ASSOCIATION OF CANCER EXECUTIVES UPDATE

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ACE ASSOCIATION of CANCER EXECUTIVES

WHAT'S INSIDE

Important Reminders:

- 2018–2019 Membership Dues Drive begin on July 1st 2018
- 2018–2019 Corporate Sponsorships Now Available! Save 10% by securing your sponsorship before 8/31.
- ACE Fellowship Program: Now Accepting Applications for 2019–2020!

For all items listed above please be sure to visit cancerexecutives.org

Optimizing the Scheduling of Infusion Appointments

BY MOHAN GIRIDHARADAS

Optimizing the scheduling of infusion appointments has been a challenge for most cancer centers for decades. Many cancer centers have taken multiple attempts at solving the problem through a variety of methods, including unlinking clinic appointments from the infusion appointment, getting the lab work done the prior day, pre-mixing drugs when possible, centralizing (or decentralizing) infusion scheduling, reserving a subset of chairs to each oncology practice, or launching value-stream mapping activities to the process by which a patient checked in and was assigned to a chair. While many of these approaches can yield some promising early results, they invariably leave the infusion center to grapple with the recurrence of the "10am–2pm peak"—the core problem that they had started out to solve in the first place!

Let's take a step back and begin with the root of the problem. In the rush to capitalize on the passage of the HITECH Act, electronic health record (EHR) vendors focused on getting all the hospital data into a single database (lab results, procedures, clinical appointments, etc.). This was an excellent and necessary step to have all of the relevant clinical and operational information consolidated into a "single source of truth". However, they failed to do the heavy-lifting that was required in order to create the right mathematical construct on which appointments could be scheduled. The shortcut they took appeared, at first glance, to be a reasonable one: Treat each appointment as a "request to reserve a resource". With this principle, all that remained to be done was to correctly identify the key resource for that specific appointment—a chair is the infusion resource, a provider is the clinic resource, the machine of the right modality is the imaging resource and so on. Having correctly identified the resource, a 3-hour infusion treatment for John Doe at 9:30am could simply be marked as occupying a specific (or virtual) chair from 9:30am–12:30pm. Simple and elegant—right? Not really—this oversimplification by all of the EHR vendors has created an incredibly weak mathematical foundation on which all health systems are expected to run their complex daily operations. It therefore should not be a surprise that in most health systems, critical assets lie idle at various points in time throughout the day even while the waiting rooms are filled with patients (who are often anything but patient about the length of time they are expected to wait).

There are at least five distinct ways in which the mathematical foundation is grossly inadequate for the complex task of scheduling infusion appointments within the health system. These include:

1 TREATING THE SCHEDULE AS A "RESOURCE GRID"

A grid method is an excellent way of reserving assets when the start and end times of the appointment are precisely known at the time that the appointment is being made (e.g., for tennis courts) and when there is no dependency on a staff person also being available at the exact time of the appointment (e.g., a tennis pro is not required to be on the court in order for players to get started). Infusion appointments cannot possibly be expected to start or end exactly on time—there are simply too many unknowns. Furthermore, the nurse has to be available at the start time in order to begin administering the

	"Virtual" Assets						
Time	1	2	3	4	5	6	7
08:00							
08:30							
09:00							
09:30							
10:00							
10:30							
11:00							

infusion treatment. Hence, it is futile for the grid to show that a chair is available without the confidence that a nurse will also be available. Using a deterministic (known in advance) template to schedule a stochastic (random) event is not simply a bad idea—it is flat out wrong!!

2 IGNORING THE INSIGHTS OF PROBABILITY THEORY

In every complex scheduling environment with large numbers of variables and uncertain outcomes, probability theory is a critical component of the solution. As an example, airlines deliberately overbook many of their routes and flights on a daily basis—they have built sophisticated probabilistic models to anticipate the number of standby passengers, cancellations, no-shows, late bookings and the likelihood of stranded passengers after an IROP (irregular operations) event. Mostly, they get it right—occasionally they have a few more confirmed passengers on the flight than the available number of seats. We have all witnessed the escalating offer of incentives to get a few passengers to give up their seat in exchange for a seat on a later flight. Nothing in an EHR scheduling system even contemplates the concept of probabilistic distributions of patient arrivals and departures—it is impossible to book more patients than the number of available slots or to squeeze a long appointment into a short slot—both of which might be justified based on the probability of patient arrivals. Further, compared to an airline (once the plane is in the air, it is no longer possible to add or remove passengers), the consequences of getting it slightly wrong are far easier for the health system to manage—a few patients may have to wait a few minutes longer than they otherwise might have (which they are used to doing far more frequently under the current system anyway).

