Top 10 Oncology Trends for 2008-2009

by Mark J. Dubow, MSPH, MBA

Oncology Issues asked Mark Dubow, senior vice president of The Camden Group, a national healthcare consulting firm, to identify the top 10 trends in oncology for 2008-2009. With more than 23 years of expertise in strategic and business planning, launching new services and products, strategic partnering, facility and medical staff planning, and the facilitation of retreats and meetings, Dubow talks frankly about some of the challenges and opportunities facing today's community cancer centers.

Trend 1: *The array of diagnostic testing techniques will continue to expand, but the volume of some modes will decline and consolidation of sites is likely.*

PET/CT continues to be the preferred diagnostic testing mode for staging and monitoring tumors. However, cancer programs are expected to increasingly use an array of new image-based screening approaches (e.g., screening lung CT and breast MRI). In 2008 most oncology-related imaging will still occur in outpatient centers and physicians' offices. One exception is virtual colonoscopy, which will largely stay in hospital settings.

Payers will continue to respond to the rapid rise in imaging volume by reducing benefit coverage. Reductions to the technical fee reimbursement for non-hospital imaging seen in 2007 (e.g., MRI [35 percent], ultrasound [30 percent], nuclear medicine [16 percent] and CT [9 percent]), will continue to result in lower revenue for physicians and is likely to drive consolidation of imaging sites.

During 2008-2009, molecular risk profiling will continue to receive increasing attention. Eventually, this technology is expected to replace a portion of the imaging studies currently in use.

Trend 2: *Interventional oncology procedures will continue to be an attractive mode of growth in profitable patient volume.*

Less invasive interventional treatments (e.g., percutaneous, endoscopic, catheter-based drug delivery; radiofrequency ablation; cryoablation; and internal radiation treatment) have increasingly shown patient and programmatic benefits, including enhanced clinical outcomes, fewer side effects, greater patient convenience, and continued attractive reimbursement. Therefore, hospital interventional radiology suites and special procedure rooms are likely to see continued growth in volume of services in 2008-2009. Increasingly, clinical attention will focus on liver, breast, kidney, and lung tumors. Together, these trends will spur increased competition for access to the suites. At the same time, medical staff credentialing committees will be pressured to resolve requests from interventional radiologists and other specialists for privileges to conduct these procedures. Over time, the revenue growth will trigger increasing payer attention to the reimbursement rates, implying a short "window of opportunity" before CMS and health plans pursue reductions.

State-of-the-art operating room featuring high-definition video distribution.

PHOTOGRAPH COURTESY OF FAULKNER HOSPITAL.

Trend 3: *Surgery will continue to contribute to oncology service line profitability with increases exceeding the rate of population growth and will require teams adept at minimally invasive techniques.*

Due to expanded cancer screening and increased attention to surgical management of the disease, the volume of oncologic surgical discharges will increase at a faster rate than population growth. One prerequisite for growth will be use of robotic and microsurgical procedures. In the short term, traditional open surgical procedures will continue to generate a higher profit margin than robotic and microsurgical procedures. However,

with increased clinical team experience, this scenario is expected to change. This trend suggests that healthcare organizations must invest in the clinical training and equipment associated with robotic and minimally invasive techniques, and that during succession planning physician and other clinician recruitment activities should focus on individuals with minimally invasive surgery expertise.

As surgical volume grows, increased attention will be focused on profiling and benchmarking clinical outcomes.

Trend 4: *Radiotherapy applications will continue to expand, leading to rapid growth in patient volume and revenue generation in the short-term.*

Collectively, the use of various forms of radiotherapy techniques (IMRT, IGRT, CyberKnife®, Gamma Knife®, proton beam) and the revenue generated from these technologies are expected to expand in 2008-2009. This expected growth is based on many factors, including technology enhancements that benefit patients, the expansion of the technology to new tumor sites, continued attractive reimbursement, and an increasing number of providers installing equipment (physician practice-based, freestanding cancer centers, and hospitals). This expansion and growth is likely to be a catalyst for increasing scrutiny by CMS and other payers in the near future.

The recent trend of upgrading intensity modulated radiation therapy (IMRT) machines will continue in 2008-2009. Stereotactic radiosurgery (SRS) modules will be added to a portion of the IMRT machines. Software supporting image gating will be added to a portion of the IMRT machines upgrading them to image-guided radiation therapy (IGRT). By the end of 2008, it is estimated that up to 60 percent of IMRT machines will have been converted. Beyond 2009, further dissemination of IGRT will be restricted by declining reimbursement, high fixed costs, and the large number of machines already installed nationwide.

Growth in patient volume and revenue associated with the CyberKnife will be particularly large as this technology is increasingly used for non-cranial tumors with initial focus on prostate, breast, and lung tumors. Since payer coverage of CyberKnife for extra-cranial procedures varies by state, the rate of growth will vary geographically.

Upgrades to the Gamma Knife—making it more comfortable for patients, expanding its application (inferior head, neck, and cervical spine), enabling multi-fractional therapy, and enhancing the protection of healthy tissue—will spur expanding utilization.

