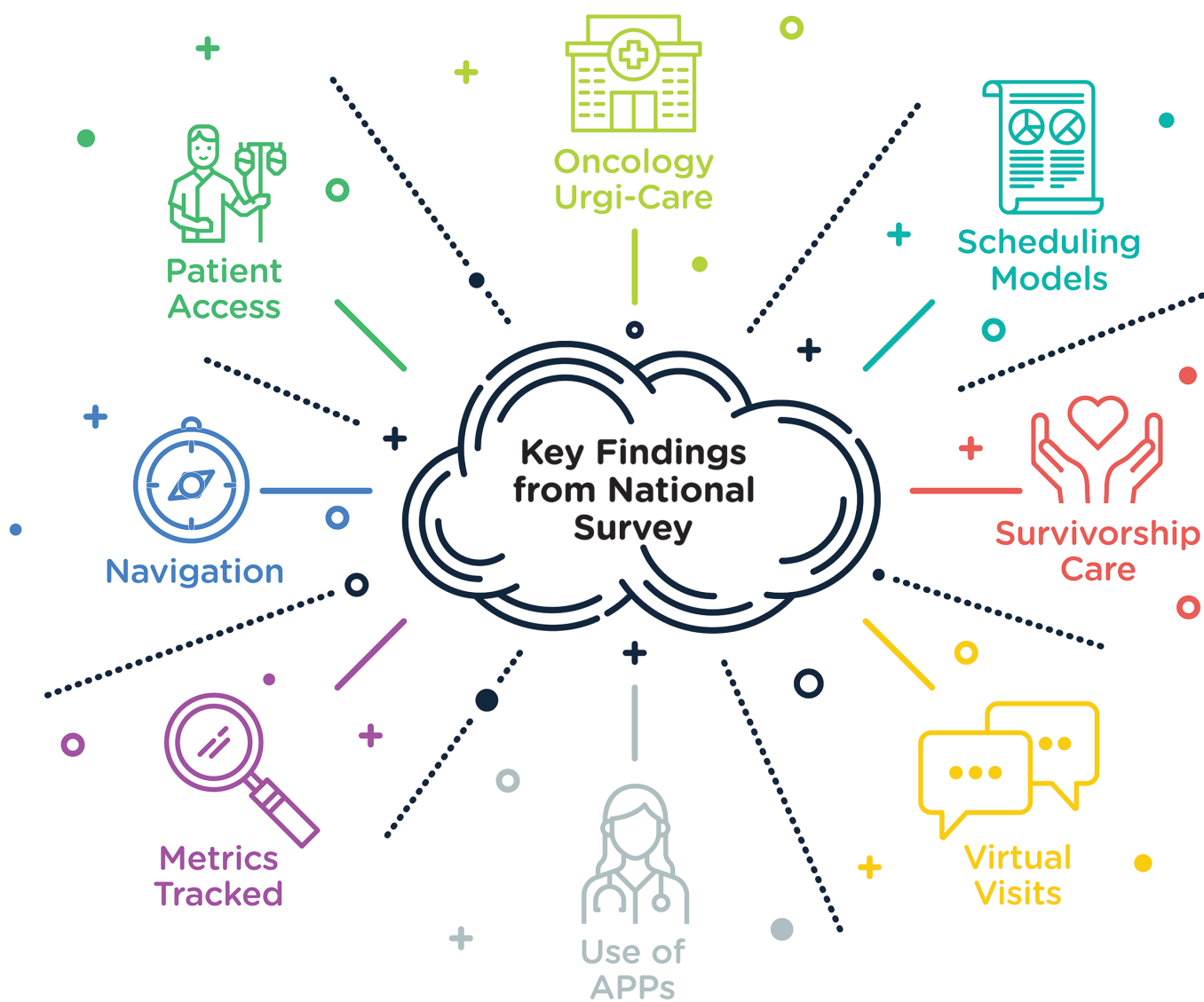


# Expanding Patient Access to Cancer Care Services



## *Key results from a national survey show a range of new initiatives*

**P**atient need for cancer care services is growing. At the same time, cancer programs face a confluence of dynamics that impact their ability to meet patient demand, including an increasing number of new cancers, an exponential volume of cancer survivors requiring follow-up care, and a looming oncology physician shortage. Most recently, longstanding patient access challenges have been exacerbated by the COVID-19 crisis.

