# Amy Carpenter Hay, BA, MS

Interview #60

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Original Segment Summaries

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## Interview Profile

**Interview Information:**

Two interview sessions: 4 February 2015, 2 June 2015
Approximate total duration: 4 hours
Interviewer: Tacey A. Rosolowski, Ph.D.

For a CV, biosketch, and other support materials, contact:

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**About the Interview Subject**

Amy Carpenter Hay (b. 16 September 1973, Dallas, Texas) came to MD Anderson in 1996 as a Patient Service Coordinator. Since 2012 she has served as Vice President of Business Development.

She rose through administrative levels in Radiation Oncology. As Director of Radiation Oncology (2001 – 2005) she developed the first MD Anderson satellite care center and assisted in the development of MD Anderson's Proton Therapy Center. She left MD Anderson to serve as Administrator and CEO Proton Therapy Center (2005 – 2007) and principle of ProBeam Oncology, returning as Division Administrator for the Division of Radiation Oncology (2007 – 2008) to develop the Regional Care System. In 2008 Ms. Hay became Head of Global Business Development, advancing to Vice President of Business Development in 2012.

**Major Topics Covered**

Personal and educational background

Evolution of the satellite/regional care system

The development of the Proton Therapy Center

The Center for Global Oncology

The Office of Global Business Development

Business partnerships in the United States and abroad

Financial challenges to MD Anderson and healthcare

Visualizing business opportunity in healthcare

Technology and business opportunity

Women and leadership

Shifts in MD Anderson research and culture to innovation and technology

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Interview Session Two: 2 June 2015

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*The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part I*
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*Dr. Ronald DePinho and Institutional Change*
Segment 13 / B: Institutional Change;

*Planning for the Next Growth Areas*
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*The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part II*
Segment 15 / B: Building the Institution;

*As VP of Business Development: Today's Initiatives and What the Future Holds for MD Anderson*
Segment 16 / B: Building the Institution;

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# Amy Carpenter Hay, BA, MS

Interview #60

## Segment Summaries

Interview Session One: February 4, 2015

Segment 00A
*Interview Identifier*

Segment 01
*An Early Interest in Health Care*
A: Educational Path;
01:40 – 08:55

Story Codes
A: Character, Values, Beliefs, Talents;
A: Personal Background;
A: Professional Path;
A: Inspirations to Practice Science/Medicine;
A: Influences from People and Life Experiences;

In this segment, Ms. Hay speaks briefly about her family background then explains that she elected to go to Southwestern University, Georgetown, Texas (B.A. conferred in 1996) because she was looking for a broad education. She lists her varied interests in college and notes that she was thinking of becoming a physician, but discovered she was better suited to a career in finance. She notes that she was always interested in health care and wanted not just a job, but a career focused on helping people. She describes characteristics she has inherited from various family members.

Segment 02
*A New Role at MD Anderson Reflects Changes in Health Care*
B: Institutional Change;
08:55 – 21:20

Story Codes
A: Joining MD Anderson;
A: Professional Path;
A: Overview;
A: Definitions, Explanations, Translations;
C: Patients;
C: Cancer and Disease;
C: This is MD Anderson;

C: Evolution of Career;
C: Leadership;
C: Mentoring;
D: The History of Health Care, Patient Care;
C: Research, Care, and Education;
B: The Business of MD Anderson;
B: Growth and/or Change;
B: Institutional Processes;

Ms. Hay begins this segment by explaining that she came to Houston in 1996 because of her fiancé's job and then began searching for a job in health care. She wanted to work for MD Anderson and describes the advantages of working for an institution with a single mission. She explains that MD Anderson was hiring college graduates to serve as Patient Service Coordinators (PSC). She explains the reasons why this role was being transformed and also recalls the period of change under John Mendelsohn [Oral History Interview] (who assumed presidency of the institution in '96). She was hired to serve as PSC in the Department of Radiation Oncology. She explains why the job was difficult and her strategy of never saying 'No, it's not my job' in order to advance. She describes her responsibilities as a PSC, noting that her early negotiation skills came from this period.

Segment 03
*Learning the Complexities of Institutions; Balancing the Goals of Administrators and Physician-Leaders at MD Anderson*
A: Overview;
21:20 – 28:00

Story Codes
A: Professional Path;
A: The Administrator;
B: MD Anderson Culture;
C: Understanding the Institution;
D: On the Nature of Institutions;
C: Leadership;

In this segment, Ms. Hay first reflects on how her role as a Patient Services Coordinator benefited her career. She developed a commitment to fixing the complexities and difficulties of institutions, prompting her to earn a Masters of Science in Healthcare Administration at Houston Baptist University (conferred 1999). She explains that she was awarded an Administrative Fellowship in 1999 and talks about the opportunities this afforded.

Ms. Hay characterizes MD Anderson as a physician-led organization. She compares administrators to physician leaders, noting the need for true partnership between the two groups/perspectives to make an institution work. Business goals must be adapted to the goals of clinicians and basic researchers, she explains, rather than overlaying

business goals over their activities. She notes that MD Anderson can advance and grow because the institution has figured out the right balance in this leadership.

Segment 04
*Planning the Proton Therapy Center*
B: Building the Institution;
28:00 – 11:30 (counter zeroed during segment)

Story Codes
B: MD Anderson History;
B: Devices, Drugs, Procedures;
B: The Business of MD Anderson;
B: Institutional Mission and Values;
A: The Administrator;
C: Patients, Treatment, Survivors;
B: Beyond the Institution;
C: The Institution and Finances;
C: Research, Care, and Education;
D: Technology and R&D;

Ms. Hay explains the mission areas that Dr. James Cox [Oral History Interview] assigned her when she joined Radiation Oncology, then focuses on her work developing a Proton Therapy Center.

She tells the story of securing financial backing, eventually involving a boutique investment company, Sanders Morris Harris Group. She explains the advantages of securing local and "patient money" [meaning investors that could patiently wait for returns]. She tells about working with Hitachi o provide equipment.

Ms. Hay then sketches the history of the institution's interest in proton therapy. She talks about the advantages of the LLC status of the Proton Therapy Center.

She explains why research demonstrating clinical efficiency of proton therapy was lacking. She talks about the use of proton therapy in treating different cancers and the effect on the quality of life.

Segment 05
*Establishing the First Satellite Center: "A Great Business and Clinical Story"*
B: Building the Institution;

Story Codes
B: Building/Transforming the Institution;
B: Institutional Processes;
B: MD Anderson History;
B: Institutional Mission and Values;

B: Growth and/or Change;
C: Patients, Treatment, Survivors;
A: Character, Values, Beliefs, Talents;
B: The MD Anderson Brand, Reputation;
B: Beyond the Institution;
B: MD Anderson in the Future;
B: Discovery and Success;
C: The Institution and Finances;

Ms. Hay notes that the story of the Radiation Oncology Center in Bellaire, Texas, is 'a great business and clinical story' that led to the creation of the entire satellite system.

She tells the story of setting up a health center in Bellaire, Texas. She explains why this was bold and controversial move. She talks about the negotiations with General Electric (which owned the note on the Center) and describes how the Center was opened, with immediate positive responses from patients. She describes the involvement of the Physicians' Network.

Next, Ms. Hay explains that the Bellaire site was the beginning of the entire satellite system and the expansion that was part of John Mendelsohn's [Oral History Interview] vision for the institution.

Ms. Hays talks about the selection of partners and factors that lead to the success of the satellite locations, including MD Anderson's willingness to terminate ineffective partnerships.

She reviews the growth of the use of satellite centers and stresses how important they are for the future of MD Anderson.

Segment 06
*A New Role as CEO of the Proton Therapy Center; Lessons in Effective Leadership*
A: Professional Path;

Story Codes
A: Professional Path;
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
C: Leadership;
D: On Leadership;
C: This is MD Anderson;
B: MD Anderson Culture;
A: Entrepreneur, Biotechnology;

Ms. Hay talks her work after 2005, when she asked to leave MD Anderson to take a role as CEO of the Proton Therapy Center. She talks

about the change in role and environment, where she had to bring a new focus to finances in addition to clinical care.

She explains Dr. Cox's approach of developing a clientele for the Proton Therapy Center. She talks about the lessons she learned through this process, notably the importance of accountability. She talks about how effective leadership finds ways of engaging clinicians in ways that are meaningful to them.

Ms. Hay then explains that the Proton Therapy Center offers an excellent example of multi-disciplinary care that breaks down barriers between disciplines and institutions. She emphasizes that this approach is crucial to MD Anderson's future and will help the institution "leverage everything we do."

Segment 07
*Global Institutional Partnerships*
B: Beyond the Institution;

Story Codes
A: Professional Path;
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
C: Leadership;
D: On Leadership;
C: This is MD Anderson;
B: MD Anderson Culture;
A: Entrepreneurs, Biotechnology;
B: Beyond the Institution;
D: Global Issues –Cancer, Health, Medicine;

In this segment, Ms. Hay talks about her role in the development of opportunities for global partnerships, beginning with the American Hospital in Istanbul, Turkey in 2006, where there was no oncology program. She talks about building a basis for MD Anderson quality abroad and traces issues involved in opening the co-branded facility ion 2010. She notes that it "works seamlessly" and that plans are underway to expand this relationship so it can operate as a regional center.

Segment 08
*Adapting a Consulting Business to MD Anderson Needs*
B: Building the Institution;

Story Codes
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;

A: Activities Outside Institution;
B: Beyond the Institution;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
A: Entrepreneurs, Biotechnology;

Ms. Hay begins this segment by explaining that when she was CEO of the Proton Therapy Center, she became interested in international consulting and set up a company, ProBeam, with some partners.

She then talks about her decision to come back to MD Anderson as Assistant Vice President of Global Business Development , a move that resulted in ProBeam being integrated into MD Anderson and a focus on international and national business opportunities. She talks about refining the mission of the consulting initiative and explains work with a client, Albert Einstein Hospital, in Brazil.

Segment 09
*The Office of Global Business Development: A First Partnership in Banner, Arizona*
B: Building the Institution;

Story Codes
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
C: Leadership;
B: MD Anderson Culture;
A: Entrepreneurs, Biotechnology;
B: Beyond the Institution;
D: Global Issues –Cancer, Health, Medicine;

In this segment, Ms. Hay talks about her role in administering the negotiations and implementation process that resulted in a co-branded partnership with MD Anderson Banner, Arizona. She explains the process of reviewing the cancer center and lists the challenges of overcoming institutional differences that could prevent a full offering of MD Anderson quality care. She describes how these challenges resulting led to the service growing the service piece-by-piece, by subspecialities. She notes that MD Anderson required that Banner employ their physicians to take financial interest out of the equation of providing cancer care. She explains why this was a challenge and how it was resolved. She explains how the program came together to form a solid partnership.

Segment 10
*Strategic Expansion and Partnerships*
B: Building the Institution;

Story Codes
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
B: Growth and/or Change;
C: Leadership;
B: MD Anderson Culture;
A: Entrepreneurs, Biotechnology;
B: Beyond the Institution;
D: Global Issues –Cancer, Health, Medicine;

In this segment, Ms. Hay discusses how, in 2011/2012, MD Anderson hired Price Waterhouse Cooper to evaluate possibilities for strategic expansion. She notes that this represents a big shift in paradigm for the institution under Dr. DePinho –a move to expand very aggressively. She explains that this happened in concert with the formation of the MD Anderson Cancer Network. She talks about the two categories of partnership that can be formed and notes that MD Anderson will seek to establish four to six co-branded partnerships in the next ten years. A partnership is evolving in Cooper, New Jersey.

## Interview Session Two: 2 June 2015

Segment 00B
*Interview Identifier*

Segment 11
*The Center for Global Oncology: Background and Operations*
B: Building the Institution;
00:00 – 25:40

Story Codes
A: Overview;
A: Entrepreneurs, Biotechnology;
A: The Administrator;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;
A: Professional Path;

C: Leadership;

Ms. Hay provides an overview of the formation and operation of the Center for Global Oncology. She served as Associate Vice President of Global Business Development, one arm of service in the Center.

She begins by explaining that healthcare institutions nationwide were seeking partnerships when the decision was made to form the Center in 2008. She the talks about how the institutions contacted MD Anderson, how their needs were assessed, and how she partnered with Oliver Bogler, in Global Academic Programs, to satisfy those needs.

She sketches her main role, to identify and negotiate legal contracts with partner institutions, and provides examples, including consideration of financial gain for MD Anderson.

Ms. Hay also sketches the challenges involved in bringing institutional (and national) cultures together in multi-disciplinary care.

Segment 12
*The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part I*
B: Building the Institution;
25:40 – 34:00

Story Codes
A: Entrepreneurs, Biotechnology;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Institutional Processes;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;

Ms. Hay explains how institutional growth has resulted in reorganization that has brought the Center for Global Oncology into the new MD Anderson Cancer Network. The aim, she explains, has been to address the disconnect between business development and research.

She talks about the “product line” of connections with MD Anderson: partnerships, sister institutions, and certified membership.

Ms. Hay also explains the process by which the MD Anderson Network’s significance has been clarified within MD Anderson, winning support from

division heads. Since division heads must approve physicians working in partner institutions, this facilitates expansion.

Segment 13
*Dr. Ronald DePinho and Institutional Change*
B: Institutional Change;
34:00 – 40:10

Story Codes
B: Growth and/or Change;
B: Institutional Politics;
B: Controversy;
C: Understanding the Institution;
D: On the Nature of Institutions;

Ms. Hay comments on the early years of Dr. Ronald DePinho's leadership of MD Anderson. She notes his emphasis on the "democratization of cancer." In response to a question about criticisms of his approach from MD Anderson faculty, she says that the value of partnerships is now being demonstrated. She comments on all institutional change being a difficult, particularly in medical institutions, which are traditionally conservative.

Segment 14
*Planning for the Next Growth Areas*
B: Building the Institution;
40:10 – 55:33

Story Codes
B: MD Anderson in the Future;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Research, Care, and Education;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: On Texas and Texans;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;

Ms. Hay explains that the Office of Business Development is looking ahead to visualize opportunities arising from research and patient care.

On the research side, she talks about big data and the opportunities to gather enormous amounts of data that can feed personalized care.

She notes that MD Anderson has created a new position: Chief Innovations Officer.

Next she talks about pursuing employers as partners, with MD Anderson supplying expertise in prevention, screening, and education. She talks about a pilot program that will begin in about a year, and explains that there is more awareness of the practical value of prevention and employers want to offer such programs.

Segment 15
*The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part II*
B: Building the Institution;
55:33 – 1:04:00

Story Codes
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Institutional Processes;
B: Building/Transforming the Institution;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;

Ms. Hay returns to the story of the Center for Global Oncology's transformation into the MD Anderson Cancer Network. She explains that this was a sign of growth and maturation and became necessary so MD Anderson could develop a clear line of products that allowed affiliation with the institution.

Segment 16
*As VP of Business Development: Today's Initiatives and What the Future Holds for MD Anderson*
B: Building the Institution;
1:04:00 - 1:24:00

Story Codes
C: Leadership;
B: MD Anderson in the Future;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Research, Care, and Education;
B: Institutional Mission and Values;

B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;
D: Technology and R&D;

Ms. Hay sketches her current projects and her vision for new directions.

Her current work focuses on refining the model of how MD Anderson establishes partnerships with other institutions in the U.S. and abroad. She talks about the need to develop payer products to address changes in the healthcare reimbursement arena. She talks about the need to diversify MD Anderson's income streams beyond patient care revenue and lists roles that the Office of Business Development serves as other offices take on this challenge as well.

Ms. Hay explains that in future she will focus on visioning business possibilities facilitated by technology and gives an example of discussions with Elekta about providing mobile treatment planning for radiation oncology.

Ms. Hay notes that "we should be a cancer knowledge network" in a nation that focuses on genetic testing, molecular immunology, and the democratization of cancer care dovetail with MD Anderson goals.

Segment 17
*Personal Sacrifice, Women, and Leadership at MD Anderson*
B: Diversity Issues;
1:24:00

Story Codes
C: Dedication to MD Anderson, to Patients, to Faculty/Staff;
C: The Life and Dedication of Clinicians and Researchers;
C: Women and Minorities at Work;
A: Experiences re: Gender, Race, Ethnicity;
C: Leadership;
C: Mentoring;

Ms. Hay begins with comments on the personal sacrifices she has made because of her belief in the MD Anderson mission.

She then offers leadership advice and comments on the experiences of women aspiring to leadership roles at the institution. She comments on what women in particular bring to leadership and negotiation.

Segment 18
*Resilience in Leadership and a Presidency Defined by Innovation*

B: Institutional Change;

Story Codes
C: Leadership;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The MD Anderson Brand, Reputation;
C: This is MD Anderson;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;

Ms. Hay begins by explaining that resilience is a key quality for a leader, particularly in a physician-led institution.

She talks about the importance of innovation and strategic thinking at MD Anderson, observing that innovation may define Dr. DePinho's legacy at MD Anderson. She explains that she visualizes a "perfect storm" coalescing, where the institution is on the "cusp of greatness."

# Amy Carpenter Hay, BA, MS

Interview #60

## Segment Summaries

Interview Session One: February 4, 2015

Segment 00A
*Interview Identifier*

Segment 01
*An Early Interest in Health Care*
A: Educational Path;
01:40 – 08:55

Story Codes
A: Character, Values, Beliefs, Talents;
A: Personal Background;
A: Professional Path;
A: Inspirations to Practice Science/Medicine;
A: Influences from People and Life Experiences;

In this segment, Ms. Hay speaks briefly about her family background then explains that she elected to go to Southwestern University, Georgetown, Texas (B.A. conferred in 1996) because she was looking for a broad education. She lists her varied interests in college and notes that she was thinking of becoming a physician, but discovered she was better suited to a career in finance. She notes that she was always interested in health care and wanted not just a job, but a career focused on helping people. She describes characteristics she has inherited from various family members.

Segment 02
*A New Role at MD Anderson Reflects Changes in Health Care*
B: Institutional Change;
08:55 – 21:20

Story Codes
A: Joining MD Anderson;
A: Professional Path;
A: Overview;
A: Definitions, Explanations, Translations;
C: Patients;
C: Cancer and Disease;
C: This is MD Anderson;

C: Evolution of Career;
C: Leadership;
C: Mentoring;
D: The History of Health Care, Patient Care;
C: Research, Care, and Education;
B: The Business of MD Anderson;
B: Growth and/or Change;
B: Institutional Processes;

Ms. Hay begins this segment by explaining that she came to Houston in 1996 because of her fiancé's job and then began searching for a job in health care. She wanted to work for MD Anderson and describes the advantages of working for an institution with a single mission. She explains that MD Anderson was hiring college graduates to serve as Patient Service Coordinators (PSC). She explains the reasons why this role was being transformed and also recalls the period of change under John Mendelsohn [Oral History Interview] (who assumed presidency of the institution in '96). She was hired to serve as PSC in the Department of Radiation Oncology. She explains why the job was difficult and her strategy of never saying 'No, it's not my job' in order to advance. She describes her responsibilities as a PSC, noting that her early negotiation skills came from this period.

Segment 03
*Learning the Complexities of Institutions; Balancing the Goals of Administrators and Physician-Leaders at MD Anderson*
A: Overview;
21:20 – 28:00

Story Codes
A: Professional Path;
A: The Administrator;
B: MD Anderson Culture;
C: Understanding the Institution;
D: On the Nature of Institutions;
C: Leadership;

In this segment, Ms. Hay first reflects on how her role as a Patient Services Coordinator benefited her career. She developed a commitment to fixing the complexities and difficulties of institutions, prompting her to earn a Masters of Science in Healthcare Administration at Houston Baptist University (conferred 1999). She explains that she was awarded an Administrative Fellowship in 1999 and talks about the opportunities this afforded.

Ms. Hay characterizes MD Anderson as a physician-led organization. She compares administrators to physician leaders, noting the need for true partnership between the two groups/perspectives to make an institution work. Business goals must be adapted to the goals of clinicians and basic researchers, she explains, rather than overlaying

business goals over their activities. She notes that MD Anderson can advance and grow because the institution has figured out the right balance in this leadership.

Segment 04
*Planning the Proton Therapy Center*
B: Building the Institution;
28:00 – 11:30 (counter zeroed during segment)

Story Codes
B: MD Anderson History;
B: Devices, Drugs, Procedures;
B: The Business of MD Anderson;
B: Institutional Mission and Values;
A: The Administrator;
C: Patients, Treatment, Survivors;
B: Beyond the Institution;
C: The Institution and Finances;
C: Research, Care, and Education;
D: Technology and R&D;

In this segment, Ms. Hay explains that Dr. James Cox [Oral History Interview] assigned her three mission areas when she joined Radiation Oncology, including instructions to develop a Proton Therapy Center without any direct institutional funds. She helped form the Proton Therapy Consortium on 2001/2002 which successfully negotiated insurance reimbursement rates for proton therapy. She tells the story of securing financial backing, beginning with the failed effort to involve Tenet Health Care Corporation. Eventually funding was secured via a boutique investment company, Sanders Morris Harris Group. She explains the advantages of securing local and "patient money" [meaning investors that could patiently wait for returns]. Next she explains how Hitachi was selected to provide equipment, noting that the Proton Therapy Center has a 98% "up time" because of quality equipment.

Ms. Hay next explains that during the nineties, the Board of Regents had originally approached Dr. Cox with the idea for a Proton Therapy Center, only to have him say that the therapy did not represent the future of radiation oncology. She summarizes MD Anderson's situation now: through the LLC status of the Proton Therapy Center, the institution has this high-tech therapy but someone else pays for it. She underscores that the contract specifies that MD Anderson has 100% clinical control, a fact that reduced controversy over adding the service.

Next, Ms. Hay explains why Dr. Cox changed his mind about the value of proton therapy. She explains why research demonstrating clinical efficiency was lacking. She talks about the use of proton therapy in treating different cancers and the effect on the quality of life. She notes that proton offer one mode of care at MD Anderson and the Center is a regional resource.

Segment 05
*Establishing the First Satellite Center: "A Great Business and Clinical Story"*
B: Building the Institution;

Story Codes
B: Building/Transforming the Institution;
B: Institutional Processes;
B: MD Anderson History;
B: Institutional Mission and Values;
B: Growth and/or Change;
C: Patients, Treatment, Survivors;
A: Character, Values, Beliefs, Talents;
B: The MD Anderson Brand, Reputation;
B: Beyond the Institution;
B: MD Anderson in the Future;
B: Discovery and Success;
C: The Institution and Finances;

Ms. Hay begins this segment by saying that the story of the Radiation Oncology Center in Bellaire, Texas, is 'a great business and clinical story' that led to the creation of the entire satellite system. She starts at the beginning, when Radiation Oncology first considered acquiring a health center in Bellaire, Texas to set up an offsite service. She explains why this was important and also why it was a bold move for the institution at the time. She talks about the risks that people perceived. She talks about the negotiations with General Electric (which owned the note on the Center) and describes how the Center was opened, with immediate positive responses from patients. She describes the involvement of the Physicians' Network in the process.

Next, Ms. Hay explains that the Bellaire site was the beginning of the entire satellite system and that this expansion formed a part of John Mendelsohn's [Oral History Interview] vision for the institution.

She then talks about the patients' positive feedback and notes her own efforts in developing the Center's clientele by personally calling patients and informing them of the new and convenient location. She notes that the success of the Center led to plans for other opportunities in Houston. Services were also expanded in these locations to include more than radiology services.

Ms. Hays then talks about the selection of partners and factors that lead to the success of the satellite locations, including MD Anderson's willingness to terminate ineffective partnerships.

She reviews the growth of the use of satellite centers and stresses how important they are for the future of MD Anderson.

Segment 06
*A New Role as CEO of the Proton Therapy Center; Lessons in Effective Leadership*
A: Professional Path;

Story Codes
A: Professional Path;
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
C: Leadership;
D: On Leadership;
C: This is MD Anderson;
B: MD Anderson Culture;
A: Entrepreneurs, Biotech,

Ms. Hay begins this segment by explaining that her work on the Proton Therapy Center was moving forward as she was setting up the satellite center in Bellaire. She then notes that in 2005 she asked to leave MD Anderson to take a role as CEO of the Proton Therapy Center. She talks about the change in role and environment, where she had to bring a new focus to finances in addition to clinical care.

