ONCOLOGY SERVICE LINE: Governance and Leadership Best Practices

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Disclosures: BMS, Consultant

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LEARNING OBJECTIVES

- Characterize the need for diverse leadership skills
- Define the value of physicians as leaders
- Describe a leadership model that effectively engages physicians at the institutional, regional, and enterprise levels

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HCA / SARAH CANNON

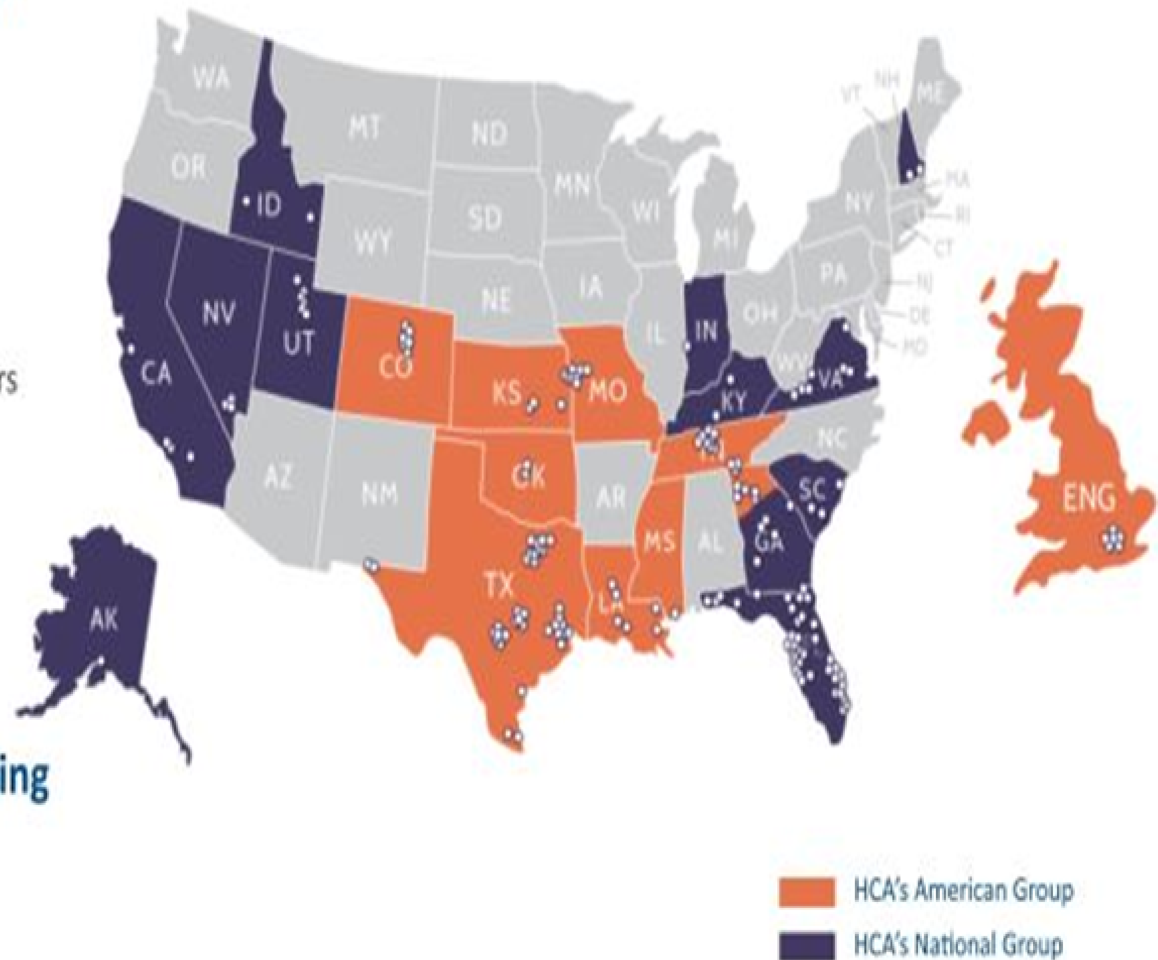
An Overview

HCA FOOTPRINT

- **27+ million patient contacts annually**
- **Approximately 5% of major hospital services in U.S.:**

Admissions	1.9 million
Clinic Visits	8.0 million
Deliveries	0.2 million
Total Surgeries	1.5 million
ER Visits	8.4 million

- 174 Hospitals, 119 Freestanding Surgery Centers
- Operating in some of the fastest growing metropolitan communities providing approximately 25% of hospital services
- 240,000+ employees, including 80,000 nurses and 47,000 allied health professionals
- **37,000 affiliated physicians, including 4,100 employed physicians and practitioners**



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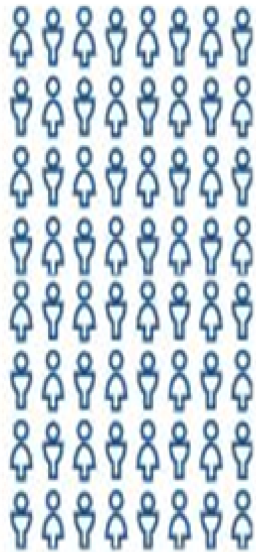
SARAH CANNON SERVICE LINE INITIATIVE

- **Sarah Cannon formed a global oncology service line to:**
  - Solidify and expand HCA's position in cancer care
  - Ensure we deliver strong growth in the future against high quality competitor offerings

