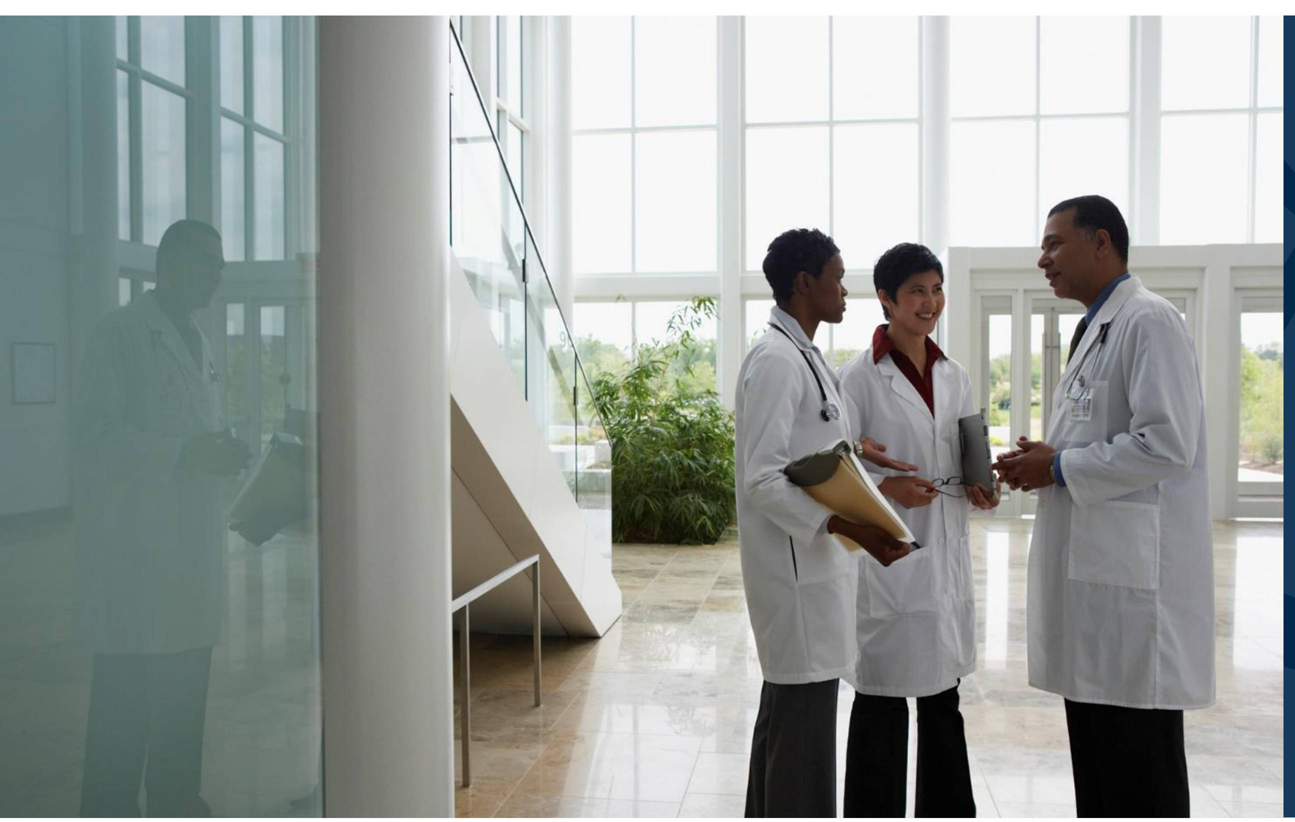

# Delivering Cancer Care in the COVID-19 Era

## Session 3: Imperatives for Oncology Success

Association of Cancer Executives Webinar
June 24, 2020

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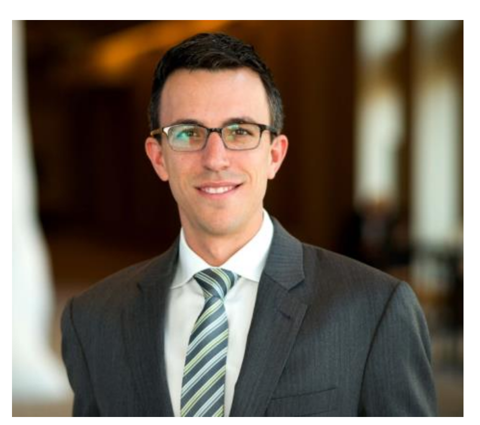
# Delivering Cancer Care in the Covid-19 Era

## Session 3: Imperatives for Health System Success: An Oncology Lens

Wednesday, June 24th | 1:00PM EDT

**Nancy Bookbinder**
*Webinar Moderator*

**Sophie Clamon**
*Practice Manager*
Chartis Oncology Solutions



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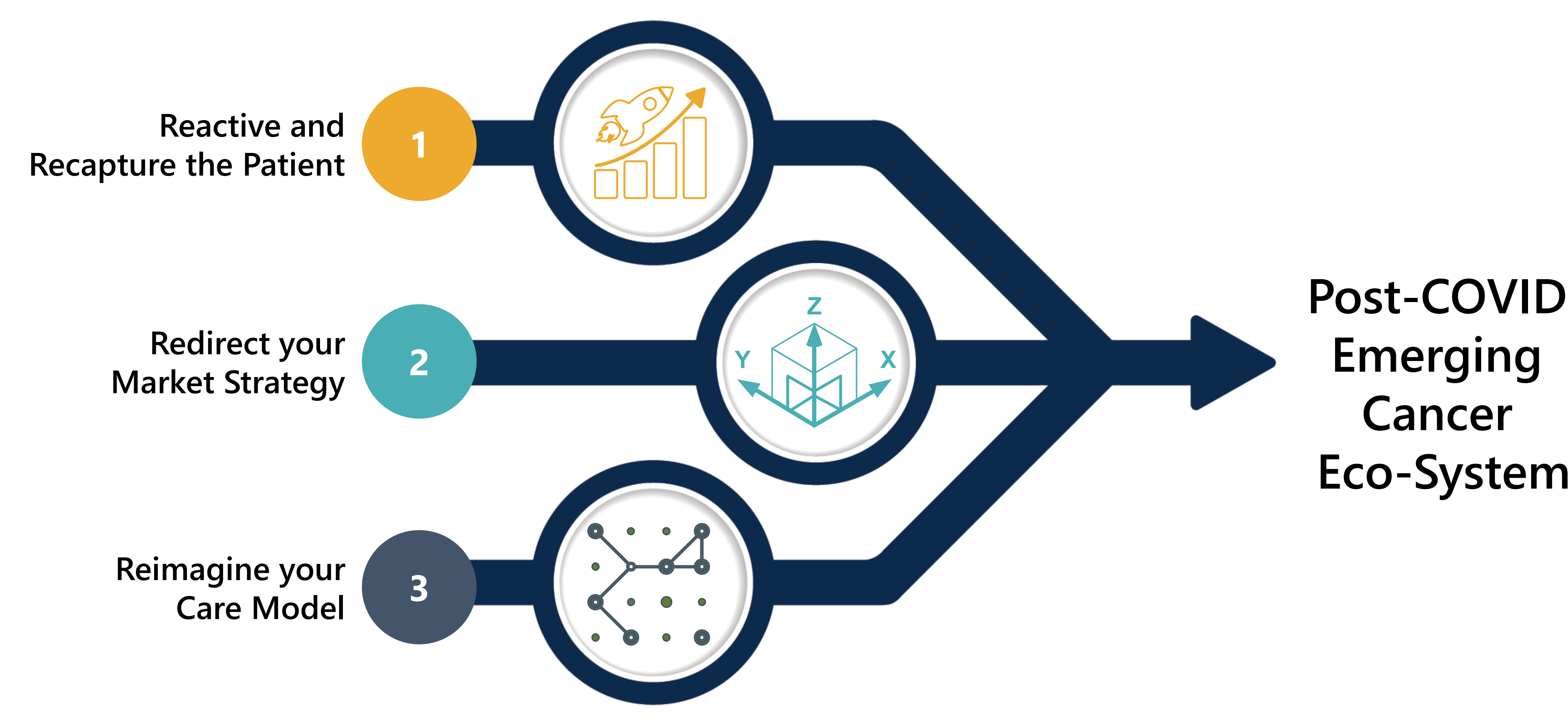
# Delivering Cancer Care in the COVID-19 Era

