Welcome to San Francisco and the 20th Annual Meeting of ACE

As we celebrate the 20th Anniversary of ACE, it is important to look back on all that has happened in cancer care over the past two decades. Who knew about IMRT, IMPT or all of the drugs that have come to market? Many of you were just starting out in your career and others still in elementary school!

In 1995, the Atlanta Braves were on their way to winning the World Series, the San Francisco 49ers, the Super Bowl, and 57 new ACE members gathered in San Antonio for the First Annual Meeting of ACE. At this first meeting, focus groups were held to find out what members wanted from the association. This is still an important aspect of the strategic planning process for our board of directors — we need to hear from you on what you want your organization to be. Many of you take full advantage of the benefits through involvement on committees, annual meeting attendance and participation in our Hot Topics. That is what this organization is all about… networking and sharing expertise.

Please take the opportunity to meet others this week in addition to coming away with all the information the wonderful speakers have to offer.

Diane Cassels, ACE President
Ted Yank, ACE President-elect

How Health Reform is Transforming Cancer Care: Spotlight on Accountable Care Organizations

V. Moysaenko, MD, FACS, Chairman, Cancer Committee, American College of Surgeons, Ohio Chapter
Toni Hare, RHIT, CTR, Vice President, CHAMPS Oncology

Cancer care is evolving. Fueled by passage of the Patient Protection and Affordable Care Act (ACA), healthcare delivery systems are being transformed to ensure care is more patient-centered and integrated. The key organizational structure embodying the ACA’s main objectives — improving healthcare quality and holding down costs — is the formation of accountable care organizations (ACOs).

ACO Background Information

An accountable care organization is a group of providers who come together voluntarily and can be held accountable for the cost and quality of healthcare provided to a defined population. While this concept is not new, what is unique about this reform approach is that ACOs put the focus of accountability for both the cost and quality of care on a local group of providers and delivery systems, rather than an individual provider or insurance company.¹

ACOs hold the common goals of providing healthcare that is coordinated and efficient in the hopes of achieving better health outcomes for patients, an exceptional patient experience and cost savings. To achieve coordinated care, ACOs need to have the ability to care for patients in various institutional settings across the continuum of care.

ACOs are often eligible to receive payments for shared savings if they meet quality performance standards and reduce the rate of growth in health spending. How this is structured varies based on the way the payer sets up the program.² Under some programs, ACOs can also take on greater risk and receive higher shared savings amounts for their performance as well as face the risk of financial losses. As of July 2013 there were 488 active ACOs operating in the U.S.³

ACOs in the Affordable Care Act

As structured under the ACA, Medicare accountable care organizations are defined as healthcare organizations that are primary care focused with a CMS-defined governing body; data management systems; designated integration; administrative infrastructure; and quality and cost control systems. The use of electronic health records and electronic prescribing are encouraged. Several pri-

Food for Thought: Pre- and Postoperation NUTRITION Status Can Help Improve Outcomes for Adult Cancer Patients

Tiffany DeWitt, MS, RD, LD, Research Scientist, Abbott Nutrition

Poor preoperative nutritional status, coupled with delayed and inadequate postoperative nutrition practices, has been associated with worse clinical outcomes, such as increased length of hospital stay and weight loss, among surgical oncology patients.¹² Malnutrition and weight loss impact many patients with cancer. The prevalence of malnutrition can range from as little as 9% in urologic cancers to up to 85% in pancreatic cancers.³⁴ Preparation for surgical procedures include common practices such as keeping patients nil-by-mouth for tests and procedures. Nil-by-mouth status can further contribute to the development of malnutrition and weight loss. In surgical pancreatic oncology patients, weight loss was found to have a significant correlation with increased surgical site infections (P = .026) and longer hospital length of stay (LOS) (P = .035).² Individuals who are malnourished prior to surgery may be at a disadvantage or ill-equipped to recover from the stress of surgery.

See “Nutrition” on page 8 >
Would you like to know how nutrition intervention can help reduce

- Unplanned hospital admissions
- Length of stay
- 30-day hospital readmissions
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References:
Spotlight on Accountable Care Organizations

> Continued from page 1

Mary care focused Medicare ACO reimbursement incentive models are authorized by the federal health reform law.

**Medicare Shared Savings Program**
The Medicare Shared Savings Program is a voluntary ACO demonstration program to help Medicare fee-for-service program providers become organized as ACOs. When an ACO succeeds in meeting quality care measures and reducing healthcare expenditures to benchmark levels it shares with Medicare in the savings it achieves. ACOs in the Medicare Shared Savings Program can choose one of two program tracks, depending on the level of risk they want to assume:

- Shared savings only track
- Shared savings and risk of financial losses

**Advance Payment ACO Model**
An Advance Payment ACO Model is also being tested under the ACA as a way to help smaller ACOs that have more limited access to capital participate in the Medicare Shared Savings Program.