Next she explains Dr. Cox's approach of developing a clientele for the Proton Therapy Center: forming teams of physicians according to disease site to research situations for effective use of the therapy. She notes that the Center was up and running in two years.

Next, Ms. Hay talks about the lessons she learned through this process, notably the importance of accountability. Clip: She explains that the Proton Therapy Center demonstrates the "magical convergence" of MDs and staff. She talks about how effective leadership finds ways of engaging clinicians in ways that are meaningful to them.

She then talks about the importance of using business development roles as a means of breaking down traditional silos in healthcare and medicine. She says that the Proton Therapy Center offers an excellent example of multi-disciplinary care that breaks down barriers between disciplines and institutions. She emphasizes that this approach is crucial to MD Anderson's future and will help the institution "leverage everything we do."

Segment 07
*Global Institutional Partnerships*
B: Beyond the Institution;

Story Codes

D: Global Issues –Cancer, Health, Medicine;

In this segment, Ms. Hay talks about her role in the development of opportunities for global partnerships, beginning with the American Hospital in Istanbul, Turkey in 2006, where there was no oncology program. She talks about building a basis for MD Anderson quality abroad and traces issues involved in opening the co-branded facility ion 2010. She notes that it "works seamlessly" and that plans are underway to expand this relationship so it can operate as a regional center.

Segment 08
*Adapting a Consulting Business to MD Anderson Needs*
B: Building the Institution;

Story Codes
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
A: Activities Outside Institution;
B: Beyond the Institution;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
A: Entrepreneurs, Biotech,

Ms. Hay begins this segment by explaining that when she was CEO of the Proton Therapy Center, she became interested in international consulting and set up a company, ProBeam, with some partners.

She then talks about her decision to come back to MD Anderson as Assistant Vice President of Global Business Development , a move that resulted in ProBeam being integrated into MD Anderson and a focus on international and national business opportunities. She talks about refining the mission of the consulting initiative and explains work with a client, Albert Einstein Hospital, in Brazil.

Segment 09
*The Office of Global Business Development: A First Partnership in Banner, Arizona*
B: Building the Institution;

Story Codes

In this segment, Ms. Hay talks about her role in administering the negotiations and implementation process that resulted in a co-branded partnership with MD Anderson Banner, Arizona. She explains the process of reviewing the cancer center and lists the challenges of overcoming institutional differences that could prevent a full offering of MD Anderson quality care. She describes how these challenges resulting led to the service growing the service piece-by-piece, by subspecialities. She notes that MD Anderson required that Banner employ their physicians to take financial interest out of the equation of providing cancer care. She explains why this was a challenge and how it was resolved. She explains how the program came together to form a solid partnership.

Segment 10
*Strategic Expansion and Partnerships*
B: Building the Institution;

Story Codes

In this segment, Ms. Hay discusses how, in 2011/2012, MD Anderson hired Price Waterhouse Cooper to evaluate possibilities for strategic expansion. She notes that this represents a big shift in paradigm for the institution under Dr. DePinho –a move to expand very aggressively. She explains that this happened in concert with the formation of the MD Anderson Cancer Network. She talks about the two categories of partnership that can be formed and notes that MD Anderson will seek to establish four to six co-branded partnerships in the next ten years. A partnership is evolving in Cooper, New Jersey.

## Interview Session Two: 2 June 2015

Segment 00B
*Interview Identifier*

Segment 11
*The Center for Global Oncology: Background and Operations*
B: Building the Institution;
00:00 – 25:40

Story Codes

A: Overview;
A: Entrepreneurs, Biotech,
A: The Administrator;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;

Ms. Hay provides an overview of the formation and operation of the Center for Global Oncology. She served as Associate Vice President of Global Business Development, one arm of service in the Center.

She begins by explaining that healthcare institutions nationwide were seeking partnerships when the decision was made to form the Center in 2008. She the talks about how the institutions contacted MD Anderson, how their needs were assessed, and how she partnered with Oliver Bogler, in Global Academic Programs, to satisfy those needs.

She sketches her main role, to identify and negotiate legal contracts with partner institutions, and provides examples, including consideration of financial gain for MD Anderson.

Ms. Hay also sketches the challenges involved in bringing institutional (and national) cultures together in multi-disciplinary care.

Segment 12
*The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part I*
B: Building the Institution;
25:40 – 34:00

Story Codes
A: Finance, Entrepreneur, Biotech
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Institutional Processes;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;

Ms. Hay explains how institutional growth has resulted in reorganization that has brought the Center for Global Oncology into the new MD Anderson Cancer Network. The aim, she explains, has been to address the disconnect between business development and research.

She talks about the "product line" of connections with MD Anderson: partnerships, sister institutions, and certified membership.

Ms. Hay also explains the process by which the MD Anderson Network's significance has been clarified within MD Anderson, winning support from division heads. Since division heads must approve physicians working in partner institutions, this facilitates expansion.

Segment 13
*Dr. Ronald DePinho and Institutional Change*
B: Institutional Change;
34:00 – 40:10

Story Codes
B: Growth and/or Change;
B: Institutional Politics;
B: Controversy;
C: Understanding the Institution;
D: On the Nature of Institutions;

Ms. Hay comments on the early years of Dr. Ronald DePinho's leadership of MD Anderson. She notes his emphasis on the "democratization of cancer." In response to a question about criticisms of his approach from MD Anderson faculty, she says that the value of partnerships is now being demonstrated. She comments on all institutional change being a difficult, particularly in medical institutions, which are traditionally conservative.

Segment 14
*Planning for the Next Growth Areas*
B: Building the Institution;
40:10 – 55:33

Story Codes
B: MD Anderson in the Future;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Research, Care, and Education;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;

B: The MD Anderson Brand, Reputation;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: On Texas and Texans;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;

Ms. Hay explains that the Office of Business Development is looking ahead to visualize opportunities arising from research and patient care.

On the research side, she talks about big data and the opportunities to gather enormous amounts of data that can feed personalized care.

She notes that MD Anderson has created a new position: Chief Innovations Officer.

Next she talks about pursuing employers as partners, with MD Anderson supplying expertise in prevention, screening, and education. She talks about a pilot program that will begin in about a year, and explains that there is more awareness of the practical value of prevention and employers want to offer such programs.

Segment 15
*The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part II*
B: Building the Institution;
55:33 – 1:04:00

Story Codes
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Institutional Processes;
B: Building/Transforming the Institution;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;

Ms. Hay returns to the story of the Center for Global Oncology's transformation into the MD Anderson Cancer Network. She explains that this was a sign of growth and maturation and became necessary so MD Anderson could develop a clear line of products that allowed affiliation with the institution.

Segment 16
*As VP of Business Development: Today's Initiatives and What the Future Holds for MD Anderson*

B: Building the Institution;
1:04:00 - 1:24:00

Story Codes

Ms. Hay sketches her current projects and her vision for new directions.

Her current work focuses on refining the model of how MD Anderson establishes partnerships with other institutions in the U.S. and abroad. She talks about the need to develop payer products to address changes in the healthcare reimbursement arena. She talks about the need to diversify MD Anderson's income streams beyond patient care revenue and lists roles that the Office of Business Development serves as other offices take on this challenge as well.

Ms. Hay explains that in future she will focus on visioning business possibilities facilitated by technology and gives an example of discussions with Electra about providing mobile treatment planning for radiation oncology.

Ms. Hay notes that "we should be a cancer knowledge network" in a nation that focuses on genetic testing, molecular immunology, and the democratization of cancer care dovetail with MD Anderson goals.

Segment 17
*Personal Sacrifice, Women, and Leadership at MD Anderson*
B: Diversity Issues;
1:24:00

Story Codes
C: Dedication to MD Anderson, to Patients, to Faculty/Staff;
C: The Life and Dedication of Clinicians and Researchers;
C: Women and Minorities at Work;
A: Experiences Related to Gender, Race, Ethnicity;
C: Leadership;
C: Mentoring;

Ms. Hay begins with comments on the personal sacrifices she has made because of her belief in the MD Anderson mission.

She then offers leadership advice and comments on the experiences of women aspiring to leadership roles at the institution. She comments on what women in particular bring to leadership and negotiation.

Segment 18
*Resilience in Leadership and a Presidency Defined by Innovation*
B: Institutional Change;

Story Codes

B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The MD Anderson Brand, Reputation;
C: This is MD Anderson;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;

Ms. Hay begins by explaining that resilience is a key quality for a leader, particularly in a physician-led institution.

She talks about the importance of innovation and strategic thinking at MD Anderson, observing that innovation may define Dr. DePinho's legacy at MD Anderson. She explains that she visualizes a "perfect storm" coalescing, where the institution is on the "cusp of greatness."

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# *Amy Carpenter Hay*

**Interview Session One: February 4, 2015**

**About transcription and the transcript**

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [ ].

In addition, the Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

## Chapter 00A
## *Interview Identifier*

***Tacey Ann Rosolowski, PhD***
[00:00:00]
Please jump in and correct it for me.

***Amy Carpenter Hay***
[00:00:02]
I will.

***Tacey Ann Rosolowski, PhD***
[00:00:03]
All right. And the counter is moving. So, I'm Tacey Ann Rosolowski, and today I'm interviewing Ms. Amy Carpenter Hay for the Making Cancer History Voices Oral History Project, run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Ms. Hay came to MD Anderson in 1999. Is that correct?

***Amy Carpenter Hay***
[00:00:24]
No. [laughs]

***Tacey Ann Rosolowski, PhD***
[00:00:24]
Okay, already, right?

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***Amy Carpenter Hay***
[00:00:27]
Nineteen ninety-six.

***Tacey Ann Rosolowski, PhD***
[00:00:27]
Ninety-six.

***Amy Carpenter Hay***
[00:00:28]
August of 1996.

***Tacey Ann Rosolowski, PhD***
[00:00:30]
Okay. And you were an administrative fellow at that time?

***Amy Carpenter Hay***
[00:00:33]
[laughs] No.

***Tacey Ann Rosolowski, PhD***
[00:00:34]
Hey, [inaudible].

***Amy Carpenter Hay***
[00:00:35]
I came to MD Anderson in 1996, actually, as a patient service coordinator—

***Tacey Ann Rosolowski, PhD***
[00:00:39]
Okay.

***Amy Carpenter Hay***
[00:00:39]
—straight out of college.

***Tacey Ann Rosolowski, PhD***
[00:00:41]
Oh, wow, okay. All right. And then, in 2000 you became senior department administrator to Radiation Oncology. Is that correct?

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***Amy Carpenter Hay***
[00:00:51]
Yes.

***Tacey Ann Rosolowski, PhD***
[00:00:52]
Okay.

***Amy Carpenter Hay***
[00:00:53]
In nine—your 1999 date was correct in that I was an administrative fellow—

***Tacey Ann Rosolowski, PhD***
[00:00:57]
Okay.

***Amy Carpenter Hay***
[00:00:57]
— in 1999. And then, when that was complete, and then I took the Radiation Oncology position in 2000.

***Tacey Ann Rosolowski, PhD***
[00:01:03]
Okay, and it's been since 2012 that you've served as vice president of Business Development?

***Amy Carpenter Hay***
[00:01:09]
That is correct.

***Tacey Ann Rosolowski, PhD***
[00:01:09]
Okay, great. This session is being held in Ms. Hay's office in the Cancer Network suite in the Mid-Main Building of MD Anderson. And today is the first of two planned interview sessions. It is February 4th, 2015, and the time is about six minutes after one. So, again, thank you very much for participating.

***Amy Carpenter Hay***
[00:01:32]
Well, thank you.

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Interview Session: 01
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# Chapter 01
## *An Early Interest in Health Care*
## A: Educational Path;

**Story Codes**
A: Character, Values, Beliefs, Talents;
A: Personal Background;
A: Professional Path;
A: Inspirations to Practice Science/Medicine;
A: Influences from People and Life Experiences;

***Tacey Ann Rosolowski, PhD***
[00:01:32]
Really appreciate it. And just for the record, to start, can you tell me where you were born and when?

***Amy Carpenter Hay***
[00:01:39]
Yes. I was born on September 16th, 1973, in Dallas, Texas.

***Tacey Ann Rosolowski, PhD***
[00:01:45]
Okay. And did you grow up in that area?

***Amy Carpenter Hay***
[00:01:48]
Yes, I stayed in Dallas until I left for college in 1992.

***Tacey Ann Rosolowski, PhD***
[00:01:54]
Okay, all right. Now you said that you thought it would be most appropriate to talk about your college experience and coming to MD Anderson. That would help tell your story the most effectively. So, why don't you start—

***Amy Carpenter Hay***
[00:02:07]
Great.

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***Tacey Ann Rosolowski, PhD***
[00:02:08]
—however you feel is the best way?

***Amy Carpenter Hay***
[00:02:09]
Great. Happy to. So as I mentioned, I grew up in Dallas, Texas—obviously very comfortable, and know Texas very well. I went to college at Southwestern University in Georgetown, a small liberal-arts college about thirty-five miles from Austin. And so, spent my college years in that area of Texas.

***Tacey Ann Rosolowski, PhD***
[00:02:32]
Why did you choose to go to that institution?

***Amy Carpenter Hay***
[00:02:34]
Southwestern is a small liberal-arts, really, based on a broad educational platform. So as I was completing high school, it was very clear to me that I was interested in so many things, and it was very intriguing to me to go to an environment with a small population. So I was looking for a small school. I was looking for, really, a broad scope of education. So Southwestern gave me the ability, quite frankly, to take a lot of courses and get exposed to a lot of things that I think I might not have had the opportunity at a larger state school or larger environment.

***Tacey Ann Rosolowski, PhD***
[00:03:18]
What were some of the interest areas? You know, you said it was pretty wide. What were some of the things that were intriguing you at that time?

***Amy Carpenter Hay***
[00:03:24]
Mm-hmm. I was very interested in psychology. I was very interested in ethics. I also, at the time, was very interested in photography, so it also had the arts component. At the—at the same time, was interested in being a physician, potentially. So, this allowed me to take some of those initial biology and chemistry courses, which I quickly figured out that I was much better suited for finance and business. And so, it really allowed me to get a broad spectrum the first two years of my education, which really ended with me having a degree in psychology and history. And I had, also, a minor in education. So, a pretty wide breadth of classes and opportunities.

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***Tacey Ann Rosolowski, PhD***
[00:04:19]
When did you discover the whole finance and business piece? Was that as an undergrad?

***Amy Carpenter Hay***
[00:04:24]
That was as an undergrad.

***Tacey Ann Rosolowski, PhD***
[00:04:26]
Oh, and how did that happen?

***Amy Carpenter Hay***
[00:04:26]
I took—I took a finance course. And the way Southwestern is set up, you must take certain courses in all the core areas to graduate. It's kind of their holistic approach. So, whether you like business or not, you had to take one of them. And I took a finance course, and I really enjoyed it. I also took a stats course, and I found that fascinating. And it nicely fed into kind of the side of epidemiology in healthcare. While I quickly figured out my acumen was not in biology and chemistry—really, organic chemistry—it was clear that there was some opportunity to still be involved in healthcare and not necessarily be a physician. So it was a nice approach.

***Tacey Ann Rosolowski, PhD***
[00:05:05]
Why were you so drawn to healthcare? It sounds like that was fairly early as an interest.

***Amy Carpenter Hay***
[00:05:11]
It was. And most of that was due to the patient aspects of it. I really enjoyed the patient contact. I've always been a big believer in doing something that meant something. I never even, early, wanted to just have a job. I wanted to have a career. I wanted my work to be part of who I am. So part of that is having something that is aligned, for me personally, with people, and helping them, and having a clear mission, and a clear drive for why you go to work every day.

***Tacey Ann Rosolowski, PhD***
[00:05:50]
Mm-hmm. You mentioned an iss—an interest in ethics as well. How—tell me about that piece.

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***Amy Carpenter Hay***
[00:05:58]
Through the psychology arm, I took some courses in ethics and philosophy, and, you know, the cool—that whole area of reading the works that have been completed, and really thinking of how you could adopt them to current environment. Again, it's kind of the approach of how could you be within the healthcare field but not necessarily be a physician? And I saw that as another avenue, just like psychology. You know, psychology was another avenue, ethics, business. So, you know, looking for areas that not only I was interested in, but also, you know, had a potential for, and how that might adapt to healthcare in the long term.

***Tacey Ann Rosolowski, PhD***
[00:06:41]
Was there something in your family that kind of oriented you towards a service mission? What do your parents—what did your parents do?

***Amy Carpenter Hay***
[00:06:50]
You know, that's a good question. I never thought about it that way. My father was in international reinsurance, and just retired this last year. And my mother is an artist, so she is very much on the arts side. So I think a lot of the photography and the ability to be very flexible and nimble comes from her. The business side comes from my father. I was very lucky in that I had the opportunity to literally live down the street from my grandparents, who were very instrumental in my life. My grandmother is still alive. She's ninety-six right now, and she still reads the paper every day, and clips things out, and sends them to me to make sure I am up-to-date on politics and healthcare and legislation. So, I don't know that there was a direct connection, but I think it might have been the convergence of having one role model, in my father, that was very business, and another very different role model in my mother, who was very artistic and very open to new things.

***Tacey Ann Rosolowski, PhD***
[00:07:55]
Mm-hmm. Tell me your parents' names.

***Amy Carpenter Hay***
[00:07:57]
Mary Ann and Neil Hasty—H-A-S-T-Y. They both live in Dallas, still, with my grandmother. And thankfully they own a home in Galveston, so they come often and spend time with us. My dad is now retired, so they're enjoying gallivanting around the world. I think a lot of my love for travel and new experiences comes from them. They—it's not uncommon for them to disappear in Europe and we have to hunt them down from time to time. So—

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***Tacey Ann Rosolowski, PhD***
[00:08:30]
[laughs] Do you know where your parents are?

***Amy Carpenter Hay***
[00:08:32]
I know. I mean, even my children, they kind of laugh and ask where's, "Where's Gammy and O.B.? We haven't heard from them." Thanks to texting and Skype, now we can find them. [laughter]

***Tacey Ann Rosolowski, PhD***
[00:08:45]
That's a great story. Well, I'll ask you at some point about your own travels.

***Amy Carpenter Hay***
[00:08:47]
[inaudible]

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# Chapter 02
## *A New Role at MD Anderson Reflects Changes in Health Care*
## B: Institutional Change;

**Story Codes**
A: Joining MD Anderson;
A: Professional Path;
A: Overview;
A: Definitions, Explanations, Translations;
C: Patients;
C: Cancer and Disease;
C: This is MD Anderson;
C: Evolution of Career;
C: Leadership;
C: Mentoring;
D: The History of Health Care, Patient Care;
C: Research, Care, and Education;
B: The Business of MD Anderson;
B: Growth and/or Change;
B: Institutional Processes;

***Tacey Ann Rosolowski, PhD***
[00:08:48]
Well, tell me about the move from college, then, to your first position.

***Amy Carpenter Hay***
[00:08:55]
So, that is probably a little bit more personal than work, in that my—I was dating a young man at Southwestern. He was older than I. And he was in the oil and gas field. And he came to Houston for a job before I graduated. So he asked me to marry him in the middle of my senior year, so he was already set and established. So I came to Houston. Quite frankly, as I suggested, while my college was, I believe, educationally, extremely sound, it was not necessarily focused on finding a job getting out. So with a psychology and history degree with a minor in education, it left a lot of, you know, question on what I was gonna do. So I came to Houston, and to be quite frank, looked around the healthcare sphere. Obviously, you know, that's one reason why we live in Houston. It's just a mecca for healthcare, and good organizations.

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***Tacey Ann Rosolowski, PhD***
[00:09:58]
So you did end up marrying that young man? [laughs]

***Amy Carpenter Hay***
[00:10:00]
I did. I did marry him.

***Tacey Ann Rosolowski, PhD***
[00:10:01]
And his name is?

***Amy Carpenter Hay***
[00:10:02]
His name is Cullen Hay. And I did marry him. I'm sure there's days where he wished that was not the case. [laughter]

***Tacey Ann Rosolowski, PhD***
[00:10:10]
Well, it probably [inaudible].

***Amy Carpenter Hay***
[00:10:12]
But, so, you know, quite frankly, I came in. I did a full review of all the healthcare entities in Houston. And it was very clear to me that I wanted to work for MD Anderson. The idea of working for an institution with one mission is something I still talk to people about. I don't think most people have the opportunity or understand how special that is. We have on mission. It's very clear. I don't have to worry about balancing cardiology and oncology and acute care. I have one mission. And so, I started applying to MD Anderson. Quite frankly, was having a really hard time getting in. You probably hear that often. It's hard to get in, but once you do, it's hard to leave.

And at the time, one of my early mentors here—her name was Sherry [Sharon] Martin—I met her. And you—she might have been someone that you've run across before. She was doing a brand new program at Anderson in which she was hiring college graduates to fill a role—a new role. And they were calling it a patient service coordinator—a PSC. To be quite frank, it was really a glorified receptionist who scheduled appointments. But they were trying to get in a new group of people. They were trying to change the old paradigm of it being kind of a secretary role. And so, they went out and hired a group of people straight out of college with, you know, bachelors prepared. And they trained us. And we were supposed to go out and change this role,

and really make it impactful, and work with the doctors more one on one, and work with the patients, and really change kind of the model out there.

***Tacey Ann Rosolowski, PhD***
[00:12:08]
Now what was the rationale for changing the model in that particular way?

***Amy Carpenter Hay***
[00:12:13]
I think it was twofold. The first fold was that MD Anderson had just, at that time, gone through a series of layoffs. It was, financially, not a great time for us. So they had this golden opportunity to really look at how we were providing patient are on that more administrative side, and make some changes. The second was that patient care was getting much more complicated. The scheduling of patients was not as easy as it used to be. It used to be more simple. You know, DI [Department of Diagnostic Imaging] would schedule their own images. And, you know, other centers would schedule their own things. Well, the paradigm was changing in that when a patient came into a clinic, the doctor would order a series of scans, tests, whatever the case may be. And one PSC, or clerk for other terminology, would schedule all of that. So this individual had to understand how to schedule everything from an MRI to a blood draw to a consult with psychiatry.

All of that sounds fairly easy, but with our systems here it's far from easy. You have to know, for example, that in order to schedule a CT [computed tomography] you have to first order a BUN [blood urea nitrogen] and creatinine, and you need two hours in order for those results to come back or they won't schedule—they won't see the patient. So they were kind of training this new line of staff who had a little bit of an educational background, and could really understand the components of oncology. While clearly not physicians or nurses, had enough background where they could logically really coordinate schedules for patients, and be that frontline for patients. So instead of just being someone behind the closed doors who is scheduling, really be up in front. You know, "Hello, Mrs. Smith. I know you need a CT. I need to get you a BUN and creatinine. How do—can you come in tomorrow? Or is next week better?" So, more of that interchange.

So, I think those two factures—factors really bled into making some changes on the clinical side.

***Tacey Ann Rosolowski, PhD***
[00:14:29]
Just a little note on context: now, was this plan—'cause John Mendelsohn was new president in '96. Was this new plan conceived under him, or was this held over from the previous administration under Charles LeMaistre?

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***Amy Carpenter Hay***
[00:14:43]
This was the end of Dr. LeMaistre's presidency. So, interestingly enough, my first day on the job was the first day of Dr. Mendelsohn on the job. So on my first day, I went to Hickey Auditorium and sat and listened to his vision, which I always tell people, it gives me an interesting perspective, because I didn't know anything under LeMaistre. And so, I didn't get the change in presidents that a lot of people felt. Now I've experienced it now from Mendelsohn to [Ronald] DePinho. But—so it was an interesting time. You know, there was a lot of things changing. I was—I was new and young and probably didn't appreciate all that was changing at the time. But it gave me a great opportunity to jump in and get involved.

