INSTITUTE FOR THE FUTURE OF ONCOLOGY

Oncology Leadership

Looking to the Future in a Shifting Healthcare Environment

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ACCC
Association of Community Cancer Centers

11600 Nebel Street, Suite 201
Rockville, MD 20852
301.984.9496
www.accc-cancer.org

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.

Executive Summary

The field of cancer care is facing enormous challenges and changes. These include an aging population, a pending workforce shortage, an influx of new and expensive therapies, continued consolidation and integration in the field, and a shift from a volume-based reimbursement system to a value-based system. These challenges call for strong leadership from cancer care providers.

In June 2013, the Association of Community Cancer Centers (ACCC) held its first Institute for the Future of Oncology forum. The Institute was launched because ACCC recognized a gap in knowledge and a need for discussion on issues unique to the multidisciplinary oncology team. At the 2013 forum, discussions among 40 participants identified the need for oncology leadership within integrated delivery models of care that are becoming the norm today.

ACCC devoted its second Institute for the Future of Oncology forum, held June 26, 2014, to two topics: Organizational Leadership and Communicating Quality. More than 20 representatives from cancer care programs throughout the country gathered for the 2014 Institute forum. The discussion on Organizational Leadership focused on key issues such as: "What should a leader in cancer care look like?" "What are the critical issues leaders in oncology today have to face?" "How do we identify and advance future leaders?" This white paper reflects that discussion.

Participants agreed that:

- Good clinicians do not necessarily make good leaders
- Cancer program leaders do not have to be physicians
- A leader's job should not be administrative, but visionary and strategic
- Effective leaders nurture and respect all employees and recognize their role in problem solving and quality cancer care delivery
- In integrated systems, leadership must cross service lines and break down silos while recognizing that oncology has to work within a larger system with competing priorities
- Oncology leaders must address cost, value, quality, and patient satisfaction in all decisions
- The patient must be at the center of all decisions.

I. Understanding the Challenges

Throughout the Institute forum discussion, participants identified numerous challenges in the cancer care field that will require strong leadership moving forward. These include, but are not limited to, a pending workforce shortage, unsustainable costs of new therapies, payment reform, pressures from sequestration, consolidation within the industry, and changes within the healthcare system itself.

Facing a Workforce Shortage

"How can we extend our leadership into the future when we're going to have fewer providers but more patients?"— Medical director participant

The incidence of cancer in the U.S. is expected to increase more than 50 percent in the next 30 years as the population ages. In addition, improved treatments and earlier diagnosis mean more patients are living longer with cancer. Implementation of the Affordable Care Act (ACA), which provides greater access to cancer screening, will also provide greater access to cancer care.[1] At the same time, the number of oncologists and other cancer specialists available to treat patients is shrinking. In 2014, the American Society of Clinical Oncology (ASCO) published an update to its pivotal 2007 workforce study, which incorporated projections related to implementation of the Affordable Care Act. The 2014 ASCO workforce shortage update found full implementation of the ACA may "modestly exacerbate" anticipated workforce shortages, increasing the demand for oncologists and radiation oncologists by 500,000 visits per year and increasing the oncologist and radiation oncologist shortage to 2,393 [full-time equivalents] in 2025.[2]

"We know the demographics are changing—the baby boomers are coming," said one Institute forum participant, an oncologist from the mid-Atlantic. "We know that we're going to see an increasing number of elderly patients and an increasing incidence of cancer, and that even though we're making some headway in terms of survival, we're not going to be seeing decreasing incidences of cancer. So we're going to be challenged to take care of a larger number of patients with limited resources."

