Everyone is a Cancer Patient

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It’s Time to Think Differently About Your Cancer Care Program.

In the early morning hours of July 28, 2017 Senator John McCain stood before members of Congress and gave the decisive thumbs-down vote on the Affordable Care Act “skinny repeal” — the drama of which was surpassed only by photographs of his face covered in bruises from brain cancer surgery days prior. The Senator’s image was the latest in a long line of “faces” that have defined the war on cancer. American icons like Peter Jennings, John Wayne and Joan Lunden have embodied the cancer cause at one point in history, but none have persisted as the defining image, primarily because the disease needs no help being personalized — the face of cancer is our own.

Cancer is a disease of accumulating genetic copy-paste errors; a Russian roulette of cell division subject to an ever-expanding list of environmental vectors. If given enough time, or a long enough lifespan, everyone will develop a malignancy. In the time it takes you to read this white paper, 20 people in the United States (U.S.) will receive a cancer diagnosis. By the end of the year, 1.6 million more people will have joined them, requiring immediate support from the healthcare ecosystem and forever self-identifying as cancer patients. Despite groundbreaking advancements and our best collective effort, a quarter of annual U.S. deaths will be caused by cancer, topping the list of mortality causes in 22 states. The overwhelming odds are that these statistics will eventually claim our families and friends. Their journeys will become our own, and the entirety of cancer’s emotional and financial burden will be shouldered as a society.

In a sense, we are all cancer patients.
As healthcare organizations, how do we respond to this reality?

A strategy for exceptional cancer care delivery begins with internalizing that the objective is not just about producing lasting remissions but also optimizing the total welfare of the cancer patient population. Brigham and Women's Hospital surgeon Atul Gawande, MD, illustrates this poignantly, writing:

“We’ve been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive. Those reasons matter not just at the end of life, or when debility comes, but all along the way.”

The job of the healthcare system is to elevate the dialogue around oncology to a strategy focused on well-being. To do so requires challenging traditional paradigms and recognizing that cancer care extends far beyond the windows of active treatment. If every patient is a cancer patient, then providers are charged with the well-being of the previvors at heightened risk of cancer, those diagnosed or under treatment, the families and loved ones of patients, and the 15.1 million Americans actively living with the ever present history of cancer. Designing the systems and onco-economics to manage the well-being of these groups will be the defining healthcare challenge of this decade.

In this white paper we offer perspectives on what hospitals and integrated delivery networks can do to foster exceptional cancer care. These reflections include three domains that will challenge your organization to:

1. **Rethink what you know about cancer care.**
   
   Our experience across the country suggests that oncology’s best practices are poorly understood and are largely, as the Institute of Medicine describes them, a “system in crisis.”

2. **Manage oncology like it is your only business.**
   
   Expert cancer acumen and execution will be a prerequisite to organizational success in the next decade. The days of dotted lines and fragmented cancer business architecture are over.

3. **Know your cancer customer.**
   
   Consumerism is on the rise in oncology, and specialization, speed and experience are paramount. Successful delivery requires an understanding of the psychology of cancer customers.
Rethink What You Know

The first hurdle in cancer strategy is challenging legacy ideas and frameworks. The science and delivery models for oncology evolve faster than most organizations can keep up with, and we tend to find leadership married to a few of the following ideas:

Cancer Is One Disease

It is tempting in planning to reduce cancer to one affliction. In reality, the National Cancer Institute (NCI) identifies more than 100 different types of cancer — each requiring a nuanced clinical approach. The landscape is further complicated by the hundreds of genomic signatures disrupting the taxonomy of cancer. In the very near future we may not be talking about “colorectal” or “endometrial” cancer programs, and instead may be organizing around molecular groups like “MSI-H/dMMR tumors.” Already the FDA is approving organ-agnostic immunotherapies, such as KEYTRUDA® (pembrolizumab), which rely on molecular biomarkers. When every tumor is understood as truly unique, consumers will expect cancer programs to deliver more than a slogan related to precision medicine. We encourage our clients to make specialization and personalization key pillars in any forward thinking cancer plan.