So, as I went through the training for that and started that fall of '96, I was assigned to the Division of Radiation Oncology. I was assigned as a PSC there. I immediately started working in the section of Head and Neck Radiation Oncology. And, you know, it's interesting. Back then, the rule was you had to work in one spot for six months before you could transfer. And I had very high aspirations. I was—wanted to do this job and do it well, but only for six months, and then I wanted the next job. And I had already started, you know, trying to figure out where my best fit was. I went to work every day, and some of the good advice that my father gave me was get up every day. Get dressed up. Present yourself. Never say no to anything. And just use this. Even if it's picking up the bathroom, go pick up the bathroom. If it's going to help a patient, go help a patient.

And I will say, it was—it was a difficult six months. It—that—I th—that role, coming from a very idealistic college grad, was hard. It was scheduling patients and answering phones, which is not what I thought I would be doing when I got out of college. That's why I went to college. But probably some of the most influential time as a young adult, because I did exactly as my father suggested. I got up every morning, and while the other clerks and so forth would wear scrubs or, you know, be very casual, I wore a suit every single day.

***Tacey Ann Rosolowski, PhD***
[00:17:12]
They always say dress for the job you want, not the job you have. [laughter]

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***Amy Carpenter Hay***
[00:17:14]
Exactly. I did, every day. I would—and I got known very, very quickly by those doctors, that they could ask me to do anything, because if I didn't know the answer I'd just figure it out. And my answer was never, "It's not my job." And that's something still, oftentimes, we struggle with here. And I've kind of—I joke with people and say that I feel like sometimes I've made my whole career on never saying, "It's not my job." Always just saying yes, and then figuring it out. Because there's nothing around here that you can't figure out. There's always someone that knows the answer, or some method to do it. But the answer is always, "Yes, yes, I can that. Yes, I would be happy to do that."

And I did that for six months. Made some incredible relationships. One of the men I do truly hope you interviewed was Dr. Kian Ang. He became a mentor, and has passed away since. But a fantastic man—really influential radiation oncologist around the world. But as that six-month clock came ticking, I went to my boss at that time and I said, "You know, I'd really like to look for opportunities for me to expand my role." And I—at the time, I found this very deflating. Now I understand much better. She said, "No, your role is a PSC. If you'd like to stay, great. And if not, that's fine." And I was very surprised by that, at the time. And so, I ended up leaving.

(phone rings) I realized that I was gonna have to make that next step. And it was at that time that I was introduced to a wonderful woman by the name of Leslie Bean. And at the time, Leslie was the head of Patient Advocacy at MD Anderson. One of the most compassionate, wonderful, committed women, again, around here. And I went to her, and I talked to her about who I was and what I wanted to do, and ended up taking a position as a patient advocate. This gave me a great opportunity to leverage everything I had just learned on the clinical side. I had been in the trenches. I had worked with doctors and patients and nurses, and really enjoyed it. But this role had me meeting with patients. And, at the time, we met with every patient that came in as a new patient. I'm not sure that's possible anymore, but it was a little smaller back then. And if they had problems, we were there to really help them work through them, to listen.

***Tacey Ann Rosolowski, PhD***
[00:20:06]
What kind of—I'm sorry.

***Amy Carpenter Hay***
[00:20:06]
Mm-hmm?

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***Tacey Ann Rosolowski, PhD***
[00:20:06]
What kind of problems would you address?

***Amy Carpenter Hay***
[00:20:09]
Really, anything at all. We were there as the patient advocate, so, you know, everything from, "I'm not happy with my appointment time," to , "I'm not happy with my doctor." And working through those issues. Not just the patients but their families, often. I covered two areas in patient advocacy. I covered Head and Neck, which was very easy 'cause I understood it now. And I also covered Pediatrics, which was much more complex because the issues that you deal with are most often family issues, and complicated, and tough.

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# Chapter 03
## *Learning the Complexities of Institutions; Balancing the Goals of Administrators and Physician-Leaders at MD Anderson*
## A: Overview;

**Story Codes**
A: Professional Path;
A: The Administrator;
B: MD Anderson Culture;
C: Understanding the Institution;
D: On the Nature of Institutions;
C: Leadership;

[00:20:09]+

***Amy Carpenter Hay***
So, during that timeframe, really, it's—I think a lot of my early negotiation skills came from being a patient advocate. Having to interface, basically, not only with the patient and their family, but also with the clinicians back at MD Anderson. So I was—I was in the middle, and it was my job to come to a resolution in a way that was palatable to both sides. So, excellent experience, but it was during that time that I realized that that was not what I wanted to do forever. Great experience. Incredible opportunities. Allowed me to meet people—specifically, the physicians across this organization. I networked. Met every doctor that I could. Tried to continue to kind of be the go-to for them

That led me into thinking through my right position, which, as I worked through administrative issues and issues of bureaucracy and, you know, how tough sometimes it is for patients and families to work through this place, it became very clear that I wanted to help fix that. And while my role was important at the time, I felt like I could do more if I went back and got a great educational background specific in healthcare—healthcare administration and healthcare business finance.

So during that time, I applied to Houston Baptist University, just here in town. They have a master's of healthcare administration program. I picked HBU because they had an after-hours program, so I could keep my job and I could go to school every night from 6:00 to 10:00, Monday through Thursday. [laughs] And we did—I did that, and was able to finish the program in two years. And when I completed the program, I had a master's in healthcare administration with an emphasis in finance. And it really pushed me to the next step, which was applying for the administrative fellowship at MD Anderson.

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And I applied for that and was awarded the administrative fellowship in 1999. And it was really another big growth for me. I was the first administrative fellow that was ever an internal candidate at MD Anderson. They'd never had that. They'd always recruited big, big names. You know, UAB [University of Alabama at Birmingham] has a strong program; Wash U [Washington University in St. Louis]; others. And Sherry Martin was in charge of this program at the time, so she knew me from early on. And I think she believed in me. And so, she gave me this unbelievable opportunity, and I took it, and I used it every single day.

It was a really interesting opportunity in that they usually hire two to three administrative fellows. That year they hired two of us, myself and a young woman who is still at MD Anderson as well, which is interesting. Because in that timeframe, a lot of people were coming and going, especially at that age group. And she came from Wash U. Excellent background, excellent credentials. Really was, administratively, over nursing, and a lot of Wash U, just excellent, you know? But we had very, very different skill sets. I came from internally, so I knew this place, and she came from externally, so had a lot of experience. So, fantastic opportunity that year, really grew, and this organization worked.

***Tacey Ann Rosolowski, PhD***
[00:24:43]
What do you feel was—what were some of the big lessons you got from that year, in that role?

***Amy Carpenter Hay***
[00:24:50]
Mm-hmm. You know, big lessons were the complexity of MD Anderson, appreciating that because this is a physician-led organization, the complexity that is required in order to push forward our research agenda and our clinical agenda, I think is not always understood. I also had the opportunity, at that time, to work with a couple strong leaders. At the time, I was in between Kevin Wardell as the CEO [chief executive officer] and also Dr. David Callendar, who's back in the system at UTMB [University of Texas Medical Branch, Galveston] now. So, really getting to see the dynamic between physician leadership and administrative leadership. And I think that was the first clear sign to me that, in order for MD Anderson to run as efficiently as it can, and to meet its goals, that it's a combination of a physician leader and an administrative leader. And it's not only a combination, it's a partnership, and it's working together in order to accomplish those goals. That's not necessarily normal out there.

***Tacey Ann Rosolowski, PhD***
[00:26:17]
How would you describe the differences in, you know, values and focus for physician leaders and then more traditional administrative leadership?

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***Amy Carpenter Hay***
[00:26:27]
I think, you know, quite frankly, on the physician-leadership side, they are physicians first and administrative leaders second. In this environment, that is the right approach—absolutely the right approach. And I think we had a great example of that between Kevin Wardell and Dr. Callendar. Kevin was a fantastic leader. He was business savvy. He's gone on to do—and done fantastic things across the US [United States]. But he wasn't a physician. And Dr. Callendar had a very different approach. He was a physician first, so he could understand the role and, quite frankly, the desires of the doctors and the basic researchers, and then adapt the business to it instead of coming something from a pure business perspective and attempting to overlay the clinical.

That's a huge lesson learned, and it's one that I th—hopefully I've matured over time. Because one of the most important things here at Anderson is that, from a business perspective, we always—we have to make sure that we're never ahead of the clinical perspective. We have to be working in tandem. And it's easy to get that out of balance if you're not very careful.

***Tacey Ann Rosolowski, PhD***
[00:27:49]
Mm-hmm. But it seems like a real subtle dance.

***Amy Carpenter Hay***
[00:27:59]
I think it is. It's something that, I think, MD Anderson has matured over time, and really evolved. And it works so well, and it's so important for the doctors and for the patients. Because without that balance, something is going to get disjointed. And so, that approach, I think, has been really part of why we've been able to grow and evolve as much as we can.

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# Chapter 04
## *Planning the Proton Therapy Center*
## B: Building the Institution;

**Story Codes**
B: MD Anderson History;
B: Devices, Drugs, Procedures;
B: The Business of MD Anderson;
B: Institutional Mission and Values;
A: The Administrator;
C: Patients, Treatment, Survivors;
B: Beyond the Institution;
C: The Institution and Finances;
C: Research, Care, and Education;
D: Technology and R&D;

[00:27:59]+

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***Amy Carpenter Hay***
So as I started to complete my administrative fellowship in that ’99 timeframe, another large opportunity came up, and it could have been just good timing, and it could have been happenstance. But at the time, I was introduced to two men that both became mentors for me. One was a Mr. Mitch Latinkic, and one was a Dr. James Cox. And at the time, Dr. Cox was pursuing a Proton Therapy Center here And it was 1999, and protons were fairly new. They really only existed at Loma Linda and at Harvard. Loma Linda had opened their center in the ’90s. And so, it was really the next—the next evolution of radiation oncology.

Dr. Cox had been discussing this with Dr. Mendelsohn, and really felt that, instructionally, we needed to be on the cutting edge. This has to be part of our Radiation Oncology Department. It has to be part of one of our modalities of care for patients that would benefit from it. So I got very interested. The whole technology kind of intrigued me. The fact that there weren’t very many centers intrigued me. And so, during the latter days of my fellowship, I started engaging with Dr. Cox and with Mitch and others in the division, almost to the point of I used to tell people I’ve made best friends with the secretaries, and I’m gonna go hang out with them until they can see me and talk about protons. [laughter]

And I continued to do that, and as my fellowship came to an end, Dr. Cox invited me to join the Division of Radiation Oncology. And right at the time, he kind of gave me three jobs. The first job was, we have to get a Proton Therapy Center. “Dr. Mendelsohn has told us that he supports us. He’s going to ensure it happens, but we can’t use any MD Anderson capital. So, therein lies the problem. So that’s your dilemma. Go fix it.” And the second dilemma is, “Oh, by the way there is no standard reimbursement rate for protons with CMS [Centers for Medicare & Medicaid Services] yet. We need that in order to go out and raise the debt and equity.” The third challenge he gave me is, “Oh, by the way, there’s this small little clinic in Bellaire that I’ve got my eye on, and that I would really like to see if we can extend radiation oncology to the community. Look into it. See what you think. But I’d really like you to see if this is something that makes sense for us.”

So I took that—those roles and started running as fast as I could. We were able, through a lot of people’s support across the United States—we formed a consortium around proton therapy. It’s still in existence today. It’s called the Proton Therapy Consortium. And now it’s—it includes more than a dozen centers, and centers up and coming. But at the time, it was very small. It was MD Anderson, Mass. General [Massachusetts General Hospital, MGH], Loma Linda—very small. And we banded together, and ultimately were able to get rates for proton therapy.

So that was the first key. That happened, gosh right around—for—in the 2001, ’02 area. At the same time, while we were doing that, I went out with a group of people—Mr. Latinkic, and Dr. Cox, and others—and we started looking for someone that was interested in partnering with us

around protons—a general partner who could help us get the funding and, ultimately, contract and do the work. It was a fascinating exercise, and it was something that I had absolutely no exposure to before. So we found ourselves, you know, in meetings with investment bankers and large banking branches, pitching protons, talking about the science, talking about what we could do for patients, literally trying to raise debt and equity. And this was all starting to happen right around September 11th.

And we thought we had it almost done. And September 11th hit. And the markets froze. And we all had to kind of take a deep breath. At the same time, we thought we had already agreed on a vendor for protons. We'd been engaged with Tenet Health Care, and they were gonna bring Ion Beam Applications [IBA] to the table as the provider of the equipment. And right before September 11th, Tenet hit Allegheny in California. And they were told that they had to spend millions and millions of dollars re—retrofitting all of their hospitals in California. So all of a sudden they turned around to us and said, "Oh, by the way, all those funds we were gonna do on protons including not you, but everything across the United States—we've got to—we've got to use that to retrofit all of our hospitals in California. So, we're out."

So all of a sudden we have—we have no Tenet. We have no manufacturer, because IBA was with them. September 11th hit, and all the markets froze. So we took a deep breath and we reevaluated where we were. And we pulled together the two parties—the Styles Group—Styles Company, as the developer of the project. We realized that we needed help developing the project, someone day-to-day to be responsible for the construction. And we also pulled in at the time, it was a small boutique investment-banking firm called Sanders Morris Harris. They were a small boutique here in Houston, and they had clients that—what I refer to as patient money. They had the firefighters union. They had the police officer union. They had local clients with funds available to put up debt and equity, but patient enough to get a return on a project that's a multi-, multiyear project.

And so, instead of, you know, finding ourselves in New York talking to Bank of America or Goldman Sachs, we found ourselves in Houston talking to the firefighters and talking to the police officers. And that message was very different because, for example, with firefighters, we could tell them a message that meant something to them. A lot of firefighters have lung cancer. Protons is an unbelievably important tool in the treatment of lung cancer. So being able to talk to people locally where it would be in their backyard, and people within their pension fund could access it and hopefully gain value from it—that was a very different discussion. So while the aftermath of September 11th was still occurring in the markets, we were able to lockdown 30 million in equity, and the remainder of the 125 million in debt, and launch our proton-therapy journey. Which has been—definitely been a journey.

And it takes, as you may know—protons takes approximately three years to construct and equip

and commission. So this is a long-term investment. This center also sits, I should say, on our South Campus, so it was one of the original tenants there. So that, in additional to the fact that we had to, then, go out and find a new vendor of equipment. At the time, there really were not a lot of options out there. IBA—Ion Beam Applications—they had done the MGH facility, and they were, at the time, a bit tired. You know, MGH had been complicated, and had taken a long time.

***Tacey Ann Rosolowski, PhD***
[00:37:05]
And that stands for?

***Amy Carpenter Hay***
[00:37:06]
I'm sorry—Massachusetts General Hospital.

***Tacey Ann Rosolowski, PhD***
[00:37:08]
Oh, okay.

***Amy Carpenter Hay***
[00:37:09]
And so, we started looking around for other opportunities. It's always interesting how small the world is, but Dr. Cox's wife is a Dr. Ritsuko Komaki, a famous lung, radiation oncologist, internationally renowned. And she grew up in Japan. Japan has been involved in proton therapy for much longer than we have in the States. They have facilities over there, and Hitachi is a leader in protons there, but also in their engineering. And so, as we started looking for vendors and started requesting proposals, Dr. Komaki introduced us to Hitachi. And we started getting very interested, and our physics staff involved with Hitachi and what they were doing, and their future evolution of protons.

We ultimately decided to go with Hitachi, and I think a lot of that was due to the fact that the strength they brought in just pure engineering was something that is unfound. You know, even today our Proton Therapy Center has ninety-eight percent uptime. That's unheard of anywhere. Just the technology is so sound in its design and construction, it's really almost stunning. It's this perfect well-oiled machine just geared to patients.

***Tacey Ann Rosolowski, PhD***
[00:38:45]
Can I interrupt you just for one sec? I want to just pa—

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[The recorder is paused]

***Tacey Ann Rosolowski, PhD***
[00:38:48]
—to hear those things. [laughs] All right.

***Amy Carpenter Hay***
[00:38:53]
Okay.

***Tacey Ann Rosolowski, PhD***
[00:38:54]
We're going again.

***Amy Carpenter Hay***
[00:38:54]
Great, thank you. So, as we started our journey with Hitachi, with the Styles Company, with Sanders Morris Harris and our funding partners, we just had this great opportunity of pulling together leaders across not only MD Anderson, but across the world, to really make this happen.

***Tacey Ann Rosolowski, PhD***
[00:39:21]
Was the decision to create this Proton Therapy Center controversial within the institution?

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***Amy Carpenter Hay***
[00:39:30]
It's interesting, and this is actually a fantastic story from a historical perspective. Before Dr. Cox had decided that he was onboard with proton therapy, about four years before the University of Texas Board of Regents had been talking about protons, and had gone to Dr. Cox and said, "What do you think about this?" And he had provided them a written response. And the mem—it was a memo to the Board of Regents and it said, "I don't believe this is going to be the next modality of radiation oncology." Four years later, with everything that he'd learned and everything he was exposed to, he was a full believer. And we oftentimes kid him about that, because we went to the Board of Regents three times before we had the proton-therapy transaction completed, for various reason. You know, the wheels fell off; Tenet fell away; our partners changed; the markets froze. But that perseverance of making sure that we got protons, I think, was almost contagious.

So, while it was a large investment for a single-modality of care at MD Anderson, the way that we accomplished it, while at the time it felt a bit difficult and uncomfortable, the business transaction behind it allowed MD Anderson to not put that capital investment into protons. Our investment, quite frankly, is the land that it sits on. That two and a half acres of land over there was our investment. The rest of it was through a triple LP [limited partnership] with the Styles Company and Sanders Morris Harris and MD Anderson. At the time, for our investment, we got a percentage of ownership of the proton triple LC—triple LP, excuse me. And we also retained the professional revenue. So, because it was our doctors and our staff, we got the professional side.

I think what that allowed is, it allowed us to have protons but somebody else paid for it through a series of seven contracts, which you can only imagine the complexity of negotiating those. But those seven contracts guide our relationship. There's a contract that says that MD Anderson will provide all medical direction. So we have full clinical control. There's a contract that says MD Anderson will provide all of the staffing, all of the physics. So, the way that we put this transaction together gave MD Anderson 100 percent clinical control including all staffing, but it had somebody else paying for it. And so, I think, for that reason, there wasn't a lot of controversy on doing protons, because we could say we're not using institutional resources other than land. We're leveraging institutional resources. We're bringing something to MD Anderson that perhaps we wouldn't have the ability to get alone. A hundred and twenty-five million, at that time, was a significant dedication of capital when Dr. Mendelsohn was—rightly so—building buildings and expanding the research program.

So the way that we formulated the transaction allowed MD Anderson to have protons. And, as a good partner, fully participate and clinically lead, but let someone else handle the business, debt and equity side.

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***Tacey Ann Rosolowski, PhD***
[00:43:24]
What was it, just going back a little bit in the story—what was it that convinced Dr. Cox? I mean, you said he told the Board of Regents no, not the future of radiation oncology. What, what turned him around?

***Amy Carpenter Hay***
[00:43:37]
You know, I think it was a couple of things. The gentleman I mentioned earlier, Mitch Latinkic—Dr. Cox had recruited him from Loma Linda. Loma Linda was the first clinically based high-throughput Proton Therapy Center. Mitch had built and run that Proton Therapy Center. So he came here with a rich understanding of the technology, and also with clinical connections back to Loma Linda that were starting to produce research. And what Dr. Cox was looking for, as with most clinicians, was, "Show me the research behind it. Show me the clinical efficacy. If you can show me that, then I will be a believer if it will help my patients."

And so, until, you know, really in the last two decades, there wasn't a lot of research—published research on protons. You know, in my opinion, a lot of that is because the field of radiation oncology in the past didn't really lend itself to that. Now I often remind people of this: the field of radiation oncology has really been dominated by the introduction of new technology and, quite frankly, being able to prove, as we treat patients, its higher efficacy. Not necessarily doing the research trials, publishing, and then widely expanding. And a great example of that is IMRT, or intensity-modulated radiation therapy. IMRT is the highest level of radiation you can do with conventional photons. But when that technology came out, it was very clear we could do a dose histogram. We could write a treatment plan and see it on the computer. We knew it was better by seeing it. So you won't find a lot of head-to-head trials of conventional photons versus IMRT. No one ever really saw the need to do that. Therefore, it wasn't as typical in the nature of radiation, whereas it's very typical in medical oncology and other disciplines.

So with protons, those that had it—which were very, very few—were treating as many patients as they could—because there were very few centers—and weren't investing a lot in research. I think that's one of the things that's hindered the science. It's also an area that we, as MD Anderson, are trying to fix. Dr. Steven Frank, who's the head of the Proton Therapy Center now, and an unbelievable leader in that field—he is dedicated to the research side, to doing head-to-head trials, to doing quality-of-life, efficacy, dose trials on protons, to be able to have that scientific data that underlines it.

So I think that's the reason. It took some time for the science to catch up, and it still is. We still struggle in certain disease sites with protons. And what's occurring, and what has occurred over

time, is that there are certain diseases with protons—for example, prostate cancer—that, in the infancy of protons, many patients were treated that had prostate cancer with protons. And the reason for that is, there are many quality-of-life indicators that clearly show that protons are better. Things like incontinence and sexual dysfunction, protons really curbs those side effects. That said, there was not a lot of science on whether or not the efficacy was better, meaning did—were you able to give more dose? Are your outcomes better? The quality-of-life side was absolutely better.

So, you know, that is one of the disease sites that's always been a bit in question. And you find, if you kind of read press and so forth, a lot of pushback on insurance companies. You know, "Am I paying for efficacy or am I paying for quality of life?" Personally, I think you should be paying for both, but that's an area that has always been a question mark, versus things like pediatrics, base of skull, even lung tumors. Anything near a critical structure we can prove is better is protons, just by the properties of protons. Proton therapy, or protons as a particle, enters the body at a very low dose, and then escalates, and we can allow it to hit the tumor. And when it hits it, it falls off, so, eliminating all of this healthy tissue on the front and the back.

So you can imagine anything near your heart or your brain or your spine, it's very important. Whereas conventional therapy, just by its property, enters your skin at a very high rate, and then decelerates. And so, you get a large front dose, but you also get a tail of radiation on the back end. In some circumstances, that's not a bad thing. And so, one of the things that I'm very proud of the fact—that we've done here at Anderson, is that we have constantly said that protons should be one method of care in radiation oncology. It's not the panacea. It is one modality of care, just like conventional, just like brachytherapy, just like all sorts of things. You know, traditionally speaking, about fifty percent of curative patients should have pro—conventional radiation as part of their standard of care; sixty percent if you include palliative. Of those fifty to sixty percent, only about twenty-five to twenty-eight percent are even appropriate for protons.

So you really need to have both in order to have a comprehensive program. Or you need to have access to protons. And I think the way that we developed our center here was always with an eye toward it being a regional resource. Shouldn't have protons on every corner. There's no need. But you should have access to it if it makes sense for the patient.

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# Chapter 05
## *Establishing the First Satellite Center: "A Great Business and Clinical Story"*
## B: Building the Institution;

**Story Codes**
B: Building/Transforming the Institution;
B: Institutional Processes;
B: MD Anderson History;
B: Institutional Mission and Values;
B: Growth and/or Change;
C: Patients, Treatment, Survivors;
A: Character, Values, Beliefs, Talents;
B: The MD Anderson Brand, Reputation;
B: Beyond the Institution;
B: MD Anderson in the Future;
B: Discovery and Success;
C: The Institution and Finances;

***Tacey Ann Rosolowski, PhD***
[00:50:06]
This is kind of leading to some broader issues. And just to pick up a detail, the position that—it—am I correct that the position that Dr. Cox offered to you was director of Radiation Oncology—

***Amy Carpenter Hay***
[00:50:21]
Yes.

***Tacey Ann Rosolowski, PhD***
[00:50:21]
—in 2001? Okay. And you held that from 2001 to 2005, and developing the pro—the—kind of financial infrastructure for the Proton Therapy Center was one of those missions.

***Amy Carpenter Hay***
[00:50:33]
Mm-hmm.

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***Tacey Ann Rosolowski, PhD***
[00:50:33]
Now, you mentioned the regional resource. Another thing you were doing was developing the satellites.

