



Oncology Innovation Showcase #1 – Chart Prep Tools



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Nebraska Cancer Center



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Florida Cancer Specialists & Research Institute



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Highlands Oncology Group



Debra Patt, MD, PhD, MBA
Texas Oncology





AI-Powered Workflow Automation for Oncology

Michal Meiri
Co-Founder & CEO



Chart Prep is Broken for Everyone

Medical Assistants

- Burnt Out
- Manual, Repetitive Work

Patients

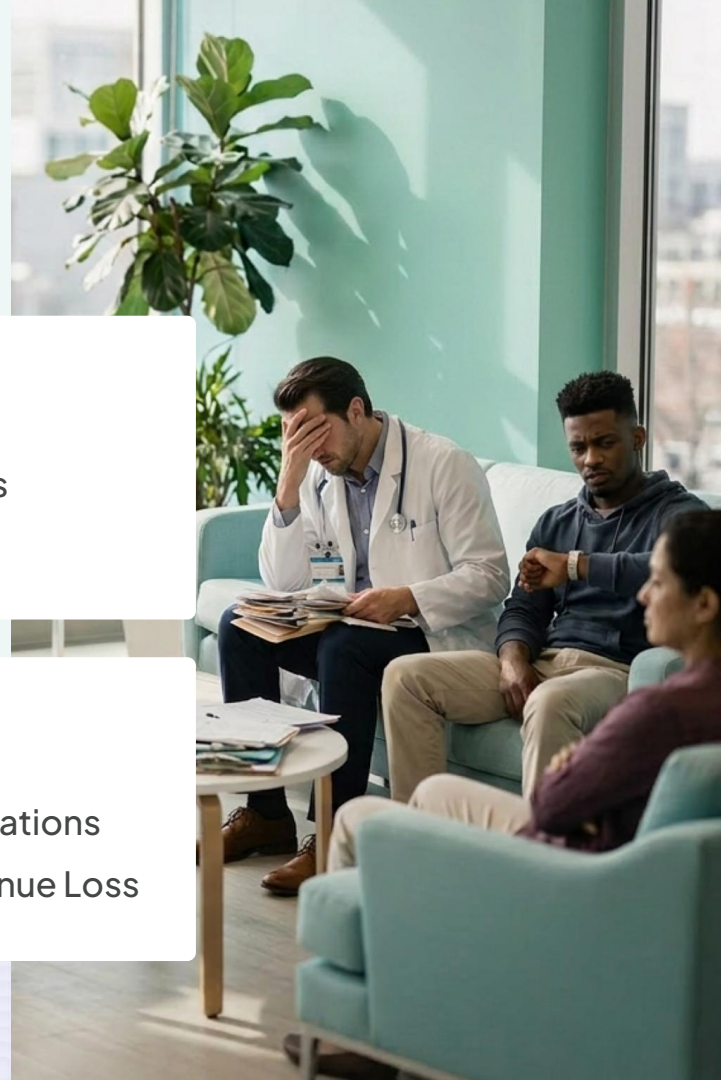
- Delayed Treatments
- Disorganized Visit

