Aligning Your Cancer Clinical Strategy Will Pay Dividends *Today* and *Tomorrow*

Is your health system ready for the future of cancer care?

Cancer is one of the most complex diseases a patient can encounter. Diagnosis through treatment, as well as through to survivorship, requires an enormous amount of health care resources. In the US, the economic burden of cancer is estimated at 1.8% of GDP [1] with annual costs at $208.9 billion in 2020. [2] This will continue into the foreseeable future, with all cancer combined incidence volume expected to increase 14% over the next ten years. [3] However, with an increased focus on value-based care, new technologies and therapies, and a focus on care management, the growth for clinical services will largely be seen in the outpatient space, as well as the patient home. With CMS' Enhancing Oncology Model, Pharmacy Benefit Manager reform legislation, CMS' patient navigation reimbursement strategy, increased use of ASCs, home infusion, and hypofractionation—the shift to value (Quality/Cost) in cancer is real.

In the near and long-term, cancer systems will have to manage the migration to value-based payment and care models, while ensuring they stay relevant with current payment models. In many health systems, different parts of the system (academic departments, physician practices, hospital departments, sites of care, etc.) likely have separate, if not competing, clinical strategies. To succeed in these cross currents, it will be imperative to have one deliberate and aligned *system* clinical strategy. This will have them poised for success in a value focused future AND will pay dividends today.

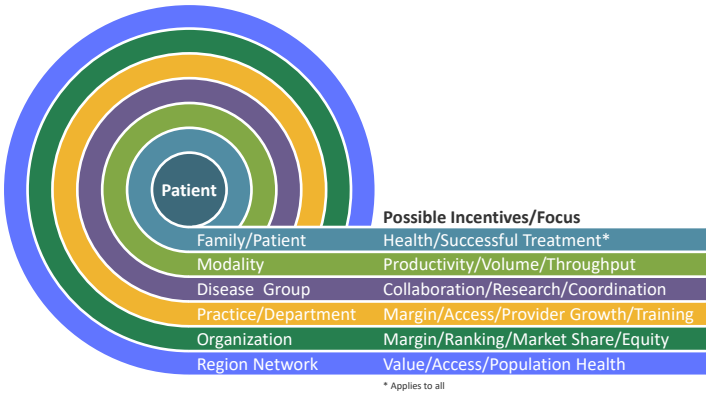
Key Takeaways

- As cancer care reimbursement moves to value-based models in the future, a system-focused clinical strategy is imperative. However, it is also important today.
- A continued focus on patient-centered structures can allow aligned incentives and resources in complex systems, regardless of the reimbursement structure.
- Different health systems require different approaches to clinical strategy. One size does not fit all.
- Taking deliberate steps to align disparate clinical strategies into one system strategy can increase your system margin.

The patient at the center of a system clinical strategy

A cancer patient's experience is often horizontal across the system (across the "silos" of care), while using many vertically aligned health system resources that often have competing incentive structures. With this complexity, the risk of providing care that *decreases* value through reduced quality/patient experience and increased cost is enormous. The most successful cancer systems will focus on drivers of value: coordinated care, shared decision making, evidence-based care paths, and the most appropriate balance of treatment modalities (surgery, chemo, and/or radiation). Regardless of your current progress in the migration to value-based care, a well-coordinated, patient-centered system of care can increase quality of outcomes while decreasing cost. [4] [5] However, it does require a system focus.