***Amy Carpenter Hay***
[00:50:40]
Yes, yes.

***Tacey Ann Rosolowski, PhD***
[00:50:41]
So tell me—tell me about that process, too. I'm sure we'll come back—

***Amy Carpenter Hay***
[00:50:44]
Yes.

***Tacey Ann Rosolowski, PhD***
[00:50:44]
—to proton therapy.

***Amy Carpenter Hay***
[00:50:45]
No, I'm sure you will. Yes, because they're—they were happening simultaneously, but they were very different. So—and I still think that the story of how we got to where we are today in the regional network is fascinating. One of these days, it's just a—it's a great, great business and clinical story on how we got there, and it all starts with Bellaire.

So, going back, Dr. Cox said, "I'm very interested in this property. It's kind of rundown. It's being operated by a radiation oncologist that no one's really happy about.

***Tacey Ann Rosolowski, PhD***
[00:51:28]
What was it—what's the name of the service that was located there?

***Amy Carpenter Hay***
[00:51:31]
It was a radiation oncology center.

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***Tacey Ann Rosolowski, PhD***
[00:51:34]
Okay.

***Amy Carpenter Hay***
[00:51:34]
I don't know the exact name, but you can fill in the detail. And so, he asked me to go take a look at it. So I went over there and took a look at it, and he was right. It was a dump. [laughter] It was—it was approximately ten miles away from the Texas Medical Center [TCM], so it was literally down the street. And it needed a lot of work, but I saw it as a huge opportunity. So, I got very involved, and started writing business plans. What could we do here? Could we take it over? Could we lease it? Could we buy it?

***Tacey Ann Rosolowski, PhD***
[00:52:09]
What was it that you saw? What got you so excited about this property?

***Amy Carpenter Hay***
[00:52:14]
I think it was the idea of extending MD Anderson out of the Texas Medical Center. So, with my background a patient advocate, and even as a PSC, MD Anderson is a—often a daunting place for patients and families. And radiation oncology—as you know, most of the time these treatments are four to six weeks. That mean that these patients have to come to the Texas Medical Center four to six weeks, every single day. That's hard. That's hard on anyone. And while we did the best we could—you know, we offer valet, and close, you know—it's really a strain, you know? And a lot of these patients are very sick, so they need help. They can't come on their own. The need loved ones to help them, and that's a loved one coming into the Texas Medical Center every day.

And so, to me, this was a—just a fantastic opportunity to see if we could build an environment. And starting with just radiation, in which the patients literally could drive up to the front door, get out of their car, walk in, get their treatment, and walk right back out. Not go through a maze, not get stuck in valet, not get stuck somewhere else, but a smaller environment. So I was very intrigued by that. You know, until that time, we really had not gone outside the Texas Medical Center. We had been very focused. And this was something new and different. And I think there's a little bit of a personal storyline there in that, all along my career here, I've been intrigued and enchanted by the new and different. You know, what's the—what is—what is new, you know? What can we do that's different in how we deliver care, how we approach care, how we access patients—whatever the case may be.

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So, as luck would have it, this center was in such distress that the owner of it had defaulted on his payments. And GE [General Electric Capital] held the note to the center. So, got to talking to GE, and got to kind of understand. And they had no interest in owning a Proton Therapy Center. They didn't want to own it. They just had that as the collateral for their note. So they were very interested in a potential buyer in order to, quite frankly, get out of this. They didn't want to own a center and they didn't want to operate it. They had no business in that. So as the facility closed and GE took the note, they looked to us to take it from them, which was a great opportunity. It needed a lot of work. It needed patching and painting and new equipment.

And oh, by the way, you had to find a doctor who is willing to go outside of the TMC, because we had been very TMC-focused. And you needed to find a physician who perhaps is not as academically inclined—so, someone that wants to treat patients most of their time. You know, is not interested in having a basic science lab. Not that the individual wouldn't be involved in clinical trials, but it would need to be someone that wanted to be at that center. Because a lot of the value I saw was having an environment where a patient could come in the front door and it's small enough that they could see their doctor every day. Doesn't mean they're seeing him in the clinic, but they would know that the doctor was there.

You don't get that on Main Campus. I wish we could. You know, you get seen every week by your doctor, and that's fantastic. But it's a big place. You come in and you get treated. Unless there's a problem, you leave. This was a new take. This was one PSC; therapists that stayed on the same machine and were dedicated to that center; and a doctor that that was gonna find his or her home there. So if you needed to see—and the first doctor we recruited was Dr. Elizabeth Bloom. She was perfect. She trained at MD Anderson. She would—did some military service, and was ready to come back. But she did not have a basic science, academic bent. She wanted to treat patients. She wanted to be there every day. She wanted to say hi to patient X, and know that his wife was sitting in the lobby, and ask how their kids were. She wanted that type of environment, so we were able to draw her in. She joined us to open up this center.

And that was right around Y2K [2000]. And the reason why that stands out is because here at MD Anderson, we all thought the world was going to come to an end. And surely all of our IT [information technology] would not work. So we were—we were pushing everyone to get the center and operational before Y2K hit, just in case all of the IT systems just crashed. And, of course, as we all know, that was a non-event [laughter] and we were all just fine, and everything worked. So we opened up that center right around 2000. And really, immediately, had just an unbelievably positive patient-care response.

One of the parts I did leave out—which I don't want to, because I think it's humorous—is, much like protons, in order to get this approved—meaning in order to purchase this distressed property from GE and to operate it as MD Anderson—we had to get it through the MD Anderson

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Physicians' Network board. And the reason for that is, we were going to sit the property and the employment of this position in MDA PN, or the Physicians' Network—the 501(c)(3). We went to the board three times, and every time went they would give me—and I was—I was still very young and enthusiastic and, perhaps, immature. They would give me a new, "This looks great, Amy, but we want to see this before we approve. We want to see the patients that you're gonna—you're gonna attract. We want to see the doctor you're gonna hire. We want to see the financial *pro forma*."

And so, every time we'd go it would be one more ask. And on the third time, I had brought everything they could possibly want, and Dr. Cox was there with me. We had a whole team of people. There was no question they could ask. And my current boss, who around that time became a friend and mentor, finally said—and that's Dan Fontaine—he finally said, "Everything division—everything we've asked the division they've given us. This is their third time here. This clearly makes sense." But then, in—for those people that know Dan, this will not surprise them at all. But then he said, "Amy, this is a flea-bitten dog. So if you can go make this flea-bitten dog successful, then we will look at doing something else. But it's a flea-bitten dog. But based on that, we approve." And I always kid him about that, because that was the beginning of a huge infrastructure we now have around Houston. Had we not done that—had we not taken the flea-bitten dog and were able to risk a little bit, we wouldn't be anywhere near to where we are today.

***Tacey Ann Rosolowski, PhD***
[00:59:49]
Just to kind of dot that *i*, what did people perceive as the risks in doing this? It seems like not such a big risk—a little center, an outpost.

***Tacey Ann Rosolowski, PhD***
[01:00:01]
At the time, MD Anderson was very self-contained. This was outside of our main walls. This was a little bit uncomfortable. How could we possibly control? This was a little different. This was the first time that we were actively hiring a physician, and her employment was with PN. It was not with PRS. It was a little different. Everything was a little different. There was a lot of concern about competing with Main Campus. Now, rationally, this is one [inaudible] accelerator. This is, at tops—at tops—thirty patients a day. But I think it was just the uncomfort of something new. It was the change. I'd like to think that people were concerned because they saw that this marked a shift. And being so introspective to maybe being fairly extra-spective. But I think a lot of it was just the change. We were very comfortable inside our own house. This was going next door.

Now, we did it with a lot of belts and suspenders. It was ten minutes away, so what's the worst

thing that could happen? We get in our car and we're ten minutes away. You know, we had a doctor we trained. All the staff was ours. The equipment was ours. Worst thing that happens: patients don't like it; we don't get the volumes; we close it down. And, thankfully, that's absolutely not what happened. But I think that was the angst. This was different. This was outside Main Campus. "Not sure we can do this. Not sure we should."

***Tacey Ann Rosolowski, PhD***
[01:01:45]
Now, you know, it just—it's interesting, kind of, that this was opened about, you know, four years after John Mendelsohn came. And, you know, he brought a little bit different vision. You know, certainly, looking outward—I mean, looking for international patients, looking for international fundraising. Just a whole lot more looking outside the institution. And I'm wondering, you know, was that kind of part of the zeitgeist? You know, things are—things are—

***Amy Carpenter Hay***
[01:02:14]
[inaudible]

***Tacey Ann Rosolowski, PhD***
[01:02:14]
—shifting here.

***Amy Carpenter Hay***
[01:02:16]
I think so. I think a lot of it was Mendelsohn's approach, and you articulated it very well. He was—he was looking external, and it wasn't just about development. He was looking external in research. He was looking external in talking to people. He came from, you know, external. And so, I think the tide was changing. And so, you know, even, even today—even with Dr. DePinho, that the tide changes, and that always provides a little bit of angst because—

***Tacey Ann Rosolowski, PhD***
[01:02:44]
Right.

***Amy Carpenter Hay***
[01:02:44]
—it's the fear of the unknown. It's the fear of the change.

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***Tacey Ann Rosolowski, PhD***
[01:02:47]
Right.

***Amy Carpenter Hay***
[01:02:48]
I think that is a lot of the reason why there was some anxiety. But I also think it's the reason why it was approved. And it was the reason why a lot of people, over time, got very committed to building externally to MD Anderson. So, the center—the center started operating, immediate patient and family positive feedback. They loved it. You know, I—early, and I was still in the division at the time—I literally would pull up every single new patient coming in the Division of Radiation Oncology by zip code. And if you lived in 77401, which was Bellaire, I called you.

You got a call from Amy Hay, and Amy Hay said, "I see you're on the schedule. That's fantastic. Happy to keep you right where you are. But you may not know that we just opened a center in your neighborhood, and it's being staffed by Dr. Liz Bloom, and she trained at MD Anderson. And if you'd like to be seen tomorrow, I can get you in tomorrow. But I'm happy to have you at Main Campus, too. I work for both sides." So—and I would literally work the phone for the first couple of months to make sure that we had patient volume and it started to sustain itself over time.

Now, that satellite, very quickly, got people's appetites whet. They realized patients love this. Financially, it works very well. Not only does radiation oncology make a nice margin, but these centers don't have the overhead that we have here on Main Campus. They don't have the burden of the research that we require here. They don't require it there. And so, it allowed me to start slowly organizing some plans to look for other opportunities in the Houston region. So, fairly quickly—about a year after we got Bellaire up and running well—we started looking at opportunities in the Woodlands with St. Luke's, at the time. And also in Richmond, with Polly Ryon [Memorial Hospital]. And both of those facilities, over the next few years, opened with radiation oncology, and also started to include medical oncology, and pharmacy and lab to support it.

And what we saw very quickly was that, as soon as you add medical oncology, your radiation volumes go up twenty-five percent. Oh, and by the way, now that we've added medical oncology, the patients are saying, "Well, can I get everything out here? Do I really have to go to Main Campus?" And so, we quickly started thinking through what were our next steps, and we started being a little bit more thoughtful in where we're gonna go and who we're gonna partner with. What that meant was that we—and years are passing during this time period—we ultimately grew our [phone vibrates]—I'm sorry. I apologize. Scared me to death.

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***Tacey Ann Rosolowski, PhD***
[01:06:07]
[laughs] I know, that scared me to death, too. It sounded almost like a—an emergency [inaudible].

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***Amy Carpenter Hay***
[01:06:12]
I know, I put it on—I put it on vibrate just in case. [laughter] We started expanding. We looked very carefully at our partners to make sure that they met our mission and really were good partners. And one of the things, actually, I'm most proud about is that we were not afraid to terminate relationships that didn't meet our expectations. And that was a new thing for, I think, MD Anderson in business development. And we kept that up. Our commitment is to the doctors and to the clinical quality, and if you're not committed to that and you're our partner, then it's probably not a good fit. So, over time, we, quite frankly, got out of our lease at Polly Ryon. And we looked for another partner in Sugarland, with St. Luke's. And then, the years following, we partnered with, at the time, Christus, and built facilities with them in the Bay Area, and also in Katy.

Today, all of those centers are fully functional. They have radiation oncology, medical oncology, pharmacy, lab, and surgery that goes out there. We very carefully orchestrated this, much like we did the Proton Center. And I think it's an important point, in that our business model was to engage with a partner—so, in this case, St. Luke's and Christus—and lease. So we would give them a ten-year, long-term lease backed by the full, you know, credit of MD Anderson, University of Texas, which is a nice lease to have in your portfolio. And they would, in turn, build the building and equip the center. And so, we were doing all of this in a way that we were not extending our personal capital. We were letting our partner do it. But we were committing to a long-term lease, and we were providing all of the medical staff and the clinicians and support necessary.

And that model worked very well for us until, you know, just recently, and some changes that we're gonna be looking at. It worked very well. Over time—and this is where it's hard to stay in chronological sequence—over time, these centers, as of FY [fiscal year] '13—these centers had over 4,000 new analytic cases that were seen. As I often remind people, some of the largest academic centers in the US don't see 4,000. We see 4,000 in our regional satellites. That's an amazing number. We have sixty-eight faculty that work out there—so, doctors committed. We have over 400 clinical staff committed. And last year alone, we did sixty million dollars in margin. If you look at the overall patient margin of the institution, it was ninety last year. So, we are able to deliver the highest quality care in the regional setting, without the infrastructure that we have to have on Main Campus. And every dollar goes back into the mission, so that sixty million that we make out there on providing the best patient care goes right back into the research that we need to do here in the Texas Medical Center.

And I think that's kind of the beauty of the whole—the whole extension process. So the regional centers, I think, are an important component of our history and, quite frankly, an important part of our future. So I guess I'll pause for a moment there.

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***Tacey Ann Rosolowski, PhD***
[01:10:11]
Sure, do you want me to pause the recorder?

***Amy Carpenter Hay***
[01:10:12]
Yeah. I'm trying to decide where to go next.

***Tacey Ann Rosolowski, PhD***
[01:10:13]
Pausing at quarter after 2:00.

[The recorder is paused]

***Tacey Ann Rosolowski, PhD***
[01:10:16]
Well let's—do you want to resume again?

***Amy Carpenter Hay***
[01:10:17]
Sure.

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# Chapter 06
## *A New Role as CEO of the Proton Therapy Center; Lessons in Effective Leadership*
## A: Professional Path;

**Story Codes**
A: Professional Path;
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
C: Leadership;
D: On Leadership;
C: This is MD Anderson;
B: MD Anderson Culture;
A: Entrepreneur, Biotechnology;

***Tacey Ann Rosolowski, PhD***
[01:10:19]
Okay, so we had the recorder off for just a couple of minutes to strategize about what to do next. And so said it made sense to go back to proton therapy a little bit, to talk about your role with that.

***Amy Carpenter Hay***
[01:10:31]
Yes.

***Tacey Ann Rosolowski, PhD***
[01:10:32]
Okay.

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***Amy Carpenter Hay***
[01:10:32]
I think it does. So as the satellites are building in the background, and we've got that up and running, I started focusing on let's get the Proton Therapy Center out of the ground. And as part of the that, there was a lot of focus on the construction of the center, and the specifications of the equipment. I started going to Japan about every other month, and spending quite a bit of time there working with the physics staff. And we literally had to write the specifications for that center from scratch. We hired Dr. Al Smith, who was a leader in protons, physics, to help us. But it was the case in which we were really writing the specifications for the future of protons.

So had this incredible opportunity to listen and be part of that. It also made me realize that dedication, in order for the Proton Center to meet a three-year timeline, was going to be required. It took not only day-to-day, but twenty-four-hour-a-day management of the center, development—out internal group that was going to support it and, quite frankly, the Hitachi group in Japan. So just the coordination alone required the level of commitment. At the time, the Proton Therapy Center management asked me to leave Anderson for a role there as the chief executive officer of the Proton Therapy Center group.

[01:12:13]

***Tacey Ann Rosolowski, PhD***
And this was 2005 to 2007?

***Amy Carpenter Hay***
[01:12:15]
That's correct. Great opportunity for me, personally, for a lot of reasons. One, I had never left Anderson. And while it was down the street, and had a lot of belts and suspenders in that it was connected back in, and I got to see Dr. Cox every day—I was just being paid by somebody else—it was a completely different environment. I reported in to a board, and I had a fiduciary responsibility. So while I had lived within MD Anderson, and a very comfortable approach of always thinking about the patients first, and really not considering, often, some of the financial ramifications, it forced me into an environment in which I had to address hedge-fund guys, and I had to explain to them the financials, and I had to make commitments, and I had to make sure that we met them or exceeded them.

So it was a great opportunity to learn how to balance that—to put protons and the clinical side first, but balance it with the business component. And I think that is also something that I've been able to bring back in to Anderson. You know, with Dr. Mendelsohn bringing on people such as Leon Leach, we were starting to cultivate a new environment internally. We were starting to bring in outsiders—even outsiders to healthcare like Leon Leach, like Dan Fontaine—

who had experience in other environments, so could bring that to healthcare, not dismissing our mission and our focus, but supporting it. So, how do we deliver the best patient care—state-of-the-art patient care—and also ensure that we are sustainable? That we can pay for our research and our clinicians, and ensure that our future makes that possible. So it was a great—

***Tacey Ann Rosolowski, PhD***
[01:14:16]
Well, and it's—and it's not just sustaining, it's growing amazingly—

***Amy Carpenter Hay***
[01:14:21]
Yeah.

***Tacey Ann Rosolowski, PhD***
[01:14:22]
—at the same time.

***Amy Carpenter Hay***
[01:14:23]
It is. It is. So, that two years, when I worked at the Proton Therapy Center, I was able to get it up and operational. Obviously, I spent a lot of time with Dr. Cox and some unbelievably wonderful clinicians. You know, one of the approaches Dr. Cox took, which was really impressive, was even before we started the Proton Therapy Center, he and I went by disease site in Radiation Oncology, and formed teams of doctors to start talking about protons, to review any literature out there to make libraries of the proton literature on an international basis. What's going on out there? What are people doing? What are the results showing? What are the outcomes? And really getting the institution prepared to have protons.

So, the approach we took really helped it being adopted within MD Anderson. So after about two years, the center was up and running. It was still maturing, but it was working well. You know, clinicians were seeing patients. We were starting to see great outcomes. The volumes were increasing steadily. So, at that time, not surprisingly for my personality I'm afraid, I start to get a little bit—a little bored. It was becoming operations, which is fantastic. But I was looking for the next thing.

***Tacey Ann Rosolowski, PhD***
[01:16:03]
Before I move on to that, though, I'm wondering if you can kind of tell me what—I mean, that was a brand new experience for you. How do you feel those two years in that slightly different role changed how you work?

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***Amy Carpenter Hay***
[01:16:18]
I think the first would be finding a mechanism to have business support the clinical agenda. Being creative, whether it's being created and creating, you know, new debt structures, refinancing, but finding other opportunities to promote the clinical agenda. I think that's very important. So that's probably the first one. The second one likely sculpted a lot of my business development, and that—it is being accountable. There's nothing quite like being 100 percent accountable to a board. Whether it's in your control or not, it matters little. And accountability is something that I think I was not as attuned with until I had that experience. And it's something that I very much believe in now. It's something that I try to mentor my team on—it's accountability. And we're gonna call it accountability.

***Tacey Ann Rosolowski, PhD***
[01:17:26]
What does—what does that mean? I mean, what impact does accountability have on culture or performance?

***Amy Carpenter Hay***
[01:17:34]
I—quite frankly, I think it is one of the drivers of the culture. And, you know, quite frankly, if you're not accountable, then your performance oftentimes is not at what it should be. We should all be accountable for our job, how we behave, the goals that we set for ourselves. And I think that's an important point at MD Anderson. You know, we've—we are this unbelievable machine with all of these resources. And it's almost magical, the convergence of scientists and doctors and staff. But we are going to have to be accountable. And with the changes in healthcare reimbursement, the dynamics of consolidations in the market, and the delineation of narrow networks, we as MD Anderson are going to have to change with the healthcare world. We're going to have to be accountable.

And for me, personally, protons was the first time that that became important me on a day-to-day basis. I was accountable, which meant that if our volumes were down, it was my job to go visit with doctors and talk to them, and find out if there were issues, or if we could approach something differently. Accountability, in my opinion, is key to the future success of MD Anderson, in allowing us to be sustainable and continue to drive the research agenda.

***Tacey Ann Rosolowski, PhD***
[01:19:24]
Were there other lessons learned? Those were the big ones?

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***Amy Carpenter Hay***
[01:19:26]
I think those were the large ones. I think the other—you know, the thing that I continually remind myself, but that was probably the first taste, is it is very important for—to engage clinicians in a fashion that's meaningful to them. Meaning a lot of clinicians value raw data. It's data. It has to be data-driven. It cannot be perception-driven. So I've utilized that, over my career here, as a tool. Because everyone has perceptions. But having the data support your position is very important. And that's something, again, that I think the culture with bringing in people during Mendelsohn's era, and even more so now with Dr. DePinho, has shifted. It is—it needs to be metrics-based. We have to have definable goals. And we have to be able to show the data. And if we can't, then we've got to pause and make sure that we're going in the right direction.

I think the—and if I was gonna add one more, it would be one that's come full-circle to me in my business-development role, which is we have to break down traditional silos in medicine and healthcare in order to be successful. And a good example of that in this is that protons, while a modality of care in radiation, has to combine with surgery and medical oncology and everything else. And just providing protons is not enough. You need to engage the medical oncologists and the surgeons, and you have to have them on-board, because in a multidisciplinary-approach environment, it really is a team—a team of physicians that is prospectively looking at these cases. So if you hold protons in a small environment, maybe kind of in a silo of radiation oncology, I think we're missing its full intent. So, educating, pulling in, engaging physicians outside a single modality is extremely important. And, quite frankly, crucial to the success of the program.

And I've seen that time and time again, even in our regional centers and a lot of things we're doing on the national side, engaging across the entire institution really helps support and mature our programs. When we allow ourselves to stay in a specific silo, it really does hamper our success. And, quite frankly, we no longer have the ability to do that. We have to start looking across and leveraging our programs. And we can obviously get into that more when we talk about the network. But it's just a crucial element to our future, is how do we leverage everything we're doing? How do protons or the satellites link in with the Moon Shots? And how does Marketing support that? And is there an angle for Development? Oh, and by the way, how can we use that to help LBJ [Lyndon B. Johnson Hospital Oncology Service] and the patients we treat over there? So, really thinking in a very large vision to connect everything institutionally is really—I think, for me personally, came from working in protons.

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# Chapter 07
# *Global Institutional Partnerships*
# B: Beyond the Institution;

**Story Codes**
A: Professional Path;
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
C: Leadership;
D: On Leadership;
C: This is MD Anderson;
B: MD Anderson Culture;
A: Entrepreneur, Biotechnology;
B: Beyond the Institution;
D: Global Issues –Cancer, Health, Medicine;

***Tacey Ann Rosolowski, PhD***
[01:23:12]
Interesting. Yeah, very interesting. Just kind of a little follow-up question. I mean, you obviously are a very global thinker. When did you know that about yourself?

***Amy Carpenter Hay***
[01:23:23]
Hm. It probably started during protons. You know, the year that I spent going back and forth with Japan, I was oftentimes, most often, traveling alone. Japan is—and I love the country. It's beautiful. I miss it, in fact. But I always tease people, if you've not seen the move *Lost in Translation*, it's very much like that. You can very easily get isolated. And having that exposure at a fairly young age was—it really defined my attraction to kind of the global environment. You know, protons opened up that door. And while I was at the Proton Center, I got more involved in that. And that—that's kind of the next page to the story.

