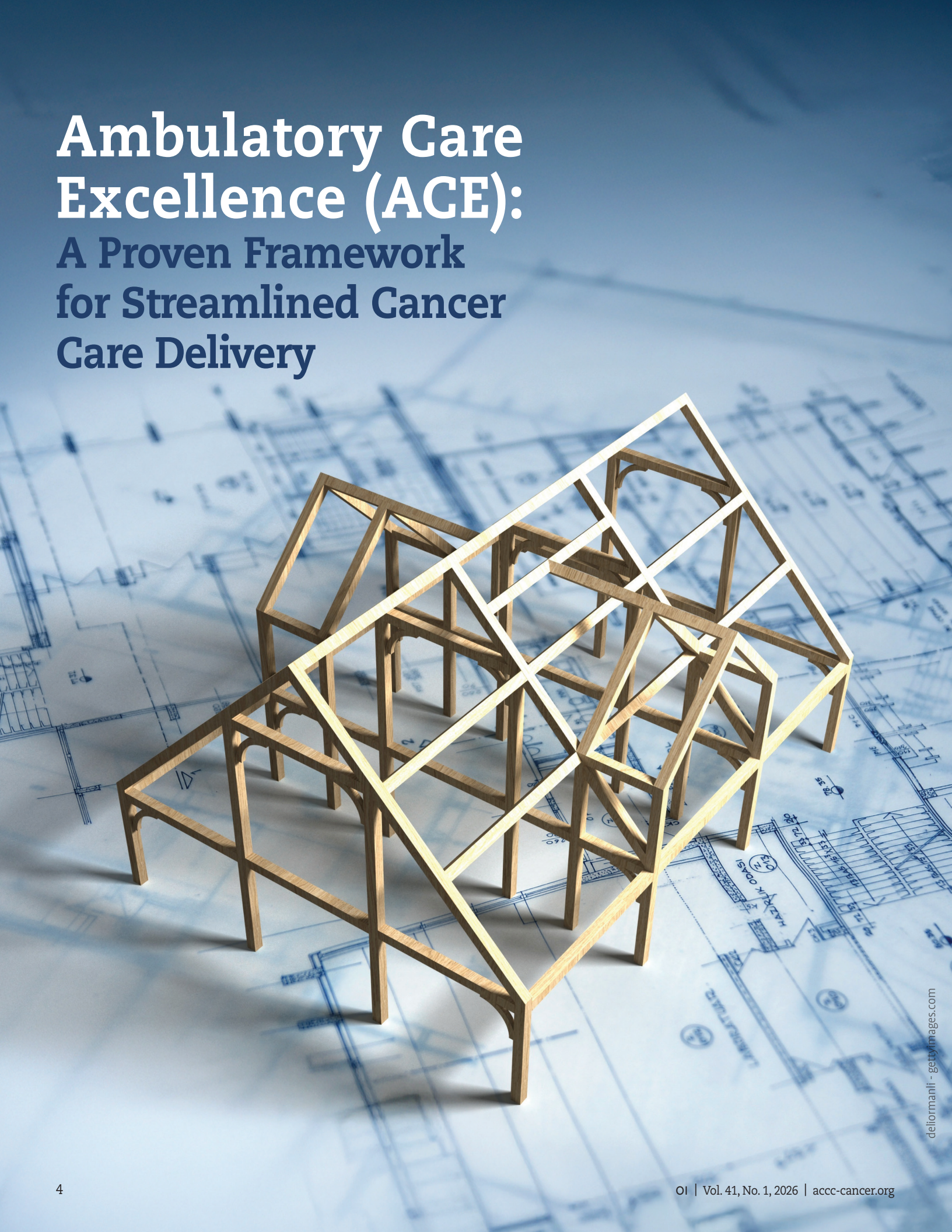
Ambulatory Care Excellence (ACE): A Proven Framework for Streamlined Cancer Care Delivery



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IN BRIEF

Ambulatory oncology programs struggle with fragmented intake processes, variable clinic workflows, and diffuse communication channels—issues that slow access, increase rework, and frustrate patients and staff alike. Ambulatory Care Excellence (ACE) is a service-line model that standardizes roles, hardwires care-coordination time, and streamlines communication and benchmarking to match resources to demand. At Fox Chase Cancer Center, ACE convened more than 30 team members; identified more than 100 issues across patient access, navigation, and clinic workflows and translated them into 73 actionable countermeasures; and then piloted a future-state design within the breast service line. This article details the problem, 2-part scope (prearrival access and arrival-to-second-appointment coordination), methods (voice of the customer, empathy mapping, process mapping, root-cause analysis), intervention components (role clarity, service-line staffing, protected registered nurse care-coordination time, single-pool in-basket routing), implementation, control plan, and measurement framework.

