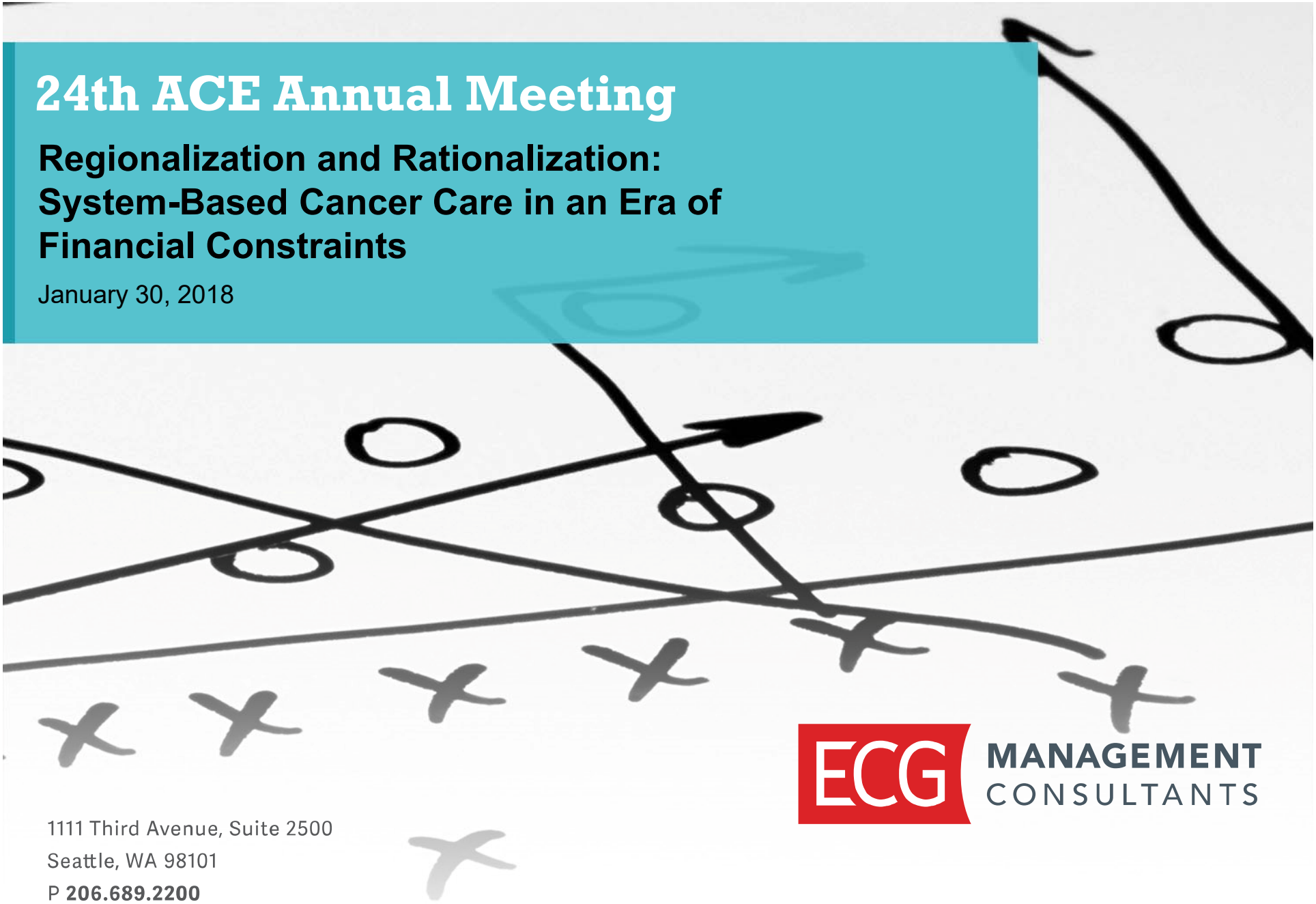
24th ACE Annual Meeting

Regionalization and Rationalization: System-Based Cancer Care in an Era of Financial Constraints

January 30, 2018



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Case for Regionalization

National Trends in Healthcare

Market trends are driving healthcare providers to be more responsive to a variety of stakeholders, transform care delivery, and work effectively with strategic partners.

General Market Trends

1. Increasing Role of Government
2. Changing Payment Models
3. Enhanced Consumerism
4. Demand for Technology
5. Changing Physician Dynamics
6. Evolving Role of Partnerships and Affiliations

Case for Regionalization

Long-Term Success Factors

In this time of change and uncertainty, many hospital leaders are focused on several reliable long-term strategies.

1. **Cost Reduction:** Healthcare is a growing market with unsustainable spending; cost per unit of service must decrease.
2. **Convenience and Outcomes:** Patients, government agencies, and insurers will demand better access, more convenience, and better results.
3. **Scale:** Multihospital systems will become increasingly focused on clinical integration, consolidation, and rationalization.
4. **Health and Wellness:** The evolution of risk-based payment models will shift the care delivery focus from "episodic sick care" to "longitudinal chronic care."
5. **New Care Models:** Population health and value-based care initiatives will accelerate the development of new care models.
6. **Integration:** Ultimately, highly integrated regional systems will emerge, resulting in significant consolidation across the industry.

Despite uncertainty, leaders can make key assumptions about the industry and consider the future implications for their organizations.

Case for Regionalization

Market Forces Driving Change and Regionalization in Oncology

Specialized Services

- Subspecialized medical and surgical oncology expertise
- Molecular profiling; mutation and biomarker testing for tumors

Changing Reimbursement

- Advantageous hospital outpatient reimbursement
- More rigid prior-authorization requirements
- Demonstration of quality outcomes
- Increased patient copays and deductibles
- Alternative payment models (e.g., capitation, episodes of care, bundled payments)

Comprehensive Care

- Full spectrum of diagnostic and treatment modalities
- Clinical trials access
- Supportive services and survivorship programs
- Screening guideline changes
- Advanced outreach and prevention programs

Legislature and Regulations

- EHR utilization and reporting requirements
- Incentives and penalties; quality targets
- 340B Drug Pricing Program uncertainties

