

“Change is upon us in healthcare and in those programs currently accredited by the ACOS CoC.”

*American College of Surgeons: Commission on Cancer (ACOS CoC)
Cancer Program Standards 2011 Project:*

The Future of Quality Cancer Care – is your program ready?

By Linda W. Ferris, Ph.D., ACE Representative to the CoC

To quote Peter Drucker, “All organizations need to know that virtually no program or activity will perform effectively for a long time without modification or redesign. Eventually every activity becomes obsolete...” So change is upon us in healthcare and in those programs currently accredited by the ACOS CoC. So where do we stand with the proposed changes? How will our structure, processes, and outcomes be redesigned and assessed?

Categories of Accreditation

With regard to the Categories of accreditation and the eligibility criteria, there are many changes. The categories are changing as indicated below:

1. The *Network Cancer Program* will now be expanded to include entities that are owned, leased, or in joint venture arrangements to be included in the Network. It will also expect that CP3R data will be evaluated for each facility and overall. Its revised name is *Integrated Comprehensive Cancer Program (ICCP)*.
2. The *Teaching Hospital Cancer Program* remains focused on post graduate medical education, but will also be

required to have a minimum caseload of 500 analytic cases with increased clinical accrual requirements. Its revised name is *Academic Comprehensive Cancer Program (ACAD)*.

3. The *Community Comprehensive Cancer Program* will include programs with a minimum of 500+ analytic cases annually and will require increased clinical accrual requirements. Its revised name is *Comprehensive Community Cancer Program (COMP)*.
 4. The *Community Hospital Cancer Program* will require a minimum of 101 to 500 analytic cases and established a clinical trial accrual requirement. Its new name will be *Community Cancer Program (CCP)*.
 5. The *Hospital Associate Cancer Program (HACP)* intends to increasingly attract smaller or rural facilities and now lowers the analytic caseload to 100 or less. These facilities remain exempt from clinical trials and retain this name.
 6. *Freestanding Cancer Center Program (FCCP)* allows participation by non-hospital facilities. This category will now allow for participation by facilities with one treatment.
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ACE Calendar

**ACE 17TH
ANNUAL MEETING**
JAN. 26–29, 2011
NEW ORLEANS, LA
THE ROOSEVELT HOTEL - THE
WALDORF ASTORIA COLLECTION

18th Annual Meeting
JAN. 18–21, 2012
SAVANNAH, GA
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19th Annual Meeting
JAN. 23–26, 2013
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President's Message

Joy Soleiman, MPA
Kimmel Cancer Center at Jefferson



As we move into the new season, those of us in the northeast are seeing the beautiful Fall foliage begin to drop. Winter is coming... and so is more uncertainty in the healthcare arena. As I said in my last message, part of our concern and what's keeping us up at night is the uncertainty of the future with the Healthcare Reform and what it will mean for our cancer centers. Only time will tell the full impact of the current elections on healthcare reform. ACE will endeavor to keep you informed.

In this issue, Linda W. Ferris, Ph.D., ACE Representative to the CoC, writes about the ACOS CoC's Cancer Program Standards 2011 Project (*above*). Linda tells us that change is upon us in healthcare and in those programs currently accredited by the ACOS CoC. Read her article to find out where we stand with the proposed changes, and how our structure, processes, and outcomes will be affected and assessed.

Also in this issue, Daniel Chang, AIA NCARB, and Tim Black, LEED AP, with help from ACE member Matt Sherer, write about the importance of vault design in our radiation facilities (*see page 4*). The article points out that “The vault is the primary safety device employed in radiation therapy for cancer treatment. [The Vault] protects staff, patients, and other building occupants from primary and secondary radiation generated during therapy.” If you are updating your radiation facility, this is an important article to read.

I hope you are planning to attend our **Annual Meeting**, to be held in **New Orleans, January 27–29th, 2011** at the Roosevelt Hotel. Kudos to President-elect **Bill Laffey** and the Education Committee – they have done an excellent job of designing a great conference! And don't forget to register yourself and sign up your new oncology administrators for our one-day, pre-conference program, **Oncology 101**, on **Wednesday, January 26**. This program introduces participants to the topics and issues that they will face as an oncology executive. A must attend for every new administrator.

Remember, if you have ideas you would like to challenge us with, please contact us. ACE is made better by the contributions of its members! ■

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New CoC Standards – Is Your Program ready?

> Continued from page 1

ment (i.e.: radiation oncology or medical oncology). A hospital partner is not required, but participation in clinical trials is required.

