Strategic Planning for Hospital-based Cancer Programs

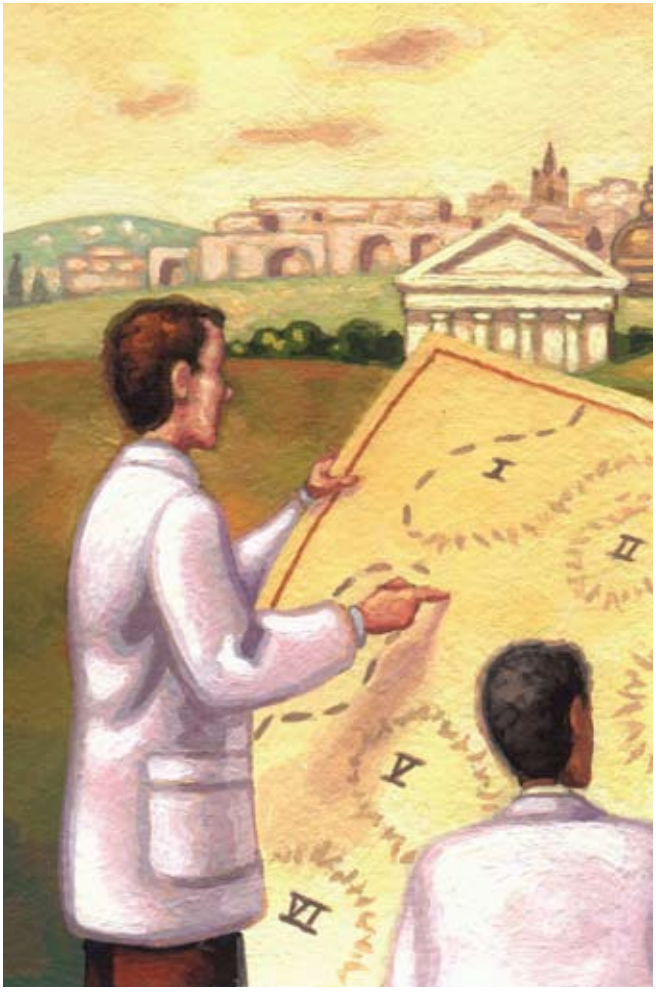
Figuring out where (or if) your program wants to grow and how to get there

Hospital leadership is coming to recognize that a complete understanding of each component of the oncology service line is essential to the hospital's continued success—both in terms of finances and reputation. Increasing competition—from neighboring community hospitals and academic hospitals operating suburban satellite facilities—coupled with declining reimbursement from government and other payers, and increasing demands from the medical staff are among the issues that hospital administrators, oncology managers, physicians, and hospital boards of trustees must address.

While community hospitals have long been regarded as the "go-to" place for everything from a broken wrist to appendicitis to diagnosis and treatment for a heart attack or cancer, the cost of providing both general and specialized care is leading some hospitals to rethink and even redefine their long-term role in the community. Increasingly, hospitals are recognizing the major costs involved in acquiring anti-cancer drugs, as well as the significant costs involved in acquiring the capital equipment necessary to accurately diagnosis this complex disease. With so much cancer care delivered on an outpatient basis, hospitals must make critical decisions regarding the use of diminishing resources to determine:

- How much space to allocate to the oncology program
- The ability of the hospital to help subsidize the recruitment of new physicians with special training in various aspects of cancer care
- How to spend resources on critical, but extremely costly technology that the specialty requires.

To answer these complex questions, hospitals increasingly are focusing their efforts on service-line analysis. More specifically, hospitals are looking at all the costs and services involved in treating a patient with cancer and identifying the associated revenue that contributes to the hospital's bottom line. To say that oncology services are not inexpensive would be an understatement. Even with the hefty price tag, most hospitals, regardless of size, are beginning either to develop or expand their cancer programs. Some hospitals are clearly struggling to distinguish themselves and their services from other hospitals in their communities. Hospitals deciding to keep or expand a cancer program must make these decisions in an informed manner—and reassess their decisions on a regular basis.



