

ASSOCIATION OF CANCER EXECUTIVES UPDATE

MAY 2024 | www.cancerexecutives.org

WHAT'S INSIDE

PAGE 2

Revolutionizing Oncology Care:
Breaking Free from Inefficiencies

PAGE 3

Redefining Diagnostic
Imaging & Cancer Care: The
Promise of AI Developments
According to Industry Leaders

PAGE 5

From Silos to A Symphony: NewYork-
Presbyterian Talks Orchestrating
Infusion Scheduling with a
Multidisciplinary Team Model

HAVE SOME NEWS TO SHARE?

Please send to Brian Mandrier at
brian@mandriergroup.com



Upcoming Events

IOLC PARIS 2024 EARLY BIRD REGISTRATION NOW OPEN!

We are very excited to announce [registration for IOLC Paris 2024](#). The meeting will be held November 10-12, 2024.

ACE NEW ORLEANS 2025

The [31st ACE Annual Meeting](#) will be held in New Orleans from January 26-28, 2025! Registration and details coming soon.



Announcements & Reminders

ACCEPTING NOMINATIONS!

Accepting nominations for the 7th Annual Marsha Fountain Award for Excellence in Oncology Administration. The award is reserved for nominees currently working in the oncology administration field. [Learn more here.](#)

LOOKING FOR A NEW OPPORTUNITY?

Be sure to visit the [ACE Job Board](#).



association of
cancer
executives

Connecting All
Oncology Leaders

Revolutionizing Oncology Care: Breaking Free from Inefficiencies

BY ALLEN FOUCHT, SENIOR CUSTOMER SUCCESS + EDUCATION MANAGER, MIDMARK RTLS

In oncology, where every moment counts in the fight against cancer, the traditional care delivery landscape is being challenged. As the demand for cancer care surges, healthcare leaders need to identify and address the inefficiencies plaguing the system. Despite the urgency of cancer treatment, patients often find themselves waiting weeks to see a provider, amplifying their anxiety and impacting their treatment outcome.

Consider the statistics: diagnosis to treatment initiation averages 29 days;¹ patients spend over 40 minutes in exam rooms beyond their scheduled time;² infusion chairs are underutilized 82% of the time;³ siloed communication between departments affects staffing for 47% of oncology leaders;² and burnout factors including workload, job stress, and inadequate time to document are felt by 56% of oncology staff.⁴

These inefficiencies not only disrupt the patient's experience but also strain the capacity of oncology clinics.

EMBRACING INNOVATION: THE ROLE OF RTLS

Real-time locating systems (RTLS) have emerged as an innovative solution to streamline oncology workflows. RTLS leverages a network of sensors and badges to provide precise—down to the chair-level—location data of staff, patients and equipment in real time. When both patients and staff wear badges, the RTLS software can help staff have a clear picture of operations, guiding a patient's visit more efficiently.

The precision of RTLS is incredibly important for oncology settings to consider because of cancer care's unique nature. Typical RTLS solutions can only definitively detect room-level location data. High-precision RTLS allows staff to monitor chair-based interactions and treatment times to inform a higher quality care experience.

By automating data collection and workflow activities, RTLS technology that is capable of tracking chair-based care can revolutionize

how oncology teams collaborate and deliver care.

An electronic whiteboard, driven by RTLS location data, displays patient progress to enhance how care teams work together to provide timely care. Answer questions like:

- How long has the patient been in treatment?
- How long has the patient been waiting?
- Who has already seen the patient? Who has not seen them yet?
- How long has the patient been with a staff member?

A digital blueprint of the clinic helps staff locate patients, colleagues and resources in real time. Answer questions like:

- Where is the patient?
- Where is a piece of equipment?
- Which rooms are available?
- Which chairs are available?
- Which rooms or chairs need turnover?

Prompts and alerts help staff keep the patient visit progressing. Streamline workflow activities like:

- Addressing patient wait times proactively.
- Rooming patients more efficiently.
- Keeping care teams in sync with the patient's current stage of care.
- Communicating with the pharmacy that the patient has arrived and is ready for treatment.

Behind the scenes, a wealth of data is collected—providing actionable insights to fuel informed decision-making and process improvements. Answer questions like:

- Are exam rooms or infusion chairs used to their full capacity?
- Could staff and equipment resources be used more effectively?
- Are provider schedules optimized to reflect the time they actually spend with patients?

To make the most use of your data, Midmark RTLS Customer Success Coaches provide expert guidance and clinical intelligence, helping enrich your workflows and

processes with efficiency and results. They help you identify areas of improvement—wait time to utilization—so you can make a positive difference on the care experience.