Physicians

- Frustrated
- Clinical Interruptions

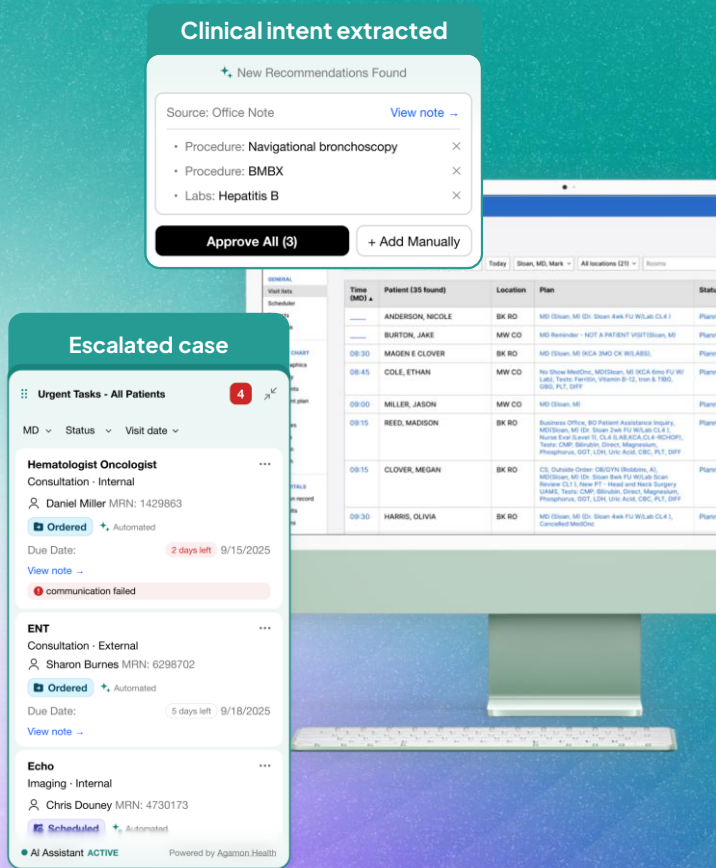
The Practice

- Last-Minute Cancellations
- Unpredictable Revenue Loss



AI Agents Working Continuously Between Visits

We built Agamon Health to automate chart prep — and ensure every oncology patient is ready for their visit before they walk through the door.



The dashboard displays a list of patients with columns for Time (MDT), Patient (35 found), Location, Plan, and Status. A pop-up window titled "Clinical intent extracted" shows a list of recommendations from an office note:

- Procedure: Navigational bronchoscopy
- Procedure: BMBX
- Labs: Hepatitis B

Buttons for "Approve All (3)" and "+ Add Manually" are visible. Another pop-up window titled "Escalated case" shows "Urgent Tasks - All Patients" with a red notification badge for 4 tasks. The tasks listed are:

- Hematologist Oncologist**
Consultation - Internal
Daniel Miller MRN: 1429863
Ordered + Automated
Due Date: 9/15/2025 (2 days left)
communication failed
- ENT**
Consultation - External
Sharon Burnes MRN: 6298702
Ordered + Automated
Due Date: 9/18/2025 (5 days left)
- Echo**
Imaging - Internal
Chris Douney MRN: 4730173
Scheduled + Automated

At the bottom, it indicates "AI Assistant ACTIVE" and "Powered by Agamon Health".

AI Widget with Seamless Integration

Continuously Running AI Agents That Track, Trigger, Follow-up, Escalate, and Coordinate Care

ONCOEMR PW MO

Inbox 📧
 Tasks 0
 Search 🔍

Office visit list [Switch to hospital](#)

Wed, 9/3/2025
📅
←
→
Today
Sloan, MD, Mark
All locations (21)
Rooms

Time (MD) ▲	Patient (35 found)	Location	Plan	Status
—	ANDERSON, NICOLE	BK RO	MD (Sloan, M) (Dr. Sloan 4wk FU W/Lab CL4)	Planned
—	BURTON, JAKE	MW CO	MD Reminder - NOT A PATIENT VISIT(Sloan, M)	Planned
08:30	MAGEN E CLOVER	BK RO	MD (Sloan, M) (KCA 3MO CK W/LABS),	Planned
08:45	COLE, ETHAN	MW CO	No Show MedOnc, MD(Sloan, M) (KCA 6mo FU W/ Lab), Tests: Ferritin, Vitamin B-12, tron & TIBG, GBG, PLT, DIFF	Planned
09:00	MILLER, JASON	MW CO	MD (Sloan, M)	Planned

Pre-Visit Tasks
 Jason M Miller (4719532) · Next visit 09/22/2025

0 Verified
1 Ordered
2 Scheduled
0 Closed

Due Date ▾ Type ▾

CT Chest ⋮
 Imaging · Internal

📅 Scheduled ⚡ Automated

Due Date: 5 days left 9/22/2025
 Scheduled: 10/28/2025

[View note →](#)

