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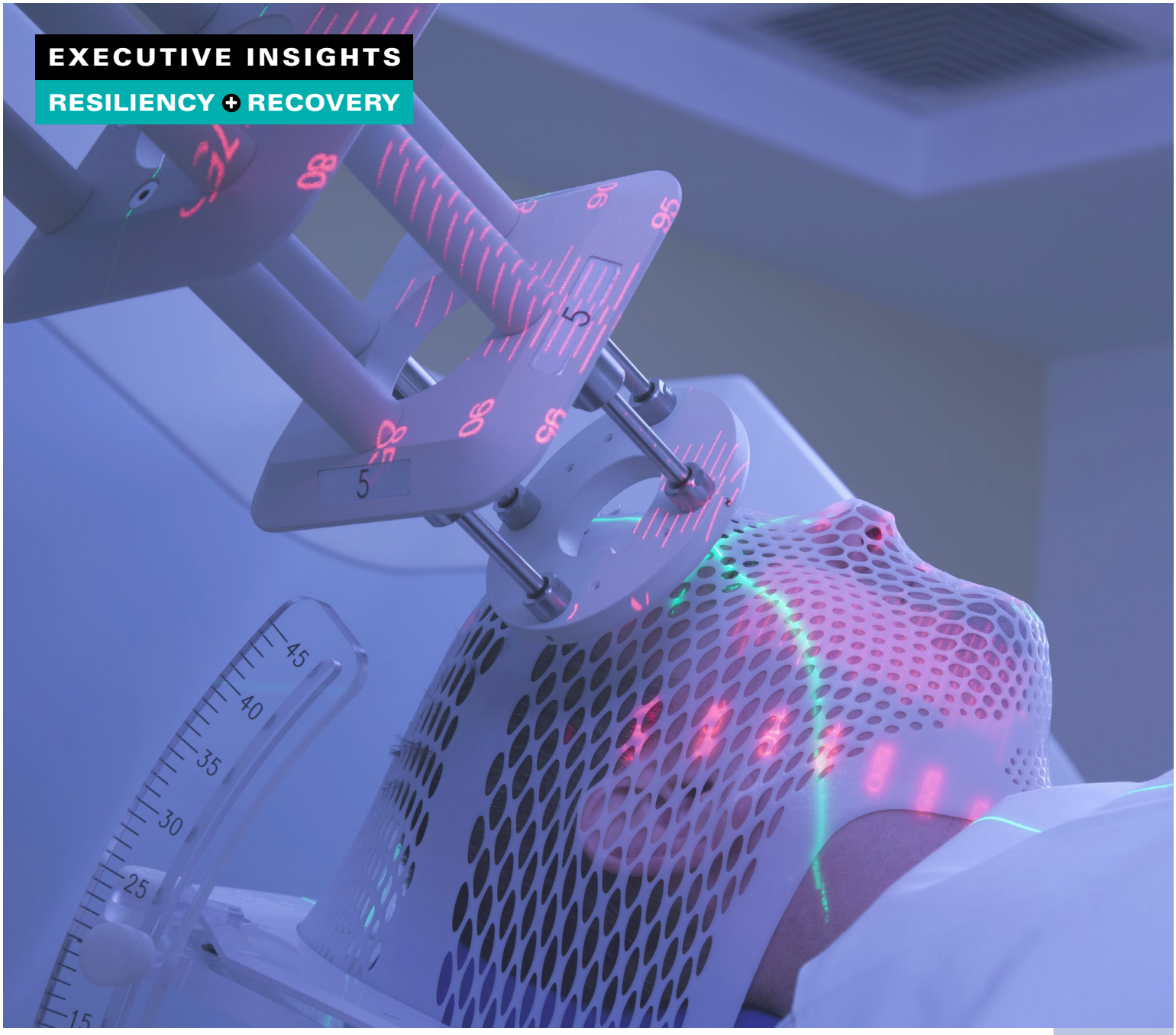

# THE FUTURE OF HEALTH SYSTEM-BASED CANCER CARE

Advances, opportunities and challenges as cancer care becomes a leading health care cost driver