A 2010 editorial in ACCC's journal, *Oncology Issues,* highlights the coming challenges of the workforce shortage, warning that cancer centers would need to "think outside the box" to confront this challenge. That includes making greater use of advanced practice nurses, using patient portals to improve patient communication and education, and identifying new ways to use technology to provide more efficient, effective care.[3]

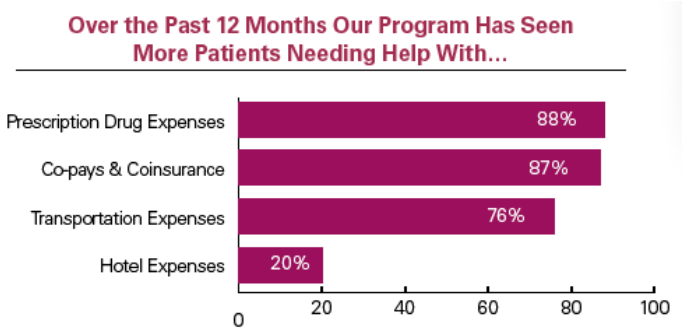
Leading in a Time of Economic Stress

"I'm constantly astounded when I look at our drug budgets from year to year and see them climbing, and they're climbing a lot faster than the volume of patients that we're treating."
—Medical director participant

The oncology leaders of today and tomorrow will have to grapple with resource allocation in a healthcare system increasingly focused on value yet confronting rising costs, particularly from new therapies that may extend survival by just a few months. "How do we start to allocate resources?" asked one participant. "Who is involved in those decisions and what metrics are included in those decision processes?"

As the cost of cancer care increases, the financial stress on patients is also growing due to high deductible health plans and increased co-payments and co-insurance. ACCC's 2013 Trends in Community Cancer Centers member survey revealed that cancer programs continue to see increases in the number of patients who require financial assistance to pay for their cancer treatment. Eighty-eight percent of respondents reported seeing more patients who needed help with prescription drug expenses and 87 percent reported seeing more patients who needed help with co-pays and co-insurance (Figure 1.).[4]

Figure 1.[4]



In ACCC's 2014 Trends in Cancer Programs survey, 90 percent of respondents report offering financial assistance services to patients, while 84 percent report having "financial specialists" on staff.[5]

"We talk about the fact that we are becoming more and more resource-constrained at a time when our therapies are becoming ever more expensive and, fortunately, in some instances, ever more effective," said a participating medical director. "But the question then becomes, how do we make those decisions, how do we figure out where the most value is for the patient, how do we look at this in a sustainable way?"

The challenge, participants said, is not only defining value for an individual patient, but for the system as a whole. For instance, the cost of a drug may be extreme for a single patient, but if it significantly improves the outcome and saves money by avoiding ineffective therapies, "that allows you to put resources towards other patients," commented one.

Drugs are not the only high-cost item stretching limited resources. An administrator participant from the Midwest described the financial challenges his hospital faced when it purchased a linear accelerator to provide access to patients who otherwise had to travel an hour or more for the treatment. None of the financial projections have been realized, he said, and the hospital now expects it will take several years to recoup its investment.

"The interesting thing is the education I've had to give to our senior management that reimbursement is different than what it was in the past, that it's not going to get any better, [and] that we still have to maintain the cutting edge as far as technology or drugs to compete. You have to understand the finances associated with it, but you also have to realize that patients in your community deserve the best treatment they can possibly get."

That's where leadership comes in, participants said. "We need people who are going to really understand the priorities of the organization and, hopefully, those priorities go back to the patient," one said. This is a theme that carries over from the 2013 ACCC Institute forum discussion on oncologist/hospital integration in the ACA era, in which participants agreed that oncology leaders have a role to play in the often difficult and challenging area of resource utilization. Oncology leadership must also be active advocates for opportunities to protect their patients both clinically and financially, participants said.

Moving to a Value-Based System

The shift from a volume-based healthcare system to a value-based system requires strong leadership to advance quality oncology care as reimbursement and healthcare delivery models change.

The transition to value-based care that is organized around a patient's condition rather than a specific treatment or symptom is rendering the current system of separate service lines—and budgets—obsolete, noted one participant.

