Delivering “Value” in Cancer Care

By Ryan Langdale, MBA
Oncology Solutions, LLC

Lost In The Value Frontier
Americans are accustomed to the idea of “value” or getting the most for their dollar. Whether a company is selling Value Meals or Volvos, the path to competitive marketplace advantage relies on a succinct value proposition. Most organizations define their value through low cost (Walmart), high quality (Mercedes-Benz), or some combination of both. Rarely are there examples of sustainable industries that deliver at the bottom of the value frontier, in other words, positioning a product of low quality and high cost. For many years, health care defied the laws of free enterprise by doing just that – demanding exorbitant costs in exchange for inconsistent, ill-quantified outcomes. While the unsustainability of this model has been discussed ad nauseam, meaningful reform has proved elusive. All of that is changing in the current era of what many deem “value-based health care.”

Most health care organizations have accepted that “value-based” reform under the Affordable Care Act means optimizing the relationship between what they are selling, healthy or improved outcomes, with the cost of delivery. In delivery networks such as primary care, this is proving to be a fairly straight-forward process as cost and quality can be easily measured and improved upon in simple care environments. In more complex specialties like cancer care, this has not been the case. Oncology providers are polarized over the feasibility of value-based cancer care, with many citing cancer’s complexity, variability and multi-disciplinary nature as precluding factors for delivering consistent “value.” On the other extreme is a growing contingent of oncologists actively pioneering value-based reimbursement models and challenging the status quo in care delivery. The environment is further colored by disagreement on where cancer care is most effectively delivered, as a growing number of oncologists are abandoning private practice in favor of hospital alignment. These diverging visions have left “value-based readiness” in cancer care in a state of disarray, characterized by fragmented initiatives and far more questions than answers.

Despite these challenges, cancer care remains one of the few areas with the most to gain from coordinated, value-based reform. With nearly $130B, or ten percent, of health care spending utilized in treating one percent of patients, oncology represents an incredible opportunity for measuring and rewarding cost-effective care. The following article examines the complexities and promise of value-based cancer care, evaluating fundamental value deficiencies in oncology, exploring diverging visions for the future, and conducting an honest assessment of cancer’s preparedness to deliver a value-based, competitive product.

The Value Deficit
In a recent piece written for The New Yorker, Atul Gawande, MD likens the future of health care to the Cheesecake Factory, an institution that has mastered the value-delivery model through quality control, standardization and best practice adoption.¹ His exposé presents the restaurant chain in stark contrast to the current state of health care, where an estimated 18 percent of GDP is spent on a product with dubious value. Cancer care is a microcosm of this problem with runaway costs and, as Gawande surmises, “…the service is typically mediocre, and the quality is unreliable.” This value deficit in oncology can be attributed to three primary factors: misaligned incentives, a lack of accountability and transparency, and a disengaged consumer.

Misaligned Incentives
In the early 19th century, paleontologists devised a program with a rural Chinese population to pay a financial reward for every fossil that could be produced. These paleontologists, baffled by the volume of fossils they were receiving, soon discovered that the enterprising peasants were breaking fossils into smaller pieces in order to capitalize on the reward, thereby ruining the scientific value of the artifacts.² For decades the Fee-for-Service (FFS) payment system has suffered from the same incentive misalignment as physicians have been reimbursed on volume-based productivity without regard for quality or cost effectiveness. The end result has been a system that often treats patients like Chinese fossils, i.e., maximizing throughput with inconsistent regard for the end product. In oncology this problem has manifested in

Creating a System Approach to High-Quality Breast Care

By Teresa Heckel, Catholic Health Initiatives, Denver, CO

As a national healthcare system of over 86 hospitals spanning 18 states, Catholic Health Initiatives (CHI) has taken a new approach to ensuring breast cancer patients treated at CHI facilities receive access to the highest quality care. In 2009, as the CHI National Oncology Service Line (NOSL) was being formed, many of the hospitals began requesting assistance in their breast program development. All the reasonably expected questions were at the heart of the request. In what technologies should we be investing? How should our organizational structure be developed? On what quality metrics should we be focusing? Should we build a dedicated breast center? Should we recruit dedicated breast surgeons? The list went on and on.

