





# The State of Access and the Healthcare Experience for Patients with Cancer



## Results from a national survey

In October 2019, prior to the COVID-19 pandemic, Chartis ([chartis.com](https://www.chartis.com)) conducted a national survey of 21 academic, community-based, and freestanding cancer programs. Survey findings at that time suggest that cancer programs are employing a variety of models to increase patient access, such as legacy models to expand capacity by growing the workforce or increasing productivity expectations, more novel approaches by opening urgent care centers, or models that transition patients in survivorship to create capacity for new patients.

In its latest survey conducted in the summer of 2022, Chartis offers new perspectives about how cancer programs function today, what is different from its 2019 survey results, and what remains important when optimizing access channels, reducing time to treatment, and improving the patient experience. Cancer program leaders must double down on their oncology ambulatory strategy in recognition of the following:

1. Patient expectations of timeliness to care are at an all-time high, particularly in the digital age. 
2. Access and the patient experience serve as competitive advantages in the oncology ecosystem, considering for-profit market entrants. 
3. Government regulatory and reimbursement trends are better supporting telehealth and hospital-at-home programs. 
4. Even if cancer diagnostics and treatment timing do not always require immediate attention given scientific evidence, these things matter to patients and their caregivers who have a choice as to where they receive treatment. 

### Survey Overview

The COVID-19 pandemic ushered in workforce shortages, cost pressures, and patient re-engagement dilemmas. Layered on top of these new realities are ever-present access challenges that are exacerbated by continued growth of newly diagnosed cases, expansion of the survivors of cancer population, and the looming

The survey intent was to better understand participants' patient access goals, current challenges, systems and processes, performance metrics, and initiatives.

oncology physician shortage, which is projected to hit 2,250 needed physicians by 2025.<sup>1</sup> To explore how cancer programs and practices are addressing patient access today, Chartis surveyed a total of 36 organizations, including 22 academic and National Cancer Institute (NCI)-designated comprehensive cancer centers (inclusive of two freestanding centers) and 14 community-based cancer programs. The survey intent was to better understand participants' patient access goals, current challenges, systems and processes, performance metrics, and initiatives. Like the 2019 survey, broad survey topic areas included patient access, care team considerations, and supportive care programs. In 2022, survey questions were broadened to capture more details regarding each participant's care delivery model.

### Access Goals for Newly Diagnosed Patients

Although most cancer programs surveyed express a goal of seeing newly diagnosed patients with cancer within 7 days, there was a significant shift over the past 3 years, with more than 40 percent aiming to get newly diagnosed patients consulted within 3 days, compared to 10 percent in 2019.

In the 2022 survey, nearly 70 percent of community-based cancer programs aim to get newly diagnosed patients seen within 3 days; comparatively, about 60 percent of academic medical centers aim to see newly diagnosed patients within 7 days.

When surveyed about benign hematology patients, 44 percent of all cancer programs and practices indicate an aim to see these patients within 3 to 7 days (compared to 35 percent in 2019).

Despite more ambitious performance expectations for many cancer programs and practices, 1 in 5 participants say they do not have an organizational goal around benign hematology patient access.

So how well are these organizations performing to reach their goal? Less than half (14 of 33, 42 percent) of those surveyed believe that most or all patients receive care within their expected timeframe. A little more than half indicate that meeting this goal is highly dependent on the independent oncology/hematology clinic and/or department, with some being more successful than others. Only 2 respondents indicate that all patients are offered an appointment within their established targeted timeframe.

### Records Collection

New to the 2022 survey was a question about medical records collection prior to scheduling. A little more than half of the cancer programs surveyed (56 percent) collect patients’ records prior to scheduling, with 1 in 5 reporting they collect records on “select patient populations” before scheduling. This is an area of improvement, as a lack of patient records can delay patient confirmation of an appointment, which potentially leads to leakage and/or patient dissatisfaction with time to consultation.

### Scheduling Systems

When asked, “What best describes the scheduling systems at your cancer center?” nearly half (16 of 36, 44 percent) report using a hybrid scheduling approach, where some areas employ centralized scheduling and others remain decentralized. This is a significant change compared to 2019 results, where 43 percent used a centralized cancer-specific contact center; only 28 percent report using this type of scheduling system in the 2022 survey.