A visible sign of this shift is the growth in accountable care organizations (ACOs), which are designed to provide coordinated, collaborative care across specialties and settings. In the ACO model, reimbursement is generally based on shared savings or other risk-based models. About half of all U.S. patients are expected to be part of an ACO in the next five years.[6]

Findings from ACCC's 2014 Trends in Cancer Programs survey indicate that participation in ACOs among ACCC members is on the rise. Twenty-four percent of respondents report that they are currently involved with an ACO that has an oncology component—up from just five percent in the previous year's survey. Twenty-two percent say they plan to participate in an ACO in the future.[5]

With ACOs on the rise, a 2014 article in the journal *Health Affairs* noted that "physician buy-in to these changes is likely to be critical."[6] Other studies find that the more involved physicians are in governing provider-based organizations like ACOs, the better the communication and trust among staff.[7]

In fact, a national survey of 173 ACOs conducted between October 2012 and May 2013 found that physicians *are* playing strong leadership roles in ACO governance. The survey found that 51 percent of the ACOs were being led by physicians and another 33 percent were jointly led by physicians and hospitals.[6] Physicians face numerous challenges as their programs transition into

ACOs, however, including the need to relinquish some autonomy and embrace team-based care and standardized processes.[6]

"How can cancer specialists take an active role in treatment decisions within an accountable care organization, especially if you're potentially part of more than one? And how does that impact your planning going forward, if it does at all?" one participant asked.

One participant said his hospital has applied to become a Medicare shared savings ACO. Both [hospital] employed and private practice oncologists will be involved, he said. Thus, he said, "to realize any savings, we have to work together."

Even if oncologists don't join an ACO, the model will still change how they practice. That's because primary care physicians in ACOs will be more likely to refer to oncologists and other cancer specialists who can demonstrate high value—not just high quality—care. That, in turn, will require that oncologists educate primary care physicians on cost and quality implications in cancer care, as well as provide such high value care.[8]

Impact of System Consolidation

"*I see the whole paradigm changing. You know if you don't join them, you might as well raise a flag and surrender, but at the same time we know the kind of care that we deliver and we know that it's top quality care. We may not be housed in [the academic center], but we know that we're [delivering quality care] and we want to keep that kind of community feel to our program.*"
—Cancer program director participant

The 2013 ACCC Institute forum white paper on *Opportunities and New Realities in Cancer Care: Oncologist/Hospital Integration in the ACA Era* noted that one of the biggest shifts cancer specialists are experiencing is consolidation in the field. With this consolidation, 2014 Institute forum participants commented that leadership is more likely to function from the top down, which is diametrically opposed to the integrated, coordinated care required for a successful comprehensive cancer program.

In the 2013 ACCC Trends in Community Cancer Centers survey, 19 percent of respondents reported consolidation through affiliation, 10 percent through acquisition, and 5 percent through mergers in the previous year, with 40 percent expecting continued consolidation of cancer programs in 2014, and 46 percent expecting continued consolidation of oncology-related physician practices.[4] While ACCC's 2014 Trends survey results indicate that consolidation may be slowing, with 72 percent of respondents reporting "no marketplace changes" in the past year,

shifts are still occurring with 16 percent of respondents reporting that they acquired a physician-owned practice, and 4 percent reporting acquisition of another cancer program.

The current reimbursement system is one reason for the consolidation, a physician participant said. The large commercial insurer in this participant's southern state pays significantly higher rates to physicians who are affiliated with a hospital than to independent oncologists because the hospital has more negotiating power. That disparity in reimbursement could affect care, he said, because health system-based providers can afford to provide non-covered services such as dietitians and social workers, while community oncology practices have to turn to foundations and other sources to pay for these costs. "I don't think it's sustainable," he said.

Too often, participants said, hospital systems do not involve community physicians enough in decision making. A participant from the Southeast described how a hospital system that he had previously partnered with brought community physicians into the institution, creating a dynamic program that consolidated cancer care throughout the region. However, because of less competition in the region, there is a sense that community providers do not need to be involved in decisions made by the hospital, since they have few options for their patients. This, in turn, he said, affects care delivery. "We [community oncologists] provide very progressive care, but there's a lot more that we could be providing."

Another participant described his institution's failed attempt to engage community cancer care specialists through a service line advisory council. The idea was to meet quarterly and discuss strategic issues. "It was a great concept, but we didn't execute it well," he said. "I think we failed to engage our community physicians as well as we could have." The community physicians didn't attend the meetings, probably because "we just weren't providing something that they felt was really worthwhile." The key to such programs succeeding is physician engagement, he said.

Another participant who is a cancer program medical director described the relationship between hospitals and physicians as having a "somewhat competitive, yet collaborative dynamic."

