ACCC
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FROM THE EDITOR

# It's All in the Delivery

BY CHRISTIAN DOWNS, JD, MHA

Most of you reading this journal are deeply immersed in treating and serving cancer patients and their families on a daily basis. And yet, if you could step back and look at our country's cancer delivery infrastructure through the lens of a casual observer, you might have some interesting observations.

For example, in the last 15 years, with the advent of guidelines and pathways, the oncology community has been able to standardize care for most cancers.

Living in the U.S., we also enjoy the benefit of a very robust delivery network. Unlike some countries, we do not have patients with cancer waiting for care because of a lack of providers or treatment options.

Affordability—on the other hand—is an altogether different issue. Nearly every day we are reminded that this country is struggling with how to pay for cancer treatment. And this is not just a matter of being able to afford expensive anti-cancer drugs. Across the cancer care continuum—medical, radiation, surgical, imaging, pathology—costs are soaring.

Another area where the oncology community could improve is in coordination of patient care. Some of the best-run healthcare systems still over-treat patients, perform tests more than once, and require patients to make multiple trips to different locations.

One of the most positive aspects of working in the field of oncology is that we are constantly striving to improve—the quality of care we provide, the patient experience, our workplace processes, and our understanding of the disease. And ACCC is here to support your efforts.

In our cover article, Thomas D. Brown, MD, MBA, shares how Swedish Cancer Institute (SCI) made personalized, genomic medicine a cornerstone of its program. SCI looks to use this personalized approach to cancer care to "make treatment fundamentally better, improve outcomes and quality of life, and deliver extraordinary care to its patients."

Next, James Pellicane, MD, describes how molecular subtyping is changing our understanding of breast cancer. One key finding: breast cancer is not just a single disease, but rather a category of diseases made up of several different tumor types (molecular subtypes). Each subtype behaves differently, which means each subtype may need to be treated differently to achieve the best outcome. Dr. Pellicane shows the multiple advantages molecular subtyping may hold for breast cancer patients, cancer programs, and the healthcare community.

Our next feature article, "The Embedded Nurse Navigator Model," is a great example of how to improve care coordination and the patient experience. After conducting a baseline assessment of the physical and psychosocial needs of cancer survivors and providers in the community, the Helen F. Graham Cancer Center and Research Institute retooled its survivorship services. Today this survivorship program has a two-fold goal: to empower survivors to take responsibility for ongoing surveillance and preventive care and to foster a more collaborative approach between the oncology team and primary care providers.

Finally, Matthew Sturm and Katherine Liljedahl Ye focus on how small, rural programs and larger urban programs can work together to improve the quality of cancer care, the patient experience, and care coordination. Further, the authors suggest that these types of partnerships can help programs compete in today's value-focused oncology marketplace.

In our final feature article, Cary Presant, MD, FACP, offers his perspective on ASCO 2015, including the studies and findings that may change how you practice.

As you can see, the oncology community is already addressing some of the weaknesses we see in the delivery infrastructure. And while we must accept that our delivery infrastructure will always have its strengths and weaknesses, our job is to leverage the expertise of our clinicians with cutting-edge technology to improve care, while simultaneously identifying ways to most wisely spend our finite healthcare dollars. OI