EGD ⋮
 Procedure · External

📅 Ordered ⚡ Automated

Due Date: 7 days left 9/20/2025

[View note →](#) Request Results

Radiation Oncology ⋮
 Consultation · Internal

📅 Scheduled ⚡ Automated

Due Date: 5 days left 9/22/2025

● AI Assistant ACTIVE
Powered by Agamon Health

AI Agents Coordinating Care Continuously Between Visits

Deliver

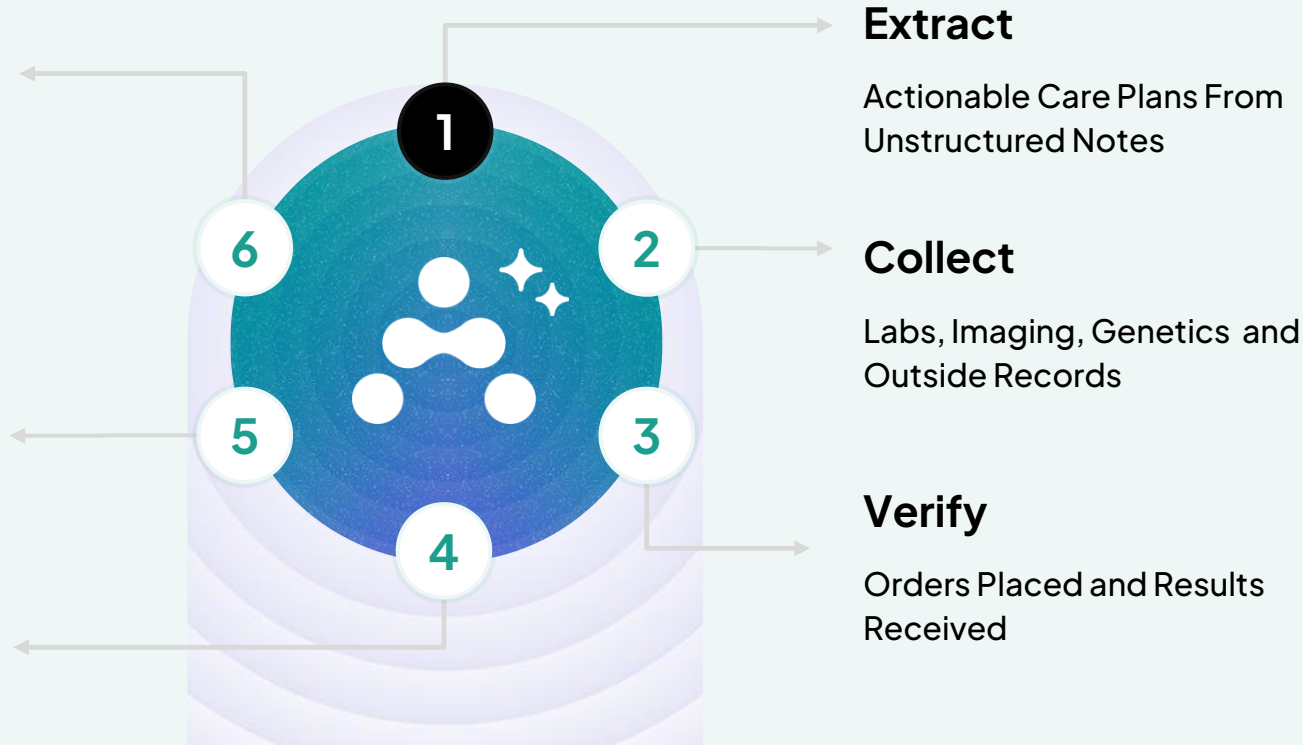
Prioritized Cases &
Oncologist Visit Brief

Match

Documents Closed and
Loop Completed

Chase

Missing Items &
External Communication





Case Study

Oklahoma Cancer Specialists

Within 3 Months of Go-Live

initial results show:

Reduction in
Chart Prep Time

34%

Reduction in Late
Cancellations

30%

Earlier Identification of
Missing Authorizations



Improved Staff Efficiency
and Workflow Consistency



**OKLAHOMA
CANCER SPECIALISTS**
AND RESEARCH INSTITUTE





Measurable ROI for Every Practice Size

Small Practice

5 – 10 Providers



- MAs save 1–2 hours per day.
- Fewer cancellations, no added headcount.
- ROI in approximately 3 months.

Large Practice

20 – 100+ Providers



- Standardized workflows across all sites.
- Reduced burnout, higher physician productivity.
- Protects downstream revenue.

Practices see 100% ROI within the first few months!



Seamless Integration Into Existing Clinical Platforms

01 Connect

OncoEMR, iKnowMed, Epic & other major platforms.

02 Configure

Map workflow, care gaps & site-specific rules.

03 Go Live

Start focused, expand gradually based on measurable results.

04 Optimize

Continuous improvement from real-world use.



Typical Deployment: **8 – 12 weeks**

Starting with MAs minimizes clinical resistance and lets value prove itself early.