- **Sarah Cannon partnered with each market to:**
  - Gather input and perspective on the local cancer care market and understand work to-date
  - Develop and refine an integrated oncology service line model
  - Mobilize around specific growth opportunities, including securing the necessary resources
  - Ensure delivery of best-in-class offerings for our patients, referrers, and physicians as well as a financial return to our company

SARAH CANNON – LEVERAGING SCOPE/SCALE/SCIENCE



One of the world's

largest

drug development /phase 1 programs

Utilizes the

largest

patient access/ER system to diagnose cancer at earlier stages

(8.4 million visits a year)

120,000+

Newly diagnosed cancer patients per year within the system

Together, we provide **state-of-the-art cancer care close to home** for hundreds of thousands of patients, **a number unmatched by any single cancer center.**

200+

oncology-trained nurse navigators

Largest

cancer navigation program in the US

1,000+

annual transplants

Largest

blood cancer transplant network

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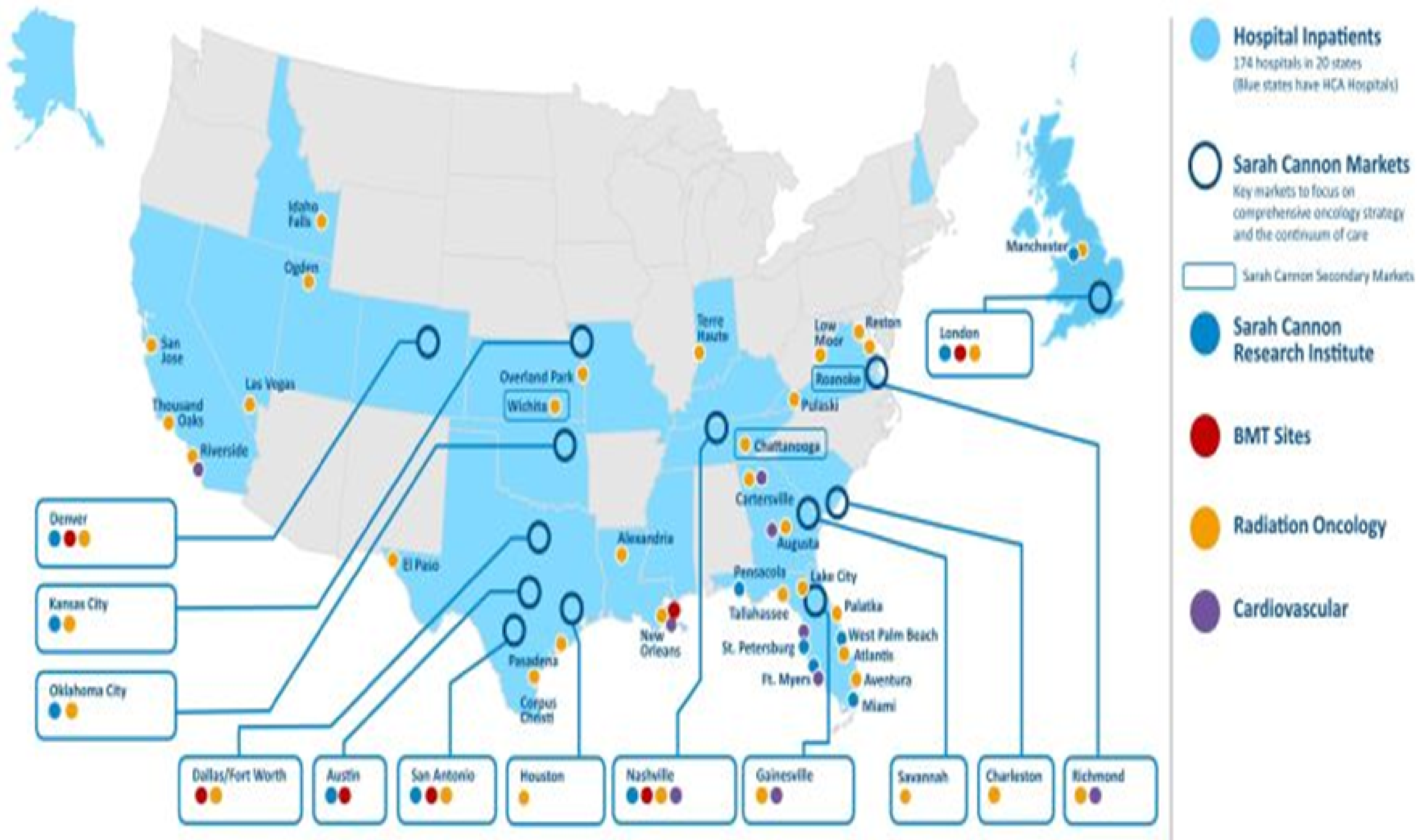
HCA/SARAH CANNON ASSET OVERVIEW



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THE IMPERATIVE FOR SYSTEM LEADERSHIP