A cancer center director in the mid-Atlantic described his organization's top/down environment and how his group was able to change it. "The most frustrating thing I found when we first came to the hospital was a group of CPAs, MBAs, and other people from the top who were making decisions who knew nothing about how things ran on the front line, especially in oncology." Top/down solutions invariably failed, he said. So the cancer center began developing its own leaders by hiring good managers and tasking them with finding people on the front line who wanted to lead, no matter what their position. "They're working the front lines, doing everything that we want them to do, but they think outside the box on how to improve patient care, patient

safety, and improve efficiencies," he explained. Once identified, these employees are sent for leadership training.

Now, he said, instead of solutions coming from the top, "they get pushed up" for senior management to approve. The hospital has embraced the new model because it's brought improvements in patient satisfaction and ratings from agencies like The Joint Commission.

Breaking Down Silos

"When we talk about leadership, we need to talk about how to integrate everyone in the field into the leadership model and ensure that their voices are heard."—Participant from academic medicine program

Effective leadership in cancer care requires breaking down the traditional silos that separate oncologists, surgeons, radiation oncologists, nurses, and allied health professional providers (e.g., social workers, dietitians, and financial counselors). Despite the movement towards more multidisciplinary care, the cancer workforce remains a highly siloed profession.[9] "People are not coming together and putting together an 'oncology package' at their institutions," said one participant.

This creates friction between departments like oncology, radiology, and pathology, despite their symbiotic relationship. Leaders need to focus on this problem, he said, because teamwork across departments and budgets "is absolutely essential if you're going to have a comprehensive program."

As mentioned previously, the shift to value-based care models is leading to care organized around a patient's condition rather than a specific treatment or symptom. This, in turn, is making the current siloed system of separate service lines—and budgets—outmoded.

Another participant said he is beginning to see some change in leadership taking place, driven by the multidisciplinary nature of oncology care today. "As cancer care continues to be multidisciplinary, we are starting to see surgeons, radiation oncologists, and others besides [medical] oncologists stepping into those leadership roles." Changes *are* occurring, participants agreed, noting the increasing number of cancer specialists other than oncologists at the major cancer conferences. Specialties like pathology and pharmacy are more prevalent, they said, because they have become more integrated in cancer patient care.

II. Identifying and Nurturing Leaders

"Leaders in really innovative organizations say: This is the mountaintop we're going to reach. They don't tell everybody how to get there. There are many different paths to get there; there are people in the organization who are really smart, on the front lines, doing it every day."—Medical director participant

One participant felt that only physicians should lead large healthcare organizations. He cited respected systems like the Cleveland Clinic, the Mayo Clinic, and Geisinger Health System, all of which are physician-led. This ensures that "the patient always comes first," he said. "It goes back to the idea that the best person to run a widget factory is somebody who knows how to make a widget."

Others disagreed. "I think sometimes what we've done in organizations with physician leaders is move people up who are good clinicians," said one of the medical director participants. "Good clinicians don't necessarily make good leaders."

Participants noted that no one individual can know it all. "A leader can be a physician, it can be an administrator, it can be a nurse, it can be a radiation oncologist, it can be a therapist, it can be anybody with the right tools," said one.

What's most important, another participant said, is to tap into the people in your organization. "They are the ones with the knowledge, so the key is to say, 'We know where we need to be, you guys tell me how to get there.' I think that's a hallmark of organizations that are successful."

Once leaders are identified, they need to be nurtured and groomed to lead. A participant added, "You have to give them the space to be able to make changes across different service lines." This is an area the Association of Community Cancer Centers could help with, he said, by identifying and sharing best practices.

Strategic and Visionary Leaders

"How are we going to identify and advance the leaders of the future? Because we clearly have significant challenges ahead."—Cancer program administrator participant

The Institute of Medicine defines a learning healthcare system as one in which leadership instills a culture of teamwork, collaboration, and adaptability to support continuous learning.[10]

Future leaders may have those qualities, but they must be nurtured through education and investment, participants said. "You can't have physicians who are in the weeds, who are seeing 50 people a day, and then dump administrative duties upon them," one said.

It is important also to differentiate between being a leader and being a manager. "Being a leader is developing a strategic goal or set of goals and objectives, assembling the right members of a team to achieve those objectives, empowering those people to achieve those objectives, and giving them the resources that they need to be successful," said a medical director participant. "It's not developing processes or designing care pathways."