As I was over there, my colleague and I started to get interested in what was going on internationally. So, through protons, we started—at annual meetings we started meeting people and listening. And I found it completely fascinating, looking at the level of cancer care on a worldwide basis, and who was doing what, and who was investing, and looking at models of care. So, while I was at protons, I got very interested in two different opportunities. One was in Turkey, with American Hospital. MD Anderson had set up, at that time, a storefront, if you will,

to educate patients on coming to MD Anderson. It wasn't very successful. We don't—not many patients came over. But it was interesting to me. It was fascinating. And so, I started—I got introduced to the head of American Hospital—the CEO. His name is Dr. Evren Keles, and he's now actually the dean of the medical school there, as well. And American Hospital is owned by the Koç Foundation in Turkey, one of the leading families. And I started a dialogue with them. They didn't have radiation oncology. They had good medical oncology and surgery, but they didn't know how to do radiation oncology. And so—

***Tacey Ann Rosolowski, PhD***
[01:25:49]
That's kind of a jaw-dropper, isn't it? [laughter]

***Amy Carpenter Hay***
[01:25:51]
Exactly. And so, here I am, very interested in international and global, finding these people that are unbelievably delightful. And my background's in radiation oncology. So, developed a rapport there, and ultimately started working with them. And I said, "I'll tell you what. Let's start small. Let's—we'll—with MD Anderson, we'll sign a consulting agreement and I'll just provide you consulting. I'll tell you how to do it, what to do, what equipment to buy, and all that sort of thing." And that started, and as the facility was being built in Turkey, they said, "And we'd really like to take it one step further. We'd really like to ensure that we deliver MD Anderson quality in radiation." Again, this was new. This was—and we'd just—we'd just stepped out of MD Anderson in Bellaire, and by now we had Polly Ryon and Sugarland, and were working on expanding regional. We're—this was—this was new.

***Tacey Ann Rosolowski, PhD***
[01:26:55]
And this—it—in Turkey, what were the years of this—the first conversations?

***Amy Carpenter Hay***
[01:26:59]
The first conversations were probably around 2006.

***Tacey Ann Rosolowski, PhD***
[01:27:07]
Okay. And so, when were they approaching you about a more formal relationship?

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***Amy Carpenter Hay***
[01:27:12]
Relationship. It was several years. Let's see—it is, today, 2015. They've been operating five years, so the center started treating patients in 2010. So it was about, probably, '08 or so. They started talking about it, but here was the dilemma: the dilemma was that, in Turkey, you can only practice medicine if you're a Turkish citizen. So we needed a doctor. Again, back to needed a doctor. At the time, we had a doctor at MD Anderson, doing his fellowship, from Turkey—Dr. Ugur Selek—fantastic man, wanted to go home. And it was almost—it was—it almost fell together. So now I have a doctor. So I engaged Dr. Selek, and he was—couldn't be happier. He [coughs] [inaudible]—

***Tacey Ann Rosolowski, PhD***
[01:28:15]
I'll pause just for a second.

[The recorder is paused]

***Tacey Ann Rosolowski, PhD***
[01:28:17]
[inaudible] we resume?

***Amy Carpenter Hay***
[01:28:18]
Yes.

***Tacey Ann Rosolowski, PhD***
[01:28:19]
Okay, we're back on after a couple of minutes of a break.

***Amy Carpenter Hay***
[01:28:24]
So, Dr. Selek is—was a perfect fit: Turkish citizen, trained with us. And so, right around 2010, we opened the facility there as a co-branded radiation-oncology center, with Dr. Selek running the operations. It seamlessly works with MD Anderson. We set it up in such a fashion that all of the systems go into MD Anderson, meaning the treatment plans, and everything. So it almost functions as if it is down the street, and it's in Istanbul, Turkey. It's a—very proud of that transaction. And five years later, we've now added a second physician who came in, did some training with us. And they are looking to expand our relationship. So that was kind of the first opportunity outside of MD Anderson.

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You know, we were able to do that based on our ability to not only implement but also operate all of the regional centers around Houston. And we were really starting, at that time, to kind of push the envelope of what should we be doing on a national level. So while this was just radiation oncology, it kind of opened up a whole new area of opportunity. It was small. It was tightly controlled. The quality was—every single definitive case, still, to this day, is reviewed here. Every single case. But it was a really nice example of the fact that we could do this. We could extend ourselves in our backyard, and we could extend ourselves internationally in a very thoughtful, methodical way. I really do think, based on that going well, we were able to do not only expansion internationally, but also to start looking at the US.

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# Chapter 08
## *Adapting a Consulting Business to MD Anderson Needs*
## B: Building the Institution;

**Story Codes**
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
A: Activities Outside Institution;
B: Beyond the Institution;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
A: Entrepreneur, Biotechnology;

[01:28:24]+

***Amy Carpenter Hay***
So as that was coming together, I also, within protons, got very interested in doing international consulting for protons and national consulting. And, in fact, to—started a company. It was called ProBeam. And I had the ability to do that at the time, because I was working for the Proton Therapy Center. And we had amassed six or so clients on a national and international basis—just pure consulting, helping them develop proton-therapy systems. But we started seeing that they didn't really only want protons. They wanted all of oncology; protons was just a component. And as that matured, it became clear that if we really wanted to expand this, not only business, but also Anderson, I needed to come back into the Anderson fold.

So, as luck would have it, right about that time my boss and mentor friend, Mr. Mitch Latinkic, invited me to come back to MD Anderson, and to be his associate vice president for global development.

***Tacey Ann Rosolowski, PhD***
[01:31:50]
Just a quick question: Had you considered not coming back to MD Anderson?

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***Amy Carpenter Hay***
[01:31:58]
Honestly, no. And the reason why is, I wasn't ready yet. I had a lot to learn. I was engaged, but I didn't have the full complement. I had not—while I had participated in negotiations and, you know, been at the table, I had not ever done that by myself. And I think, you know, my exposure in kind of a startup company with ProBeam, while it was so much fun and, you know, you have so much flexibility, you also don't have MD Anderson behind you. And what became clear over time is that these clients—they were delighted to have me and ProBeam, but they really needed more. And I could never give them more if I wasn't part of Anderson. And so, it was more of a natural direction back to Anderson. It just made sense.

It was—so we collapsed ProBeam into MD Anderson. Those just became MD Anderson contracts and the company went away And we started really focusing on opportunities nationally and internationally. We already had the regional centers, you know, up and running. They became on the business side, underneath our purview, run by the divisions. We had expanded those, and we folded our relationship with Turkey into that book of business. We also, during that timeframe while I was at protons, the Division of Radiation Oncology had constructed another radiation relationship in Albuquerque, and that was part of the portfolio. And then we set a s—our sights on converting our consulting clients into some sort of a more in-depth relationship with MD Anderson.

That led us to building up that consulting book, and really looking at what's the long-term play? You know, what do we want these consulting clients to be, long-term? Consulting is great. It's definitely mission. We're extending our knowledge. But is that what we should be doing? Should it be more than that? A great example of that would be, during those early years, I became very involved with Albert Einstein [Hospital], in Brazil, in São Paulo. And we did consulting with them for years—five years—through MD Anderson. And really created a multidisciplinary approach to care in São Paulo that doesn't exist. But it took five years of consulting to get them at a point where they were ready to expand our relationship, to make it much more clinically focused, and to really integrate them with our doctors.

***Tacey Ann Rosolowski, PhD***
[01:35:06]
What are some of the—tell me a little bit about the process. You know, 'cause—I mean, I'm just imagining that multidisciplinary care can be some—I mean, at the very least, is something kind of complicated for people to get their heads around, at least the way MD Anderson practices it. So, you know, as you're establishing these conversations with the people at Albert Einstein, you know, what are the phases that that conversation takes?

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***Amy Carpenter Hay***
[01:35:32]
You know, in the—in the beginning, it's generally more of a business discussion. It's, you know, what is the status of your program now? What do you hope to accomplish? But then it very quickly becomes a clinical engagement. You know, the best relationships are anchored to clinician relationships, meaning a clinician at MD Anderson fully involved with clinicians at Einstein, and working with the directly on multidisciplinary care, peer-to-peer reviews, whatever the case may be, but having that connectivity.

So, in Albert Einstein, over the years Dr. Deborah Kuban, who is a GU [genitourinary] radiation oncologist—fantastic leader at MD Anderson—she became my key clinical partner in that relationship. And she would work directly with the doctors. She would bring in other doctors in different disciplines and connect them. And that's really the glue that makes this work. You know, I often tell people in my role that, over time, I can construct a business deal around anything. There's nothing you can give me that I can't figure out the business side. But that means absolutely nothing if the doctors are not engaged and integrated back in Anderson. You can have the prettiest financial *pro forma* you want, but if the doctors aren't talking, and they're not engaged and working together, the relationship's not going to work.

And that's one of the cornerstones that I've learned in this place over time. And it means—from a business perspective, it means you can never fall in love with a deal. It means that most good deals fall apart two or three times. But the ones that make it are deals that you never have to look at the contract, because they're deals where you are so fully in partnership that the clinicians are talking every day. And that you've developed that rapport that is so important.

***Tacey Ann Rosolowski, PhD***
[01:37:46]
So what do they talk about, one-on-one, with these—

***Amy Carpenter Hay***
[01:37:49]
Cases—patients, patients. You know, it's—delivering multidisciplinary care, the approach. It's patients. It's case reviews. It's tumor boards. It's talking about research. You know, what research are you doing? What am I doing? How can we extend clinical trials from here at MD Anderson to you? And what makes sense? But it really centers around the patients.

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***Tacey Ann Rosolowski, PhD***
[01:38:11]
Hm. And setup of the organization, too? I mean, have—so—I mean, how does that all fit? You know, because I'm—can imagine that the way that certain institutions work, you know, at other cities or other countries may not be entirely—you know, at a structural level—

***Amy Carpenter Hay***
[01:38:28]
Mm-hmm.

***Tacey Ann Rosolowski, PhD***
[01:38:27]
—there may have to be some alterations in order to deliver care in a particular way.

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# Chapter 09
## *The Office of Global Business Development: A First Partnership in Banner, Arizona*
## B: Building the Institution;

**Story Codes**
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
C: Leadership;
B: MD Anderson Culture;
A: Entrepreneur, Biotechnology;
B: Beyond the Institution;
D: Global Issues –Cancer, Health, Medicine;

***Amy Carpenter Hay***
[01:38:32]
Yeah, and maybe that's a good segue. So, while all this was happening, the Global Business Development Office, which I was part of, was tasked with looking nationally. So while we were busy building relationships in consulting in Turkey and São Paulo and other places, administration had come back to us and said, "Okay, you clearly know how to do this. So why are we not extended our reach across all of cancer on a national basis?" And that is when we first started engaging with Banner in Arizona.

***Tacey Ann Rosolowski, PhD***
[01:39:11]
Okay.

***Amy Carpenter Hay***
[01:39:12]
Again, we approached it in a similar fashion. We kind of did consulting and a development agreement, and went in, and reviewed everything from top to bottom. We looked at their market. We looked at their financials. We sent teams of clinicians to go in the ORs [operating rooms] and watch cases; to talk to medical oncologists about order sets; to go into the radiation centers and look at the quality indicators on the machines; everything, A to Z. And wrote a formal report on, "Here's everything that you do today, and here's everything that you would do if you were MD Anderson. And there's the gap. And here's how, together, we could fill the gap."

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That led us to, I think, what you're alluding to, which—there are always areas that can't possibly be exactly the same. And that's tough. That's tough sometimes, because we at MD Anderson like to believe that the only way to do it is the way that we do it. And sometimes that's the case, but sometimes there's another way to do it that gets you to the same outcome. And I think part of the challenge, and maybe what you're hitting on, is that from a business-development-expansion perspective, part of what I have to do every day is talk to folks about how do we get to the right place. And it may be that the road is a little bit different than it has been at 1515 Holcombe. And that's okay. And that's an interesting conversation. And it takes time, and it also takes time to prove it. And that almost goes back to the Bellaire treatment center. No one believed it until we proved it, but we proved that the quality and the patient outcomes were equal to that which we have on Main Campus. If we can do that ten miles away, and we can do that over an ocean in Turkey, surely we can do that in Arizona. And that became the discussion point.

Because there are differences. Arizona is a great example. That was my first, what we call now, "partner member." So, a co-branded facility that I negotiated with my partner, and really implemented that center. You know, that's when I got involved, and became close friends, confidants. She's a mentor to me in many capacities, with Dr. Maggie [Margaret] Row. I don't know if you've met Maggie yet—

***Tacey Ann Rosolowski, PhD***
[01:41:50]
Uh-uh.

***Amy Carpenter Hay***
[01:41:50]
—but she'd be an excellent, excellent person. Maggie was the clinical lead on Banner. She is an Emergency Medicine doctor here at MD Anderson. She also went back and got her MBA [master of business administration]. So not only does she have the business, but she clearly has the clinical. I often tease her that every Thursday she works in the OR—our ER [emergency room], excuse me. And I always tell her that, you know, that's her day to be a doctor. The rest of the time [laughs] she's gotta work with me. She is fantastic. But we worked together to implement that facility. At that location, they had to build from scratch, because we all agreed that their current infrastructure was really not conducive to multidisciplinary care. They didn't have big clinics. They didn't have—they had a very traditional, old-school, acute-care hospital. They had multiple of them, but it wasn't conducive to a cancer center. We couldn't put everything together and treat patients in the way that we wanted to.

Because of this, it took us three years to build a new outpatient cancer center there with them. And we spent those three years recruiting literally every single doctor to the program, setting up

the program. But to your point about differences, because we were starting that program from scratch, if you will, it couldn't possibly start on day one with sub-specialized care in every disease site. We simple don't have the patients. So we started it, and it grew organically. You know, we brought some leadership in from Breast Medical Oncology. So, breast skyrocketed, and we were able, within the first year, to have a breast-only clinic. But having some of those sub-specialized disease areas, we had to acknowledge, were—was gonna take time, and recruitment, and volumes. And without the volumes to support, we couldn't recruit. That was a little different. That was a little bit of a growing pain for us, because we were so used to having 35,000 new cancer cases and over 1,000 faculty. Of course, everything should not only be sub-specialized, it should also be sub-sub-specialized. And so, that's a good example.

***Tacey Ann Rosolowski, PhD***
[01:44:15]
Yeah, yeah.

***Amy Carpenter Hay***
[01:44:15]
Another good example is that, in this situation, we were requiring Banner to employ doctors, because that's a model of care that we believe in. I know—employing doctors means you take out any potential incentive. It doesn't matter if you see one or a hundred. It doesn't matter if the patient is better off having surgery than radiation. It's a multidisciplinary environment, and it's something that we, as Anderson, are very committed to, for good reason.

Full employment across every specialized area is difficult in a community. It's hard to employ a neurosurgeon if you only have two neuro cases. It's hard to employ some of the internal-medicine sectors for only oncology because, generally speaking, a pulmonologist and a cardiologist—they see a lot of different things. They see oncology, but they see different things Because of our volumes here, we have these luxuries that other people don't.

And so, part of our learning was that, in circumstances such as that, we were going to need to go in and review and ensure the quality was there, and go a little bit out of our comfort zone. They may not be employed until such a time that we can justify it from a business perspective.

So there are subtle differences. I like to think that part of my job and Dr. Row's job is to get to the right outcome, but find creative solutions. And I think we've done that well in Banner. Banner, you know, has been in existence now for four years or so. And, you know, I couldn't be more proud. It's its own standalone cancer center. It's already gone to phase two of construction. It started as 125,000 square foot. It's now over 200. And has really expanded their sub-specialized approach, expanded their clinical trials. They're working with us on Moon Shots. Really solid, solid partner. The doctors there feel like they are MD Anderson. So when

they go to a conference, they are not Banner. They are Anderson, and they're treated as such.

And that's the environment that works, based on that relationship and our ability to mature it and grow it.

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# Chapter 10
## *Strategic Expansion and Partnerships*
## B: Building the Institution;

**Story Codes**
A: The Administrator;
B: Institutional Processes;
B: The Business of MD Anderson;
B: Building/Transforming the Institution;
B: Growth and/or Change;
C: Leadership;
B: MD Anderson Culture;
A: Entrepreneur, Biotechnology;
B: Beyond the Institution;
D: Global Issues –Cancer, Health, Medicine;

[01:44:15]+

***Amy Carpenter Hay***
Over time, MD Anderson really looked at—we need to get more organized. We need to put all of these relationships in some sort of context, because we've got—we've got Turkey over here. We've got Banner now. We've got regional. Oh, and by the way, we have this other thing over in Physicians' Network that is a quality-assurance program. We need to pull these together in a very orchestrated fashion, and make sure—again, back to the point of how do we synergize across all of these? How do we make sure that we protect our brand, we protect our clinicians, and we have the quality that we require? And that was right around—and let's see here. I'm trying to think of dates. That was probably three or four years ago. And I still have on my wall my recommendations for accountability, for what we were gonna accomplish. And I would—I would—as you can see, I would literally check them off. But at the time, MD Anderson hired—

***Tacey Ann Rosolowski, PhD***
[01:48:08]
And so, this was around 2011, 2012?

***Amy Carpenter Hay***
[01:48:12]
Right around 2011 and '12. MD Anderson hired PwC [PricewaterhouseCoopers] to come in and review what we were doing—everything.

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***Tacey Ann Rosolowski, PhD***
[01:48:21]
PwC is?

***Amy Carpenter Hay***
[01:48:22]
PricewaterhouseCoopers—a consulting firm, to come in, look at everything we're doing. Let's try to figure out what we should be doing. And let's look at this as a strategic expansion, not one-offs. Which was a very good exercise. There was a time in MD Anderson's history where, from a business perspective, we were only allowed to field phone calls. We were not allowed to find a partner and then for us to initiate. Banner was a good example. They came to us. We didn't come to them, they came to us.

That timeframe—2011, 2012—kind of marked a significant change. It marked MD Anderson saying, "You know what? We are going to expand. It meets our mission. And we're gonna do it in a very clear, a very meaningful way. And we're gonna do it aggressively. We are gonna do the diligence. We're gonna look across the country and we're gonna find people that we want to partner with. And then, we're gonna contact them and we're gonna talk to them." That was a major shift for us. There was always a great hesitation in doing that. And so, this really allowed a different approach to business—it—a much more aggressive, much more attuned to finding the right partner and not just who came in the door. So, a large shift.

As they finished their work and we reviewed it, it became very clear that we needed to organize ourselves in what we're calling the MD Anderson Cancer Network. And the Cancer Network was, therefore, formed. And from a business perspective, we categorized what we were doing from a national perspective in really two categories.

We had a certified membership, which was our quality-assurance and quality-safety program; smaller agreements, usually three to five years; not suggesting that it's MD Anderson care. But what we provide is—we provide the guidelines to providing care, and then we review the physicians to make sure they're staying within the guidelines. So, really geared at community hospitals—smaller community hospitals where you see non-employed community physicians, but the hospital is very concerned in wanting in ensure that they're providing the best quality. Great program, but that was the first level.

The s—the other level is what I refer to as the partner members, and that would be like Banner. So Banner was our case study. These are folks that would be co-branded with us, and the expressed intent was that they would deliver the same level of care as MD Anderson. So the expectation would be that every single physician was reviewed and approved by us. That we are providing all of the clinical oversight on a day-to-day basis. Really trying to extend ourselves in

an impactful way, and also agreeing that we have a limited number of these we can do. They take a lot of bandwidth. They take a lot of time.

And so, we all agreed that, over kind of a ten-year timeframe, we wanted four to six partner members geographically spread across the United States. I always like to say I see it as a pool table. You know, we really need to cover all of our pockets. So at the time, we had Houston covered, and we had Arizona covered. And the next one coming up was going to be Cooper in New Jersey, so we could cover that coast. So immediately started working on Cooper.

***Tacey Ann Rosolowski, PhD***
[01:52:30]
Could I interrupt you, because I'm just—I'm aware that it's three o'clock.

***Amy Carpenter Hay***
[01:52:33]
Oh, goodness. [laughter] I didn't even know it was three o'clock. I can—

***Tacey Ann Rosolowski, PhD***
[01:52:36]
Oh, goodness. There we go. So is Cooper a good place to kind of stop the story?

***Amy Carpenter Hay***
[01:52:40]
Cooper's a great—yeah, that's a great place to stop the story.

***Tacey Ann Rosolowski, PhD***
[01:52:42]
And then we can resume. Okay. Okay. We can resume—okay.

***Amy Carpenter Hay***
[01:52:43]
Super. Good. That went a little bit faster than I expected. So, okay, great.

***Tacey Ann Rosolowski, PhD***
[01:52:43]
Well thank you very much for today.

***Amy Carpenter Hay***
[01:52:48]
Okay, great. Thank you.

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***Tacey Ann Rosolowski, PhD***
[01:52:49]
Well, sure, thanks for today. And I'm just—for the—for purposes of the recorder, I'm turning off the recorder at about one minute after 3:00.

***Tacey Ann Rosolowski, PhD***
[01:52:57]
Great, thank you.

***Amy Carpenter Hay***
[01:52:58]
Sure.

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# *Amy Carpenter Hay*

**Interview Session Two: June 2, 2015**

## Chapter 00B
## *Interview Identifier*

***Tacey Ann Rosolowski, PhD***
[00:00:00]
All right, we are recording. The time is 1:45, and today is June 2nd, 2015. I'm Tacey Ann Rosolowski, and today I'm in a conference room in—let's see. This is the suite that's the office of Can—the Cancer Network suite, right?

***Amy Carpenter Hay***
[00:00:20]
That's correct.

***Tacey Ann Rosolowski, PhD***
[00:00:20]
Correct, okay. And I'm interviewing Amy Hay. This is our second session together, so thank you very much for making the time amid your very, very busy schedule.

***Amy Carpenter Hay***
[00:00:29]
Oh, no, no. My pleasure.

Interview Session: 02
Interview Date: June 2, 2015

# Chapter 11
## *The Center for Global Oncology: Background and Operations*
## B: Building the Institution;

**Story Codes**
A: Overview;
A: Entrepreneur, Biotechnology;
A: The Administrator;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;
A: Professional Path;
C: Leadership;

***Tacey Ann Rosolowski, PhD***
[00:00:31]
And we were—we were just kind of reviewing where we were from the last time. And you did, indeed, talk about Cooper. But I kind of wanted to go back in time just a tiny bit and talk more formally about the formation of the Center for Global Oncology.

***Amy Carpenter Hay***
[00:00:51]
Okay.

***Tacey Ann Rosolowski, PhD***
[00:00:52]
So I wonder if you could tell me about that. Would—that was in what year, about?

***Amy Carpenter Hay***
[00:00:58]
Global Oncology predates the Cancer Network.

***Tacey Ann Rosolowski, PhD***
[00:01:01]
Right.

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***Amy Carpenter Hay***
[00:01:02]
So Global Oncology was around the period of 2008 timeframe.

***Tacey Ann Rosolowski, PhD***
[00:01:10]
Okay, yeah, because you became associate VP [vice president] in 2008, so that would have been—

***Amy Carpenter Hay***
[00:01:14]
Yes, that would have been correct.

***Tacey Ann Rosolowski, PhD***
[00:01:15]
Okay, okay.

***Amy Carpenter Hay***
[00:01:15]
That's when I came back to MD Anderson.

***Tacey Ann Rosolowski, PhD***
[00:01:17]
Okay.

***Amy Carpenter Hay***
[00:01:18]
So, the two to three years preceding that, I was the COO [chief operating officer] of the Proton Therapy Center, and—

***Tacey Ann Rosolowski, PhD***
[00:01:24]
Right, you did tell us ProBeam—you told us about that, yeah.

***Amy Carpenter Hay***
[00:01:26]
Exactly. And when they formed the Center for Global Oncology is when I returned back [inaudible].

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***Tacey Ann Rosolowski, PhD***
[00:01:32]
Right, okay. So tell me about that process of forming the center, at that time. You know, why was it formed in 2008? What was going on in the institution?

***Amy Carpenter Hay***
[00:01:43]
I think it was an acknowledgement that there was a lot of connectivity and relationships being formed both nationally and internationally, but it wasn't being done in an organized and precise manner. It was being done on a one-off basis. And a couple of things predated that. One of them was the development of our relationship with Albert Einstein in São Paulo. And one of them was the development of our Radiation Oncology Center in Istanbul with American Hospital.

