

# ASSOCIATION OF CANCER EXECUTIVES UPDATE

JANUARY 2020 | ANNUAL MEETING EDITION | [www.cancerexecutives.org](http://www.cancerexecutives.org)



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Oncology Leaders

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## The 2020 ACE Webinar Schedule

WEDNESDAY, JANUARY 29

**Breast Cancer: Global Quality Care, publication by OUP**

12:00 - 1:00 PM EST

### Webinar presenters:

Prof. Didier Verhoeven, Medical Oncologist,  
Chair Breast Clinic Voorkempen,  
Guest Professor University of Antwerp



For complete ACE webinar information [please visit us here.](#)

## How to Unlock Hidden Capacity in your Oncology Clinic

JEANNE KRAIMER, MIDMARK RTLS

In cancer care, making the most of your resources is crucial. On a daily basis, administrators face the puzzle of how to optimize clinical workflow—the utilization of staff, equipment and clinical spaces—to provide exceptional care to as many patients as possible.

When it comes to space utilization, staff and providers often feel there aren't enough rooms or infusion chairs because they are always occupied or unavailable. Physically expanding the cancer center seems to be the logical solution, but in reality, your center may have unused capacity, and you may not even be aware of it.

Yes, you read that right. From exam rooms to infusion chairs, your care locations are likely used less efficiently than they

could be. But how can you uncover this hidden potential to care for more patients and set goals to achieve better [workflow optimization](#)? To start, you need to clearly understand how your resources are currently used.

### REAL-TIME SITUATIONAL AWARENESS

Using a real-time locating system (RTLS) is an excellent way to understand cancer center operations. RTLS gives real-time visibility into the entire clinic—so staff can see where teammates and patients are, how long they've been waiting, who has seen the patient and who may need to see them next.

To begin to better understand clinical space utilization, your staff and providers can use RTLS to answer two simple, yet critical questions for better situational

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### QUESTIONS?

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[cancerexecutives.org](http://cancerexecutives.org)

awareness: **“Which exam rooms or infusion chairs are available?”** and **“Which exam rooms or infusion chairs are ready for turnover?”**

## GATHERING DATA FOR PROCESS IMPROVEMENT

RTLS provides more than real-time awareness. Data can be [collected and analyzed in retrospect via reports](#), so that administrators can understand patterns and identify potential process bottlenecks.

## The Value of Remote Symptom Monitoring in Cancer Care

The healthcare landscape is shifting from a fee-for-service model to a value-based care world. Medicare led the way by launching the Oncology Care Model in 2016, with a focus on improving patient care and reducing costs for cancer patients. Since then, value-based care initiatives have also been tested and championed by state governments and private payers. Some payers are even testing outcomes-based contracts with pharmaceutical companies to ensure patients receive the best, most effective treatments. In value-based cancer care, remote symptom monitoring and patient-reported outcomes (PROs) have emerged as necessary aspects to succeed in value-based cancer care.

Symptom management and medication adherence are key to better patient outcomes. More patients are receiving oral therapies, and care teams have less insight into a patient's self-administration or adherence between visits. Adherence to their treatment plan, prompt symptom management, and remote monitoring are needed to improve outcomes for cancer patients today.

Data published has shown that that managing patient symptoms proactively and capturing patient-reported outcomes can improve clinical outcomes for patients. In the move to value-based care, it's essential for healthcare practices to implement the right tools to improve cancer patient care. We will take a look at the benefits of remote monitoring and how practices implement this tool into their practice, as well as the kinds of tools available and resources needed for

This data is key in answering the current state of clinical capacity question: **“Which areas of the clinic are under- or over-utilized?”**

RTLS reports help you benchmark not only data about clinical spaces, but staff utilization, patient wait times and several other useful metrics. These data can be helpful for scheduling decisions. And because RTLS is continually collecting data, measuring progress toward improvement is easy and accurate.

practices to succeed in improving patient care.

## PROVEN RESULTS FOR PATIENT-REPORTED OUTCOMES AND REMOTE MONITORING

Emergency room visits and hospitalizations are often preventable through earlier detection of concerning symptoms by a patient's care team. [Research led by Ethan Basch, MD, MSc](#), found that collecting patient-reported outcomes resulted in fewer hospitalizations, better medication adherence, and improved quality of life. In Dr. Basch's follow up study it was found that the median survival for patients who self-reported symptoms was 5 months longer than the control group.

