How to Survive—and Thrive—in a System

Using oncology systemness to improve financial performance

The best practices are the ones that work for you.
1. Not realizing the benefits of system integration

2. Using oncology systemness to improve financial performance

3. Securing executive support
Systemness top of mind for oncology leaders

Majority of cancer programs impacted by continued consolidation

Results from Oncology Roundtable 2018 Agenda Setting Topic Poll

Percentage of respondents who ranked topic in top five research topics of interest

n=44 cancer program administrative and medical directors

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing for value-based reimbursement in oncology</td>
<td>66%</td>
</tr>
<tr>
<td>System strategy</td>
<td>57%</td>
</tr>
<tr>
<td>Patient consumerism</td>
<td>43%</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>39%</td>
</tr>
<tr>
<td>Staff engagement and retention</td>
<td>25%</td>
</tr>
</tbody>
</table>

1) Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; long term acute-care; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.

2) 3,494 of the 5,262 community hospitals in the US.

The elusive system advantage

Health systems struggle to realize potential benefits

Opportunities for health systems to improve financial performance

The hope  The reality

Drive market share and revenue growth

Facilities compete against each other for patients and program investments

Improve quality of care

No mechanisms to ensure care is standardized

Decrease cost of care

Overhead not reduced enough to achieve real savings

Source: Oncology Roundtable interviews and analysis.
Figuring out costs essential to survival

Operating expense growth outpacing revenue growth

Revenue and expense growth rates for non-profit hospitals

2009-2018 medians

Cancer program finances increasingly under threat

Reimbursement and policy changes impacting hospital-based cancer programs

2019 reimbursement updates
• 340B reimbursement holds steady at -22.5% for most providers, expands to non-excepted HOPDs
• Graded payment reduction for all off-campus HOPD clinic visits finalized
• Reimbursement for drug administration and radiation therapy remains steady, despite increasing cost of delivering care

New payment models
• CMMI’s voluntary Oncology Care Model pilot enters fourth year
• Mandatory radiation oncology bundle proposal pending
• Proposed new mandatory Medicare Part B drug pricing model pending

Payer mix shifts
• Increasing number of Medicare patients as Baby Boomers age
• Private practice physicians continue to shift unprofitable patients to HOPD as profitability of certain patients, drugs declines

Site-of-care shifts
• Commercial payers moving certain treatments out of HOPDs to combat rising drug costs
• Most currently exclude oncology patients, but could be expanded in the future

Source: CY 2019 Hospital Outpatient Prospective Payment System Final Rule, CMS; Oncology Roundtable interviews and analysis.

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Cancer program finances increasingly…(cont.)

Related resources available on advisory.com

- [2019 Oncology Medicare Reimbursement Update](#)
- [4 takeaways for cancer programs from the 2019 HOPPS final rule and HHS announcements](#)
- [Resources to optimize infusion center business and operations](#)
- [Your 4-step guide to prepare for a mandatory radiation oncology bundle](#)
- [Trump’s plan to cut drug spending: Let Medicare pay the same prices as international buyers](#)
- [Resources on CMMI’s Oncology Care Model](#)

Source: Oncology Roundtable interviews and analysis.
National scrutiny on hospital consolidation

Imperative 2: Reduce cost to customers

The New York Times

When Hospitals Merge to Save Money, Patients Often Pay More

Jennifer Lamprey, a radiologic technologist, adjusting a CT scan at the Saint Raphael campus of Yale New Haven Hospital, part of a bigger system set to control a quarter of Connecticut’s hospital beds. Christopher Capozziello for The New York Times

By Reed Abelson
Nov. 14, 2018

The New York Times

Hospital Mergers Improve Health? Evidence Shows the Opposite

The claim was that larger organizations would be able to harness economies of scale and offer better care.

By Austin Frakt
Feb. 11, 2019

The New House Democratic Majority Will Take Antitrust Oversight Seriously

Democrats will investigate monopolies, oversee the regulators and write new antitrust legislation.

By Paul Blumenthal

When it takes control on Thursday, the new House Democratic majority plans on serious oversight of corporate monopolies and the lax enforcement from federal antitrust agencies. It will target tech giants like Google and Facebook and health insurers Aetna, Cigna, Humana and Anthem while making sure Federal Trade Commission regulators are doing their job.

The Dems’ new push will focus on three areas: consolidation of health care markets driving up prices for consumers,

### Costs more prominent in stakeholder decisions

#### Customer reasons for being cost-driven and impact on high-cost cancer programs

<table>
<thead>
<tr>
<th>Customer</th>
<th>Cancer cost challenges</th>
<th>Implications for lower performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payers</td>
<td>63% increase in costs per commercially insured cancer patient between 2004-2014</td>
<td>Exclusion from narrow networks</td>
</tr>
<tr>
<td>Employers</td>
<td>1% of employer medical claims are for cancer treatment, but 12% of employer medical costs are for cancer treatments</td>
<td>Exclusion from preferred provider networks</td>
</tr>
<tr>
<td>Physicians</td>
<td>15% of providers’ 2019 MIPS&lt;sup&gt;1&lt;/sup&gt; score is based on total costs</td>
<td>Exclusion from ACOs&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Patients</td>
<td>Annual cost of cancer care is 49%&lt;sup&gt;3&lt;/sup&gt; of median annual household income for patients 65 years and older</td>
<td>Failure to capture self-directed patients</td>
</tr>
</tbody>
</table>

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1) Merit-based Incentive Payment System.  
2) Accountable care organizations.  
3) Accounts for direct and indirect costs of cancer care.

Ample room for improvement

Cost variation within systems needs to be a top priority

Panther Health System
Nine-hospital system in the Midwest

Chemotherapy
$3,331
difference in outpatient direct cost per case for chemotherapy between lowest- and highest-cost hospitals in the system

Radiation therapy
$1,390
difference in outpatient direct cost per case for radiation therapy between lowest- and highest-cost hospitals in the system

Serval Health System
Eight-hospital system in the Northeast

Chemotherapy
$4,050
difference in outpatient direct cost per case for chemotherapy between lowest- and highest-cost hospitals in the system

Radiation therapy
$3,780
difference in outpatient direct cost per case for radiation therapy between lowest- and highest-cost hospitals in the system

1) Pseudonym.
2) Outpatient direct cost per case only includes Medicare Part B hospital outpatient facility claims.
3) Data shown for 2017 Q3 through 2018 Q2.

Source: Health Care Advisory Board, The Hospital Performance Profiler, Washington, DC: Advisory Board, 2015; Oncology Roundtable interviews and analysis.
We know the playbook

Three major areas to control costs and appeal to purchasers

Maximize staff capacity
- Ensure top-of-license practice
- Flex staff across sites to meet patient demand
- Leverage telemedicine to extend staff capacity
- Find opportunities for automation

Streamline operational overhead
- Consolidate contract negotiations
- Centralize administrative functions
- Rationalize sub-specialized services
- Outsource select non-core functions

Reduce care variation
- Eliminate unnecessary care
- Develop clinical care standards
- Implement clinical pathways
- Create comprehensive care pathways

Source: Oncology Roundtable interviews and analysis.
But lack of integration stands in the way

Poor communication, lack of unified strategy lead to duplication of efforts

A system in name only...