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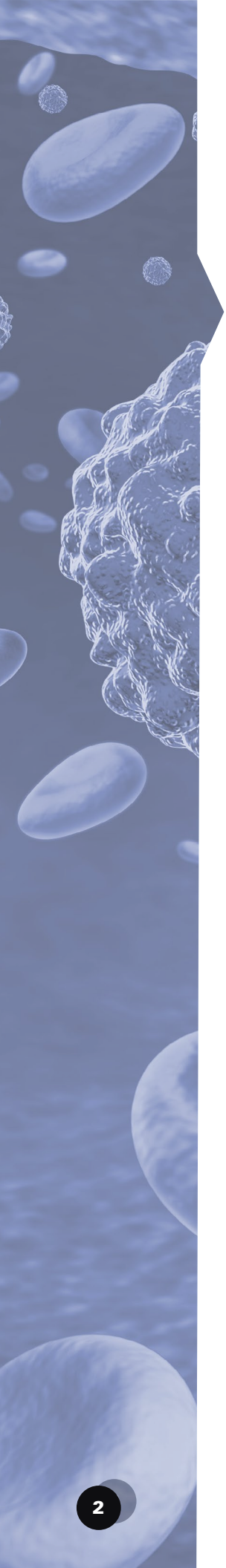

# THE FUTURE OF HEALTH SYSTEM-BASED CANCER CARE

## Advances, opportunities and challenges as cancer becomes a leading health care cost driver

**Cancer care costs in the United States are projected to exceed $245 billion by 2030, reports the American Association for Cancer Research.** The stakes have never been higher for hospital- and health system-based cancer centers. Innovative treatments and technologies, organizational alignments and shifting sites of care show promise to fundamentally change the way care is delivered. At the same time, nontraditional competitors seek to carve out market segments that threaten the viability of hospital-based programs and their ability to make these advances accessible for all patients. With costly treatments, patients face financial toxicity, which can impact their mental health, clinical outcomes and survival rates. This executive dialogue explores how leaders are streamlining operations and access to improve cancer care outcomes and affordability.

## KEY FINDINGS

1. Partner with top cancer research centers so patients have access to advanced oncology services and cutting-edge treatments as soon as they are available.

2. Set up cancer centers of excellence in the health system with a multidisciplinary team to share information, make informed decisions and coordinate care. Standardize cancer care across sites for efficiencies and cost containment.

3. Prioritize the patients who need care the quickest to counter the new entrants and nontraditional players. Employ navigators and efficient systems to provide cancer services seamlessly in a timely manner — schedule appointments, assist through the surgical and treatment processes and help patients make informed decisions about their care.

4. In medically underserved communities, use population data to target survivorship and integrative health programs for a holistic approach to patient care. To address language barriers, match clinician makeup or navigators with patients. Work closely with churches, synagogues and community groups to establish relationships and trust within the community for prevention, screening and earlier-stage diagnosis.

5. For uninsured, underinsured and Medicaid populations, scale specialty pharmacy services offered by the health system to the level needed and make 340B arrangements with other specialty pharmacies to fill the gap for vulnerable populations. Work with payers to use the health system's specialty pharmacy instead of white bagging.

6. Look at providing home-infusion services as part of the hospital's at-home program to counteract fragmentation and lower costs.

7. Address social determinants of health that are barriers to cancer care, such as transportation and lodging, with grants from the American Cancer Society and state programs.

8. Make provider teams available to rural areas weekly or biweekly to provide follow-up and supportive services locally so that patients only need to travel for higher-level care.

## PARTICIPANTS

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**MODERATOR** *(Suzanna Hoppszallern, American Hospital Association):* **What major trends and advances in cancer diagnosis and treatment are affecting the provision of care at your hospital or health system and plans for growth? How does oncology fit into the organizational strategy?**

**ROBERT V. LEVINE** *(Flushing Hospital Medical Center):* Our organization is beginning a new relationship with Memorial Sloan Kettering Cancer Center (MSK). In our borough of Queens with a population of more than 2 million, there is a need for access to advanced oncology services beyond what we currently offer and this relationship is important for the residents we serve. We look forward to working with MSK to provide services locally at our institutions and, when and where necessary, refer patients to their facilities for services that we can't provide initially or down the road.

I'm happy to see that my colleague, Bill Lynch, is on the program with me. We are both chief operating officers for the MediSys Health Network.

**MODERATOR: Bill, did you want to add anything?**

**WILLIAM LYNCH** *(Jamaica Hospital):* We looked at our strengths and our weaknesses as an organization, and we knew that oncology and cancer care were not our strengths. It is a significant need in the communities we serve, primarily medically underserved communities with more than 60% Medicaid. As Bob mentioned, we knew that it would take forever to set up a program, so we reached out and were fortunate that we have a partner willing to collaborate to deliver the kind of cancer care that we all would want in our communities.