Coordinated Services

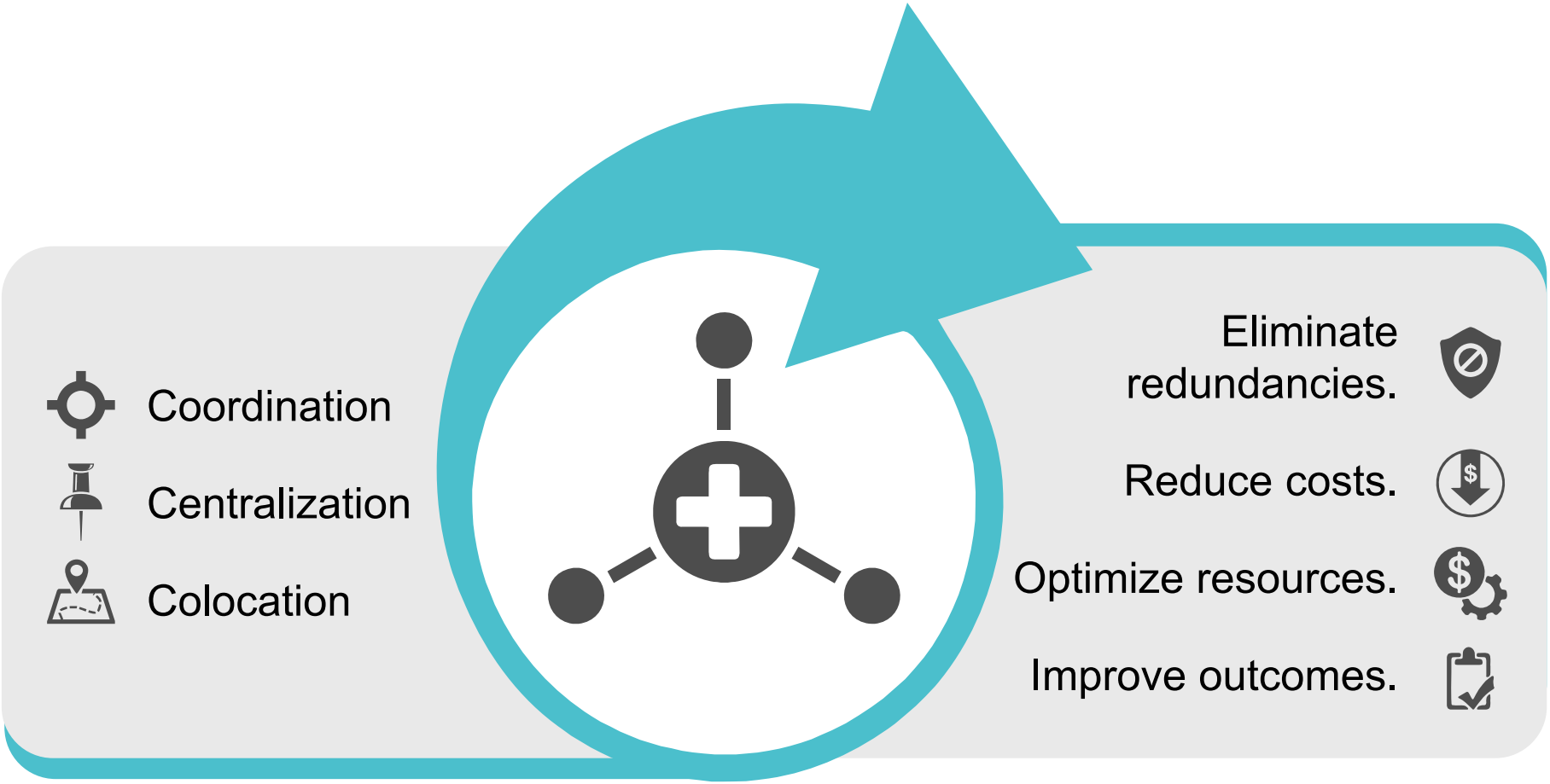
- Multidisciplinary care model
- Clinical pathways and evidence-based guidelines
- Coordinated care transitions

Partnerships and Affiliations

- Acquisitions/affiliations with 340B hospitals
- Academic/community partnerships
- Brand awareness
- Shared resources

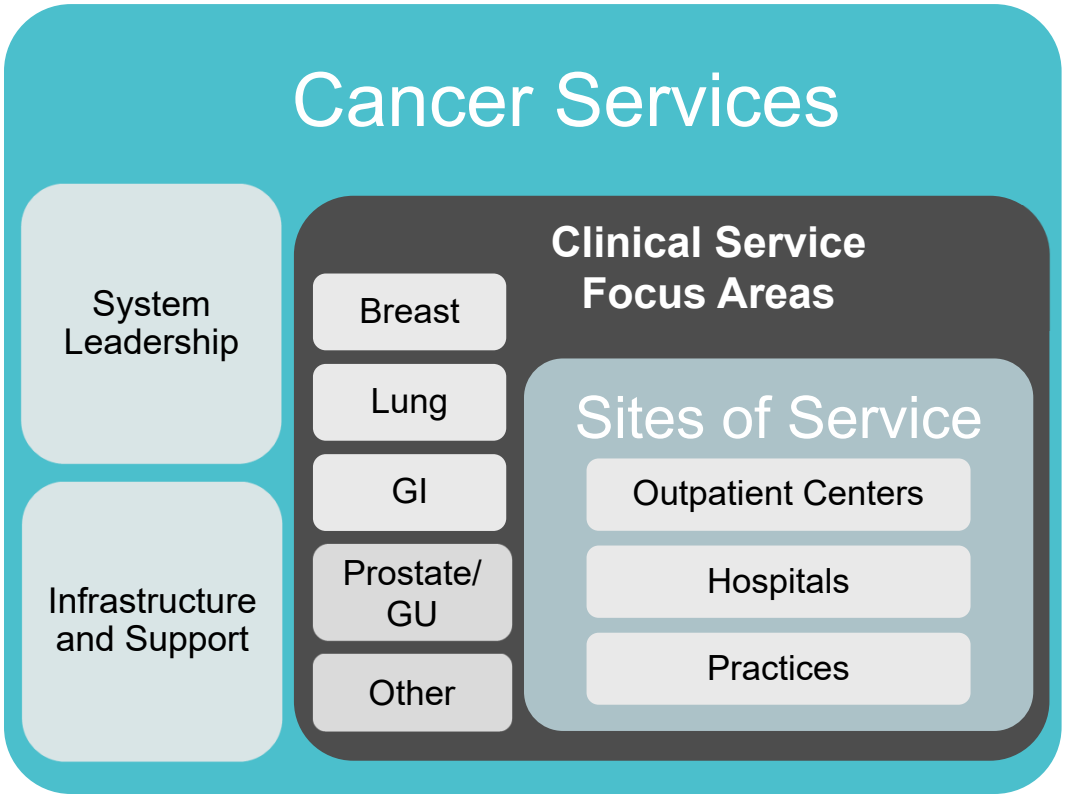
Case for Regionalization

Why Regionalize?