Imperatives for Oncology Success

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# Imperative 1: Reactive and Recapture the Patient

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# Imperatives: Reactivate & Recapture your Patient

Key Take-Aways

**Reactivation** | Market Positioning | Care Model

| Key Observation | Implications |
|---|---|
| • Cancer care was profoundly disrupted in March-May, in highly localized fashion | 1. Volumes of screening, diagnostics and cancer surgery reduced significantly<br>2. Access disparities aggravated existing disparities in care<br>3. Threats of re-surge make COVID a “new normal” for foreseeable future |
| • Reactivating cancer care is a mission and financial imperative for programs | 1. Reactivation should begin with the screening and surveillance populations – critical to the pipeline for all other cancer services<br>2. The human and financial costs of further delay may be profound |
| • Cancer programs must take ownership of the reactivation response given the diffuse “ownership” of screening and surveillance | 1. Coordination will be critical – and oncology service lines should lead<br>2. Market needs reminder that screening/surveillance are routine for a reason<br>3. Cancer program should lead in process redesign and signaling safety of care environments to the market |

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# Key Context: Disruption

Volumes of screening, diagnostics and cancer surgery reduced significantly

| SCREENING & DIAGNOSTICS | SURGERY | HEM/ONC & INFUSION | RADIATION ONCOLOGY | SURVEILLANCE |
|---|---|---|---|---|
| • **90%** colonoscopy reduction in April<br>• **87%** reduction in mammograms<br>• **39%** decrease in LDCT, 83% in pap smears | • **3-6** month delays for multiple types of cancers<br>• **>20%** of cancer surgery canceled in 50% of sites<br>• **50-70%** canceled in hot spot geographies | • **60%** increase in cancelled clinic visits<br>• 40% decrease in new pt. consults (Feb.> April)<br>• **13%** decrease in chemo infusions | • **43%** of sites report no change to RT volumes<br>• **24%** report < 10% decrease in radiation visits<br>• **15%** report greater than a 10% reduction | • **65%** of programs report significant decline, with some conversion to telehealth<br>• **22M** screens (initial and surveillance) missed H1 20 |
| *Source: IQVIA Institute for Human Data Science* | *Source: Bartlett, et al.. Ann Surg Oncol 27, (2020)* | *Source: OncoEMR® as of April 15, 2020 (54 sites)* | *Source: HCAB survey April 2020 (55 hospitals)* | *Source: IQVIA Institute for Human Data Science* |
| • *>80K fewer cancer diagnoses_expected through June 2020*<br>• *Stage shifts possible for delayed diagnoses* | • *Working through delayed procedures, but requires reactivation of dx pipeline*<br>• *Feeds adjuvant therapies* | • *Infusion a lagging indicator, possible further disruption forthcoming*<br>• *New operating models being tested to reduce exposure* | • *Dependent on the pipeline – may be subject to "delayed impacts"*<br>• *Limited capacity flexibility* | • *Possibility of missing early recurrences/ interventions* |

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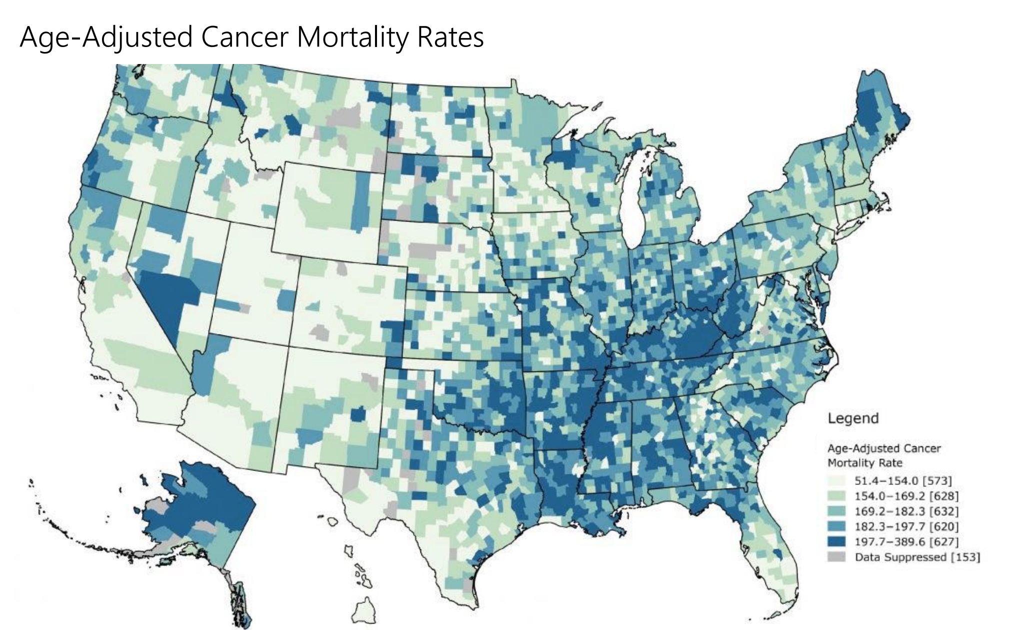
# Key Context: Disparity

Cancer's existing disparities are being compounded by COVID-19

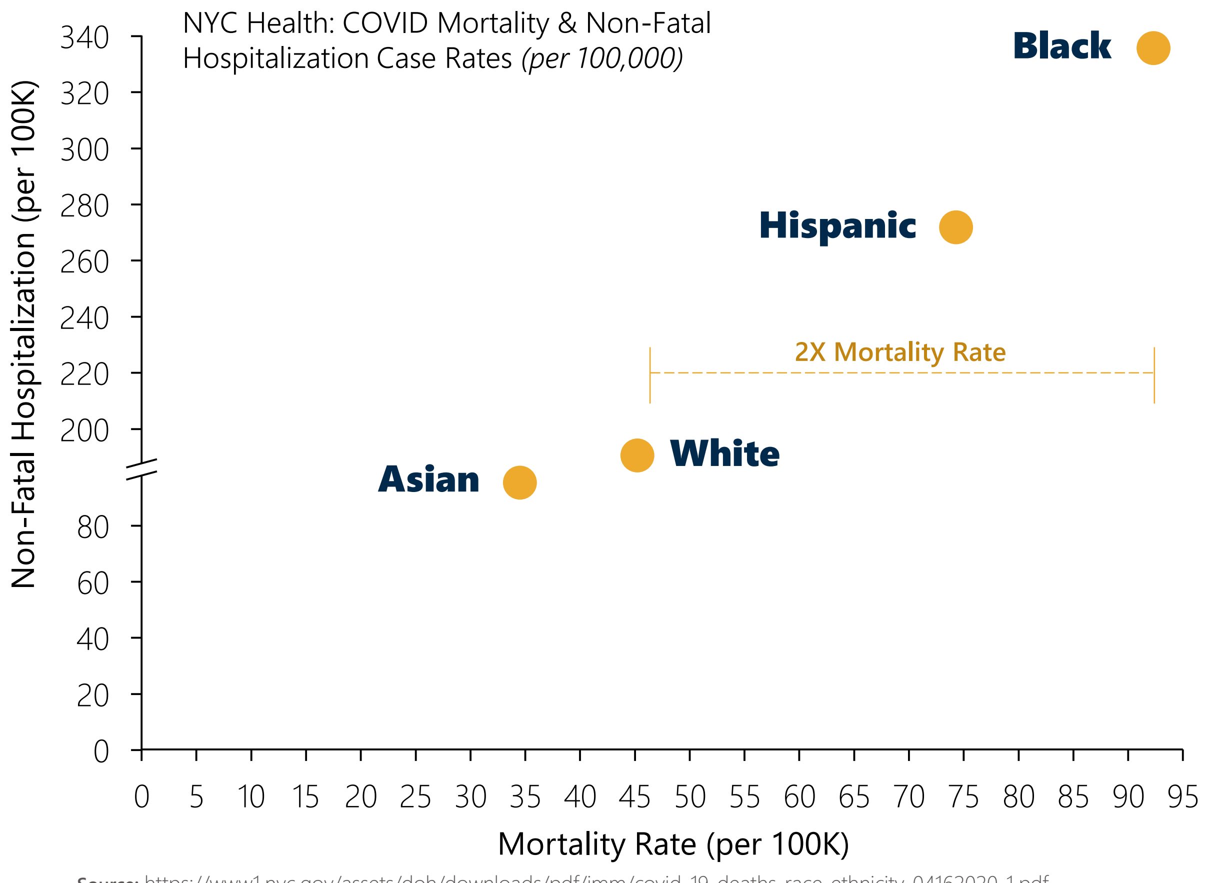
**At its pre-COVID baseline, cancer care was characterized by enormous socio-economic and racial outcome disparity**