***Tacey Ann Rosolowski, PhD***
[00:02:20]
Mm-hmm, you did talk about both of those.

***Amy Carpenter Hay***
[00:02:22]
Both great opportunities, but they were kind of done one-offs, based on relationships. At the same time, there was a lot of movement in the national market around partnering. So we were starting to get calls from other healthcare entities such as Banner Health that were interested in finding ways in which we could collaborate in oncology. So, there was both national and international forces that forced us to relook at the business, the clinical side, and the research side, in a more holistic fashion.

***Tacey Ann Rosolowski, PhD***
[00:02:59]
So let me ask you, why was this a trend? What were institutions seeing a the possibilities for this kind of partnering?

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***Amy Carpenter Hay***
[00:03:07]
I think it was kind of a natural acknowledgement, both nationally and internationally, of acute-care institutions acknowledging that they did not have specific expertise in oncology. While they might have oncology services, they did not have an oncology program. So as a result of that, you saw a lot of institutions—really more healthcare systems—reaching out to academic providers. So it was around this same time that you saw a large presence of people like Hopkins and people like Cleveland Clinic that are now our competitors, that were being also called, and asking for services. Not just in oncology, but kind of in any high intensity and tertiary service line. So you were seeing oncology, you were seeing cardiology, you were seeing orthopedics as major areas in which health systems identified they didn't have the in-house expertise.

***Tacey Ann Rosolowski, PhD***
[00:04:11]
So, you know, you mentioned specifically that there was a reaching out to academic institutions. So part of this was that academic ob—institutions obviously are a repository of very intense specialists.

***Amy Carpenter Hay***
[00:04:22]
Knowledge, mm-hmm.

***Tacey Ann Rosolowski, PhD***
[00:04:22]
But there's also the research piece. So, to what degree was the research piece desirable for these entities that were looking for partnership?

***Amy Carpenter Hay***
[00:04:33]
It was critical. I mean, it's part of what they were looking for, and it still is. I mean, most healthcare providers or acute-care networks are looking not just for the clinical delivery, but they're also looking for the research side. So that's a key component—specifically in the national accounts or the national partners—of what we collaborate on. They don't have the research backing, nor should they. And they shouldn't, and most don't, have bench-top research. So they need assistance from large academic providers that have that basic science knowledge that can be leveraged into translational research.

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***Tacey Ann Rosolowski, PhD***
[00:05:16]
So was this—I'm trying to get an understanding of, you know, what kind of resource the research represented for these partners. Did they want clinical trials to enroll patients in? Did they want researchers to partner with? You know, what was going on?

***Amy Carpenter Hay***
[00:05:32]
They want clinical trials.

***Tacey Ann Rosolowski, PhD***
[00:05:34]
Okay.

***Amy Carpenter Hay***
[00:05:34]
So it's all about the delivery. So, health networks are looking for a way to offer their patients clinical trials at home within their network.

***Tacey Ann Rosolowski, PhD***
[00:05:45]
Okay.

***Amy Carpenter Hay***
[00:05:45]
So it really is on the clinical-delivery side, and how research can be leveraged in order to provide that to patients closer to their home.

***Tacey Ann Rosolowski, PhD***
[00:05:54]
Mm-hmm. So the setup of the Center for Global Oncology—were you part of those setup discussions?

***Amy Carpenter Hay***
[00:06:01]
At that time, I actually was over at the Proton Therapy Center.

***Tacey Ann Rosolowski, PhD***
[00:06:04]
Okay.

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***Amy Carpenter Hay***
[00:06:04]
So I was—when they promoted Mitch Latinkic as the vice president of that area, he then invited me to come back. So I was not part of that setup.

***Tacey Ann Rosolowski, PhD***
[00:06:17]
The setup part. So when you came in, I mean, what was the mission of the Global Oncology Center? What were the parts? And what part did you serve?

***Amy Carpenter Hay***
[00:06:26]
The setup of the center was to put clinical care, business, and kind of their research component all together, and try to organize what we were doing nationally and internationally. At that time, it only included really our partner members—so we were negotiating Banner at the time, at the formation—and also, our international relationships. It also included—and the membership at the leadership level was Mitch Latinkic, Dr. Ed [Eduardo] Diaz [, Jr.], and Dr. Oliver Bogler. And, therefore, it also included the sister institutions as well. So those were the three main components of the Center for Global Oncology.

***Tacey Ann Rosolowski, PhD***
[00:07:12]
The sister institutions being the academic partners—

***Amy Carpenter Hay***
[00:07:16]
Yes.

***Tacey Ann Rosolowski, PhD***
[00:07:16]
—through Global Academic Programs [GAP]?

***Amy Carpenter Hay***
[00:07:18]
Yes, that's correct.

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***Tacey Ann Rosolowski, PhD***
[00:07:18]
Yeah. That was just for the recorder's sake. [laughter] And I did actually interview Oliver Bogler and—about GAP. And he talked to me about partnering with you, so I'd kind of like to get the story from your side, too. Because one of the interesting things to me was, when an institution would contact MD Anderson, what's the process that that institution goes through, through the Center for Global Oncology, to figure out exactly how they can be given the services they need?

***Amy Carpenter Hay***
[00:07:49]
Yeah, and at that point—which is a—definitely a moment in time—when individuals reached out to us, we as a group defined what they were asking for. And sometimes that was business, and sometimes that was pure research. If it was pure research, then it appropriately fit in the Global Academic Programs component. If it was pure business and clinical delivery, that would fit in the business and clinical side. Often it was both, so the, really, drive was to try to manage that. And a good example of that is Albert Einstein in São Paulo. They were our first sister institution. They were also our first MD Anderson Cancer Network associate member. So we—there is overlap.

***Tacey Ann Rosolowski, PhD***
[00:08:40]
So, to understand, São Paulo actually had—was both academic and business?

***Amy Carpenter Hay***
[00:08:44]
Yes.

***Tacey Ann Rosolowski, PhD***
[00:08:44]
Okay, mm-hmm.

***Amy Carpenter Hay***
[00:08:46]
Yes, they are today. At the time, they weren't. At the time, they were the first sister institution.

***Tacey Ann Rosolowski, PhD***
[00:08:50]
Oh, okay.

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***Amy Carpenter Hay***
[00:08:50]
And over time, they have become a co-branded partner in our cancer network.

***Tacey Ann Rosolowski, PhD***
[00:08:59]
So tell me about your sphere of influence within the center at that time.

***Amy Carpenter Hay***
[00:09:06]
Well, I was working for Mitch Latinkic, who was the leader on the business-development side. So my normal function was around both identifying, negotiating and supporting the legal contacting of any opportunities. And during that timeframe, and internationally it was focused on Albert Einstein in São Paulo. We closed Istanbul at American Hospital in Turkey. And then, a lion's share of the time was spent focused on Banner at the MD Anderson—what is today the MD Anderson Banner facility. That took twelve to eighteen months to really do deep due diligence on Banner Health as a system and close the legal transaction. Because it was very important at that time that we ensure that it was very clinically integrated into MD Anderson, because there were some lessons learned with our previous relationship in Orlando.

We had identified some ways that we could do much better and strengthen those ties, and we wanted to ensure that when we had our first partner with Banner, that when it came up and was operational, it really was completely integrated into MD Anderson, including the, you know, physicians, the recruitment, and the training of all the staff.

***Tacey Ann Rosolowski, PhD***
[00:10:41]
So tell me about the types of legal issues that would arise in this kind of negotiation, 'cause not doing what you do—and most people don't—I have no idea. You know, kind of—so, con—some concrete examples would help.

***Amy Carpenter Hay***
[00:10:56]
You know, it's across the board. So if I tried to think through our partnerships, and what are the—when I had someone a draft contract, what are the things that they typically want to discus? That's probably a good way to put it. Always—and unfortunately or fortunately—foremost is always the business transaction. So, you know, the approach that we've taken and we've continued over the years is to develop full oncology financial *pro formas* in which we estimate, based on the market, what we think the growth patterns are going to be, and then the associated financials. So—

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***Tacey Ann Rosolowski, PhD***
[00:11:36]
I'm sorry. I have no idea what that means. [laughs]

***Amy Carpenter Hay***
[00:11:39]
Okay. So, financial *pro forma* means that we develop, based on the market, the number of new cancer cases that we think will come to that center.

***Tacey Ann Rosolowski, PhD***
[00:11:50]
Oh, I see. Okay.

***Amy Carpenter Hay***
[00:11:51]
And then, based on that, we develop both from a professional and from a technical perspective what we think the financial results of operating a full oncology program.

***Tacey Ann Rosolowski, PhD***
[00:12:06]
Okay.

***Amy Carpenter Hay***
[00:12:06]
And so, once we have created that, then both partners—in this circumstance, Banner and MD Anderson—both agree that this is our business plan, for lack of a better word.

***Tacey Ann Rosolowski, PhD***
[00:12:17]
Mm-hmm, okay, mm-hmm.

***Amy Carpenter Hay***
[00:12:18]
This is the plan that we have to develop our business. This—these are the financial outcomes that we think will result. And also, and importantly in there, these are the expenses that will be incurred if we want to accomplish what we planned to do—things like staffing and equipment and facilities. So once that is complete, then you're gonna have a much better discussion around the financial implications of the relationship.

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***Tacey Ann Rosolowski, PhD***
[00:12:51]
This may not be—I'm not sure if this is a relevant question or not, or when this might be relevant, but I assume that part of the motivation to co-brand with MD Anderson is that the MD Anderson name is worth something. How do you factor that into these kind of market projections?

***Amy Carpenter Hay***
[00:13:09]
There is a—there is a fee for our relationships. We have looked at it as a fixed fee that is for our intellectual property and our expertise that we provide. And then, we've organized these in a fashion where there's also a variable fee that is associated with the performance of the center. So we—there is a financial component of this, and that financial component is used to ensure that we can reinvest back into the Main Campus. So there's two financial components. In addition to those two, we also have a yearly budget with all our partners in which they pay for our time and our travel. The way that MD Anderson has approached it, which I think has been successful thus far, is that our partners cover all of our cost. So as a state agency, one of our important considerations is that, if we are allocating any time or any resources, those resources are paid for, and we can take those funds and reinvest them back into the institution.

***Tacey Ann Rosolowski, PhD***
[00:14:29]
Also, it's a legitimate recognition of the intellectual value—

***Amy Carpenter Hay***
[00:14:36]
Absolutely.

***Tacey Ann Rosolowski, PhD***
[00:14:36]
—and the practical value that's being offered. So when you say "we"—"the partners cover our expenses"—I mean, whose time is being paid for here?

***Amy Carpenter Hay***
[00:14:47]
MD Anderson's. So—and when I say "MD Anderson," it goes across the board: so, any doctors that work on the relationship, attend tumor boards, go to the locations, etc; any support staff that focus on the relationship; things like pharmacists and nurses and technicians and even project managers that are responsible for ensuring that those relationships are managed appropriately and tightly interconnected.

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***Tacey Ann Rosolowski, PhD***
[00:15:24]
How—to what degree does your experience—I mean, you started as a patient-support assist—I'm trying to recall the exact name—

***Amy Carpenter Hay***
[00:15:37]
Patient—PSC—patient service coordinator, uh-huh.

***Tacey Ann Rosolowski, PhD***
[00:15:40]
Patient coordinator—[inaudible] coordinator. That's it. I mean, you came up, really, through an interesting track. How has that helped you perform this kind of work now?

***Amy Carpenter Hay***
[00:15:51]
Actually, I think it's pretty pivotal in what I do and how I do it, because I grew up—and I often say I grew up at MD Anderson. I learned MD Anderson from the ground up. I know how to order a CT [computed tomography], and make a referral to a clinic, and navigate the system. So I know MD Anderson from a provider perspective, and I know MD Anderson from a patient perspective through my work with patient advocacy. All of that allows you to understand the impact of what we're doing in the network, both on the patients we're serving and the providers here at MD Anderson. So, I think my background is pretty important.

You know, I was actually saying—just today someone asked me how long I've been here, and this summer it's coming up now on nineteen years. And part of that success, I'd like to think, is based on the fact that I have worked in such a diverse array of not only divisions and departments, but also at different patient access points. So from the front door, to specialized services, to patient advocacy, I've learned MD Anderson, and that's allowed me, then, to help translate that into different environments.

***Tacey Ann Rosolowski, PhD***
[00:17:19]
Can you give me some examples of kind of communication challenges, or—you know, what you're doing is figuring out how—you know, not only the legal issues, but just how to bring two organizational cultures together. I'm wondering the kinds of issues that arise in that process.

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***Amy Carpenter Hay***
[00:17:42]
Yeah, and that's a—and especially in our partnerships nationally, that's a really important component. If the cultures are not able to be bridged, then it's going to be extremely difficult for the providers to find the right integrated connection. And part of that is two-sided. It's an acknowledgement from MD Anderson's side that not every location can be identical to what we have on 1515 Holcombe. And examples of that are not every partner will have the ability to have bench-top research. They shouldn't. Not every partner will have the ability on day one to have super-sub-specialized delivery. That will take time based on volumes.

On the other side of the equation, the partner must have a culture that is desiring to move toward excellence. So, if they are not interested in elevating their cancer-care delivery, then the cultures will never bridge. There has to be some give and take, and some focus on what the two organizations want to accomplish together, in a very methodical manner. It doesn't happen overnight. It takes time. It's the reason why we have usually a fairly long pre-op diligence period with partners—is to ensure that they fit our culture and we fit theirs.

And I think this is a pretty important lesson learned in some of our past relationships. A—you know, the facility that we had in Orlando did some very good things for patients. But when it came time to fully integrate them, they, culturally, were not interested in doing that. And without the doctors—and it boils down to the doctors being able to relate and be open and be focused on what we're trying to accomplish, then a partnership will never work. It will be a piece of paper—a legal document. It will not be a real relationship that impacts cancer patients.

***Tacey Ann Rosolowski, PhD***
[00:20:04]
Tell me more about what the doctors may or may not do to push forward this cultural fit.

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***Amy Carpenter Hay***
[00:20:12]
Mm-hmm. Well, I think what I would state is the doctors at both locations, but specifically at the partner locations, have to be willing and open and motivated. And the—one of the ways that we do that is, in the diligence period, we meet with all of the potential doctors that want to be part of the program. In fact, we vet—and our division heads review and approve every single doctor in the partner membership. So those physicians now have a—not only a relationship, but an obligation to be part of MD Anderson, and how we do care—how do we deliver that to patients.

So, you know, that—it really gets down to the doctors at the partner wanting to participate. You have to be willing and—not only willing, but you have to be committed and passionate about prospective, multidisciplinary, research-driven care. And if that's not something that you're interested in doing, then you shouldn't be part of the MD Anderson program.

***Tacey Ann Rosolowski, PhD***
[00:21:24]
Mm-hmm. So how would that play out in an actual situation with a patient? I mean, what would a physician actually do if a patient comes in with leukemia or breast cancer or prostate cancer? So, how would a patient know that they're getting MD Anderson care if they're in Banner, for example?

***Amy Carpenter Hay***
[00:21:48]
Well, it—

***Tacey Ann Rosolowski, PhD***
[00:21:48]
In terms of how the doctor interacts with them.

***Amy Carpenter Hay***
[00:21:50]
The doctors have all been reviewed and approved. I would assume the patient would know because it says MD Anderson on the door.

***Tacey Ann Rosolowski, PhD***
[00:21:57]
Sure, sure.

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***Amy Carpenter Hay***
[00:21:58]
But, you know, I think it's more about the interaction of the physicians. So, the patient is seen at Banner MD Anderson. The case is reviewed in a multidisciplinary fashion. MD Anderson does tumor boards and joint conferences with Banner and with all of our partners, and reviews cases prospectively, not only by disease but also by modality. So the patient, I think, has comfort by the fact that they have come to the co-branded location, therefore our commitment is to ensure that what they receive is MD Anderson care.

***Tacey Ann Rosolowski, PhD***
[00:22:41]
So what you're—what you're saying is, basically, you need to move away from the model of doctors operating pretty much individual in—and suddenly physicians are operating in teams—multidisciplinary teams.

***Amy Carpenter Hay***
[00:22:52]
Absolutely.

***Tacey Ann Rosolowski, PhD***
[00:22:53]
Gotcha. Okay.

***Amy Carpenter Hay***
[00:22:54]
That's—and that's the requirement to be co-branded in the program. So, you know, that's the same feel that you should get in Houston—is the same feel you should get at our partner locations.

***Tacey Ann Rosolowski, PhD***
[00:23:06]
Mm-hmm. And that is a real shift for some physicians. And I can see where, you know, there would be resistance. And some—are there ways in which some institutions just structurally don't support that? Or maybe I should ask the question differently. You know, as you're figuring out how to arrange the business relationships, are there certain structural changes that have to happen in an institution in order to make that multidisciplinary care possible?

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***Amy Carpenter Hay***
[00:23:34]
Yes. And, you know, contractually, we obligate some of those things. So, for example, at Banner, all the physicians are employed. There are no community physicians that participate. At Banner, all of the physicians are required—and we track participation in multidisciplinary care, tumor boards, etc. You know, from a healthcare-organizational perspective or a hospital perspective, there are things like closing your oncology practice. So, bylaws have to be changed, privileges have to be changed, in order to really make the location MD Anderson-only from an oncology perspective.

***Tacey Ann Rosolowski, PhD***
[00:24:19]
Gotcha. Okay, all right, [inaudible].

***Amy Carpenter Hay***
[00:24:21]
So that's a big commitment, you know? It's a big commitment of an organization to do that. You know, there are physicians—and every community has been the same—that have opted not to participate. And so, our partners have to know that going in, that there will be some pushback. There will be some—potentially folks that decide not to participate, which means that they'll go to another hospital.

***Tacey Ann Rosolowski, PhD***
[00:24:46]
Mm-hmm. Organizational change is tough. Are there certain supports or—that MD Anderson offers to help an organization move through that change period? How do you—how do you work with that?

***Amy Carpenter Hay***
[00:25:00]
Mm-hmm. Well we plan it all out with them. You know, we've done this a few times now, so we kind of have a nice model of what we suggest, and examples of bylaws and privileges and things like that. So the intent is that, during the diligence and the pre-op period, that we work with them—are giving them all the tools to accomplish this. Now, at the end of the day, they have to do it themselves, but we're giving them, really, the toolkit in order to make it happen.

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# Chapter 12
## *The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part I*
## B: Building the Institution;

**Story Codes**
A: Entrepreneur, Biotechnology
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Institutional Processes;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;

***Tacey Ann Rosolowski, PhD***
[00:25:28]
Okay. Well, let's go back to this story of the Center for Global Oncology. You kind of said, back then—and I guess there have been changes since. So tell me about how the Center for Global Oncology morphed over time.

***Amy Carpenter Hay***
[00:25:45]
Over time, it's—as, quite frankly, the partners grew, and as, institutionally, all of our programs started to grow, there was a shift from the Center of Global Oncology to what we now call the MD Anderson Cancer Network. Now, the components of the MD Anderson Cancer Network are different than the Center of Global Oncology. They included—or include still today—leadership from Business Development, which now is myself; leadership from Clinical Operations, which is now Dr. Maggie [Margaret] Row; leadership from our Physicians' Network, which is Mr. Bill [William] Hyslop; and leadership from our regional care centers.

What this has done, with the oversight of Dr. Tom [Thomas] Burke [Oral History Interview] and his role, is created a—kind of a next step in the evolution of our relationships. So, now, instead of only having our partners nationally, within the Cancer Network is also our certified members. Our certified membership is a quality program at—that is a program really geared to smaller

community hospitals. It's around quality and safety, and adherence to guidelines. So it's not intended to be a full integration. It's not intended to be prospective. It's a retrospective review of the doctors providing care. And that's run out of our Physicians' Network.

So we pulled that into the Cancer Network, but we pulled in a much greater focus on what we were doing regionally here in Houston. So, from a leadership perspective, that became part of the Cancer Network. And the one change that did occur was that the sister institutions in Global Academic Programs actually left the Cancer Network, or, at that time, the Center for Global Oncology, and has been residing since that time in the research side.

Now I think what Dr. Bogler was, perhaps, alluding to in your conversation is that this—while this occurred, what he and I had noticed over the last year is that it is very easy for a disconnect for business and research to occur internationally. Because he has a group that is working on the research relationships, and we have a very large group working on the business international relationships. So we have been trying to bridge that gap, meaning we've been working on ways to keep each other informed, keep our groups informed, have joint committees that focus on international relationships, to try to be more consistent across MD Anderson.

***Tacey Ann Rosolowski, PhD***
[00:28:59]
What kind of problems arise when there's that disconnect?

***Amy Carpenter Hay***
[00:29:02]
Well, the disconnect is that, you know, the sister institutions' relationships really should be research-only relationships. As human nature, everyone always asks for a bit more than what they should, and so, oftentimes, those sister institutions will request more and more services that tend to fall into the business category—more clinical delivery. And at the same time, when we in Business Development and Clinical are talking internationally, oftentimes individuals also would benefit from their research collaboration. So, not having those two programs aligned presents a challenge, and one in which, I think Dr. Bogler and I both agree, if we can keep a higher level of communication we can overcome. But, you know, that is something that we continually work on.

***Tacey Ann Rosolowski, PhD***
[00:30:09]
Mm-hmm. Do you find you're—here I'm switching our perspective to just inside MD Anderson—is there—do you find there's a good alignment, you know, value-wise? Do you find you have to do a lot of explaining within MD Anderson of what you do, and how there should be

buy-in from other folks? I mean, is there a kind of mystery about what your role is within the institution?

***Amy Carpenter Hay***
[00:30:39]
I think there has been, over time. And I'm not sure I would—I would put it as much on my role as an individual, but the network's role as a whole. Now, what I would tell you, though, is I think that's—over the last year to two years, that's significantly changed. And a lot of that has to come—has come with Dr. [Ronald] DePinho's entry into the institution. And a higher level of communication with the division heads and the leadership at MD Anderson.

There's really, you know, I think, two components of that. First, approximately two years ago, I was invited to sit on the executive committee of Dr. DePinho. I think that was the first big step of trying to ensure that the business development aspects of the institution were at the table and transparent across the organization. The second step is a much higher integration and direction from the division heads of MD Anderson.

***Tacey Ann Rosolowski, PhD***
[00:31:42]
And what did that—effect did that have?

***Amy Carpenter Hay***
[00:31:46]
The division heads?

***Tacey Ann Rosolowski, PhD***
[00:31:47]
Mm-hmm.

***Amy Carpenter Hay***
[00:31:48]
It—well, it in—it had the effect of, quite frankly, keeping them informed and involved in what was going on outside of MD Anderson. You know, for many years, there was a much greater focus internally on our operations. And so, this was a gradual approach to really making sure that the entire institution was informed and responsible for what we were doing outside of the Texas Medical Center.

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***Tacey Ann Rosolowski, PhD***
[00:32:20]
Yeah, you told the story about setting up that first proton—or Radiation Therapy Center in Bellaire, and how that was, like, a new idea for people. But it sounds like it's been a slow cultural change—

***Amy Carpenter Hay***
[00:32:32]
It has.

***Tacey Ann Rosolowski, PhD***
[00:32:33]
—at MD Anderson, to get people to look beyond the physical boundaries of the institution.

***Amy Carpenter Hay***
[00:32:38]
Absolutely. It's been a very slow cultural change. And I think that we're in a very nice place now. Our future development on the regional side—so, just within a thirty-five-mile radius around the Texas Medical Center—is to not only have services but to also, quite frankly, have our own unique buildings and have our own unique space in which we can control the services that are being delivered. So it's been a very large shift in thinking, not only internally, but also externally. This has translated into a much greater influence and relationship on our partner members, because the division heads should be, and delegate their—within their staff, the authority to approve and disapprove any doctors across the network. So, by virtue of that, they have to be not only informed and involved, but also responsible for those clinical-delivery systems.

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# Chapter 13
# *Dr. Ronald DePinho and Institutional Change*
# B: Institutional Change;

**Story Codes**
B: Growth and/or Change;
B: Institutional Politics;
B: Controversy;
C: Understanding the Institution;
D: On the Nature of Institutions;

***Tacey Ann Rosolowski, PhD***
[00:33:48]
Now you mentioned things changed when Dr. DePinho came into the institution. Tell me about that, kind of, benchmark event.