- Regional system in urban market includes two large teaching hospitals; system operates mainly as holding company
- Each hospital pursuing partnership strategies independently
- “Gentleman’s agreement” defines spheres of influence in surrounding region

...tripping over its own feet

- Both hospitals begin to court out-of-market partners for emerging national strategy
- Parent system exercises no oversight; efforts uncoordinated
- **Hospitals discover each other’s representatives in distant state competing for same affiliation agreement**

Source: Health Care Advisory Board interviews and analysis; Oncology Roundtable interviews and analysis.
Missing foundational elements

System efforts to control oncology costs hampered by integration barriers

Barriers to optimal system integration in three key areas

**Leadership**
- Lack of forums for collaboration
- Incentives tied to site performance
- Tension between site- and system-level priorities
- Lack of executive support

**Data**
- Lack of IT platforms to aggregate data
- Lack of funds for investment
- Lack of analytic support
- Lack of data accountability

**Physicians and staff**
- Lack of opportunities to collaborate
- Incentives tied to site performance
- Cultural differences between sites
- Unfamiliarity with peers at other sites

Source: Global Forum for Health Care Innovators, *From Gridlock to Governance*, Washington, DC: Advisory Board, 2018; Oncology Roundtable interviews and analysis.
Using systemness to improve financial performance

Three hallmarks of successful health systems

1. **Unified oncology leadership**
   1. Create collaboratives to drive system progress
   2. Use incentives to promote system priorities
   3. Ensure system-level oversight of investment decisions

2. **Data-driven decision-making**
   4. Use data as a common language to assess system performance
   5. Assign accountability for ongoing performance analysis

3. **Shared system identity**
   6. Standardize role responsibilities across sites
   7. Implement a site-agnostic staffing model
   8. Tie staff bonuses to system performance

Source: Oncology Roundtable interviews and analysis.
1. Not realizing the benefits of system integration

2. Using oncology systemness to improve financial performance

3. Securing executive support
Unified oncology leadership

- Tactic 1: Create collaboratives to drive system progress
- Tactic 2: Use incentives to promote system priorities
- Tactic 3: Ensure system-level oversight of investment decisions
## Structural, operational barriers prevent collaboration

### Ideal state of oncology service line leadership

#### Collaboration
- Site leaders work together on cost control initiatives on an ongoing basis
- Advocate to executives as a team

#### Prioritization
- Consider impact on system costs when making decisions
- Willing to change clinical and support service offerings to maximize utilization and minimize costs across the system

#### Decision-making
- Yield authority for cost-related decisions to the system-level leadership

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### The reality

#### Collaboration
- Site leaders speak to each other on an ad hoc basis
- Struggle to make the case for investment to executives

#### Prioritization
- Compete for limited resources, including subspecialists and patients
- Do not prioritize referring patients to the most cost effective and convenient site of care

#### Decision-making
- Make cost-related decisions based solely on implications for their site

Source: Oncology Roundtable interviews and analysis.
Better together

Three tactics to unify oncology leaders to achieve system goals

TACTIC 1
Create collaboratives to drive system progress

TACTIC 2
Use incentives that promote system priorities

TACTIC 3
Ensure system-level oversight of investment decisions

Source: Oncology Roundtable interviews and analysis.
We don’t have a formal oncology council, but I’ll network with cancer program administrators at other hospitals in the system when I have a specific question. For example, when I wanted to learn how other cancer programs in my system were providing physician supervision, I built my own ‘network’. I went online and looked up each hospital in my system to see if they offered infusion services. Then I called the cancer program administrators for those sites myself.”

Director of Cancer Services,
National network of 50+ hospitals
System progress requires formalized collaboration

Many ways to improve financial performance of the oncology service line

- Share best practices for cost control
- Rationalize investments
- Understand and benchmark service line costs
- Identify opportunities to capture operational efficiencies
- Evaluate opportunities for standardization
- Find innovative solutions to common challenges

Source: Oncology Roundtable interviews and analysis.
Forum helps site leaders team up to reduce costs

Collaborative formed to foster system-level thinking and reduce variation

Franciscan Health’s Oncology Service Line Collaborative

Impetus
Increased pressure to improve operational and financial performance due to:
• Increasing payer pressure (narrow networks, shifts in payer mix, declining reimbursement)
• New emerging competitors and disruptors
• Variation in quality processes and outcomes
• Growing cost of equipment, IT, service agreements
• Uncertainty of health care reform

Mission
• Engage decision-makers at each hospital in the system
• Cultivate system-level thinking so they make decisions with the whole system in mind not in a vacuum
• Identify and standardize variation

Composition
• Director of Cancer Services from all 13 sites
• System Director, Operations Transformation
• Supply chain management, revenue cycle, clinical engineering, information technology

Source: Franciscan Health, Mishawaka, IN; Oncology Roundtable interviews and analysis.
Franciscan Health

- 13-hospital non-teaching community health system based in Mishawka, Indiana with locations throughout Indiana and Illinois
- 4,500 analytic cases annually
- Mix of employed and independent oncologists; Aria and Mosaic EHRs for radiation oncology, Epic for medical oncology

► Franciscan Transformation Team (FTT) formed Oncology Service Line Collaborative as a forum for oncology program leaders to work together as a system to improve operational and financial performance

► Directors of Cancer Services from all 13 sites in the system meet every six to eight weeks at a central location to share experiences, solve common challenges, and identify opportunities to standardize variation

► Collaborative has undertaken a number of initiatives, including a centralized tumor registry service; standardization of national accreditation program policies and procedures (e.g., CoC, NAPBC); reduction in variation of IT systems; system-level service agreements; and standardization of lung cancer screening programs

Source: Franciscan Health, Mishawaka, IN; Oncology Roundtable interviews and analysis.
Off to a good start

Collaborative has undertaken a variety of standardization projects

Sample Oncology Service Line Collaborative initiatives

**STANDARDIZE TECHNOLOGY**
- Supply and technology vendors
- Tumor registry software

**STANDARDIZE PROCESSES**
- National accreditations (distress screening, survivorship care planning)
- Screening programs (lung CT, high-risk breast cancer)

**CENTRALIZE AND CONSOLIDATE KEY TASKS**
- Vendor service agreements
- Oversight of tumor registrars
- Prior authorization and denials management

**MEASURING SUCCESS**
Collaborative is in the process of creating a dashboard to track progress and impact of service line initiatives

Source: Franciscan Health, Mishawaka, IN; Oncology Roundtable interviews and analysis.
Focus your collaborative on high-value projects

Top priorities for collaboratives to tackle

**One-off projects**

- Standardize technology
- Consolidate vendor contracts
- Centralize and/or consolidate administrative functions
- Develop a system to flex staff across sites based on patient demand

**Ongoing projects**

- Pilot initiatives at different sites
- Share best practices
- Develop care guidelines
- Drive strategic plan initiatives
- Communicate about staffing needs
- Evaluate optimal placement of services within the system
- Review system-level data and benchmark site performance

Source: Oncology Roundtable interviews and analysis.
The biggest road block to building synergy across oncology leadership groups in our system is that we measure and reward individual location performance. You see this in the way we set up budgets and how we structure compensation and incentives for leaders. If these aren’t at a system level, leaders are incentivized to work for their individual good, not across sites.”

Director of Cancer Services,
Regional health system with 10+ hospitals
Many oncology leaders’ salaries are already at risk

Next step: Tie site leader bonus to both system and site performance

Tactic 2: Use incentives that promote system priorities

Oncology leader salary at risk

44% of oncology administrators (n=84) reported that their bonus is tied to service line performance

Percentage of oncology service line administrator salary at risk

Percentage of respondents who indicated risk-based incentive structure

n=47

- 26%
- 30%
- 17%
- 13%
- 15%

1) Percentages do not add up to 100% due to rounding.
2) Percentages do not add up to 100% because respondents were asked to select all that apply.