**Pioneer ACO Model**
An initial model, the Pioneer ACO Model, signed on 32 large provider groups known as the “Pioneers” that had experience operating in configurations similar to the ACO model. Applications are no longer being accepted for this program.

**ACO Quality Measures Reporting**
Currently, ACOs authorized under the federal health reform law must report data on 33 evidence-based quality measures that cover the following broad categories: care coordination and patient safety; appropriate use of preventive health services; improved care for at-risk populations; and patient and caregiver experience.

**Oncology Service Line and ACOs**
Healthcare experts have discussed oncology ACOs and how large oncology practices, hospitals and third party payers are exploring those. In the ACA the quality measures that Medicare ACOs must report on are particularly applicable to primary care practices. Of the 33 quality measures, only the preventive measures of breast cancer screening and colorectal cancer screening relate specifically to cancer care – none relate to cancer care treatment. If one examines the CMS definition and the CMS-defined structure of an ACO, it does not allow for a pure cancer care ACO.

Cancer is a top cost driver in healthcare and some estimates suggest that **10 percent of all healthcare costs** are attributable to cancer care, with $124.6 billion spent on cancer treatments in 2010. Given the large chunk of the nation’s healthcare tab that cancer care comprises, many have questioned why cancer care delivery hasn’t been more specifically targeted for achieving ACO cost savings under the ACA models.

What do we know about how oncology care is being incorporated into the ACO structure? In a 2011 survey of health plan and health system executives forming accountable care organizations, 65 percent indicated that oncology services were already employed or closely aligned with their organization and 30 percent had loose affiliations with oncology providers.

Despite the challenges inherent in designing oncology-specific ACOs, large private insurers are actively pursuing oncology ACOs and payment redesign methodologies for oncology services. To date, oncology-specific ACOs are attempting to rein in costs, in particular drug costs, as well as better standardizing care protocols and helping patients wade through the vast amount of information available to them following a diagnosis.

**Oncology-Specific ACOs**
Florida Blue announced in December 2012 that it was launching an ACO specifically for cancer patients being cared for by Moffitt Cancer Center and their 330 oncology practitioners. This move follows on the heels of the insurer’s announcement that it had formed an ACO specific to cancer treatment between a large health system, Baptist Health South Florida, and an oncology group, Advanced Medical Specialties.

Aetna has also been exploring an oncology ACO model for the past few years to highlight the importance of clinical pathways. Results of the insurer’s shared savings partnership with U.S. Oncology Network’s Texas affiliate included:

- Outcomes that were the same or better for participants than for those who were not part of the program
- Decrease in emergency department visits of 39.8 percent
- Decrease in hospital admissions of 16.5 percent
- Cost savings of roughly 12 percent among breast, colorectal and lung cancers alone.

To learn more about how the ACA is impacting cancer care delivery, please stop by CHAMPS Oncology’s booth (#907) to pick up Moysenko and Hart’s cutting-edge paper “How Health Reform Is Transforming U.S. Healthcare: Implications for Cancer Care Providers.”

**Endnotes**

Cancer Care in the Spirit of Accountable Care

Accountable Care Organizations (ACOs) have emerged as a lynchpin of U.S. healthcare reform — with the goal of improving care quality by encouraging efficiencies, streamlining processes, and enhancing coordination among a patient’s providers. The long-term expectation is that ACOs will result in better health outcomes and cost savings from an integrated, performance-based health care delivery system.

The concept behind ACOs makes perfect sense: a patient’s primary care physician — who is the most knowledgeable about the overall health picture — coordinates care among various specialty providers. With one person at the helm and responsible for bringing together the various disciplines, information is shared, duplicative tests and treatments are avoided, and the patient benefits from communication and coordination regarding health issues that are most often related.

But cancer care is more complex, since it is the oncologist and not the primary care physician who manages care and treatment after a diagnosis. Yet, as cancer care professionals across the country have discovered, a targeted approach toward “specialty ACOs” creates an outstanding opportunity for cancer care providers to play an important role in this new model.