Age-Adjusted Cancer Mortality Rates




- Mortality variance directly trackable to socio-economic burden (e.g. income)
- Black men have +8% incidence and **+20% mortality rate** than white men
- Black and Hispanic individuals make up 21-31% of cancer population but only **5-7% of clinical trial** representation

**COVID has exploited existing health care disparities, with mortality rates in some locations 2X higher for black patients than white**




**Source:** Scott LC, Barker. Pop. Health to Evaluate the Environ. Burden of Cancer at County Level. Prev Chronic Dis 2019;16:180530.

**Source:** https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf

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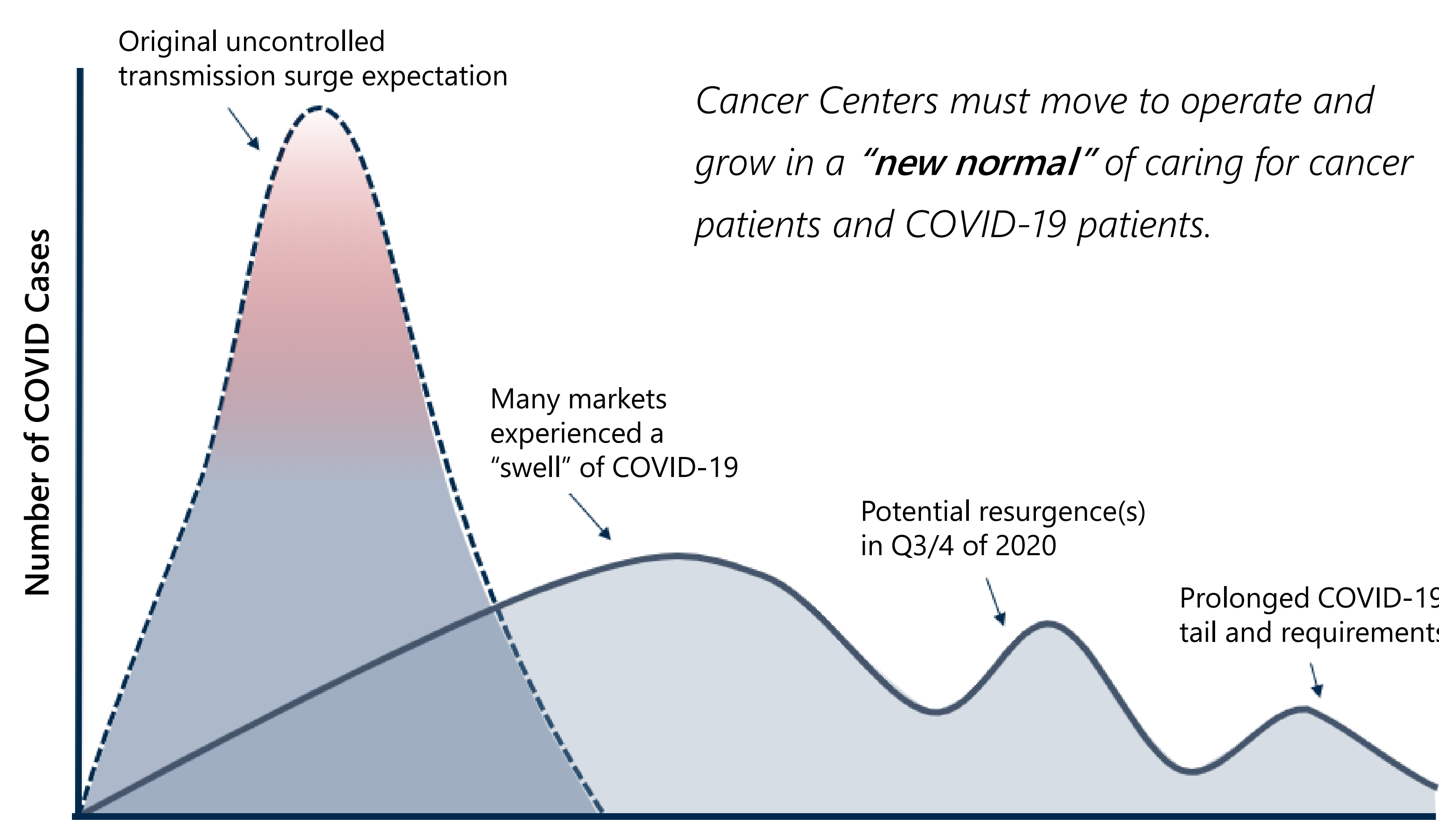
# Key Context: Delay

The COVID experience will likely be our new normal for the foreseeable future

## National Context, Local Implications

- Cancer diagnostics and surgery were significantly disrupted in March/April for COVID-19 surge readiness
- While local cases may have "peaked" in some markets, others continue to set new highs and many expect resurges / prolonged exposure to COVID-19
- "New normal" will require careful navigation for cancer demographic – older, immuno-compromised, high/medium acuity (*2-3x likelihood of mortality from COVID-19 infection*)



# Key Context: Impact of Delay

The human and financial costs of delaying cancer care will be profound

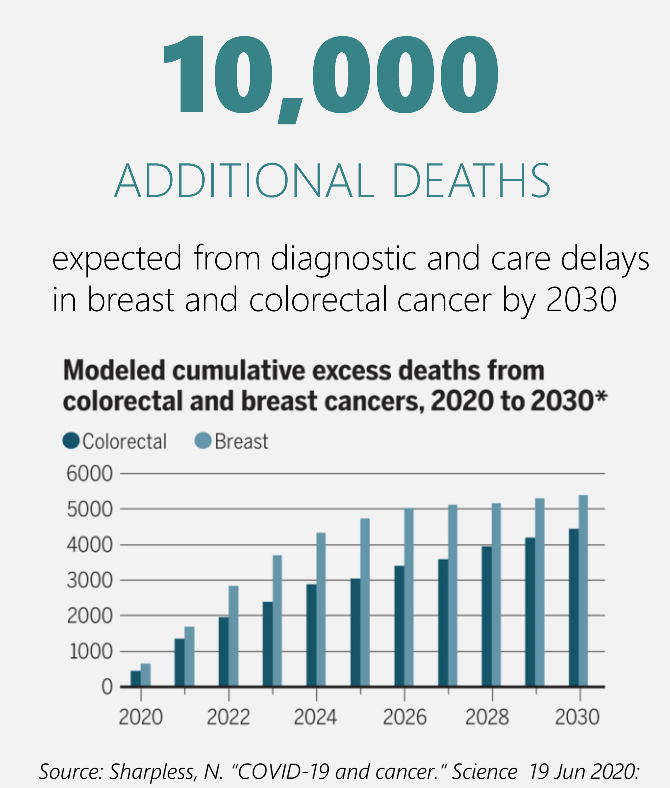
According to the American Cancer Society Cancer Action Network:

**OF PATIENTS**

*experienced delays in their care due to COVID-19 pandemic*

**Impacts**: upstaging, disease progression, dose reductions,

*Source: ACS CAN survey COVID-19 Pandemic Early Effects on Cancer Patients and Survivors: April 2020*




*Source: Sharpless, N. "COVID-19 and cancer." Science 19 Jun 2020:*

Many cancer programs experienced

**30-50%**

**REVENUE CONTRACTION**

from cancer surgery and diagnostic delays, and further postponement may further erode the standard contribution of the oncology service line:

- $15-20K contribution margin per NCC
- 25-40% of health system margin

*Source: Collateral damage: the impact on outcomes from cancer surgery of the COVID-19 pandemic; Annals of Oncology May 19, 2020*

**Time is of the essence** in retooling care processes to encourage patient presentation, allaying fears, and ensuring screening, diagnostics and surgery are not canceled wholesale in new surges of COVID

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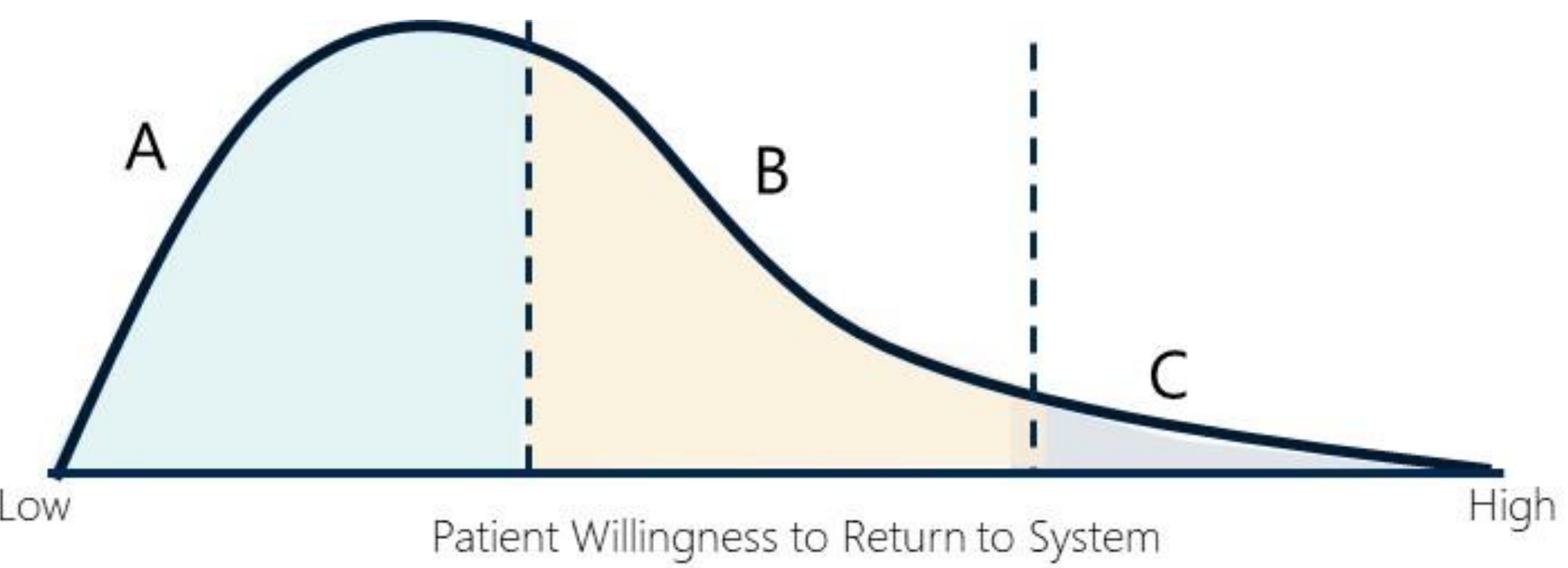
# Reactivate: Prioritize Patient Population

Reactivation begins with the screening and surveillance cohorts – critical pipeline to all other cancer services

| **A. Screening & Long-Term Surveillance** | **B. Recent Survivorship** | **C. Active Treatment** |
|---|---|---|
| • Patients with perceived low-risk (e.g., screening or long term survivorship) who avoid any in-person health care environment<br>• Avoid care due to significant financial or safety concerns | • Large population of established, post-treatment cancer patients being routinely surveilled, imaged, seen for follow-up<br>• Hesitant to return to in-person care; may seek virtual modalities | • Patients with a suspicious finding, ongoing diagnostic work-up, or active cancer treatment plan<br>• Generally eager to return to care/ seek resolution to cancer |

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# Reactivate: Instill Urgency & Lead with Safety

Remind the market that screening and surveillance are routine for a reason, and its safe to visit your environment

## Create Urgency

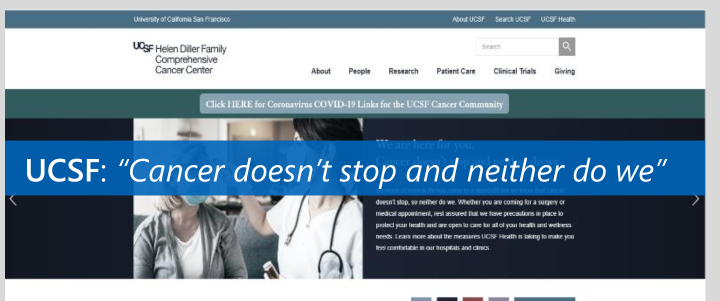
- Prioritize high risk screening programs/ populations and active surveillance
- Contextualize risk of deferred care by disease type and patient subset
- Lean on care coordinators to personalize the conversation
- Reinforce urgency of presentation in all direct pt. and referring communications

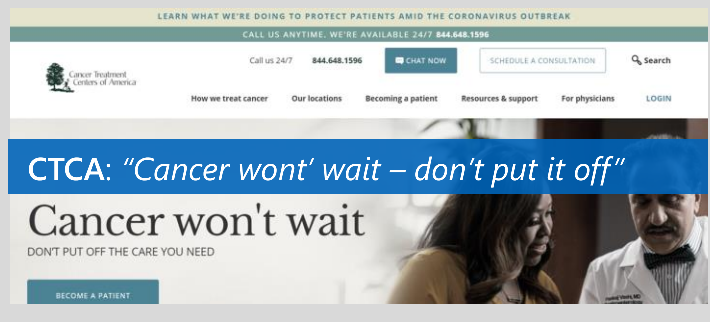
## Sell on Safety

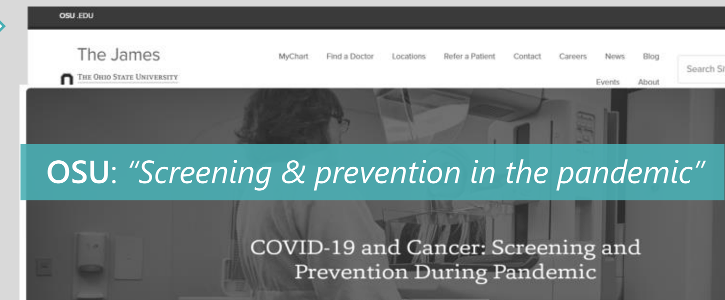
- Universal masking
- COVID testing at start of new courses of treatment
- Reduce throughput to create social distance
- Create one-way foot traffic systems utilizing new exits
- Stagger shifts, utilize extended hours for infusion and radiation therapy