3 THINKING (WISHFULLY) THAT THE PRINTED ITINERARY FOR THE PATIENT WILL ACTUALLY HAPPEN

Patient itineraries with multiple encounters within the same overall appointment (e.g., an oncologist visit at 9:00am followed by an infusion appointment at 10:15am) are a wishful fantasy from the moment they come off the printer; it is very unlikely that the appointments will happen at the times that were carefully printed out. An itinerary is like an airline trip with a stopover as illustrated in the figure above with a flight from San Jose to Dallas/Fort Worth and a connection onto London Heathrow. There are two issues with the way these linked appointments are scheduled in most health systems. First, the on-time performance of the first leg is often woefully inadequate to build connected schedules. Imagine if the incoming flights to major hubs in the US were only 30% likely to run on time—each hub would have tens of thousands of stranded passengers on a daily basis who had missed their connecting flight. Second, imagine if the captain of each incoming flight (e.g., the Oncologist) tried to influence the departure time of the second flight (i.e., "I would like my patient to start their infusion within an hour of leaving my clinic"). This makes about as much sense as the pilot of the Charlotte-to-Atlanta flight trying to influence the departure time of the connecting flight from Atlanta to Los Angeles. The airline will obviously have to consider all of the inbound flights from other cities into Atlanta—e.g., Birmingham, Miami, Jacksonville etc., and estimate the number of passengers likely to be continuing on to Los Angeles to determine the optimal departure time of the Atlanta-to-Los Angeles flight on the schedule. The objective has to minimize the overall wait time for all passengers rather than simply trying to make it convenient for the passengers from Charlotte.

4 BELIEVING THAT "FIRST-COME-FIRST-SCHEDULED" IS THE CORRECT WAY OF SCHEDULING

All health-systems try to schedule in a mostly first-come-first-scheduled manner. For example, if a patient were to call the infusion scheduler looking to make an appointment that was 9 months into the future, the scheduler is liable to be very patient-friendly and cheerfully say "That is so far into the future that the calendar is wide open—pick a spot, any spot—we are open from 8am to 6pm". That is **exactly the wrong way** to schedule an infusion appointment. The scheduler ought to have tried to steer the patient toward the optimal slot by saying (for example) "I see that you need a 3-hour infusion treatment—I have 3-hour slots in the morning at 8:40am, 9:20am, 10:30am and 11:10am. Since the date you are requesting is very far into the future, all 4 slots are open—as we get closer to the date, some or all of those slots will get taken". The simplest way to grasp this concept is to think of each appointment as a piece of a jigsaw puzzle—if the scheduler followed a first-come-first-placed approach to solving the puzzle and simply placed each puzzle piece at a random spot on the table in the order in the piece was handed to him/her, there is no chance that the puzzle will solve

correctly. However, if the scheduler were to be given the outline of each piece and then be handed the puzzle pieces in the same random order as the last example, he/she would know exactly where to place each piece in order for the puzzle to solve. Laying out the puzzle pieces in the right sequence is a complex mathematical optimization problem that requires predictive analytics, discrete event simulation and machine learning algorithms to continuously improve the appointment placement models. The EHR does none of these things—it simply "reserves the resource for the requested time interval". As a result, it leaves the operational leadership to fend for themselves when the grid that was perfectly laid out at the start of the day never actually materialized as expected and, just like in the movie "Groundhog Day", happens all over again the next day, and the next day and so on.