The shift to a hybrid model and away from centralization was a surprise, but it may signal how challenging it can be to standardize elements of a centralized healthcare program. One organization described an extremely effective practice that includes robust training of contact center personnel, in-person introductions of new providers during onboarding, and weekly in-person meetings with call center and clinic physician and administrative leadership. In our experience, this practice style does not happen as often as it could or should and is often coupled with a comprehensive management and communication plan.

Of the 30 cancer programs with some centralized call functions, more than 80 percent offer new patient scheduling and second opinion scheduling. Figure 1, below, provides a list of the centralized services offered, including appointment reminders. Note: 50 percent of these cancer programs employ access analytics to measure success.

New to the 2022 survey were insights about patient access through self-service options like app usage, website, and patient portals. The survey found that most cancer programs offer online bill-pay, access to medical records, and the ability to message their provider online. However, very few offer self-scheduling (23 percent allow return patient scheduling), and 3 of 36 (8 percent) offer no self-service options. Not surprisingly, no cancer programs offer online infusion scheduling.

### Access Metrics

Leadership from most surveyed cancer programs track similar access metrics, including new patient volumes, patient satisfaction, no-show rates, lag time, schedule utilization, and cancellation rates (Figure 2, page 44). In 2019, 38 percent of cancer programs

Figure 1. Appointment Scheduling and Support Services Provided by the Centralized Call and/or Contact Center

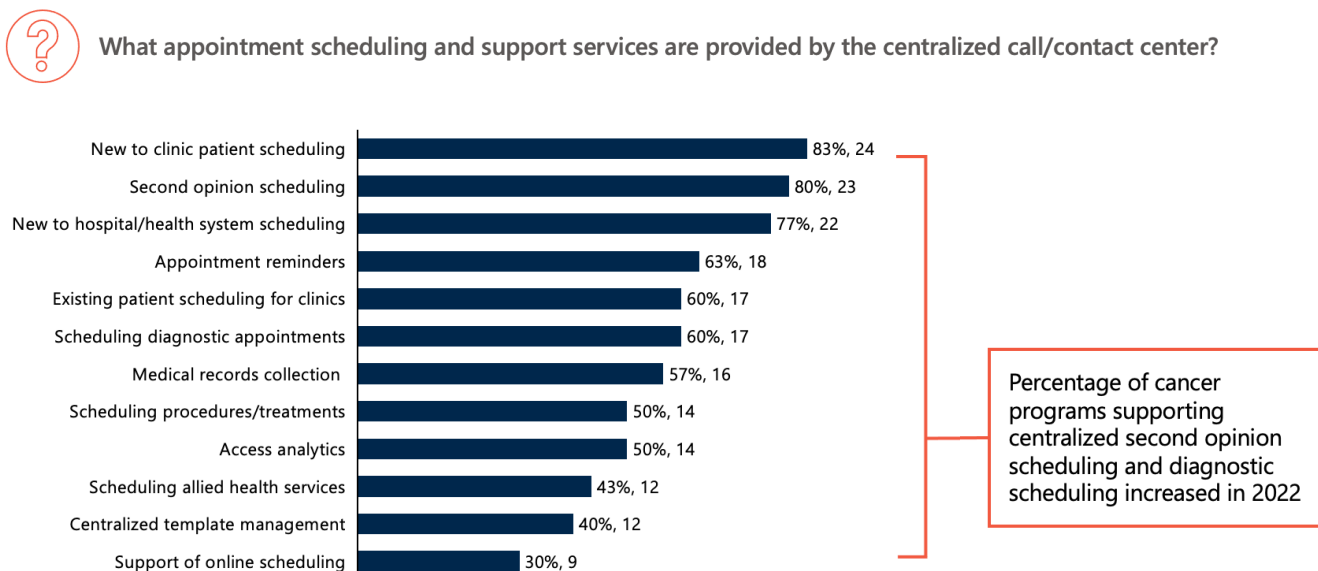
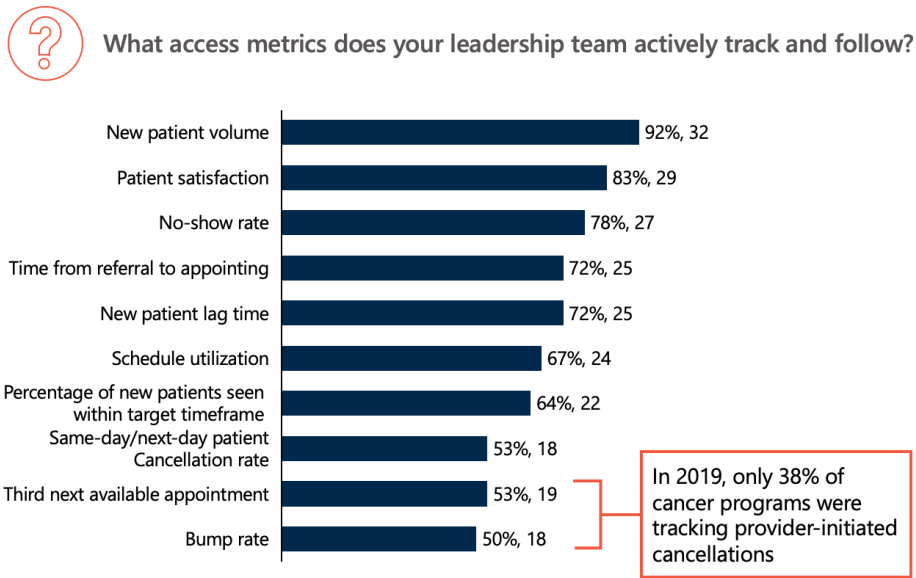