***Amy Carpenter Hay***
[00:33:58]
Well, I mean, I think the benchmark event was, you know, after he took time the first year to understand the organization fully, I think that his vision is one in which there is a large emphasis on the democratization of cancer. Meaning how do we push out our knowledge both nationally and internationally in a way that's impactful? So we often say that, you know, right now, today, as we sit here, we treated 35,000 new cancer cases at Main Campus. We treated four in our regional c—4,000 in our regional system. And we treated another 35,000 across our network. So, it's about impact, and knowledge sharing on oncology, from screening and prevention to treatment to survivorship. So, a big push on thinking externally on how we can push out our knowledge.

***Tacey Ann Rosolowski, PhD***
[00:34:56]
Mm-hmm. Now, I've talked to a lot of people, you know, because I've been interviewing through the period of Dr. DePinho's—when Dr. DePinho arrived, and, you know, going through a lot of cultural change at MD Anderson, and some turbulence and criticism. So, what's your view of—how do you respond to some of the questions about growth, and the questions about the value of spreading MD Anderson quite this widely, and expansion and proliferation of function rather than focus on a much narrower band of what MD Anderson traditionally has done well?

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***Amy Carpenter Hay***
[00:35:38]
Well, I mean, what I would say is, I think any knowledgeable researcher would tell you that we're not gonna cure cancer sitting in Houston, Texas. If we are gonna make an impact, it has to be a global impact. And that requires MD Anderson to have not only a clinical presence, but an ability to conduct research on a worldwide basis. The world we live in is not one location. That's, I would suggest, small thinking that's not gonna lead to any sort of innovation.

***Tacey Ann Rosolowski, PhD***
[00:36:12]
Mm-hmm. What are some examples of kind of the positive outcomes of creating these wide partnerships?

***Amy Carpenter Hay***
[00:36:22]
I mean, I think the examples are, first and foremost, impact on patient lives. We've made significant impact in our partner memberships. We've done so internationally. We've changed the level of care being provided across the board. I think research would—is the second impact, in that we have been able to push out and accrue patients in not only higher volumes, but in a much more meaningful way. And third, really goes back to the disparities in healthcare. If MD Anderson, as the leader of oncology, is not supposed to be eliminating those disparities, then my question would be, who is supposed to be?

***Tacey Ann Rosolowski, PhD***
[00:37:02]
And when you're talking about disparities, what are you referring to there?

***Amy Carpenter Hay***
[00:37:04]
Disparities in healthcare, as cited by the IOM [Institute of Medicine] report, is the clear acknowledgement, both nationally and internationally, that all patients don't have the ability to access high-level oncology care. The IOM is the Institute of Medicine, and they have done, you know, a fantastic review, and continued documentation of the fact that most Americans—not even looking globally—don't have access to the highest-level oncology care, and they should. So part of our mission, I would suggest, is to ensure that we democratize the knowledge and expertise we have in order to eliminate these disparities.

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***Tacey Ann Rosolowski, PhD***
[00:37:53]
Mm-hmm. Do you think the—your perspective—I'm just curious about whether your perspective of Dr. DePinho and some of the individuals who've been brought into MD Anderson more recently, kind of represent, I don't know, a boundary between an old guard, a new guard—you know, a sort of big change in the institution and its perspective. Because I'm always thinking about, you know, well, where is this institution in its path from past to future, you know? And is it, at MD Anderson today, a little different than it was five years ago, ten years ago, because of this thinking?

***Amy Carpenter Hay***
[00:38:34]
I think it's different every year. It has to be. I mean, if you're standing still you're moving backwards. So it has to be evolving. I mean, that's—that is part of medicine. It's part of research. It's part of the global civilization. So it absolutely moves, and if we were behaving the way that we were five years ago, we would not be the number-one cancer center in the world. Quite frankly, next year, if we're behaving the way we are today, we won't be the number-one cancer center in the world. We have to be constantly thinking of what's three steps forward, not keeping stagnant.

And so, that does create changes, and change is hard. And it's especially hard in an environment in the United States where the medical community is fairly resistant to change. Doctors who went to med school twenty years ago didn't sign up for this. They didn't sign up for changes in how we're paid. They didn't sign up for electronic-medical-record requirements. They didn't sign up for fighting insurance. They signed up to treat patients, which is admirable and fantastic. But that's not in the world in which we live in today.

I would actually even go further and say that most physicians at MD Anderson that have never left MD Anderson don't realize how fortunate we are. We have access to resource s that no one in the world does. We have access to not only financial resources but staffing and equipment resources that most doctors around the United States will never have the opportunity to provide for their patients.

So, yes, is there pain in change? Absolutely. But without it, we would be moving backwards.

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# Chapter 14
## *Planning for the Next Growth Areas*
## B: Building the Institution;

**Story Codes**
B: MD Anderson in the Future;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Research, Care, and Education;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: On Texas and Texans;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;

***Tacey Ann Rosolowski, PhD***
[00:40:31]
Mm-hmm. What's next? I mean, you said if we're doing the same thing next year that we're doing now, you know, we're slipping. What do you see coming, you know, that's gonna need adjustment?

***Amy Carpenter Hay***
[00:40:42]
Well, we—you have to start getting much more involved in the big-data initiatives. Some of the things that we're doing right now with Dr. Lynda Chin, with our work with IBM and Watson on the democratization of knowledge across the world, it has to take the form of a sustainable, big-data model. And that is—that's the future. You know, in the future world, we won't need big hospitals. We will have patients getting their chemotherapy in oral form at their CVS. We need to be able to not only track but also ensure that patients are being taken care of for the right disease at the right time at the right location.

So, moving forward, we are going to continually have to change the way that we deliver care. And I think, on our Main Campus, our mission is going to have to be how do we fuel the

research behind that change? You know, it's a fact that most human beings take three pieces of knowledge to make a decision. There's absolutely no way that any physician in today's world can read every single research paper, every single bit of information, and utilize it to make an informed decision. So, in the future world of MD Anderson, we'll be utilizing systems—big-data systems—in order to put pieces of information together that we never thought possible, in order to make better, more precise decisions for patient care.

A great example of that is our work in genomics, our work in immunology—the future focus of personalized medicine. I personally think we've just scratched the surface. That's—I could envision an MD Anderson where we're no longer disease-based. You don't go to the Breast Center or the GI [Gastrointestinal] Center. You go to the center based on your gene mutation. That's the direction that we're headed in. And we have to leverage all of this knowledge in a way that captures the metrics, and then allows us to make better decisions every day for the future. And I think that's what our focus is gonna be the next five years—is how do we leverage innovation in programs that guide our decision-making.

***Tacey Ann Rosolowski, PhD***
[00:43:22]
What—what's that looking like? I mean, are there initiatives that you're working on right now with partners that are starting to set that kind of big-data model in place?

***Amy Carpenter Hay***
[00:43:32]
Absolutely. You know, I'm participating quite a bit with, a I mentioned, Dr. Lynda Chin and the work she's doing with the Oncology Expert Advisor, which includes the Watson technology and IBM and AT&T, and how do we utilize all of these resources and be able to track, predict, and place patients on clinical trials? Her work right now has focused around leukemia, and also around personalized medicine in lung. And the long-term plan is to build other diseases, other personalized-medicine components, out in the future.

So, a lot of thought is going into what that will look like. I think based on that, and a lot of other programs, we've recently hired a chief innovation officer that will be starting this summer. He'll be responsible for, kind of, harnessing and directing this type of knowledge and power. And I think that's important.

***Tacey Ann Rosolowski, PhD***
[00:44:40]
Who is this person?

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***Amy Carpenter Hay***
[00:44:42]
I don't know her name.

***Tacey Ann Rosolowski, PhD***
[00:44:44]
Okay.

***Amy Carpenter Hay***
[00:44:44]
She was recently announced to—so I'm sure we can follow up on that.

[00:44:48]

***Tacey Ann Rosolowski, PhD***
Mm-hmm, yeah, sounds like a really interesting position.

***Amy Carpenter Hay***
[00:44:50]
Very interesting [inaudible].

***Tacey Ann Rosolowski, PhD***
[00:44:52]
Yeah. What's this person's background? Do you recall?

***Amy Carpenter Hay***
[00:44:54]
Innovation—

***Tacey Ann Rosolowski, PhD***
[00:44:55]
Innovation, yeah.

***Amy Carpenter Hay***
[00:44:56]
—at another academic cancer center. So—

***Tacey Ann Rosolowski, PhD***
[00:44:58]
Wow, well, very, very interesting.

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***Amy Carpenter Hay***
[00:45:00]
So a lot of work there.

***Tacey Ann Rosolowski, PhD***
[00:45:01]
And that person will be part of what office? I mean, where is—

***Amy Carpenter Hay***
[00:45:05]
She'll be the chief innovation officer, is my understanding.

***Tacey Ann Rosolowski, PhD***
[00:45:09]
So is this gonna be a separate office, constructed?

***Amy Carpenter Hay***
[00:45:11]
Mm-hmm.

***Tacey Ann Rosolowski, PhD***
[00:45:12]
Wow, very interesting, indeed.

***Amy Carpenter Hay***
[00:45:14]
Yes, so that's coming down the—down the pike. And hopefully will help us kind of manage that in—and coordinated across all these different areas, 'cause it has to be—it has to be—it had to connect everyone and not be siloed. So—

***Tacey Ann Rosolowski, PhD***
[00:45:31]
Mm-hmm. Exactly.

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***Amy Carpenter Hay***
[00:45:33]
So that's a big direction. I think, from a Business Development, the other big directions are while we've been focusing on providers, whether they're doctors or healthcare systems, we've also been focusing on consumers. The next iteration is focusing on employers and corporations. So, how do we develop programs, specifically in the area of cancer prevention, education, screening, and survivorship, that really pull in those employers, pull in those corporations, and try to push this education to people instead of just to patients?

***Tacey Ann Rosolowski, PhD***
[00:46:19]
To—I see. Wow, okay, yeah, I hadn't even thought about that as a distinction. So, what might that look like? So, you know, going to a General Electric and saying, "We have an education program about cancer privation—prevention for all of your employees," or something like that.

***Amy Carpenter Hay***
[00:46:35]
Mm-hmm, exactly.

***Tacey Ann Rosolowski, PhD***
[00:46:37]
Wow.

***Amy Carpenter Hay***
[00:46:38]
We're working right now, and it's—it kind of leverages all of our work in cancer prevention and education and screening with some of the elements of how we leverage technology and big data. We're working—we're about twelve months out from a pilot of an employer program that has really two defined components. The first component is how do we, as MD Anderson, go into an employer—a large employer—and review their employees, their risk profiles, you know, the types of education and services that would be appropriate for them. And then, the other component is, how do we get in front of those employees? How do we offer them cancer-risk assessments? How do we offer them educational opportunities? How do we offer them screening and prevention opportunities? So, really trying to get upstream, because as—we know that if we can prevent cancer—if we can get as far upstream as we can—we can find the keys to treating it.

So we've put a lot of thought into how do we really start aligning ourselves with large employers. And, you know, that leaks into how do we align ourselves with corporations. For example, our team right now is looking to participate in a health fair with Walmart. All the way

across the United States, Walmart has 5,000 em—stores. They have—2,500 of those stores have actually kiosk that we can put cancer-risk assessments on, that people could walk into the Walmart and they could answer the questions and kind of see the areas in which they need to be concerned about. So really trying to access and provide that information as closed to the consumer as we can.

***Tacey Ann Rosolowski, PhD***
[00:48:37]
So what would the financial arrangement look like for that kind of relationship? I mean, would the employer pay MD Anderson a service? Is—would they arrange with, you know, the health insurer, for that provider?

***Amy Carpenter Hay***
[00:48:52]
We're really—we're focused on self-insured employers. So, there would be a fee associated with our relationship, and that fee would cover kind of the cancer education, prevention, all of the outreach component. Now, the concept is that should an area of concern be identified, that that employer, who's self-insured, would then have a clear navigation path into MD Anderson.

***Tacey Ann Rosolowski, PhD***
[00:49:34]
It sounds like an amazing safety net to offer employees.

***Amy Carpenter Hay***
[00:49:36]
It's something that—a few other academics have been dabbling in this area, not as much in oncology but specifically in cardiology, which has been—you know, 'cause if you really look at chronic disease, you're talking about oncology now; you're talking about cardiology—so, high blood pressure; and you're talking about, quite frankly, wellness. You're talking about BMI [body mass index] and, you know, obesity, and factors like that. So, providing products and education in these core chronic disease areas before they become chronic—

***Tacey Ann Rosolowski, PhD***
[00:50:13]
Right.

***Amy Carpenter Hay***
[00:50:14]
—is something that we're seeing a lot more interest in, which is fantastic. It meets our mission. And I'll give you an example with Walmart. The 2,500 stores I mentioned that have kiosk.

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These kiosk allow the shopper to come on and take their blood pressure and measure their BMI and do a couple of other things. All of that data is fully retained, and is synched to their Walmart pharmacy account. That is an unbelievable amount of information that's sitting out there that we, as a research community, could start to leverage as far as the indicators for chronic disease, whether its diabetes or whether its oncology.

It's a tool that, I think—that we've all not focused on. You know, in the United States, my opinion is that everyone likes to talk about cancer education and screening and prevention, but very few people like to pay for it. I think the turn that's happened with accountable care and paying for quality, not quantity, has forced the US to start investing in programs such as prevention and education, 'cause that's the only way we're gonna be able to lower the risk of having some of these long-term, chronic diseases.

***Tacey Ann Rosolowski, PhD***
[00:51:49]
So many people have made a mention of, you know—that it's been known for so long that some diseases—cancer being one of them—can be very much addressed in—on the preventative side, and there's not been much investment—

***Amy Carpenter Hay***
[00:52:04]
No.

***Tacey Ann Rosolowski, PhD***
[00:52:05]
—in doing that. So—

***Amy Carpenter Hay***
[00:52:06]
No one wants to pay for it.

***Tacey Ann Rosolowski, PhD***
[00:52:07]
Yeah, yeah.

***Amy Carpenter Hay***
[00:52:07]
They ne—I think we're just—we're just getting there. People are starting to want to pay for it. Corporations are starting to see the value. You know, you're even—it's not uncommon to pick up the *Wall Street Journal* and see articles about large employers who are subsidizing, every day,

the healthy lunch, and marking up the expensive hamburger. And I think those are the types of incentives we're gonna start to see. You know, we're gonna start to see—and they—you know, if you allow yourself to go through this thought process, even with the Walmart example—so, if you take the time to measure your BMI, and you take the time to update your health record, and maybe the incentive is that we give you coupons for healthy food. And so, there's these—all of these mechanisms we can use to try to change behavioral patterns.

***Tacey Ann Rosolowski, PhD***
[00:52:59]
Mm-hmm. So what's the benefit that you would offer for—to an organization or corporation to offer this kind of thing to the employees?

***Amy Carpenter Hay***
[00:53:09]
Well, I think I would change the question, because what we're seeing is the employers want to offer this to their employees for two reasons. One, they're looking at this as a long-term commitment, meaning this is a perk to the employee—so, a positive. "I work at Shell, and because I work at Shell I have access to MD Anderson." That's a positive. They're also seeing the long-term of, "If I can incentivize and provide prevention education, maybe twenty years from now my insurance premium's not gonna go up because I'm not gonna have unhealthy lifestyle, bad habits that contribute to malignancy."

***Tacey Ann Rosolowski, PhD***
[00:53:55]
That does seem like a real conceptual shift for a lot of people.

***Amy Carpenter Hay***
[00:53:59]
It's the major conceptual shift. You know, we've—our business plan right now—and as I said, it's twelve months out to having the prototype—is focusing first, locally, in Houston, on the energy community. Because we find a lot of those companies are not only self-insured, but very progressive. They are thinking about, how do we save energy? How do we get the consumer? How do we educate them? And that type of a mentality fits very well with what we're trying to accomplish. It will take time, but I think we are committed to really pushing that prevention-education aspect.

***Tacey Ann Rosolowski, PhD***
[00:54:37]
Interesting. Yeah, it's interesting that you say the energy community is particular—has a culture that's very open to this kind of innovative thinking.

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***Amy Carpenter Hay***
[00:54:47]
On the corporate kind of side, absolutely. You know, in Houston we're seeing, obviously, you know, just the proliferation of the Exxons and the, you know, large, you know, communities that are popping up around the city. So they provide a great opportunity.

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# Chapter 15
## *The Center for Global Oncology Becomes the MD Anderson Cancer Network, Part II*
## B: Building the Institution;

**Story Codes**
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
B: MD Anderson History;
B: Institutional Processes;
B: Building/Transforming the Institution;
B: Growth and/or Change;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;

***Tacey Ann Rosolowski, PhD***
[00:55:02]
Very interesting. So, I'm interested—that kind of shift from the Center for Global Oncology to the MD Anderson Network. Is there any other facets of that morphing of that closed group into a more open group that you want to tell me about, in terms of culture shift at MD Anderson, or shift in focus?

***Amy Carpenter Hay***
[00:55:31]
No, I mean, I think that the whole—the real reason for that was to align all of the national programs. So, you know, in the Center for Global Oncology, it was nationally only about the partner members. The new Cancer Network was an attempt to align all of the products, so you had the certified membership, the partner members. You know, you were—we were trying to aggregate everything together. It was also an acknowledgement that we had our MD Anderson's Physicians' Network, which is the separate 501(c)(3) that the certified members sit in, and it needed to be pulled into MD Anderson. We no longer—because we were all growing so quickly—should have had a kind of outside product that wasn't aligned with everything else. And that was really the focus, was to pull in the certified members and ensure that we had a product line that was clear, and that we all understood.

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***Tacey Ann Rosolowski, PhD***
[00:56:41]
That's—I mean, it's a measure of your specialization that, you know, you talk—speak this—in this kind of language, of product line and that kind of thing. It's a different way of thinking about the institution than most of the people that I interview. So, thinking about that idea—aligning a product line—what does that—what does that do? What's the impact of that, for MD Anderson, to align—to align products within one organizational division within the institution, rather than have them split among several? I mean, it may seem like an obvious question for you, but believe me, there are people who are like, "Wait a minute—product line? I don't think of MD Anderson in that way."

***Amy Carpenter Hay***
[00:57:28]
Yeah, they don't. And that—but that's what I get paid for. I mean, I get paid to think about how do we make the business of MD Anderson successful, in order to support the research of MD Anderson. So, you know, I think the importance of having the products all under one umbrella is to ensure that there's clarity on what they are. They don't overlap. They don't step on each other. It's organized in a fashion that everyone should understand. Now that doesn't mean everyone does, but we need to be better, as an organization, and clearer about what is a certified membership. What does that entail? What do you get? What's the branding associated? Versus a partner member: what does that entail? What do you get? And what's the branding component?

So, it—the attempt was to ensure that we understood what we were doing out there, whether it's nationally or internationally. And in doing so, really tried to have an orchestrated effort around it. So, for example, if I am in Jacksonville, Florida, I shouldn't be working on a partnership when someone in another company is working on a certified member. That doesn't make sense. We have to be organized. We've gotten too big to do it one-off. And I think a lot of this kind of maturation from Center for Global Oncology to the Cancer Network has been a growth pattern. As we've gotten bigger, we've had to reevaluate how we organize ourselves, in order to be more transparent and, quite frankly, more efficient.

***Tacey Ann Rosolowski, PhD***
[00:59:20]
Now, the Physicians' Network—you mentioned how it just didn't make sense to have it out there. What was—what was the problem with having it just kind of hanging out there, and what's been the effect of bringing it into the MD Anderson network?

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***Amy Carpenter Hay***
[00:59:37]
Well, now it's organized and it is at least informed and acknowledged by MD Anderson as a whole. Much like Orlando, the Physicians' Network used to be seen as this separate 501(c)(3). That's not us. That's something else. By pulling it into the Cancer Network, we were acknowledging that this is part of what we do as MD Anderson. [inaudible].

***Tacey Ann Rosolowski, PhD***
[01:00:06]
And what—what is—just quickly summarize what is the Physicians' Network.

***Amy Carpenter Hay***
[01:00:09]
Well, it's more about the products—so, the certified membership. The certified membership is the quality-assurance tool. So, the retrospective quality-assurance tool—so that's something that we do as an organization. Now, the Physicians' Network is, from a legal perspective, a separate 501(c)(3) that, quite frankly, we just used for contracting. So as a state agency, it's oftentimes very difficult to [laughs] to contract.

***Tacey Ann Rosolowski, PhD***
[01:00:39]
Right.

***Amy Carpenter Hay***
[01:00:39]
This allows us some flexibility. And it also allows us to have a repository for our contracts that are outside the state of Texas. That said, when I mentioned bringing it in, it's bringing in the product. It's bringing in that certified membership. So it's acknowledging that that is part of MD Anderson and what we do, instead of this thing out there.

***Tacey Ann Rosolowski, PhD***
[01:01:05]
Out there, right, right.

***Amy Carpenter Hay***
[01:01:07]
And I think it's been moderately successful. I s—I think there's still a lot of questions around how do we ensure that we truly differentiate the certified membership and the partner members. I think that we will continue to work on that. I think that's something that's just going to take time and attention as we grow.

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***Tacey Ann Rosolowski, PhD***
[01:01:33]
So is the issue with that really the way that an institution that wants a partnership—how their relationship kind of morphs, and it turns out that their needs may be a little different, or desires may be a little different, as their relationship with MD Anderson evolves. I'm not quite sure of where the slippage is, in the designation.

***Amy Carpenter Hay***
[01:01:56]
Well, they're very different relationships. So, I don't know that there's—the issue is that the certified membership is retrospective. It is not integrated. We do not say that that is the same level of care at MD Anderson. Therefore, it's very important that we put tight controls around our certified members so they don't, perhaps, suggest that to the population. I think that's the slippage factor.

***Tacey Ann Rosolowski, PhD***
[01:02:30]
Okay.

***Amy Carpenter Hay***
[01:02:31]
It used to be that our certified members were very small community hospitals. Over the years, we've had much larger health systems want to participate in that. That's good, but it also breeds another level of problem, meaning that there are some members in our certified sites that are of a size and significance that they probably would qualify for partner member if they wanted to.

Now, on the partner-member side, we have strategically defined where we feel like we need to be. You know, and as I've said, I know, a couple of times before, you know, four of six of these in the United States, we have three complete, and we're already working on two more—they're very focused on where we need to be, and the criteria for them are very strict. So, that's something that many organizations can't, and mostly don't want to, be part of. And that's okay, because those we hold very dear, as they hold our name.

***Tacey Ann Rosolowski, PhD***
[01:03:37]
Mm-hmm, right. Let's see. So, you took over as vice president for Business Development. This was in 2012. You were looking puzzled there.

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***Amy Carpenter Hay***
[01:03:55]
Yeah.

***Tacey Ann Rosolowski, PhD***
[01:03:55]
Am I getting that wrong? [laughter]

***Amy Carpenter Hay***
[01:03:56]
No, no, no. I was just doing the math.

***Tacey Ann Rosolowski, PhD***
[01:03:57]
Okay.

***Amy Carpenter Hay***
[01:03:59]
It's about three years ago, I guess.

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# Chapter 16
## *As VP of Business Development: Today's Initiatives and What the Future Holds for MD Anderson*
## B: Building the Institution;

**Story Codes**
C: Leadership;
B: MD Anderson in the Future;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Research, Care, and Education;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The Business of MD Anderson;
B: The MD Anderson Brand, Reputation;
D: Business of Research;
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;
D: Technology and R&D;

***Tacey Ann Rosolowski, PhD***
[01:04:00]
Yeah, okay. So I wanted to make sure that I've covered everything, you know, so that, you know, we understand, for the record, you know, what's the scope of your responsibility. And I guess—I guess the way I want to start that, rather than kind of going with the official line, is, you know, did you have a personal set of goals when you took on that new, expanded role? You know, there's the—what was my mandate? What was my—what were my marching orders? But, versus, you know, did you have a personal sense of what you wanted to accomplish in this particular role?

***Amy Carpenter Hay***
[01:04:42]
Yes, I mean, I think that my—their—the task that was put in front of me was to mature our partnership model, to gain partners, and, quite frankly, to grow our international business. The goal, in my opinion, has always been really four-field. It's been, one, we need a consumer-facing product. Two, we need a provider-facing product. Three, we need a corporate product. And four, we need a payer product. And so, those are the categories I typically think through.