Many cancer programs saw a temporary reduction in patient volumes and a dramatic increase in virtual visits as a result of COVID-19 as they shut down routine cancer screening, deferred treatments (when safe to do so), and altered approaches to care to minimize risk for this vulnerable patient population. With screenings, diagnostics, and other care restarted and postponed services (re)scheduled, there is even greater need for cancer centers to expand access to meet pent up demand.

In October 2019, prior to the COVID-19 public health emergency, The Chartis Group ([chartis.com](http://chartis.com)) conducted a national survey of 14 academic medical cancer programs, five community-based cancer programs, and two freestanding, independent cancer centers. Participating organizations answered 23 standard questions about organizational background, patient access goals and metrics, scheduling and registration systems, use of virtual care and telehealth, care team staffing models, and referral management, among others. Follow-up discussions focused on specific challenges and performance optimization initiatives being implemented to improve patient access to care.

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Survey findings suggest that, though efforts are underway to improve patient access to cancer care, many academic- and community-based cancer programs continue to struggle to meet the growing demand for services. Cancer programs are implementing a variety of new models to increase patient access and capacity, demonstrating their commitment to patient-centered care, while acknowledging that newly diagnosed patients with cancer may go elsewhere if they cannot quickly access services. Some strategies include implementation or expansion of “tried and true” approaches, such as expanding capacity by growing

the workforce or increasing productivity expectations. Others are more novel, such as creating new sites of care to support specific patient populations (e.g., urgi-care centers, survivorship clinics). Through survey questions and follow-up conversations, survey participants shared data on efforts to improve access, accomplishments and frustrations, and future plans.

### Patient Access to Cancer Care: Current State

The goal for most cancer programs surveyed is to see newly diagnosed cancer patients within five to seven days (Figure 1a, right). A few cancer programs in more competitive markets set a stricter goal of three days or less, which aligns with The Chartis Group’s leading practice of two to three days. Ensuring that patients are seen by an oncologist within this time frame helps to reduce patient stress and anxiety, maximize speed to intervention and treatment to optimize outcomes, and attract and retain patients. For benign hematology patients, the goal in most cancer programs is to see patients within 14 days (Figure 1b, right). Longer lag times for both newly diagnosed patients with cancer and benign hematologic disorders are often associated with higher cancelation and no-show rates—along with higher levels of patient and referring physician frustration.

The ability of organizations to achieve their goals varies. Most respondents indicate that performance against goal is specialty specific, because some disease-specific programs and clinics are more successful than others. Only two respondents reported that “all patients are offered an appointment within our target time frame,” suggesting that delay in accessing needed services remains a significant concern for most of the participating cancer programs.

### Scheduling Model: Centralized vs. Decentralized

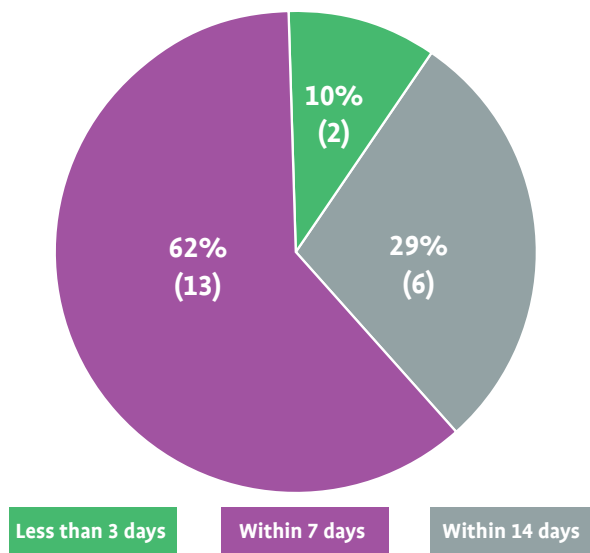
More than half of cancer programs surveyed (53 percent) provide centralized scheduling for cancer (and other) services (Figure 2, right). The rest rely on either a hybrid or primarily decentralized model requiring new and existing patients to contact individual clinics or departments to schedule services and treatment. These models can be frustrating and time-consuming for patients who need to coordinate and schedule multiple visits for different services.