5 BELIEVING THAT CONTROLLING THE RESOURCE WILL LEAD TO IMPROVED PERFORMANCE

The clinical leadership of various departments will eventually get frustrated with the operational performance of a downstream resource (e.g., turnaround time for labs or imaging departments or the inability to place their patients in an infusion chair). They will try to take matters into their own hands by setting up a dedicated resource in their area (e.g., a small lab or a mobile imaging unit) or will insist that 6 chairs in the infusion area be reserved for their patients. While well-intended, it is also completely incorrect from a mathematical point of view. Breaking up a resource into dedicated (reserved) subsets damages the performance of the entire pool for everyone. Imagine if the transportation authorities were to decide that the left lane was intended for red cars, the middle lane for white cars and the right lane for blue cars; while it is an absurd example, it is not hard to predict that the performance of the freeway as a system will be a lot worse than simply allowing cars of all colors to travel on whichever lane they chose.

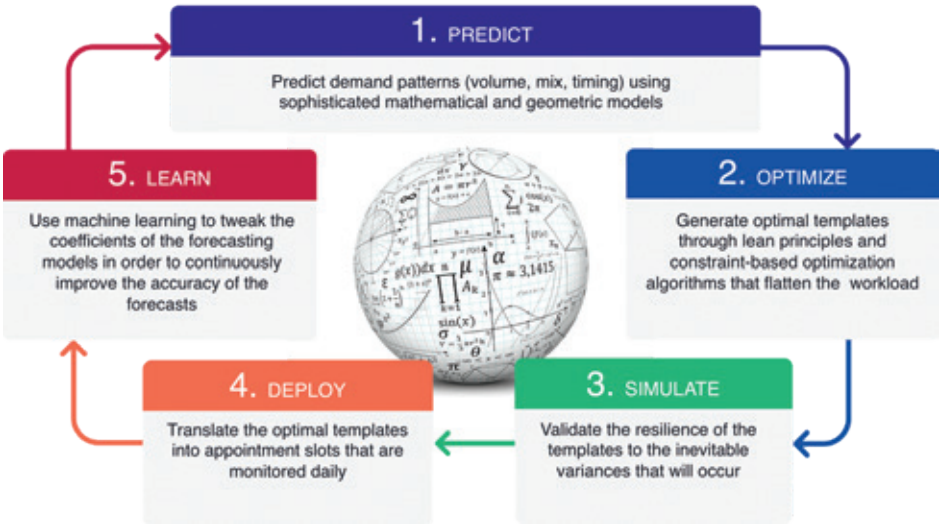
ELEMENTS OF A SOLUTION TO THE INFUSION SCHEDULING PROBLEM

Our team has deployed (or is in the process of deploying) ***iQueue for Infusion Centers*** at over 100 infusion centers over the last 4 years to solve this exact problem. Many of these infusion centers are part of a leading cancer institution (e.g., 50% of the NCCNs, 15 of the top 30 cancer hospitals in the country, over a dozen leading academic medical centers, etc.). Others are small, community-based infusion centers. Regardless of size or stature, these infusion centers all had a remarkably similar set of issues:

1. Patients waited a long time—particularly in the middle of the day
2. The chair utilization profile was like a mountain with a peak in the middle of the day
3. Infusion nurses were often forced to skip or delay their lunch breaks

Solving this problem required a disciplined, 5-part effort as depicted in the picture below.

1. Predictive algorithms should forecast the volume and duration mix very accurately for each day of the week given that the set of oncologists who practice on each day of the week are often different
2. Optimization algorithms need to incorporate the variability of duration estimates and include a very large set of operational constraints (e.g., nursing shifts and roster, pharmacy hours, number of chairs, approach for dealing with fast-track appointments, etc., etc.) in order to suggest an optimal layout of appointments slots based on duration that would be most likely to generate a chair utilization profile that ramps up smoothly, stays flat for most of the day and then ramps down smoothly
3. Templates that look good on paper—often don't perform well in practice (as evidenced by the grid-based schedule). Hence, simulation algorithms that cycle through millions of permutations and combinations of patient punctuality and actual versus expected treatment duration can identify the templates that will be most resilient to "shocks to the system" caused by unexpected delays
4. The optimal templates have to be deployed back into the EHR—schedulers can't be expected to interact with an entirely different system. Once the appointment choices have been baked into the EHR, it makes it easy and natural for the scheduler to "steer" the patient into the most optimal appointment slot that matches the needs of the patient while enabling a smooth flow through the infusion center
5. The templates have to "learn" by continuously matching the actual performance versus the expected performance to determine whether the forecasting, the mix estimation, the constraints or the appointment slots themselves need to be tweaked. By monitoring over 7,000 infusion appointments being scheduled each day, the algorithms have the ability to get smarter at a scale that is hard for



any single institution to match—even if they happened to be a very large infusion center.