Agamon Oncology Suite

Start With Chart Prep –
Expand Into Every
Oncology Workflow



Chart Prep



Follow-Up Management



Referral Coordination



Cohort Identification for
High-Value Programs



New Patient Intake



Cancer Registries



Trusted by Leading Oncology Centers and Health Systems

Schedule a demo at the conference.

www.agamonhealth.com

michal@agamonhealth.com



Rethinking Chart Prep

Tommy Mullaney

tommy@apollo-oncology.com

Co-Founder, Apollo Oncology

COA 2026



The Whole Practice Relies on Chart Prep

Chart Prep

Clinic Flow

Billing / Auth

Navigation

Quality Metrics

Patient Experience

The High Cost of Keeping Up

A full day every week...



Detective

550 pages



Record Chaser

120 new action items



Data Entry Clerk

2,100 fields to re-enter

...just to stay one day ahead.

Recent Documents



1



3



1



9/24/25: [ctDNA NGS panel](#) negative for pathogenic variants in 70 genes.



9/22/25: [CT Chest/Abdomen/Pelvis w Contrast](#) showed multiple pulmonary nodules consistent with metastatic disease. No evidence of abdominal or pelvic metastatic disease.



9/12/25: [Pathology addendum report](#): HER2 FISH negative for amplification (HER2/CEP17 ratio 1.3).



9/10/25: [Right breast core needle bx](#): Invasive ductal carcinoma, Nottingham grade 2, ER+ (95%, 3+), PR+ (80%, 3+), HER2 2+ (equivocal).




1/1/18: [Right breast lumpectomy](#) showed (1:00 position) invasive breast carcinoma, mixed ductal and lobular features, size 13 mm, intermediate grade 2, all surgical margins widely negative for malignancy (>5 mm). Large hemorrhagic and fibrotic prior biopsy procedure site. AJCC pathologic stage: pT1c, pN0. Right sentinel lymph node #1, excision: one negative lymph node (0/1). ER+, PR+, HER2 negative by IHC (1+), not amplified.

Principle #1

Don't Start from Scratch

Start every workflow with a **prepared draft**, not a raw pile of documents.

 **NGS testing:** mCRPC with no prior NGS testing;
potential tissue from prostate biopsy on 1/1/2026

Draft order set

Dismiss

 **Add diagnosis - breast cancer**

From Right breast lumpectomy on 1/1/18

Right breast lumpectomy showed (1:00 position) invasive breast carcinoma, mixed ductal and lobular features, size 13 mm, intermediate grade 2, all surgical margins widely negative for...

C50.211: Malignant neoplasm of upper-inner quadrant of right female breast

- Pathological TNM: pT1c, pN0
- Receptors: ER+, PR+, HER2 1+, HER2 FISH -
- Histopathology: Infiltrating Ductal Carcinoma
- Diagnosis date: 2018-01-01
- Nottingham Grade: G2

Add diagnosis

Dismiss




Principle #2

Remove Friction

Clinicians make the decisions.

Software automates the data entry.

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potential tissue from prostate biopsy on 1/1/2026

Draft order set

Dismiss

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From [Right breast lumpectomy on 1/1/18](#)

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Add diagnosis

Dismiss

Principle #2

Remove Friction

Right breast lumpectomy showed (1:00 position) invasive breast carcinoma, mixed ductal and lobular features, size 13 mm, intermediate grade 2, all...

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- Diagnosis date: **2018-01-01**
- Nottingham Grade: **G2**

Add diagnosis

Dismiss

Recent Documents

 1  3

 9/22/25: [CT Chest/Abdomen/Pelvis w Contrast](#) showed multiple pulmonary nodules consistent with metastatic disease. No new sites of disease. 

 9/12/25: [Pathology addendum report](#): HER2 FISH negative



< **Friday, 4/17** >

Demo Physician • updated overnight

🚨 1 📄 7 ⓘ 0 ✅ 8

Demo Physician

Parker, Peter (100001)

- ✅ **Colon biopsy pathology:** See [ASCENDING COLON BX](#) uploaded 4/15
- 📄 **CBC:** CBC w/ Differential ordered for 4/17

Stark, Tony (100002)

- ✅ **Prostate biopsy pathology:** See [Prostate Bx Path](#) uploaded 4/14
- 📄 **CMP:** Comp Metabolic Panel ordered for 4/17

Danvers, Carol (100010)