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Strategic Planning

Many factors may drive hospitals to initiate a strategic planning effort including:

- Improving the hospital's financial position
- Making major equipment decisions, such as the purchase of a new linear accelerator, shaped beam, stereotactic radiosurgery capability, etc.
- Hearing that another hospital in town is considering acquisition of new state-of-the-art technology
- Discussing a possible merger between hospitals or between two cancer centers
- Recruiting a physician or physician group with a particular strength or expertise—i.e., a breast surgery group or a female medical oncologist with a special interest in breast cancer. In this instance, a strategic plan could help the hospital best determine how to develop its breast cancer service to capture patients in its community.

Whatever the impetus, it is critical that community hospitals engage in a strategic planning process on a regular basis. Most important, the process must include a comprehensive operational plan, ensuring that the strategic plan includes a

workable guide for implementation, so that the plan, once completed, does not become just another binder on the administrator's office shelves.

Choosing the Right Team

Knowing who to include in the strategic planning process is key to a successful strategic planning effort. The oncology service line has many stakeholders—both internal and external. Be inclusive rather than exclusive, and solicit a wide range of perspectives to strengthen the strategic plan and garner support from key players. Employ a fair and transparent selection process. Consider including:

- Board member(s)
- Senior executives, such as the CEO, CFO, COO, and CNO
- Director or VP of planning
- Director or VP of marketing
- The cancer center director or administrator
- Key cancer center staff, such as department managers (inpatient and outpatient), and staff from community outreach and clinical research
- Director of pharmacy
- Director of radiology
- Director of surgery
- Director of the laboratory.

Having the right medical staff as part of your strategic planning process is crucial for success. Select physicians who are in alignment with your hospital and cancer center and have the ability to focus on the vision and long-term strategy—not on personal agendas. To maintain and improve market position, consider including physicians who are key drivers of volume. Include a cross section of both hospital-employed physicians and private practice physicians who are key players in hospital affairs. Potential participants include:

- Director of medical oncology
- VP of medical administration or chief medical officer
- Chief of surgery
- Chief of radiology
- Chief of medicine
- Chief of radiation oncology
- Chief of pathology
- High volume surgeon(s) or surgical oncologists
- Other surgical specialists, such as colorectal surgeons, urologists, neurosurgeons, and breast surgeons
- Radiologists, possibly breast imagers and/or interventional radiologists
- High volume referring physicians.

Other stakeholders can provide key input into the strategic planning process, including information on patient satisfaction, access to care, and market perception. These include: cancer survivors, cancer patients in treatment, and community leaders.

Choosing the Right Leaders

Often the cancer center director or cancer center administrator can serve as the driver of the strategic planning process, with support from administration. Keep in mind, however, that outside consultants can provide an unbiased perspective that is difficult, if not impossible, for a staff member to retain. Given the plethora of projects, daily operations, reimbursement analyses, human resource issues, and more that a cancer program administrator deals with on a daily basis, your hospital may choose to bring in outside expert(s) to guide the strategic planning process. In addition to other responsibilities, an experienced consultant can help the cancer center 1) identify the data that need to be gathered and analyzed, 2) streamline the decision-making process, and 3) keep the emphasis on the end result.

If your cancer center plans to retain a consultant(s), do so at the start of the planning process. The first step: submit your request for proposal (RFP) to individuals and companies that meet the following criteria:

- Extensive oncology expertise, including all components of the cancer service line
- Experience working in a cancer center, usually as a cancer program administrator
- Experience with all cancer center models, i.e., community settings (both large and small), NCI-designated programs, academic models, employed-physician models, multi-hospital systems, etc.

In addition, the consultant(s) must be able to:

- Analyze complex financial data
- Conduct market and environment assessments
- Understand industry trends and implications
- Conduct a SWOT analysis
- Assist the cancer center in developing mission and vision statements
- Identify and help develop niche programs and specialty services
- Prioritize goals and develop implementation plans.