Overall satisfaction with centralized scheduling varies. One organization reported a 70 percent turnover rate for centralized staff and expressed a need to “reimagine” the objectives, roles, and training of centralized staff with an added focus on care coordination. Another organization described an extremely effective (leading) 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 leading practice does not happen nearly as often as it could or should.

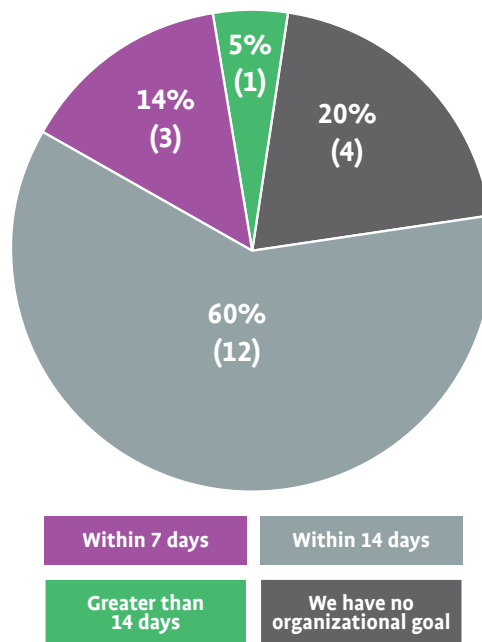
Of the cancer programs with a centralized scheduling model, the majority offer new and existing scheduling, appointment reminders, patient registration/intake, and records collection (Figure 3, page 52). Very few offered Find-a-Doc services,

Figure 1. Days to Schedule Initial Visits\*

A. What is your organizational goal for newly diagnosed cancer patients or patients with suspicion of cancer to be scheduled and undergo an initial visit?



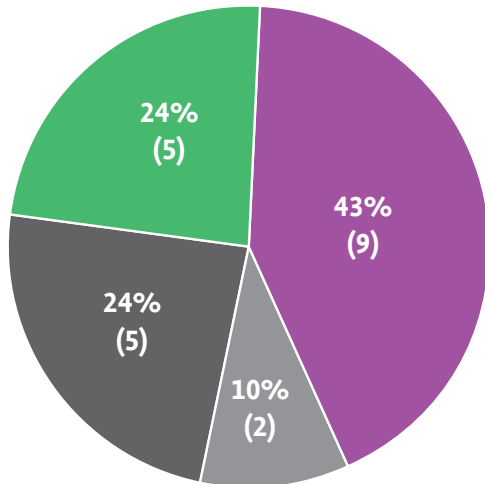
B. What is your goal for benign hematology patients to be scheduled and undergo an initial visit in your cancer center?



\*Percentages total more than 100% due to rounding.

Figure 2. Scheduling Systems\*

What best describes the scheduling systems at your cancer center?



- We have a centralized call/contact center that supports scheduling solely for the cancer center/cancer clinics.
- We have a centralized call/contact center that supports the cancer center and other sub-specialty areas.
- We have a hybrid; some cancer center services or specialties are scheduled centrally while others are decentralized.
- We have decentralized scheduling; new and existing patients contact individual clinics or departments to schedule services and treatment.

\*Percentages total more than 100% due to rounding.

centralized template management, or support of online scheduling.

Only 33 percent of cancer programs surveyed will schedule patient visits without records, and the rest will not schedule patient appointments for all or select patient populations until they collect all patient records (Figure 4, page 52). The primary reasons for collecting the records in advance of scheduling are provider preference and ensuring that the visits are maximally productive (i.e., scheduled with the right provider at the appropriate time and based on patient needs). Yet, this practice frequently causes delays in scheduling and significant patient and referring provider frustration. The Chartis Group experience suggests that appropriate processes can be put in place to ensure that records are obtained prior to the visit and scheduling adjustments can be made when records indicate a required change. These processes can include partnering with referring providers to send records electronically or outsourcing to a third party for records collection. Outsourcing is an expensive proposition, but

one academic medical center surveyed credits the move to third-party record collection with reducing days to appointment for new surgical patients from seven to eight days to three to four days.