Earlier in 2019, the Washington Post published an article about [the work by Lisa Barbera, MD, MPA, FRCPC](#), making the case that remote symptom monitoring, or patients simply routinely checking in with their doctors and having their symptoms managed, can make a huge impact on patient outcomes. In Dr. Barbera's study, patients who completed the survey had a mortality risk of less than half of those who did not answer the survey questions.

## IMPROVING PATIENT OUTCOMES WITH REMOTE SYMPTOM MONITORING

Remote monitoring allows care teams to check-in with patients while they are out living their everyday lives. Even with patients becoming more active participants in their care, it can be hard sometimes to know what to report and when.

## WANT TO LEARN MORE?

[Download “7 Benefits of RTLS for Cancer Care” eBook](#) from Midmark RTLS for more insights on how RTLS can help you unlock hidden capacity and design a better oncology care experience.



**Unlock hidden capacity in your oncology clinic with Midmark RTLS.**

Visit us in booth #308 at the ACE Annual Meeting



That's why implementing a non-invasive communication tool for patients to stay in touch with their care team and report symptoms when it is convenient for them is so important. Studies on remote monitoring and PROs are continuing as more studies look at this tool, and the results show that patients are very likely to report symptoms when given the opportunity. Patients have been shown to be comfortable with digital tools, such as web platforms, text reminders, and apps for managing their care. Care teams are able to monitor and manage patient symptoms and act quickly when needed to help patients without sending them to the ER.

Cancer care clinics incorporate remote monitoring into their routine cancer care for several reasons. Improving patient care and outcomes is an important goal for physicians, and remote monitoring provides the opportunity to enhance communication between the patient and their care team. Patients check-in with their care team in-between visits at a time that is convenient for them. They may not be feeling poorly, but any symptoms that get logged and information that can help augment care can be important for the entire treatment cycle. Patient-reported outcome data can then be used to risk-stratify patient issues and respond appropriately to ensure patients receive the best timely care.

### DATA INTEGRATION IS IMPORTANT

Patient reported outcomes are important, but they require a system that integrates with their existing EHR and helps translate the data received into something actionable. Gathering all the data from your patients won't be helpful if it doesn't go to the right person or isn't monitored properly.

The NCI has developed and released a PRO measurement system designed to capture symptomatic adverse events in patients on cancer clinical trials. This system is called Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE). This validated tool provides questions to ask about the severity, intensity, and interference of particular symptoms patients may experience during treatment. Patients under the PRO-CTCAE are expected to receive a check-in every 7 days. While currently the PRO-CTCAE is

only permitted for use in clinical trials, Dr. Basch has been a vocal proponent of NCI approving this system for use in routine cancer care.

### HOW TO IMPLEMENT REMOTE MONITORING IN ROUTINE CANCER CARE

There are several ways to approach implementing remote symptom monitoring. Having a care team in place or system to track data is important. Gathering data without a clear way to track is not very valuable.

