work, all the private practice physicians have to buy into the partnership idea, Dr. Briccetti said, and they need to have an interested partner who respects what the community oncology practice does. To pursue a marriage such as the Dana-Farber–NHOH nuptials, the medical center has to be a partner prepared to work with the community oncologists, and "not impose its will."

Mr. Barkley added that "this is the challenge of the day for practices and medical centers. They need to have a workable joint clinical program." He believes that community oncology practices "need to look to the future and figure out what they should do to be sustainable 3–5 years from now. You need a clear and compelling vision of the future."

A lot of people will be watching closely to see how this partnership works, says Ms. Guidi. "NHOH is a leader in this area. There are not a lot of physician-based practices linking directly with academic centers. Usually it is a community hospital linking with an academic center." Many practices have been acquired, she said, but they have been "essentially owned and managed" by a medical center.

Dr. Briccetti does not envision the combined practice in Londonderry pulling patients from NHOH's five other centers, because he does not believe that people want to drive 35 or 40 miles for care that is available in their communities. However, patients seeking a second opinion might drive from Concord to Londonderry rather than all the way to Boston.

One of his patients, John Michels, an attorney, agrees with Dr. Briccetti. He says that when he consulted with Dana-Farber about his chronic lymphocytic leukemia, he talked to clinicians there about possible clinical trials. But Mr. Michels did not want to give up an entire day to travel regularly to Boston. People who need treatment that takes place over several days could lose weeks of time that employers might not be willing to give, he points out. And if the cancer patient needs to rely on, say, a family member to drive him or her to appointments, the caregiver must also take time off work as well. Dana-Farber, he said, "is first-class care. Why shouldn't we have it up here in a community practice?"

Dr. Briccetti can be reached at f.briccetti@nhoh.com. Dr. Shulman can be reached at Lawrence_shulman@dfci.harvard.edu.