- ✅ **Breast MRI:** See [Bilat breast MRI](#) uploaded 4/15
- ✅ **Outside breast pathology:** See [LT Breast Needle Core Bx](#) uploaded 4/16
- 🚨 **Solid tumor NGS:** No orders/reports found; due 4/15

Principle #3

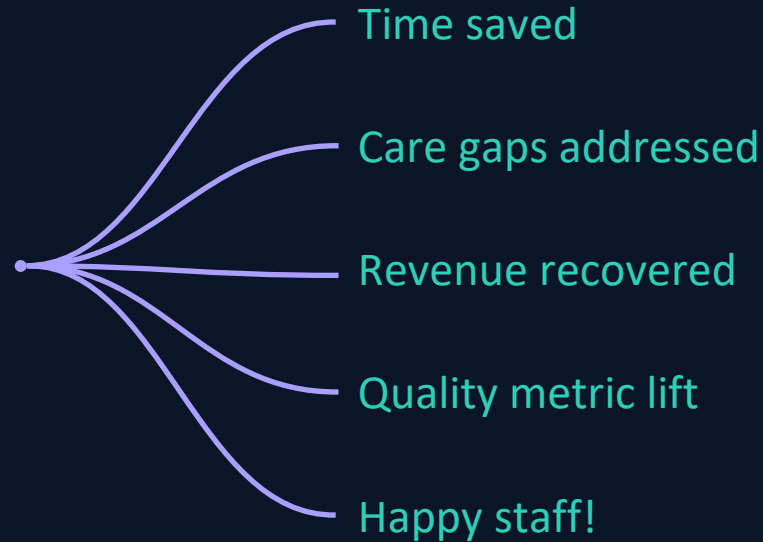
Reactive → Proactive

Automate the routine checks.

Flag gaps early – when there is still time to fix.

Start Small

- One team
- One painful step
- Measure the impact
- Expand



apollo-oncology.com/coa

Thank you!

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Co-Founders, Apollo Oncology

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Text us:
[973-525-9485](tel:973-525-9485)



Triomics Oncology Data Platform

Pre-Charting & Visit-Prep

AI visit prep for oncology practices, with trial screening built into the same workflow.

One record. Hundreds of signals. Dozens of workflows.

1

patient journey

100s

documents across the record

8+

major unstructured doc types

1,000s

trials & treatment pathways

CLINICAL DATA

 Clinic notes


 Pathology

 Radiology

 Biomarkers

CONTEXT & KNOWLEDGE

 Outside records

 Prior treatments

 Trial criteria

 Guidelines

Extracting data in a discrete format

- ✓ Read the full longitudinal record
- ✓ Extract key variables at >95% accuracy
- ✓ Deliver source-backed outputs

Below expert-level accuracy the whole stack collapses



Visit Prep

Pre-charting & chart review



Trial Matching

Proactive eligibility screening



Data Abstraction

Registry, QI & Real-World Data



Dozens of Clinical Operations

e.g. finding patients lost to follow-up

When the note is ready, export it.

Pick which sections to include, reorder them if you want, preview exactly what will go in, and push it to the EHR such as **iKM G2** or **OncoEMR**.

One click.

Export to EHR

Upcoming visit date: 07/14/2025 at 2:00 PM

Date of note: 07/14/2025

Following sections will be exported:

- Reason for visit
 - 02/15/2023
 - 02/15/2023
 - 03/10/2023
 - 05/10/2023
- History of present illness
- Objective
- Imaging
- Pathology

Export option:
 Export to EHR
 Export as doc
 Export as pdf

Pre-charting note preview

Reason for visit
Follow-up with primary oncologist to review restaging imaging, assess treatment tolerance, and discuss clinical-trial options.