7. The **Pediatric Cancer Program (PCP)** and the **Pediatric Cancer Component Program (PCCP)** have been combined to increase the number of programs applying for accreditation. This category increases clinical trial accrual requirements. NCDB comparison data is being assessed for this category.
8. **NCI-designated Comprehensive Cancer Center Program (NCIP)** retains its name with increased clinical trial accrual requirements.
9. The **Veterans Affairs Cancer Program (VACP)** will retain its current name and clinical trial accrual requirements. The option to add military facilities to this category is being assessed.
10. The **Hospital Affiliate Cancer Program** category has been eliminated.

Eligibility Criteria

Eligibility criteria is defined as those program components that are core and essential, those aspects are applied to all accredited programs, whether on site or via referral. The scope of these services will be assessed annually by the Cancer Committee. The CoC staff will evaluate your Eligibility Criteria data submissions prior to your on-site survey. Briefly, the eligibility criteria will include:

1. Facility accreditation expanded to include recognized authorities;
 2. Physician credentials (Board certified or eligible for surgery, radiation oncology, or medical oncology);
 3. Radiation Oncology services (on site or via referral);
 4. Radiation Therapy services follow quality assurance practices (ACR or ASTRO accreditation, attestation if not accredited);
 5. Systemic Therapies (chemotherapy, biologics, and immunotherapy agents) are provided on site or via referral in a safe environment;
 6. Policies and procedures are used to guide the safe administration of systemic therapies;
 7. Oncology nursing leadership is credentialed;
 8. Clinical trials information is provided through a formal mechanism as designated by the Cancer Committee;
 9. Psychosocial support services are provided on-site or in coordination with local agencies and facilities;
 10. Rehabilitation services are provided on-site or by referral, and the needs of the patients are assessed;
 11. CoC data standards and coding instructions are used to capture all reportable cases;
- Programs are to complete the SAR and assess their eligibility criteria annually.

Registry Operations

The Registry Operations group has developed changes to Standard #.1. The current standard allows for case abstracting to be 'performed or supervised' by a Certified Tumor Registrar (CTR). The new standard will require that case abstracting is performed by a Certified Tumor Registrar (CTR). Beginning on January 1, 2012, **all cancer registry staff who performs case abstracting at a CoC facility must:**

1. Hold a current CTR credential; or
2. Be in a one-time only, three-year "grace period" to actively pursue eligibility requirements to sit for the CTR examination. This option applies to all newly-hired non-credentialed staff employed in the cancer registry after 1/1/2012.

Current registry staff must be credentialed by 1/1/2015, and newly-hired staff will have a one-time, three-year window to obtain credentials.

3. The Cancer Registry will have a procedural manual.

No Change or Minimal Revision to Standards

1. Standard 2.4: The Committee meeting options are clarified;
2. Standard 2.9: The monitoring of cancer conferences should lead to improving care processes;
3. Standard 4.4: Oncology nursing credentials retains a focus on OCN certification;
4. Standard 7.1: Staff education focuses on education surrounding staging, prognostic factors, and national treatment guidelines;
5. Standard 3.6: NCDB data submission has no changes;
6. Standard 3.7: NCDB quality data standards are not changed; and
7. Standard 3.8: CoC Special Studies requirement are not changed.

Minor Revision to Standards

1. Standard 2.2: With regard Cancer Committee Membership, the chair must be a physician. Coordinators have been added to required membership. Research representatives have been added to all categories, and genetic counselors have been included if services are provided on site.
2. Standard 2.5: Community outreach and quality improvement goals have been deleted. Definitions and examples may be found in the Best Practice Repository.
3. Standard 2.8: The required case presentations have been increased to 15% of annual caseload and 80% are prospective case discussions for treatment planning and must include discussion of prognostic factors.
4. Standard 2.10: The Cancer Committee is to address data errors related to the Registry data.
5. Standard 3.3: The abstracting timeliness is assessed on an annual caseload from NCDB submissions. Commendation has been increased to a 96% compliance rating.
6. Standards 3.4 and 3.5: A 96% rating for commendation has been added to standard 3.5.
7. Standard 7.2: Commendation for registrar education has been deleted.

