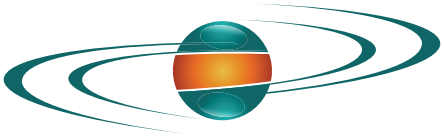

INSTITUTE FOR THE FUTURE OF
ONCOLOGY

What Will It Take?

Five Essential Actions to Achieve a Positive Impact on Patient Care in the Integrated Healthcare Environment

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Association of Community Cancer Centers
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ACCC
Association of Community Cancer Centers

About the Association of Community Cancer Centers

The Association of Community Cancer Centers (ACCC) is the leading advocacy and education organization for the multidisciplinary cancer care team. Approximately 20,000 cancer care professionals from 2,000 hospitals and practices nationwide are affiliated with ACCC. Providing a national forum for addressing issues that affect community cancer programs, ACCC is recognized as the premier provider of resources for the entire oncology care team. Our members include medical and radiation oncologists, surgeons, cancer program administrators and medical directors, senior hospital executives, practice managers, pharmacists, oncology nurses, radiation therapists, social workers, and cancer program data managers. For more information, visit the ACCC website at www.accc-cancer.org. Follow us on Facebook, Twitter, LinkedIn, and read our blog, ACCCBuzz.

About the Institute for the Future of Oncology

The Association of Community Cancer Centers (ACCC) launched the Institute for the Future of Oncology (the Institute) in 2013 because ACCC recognized a gap in knowledge and a need for meaningful discussion on issues unique to the multidisciplinary oncology team. The Institute serves as a clearinghouse of information and knowledge, addressing these issues and offering solutions that can be utilized across the community oncology continuum. For more information, visit www.accc-cancer.org/institute.

Comments expressed by forum participants are their own and do not represent the opinions of the Association of Community Cancer Centers or the institution with which the participant is affiliated.

What Will It Take?
Five Essential Actions to Achieve a Positive Impact on Patient Care in the Integrated Healthcare Environment

Executive Summary

The U.S. healthcare industry, including oncology, is undergoing unprecedented consolidation and integration. Hospital systems are merging, hospitals are purchasing provider practices, provider practices are joining to create "super-sized" groups, insurance companies are purchasing hospital systems, and the insurance industry itself is undergoing what some are calling "merger madness," potentially leaving just three companies controlling half of the commercially insured population in the United States.[1]

In June 2015 the Association of Community Cancer Centers (ACCC) held its third annual Institute for the Future of Oncology forum. The invited participants, comprising oncologists and cancer program executives from hospitals, practices, and healthcare systems across the country, convened for a discussion that—within the context of ongoing consolidation and integration pressures—aimed to identify challenges and elicit solutions needed to realize a positive impact on patient care within the next decade. Marisa Deline, senior consultant with The Advisory Board's Oncology Roundtable, helped set the stage for the discussion by presenting a brief overview of physician integration in oncology.

During the forum discussion, participants identified five essential actions for achieving a positive impact on patient care within the next decade. These are the focus of this white paper:

1. Aligning stakeholders and requiring accountability
2. Defining quality in a value-based reimbursement system and providing access to quality care
3. Using non-traditional delivery systems (telehealth) and providers (primary care physicians and non-physician providers) to deliver cancer care
4. Integrating the use of Big Data to drive treatment decisions
5. Moving to patient-directed care in which the patient is at the center of all decisions and systemic change.

What Will Cancer Care Look Like in 10 Years?

The Institute forum discussion began with participants answering the question: *What will cancer care look like in 10 years?* Several themes emerged:

- More decentralized care and greater collaboration via telehealth and telemedicine
- Greater emphasis on evidence-based guidelines and standards that evolve over time based on data and patient experience
- Patient-directed care that treats patients as true consumers of their healthcare
- Value-based reimbursement
- Care teams matched to patient need, powered by data, and mapped to appropriate reimbursement
- Greater consolidation within the healthcare system
- Increased reliance on team-based care and care provided by non-physicians
- More use and understanding of targeted therapies
- Better understanding of which cancers require treatment and which do not
- Value-based drug pricing
- Evolutionary, if not revolutionary, diagnostics and therapeutics guided by genomic information that will affect how we manage prevention, screening, diagnosis, treatment, and surveillance

Framing the Discussion: Consolidation & Integration in Oncology

"Doctors aren't driven by science to merge or to join hospitals or to sell their practices, and it isn't because we can give better cancer care outside the private practice setting and inside a hospital-owned setting. It is all driven by external economic and societal forces."