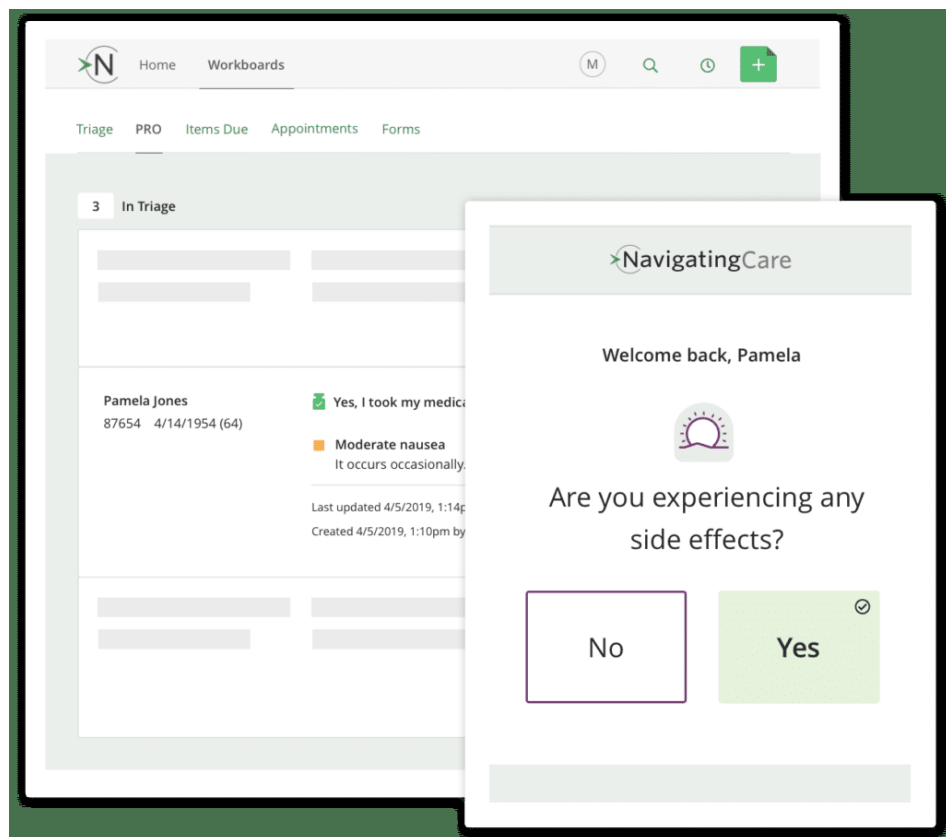
Practices that implement a comprehensive workflow solution can reduce barriers to patients reporting symptoms and communicating with their care team more by giving them a simple tool to use on a regular basis. There are several barriers patients face when it comes to sharing symptoms or side effects with their care team. Advisory Board's Oncology Roundtable presented research on these barriers, which include not wanting to bother their doctor, being unsure of who to contact, and fearing that their treatment may change or be stopped if they report an issue. The Advisory Board reported data

that ~40% of active cancer patients do not report symptoms because they do not want to bother their doctor. Sometimes patients may not report a symptom because they assume that some side effects are expected during cancer treatment and suffer through something that their care team could have helped them manage better.

Remote monitoring tools that are integrated into the clinic workflow can be scheduled to prompt patients via text message or email. Patients will be able to report any symptoms they may be experiencing at a time that is convenient for them. That information is then returned to the clinic care team, and in some systems the patient-reported outcomes will be triaged in order of severity. The care team can decide on the appropriate monitoring or follow up - all the patient had to do was report how they were doing.

Remote symptom monitoring does require practice transformation. Finding a trusted partner in implementing remote monitoring and PRO tracking is key to continued success.

**FIGURE 1:** Example of remote monitoring tool with triage workflow integration.



## DEDICATED RESOURCES ARE NEEDED TO MANAGE URGENT PATIENT SYMPTOMS

Implementing a system for remote patient monitoring and collecting patient-reported outcomes is only part of the process. Cancer care clinics need to ensure they are properly resourced to manage the patient symptoms they receive, and staff is empowered to take action. This means streamlining clinic duties and overall

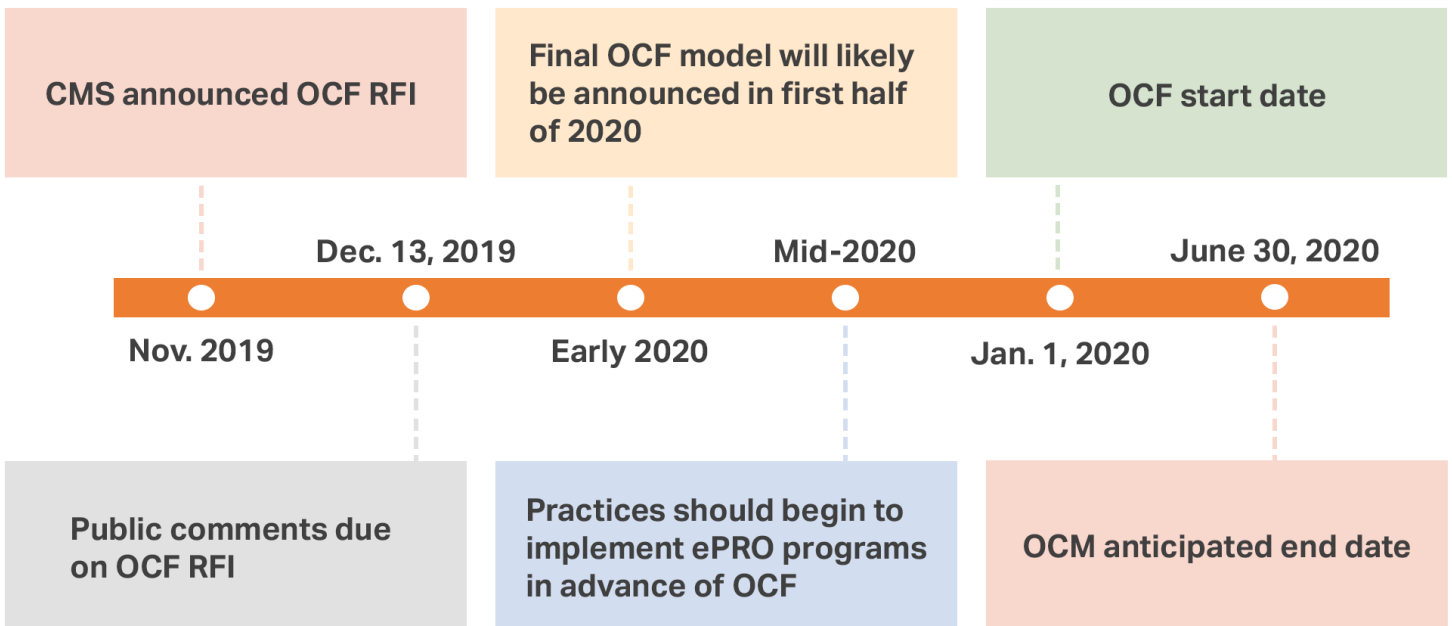
workflow. For example, there needs to be room in the schedule if a patient needs to be brought in same-day to address escalating symptoms. Clinics also need to manage symptom reporting that may occur outside regular hours

