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**What is the Institute for Cancer Care Innovation?**
A message from Dr. Thomas W. Feeley
Who we are

**The framework: The value proposition**
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The University of Texas MD Anderson Cancer Center created the Institute for Cancer Care Excellence in 2008 to lead value-based cancer care delivery.

In 2012, the institute’s name was changed to the Institute for Cancer Care Innovation to better reflect its focus on breaking free from current ideas of care and pioneering a better approach to serving patients and providers.

Our Mission: To deliver improved value to cancer patients and individuals at risk for cancer throughout the entire cycle of cancer care, including prevention, treatment and survivorship.

Our Vision: To be the world leader in enhancing the value of cancer care for patients, individuals at risk for cancer, families and other providers.
Dear friends and supporters,

This year marks the fifth year of operation of MD Anderson's Institute for Cancer Care Innovation. We were created in 2008 to demonstrate the value of MD Anderson's research-driven, multidisciplinary care model of how to deliver state-of-the-art cancer treatment. Since its inception, ICCI's focus has been on value – the balance between patient-centered outcomes of care and the costs to achieve those outcomes. In the five years since the creation of ICCI, the value-based health care movement has gained tremendous impetus and attention nationally and internationally. There is increased recognition that our cancer care delivery and reimbursement system is in need of intelligent redesign and that a value-based approach provides a useful framework for that redesign. As cancer detection and treatment improve, there are ever-increasing numbers of patients in active treatment and long-term cancer survivors. In addition, since age is the most significant risk factor for the development of cancer, our aging population only compounds the problem.

The costs of cancer detection and treatment are extremely high and many Americans are suffering financial hardships as a result of cancer treatment. We therefore must work hard to better understand how to control the costs of cancer care, eliminate things that do not work in cancer care and provide the most efficient, cost-effective treatments with the best possible outcomes.

The value-based framework is what we are using to measure and improve on our patient-centered outcomes as well as to measure and improve our cost structure. Our work received national recognition with the 2012 Edgar C. Hayhow Award from the American College of Healthcare Executives for our paper on value-based cancer care.

In addition to programs looking at outcomes and costs, we have been carefully evaluating how innovations in health care information technology can improve the patient care experience for our patients.

We are firmly committed to providing the best value in cancer care through our research-driven patient care and redesigning our care delivery system so we provide the best outcomes at the lowest possible costs. Through our partnerships internally and externally, we will do the research and development necessary to be sure that MD Anderson is the value leader in cancer care delivery worldwide.

Thomas W. Feeley, M.D.
Helen Shafer Fly Distinguished Professor of Anesthesiology
Head, Institute for Cancer Care Innovation
Head, Division of Anesthesiology and Critical Care
Who we are: Leadership

**Thomas W. Feeley, M.D.**
Head, Institute for Cancer Care Innovation
Helen Shafer Fly Distinguished Professor of Anesthesiology
Head, division of anesthesiology and critical care

**Heidi Albright, M.H.A, F.H.F.M.A.**
Director, Institute for Cancer Care Innovation

**Thomas W. Burke, M.D.**
Executive sponsor, Institute for Cancer Care Innovation
Executive vice president and physician-in-chief
Professor, department of gynecologic oncology, division of surgery

**Leon J. Leach, Ph.D., M.B.A., M.A.**
Executive sponsor, Institute for Cancer Care Innovation
Executive vice president, business and regulatory affairs
Who we are: Faculty associates

John C. Frenzel, M.D., M.S.
Chief medical information officer
Professor, anesthesiology and preoperative medicine
Adjunct associate professor, School of Health Information Sciences,
The University of Texas Health Science Center

Sharon Giordano, M.D., M.P.H.
Chair, department of health services research, cancer prevention and population sciences
Professor of breast medical oncology, division of cancer medicine

Barbara L. Summers, Ph.D., M.S.N., R.N., F.A.A.N.
Vice president and chief nursing officer
Professor and chair, department of nursing
Division head, nursing

Ronald S. Walters, M.D., M.H.A., M.B.A., M.S.
Associate vice president, medical operations and informatics
Professor of clinical medicine, department of breast medical oncology
Medical director, managed care programs
Medical director, case management program