THE REVOLUTION / EVOLUTION IN HEALTHCARE

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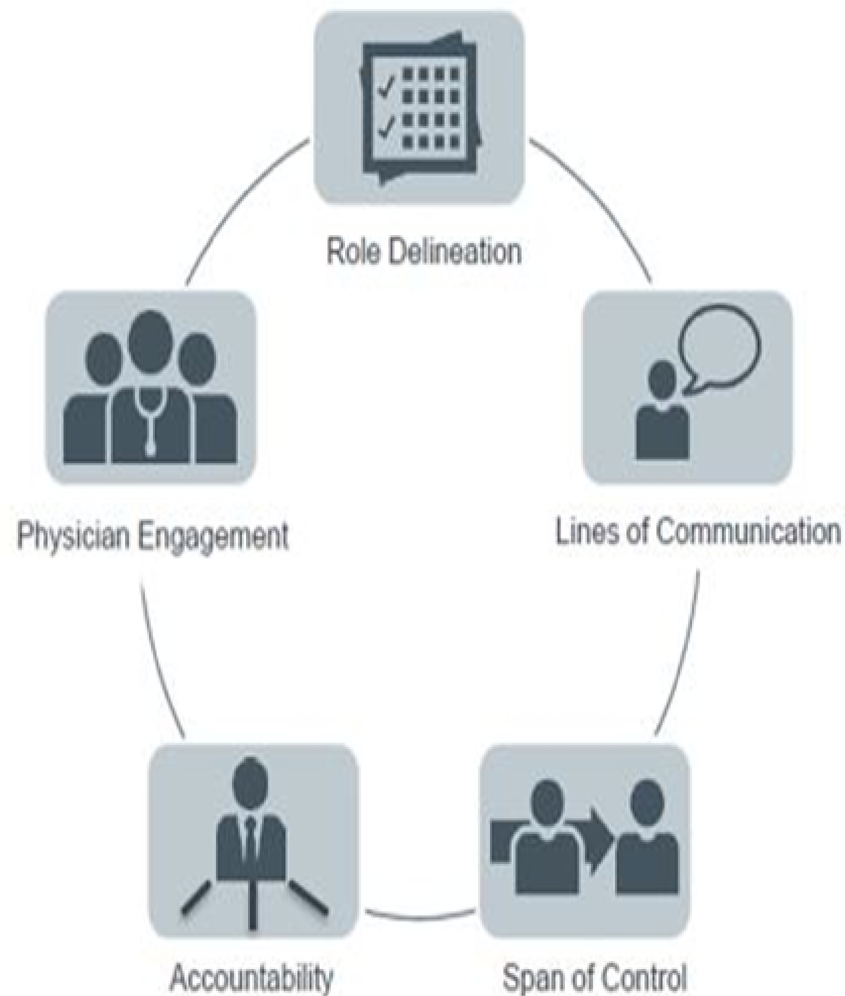
LEADERSHIP STRUCTURE MUST SUPPORT KEY COMPONENTS OF ORGANIZATIONAL DESIGN



Source: ECG Management Consultants, "The Strategic Imperative of Adapting the Hospital's Management Structure", available at: http://www.healthleadersmedia.com/content/86219.pdf, accessed September 4, 2012; Oncology Roundtable interviews and analysis.

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THE FOUR MAJOR LEADERSHIP FUNCTIONS

To bring about congruence of goals between members of an organization

To balance group resources and capabilities with environmental demands

To provide group structure that will focus information effectively upon problem solutions

To make certain that all information is available to decision makers when required

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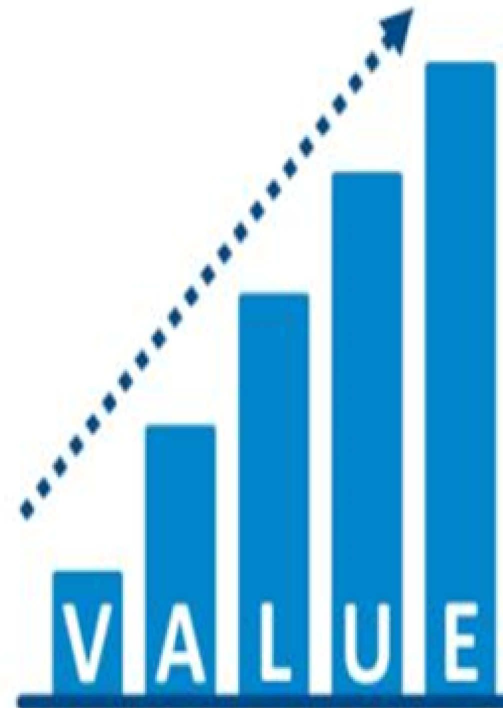
HEALTH SYSTEM EXECUTIVES AS CLIENTS OF THE ONCOLOGY SERVICE LINE

- Alignment with System Priorities
- Effective Conduits of Information
- A Vehicle for Physician Alignment
- Translation and Mapping of Service Line Goals with Executive Priorities
- Prioritized Focus on Clinical Quality, Patient Experience, and Growth



UNRECOGNIZED NEEDS POSE LEADERSHIP RISK

- Outpatient Focus and Expertise Still Not Prevalent
- Rapid Pace of Scientific Discovery Changing the Landscape
  - Lines Between Research and Practice Blurring
  - Precision Medicine Chaos
  - Expensive Targeted Therapies
- Complexity of Interdisciplinary Interactions Challenge Historical Hospital Structures
- Value Based Care Models Ambiguous and Dynamic for Oncology

For some…

For others…

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PHYSICIAN LEADERSHIP MAKES A DIFFERENCE