**MODERATOR: Let's hear from others on how oncology fits into your organizational strategy and the trends affecting the provision of care as well as your plans for growth.**

**DENISE BLACK-ANDERSEN** *(Intermountain Health):* Last year, SCL Health merged with Intermountain Healthcare (now Intermountain Health). Oncology hasn't started its integration yet, but we are looking to set up centers of excellence in the Denver metro area so we can utilize our systems better. When a patient needs a specific service that may not be provided at that hospital, how can we seamlessly move the patient to one of our other hospitals? Whether it's in the Denver metro area, Utah or our Montana sites, how do we give those patients the care that they need seamlessly?

I'm the director of the oncology service line for what we call the Peaks region; that's Montana, Wyoming, Denver and Western Colorado. Barb, is there anything you would like to add?

**BARB JAHN** *(Intermountain Health):* I'm the chief operating officer for the Peaks region within Intermountain Health. In our market the nonprofit hospital systems tend to receive a higher mix of patients who are Medicaid, underinsured and uninsured than the competing large medical oncology practices. This presents some challenges in terms of our cost of care and being able to deliver care across all our patient populations. We invested in doing a deep-dive strategic plan this year, and now we're executing it.

**LEVINE:** I'd like to add to the last comment about competing interests. We deal with that here in the New York market and it's a serious concern. We are all nonprofit, but now we're competing with the private-equity money that's been involved in establishing for-profit ambulatory surgery centers, imaging centers, laboratory centers, urgent care centers and the list goes on. The private-equity investment money has taken over so many of the services that hospitals typically used to provide.

**GREG SONNENFELD** *(Ochsner LSU Health):* We are a safety net hospital and an academic medical center with a large Medicaid population — about 42%. North Louisiana is largely rural with 1.6 million

people, and only half a million are in a suburban location. Not only do we have a poor payer mix, but we also have major transportation and broadband access issues. We were just awarded a large grant from the American Cancer Society (ACS) for lodging. If we give patients a $50 gas card, that doesn't help if they're driving two hours each way, every day for radiation. We end up spending $1,500 to $2,000 to put them up in a hotel for four weeks.

With cancer care, a key driver is getting providers and teams into the rural areas. Even if it's one day a week or one day every other week, patients don't have to travel as far for follow-up appointments and they can get supportive care. That way, patients only have to travel to the academic medical center for their higher-level care.

**DOUGLAS LOWDEN** *(Northern Arizona Healthcare):* We're a two-hospital system with several outpatient clinics in the Northern Arizona region with a service area of 50,000 square miles and some 700,000 to 800,000 people. This year, we opened a multidisciplinary clinic for medical oncology and hematology at the current Flagstaff Medical Center, which will be able to serve the community by having medical oncology, radiation oncology and infusions under one roof. One of our biggest challenges is recruiting medical oncologists to our rural clinics in Flagstaff and the Verde Valley because of the expensive housing costs. In one of our cancer clinics, we haven't been able to recruit a full-time medical oncologist for more than a year. We've been relying on locum tenens. It makes keeping patients difficult because they don't want to establish oncology with a temporary provider. Patients end up either going to Phoenix or Flagstaff, because they're not able to get the care they need in their community, which we're hoping to change.

**"With cancer care, a key driver is getting providers and teams into the rural areas. Even if it's one day a week or one day every other week, patients don't have to travel as far for follow-up appointments and they can get supportive care."**

— Greg Sonnenfeld —
Ochsner LSU Health

**BLACK-ANDERSEN:** We also work with the ACS on grants to help with transportation and lodging to help patients travel where they need to be for the best care possible.

**MODERATOR: Which health systems represented here have their own specialty pharmacy and what are the most significant operational pain points that it is experiencing in achieving access and speed to therapy for your patients.**

**SONNENFELD:** Our system had a specialty pharmacy for several years before this partnership was developed between Oschner and the state of Louisiana. Because of our volume, it's been difficult for them to service our patients to the level needed. We're trying to scale that, but we're not there yet. Probably the biggest pain point for us is that we have such a high Medicaid population and we can't fully take advantage of 340B. We do have a couple of other specialty pharmacies with whom we work and have established some 340B arrangements. Another challenge is that some payers will only use designated specialty pharmacies, and then certain drugs are only available at certain specialty pharmacies. That also limits our ability to take advantage of 340B.