Everyone Flies To Houston

We commonly hear “the majority of our patients out-migrate to (fill in the blank) NCI Cancer Center.” Our experience suggests most health systems within a one hour drive of an NCI center lose less than 20 percent of cancer cases to these organizations. Even in urban areas like Chicago, Miami and Atlanta, we find non-academic health systems successfully competing directly with NCI programs. For the past two decades, a confluence of dynamics has pushed higher-end cancer capabilities into the community setting. These include the migration of surgical subspecialists into community practice, NCI support for community cancer excellence through programs like the NCI Community Oncology Research Program (NCORP), and the scale achieved through consolidation of hospitals and populations. This shift has forged new paradigms — like McLaren Health Care’s merger with NCI-designated Barbara Ann Karmanos Cancer Institute — and a host of models aimed at harmonizing the value of NCI research, teaching and clinical competencies with community scale and capabilities, e.g., MD Anderson Cancer Network.

Acquisition = Vision

More than 750 medical oncology practices were acquired during the past eight years — a function of physicians seeking refuge from a challenging reimbursement environment and health systems capitalizing on 340B drug purchasing and commercial rate arbitrage. In some cases these transactions represented the entirety of a cancer program’s strategy, and predictably, patient care and caseload growth did not materially improve. Other health systems sought medical oncology alignment within the context of a comprehensive vision for cancer delivery and invested with their new physician partners in meaningful program building. While both took a critical step toward integrated delivery, these two types of organizations have ended up miles apart in program excellence.
Baptist Health South Florida is one of the organizations that got it right, integrating a large oncology practice in 2015 as part of a broader $400 million commitment to cancer care through its newly-opened Miami Cancer Institute. The oncologists were enlisted in building the core foundation of a destination institute through multi-disciplinary clinics, advanced clinical research and subspecialized tumor-site centers of excellence. This commitment extended beyond medical oncology and permeated the entire medical group. The organization focused on creating and communicating compelling value to referring physicians, eliminating any need to worry about referral “leakage.” Baptist’s success is a hallmark of what can be achieved when hospitals and their oncology partners team up for a vision bigger than themselves and build quality destination programs.

Manage Oncology Like It’s Your Only Business

How would you approach cancer differently if it were your only business? This thought exercise produces interesting answers in our conversations with healthcare executives:

“We’d probably need someone with more executive experience managing it ...”

“The care experience would be more efficient ...”

“I have no idea what we spend, or whether it’s profitable ...”

“We’d probably go out of business ...”

Given the breadth of cancer and its subtypes, it should be no surprise that it is managed in a fractured manner in most systems. Diagnostics, surgery, infusion, radiation and a host of other services often sit in different cost centers across multiple hospitals — tiny fiefdoms attempting to produce a cohesive and viable business in oncology. Organizing a business architecture around this heterogeneity is challenging, but best practice models abound for governance, financial management and cancer care delivery.
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When Inova Health System made the commitment to develop the Inova Schar Cancer Institute it elevated the caliber of administrative and clinical leadership, empowering a VP of Oncology, who later became CEO of two of its hospitals, and recruiting a medical director from NCI-designated Roswell Park Cancer Institute. High caliber leadership was the first signal to the organization – and to northern Virginia – that Inova was making a serious movement in the cancer care space.

Financial Management

Health systems with aligned medical and radiation oncology typically see approximately $20,000 in contribution margin for every new cancer case. The importance of this margin to the overall financial health of the hospital is self-evident as programs gather 1,000, 3,000 or 5,000 cases. Oncology economics are seldom appreciated because most providers do not manage a global budget for cancer. Assembling the total inpatient and outpatient financials is a first-of-its-kind analysis for many of our clients. Once measured, the optimization of a cancer program budget is a high wire act. Success demands balancing business objectives in a volatile reimbursement landscape, with high spend pharmaceuticals and an ever-changing ruleset on site neutral payments and 340B policy. It requires proficiency in joint ventures, professional services agreements and clinical co-management to capitalize on partnerships. With slimming margins elsewhere, cancer contribution must be expertly monitored, measured and continually optimized.