Traditionally, oncology care has focused on the inpatient setting. In recent years, care delivery has shifted to the outpatient setting.[1] Ambulatory care is increasing in complexity, requiring efficient processes, effective communication, seamless care coordination, and continuous collaboration among disciplines. An ambulatory care encounter for a patient may involve several events and multiple patient transitions between sites of services (eg, laboratory, imaging, diagnostic, procedural, and physician clinics) that necessitate communication and coordination among several clinicians, care team members, the patient, and, when appropriate, the patient's family or caregiver.[2] However, ambulatory care in the United States remains highly fragmented, and 1 study demonstrated that this fragmentation results in approximately $1085 more in total adjusted costs per person per year.[3] Often, ambulatory clinic operations exhibit inefficient processes, variations, repetitive work, and missing documentation—functional problems that impede throughput, increase access time to care, and degrade the experience for patients, staff, and providers.

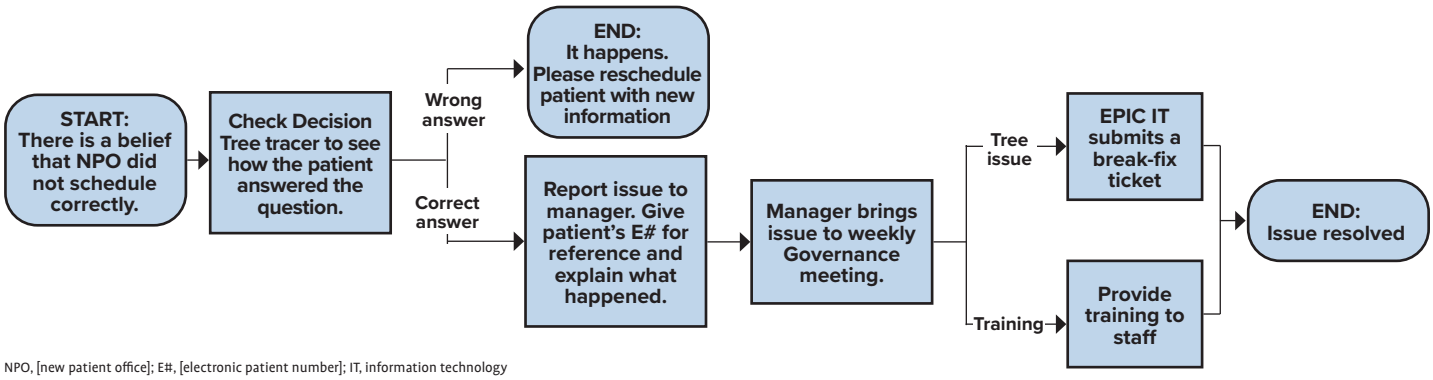
Reimagining Our Ambulatory Care Model

The Ambulatory Care Excellence (ACE) Model was developed under the leadership of the chief nursing officer and vice president of nursing and patient care services at Fox Chase Cancer Center in response to growing gaps in care coordination and workflow inefficiencies across ambulatory clinics. The initiative aimed to transform the ambulatory care delivery model to meet the needs of a growing and diverse oncology population while promoting staff engagement, operational excellence, and high-quality patient outcomes.

The ACE Model was developed through a highly collaborative process. Over 30 team members from every part of the ambulatory ecosystem participated, with the following key stakeholder groups from multiple disciplines and leadership levels engaging to achieve a thorough and lasting redesign:

- ***Clinical nursing staff.*** Registered nurses (RNs), medical assistants (MAs), and nurse navigators offered critical frontline insights regarding workflow inefficiencies, care coordination gaps, and

Figure 1. Scheduling Decision-Tree Governance and Monitoring



NPO, [new patient office]; E#, [electronic patient number]; IT, information technology

patient communication needs. Their feedback directly informed the role delineation and standardization processes.