Major Revision to Standards

1. Standard 2.7: With regard to the multidisciplinary cancer conference attendance, the Cancer Committee will develop the policy and address frequency, format, attendance, and attendance rates.
2. Standard 3.1: CTR's will be required to be credentialed by 1/1/2015. Newly-hired staff has a one-time three-year window to obtain credentials.
3. Standard 4.3: When monitoring the stage and treatment planning activity, the use of stage, prognostic factors, and treatment guidelines will be used to plan the first course of treatment.
4. Standard 4.6: The CAP protocol compliance rate has been increased to 95% of pathology reports. Reporting in synoptic format in 95% of cases will result in commendation.
5. Standard 5.2: The minimal accrual rates and commendation rates have been increased in most categories. The Community Cancer Program will now have clinical trial accrual requirements.
- 6) Standard 6.2: The Cancer Committee will assess community needs and provide one screening activity annually that addresses community needs.
- 7) Standard 6.3: The coordinator role for community outreach has been expanded to include evaluation of program effectiveness. A Community

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New CoC Standards – Is Your Program ready?

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Outreach Activity report will be required.

- 8) Standard 8.1: With regard to quality studies, the enhanced coordinator role will focus on evaluating problematic areas.
- 9) Standard 8.2: One annual quality improvement activity will relate directly to completed studies of quality and the commendation has been deleted.

Getting Ready for the New Standards with a Phase-In Period

Several new standards have been proposed. They are:

1. **Cancer Liaison responsibilities:** The CLP will be responsible for evaluating, interpreting and reporting on the facility performance using the NCDB data.
2. The **Cancer Committee attendance rate** will be 75% of members attending each meeting.
3. The provision of **risk assessment, genetic counseling, and genetic testing** must be provided on-site or by referral.
4. **Psychosocial distress screening process:** The screening and assessment of psychosocial distress, and referral to services when distress is identified.
5. **Survivorship Care Plan Process:** Programs must provide comprehensive care summary and follow-up plans.
6. **Patient Navigation Process:** Programs must focus on assessing and addressing disparities.
7. **Quality of Care Metrics for accountability measures:** Specific performance levels are set annually for each of the accountability measures and

the Cancer Committee will monitor performance through the work of the Cancer Liaison Physician.

8. **Quality of Care Metrics for Quality Improvement measures:** Specific performance levels are set annually for each of the quality improvement measures. The Cancer Committee will monitor performance through the work of the Cancer Liaison Physician.
9. **Clinical Trials Screening:** A process to screen for clinical trials eligibility is in place. The Cancer Committee identifies and assesses barriers to clinical trial participation.
10. **Annual Prevention Program:** The Cancer Committee assesses community needs and provides one prevention activity annually that address community needs.
11. **Nursing Leadership:** The criteria have been defined, and it has been agreed that this standard should move to eligibility criteria.

Implementation Timeline

The working draft will be released by the beginning of 2011. On site discussions of new standards will occur during the 2011 surveys. Beta sites will be determined to test the standards and measures.

The final standards will be released in July of 2011 and the final standards implements on January 1, 2012.

If you have any questions, please e-mail them to lferris@renown.org. You may also e-mail inputs to CPS2011@facs.org. ■



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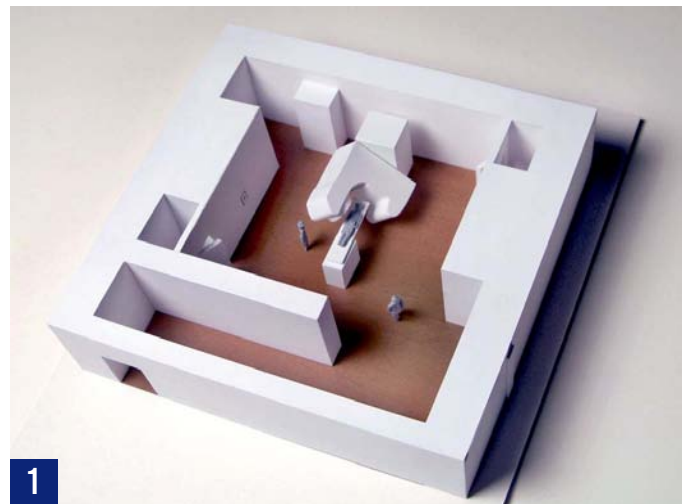
Which Way to Go: Navigating the Maze of Vault Design

By Daniel Chang, AIA NCARB
and Tim Black, LEED AP

While many factors determine the comfort and efficiency of a radiation oncology facility—and ultimately, its productivity and profitability—architects inexperienced in cancer center design typically focus on the demands of the equipment to the exclusion of other factors. Developing a cost-effective solution that meets equipment needs, maximizes productivity and comforts patients requires a higher degree of understanding of the unique demands of oncology architecture. A quick look at the myriad factors to weigh in vault design illustrates the need for an experienced oncology architect to achieve the best results for your cancer center.