EXPANDING THE OPTIMIZATION TO COVER THE ENTIRE "FLIGHT PATH" OF THE PATIENT THROUGH ONCOLOGY

Our ultimate objective is to apply the same mathematical principles in optimizing the end-to-end journey of the patient through the oncology center each day—labs, clinics, infusion, diagnostic imaging and radiation oncology. We are therefore working closely with several leading cancer centers in structured pilot experiments that expand the impact we have demonstrated in infusion into other areas of the oncology service line. There are two simultaneous pilots at oncology clinics underway—one in Texas and the other in New York. We are also working on launching several pilots in diagnostic imaging and radiation oncology over the next month. Finally, we have delivered a model that shortened the turnaround time for lab results from 90 minutes to 15 minutes at the cancer center of a leading academic medical center in the Southeast.

Mohan Giridharadas is the Founder & CEO of LeanTaaS, a healthcare analytics company based in Silicon Valley. LeanTaaS employs ~70 product managers, data scientists and software engineers in California and has two flagship products—***iQueue for Infusion Centers*** and ***iQueue for Operating Rooms*** with several other products at various stages in the R&D pipeline. Prior to starting LeanTaaS, Mohan was a Senior Partner at McKinsey & Company and led the Lean practices for Manufacturing and Service Operations in both the North American and Asia-Pacific regions. Mohan was formerly a faculty member of the Continuing Studies program at Stanford University and the Haas School of Business at the University of California at Berkeley. He holds an MBA from Stanford, an MS in Computer Science from Georgia Tech and a B Tech in Electrical Engineering from IIT Bombay.

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The University of Texas MD Anderson Cancer Center: Sequencing Patients in a Complex Itinerary

Would your patients travel the globe with no luggage, no clothes, no toiletries, no form of entertainment? Not likely. However, the Ambulatory Treatment Center (ATC) of the University of Texas MD Anderson Cancer Center has been turning patients away for arriving at their gates short-handed—without prior physician and lab visits.

Unless you've been issued a boarding pass, the ATC cannot operate efficiently. A "ready patient," according to the ATC's Clinical Administrative Director Brenda Brown, MSN, RN, OCN, NEA-BC, has everything packed and prepared for a best practice visit. This pre-visit preparation is only one of many elements that the ATC requires; the nature of the center's services also necessitates the airport runways to be managed proactively. A new tool—the out-of-sequence report—gave MD Anderson the ability to manage its ambulatory traffic control in a more effective way. This best practice not only focuses on the patient's experience, but also the ATC's ability to provide timely, efficient and quality care.

AN EPIC CHALLENGE

Transitioning between management information systems can be a complicated and long process, which can reveal new gaps within the healthcare structure. MD Anderson faced multiple challenges after their implementation of Epic, including the transition of patients between the patient's oncologist, the laboratory, and the Ambulatory Treatment Center. The MD Anderson ATC provides chemotherapy, infusion and other services to more than 10,000 patients each month.

Prior to implementing Epic, appointments were coordinated via an order set, delivered as a "package" to the clinics and ATC for scheduling. After making the transition, however, the order set was split into two work queues, so it is more challenging for schedulers to see a comprehensive view of a patient's intended schedule to ensure coordination. At present, two people—the scheduler in the treating physician's practice (the Breast Center, for example) and a different scheduler in the ATC must coordinate scheduling appointments based on the treating physician's order set. In some cases, the order of appointments —typically lab work, the physician's appointment, and then the ATC—can get out of sequence.