ONCO-ECONOMICS 101

Population
500,000 People

Financials
+$130M Net Revenue
+$45M Contribution Margin

Cancer
+2,250 Annual New Cancers
+19,000 Living with Cancer
+7.0 Medical Oncologists
+4.0 Radiation Oncologists
Delivery Design

Best practice programs have learned that maximizing the well-being of patients requires minimizing the anxiety produced in poorly operated cancer environments. To visit a freestanding cancer hospital like Memorial Sloan Kettering Cancer Center (MSKCC) is to understand how operational excellence minimizes discomfort in a singularly focused business model. The entire workflow for patient intake, registration, clinical work-up, infusion and radiation therapy has been studied and engineered to produce a sense of control for patients in an otherwise chaotic moment of their lives. Providing exceptional cancer care requires this degree of operational commitment and attention to detail. Innovative programs are also increasingly reorienting their space and operations around disease “pods” that allow a cancer patient to see all specialists and supportive care professionals in a single geography entirely devoted to best-practice delivery of their specific cancer type.

Know Your Customer

What Cancer Patients Truly Value

Much has been written in recent years about the emergence of healthcare consumerism. The prevailing thought is that transparency in health cost and outcomes data is eroding information asymmetry, creating an ability for consumers to seek out the highest value in their purchasing decision. However, the cancer consumer requires nuance around this search for “value” as cost is difficult to track, and quality is assessed through proxies like efficiency, accreditation and brand name recognition.

So how do cancer patients assess value through this imperfect lens?

We recommend programs focus on outcomes as a means to value, consistent with tiers developed by Harvard’s Michael Porter.

Tier 1: Survival

Porter’s framework suggests that the cancer consumer’s fundamental priorities are survival and the ability to function normally. In our experience, very few cancer programs advertise survival statistics, instead leaving the consumer to assess the “likelihood of surviving” through a series of surrogates. One of the most effective proxies is sub-specialization. Recent consumer research indicates that “physician specializing in my cancer” ranks #1 in the purchasing decision for cancer patients. We routinely advise programs with sufficient scale to start orienting their physicians, programs, facilities and marketing around tumor-specific specialization. Another important proxy is availability of clinical trials, both for the optics and reputational benefit it connotes, as well as for the access to cutting-edge treatment typically reserved for academic medical centers. Historically, less than three percent of cancer patients have been accrued to clinical trials — a number we expect to change dramatically as more programs align their oncologists and delivery models around research. A final survival proxy is reliability — or the ability of the program and its physicians to consistently deliver high-quality outcomes. Our client engagements frequently include
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Tier 2: Utility
The second tier of outcomes is where most cancer programs focus their efforts – minimizing disutility. Disutility refers to elements like delays in diagnosis or treatment, non-value-added steps in care, anxiety or discomfort and clinical complications. A common fallacy in cancer planning is the belief that these elements can be eliminated by building a comprehensive cancer center facility. Co-location of services is important, but we encourage our clients to take a multi-pronged approach to maximizing utility through mechanisms like multi-disciplinary consult environments, same-day appointments, digital health platforms and concierge supportive care. All of these elements require investment. Our experience is that successful cancer programs do not focus on the non-revenue-producing nature of these resources, but rather the disutility that they prevent. Providing exceptional cancer care requires a commitment to the people, processes and places that reduce the burden in a cancer patient’s journey.

Tier 3: Sustainability
The final tier of outcomes features sustainability of life after cancer. Porter’s view is fairly narrow, focusing on cancer recurrence and long-term toxicity. We would challenge your cancer program to expand on that construct and return to the idea of well-being. This means supplementing a durable clinical outcome with the elements that equip a cancer survivor to return to a normal life – be that re-enabling productivity and career aspirations, restoring sexual intimacy with a partner or navigating the financial recovery from a disease that often leads patients perilously close to bankruptcy. This service, popularly called “survivorship,” is an absolute requisite for organizational excellence in cancer care delivery. When appended to best-practice management of the at-risk population, optimized diagnostic and treatment utility and reliable clinical outcomes, survivorship closes a loop of care and provides lasting, sustainable value.

Plan For Exceptional Cancer Care

Articulating A Powerful Cancer Strategy
A plan is required to challenge convention, dedicate expertise and define a value proposition in cancer care. We strongly recommend organizations engage in oncology-specific strategic planning through a process visibly supported by executive leadership, driven by a diverse coalition of physician stakeholders and grounded in data-driven observations. The assembled group should be charged with developing a broadly-endorsed vision and a set of actionable strategies aimed at maximum value creation in each of the key domains for cancer program planning (Figure 1).
This strategy framework has been leveraged in NCI cancer centers like Rutgers Cancer Institute of New Jersey and community health systems like St. Elizabeth Healthcare in northern Kentucky. In both environments, the organizations engaged over 75 clinical and administrative stakeholders and produced ambitious five-year roadmaps for oncology with multi-million dollar requests for cancer programming and capital investment. Their strategies and tactics were highly disease-centric, growth focused and tested with robust financial models tailored to market expectations, reimbursement evolution, and the unique onco-economics of the academic and community environments.
We Are All Cancer Patients.