## Start with Screening

- Create outreach plans for each modality – mammo, Pap Smear, LDCT, colonoscopy, PSA testing
- Evaluate delivery network – mobile mammo, decanting busy screening/diagnostic sites





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# Imperative 2: Redirect your Market Strategy

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# Imperatives: Redirect your Market Strategy

Key Take-Aways

Reactivation | **Market Positioning** | Care Model

| Key Observation | Implications |
| --- | --- |
| • COVID accelerated trends that were already reshaping the oncology industry | 1. The industry continues to feel the effects of new entrants, technology/ digital revolution, and an ever-changing policy landscape<br>2. Consolidation in oncology practices has been a persistent force, and further consolidation is inevitable as screening/surgical delays cascade through cancer's sequential value chain to chemo/RT<br>3. Programs have traditionally planned around consumer preference for expertise/ facilities but we may see a mind shift – placing premium on risk avoidance, convenience, and personalized cancer care |
| • Post-COVID market dynamics require a reassessment of legacy market strategies | 1. Systems' financial health and market landscape changes need to be understood – and whether they necessitate an offensive or defensive posture<br>2. New threats of disruption abound and need to be studied/ mitigated<br>3. Fundamental assumptions about how/ where care will be delivered need to be challenged and contextualized relative to current investment plans |

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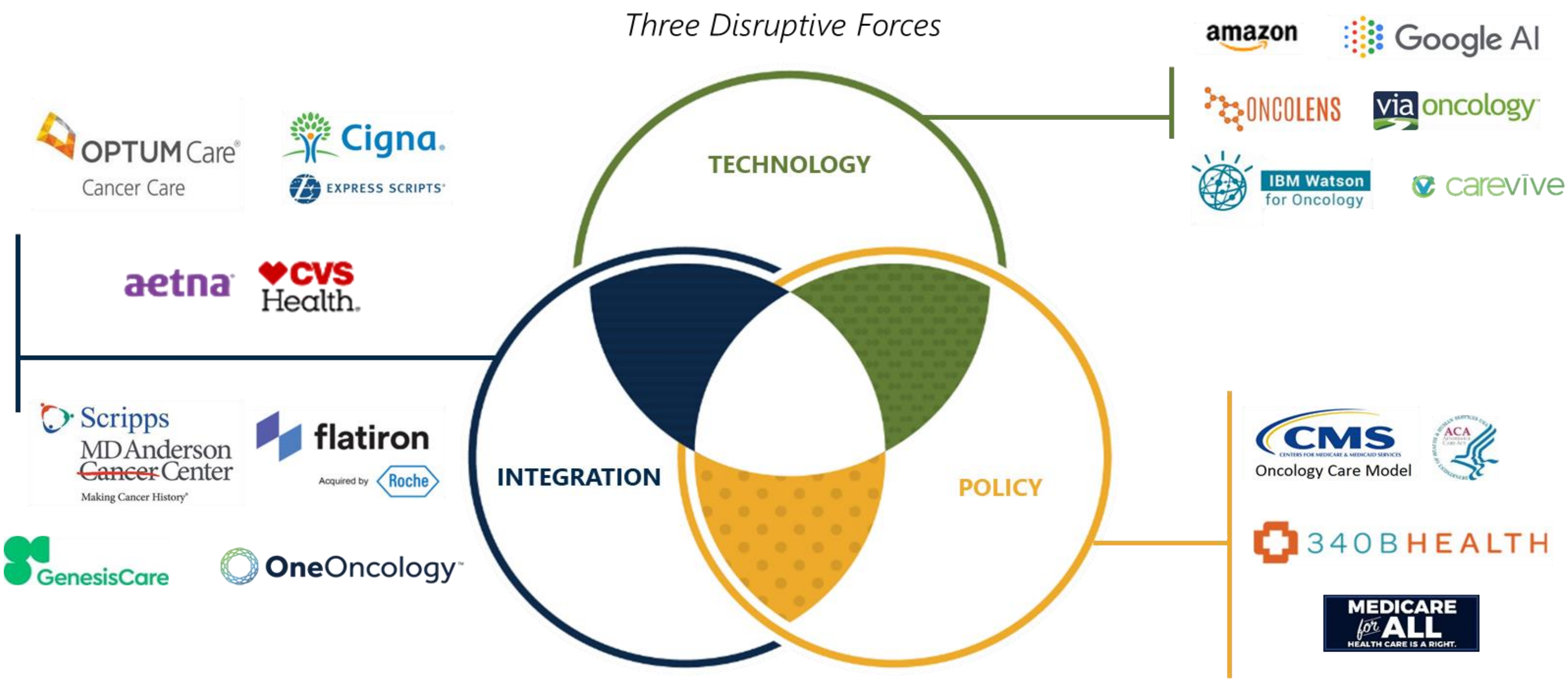
# Redirect: Assess the Market

COVID has introduced new market pressures and demands a reassessment of legacy strategy

Cancer care was experiencing significant **industry disruption** before COVID introduced new complexities




## Legacy model characterized by….

- Constructed around hospital assets and capital
- Predicated on physical distribution model and sequentially discrete cancer value chain
- Focused on horizontal integration

## Emerging model characterized by….

- Constructed around end-user experience
- Disrupted by new competitors, suppliers
- Connected digital/physical cancer environments
- Disintermediation of traditional value chain

## + COVID-19

- Rapid shift in financial health of providers
- Demand for non-traditional environments
- Vast virtual health adoption
- Uneven impact –*offense vs. defense*

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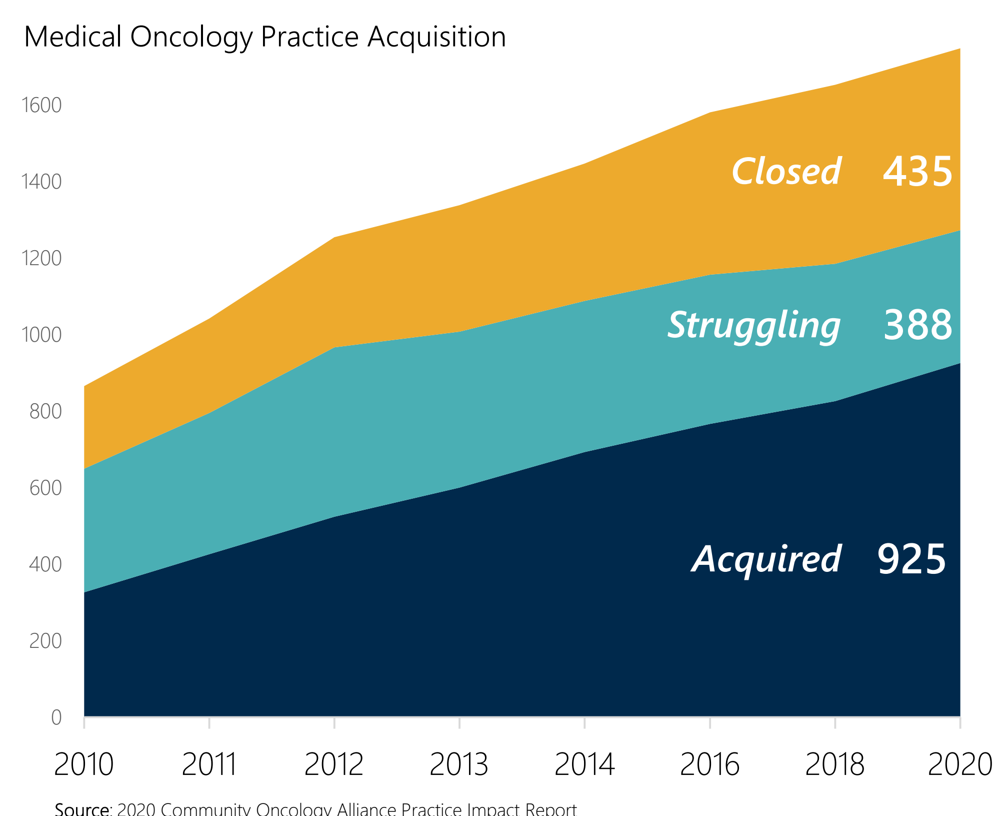
# Redirect: Pursue Partnerships