**BLACK-ANDERSEN:** Our issues are with payers that want to use specific pharmacies for our patients who are being seen within our facilities and want to white bag those medications. We've been working with the payers so that we utilize our specialty pharmacy instead of utilizing the white bagging.

**JAHN:** I would add that, overall, our specialty pharmacy has been successful. We have a fair number of contracts with pharmacies that can provide for patients.

**EILEEN O'DONNELL** *(Northwell Health):* Our specialty pharmacy has contracts to help us in terms of pricing for our oncology drugs.

**DAVE EHLERT** *(McKesson):* There have been several manufacturers over the last 18 months that have pared back the ability to have contract pharmacy relationships. They've pulled back some of the pricing. It's not just limited to oncology products, so that may be why many of you are not necessarily seeing that as much. With certain other drugs and indications, that has been a challenge for some of our health system customers.

**MODERATOR: Payers are seeking to control the growth of cancer care costs by pushing care to lower-cost or home-based settings, value-based contracts and restrictive formularies. Are these efforts significantly impacting the way you deliver care and what kinds of data and solutions will you need to make these transitions effectively?**

**ROMAN RODRIGUEZ** *(Shannon Medical Center):* We face some of those challenges around payers trying to push our services elsewhere. Most of our service area is rural. We serve 25 counties in central Texas and our primary service area is 35,000 square miles. Because the nearest site is about a hundred miles away, we're successful in calling them to say, 'Hey, this isn't reasonable.' The biggest burden for us is the administrative time to push back on them.

**BLACK-ANDERSEN:** We are seeing an impact. Payers are pushing our patients to not only different pharmacies for medications, but also to free-standing infusion centers. There are a few in the Denver metro area and in some of our other areas. We operate one free-standing infusion center in the Denver metro area. We are looking at continuity of care for our patients. They may receive one dose at one of our hospital-based infusion centers, and then we must transfer them to our free-standing center. It's unfortunate for the patient because they must change caregivers and sometimes providers.

We also see our patients having to move from site to site, and they may not even be able to see us. Patients will receive their diagnosis at a hospital, they'll have surgery, and then their care will change over to a free-standing center. We are looking at a proposal on how to provide home infusion around a centralized pharmacy model.

**"We are definitely seeing more health systems across the United States focusing on expanding home-infusion services. Specialty pharmacy has been a big wave for a lot of health systems. Now, we're seeing home infusion as that next wave. In part, it counteracts the fragmentation created by payers that drive patients to sites with lower costs of care, but also hospitals are expanding at-home programs."**

— Dave Ehlert — McKesson

**EHLERT:** I wanted to underscore a point that Denise made. We are definitely seeing more health systems across the United States focusing on expanding home-infusion services. Specialty pharmacy has been a big wave for a lot of health systems. Now, we're seeing home infusion as that next wave. In part, it counteracts the fragmentation created by payers that drive patients to sites with lower costs of care, but also hospitals are expanding at-home programs.

Oncolytics are expensive, and we're seeing more cell and gene therapies that have been approved or are in the pipeline. I'm interested in the thoughts of our panelists on what they are doing to plan for cell and gene therapies and the exponentially higher costs that this can mean to our patients as well as to our health systems.

**O'DONNELL:** We operate 10 cancer centers in the greater New York region. We have close to 16,000 analytic cases. We continue to look at ways to ensure

access to all. Even within the greater New York area, we have transit deserts and other deterrents to care. Language is a significant issue here as well. Queens residents speak more than 200 languages. This is an issue for oncology care when we're looking to have many of these patients participate in and have access to clinical trials. We see some barriers, and we continue to explore opportunities to ensure appropriate treatment in appropriate settings.

**MODERATOR: How is your organization using patient-level strategies and services to engage patients in discussions of treatment preferences, their individual circumstances, the social determinants of health and other challenges that may lead them to delay or even forego care and that may affect their treatment adherence?**

**JAHN:** As part of our comprehensive cancer centers, we accept patients who either do not have insurance or who are underinsured. We can provide many support services like social work and nutrition services within the cancer center itself. We also have financial counselors anchored in the cancer centers who work with our patients to help them qualify for some sort of plan or support that's offered within the state. Those things work. We run into issues where people don't have the capacity to come in and we've instituted some telehealth options that have been helpful. We're also setting up some additional telehealth points of care where we don't have a provider or when the patient can't come in for services.

