ASSOCIATION of CANCER EXECUTIVES

ACE update

Renew YOUR ACE Membership today! 2011-2012 dues drive is going on now!

September 2011

cancerexecutives.org

Elekta and Product Safety: *A View From the Inside*

By Joel Goldwein, M.D., Senior Vice President, Medical Affairs, Elekta

As an industry pioneer, Elekta constantly strives to deliver equipment, software and workflow solutions that help ensure the safest patient treatments. We are committed to saving and improving the lives of cancer patients worldwide.

Radiotherapy delivery is an extremely complex process. During a single radiotherapy course, thousands of data elements may be collected and analyzed over hundreds of treatment steps. The multitude of workflows and processes comprised in these steps may vary from department to department, from disease to disease, and from patient to patient. Exact conditions in which our products must operate are nearly impossible to predict.

Nevertheless, Elekta's safety strategy is robust and accounts for these varied conditions. Indeed, safety factors are considered and reconsidered during every step of a product's life cycle, minimizing potential hazard during its lifetime.

Elekta's safety and quality control processes are highly controlled and structured, and adhere to numerous quality assurance and regulatory standards. These standards apply not only to safety in relation to general controls for design, development, manufacturing, installation, and service, but also to safety considerations for our accelerators, treatment planning systems and oncology information systems. These include safety process standards themselves, such as ISO 14971 (process for a manufacturer to identify the hazards associated with medical devices) that ensure basic requirements are met, supplemented and specifically tailored to our products. Compliance is governed by both internal and external entities, and is subject to independent audit from regulatory agencies.

Safety Built-in

Elekta has built a number of safety-related features into the products. Checklists, incorporated at various high-risk points, are

Continued on page 2 >

ACE CALENDAR

18TH Annual Meeting
JAN. 18–21, 2012
SAVANNAH, GA
HYATT REGENCY SAVANNAH

19TH Annual Meeting
JAN. 23–26, 2013
SAN ANTONIO, TX
GRAND HYATT SAN ANTONIO

20TH Annual Meeting
JAN. 29 – FEB. 1, 2014
SAN FRANCISCO, CA
PALACE HOTEL

Media Relations: *The Most Powerful Tool in Your Marketing Arsenal?*

By Brad Fixler, University of Colorado Hospital

Several months ago, our cancer center received an inquiry from a gentleman diagnosed with lung cancer. The man, in his early 30s, was a computer technologist from Africa on a worker's permit trying to earn enough money to bring his wife and two children to the U.S. But due to the rough economy, he hadn't been able to locate a job within his trained profession and instead had taken a job as an environmental services worker at, coincidentally, another cancer center in a different state.

The young man was working at this cancer center when he was diagnosed, and it so happened there were two different clinical trials underway in various locations around the country to treat the same form of cancer with which he was diagnosed. One of those trials was offered at the cancer center where he worked, but he didn't fit the profile to participate. He could, however, participate in the other trial. Our cancer center was involved in both trials, and so that's when the other center contacted us about getting him enrolled. So far, so good. This is how it's supposed to work.

As part of the process of getting him enrolled, this social worker contacted our media relations department to discuss the possibilities of gaining media coverage about this man's plight in order to raise funds for what would be a series of treatments that would require him to fly back and forth between the two centers. Our media relations department agreed and began the process of gathering the necessary information and approvals to "pitch" the story to local media in his current home state. During this process, we contacted our media relations counterparts at the other center to let them know about the situation, thinking they would take the story and run with it. But an odd thing happened.

Instead of taking over the point position of the story to their own local media, the other media relations department

Continued on page 4 >

Elekta and Product Safety

> Continued from page 1

a prime example. These checklists impose treatment interlocks that help make therapy safer and improve efficiencies.

Specific examples range from the checklist on the treatment console of a Leksell Gamma Knife® Perfexion™ that can incorporate hard interlocks when the device is not in a ready and safe state, to the MOSAIQ® Universal Timeout (or Universal Protocol) that prevents treatment from being delivered unless an authorized set of users verify they are about to treat the correct patient, to the correct site, using the correct parameters within pre-determined clinical tolerances.

Numerous other examples of safety-related features are available throughout the Elekta product line. Image guidance, used in Elekta's Synergy® system, represents an ultimate in patient site verification.

Similarly, Elekta's Clarity, an ultrasound-based soft tissue visualization product, helps assure the same level of confidence for structures not well imaged by conventional radiographic modalities without using ionizing radiation.

"The digital control system for Elekta linacs is unique in that it employs three tiers of safety, each operating independently, for absolute confidence in the delivery of radiation dose."

Multiple Levels of Confidence Throughout the Patient Experience

Elekta installed its first digital linac control system, the first of its kind, more than 25 years ago. In that time, Elekta's digital control system has been transformed as we have developed and improved it over the years. The digital control system for Elekta linacs is unique in that it employs three tiers of safety, each operating independently, for absolute confidence in the delivery of radiation dose.