- **2013 US News and World Report Hospital Rankings**
  - Top 5 are physician led
  - 10 of 18 are physician led
- **2011 Study of Association Between Physician Leadership and Performance**
  - Indicated that "the best performing hospitals are led disproportionately by physicians."
  - Quality scores in oncology were 33% higher for physician led institutions
- **McKinsey & Co Examined Factors Associated with Healthcare Productivity**
  - Physician leadership a key contributor to organizational performance across domains (quality, patient satisfaction, and financial margins)

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Clinical Excellence ≠ Leadership Excellence

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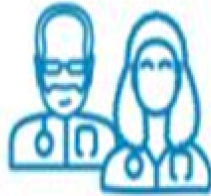
CORE COMPETENCIES DIFFER ACCORDING TO ROLE



PHYSICIAN CORE SKILLS

- Medical Knowledge
- Patient Care
- Practice-based Learning
- Professionalism
- Interpersonal/Communication Skills

Do Not Underestimate the Value of Investing in Physician Leadership Training

NEXT GENERATION SKILLS

- Systems Theory And Analysis
- Utilization Of IT And Analytics
- Cross-disciplinary Team Leadership
- Models Of Care Awareness
- Expanded Knowledge
- Relationship Management
- Influence Skills
- Authenticity
- Capacity To Inspire

A MODEL FOR COLLABORATIVE GOVERNANCE

THE SARAH CANNON EXPERIENCE

ELEMENTS OF HIGH QUALITY CARE ARE CONSISTENT ACROSS TUMOR PROGRAMS

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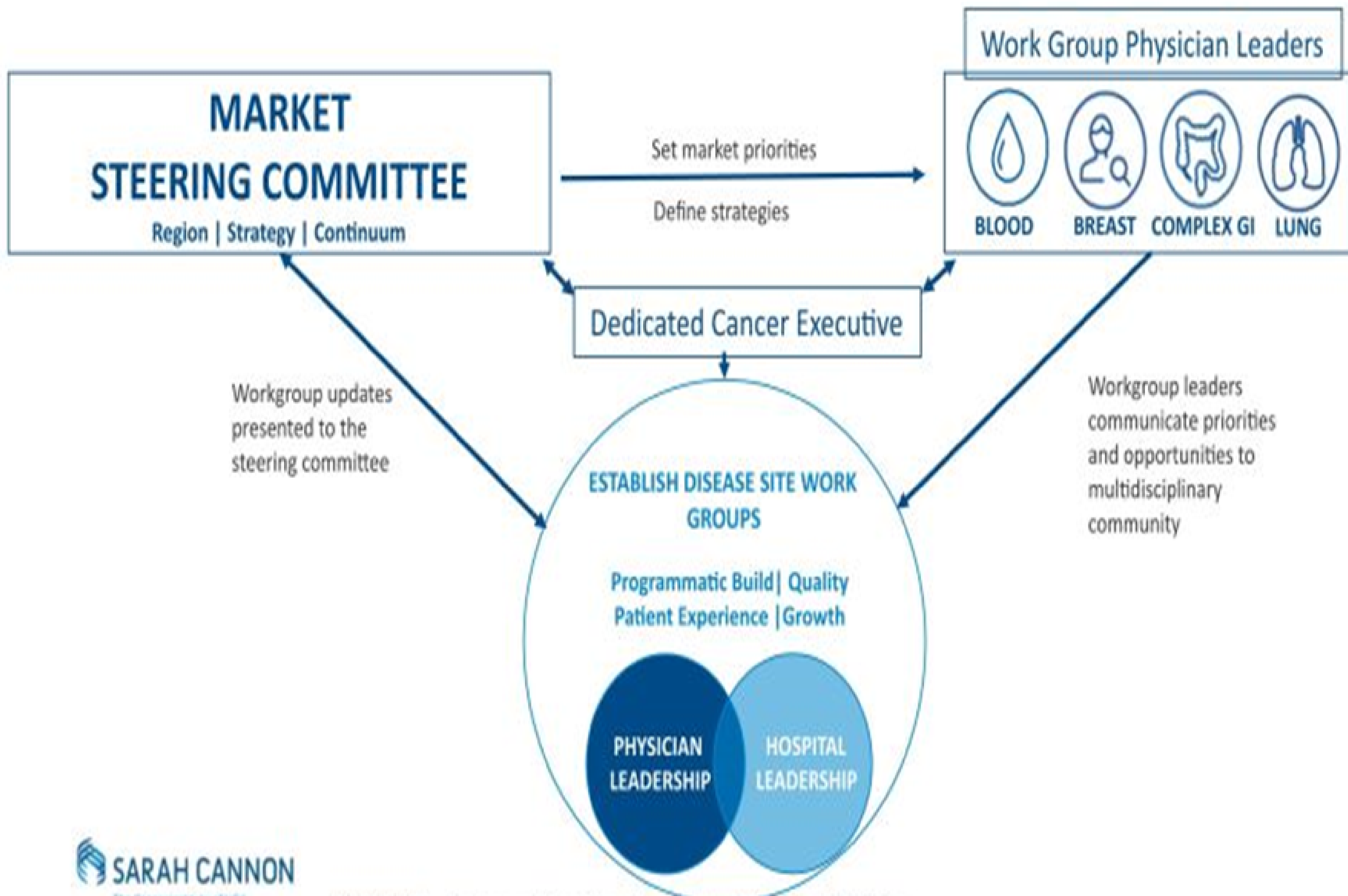
SUCCESSFUL CANCER GOVERNANCE MODEL WITH HIGH PHYSICIAN ENGAGEMENT