This is more than a nuisance, since the ATC has to turn patients away if they have not had an appropriate physician's encounter or lab work. This is obviously dissatisfying to patients, but also leads to angst for the physician, because patients are sent back to their treating physician to "reinitiate" the treatment. The center must then absorb the patient at a later, unscheduled time, disrupting the center's workflow—and putting the lab behind as well. Most often, the ATC must subsequently integrate the patient into the schedule, leading to late evenings, staff overtime and poor morale. In sum, each patient who is out of order proves to have significant negative ramifications.

GETTING BACK IN CADENCE

In the months after the Epic implementation, MD Anderson had, on average, 10 out-of-order patients per day. After recognizing the ensuing problems, ATC management, in collaboration with the Office of Performance Improvement (OPI), uncovered a relatively simple solution that has eliminated the problem: a custom-built, daily out-of-sequence report from Cadence, the scheduling module of Epic.

The out-of-sequence report runs seven days out, capturing patients whose itineraries are not in order. In addition to identifying these patients, the report also monitors the time between appointments. If the time is not 90 minutes—which allows an adequate "runway" between events—the report detects the problems. This report is a key "traffic control" tool for the center.

Led by ATC Lead Patient Service Coordinators Demerris Baker and Steinley Rosier, the scheduling team runs the report, providing the opportunity to resolve out-of-sequence patients prior to their date of service. The out-of-sequence report has made a significant difference at MD Anderson. This identification triggers a call to the center for the patient's treating

physician. The scheduler there can assess the situation, and revise the order of events, working in collaboration with the ATC scheduling team.

MD Anderson's out-of-sequence report is a simple, yet comprehensive solution, which not only promotes a positive patient and provider experience, but also identifies other issues that persist in the structure. An example of the latter at MD Anderson was the report uncovering the need for additional early morning capacity in the lab to accommodate ATC patients in a specific infusion location. Collaborating with lab medicine colleagues, MD Anderson recently opened a draw station within the ATC.

Solving the sequencing challenge is the goal. There have been extensive discussions about having the physician's scheduler make all three appointments, but there are barriers. First, scheduling chemotherapy is a complex process that requires specialized knowledge and is currently not part of the physician scheduler's work flow. Second, most infusion visits are scheduled as soon as they are ordered to ensure adequate time for financial clearance. Finally, in the midst of a busy clinic, the physician doesn't always place requests for all services at the same time. The infusion visit may first be ordered, and the follow-up visit and additional labs may be ordered at a later time. Moreover, the ATC handles these visits in concert with other appointments, such as physical therapy, nutrition services, and other provider visits and/or procedure. The out-of-sequence report catches problems that may emanate from an asynchronous order set.

Although the out-of-sequence report is still being refined, MD Anderson plans to apply the report to other settings and situations as well. This simple tool is the "best practice" solution that allows patients to embark on their ATC journey with no delays.

Congratulations to the team at the University of Texas MD Anderson Cancer Center that led this "best practice" initiative:

Demerris Baker, Lead Patient Services Coordinator, Ambulatory Treatment Center

Brenda Brown, MSN, RN, OCN, NEA-BC, Clinical Administrative Director, Ambulatory Treatment Center

Dalia Farhat, MS, SSMBB, Senior Healthcare Systems Engineer, Quality Measurement and Engineering

Kristine Garcia, MSN, RN, OCN, Business Systems Analyst, Ambulatory Treatment Center

Michelle Lawrence, MSN, RN, OCN, PC, Nurse Manager, Ambulatory Treatment Center—Main

Christopher Newhouse, BS, Associate EHR Application Analyst, OneConnect Access and Revenue

Steinley Rosier, Lead Services Coordinator, Ambulatory Treatment Center

Joy Yates, MSN, RN, OCN, PC, Nurse Manager Ambulatory Treatment Center—Mays

A special thanks to Varsha Kottamasu for her contribution to this article.

This "best practice" is brought to you by the Patient Access Symposium, a members-only consortium of academic health systems and children's hospitals.