—Medical oncologist participant from southern state

In 2013 the inaugural ACCC Institute white paper on *Opportunities and New Realities in Cancer Care* noted multiple drivers fueling the trend toward consolidation and integration.[2] Healthcare reform, particularly the move to value-based reimbursement, continues to propel this trend. Hospitals are buying or partnering with other hospitals and/or physician groups. Physician groups themselves are consolidating—merging with other practices or developing cooperative agreements. In 2014, according to the Advisory Board, 100 hospitals merged or purchased other hospitals compared to just 52 in 2009.[3] The 2015 American Society of Clinical Oncology (ASCO) *State of Cancer Care in America* report finds that, overall, the number of hospital/health system-owned oncology practices skyrocketed 185 percent between 2013 and 2014.[4]

Meanwhile, the Community Oncology Alliance's *2014 Community Oncology Practice Impact* report noted that 313 cancer practices have closed and 544 community cancer practices have been acquired by or affiliated with hospitals in the past eight years, an 82 percent increase in clinic closings since 2010. Practices most likely to close are those in financial trouble and those that send patients elsewhere for treatment (i.e., to outpatient centers).[5]

In the Association of Community Cancer Centers 2015 *Trends in Cancer Programs* survey, 23 percent of respondent programs reported a merger or acquisition in their market in 2014, down from 28 percent the previous year. However, about one-fourth of those responding reported that they would likely consider affiliating with a hospital in the next 12 months.[6]

Finding Value in Integration

"As we move towards this world of greater cost accountability and providers are asked to take more responsibility for the healthcare of patient populations as a whole, it's actually an advantage for [hospitals and health systems] to have control over all elements across the continuum in which patients receive care," noted Advisory Board senior consultant Marisa Deline. At the same time, however, she said that hospital-based cancer programs must demonstrate value and quality, a statement that brought skepticism from several participants.

"I think there's a lot of integration for the sake of integration," said an executive from a midwest cancer program. "I spend a lot of time with the hospitals I'm working with trying to convince them that integration is about doing what you *can do* well, knowing when you *can't do it* [emphasis added], and finding somebody else to partner with to do it. That's a pretty advanced concept. Those who are truly thinking ahead are thinking about patients, not just as cancer patients but as patients for the next 30 years who are going to need orthopedic care; they're going to need cardiology care, etc. That's something that we're challenged to do."

The shifting landscape represents a new paradigm, participants said, one in which some care will be delivered by non-oncologists, patients will play a greater role in the delivery of that care, and quality will be not only measured, but disseminated. That, in turn, requires that clinicians articulate new goals. "Is the goal better oncology care? Is it using resources better? Is it keeping people healthy? What is the goal of a new paradigm?" asked one participant.

"We've got to think about providing high-quality care when it's needed, and then appropriate systems for reimbursement for the care that is needed," said an oncologist from a southern state, "so that good care, high-quality care can be given to all patients in any setting."

Bigger is not necessarily better, participants said. The executive director of a southern cancer program described a situation in which his group saw a patient who had initially been seen in an integrated hospital system. Forty-five days after the patient's first appointment in that system, he still didn't have a diagnosis. "So there was no benefit to an integrated system in that situation," he said.

"The challenge is when a hospital system thinks that oncology can fit the same model as cardiology," said the director of a midwest oncology group. Many times, he said, hospital leadership thinks it can use the same structure or standardization or decision-making it uses in other service lines. Yet oncology is much more complex, he said. "An EKG is an EKG; but a chemotherapy is not a chemotherapy—patients react differently [to the same agent or regimen]."