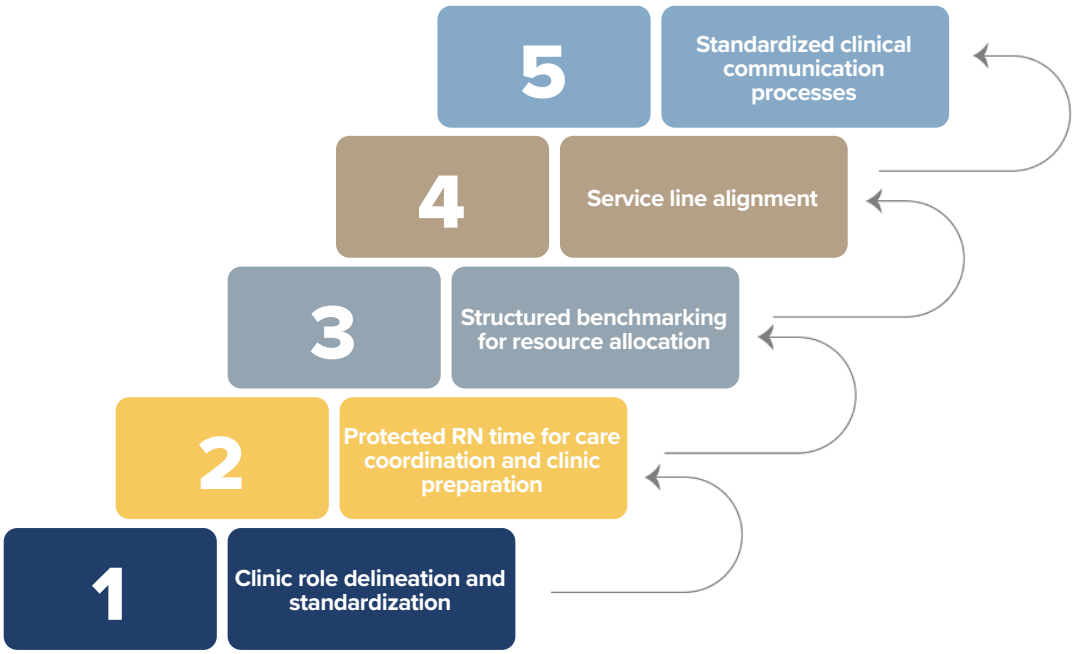
- ***Executive leadership.*** These executive leaders (CEO, COO, CFO, CMO, CNO) played a critical role in driving the ACE redesign and providing the sponsorship, governance, and decision-making structure necessary to remove barriers, allocate resources, and sustain organizational focus. Their visible commitment and active engagement transformed ACE from a conceptual framework into a fully operational model that redefined ambulatory care delivery across service lines.
- ***Information technology and electronic health record analysts.*** Informatics specialists supported the standardization of clinical communication processes, including the design of in-basket workflows to improve message tracking, documentation, and team coverage.
- ***Nursing and administrative leaders.*** These stakeholders were the driving force behind the planning, execution, and sustainment of the ACE model. Nursing leaders guided the redesign through the lens of professional governance, ensuring that care delivery models reflected nursing excellence, role optimization, and accountability to quality outcomes. They partnered closely with practice administrators and service line managers to integrate the ACE model staffing, clinic templates, and workflows with the service line structure, ensuring the operational feasibility of proposed changes
- ***Patient and caregiver advisers.*** Patient, caregiver, and family member representatives served as essential partners in the development of the ACE model. Their lived experience and insight into the patient journey provided a critical lens for ensuring that care redesign efforts remained person-centered and responsive to the needs of the populations served.
- ***Physician and advanced practice provider leadership.*** Medical directors and service line physician champions collaborated to optimize clinical workflows and reengineer provider scheduling templates to enhance efficiency and timely patient access to care. Physician champions modeled accountability for shared outcomes.
- ***Quality and performance improvement teams.*** Experts in Lean Six Sigma and Value Stream Analysis guided process mapping, root cause analysis, and identification of high-impact improvement opportunities. They assisted in establishing key performance indicators (KPIs) and partnered with ACE stakeholders to monitor progress, analyze data trends, and identify opportunities for improvement.

