Initially, there were two rooms and seven doctors, including two endocrine surgeons and two endocrinologists. Slowly they were able to bring in more doctors and get support from the University. Now there is just more than Dr. Hammer seeing adrenal cancer patients. In one day, Dr. Hammer says he may see five to 10 patients. At the clinic the experts are all together one day a week, and they now offer a remote second opinion telemedicine kind of platform for patients who can’t travel.

Because adrenal cancer is rare, there has been less development of multidisciplinary programs. Adrenal is such a niche market that the UM now sees patients from Australia, Africa, Europe, and Hong Kong. Dr. Hammer says the UM has a multidisciplinary program of excellence that’s coupled with a scientific program that grows the new therapies.

“I think that requires time because you need both the scientific and clinical expertise, and so ideally you’re at a place that allows you to grow both pieces so you can attract people from around the world to join your team, but that’s taken 15 years to do,” he says.

“For me personally, it’s been a privilege, I guess is the way to say it, and to be given the opportunity… and the fact that patients have entrusted their care in me is quite a privilege, and it’s a driving force, I think, to make a difference in people’s lives and for rare cancers in general,” he says.

References

Using Communication to Reduce Healthcare Expenditures in Radiation Oncology and Imaging Services

By Michael Peters, MBA, CSSBB, R.T(R)(T)

In today’s healthcare environment it’s easy to see how technology impacts overall expenditures to meet growing demand for, and improved quality of, care. Thanks to continuous technology development we are able to diagnose and treat patients earlier than ever before. New technologies are evolving diagnostic imaging and radiation oncology options.

While such advances often improve cancer care and save lives, overuse or misuse inflates cost and can result in subsequent illness. Meanwhile, payers and physicians face ongoing challenges in keeping up with the latest medical evidence.

Controlling treatment cost and improving quality have become imperative not only for payers, but also for healthcare providers and patients. The effort to keep cancer care affordable and accessible while ensuring quality and safety are priorities of the Affordable Care Act.

As we look to the future of health care in the United States, we cannot improve outcomes and lower costs without the lens that medical imaging and minimally invasive radiotherapy provide. With an estimated 1.66 million Americans diagnosed with cancer in 2014 alone and malignancies claiming roughly 580,000 lives annually,1 access to imaging services is essential for diagnosing cancer when it is most treatable and enabling physicians to determine if a therapy is working. Medical imaging also plays an integral role in therapeutic treatments offering highly personalized, non-invasive and cost-effective care for 50–60% of all diagnosed cancer patients today.2

How can we improve earlier cancer screenings, increase quality of technology, and manage a department more cost effectively in order to better serve our patient population with a greater chance of cure through earlier diagnosis?

Based on my experience, I believe the answer lies in better communication between a more united, less siloed environment within radiation oncology and diagnostic imaging departments. Being on the healthcare provider side for 15 years in imaging and oncology, and having spent the past five years providing consulting services for diagnostic and therapeutic vendors, I’ve witnessed a communication disconnect between both service lines when it comes to capital imaging purchases.

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1. Michael Peters has spent more than 20 years seeking to understand and influence the healthcare industry as a healthcare administrator and an industry consultant. He is an outspoken advocate for patient-centered care and delivers innovative yet pragmatic solutions to his clients’ problems.
Case scenarios

To support my assertion, I provide two examples that I have experienced within my past five years of consulting.

Example 1: The radiation oncology department requested capital dollars to replace a 4 Slice CT Scanner with a 16 Slice Scanner. The radiology department wanted to replace a 64 Slice Wide Bore (owned by the hospital) with a 128 Slice Low Dose Scanner. Both departments worked out a separate pro forma, scoped out competitive bids for new and refurbished units, and provided a competitive analysis of the surrounding market. What they didn’t do was communicate internally to see strategically where each department was headed. In the end, the radiation oncology department acquired the hospital 64 Slice Scanner at residual cost, while the imaging department received the residual monetary interdepartmental transfer of funds toward a new 128 Slice Scanner.

Example 2: An oncology service line wanted to replace a contracted mobile PET/CT with a purchased fixed unit in the oncology service area. The imaging department wanted to put any new PET/CT deep within the hospital in the imaging department to use for cardiac and neurodegenerative disorder cases in addition to oncology. The imaging department reflected on the need to share staff between PET and nuclear medicine as a secondary qualifier. The radiation oncology department felt that statistically the primary case mix load was outpatient oncology-related procedures, and needed to be easily accessible to patients and physicians. What transpired was the institution seeing a decrease in PET/CT volume compared to that of its mobile unit due to difficulty of access within the hospital imaging department as well as the decision not to pursue cardiac imaging on the PET/CT.

Analysis

The first example may have ended with a win-win for both departments. Initially, the hospital’s CFO declined both requests. Upon receiving the denial, the two departmental administrators connected, discussed the scenario of an interdepartmental transfer of the 64 Slice CT, and prepared a new pro forma, which was approved the following year. If both administrators had met and discussed their capital request and departmental needs sooner, they could have achieved a desirable outcome a year earlier.

In the second example, both directors had extensive discussions stating their need for the PET/CT unit in their own department. What transpired was an unwillingness to work together and compromise. As a result, there was decreased patient volume from the prior year, patient attrition, and failure to meet the proposed ROI. The issue to this scenario was not lack of engagement, but rather failure to listen and understand. Better communication around patient flow versus staff flow would have been valuable in this instance, as well as communication with referring physicians to see if their patients would find the impact of access an issue.