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MARKET GOVERNANCE BOARD – CRITICAL ATTRIBUTES

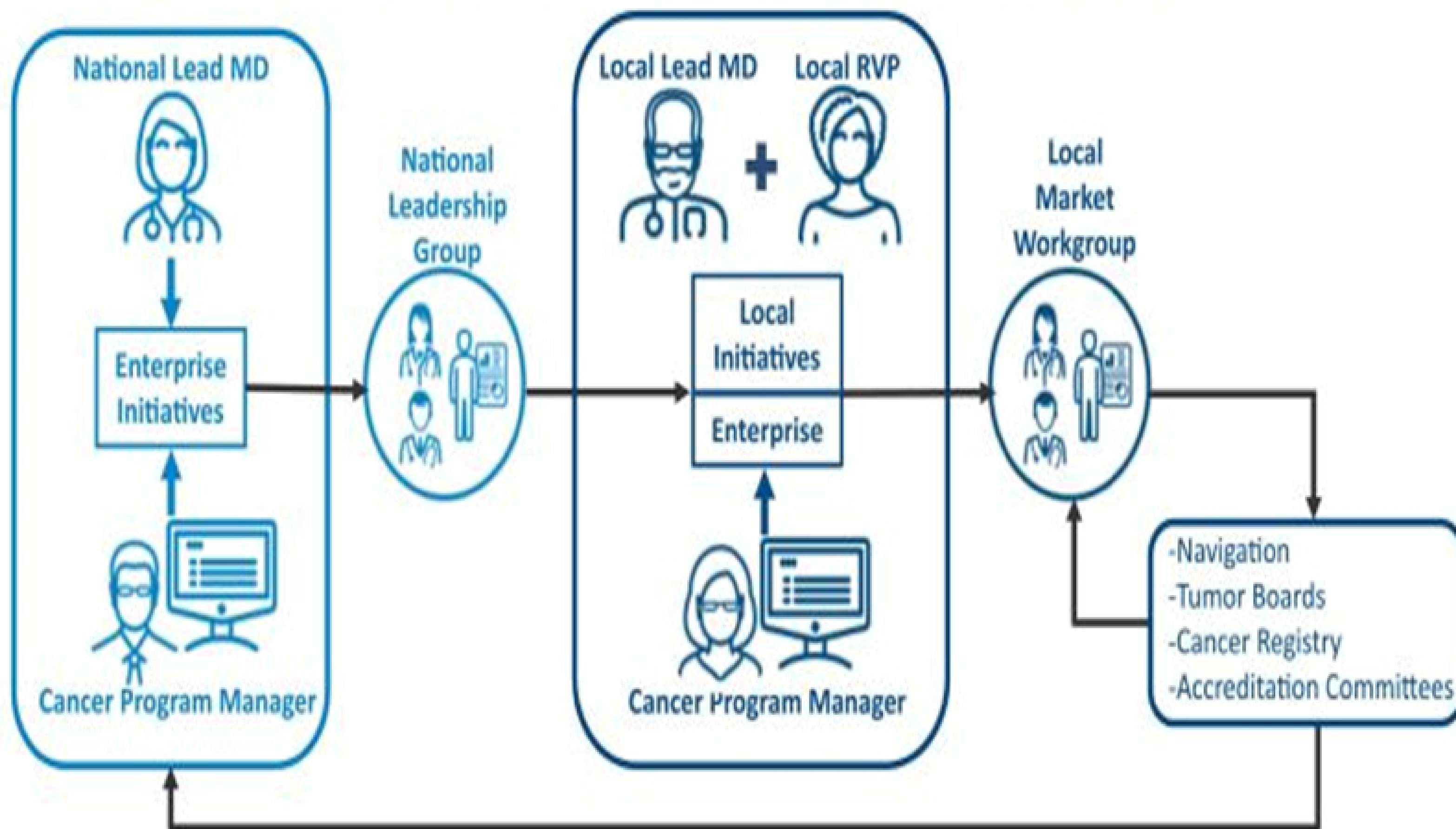
- Health System Senior Executive Presides
- Cancer Executive Facilitates Discussion
- Focus: Strategy
- Physicians Lead Discussions for High Value Programs
- Small Group
- Physicians Invited for Defined Terms
- Essential Physician Attributes
  - Leadership Skills Paramount
  - Capacity for Enterprise Strategic Thinking
  - Have the Clout to Align Their Groups
  - Loyalty/Historical Alignment

SAMPLE AGENDA

5:30 p.m. - 5:40 p.m.	Dinner & Welcome	Division President
5:40 p.m. - 5:50 p.m.	Market Intelligence	Board
5:50 p.m. - 6:00 p.m.	• Market Operations Update • Service line Trends	Service Line Leader
6:00 p.m. - 7:00 p.m.	Disease Site Strategic Planning • Blood Cancer & Cellular Therapy • Breast • Complex GI • Radiation Oncology • Thoracic	Physician Tumor Site Workgroup Leaders
7:00 p.m. - 7:15 p.m.	Program Performance Review	Service Line Leader
7:15 p.m. - 7:30 p.m.	Questions/Open Discussion	Board

COMMUNICATION PROCESS

INDIVIDUAL WORKGROUPS: Breast, Complex GI, Thoracic, GYN-Onc, Sarcoma, Neuro



MANAGED MARKETS: Austin • Dallas • Denver • Houston • Kansas City • Nashville • North Florida • Richmond • San Antonio