Lab, Clinic and ATC Appointment Record

MRN	Patient	Dept	Provider/Resource	Appt Date Time	Type	Time Until Chemo Appt	Entry Person	Made Date	Patient Home Center
2001005	Test, Debbie	MN DIAG LAB [101014233]	TEST, PROVIDER [104367]	4/17/2018 8:00 AM	Lab [1007]	6:15	TEST, CADENCE PSC [ESPSC]	3/20/18	Melanoma [27]
		MN MELA MED [101014272]	TEST, PROVIDER [104367]	4/17/2018 1:00 PM	Follow Up [1002]	1:15	TEST, CADENCE PSC [ESPSC]	3/20/18	Melanoma [27]
		MYS ATC BLUE [101015457]	TEST, PROVIDER [104367]	4/17/2018 2:15 PM	Chemo [33030]	0:00	TEST, CADENCE PSC [ESPSC]	3/26/18	Melanoma [27]
2001654	Test, Adam	MYS ATC TAN [101015461]	TEST, PROVIDER [104367]	4/17/2018 7:00 AM	Chemo [33030]	0:00	TEST, CADENCE PSC [ESPSC]	4/6/18	Breast [9]
		MYS DIAG LAB [101015350]	TEST, PROVIDER [104367]	4/17/2018 1:00 PM	Lab [1007]	-6:00	TEST, CADENCE PSC [ESPSC]	4/5/18	Breast [9]
		MYS RADTX [101015384]	TEST, PROVIDER [104367]	4/17/2018 1:55 PM	Rad Txation [33014]	-6:55	TEST, CADENCE PSC [ESPSC]	3/15/18	Breast [9]
203975	Test, Cathy	MYS ATC TAN [101015461]	TEST, PROVIDER [104367]	4/19/2018 9:30 AM	Chemo [33030]	0:00	TEST, CADENCE PSC [ESPSC]	4/6/18	Thoracic [4]
		MN DIAG LAB [101014233]	TEST, PROVIDER [104367]	4/19/2018 12:00 PM	Lab [1007]	-2:30	TEST, CADENCE PSC [ESPSC]	4/5/18	Thoracic [4]
		MN THOR MED [101014330]	TEST, PROVIDER [104367]	4/19/2018 1:20 PM	Follow Up [1002]	-3:50	TEST, CADENCE PSC [ESPSC]	4/5/18	Thoracic [4]
204120	Test, Emily	MN DIAG LAB [101014233]	TEST, PROVIDER [104367]	4/20/2018 8:15 AM	Lab [1007]	4:45	TEST, CADENCE PSC [ESPSC]	3/30/18	Head and Neck [21]
		MN MELA MED [101014272]	TEST, PROVIDER [104367]	4/20/2018 10:15 AM	Follow Up [1002]	2:45	TEST, CADENCE PSC [ESPSC]	3/30/18	Head and Neck [21]
		MN ATC PC [101014464]	TEST, PROVIDER [104367]	4/20/2018 1:00 PM	Chemo [33030]	0:00	TEST, CADENCE PSC [ESPSC]	4/9/18	Head and Neck [21]
205604	Test, Amy	MN DIAG LAB [101014233]	TEST, PROVIDER [104367]	4/18/2018 12:30 PM	Lab [1007]	3:15	TEST, CADENCE PSC [ESPSC]	3/28/18	Thoracic [4]
		MN THOR MED [101014330]	TEST, PROVIDER [104367]	4/18/2018 1:30 PM	Follow Up [1002]	2:15	TEST, CADENCE PSC [ESPSC] [236344]	3/28/18	Thoracic [4]
		MYS ATC BLUE [101015457]	TEST, PROVIDER [104367]	4/18/2018 3:45 PM	Chemo [33030]	0:00	TEST, CADENCE PSC [ESPSC]	4/8/18	Thoracic [4]
203976	Test, Dana	MN DIAG LAB [101014233]	TEST, PROVIDER [104367]	4/17/2018 9:15 AM	Lab [1007]	3:00	TEST, CADENCE PSC [ESPSC]	3/27/18	Melanoma [27]
		MN MELA MED [101014272]	TEST, PROVIDER [104367]	4/17/2018 11:15 AM	Follow Up [1002]	1:00	TEST, CADENCE PSC [ESPSC]	3/27/18	Melanoma [27]
		MN DERM [101014231]	TEST, PROVIDER [104367]	4/17/2018 12:00 PM	Follow Up [1002]	0:15	TEST, CADENCE PSC [ESPSC]	3/30/18	Melanoma [27]
		MN ATC TUPB [101014466]	TEST, PROVIDER [104367]	4/17/2018 12:15 PM	Chemo [33030]	0:00	TEST, CADENCE PSC [ESPSC]	3/27/18	Melanoma [27]
2003433	Test, Bailey	MN DIAG LAB [101014233]	TEST, PROVIDER [104367]	4/16/2018 8:00 AM	Lab [1007]	3:00	TEST, CADENCE PSC [ESPSC]	4/3/18	Internal Medicine [41]
		MN GI MED [101014245]	TEST, PROVIDER	4/16/2018 9:00 AM	Follow Up	2:00	TEST, CADENCE PSC	4/2/18	Internal Medicine [41]