History of present illness
Date of diagnosis-- 02/15/2023
Primary diagnosis -- Metastatic adenocarcinoma of the ascending colon confirmed on right-hemicolectomy (moderately differentiated, mucinous component 15 %). Initial presentation with iron-deficiency anemia and 8 kg weight loss over 6 months. Sites of metastasis at Dx: multiple bilobar hepatic lesions (largest 2.8 cm), omental studding, trace ascites.
02/15/2023
Stage -- AJCC 8th Edition: pT3 (tumor invades through muscularis propria into pericolorectal tissues), N2 (19/28 LN positive), M1a (>2 extra-colonic sites). Overall Pathologic Stage: M1b. Path report: tumor budding: high grade; LVI present.
03/10/2023
1st-Line Systemic Therapy: mFOLFOX6 (Oxaliplatin 85 mg/m² d1 LV15-FU bolus/infusional 400/2400 mg/m²) + Bevacizumab 5 mg/kg q2wk. **March 10 2023 → Sept 08 2023 (12 cycles)**. Best Response: Partial Response -42 % by RECIST 1.1 on 06-20-2023. Oxaliplatin discontinued cycle 8 for cumulative neuropathy grade 2. Disease progression in liver recorded on 09-10-2023.
05/10/2023
2nd-Line Systemic Therapy: FOLFIRI (Irinotecan 180 mg/m² LV, 5-FU bolus/infusional) + Bevacizumab 5 mg/kg q2wk. **Oct 05 2023 → present (cycle 18 delivered 07-02-2025)**. Best Response: Stable Disease (-10 %). Cumulative Irinotecan dose 3240 mg/m². Notable AEs: Grade 3 neutropenia post-cycle 14, managed with filgrastim and 20 % dose reduction of Irinotecan.

Objective
06/25/2025
• KRAS c.35G>A p.G12D mutation, Variant Allele Frequency 28 % (NGS, Illumina TruSight™ Oncology v6)
• KRAS Gene Copy-Number Gain CN 5 (Guardant360 ctDNA, 06-25-2025)
• Microsatellite Stable / Low Tumor Mutational Burden 3 mut/Mb (Caris MI Tumor Seek)
• PD-L1 Combined Positive Score 5 (IHC 22C3, Dako)
• UGT1A1 *28 heterozygous

Imaging
07/01/2025
CT Chest/Abdomen/Pelvis w/contrast: Liver segment 6 lesion increased from 2.0 cm to 2.3 cm (+15 %); new 5 mm spiculated nodule RLL; mild increase ascites. No new peritoneal implants detected. Radiology impression: **Progressive disease

Pathology + added from previous note

Cancel Export

Case Study

How Physicians at Southern Cancer Center Use Triomics to Save Time



Dr. Brian J. Heller

President, Southern Cancer Center
Medical Oncology & Hematology

"I walk into every visit already knowing the patient's story, without spending my morning in the chart. Not only is it faster, but it's more accurate and comprehensive. It is a game changer for me."

790

VISITS ANALYZED

477

CHARTS REVIEWED

60%

UTILIZATION

- **Faster prep:** Full cancer journey at a glance: diagnosis, treatments, responses
- **Less cognitive strain:** No more jumping between 20+ notes
- **Better notes:** More accurate and comprehensive documentation



Dr. Eric Roberts

Managing Partner, Southern Cancer Center
General Surgery

"My pre-charting time is essentially zero now. I used to spend 10 to 20 minutes per patient just getting up to speed. This is the biggest positive change in my documentation workflow in 20 years."

193

VISITS ANALYZED

150

CHARTS REVIEWED

78%

UTILIZATION



20 hours saved

That's 3 to 4 full workdays over this period

- **Zero prep time:** Patient history ready before the visit
- **Hours back:** Less after-hours work, more time for family

Ask questions in chat

While you are reviewing the pre-charting note, an AI assistant sits right next to it. Select any section and ask it to revise the language, shorten a paragraph, or rewrite it for a specific audience. Or ask it questions about the patient record directly.

You can also calculate scores, run checklists against the patient record for screening.

The screenshot shows a medical record interface with a chat window overlaid. At the top right, there is a notification bell icon and a 'CD' button. Below that, a status bar indicates 'Last refreshed at: May 22, 2025 at 11:40 PM' along with menu and user icons. The chat window is titled 'Edit with AI' and 'History of present illness'. It contains a user prompt: 'can you give me two more iterations of your choice. beside this one.' The AI response shows a section of text from the medical record, followed by a prompt: 'Shorten the section while keeping all clinically relevant details. Remove redundant phrasing and parenthetical context.' Below this, the full text of the 'History of present illness' is visible, including a date '02/15/2023', a primary diagnosis of metastatic adenocarcinoma, and details of treatment and response. At the bottom of the chat window, there are buttons for 'Make it more concise', 'Add treatment timeline', and 'Rewrite for tumor board', along with a '+2' button. A final prompt is shown in a white box: 'Shorten the section while keeping all clinically relevant details. Remove redundant phrasing and parenthetical context.' with a blue arrow button to the right. At the very bottom, a disclaimer reads: 'OncoLLM AI can make mistakes. Please double-check responses.'