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TUMOR SITE WORKGROUPS – CRITICAL ATTRIBUTES

- Physician Leader Presides
- Clinical Program Manager Facilitates
- Focus: Tactical, Operational
- Multidisciplinary Representation is Requisite
- Open to Community of Practitioners in that Specialty
- Essential Physician Attributes
  - Subject Matter Expert > Leadership Skills
  - Commitment to Quality Improvement and Collaboration
  - Recognized as Credible by Peers

2018 TUMOR-SITE LEADERSHIP COMMITTEE GOALS

	Q1	Q2	Q3	Q4
Focus	Recap	Assess Landscape	Pathways/Prioritize Local Opportunities	2019 Prioritization
National Leadership Meeting	January 16, 2018	April 17, 2018	July 19, 2018	October 16, 2018
National Tumor Conference	March 13, 2018	June 12, 2018	September 11, 2018	December 4, 2018
Focus Details	• 2017 Recap • Pathway adherence & program performance metrics review	• 2019 Leadership Planning • Identify 2019 goals/deliverables • Identify new pathways and required updates	• Assess vital project progress • Identify 2019 investments required • Execute pathway builds/revisions	• Assess project status/yields • Identify course corrections • Succession planning • Discuss successes and/or barriers

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LEVERAGING YOUR GOVERNANCE INFRASTRUCTURE TO DRIVE CLINICAL PROGRAMS

CLINICAL PROGRAMS OVERVIEW: PHYSICIAN LED AND PATIENT CENTRIC APPROACH

Infrastructure	Collaboration	Data Collection
Sustainable and comprehensive tumor site specific programs	Establish a platform for multi-disciplinary communication across Sarah Cannon	Capture, review and distribute data to enhance decision making capabilities

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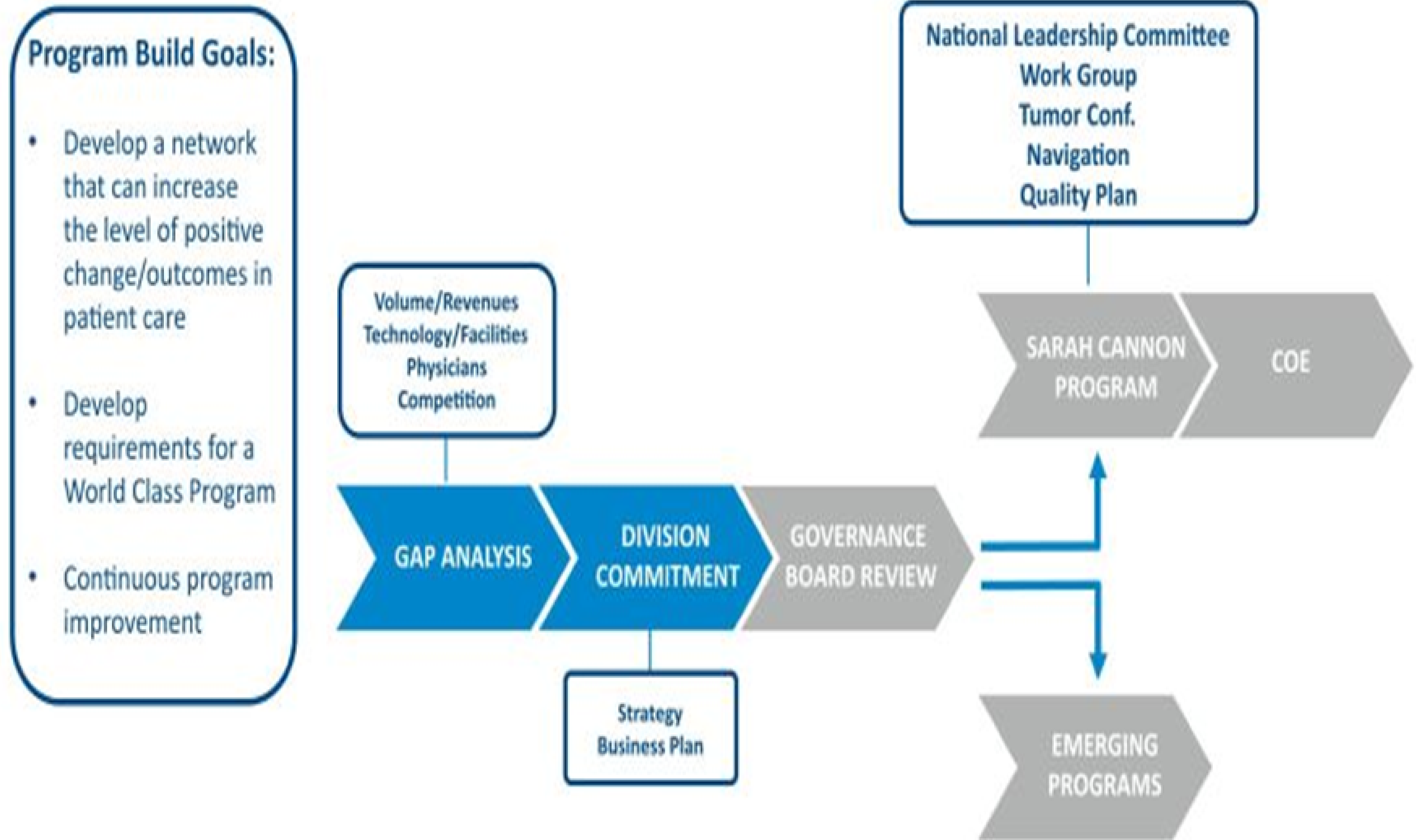
PROCESS FOR CLINICAL PROGRAM BUILD



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Clinical Pathways Aim to Improve, in Particular, the Continuity and Coordination of Care Across Different Disciplines and Sectors

Standardize Evidence-based Practice Throughout Sarah Cannon Network	Utilization and Distribution of Expertise Across National Network	Provide Synchronicity to Enact Impactful Change	Provides Metrics and Standards for Navigation

Who Develops the Pathway?