Figure 2. Patient Access Metrics Tracked



were tracking provider-initiated cancellations, and this number jumped to 50 percent in 2022. These metrics are actively being used to drive performance initiatives. Cancer programs are looking to meet their access goals through efforts to improve capacity by optimizing provider templates and call centers, elevating the patient experience by building and expanding cancer navigation programs, and addressing health disparities for the communities they serve.

### Use of Advanced Practice Providers and Panel Sizes

The number of cancer programs tracking advanced practice provider (APP)- and medical assistant (MA)-to-provider ratios increased between 2019 to 2022. Fifty-three percent track APP-to-provider ratios (compared to 33 percent in 2019), and 33 percent track MA-to-provider ratios (compared to 24 percent in 2019). When asked about APP- and MA-visit ratios, 22 percent report tracking these metrics.

While we continue to find role ambiguity for APPs across organizations, many of those surveyed are actively working to promote independent visits for their APPs. A little more than 40 percent report that they are using APPs at “top of training,” with 22 percent (up from 14 percent in 2019) using APPs predominately for independent visits (e.g., within an APP intake clinic and/or during active treatment). An additional 22 percent report that APPs perform shared visits with physicians, provide assessments, conduct ordering, etc.

APPs are increasingly being positioned to conduct initial visits with patients. Often this practice is done in highly competitive markets where “rapid access” is a priority and at academic programs where wait times to see a specific specialist are particularly high.

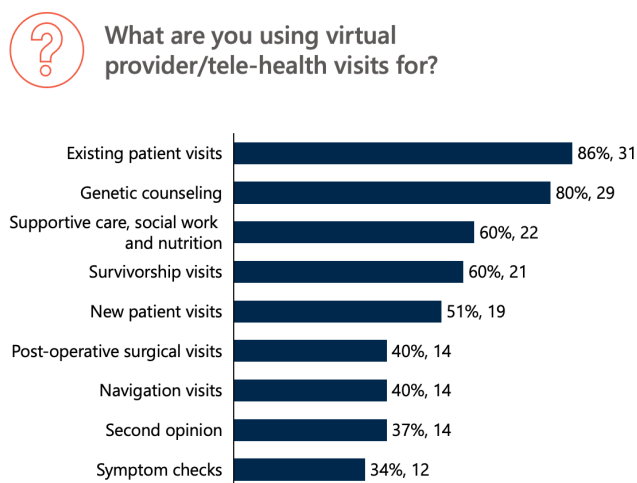
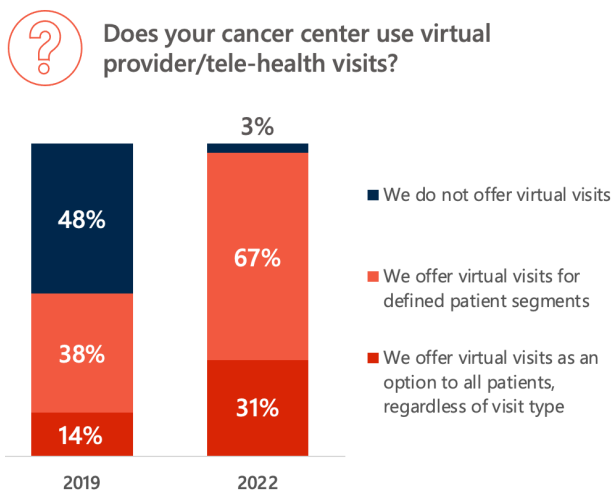
### The Role of Navigators