Regionalization Overview

A Regional Service Line Vision



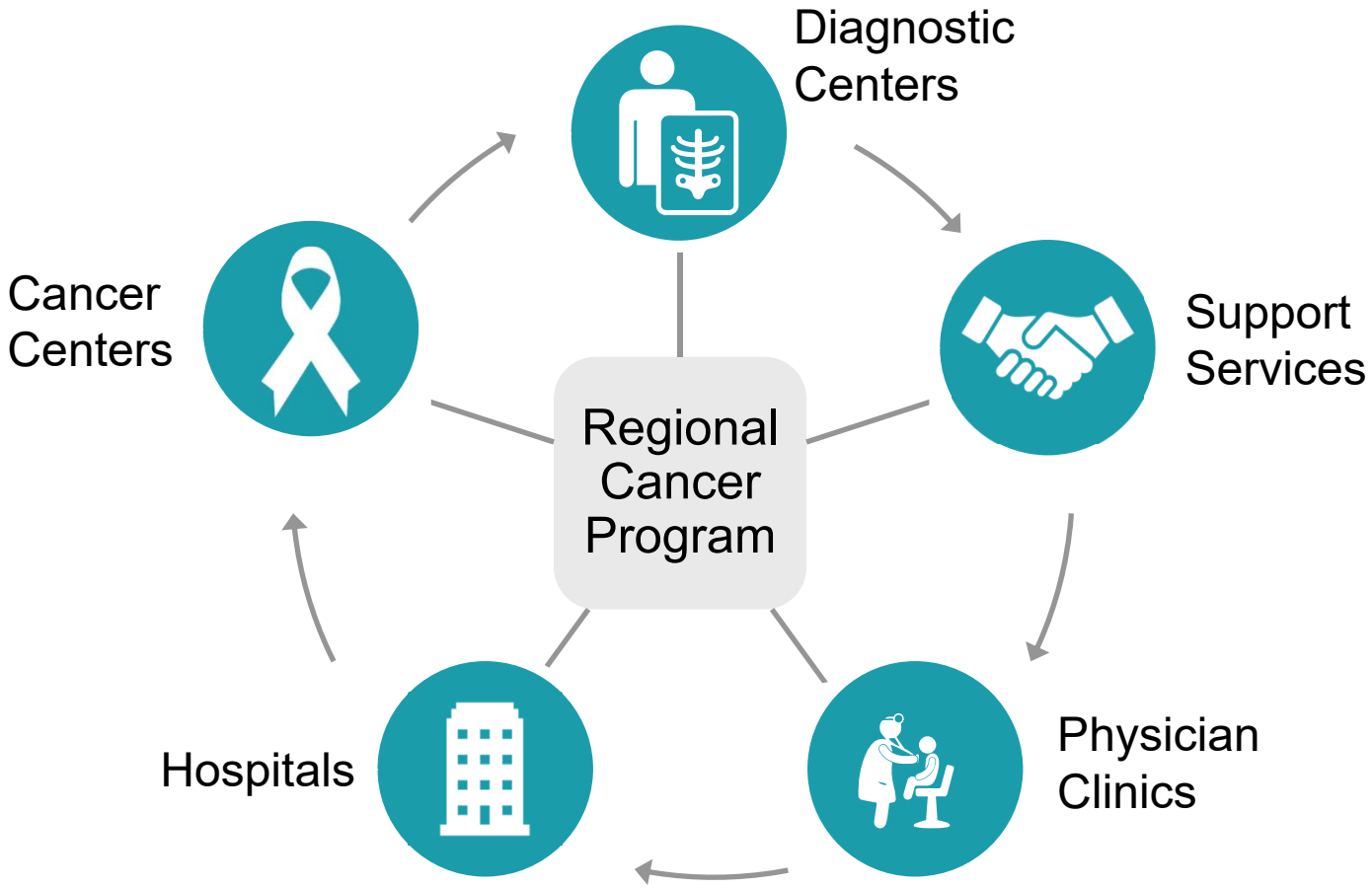
Key Characteristics

- All care delivery elements (patient-facing and general operations) are **standardized** across the system.
- The approach to **care is consistent**, and variability in patient experience across sites is minimized.
- Clinical assets are organized and managed in a way that enables patients to **seamlessly** navigate care at various sites and providers.
- A **single leadership team** for cancer (clinical and administrative) is accountable for program performance.
- Resource allocations and major program development **decisions are centralized** at the system level.

Regionalization Overview

Components of a Regional Program

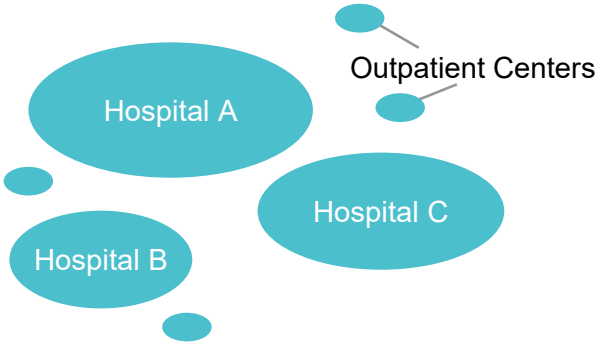
The regional cancer service line will include all existing and future clinical and support services within the designated geography.



Regionalization Overview

Regional Service Line Models

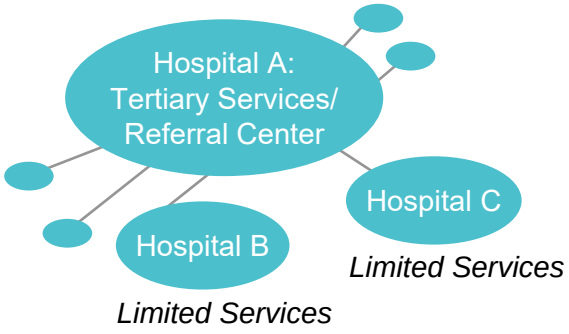
Uncoordinated Model



Features

- No coordination among facilities
- Duplicative services and technology
- Occasional turf wars

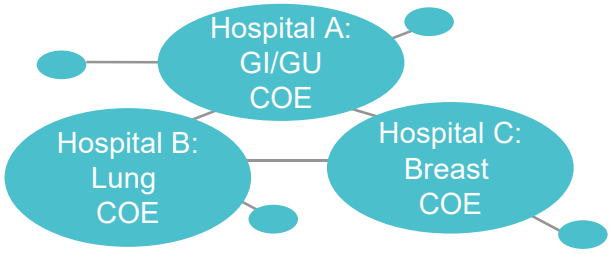
Hub-and-Spoke Model



Features

- Limited services for selected specialty at spoke hospitals
- Coordination between the hub and its spokes

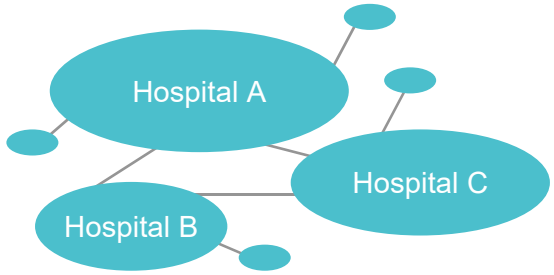
Distributed Model



Features

- Tumor site specialty focus (COE) varying by location
- Consistent policies and protocols within a service line

Coordinated Model



Features

- Service line coordinated across hospitals
- Relocation/consolidation considered based on a business case
- Service line distribution potentially driven by mix of clinical programs (similar to distributed model) and technological assets
- Extensive coordination required as patients may frequently receive care components at multiple locations

Regionalization Overview

Selecting the Right Service Line Model: Key Considerations

The optimal regional service line structure will vary by organization; success should be measured by the attainment of program goals. Numerous factors need to be considered when selecting the structure to implement.