ICCI also has an internal executive committee with the following members: John Bingham, M.H.A.; Thomas Buchholz, M.D.; Thomas W. Burke, M.D.; Gerard Colman, Ph.D.; Thomas W. Feeley, M.D.; John C. Frenzel, M.D.; Sharon Giordano, M.D.; Ernest Hawk, M.D.; Leon J. Leach, Ph.D.; Mark Moreno; Dwain Morris; Barbara L. Summers, Ph.D.; and Ronald S. Walters, M.D.
Who we are: Staff

LaToi Tatum, M.H.A.
Program manager, Institute for Cancer Care Innovation
Background: Health care administration, health studies

Jessica Jones
Program coordinator, Institute for Cancer Care Innovation
Background: Chemistry, mathematics

Tiffany Jones, M.P.H.
Senior data analyst, Institute for Cancer Care Innovation
Background: Behavioral science, quantitative analysis, health services research
Robert Watson, Jr.
Office manager, Institute for Cancer Care Innovation
Background: Applied science, design

Nashota Jefferson
Administrative assistant, Institute for Cancer Care Innovation
Background: Business administration, education

Elizabeth Bassett, M.S.
Publications coordinator, Institute for Cancer Care Innovation
Background: Medical and scientific journalism
“Value in healthcare can be described as the balance between outcomes and costs.”

ICCI evaluated cancer care outcomes to examine these three questions:

- Which outcomes matter to patients with a cancer diagnosis so that they are informed decision makers?
- How can we include patient opinions in assessing the value of health care outcomes and options?
- How can we provide patients with the support and tools they need to find and access high-value health care?

The answer to the first question will determine the appropriate course of action to address the other two questions.

Surprisingly, a major hurdle to initiating the work of understanding and demonstrating the value of care provided at MD Anderson is to develop a common understanding of “value.” In their book, *Redefining Health Care*, Harvard Business School professor Michael E. Porter, Ph.D., and University of Virginia professor Elizabeth Olmsted Teisberg, Ph.D., were first to suggest that value can be defined as outcomes of care per the dollar of cost expended for that care.

Porter and Teisberg also suggested that multidisciplinary care should be the model for how all care is delivered to obtain optimum value.

Using this relationship as a framework, ICCI has addressed the outcomes portion of the equation by facilitating outcomes research initiatives for a number of disease sites throughout the institution.

The goal of each study has been to identify relevant critical outcomes unique to each disease site and then gather data on whether and to what extent MD Anderson was able to achieve those outcomes for its patient population.

While different disease sites identified different outcomes, studies required a team of research data coordinators to search through a variety of data sources to obtain and record the necessary information. This data abstraction provided a useful retrospective snapshot of the outcomes achieved at a given point in time.
Assessing outcomes from cancer treatment is one of the best ways to evaluate just how valuable care is, not only to patients, but also to providers and others involved in delivering care.

Perhaps the most recognizable way to measure outcomes is to look at disease-free survival rates and recurrence rates for patients. For physicians, this is one of the fundamental ways to assess care: how often are patients surviving, and how often does their cancer return?

To get a better understanding of outcomes, ICCI conducted a retrospective pilot study assessing patients at the MD Anderson Head and Neck Center. The first major characteristics to be measured were survival and degree of recovery based on major quality-of-life indicators, including the ability to speak and swallow.

The head and neck study included reviewing the records of 2,467 newly-diagnosed patients with oropharynx, larynx and oral cavity cancer and is slated for publication in the journal *Head & Neck*. It broke down various outcome rates, including three- and five-year survival rates, the ability to speak and swallow after one year, as well as important information about the frequency of true multidisciplinary care, adherence to established treatment guidelines and complication rates. The study reported on key times to certain events, including times to initial appointments and to the completion of therapy – an important determinant of survival. The study also gave a clear understanding of the limitations of the current electronic medical records (EMR) system in place at MD Anderson. In order to obtain these key metrics on a one-time basis, it took thousands of hours of time on the part of abstractors, even with the presence of an EMR.

A result of the study was a clear need for better information technology, not only for MD Anderson but also for other providers. John C. Frenzel, M.D., one of ICCI’s faculty associates, recently became MD Anderson’s chief medical information officer to address the need for improved approaches to patient data collection. He oversees all clinical information technology areas such as EMR development, implementation and support; clinical applications and support; and clinical analytics and informatics.