There is variability in how surveyed cancer programs use care navigators. In the 2022 survey, almost 60 percent (21 of 36) of surveyed participants connect “all new patients” (25 percent) or “select new patients” (33 percent) with a navigator prior to their first visit. Only 1 in 5 have navigators wait to connect with patients until after they are seen in the clinic. Chartis is seeing growth in navigation programs across the country, including “top of training” use of clinical navigators very early in the access and intake process to:

- Provide provisional clinical review, working with patient access representatives to guide “matched scheduling” for first consultations with needed oncology sub-specialists and/or multidisciplinary clinics, enhancing the patient experience, and driving patient and care team satisfaction.
- Conduct barriers to care assessments to provide the care team with a patient summary before their initial consultation, making recommendations about accessing potential support services to abate these barriers.

Navigators then follow patients on their care journeys with templated touchpoints to help patients understand how best to access supportive services. When access questions or issues arise, navigators act as internal advocates for patients, working with schedulers and clinicians to create an efficient treatment schedule that ensures patients receive all required treatments and services.

**Figure 3. Services Provided Via Virtual and/or Telehealth Visits**



### Cancer Survivorship Programs

An estimated 18 million individuals with a history of cancer were living in the United States on January 1, 2022.<sup>2</sup> Considering the expected number of 1.9 million newly diagnosed cancer cases in 2021<sup>3</sup>, this equates to approximately 9.5 survivors for every newly diagnosed cancer case. Since 2011, the population of individuals living with cancer has grown to include 4.3 million persons who are actively surveilled in the cancer care ecosystem.<sup>3</sup>

In recognition of this need, 75 percent of the cancer programs surveyed in 2022 have formal survivorship programs, whether supported by independent clinics, embedded within specialty-specific clinics, or delivered using a hybrid approach. (This percentage is comparable to 2019 survey data.) Survivorship programs serve patients' physical and emotional needs after treatment with the added benefit of expanding provider capacity for newly diagnosed patients and those in active anti-cancer treatment. On the

flip side, 1 in 4 cancer programs report the lack of a formal survivorship program (also unchanged from 2019 survey data).

### Oncology Urgent-Care and Symptom Management Clinics

In the 2022 survey, 42 percent of surveyed cancer programs (15 of 36) have a dedicated oncology urgent-care center, and another 33 percent (12 of 36) have plans to design and build one. Nearly 20 percent of survey participants offer extended hours for expedited symptom management and patient care, including infections, shortness of breath, nausea and vomiting, and neutropenic fever. Survey respondents indicate their urgent-care centers help reduce unnecessary hospitalizations and emergency department visits, while improving patient convenience and their overall experience.

### Second Opinion Services

More cancer programs indicate having a formal second opinion program in 2022 (50 percent), compared to 2019 (33 percent). Some respondents reported offering additional services, such as:

- Patients can submit records with the cancer program that is providing written documentation to the patient (and/or their referring provider) about recommended treatment
- Patients can submit records with the cancer program that is providing a video visit for the patient (and/or their referring provider) about recommended treatment.

Chartis continues to see a growing number of organizations that partner with external vendors to offer second opinion services. These third parties act as the primary interface between the patient and cancer program by collecting patient records, working with a select group at the cancer program to evaluate records and gather patient results, and educating patients about their treatment options.