Strategic

- Patients' ability/willingness to travel to another facility for differentiated services
- Degree of competitive response
- Size of service area/population to be served

Financial

- Nature of existing financial investments
- Effect of value-based reimbursement and other cost/financial factors
- Hospital and CEO performance incentive structures
- Available financial resources to support growth or restructuring efforts

Operational/Clinical

- Proximity of related services, resources, and expertise
- Potential to improve outcomes through service line redistribution and integration
- Type and location of existing clinical assets and expertise
- Existing data management and sharing capabilities
- Experience with clinical pathways

Cultural and Political

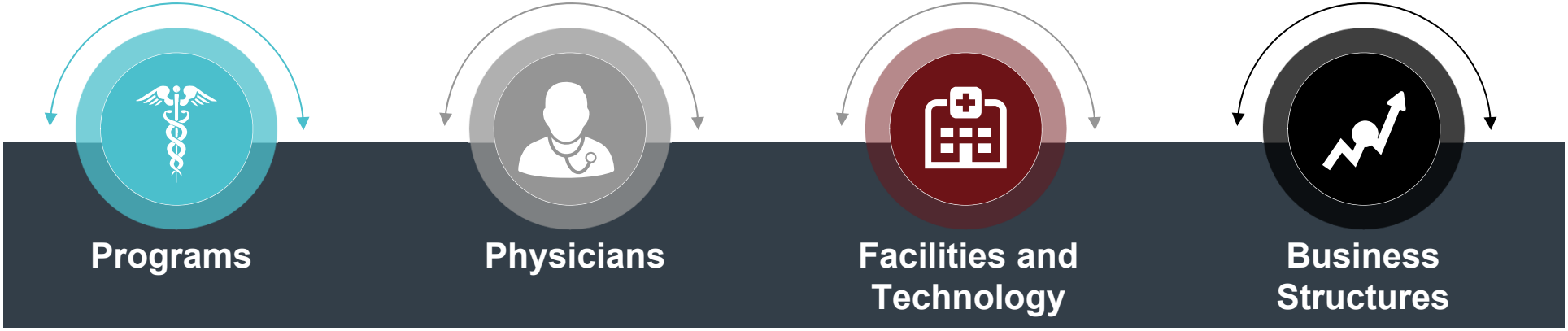
- Reactions of medical staff and hospital leadership
- Shift in mind-set from silo to system orientation
- Historic referral patterns and competitive dynamics: "us versus them" mentality
- Promises or agreements previously made with Boards of Directors, communities, local governments
- Prior commitments to medical staff members

Regionalization Framework

Aspects of a Service Line

A clinical service line has four key components. How these elements are addressed will define how the service line functions.

Service Line Components



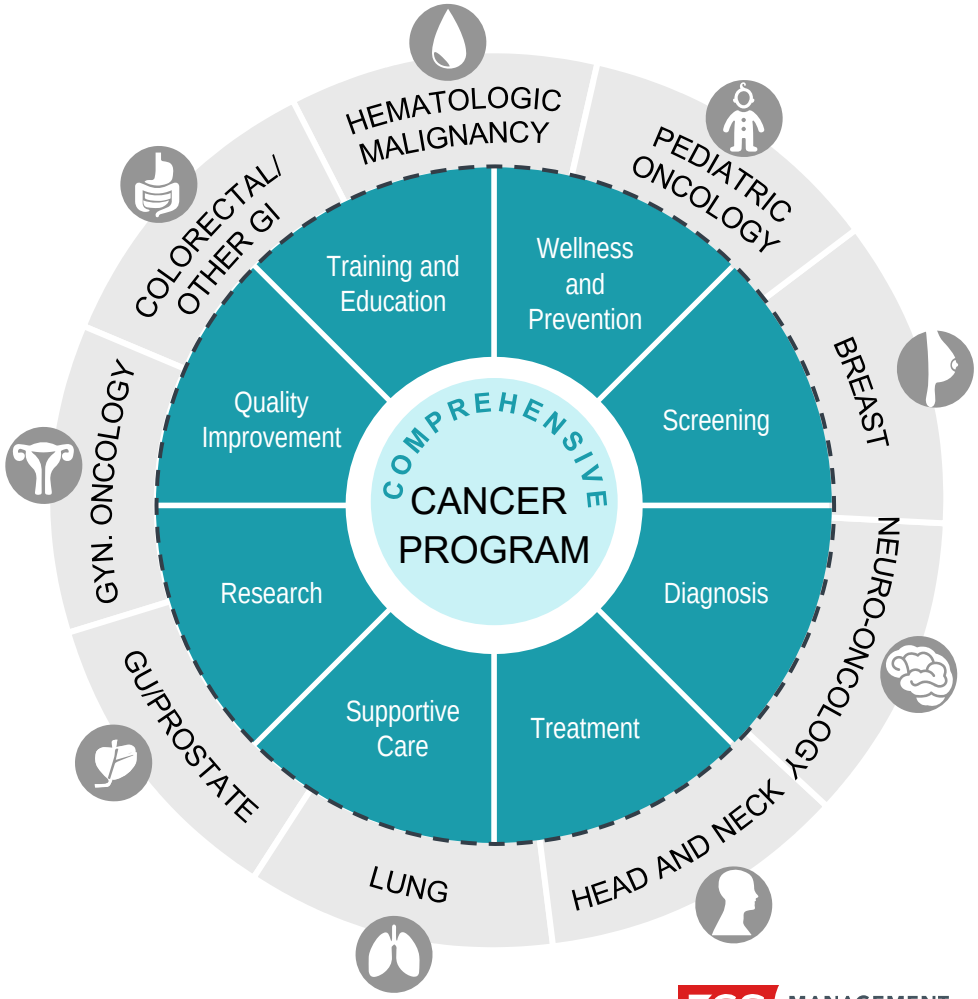
Programs	Physicians	Facilities and Technology	Business Structures
» Wellness and prevention » Screening » Diagnosis » Treatment » Supportive care » Research » Training and education » Quality improvement	» Subspecialty expertise » Leadership » Participation in clinical programs » Compliance with clinical pathways	» Specialty-, patient-, and provider-friendly facilities » Diagnostic imaging capabilities and access » State-of-the-art procedural, surgical, and medical capabilities » Appropriate mix of inpatient and outpatient facilities	» Governance and leadership » Regionalized or campus-based orientation, as appropriate » Financial stewardship » Operational effectiveness » Marketing and community outreach initiatives

Regionalization Framework

Programs

Service distribution in a regional program is a multivariate equation, addressing both tumor sites and clinical and supportive services.

