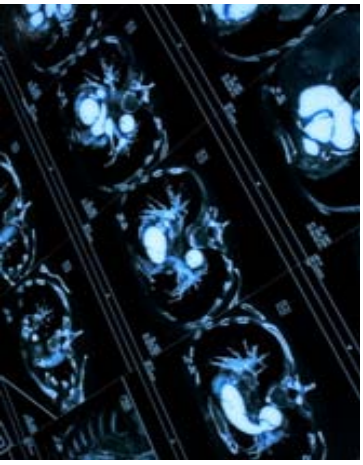
ASSOCIATION of CANCER EXECUTIVES

ACE update

cancerexecutives.org



December 2011



# Lung Cancer Screening Programs

**Kimberly Woods-Smith, RN, BSN,** U.S. Medical-Advocacy Liaison, Lung Cancer Alliance

Just prior to Lung Cancer Awareness Month, **Lung Cancer Alliance** and **ACE** co-hosted an October "Hot Topics" conference call on Lung Cancer Screening Programs. The topic was spurred by the recent publication of the results of the National Lung Cancer Screening trial (NLST) in the *New England Journal of Medicine* which showed utilizing Low-Dose Computed Tomographic (CT) Screening resulted in a 20% reduction in mortality for lung cancer in a high risk population. This data has caused many cancer centers across the country to evaluate lung cancer screening as a potential tool to reach those at higher risk for lung cancer in their communities. As most ACE members are clearly aware, lung cancer is the leading cause of cancer death in the U.S. in every ethnic group, claiming the lives of twice as many women as breast cancer and three times as many men as prostate cancer.

The statistics on lung cancer are astonishing:

- A majority of lung cancers are diagnosed at later stage (Stage III or IV) and there has been no early detection screening to be able to diagnose and treat earlier lung tumors.
- 60% of lung cancer patients either never smoked or quit smoking decades ago
- Over 450 people die a day of lung cancer in the U.S., 19 an hour.
- The overall survival rate for lung cancer is still 15.5% – the same as it was over 40 years ago. Breast cancer has an overall survival rate of 89% and Prostate cancer is at 99%.
- Lung cancer is the leading cause of cancer death in both men and women, and accounts for 30% of all cancer deaths.

No wonder the leadership of cancer centers across the U.S. are energized to "tune in" on the progress made in screening for lung cancer… the damage is seen every day in these centers. It is difficult to talk to any group of people about lung cancer and ***not*** find someone who has been touched by it.

Lung Cancer Alliance (LCA) is a twice awarded, four star charity and is the oldest lung cancer organization uniquely providing support and advocacy for the greater lung cancer community. Based in Washington D.C., LCA works diligently

*Continued on page 3 >*

**"Lung cancer is the leading cause of cancer death in both men and women, and accounts for 30% of all cancer deaths."**

# Overcoming Organizational Inertia: Evidence-Based Culture Change

**John Robb,** FACHE, CHFP, MBA, AIA, FKP Architects

Today's health care leader is familiar with their role as change manager. Less clear is the role of change instigator. In physics, Sir Isaac Newton theorized that the current state remains constant until "acted upon by an unbalanced force." Intuitively, every manager knows that Newton's Laws of Motion apply in health care as well.

- Attempts to innovate are often drowned in a quagmire of industry-wide regulation. Mere "compliance," rather than improvement, often becomes the organizational objective.
- The litigious culture surrounding health care reinforces "tried and true" processes and methods. The status quo offers the lowest level of business risk.
- Requirements for increased revenue and reduced cost is challenging for direct patient care services. For indirect patient care functions, meeting financial hurdles is often impossible.

Regulatory mandates, legal requirements and financial constraints are strong forces that mitigate against change and reinforce organizational inertia. So, what might constitute the "unbalanced force" required to instigate culture change?

A properly structured and successfully executed planning and budgeting process can provide the evidence and consensus needed to overcome organizational inertia. Positive change to the decision-making culture is a value-added by-product.

Start with a new perspective on the annual planning and budgeting approach to provide the evidence necessary for building consensus. Focus the process on: 1) Discovering the substance of operational challenges; 2) Defining organization-wide success; and 3) Determining the form of innovations that hold the most promise.