Methods

The development process followed a structured redesign framework grounded in systems thinking and process improvement methodologies, particularly Lean Six Sigma. This emphasis on a proven, structured approach instilled confidence in the team and ensured a systematic, effective process.

- ***Lean Six Sigma framework.*** Following the Define, Measure, Analyze, Improve, and Control (DMAIC) methodology, the project began with a multidisciplinary Kaizen event, empathy mapping, and value-stream analysis. Over 100 issues were decomposed by process step into such themes as inconsistent care, inadequate team coverage, unclear role delineation, inadequate resource allocation, and varied patient communication processes. Root-cause analysis categorized issues into 3 categories (patient access, clinic workflow, and care coordination), producing 73 actionable items for the future state.
- ***Voice of the customer and empathy mapping.*** Empathy mapping grounded our teams in understanding what the patient says, does, thinks, and feels. Integrating the voice of the customer provided perspectives on patient preferences and pain points, which highlighted speed to appointment, readiness (eg, records and tests in place), and communication of delays as opportunities in the ambulatory workflow.

Figure 2. Core Elements of the ACE Model



- ***Process mapping and waste identification.*** Mapping of the patient journey from initial new patient contact through the second appointment identified issues in our workflows. The end-to-end maps for access and clinic workflows revealed queueing, redundant documentation, role ambiguity, and off-workflow communications that created variation and rework.
- ***Benchmarking and workload modeling.*** Benchmarking provided a data-driven framework that informed staffing needs based on visit volume or worked relative value unit. Workload modeling informed resource allocation.

Scope of Work

The stakeholders defined 2 complementary workstreams to focus on:

1. ***Patient access (prearrival)*** ensures that intake work is completed correctly the first time, so clinics are prepared for the patient's initial visit (eg, correct provider, necessary records and orders, timely scheduling).
2. ***Arrival-to-second-appointment coordination*** standardizes what happens at and after the first visit to ensure tests, referrals, and follow-ups are completed or scheduled prior to the second appointment.

A governance structure with clinical informatics was established to support the above workstreams. Decision tree audits with providers and navigation were conducted on a defined cadence to prevent triage errors and ensure scheduling algorithms reflect current pathways (**Figure 1**).

Emergence of the ACE Model

Using data-driven insights following the value-stream analysis, 5 high-impact opportunities were identified. The future state that was envisioned focused on reducing variation, eliminating non–value-added steps, and aligning service lines for balanced resource deployment. These standard practices became the core elements of the Fox Chase Cancer Center ACE model (**Figure 2**).

Clinic Role Delineation and Standardization

A baseline scope of work inventory was conducted in all ambulatory site locations to understand the workload of our clinic staff, including the RNs, MAs, licensed practical nurses, nurse navigators, and advanced practice providers. Results indicated variations in staff roles and responsibilities, role confusion, and role ambiguity resulting in task duplication, staff and provider dissatisfaction, and increased risk for gaps in care. A multidisciplinary workgroup was formed to clarify and delineate tasks by roles. **Table 1** summarizes the standardized roles for MAs and RNs.

Protected RN Time for Care Coordination and Clinic Preparation

Many ambulatory clinics lack structured processes that allow nurses the administrative and coordination time needed to address patient needs beyond direct clinic sessions. The absence of dedicated care coordination roles can result in communication gaps, delayed follow-up, and inefficiencies that affect both patients and providers.

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Table 1. Standardized Responsibilities for Clinic MAs and RNs