### Virtual Care Visits

In 2019, most respondents (52 percent) reported using virtual care visits, either across or within select sub-specialties, or were planning to roll them out within the next year for patients who did not require a physical exam or procedure (e.g., symptom checks, return visits, navigation visits). Conversely, a notable 48 percent of respondents were not offering and had no plans to offer virtual care within the next year.

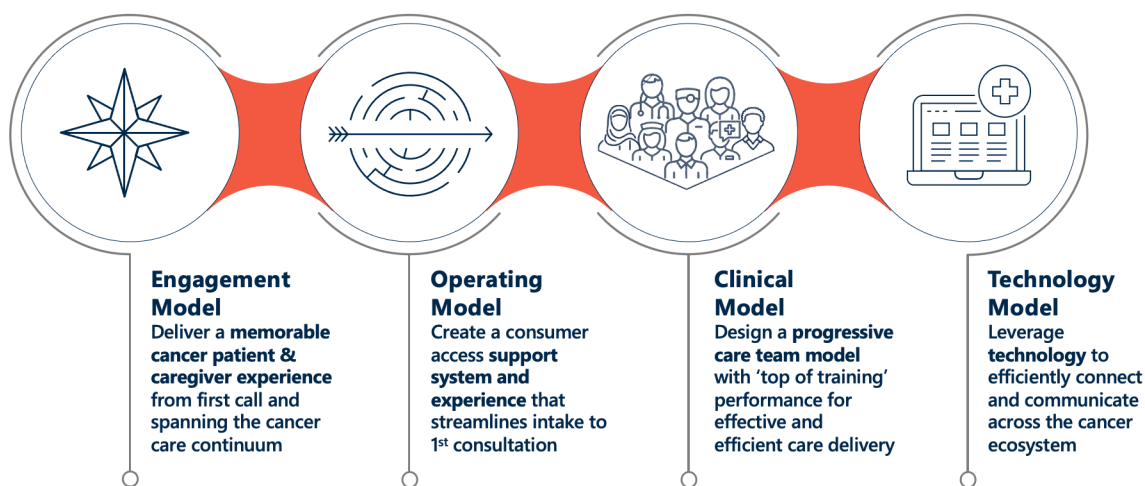
Fast forward to 2022, survey results found that nearly all respondents (35 of 36, 97 percent) offer virtual and/or tele-health visits, either across or within select sub-specialties, which is an exponential increase from 2019 survey results. The majority of 2022 survey respondents report using virtual or tele-health visits for existing patients, genetic counseling, survivorship visits, and supportive care interactions (Figure 3, left).

### The Patient Experience Reimagined

Like never before, individuals accessing cancer care demand and deserve a seamless experience, with their preferences considered every step of the way. Patients with cancer have an array of



Figure 4. Reimagining the Patient Experience: Key Capabilities and Processes



provider options, both locally and across the U.S., within academic and NCI-designated comprehensive cancer centers, so reimagining patient access is a mandate. What do cancer programs need to do today to position their organization as a market leader in cancer care access for years to come? The answer: understand that delivering the best patient experience requires a team, as cancer care is a team sport, involving access, navigation, and care team transformation. The synergistic nature of these elements cannot be underestimated and advancing one in misalignment with the others leads to implementation delays. Figure 4, above, illustrates how cancer programs must develop key capabilities and processes across quaternary dimensions to successfully maximize the patient experience.

### Engagement Model

Many cancer programs employ navigation services at varying levels, but we often find, despite good intentions, that providers overuse the term “navigator” and inconsistently manage these services, leading to overwhelmed navigators taking on tasks that would be more appropriately completed by access or other care team colleagues. Patient navigation suffers from definitional ambiguity, moving from “holistic” intent (Figure 5, right) to functional activities to describe any task in the patient journey. Examining your own navigation program for fit and effectiveness within the access and clinical care delivery model construct is essential. This assessment should include a review of five core elements:

1. *Foundation.* Vision and goals, model, general/disease assignment, span of role
2. *Operation.* Organizational structure, caseload targets, orientation and competencies, standard operating procedures
3. *Education.* Value proposition, organization education, resources, continuing education
4. *Integration.* Tumor conference participation, communication, care transitions, outreach, collateral

5. *Performance.* Technology enablement, documentation, metrics and patient surveys, key performance indicator reporting.