To support what I perceived as a communication disconnect between both service lines, I initiated an online survey, which was sent to medical imaging and radiation oncology professionals working in administration. The survey was designed to find out how effective internal communication was between both service lines. Fifty-one (51) oncology service line administrators and 27 imaging service line administrators responded. The survey results are summarized below.

Market research

Nearly 40% of radiation oncology (RO) and 37% diagnostic imaging (DI) administrators felt that there was no open communication between the two service lines with regard to technology acquisition (Figures 1 and 2). The survey results suggest most respondents felt that there is at least some level of effective communication between the two groups, but that further opportunities to enhance communication exist.

Figure 1: From RO’s perspective, is there open communication between DI and RO regarding new technology in order to see how purchase impacts both service lines?

Figure 2: From DI’s perspective, is there open communication between DI and RO regarding new technology in order to see how purchase impacts both service lines?
In Figure 3, the responses received suggest that diagnostic imaging administrators are more amenable to placing shared technology in a radiation oncology department, whereas radiation oncology administrators prefer to place shared technology in a diagnostic imaging department for the sake of cost savings.

**Figure 3:** To save costs and obtain new imaging equipment, would you consider sharing and having the technology installed in the DI Department/RO Department?

![Bar chart](chart1.png)

Diagnostic imaging administrators and radiation oncology administrators reported that funding is allocated toward new business development, while radiation oncology administrators reported that funding is directed toward technology replacement. This may not be surprising given that radiation oncology typically does not receive capital for technology purchases as often as diagnostic imaging does. When radiation oncology receives capital, it is geared toward replacement due to age, more than for new business initiatives (Figure 4).

**Figure 4:** How is capital allocated/prioritized between the two service lines?

![Bar chart](chart2.png)

Survey respondents were asked if services fall under a single service line structure. Eighty-four (84) percent of radiation oncology administrators and 88% of diagnostic imaging administrators said they did not (i.e., the services were separate) (Figure 5).

**Figure 5:** Are DI and RO under the same service line?

![Bar chart](chart3.png)

Diagnostic imaging administrators and radiation oncology administrators definitively reported that they had multiple areas or departments reporting under them, most notably the breast center. The survey results showed that radiation oncology administrators and diagnostic imaging administrators did not oversee their respective counterpart. Regarding whether RO or DI oversaw the other service line, the survey results suggest the differences were negligible (Figure 6).

**Figure 6:** What additional areas of responsibility are assumed by DI and RO administrators?

![Bar chart](chart4.png)

The solution

The two examples show how the lack of communication between diagnostic imaging administrators and radiation oncology administrators can impact healthcare expenditures. I have also seen organizations that have embedded a culture that fosters teamwork, communication and a foundation that makes administrators responsible for capital expenditures. I offer three recommendations that, if implemented success-
fully, could result in better understanding of one’s business needs:

1. Establish weekly or bi-weekly leadership meetings at which each manager or director informs the group of any equipment or program-related initiatives.

   This works best from a hospital-led perspective, but ultimately if both radiation oncology and diagnostic imaging establish monthly meetings at the very least, the opportunity presents itself to explore more issues that naturally arise in healthcare delivery.

2. When seeking capital dollars for technology, administrators within radiation oncology and diagnostic imaging should seek approval and/or support from fellow directors/leaders to secure funding for their projects.

   Administrators can demonstrate to colleagues the relevance of any new acquisitions, and in doing so discover other new business opportunities that may have not emerged without open discussion.

   One example is the addition of wide bore CT scanners. A radiation oncology department requested better scanning coverage to include positioning apparatuses. The cost was typically outside the radiation oncology budget, but discussions amongst fellow directors led to the discovery that the bariatric program could also use the positioning apparatuses. What was a hard sell based upon ROI became a reality when figuring in other, non-cancer related uses.

3. Require vendors to present any new diagnostic imaging technology to both the radiation oncology and diagnostic imaging departments.

   Placing the onus on the vendor tends to yield a compelling story as to how and why both departments would benefit from this purchase. An added, and perhaps greater, benefit of this approach is increased communication and awareness of both administrators in discussing the relevance and need of the new technology within their department(s).

Conclusion

After working in health care for more than 20 years, I have encountered situations of lack of coordination and/or cooperation between diagnostic imaging and radiation oncology administrators. I personally do not believe this stems from lack of mutual respect for one another, but from an inherent competitive nature between both imaging and oncology service lines. As financial resources become more difficult to obtain for program growth and expansion, there appears to be less rather than more cooperation in meeting these financial and strategic challenges.

To be successful in meeting an increased demand for quality and access to services, while providing care at lower costs, diagnostic imaging and radiation oncology leaders will need to be more collaborative and adaptable than in the past, assuming greater responsibility in streamlining processes within the health system and support an integrated approach to healthcare spending.

The most cost effective way to accomplish these initiatives in a forward-thinking strategic approach is through open communication, coupled with effective listening and openness to reasoning.

References


Editor’s Note: The opinions expressed in the article are those of the author, and do no reflect the opinion of SROA. Michael Peters is a member of SROA.

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