Red highlight – not enough time (under 90 minutes) between lab or follow up and ATC appointment
Yellow highlight – out of sequence appointments

International Oncology Leadership Conference Registration Opens!

Early-bird registration is now open for the 2nd International Oncology Leadership Conference. ACE members are also eligible for an additional 20% off registration along with lowest early-bird pricing available till June 30th.

The 2nd International Oncology Leadership Conference (IOLC) to be held in Milan, Italy from November 4–6, 2018 at the Hotel Excelsior Gallia. IOLC is a partnership with the Association of Cancer Executives, Humanitas Cancer Center and Hauck & Associates, Inc.

IOLC attendees will have the opportunity to tour the largest cancer center in Italy on day one of IOLC and then two days of sessions and networking opportunities at the Hotel Excelsior Gallia located in the Milan city center.

Here is a preview of the sessions to be presented in Milan:

- Bending the Cost and Quality Curve—How Nations judge their Clinical Quality of Care
- Economics of Cancer Care: Access to Budgetary Decisions and Negotiations related to Pharmaceutical Pricing
- Cost of Cancer Care Internationally—Global Value and Access
- Networking Opportunities and Pitfalls: A Tale of Four Cities
- MD and Administrator Burnout
- The United Nations of Oncology: How Sarah Cannon has brought together programs, people, processes and places to form a united front in the fight against cancer
- Rethinking Fight against Cancer from a Determinants of Health Approach
- Patient satisfactory and delivery—Measuring Outcomes

A big thank you to the IOLC Planning Committee for putting together a dynamic agenda with very timely topics and pairing each session with a great speakers. The goal of the planning committee is to provide attendees with speakers from different countries on each session to provide different perspectives.

2018 IOLC PLANNING COMMITTEE:

Co-Chairs:

Dave Gosky, Markey Cancer Center—University of Kentucky
Camille Grosso, Humanitas Cancer Center

Committee Members:

Nancy Bookbinder, Oncology Resource Consultants, Inc.
Cindy Chavira, Samuel Oschin Comprehensive Cancer Institute
Teresa Heckel, T & C Consulting
Shreya Kanodia, Moores Cancer Center at UC San Diego Health
Luis Lasalvia, Siemens Healthineers
Brian Mandrier, Association of Cancer Executives/Hauck & Associates, Inc.
Kevin Massoudi, Varian
Linda Weller Newcomb, Lahey Health Cancer Services
Ollieta Nicholas, UT MD Anderson Cancer Center
Roger Saadeh, Sante Care
Didier Verhoeven, University of Antwerp

Important IOLC Links:

- IOLC Conference Website: http://oncologyleadership.org/
- IOLC Hotel Booking Website: https://www.starwoodmeeting.com/events/start.action?id=1804208534&key=29CC30A0
- IOLC Registration Website: https://www.regonline.com/IOLC2018

IOLC is a new type of oncology conference that provides attendees with a fresh perspectives on some of the most pressing issues facing oncology administrators. We sincerely hope to be able to welcome you to IOLC and the great city of Milan this fall. If you have any questions on IOLC or travel/hotel please contact ACE Executive Director Brian Mandrier.