TRANSFORMING THE ONCOLOGY LANDSCAPE

The path to optimizing oncology care begins with a critical examination of inefficiencies and a commitment to embracing innovative solutions. By leveraging RTLS technology to streamline workflows and enhance resource allocation, oncology leaders can usher in a new era of patient-centric care in the fight against cancer.

SOURCES:

1. "Time to initial cancer treatment in the United States and association with the survival over time: An observational study." *PLoS One*. April 2019.
2. "Measuring the Use of Examination Room Time in Oncology Clinics: A Novel Approach to Assessing Clinic Efficiency and Patient Flow." National Library of Medicine. November 2014.
3. "How Does Your Infusion Center Measure Up?" Association of Community Cancer Centers. 2015.
4. Burnout among Radiation Oncology Providers and Staff in a Large Academic Center. National Library of Medicine. 2020.

Redefining Diagnostic Imaging & Cancer Care: The Promise of AI Developments According to Industry Leaders

BY RON DIGIAMO, MBA, FACHE, AND BRI DRIGGERS

FEATURING OREST BOYKO M.D., PH.D., ABAIR, LAURENCE COURT PH.D.

INTRODUCTION

In the current landscape where technological innovation and healthcare converge, artificial intelligence (AI) stands at the forefront, bringing forth a new era of precision and efficiency in medical diagnostics and treatment strategies. Leaders in the cancer care industry stand at the threshold of harnessing unparalleled opportunities to integrate cutting-edge AI technologies, including large language models, foundational models, and multimodal fusion, among others. These advancements stand to address the challenge of healthcare burnout from repetitive tasks, skilled staffing shortages, and the expectation of continuous breakthrough treatments and cures. We are also presented with a critical opportunity to revolutionize cancer care, transitioning from predictive analytics to comprehensive diagnostics and targeted treatments. Many practices are already employing AI and analytical tools to discern which patients will benefit from specific treatments, qualify for clinical trials, or are predisposed to early-onset conditions. These advancements are both exhilarating and daunting, demanding a thoughtful approach to navigating the complexities of modern cancer care.



Pictured left to right: Dr. Orest Boyko and Dr. Laurence Court

Ron DiGiaino, CEO of Revenue Cycle Coding Strategies, and Bri Driggers, Content Marketing Manager, engage in a thought-provoking dialogue with Dr. Laurence Court, professor in the Department of Radiation Physics, Division of Radiation Oncology at The University of Texas MD Anderson Cancer Center and

Dr. Orest Boyko, Diagnostic Radiologist and Chief Scientific Officer for the American Board of Artificial Intelligence in Healthcare, both of whom stand at the forefront of integrating AI within their realms, speak on how AI is affecting their spheres of influence

Q: You both work in healthcare and represent Physics in Radiation Oncology as well as Radiology. How is AI currently being utilized in your respective fields, and what future advancements are you most excited or concerned about?

Dr. Laurence Court: “In radiation therapy, AI is not just a tool; it’s a game-changer. We’re leveraging AI to tailor treatments to individual patients, optimizing doses while sparing healthy tissue. The future? I’m looking towards AI’s potential to make these sophisticated treatments accessible worldwide, especially in low-resource settings.”

Dr. Orest Boyko: “Diagnostic radiology has been transformed by AI, particularly in how we interpret imaging studies. AI helps us detect patterns that would otherwise take more time for the human eye to pick up on, making our diagnoses more precise. My greatest anticipation is for AI to further personalize medicine, though it comes with a caveat—ensuring these technologies are robustly validated before widespread adoption.”

Q: There are many real and perceived concerns and maybe even fears of AI. What are the major challenges and ethical considerations facing the adoption of AI in healthcare?

Dr. Court: “One of our biggest challenges is ensuring the safety and accuracy of AI applications. There’s also the ethical dimension—maintaining patient privacy and avoiding biases in AI algorithms that could influence treatment outcomes.”

Dr. Boyko: “The ethical implications are profound, especially concerning data use and patient consent. Additionally, we must guard against creating a digital divide in healthcare, where only patients in high-income areas benefit from AI advancements.”

Q: There are material lack of access issues not only in the United States but also around the world. Lack of insurance affects low income and other disparities that are social determinants of health are major issues that affect most countries. How can AI improve healthcare accessibility in underserved or remote areas?

Dr. Court: “AI has the potential to bridge the gap in global health disparities. By bringing expert-level diagnostics and treatment planning to remote areas, we can offer high-quality care where it’s needed most.”

Dr. Boyko: “In diagnostic radiology, AI tools can support healthcare professionals in regions lacking specialists, ensuring patients receive timely and accurate diagnoses. This is a step towards democratizing healthcare access.”