CATEGORY	MEDICAL ASSISTANT	REGISTERED NURSE
Patient intake and preparation	• Call and escort patient from the waiting room to the examination room. • Obtain and document vital signs. • Determine the reason for visit/chief complaint. • Review and revise allergies, medication list, and problem list in the EHR. • Prepare the patient for examination. • Call for interpreter services. • Complete the intake and history forms.	• Perform all MA tasks when the MA is unavailable. • Evaluate the patient prior to the provider's visit. • Obtain consent form signatures after the provider has informed the patient. • Conduct full nursing assessments, including review of systems. • Prepare and assess patients for complex procedures or treatments.
Documentation and EHR management	• Enter all data accurately into Epic or other EHR systems. • Document screenings (eg, falls, nutrition, pain, safety, suicide risk). • Enter specific health assessments. • Ensure HIPAA compliance.	• Document comprehensive nursing assessments and interventions. • Enter and verify orders per policy. • Respond to in-basket messages and communicate the provider's instructions. • Manage physician to-do items within the RN's scope. • Complete outcome measurement documentation.
Clinical support	• Assist providers with examinations and procedures. • Set up sterile/aseptic fields. • Perform nonsterile dressing changes. • Administer injections (IM, SC) per protocol. • Perform phlebotomy and specimen collection. • Clean instruments before use and disinfect surfaces.	• Perform all MA clinical duties, if needed. • Administer medications via oral, IV, IM, SC, or aerosol routes. • Administer sedation under protocol. • Start and manage IV therapy. • Insert and manage urinary catheters. • Access, flush, and de-access implanted ports. • Remove PICC lines. • Perform central line dressing changes and specimen collection. • Manage negative pressure wound therapy changes.
Patient education and coordination	• Distribute preapproved educational materials. • Reinforce provider instructions. • Collaborate with the MD/RN on the plan of care. • Coordinate follow-up appointments or referrals. • Conduct new patient calls as assigned.	• Provide detailed patient/family education on disease management, medication administration, and procedures. • Educate on pre- and postoperative care plans. • Lead patient discharge education. • Participate in outcome measurement and patient progress tracking.
Prescription and order management	• N/A (outside MA scope).	• Process prescription renewals per the approved protocol. • Enter urgent verbal orders per policy. • Verify provider orders, and ensure timely execution.
Clinic maintenance and safety	• Clean and stock examination rooms after each patient. • Order and maintain supplies. • Provide necessary equipment in the room. • Dispose of waste properly. • Monitor temperature logs for vaccines and medications. • Check code carts and AEDs. • Assist with cleaning before procedures and infection control.	• Maintain oversight of adherence to safety and infection control. • Support or verify code cart/AED readiness. • Ensure sterile technique and procedural safety. • Collaborate with clinical leadership on quality and safety measures.
Compliance, quality, and professional development	• Participate in ongoing training and competency checks (eg, injections, phlebotomy). • Maintain certification (CMA/RMA). • Adhere to OSHA, HIPAA, and clinic safety policies. • Participate in quality improvement projects.	• Maintain active RN license and certifications (eg, BLS, ACLS). • Participate in continuing education and specialty training. • Support QI and performance improvement initiatives. • Participate in clinic preparation for upcoming sessions (0.2 FTE RN preparation).

ACLS, advanced cardiovascular life support; AED, automated external defibrillator; BLS, basic life support; CMA/RMA, certified medical assistant/registered medical assistant; EHR, electronic health record; FTE, full-time equivalent; HIPAA, Health Insurance Portability and Accountability Act; IM, intramuscular; IV, intravenous; MA, medical assistant; MD, medical doctor; N/A, not applicable; OSHA, Occupational Safety and Health Administration; PICC, peripherally inserted central catheter; QI, quality improvement; RN, registered nurse; SC, subcutaneous.

Table 2. RN Tasks to Prepare for Next Patient Visit

RN PREPARATION FOR CLINIC
• Complete any tasks assigned during clinic sessions.
• Collaborate with SWs, CMs, and DC team as needed.
• Obtain scripts as needed.
• Ensure that outstanding laboratory results, x-rays, reports, referrals, and consults are available for the next appointment.
• Review patient EHR prior to appointment to validate that necessary records are present.
• Follow up on pending laboratory results.
• Prescription renewal per protocol regimen.

CMs, case managers; DC, discharge coordinator; EHR, electronic health record; SW, social workers.

Table 3. Care Coordination RN Responsibilities

CARE COORDINATION FUNCTIONS
• Perform inpatient rounding (future state at FCCC).
• Stratify risk to prevent readmissions.
• Perform risk screening for high-risk hospitalization.
• Facilitate internal referrals.
• Review the patient medical summary.
• Facilitate and scheduling external referrals.
• Make follow-up and new patient phone calls.
• Send and receive in-basket messages in the disease-specific EPIC pool.
• Ensure prescription renewal per protocol regimen.
• Obtain missing reports and diagnostic results.
• Solicit, organize, and receive outside medical records.
• Complete calls and faxes and following up with outside entities for missing medical records.
• Follow up on anything abnormal.
• Perform post-procedure follow-up.
• Place the hospital discharge call.
• Perform phone assessment and evaluation.
• Evaluate patient data.
• Collect patient data.
• Educate on pre-/postoperative plan of care.
• Ensure that all postoperative appointments are made.
• Follow up with SNFs and facilities to assure plan is being followed.
• Complete outcome measurements.
• Coordinate with external patient access staff to adhere to SOPs and provide scheduling optimization.
• Communicate with multidisciplinary teams to facilitate patient appointments.
• Ensuring communication with the clinical team regarding patient scheduling needs, coordination of services, and notification of changes.

