Cancer Center Business Summit

Business and Science: Lessons From the 2011 Cancer Center Business Summit

By John V. Cox, DO, MBA, FACP, and Elaine L. Towle

This issue of *Journal of Oncology Practice* presents a special series, including abstracts and two primary articles, derived from the fifth annual Cancer Center Business Summit convened in Chicago in October 2011.¹ The theme of the meeting was achieving accountable cancer care. The meeting is co-operatively hosted by three organizations: the health care section of the law firm Foley & Lardner, LLP; Altos Solutions, through their Oncology Metrics division; and the Cancer Center Business Development Group. Over the past 2 years, ASCO has been an active participant in the planning group for the meeting.

What is striking about the meeting is the eclectic membership of the planning committee and the audience the meeting serves. Represented are large and small oncology practices, financial firms, a host of consultancies, academic medical centers, community health systems, analytic firms, health information technology firms, and more. Attendees include oncologists of all stripes, nurse managers, administrators and service line managers, pharmacists, and an array of business representatives. On reflection, this diversity of attendees is understandable. To coordinate and run an oncology practice—whether institutional or community, privately owned or hospital employed—requires more than a “village” of support, and many transactions. The astute oncology practice will ask for help and tap into professional advisors and knowledgeable colleagues frequently. No longer can a practitioner look forward to a career served in a single, stable practice model. One has to re-evaluate the market place regularly and embrace change.

How does this affect our profession and our professional organization? What role can clinicians play in these business conversations? At the end of the day, oncology practice is about patient care: the interaction of an oncologist with a given patient. We know that this interaction requires skill on the part of oncologists, as well as a supportive clinical team to provide and implement a coordinated treatment plan. Our profession’s strengths over the years (and ASCO’s strengths) are its focus on the interactions between the care team and patient and advocating for quality oncology care. ASCO provides a wealth of educational offerings to support the development of clinical decisions, to educate oncologists on how to communicate effectively with the patient, and to define what quality means in oncology.

However, as the delivery of oncology care becomes ever more complex, oncologists who wish to effectively advocate for access to quality oncology care will require a deeper understanding and working knowledge of the myriad business

and transactional forces that shape our practice structures. These include all of the business and commercial entities and skills that are represented in the attendees and planners of the Cancer Center Business Summit.

ASCO’s involvement in the Business Summit has a virtuous motivation. The multiple business-oriented folk that support our practices must develop an understanding about how oncologists think, how clinical decisions are made, and the complexity of the patient-doctor relationship. Indeed, the entirety of how oncologists process information and assess its validity is based on our science, yet often business information and data do not conform to the rules or rigor that we apply to a scientific experiment. Conflicting data and information are common in the marketplace, but oncologists are not familiar with the available methods that can provide a framework to resolve such conflicts. Might the transparent methodologies of our science have something to offer the business communities that support us?

It was in this spirit that before the 2011 Business Summit, the planning group decided to approach a portion of this business-oriented meeting in a similar fashion to how we approach a scientific meeting. A call for abstracts was developed, and businesses, practices, and institutions were invited to submit work that described new methods for dealing with problems or best practices that were working in their settings. Clearly, this set a new tone for the meeting.

In this issue of *JOP*, we present nine accepted abstracts from the 2011 Business Summit. The topics are diverse, ranging from an approach using telemedicine to cover under-served rural areas, to a quantitative analytic for dealing with operating room inventory management, to a framework for practices that might enable them to survive in reimbursement models in which there is no margin on drugs. In addition, two of the meeting organizers present articles that were derived from talks at the Business Summit. Barkley presents survey results gathered from high-performing systems, divining attitudes and plans concerning the development of new payment models for care. Blau provides a legal analysis and assessment of oncology professional service agreements as tools to preserve practice autonomy in affiliation with institutions.

This process will be repeated in the 2012 Business Summit. The organizers hope that the meeting will blend the diverse business-related information needed to support a practice with the scientific spirit of open communication and critical assessment.

Accepted for publication on January 26, 2012.

Authors' Disclosures of Potential Conflicts of Interest

Although all authors completed the disclosure declaration, the following author(s) indicated a financial or other interest that is relevant to the subject matter under consideration in this article. Certain relationships marked with a "U" are those for which no compensation was received; those relationships marked with a "C" were compensated. For a detailed description of the disclosure categories, or for more information about ASCO's conflict of interest policy, please refer to the Author Disclosure Declaration and the Disclosures of Potential Conflicts of Interest section in Information for Contributors.