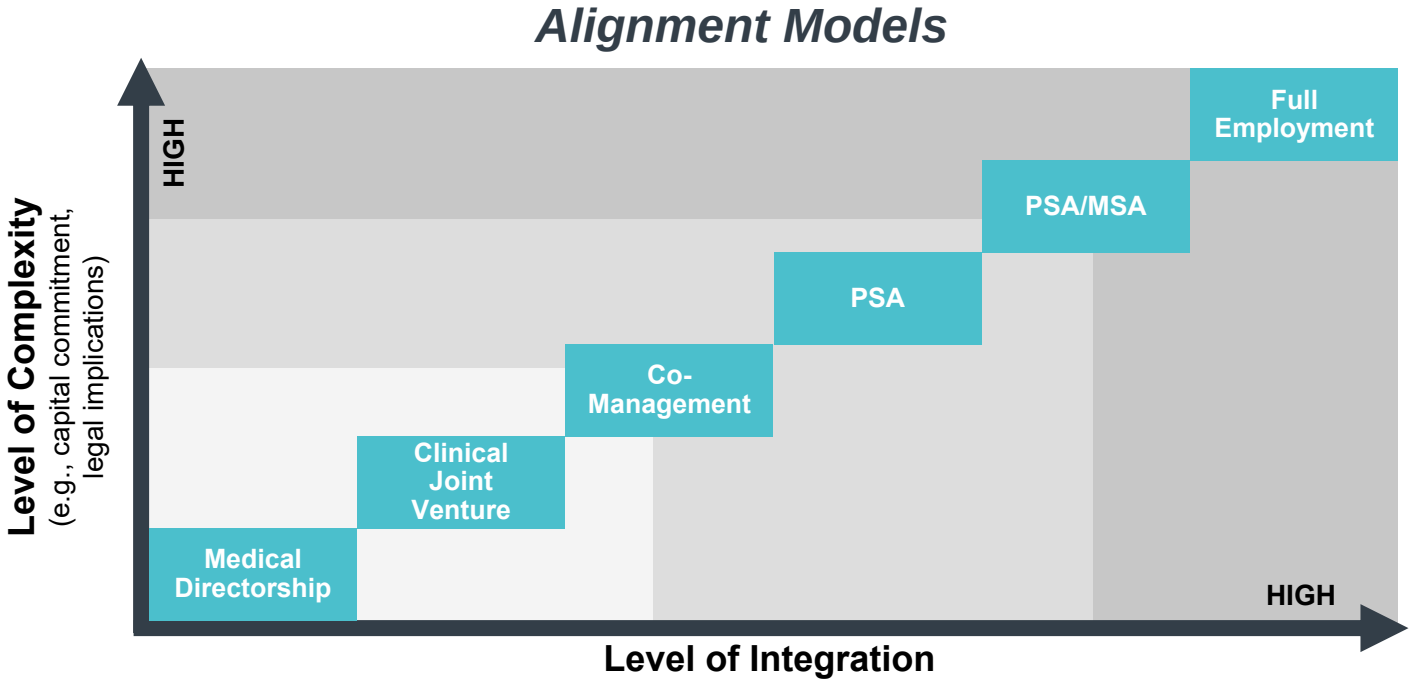
- In a hub model, all services would be centralized.
- A distributed model would allocate complete tumor-based programs (outer ring), including clinical and support services, to discrete locations.
- In a coordinated model, each site would have a service-centric focus (inner ring), and comprehensive tumor-based care would require visits to multiple locations.



Regionalization Framework

Physicians: Alignment Models

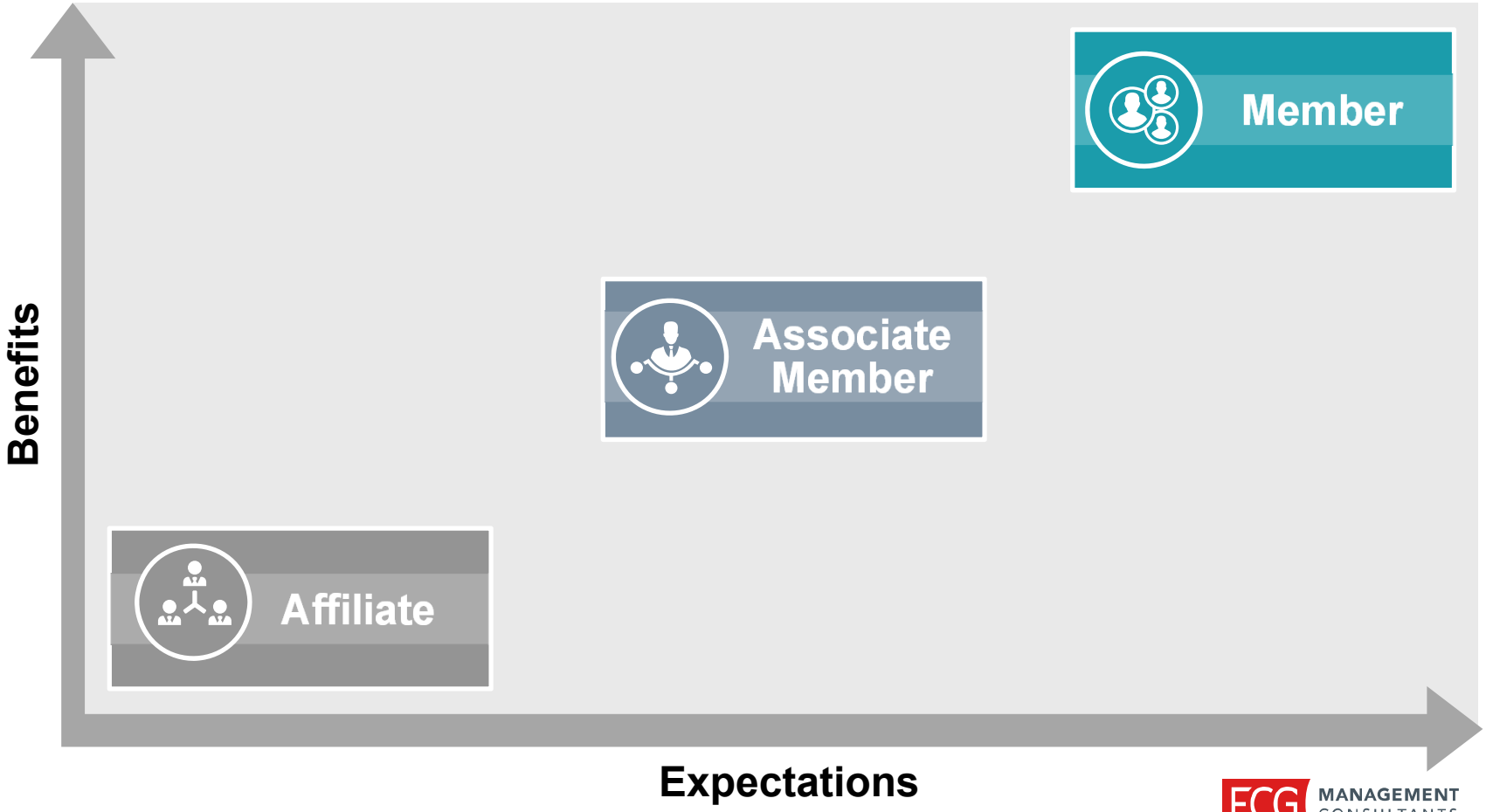
The physician alignment models will determine how physicians relate to the program. The greater the provider alignment, the easier it will be to improve coordination and navigate more complex regionalization structures. In many cases, however, organizations will have a mix of alignment models with providers.



Regionalization Framework

Physicians: Program Engagement

In addition to contractual alignment, physicians may choose to differentially engage with the program. Programs may create additional incentives/benefits for physicians who are willing to engage more significantly.