Metrics included in oncology administrator incentive bonus

Percentage of respondents who indicated risk-based incentive structure

n=47

- Financial performance: 88%
- Patient experience: 83%
- Operational performance: 81%
- Clinical quality: 75%
- Staff engagement: 63%
- Other: 7%

Source: 2014 Oncology Roundtable Service Line Strategy Survey; Oncology Roundtable interviews and analysis.
Measure performance as a system, not by site

MedStar consolidates financial reports to remove barriers to collaboration

Evaluation of oncology service line financial performance at MedStar Health

- System leaders review consolidated financial statement for all four cancer centers in system

Don’t look at individual cancer center performance

- Performance is on target

- Performance is below target

Look at individual cancer center performance

Benefits of shared bottom line approach

- Reduces intra-system competition
  Cancer program leaders at each site measured by system performance, not their individual cancer program’s

- Enhances visibility of system-level performance
  Enables accurate assessment of financial state of the oncology service line across system as a whole

- Enables patient tracking across sites
  Reveals patterns about patient movement between sites of care

- Improves decision-making capabilities
  Consolidated report expected to make data needed for strategic planning more accessible

Source: MedStar Health, Washington, DC; Oncology Roundtable interviews and analysis.
CASE EXAMPLE

MedStar Health

• Five-hospital health system based in Washington, District of Columbia
• Cerner EHR

► Consolidated each of its four cancer programs’ financial statements into a single report to encourage cancer program leaders to work together as a system rather than four individual facilities

► Spent years determining the optimal coding to identify cancer patients within the health system’s IT platforms, validating data inputs from each site, and refining metrics to create a consolidated statement that accounts for 99% of all oncology services provided at MedStar; report is automatically generated each month and maintained by one FTE financial analyst

► Because system leaders no longer review facility-level performance unless the service line is underperforming, competition between sites for resources (e.g., subspecialists and patients) has decreased; consolidated report also enhances visibility of system-level performance, enables patient tracking across sites, and improves decision-making capabilities

Source: MedStar Health, Washington, DC; Oncology Roundtable interviews and analysis.
Creating combined statement not easy but worth it

MedStar Health’s process for creating system-wide oncology financial statement

- Determine optimal service line definition based on ICD-9 codes
- Validate that data collection and compilation processes are correct by running sample reports
- Ensure all hospitals in system are on same reporting system
- Standardize metrics collected across all sites, correct for differences in reporting dates
- Continuously refine reports to improve accuracy and relevance

Source: MedStar Health, Washington, DC; Oncology Roundtable interviews and analysis.
# How to define oncology’s financial contributions

<table>
<thead>
<tr>
<th>Resource requirements</th>
<th>Challenges</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-10 analysis</strong></td>
<td>• Standard billing and clinical systems currently at use in most hospitals&lt;br&gt;• Advanced decision support capabilities helpful, not essential</td>
<td>• Appropriate ICD-9/10 code not always used in OP setting&lt;br&gt;• Gaining executive buy-in often challenging</td>
</tr>
<tr>
<td><strong>Expected value analysis</strong></td>
<td>• Tumor registry with complete, up-to-date patient information&lt;br&gt;• Advanced decision support capabilities, standardized data pulls</td>
<td>• Linking volumes with financials often difficult&lt;br&gt;• Time consuming to replicate for tumor sites</td>
</tr>
<tr>
<td><strong>Downstream revenue analysis</strong></td>
<td>• Advanced decision support capabilities&lt;br&gt;• Linkage between systems at satellite locations and hospital systems</td>
<td>• Defining appropriate patient population for analysis&lt;br&gt;• Linking volumes with financials</td>
</tr>
<tr>
<td><strong>Activity-based costing</strong></td>
<td>• Advanced activity based cost accounting with necessary systems support&lt;br&gt;• Ability to link departmental systems into system</td>
<td>• Very resource intensive, with long roll-out period&lt;br&gt;• Implementation of ABC system usually hospital-wide decision</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
## Figure out what you can roll up

### Sample metrics impacting the financial performance of the oncology service line

<table>
<thead>
<tr>
<th></th>
<th>Fee-for-service metrics</th>
<th>Value-based care metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Market position</strong></td>
<td><strong>Operations</strong></td>
<td><strong>Share of continuum</strong></td>
</tr>
<tr>
<td></td>
<td>• Total volumes</td>
<td>• Outmigration by treatment modality</td>
</tr>
<tr>
<td></td>
<td>• Percent of appointments used</td>
<td>• Change in market share by tumor site</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td><strong>Service line profitability</strong></td>
<td><strong>Episode value</strong></td>
</tr>
<tr>
<td></td>
<td>• Payer mix</td>
<td>• Number of ED visits per cancer patient per year</td>
</tr>
<tr>
<td></td>
<td>• Direct cost variation by subspecialty, procedure</td>
<td>• Percentage of patients receiving chemo in last two weeks of life</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td><strong>Satisfaction</strong></td>
<td><strong>Service quality</strong></td>
</tr>
<tr>
<td></td>
<td>• Patient satisfaction</td>
<td>• Rate of hypofractionation</td>
</tr>
<tr>
<td></td>
<td>• Employee satisfaction</td>
<td>• Patient likelihood to recommend</td>
</tr>
<tr>
<td><strong>Clinical performance</strong></td>
<td><strong>Quality</strong></td>
<td><strong>Evidence-based care</strong></td>
</tr>
<tr>
<td></td>
<td>• Joint commission patient safety metrics</td>
<td>• Percentage of patients discussed in multidisciplinary conference</td>
</tr>
<tr>
<td></td>
<td>• Five-year survival rates</td>
<td>• Percentage of patients screened for symptoms</td>
</tr>
</tbody>
</table>

Figure out what you can roll up (cont.)

Related resources available on advisory.com

- Measuring Oncology Service Line Performance
- Oncology Dashboard Toolkit
- Keep a close watch on service line performance
Centralize decision-making authority

Elevate investment decisions to avoid unnecessary spending

Consequences of local autonomy

- Organizations hemorrhage avoidable, low-value spending
- Having too many decision-makers leads to varying choices
- Subject matter and supply chain experts are not consulted
- No or limited accountability
- Unnecessary duplication of purchases (e.g., human capital, technology, drugs)

Benefits of centralization

- Represents the collective voice of entire oncology service line
- Balances site needs against available resources and impact on system
- Serves as conduit for idea-sharing and problem-solving across sites
- Helps identify shared goals across sites and between sites and system
- Manages differences of opinion and facilitates consensus when possible

Source: Oncology Roundtable interviews and analysis.
Main Line Health’s oncology service line re-organization to better control costs

**Phase 1**
- Branded their four cancer programs as Main Line Health Cancer Care
- Centralized several administrative functions (e.g., registry, genetics)
- Created tumor site workgroups
- Appointed system-level oncology administrative and medical directors with system goals and objectives but **limited direct authority over sites**
- Formed Cancer Leadership Council (CLC) to incorporate key physician leaders into program discussions

**No impact on cost control**

**Phase 2**
- System appointed executive lead (campus president) for oncology
- Redefined administrative and medical director roles to focus on strategic initiatives and include more **direct authority over sites**
- Reconstituted Cancer Care Council focused on evaluating clinical and programmatic needs across the system
- Formed Cancer Care Management Committee (CCMC) with **formal oversight of all cost-related decisions** across the system

**Improved cost control**

Source: Main Line Health, Bryn Mawr, PA; Oncology Roundtable interviews and analysis.
Main Line Health

- Four-hospital health system based in Bryn Mawr, Pennsylvania
- 3,400 analytic cases annually
- Mix of private and employed oncology physicians; Epic EHR used by employed physicians

► Formed the Cancer Care Management Committee (CCMC) to centralize spending and other strategic decisions at the system level in an effort to better control oncology costs to offset declining reimbursement

► Composed of oncology service line executive sponsor, VPs of each hospital, System Director of Cancer Care, Medical Director for the Cancer Program, medical oncologist over clinical research, and representatives from finance, marketing, and business development