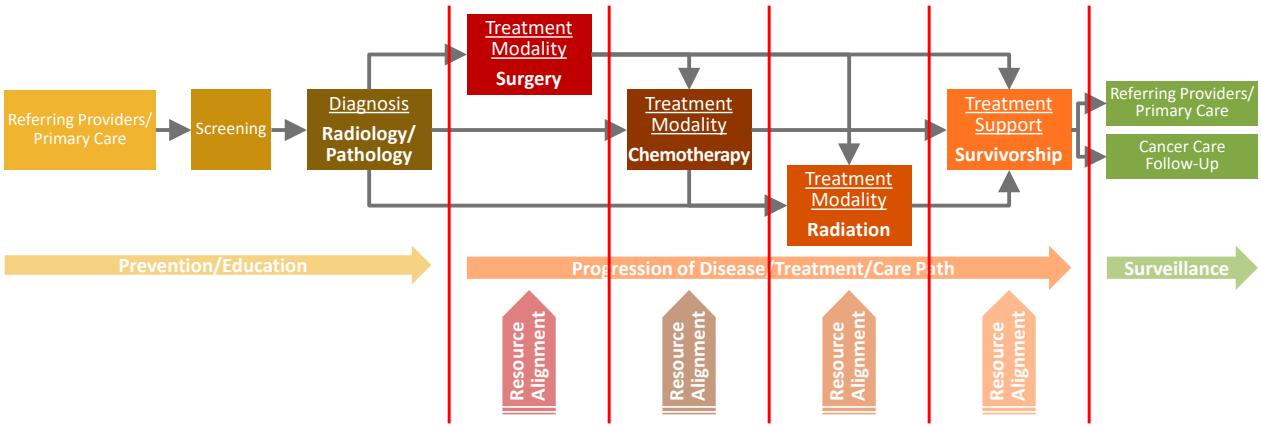
Figure 1. All system structures share the mutual goal of patient success, regardless of their own incentives and financial structure.[6]



As a result of varied goals and measures of success for different parts of the health system, many cancer programs struggle with overarching system alignment of measures, tactics and incentives that contribute to progress towards a shared goal of a positive patient experience and successful treatment. It can be time well spent to gain a deep understanding of the role and focus of each part of your system of care—and how it may contribute to, or detract from, overarching cancer system goals. In this example (Figure 1), the patient is at the center with concentric circles showing the most intimate to the least intimate system structures, with each part of the system having its own incentives and financial structure. However, they all share the mutual goal of patient success.

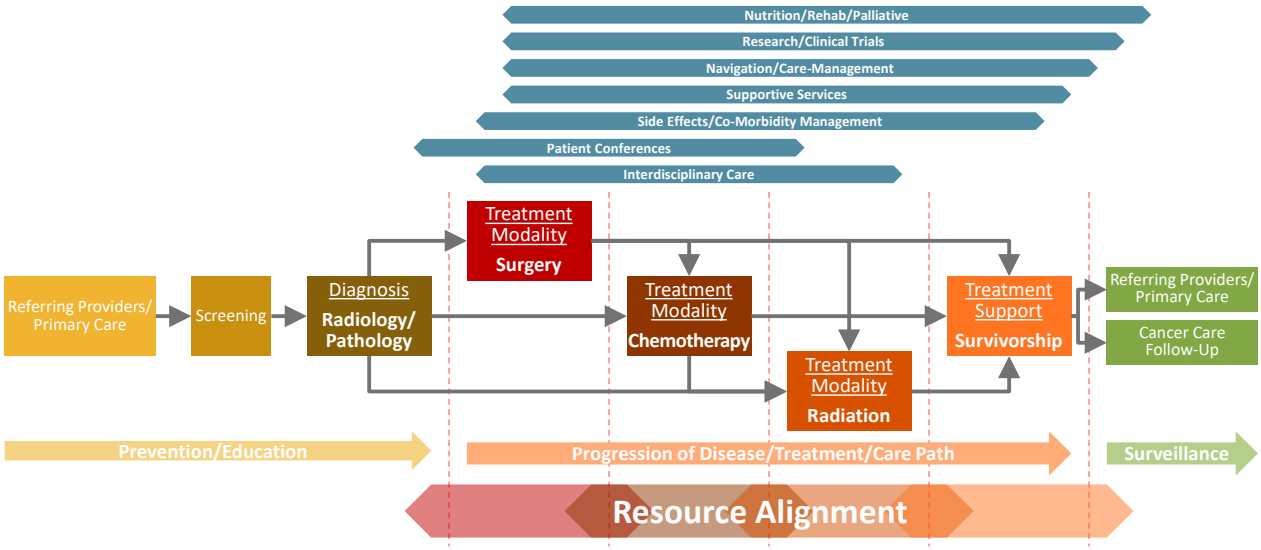
Along the patient care path (Figure 2), there are many opportunities for a patient to "fall through the cracks" between the modality silos and multiple system handoffs. What complicates this further is the vertical alignment of resources by modality business units (divisions, departments, and organizations) each with their own unique structures and incentives.