Using a scoring rubric to assess your navigation program against leading navigation practices will inform alignment with access and clinical care models to solidify the role of navigation in the patient experience. The assessment then leads to redesign needs

Figure 5. Overarching Goals of Navigation



and performance improvement initiatives that move in concert with other access and care team initiatives. Navigators can then lead in their intended roles to deliver a memorable experience spanning the patient care journey.

### Operating Model

While navigation is an emotive and advocacy connection for patients and caregivers, the process of moving through the access realm can be complex and often frustrating. Leaning into design with key constituents in mind—patients and caregivers, physicians and APPs, and the broader clinical and supportive care team—is essential. The primary goal of operating model redesign is to enable a system that provides patients with exceptional customer service, while allowing providers to focus on cancer care delivery. The operating model should facilitate timeliness to care. With these goals at the center, cancer programs should follow the below approach to assess, design, stabilize, and implement their access strategy:

- **Step 1.** Patient acquisition and referral management linked to navigation
- **Step 2.** Curated access solutions for disease-specific populations and care teams
- **Step 3.** Integrated digital solutions across the cancer access journey
- **Step 4.** Capacity management linked to care team “top of training” and optimization practices
- **Step 5.** Access strategy supporting a technology roadmap
- **Step 6.** Performance analytics to drive continuous improvement.

Transforming patient access squarely involves people, processes, and technology. Strategies and implementation must stay intimately aligned with navigation and clinical models as well as care team initiatives. While the task of access redesign is not for the weary, a comprehensive change management and communications plan to overlay initiatives is important and can help break down barriers like legacy thinking and behaviors. Successful access redesign efforts can expect the below results:

- Improved use of existing capacity to serve about 15 percent to 30 percent more patients
- Acquisition of new patients to the oncology service line
- Retention and sustained activation of existing patients
- Strengthened relationships with referring providers
- Provider and care team commitment and engagement
- Enhanced adoption and use of information technology (IT) investments
- Transformed patient experience and greater satisfaction.

### Clinical Model

With an often overwhelming patient volume, it is difficult for cancer programs to dive deep into their day-to-day operations and workflows to embark on re-design efforts. But to be more successful tomorrow, oncology professionals need to fundamentally rethink how they approach supply and demand today. Access initiatives are about supplying services to meet a demand—it is

also increasingly about creating a demand. The connective tissue then becomes care team transformation.

This is critically important for oncology professionals, considering the ever-growing newly diagnosed and survivorship populations and an impending shortage of oncologists that is expected to be greater than 2,200 providers by 2025.<sup>1</sup> The COVID-19 pandemic has brought extreme workforce challenges to the broader cancer ecosystem, making employee engagement and satisfaction competitive advantages in many markets. Care team transformation will be a critical focus area to support providers and obtain optimal use from every allied healthcare professional. So how do cancer programs transform their clinical model to meet these market realities?

The first step is to optimize your current oncology provider base. The second step is successful development and deployment of next-generation care teams, which includes leveraging APPs in ways that expand the provider base rather than being duplicative. The third step is to focus on technology and digital solutions to support these efforts (this will be addressed in the following section). Here, let’s focus on care team transformation with the goal of providing care to more patients with process ease and the timeliness to care they need.

Cancer care providers should map out the end-to-end patient journey, including necessary touchpoints throughout, taking stock of every touchpoint. What one attends to first, second, and third will be different for each organization. Additionally, understand what those priorities need to be. Then create a plan that overlays the broader team-based clinical model strategy. Focus on understanding the organization’s supply—how much capacity the cancer program actually has—and then understanding demand, including both how many patients are walking through the doors and how many new patients one can generate. These data will provide a baseline. From there, one can grow and think differently about how their organization manages supply and demand within the broader care team context, including access colleagues, up-front clinical triage, navigation to first visit, and ongoing care throughout the continuum for MDs, APPs, MAs, and RNs, support services, survivorship roles, and responsibilities at “top of training.”