Why Vision Matters

In simple terms, vision allows us to see what lies before us. In business and strategic planning, a "vision statement" expands on this definition by putting in writing what an organization intends to become and to achieve at some undefined point in the future. Vision is vital to the success of a strategic plan because it gives employees, at all levels, an understanding of where the organization aspires to go or what it hopes to achieve. Equally important, a vision statement presents a critical message to the community, convey-

Table 1. Sample 5-Year *Pro Forma*

	Investment	Year 1	Year 2	Year 3	Year 4	Year 5	5-year Total
Gross Patient Services Revenue		$33,062,764	$36,369,041	$41,824,397	$50,189,276	$62,736,595	$224,182,074
Less Deductions from Revenue		$20,416,257	$22,457,883	$25,826,565	$30,991,878	$38,739,848	$138,432,431
Net Specific Service Revenue		**$12,646,507**	**$13,911,158**	**$15,997,832**	**$19,197,398**	**$23,996,748**	**$85,749,643**
Percent Deductions		62%	62%	62%	62%	62%	62%
Other Operating Revenue		___	___	___	___	___	___
Net Operating Revenue		**$12,646,507**	**$13,911,158**	**$15,997,832**	**$19,197,398**	**$23,996,748**	**$85,749,643**
Salaries, Wages, and Benefits		$822,010	$894,214	$1,013,423	$1,196,169	$1,470, 288	$85,749,643
Direct Expenses		$7,073,257	$7,780,582	$8,947,670	$10,737,204	$13,421,505	$47,960,217
Other Expenses		___	___	___	___	___	___
Depreciation		$2,190,000	$2,190,000	$2,190,000	$2,190,000	$2,190,000	$10,950,000
Total Direct Expenses		**$10,085,267**	**$10,864,824**	**$12,151,093**	**$14,123,373**	**$17,081,792**	**$64,306,348**
Contribution Margin		**$2,561,241**	**$3,046,334**	**$3,486,739**	**$5,074,026**	**$6,914,956**	**$21,443,295**
Indirect Expense		$2,268,922	$2,495,815	$2,870,187	$3,444,224	$4,305,280	$15,384,428
Net Income		$292,318	$550,520	$976,552	$1,629,801	$2,609,676	$15,384,428
Cash Flow Adjustments							
Plus: Depreciation		$2,190,000	$2,190,000	$2,190,000	$2,190,000	$2,190,000	$10,950,000
Less: Capital Equipment	$3,750,000	___	___	___	___	___	___
Less: Renovations/ Construction	$14,400,000	___	___	___	___	___	___
Net Cash Flow, Total Cost, per Year	$(18,150,000)	$2,482,318	$2,740,520	$3,166,552	$3,819,801	$4,799,676	
Present Value of Cash Flow (Y1-Y5)	$12,489,819						
Net Present Value	$(5,660,181)						
Internal Rate of Return	-1.9%						

ing the goals of the cancer program and its commitment to community residents.

A clear vision provides hospital physicians and staff with the information necessary to align their strategic planning efforts in the organization, as well as all subsequent operational decisions. To draw an analogy to the sport of crew, think of a racing shell with eight oarsmen. Imagine the chaos that would ensure if each rower set his own rhythm or speed. Instead, the boat's coxswain plays a pivotal role, calling the rhythm and getting the rowers to pull in unison toward the finish line. Likewise, a vision statement provides the key operational direction for your cancer program, allowing everyone to pull together for your program's success.

The institution's vision aids the oncology service line, helping it to function in concert with the wider institution (hospital) while focusing on the goal of providing quality care for cancer patients. And, just as the coxswain ensures

Return on Investment

Your cancer program has gotten approval to engage in a strategic planning process. You've hired the consultant to help or completed all the work in-house. Key stakeholders were interviewed, provided input, and heard the results of the planning effort. And the implementation plan was completed and included in Appendix E of the binder. Now what? How do you ensure that your hospital and cancer program gets the value out of this planning effort? Here are a few key determinants to successful implementation of your strategic plan.