Employment or Leadership Position: John V. Cox, Cancer Center Business Summit (U); Elaine L. Towle, Altos Solutions (C) **Consultant or Advisory Role:** John V. Cox, Cancer Center Business Summit (U) **Stock Ownership:** None **Honoraria:** None **Research Funding:**

None **Expert Testimony:** None **Other Remuneration:** None

Author Contributions

Conception and design: John V. Cox

Administrative support: John V. Cox

Manuscript writing: All authors

Final approval of manuscript: All authors

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DOI: 10.1200/JOP.2012.000584

Reference

1. Cancer Center Business Summit. <http://www.cancerbusinesssummit.com/program.htm>

Abstracts

Extending Oncology Clinical Services to Rural Areas of Texas Via Teleoncology

By Jivesh J. Sharma, MD, Gary Gross, MD, and Poonam Sharma, PhD

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Purpose: For patients in rural Texas, accessing cancer specialists is quite challenging. Texas has many remote areas without community-based cancer care, requiring patients to travel long distances for specialized cancer professional consultations and services. An anticipated shortage of medical oncology expertise will exacerbate this situation. The advent of telemedicine tools has created an opportunity to easily extend specialized cancer services to underserved populations of patients with cancer in Texas. However, more research is needed to explore how well telemedicine tools will be accepted and used by both patients and oncologists alike. Data suggesting that teleoncology services are well accepted and liked by patients and health care professionals would provide a basis for expanding this method of delivering care. If effective, telemedicine tools could help patients with cancer in rural Texas, and throughout the United States, access the same quality of cancer care as their counterparts living in urban areas.

Methods: This pilot study will compare the effectiveness and reliability of remote oncologic clinical evaluations conducted via a telemedicine application with the traditional method of onsite evaluations in a private practice setting in rural East Texas. Patient and physician satisfaction with the clinical consultations and their perceptions of the telemedicine application will be assessed using a questionnaire administered at the conclusion of the clinical meetings.

Results: Initial results indicate high patient and physician satisfaction scores as well as high reliability and adequacy of the equipment and technology being used.

Conclusion: Both patients and physicians are highly satisfied with the quality of teleoncology examinations and express openness to this method of delivering care.

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DOI: 10.1200/JOP.2011.000436

Quantitative Analysis of Operating Room Inventory Management Practices at a Tertiary Cancer Center

By Faye A. Queresly, MD, MBA, FRCS(C), and Joseph Milner, PhD

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Purpose: In Ontario, health care spending has grown to 45% of total government expenditures. In a public health care system, changes in demographics and the emergence of innovative technologies challenge our ability to adapt to evolving patient needs. To maintain a high standard of clinical effectiveness, there is a need to identify opportunities to improve health care delivery. This study was structured to meet the following objectives: to understand the operating room (OR) inventory practices at a tertiary academic hospital, to mathematically model this process to ascertain service levels based on changes in inventory and demand, and to define the appropriate level of reusable inventory for open and laparoscopic colorectal surgery.

Methods: We retrospectively reviewed OR throughput for all cases of colorectal cancer from January 1, 2010, to January 31, 2011. The process flow of OR instrumentation was studied to understand delays in the provision of inventory. Combining total surgeries performed with surgeon-specific instrument preferences generated daily instrument demand. We fitted parametric demand distributions for two instrument sets for major colon resections. Markovian models were used to estimate the distribution of available inventory and the likelihood of insufficient instruments on any given day.

Results: We reviewed 1,458 cases, 39.5% of which involved major open surgery, whereas 26.2% involved laparoscopic surgery. Demand for open and laparoscopic instrument sets was observed to fit binomial (20, 0.15) and Poisson (1.41) distributions, respectively. On the basis of these curves, we estimated the probability distribution of the in-stock inventory and, subsequently, the probability that demand would exceed supply on any given day (Table 1). In particular, with 10 open and six laparoscopic sets currently owned by the institution, the probabilities that there would be insufficient inventory were 3.02% and 2.17%, respectively.

Conclusion: This analysis will guide purchasing decisions based on desired service levels and forecasted changes in demand. Furthermore, by ensuring that demand is being serviced, this analysis will help to curb loss of revenue, decrease wait times, and limit potential patient morbidity. Strategic purchasing can also reduce excessive inventory and therefore minimize shrinkage and obsolescence and increase working capital and institutional flexibility.