In response to the requests of the facilities, one of the first initiatives of the NOSL corporate team was to assist the local facilities in their pursuit of developing high quality, comprehensive breast programs. The ultimate goal is to ensure that breast patients cared for at a CHI facility are receiving the highest quality of care and service possible. At the outset of the initiative, a significant

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the form of the so-called “buy and bill” reimbursement system, wherein oncologists buy cancer reagents at wholesale pricing and then bill at “retail” rates to insurance companies, allowing the drug margin to cover practice expense. “Buy and bill” has created a predictable value deficiency by incentivizing physicians to treat using the most expensive cancer drugs to maximize potential margin.

Lack of Accountability & Transparency

In addition to incentivizing higher cost drug regimens, the FFS system has traditionally omitted any requirements on quality. In ancient times, outcomes were inextricably tied to physician livelihood through King Hammurabi’s edict that surgical error result in the removal of doctors’ hands. While modern physicians may feel like they still pay an arm and a leg, or hand, for malpractice coverage, the fundamental misalignment remains between payment incentive and quality of work product in health care. The lack of accountability in oncology is largely driven by the broad lack of consensus in defining “quality” and the systems to track it.

From a definitional standpoint, does quality refer to the perception lens, i.e., reputation, affiliations and brand, or the process lens, defined by efficiency and reliability; or alternatively does it refer only to outcomes, survival and the ends-justifying means? While many providers would endorse the latter, much of the conversation around quality has been framed around process efficiency, reliability and standardization — the key tenants to cost control. In the world of industrial manufacturing, cost and quality are inseparable and are often controlled through heavily engineered processes and a commitment to Six Sigma controls, allowing three quality defects, or deviations, per million items produced. While patients are not cogs in an industrial process, is there something to be borrowed from this approach in the world of cancer care? Oncology also suffers a lack of transparency in outcomes data and standardized frameworks for tracking quality. The absence of both conceptual alignment and monitoring capabilities begs several questions of value-based cancer care. Can the era of accountability, being ushered in by the Patient Protection and Affordable Care Act (PPACA) truly foster a reliable cancer delivery model? And can the alphabet soup of cancer quality initiatives, like ASCO’s QOPI, ACOS’ NOF, CMS’ PORS and the NCOA, succeed in defining a common vocabulary, reporting structure and consensus-driven goals for acceptable deviation?

Consumer Engagement

The final macro-level deficiency of health care is consumer choice, the engine of American enterprise, and strangely absent player in the health reform discussion. Consumers of health care, namely individuals and employers, have not traditionally directed their purchasing power towards organizations with optimal value propositions. This aberrance in consumer behavior may be a function of the historical role of intermediaries in the health care purchase decision, leaving a fairly disengaged end customer, or perhaps is attributable to a general sense of futility in trying to decipher true cost or proxies of value. The end result is an industry that remains one of the last stalwarts of information asymmetry with its consumer. Value-based care seeks to address disengagement by empowering the public with transparency of cost and quality, enabling informed consumer preference — the life force of capitalism — to weed out inferior providers and begin raising the standard of care.

To date, the shared savings bonanza has been heavily focused on primary care, leaving specialties like oncology with a fairly ambiguous place in the new ACO world.

Building Value-Based Cancer Care

Correcting for the intrinsic defects of health care will require not just a refresh, but a complete redesign of the mechanisms that promote accountability, shared responsibility, coordination, efficiency, and a focus on outcomes. The desired end result is maximum utility for every dollar spent, and consequently, a health care system that is leaner, smarter, and capable of self-reflection and continuous improvement. So how does oncology care move from its current state to one grounded in value? The process begins with addressing cost effectiveness and quality through standardization of care and experimental reimbursement models. The value continuum relies on more standardized care driven via clinical pathways and enables the development of many of the innovative payment models discussed hereafter.