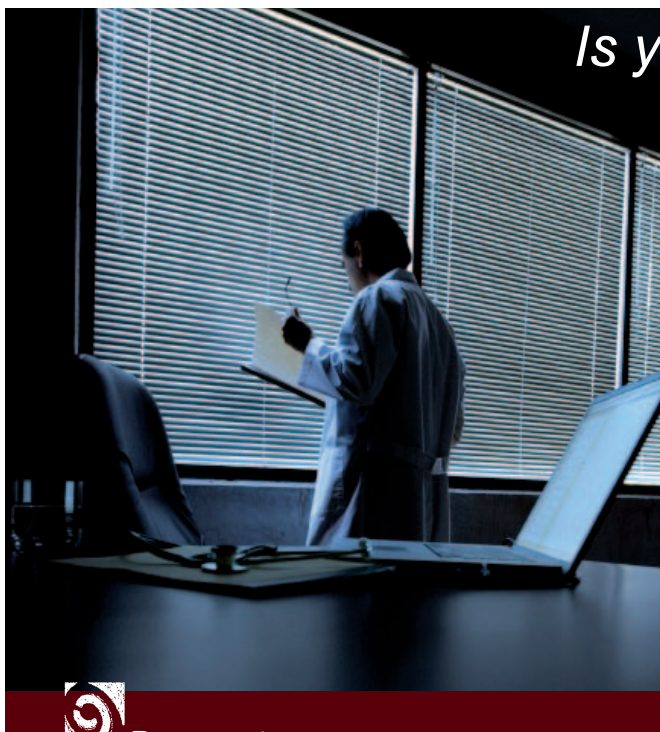
The Vault

The vault is the primary safety device employed in radiation therapy for cancer treatment. It creates an enclosure around the treatment equipment that protects staff, patients, and other building occupants from primary and secondary radiation generated during therapy. Vault construction typically uses high-density materials such as lead or block, steel, or precast concrete to provide protective shielding. Of these, the most common and economical material used is a 147 pound-per-cubic foot density, cast-in-place (poured) concrete, though other materials may be considered given space constraints. Regardless of the type of material used for shielding, the architect must still



determine how best to provide protection around the perimeter of the door. This one decision significantly affects the total facility cost, size, and location of equipment, staff productivity, patient comfort and number of treatments possible per day in each vault.

Vault entries fall into two broad categories: maze or mazeless. The maze style incorporates an internal wall that runs parallel to the entry (seen at lower left of Image 1) and creates an L-shaped corridor that terminates in the treatment space (at center). For linear accelerator equipment or a patient gurney to pass comfortably through and turn in the corridor, the corridor



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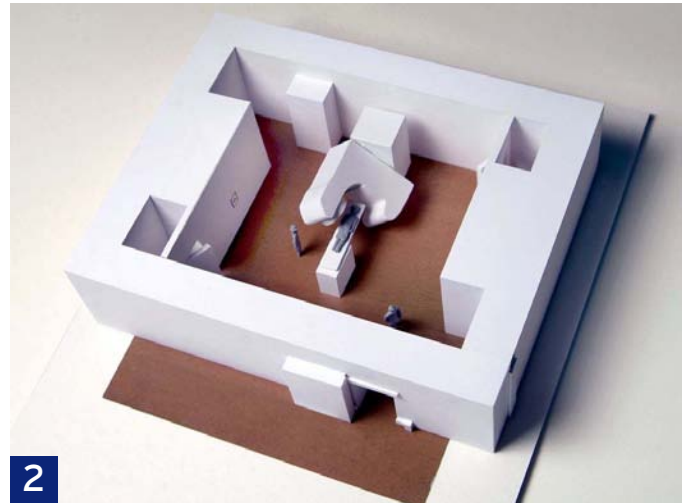
Navigating the Maze of Vault Design

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must have at least a six foot clear width, significantly increasing the overall footprint of the vault. In facilities where space is at a premium, like existing hospital settings, the 200 – 300 square feet of space necessary to accommodate the corridor may be a critical loss of area. At a cost from \$350 to \$500 per square foot for vault construction, the corridor may add approximately \$150,000 per vault in construction costs.