Finding Matching Clinical Trials

While reviewing the pre-charting note, you realize the current standard of care may no longer be working and want to know which open trials at your practice could be an option.

For each such patient, you can see likely eligible trials, how well they match to the trial, and what information is still missing or needs to be clarified with the patient.

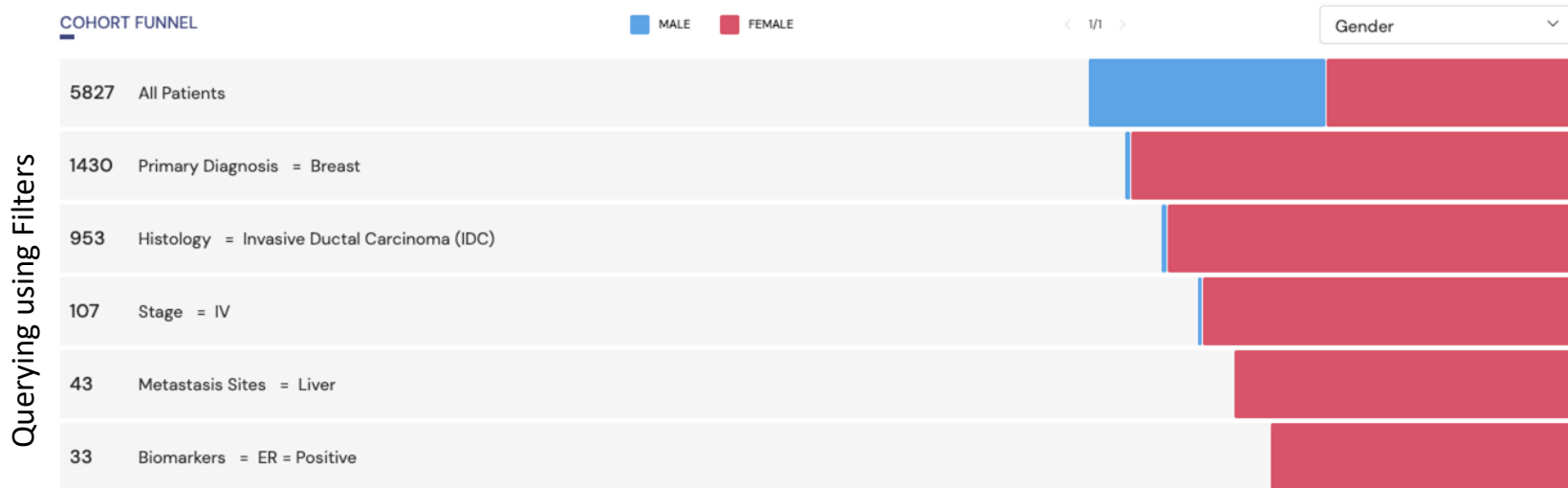
Working with leading cancer centers such as **Yale** and **MSK**, as well as practices like Texas Oncology and **Highlands Oncology**.

The screenshot shows a patient profile for Claudette Smith, 33 years old, female. A cohort summary indicates 16 Satisfied, 2 Awaiting Response, and 2 Unknown. Below this is a table of criteria and patient data insights.

CRITERIA NAME	PATIENT DATA INSIGHTS
INC Triple negative breast cancer: Patients with a history of stage T1cN1-2 or T2-4N0-2 breast cancer according to the AJCC 8th edition	The patient qualifies as having Triple Negative Breast Cancer (TNB) confirmed HER2-negative status with a HER2:CEP17 ratio of 1.46, a cancer, fitting the AJCC 8th edition criteria for staging (T1cN1-2 or T2-4N0-2). 1 2 3
INC Primary tumor must harbor an activating mutation in the PIK3CA gene with or without PTEN loss, either previously documented or determined during screening.	The results show that there is a mutation detected in the PIK3CA gene pathogenic. The PTEN gene does not show any detected mutations requirement for the study or treatment that requires such a genetic test. 1 2
INC No history of serious digestive and/or absorptive problems, severe cardiovascular, respiratory or musculoskeletal disease or joint problems that preclude moderate physical activity. No history of psychiatric disorders that would preclude participation in the study intervention (e.g. untreated major depression or psychosis, substance abuse, severe personality disorder) or prevent the patient from giving informed consent.	There is no mention of serious digestive and/or absorptive problem. She is reported to have labored breathing and dry cough, which could be a context of potential lung involvement due to metastases. However, musculoskeletal diseases or joint problems that would explicitly preclude potential concerns about her respiratory symptoms, she does not have any listed in the criteria. 1 2
INC No residual invasive disease in the breast or lymph nodes after neoadjuvant therapy: Isolated tumor cells are considered node-negative	The patient's medical records reveal a diagnosis of stage IV (T2N2M1) breast cancer, which is consistent with the criteria for inclusion. The patient has received neoadjuvant therapy resulting in no residual invasive disease in the Carcinoma In Situ (DCIS) requiring monitoring. This outcome aligns with the specified criteria for inclusion based on her response to treatment.