Clinical Pathways

Time and again, industries have proved that cost and quality can be improved upon with a measure of standardization. The large-scale delivery models of Ford’s F-150s and the Cheesecake Factory’s Maple Salmon share a common ingredient: assembly line’s standard approach. Many providers refute this model’s effectiveness in medicine, citing the “art” of physician craft, or a clinical need for improvisation. Others, such as Brigham and Women’s surgeon, John Wright, MD, disagree, claiming that, “Customization should be five percent, not ninety-five percent of what we do.” The advent of the clinical pathway in medical oncology has proved to be a promising compromise to this dichotomy, offering a set of mutually-agreed upon regimens that a provider may choose from in delivering care while preserving a measure of autonomy in decision making. These cancer pathways incorporate the latest in evidence-based medicine and are generally expected to cover approximately 80 percent of cases, with 20 percent expected to be “off-pathway” for complicated tumor presentations.

A recent survey of American payers revealed that as of July 2012, 40 percent had adopted medical oncology pathways, with an additional 36 percent expecting to implement within the next 24 months. This broad adoption has been driven in large part by successful pilot models, such as US Oncology’s Level I Pathways, which produced a 35 percent drug cost reduction in thoracic oncology treatment. Other pilot programs in colon cancer have shown cost savings in excess of 30 percent for on-pathway treatment. The use of pathways in the broader health care conversation has been heavily contentious, particularly as it relates to “panels” choosing approved treatments for Medicare patients. The subject has garnered far less opposition in oncology due to the incredible effort that has been made by private groups in aggregating best-practice evidence for clinical treatment and organizing detailed pathways for cancer. Among these groups are Cardinal Health (P4P Pathways), Via Oncology and the aforementioned US Oncology’s Pathways, which are currently being merged with the National Comprehensive Cancer Network (NCCN) guidelines to create “Value Pathways powered by NCCN.”

Shared Savings/Risk

The broad adoption of clinical pathways, coupled with increased publicity for innovative reimbursement models, has begun to create the perception that the FFS system is, as Modern Healthcare writes, “…on life support.” It is important to temper this rhetoric by noting that the transformation to value-based care will take time, and will evolve organically through experimentation and trial and error. This evolution of value-based care is certainly progressing, most notably in the widespread movement towards the use of clinical pathways with-
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in “shared savings” payment models.

Shared savings, as the name suggests, is a payment model that realigns incentives by allowing physicians to realize a percentage of whatever savings they can achieve through improvements in their care process. While these types of arrangements have existed for quite some time, they’ve gained notoriety and appreciable traction under the PPACA’s “Accountable Care Organization (ACO)” appellation. As of February 2013, the number of shared savings ACOs in the United States stood at 428, with a mix of both Medicare and commercial representation.13 In the aforementioned payer survey, nearly 60 percent of respondents indicated that they have, or will have, an ACO within the next two years.14 To date, the shared savings bonanza has been heavily focused on primary care, leaving specialties like oncology with a fairly ambiguous place in the new ACO world. Many attribute this to the numerous obstacles specific to oncology, including a lack of IT infrastructure for tracking cost or quality, a complex disease that does not lend well to mechanized medicine, an unwieldy network of specialists involved in patient care, and the amplified risk of outlier patients with excessive medical costs. While these hurdles are legitimate, so too are the success stories emanating from around the country from those who are experimenting in value-based payment. For example:

1. In mid-2012, Aetna’s Chief Medical Officer cited cancer as responsible for nearly 11 percent of the organization’s total spend.15 As a result, Aetna teamed up with Innovent Oncology and Texas Oncology to pilot shared savings amongst Texas Oncology’s network of 248 medical oncologists. The program, designed around Innovent’s emphasis on supportive care services, clinical pathway adherence and advance directives for end-of-life, has proved to be tremendously successful. Most recent reports indicate that the value-based collaboration reduced emergency room visits by 39.8 percent in 2012, leading to a 16.5 percent reduction in inpatient admissions and a total cost savings of 12 percent amongst select tumor sites.16