### Technology Model

The fourth and final pillar of access and the patient experience looks at leveraging technology to efficiently connect and communicate across the cancer ecosystem. Digital transformation requires two equally essential components:

1. A comprehensive understanding of an organization’s underlying engagement and adoption for cultural, clinical, and operational technology
2. A technology-forward, break-the-rules perspective of digital transformation to revolutionize cancer care delivery and the patient experience.

The first step is optimization of current capabilities. Before any dream-big digital transformation, cancer programs must look to current provider-based supply, while simultaneously developing digitally enabled care models, to position their organization to

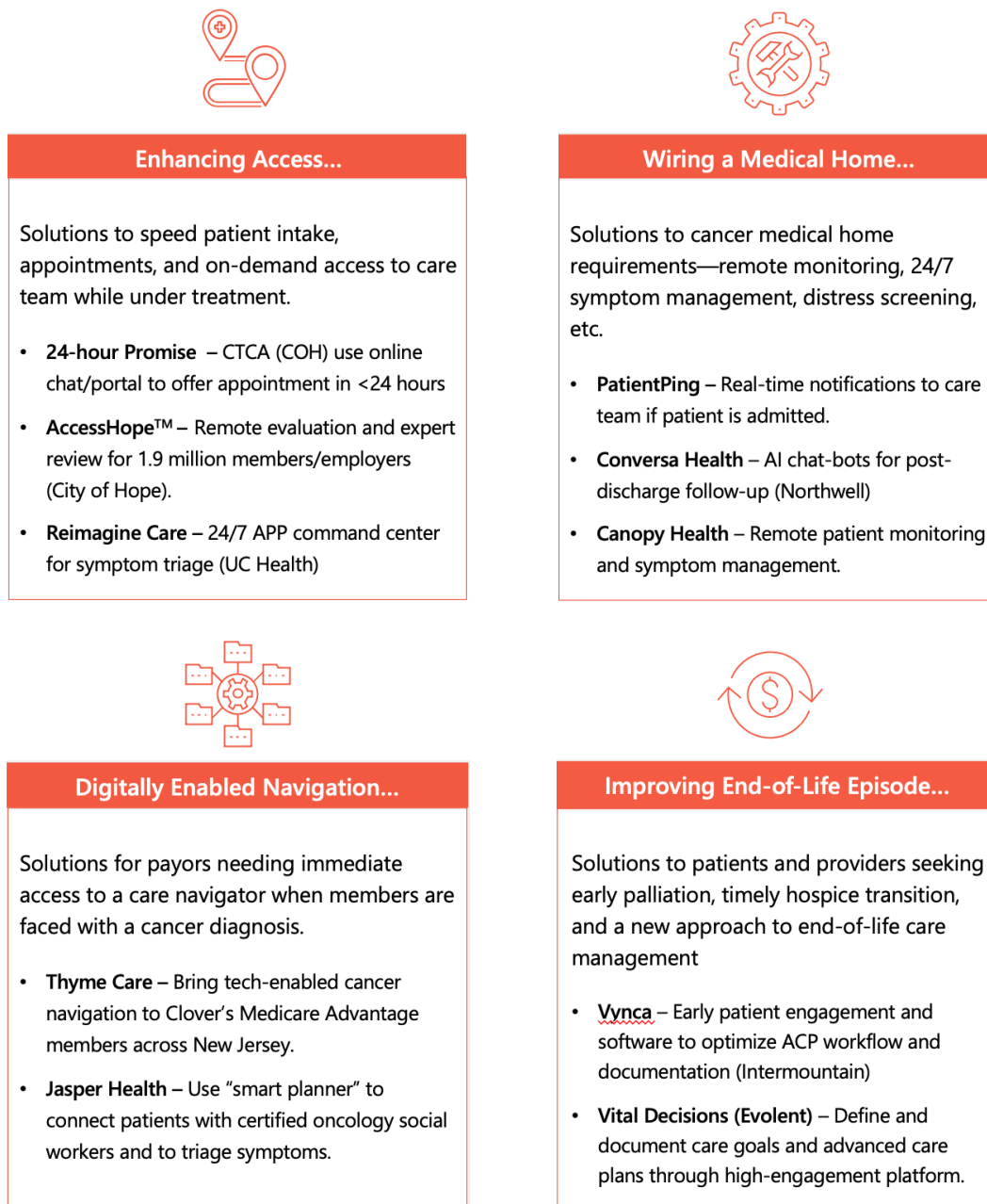
meet demand in a cost-efficient manner. Planning a digitally forward care delivery model requires thoughtful, purposeful alignment between the way health services are delivered and experienced—that is, the work that needs to be done, which roles do what work, when and where the work is done, and which tools are required to do it.