### Cancer Program Metrics Tracked

Most surveyed cancer programs track an array of patient access metrics, establishing a baseline for continuous measurement and monitoring that can inform process improvement initiatives (Figure 5a, page 53). Far fewer track operational metrics or set operational targets to ensure they have the space and resources to support their access goals (Figure 5b, page 53).

One academic medical center that participated in the survey is using a third-party customer experience platform to survey patients on whether they would recommend their physician and/or the organization through a text that is sent within four hours of the patient leaving the facility. This immediate feedback loop allows managers to assess and resolve—in real time—issues around wait times, care coordination, etc.

### Patient Access and the Patient Experience

Survey responses revealed several innovative solutions being employed to expand organizational capacity and improve access. Select findings and examples are highlighted below.

#### The Use of Advanced Practice Providers

Though survey respondents reported significant utilization of advanced practice providers (APPs) to expand capacity, how these APPs are utilized—either through shared visits with physicians or independent visits—differed by program and often by disease-based clinic within a single program (Figure 6, page 54).

APPs at one organization independently see established visits, survivorship visits, and same-day and urgent care visits in the clinic and support consults and discharge planning in the inpatient setting while also supporting remote symptom management through virtual visits. The relationship between the APPs and the physicians is described as a “very strong partnership” due to careful recruitment, thorough orientation, and a multi-month training program with physician colleagues. The Chartis Group recognized this model as a leading practice that increases clinic capacity and streamlines access to care; unfortunately, this type of leading practice is rare.

#### Navigation Services

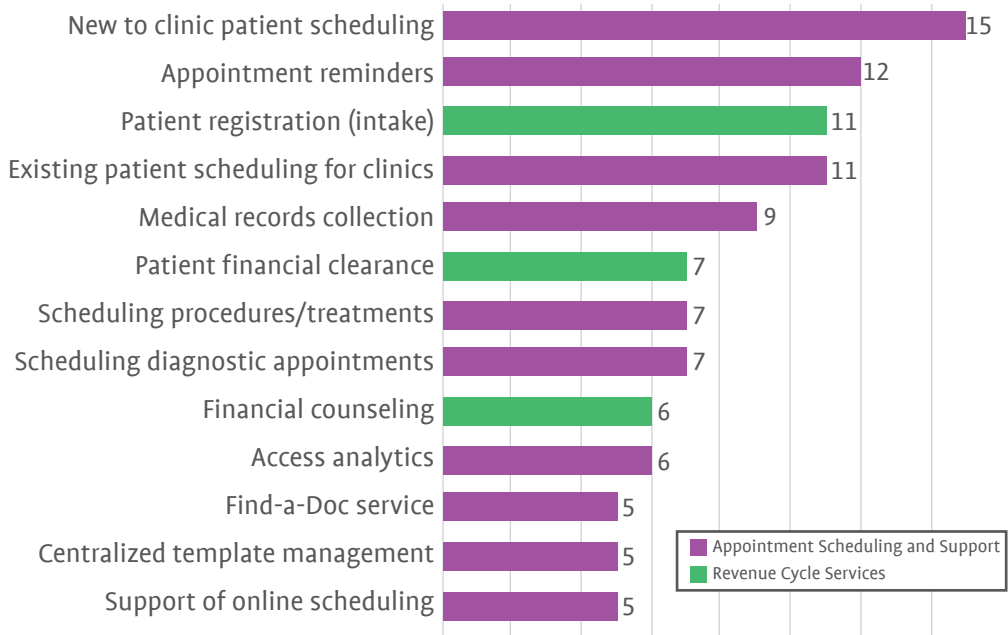
In follow-up conversations with survey respondents, many indicated that their navigation services are critical to helping patients understand how best to access care along their care journey. When access questions or issues arise, navigators act as internal advocates for the patient, working with schedulers and clinicians to create an efficient schedule that ensures that the patient receives all required treatments and services.