1. ***Each initiative identified in the strategic plan should be prioritized relative to its contribution to the key goals for the service line and the resources and effort that it will take to accomplish.*** Often cancer programs cannot (and should not) pursue every initiative simultaneously. Instead, focus on initiatives that will make the greatest contribution to the goals and can be easily accomplished with available resources in the shortest time frame. Identify "quick wins" and get them done to show the value of the effort and make initial progress toward the goals. For example, if increasing the profitability of the cancer services is one of the goals, and focusing on improved charge capture is possible by process improvements in staff work routines without additional staffing—attack that goal first rather than going after the new clinical service that requires new facilities, medical staff, employees, and equipment to get up and running. You might start taking the first steps to this longer-range project, but make sure charge capture improvement gets the attention that it needs immediately.

2. ***The goals for program growth and development should be well defined, in measurable terms, by the plan and detailed in the implementation plan.*** For example, if a new genetic counseling service is identified as a planning goal, outline all the necessary steps to get this service established, including target dates, persons accountable for accomplishment of specific tasks, the resources required, and support activities (such as marketing and communications). Define the goals of this effort in measurable terms. For example, at the end of four months we will have hired the counselor, established the space, announced and marketed the new service, and be seeing at least one new patient every week.

3. ***Institution leadership has to support the implementation effort with their attention and resource allocation decisions.*** Typically a leadership group has participated in the data gathering and decision making components of the strategic planning process, identifying goals and initiatives for the cancer service line. This group must meet periodically to review progress, reassess implementation timelines, and support progress with decisions on resource allocation. If a new service is on the goal list, but the capital review and allocation process will not approve the equipment to get the service operational, the item will be dead ended before it even makes any progress along its implementation plan.

4. ***The strategic plan and the initiatives that it identifies should be revisited at least annually to revalidate where the program needs to put its development efforts.*** Clinical practices are constantly changing, technology keeps introducing new equipment and capabilities to the cancer treatment arena, and the underlying growth in the number of new cancer patients and the longer survival times of patients under treatment ensure that this year's plan and priorities should not just be an extension of the planning effort from a year to two years ago. Use the framework of the planning effort to refresh the data and the input, critically review the areas that need improvement and the new opportunities, and keep your cancer services growing and improving.

that the boat stays on course for success, a cancer center's vision helps unite efforts toward a common mission.

Once your cancer center has developed and/or revised its vision statement, it can take this information and translate it into more specific language—the mission statement. Successful mission statements make concrete the direction and purpose of the cancer center, and provide employees with a sense of organizational priorities. According to management literature and best practices, a mission statement should be a short, concise statement of goals and priorities. In turn, these goals are specific objectives that relate to specific time periods. Hospitals may have only one vision statement, but will generally establish various mission statements (goals) related to attaining that vision. In other words, the mission statement (goals and objectives) of the cancer service line will differ from the mission statement (goals and objectives) of the OB/GYN service line.

Hospital-based cancer programs must make a number of defining decisions that will align the cancer service line with and contribute to the vision statement of the larger organization (hospital). These decisions can be identified as goals or incorporated into the mission statement—but they should never be confused with the vision statement. Examples of "defining decisions" include:

- Do we want to be the "go-to" center for all oncology? If so, by what target date?
- Will our program address all diagnoses of cancer, or will we specialize? This might entail sub-decisions such as having "go-to" practice(s) for those diseases that our program does not address, such as GYN oncology or pediatric oncology. This decision might also entail a need for a "go-to" referral center for treatments that our program does not offer, e.g., bone marrow transplants, Gamma Knife® treatments.
- Do we want to formalize our referral relationship(s) or

should we deal with each referral based on the patient's desire?
- Should we seek new technology and expertise? How will we make that decision?
- What technologies will our program purchase and when?
- What is our image in the community? Are we perceived as "patient-centered" (high tech-high touch)? Is treating the cancer patient our only focus, or do we actively advocate for health by offering educational programs of prevention in the community?