Consolidation has been a persistent force in the market – driven by simple economic forces

**Horizontal integration has remade the med onc delivery landscape: >1,300 practices acquired or closed since 2010**




Source: 2020 Community Oncology Alliance Practice Impact Report

**The alignment activity in oncology has been the byproduct of simple market forces centered around drug buy**

### Drug Demand

- Growth market for MO and its logarithmically-increasing buy-and-bill drug prices
- Attractive to scale players (One Oncology), distributors (USON), PPS-exempt and DSH hospitals

### Margin Attractiveness

- HOPD commercial rate advantage and 340B discounts of 20-30%
- $1.0-2.0M of incremental margin per FTE onc in HOPD/340B setting

### Competition

- Cancer market is crowded and providers pursuing competitive advantage via integration
- Oncologists are fundamental to integrated cancer care

### Labor Supply

- Shortage of >2,200 oncologists (*20% demand gap*) by 2025
- Scarcity compelling programs to build integrated cancer care through practice acquisitions

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# Redirect: Pursue Partnerships

Further consolidation inevitable as screening/surgical delays cascade through cancer's sequential value chain

## The Struggle is Real

Flatiron Health's report of 270 oncology practices:

- 40% drop in new pt. visits between Feb-Apr.
- 2X cancellations and no-shows
- Chemo cancellations modest at 3-17%…but infusions a trailing indicator

*"There's a lot of financial concern that's out there right now about being able to stay open and keep the lights on."*

Dr. Bobby Green, Flatiron CMO

## Options for Struggling Oncology Practices

*Increasing Likeliness*

**Restructuring**

- Service rationalization and clinic or infusion site closures
- Likely limited to smaller or solo-practice groups, oncologists approaching retirement, or practices in rural settings without viable partner channels

**Private Equity and Corporate**

- While there has been a flurry of recent PE-acquisitions, deals were likely already in advanced stage before COVID started (e.g., OneOncology, 21$^{st}$ Century)
- PE firms have also been impacted financially and it is unclear how turbulence will impact valuation multiples or the appetite of private equity in the near term

**Hospital Alignment**

- Most likely path for oncology practices, assuming health systems able to dedicate resources and bandwidth in midst of recovery
- Oncology acquisitions have short timeline to margin accretion, hence the business imperative to move quickly is strong relative to other opportunities
- Systems with strong pre-COVID-19 balance sheets will be best positioned to take advantage

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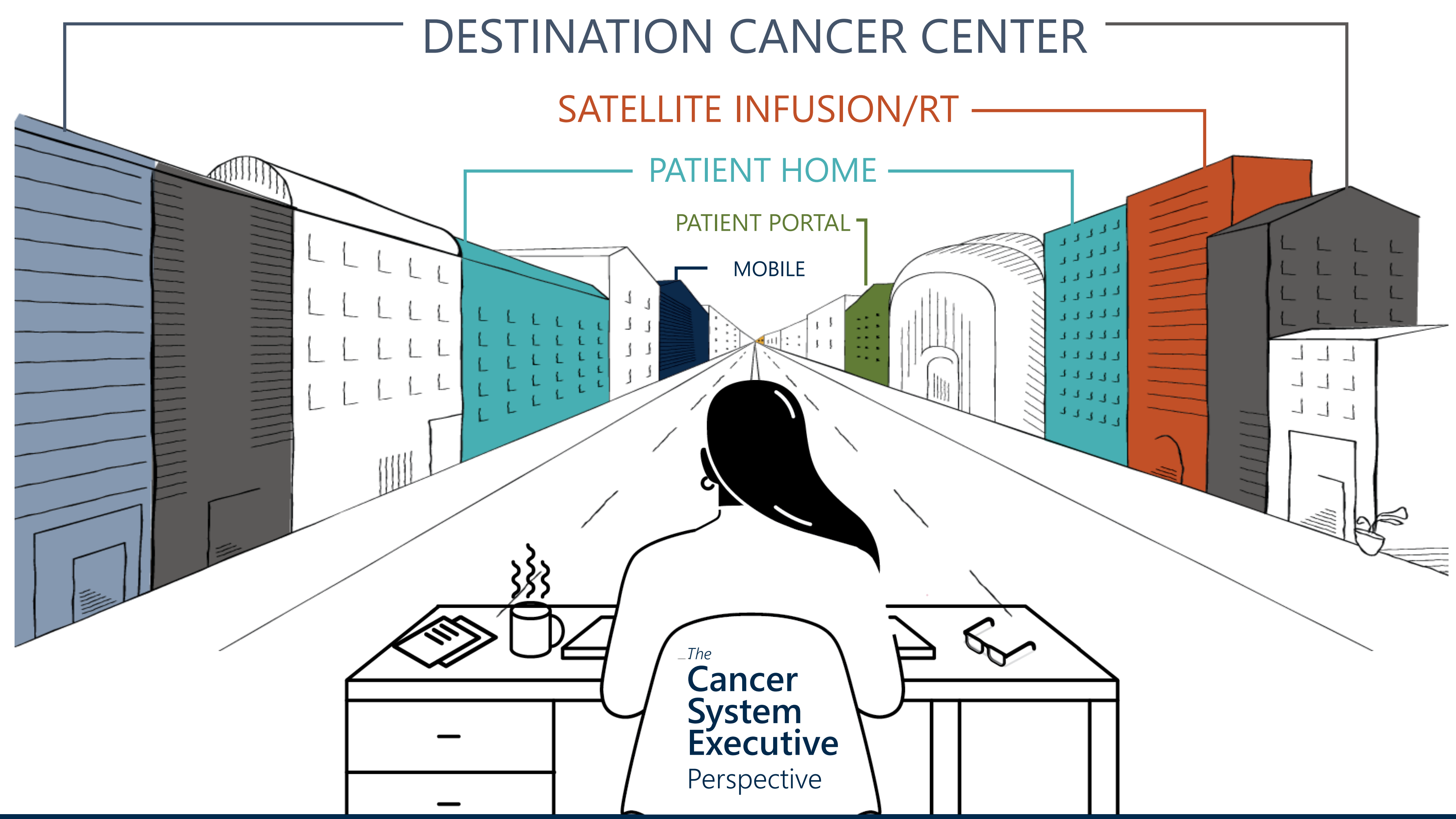
# Redirect: Measure Mindshift

Cancer programs have traditionally planned around consumer preference for expertise and destination facilities