#### Dedicated Oncology Urgi-Care Centers

Nearly half of survey respondents (48 percent) have a dedicated oncology urgi-care center with extended hours to offer patients expedited treatment and care for common cancer-related com-

(continued on page 53)

Figure 3. Services Provided by Centralized Scheduling Systems



Note: Data only includes the cancer centers that have some level of centralized scheduling services. Data only includes services that were provided by at least 5/16 cancer centers.

Figure 4. Scheduling Patient Appointments

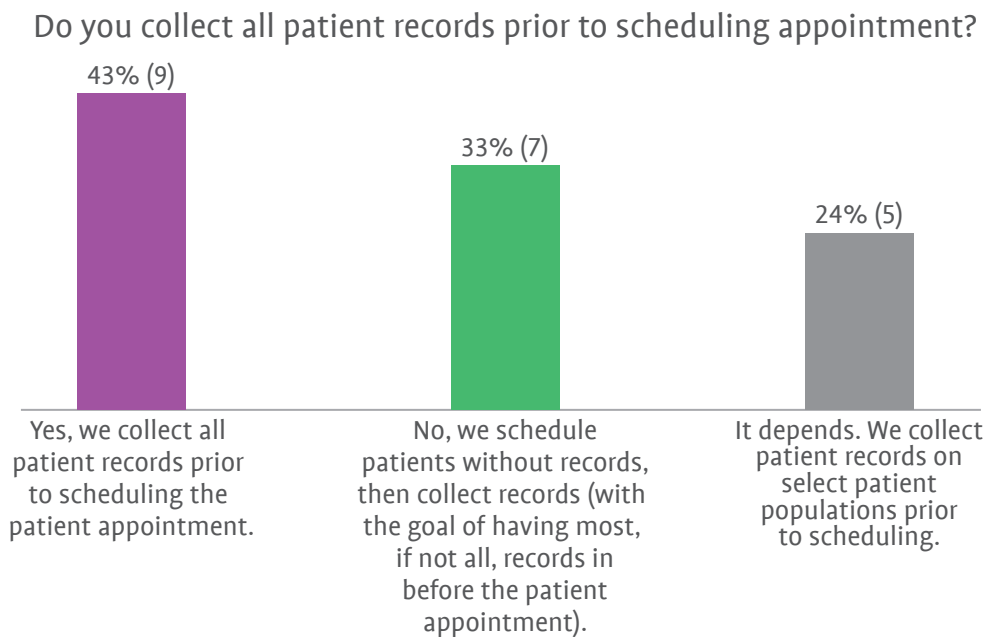
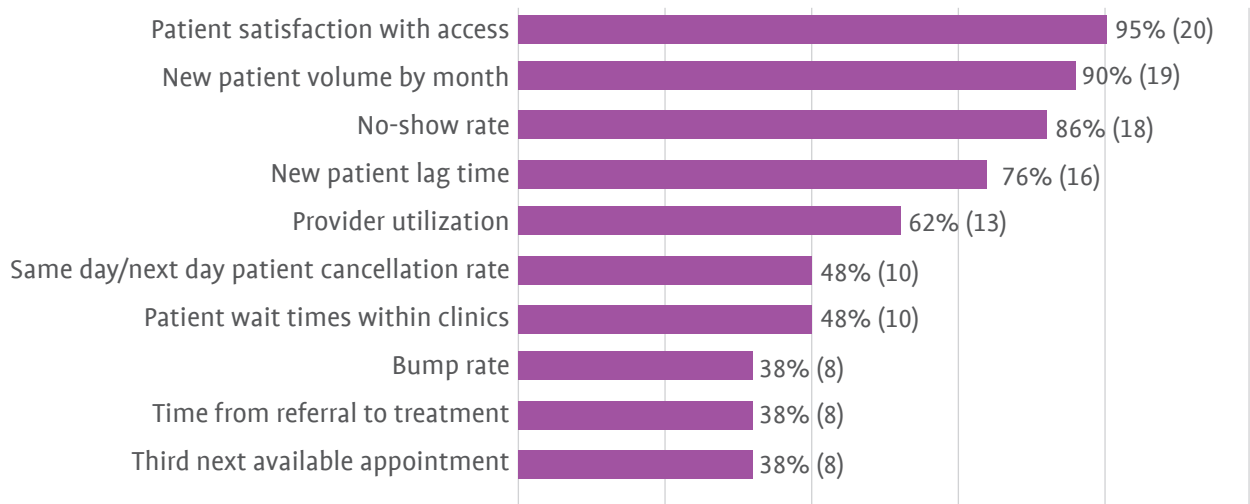
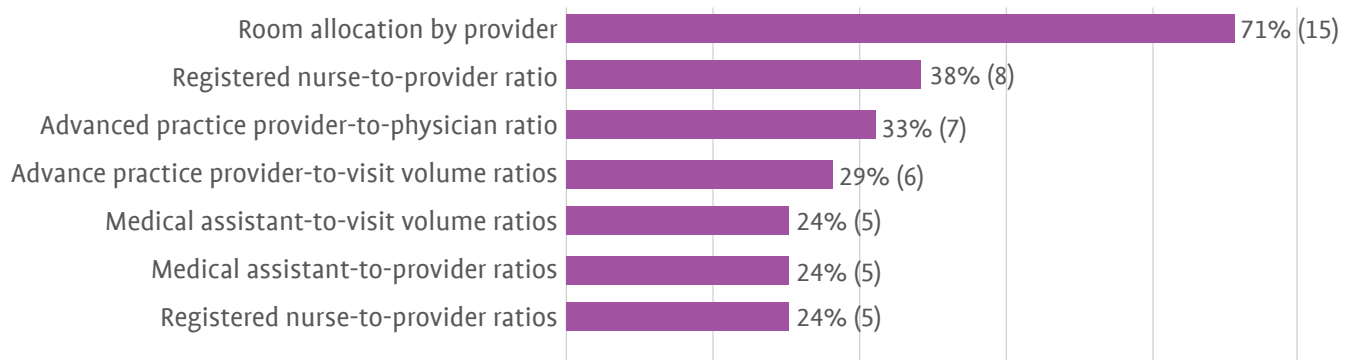