As a safety feature, the barrier created by a maze works quite well. The corridor “scatters” the radiation by dissipating it against the walls, effectively reducing the intensity of the radiation before it reaches the vault door. This reduction in radiation at the entry allows a less shielded door to be used and can keep the cost of the door itself to about \$30,000 to \$50,000, subject to shielding requirements. While lighter than some other options, the swing doors used in this application still weigh 4,000 to 8,000 pounds. As a result, they are difficult to operate manually, and the heavy-duty operators required to open and close the door under routine function often takes more than a minute to completely open or close. In addition, the time it takes to travel the corridor between the entry and the patient couch may add another 1 to 2-1/2 minutes to the average treatment cycle time. Over a normal day of operation, these two factors may represent from one-half to over one hour of operating time difference between using swing and sliding doors.

Matt Sherer, Director of John B. Amos Cancer Center in Columbus, Georgia, confirmed these findings in an internal review of operational efficiency employing swing doors on treatment vaults. In Mr. Sherer’s study,



three vaults with swing doors were analyzed to determine average times to open, to close, and to fully cycle, as well as total operations per day, average number of operations per patient, and average number of patients treated in each vault. Mr. Sherer found that it required nearly ninety-six minutes, or over an hour and a half to operate the doors on the three vaults. Mr. Sherer then compared this to the operating times of direct vaults with sliding doors. He found that the direct entry design only required little more than twenty-six minutes to cycle for the same number of patients. His study revealed modifying the vault entry design, and adding sliding doors would allow his facility

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Navigating the Maze of Vault Design

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to treat four more patients per vault, per day, or add a total of sixty treatments per week.

The design of a direct entry, or mazeless, vault eliminates the corridor in the overall footprint. This allows a reduction in the total size of the vault while maximizing the amount of space used for treatment and equipment. The smaller vault size also reduces the amount of real estate needed for the facility and cuts construction costs.

Lacking the concrete barrier wall that scatters radiation, however, this design requires a door with shielding equivalent to that of the vault wall (as shown at lower right of Image 2, in the previous page). In addition, this vault design needs supplemental shielding around the door opening to block any radiation leakage at the perimeter. The heavily shielded sliding doors typically used for this application weigh more than 25,000 pounds and can cost as much as \$90,000. Because of their weight, sliding doors are usually mounted on structural steel framing with a heavy-duty mechanical operator. Sliding doors do not have to open fully before the vault can be accessed, so a technician can reach the patient more quickly. In addition, the direct access design eliminates the time needed to walk through a corridor. These two elements increase staff comfort and productivity and reduce the stress patients feel when alone in the vault. In addition, by reducing overall treatment time for each patient, the direct entry design increases vault utilization.

In reality, no two linear accelerator vaults are identical, and no single design works in every facility. Site conditions dictate the vault design and a

seasoned designer can provide the best range of solutions. An overreliance on an equipment-centered approach increases the risk the vault design will fail to meet the needs of the specific treatment program. It is not uncommon for vault layouts, entries and shielding employing this approach to require extensive intervention to meet the functional needs and objectives of the cancer treatment program. An inexperienced architect can meet the technical requirements of equipment site planning guides or physicist's reports, but may overlook other critical factors in a program's success, otherwise apparent to an architect experienced in radiotherapy facility design.

To obtain the best result, the project team must work in collaboration to consider the design of the vault from all aspects. Fiscal and operational imperatives, as well as technological advances and safety, must be fully considered in selecting which approach works best for your facility. Partnering with an experienced oncology architect will help you quickly identify the key issues for your project and choose solutions that meet all your objectives. ■

Acknowledgements

Thanks to **Matt Sherer** (*Director, John B. Amos Cancer Center*), for information regarding study of operation efficiency in radiotherapy environments employing swing doors on treatment vaults; to **Jim Davis** (*President, James L. Davis, Inc.*), for information regarding the construction cost impact of vault design; and to **Walter Little** (*President, Pitts Little Corporation*), for data regarding shielded doors.

For more information regarding this article, or additional information on cancer treatment facility design, contact AE Design at studio@ae-design.com.