Regionalization Framework

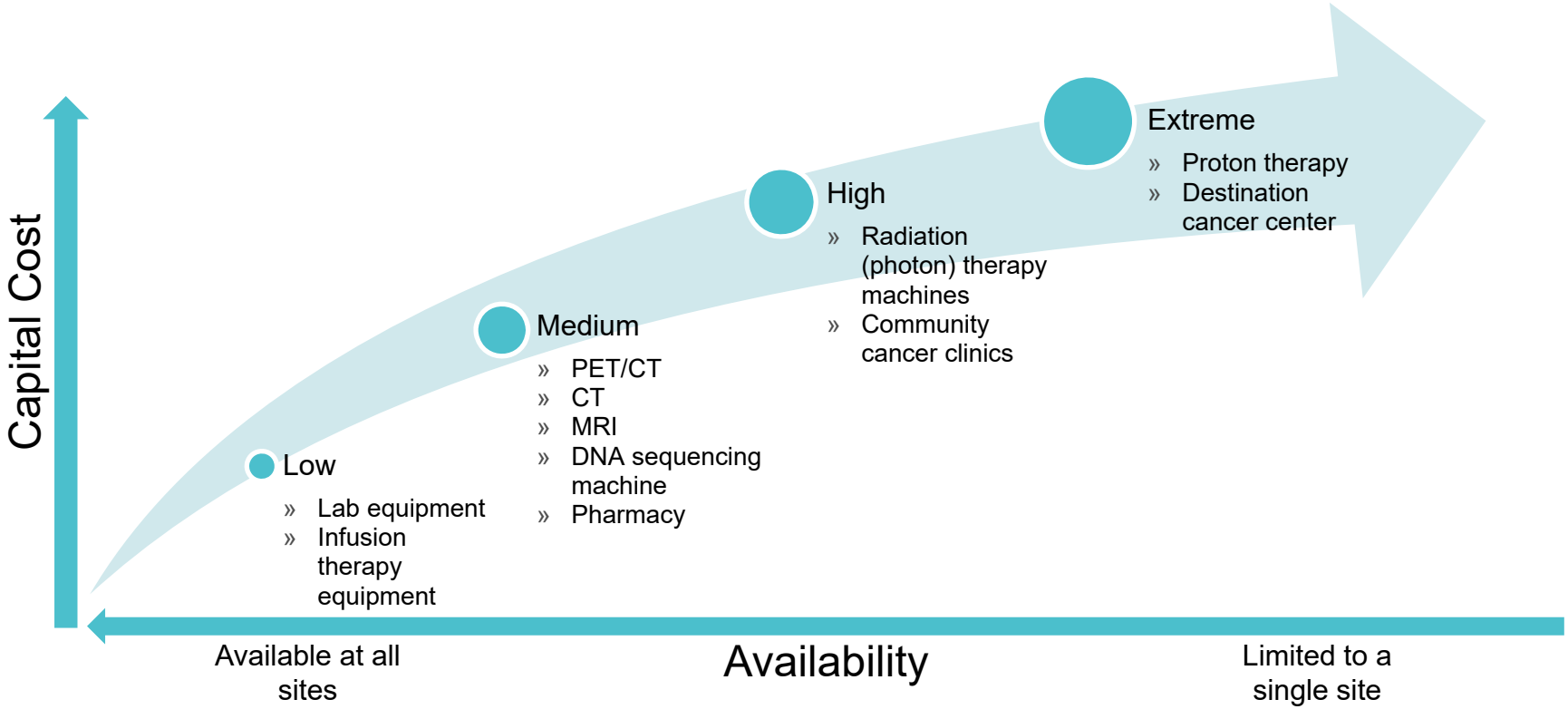
Physicians: Program Engagement Summary

	Affiliate	Associate Member	Member
Benefits	» Brand awareness/access to hospital name » Access to program communications » Connection to clinical support infrastructure » Participation in clinical care program committees » Access to health system–owned clinical services	Affiliate benefits plus: » Advertising cobranding » Priority access to clinical trials » Use of system support resources and technology » Clinical care program leadership opportunities » Access to multidisciplinary clinics	Associate member benefits plus: » Preferred designation in narrow network contracts » Shared savings opportunities » EHR integration » Clinical care program governance opportunities » Further financial alignment
Requirements	» Is affiliated with hospital » Is active in oncology services	» Is affiliated with hospital » Is active in oncology services » Participates in tumor board and multidisciplinary clinics » Participates in clinical research	» Is affiliated with hospital » Is active in oncology services » Participates in tumor board and multidisciplinary clinics » Participates in clinical research » Is involved in quality and outcomes initiatives
Expectations	n/a	» Shares data » Adheres to guidelines and protocols » Participates in tumor boards or multidisciplinary clinic » Participates in clinical research » Is active in teaching	Associate member expectations plus: » Is committed to clinical integration » Participates in outcomes and utilization review processes » Is active in teaching » Implements system initiatives » Integrates through EHR

Regionalization Framework

Facilities and Technology

Low-cost technologies (e.g., infusion therapy) can be deployed in large scale over a sizeable geography. High-cost clinical assets will be more selectively deployed.



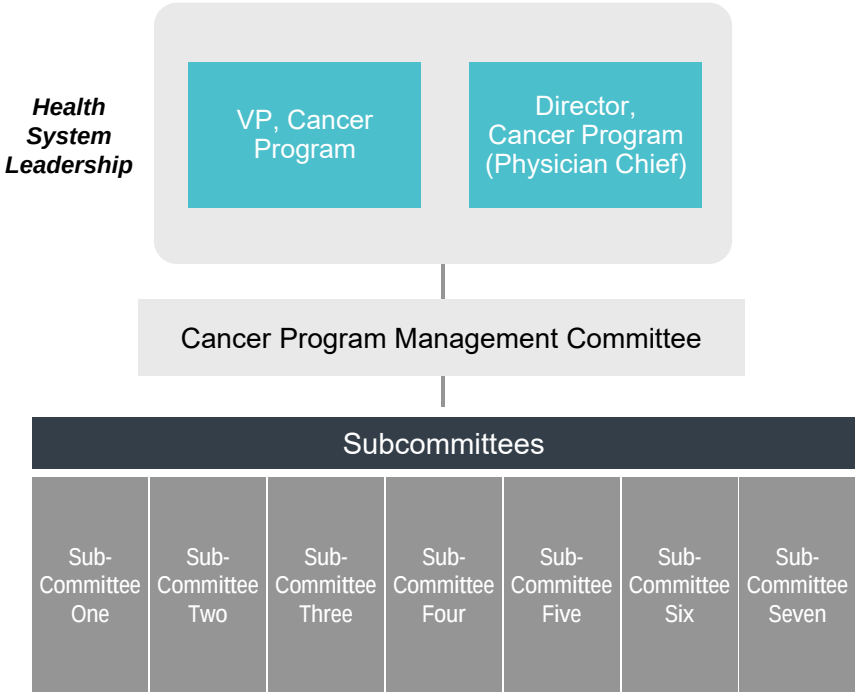
- **Hub:** All available at hub; limited availability at other sites
- **Distributed:** Required assets to support clinical programs at each site (most medium- and high-cost assets)
- **Coordinated:** Selective distribution of medium- and high-cost assets to minimize duplication; all assets available within a relevant geography

Regionalization Framework

Business Structure: Service Line Management

Optimally, a regional cancer service line business structure will balance the need for centralized decision making with the needs for local operational controls and tumor site–driven clinical leadership and program development.