Figure 5. (A) Patient Access and (B) Operational Metrics.

**A. What access metrics does your leadership team actively track and follow?**



**B. What operational standards do you have in place to ensure you have the resources and space to support your access goals?**



(continued from page 51)

plications, including infections, shortness of breath, nausea and vomiting, and neutropenic fevers (Figure 7, page 54). An additional 19 percent have design and build plans underway. The greatest benefits of urgi-care centers are improved patient experience and reduction of avoidable hospitalizations and emergency department visits.

**Virtual Care Visits**

At the time of the survey (October 2019), most respondents 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 do not require a physical exam or procedure (e.g., symptom checks, return visits, navigation visits). However, a notable 38 percent of respondents were not offering and had no plans to offer virtual care within the next year. This delivery

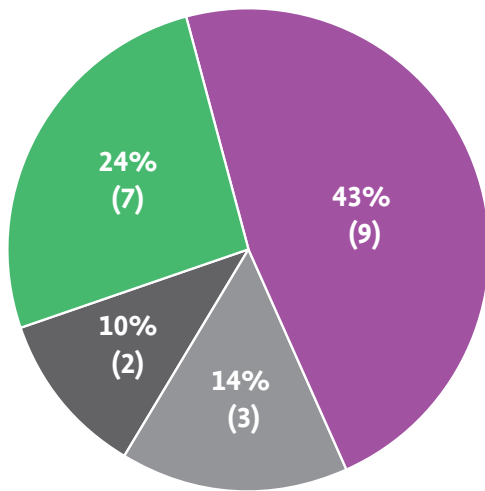
model is one of the most highly impacted by the COVID-19 pandemic, because virtual care services quickly accelerated across the healthcare industry to meet patients’ needs during this crisis.