Q: It has been said in various ways that AI will not replace Healthcare Workers but it will replace those that don’t adopt AI. We have discussed throughout our conversation that you agree with this position, as such; what steps should healthcare professionals take to adapt to AI-driven technologies in their practice?

Dr. Court: “Healthcare professionals should embrace a mindset of continuous learning. It’s crucial to understand not just how to use AI tools, but also the principles behind them. This knowledge empowers clinicians to make informed decisions about when and how to incorporate AI into patient care.”

Dr. Boyko: “Integration of AI into medical education and healthcare is essential. Future and current healthcare providers

need to be proficient in AI technologies to ensure they can leverage these tools effectively. This includes understanding the limitations of AI and the ethical considerations in its application.”

Q: As two prominent experts in AI: What does the future hold for healthcare with the integration of AI, and how will it affect healthcare professionals and patients?

Dr. Court: “The future is promising. AI will enable us to offer personalized, efficient, and accessible care to a wider population. It’s not about replacing healthcare professionals but augmenting their capabilities to serve patients better. The key will be in finding the right balance between human touch and technological innovation.”

Dr. Boyko: “We’re looking at a future where AI significantly enhances patient outcomes through precision medicine. Healthcare professionals will need to adapt to new roles where their expertise is used in tandem with AI, ensuring that patient care remains compassionate and individualized.”

CONCLUSION

Dr. Laurence Court and Dr. Orest Boyko’s insights point to an important shift in healthcare: integrating more AI into oncology and radiology practices. Looking ahead, AI promises to significantly improve patient care, efficiency, and access to treatment worldwide. However, this future requires healthcare professionals to adapt and ensure that patient care remains central to technological advancements. The introduction of AI in healthcare is just beginning, but its impact could revolutionize how we approach cancer treatment, making it more effective, personalized, and fair.

We are pleased to announce the following new members and renewals!

Marylou Anton, Sidney Kimmel Cancer Center - Jefferson Health

Hannah Batakis, Oregon Oncology Specialists

Paul Berkson, Akumin

Kevin Billingsley, Yale School of Medicine

Tina Bowdish, Vanderbilt University/Ingram Cancer Center

Danielle Brown, Florida Cancer Specialist

Natacha Caballero, Sylvester Comprehensive Cancer Center

Gregory Calosso, Dana-Farber Cancer Institute

Claire Cote, New England Cancer Specialists

Ellen Feinstein, Advocate Health

Jennifer Foltz, Hendricks Regional Health

Steven Friedman, National Institutes of Health

Jennifer Hasbrook, Sarah Cannon/HCA

Danielle Hoffman, PennMedicine

Carol Huijbregtse, Advocate Health

Melissa Higdon, Wellstar Health System

Sean Hobson, Dartmouth Cancer Center

Kathy Jennings, St. Elizabeth Healthcare

Judy Koutlas, Sarah Cannon Cancer Institute

Kassandra Lage, Sylvester Comprehensive Cancer Center

Rochelle Lonn, Sutter Health

Ashley Lovingood, The O'Neal Cancer Center at UAB

Dawn Miller, City of Hope Medical Center

Madelyn Van Tassel, Henry Ford Health

Ariel Zhu, The Chartis Group

From Silos to A Symphony: NewYork-Presbyterian Talks Orchestrating Infusion Scheduling with a Multidisciplinary Team Model

NewYork-Presbyterian, one of the nation's most comprehensive and integrated academic healthcare systems, is at the forefront of cancer care. In partnership with two renowned medical schools, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons, it offers a network of infusion centers across three boroughs - Brooklyn, Manhattan, and Queens.

Columbia's Herbert Irving Comprehensive Cancer Center (HICCC), one of only 51 National Cancer Institute (NCI)-designated comprehensive cancer centers, and Weill Cornell's Meyer Cancer Center, a multidisciplinary care network, are key components of this system. These centers, with their state-of-the-art facilities and patient-centric approach, exemplify NewYork-Presbyterian's commitment to providing top-tier cancer care.

HICCC Infusion Profile:

- Oncology Unit: 49 chairs, 4 fast track
- Non-Oncology Unit: 9 chairs, 3 fast track

- Research Unit: 9 chairs
- Epic EHR

Meyer Cancer Center Infusion Profile:

- Starr Adult Infusion Center (Oncology): 34 chairs, 6 fast track
- DHK4 Infusion Center: 20 chairs, including Phase 1 clinical trials
- BMT Day Hospital: 8 chairs, post-stem cell transplant treatment
- Epic EHR

In a recent interview, Justin Ngai, MSN, RN-BC, NE-BC (Operations Manager Adult Infusion Centers, NewYork-Presbyterian Columbia University Irving Medical Center) and Celsus Auguiste, MSN, RN (Patient Care Director, New York-Presbyterian Weill Cornell Medical Center) discussed the multidisciplinary operations improvement initiative they undertook throughout their centers, aligning clinical and non-clinical teams on a patient-centered, streamlined approach with the support of predictive AI technology.