- ***Health System Leadership:*** Senior leadership will oversee the cancer program direction and advise on and support service line activities.
- ***Cancer Program Management Committee:*** This entity maintains overall responsibility and oversight of program activities. It consists of physicians and members from the health system leadership team.
- ***Cancer Program Subcommittees:*** These subcommittees are responsible for the development, implementation, and review of site-specific, campus-level, and functional area activities; they will be composed of physicians.

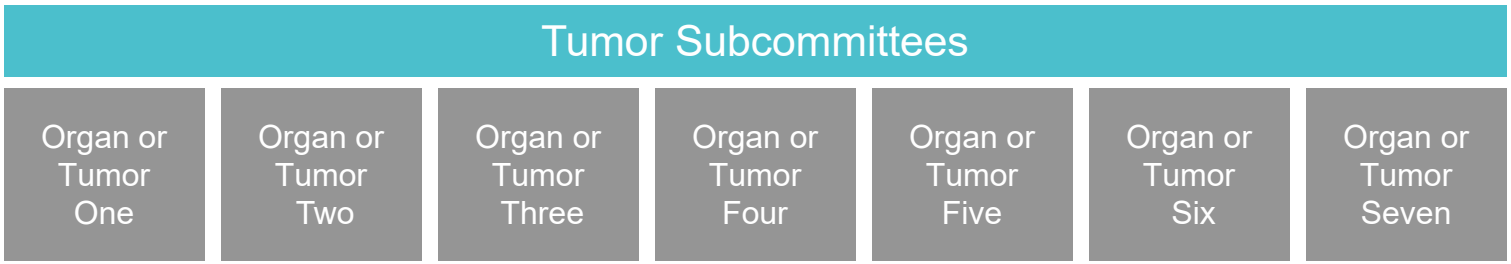


The design of the business structure should align with the type of regional model selected and the specific needs attendant to the model.

Regionalization Framework

Business Structure: Tumor Subcommittees

Tumor-based subcommittees are important to manage a regional clinical program; however, these subcommittees are especially vital in a coordinated program, where clinical assets and services to support a tumor program are distributed over multiple sites.



Characteristics

Address issues related to tumor sites.

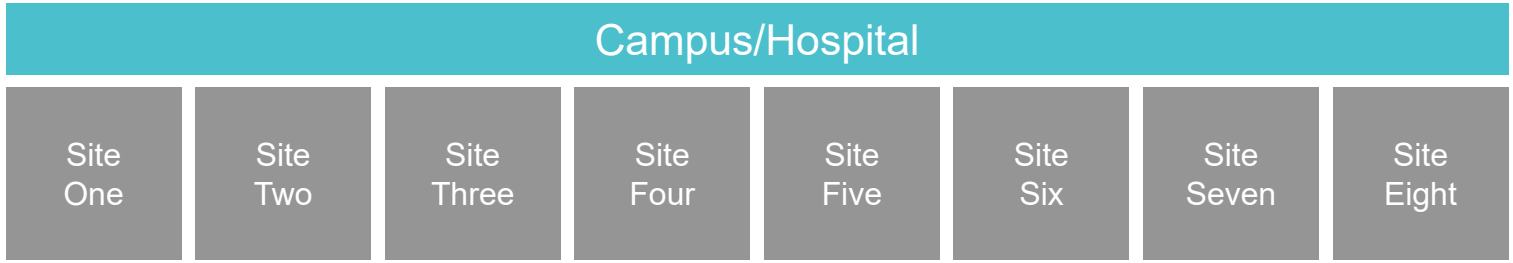
Roles and Responsibilities

- Recruit core group of providers.
- Develop treatment guidelines and pathways.
- Increase clinical trial accruals.
- Set tumor site standards of care across system, track data, and monitor clinical activity and provider performance related to criteria.
- Organize and oversee tumor boards and multidisciplinary clinics.
- Develop recommendations regarding strategic, clinical, and research initiatives at the tumor site level.

Regionalization Framework

Business Structure: Operational Subcommittees

Additional subcommittees may be used to oversee operations at the various sites. The scope of responsibilities and the committee membership will vary with the regional model selected.



Characteristics

- Dedicated to goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities at the site
- Multidisciplinary committee (represents all cancer services at the site)

Roles and Responsibilities

- Oversee the cancer program at the site, including operations.
- Implement strategies developed by system leadership.
- Develop programmatic needs for the local division based on direction from the Cancer Program Management Committee.
- Engage and empower local teams.
- Continue to conduct current-state assessments by site of service/facility.
- Analyze and refine current cancer program structure and processes (multidisciplinary clinics, tumor boards, clinical trials, etc.).
- Plan for system versus local needs (clinical, economic, quality and service, etc.).

Conclusions

Regionalization Model Options

While there is clear differentiation between the three regional models discussed, in reality many organizations will likely end up with a hybrid of these models.

	Programs	Physician	Facilities and Technology	Business Structures
Uncoordinated	Duplicated, incomplete	Fragmented, inconsistent alignment	Duplicated, incomplete	Local hospital-based governance and management
Hub-and-Spoke Model	» Breadth and depth at hub » Limited capabilities at spokes	» Strong alignment at hub; deep physician expertise » Less consistency in spokes	» Comprehensive at hub » Limited technology at spokes	» Dedicated service line management and governance for hub » Spokes managed/governed by hub or local structures
Distributed Model	Unique tumor-based focus at each location	» Physician alignment that varies by location » Clinical capabilities based on tumor site focus	» Potential for duplication of technology » Technology as needed to support programs at each site	Centralized management and governance for the program, spanning sites and programs
Coordinated Model	Clinical programs spread over campuses, each with unique capabilities	» High degree of collaboration between physicians/sites » Need for consistent physician alignment	Technology differentiated by campus to reduce duplication	Centralized management and governance for the program, spanning sites and programs