Bolstering information technology is not just for providers, though; patients, too, wanted more access to their own health information online. In 2009, all MD Anderson patients were given access to nearly the entirety of their medical records via the Internet portal myMDAnderson, a secure, personalized website. This trend is increasing in health care today and was discussed in an editorial written by Drs. Thomas W. Feeley and Kenneth I. Shine in the *Annals of Internal Medicine* in 2011.

Other disease sites, including breast, esophagus, gynecology and soft tissue sarcoma were also assessed for outcomes by ICCI through abstracting medical records. While providers have opinions about what outcomes are most important, patients may measure outcome success by other standards, including more varied quality-of-life indicators. In order to identify ways to increase patient centeredness in MD Anderson’s care delivery, ICCI convened the Outcomes Task Force, comprised of leadership from clinical and operational entities. As a part of the ICCI study, focus groups gave cancer patients with five different types of cancer the opportunity to air their views on care outcomes.

ICCI learned that for some patients, the most important outcome considered in coming to MD Anderson was the experience of the treatment team in handling their condition and various aspects of the patient experience during and after treatment. The focus groups provided valuable new insights into what patients think is important in the care process and how that changes during the course of their journey in treatment and survivorship, and also pointed to a research area ICCI will continue to focus on in the future.
Initially, ICCI attempted to address the cost portion of the value proposition using data from MD Anderson’s charge-based costing system, which is maintained by the Clinical Revenue and Reimbursement department. However, it quickly became clear that charge-based methodology for determining costs does not necessarily correlate with actual expenditures and resources consumed in the care delivery process.

MD Anderson knows what patients and insurers pay for the care that is received, but not what it costs the institution to provide that care for a given patient with a specific diagnosis. With potential reimbursement reform on the horizon, such as a bundled payments and payments to accountable care organizations, it is critical to understand the true cost of the care for patients.

On the recommendation of Harvard Business School professor Michael E. Porter, ICCI partnered with his colleague, professor Robert Kaplan, who developed time-driven activity-based costing (TDABC), a model of understanding costs that involves identifying the amount of time spent to perform a certain activity and the cost per unit of time. TDABC also provides a means to assign costs to patient care activities with appropriate allocation of all overhead drivers based on actual resource utilization. The system allows for simple aggregation of cost by patient or by medical condition. TDABC is a system that measures the true cost of providing care to individual patients and groups of patients.

ICCI’s work with Kaplan and other health care partners through the Harvard Business School marked the first attempt to develop a cost accounting model that assesses the true cost of health care provision by patient or medical condition. The project will not only allow ICCI to address the cost portion of the value proposition, but it has the added benefit of revealing waste and inefficiencies within the system. Through pilot work reported in the Harvard Business Review in 2011, ICCI demonstrated that lower-cost but still safe and effective care could be delivered in one center at MD Anderson by using TDABC. ICCI is working to expand that work to other areas measuring costs and outcomes while improving the care experience for patients and providers.

Furthermore, by providing MD Anderson with an understanding of what it costs to provide care, this work will facilitate the development of episode-based or bundled reimbursements for specific cancers that cover variable periods of care. The use of this type of reimbursement reform has been hypothesized to control the rising costs of care by driving the incentive to control costs and improve efficiency back to providers.

How does TDABC measure costs of care? To determine how TDABC could measure costs at MD Anderson, ICCI conducted a pilot focused on the experience of patients seeking treatment for head and neck cancers at MD Anderson. The project team examined the processes associated with the majority of services that a head and neck cancer patient might encounter in the course of being treated. Teams followed patients through the care delivery system and created maps of the processes that patients experienced. These maps permitted the team to understand the cost at every step in the care of a patient, since every person, place or supply encountered has a cost to MD Anderson that can be precisely measured based on the time spent in each step. The pilot demonstrated that it is possible to determine the true costs of providing care to MD Anderson. ICCI is now planning how to perform this analysis in all of MD Anderson’s multidisciplinary care centers.

Not only has this work provided the institution with a better understanding of where costs are incurred, but it has also inspired clinical areas to become more actively involved in reducing their costs and improving processes of delivering care. The team is currently developing educational materials to empower clinical areas to make substantive improvements immediately.