These initiatives led to the addition of 9,000 more appointments, a zero waitlist with 600 appointments eliminated, and an additional annualized 7,750 treatment and 1,250 lab appointments generated from schedule enhancements.

1. WHO ARE THE PATIENT COMMUNITIES YOU SERVE AT YOUR INFUSION CENTERS?

Auguiste: Our infusion centers are in the heart of New York. Starr Infusion is world-renowned, and patients come from all over to receive care at both our infusion centers. We give a very diverse mix of treatments, oncology and non-oncology, and almost all types of infusions.

Ngai: We serve unique communities here at Columbia: the community that seeks out our physicians for their expertise in their fields, the surrounding underserved Washington Heights community that faces various health disparities, and the NYP ambulatory care network that refers community patients to us.

2. WHAT CHALLENGES WERE YOUR INFUSION CENTERS EXPERIENCING THAT MADE YOU REALIZE FOSTERING A MULTIDISCIPLINARY INFUSION OPERATIONS TEAM WAS THE RIGHT SOLUTION?

Ngai: There are many moving pieces involved in running an infusion center to deliver care, and just as many teams are responsible for them. From our admin team that manages the front-end schedulers, to the physicians, to the clinical infusion nurses and managers, we lacked a strong and consistent collaboration among departments or air traffic control. The complexity of bridging them all together is an art in itself.

My position was created to help bolster collaborative efforts with these various departments. As a clinician in a non-clinical role, I can help bridge the gap between clinical nuances and the nonclinical workflows, so all our teams can work together to solve problems effectively.

When we see a problem like excessive wait times, we must examine how interwoven the processes are from every team involved, from the physician to their practice management and then the infusion center side. We needed a team that could understand and break those high-level problems down to show how everyone's role was critical in solving them.

Auguste: A pain point at Starr Infusion was midday congestion. We'd try to understand why chairs couldn't turn over efficiently between 10:00AM to 3:00PM. Realizing we had to fix this issue, which resulted from how we scheduled linked appointments, led us to the multidisciplinary infusion operations approach.

3. HOW DID YOU OBTAIN AND SUSTAIN BUY-IN FROM ALL YOUR STAKEHOLDERS AS YOU CREATED AND IMPLEMENTED YOUR MULTIDISCIPLINARY TEAM APPROACH?

Ngai: I shadowed the different roles, from the patient's point of entry to when they finish treatment, to find opportunities to bring non-clinical and clinical teams together. Now we can address problems with all different clinical and non-clinical perspectives at the table.

To support their buy-in, we always ask our team members, "how does this change benefit you?" Schedulers buy into scheduling updates, for instance, when they realize those changes will streamline the work they do.

It helps that everyone at this organization keeps the patient at the center. Highlighting how the changes in how we work and collaborate will impact the patient – whether it's lower wait times or increased accountability on the different moving pieces of the treatment – really drives home the "why." We can come through any discussion or conflict with a positive outcome that way.

Auguste: Buy-in and collaboration come from open communication. Establishing a channel to facilitate that communication was key for the leadership and our team. We made sure the feedback from the front line staff was fully heard and involved in any changes happening on our end, like template updates or new hires.

4. HOW DID TECHNOLOGY AND DIGITAL SOLUTIONS SUPPORT THIS ONGOING COLLABORATION AND COMMUNICATION?

Ngai: LeanTaaS' iQueue for Infusion Centers solution has been at the forefront for the infusion centers here at NYP, especially for building the right templates we can all align on together to set the stage for success. There's a lot of math involved in mapping out the chair utilization and chair loads for optimal patient throughput.

iQueue not only helps with the scheduling build of the cascade of appointment starts, but also lets us drill down on specific numbers and metrics for our operational efficiency.

Auguste: Implementing and utilizing iQueue has been instrumental, especially

as I meet with provider leadership. I can use the technology to share real time data with them in one or two clicks, without having to dig for it. I can show leaders what's happening in real time, the benefits we'll see if we can make the changes I might be pushing for or challenges we're facing.

This helps the team in general, because when we have provider buy-in, we have the voice of the institution. Because our department is using LeanTaaS, we have the eyes of the VP that oversees us. The CEO is also interested in what's happening in outpatient oncology, on my end and for the entire institution. There's a lot of data we can use to show there's room for growth, and growth means more money as well as access.