*Continued on page 4 >*

**"A properly structured and successfully executed planning and budgeting process can provide the evidence and consensus needed to overcome organizational inertia."**

## ACE Calendar

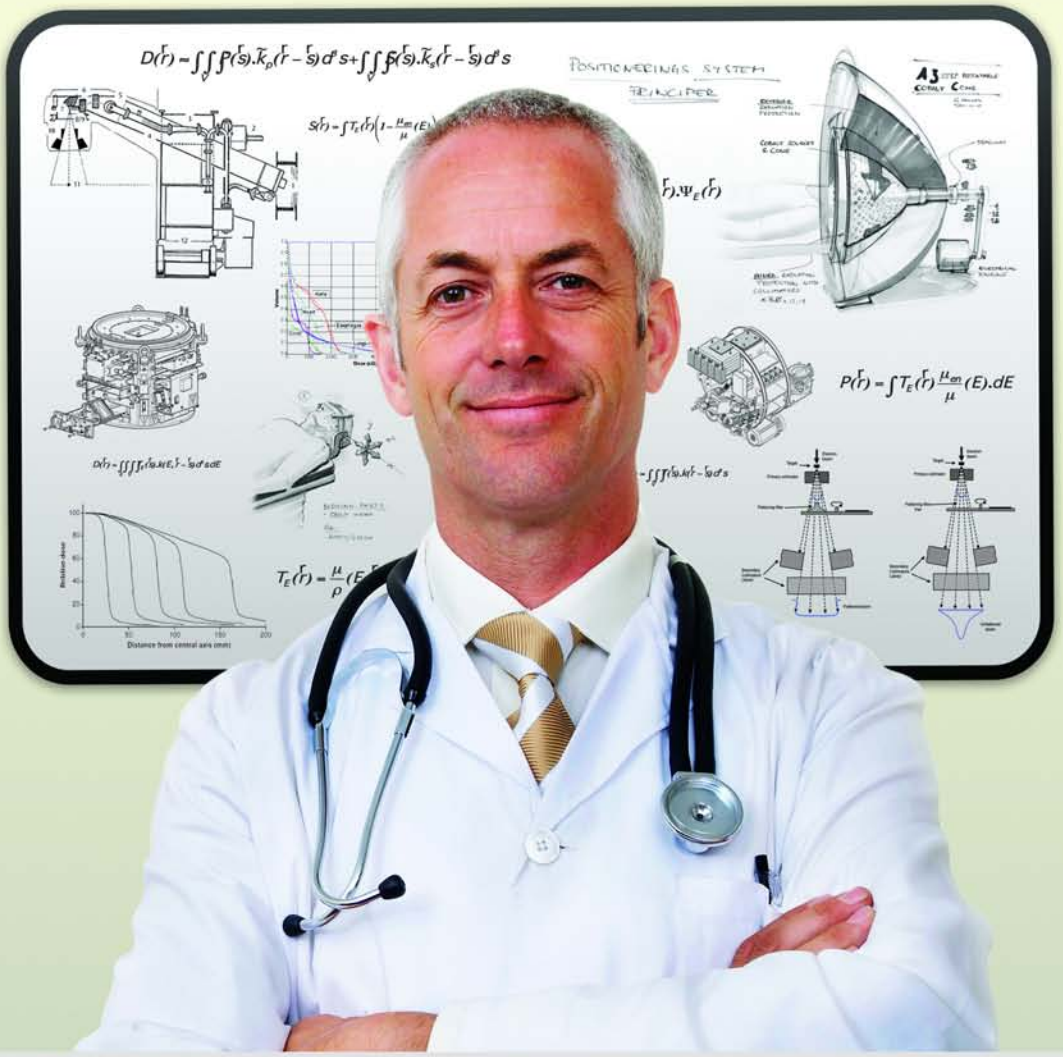
**18TH Annual Meeting**
**JANUARY 18–21, 2012**
**SAVANNAH, GA**
Hyatt Regency Savannah

**19TH Annual Meeting**
**JANUARY 23–26, 2013**
**SAN ANTONIO, TX**
Grand Hyatt San Antonio

**20TH Annual Meeting**
**JAN. 29 – FEB. 1, 2014**
**SAN FRANCISCO, CA**
Palace Hotel

# Managing complexity

## so you can focus on what matters



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## *Lung Cancer Screening Programs*

> *Continued from page 1*

to erase decades of stigma and shame that people diagnosed with lung cancer face. Giving family and survivors hope and options through support networks, working diligently to advance public policy change, the LCA is bringing a compassionate voice to the lung cancer community. They are also a leader in the conversation to bring screening access to those at risk.