► Decisions about division strategies, cost allocation, capital resources, and physician recruitment now made with financial impact on the system in mind, not just individual sites

Source: Main Line Health, Bryn Mawr, PA; Oncology Roundtable interviews and analysis.
Oversight of oncology cost decisions

Composition

- Oncology service line executive sponsor
- VPs of four hospitals
- System Director of cancer care
- Medical Director for the cancer program
- Medical oncologist over clinical research
- Representatives from finance, marketing, and business development

Purview and Impact

- Decisions impacting all four campuses in the system
- Strategic decisions, such as cost allocation, capital resources, physician recruitment, and clinical investments
- Cost-related decisions made with respect to what will benefit the whole service line, although funds still flows through individual campuses

Source: Main Line Health, Bryn Mawr, PA; Oncology Roundtable interviews and analysis.
Committee achieves savings for system in year one

CCMC has final vote after tumor site groups and physician council vet

Main Line Health’s process for reviewing capital requests

<table>
<thead>
<tr>
<th>TUMOR SITE WORKGROUP</th>
<th>CANCER CARE COUNCIL (CCC)</th>
<th>CANCER CARE MANAGEMENT COMMITTEE (CCMC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Discusses capital requests to identify clinical impact, quality and patient safety, and to vet system/campus dynamics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Presents capital request at CCC and CCMC meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reviews all capital requests related to clinical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prioritizes requests in order of recommendation for approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reviews requests recommended for approval by CCC with respect to system strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Makes final recommendation to Senior Executive Committee for or against approval of requests</td>
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</tr>
</tbody>
</table>

Sample cost savings

- **$210K** saved by deciding to flex physicists and dosimetrists between sites
- **$120K+** saved by assessing surgeons’ interests at each site to inform purchasing and placement of SAVI SCOUT®

Source: Main Line Health, Byn Mawr, PA; Oncology Roundtable interviews and analysis.
Be thoughtful in establishing centralized oversight

### Three key questions for centralizing oversight of investment decisions

1. **What types of decisions fall under purview?**
   *For example: spending decisions, all investment decisions, or all service line decisions*

2. **Who is responsible for oversight?**
   *For example: system-level role and/or committee with representatives from all sites in the system*

3. **How will oversight entity be created?**
   *For example: create new entity or assign authority to existing centralized entity*

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### Key responsibilities of centralized oversight entity

- Vet proposals for deployment and placement of new services and technologies
- Provide preliminary approval for strategic capital requests
- Maintain control over a central service line supply budget
- Participate in workforce planning decisions and assist with physician recruitment strategy
- Identify and implement cost improvement initiatives

Source: Oncology Roundtable interviews and analysis.
Partner to get executive support to unify service line

Tips for making a compelling business case to system executives

Power in numbers
Partner with other oncology site leaders to give more weight to the request

Use physicians to help your case
Enlist the help of a physician and/or executive champion to help convey your message more effectively

Your agenda is their agenda
Map service line request to institutional priorities and highlight the oncology service line’s contribution to the institution

Show the ROI
Quantify the problem and potential impact of request

Need help with your next business case?
Leverage the Oncology Roundtable’s research team and resources to help you build your case and reinforce key messages to executives

Source: Oncology Roundtable interviews and analysis.
Don’t take “no” for an answer

Questions to ask if executives reject initial request

- What’s the key decision-making factor for you?
- What investments are in competition with my request?
- How well-matched is this request with current institution priorities?
- When should we address this issue again?
- What information was I missing that you would have liked to see?
- How can I structure information to make decision-making easy for you?
Next steps: Unified oncology leadership

At the system level

- **Communicate and emphasize** the value of cross-site collaboration

- **Ensure** leaders have time to share ideas, discuss challenges, and brainstorm solutions together

- **Propose and vet** biggest opportunities for collaboration

- **Provide clarity** on how service line goals and overall system goals intersect

- **Be prepared** to address site concerns about losing independence

- **Gather input** on ways to re-incentivize site leaders

At the site level

- **Garner support** from other site leaders and executives for system-wide collaboration

- **Reframe success** in terms of the system, rather than your site specifically

- **Be open and transparent** about your site’s performance and opportunities to improve— as well your best practices and challenges

- **Include** a system-wide oncology goal in your individual performance or business goals

Source: Oncology Roundtable interviews and analysis.
Data-driven decision-making

Tactic 4: Use data as a common language to assess system performance
Tactic 5: Assign accountability for ongoing performance analysis
Systems struggle to use data to improve finances

Ideal state of oncology decision-making

**Data synthesis**
- Cost, quality, and clinical data is collected from all sites across a system
- Data is integrated from multiple sources into a centralized, usable format

**Accountability for data analysis**
- Data integrated from all sites to identify areas of variation and cost reduction opportunities across the system
- Opportunities are contextualized and prioritized based on system goals

The reality

- Data is collected at the site level, or not at all
- Lack of integration between sites and across platforms hinders data collection
- System-level data is not usable

- Data analyzed in isolation at each site, without broader system context or insight
- Data used to justify previously made decisions

Source: Oncology Roundtable interviews and analysis.
Data is critical to your success

Two tactics to help systems make data-driven decisions

**TACTIC 4**

Use data as a common language to assess system performance

**TACTIC 5**

Assign accountability for ongoing performance analysis
Tactic 4: Use data as a common language to assess system performance

Infrastructure needed to speak the same language

Analytic support and IT critical for overcoming data challenges

<table>
<thead>
<tr>
<th>Potential resources</th>
<th>Current resources</th>
<th>Impact of poor data on downstream decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT team</td>
<td>40% of cancer programs have partial or full-time dedicated financial analyst (median 0.28 FTE)</td>
<td>Systems don’t collect complete data from all sites</td>
</tr>
<tr>
<td>Business intelligence team</td>
<td>33% of cancer programs have partial or full-time dedicated data analyst (median 0.25 FTE)</td>
<td>Decision-makers lack the data to inform a shared understanding of system issues</td>
</tr>
<tr>
<td>Tech platform vendor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existing cancer program staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Platforms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data marts</td>
<td>97% of cancer programs have EHR interoperability challenges</td>
<td>Lack of consensus on system agenda and measuring progress</td>
</tr>
<tr>
<td>Data warehouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data lake</td>
<td>14% of health systems have data lake architectures in mainstream production</td>
<td></td>
</tr>
<tr>
<td>Automated data collection platform</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: 2014 Oncology Roundtable Service Line Strategy Survey; 2018 Trending Now in Cancer Care Survey; 2018 Health Care IT Advisor Analytics and AI Survey; Oncology Roundtable interviews and analysis.
Get the right team in place

Jaguar overhauls data analytics to provide dedicated service line support

Analytic support for Jaguar Health¹ Cancer Center

Quality teams

- Composed exclusively of clinicians
- Separate teams across multiple sites

Registry teams

- Composed exclusively of registrars
- Separate teams across multiple sites

Cancer Informatics Team

33 FTEs

- 19 registrars
- 14 dedicated clinicians, industrial engineering analysts, and project managers

Benefits

- Removes bias from data analysis and variance identification
- Provides an objective perspective on data interpretation
- Provides the raw material for clinical leaders to make decisions

Source: Oncology Roundtable interviews and analysis.