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So in the consumer, those are all of the cancer prevention and screening and wellness things we're doing. In the provider, those are the partner members and the international associate members. In the corporate, that's what we're focused on—the employer membership and large corporate alliances. And then, on the payer side, I think there's a lot of work still to be done there.

Now, the way that I personally have always viewed Business Development is that we should really be the conduit for every other piece of the organization. Meaning I, as Business Development, should be opening the doors to Marketing and Communication and Corporate Alliances and Industry Ventures and Development. So I should be kind of the tool that they utilize in order to accomplish their goals. So, to me, it was never about just opening up the next partner. It was always about kind of a bigger vision of how do you—going back to the word—democratize cancer across consumers, providers, corporations, and payers?

***Tacey Ann Rosolowski, PhD***
[01:06:35]
Talk to me a little bit about the payer piece, because, you know, we've talked a little bit about the other ones. But what about the payers?

***Amy Carpenter Hay***
[01:06:43]
The payer piece is still, you know, something that, institutionally, we have devoted a lot of time and effort to. My role on the payer side is more support. So, a good example of that is that, institutionally, we are starting to get involved in bundled payments. We currently have a relationship with United for a bundled-payment plan in Head and Neck for four specific disease sites there. So, these are the type of innovative payment mechanisms that we have to start looking into.

Now, as—from a Business Development standpoint, I think that those payment initiatives are gonna have an impact on everything else. I think they're gonna have an impact on who we're partnering with, and who we're working with on the employer side. Because the payer community is really changing. We're seeing that not only within the changes in healthcare regulations, but also in the managed-care environment as well. You know, if—when people ask me, "What kind of keeps you up at night?" One of the things that does keep me up at night, specific to MD Anderson, is that we have had quite the luxury of living in an environment in which we continue to be paid for our fee-for-service. Most people don't have that luxury anymore. We continue to be paid a "hold harmless" payment, meaning we're kept whole with Medicare.

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***Tacey Ann Rosolowski, PhD***
[01:08:21]
What was that phrase again? The hold—

***Amy Carpenter Hay***
[01:08:24]
"Hold harmless" payment, which is our Medicare exemption. So we have a lot of luxury based on our designation as a comprehensive cancer center, which we deserve. The healthcare politics and the gravity of the healthcare financial situation in the United States is going to continue to erode our bottom line. It just is. And we know that. And so we, as an organization—while we are not feeling that pressure as much as typical acute-care providers, we have to start preparing for it.

I think part of my job in Business Development is to continue to support the institution in thinking through these things. The ways that I do that are really twofold. First, a lot of our partners are already dealing with this, so we can learn from them. Our relationship at Banner, for example—they are very active in risk-sharing with managed-care companies. They're very active in the ACO [accountable care organization] environment. We need to be learning from that.

***Tacey Ann Rosolowski, PhD***
[01:09:38]
ACO?

***Amy Carpenter Hay***
[01:09:39]
Accountable care organization—

***Tacey Ann Rosolowski, PhD***
[01:09:40]
Oh, okay, mm-hmm.

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***Amy Carpenter Hay***
[01:09:41]
—environment. And the other way that I think that we have a responsibility in Business Development is that we have to continue, as an institution, to diversify our bottom line. We are—in the future environment of healthcare delivery, we cannot be completely reliant upon patient-care revenue. We have to have other revenue streams. Some of that will come from the partnerships that I'm talking about. Some of that will come from transactions with big pharma on drug development. Some of that will come from innovation. But as an organization, we need to continually be identifying opportunities to diversify our revenues, to plan for the day when we maybe don't get paid the way we are paid today and, therefore, our patient-care revenue is significantly decreased. If that happens, we have to find another way to fund our research. If we don't, we won't continue to be who were are.

***Tacey Ann Rosolowski, PhD***
[01:10:44]
What are some of the things you're working on now, to anticipate that?

***Amy Carpenter Hay***
[01:10:50]
I guess I don't understand your question.

***Tacey Ann Rosolowski, PhD***
[01:10:50]
Revenues—I mean, what—are there specific opportunities that you're looking into now to develop—

***Amy Carpenter Hay***
[01:10:58]
I think it's everything we've been talking about.

***Tacey Ann Rosolowski, PhD***
[01:10:59]
Okay, mm-hmm.

***Amy Carpenter Hay***
[01:11:00]
I mean, it's the partner memberships. It's the employer program. It's the big data and the implementation of, you know, technology tools. So, it's—all of these components contribute to how are we diversifying our bottom line.

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***Tacey Ann Rosolowski, PhD***
[01:11:15]
Okay, okay, yeah. Okay. And so, the way that, financially, that would work is the fee that MD Anderson would receive goes, first of all, to pay the bills for the people who have actually, you know, helped support that initiative. And then, the surplus goes into research.

***Amy Carpenter Hay***
[01:11:34]
No, as I—as I stated earlier, you know, the fees that we get paid go directly to the mission. In addition to that, we get paid for our time and attention.

***Tacey Ann Rosolowski, PhD***
[01:11:43]
Oh, okay.

***Amy Carpenter Hay***
[01:11:44]
So, all of that time and expense attention is a direct payment.

***Tacey Ann Rosolowski, PhD***
[01:11:49]
Okay, gotcha.

***Amy Carpenter Hay***
[01:11:50]
So all of the fixed and variable fees across all programs just go directly to the bottom line. It's pure margin.

***Tacey Ann Rosolowski, PhD***
[01:11:56]
Okay, wow. That's great.

***Amy Carpenter Hay***
[01:11:56]
So that helps us. And, you know, I think, as to your question, the other component is not just the new programs Business Development is creating and trying to mature and sell. It's the support Business Development provides across the entire institution. You know, for example, Development. You know, we have a very large philanthropic base. I see as part of my job—is to support the people in Development, whether it's talking to donors or whether it's introducing them to major international entities and organizations, there's a support component that needs to

be done across the institution. And that's—I think part of our role in Development is to ensure that those conduits are open. So it's not just about a new product. It's also about how can we leverage it for philanthropic dollars? How can we leverage it for marketing? How can we leverage it for tech transfer? How can we leverage it for clinical-trials accrual?

***Tacey Ann Rosolowski, PhD***
[01:13:09]
Now you mentioned that you've hired another person—another you, or almost you. [laughter]

***Amy Carpenter Hay***
[01:13:15]
I did. I did. And you can talk to him when he comes [inaudible].

***Tacey Ann Rosolowski, PhD***
[01:13:18]
Yeah, but I'm just wondering—I'm anticipating, you know, like, so, in July, when this individual comes. And his name is?

***Amy Carpenter Hay***
[01:13:24]
His name is Mike [Michael] Brown. He actually has a history with the organization as well. Mike Brown was an administrative fellow, as I was, back in the day. I don't know the specific years. He was an administrative fellow, and then after his fellowship started working the network on the clinical side. He then transitioned to the Business Development side. I had him working over our analytics and our financials, and really was quite remarkable.

He was actually so remarkable that he got recruited away to be the vice president for Business Development for the University of Chicago. He's been there for approximately one to two years, and done some really innovative things up there. It's given him the chance to do some things that are more diverse, that I think we can really learn from. Had a chance these last few months to recruit him back to MD Anderson. So he'll be returning in July as the associate vice president for Business Development.

***Tacey Ann Rosolowski, PhD***
[01:14:31]
So how will your spheres of influence be constructed after he arrives?

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***Amy Carpenter Hay***
[01:14:37]
You know, really, at this point, the growth is so tremendous [laughs] that we're—he and I partner very well together, so he likely will start working on a day-to-day basis on our regional growth—so, here in Houston. And I will continue focusing a lot of my time on the partners in the partners in the US. We likely will split the international. And where I, personally, have—want to find time is, to spend much more time on the vision component—on thinking about the future, where we're going, collaborating with the new chief innovation officer, specifically in the area of big data and democratization. So I'm hoping that he'll come in and be able to do a lot of the day-to-day management, so that will allow me to be able to elevate on a more visionary—what's com—what's next five years? What's next ten years? What do we need to be thinking about, and how can we prepare ourselves, today, to accomplish that?

***Tacey Ann Rosolowski, PhD***
[01:15:45]
Mm-hmm. Now, I am aware that we're at three o'clock, and we were supposed to stop today at 3:00.

***Amy Carpenter Hay***
[01:15:50]
That's okay.

***Tacey Ann Rosolowski, PhD***
[01:52:49]
Well, sure, thanks for today. And I'm just—for the—for purposes of the recorder, I'm turning off the recorder at about one minute after 3:00.

***Amy Carpenter Hay***
[01:52:58]
Sure.

***Tacey Ann Rosolowski, PhD***
[01:15:50]
It's okay? Because I thought— you know, and we can probably finish up if we go another half hour or so. Does that work?

***Amy Carpenter Hay***
[01:15:54]
Yeah, no, that's great.

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***Tacey Ann Rosolowski, PhD***
[01:15:54]
Okay, cool.

***Amy Carpenter Hay***
[01:15:55]
Yeah.

***Tacey Ann Rosolowski, PhD***
[01:15:55]
Great. So let's—I—let's talk a little more about that vision component. I mean, if there's some pieces of that that we haven't hit already, because you've kind of talked a little bit about future of MD Anderson. But what are you really excited about pursuing for a future vision?

***Amy Carpenter Hay***
[01:16:15]
Well, I mean, I—to me, it goes back to the innovation side. You know, as we create what I—what I call the interchange, which is really this cloud-based repository of knowledge, I think that is the future. You know, I envision that will hold our telemedicine in the future. I envision that will hold very disease-specific quality-assurance tools, metrics, tracking of everyone across the MD Anderson network, whether it's regionally, nationally, or internationally.

***Tacey Ann Rosolowski, PhD***
[01:16:52]
Now you're looking at an image here. Is this—

***Amy Carpenter Hay***
[01:16:54]
[laughter] Oh, I'm sorry.

***Tacey Ann Rosolowski, PhD***
[01:16:55]
Oh, no, I was just wondering if it was relevant—

***Amy Carpenter Hay***
[01:16:56]
It is.

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***Tacey Ann Rosolowski, PhD***
[01:16:57]
—'cause I could take a picture.

***Amy Carpenter Hay***
[01:16:57]
Oh, no, it's—no, it's just something that I have been playing with. You know, kind of, how does this interchange work, and how do consumer access it? How do providers access it? How do payers and corporations access it? How does it become this huge repository of knowledge that kind of fuels the future of oncology? And that's —that, I think, is the key, you know? So, how do you leverage technology in a meaningful way? And it has to be meaningful, because I think the challenge—and I was—actually had a meeting on this, this morning. The challenge is that we can all sit in a room—brilliant people—and all agree on the vision. And I see the vision. But the hard part is how do we get to the vision?

You know, if I—if I don't have a widget. If I don't have something that encompasses that vision, all I have is a vision. And it might be wonderful, but it needs to have the backing and the development behind it. It has to be accessible to patients. It has to be accessible to providers. It has to show outcomes. It has to show value. And those are the drivers that I think that we need to start orchestrating in a very meaningful way. And it's where the big-data component gets in. You know, how do we learn every single time from every single patient in order to do the next patient better? That's the future, in my opinion, of where we need to be going.

***Tacey Ann Rosolowski, PhD***
[01:18:34]
So how are you—how are you working on that? I mean, that—making it accessible, making it meaningful, making it implementable? What's happening with that?

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***Amy Carpenter Hay***
[01:18:43]
Yeah, I mean, that's where, you know, with a little bit more time—but we're doing it now—is collaboration. It's collaboration with Dr. Chin, with what she's doing with Watson and the Oncology Expert Advisor. It's collaboration with corporations like IBM, like AT&T. It's collaborations—this morning, my—this morning, my meeting was with an equipment company—Elekta. And they traditionally are a LINAC [linear accelerator] neuroscience company. But they've come back and said, "We're interested in big data. What if we could come and partner with you and think through how do—how do we provide mobile treatment planning for radiation oncology?" What if you, as a physician in small-town Arkansas, had a patient that you s—put that patient on the CAT [computerized axial tomography] scan. You've uploaded the CAT scan. And on our interchange, we did the treatment plan for you. And then you know you're delivering a treatment plan that has been reviewed and approved by MD Anderson.

So it all kind of gets back to how do we impact? How do we reach these people? And so, I think it's the combination of finding corporations that are interested in this and want to have innovation in programs, and collaborating with our doctors here at MD Anderson to do things like we're doing with Watson, teaching Watson oncology; tracking those outcomes; pushing it out into our network to test it. So those are the types of ways in which we're trying to push into this space.

***Tacey Ann Rosolowski, PhD***
[01:20:29]
Do you find—I mean, is it generally younger physicians at MD Anderson who want to do this? You're nodding, yeah.

***Amy Carpenter Hay***
[01:20:38]
It's generally younger to mid-range, you know, kind of back to your culture question. Some of this is a little difficult for those that have been practicing medicine for a long time, because, you know, the criticism that I often hear is, "Well, a computer will never be able to tell me how to treat a patient." Well, yes, you're right. Absolutely right. But that computer might be able to access 10,000 clinical trials around the world, and at least give you a list of ten that your patients would be appropriate for. And no human brain can do that. We can't, you know? So I think, culturally, you're looking at the assistant-to-associate mid-range, with kind of the innovation at the division-head level. And, you know, as an institution, we have the right division heads now that understand this. And they're willing to not only contribute, but also advocate for resources to assist.

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You know, tomorrow's consumer—tomorrow's cancer patient is going to get on their app, and they're gonna say, "Who's the best provider of breast cancer?" And they're gonna wait for an answer, and then they're gonna say, "Okay, show me your outcomes." And they're gonna get an answer. And they're gonna say, "Okay, show me where I can go to get that—to get that therapy." And that's what we have to be preparing for now.

***Tacey Ann Rosolowski, PhD***
[01:22:04]
You sound very excited when you talk about this.

***Amy Carpenter Hay***
[01:22:09]
Oh, it's—I think it's fantastic. I mean, I really think that I, as—in my role at MD Anderson, I think that I have no laid the groundwork, from a business perspective, on how we do partners and how we do, you know, international associate members. And we've done that. I—you know, we've done—I've negotiated three partners now. I've negotiated multiple international contracts. We know how to do that. It's time for me to let someone else do that, and it's time for me to start thinking about what's the next generation of this. So how do we leverage all of these partners? How do we have them not only contribute, but also be part of this global expansion of knowledge?

You know, and I kind of go back to one of the things that I've really, kind of, continued to think about—is the precision-medicine initiative that Obama has. He has legislated $215 million to precision medicine. Seventy-one, I believe, million of it is specifically for the National Cancer Institute. There are only three goals to that $70 million. It is genetic-based testing and treatment. It is molecular immunology. And it is—and the democratization of cancer care around the world—exactly what we do. And it's—it—you know, it struck me when I read it. I mean, it's—we should be a cancer knowledge network. That's what we're doing. And I think that if we are able to coordinate and to have the right resources and the right, brilliant people—which we have within Anderson—this is something that can become a reality. But it will take thought and innovation and collaboration.

***Tacey Ann Rosolowski, PhD***
[01:24:09]
It's a great vision. This kind of sounds like what keeps you getting up in the morning—

***Amy Carpenter Hay***
[01:24:16]
It does.

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***Tacey Ann Rosolowski, PhD***
[01:24:16]
—and coming in. Yeah.

***Amy Carpenter Hay***
[01:24:17]
It does.

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# Chapter 17
## *Personal Sacrifice, Women, and Leadership at MD Anderson*
## B: Diversity Issues;

**Story Codes**
C: Dedication to MD Anderson, to Patients, to Faculty/Staff;
C: The Life and Dedication of Clinicians and Researchers;
C: Women and Minorities at Work;
A: Experiences Related to Gender, Race, Ethnicity;
C: Leadership;
C: Mentoring;

[01:24:17]+

***Amy Carpenter Hay***
It does. I mean, I travel too much. I've devoted my—probably too much of my life. I've missed every recital, every kid awards presentation, most of baseball, football, soccer, and swimming. And part of it is because I believe in this. This defines who I am and what I do, good or bad. [laughs]

***Tacey Ann Rosolowski, PhD***
[01:24:43]
Well, I wanted to talk a little bit about, you know, your kind of personal philosophy of leadership, and how you feel you were able to get to the point where you could step into, you know, a very significant leadership role at this institution. And part of what I'm interested in, you know, is stepping into that role as a woman, as well. So tell me a little bit about that process. What were some key leadership learning moments for you?

***Amy Carpenter Hay***
[01:25:14]
That's a great question. I think part of—well, I'm a big believer in leadership as defined by surrounding yourself with leaders. I think that the strongest leaders that we have surround themselves with very strong leaders. You don't have to know everything. You don't have to be able to do everything. You have to know where to get it and who to ask. And so, what I've been fortunate to have is people that have mentored and grown me, that were strong leaders, and allowed me to be a strong leader. And I've tried to do the same around here, 'cause I think that's important.

I think another cornerstone of my leadership approach is to allow other people to thrive, grow,

and, quite frankly, get the accolades for that growth. That is something that is often forgotten. You know, it's not uncommon for me to go to executive committee and have someone on my team present. I don't need to present. I'm already here. I need—we need to grow the next generation of people.

You know, being a female leader at this organization is oftentimes challenging. And I think that's changed over the last decade. I can honestly say that. It really has changed. We've come much more diverse in both ethnic background, but also in sexual background.

***Tacey Ann Rosolowski, PhD***
[01:26:49]
Tell me about how—what do you mean when you say it was a challenge? What were some issues that arose, or that you observed?

***Amy Carpenter Hay***
[01:26:57]
Oh, I think there was a l—a generation of MD Anderson that tended to be male-dominated by the leadership positions. And I think that has changed over time. And part of that changing has come with individuals like myself, and my clinical partner Dr. Maggie Row, who are fully invested in the institution, and are passionate enough to be assertive and to stand up for not only what we believe in, but what is best for the institution. You know, the biggest advice I give everyone is, if you don't know what to do, ask yourself what is best for the institution? Oftentimes, it may not be what's best for you personally. But if you are always doing what's best for the institution, then you're making the right decision.

And I think there's been—maybe it's through growth internally of women, but also some key recruitments externally—that we've really brought in some very strong female leaderships at important components. That provide, in my opinion, kind of a nice balance of how we approach things—how we not only coordinate, but also negotiate.

***Tacey Ann Rosolowski, PhD***
[01:28:25]
I was gonna ask you, you know, I mean it's—seems like a really reductive question, but is—do women have a different style, or do they bring something different to the leadership environment?

***Amy Carpenter Hay***
[01:28:36]
I think so. You know, I—that's a personal—I can't—I can't pull out a literature study that says that, but I do believe so. You know, my negotiating style as a female is very different than even

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my mentor or my, even, current boss. I am much more focused on the win-win of the situation. While I am fully able to hold our ground and get what we need, I'm constantly trying to figure out how do we both get more. And I think that oftentimes is a bit different than my counterparts, especially in academic medicine. A lot of physicians are trained, by their very nature, to make quick decisions, and to not ask for consensus, and move forward.

You know, I think you see in a lot of female leaders an approach that is more consensus-driven, is more win-win, and is based on kind of a thoughtful, deductive process. There's room for both styles, but being a physician-driven organization, I think we are constantly surrounded by more of a surgical mentality of accomplish your goal first, ask for consensus later, versus the opposite.

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# Chapter 18
## *Resilience in Leadership and a Presidency Defined by Innovation*
## B: Institutional Change;

**Story Codes**
C: Leadership;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The MD Anderson Brand, Reputation;
C: This is MD Anderson;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;

***Tacey Ann Rosolowski, PhD***
[01:30:04]
Interesting, interesting. So, what do you think has enabled you to rise and succeed? You know, how would you evaluate your personal style? I mean, you've talked in general about consensus, but, you know, is there s—what's more subtle and deeper there about what you bring as an individual?

***Amy Carpenter Hay***
[01:30:28]
I mean, I think the question is more geared to, "How did you accomplish getting here?" You know, I think that's kind of the way that I would look at it. I'll work harder and longer than anyone. I have more passion about what I do and who I do it for than my counterparts. You know, I've—the resilience factor is important around here. [laughs] And I think that is something that has to be taught over time.

***Tacey Ann Rosolowski, PhD***
[01:31:00]
What do you mean, "resilience factor"?

***Amy Carpenter Hay***
[01:31:04]
MD Anderson is an incredible institution, but it is a physician-led organization. And oftentimes, from a Business Development perspective, that can be challenging. Change is hard. What I do pushes people to change every single day. So that takes a lot of thoughtfulness and, quite frankly, a lot of emotional commitment, to make that happen. It's constantly thinking about the

chess board, if you will. So, what do we need to accomplish as an institution, and how do we get there? What are the steps required? And how do I—how do I behave today in order to get what I need to get one three months from now? And it's—it takes some—it takes some planning in order to make that happen.

***Tacey Ann Rosolowski, PhD***
[01:31:58]
You know, I've been struck—'cause you're talking about strategic thinking, and a word you've been using a lot today is *innovation*, you know? Sort of creativity, strategic thinking—where did that come from?

***Amy Carpenter Hay***
[01:32:11]
I think that's the—I, personally, think that's the dynamics of the future. You know, I—you know, everything I—I'm an avid reader, and so I'm constantly kind of challenging myself on what is—what's next? What's the future hold? I think that mentality, as well, is starting to get more ingrained in MD Anderson as an institution. And, you know, I attribute that back to Dr. DePinho again. It's—*innovation* was a word that—I think it may define his presidency. It may define what he leaves as his legacy. And I think all of us have gotten not only passionate about that, but are constantly trying to find the best angle for MD Anderson to accomplish [inaudible]. So, it is a word I use a lot—maybe too much. But it is, because I think innovation is the key to what we're doing. It's the key to solving the cure. It's the key to really making impact across a global healthcare crisis in a time when we are, ourselves, financially, in a healthcare crisis.

So it's almost as if we're entering into the perfect storm. You know, we have all these incredible advances happening. We have all of this technology at our fingertips. Yet healthcare finance is a mess, and the status of academic organizations is being questioned. And funding for research is drying up. And most new drugs can't make it even through the pharma pipeline without being cut. So we have all of these inhibitors, but at the same time we're at the cusp of greatness around immunology and genetic testing. And how do we start looking at panels, and using that as a predictive indicator of who's gonna respond to which chemotherapies?

So it kind of goes back to—I think that's the—that's the future.

***Tacey Ann Rosolowski, PhD***
[01:34:23]
Mm-hmm. Well, I wasn't pointing out your use of the word *innovation* to be in any way judgmental.

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***Amy Carpenter Hay***
[01:34:27]
Oh, no, no, no. [laughs] No, no.

***Tacey Ann Rosolowski, PhD***
[01:34:28]
I was—I'm a professional listener, so I listen for those sorts of cues. And, yeah, I mean, it's kind of interesting that, in a certain generation that I've interviewed, there was almost—certainly a reluctance to use the word *creativity*, and a shift away from the use of the word *creativity* to *innovation*. And then, even not too much discussion about innovation—not that people weren't being innovative, but that wasn't like a big key word. And obviously we've entered a time now when that is an important word to bring in, as part of the culture. You know, what is—what is the present and the future of MD Anderson? So, very, very interesting perspective.

I wondered if there's anything final that you'd like to say? No?

***Amy Carpenter Hay***
[01:35:13]
No, I mean, I think we've kind of—I've had a—an opportunity to kind of talk about, you know, the future as I see it, and where we're headed. I do think that where we're headed is very important. It has the opportunity to really make not just a lasting impact, but a global impact on cancer. So, my pleasure.

***Tacey Ann Rosolowski, PhD***
[01:35:39]
Yeah, it's been a pleasure. Very interesting. And I want to thank you for your time today.

***Amy Carpenter Hay***
[01:35:43]
No, it's great. Thank you.

***Tacey Ann Rosolowski, PhD***
[01:35:44]
All right. And I just want to say, for the record, I am turning off the recorder at twenty-one minutes after three.