RN, registered nurse; SNF, skilled nursing facility; SOP, standard operating procedure.

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Nurses play a critical role in ensuring continuity and quality of care through timely coordination of diagnostic and supportive services and multidisciplinary collaboration. Benchmarking and workload modeling identified the need for protected nurse care coordination time hardwired into schedules to create predictable capacity for validation before visits, results management, and coordination between visits. **Table 2** lists the standard RN tasks to prepare for the next patient visit. Care coordination tasks embedded in the clinic RN workload are listed in **Table 3**.

Structured Benchmarking and Resource Allocation

We developed our own framework using American Medical Group Association benchmarking to determine the appropriate number of staff members—both nurses and MAs—required per clinic session. In designing this model, we accounted for 15% indirect time, 4 hours of clinic preparation time per nurse each week, and 2 daily 4-hour sessions per nurse per week devoted to care coordination. These factors allowed us to assess our current staffing levels and identify the number of incremental full-time equivalents (FTEs) needed to achieve a full and balanced staffing complement.

Service Line Alignment

Patients often see multiple specialists and clinicians, which can sometimes lead to inconsistencies in care. RNs and MAs were

assigned to a specific service line to enhance continuity of care and strengthen the nurse-patient relationship.

Standardized Clinical Communication Process

A standardized in-basket communication workflow was established to streamline the flow of messages coming from multiple sources, reducing the medico-legal risk and improving response tracking. Disease-specific nursing pools were created within the electronic health record (EHR) to streamline communication among the team and eliminate the use of emails and text messages for physician tasks and follow-up.

Measurement and Integrated Control Plan

To sustain performance, ACE embeds a formal control plan within routine operations—no separate appendix is required—so that each metric has 6 components:

1. A clear definition and data source
2. An accountable owner and process owner
3. A review cadence
4. Targets and thresholds
5. Explicit signals that indicate when the process is drifting
6. Predefined actions and escalation paths.

The plan is reviewed in daily, weekly, monthly, and quarterly rhythms with visualized via scorecards and control charts.

Metrics and Definitions

The ACE model measures of success span:

- Access
- Readiness (eg, records and slides received prior to first visit; time to first appointment)
- Communication reliability (eg, in-basket resolution time; first-contact resolution, Informed About Delays top-box)
- Throughput and completion (eg, percent of follow-ups scheduled before departure; in-room on-time)
- Experience of care (eg, likelihood to recommend)
- Defect rates (eg, incorrect provider assignment; missing/incorrect records; diagnostics not completed by next appointment).

Records-specific key performance indicators include the percentage of tasks auto-triggered with facility-of-origin and slide retrieval turnaround time.

Ownership and Cadence

Each metric lists both an accountable owner and a process owner. Daily RN/MA huddles monitor backlog and time to first response. Weekly service-line reviews track access and/or readiness defects and record turnaround times. A monthly clinical informatics governance huddle audits decision-tree performance (eg, triage errors, change tickets, training adherence). A quarterly executive review validates targets, staffing benchmarks, and vendor service level agreements.

Targets, Thresholds, and Signals

Targets and thresholds are defined for each measure (eg, ≤ 10 days to first appointment, in-basket response time within policy, zero tolerance for incorrect provider assignment). Statistical bounds (eg, upper and lower control limits where applicable) and practical trigger thresholds identify signals such as rising backlog, delayed slide turnaround, or an uptick in readiness defects.