¹) Pseudonym.
Jaguar Health System\(^1\)

- Multi-hospital health system on the East Coast
- 5,000+ analytic cases
- Cerner EHR

- Consolidated existing quality and registry teams based at each hospital into a system-wide Cancer Informatics Team to monitor cost and quality variation across the oncology services line

- Team is composed of registrars, clinical experts, and engineering support to collect, analyze and interpret data from all sites across the system

1) Pseudonym.
Create a single source of truth

Informatics Team supports oncology projects with rigorous data analysis

Jaguar Health’s\(^1\) Cancer Informatics Team process for collecting and analyzing data

Clinical leader voices concern or project idea

- Informatics Team defines relevant patient population
- Pulls in service utilization and cost data for relevant patient population
- Identifies trends, abnormalities, or variances in service utilization or cost data
- Presents findings to Clinical Value Committee for discussion

Director of Cancer Informatics Team and clinical leaders select Committee initiatives based on data and Committee member input

- Informatics team monitors progress of Committee initiatives

Benefits of dedicated, oncology-specific data support

- Single source of truth on analytic pathways
- Ongoing variance monitoring
- Familiar with which data sources are useful for various tasks
- Understands the capabilities and limitations of data
- Unbiased voice to presenting data for leadership decisions

Source: Oncology Roundtable interviews and analysis.

---

1) Pseudonym.
A shared database for performance transparency

UAB uses database to target care variation across the network

**Shared network database**

*Data aggregated from 12 network sites*

- Tumor Registry
- Claims Data

**Performance reports**

- Produces overall and site-specific reports outlining physician adherence to nine Choosing Wisely metrics
- Includes six ASCO-endorsed metrics and three ASTRO-endorsed metrics

**Why Choosing Wisely?**

- Sets fairly low, uncontroversial bar for care standardization
- Focuses on areas of care overuse without proven clinical benefit

Source: Rocque G, “Choosing Wisely: Opportunities for Improving Value in Cancer Care Delivery?” *Journal of Oncology Practice*, 13, no. 1 (2017): e11-e21; UAB Medicine, Birmingham, AL; Oncology Roundtable interviews and analysis.
UAB Medicine

• Academic medical center based in Birmingham, Alabama supporting a 12-site Community Cancer Network
• Cerner EHR

▶ Pulled tumor registry and claims data, including Medicare inpatient, outpatient, and hospice, into one shared database across their 12 network sites; used this database to assess physician concordance with nine Choosing Wisely metrics

▶ Found that concordance varied widely across their sites (average of 34% to 94%); estimated that if they achieved 95% adherence to each metric at every site, they could have saved $19 million per quarter

▶ Data reports comparing physician performance at site level are presented to each UAB network site by a physician champion; open discussion and sharing of best practices encouraged to improve adherence

Source: Rocque G, "Choosing Wisely: Opportunities for Improving Value in Cancer Care Delivery?" *Journal of Oncology Practice, 13*, no. 1 (2017): e11-e21.; UAB Medicine, Birmingham, AL; Oncology Roundtable interviews and analysis.
### Nine Choosing Wisely metrics measured by UAB

<table>
<thead>
<tr>
<th>Category</th>
<th>Guideline</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging</td>
<td>1</td>
<td>Do not perform PET, CT, or radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Do not perform PET, CT, or radionuclide bone scans in the staging of early breast cancer at low risk for metastasis</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Do not perform surveillance testing (biomarkers) or imaging (PET, CT, radionuclide bone scan) for asymptomatic individuals who have been treated for breast cancer with curative intent</td>
</tr>
<tr>
<td>Treatment</td>
<td>4</td>
<td>Do not use combination chemotherapy (multiple drugs) instead of chemotherapy with one drug when treating an individual for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms</td>
</tr>
<tr>
<td>Supportive medications</td>
<td>5</td>
<td>Do not use white cell-stimulating factors for primary prevention of febrile neutropenia for patients with &lt;20% risk of this complication</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Do not give patients starting a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting an antiemetic drug intended for use with a regimen that has a high risk of causing nausea and vomiting</td>
</tr>
<tr>
<td>Radiation</td>
<td>7</td>
<td>Do not routinely use extended fractionation schemes (&gt;10 fractions) for palliation of bone metastasis</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Do not initiate whole-breast radiotherapy as a part of breast-conservation therapy in women 50 years or older with early-stage invasive breast cancer without considering shorter treatment intervals</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Do not routinely use IMRT to deliver whole-breast radiotherapy as part of breast conservation therapy</td>
</tr>
</tbody>
</table>

Significant variation across sites

Surfacing millions in potential opportunity

Average adherence to nine Choosing Wisely metrics across UAB network

estimated cost savings per quarter if all sites achieved 95% adherence to the nine metrics

Sample rate of variability for one Choosing Wisely metrics

Tactic 5: Assign accountability for ongoing performance analysis

Systems struggle to go beyond one-off data analysis

Goal
Continuous review of system-wide cost data

Barriers
- Lack of aggregated data
- Perceived lack of time
- Lack of dedicated staff and analysts
- Unwillingness to change current process
- Lack understanding of implications
- Lack forums for system-wide communication

Source: Oncology Roundtable interviews and analysis.
Form group to regularly review cost and quality data

Overview of Jaguar Health\(^1\) Clinical Value Committee

- System-wide oncology committee oversees all quality and cost initiatives across the service line
- Chaired by VP of Oncology and Director of Cancer Informatics Team
- **Multidisciplinary group**, including pharmacy, infusion, quality, medical directors, administrators, and physicians
- Meets monthly

Committee decision-making

- Convenes members for data-driven decision making
- Sets agenda based on input and data from the Cancer Informatics Team
- Divided into **workgroups that provide quarterly** updates on their specific quality and cost initiatives

\(^1\) Pseudonym.
Jaguar Health System

- Multi-hospital health system on the East Coast
- 5,000+ analytic cases
- Cerner EHR

► Clinical Value Committee sets annual oncology initiatives based on cost and quality opportunities across the system and divides into workgroups to maintain accountability

► Committee was created to form one organization for oncology service line governance and collaboration on quality initiatives

► Committee has addressed appropriateness of chemotherapy administration in the inpatient versus outpatient setting and is creating leukemia tumor site care guidelines
Examples of Jaguar Health’s¹ quality and cost improvement projects

**Developing leukemia/lymphoma treatment guidelines**
- Recognized lack of national leukemia and lymphoma treatment guidelines
- Working with physician leaders across sites to determine treatment protocols and preferential medications

**Assessing chemotherapy site of care appropriateness**
- Analyzing inpatient and outpatient reimbursement for various chemotherapy treatments
- Setting system-wide guidelines for site where different types of chemotherapy should be administered

**Deciding appropriate use for central venous devices**
- Developed rigorous algorithms retrospectively considering patient diagnosis, care pathways to determine if port placement was necessary
- Algorithms inform future appropriate use

1) Pseudonym.

Source: Oncology Roundtable interviews and analysis.
### Tumor site-specific groups identify cost variation

#### Lion Health System’s¹ tumor site cost per case groups

<table>
<thead>
<tr>
<th>Composition</th>
<th>Logistics</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Representatives from all sites</td>
<td>• Monthly meetings for breast, gynecologic, and GI surgery</td>
<td>• Compare observed cost per case to expected cost per case</td>
</tr>
<tr>
<td>• Physicians</td>
<td>• Central meeting location at main site</td>
<td>• Identify cost variation between providers and sites across the system</td>
</tr>
<tr>
<td>– Medical director of cancer center</td>
<td>• Virtual WebEx option</td>
<td></td>
</tr>
<tr>
<td>– Tumor site division head</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Palliative care physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Administrators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Quality team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Finance team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Pseudonym.