Drivers of Consolidation

A major driver of consolidation is Medicare reimbursement cuts due to sequestration, which effectively cut reimbursement for chemotherapy drugs from average sales price (ASP)+6 percent to ASP+4.3 percent between April 2013 and today.[3] Indeed, when the Association of Community Cancer Centers surveyed its membership regarding effects of the sequester, 75 percent of respondents said the sequester had an impact on cancer patients, regardless of insurance type.[7]

Other drivers include:[2,3]

- The growing incidence of cancer
- The need for hospitals to attract and retain a dedicated group of oncology providers
- A healthcare landscape that demands greater clinical coordination between providers
- Increased competition for high-reimbursement ambulatory services, such as imaging and radiation oncology
- Expansion of interest and participation in the 340B program
- Declines in private practice oncologists' net income resulting from reimbursement changes for chemotherapy drugs
- Risks associated with buying and billing drugs that carry increasingly exorbitant prices
- The need for greater negotiating power with vendors and payers
- The retirement of older physicians and their replacement by younger doctors searching for a greater work/life balance

So, he concluded, "it's going to take a lot of coordination and education of hospital systems in order to get to where we want in regards to oncology care that is collaborative, standardized, and efficient."

The director of a large mid-Atlantic group explained why his practice plans to remain independent. "We believe that through independence, we can serve our patients best because we work for the patient." Nonetheless, he said, practices like his still need to be able to provide integrated cancer care which, in turn, requires high levels of communication with specialists outside of the group and the ability to coordinate care in non-traditional ways. For instance, his practice has formed an accountable care organization with 21 other groups in its community and, in 2014, was awarded a three-year contract to participate in the Medicare Shared Savings Program.

> *"The goal of integration has to be to provide seamless quality care to the patients as opposed to simply being bigger and capturing market share."*
>
> —Executive director of a large, mid-Atlantic cancer practice

"We are working on coordinating care, improving communications among those groups, reducing costs, and increasing quality," he said. Building such networks offers community oncologists an important alternative option to hospital employment, Deline added.

1 *Essential Action: Aligning Stakeholders & Requiring Accountability*

Participants discussed the "constant tension" between the business side of healthcare and the clinical practice side. "It seems we've had this monumental shift of the business side that is dominating so much of what we do," said an oncologist from the midwest. "Even though I certainly applaud the accountability that we in the clinical arena are now being charged with, and I think there are a lot of good things emerging from that to justify what we do to offer the very best, most efficient and effective care, what I don't see is the accountability on the business and regulatory side."

The vast healthcare bureaucracy in the U.S., he said, provides little value. "Since we are being held accountable for what we do, we need to see, on behalf of our patients, what the payoff is. How will these mergers and so forth actually affect healthcare delivery in the long run? What are we getting back from the regulatory environment we're in?" This requires an assessment of how well existing regulations have worked before more are added, he said.

"If everyone is growing, then everyone's purchasing power is increasing, so we have to look beyond initial financial benefits of being an integrated system to really derive the benefit from working more closely together," said one participant. "We need to leverage our scale to elevate clinical quality, to integrate and coordinate care, and to secure a market position as an in-network preferred provider for as many [individuals] as we can."

This requires an understanding of how integration can achieve a positive impact on patient care. An important step is ensuring that the provision of care is aligned with regulations and payment. Otherwise, participants noted, consolidation may leave some patients out in the cold.

2 *Essential Action: Defining Quality in a Value-Based Reimbursement System & Providing Access to Quality Care*

"We're going to have to try to define and measure outcomes while understanding that there will be variation in value depending on how we subdivide the populations. We will have to accept that degree of variability."

—Oncologist participant from a midwestern cancer program

Oncology has not been good at looking at quality indicators, said an oncologist who heads a cancer program at a hospital system in the northeast. "I think if we're going to move the needle for quality and for outcomes and for cancer care delivery, we really need to start measuring outcomes…we've done that now with some of our partners [and] we see there is tremendous variations in the care of [patients with the exact same disease]." For instance, an analysis of lung cancer cases in his state found that just 60 percent of patients who should have had *ALK* and *EGFR* testing had the right test. "That means that 40 percent of patients aren't even being tested for something that's in an NCCN (National Comprehensive Cancer Network) guideline. But if we don't measure that, how do you even know it?" he asked.