In the oncology area, we provide many charity care services, and financially it is a challenge because treatment is expensive.

**BLACK-ANDERSEN:** I'll also add that our financial counselors are great at working with our embedded pharmacists within the clinic and with physicians working with patients on their care plans to ensure that the patients aren't making decisions based only on their financial status.

**SONNENFELD:** One thing that has been helpful is separating benign hematology patients from our cancer service. Our hematology oncologists still see those patients, but benign hematology patients are seen in a separate department with their own schedule inside of Epic, which allows us to ensure that we're prioritizing the patients who need care quickly. We've started using an e-consult feature in Epic. The primary care provider sees a patient with low iron or another issue, and then sends the e-consult to the hematology oncology department and the specialist can spend five or 10 minutes reviewing the patient's file. It's not compensated for Medicaid but can be for other providers. They send it back to the primary care provider and say, 'Everything's OK here. Follow up in three to six months.' Then there's room on the schedule for a cancer patient. The hematology oncologists appreciate that.

The single biggest issue for us is the lack of screening and the high rate of late-stage diagnoses. We've tried to grow these screening programs in our Northeast Louisiana Hospital. The year before starting this partnership, fewer than 100 colonoscopies were performed, almost all done by family medicine providers. Three and a half years later, we're doing more than 1,000 colonoscopies, all done by gastroenterologists. That's a massive increase in screening. Over the first year, there was a high percentage of positive findings, and now it's gone down to a more normal rate of findings. That's been a big driver for us.

Louisiana had dropped from 49th to 50th in the state health rankings. We're trying to grow services to help people become healthier by focusing on growing our survivorship and integrative health program. We know that one of the best ways to help patients avoid a recurrence of cancer is regular exercise. So, we've started a shared medical appointment where eight to 12 patients meet with an integrative health provider for group counseling, education on diet or exercise, yoga and mindfulness. We've also piloted an exercise program specifically for cancer

survivors at our local YMCA, and the results have been remarkable.

**O'DONNELL:** We have a significant Medicare and Medicaid population, and we have many programs in place to help the overall population. For oncology mortality, the denominator is the whole population, and financial toxicity is a factor. We have financial counselors and ancillary services as well. We have significantly grown our survivorship program — starting at diagnosis and looking at survivorship before diagnosis in terms of prevention and screening. Our survivorship program manages the comorbidities of care to increase efficiencies and touch points with the patients throughout their care journey.

We are working closely with churches, synagogues and other groups in our communities to establish relationships and trust because that's a significant piece. We learned a lot from COVID-19 in terms of the vaccine and how to work closely with our communities. We have continued to use that experience and outcome to continue to build those relationships and it also has been helpful in oncology.

We continue to work on standardization of oncology care throughout all our sites. Because we are so large, with 21 hospitals and 10-plus cancer centers across a diverse population, we must be efficient, which also helps us contain costs.

To eliminate language as a barrier to cancer screening and treatment, we try to match our physician makeup with our patients. For example, in our Queens group, there are seven medical oncologists who collectively speak 32 languages. It's helpful from the standpoint of an oncology journey, but also in terms of obtaining access to clinical trials and accruing them to therapeutic trials.

**"Our financial counselors are great at working with our embedded pharmacists within the clinic and with physicians working with patients on their care plans to ensure that the patients aren't making decisions based only on their financial status."**

— Denise Black-Anderson — Intermountain Health

**MODERATOR: What are the major headwinds facing your organization in the next one to two years? Are any of you looking at starting something new or working with partners to make sure that you're anticipating future challenges?**

**RODRIGUEZ:** Our service area is regional, and one of our challenges is bringing that high-level surgical specialty care to our patients so they don't have far to travel. Our organization has announced a partnership with the Mayo Clinic Care Network, and we're looking to bring eConsults, doc to doc, and then down the road specialty care here to our patients.

**O'DONNELL:** As we anticipate some of those headwinds and new entrants, sensuring that patients have timely access is key. An initiative that we will continue to work on is navigating our patients appropriately from their first phone calls and staying with them. Oncology is multidisciplinary and patients can get lost at any point throughout the care journey, whether it's primary care to pathology or to surgery, and you can lose them after surgery. Our focus is on being more efficient in staying with our patients and providing the right navigation and timeliness. Prioritizing and setting up an appointment when a diagnosis comes through is an area that we will continue to concentrate on in 2023 and beyond.

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