Source: Oncology Roundtable interviews and analysis.
Lion Health System\(^1\)

- *Multi-hospital academic medical center based in the Mid-Atlantic region*
- *20,000+ analytic cases*
- *Epic EHR*

▶ To better understand operational costs to the cancer program, formed system-wide, tumor site specific cost per case groups to examine real versus expected cost per case for top procedures

▶ Monthly meetings bring together administrative leaders, quality and finance representatives, physician leaders, and department chairs to analyze variances in costs and implement solutions

▶ Identified one breast surgeon as more expensive than her peers; analyzed claims data and other surgery metrics to determine that her surgeries lasted longer than other surgeons due to improper use of OR time

\^1 Pseudonym.
Contextualize data and identify solutions

Lion Health System’s¹ analysis of breast surgery outlier

<table>
<thead>
<tr>
<th>Review data</th>
<th>Identify outliers</th>
<th>Contextualize performance</th>
<th>Explore reasons for variance</th>
<th>Implement solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pull cost per case breast surgery data</td>
<td>• Identify one surgeon with higher cost per case than peers</td>
<td>• Analyze other features of each surgeon’s procedures, such as time to complete surgery</td>
<td>• Interview surgeon about her process</td>
<td>Encourage the surgeon to delegate walking samples to pathology</td>
</tr>
<tr>
<td>• Include four breast surgeons</td>
<td>• Identify one surgeon with higher cost per case than peers</td>
<td>• Realize the outlying surgeon’s average surgery length was longer than peers</td>
<td>• Realize the surgeon walked sampled to pathology instead of assigning task to technician, increasing surgery time and costs</td>
<td></td>
</tr>
</tbody>
</table>

¹) Pseudonym.

Source: Oncology Roundtable interviews and analysis.
Ensure cost analysis accountability at your system

Additional tips for hardwiring data analysis

- Designate responsibility
  - Dedicate a team or create a specific role for cost data analysis
- Identify necessary partners for data collection and analysis
- Ensure accountability through regular meetings and reports
- Find ways to share results with your executive team and board
- Review top impact stories from across the organization

Related resource available on advisory.com

OhioHealth_Service_Line_Financial_Advisor_Job_Description
Many places to turn for analytic support

Partner with other service lines to strengthen your request for support

Potential sources of analytic support for the cancer program

- Information technology team
- Business intelligence team
- Existing cancer program staff
- Institution’s technology platform vendors

Case in brief: Cheetah Health

- Non-teaching community health system based in the Northwest
- Formed coalition of physicians and leaders from each of their five key service lines, including oncology, to ensure they were using existing data to full capacity
- Identified need for technical and analytic support in identifying data sources, understanding available data, and getting the data for each service line
- Gained approval for dedicated analytic support from existing health care intelligence team for each of the five service lines

Related resource available on advisory.com

Oncology Business Case Template

1) Pseudonym.

Source: Oncology Roundtable interviews and analysis.
# Start with three key opportunities for cost savings

## Opportunities for system-wide cost savings

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Potential data sources</th>
<th>Key analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rationalize service placement</td>
<td>• Tumor registry&lt;br&gt;• Claims data&lt;br&gt;• Certificate of Need reports&lt;br&gt;• Cancer Incidence Estimator&lt;br&gt;• Oncology Market Estimator&lt;br&gt;• EHR</td>
<td>• Outmigration analysis&lt;br&gt;• Incidence rates by region&lt;br&gt;• Service utilization by facility</td>
</tr>
<tr>
<td>2. Reduce care variation</td>
<td>• Tumor registry&lt;br&gt;• Cancer Quality Dashboard Metric Selection Toolkit&lt;br&gt;• Claims data&lt;br&gt;• EHR</td>
<td>• Outcome variance&lt;br&gt;• Service utilization by facility&lt;br&gt;• Guideline adherence</td>
</tr>
<tr>
<td>3. Reduce operational variation</td>
<td>• Oncology Volumes, Staffing, and Operations Benchmark Generators&lt;br&gt;• Expense report&lt;br&gt;• EHR</td>
<td>• Cost per case&lt;br&gt;• Service utilization by facility&lt;br&gt;• FTE distribution</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Next steps: Data-driven decision-making

At the system level

- **Understand** data sources, where they are housed, and their limitations
- **Make the case** for dedicated resources—including data analysts and technology
- **Partner** with other service line leaders to learn from their experience, and make shared data requests
- **Compare** performance (i.e., costs, care variation, staffing expenses) across sites to identify a short-list of immediate opportunities
- **Establish** regular channels for sharing data across sites

At the site level

- **Support and advocate for** system efforts for data collection, analysis, and sharing
- **Make the time** to regularly review data and **identify areas** where your site has room to improve
- **Be open** to learning from data and **changing behavior** to improve performance
- **Develop a strategy** and hold yourself accountable to sharing data when needed with your team and executives

Source: Oncology Roundtable interviews and analysis.
Shared system identity

Tactic 6: Standardize role responsibilities across sites
Tactic 7: Implement a site-agnostic staffing model
Tactic 8: Tie staff bonuses to system performance
Sites often operate as stand-alone entities

Ideal state of oncology system identity

<table>
<thead>
<tr>
<th>Role responsibilities</th>
<th>Site relationships</th>
<th>Staff performance incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Responsibilities for a given role are the same across sites</td>
<td>• Staff are primarily allegiant to the system</td>
<td>• Staff are incentivized to prioritize system performance over site performance</td>
</tr>
<tr>
<td>• Scope of practice for each role is clearly documented; all clinicians practice at top of license</td>
<td>• Staff consider themselves to be part of one system-wide team</td>
<td>• Staff understand system goals and work together to meet them</td>
</tr>
</tbody>
</table>

The reality

<table>
<thead>
<tr>
<th>Staff in the same role have different responsibilities at different sites</th>
<th>Staff are primarily allegiant to their site</th>
<th>Staff are incentivized to prioritize site performance over system performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No clear documentation of scope of practice for each role; some clinicians perform tasks that aren’t unique to their skills</td>
<td>• Staff are not familiar with staff or protocols at other sites</td>
<td>• Staff lack attachment to system goals</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Shifting from “me” to “we”

Implement practices to realign staff allegiance

Promoting system loyalty

**Barriers**
- Responsibilities for a given role vary between sites
- Unfamiliarity with people and processes at other sites
- Incentives aligned to individual site

**Strategies**

1. **New staff**
   - Centralize hiring at system level
   - Centralize onboarding to standardize communication of values and expectations
   - Set expectations in contract that staff may be required to work across sites

2. **Existing staff**
   - Tie staff bonuses to system-wide performance
   - Standardize role definitions to facilitate sharing or rotating of staff between sites
   - Create affinity groups for staff with the same role at different sites to meet regularly
   - Centralize certain staff roles

Source: Oncology Roundtable interviews and analysis.
# Promote unity at all levels of the system

Three tactics to create a shared system identity

<table>
<thead>
<tr>
<th>TACTIC 6</th>
<th>Standardize role responsibilities across sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>TACTIC 7</td>
<td>Implement a site-agnostic staffing model</td>
</tr>
<tr>
<td>TACTIC 8</td>
<td>Tie staff bonuses to system performance</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Tactic 6: Standardize role responsibilities across sites

Inconsistency in roles leads to missed opportunities

Unable to capture operational efficiencies or make connections

1) Medical assistant.