There are many benefits realized through virtual care visits. For patients and their caregivers, virtual visits remove the hassle of travel and parking and limit exposure to pathogens such as COVID-19. For cancer programs, virtual visits extend the reach of providers and free up space and resources within the clinic to open additional new patient appointment capacity.

COVID-19 provided the impetus for rapid expansion of virtual visits at many cancer programs. Accordingly, virtual visits will likely continue to be an important care delivery model given the many benefits to both patients and providers, as well as the continued risks specific to COVID-19.

Figure 6. Use of APPs\*

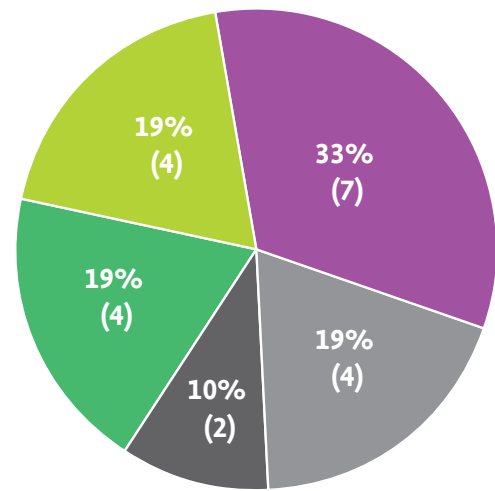
How do you use Advanced Practice Providers within your ambulatory clinics?



- Combined shared and independent visits.
- Predominately independent visits.
- Predominately shared visits with physicians.
- The practice model depends on the clinic and/or provider.

\*Only includes centers that use APPs within their ambulatory clinics.

Figure 7. Availability of Urgi-Care Centers



- The cancer center does not have a dedicated urgi-care center.
- The cancer center does not have a dedicated urgi-care center, but we have plans to design and build one.
- Yes, open 24/7.
- Yes, it is open weekends.
- Yes, it is open weekdays and weekends.

### Second Opinion Programs

In some cancer programs, a significant portion of new patient visits are second opinions, though many of these patients may not continue with treatment at the institution. Only seven survey respondents provide a formal Second Opinion Program where patients can come on-site to see a provider (Figure 8, page 55). Of these, three also provide patients with a virtual second opinion option.

The Chartis Group has seen a growing number of organizations partner with an external vendor to offer second opinions. The third party acts as the primary interface between the patient and the cancer program, collecting patient records, working with a select group from within the cancer center to evaluate records and gather patient results, and educating the patient about treatment options.

### Survivorship Programs

There are currently 16.9 million cancer survivors in the United States, and estimates suggest that by 2030 the population of cancer survivors will increase to more than 22.1 million.<sup>1</sup> Most cancer programs surveyed (86 percent) have a formal survivorship program, either embedded within specialty-specific clinics or supported by an independent clinic (Figure 9, page 55). Though the format and location of the survivorship programs differ, most

have a shared goal: to provide access to patients to meet their physical and emotional needs after treatment and free up provider capacity for new patients and those undergoing treatment.

### Improving Patient Access

Doubling down on ambulatory patient access is more critical than ever for cancer programs striving to attract patients in the post-COVID environment and retain and serve a growing patient population. The Chartis Group recommends these four foundational and more advanced strategies to cancer programs looking to improve patient access.

#### Strategy 1. Optimize Patient Service

- Assess scheduling and other pre-visit processes from the patient’s perspective; that is, how easy versus how difficult and/or time consuming is it to schedule multiple services in different departments? How much do internal processes (e.g., record collection, insurance processes) delay scheduling?
- Establish appropriately aggressive patient access goals to set expectations and raise performance levels.
- Offer navigation services with initial intake and support to assist patients with accessing services across different departments.
- Evaluate current records collection processes to identify ways to streamline the process.



Figure 8. Second Opinion Programs

What best describes your second opinion program?