The Oncology Care First (OCF) model proposed by CMS in November 2019 included a new improvement activity for gradually implementing ePROs into the

practice. Practices in the current Oncology Care Model already seeing success in reducing ED visits, reducing costs, and improving patient outcomes through remote patient monitoring and value-based care initiatives. With a new model on the horizon that may implement the ePRO requirement, practices that want to participate will need to ensure their ability to get up to speed in time.

**FIGURE 2:**

Timeline of OCF for clinics to prepare for collecting ePROs.



## LOOKING AHEAD IN REMOTE MONITORING AND PROS

Drug manufacturers are studying patient reported outcomes in [clinical trials](#) to show the real-world impact of a treatment. While randomly controlled trials are important to verify the safety and efficacy of a drug for approval, patient reported outcomes can be used to help doctors properly assess the real-world use of a particular treatment for their patients.

Deborah Shrag, MD, MPH, from Dana Farber recently launched a study looking into optimizing remote symptom monitoring in oncology. The clinical trial has a team of investigators from 6 health systems who will use functioning ePRO prototypes to create and refine the electronic symptom management system.

## CONCLUSION

Remote symptom monitoring has been proven to improve patient outcomes in cancer care. With value-based care here to stay and CMS considering including ePROs in their next oncology value-based model, it is important for practices to prepare to deliver patient-centered care. Implementing a remote patient monitoring program is important, but it is important to ensure the rollout will integrate with your clinic's current system and workflow for successful adoption and utilization. Finding a vendor or partner that can help you succeed in practice transformation for oncology is essential.

## ABOUT NAVIGATING CANCER

Navigating Cancer is the leading Patient Relationship Management technology and

solutions company focused on improving the patient experience, delivering more effective care management and enabling oncology care innovation. With over 1,700 providers adopting our platform, Navigating Care is the most broadly deployed patient management platform in oncology. Our solutions improve clinical workflows, oncology content, and data capabilities together to empower more personalized care, increase performance, and deliver insights that help improve care for cancer patients. For more information, please visit [www.navigatingcancer.com](http://www.navigatingcancer.com) or follow us on Twitter @navcancer. [www.navigatingcancer.com](http://www.navigatingcancer.com)

# EMR's: So Many, So Expensive, and So VERY Confusing

STEVEN CASTLE, MBA, RT(T)

During our own professional careers, we have observed the rapid development of Electronic Medical Records (EMR) at various levels; from the wide enterprise level EMRs (Epic/Cerner/Athena/Meditech) that reach across hospitals and health systems to more specialized software that resides at a department level (ARIA/MOSAIQ/Beacon) and those even more granular at a functional level (Equicare/PACs/PowerPath) that provides specialized functionality not provided in other levels. Selecting a software involves a large range of influencers: CEO/CFO/CIO/Service Line Administrators, Department Director, clinical staff, physicians, nurses, and other ancillary staff with each having their own requirements influencing their choice. This complexity contributes to a somewhat less than ideal EMR infrastructure.