Exceptional coordination in the spirit of the new ACOs already exists in the radiation therapy community and can serve as a model for how multidisciplinary collaboration can improve care. For example, treatments delivered in a modern radiotherapy or radiosurgery suite utilize a comprehensive team approach based on coordination and best practices. A team consisting of a radiation oncologist, dosimetrist, medical physicist and a radiation therapy technician work together to share information, devise a treatment plan, and follow the treatment protocols that have been shown to have the best results. Patients benefit from this model, which rapidly delivers the appropriate type of radiotherapy, with either palliative or curative intent, while minimizing harmful side effects that can impact the patient’s post-treatment quality of life.

Integrating our existing cancer care best practices into an ACO treatment model is an increasing focus of providers nationwide, as they aim to ensure patients have ongoing access to quality cancer care under their health plans. Three years ago, 65 percent of respondents at a Cancer Center Business Summit reported the inclusion of oncology providers within their ACO frameworks, and another 30 percent had loose affiliations with cancer care providers.

There are many opportunities for ideas and thoughtful partnerships that benefit cancer patients and meet the goals of ACOs. In Florida, the nationally renowned Moffitt Cancer Center has partnered with Florida Blue (Florida’s Blue Cross and Blue Shield company) to create a cancer-specific accountable care program. Moffitt is the only NCI-designated Comprehensive Cancer Center based in Florida and the Moffitt Medical Group includes 330 cancer practitioners throughout the state who are well equipped to deliver cutting edge radiation therapy treatments like IMRT, IGRT, SABR, SRS, RapidArc™ radiotherapy and radiosurgery, accelerated partial breast irradiation, and four-dimensional radiation therapy. Together, Moffitt and Florida Blue are developing quality metrics for a multiyear program that began this year and are working to further enhance patient care by sharing clinical and administrative claims data.

According to researchers, oncology-specific programs will certainly stand to benefit patients. The Journal of Oncology Practice offers an interesting analogy and a transitional option: “The approach taken by the oncology ACO is similar to the approach taken by the oncology medical home. The oncology ‘medical homes’ provide care for patients by reducing emergency room visits, inpatient admissions…..and provides a promising option for oncologists to dip their feet into the ACO movement.”

As the radiation therapy community and other cancer care providers work toward becoming integral partners of effective ACOs, we at Varian believe it benefits us to draw upon that which we already do well. Information sharing is crucial to streamlining processes and improving care. Varian’s new RapidPlan™ knowledge-based treatment planning has a great deal to offer — it allows clinicians to enter their best cases in terms of achieving clinical objectives in order to develop a “knowledge library” that can inform all subsequent treatment planning activities. Seamless access to this kind of information can help to create a standard of care across an ACO network that puts best practices at the fingertips of the oncologist.

The value that cancer care providers bring to ACOs will play out over time, and certainly in the coming years we can hope to see evidence of improved outcomes, reduced costs and a better overall patient experience. While the path may be a complicated one at times, our providers and professionals are uniquely equipped to lend remarkable technological innovations that continue to improve cancer treatment while preserving the position of the key decision maker — the physician.

References

Exceptional coordination in the spirit of the new ACOs already exists in the radiation therapy community and can serve as a model for how multidisciplinary collaboration can improve care.

By Andy Whitman
Vice President of Government Affairs
Varian Medical Systems
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THREE QUESTIONS with an ACE Member

Teresa Heckel
Director, National Oncology Service Line, Catholic Health Initiatives
Englewood, CO

Stats: Cancer Executive for 22 years. ACE member for 15 years; served on numerous ACE committees and on the Board of Directors, including two terms as Board Secretary. Education: Numerous undergraduate degrees including radiologic technology, radiation therapy and business administration; is currently completing MBA.

What keeps you up at night?
- Preparing for challenges associated with coverage expansion, new payment methodologies and positioning within clinically integrated networks.
- Optimizing physician integration and alignment
- Balancing shrinking margins with the high cost of cancer delivery; how to improve cost savings and increase revenue.
- Creating the right strategy for a national cancer network.

How are you readying your program for quality reporting and pay-for-performance?
- With a focus on improving our data acquisition and analytics capabilities.
- Creation of a national dashboard to monitor local and national performance.
- Utilizing national tumor-specific quality teams to identify key quality measures.
- Initiating conversations with payers — how can we become desirable partners?
- Standardizing our Oncology EHR and Cancer Registry; creating easier data access.