**TDABC is a system that measures the true cost of providing care to individual patients and groups of patients.**
Internal collaborations with various members of the MD Anderson community means ICCI can tap into the expertise of others for new approaches to cancer care, both within the community and in other patient care environments in the future.
In addition to participating in research initiatives with other departments and groups, the ICCI supported a number of committees and work groups with the goal of ensuring that thinking critically about value is taking place at a high level throughout the system.

**Ad-Hoc Institutional Expense Analysis Committee and Productivity Work Group**

In the fall of 2010, ICCI supported the convening of a group that was charged with exploring ways to readjust MD Anderson’s cost structure in all mission areas with the input of five distinct subcommittees: revenue enhancement, administration and information services, clinical and basic research, clinical operations, and education. These groups of faculty and administrators presented their recommendations to MD Anderson’s executive committee in late March 2011.

The committee made over 75 recommendations, many of which have been implemented or continue to be under active evaluation.

**End-of-life care**

Many of the costs associated with cancer care are incurred in the last days of a patient’s life. ICCI collaborated internally with the clinical operations and intensive care unit teams to examine issues associated with that care.

ICCI studied MD Anderson’s performance on five different end-of-life indicators. The indicators identify potentially high-cost, low-reward actions taken within a patient’s last days of life and were modeled off measures endorsed by the National Quality Forum (NQF). The project also evaluated the charges associated with the care provided. These projects have led to collaborations internally to introduce supportive care services earlier in the course of care for patients with advanced lung cancer and externally with Partners HealthCare in Boston to study the impact of reporting the overuse cancer treatment services on utilization of costly patient care modalities.
Support systems

Clinical effectiveness research grant awardees
The purpose of the program was to encourage comparative effectiveness research (CER) at MD Anderson in order to allow faculty to obtain preliminary data to improve the competitiveness of CER grant proposals submitted to external agencies. Awarding these grants was a one-time special project through ICCI to improve its collective efforts in performing and developing infrastructure to conduct CER and provided valuable opportunities for investigators. Four projects were funded for $25,000 each and were completed in FY11.

- Ann-Marie Chaftari, M.D.
  *Infectious Diseases and Infection Control Research*
  The Impact of Antimicrobial Catheters in Reducing the Risk of Resistance and Complications in Patients with Catheter Related Bacteremia

- Carmen Escalante, M.D., and Maria Suarez-Almazor, M.D., Ph.D.
  *General Internal Medicine, Ambulatory Treatment and Emergency Care*
  Collaborative Group Clinics for Cancer Survivors

- Joseph L. Nates, M.D., M.B.A.
  *Critical Care*
  Effectiveness of Non-Invasive Ventilation in Hypoxemic Respiratory Failure in Cancer Patients

- David Ost, M.D., M.P.H.
  *Pulmonary Medicine*
  Comparative Effectiveness of Indwelling Pleural Catheters versus Thoracoscopic Pleurodesis for Treatment of Malignant Pleural Effusions

The following divisions and departments at MD Anderson have given their support, dedication and commitment to ICCI: the Division of Finance and Department of Business Analytics; the Head and Neck Center; Clinical Operations; Office of Performance Improvement; Clinical Analytics and Informatics; the Department of Government Relations; the Division of Public Affairs.

ICCI funding
By developing external relationships with several well-recognized organizations, we hope to develop systems that allow us to provide innovative care for all patients at MD Anderson.
Partners in public reporting

Although understanding and applying the value proposition has clear internal benefit to MD Anderson, the outcomes research in particular also positions MD Anderson to be a leader in the effort to define national quality measures relating to cancer. With the passing of the Affordable Care Act, or ACA, signed into law in 2010, a number of questions have arisen about how cancer centers and cancer care in general will be affected by the new law. ICCI evaluated how the ACA would impact cancer care in an article in the journal Cancer in 2011, and one finding was that while the law outlines a new program for public reporting of measures of how cancer programs deliver care, broader measures that will impact payment systems and access to care are more nebulous. More emphasis will be placed on primary care, early detection and disease prevention, and additionally, public reporting of quality measures, costs and outcomes will bring a heightened sense of competition into the cancer care delivery process. Furthermore, the bill focuses on new reimbursement models that will have critical implications for cancer care delivery in the future. As part of the ACA, MD Anderson will be required to report compliance with quality measures beginning in 2014.