Missed opportunities to:
- Capture operational efficiencies
- Feel connected to counterparts at other sites

---

MA¹ responsibilities at Site A
- Collect data at the direction of RNs or providers
- Triage phone calls
- Prepare blood samples for laboratory tests

MA responsibilities at Site B
- Update disease prevention lists
- Record patient history and personal information
- Room patients

---

Source: Oncology Roundtable interviews and analysis.
Clearly define scope of practice for each role

Gundersen’s Scope of Practice (SOP) Matrix

- Created by nursing department as part of an institution-wide initiative to ensure top-of-license practice
- Outlines different clinicians’ scope of practice relative to patient assessment, planning, intervention, documentation, evaluation, delegation, and leadership
- Resource available on advisory.com/or

<table>
<thead>
<tr>
<th>Mastered Prepared Nurse (MSN) or Clinical Nurse Specialist (CNBS)</th>
<th>Registered Nurse (BSN, ADN, Diploma)</th>
<th>Licensed Practical Nurse (LPN)</th>
<th>Medical Assistant (MA)</th>
<th>Certified Nursing Assistant (CNA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performs an independent assessment, analyzes information, monitors patient, and takes action to facilitate wellness and healing.</td>
<td>Collects data at the direction of the RN or provider.</td>
<td>Collects data at the direction of the RN or provider.</td>
<td>Collects data at the direction of the RN and under the supervision of RN or LPN.</td>
<td>Collects data at the direction of the RN and under the supervision of RN or LPN.</td>
</tr>
<tr>
<td>Assesses and evaluates health status of groups and individuals:</td>
<td>Contributes to assessment of health status by:</td>
<td>Contributes to assessment of health status by:</td>
<td>Contributes to assessment of health status by:</td>
<td>Contributes to assessment of health status by:</td>
</tr>
<tr>
<td>Collects objective and subjective data</td>
<td>Collecting, reporting, and recording objective and subjective data:</td>
<td>Collecting, reporting, and recording objective and subjective data:</td>
<td>Collecting, reporting, and recording objective and subjective data:</td>
<td>Collecting, reporting, and recording objective and subjective data:</td>
</tr>
<tr>
<td>Analyzes, reports, and records data</td>
<td>Observation of conditions or change in condition signs and symptoms that deviate from normal or expected health status</td>
<td>Observation of conditions or change in condition signs and symptoms that deviate from normal or expected health status</td>
<td>Observation of conditions or change in condition signs and symptoms that deviate from normal or expected health status</td>
<td>Observation of conditions or change in condition signs and symptoms that deviate from normal or expected health status</td>
</tr>
<tr>
<td>Validates and refines data</td>
<td>Reports the patients’ response to care</td>
<td>Reports the patients’ response to care</td>
<td>Reports the patients’ response to care</td>
<td>Reports the patients’ response to care</td>
</tr>
<tr>
<td>Selects appropriate specialized assessments using critical thinking</td>
<td>Performs triage, including telephone and other technology triage, duties in various settings.</td>
<td>Performs triage, including telephone and other technology triage, duties in various settings.</td>
<td>Performs triage, including telephone and other technology triage, duties in various settings.</td>
<td>Performs triage, including telephone and other technology triage, duties in various settings.</td>
</tr>
</tbody>
</table>

Source: Gundersen Health System, La Crosse, WI; Oncology Roundtable interviews and analysis.
Gundersen Health System

- Six-hospital health system based in La Crosse, Wisconsin
- 1,400 analytic cases
- Employed oncologists and physicists; Epic EHR

► Re-evaluated staff responsibilities during system rework of patient flow and care team configurations to ensure top-of-license practice; sought ways to off-load low-priority tasks from higher-paid to lower-paid staff

► Developed Scope of Practice (SOP) Matrix to clearly define top-of-license responsibilities for each role; used SOP Matrix to identify opportunities to shift responsibilities to appropriate-level staff

► Determined they would need an additional two RNs and five MAs (a role which they hadn’t used before) to cover cascading staff responsibilities; calculated that they could generate enough revenue to cover cost of additional FTEs if each physician saw one additional patient per day

► Saw increase in capacity and patient, staff, and physician satisfaction since completing the staff redesign

Source: Gundersen Health System, La Crosse, WI; Oncology Roundtable interviews and analysis.
Matrix helps shift tasks to appropriate staff

Zeroing in on top-of-license tasks for each role surfaces need for MAs

Gundersen’s process of cascading responsibilities to appropriate staff based on SOP\(^1\) matrix

Physicians
- Nursing assessment
- Capacity to take on new patients

Registered nurses
- Nursing assessment
- Phone triage
- Rooming patients
- Chemotherapy education
- Symptom management
- Port draws

Medical assistants
- Phone triage
- Rooming patients

Source: Gundersen Health System, La Crosse, WI. Oncology Roundtable interviews and analysis.

1) Scope of Practice.
Finding the money for additional staff

Adding one patient visit per physician per day would cover new FTEs

Gundersen’s calculations of additional revenue required to cover additional staffing costs

2 RNs x $62K average salary\(^1\) = $124K per year
5 MAs x $28K average salary\(^1\) = $140K per year

Total = $264K per year

$110 average collection/visit\(^2\)

2,400 extra visits/year

10 physicians

240 extra visits/year/physician

250 working days/year

Additional revenues required: **1 extra visit/physician/day**

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\(^1\) Salary data based on national average from the Bureau of Labor Statistics.

\(^2\) Collection data based on Medicare reimbursement data.

Source: Gundersen Health System, La Crosse, WI; Oncology Roundtable interviews and analysis.
Tactic 7: Implement a site-agnostic staffing model

Shifting allegiances from site to system

Three steps for building out a site-agnostic staffing model

1. **Standardize operations**
   - Reevaluate job descriptions to ensure system standardization
   - Standardize treatment guidelines and technologies across the system

2. **Create a common culture**
   - Consider collaboratives or social opportunities to encourage relationship building between sites
   - Promote a system-first mentality

3. **Reset expectations**
   - Set expectations for travel or additional licensure early on
   - Revamp staff responsibilities to prioritize a system perspective

Source: Oncology Roundtable interviews and analysis.
Navigators are system employees first

Patient navigation at MaineHealth not tied to specific site

Overview of navigator interactions with cancer patients at MaineHealth

Patient calls central MaineHealth phone number and is triaged to tumor-site specific navigation at any location.

Oncology provider and/or referring physician notifies navigation team about new patient; tumor-site specific navigator at any location proactively reaches out to patient.

Navigator assess patient circumstances:
- Distress screening
- Location of residence
- Support system
- Barriers to care
- Treatment needs

Navigator directs patient to closest of 11 MaineHealth cancer centers with appropriate services, regardless of navigator home site.

Navigator provides ongoing support to help patients understand treatment options and overcome barriers to care.

Source: MaineHealth, Portland, ME; Oncology Roundtable interviews and analysis.
MaineHealth

- 11-hospital system with academic tertiary center headquartered in Portland, Maine; primary teaching hospital for Northern New England
- 6,200 analytic cases, representing 72% of Maine
- Mix of employed and independent oncologists; multiple EMRs across physician practices, with ongoing MaineHealth Epic rollout

- Uses system funding to support 36 tumor site-specific patient navigators that are placed strategically across the system to fill gaps in care
- Navigators are connected with patients through referring physicians or a central MaineHealth phone number; navigators assess patients’ circumstances and direct them to closest MaineHealth site with appropriate services
- Navigators work to keep patients informed about the range of treatment options throughout the system and address barriers to care
- Navigators coordinate care between hospitals, ensuring care close to home when appropriate or returning certain aspects of care (e.g., radiology, labs) back to home site

Source: MaineHealth, Portland, ME; Oncology Roundtable interviews and analysis.
Sharing staff across sites promotes systemness

Nebraska Methodist Health System shared radiation oncology staffing model

Providers
- Five physicians and four physicists rotate between three sites across Nebraska and Iowa
- Sites span two states

Goals
- Foster system unity
- Standardize processes and protocols across sites
- Collaborate to achieve American College of Radiology accreditation as a system

Logistics
- Radiation oncology treatment technology and software standardized across all sites
- Providers expected to maintain licensure in Nebraska and Iowa

1) Nebraska Methodist Health System.