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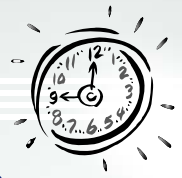
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ALL DAY **Oncology 101 Pre-Conference Program** (Separate registration fee applies)

6:00PM - 7:30PM **Annual Meeting Welcoming Reception**

THURSDAY, JANUARY 27

8:30AM - 8:45AM **Welcome and Opening Remarks**
William Laffey, ACE President-Elect, Aurora Healthcare

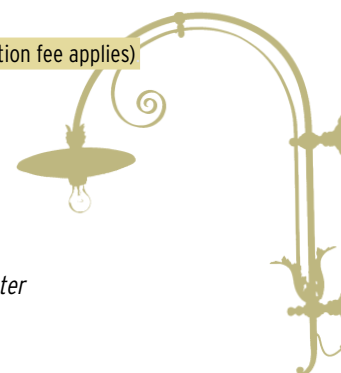
8:45AM - 9:30AM **Elekta Platinum Sponsor Keynote Speaker**
Terry McKay, ACE Co-Founder, West Michigan Cancer Center

9:45AM - 10:45AM **Patient Navigation Strategies**
Lindsay Thomas, Virginia G. Piper
An overview of the importance of patient navigation and care coordination services for newly diagnosed cancer patients and their families, including the advantages and challenges faced by navigation and coordinator programs. Such services help to ensure Patient First and Service Excellence from both the patient's and the healthcare provider's standpoint.

11:00AM - 12:00PM **Monitoring Clinical Performance/Outcomes Reporting**
Amitabha Sarma, MD, MD Anderson Cancer Center
This presentation will provide attendees with knowledge and the tools to understand:
1. Where to obtain external benchmark data at the national level in order to align internal monitoring systems with national metrics.
2. Ways to implement monitoring of Clinical Performance/Outcomes Reporting.
3. How clinical outcomes monitoring in an outpatient and an inpatient environment compare and contrast.
4. The doctor's perspective on measurement and the complexities involved in interpreting Clinical Performance data.
5. Strategies for driving improvement.

12:00PM - 1:00PM **Networking Luncheon**

1:15PM - 2:15PM **Biofield Therapy – It Ain't Voodoo Anymore**
Kathy Moreland Layte, MScN, CS, HTCP/I, Healing Touch Program
Complementary and alternative therapies (A.K.A. Integrative Therapies) bring out the best in skeptics but continue to be in high demand by the public, particularly those experiencing cancer. Oncology administrators have to make prudent decisions about meeting this demand by considering cost, safety and efficacy of CAM practices This session will focus on *Healing Touch*, a form of biofield therapy. The current state of research in this therapy will be outlined, as well as practical tips on how to introduce a trial of this therapy into your center. This therapy costs little to provide and shows promise in the promotion of health and well being of staff and patients.



Continued >



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**PRELIMINARY PROGRAM
(CONTINUED)**



Conference participants will be invited to visit the **RELAXATION STATION** in the EXPO Hall to experience **Healing Touch**, a biofield therapy (recognized by NIH) that has demonstrated significant decreases in fatigue and stress in cancer populations. Other promising research has demonstrated positive changes in IgA, reductions in pain and improvements in quality of life. Healing Touch Certified Practitioners will be on hand to help you unwind.

2:30PM - 3:30PM

Adoption of New Technology

Matthew Garabrant, *The Advisory Board Company*

With increasingly scarce revenues and physicians and public wanting the latest-and-greatest, each organization must evaluate how to adopt new technology appropriately. This session will highlight key steps to assessing and introducing new technology. The focus is not on a specific technology; case studies will reflect the need for appropriate research, market analysis and financial return.

3:30PM - 4:00PM

Refreshment Break

4:00PM - 5:00PM

Making Your Strategic Plan a Reality

Phil Okala, *University of Pennsylvania Health System*

A disciplined approach to strategic planning is critical to turning cancer program future dreams into realities. This session will illustrate the "how to" of implementing a strategic plan by outlining the related hospital committee presentations and approvals needed; budget process and timing for resources; planning groups facilitated to lead change; timelines and responsibility assignments; implementation tasks; etc. to make the plan a reality.

5:30PM - 7:30PM

Opening EXPO Reception

FRIDAY, JANUARY 28

8:00AM - 9:00AM

Expo Breakfast

9:00AM - 10:00AM

Establishing Multidisciplinary Clinics in Non-Academic Settings

Jeffrey Margolis, MD, *Beaumont Oncology Network*

To effect a change in physician collaboration and enhance quality care, some community cancer centers have used an approach built around disease-site teams. The concept of multidisciplinary disease-site teams is not new, particularly within academic medical center environments. These are now being established in many community-based institutions to help differentiate cancer services in their local communities and dictate quality, clinical outcomes, and patient satisfaction.

10:15AM - 11:15AM

Accountable Care Organizations and Medical Homes

Craig Comish, *Baptist Health System*

The speaker will introduce a basic knowledge of the definition and operation of ACOs, their key features, and legal structure. Risk components and required investments will be analyzed, as well as decision support tools utilized throughout the evaluation process.