Fortunately, virtual care learnings and the case for change that many organizations successfully navigated early in the

pandemic should allow them to determine the requirements, scale, and workflows necessary to intentionally operationalize a digitally forward care delivery model. A strategic focus on benefit realization, combined with an intentional and programmatic approach to execution, will truly transform a cancer program’s care delivery platform.

Healthcare organizations need a methodology to apply across the oncology service line from defining, developing, and

Figure 6. Innovation In Oncology



Source. Research by Chartis Oncology Solutions.



operationalizing the model to engaging clinical leadership and making the case for change. Grounding this methodology in a set of operating model principles like the ones identified below creates insight and ensures that a holistic care model emerges:

- Disease-specific patient segmentation and navigation are vital to ensure the right care.
- Digital capabilities are leveraged to their fullest potential.
- APPs and nurses drive lower-cost, digitally enabled care.
- Care options expand and extend beyond traditional hours and locations.
- Care teams are configured to support access and the provider experience.

These operating model principles articulate the requirements that must be met by technology-leveraged and digitally forward care models. The clinical, service-specific work steps test each principle, as care models are designed and implemented. Based on these operating model principles, healthcare organizations should consider five workplan components, while optimizing the use of technologies, to make cancer care delivery more efficient and effective:

1. Intentionally match patient encounter types to a provider and modality
2. Create use cases to illustrate and discuss how care should be triaged to providers and the care team
3. Evaluate the care team complement
4. Create the case for change
5. Address organizational- and service-specific supporting capabilities.

Start the work with eager and amenable oncology clinical leadership to refine the approach and templates, as well as to understand support requirements and capabilities. To be a truly valuable and scalable integrated facet of cancer care delivery, change management and communications will be critical.

## Dreaming Bigger

The accelerated shift to digitally driven care delivery, demand for a person-centric experience, and COVID-19 pandemic-propelled pressures have made digital transformation an essential and existential requirement for stakeholders across the healthcare delivery ecosystem. Digital cancer care is the overarching spectrum of experience and capabilities required for the material transformation of care delivery beyond specific patient-provider interactions. Cancer programs (and new technology entrants) are increasingly focused on creating fast, frictionless, and seamless care experience with an emphasis on patient access and digital enablement. “Winning in access” is a common cancer program strategy theme.


Cancer programs are transforming oncology through patient access, agency, and the patient experience in three distinct ways. Reconfiguring the care delivery model to be digitally forward requires integrating clinicians’ roles with digital tools to create a deliberate impact—optimizing clinical effectiveness, patient-centricity, provider experience, and net income. Chartis predicts

oncology industry innovations for 2023 will include:

- Digital, cancer-specific care management platforms that proliferate, often with payers as the customer.
- Healthcare organizations will seek to activate and retain patients through mobile “medical home” technologies.
- Consumer innovation will go hand-in-hand with developing toolsets needed to deliver value-based care.

Several examples of the digital innovation being realized in cancer care range from enhancing access; enabling oncology medical home programs; providing digitally enabled support services; and managing end-of-life episodes of care. Figure 6, page 48, illustrates just a few examples of where innovation is showing up on the oncology landscape across provider and biotech platforms.

## A Look to the Future

Oncology care is unique in its far-reaching impact on healthcare professionals, requiring a high level of coordination. Like oncology care itself, designing the roadmap for transformation—access, navigation, care team transformation, and technology—is one of the toughest tactical jobs of healthcare organizations. To navigate these complexities and ensure legacy culture and siloed behaviors coalesce into a symphony of team-based care delivery for patients and providers, organizations must act now to craft or optimize their cancer ambulatory strategy. 

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