The oncologist, who specializes in leukemia, also noted that just 40 percent of patients with the disease in the U.S. are being monitored appropriately with polymerase chain reaction (PCR) tests. In addition, a recently published study found that only about half of women with ovarian cancer are receiving intraperitoneal chemotherapy despite strong evidence that it improves survival.[8]

One reason oncology needs to focus more on outcomes and demonstrating evidence-based care is that such measures are rapidly becoming an integral part of reimbursement. In January 2015, Health and Human Services (HHS) Secretary Sylvia Burwell announced that a third of fee-for-service Medicare payments would be linked to value-based reimbursement by 2016; half by 2018. Of the remaining fee-for-service payments, 85 percent will be tied to quality and value beginning in 2016; 90 percent by 2018, and close to 100 percent by 2019.[9]

Value-based purchasing has already arrived in oncology with the Oncology Care Model announced by the Centers for Medicare & Medicaid Services (CMS) earlier this year. It represents the first attempt at a national level to tie oncology outcomes to payment.

Participating practices will receive a $160 per-beneficiary-per-month payment (in addition to fee-for-service reimbursement) for every six months a patient is under active treatment, and the potential for a performance-based payment for episodes of chemotherapy care. The goal is to incentivize practices to more effectively manage and coordinate care for oncology patients, lower the total cost of care, and improve care for beneficiaries during treatment episodes.[10]

The New Reality of Payers

Consolidation is occurring not just at the physician and hospital level, but also at the payer level. In July 2015, several large insurers announced proposed mergers that would leave just three companies providing health insurance to half the country's commercially insured population.[1]

That, coupled with higher premiums in 2018 when employers and insurers become subject to the 40 percent excise tax on high-cost health plans, means more demanding customers, said the administrator of a large midwestern oncology practice. That presents a significant challenge, he continued, given that even patients with the same type of cancer often require different treatments. This is something that employers, used to standardization, may not understand.

As consolidation continues, participants predicted that more healthcare systems will have their own health plans and compete with other payers. This, in turn, could lead to frequent changes in insurance coverage, creating discontinuity and fragmentation of care. "It will be January 1," said one participant, "and you don't know if you're going to be taking care of your patient because he or she may be switching hospital systems."

3 *Essential Action: Embracing Non-Traditional Providers & Non-Traditional Delivery Systems to Ensure Access*

Participants expressed significant concerns about access to quality care in rural areas given continued consolidation. An oncologist from Hawaii noted that hospitals and clinics in his state are closing because of consolidation and reimbursement changes. This, in turn, requires that patients travel hours for treatment, creating stress and hardship on them and their families.

Another participant from the south noted that even when oral therapies are used in rural areas, most patients are underserved, uncompensated care patients who can't afford their medications, creating tension and challenges in the delivery of care.

Overall, while nearly a fifth of Americans live in rural areas, just 5.5 percent of oncologists practice there, and three-fourths of those have only one office location.[4]

As consolidation continues in rural areas, clinicians need to identify new approaches for cancer treatment, participants said. "Because you simply can't afford to have individual oncologists in places where you've only got 3,000 people," said an oncologist participant.

That involves using more technology and developing relationships with non-oncologists, such as primary care doctors. In Alaska and the San Juan Islands, where many clinics are accessible only by boat or plane, primary care physicians often manage cancer patients with long-distance direction from oncologists, said an oncologist from the northwest.

As the healthcare field overall has access to big data in all specialties, "It's going to become a little less important who you are, because knowledge is power," she said. "As we disseminate that knowledge, people can provide care that traditionally they may not have had the expertise to provide. So I think the future is going to be non-traditional models of providing care, especially in these rural areas."

"The truth is that there's no magic to being an oncologist," said another participant. "If there is a standard of care that is pathway-driven, then that care can be delivered outside the context of a medical oncologist's office." For instance, a primary care physician can follow women for the five or 10 years they take tamoxifen or other estrogen-blocking drugs, he said. He envisions the oncologist's role as evolving to focus on the more complicated, more complex areas of oncology care delivery.