2. In Miami-Dade County, Florida, a similar payment experiment is underway between Baptist Health South Florida, Florida Blue (formerly BCBS of Florida), and Advanced Medical Specialties (AMS), Miami’s largest medical oncology practice. This three-party collaboration, deemed an “Oncology Shared Savings Program (OSSP)” by AMS Chairman, Leonard Kalman, MD, is one of the nation’s first models to build a value-based network between a payer, hospital, and private physician practice. Over the course of several months, the Miami-based OSSP established baselines for measuring improvement, negotiated the terms for sharing savings, and agreed on a path forward for improving care processes. Process improvement focused on chemotherapy regimen compliance, pathways for imaging and radiation oncology, patient transition management, supportive care services, and investment in IT infrastructure for tracking compliance, quality, patient satisfaction, and cost effectiveness.17

Bundled/Episodic Payment

In the continuum of value-based care, the next iteration beyond shared savings is “bundled” or “episode-based” payment, the final proving ground before full capitulation. Bundled payments got their start in the early 1980s when Denton Cooley, MD began offering flat fee coronary bypasses at the Texas Heart Institute. Elsewhere, Michigan-based orthopedic surgeons were accepting case rate payment for arthroscopic surgery, going so far as to offer a two-year warranty for re-operations.18 More recently Medicare adopted forms of bundling in both its acute care prospective payment system and in outpatient end-stage renal disease. The Congressional Budget Office estimates that bundled payments, if extended to the entirety of health care, could drive as much as $198 billion out of federal spending over the next six years.19

The model for bundled payments, as illustrated in oncology, involves paying an upfront fee to the oncologist for an entire “episode” of a patient’s care. The services included in the bundle might vary, but would typically include chemotherapy drugs, non-chemotherapy biologicals, case management and possibly cognitive services or supportive care consults. This simple model stands to revolutionize the practice of medical oncology for a simple reason: incentive alignment. Like the Chinese paleontologists of yesteryear, insurance companies are discovering that realigned incentives can fight the excesses of “buy and bill” by discouraging oncologists from choosing the most expensive amongst clinically equivalent regimens. Bundling essentially decouples drug margin and volume of services from physician compensation by paying a flat, pre-negotiated rate for specific cancers.

The complaints about bundled care are numerous, most classically that the model encourages providers to withhold treatments in an effort to maximize their take-home portion of the episodic fee. This risk is typically mitigated through feedback loops that require adherence to national quality metrics and by having future increases to the bundled payment tied to improvement in disease-free survival, patient satisfaction, and similar metrics. More legitimate criticisms of bundled payments involve the complexity of proper information sharing; the ambiguous path forward for a total cancer care bundle, including radiation oncology, imaging and surgery; the scale required to mitigate risk of outlier patients; and the unintended stifling of innovation that may occur if pharmaceutical companies are forced to “race to the bottom” in order to offer their reagents as the cheapest alternative in a regimen set.

Despite these inherent complexities of bundled payments, Linda Bosserman, MD, a pioneer in oncology episodic payment, explains the success of her model in these simple terms: “Our process is a very transparent way of saying, ‘Here is the population you are asking us to manage. Here is what they have. Here is what we did. Here is how we did it. Here are the complications. Here is how they were managed. Here are our costs. Let’s benchmark these and continuously work to provide cost-effective, high-quality care to your patients.”20

The essence of Dr. Bosserman’s message is that transparency, data exchange, and continuous improvement can overcome many of the perceived obstacles to oncology payment reform. Indeed, as the PPACA catalyzes a nation-wide exploration of viable alternatives to the FFS payment model, numerous organizations are reporting substantial advances in the implementation of episodic payment innovation in medical oncology. For example:

1. United Healthcare made its foray into bundled payment methodology in 2010 with the selection of five medical oncology practices for a reimbursement pilot model. The key tenants of the United model are twofold: first the medical oncologists all select a specific regimen for treating each of 19 different cancer episodes, to which they are expected to adhere in at least 85 percent of cases; secondly, United issues an upfront bundled payment for the specific episode, covering the drug cost, an allowable margin, and a case management fee, leaving the physician to bill other ancillary and professional services under traditional FFS method.21 The United pilot has proved extremely successful and has allowed participating practices to benchmark their data against regional and national benchmarks.