Standard Responses and Escalation

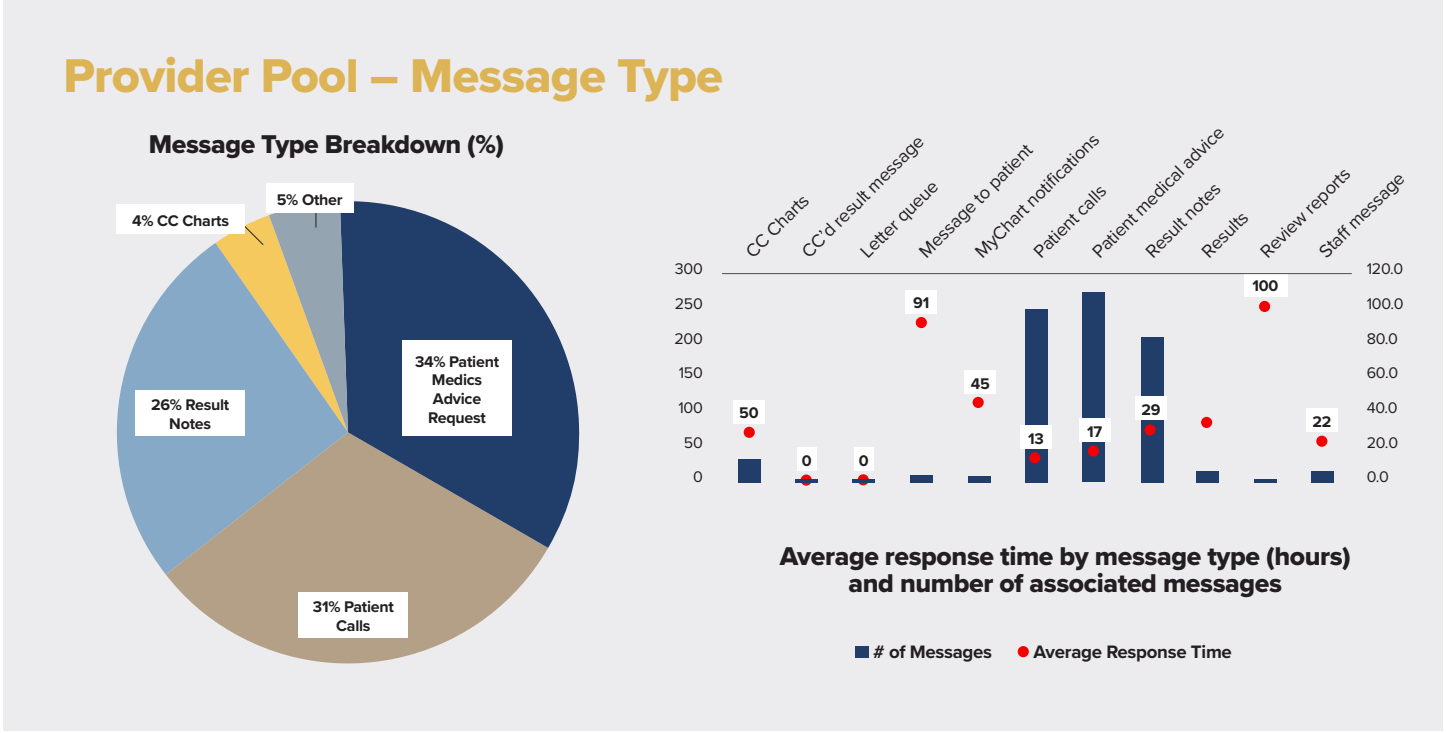
For each metric, standard actions are prespecified:

- Applying job aids and tip sheets
- Activating rapid plan-do-study-act cycles
- Adjusting staffing or templates
- Escalating from service line to clinical informatics to executive sponsors when required.

Decision-tree defects trigger an immediate audit, change control, micro-training, and verification in the next cycle.

The principles embedded in this model—consistent nurse assignment to defined disease sites, clear role delineation between nurses and MAs, and structured allocation of indirect and coordination time—can serve as a foundation for improving continuity of care in these settings.

Figure 3. Response Time by Message Type to Provider to RN Message Pool



Visualization and Governance

Operations dashboards visualize ownership, response times, backlog, and trend signals. Scorecards support weekly reviews, and control charts flag special-cause variation. Governance artifacts (eg, defect log, audit checklist, change tickets) are maintained by Clinical Informatics and service-line operations.