What does each individual care about? For a CFO, the cost savings associated with consolidation to a single enterprise level EMR is clear. For a CIO, an enterprise level EMR means fewer applications to manage, fewer resources to support,

while also decreasing the risk for cyber vulnerability and record loss. Clinicians value the specificity to software while also the availability of information with fewer applications. Administration values reliability, availability of analytics/data, user satisfaction, costs, and other factors. In the end, no single person fully owns the outcome as there are numerous influencers and decision makers that weigh in with various and even competing expectations.

Enterprise level EMRs offer an opportunity to consolidate patient-related information into one centralized database. This alone is highly attractive as it provides a single source, high-level view of patient, clinical and financial information. Department-specific software provides functionality that enterprise level EMRs are simply incapable of, e.g. ARIA and Mosaiq. Both evolved from FDA approved Record and Verify systems that drove linear accelerators to become full departmental level information systems incorporating all treatment related activities that take place for a

patient, such as: treatment schedules, simulation workup, treatment plan, billing, and consult/nurse documentation. As clinical care has become increasingly subspecialized, so have the tools to effectively manage. Functional level software is designed specifically to meet this increasingly complex demand that department and enterprise level are unable. For examples, a PowerPath software is necessary for tissue analysis while Equicare delivers end-to-end cancer care coordination including: interactive patient communication, screening, education, treatment summaries, and a comprehensive follow up plans. All of which are necessary when managing a chronic disease like cancer with efficiency and specificity. The value increases as we move away from a fee-for-service model and become more value based. This leaves us as oncology leaders to ask... *what software do I really need to meet our goal of coordinating care for our patients and providing value-based care to our patients?*

## ENTERPRISE LEVEL

ie: Epic, Cerner, Athena, Meditech



Incorporates a collection of digital data on patients within a health care organization

**Pros:** Single source, wide scope, cost, cyber security

**Cons:** Lacks deeper functionality to meet complex oncology service, historical little effort towards interoperability

Rather than developing a comprehensive software plan that achieves our goals across departments, service lines, and even hospital networks, we often

tackle software in silos not realizing the possibilities. Correcting this involves weighing the ambitions and vision of the organization with the financial expense,

sensitivity to cyber security, and accepting the pain of implementing a software application plan.

## ANCILLARY

ie: PowerPath, PACs



Pathology



Radiology

Serves nearly all cancer cases

**Pros:** Specialized tools, un-replaceable

**Cons:** Frequently stand alone software, benefit from interoperability

The argument to consolidate and migrate all information to one enterprise level EMR offers great value on the surface. The issue with this, however, is that the scope of an enterprise level EMR is rather limited as no single EMR provides enough specificity to support and manage a complex service like oncology. The number of ongoing regulation and

accreditation changes alone which must be kept current often creates a choice in labor intensive/inaccurate data or automated/accuracy. Our software tools provide the infrastructure we use to deliver care to our patients, yet we spend little time designing our platform. Most software applications do a good job within their scope and level; however, issues

often arise when software is procured to do more than it is capable. Within our oncology space, this is a common occurrence. We should accept that this is less a fault of the software and more a fault of the organization implementing the software, as we are often asked and/or we attempt to utilize the wrong tool.

## DEPARTMENT OIS:

ie: ARIA, Mosaiq, Beacon, Powerchart



Surgical Oncology



Medical Oncology



Radiation Oncology

Provides EMR like services scaled within a single dept

**Pros:** Unmatched functionality, deeper analytics, & quality measures, interoperability capable

**Cons:** Serves 1 modality within a multi-modality service, frequently under utilized, chief competitor is EMR

Here is an important factor to consider: once you have your software in place as designed, you are not done. You have consolidated in some areas and may add in others, need to address cyber threats, improved work flows, upgraded as entitled in service agreements, but still you have silo'd services. Everything we do in healthcare involves collaborating across services (adjuvant therapy). As our patients travel through the organization, our software should provide the infrastructure for their specific information to travel with them by being

easily accessible to other care providers. This is only achieved via interoperability or establishing interfaces. When weighing software, value those that offer information exchanges with each other. Enterprise level EMR's can offer bi-directional information exchanges with department level as well as specialized functional software. Not all information needs to convey, only what makes sense for patients, supportive services, providers and their referring network. Many software providers already have experience in identifying what data information is in

demand, which is why they likely offer standard interface packages. Note, this serves as a starting point as each facility needs to identify what data they want to travel vertically and if up, down, or bi-directional. Additionally, you may need to specifically ask for the interoperability as the software provider likely prefers a consolidation to their own product or is not vested in an integrated solution ultimately serving our patients and network of providers.