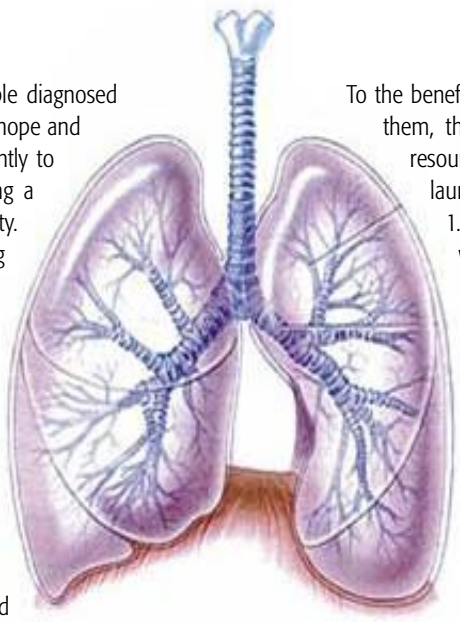
### Next Steps

After the results of the NLST, the LCA launched its consumer based website, www.screenforlungcancer.org, to inform the public on the risks for lung cancer and educate those who find themselves at risk for lung cancer, and to provide consumers information on accessibility of lung cancer screening sites.

As a patient advocacy organization, LCA has led the charge in providing information to consumers related to lung cancer and risks for lung cancer. In talking with physicians and Cancer Center executives around the country in my role with LCA, I have found that the majority of comprehensive cancer centers have evaluated or are currently reviewing lung cancer screening. Of those who are moving forward to implementation there are common components that experienced lung cancer screening sites are including as part of their lung cancer services.

These common components begin with:

- A multidisciplinary team including Radiology, Pulmonology, Thoracic surgery, Oncology, Radiation Oncology, Nursing, and administrative support and clear definition of roles.
- A process for informing and education of referred consumers on what screening is "a process" and what it is not…"just a test".
- A commitment to nurse navigation and understanding it to be key to a successful program
- A robust and honest discussion and evaluation of referral processes, patient follow-up and patient flow from diagnosis to treatment in those found to have lung cancer
- A standardization of reporting and follow-up mechanisms
- A consensus of what criteria will be followed for screening, intake process, handling of self-referrals; access point for patients via web based or phone evaluation, etc.
- A commitment to the education of the Primary Care community and the community-at-large about screening and who should be screened and how follow up will be handled.
- A commitment to partnerships with lung cancer advocacy organizations.



**"If your center currently offers lung cancer screening in a comprehensive lung program, LCA would like to hear from you and ensure that your center information is listed as a resource on our Screen for Lung Cancer website."**

To the benefit of all those who are at risk and those who care for them, the NCCN has just released a tremendous tool and resource for centers evaluating screening with their newly launched Lung Cancer Screening Guidelines Version 1.2012. This can be found on their website, **www.nccn.org**. This evidenced-based and weighted guide can offer much assistance to those cancer centers looking to develop a lung screening program. I would encourage each of you in leadership within your cancer centers to be the person who moving forward helps to guide the discussion regarding lung cancer screening.

### Follow up

Based on the NLST data, LCA has issued a statement to the U.S. Preventative Task Force calling for action and a ruling on screening for those at risk. LCA continues to advocate for consumers and the greater lung cancer community and strives to raise awareness for patients at risk to have access to screening at a cancer center where informed and comprehensive care is offered.

If your center currently offers lung cancer screening in a comprehensive lung program, LCA would like to hear from you and ensure that your center information is listed as a resource on our Screen for Lung Cancer website. We also would like to hear from those centers that are in the current process of evaluating screening for lung cancer. Finally, we certainly hope that you will utilize the wonderful resources that we have currently in place for all of your lung cancer patients.