11:15AM - 12:15PM

Break in EXPO Hall

Enjoy our Relaxation Station in the Expo Hall. Experience Healing Touch and other complementary modalities in a soothing atmosphere of music and contentment.

12:15PM - 1:15PM

Lunch - Annual Business Meeting

1:30PM - 2:30PM

Varian Medical Systems Platinum Sponsor Keynote Speaker

Joshua Lawson, MD, *UCSD Moores Cancer Center*

This presentation will address "The Future of Radiation Therapy: Clinical & Technical Applications"

2:45PM - 3:45PM

BREAKOUT SESSIONS

• Cancer Rehabilitation

Leslie Waltke, PT, *Aurora Health Care*

The NCCN estimates that as many as 70-90% of people undergoing medical management for cancer will develop one or more musculoskeletal, cardiopulmonary or functional deficit as a result of their treatment. With cancer incidence rising and mortality decreasing, more and more cancer survivors are in vital need of diagnosis and treatment of these impairments. Cancer rehabilitation incorporated from diagnosis into survivorship can eliminate, reduce or completely prevent many of the common physical side effects of cancer treatment leading to improved patient satisfaction and outcomes.

• Facility Planning

Bill Karanian, *S/L/A/M Collaborative, Inc.*

Learn to identify space needs with cancer programs; how to effectively present your findings to senior leadership; and how to work with staff to ensure the outcome meets program and patient needs.

Continued ►



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**PRELIMINARY PROGRAM
(CONTINUED)**



3:45PM - 4:00PM

Break

4:00PM - 5:00PM

BREAKOUT SESSIONS

• **Models of Genetic Counseling**

Stephanie Cohen, MS, CGC, LGC, Saint Vincent Hospital

The various models cancer programs might follow in establishing a risk assessment and/or genetic counseling program will be discussed, as well as compliance with the new CoC standard.

• **Survivorship and Psychosocial Service Models**

Karin Hahn, MD, MPH, MSc, MD Anderson Cancer Center

This session will focus on how cancer programs can establish and maintain survivorship programs which are effective and will fulfill the requirements of the new Commission on Cancer Standards.

SATURDAY, JANUARY 29

8:00AM - 9:30AM

Breakfast & Table Topic Discussions

Facilitated by ACE members

9:45AM - 10:45AM

Accreditation Under the new ACoS Standards

Daniel McKellar, MD, FACS, American College of Surgeons

The new standards from the American College of Surgeons will become effective in 2012. This session will cover the major changes from the former standards, explain the rationale behind the changes, and discuss strategies for successful compliance.

10:45AM - 12:00PM

Clinical Trials Update Panel: ASCO, NCI Centers, Community Settings

Patrick Grusenmeyer, Sc.D., FACHE, Helen F. Graham Cancer Center

Roy Herbst, MD, PhD, MD Anderson Cancer Center

Srini Kaluri, Forte Research Systems

With the recent IOM report on the need to change clinical trials due to "the program falling short of its potential," this talk will center on methods to improve clinical trial participation. Speakers from the major clinical trials research bases will discuss how academic and community programs can improve access, accrual and support of clinical trials.

12:00PM

Adjourn

PLUS: ONE-DAY PRE-CONFERENCE PROGRAM

See schedule on next page. Separate registration is required.

Oncology 101
JANUARY 26, 2011

**REGISTER FOR ONE
OR BOTH PROGRAMS!**



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ONE-DAY PRE-CONFERENCE PROGRAM

ONCOLOGY 101

ONE DAY PRE-CONFERENCE PROGRAM* ON WEDNESDAY, JANUARY 26, 2011

*Separate registration is required

New oncology administrators, new ACE Members, and those seeking a refresher course are urged to attend the one-day program, **Oncology 101**.

This program precedes the ACE Annual Meeting and will prepare you for the topics and issues that you will face as an oncology executive.