Pilot Implementation

Implementation of the ACE model was launched first within the Breast Service Line to assess its feasibility and scalability across the ambulatory enterprise. Operationally, the pilot encompassed the patient journey from the initial point of contact with the cancer center through the second clinic visit. Dedicated RNs and MAs were assigned to the service line with clearly defined roles, standardized workflows, and delineated escalation pathways. The ACE model clarified RN and MA responsibilities, established shared task ownership, and embedded structured communication processes.

Care coordination responsibilities were integrated into the clinic RN role, supported by protected time allocations (≈ 0.2 FTE/RN or 1.0 FTE/disease team) to ensure consistent follow-up, external communication, and clinic preparation coverage. Key performance metrics for success were identified, and compliance with the redesigned workflows was monitored through monthly data collection and performance review cycles.

Early Results

Early results from the ACE model pilot demonstrate promising improvements in coordination efficiency, staff engagement, and patient experience. Continuous monitoring using EHR data and satisfaction surveys provided actionable insights during the first phase of implementation. Data were reviewed monthly to evaluate adherence to standardized workflows and to identify opportunities for refinement.

Compliance with the standardized communication process was assessed through analysis of provider message volumes directed to service line–specific nursing pools (**Figure 3**). Clinic nurse efficiency in managing patient portal messages was reviewed monthly, focusing on responsiveness, message volume, and usage trends. Role-based message analysis revealed that physicians generated the majority of nursing pool messages. Across 807 physician-initiated communications, the average response time was 30.4 hours, confirming that all routine messages were addressed within the 2-day target. Message volumes and response patterns were tracked longitudinally to inform workload balancing and improve communication flow.

Following ACE implementation, post-pilot satisfaction surveys were distributed to participating service lines to assess perceived effectiveness, role support, and timeliness in responding to patient needs. Seventy-six percent of respondents reported greater ability to respond to patient needs promptly. Providers indicated increased

support outside of clinic sessions, while nurses reported improved capacity to manage non-clinic responsibilities. These early outcomes highlight the ACE model's potential to enhance care coordination, operational efficiency, and staff satisfaction across the ambulatory enterprise.

Implications for Other Cancer Programs and Scalability

The development of this ambulatory care model has significant implications for cancer programs seeking to enhance care coordination and operational efficiency. Oncology practices face similar challenges with fragmented care delivery, limited nursing resources, and increasing patient complexity. The principles embedded in this model—consistent nurse assignment to defined disease sites, clear role delineation between nurses and MAs, and structured allocation of indirect and coordination time—can serve as a foundation for improving continuity of care in these settings. The ACE model offers a scalable and flexible framework that may be adapted to various program sizes, patient volumes, and staffing capacities. Service line alignment with RNs and MAs embedded within disease-specific teams fosters stronger provider-patient relationships, reduces communication gaps, and improves both patient satisfaction and clinical outcomes. Benchmarking informs workforce planning. Allocation of indirect and coordination time supports sustainable workloads and mitigates burnout—an important consideration in programs where staffing is often limited.

The ACE model represents a strategic effort to improve continuity, efficiency, and patient outcomes in our ambulatory care setting, ensuring that services provided are not only clinically effective but also empathetic, accessible, and respectful of the patients' experiences. Implementation of the ACE model in a community cancer setting requires thoughtful adaptation to local context, including adjustments for smaller clinic sizes, resource constraints, and potential cross-coverage needs. These achievements culminated in national recognition when Fox Chase Cancer Center received a 2025 ACCC Innovator Award for excellence in ambulatory care transformation. OI

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Additional Resources

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Fox Chase Cancer Center At-a-Glance

Part of the Temple University Health System Fox Chase Cancer Center is a National Cancer Institute (NCI)-designated Comprehensive Cancer Center located in Philadelphia, Pennsylvania. Established in 1974, Fox Chase is among the nation's first cancer centers and remains a leader in cancer research, education, and clinical care. The organization has earned Magnet® designation for nursing excellence 6 consecutive times from the American Nurses Credentialing Center, reflecting a deep commitment to nursing professionalism, innovation, and quality outcomes. Ambulatory care at Fox Chase serves as the hub for comprehensive cancer management encompassing diagnosis, treatment planning, clinical trials, survivorship, and palliative care. Given the high acuity and complexity of this population, the ambulatory teams balance specialized clinical expertise with coordinated, patient-centered care delivery.