All Sarah Cannon Pathways are Developed by Physicians and Practitioners from Every Market

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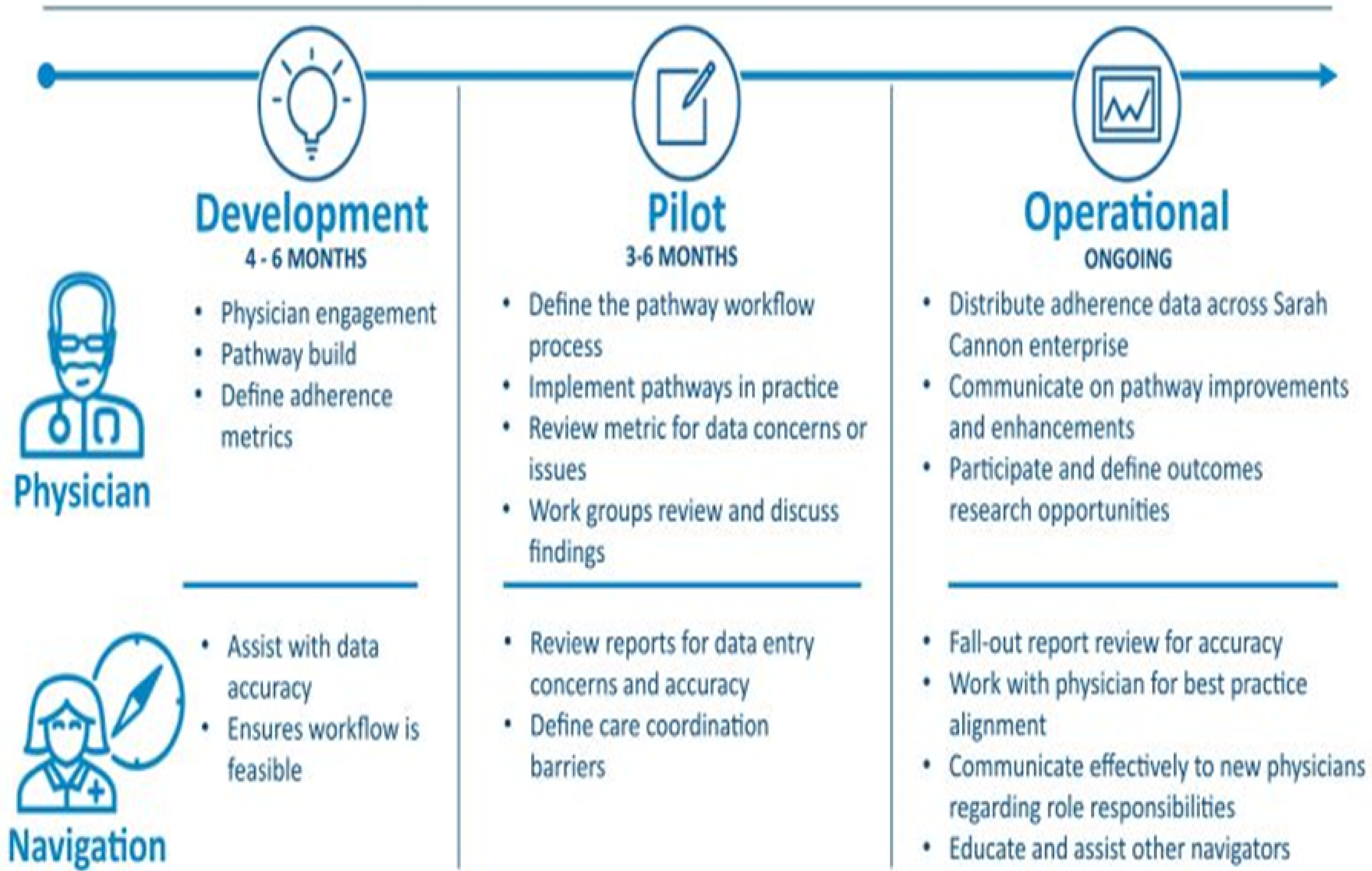

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PATHWAYS = IMPROVED PATIENT CARE

5,500+

Patients on Pathway

220+

Engaged Physicians across **11 Markets**

(Austin, Dallas, Denver, Houston, Kansas City, Nashville, N. Fla, Richmond, San Antonio, Wichita, Southwest Virginia)

Complex GI Pathways

Measure	Pathway	Pre-Pathway
All GI – Multidisciplinary Meeting (943 Patients)	83%	49%
Pancreatic – CA 19-9 (349 Patients)	84%	NA
HCC – Overall Adherence (171 Patients)	82%	15%
Gastric – Her 2 (75 Patients)	89%	28%