Demonstrated Impact (ASCO 2025, Nature Digital Medicine):
33% increase in treatment trial accruals across 100+ trials

Using Extracted Data for Practice-Level Analytics



Free-text Query

CRITERIA

STATUS

INC Does the patient currently have breast cancer? Tier 1	7	4	1
INC Does the patient have Breast cancer with ER-, PR- and HER2-? Tier 1	10	1	1
INC Is the patient currently on second-line therapy, or have they progressed on it but not yet started third-line therapy? Tier 1	4	8	0

The Clinical Co-Pilot for Modern Oncology

AI that fits oncology workflow, from chart review to trial screening



Built for oncology workflow

Embedded into visit prep, chart review, and trial screening natively.



Reads the full patient record

Analyzes notes, labs, imaging, pathology, genomics, and scanned PDFs.



Source-backed & reviewable

Every key statement can be traced securely back to the underlying EHR record.



Works inside existing systems

Designed to fit seamlessly into standard EHRs like iKM G2 and OncoEMR.

Unstructured Record

Clinical Notes
Pathology Reports
Imaging & Scans
Genomics Data
Scanned Faxes



Triomics Clinical Co-Pilot

- 🔍 Reads all document types
- 📄 Structures critical variables
- 📋 Summarizes clinical history
- 🗣️ Cites sources for every claim
- 🚩 Screens for trial eligibility



Workflow Outputs

Pre-charting notes
Patient summaries
Trial match alerts
Chart Q&A responses
Queryable structured data



Practice Impact

Less time on charts
Consistent prep
Better trial IDs
Actionable data

TRIOMICS

Less time on charts. More time with patients.

sebastien@triomics.com or mark.steiner@triomics.com

Questions?

2026 Community
Oncology
Conference
Innovation in Practice



Closing: From Innovation to Adoption

- COA Innovation Showcase
- Turning AI Possibility Into Practice Reality
- Agamon | Apollo | Triomics





Why This Matters Now

- Increasing complexity and staff pressures
- Rising patient volumes + workforce shortages
- Administrative burden on clinicians
- Pressure on margins and reimbursement
- AI can unlock efficiency, accuracy, and patient outcomes
- The opportunity is real – but adoption is the challenge





What We Heard Today

- Agamon: Data insights and workflow optimization
- Apollo: Automation and operational efficiency
- Triomics: Clinical intelligence and decision support at scale

- → The 'art of the possible' is here





The Real Barrier: Change

- The hard part isn't the Tech
- Cultural resistance is the #1 barrier – slows adoption
- Physician skepticism
- Staff fear of change
- Competing priorities and risk aversion
- 'We've always done it this way' mindset





Driving Leadership & MD Buy-In

- Start with outcomes that matter, the problems they care about: patient care, revenue, burnout
- Use data and pilots to demonstrate ROI
- Identify and engage physician champions early
- Align with strategic priorities





Change Management That Works

- Start small and scale: pilot programs, quick wins
- Communicate clearly and often – include the ‘why’
- Invest in training; support staff continuously
- Measure and share wins





Making the ROI Real

- Quantify time savings and cost reduction for staff and clinicians
- Highlight revenue capture opportunities
- Show impact on patient experience
- Share success stories





Call to Action

- Don't wait for perfect – start now
- Identify **one use case** to pilot
- Partner with vendors strategically
- Lead the change – your teams will follow
- Build momentum with early wins
- This is about leadership and staying competitive





Thank you

- COA wants your feedback for future sessions, please click on the QR code to answer a few quick questions.