What advice do you have for new cancer executives?
- Partner with your marketing and strategic planning/business development team to perform a full assessment of the oncology program. Identify key strengths, weaknesses, opportunities and threats. Develop strategic and operating plans.
- Develop an Oncology Executive Council to provide overall governance and leadership of the program — also ensures that the program is physician-led and supported by executive leadership.
- Gain full understanding of your cancer registry.
- Perform physician alignment/engagement assessment; ensure strong alignment with all key specialists, identify gaps for recruitment, identify current and future physician leaders.
- Identify key performance measures (financial, operational, quality, patient satisfaction) and develop an oncology dashboard. Discuss performance routinely with physicians, staff and executives.
- Ensure you have the right team on board — you can do anything with a highly engaged, positive, and motivated team.
- And most importantly, don’t try to do this on your own! Network with oncology administrators across the country — there is a wealth of knowledge and oncology leaders are very gracious in sharing. There is no better way to do this than through ACE! Get involved!

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NUTRITION

Continued from page 1

Surgical treatment for gastrointestinal (GI) cancers is common. A recent study investigated the impact of malnutrition on clinical outcomes in surgical patients with GI cancer. The study determined a relationship between preoperative malnutrition and postsurgical adverse outcomes. Because of this relationship, the investigators stress the importance of nutrition screening to help identify patients at risk of malnutrition. By identifying patients at risk, appropriate nutritional intervention can be offered to patients to help improve outcomes.

Garth et al examined certain nutritional status markers and common pre- and postoperative interventions. These included preoperative nutritional status, postoperative intake, and number of days until soft diet commenced during the pre- and postoperative period. The objective was to determine an association with these parameters and clinical outcomes in patients undergoing elective surgery for upper GI or colorectal cancer. A two-part study design was used: the first part consisted of a retrospective medical record review of 95 patients (37 upper GI cancers and 58 colorectal cancers); the second part involved nutritional assessment using the validated Subjective Global Assessment tool prior to surgery in a subset of 25 patients.

Nutrition screening revealed that 48% of the patients were malnourished – 32% were mild-moderately malnourished and 16% were severely malnourished which is consistent with previously reported prevalence data. Mean hospital LOS for malnourished patients was 15.8 days compared with the LOS for well-nourished patients of 7.6 days ($P < .05$). Patients with significant preoperative weight loss compared with those without significant weight loss also had a longer mean hospital LOS, 17 days versus 10 days ($P < .05$). The retrospective medical record review found significantly longer LOS in patients with either weight loss or low albumin levels prior to surgery. Low preoperative albumin and LOS were significant correlated ($r = -0.325$; $P < .05$). There is the possibility to shorten LOS by improving or maintaining the nutritional status of patients preoperatively.

Clinical outcomes were also negatively affected by inadequate postoperative nutrition intervention. Time to meet adequate nutritional status, defined as consuming >75% of daily energy requirements, was measured in patients. Patients who took 7 days or more to achieve adequate nutrition were significantly more likely to experience at least one complication such as wound dehiscence, prolonged postoperative ileus, or wound and urinary tract infections compared with those who achieved adequate nutrition in less than 7 days (52% vs 13%, respectively; $P < .01$). Patients may be discharged soon after tolerating a soft diet but are still not consuming adequate energy intake. In this study, 68% of the patients were consuming less than half of their daily energy requirements at the time of discharge.

Providing nutritional intervention pre- and postoperatively will help ensure patients consume adequate caloric intake and can help correct malnutrition and maintain weight. For GI and colorectal surgical oncology patients, worse clinical outcomes can result when patients have poor preoperative nutrition status and a delay in postoperative nutrition. There is evidence to support identifying the risk of malnutrition early to pro-vide proper intervention. Correcting preoperative malnutrition, limiting nil-by-mouth days, and properly advancing postoperative diets may improve clinical outcomes for surgical oncology patients.

Table. Relationship Between Length of Stay and Nutritional Status in Surgical Patients With Upper GI or Colorectal Cancer

<table>
<thead>
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<th>Nutritional Status</th>
<th>Length of Stay</th>
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<td>Well nourished</td>
<td>7.6 days</td>
</tr>
<tr>
<td>Malnourished</td>
<td>15.8 days</td>
</tr>
<tr>
<td></td>
<td>$P &lt; .05$</td>
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</tbody>
</table>

References

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20 Years of ACE

Join us in celebrating the first 20 years of ACE and begin looking forward to the next two decades at the 20th Anniversary Ball on Friday, January 31.

**A Time Line of ACE Presidents**

1994–95 Marsha Fountain
1996 Sharon MacDonald
1997 Terry McKay
1998 Michael Martin
1999 Brian McCagh
2000 Nancy Harris
2001 Michael Darling
2002 Shirley Johnson
2003 Tim McMahon
2004 Kay Petras
2005 Kim Brodie
2006 Wendy Austin
2007 Susan Brown
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