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2. The concept of the Oncology Patient-Centered Medical Home (OPCMH) as an episodic payment model has received much interest since pioneer, John D. Sprandio, MD, first published his six years of data, demonstrating a phenomenal 65 percent decrease in ER visits per chemotherapy patient in Drexel, Pennsylvania.22 Wilshire Oncology, based out of Pomona, California, has followed in Dr. Sprandio’s footsteps with an oncology medical home model of their own. Wilshire is combating the structural decay in reimbursement with a renewed focus on cognitive services. This resurrected patient-centric approach to cancer care proactively manages side effects for interval care, offers extended hours to avert ER visits, tracks advance directives and palliative care consults, and measures quality and benchmarking on a regular basis.23 The early results, presented at the 2012 Cancer Center Business Summit, indicate that treatment management fees have been more than offset by savings gained from pathway compliance, with additional savings driven by reduced hospital admissions and avoided ER visits, particularly for hematological malignancies.24

3. Two other bundled payment initiatives have grabbed national attention in recent months including Priority Health’s bundled payment program in Michigan, and Barbara McAneny, MD’s “Come Home” project in New Mexico. For Priority Health, the focus has been moving beyond pathways by paying a bundled payment that covers the cost of drugs (without margin) and a monthly case management fee with the expectation that care-process improvement will drive additional savings, eligible for annual distribution to participating physicians.25 In New Mexico, Dr. McAneny was recently awarded a $19M innovation grant from the Medicare & Medicaid Innovation Center for her proposal to create the “Come Home” virtual medical home, a 10,000 patient, seven-state initiative. The “Come Home” project will use care coordination and timely intervention to drive an expected $20M in savings during the project’s lifecycle.26

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amount of research was done to evaluate the key services, quality metrics, human and capital resources, facilities, etc. that were needed to create a high quality, comprehensive breast program. We also researched many journal articles and other national breast programs, especially those that marketed themselves as a Breast Center of Excellence. What we found were many programs that had indeed created high quality programs, but also many that marketed themselves as a Breast Center of Excellence but had no supporting evidence demonstrating “high quality.”

In order to ensure that our facilities were truly providing high quality when marketing themselves as a center of excellence, CHI decided to take a new approach and create a model for a CHI Breast Center of Excellence (BCOE).

With the assistance of the CHI National Physician and Breast Advisory Groups and through consulting with national leaders and organizations in breast care, we developed a model for a CHI BCOE which would significantly raise the bar in breast care. This model helps to ensure a patient-focused alignment with evidence-based medicine and documented performance of high quality. It ensures our patients have access to appropriate technology, services, resources and support with a goal of providing superior care and outcomes.

Although our focus is at a national system level, any size program can use these steps as a roadmap to creating a high quality individual breast program. Likewise, any network healthcare system can take the same approach.

Since there are many CHI facilities, the decision was made to initially focus on those facilities that had Commission on Cancer accredited oncology programs. At this point, there are 17 CHI markets (made up of over 36 facilities) at various stages of accreditation/certification.

The CHI model requires the facilities to accomplish three key national certifications/accreditations, thus having documented performance of excellence as deemed by the three sponsoring organizations. CHI believes the model provides a balanced approach for ensuring high quality breast care. And, while the achievement of these awards is not our end-game goal, it helps to build the roadmap for where to focus the efforts. Just by going through the process of evaluating baseline performance in these areas, a program is sure to improve.

The three accreditations/certifications we selected include the following organizations.

1. NCBC’s National Quality Measures for Breast Center’s Certified Breast Center of Excellence

   CHI believes this effort will help to ensure we are providing high quality, and are actively benchmarking ourselves with peer facilities also interested in delivering high quality breast care.

2. National Accreditation Program for Breast Centers

   CHI believes this accreditation serves as a good roadmap for our facilities in identifying the structure, resources and services that are needed in developing a comprehensive breast program.

3. American College of Radiology’s Breast Imaging Center of Excellence

   This certification helps to ensure excellence in breast imaging, which is such a significant part of the overall breast program.

   These are organized into 3 “pillars” which help to demonstrate our balanced approach.

   There is a clear understanding at the CHI national office that it takes tremendous commitment and dedication on the part of the medical and administrative staffs to achieve what is required in each of these quality-based pillars. To augment that commitment, CHI has developed some supporting programs/services to assist our sites in their endeavors, and to reward them for their efforts and high performance. The programs/services CHI has developed to assist our facilities include the following services.