Figure 2. Note the vertical alignment of modality and support resources.[6]



The mutual goal of patient success can and should be the impetus to create a system clinical strategy, and with this an overarching increased margin today—and alignment for value down the road (Figure 3).

Figure 3. Resources aligned from a cancer program perspective allow for more effective patient care as they progress through the system over time.[6]



Detrimental for the system, but great for the department! Seeing the forest through the trees...

A comprehensive cancer program with a well-established prostate cancer group had a highly efficient "high-risk PSA" clinic that included two urologists that expedited high risk patient referrals and performed same day biopsies with results. Patients with identified cancers moved quickly to treatment. This program had a very high contribution margin from its Surgery and Radiation Oncology components. When one of the two participating urologists left the institution, the Department of Surgery did not send a replacement to the high-risk clinic. Why? Urologists were incented by wRVUs and the Department was incented on that benchmark alone. The results? The *program* volume—and the significant margin—were cut in half in six months.

Clearly this program needed a clinical strategy with a system perspective.

One size does NOT fit all

In many ways, complex cancer systems provide the best opportunity for improvement and a shift towards value—and how your service line is organized will play a critical role in the ability of your system to deliver value. Some examples of cancer service lines include:

ACADEMIC MEDICAL CENTERS (AMCS) AND NATIONAL CANCER INSTITUTE (NCI) DESIGNATED CENTERS
Typically have all components of cancer services, from screening/diagnosis through to survivorship. Usually have an academic and research focused "Institute" with central governance of strategy and clinical care delivery models.

CLINICALLY INTEGRATED/QUALITY NETWORKS
Allows large centers, affiliates, and independent physician groups to align their quality infrastructure, share governance and vision, and share/improve quality/cost metrics.

COMMUNITY CANCER CENTERS
Smaller community/regional cancer programs with lower volumes that treat the most common types of cancer. May focus on some, but not all, treatment modalities and may be reliant on other health systems for other critical care path components.

CENTRALIZED "INSTITUTE" INFRASTRUCTURES
Includes large hospital system networks that rely on central governance of strategy, program development, quality standards, etc., with "local" member hospitals responsible for care delivery.

A COMBINATION OF ALL OR SOME OF THE ABOVE

Just as there are a range of organizational models, a comprehensive ***System Clinical Strategy must be tailored to your situation.***

How have others approached this?

The impacts of a well-developed clinical strategy include: the opportunity for system metrics, quality assurance, reduced volume leakage, improved coordination of care, shared decision making, management of co-morbidities and side-effects, adherence to treatment, reduced (re)admissions rates, and improved access to timely care.

Following are common challenges we see and some examples of the best practices to overcome them:

1 **VARIABLE PROVIDER PHENOTYPES:** Academic and non-academic providers, sub-specialists and generalists, variation in contracts and incentive plans. As more and more AMCs are acquiring, affiliating with, or otherwise partnering with community-based oncology services, it has become imperative for alignment around the clinical management of patient care.

Best practice: City of Hope (COH) has looked to the development of multidisciplinary oncology care pathways as the unifying vehicle for care coordination, evidenced based care, and objective measures of success. "As more community oncology practitioners with practical implementation and local cultural expertise join local, regional, and national networks with experts who maintain the intense, detailed focus in subspecialty areas of oncology care, this combined knowledge and perspective can be shared through standardized decision support oncology pathway tools supplemented with real-time, team-led modifications as new knowledge helps us to achieve better outcomes with less toxicity for patients, regardless of where they live."[7] Through their "Value Realization Project (VRP)," their multi-disciplinary team developed a value framework, each with dedicated resources and improvement projects. Beyond the development of care paths and pathways, they prioritized the enhancement of their system electronic health record to avail pathways to all providers in the system and provide a platform for measurement. VRP efforts have been further enhanced by the integration of AMC and community providers through didactics, tumor-boards, and joint multi-disciplinary clinics. As they continue to measure their efforts, COH is starting to see the positive impact.[7] They are also well positioned for current and evolving payment models.