WEDNESDAY, JANUARY 26

- 8:00AM - 9:00AM **Breakfast with your ACE Member**
- 9:00AM - 9:15AM **Welcoming Remarks** - ACE Oncology 101 Co-Chairs
Cat Taylor, *South Nassau Community Hospital*
Brian McCagh, *Greater Baltimore Medical Center*
- 9:15AM - 9:45AM **What is ACE? How to Get Involved in ACE**
Bill Laffey, *ACE President Elect, Aurora Health Care*
- 9:45AM - 10:45AM **Cancer ABCs - Terminology We Use Every Day**
Matt Sherer, *Amos Cancer Center*
- 10:45AM - 11:00AM **Break**
- 11:00AM - 12:00PM **Going Outside: When and How Best to Use a Consultant**
Moderator: **Bill Laffey**, *Aurora Health Care*
Panel: **Teri Guidi**, MBA, FAAMA, *Oncology Management Consulting Group*
Kelley Simpson, *Oncology Solutions*
Marsha Fountain, *The Oncology Group*
- 12:00PM - 1:00PM **Networking Luncheon**
- 1:00PM - 2:00PM **Maximizing Your Matrix**
Patrick Grusenmeyer, Sc.D., FACHE, *ACE Immediate Past President*,
Helen F. Graham Cancer Center, Christiana Care Health System
- 2:00PM - 3:00PM **Strategic Planning**
Linda Rogers
- 3:00PM - 3:15PM **Break**
- 3:15PM - 4:15PM **Financial Reporting and Accountability**
Brian McCagh, *Greater Baltimore Medical Center*
- 4:15 pm - 5:00 pm **Q&A With Your ACE Member**
- 6:00PM - 7:30PM **17th Annual Meeting Welcoming Reception**
Oncology 101 Attendees are Welcome to Attend



REGISTER FOR
ONE OR BOTH
PROGRAMS!

REGISTER ONLINE! www.regonline.com/ACEmeeting2011

General Information



ANNUAL MEETING KEYNOTE SPEAKERS



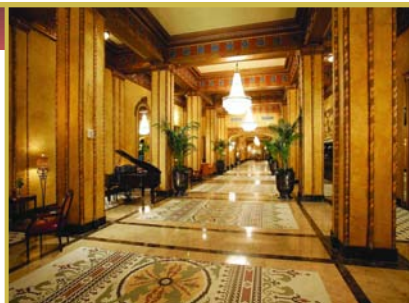
Terry McKay
CEO, West Michigan Cancer Center
ACE Co-Founder

Sponsored by:



Joshua Lawson, MD
UCSDiego Moores Cancer Center,
Department of Radiation

Sponsored by:



ACCOMMODATIONS

The Roosevelt New Orleans
The Waldorf Astoria Collection
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New Orleans, LA 70112

Reservations: 1-800-WALDORF

ACE Group Rate \$189

Contact the hotel directly and be sure to mention you are attending the ACE Annual Meeting. Come early or stay late – the world-famous French Quarter is just one block away!

2011 ANNUAL MEETING EXHIBITORS

As of Nov. 15, 2010

ACCC	FKP Architects	Pyramid Healthcare Solutions
Accuray Incorporated	Forte Research Systems	Relaxation Station
Altos Solutions, Inc.	GE Healthcare	Robins & Morton
Aptium Oncology	Genentech	Siemens Healthcare
Bogardus Medical Systems Inc.	Integrated Healthcare Strategies	The Oncology Business Institute (TOBI)
Calypso Medical Technologies	James L. Davis, Inc.	The Oncology Group
CHAMPS Oncology	National Coalition of Oncology Nurse Navigators	Tomo Therapy, Inc.
D3 Radiation Oncology Solutions	Oncology Solutions	Varian Medical Systems
Elekta, Inc.		

Connect with the attendees! Additional Exhibitor and Sponsorship opportunities are available! For details visit www.cancerexecutives.org

ANNUAL MEETING & ONCOLOGY 101 PRICING

REGISTRATION FEES / PER PERSON

Early-Bird Full Fee

PRE-CONFERENCE PROGRAM / January 26, 2011 (by 12/17/10) (after 12/17/10)

> **Oncology 101** \$ 299 \$ 349

■ **Fee includes:** Lunch and reception on Wednesday; Oncology 101 sessions; and program notebook.

ANNUAL MEETING / January 27-29, 2011 (by 12/17/10) (after 12/17/10)

> **ACE Member** \$ 649 \$ 749

> **Non-Member** \$ 899 \$ 999

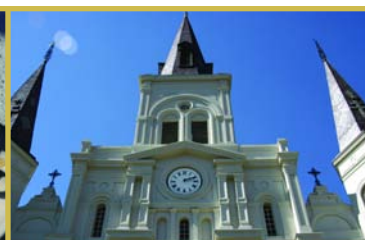
■ **Fee includes:** all Annual Meeting meals, sessions, and meeting materials on flash drive.

DAY PASS / Good only for one day of your choice

> **Thursday, January 27 / OR / Friday, January 28** \$ 299

■ **Day pass includes:** meals, sessions, and meeting materials for the one day selected.

Register today for ONE or BOTH programs!



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