   • CHI Breast Consulting Service – This is a multiphase process that helps the facilities to identify their internal/external strengths, weaknesses, opportunities and threats. This is the first step and is the baseline from which each facility moves forward toward an agreed-upon vision. The on-site consulting engagement utilizes both internal and external experts and results in a written strategic implementation plan. There is a focus on the development of an interdisciplinary team with close communication, collaboration, and coordination.

   • Breast Program Playbook – One of the most time consuming components of breast center development is the process of wading through the myriad of breast-related materials that are available and evaluating their relative usefulness to this project. To assist the facilities in this process, and to standardize as much as possible across all facilities, CHI compiled a comprehensive, internal web-based resource for all things related to breast care. The Playbook contains algorithms, forms, gap analysis worksheets, job descriptions, organizational charts, patient flow sheets, etc.

   • BCOE Incentives – One of the advantages of a healthcare system is that there are economies-of-scale that can be offered to individual facilities that both save money for the facilities, but also serve as rewards for program achievement. To assist and reward our facilities for their efforts, CHI has developed numerous incentives including marketing campaigns, payor negotiations, pro bono consulting services, and a beautiful crystal trophy for accomplishing all three pillars of the CHI BCOE model. This also assures that there is a consistent “CHI message” across the varied regions.

   • Breast Dashboard – The dashboard promotes quality improvement by monitoring performance across the CHI system. A new initiative to add identified breast quality metrics to our NOSL Dashboard allows us to have a national focus in tracking and improving key breast measures. Metrics were selected by our NOSL Breast Dashboard Advisory Team which includes physicians of all specialties and breast leaders/team members from across our CHI facilities. The metrics are reflective of the nationally accepted breast measures promoted by the National Quality Forum and the breast-related organizations and professional societies.

   This has certainly been a rewarding and challenging journey. The biggest challenge has been creating a high quality and consistent model across many diverse facilities, each with their own unique strengths, weaknesses and market dynamics. By developing an approach that combines the local efforts and passions for delivering high quality with national resources, support and incentives, CHI is poised to deliver on the promise of value-based cancer care.

   Although CHI is a national health system and the approach was part of a large, national initiative, many of the elements could be adapted for organizations of any size. Since the inception of our BCOE initiative in early 2011, the achievement of the CHI BCOE pillars by our market-based breast programs has increased over 100%.

   CHI strives to be a leader and pioneer as healthcare moves from payment for volume to payment for value. With the value equation shifting to more integrated, interdisciplinary care, our strategies must be reflective of that change. We believe the CHI BCOE model helps to ensure high quality and value for the patients we serve and positions the organization for success. ■

Teresa Heckel is Director, National Oncology Service Line, for Catholic Health Initiatives in Denver, Colorado.
James P. Wilmot Cancer Center at University of Rochester Medical Center Solves Challenges of New Patient Intake

The James P. Wilmot Cancer Center has a 30-year history of excellence in patient care, research, education and community outreach in central New York State. It offers a wide range of state-of-the-art treatment options, including surgery, chemotherapy, radiotherapy, immunotherapy and blood and bone marrow transplantation.

With some of the best oncologists and surgeons in the country, according to America’s Top Doctors for Cancer, it is no surprise the University of Rochester Medical Center’s James P. Wilmot Cancer Center treats hundreds of patients each day. According to Lynn Leandowski, Clinical Administrator, the Cancer Center has over 200 patients in one day, although the typical volume is between 100-200 patients daily. “We’ll also receive 40-50 new patients each week,” stated Leandowski.

Coordinating the care for a large volume of patients can be a huge burden on the staff, especially in a setting where doctors and patients are fighting against potentially deadly diseases. Even with a clerical staff of 23 and a dedicated new patient intake coordinator, one of the most difficult and labor intensive administrative tasks is obtaining new patient records, said Catherine Lyons, RN, MS, CNAA, Associate Director, Clinical Services. “Hard copies of patient films have to be mailed and returned, which is difficult to track. Plus, we usually experience delays with outside institutions mailing the films to us.”