Once the strategic planning team is identified and the vision statement, mission statement, and goals and objectives are defined, your program will have laid out the foundation for building a strategic plan.

Data Drives Decisions

To identify and prioritize strategic imperatives, you must have a clear picture of the current state of cancer—both at your institution and in the marketplace as a whole. This understanding must include a definition of the market, estimates of the demand for services, the market share captured by each provider in the market, and the present financial value of the services currently provided.

Definition of the market is best done at a very granular level, mapping zip codes into primary, secondary, and tertiary service areas. Remember that the "front door" to cancer care is more likely to be imaging and surgery than medical and radiation oncology, and that patients are generally more willing to travel for surgical intervention than they are for recurring services such as chemotherapy and radiation therapy. Thus, if your program is considering surgery-related initiatives, you may want to expand the "primary" service area.

Once your service areas are defined, population projections (preferably by age-specific cohorts) should be calculated and estimated incidence rates should be applied. Incidence rates for specific disease sites may be useful, particularly in markets where such program differentiation may be especially important. This portion of data collection can often be performed by the hospital or cancer center's marketing or planning department, with input from others in the organization as necessary.

Most cancer care today is delivered in the outpatient setting; therefore, we recommend against using inpatient market share data as a means of measuring your program's current position and growth opportunity. Instead, we find it far more revealing to use tumor registry data as compared to estimated incidence figures. This data can be especially useful if the registry captures details about where patients receive the three major treatment modalities (surgery, medical oncology, and radiation). Again, examining the data for specific sites of disease is also useful when setting program priorities.

Understanding the present financial value of providing care to patients with cancer is crucial. Without this information, your cancer program runs the risk of selecting strategies that result in adverse financial outcomes. Further, with such an analysis, you can readily defend expenditures based on the revenue that the entire cancer service line generates to the hospital and quantify—to some degree—the financial risk should the overall cancer program strategies fail.

This type of analysis is complicated, requiring that you sort enormous amounts of billing and collection data for only those patients whose care was related to a diagnosis of cancer. We recommend using ICD-9 diagnosis codes to segregate the financial data, and then sorting these data by major disease categories. For charges, costs, and revenue, consider cross-tabulating the data by cost/revenue center or similar departmental groups. This financial analysis will also require a coordinated effort. The finance department will carry the bulk of the work, guided by the cancer program staff to identify the appropriate selection of records. This selection can take the form of a full year of data for all patients with an applicable diagnosis, and/or it can be structured to track each patient entered into the tumor registry, beginning one month prior to diagnosis and ending 11 months following diagnosis.

In the end, this hard work will provide a wealth of information not only to inform strategic decisions, but also to uncover opportunities for improvement that may not have been apparent in the traditional department-level assessments. For example, this type of analysis may reveal that each new prostate cancer patient generates $3,000 in contribution margin to the institution in the first year of care. Or that breast cancer patients account each year for $2,800 per case in net revenue.

As strategic planning progresses to the level of *pro forma* development and business planning, the question of predicting reimbursement invariably arises. Oncology is different than other service lines in this regard, in large part due to the outpatient-focused nature of care. While predicting reimbursement is always, to some degree, a guessing game, following trends and keeping current on proposed legislation and CMS rules allows for better informed predictions, leading to more accurate estimates of future revenue.

Developing a *pro forma* requires careful thought in order to ensure that the appropriate revenues and cost are incorporated. Assumptions need to be clearly articulated and reviewed by both finance and institutional leadership. These assumptions will define:
- The presumed customer base and growth rate
- The specific services that will generate revenue
- Payer mix and collection rates
- Operating costs (staffing, materials, marketing, etc.)
- Anticipated changes in reimbursement and cost increases
- Start up costs (minor equipment, training, etc.)
- Capital investment.

Once assumptions are constructed and vetted, actual data can be generated and figures projected forward for 3, 5, or even 10 years (see Table 1, page 34). For community cancer centers that employ a rigorous and focused process, strategic planning can be a powerful tool that provides direction and reasonable expectations of outcomes.

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