Telemedicine also has a role to play in ensuring patient access to care,

participants said. Indeed, several cancer centers in the U.S. and elsewhere are using telemedicine to evaluate patients prior to chemotherapy; provide genetic screening; perform surgeries (or telementor a non-oncologic surgeon); and provide postsurgical and post-treatment surveillance and follow up.[11-17] In 2011 and 2013 the ACCC Innovator Awards recognized cancer programs that piloted and implemented telehealth solutions. One award recipient from Oregon implemented a telepharmacy program that employs remote medication verification technology that reduced risk, improved safety, and resulted in cost savings. Another Innovator Award winning program from Idaho used telehealth to improve access to genetic counseling and risk assessment for patients in rural areas and resulted in increased patient convenience and care access, cost saving, and improved quality of care.[18,19]

4 *Essential Action: Integrating Big Data to Drive Treatment Decisions*

"I think what we see as maybe a threat or a disappointment, because it's not what we've traditionally seen, may actually be a really good thing for patients and a huge opportunity."

—Administrator participant from midwestern oncology practice

Big data, defined as a collection of data from traditional and digital sources that provides information for ongoing discovery and analysis, is a major driver expected to transform the delivery of cancer care in the next 15 years. It is anticipated that big data will enable physicians to make treatment decisions based not only on national and international guidelines, but on the experiences and outcomes of hundreds of thousands of patients. Further, big data will likely not only transform patient care, but the oncology workforce as well, enabling primary care physicians and allied health professionals to care for patients with less complex cancers and for cancer survivors.[20, 21]

At one large healthcare system, physicians have been using the IBM Watson cognitive computing system to cull through millions of data points from the center's patient and research databases to uncover valuable insights on the most effective, safe, and evidence-based standard of care available for individual patients.

At the same time, explained an oncologist participant from that program, clinicians are teaching the computer about the importance of individual patient characteristics in any treatment algorithm. He called it "one of the big disruptors that are going to come in totally unexpected, that maybe helps a very rural oncologist access highly specialized knowledge without having to travel [to obtain that knowledge] or [require] that patients travel [for care]."

Big Data and the "Internet of Things"

With big data comes an inexorable shift in oncology to "The Internet of Things," one participant said. *Wired* magazine defines this as systems built around machine-to-machine communication, cloud computing, and data gathering sensors.[19] This is information provided in real-time with real data, and it's already occurring in medicine with, among other things, the use of sensors in and on a patient's body that transmit data to a computer where analytics transform it into action. Action, said an oncologist participant from the northeast, "that may not even involve a person. You collect the data, you have advanced analytics, it translates into an automatic action, and then it goes to the right team member or even bypasses a team member."

Understanding how to use big data to improve services, ensure quality, integrate new systems of care, and meet new demands is critical, an executive with a large cancer advocacy organization said during the discussion.

Big data holds the potential to not only improve quality, but reduce costs. For example, the first NCQA-certified oncology patient-centered medical home used data from its customized electronic health record to modify how it delivered care, demonstrating an overall annual per-physician savings of $1 million through reduced emergency department and outpatient visits, as well as fewer inpatient admissions.[22,23]

One oncologist participant from a northeastern cancer center found that using data to analyze the quality of treatment and improve monitoring of patients with chronic myeloid leukemia reduced per-patient costs by approximately $4,000 to $6,000. “There’s money to be saved, and money to be saved means better outcomes for the patients, better for the payer,” he said. That, in turn, will lead to better outcomes across the board “because then you can start identifying the physicians who are not doing the appropriate monitoring and you start teaching them, so [that way] you have a feedback loop.”

“There could be a lot of money saved by utilizing new agents and diagnostics in an effective way to cut down on costs and mitigate toxicities,” said a cancer program executive director from the northeast, “but we need to define those patients that really need to be treated and with what agents. The technology is exploding way ahead of the [healthcare] system’s ability to deal with it.”