## FUNCTION SPECIFIC/CARE COORDINATION SW:

Equicare Care Coordination - Pt engagement, Education, Trials, PROMS, Survivorship, Accreditation, MDT, screening



Social Work



Registry



Tumor Board



Dietary



Survivorship



Navigation



Research



Analytics

Coordinates care for patients, providers, & services

**Pros:** Efficiency gains to leverage staffing resources, decrease leakage, quality and accreditation tools, >value of under utilized services

**Cons:** Capable of Interoperability, but investment not often made

## PROFESSIONAL OPPORTUNITY

Within your organization, consider leading an initiative to organize your software so that it is aligned to the goals of your organization vertically. Ensuring it delivers horizontally within oncology on meeting security standards, reduces data-entry error/duplication, improved work flows for clinicians, access to data for analysis, accurate billing, timely scheduling, provides quality care coordination, patient education, data for accreditations, Patient Reported Outcomes (PROs), screening and long term Follow up plans. With senior leadership support, establish a small committee comprised of a representative from IT&S, clinical support, administration, fiscal/billing, quality, and risk management to drive the project. Below is a short list of suggested steps to begin with:

1. Set a comprehensive goal for delivering end-to-end cancer services:
  - Security (meets recognized standards)
  - Functionality (comprehensive care coordination from screening through survivorship)
  - Interoperability (create connectivity between functional, department specific, ancillary and enterprise wide EMR's)
2. How many software applications do you operate within your service line?
  - List them and the functions you utilize as well as functionality not utilized
  - Are your current applications HL7 compliant?
  - Identify duplication
    - Are you due for upgrades per service agreement that would enable additional functionality?
  - Identify redundancy where either toggling between or re-entering data
  - Review contract terms to determine if owed upgrades, training, and out clause.

3. Determine if you can consolidate?
  - What do you utilize one for that another can do, maybe not do as well, but meets a standard? Consider the cost of errors if you plan to expose yourself to a manual process over an automated one, as well as the staffing resources for duplicate entry.
  - Are you remaining current with your upgrades and would newest versions provide additional functionality?
4. Is there a gap in what you have that cannot be made with existing software?
  - Do you have IT&S staff who understand the products and have relationship with the vendors?
  - Consider the safety implications of a patient presenting at an ER if the upstream EMR cannot adequately display what the patient's previous treatment regimen has been.
  - Is your IT&S staff capable of testing and implementing the required interfaces.
5. What opportunities are there for bi-directional information exchanges through a set of standard interfaces?
  - Can cost be bundled into purchase agreements?
  - Can cost be amortized?
  - Is it a capital or operational expense?

When you have selected the software design that supports your goals, work towards them understanding it will take time while remembering the value of integrated software applications. Existing contracts do not limit our ability, only the timeline and you may find you are owed upgrades and training. Do not simply purchase the cheapest software or the "best" software; rather, take time to identify what software is best for your organization given the level where it will reside with others along the vertical environment.

## SUMMARY

When a cancer program offers true care coordination across the service line, a byproduct is reduction in duplication, data-entry errors, missed billing, less toggling, better engagement between physicians-patients-departments, less volume leakage, more efficient passage through services, reduced cyber threats, increased staff capacity, adherence to Evidenced Based Guidelines (EBG), Patient Reported Outcomes (PRO), and a more streamlined patient centric approach. Regardless of what level the software resides at, the selection should not be a decision made in a vacuum. Rather, a multi-year strategic plan that leads to an agreed upon goal while understanding the value of leveraging your software together through information exchanges and interfaces.

In the end, providing comprehensive end to end cancer services that integrate with all EMR levels to deliver evidenced based guidelines, gain efficiency through automation and increases synergy between service lines, should be our goal. This means your functional software solution should coordinate patient care beginning with screening, managing the workup phase, seamlessly connect to multi-modality treatment care, inpatient/outpatient care, registration(s), billing, portal, and smoothly transitioning a patient through survivorship. Ideally, care coordination software will do all this and exchange the meaningful information with horizontal enterprise level EMR's, ancillary support tools, i.e. pathology, radiology, etc... as well as department specific support tools, i.e. radiation, medical and surgical oncology information systems. Remember the winner is not the software that does it best, the winner is the patient with a SW that does interoperability both vertically and horizontally the best.