Thanks to each of you for all that you do serving cancer patients and your community each day, together we are making a difference in Lung Cancer! ■

For more information please visit:
Lung Cancer Alliance: **www.lungcanceralliance.org**
Lung Cancer Screening: **www.screenforlungcancer.org**
To update us on your program and to learn more please email
**kwsmith@lungcanceralliance.org**

## *Overcoming Organizational Inertia*

> *Continued from page 1*

### Instigating Change

Successful execution will depend on maintaining process momentum to the point where consensus is realized. Communication amplifies momentum by creating broad-based understanding and support of the decisions resulting from each planning step.

In general, the following steps are sequential, because each step provides data and direction that are critical for subsequent decisions. Delay or indecision at key transition points between steps diminishes momentum by diluting evidential data and confusing consensus building efforts.

### Step 1 – Discover Substance

Planning initiatives arise out of perceived needs. Often, the perceived need is not the

Planning efforts focus on problem service lines, departments or technologies. However, the real substance of the problem is typically associated with input/output relationships between constituent operations of the overall service delivery process. Breakthrough progress is made with process-focused solutions.

Consideration of variable input/output relationships adds complexity to the planning process. In addition, planning must consider alternative solution scenarios the best bet for future success.

Similar to a fine art painting, data is used to highlight the substantive issues within the context of their operational background. Quantitative data sketches an outline of the issues. Qualitative data, from interviews and surveys, provide "color" by illustrating preferences and levels of satisfaction. Effective planning utilizes both quantitative and qualitative techniques to realistically assess the perceived need and discover the substance.

However, "analysis paralysis" must be avoided. Complexity, variability and discussion threaten to bog down the decision-making process. The change instigator runs the risk of getting lost in a "forest of opinion." Prolonged sur-

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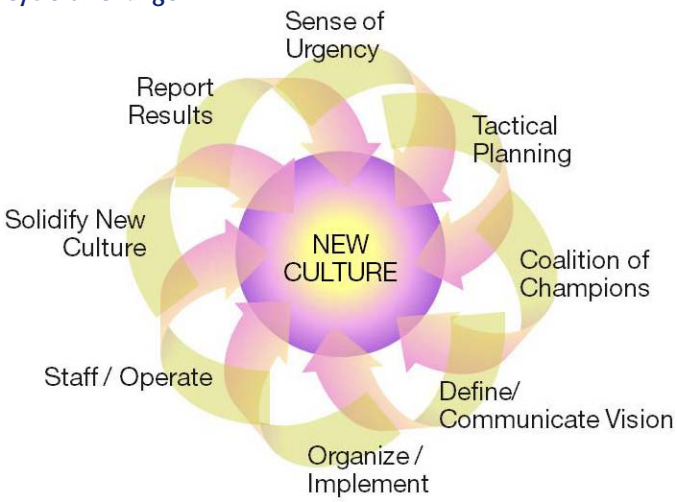
### Cycle of Change



## Overcoming Organizational Inertia

> Continued from page 4

vey and analysis will diffuse momentum.

The results of Step One must elevate the discussion from fault-finding to an understanding of the relationship between components affecting organizational performance. Once identified, issues of substance generally have implications far beyond the need as originally perceived. When the substance of the issues can be clearly stated, move to the next step.

### Step 2 – Define Success

When combined into dashboards or scorecards, relevant statistical ratios for assessing the effectiveness of organizational processes are powerful management tools. The challenge is developing consensus among key stakeholders on key indicators of success that accurately assess prospective success of the change initiative. Application of contemporary business management tools are needed to define success indicators.

Benchmarking against peer groups can be helpful. LEAN/six sigma techniques, such as process mapping and control charts, help illustrate potential solutions. In addition, computer simulation tools can turn volumes of disparate data into useful information.

Multidisciplinary group discussions are needed to define success and provide guidance for the planning process. Keep in mind that the same stakeholders interviewed in the Step 1 discovery process will also have a role in successful implementation of change. By involving a broad array of "key constituents" consensus and momentum builds.