A nurse participant agreed, saying that too many of the leaders in her organization spent their time with daily details, like staffing schedules. "That's not a leader," she said. "That's a computer project where you plug in everybody's hours…." However, she said, this type of leadership is too common in many hospitals and must change if the system is to change.

One participant from a cancer program in the South said her organization uses formal tools such as emotional intelligence assessment to help identify staff leadership potential. It also has a strong succession-planning program to identify potential leaders early and develop them over time. In addition, the cancer center has an emerging leader program for younger people in the organization, in which promising individuals are paired with a mentor and challenged to bring about change in the organization. Such approaches are possible and successful because they receive support from the hospital's board of directors and top executives, she said.

Succession Planning[11]

Succession planning is defined as ensuring that an organization recruits and develops employees to fill key roles and develops those employees through special assignments, team leadership roles, and training and development opportunities to lead the organization. This requires:

- Retaining superior employees
- Providing a career path for continued growth and development
- Ensuring that employees are ready to step into leadership roles as they become available.

III. Leadership and the Patients We Serve

"At the end of the day, it is about the patient experience . . . if we don't look at quality, we're going to be the losers in the game."—Assistant vice president participant

It is not surprising that some overlap occurred in the 2013 Institute forum discussion on hospital/oncologist integration in the ACA era and the 2014 Institute forum discussion on organizational leadership. As mentioned previously, as healthcare reform efforts continue, there is a need for oncology leaders to advocate for patients both clinically and financially.

A forum participant who is a patient advocate said leaders need to be cognizant of the perspective of those going through the experience of cancer. "What can you do to make it less painful?" he asked. Often this goes to the environment of care and non-clinical features such as design elements that create a soothing environment; massage therapy and acupuncture; navigation services—many of which are out-of-pocket costs to the patient.

As discussed in the 2014 Institute companion white paper on "Communicating Quality in Oncology," the patient experience is often determined by the patient's perception of quality rather than objective measurement of it. Nursing leadership is critical to the patient experience, said one participant. "Nursing has a huge impact on patient outcomes," she said. "It's the nurse who contacts the physician if there's an issue, engages the family, does the teaching; they have a huge impact on the outcomes of patient care."

Another participant highlighted the importance of patient-centered research and clinical trials with patient-centered outcomes. "I would challenge the conversation about what cancer leadership looks like [and ask] what opportunities and gaps can you identify as clinicians or administrators that can be brought in partnership to researchers, so that we can have meaningful work that's truly improving the quality of care for cancer patients?"

Focus groups of cancer survivors conducted by one participant's mid-Atlantic hospital found that patients wanted supportive policies and systems, to feel empowered, and to have productive partnerships with providers, said the system's community coordinator, including strong communication and coordination of care. This fits with any leadership discussion, she said, because it shows that leaders must be concerned not only with the clinical and administrative sides of an institution, but also with creating policies and processes that support physician

communication with patients—without overtaxing the delivery system so that this becomes unsustainable.

Summary—and a Look to the Future

The paradigm of healthcare delivery in this country, including the delivery of cancer care, is undergoing astounding shifts. New reimbursement mechanisms, an increased focus on cost versus outcomes, and an emphasis on patient-centered care, multidisciplinary teams, and care coordination are all driving significant changes.

This, in turn, is requiring that the delivery of cancer care change. Moving the field into the future requires strong leaders at every level of the organization. It is clear from the ACCC Institute forum discussion on organizational leadership that identifying, developing, and supporting those leaders is critical for the future of the cancer care delivery system.

The ACCC's Institute for the Future of Oncology forum participants concluded that ACCC has a role to play in providing support in this arena by developing information, disseminating resources, and providing training to help mentor future oncology leaders, and by identifying successful, replicable leadership models that encourage a more integrative approach to cancer care.

End Notes

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About the Association of Community Cancer Centers

The Association of Community Cancer Centers (ACCC) serves as the leading advocacy and education organization for the multidisciplinary cancer care team. Approximately 20,000 cancer care professionals from 1,900 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 ACCC's 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.