Timely and efficient care is crucial for these patients. When Lyons heard about a service offered by eHealth Technologies™ that streamlines the process for obtaining patient records from other medical centers and physician offices, she quickly organized a meeting to learn more.

Instant Results
In late 2005, the James P. Wilmot Cancer Center began using eHealth Technologies eHealth Connect® Record Retrieval Service to obtain new patient records. They experienced instant results. “We saw an immediate impact on our staff workflow and efficiency,” noted Leandowski, “and we were able to schedule more patients.” The company combines information technology with a clinical support team to retrieve, digitize, organize, store and secure patient medical records.

Access to Images
Obtaining a patient’s prior medical images is a crucial component to treatment. “We need to know what tests – and in particular imaging studies – the patient has had and when those were conducted,” said Leandowski. Approximately half of the patient records that the company obtains are film; the service digitizes and uploads them to a secure website for viewing. With advanced imaging technology such as MRI and PET/CT, it is not uncommon for a patient’s record to contain 1,500 images.

The average turn-around time at URM C from the initial request to compilation of the complete patient record is three days. For Lyons, having outside images and documents organized digitally before the patient arrives for his/her consultative appointment streamlines patient care. “We can get patients into the center much faster and make better use of that first appointment because more information is readily available,” she noted. Lyons knows her staff is more efficient even though she hasn’t measured the results. “eHealth Technologies certainly cuts down on the time it takes to procure records in advance of the new patient visit.”

Streamlining the patient care process
Nearly 40 percent of the record requests are outside the metropolitan Rochester area, even as far as Florida and California. The staff at eHealth Technologies must often contact different sites and offices to gather a patient’s complete history.

“This service truly streamlines the patient care process and enables us to see a new patient in a timely manner,” said Leandowski. “If we urgently need a record, I know we can get it as soon as possible without placing any burden on the patient. They already have enough to worry about.”
**PRESIDENT’S MESSAGE**

*Diane Getchel Cassels, ACE President*
*Executive Administrator, Winship Cancer Institute*

So, if you had $225 to invest in your future, what would you do with it? If I had a crystal ball and could see into the future I would most likely buy lottery tickets or spend the money on the “hot stock” of the day. Unfortunately, I can’t count on that happening and along with most of you, I am working for a living and will be for some time. Investing in our future in these days of healthcare management changes is something imperative to success.

Many of you have asked, “what do I get by being a member of ACE?”

At our recent Board of Directors meeting we explored that very question and wanted to make sure that our members felt there was value added by belonging to our association. We reviewed other organizations and their dues structure and felt it was important to keep our dues at the same level.

A recent survey of our members emphasized the desire for more Hot-Topic calls and sessions devoted on a wide variety of topics such as quality initiatives, survivorship programs, bundled payments and ACoS standards. These will be great suggestions to build our future calls and conferences around.

In July we will be once again rolling out our Member-get-a-Member promotion. All of us know at least one person that would benefit from ACE membership. This could be a nursing director, radiation oncology manager, cancer registry manager at your institution or a colleague that you have met at other meetings. Everyone I know is looking for benchmarking data, quality initiatives and other information related to cancer administration. We want people to think of ACE when they need a professional organization and 300+ colleagues to interact with. Look for more information by e-mail soon.

Our Board of Directors is here to serve our members any way we can. Please let us hear from you whenever you have questions, concerns or new ideas. Every member should make it their mission to enhance the organization and spread the news to potential new members. There are still oncology leaders out there that are not aware of ACE and the wonderful opportunities and benefits provided to its members.

Getting involved with an ACE committee is also a great way to get even more benefits and stand out among your peers. Don’t hesitate to reach out to our committee leaders to learn how you can participate. Our 2013 ACE committee chairs/co-chairs are:

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- **Membership** – Deena Gilland & Tammy McClanahan
- **Member Services** – Veronica Decker & Josh Schoppe
- **Vendor Relations** – David Gosky & Teresa Heckel

A complete description of each committee and contact information is at [www.cancerexecutives.org](http://www.cancerexecutives.org).

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