5. WHAT'S THE IMPACT YOU'VE SEEN ON CARE ACCESS, ESPECIALLY FOR UNDERSERVED COMMUNITIES?

Auguiste: With more data, using iQueue together, we can better utilize our infusion schedule. My center was open seven days a week and with one or two patients on Sundays and fewer than eight patients per day on a Saturday. Now we're averaging over 30 patients on those weekends. Clearly we're better utilizing our schedule, and that's also improved patient satisfaction.

So we have a more balanced schedule, we have more patients on the schedule, we see more volume. We're overall in a better place than we were previously. This shows our efforts are working.

We're also able to see the good we're doing for our community. All our physicians and providers have signed an equity contract. Our centers shouldn't turn any patients away, regardless if they're on Medicare or Medicaid instead of commercial insurance. By collaborating and using our data tools, we could make sure other infusion centers did not disproportionately offload their Medicare and Medicaid patients to our site. **Ngai:** Our center is only open Monday through Friday, which is hard when many of our patients work. Finding opportunities

for appointments at off-work hours is an important part of addressing and increasing improving access to care. The last thing someone may need when they're in financial constraints is to take off from work so they can go to treatment.

Using the data we have to show the availability that we can create out of those off hours is very compelling. If we pulled the data, we could show you an X percent increase in off-peak hour utilization as well as the availability shifts into those hours after realigning our scheduling templates.

6. WHAT FURTHER ROLES HAVE DATA AND PERFORMANCE METRICS FROM IQUEUE HAD IN DRIVING EFFICIENCY AND IMPROVEMENT TO CARE ACCESS?

Ngai: Filtering raw data shows our areas for opportunity. We use quite a lot of metrics from iQueue and other sources to show the distribution of appointments across weekdays to bucketed times of the day. These show how we have different times available that we need to leverage for more appointments.

Executing process improvements around specific data points is also important. Celsus and I have been working on standardizing patient treatment status across their journey, so we can differentiate specific points on the throughput and identify where we should focus to improve the overall wait time.

Auguiste: Our current goal is to expand operating hours from 10 per day to 12. We hope to add many more patients in those two hours. The reason that we can change the timing for additional staff, or have schedulers start nurses at different times, is because we have the data to show there is both room and need to use our infusion center.

We can point to the data that shows we still have still requests, patients who would be turned away, and many add-ons, and say we do have room to grow the infusion center. This couldn't happen if we didn't have a full review of the information.

7. WHAT ADVICE WOULD YOU HAVE FOR AN INFUSION CENTER THAT'S LOOKING TO START AN OPERATIONS IMPROVEMENT INITIATIVE, OR IS IN THE MIDDLE OF ONE?

Ngai: It's important to listen to the stakeholders, including patients, about their biggest pain points.

Also, changes in complex healthcare settings like ours should really be focused on being data guided, rather than being purely data driven. Looking at data holistically, and accounting for the perspectives of all the people involved, is crucial to making a sustainable and successful change initiative in an infusion center.

Auguiste: Leveraging that data is essential to get buy-in from providers and senior leadership. This was key to us reaping the benefits we did. iQueue was already implemented at our center, so it was easy for us to use the solution to execute changes.

It's also crucial to establish clear, standardized protocols amongst your scheduling team, your frontline team, nursing teams, etc., so they understand their responsibilities. This is how to get feedback, minimize confusion, and streamline operations. This is where we see results.

HAVE SOME NEWS TO SHARE?

Please send to Brian Mandrier at brian@mandriergroup.com or tag us on social!



GET INVOLVED! JOIN A STANDING COMMITTEE

If you are a member in good standing and interested in joining a committee please contact Brian Mandrier, Executive Director, brian@mandriergroup.com.

Standing Committees:



Bylaws & Election

This committee is charged with recommending and maintaining current and thorough bylaws for the organization and coordinating the conduct of the annual election process in a manner consistent with established bylaws.



Conference Planning

This committee is charged with developing, implementing, and evaluating the success of organizational initiatives directed at enhancing its members' knowledge, skills, and competencies.



Fellowship Committee

This committee is charged with increasing oversight of the Fellowship Committee.



Membership & Member Services

This committee is charged with increasing the membership of the organization along with with all matters regarding membership services — resources, website, communications, and more.



Communications

This committee is charged with supporting the efforts of the ACE Newsletter Editor and assisting with the development of written publications that promote the organization.



Vendor Relations

This committee enhances and maintains productive and mutually beneficial relationships with vendors to maximize their financial support of organizational initiatives and conferences.