### Step 3 – Determine Form

Process improvement will generally imply changes to the existing allocation of facilities, staff, and technology resources. Facilities and technologies are complementary approaches to improved process efficiency. Staffing and technology can be employed to improve process effectiveness. The planning process uses the success measures for Step 2 to objectively evaluate trade-offs that are inevitable in the world of finite resources.

However, the consideration of various combinations of resources can be daunting. If not careful, spinning in a "re-engineering whirlpool" of quick-wins, and short-term paybacks can diffuse focus on long-range, breakthrough improvement.

Computer modeling can quickly analyze the cost/benefit trade-offs of alternative future business scenarios. In addition, simulation modeling is useful for assessing potential solutions and ruling out unfeasible options.

Virtual "test driving" supports consensus among stakeholders for innovations that have the highest potential impact with the least business risk. A transparent process for review and discussion of analytical results is critical for establishing a broadly acceptable solution.

Armed with consensus on issue substance and ultimate measures of success, the change instigator has outlined the form of a preferred solution supported by a consensus of key stakeholders. The planning process has been refocused beyond perceived need to a solution benefitting the entire organization.

### Mandate for Change

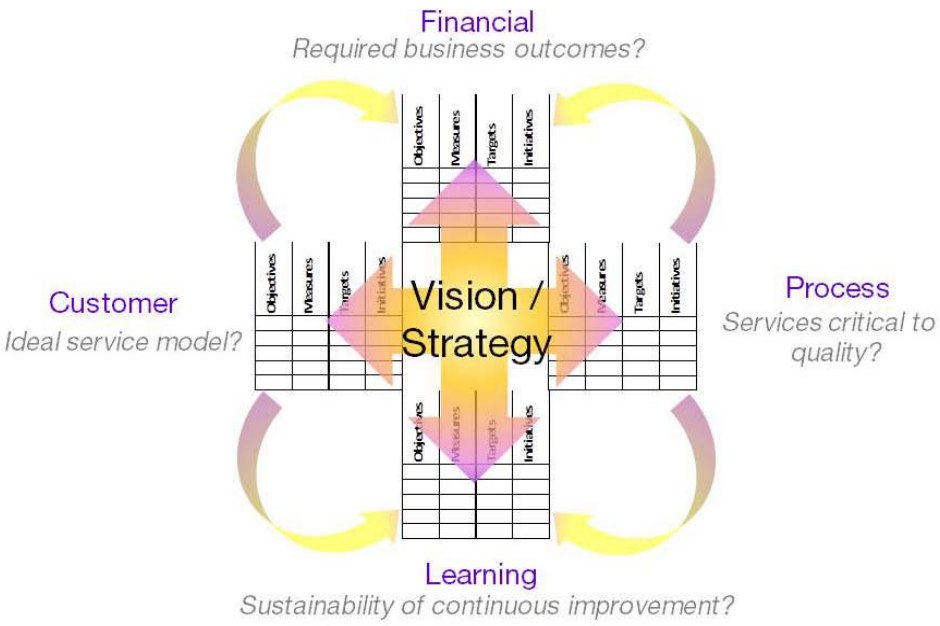
Succinct organization of the planning process provides the information needed for timely decision-making. As evidence is developed, consensus emerges, momentum builds, breakthroughs identified and entrenched inertia is overcome. Inclusivity, instead of exclusivity, creates stakeholder support.

The key is in the execution. The process can build momentum to the point where consensus *about* change is transformed into a mandate for change from such a broad constituency that implementation is inevitable. When that happens, the planning process has been leveraged to instigate change.

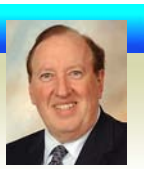
In addition, the organization's cultural approach to planning has been changed. Through experiential learning, the benefits of informed dialogue can now be a defining characteristic of the organization's decision-making culture. ■

*About the author: Mr. Robb has more than 30 years of health care experience with international management consulting and architectural firms. He specializes in application of LEAN/Six Sigma and computer simulation for strategic business and capital asset development planning. Currently a Vice President at FKP Architects, he is a certified health care financial professional and a fellow of the American College of Health care Executives.*

**Balanced Scorecard**



## President's Message



**William Laffey**
*System Director, Cancer Services*
*Aurora Health Care*

**Stop managing – be a leader!** What's the difference?? Well, *leadership* is the key, dynamic force that motivates and coordinates the organization in the accomplishment of its objectives. A *leader* makes frequent use of creative problem solving and imagination to bring about change. *Management* relies on skills such as planning, budget control, and use of information technology. A *manager* tends toward making more frequent use of standard, well-established solutions to problems.