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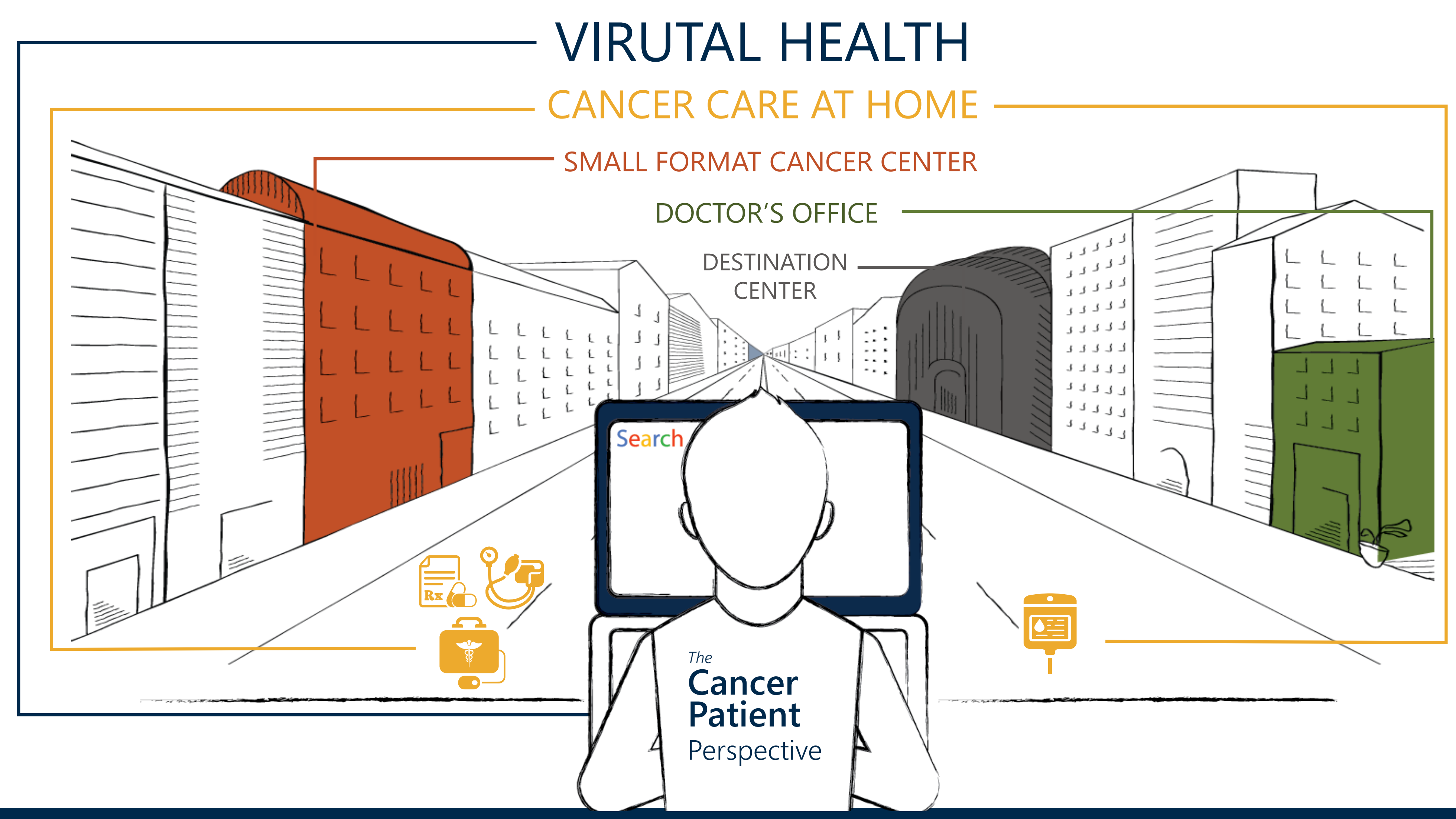
# Redirect: Measure Mindshift

We need to prepare for mind shift – including a premium placed on risk avoidance, convenience, and personalization

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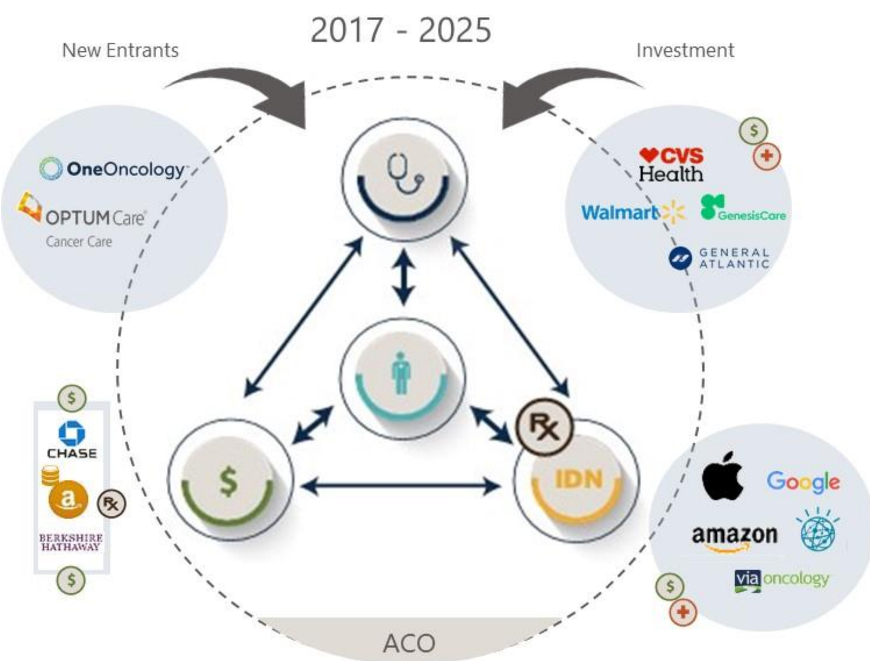
# Redirect: Assess the Market

As a cancer executive, what is your cancer program strategic posture?

## New Ecosystem




**How will COVID influence your cancer program's market strategy?**

## New Strategic Questions

**1**

### Are we offensively or defensively postured?

- *Offense* – where do we capitalize on market changes to drive growth and margin accretion in cancer care?
- *Defense* – how do we protect programs/ services from better capitalized competitors/ corporate players

**2**

### Are there new threats of disruption?

- *What role will our payers, large corporations and PE firms play in the post-COVID marketplace?*
- *Are there new partnerships we should be considering to mitigate the risks of disruption?*

**3**

### How/ where will we deliver care?

- *Do we need to rethink our delivery network, physical assets, and capital investment plans for cancer care?*
- *What is our investment roadmap for oncology digital health and is it sufficient to meet the recent quantum leap in adoption?*

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# Imperative 3: Reimagine your Care Model

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# Imperatives: Reimagine your Care Model

## Key Take-Aways

Reactivation | Market Positioning | **Care Model**

| Key Observation | Implications |
| --- | --- |
| • Oncology programs are being asked to seek margin improvement, demonstrate financial stewardship, and contribute to broader enterprise financial recovery | 1. Optimizing the care model will require improving clinical resource efficiency<br>2. Reworking front/back office functions and rationalizing non-revenue producing programs/services may be necessary steps to close margin gap |
| • COVID-induced explosion of telehealth will have a lasting impact on the care model | 1. While digital health is receding from its "peak", we expect adoption to endure given cost efficiencies and patient convenience<br>2. Digital impacts on the care model are significant and will need to be factored into facilities and staffing plans, and will potentially alter competitive landscape |
| • As with all paradigm shifts – the winners in cancer care will be those innovating and seeking to disrupt themselves | 1. Innovation has been accelerated due to COVID in alterative care delivery settings (e.g., hospital at home), care team connectivity, and environmental safety for on-treatment patients<br>2. New opportunities are emerging for forward thinking providers to differentiate on patient options and experience |

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# Reimagine: Optimize the Model

While generally a profit center – oncology will need to demonstrate financial stewardship as systems recover

### IMPROVE RESOURCE EFFICENCY

- Right size department-specific workforce in infusion, radiation, clinics, supportive care
- Optimize APP role and working to top of licensure
- Reassess physician compensation models to align with programmatic goals
- Lean into virtual encounter integration and schedule/template redesign
- Rationalize sites of care

### REVIEW YOUR FRONT/BACK OFFICE

- Evaluate charge master, charge capture, drug costs, billing/collections for revenue recapture opportunities and cost out
- Assess automation/self-service to streamline front-end processes and reduce overhead