Source: Nebraska Methodist Health System, Omaha, NE; Oncology Roundtable interviews and analysis.
Nebraska Methodist Health System

- Four-hospital teaching health system based in Omaha, Nebraska
- 3,000 analytic cases
- Employed oncologists and physicists; Cerner EHR

- Radiation oncologists and physicists rotate between two hospitals and one satellite site in system to create shared identity and standardize processes and protocols
- Clinicians are expected to maintain licensing in both Nebraska and Iowa
- Moved all sites to same radiation oncology EHR and treatment technology to facilitate staff sharing

Source: Nebraska Methodist Health System, Omaha, NE; Oncology Roundtable interviews and analysis.
Considerations for flexing staff at your organization

Set expectations
- Include contract language that sets the expectation for rotating between sites
- Determine if your providers will need to be licensed in multiple states, and communicate that expectation

Minimize obstacles
- Standardize technology vendors and platforms between sites
- Develop shared standards of care
- Set clear timelines and ownership for scheduling across sites
- Determine how reimbursement will work for:
  - Hourly staff (nurses, radiation therapists, etc.)
  - Contracted staff (physicians, APs, etc.)

Source: Oncology Roundtable interviews and analysis.
Tactic 8: Tie staff bonuses to system performance

Systemness stifled by misaligned incentives

Examples of common incentives rewarding “site first” mentality

**Frontline staff**
Performance review metrics tied to site-level priorities

Fails to promote understanding of and commitment to system goals

**Site leaders**
Bonus tied to site-level revenue

Rewards competition with other sites within system for same patients

**System leaders**
Promotion pathway tied to growth of high-end services

Encourages exclusive focus on growth of cutting-edge services at largest site

Scripps Health

- Five-hospital health system based in San Diego, California
- 4,000 analytic cases
- Mix of employed and private practice physicians; Epic EHR

- Encouraged by the system-wide goal of creating a “OneScripps” culture, integrated imaging center finances in 2011 to encourage all sites to act like a system rather than disparate entities

- Began by standardizing back-end processes and sharing financial performance across the imaging system; used financial data to make informed strategic decisions that benefited the imaging service line

- Tied staff bonus potential to system financial performance to encourage a system-first mindset; saw a 31% increase in staff satisfaction with pay

Align incentives to prioritize system performance

Scripps ties system success to staff rewards

System financial performance determines staff bonus potential...

<table>
<thead>
<tr>
<th>EBIDA¹ target for fiscal year</th>
<th>Funding amount (staff bonus potential)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.0% to 9.19%</td>
<td>One day’s pay</td>
</tr>
<tr>
<td>9.2% to 9.39%</td>
<td>Two day’s pay</td>
</tr>
<tr>
<td>9.4% to 9.59%</td>
<td>Three day’s pay</td>
</tr>
<tr>
<td>9.6% to 9.79%</td>
<td>Four day’s pay</td>
</tr>
<tr>
<td>9.8% or more</td>
<td>Five day’s pay</td>
</tr>
</tbody>
</table>

By hitting highest financial target, all Scripps staff had the potential to earn an additional five days’ pay as a bonus

...but individual staff’s bonus payout depends on site patient satisfaction scores

<table>
<thead>
<tr>
<th>Site</th>
<th>50% of bonus</th>
<th>75% of bonus</th>
<th>100% of bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encinitas</td>
<td>68%</td>
<td>68.5%</td>
<td>69%</td>
</tr>
<tr>
<td>Mercy</td>
<td>68%</td>
<td>68.5%</td>
<td>69%</td>
</tr>
<tr>
<td>La Jolla</td>
<td>74%</td>
<td>74.3%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Encinitas hit their patient satisfaction target, so all staff at that location will receive 100% of bonus amounting to five days pay

¹Earnings before interest, depreciation, and amortization.

Source: Scripps Health, San Diego, CA; Imaging Performance Partnership, Imaging’s System Advantage, Washington, DC; Advisory Board, 2016; Oncology Roundtable interviews and analysis.
Bonus change improves staff, patient satisfaction

Staff satisfaction with pay
Percent satisfied staff before and after re-aligning staff incentives

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff satisfaction with pay</td>
<td>54%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Patient satisfaction scores
Percentile before and after re-aligning staff incentives

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction scores</td>
<td>38th</td>
<td>72nd</td>
</tr>
</tbody>
</table>

Source: Scripps Health, San Diego, CA; Imaging Performance Partnership, Imaging’s System Advantage, Washington, DC; Advisory Board, 2016; Oncology Roundtable interviews and analysis.
# Next steps: Shared system identity

## At the system level

- **Evaluate** the current sense of identity and level of integration across sites

- **Assess** and **standardize** role descriptions and responsibilities

- **Evaluate** opportunities to have staff work and collaborate across the system

- **Centralize** certain elements of onboarding and training across all sites

- **Consider** adjusting performance incentives to reflect system and site performance

## At the site level

- **Update** your team on system priorities and initiatives

- **Clearly communicate** how changes in job descriptions or responsibilities tie to system goals

- **Lead by example** by modeling a system-focused perspective and identity

- **Normalize** the expectation of system-wide collaboration and staffing

- **Find opportunities** to make system goals more relevant to staff (e.g., track individual or team performance on system-wide goals)

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*Source: Oncology Roundtable interviews and analysis.*
1. Not realizing the benefits of system integration

2. Using oncology systemness to improve financial performance

3. Securing executive support
Using systemness to improve financial performance

Three hallmarks of successful health systems

1. Unified oncology leadership
   1. Create collaboratives to drive system progress
   2. Use incentives to promote system priorities
   3. Ensure system-level oversight of investment decisions

2. Data-driven decision-making
   4. Use data as a common language to assess system performance
   5. Assign accountability for ongoing performance analysis

3. Shared system identity
   6. Standardize role responsibilities across sites
   7. Implement a site-agnostic staffing model
   8. Tie staff bonuses to system performance

Source: Oncology Roundtable interviews and analysis.
Shared accountability at the site and system level

All leaders play critical roles in achieving systemness

Oncology site and system leader roles in cultivating systemness

Site leader
- Provide insight into site needs and local market dynamics to inform rationalization decisions
- Communicate with staff about integration efforts
- Tailor and implement system-wide initiatives
- Monitor site progress on system initiatives

System leader
- Provide strategic direction for service line
- Balance site needs against available resources and impact on system
- Identify opportunities for integration and collaboration
- Manage differences of opinion

Build the case to secure executive support for service line integration

Source: Oncology Roundtable interviews and analysis.
Making the case for systemness

Highlight oncology’s strategic value to secure executive support

Explicitly link service line requests to institutional goals

- Understand executives’ priorities
- Highlight how request advances institutional priorities
- Prioritize requests by importance, strength of argument, and chance of approval

Provide a comprehensive picture of oncology’s contributions

- Ensure service line definition captures majority of cancer patients
- Teach executives about oncology’s complexities
- Highlight success of previously approved service line initiatives

Present evidence to support your request

- Quantify the problem and potential impact of request
- Summarize key takeaways from data that are most relevant to the audience
- Reinforce key messages with an external voice

Source: Oncology Roundtable interviews and analysis.
Further guidance from the Oncology Roundtable

Resources to guide your system strategy

**Oncology System Strategy Playbook**

Discover how to promote collaboration across cancer programs within a health system to boost operational efficiencies, improve clinical quality, and ensure optimal allocation of resources.

*Access here*

**Guides for Service Line Rationalization**

Find service line rationalization guides for cardiovascular, oncology, neurosciences, orthopedics and spine, general surgery, imaging, and women’s services.

*Access here*

**The Eight-Step Oncology Market Assessment**

Learn how to use Oncology Roundtable tools to conduct a comprehensive market assessment that will allow you to make informed decisions about service line strategy.

*Access here*

Source: Oncology Roundtable interviews and analysis.
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