That reality of metric reporting, which was clear as the language of the bill was being developed in 2009, resulted in ICCI coordinating efforts with two major entities, the National Quality Forum (NQF) and the Alliance of Dedicated Cancer Centers (ADCC). The NQF was identified in the bill as the organization responsible for evaluating and approving metrics that would be reported. The ADCC represents the 11 cancer hospitals, including MD Anderson, that were identified in the bill as the first ones in the nation required to report cancer quality metrics. ICCI worked to re-establish its relationship with NQF and supported the activities of the ADCC’s then-newly created Quality and Value Committee to initiate and gain consensus on quality measures that best represent the interests of all cancer-dedicated hospitals. ICCI provided support to the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System-Exempt Cancer Hospitals Work Group to gain consensus on mandatory federal quality measure selection and reporting, to facilitate necessary quality measure testing for feasibility, usability, and reliability, and to communicate any barriers to that reporting.

This work led to the publication of an article in the health policy journal Health Affairs that outlines a path to improving the quality of cancer care in America through metric reporting and identifies what would constitute “meaningful measures” for cancer care. The work also highlighted a critical point in the institute’s
history, showing that ICCI could not keep taking on ever-increasing numbers of projects without moving some of the key ones to operational portions of MD Anderson. The metric reporting program was one that started out as investigational and clearly evolved to operational, and in 2012 these metric reporting functions were transitioning to clinical operations and performance improvement departments, allowing ICCI to focus on new and evolving value-based projects.

In addition to initiating the work with the NQF, CMS and ADCC, ICCI provided support in a number of different venues to initiate and gain consensus on quality measure development and reporting to inform the NQF. Within MD Anderson, ICCI supported strategic planning to assist faculty members with obtaining appointments to NQF measure project committees. For example, ICCI assisted Dr. John Skibber in obtaining an appointment to the Cancer Technical Advisory Panel. ICCI also assisted Dr. Eduardo Bruera in getting and appointment to the steering committee for the NQF Palliative Care and End-of-Life Care Project.

In all of the efforts, ICCI works closely with representatives from MD Anderson’s Department of Government Relations and the Office of Performance Improvement to ensure that they are aware of current NQF measure development and related activities and can contribute according to their areas of expertise.

Harvard Business School

Through testing and measuring the value proposition in cancer care, ICCI continues to foster a strong working relationship with professors Porter and Kaplan and the Institute for Strategy and Competitiveness at the Harvard Business School. In addition to research conducted with faculty and staff at the Harvard Business School, the ICCI leadership team has had the honor of participating in teaching the concept of value-based health care at three different executive education courses offered regularly at the Harvard Business School.

Institute of Medicine

In 1999, the Institute of Medicine (IOM) published a report titled “Ensuring Quality Cancer Care.” The 10 recommendations in that report provided a solid foundation to improve the quality of cancer care in America and also were instrumental in how to think of ICCI’s role in the early period following its creation. ICCI assembled an MD Anderson team to evaluate the progress that had been made since 1999 and published that review in the journal Cancer in 2012. At the same time, the IOM convened a new committee to review the quality of cancer care in America. In early 2012, Dr. Feeley was asked to serve as a member of the Institute of Medicine’s Committee on Improving the Quality of Cancer Care: Addressing the Challenges of an Aging Population. The committee has been examining all aspects of the quality and costs of cancer care delivery in the United States, especially as it relates to the aging population. The committee anticipates publishing its report in the summer of 2013 with recommendations about how our nation needs to address these issues.
Sharing the approach

Welcoming others to the institute

ICCI believes that if it leads the way by incorporating bold new approaches to cancer care, others will follow. As a part of that aim, ICCI has opened its doors and encourages other health care leaders to visit MD Anderson and learn more about the ICCI research while at the same time creating an open discussion about approaches in other health care settings that may be useful to the institution.

Over the past two years, ICCI hosted leaders from around the world, including executives from Aso-Iizuka Hospital in Japan, which is a general hospital with over 1,100 beds; health ministers from Denmark; executive leadership from Clínicas Oncológicas Integradas (COI) Group in Rio de Janeiro, Brazil; representatives from the Office of the National Coordinator for Health Information Technology; executives from the Schön Klinik, which operates multiple hospitals throughout Germany; faculty and staff from Boston Children’s Hospital Department of Plastic Surgery, and also officials from SOZA Group in the United Arab Emirates.