There is nothing wrong with possessing and using management skills. Leaders frequently need to be managers. But don't lose sight of the value you can add to your organization by ***leading.*** Set the organizational agenda; create a sense of urgency; provide a vision; identify and maintain the competence of the organization; establish the expected level of effort; and establish the level of quality. In the 20th century, the focus of work was on performing the right process. In the 21st century, the focus is on obtaining the right outcomes.

In his book, *Developing the Leader Within You,* John Maxwell defined five phases of leadership:

- Position – People follow because they have to
- Permission – People follow because they want to
- Production – People follow because of what you have done for the organization
- People development – People follow because of what you have done for them
- Personhood – People follow because of who you are and what you represent

Wherever you may be in this continuum, strive to reach the next phase. Surround yourself with others who complement your leadership and are strong in areas you may not be. Have the confidence to hire people who are good enough to take over your job some day, and mentor them so they are as prepared as possible.

Be a leader! And don't forget to join your leadership colleagues at the 2012 ACE Annual Meeting in Savannah!! ■



# ACE Executives Contribute to CoC

**Linda W. Ferris, Ph.D.,** ACE President-Elect, was elected Vice Chair of the Accreditation Committee for the ACoS Commission on Cancer at the annual meeting of the CoC during the recent Clinical Congress in San Francisco. Linda will continue in her roll as Chair of the Member Organization Steering Committee for 2012, and as the organization representative on the CoC for the Association of Cancer Executives.

**Bill Laffey,** ACE President, has been named a surveyor for the CoC, the first non-MD program administrator to become a surveyor. Currently a member of the CoC Retention and Recruitment Committee, Bill will survey network cancer programs nationwide beginning in 2012. The CoC is expecting that the addition of an administrator to survey teams will promote the sharing of administrative knowledge among accredited programs. ■

# ACE Member Highlights

**Strode Weaver (University of Colorado Hospital)** presented at ACCC's National Oncology Conference in Seattle, October 21, 2011. Session title: *A Short Case Study on Academic Medicine Joint Strategic Planning.* Mr. Weaver is a member of the ACE Board of Directors.

**Steven Castle** reports that **Thomas Johns Cancer Hospital, CJW Medical Center** has won a 2011 Virginia Healthcare Innovators Award (category: Patient Care, more than 250 employees). The goal of the award is to recognize innovation in healthcare quality and efficiency. The selection was open to all healthcare services and there were 29 nominations from throughout the state. The winning award was for developing a financially viable delivery model with the associated technology to support cancer survivorship services to Institute of Medicine standards. The services can be integrated into any provider's existing structure.

**Teresa Heckel, CHI National Oncology Service Line,** presented at several oncology conferences in 2011:

- On May 4, a poster presentation on CHI's National Oncology Service Line Dashboard Development at the CHI National 2011 Clinical Services, Corporate Responsibility and Risk Management Conference.
- Presented at all three of the Sg2 2011 Annual Cancer Insight Meetings – June 28 in San Francisco, CA; September 14 in Atlanta, GA; and September 20 in Skokie, Il. Topic: *Peer Perspectives: Creating a National Oncology Dashboard.*
- Presented at the CHI National Oncology Conference on July 28, 2011. Topic: *Developing a CHI Model for Breast Center's of Excellence.*

Next year, Ms. Heckel will be presenting at **ACE's 18th Annual Meeting** to be held **January 18–21, 2012,** in Savannah, GA. Topic: *Developing a National Oncology Dashboard.*

She is also scheduled to present at the National Consortium of Breast Center's 21st Annual National Interdisciplinary Breast Center Conference, **March 10–14, 2012,** in Las Vegas. Topic: *Build It and They Will Come: Creating a National Breast Center of Excellence Model.*