### RATIONALIZE NON-REVENUE PRODUCING PROGRAMS

- Set clear KPIs for all non-revenue producing services with clear line of influence to the clinical enterprise – e.g., patient navigation, social work, financial counseling, supportive care
- Evaluate virtual alternatives/ contract solutions in certain services – e.g., genetic counseling, tumor registry, patient education

Drive higher margin, high value cancer care

**Contribute to enterprise financial recovery**

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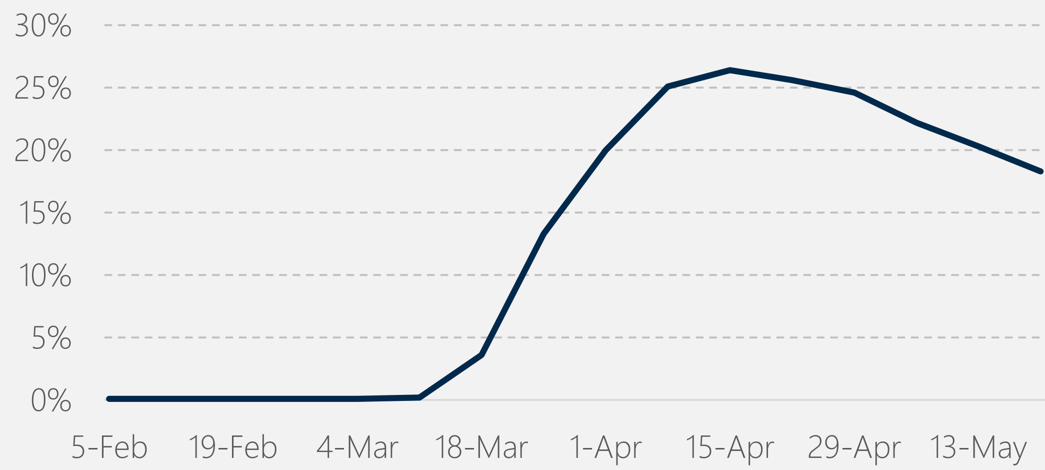
# Reimagine: Digital Health

Telehealth is here to stay and must be considered in care model redesign

COVID-19 brought and explosion in telehealth. While usage may have peaked, we expect it to settle well above the its starting point.




**Source**: The Chartis Group and Kythera Labs Telehealth Adoption Tracker

This requires incorporating telehealth as a critical component of care model and strategic planning.

Rapid proliferation and advancement of new platforms and applications in cancer care

Change in facilities, staffing and equipment demand as in person visits move to virtual

Process redesign for appointment scheduling, preparation, check in and communications

Disruption to the traditional competitive landscape, potentially reducing geographic barriers to entry

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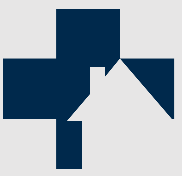
# Reimagine: Embrace Innovation

COVID has brought a wave of innovation to maintain access and patient experience while enhancing safety.

## 1. ALTERNATIVE **CARE SETTING**



- Drive-thru port flushes and injections – e.g., Neulasta *Spectrum, Grand Rapids*[1]
- In-home hydration, injection, and chemo infusion for patient subsets (300% increase in March) *University of Pennsylvania*[2]

[1] Mlive Spectrum Health link
[2] "Home Based Chemo Skyrockets at One U.S. Center." Medscape Online. link

## 2. GROWING **TELEHEALTH**

- Platforms like CancerIQ to extend tele-genetics for virtual genetic counseling *Dignity Health, San Fran.*[1]
- Remote clinical trials – virtual consults, direct home drug shipping and offsite evaluation[2] *UM Masonic Cancer Center*

[1] Advisory Board Oncology Roundtable link
[2] IQVIA Article link
[3] ACCC Webinar link

## 3. SAFETY **ASSURANCE**

- COVID testing, in-home swabbing (Ready Respond) *Ochsner, New Orleans*[1]
- Machine learning (e.g. LeanTaas) for infusion scheduling/spacing[2]
- Virtual waiting room *Banner Health, Arizona*[3]

[1] Louisiana Weekly link
[2] LeanTaas iQueue link
3 Banner Health virtual waiting room link

## 4. MULTI-MODAL **CONNECTIVITY**

- iPads and FaceTime video chat in exam room if visitors limited; *MDACC*[1]
- Symptom management apps to track on-treatment well being and assess COVID infection risk *OU Stephenson Cancer Center*[2]
- Virtual patient navigation[3]

[1] MD Anderson Cancer Center link
[2] University of Oklahoma Health Center link
3 Association of Oncology Nurse Navigators link

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# Reimagine: In-Home Cancer Care

## Renewed interest in in-home chemotherapy infusions

COVID has created the perfect environment to reconsider the site of care for chemotherapy infusion. Pilot models are underway and CMS is actively removing the legal/regulatory barriers to in-home delivery models.

### CARE CONTINUITY

Use in-home care to limit immune suppressed patients exposure to COVID-19 and increase confidence / compliance with care plans that avoid healthcare settings.

### PATIENT EXPERIENCE

Patients report enhanced well-being through the reduced travel, improved symptom management and higher adherence to chemotherapy schedules.[1]

### REGULATORY CHANGE

CMS is making regulatory and reimbursement changes that enable the expansion of home infusion.

### CAPACITY CONSTRAINTS

Shortage of infusion capacity is driving interest in a model that offloads select patient types to the home-based setting

### INTERNATIONAL SUCCESS

Adoption in sophisticated healthcare markets like the UK and Australia and isolated pilots in the U.S. demonstrate the hurdles of patient safety and economics can be overcome.

### FINANCIAL VIABILITY

The economics are complex, but with evidence in-home chemo infusions can be safely delivered at half the cost[2], payor pressure to review care settings is likely to mount.

UPenn piloted a home-based chemotherapy program when COVID-19 arrived. In a 4-week period from March to April 2020:

- **Referrals rose 300%** from 40 to 135
- **Expanded** the list of chemotherapy agents delivered from 2 to 7
- **Outstanding patient feedback** received, with pilot expansion planned

1. https://chemoathome.com.au/research/
2. https://www.ncbi.nlm.nih.gov/pubmed/21384139
3. https://www.medscape.com/viewarticle/928505

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# Summary

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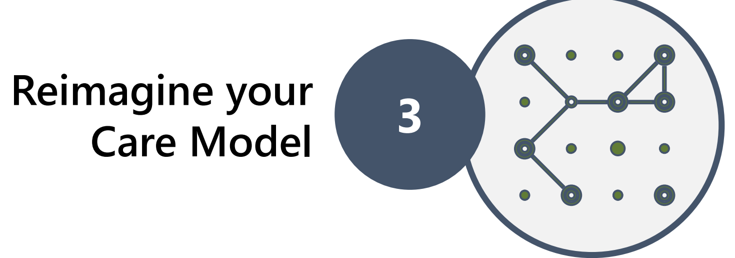
# Summary: Delivering Cancer Care in the COVID-19 Era

## Imperatives for Oncology Success

- It is a moral and financial obligation to recover patient volumes
- Threats of re-surge make COVID a “new normal” for foreseeable future
- Reactivation should begin with the screening and surveillance populations
- Cancer program should lead in process redesign and signaling safety of care environments to the market

- COVID accelerated trends were already reshaping the oncology industry and it is critical that these trends are understood and embraced in revised market strategies
  - New entrants, technology/ digital revolution, and a changing policy landscape
  - Consolidation in oncology practices
  - Potential shift in patient preference and decision criteria




- Ensure efforts to improve margin and support financial recovery support long run care model optimization and clinical resource efficiency
- Make digital health a permanent element in care model and strategy
- Embrace disruptive innovation in cancer care

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# Questions?

Please reach out to one of our colleagues at Chartis Oncology Solutions with any questions about today's content.

Thank you for your time and attention!

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