Taking On the Challenge to Transform Cancer Care

An Organizational and Industry Imperative

During the next decade there will be no distinction between healthcare delivery excellence and cancer care delivery excellence. Maximizing the well-being of the cancer population will require a full marshalling of the knowledge capital, clinical expertise and passion of the organization toward a clear oncology vision and strategy. Successful execution will demand a willingness to free the organization from outdated constructs — most notably that cancer care is confined to a few specialists within four walls of an oncology department. Performance excellence will require running the cancer business as if it were your only business, leveraging the best and brightest in your ecosystem toward incentive alignment, high-touch delivery and astute financial management. The final — and most profound — measure of success will be the degree to which all of this energy and investment can be strategically directed toward optimizing the outcomes and experiences that truly matter to consumers of cancer care.

We move forward into 2018 with the knowledge that cancer will find 1.6 million more faces — each with a story, a family and a list of "reasons to be alive." Some, like Senator McCain, will find themselves in the hallowed halls of Mayo Clinic or Dana-Farber, but the majority will be spread far and wide across a patchwork of community hospitals and health systems. It will be the province of these institutions, big and small, to take on the mantle of exceptional cancer care and the pursuit of well-being.
Sources


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Ryan Langdale is a Principal with The Chartis Group in the Oncology Solutions practice. He has consulted for more than 60 cancer programs, including some of the nation's top health systems. His areas of focus include hospital and health system strategy, delivery network design, and mergers and partnerships. Mr. Langdale's recent work included design of an integrated delivery model for one of the largest health systems in upstate New York; care design for the opening of a $400M cancer center in south Florida; and strategic planning for the affiliation programs at two of the top NCI cancer centers. He is a regular contributor to industry publications, including a recent article “Integrating Cancer Care Isn't Always Easy—But It Brings Results” in Hospital & Health Networks.

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Rhonda Mealer is a Director and Practice Leader with The Chartis Group in the Oncology Solutions practice. She offers more than 30 years of experience assisting healthcare organizations with the alignment of current operations and strategic goals to improve performance and achieve long-term growth. She has helped many organizations reduce costs, improve resource utilization, enhance the patient and physician experience, and provide more efficient, coordinated care through the development of multidisciplinary, tumor-specific programming. Ms. Mealer has facilitated multidisciplinary tumor site teams for more than 60 clients and has facilitated more than 750 meetings helping to implement best practice, improve resource utilization and provide more efficient care.

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Kelley Simpson is a Director with the Chartis Group in the Oncology Solutions practice. Ms. Simpson has a passion for helping hospitals and physicians drive transformative cancer care delivery. Her strategic, analytical, and operational skills and organizational experience enable her to be a catalyst for change with physician enterprise and ambulatory networks. Hospital and oncology executives, faculty practice plan, and medical staff trust Ms. Simpson to work alongside their care teams to enhance oncology service line performance. Her 27 years of experience with the full range of challenges facing community hospitals/health systems and NCI/academic centers allows her to identify high-impact opportunities while mitigating the tendency to problem-solve isolated issues that may not lead to sustainable practices.
About Chartis Oncology Solutions

Chartis Oncology Solutions was established in January 2018 when Oncology Solutions joined The Chartis Group, a comprehensive healthcare advisory and analytics firm. Chartis Oncology Solutions offers preeminent cancer care advisory and analytics services to community hospitals, health systems, NCI-designated and academic cancer programs across the country. With an unparalleled depth of expertise and experience, Chartis Oncology Solutions works collaboratively with healthcare professionals to strategically and operationally implement cancer care programs that enhance patient experience, improve provider performance and impact communities. Oncology Solutions was founded in 1973 as the first firm exclusively dedicated to serving cancer providers. For more information, visit www.oncologysolutions.com.