External advisory board

ICCI also convened an external advisory board to encourage the ongoing influx of new ideas from other sources. These experts come from various organizations across the U.S. and bring with them myriad experiences and advice for how ICCI can meet its mission.

Peter Bach, M.D., MAPP, attending physician, Memorial Sloan-Kettering Cancer Center
Robert H. Brook, M.D., Sc.D., vice-president and director, RAND Health, professor of medicine and health service, University of California Los Angeles
Vivian Ho, Ph.D., James A. Baker III Institute Chair in Health Economics, Rice University, professor, Baylor College of Medicine
Brent C. James, M.D., M.Stat, executive director, Institute for Health Care Delivery Research, and vice president, medical research and continuing medical education, Intermountain Health Care, professor in the Department of Family and Preventive Medicine, University of Utah School of Medicine
Robert Kaplan, Ph.D., M.S., Baker Foundation Professor, Harvard Business School, chairman, professional practice, Palladium Group Inc.
Lee N. Newcomer, M.D., M.H.A., senior vice president of oncology, women’s health and genetics, United Healthcare
Michael E. Porter, Ph.D., M.B.A., Bishop William Lawrence University professor, Harvard Business School
Kenneth I. Shine, M.D., executive vice chancellor for health affairs, The University of Texas System
William M. Sage, M.D., J.D., vice provost for health affairs, The University of Texas at Austin
The central question for ICCI is this: “How do we demonstrate and improve the value of cancer care at MD Anderson?” But we also want to look at the future of care, which involves open dialogue on how to keep moving forward.
Publications


*Winner of the 2012 Edgar C. Hayhow Award from the American College of Healthcare Executives*

“Competition should drive providers to improve outcomes and limit costs. Our model can be used to evaluate the value proposition in the treatment of other cancers with the understanding that outcomes beyond survival vary with disease and patient preference.”


“The true impact of these reforms, particularly in cancer care delivery, will not fully be realized for several years, but in the near-term the cancer care community can anticipate changes relating to quality reporting as well as the continued exploration of alternative payment and delivery systems.”


“In identifying meaningful cancer measures, developers must not allow the logistics of reporting to dictate the selection of the measures. They must instead focus on the following questions: Which health outcomes are providers attempting to deliver? Which outcomes are most important to the patients receiving services?”

Kaplan RS, Porter ME. The Big Idea: How to Solve the Cost Crisis in Health Care. Harvard Business Review. Sept 2011; 89(9); 46-64.

“Adjusting only the level of reimbursement, however, will not be enough. Any true health care reform will require abandoning the current complex fee-for-service payment schedule altogether. Instead, payors should introduce value-based reimbursement, such as bundled payments, that covers the full care cycle and includes care for complications and common comorbidities.”


“Current electronic technology makes it possible not only to enable patients to view their own record but also to grant permission for others to see it, be it a family member, a caregiver, or an involved provider in another location. Such sharing of information could greatly improve communication, engage patients in their care, and help them formulate questions in advance of a visit on the basis of prior notes and test results.”


“The greatest challenges center on how to define and implement nationwide solutions, especially universal transparent metrics, access to care, and end-of-life care.”
Contacting the institute

The ICCI benefits from internal and external relationships, and those interested in learning more can visit its website at mdanderson.org/innovation, on Twitter by following @CancerInnovate or by reaching out to the following individuals.

- **Dr. Thomas Feeley** is head of ICCI as well as Helen Shafer Fly Distinguished Professor of Anesthesiology and division head, anesthesiology and critical care. He can be reached at tfeeley@mdanderson.org

- **Heidi Albright** is director of ICCI and can be reached at halbright@mdanderson.org

- **Robert Watson** is office manager of ICCI and can be reached at rwatson@mdanderson.org

ICCI is located in the John Mendelsohn Faculty Center on the North Campus of MD Anderson, and its mailing address is

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More about The University of Texas MD Anderson Cancer Center can be found at mdanderson.org, on Twitter by following @MDAndersonNews or on Facebook at facebook.com/mdanderson