Reimbursement for proton beam therapy is expected to remain favorable in 2008-2009, and the cost of the equipment is declining as new manufacturers enter the market. While relatively few proton beam centers are now available in the United States, three to five new sites are expected to become operational in 2008-2009. Cost is the principal factor limiting expansion of this technology. The full cost (equipment, facility construction, and installation) of implementing a proton beam center is about $100 million, requiring a very large volume of patients to achieve breakeven. In addition, while CMS reimbursement continues to be favorable, private payers are beginning to reduce their payment for proton beam treatment, extending the breakeven period and lowering the ROI (return on investment).

Leksell Gamma Knife® Perfexion™

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Trend 5: *Utilization of drug therapy will continue to grow despite declining reimbursement.*

Despite continued downward pressure on drug reimbursement, the utilization of medical therapies will continue to increase in 2008-2009 and beyond due to demographic trends and new drug development. Despite lower margins, physicians are expected to continue to administer office-based therapy where the level of reimbursement is financially viable. Where it isn't, drug therapy will shift to hospital settings.

Given the evolving focus on oncology as a chronic disease, research and clinical trials will continue to focus on the development of new targeted therapies such as cancer vaccines and gene therapy. Multiple vaccines, including those specific to cervical, prostate, melanoma, and non-Hodgkins lymphoma, are on the near horizon.

These trends imply the need for cancer programs to devote large portions of their budgets to expanding and/or shifting staffing and to improving information technology.

Trend 6: *Within multidisciplinary cancer clinics, a major focus for 2008-2009 is on streamlining and coordinating patient care.*

In recent years the number of hospital campus-based and freestanding multidisciplinary (comprehensive) cancer centers has grown. Following the preliminary focus on aggregating clinicians and services, expect increased attention to better managing the patient care delivery process. Specifically, the team treatment planning concept will evolve to include a greater use of tumor-site-specific specialists, and tumor-site-specific care coordinators will be used to guide patients through the diagnostic and treatment steps. In addition expect a growing number of cancer centers to adopt remote scheduling and automated registration processes. These trends imply the need for cancer programs to devote large portions of their budgets to expanding and/or shifting staffing and to improving information technology (IT).

Trend 7: *The momentum for bringing pay for performance (P4P) to oncology services will require a progressive evolution in how cancer programs are managed.*

As the pool of aging baby boomers adds to an escalation in the utilization of oncologic care and to a proliferation of cancer centers, CMS, private payers, and public organizations are expected to demand quality benchmarking and P4P in oncology care. Consequently, during 2008-2009, oncology programs nationwide are likely to devote increased attention to internal tracking and benchmarking against peer organizations. Expect cancer programs to invest in implementing and/or enhancing electronic medical records (EMR) to support reporting and to modify role descriptions, annual goals, and compensation processes for clinicians and staff to reinforce achieving performance targets. Increasingly, a portion of the agenda at management team meetings will be devoted to reporting status on quality and P4P. Finally, favorable quality and P4P performance will be profiled in marketing activities.

Trend 8: *Cancer program differentiation will increasingly focus on customized patient care, quality of life during treatment, and outcomes rather than on the adoption of new technology.*

Continuing a trend begun in recent years, in 2008-2009 cancer centers in competitive markets are likely to devote attention to differentiation based on:

- Customizing or personalizing patient care
- Maximizing patients' quality of life during treatment
- Demonstrating clinical outcomes
- Treating the whole patient (body, mind, spirit).

In support of this, clinicians will work with care coordinators and other staff to fine-tune evidence-based protocols to the needs of each patient and to expand psychosocial services as a component of care.

Programs will continue to focus on accelerating the diagnosis and treatment planning process. Administrator(s) and medical director(s) are likely to spend time working with oncologists and other clinical staff to evaluate outcome measures used by leading-edge programs and tailoring and adopting these for use in their center. Additionally, cancer program leadership will collaborate on establishing related data collection and benchmarking, as well as corrective action processes.

In 2008-2009 cancer programs will increasingly define their patient market not only in terms of segments based on place of residence (traditional) but also in terms of tumor sites and other factors. As survival rates increase, the chronic-care patient segment will continue to grow in size and importance. Differentiation strategies will be fine-tuned to address the needs and interests of each segment.

Trend 9: *The role of evidence-based medicine will continue to expand in 2008-2009.*

In support of streamlining patient care, enhancing positioning for P4P, and managing care in an environment with pending declines in reimbursement, clinicians will expand the number of procedures managed through evidence-based protocols.

Trend 10: *Managing the clinical workforce will require an increasing proportion of the oncology service line director's time.*

Increasing tumor complexity and the co-location of oncologists in cancer centers will drive growing sub-specialization among oncologists practicing in a shared site. This, in turn, will require support for clinical sub-specialization and adroit leadership to avoid "turf battles" and manage revenue sharing. At the same time, given the high average age of practicing oncologists (more than half are age 50 or above) and the fact that the number of patients is increasing faster than the number of new graduates, the shortage of oncologists is increasing and competition for recruitment is escalating. This scenario implies that cancer centers and oncology medical groups will have to pay increasing attention to making their clinical environment highly attractive both to newly recruited staff and current providers.

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