# National Accreditation Program for Breast Centers Update

TERESA HECKEL, MBA, *Immediate Past-President, ACE; NAPBC Board Member*

The National Accreditation Program for Breast Centers (NAPBC), administered by the American College of Surgeons (ACS), continues to serve as **the** roadmap for organizing and managing a breast center to ensure multidisciplinary, integrated and comprehensive care services. Facilities that achieve NAPBC accreditation can be assured that they are being held to the highest standards of care for patients with diseases of the breast. There are currently 657 accredited NAPBC centers which includes three accredited international sites in Dubai, South Africa and Toronto. There are accredited facilities in all states of the U.S. except for Wyoming.

The NAPBC Board of Directors works diligently to continue to improve the program and value to its member organizations and the patients they serve. Below is a summary of some recent activities that may be of interest.

## STANDARDS UPDATES

The NAPBC Board of Directors recently agreed to modify requirements to the *2018 NAPBC Standards Manual (2018 edition)* for two standards: **Standard 1.2: Multidisciplinary Breast Care Conference** and **Standard 6.1: Quality and Outcomes**. These changes will go into effect on **January 1, 2020**.

The 50% required attendance for individual surgeons, medical oncologists, and radiation oncologists detailed in **Standard 1.2: Multidisciplinary Breast Care Conference** has been retired. The Breast Program Leadership Committee (BPLC) is expected to set attendance requirements for all specialties attending the Multidisciplinary Breast Care Conference (MBCC). It is still expected that there be at least one surgeon, radiologist, pathologist, radiation oncologist, and medical oncologist at

each MBCC meeting. It is also strongly encouraged that treating physicians attend the MBCC when their patients are being presented. The BPLC is responsible for monitoring individual and specialty attendance on an annual basis.

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The banner features a stylized night landscape with palm trees, a crescent moon, and a starry sky. The ACE logo is prominently displayed in the center.

**NavigatingCancer**

**PATIENT RELATIONSHIP MANAGEMENT**

THE NEW STANDARD FOR BREAST CARE  
**PATIENT RELATIONSHIP MANAGEMENT**

Succeeding in value based care requires transformation: PRM can help.

**GET THE EBOOK**

The image shows the cover of an eBook titled 'Patient Relationship Management' from NavigatingCancer. The cover features a photograph of a doctor talking to an elderly patient. Below the image is a green button that says 'GET THE EBOOK'.



The number of quality studies required each year in **Standard 6.1: Quality and Outcomes** has been lowered. Programs are only required to complete two quality studies for Standard 6.1, one of which may be a physician-specific quality improvement program.

The NAPBC Clarifications, Reminders, and FAQ document released in May 2019 has been updated to reflect these changes. It may be downloaded from the [NAPBC website](#) and the resources section of the [NAPBC portal](#). October 2019 additions/updates are designated in the document.

If you have any questions regarding the interpretation of NAPBC standards, please be sure to post your question to the NAPBC section of the [CAnswer Forum](#).

With the recent updates to the Commission on Cancer (CoC) Standards, many may be wondering about any additional updates that may be made to similar NAPBC Standards. The CoC and NAPBC programs are working together to harmonize those standards that impact both programs. Stay tuned for any future standard updates.

Accredited centers will receive an annual report in January.

### NAPBC BOARD UPDATE

The NAPBC Board held a facilitated strategic planning retreat in July to review the results of a data-driven assessment of NAPBC and identify strategic priorities for continuing to bring program value to patients and breast centers. The assessment included qualitative interviews with key leaders, board members, surveyors and

accredited centers. The outcome of the retreat resulted in a pending revision of the NAPBC mission and a set of three primary strategic drivers and indicators of success. The NAPBC Board has created and launched task forces to focus on the three strategic areas.

The NAPBC Board Standing Committees continue to meet regularly to enhance the accreditation program and offerings to centers:

- Standards and Accreditation Committee
- Education and Dissemination Committee
- Quality Improvement & Information Technology Committee
- Advocacy & Outreach Committee

If you have any questions regarding NAPBC, please contact Connie Bura at [cbura@facs.org](mailto:cbura@facs.org).



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