Clinical Trials and Integration

The wave of integration and consolidation may have positive results when it comes to clinical trials. As cancer treatments become driven more by genomics and proteomics, more patients will be needed for clinical trials. More integration and the globalization of cancer care can provide that, said one participant. And, in fact, an ASCO 2014 survey of oncology practices found most planned to increase the number of clinical trials they conduct in 2015.[4]

5 Essential Action: Moving from Patient-Centered Care to Patient-Directed Care

"If we really ask the patients what's important to them, how can we create a world that delivers resources around that?"

—Patient advocate participant

The shift from provider-centered to patient-centered care delivery, with greater transparency around costs and quality, puts greater power in the hands of the patient, participants noted. Thus, it's critical that any effort to reimagine oncology care over the next decade centers on what patients want, said the director of a patient advocacy group. It isn't necessarily low-cost services; a poster presented at the Conference of the Association for Value-Based Cancer Care found that just 5 percent of patients connect financial transactions with value in the care provided.[24]

Value today means finding ways to incorporate the patient in a meaningful way. "If we really ask patients what is important to them, [we need to ask ourselves] how can we create a world that delivers resources around that? Do patients need to see the physician as much as they do? Do they want to have overall survival versus progression-free survival with a different level of quality?" [Looking at the ASCO Value Framework] should we be giving 80 points to clinical benefit and only 20 to toxicities [when considering value of a therapy]? "We need to think about what a consumer-based model looks like and how we can treat patients as true consumers of their healthcare and adjust our resource allocation" to account for this, said a patient advocate participant.

Thus, it's critical that any effort to reimagine oncology care over the next decade centers on what patients want...

To do that, all stakeholders—regulators, pharmaceutical companies, providers, and patients—must come together and develop systems that put the patient in the center, said the administrator of an oncology service line in a southern hospital.

Participants also discussed the consumerization of oncology, which requires greater transparency. Today, said an oncologist from a university medical center in the northeast, "patients don't know where a good cancer doctor is; it's all word of mouth. Providing patients with data on outcomes and quality empowers them to choose where to receive their therapy. . . ." That, in turn, drives competition between cancer care delivery systems and spurs new innovations, he said.

Conclusion

The Institute discussion underscored five imperatives for achieving a positive impact on patient care in the integrated healthcare environment. Essential actions to protect and strengthen patient access to quality oncology care over the next decade include:

1. Aligning stakeholders and requiring accountability
2. Defining quality in a value-based reimbursement system and providing access to quality care
3. Using non-traditional delivery systems (telehealth) and providers (primary care physicians and non-physician providers) to deliver cancer care
4. Integrating the use of Big Data to drive treatment decisions
5. Moving to patient-directed care in which the patient is at the center of all decisions and systemic change.

As one participant concluded, the patient must be "the focus of everything. When we close that door, when the doctor or the nurse practitioner is in the room with the patient, the patient has to be the focus. All these [actions have] to be considered, but, ultimately, the patient has to be the center of everything we do."

Goals for Oncology Care in 2025

As the session ended, participants were asked to share their goals for oncology care in 2025. Selected responses are highlighted below:

- Be delivered by traditional and non-traditional providers based on evidence-based standards that are communicated to patients who make their own decisions for the care they want to receive and where they want to receive it.
- Have an infrastructure that includes clear, quality-based guidelines; novel delivery of care using non-traditional structures; resources and partnerships that support novel therapies in all community settings; research implemented in a compliant and safe environment; and patient access to care at the right time and closer to home.
- Use all available knowledge and technologies to provide seamless, personalized, holistic, and quality care to patients based on their individual characteristics and the individual characteristics of the disease. This, in turn, requires a restructured payment system, data that is available on a timely basis, and providers who are held accountable for quality and value.
- Address drug and device pricing and involve physicians in creating rational and sustainable pricing.
- Revise and improve healthcare delivery systems, information technology and data analytics, healthcare reimbursement models, wellness and disease prevention processes, provider education and monitoring, and regulatory and policymaking organizations.
- Provide personalized cancer care through genomics and proteomics, but also by incorporating patient values and shared decision-making.
- Represent a system of care in which independent groups align and collaborate with healthcare systems to provide seamless integrated care and in which technology and data provide a platform for patients, clinicians, and payers to make quality, value-based decisions that are not governed by current models of payment and regulation.

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