■ Pathway ■ Pre-Pathway

Thoracic Pathways

Measure	Pathway	Pre-Pathway
Clinical Stage Recorded (I & II) (324 Patients)	100%	26%
All Thoracic - MDM (453 Patients)	87%	31%

Breast Pathway (3499 patients)

BRCA

	Performed	Eligible w/ No Record
Pre-Pathway	18%	82%
Pathway	67%	33%

[1]Data Range: 10/15 to 12/18

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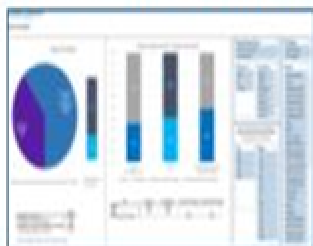
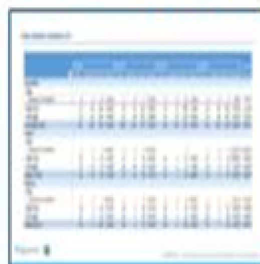
REPORTING

Overall Adherence Report



- Monthly Operational Pathways
- Contrasts Navigated vs Non
- Core vs Non Market

CP3R Data Reports



- Tumor Specific Quality Measures
- Comparative Data for Physicians
- Fosters Pre-Emptive Awareness of Quality

Tumor Specific Adherence Reports

- Tumor Specific Pathways
- Pathway Specific Adherence Metrics
- Filterable by Navigator/Physician

Trended Adherence/Fall-Out Reports

- Pulls Non-Adherent Patients for Navigation Review
- Details Reason for Non-Adherence
- Displays Non-Adherent Reason Trends

Adherence Report Visuals

- Built Quarterly for Presentations
- Contrasts Different Patient Cohorts

Outcomes Measures Report

- Displays Survivorship and 30 Day Post-Op Mortality Rate for Different Patient Cohorts

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CASE STUDY – HIGH RISK WOMEN'S PROGRAM

Problem Statement:

The development of comprehensive women's high risk screening and care programs is compromised by the lack of defined best practices and workflows, dedicated leaders, inter-departmental accountability challenges, lack of operator understanding, and IT heterogeneity.

For Sarah Cannon the challenge is compounded by the requirement to operate solutions at scale.

Purpose Statement:

To develop a Sarah Cannon High Risk Women's Program using evidence-based pathway(s) for identifying women who are at increased risk for cancer, then providing personalized management, risk reduction and surveillance.

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HCA'S OPPORTUNITY – SOURCED BY CLINICAL EXPERTS

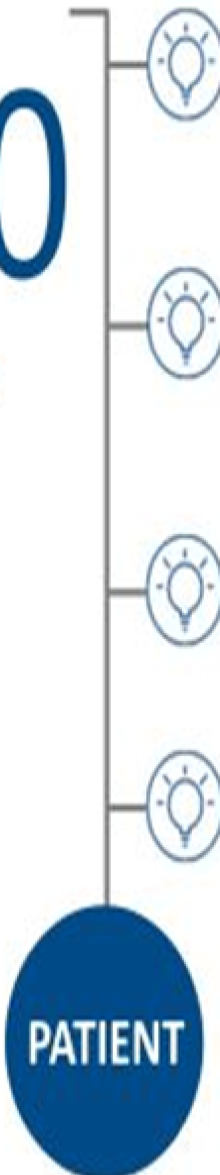
Advisory Committee Participants **+50**

- Genetic counselors
- Administrators
- Navigators
- 21 Engaged Physicians (Gyn Oncs, Med Oncs, Radiologist, Surgeons, PCPs)

Across **8** Markets

Working Groups Developing **13** Best Practices

- Risk Assessment model
- Genetic counseling models
- Workflows
- Guidelines/Pathways



Patient Identification and Coordination

- No standardized comprehensive risk assessment strategy in place
- Variable access to genetic counseling and genetic testing
- Marked gaps in care coordination

Strategy

- Subject matter expertise is extremely limited
- Most markets are actively investing in high risk women's programming
- High fragmentation of care; outmigration

Technology

- Highly manual, labor-intensive processes
- Spreadsheets, sticky notes to track patients

Finance

- No clear understanding of needed investments
- No clear understanding of ROI opportunities
- Multiple markets pursuing disparate technical solutions

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DEVELOPMENT DETAILS

Phase I

- Engage Physicians and care team
- Develop HRWP Playbook – comprehensive document outlining all components of a high risk program
- Develop HRWP Toolkit – repository of tools, documents, resources for program planning and implementation

Engagement and Define Infrastructure/Best Practices

Play Book

Toolkit

Phase II

- Establish Steering Committee for operational oversight - Establish business plan imperatives
- Share best practices nationally
- PILOT programmatic build and Technology
- Define Genetic counseling models
- Prove technology
- Design HRWP Outcomes Research Study

Assessment

GAP Analysis

Pilot

Measure and Report

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SUMMARY

OSL: GOVERNANCE AND LEADERSHIP PEARLS

- The complexity of the healthcare endeavor, particularly within cancer care, requires diverse leadership skills that span clinical, business, and operational domains
- Physicians are essential in leadership roles but are not trained for those roles
- Selection of physician leaders should involve matching of the physician skill set against the role to be filled
- Dyad leadership models can be synergistic
- Well-conceived governance structures are vital to ecosystems where providers, administrators, and operators are effective in driving quality and business goals

THANK YOU

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