2 **POOR CLINICAL STRATEGY DEVELOPMENT, ARTICULATION, AND IMPLEMENTATION:** Though often part of one organization, an AMC based cancer service line usually exists in complex matrixed environments. Modalities, divisions, departments, hospital locations, and affiliated practices can all have individual "silo" goals, strategies and incentives that do not align with an overarching cancer system clinical strategy. This can result in no strategy, short-sighted strategy, lack of buy in, lack of needed investments, lack of a practical implementation, reduced overall margins, or a system that is missing key clinical network components.

Best Practice: Duke University Health System (DUHS) and the Duke Cancer Institute (DCI) recognized the need for a system strategy and for the need for increased alignment for cancer care by disease site across the system. They engaged in two critical interdependent efforts:

- Strategic planning efforts leveraged existing or to-be-developed governance structures. Accountable to the most senior executive leadership teams, Governance Committees (GCs) that included key stakeholders from all impacted parts of the system worked with the strategy team to prioritize, remove barriers, and gain system alignment for short and long-term goals. GCs then monitored implementation and metrics of success.
- The DCI evolved their individual disease groups to gain system alignment and achieve their goal of a system approach to patient cancer care. Historically, disease groups focused on "main campus" multi-disciplinary treatment efforts. The expanded "Disease Based Integrated Service Line" (DBISL) looks to provide a structure for regional stakeholder participation and for leaders from other critical services along the care path (medical/surgical specialists, imaging, pathology, screening, etc.). Additionally, DBISLs became the partners for strategy implementation, marketing, access, QA, Survivorship, and primary/secondary resource care planning.

3 **POORLY DESIGNED INTER-ENTITY CLINICAL STRATEGIES:** Two competing health systems serving a mutual population had the goal of collaboration related to the cancer population. Each entity brought unique value to the table, one community recognition and some cancer infrastructure, the other NCI level comprehensive cancer care. The organizations entered into a Joint Operating Agreement (JOA) and Revenue Sharing arrangement.

Case Study: While the goals of the well-intended JOA were patient centered, the structure only applied to diagnosed cancer patients that were under treatment. It did not include all sites of care or the cancer related resources along the care path. The narrow guardrails of the JOA did not include developed care paths, EHR solutions, incentives at the provider level, and left key areas in the competitive space (imaging, inpatient, medical specialties, primary care, etc.). The collaboration actually eroded pre-existing provider relationships and created a high level of distrust between the organizations.

Alternatives: Instead of a narrow JOA, the cancer programs may have been better served by the development and implementation of a Clinically Integrated Network. This would have allowed for shared governance of value focused coordination of care between the two entities. Further, the relationship would have been provider led and driven.

About The Innova Group

The Innova Group is a national healthcare consultancy that specializes in strategic, operational, financial, and facility planning. Since 1995, health systems and medical groups have sought our advice on their most difficult strategic and facility planning challenges. More information about our team of professionals and consulting services can be found at **www.theinnovagroup.com**

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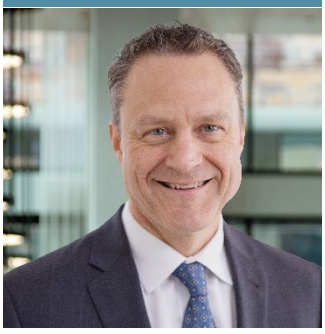

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What are your next steps to develop a system clinical strategy?

- Take inventory of current cancer related clinical strategies and incentives. Are they aligned? Is there an opportunity for one overarching clinical strategy?
- Develop strategies and goals that align cancer services with the health system's strategy and goals.
- Establish specific modality strategic objectives and tactics that align with the system clinical strategy, including, but not limited to: program development, outreach, potential partnerships, facility development, recruitment plans, new access points, etc.
- Create detailed action plans that include an assessment of the strategic, operational, and financial requirements and impact of each tactic on the system as a whole.
- Create key measures of success and monitor the implementation of your system clinical strategy.

In our next article, we will take a deeper dive into the shift to value, from inpatient to outpatient, the evolving payment models related to cancer, and the impact of your clinical strategy.

NEXT: SHIFTS IN TREATMENTS, SITES OF CARE, AND REIMBURSEMENT

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