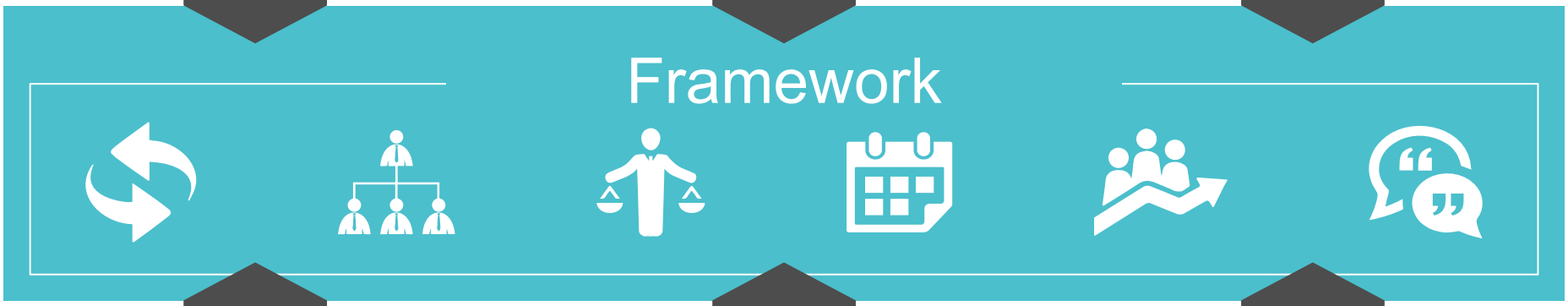
Conclusions

Framework for Success

System-wide base of cultural readiness

Clear ground rules and transparent decision-making criteria

Prioritization of areas with greatest potential



Stakeholder engagement at all levels

Adherence to a timeline

Regular communication of decisions, strategy, and progress

Questions & Answers

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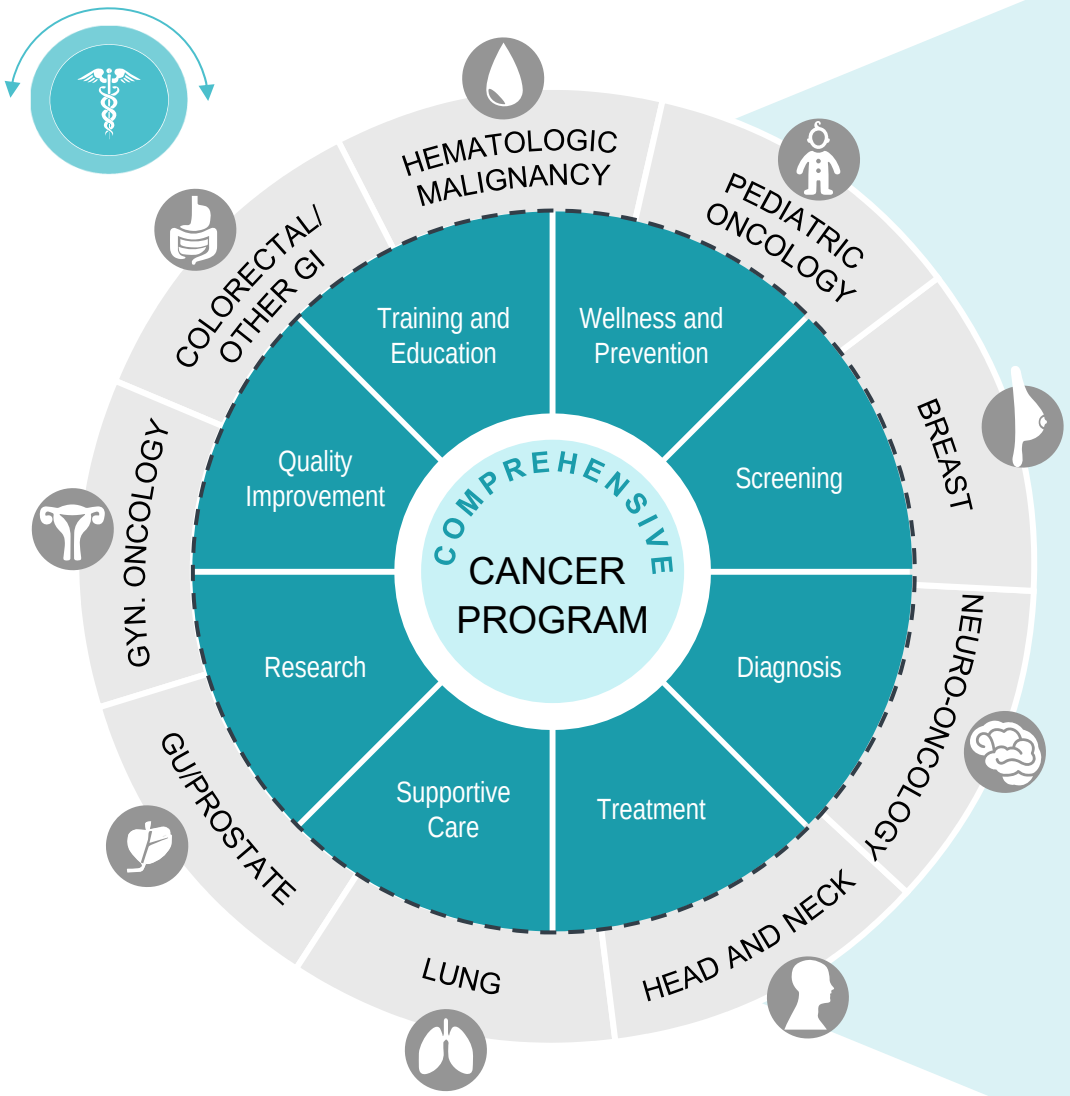
Appendix A: Programs

Service Line Framework



Wellness and Prevention
- » Adherence to National Guidelines
- » Genetic Counseling/Familial High-Risk Assessment
- » Education for Both Public and Professionals
- » Formalized Community Outreach
- » Integration with Primary Care/Other Specialties
- » Partnerships

Screening
- » Online, Self-Administered Tools
- » Patient Access
- » Primary and Specialty Care Clinics
- » High-Risk Assessments and Communication

Diagnosis
- » Early Detection Programs
- » Seamless Evaluation Completed in One Visit or Virtually in Two to Three Days
- » Pathology Expertise
- » Access to Advanced Imaging, Lab Testing, and Biopsy

Treatment
- » Evidence-Based Clinical Care
- » Prospective Tumor Boards
- » Multidisciplinary Care Plans
- » Care Coordination between Specialists
- » Complete Integration and Customization of NCCN Guidelines
- » Clinical Pathways Utilized in 90% of Applicable Cases

Appendix A: Programs

Service Line Framework *(continued)*

Training and Education
- » Professionals: CME, CEU, Clinical Rotations, Practicums, Internships, Residencies, Fellowships, Clinical Nurse Specialists, Credentials, Grand Rounds, and Care Team Conferences
- » Patients: Community Support Groups, Awareness and Marketing Campaigns, Self-Care, and Assessment Options

Quality Improvement
- » Real-Time Data to Actively Inform Program (Re)Design
- » Participation in National Quality Initiative
- » Tumor-Specific Reporting and Drillable Dashboards
- » Preparation for Value-Based Care

Research
- » Tumor-Specific Trials and Various Stages of Cancer
- » Activities Addressing Health Disparities
- » "Critical Mass" of Research Excellence, Innovative Scientists, and Relevant Grants
- » Collaboration with National and Other Entities (e.g., National Cancer Institute, WHO) or Trials (e.g., I-ELCAP, NLST)
- » Dedicated Research Coordinators and Data Management Support

Supportive Care
- » Dedicated Navigators
- » Physical and Occupational Therapy
- » Social Work, Psychosocial, Nutritional and Financial Counseling, and Support Groups
- » Complementary/Alternative Medicines
- » Integrated Palliative Care
- » Seamless Transition to Survivorship