Teresa Heckel is a member of the ACE Board of Directors. ■

# ACE Welcome New Members

*As of October 27, 2011*

■ **Deirdre Cahill MHA**
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■ **Phillip Dorsey**
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dorseypm@me.com

■ **Deborah Fleming**
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*CEO*
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*Corporate Vice President*
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sgold@chpnet.org

■ **Kelly Hall, MBA**
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kehall@mhs.net

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■ **Dana Regnier, RN, BS, MHA, FACHE, FAAMA**
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■ **Edward Smith, MHSA**
*Director, Oncology Service Line*
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■ **Holley Stallings, BSN, CPHQ**
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holley.stallings@nortonhealthcare.org

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## YOUR FEEDBACK IS IMPORTANT TO US...

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# Marketing has Found its Big Brother's Warm Embrace

**Brad Fixler,** Associate Director of Marketing, University of Colorado Hospital

*"It was terribly dangerous to let your thoughts wander when you were in any public place or within range of a telescreen. The smallest thing could give you away."*
– George Orwell, 1984

Did you ever see the movie Minority Report? There's a scene where the hero, John Anderton (played by Tom Cruise), walks through a shopping mall while being bombarded with custom advertising messages tailored specifically for him once the technology du jour of corporate America is able to scan his eyes to identify what his previous purchasing behavior has been.

"John Anderton!" one such 3-D ad calls out to him as he rushes by. "You could use a Guinness right about now." He cruises (pun intended) on by and passes another 3-D video screen, this one showing his name and a familiar blue cube with the words "Member Since 2007" displayed. "John Anderton," a serene voice calls trying to get his attention. It's obviously an overture from American Express, although the actual brand isn't identified, which merely means the producers of the movie and the credit card company couldn't come to any agreement on a product placement fee and so they fudged it. But I digress.

While watching this movie when it was released in 2002, I remember being more intrigued by this scene than any other during the film. My thoughts ranged from, "Is this possible? Can we do this soon?" to "I hope we can't do this soon." I was torn, but the scene really stuck. I guess that makes me a marketing geek. The thing is, though, is that we–and I use "we" somewhat pejoratively here–are getting close.

Take internet "retargeting" for example, also referred to as "remarketing." Retargeting is simply a way to reach people based on their previous internet behavior/actions/interests (Fig. 1). Retargeting works like this: a visitor to a particular website gets anonymously tracked by a piece of code embedded in the site, called a cookie. When the user goes to other sites, ads generated from the originating site are served up, trying to attract the user back. As long as the user doesn't clear his/her history or cache, relevant ads can be served for 30 days or even longer. If you think about it, though, this is really not all that different from LL Bean putting you on its forever-and-then-a-bit-longer mailing list after you make a purchase. The subtle difference–and perhaps it's a bit more than just subtle–is that you are targeted, or rather, "cook-

*Continued on page 10 >*

Figure 1


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Thank You!

Contact ACE to learn more about our sponsorship opportunities

## Marketing has Found its Big Brother's Warm Embrace

> Continued from page 9

ied", if you just happen to peruse the website. No purchase necessary.

Okay, so that's level I in the cool-for-marketers, not-quite-sure-if-this-is-cool-for-me-as-a-regular-consumer sweepstakes. But wait, it gets better. Because we also have something called "search retargeting." And, trust me; this really is a nifty little piece of marketing.

Search retargeting uses what I assume is code similar to that with general retargeting because the principal is the same. The main difference is that the cookie is embedded based on what a user is searching for on one of the search engines (Figure 2). So, let's say you do a search for "back pain" on Google, and then you conduct your research, complete it and move on to something else on the internet, like checking out the latest news for instance. On this news site, you might start seeing dynamic display ads for "Apex Spine Center" in your area. That's because Apex Spine Center has engaged in a search retargeting campaign in your market and you've been tagged as someone interested in what they offer based on your recent search.