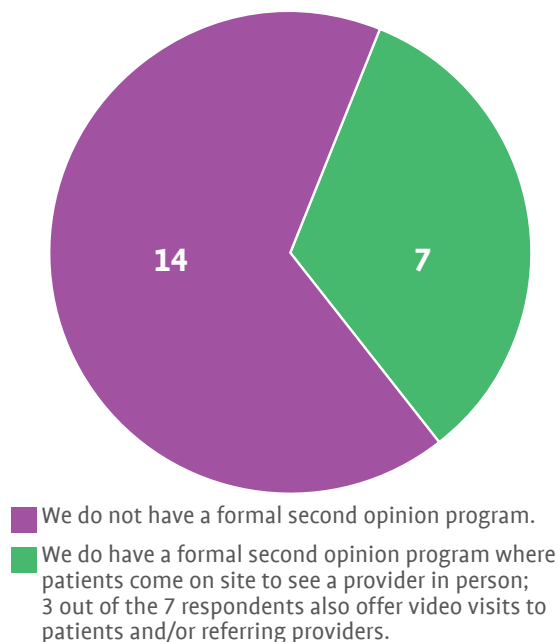
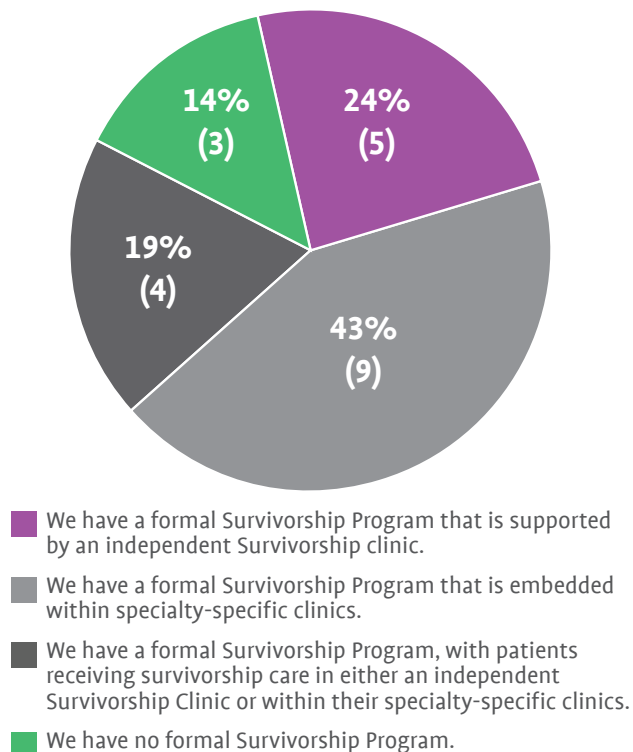


Figure 9. Survivorship Programs

Availability of Survivorship Program



### Strategy 2. Maximize Existing Capacity

- Integrate APPs appropriately into the care model to support physicians and increase access. Effective use of APPs can allow physicians to conduct more new patient visits.
- Develop a survivorship program to more efficiently support existing patients and increase ability to accommodate newly diagnosed patients.
- Focus on cancelation and bump rate reduction; employ provider template optimization to increase capacity for new and existing patients.

### Strategy 3. Expand Visit Pathways

- Employ and expand new modalities (i.e., virtual provider visits, remote monitoring, and case management) to make it easier and more convenient for patients to access needed information and services.
- Establish an urgent-care center or extended hours clinic to make accessing care more convenient for patients.
- Develop a remote second opinion program that efficiently provides a needed service, while also “saving” on-site appointment slots for patients who likely require treatment at the cancer center.

### Strategy 4. Establish Structure and Leadership to Support Patient Access Goals

- Routinely monitor a comprehensive set of patient access metrics to understand current performance and gaps against goals.
- Establish a leadership structure—inclusive of physician leaders—to monitor access performance, actively address issues, and oversee access initiatives.
- Establish expectations for provider time to expand capacity and optimize utilization of provider time.

Even before COVID-19, the need for expanded patient access was well documented. Post-pandemic, to be able to accommodate patients who put off screening and follow-up visits during the public health emergency, cancer programs will need to purposefully and intentionally improve patient access to establish, continue, and/or complete cancer treatment.

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### Reference

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