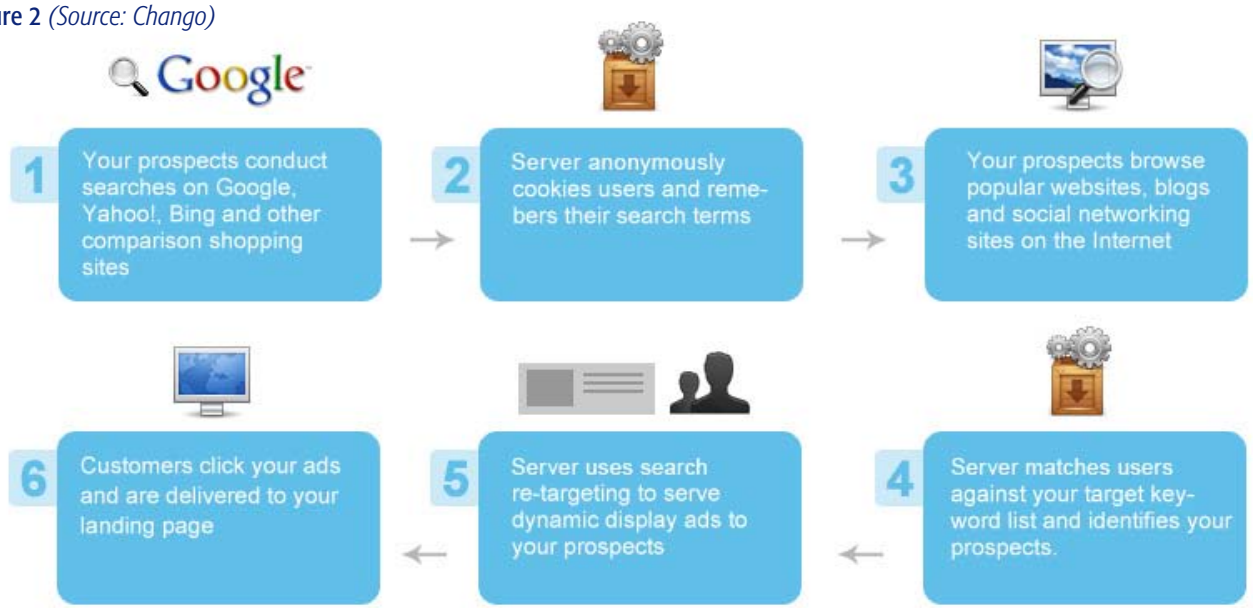
Earlier this year in our marketing department, we were so intrigued by such precise targeting we decided to test a search retargeting campaign among a handful of service lines, cancer included. Without going into too much detail, it was a resounding success in terms of overall web traffic, click-through rates and conversions, providing a true "Eureka!" moment for us.

While search retargeting has been around for some time now, in my opinion only recently has it become refined to the point where it's a truly effective and measurable tool. The reporting we received was remarkable, fulfilling an as-yet unfilled promise of the power of marketing via the internet, pay-per-click notwithstanding. I suppose part of my excitement has as much to do with the creative messaging in the display ads as anything else. Perhaps it's not all about the technology after all. But, to be fair, this is what technology has wrought for us marketers, and, for now, I feel it's very much worth the effort and can produce wonderful results.

Which brings us back to that advertising sequence from Minority Report. If that's where we're headed, then retargeting is merely its prehistoric equivalent. As a marketing professional, I find this notion extraordinary. Although as a consumer, I have to admit it's a little creepy. Perhaps even a lot creepy.

But call me old-fashioned. ■

**Figure 2** *(Source: Chango)*




## ACE THANKS THE 2012 ANNUAL MEETING EXHIBITORS

ACE
ASSOCIATION of CANCER EXECUTIVES

**18TH ANNUAL MEETING**
**JANUARY 18–21, 2012**
SAVANNAH, GEORGIA

Association of Community Cancer Centers
Accuray, Inc.
Altos Solutions, Inc.
American College of Surgeons Commission on Cancer
Aptium Oncology
Bogardus Medical Systems, Inc.
Brainlab
CHAMPS Oncology
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D3 Oncology Solutions
Duke Realty
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Elekta
FKP Architects
GE Healthcare
Oncology Management Consulting Group
Oncology Solutions
Priority Consult
Pyramid Healthcare Solutions
Radiation Business Solutions
Radiation Oncology Consulting
Reflex Oncology Resources
Sky Factory
The Oncology Group
Varian Medical Systems

*– As of December 7, 2011*