- The first tier verifies the prescription when it is received from an external system like MOSAIQ. Integrity is a smart control that checks all the linear accelerator parameters are deliverable and that they are set correctly according to the prescription. This control will reject untreatable plans before the patient gets on the table or a QA procedure starts.
- The second tier checks and controls the MLC leaves, gantry, collimator and the dose delivery every 40 milliseconds to ensure that all parameters are in the correct position and the correct dose is being delivered.
- Overseeing all of this is the third tier, Guardian, which supervises and checks that all the systems are operating correctly.

Extra Steps

It is important to recognize that all the stakeholders have a role in ensuring safe product use. These include team members involved in the development cycle, all of whom are empowered and obligated to raise safety-related concerns. Stakeholders include not just developers, but also product users. And, these safety considerations pertain not just to patients, but also to product operators and service and maintenance personnel.

For our part, Elekta remains fully committed to continually improving the safety of our products and their use, to make radiation treatment one of the safest and most effective methods to treat cancer. ■

Radiation Therapy Readiness Check Initiative

As part of an ongoing commitment to safety, Elekta has embarked on an industrywide effort known as the Radiation Therapy Readiness Check Initiative. This initiative incorporates three main components aimed at assuring that by July, 2012:

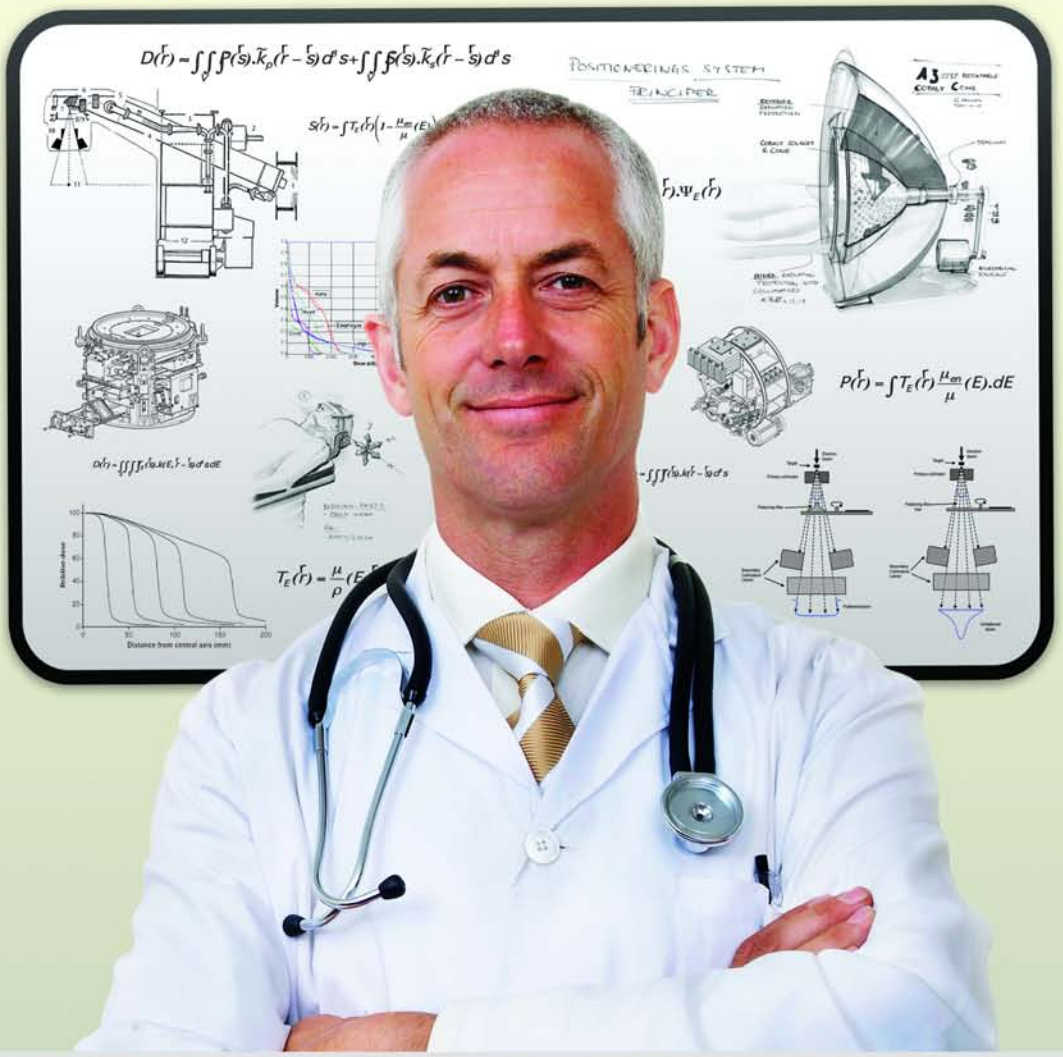
1. No treatment is delivered without pre-treatment quality assurance verification and approval.
2. All treatment accessories are verified prior to use, and no required accessories are accidentally omitted.
3. Patient position and treatment site are verified prior to treatment.

Elekta is fully committed to these initiatives, has already implemented most of them, and will provide them as retrofits to our existing MOSAIQ installed base.

Furthermore, Elekta will augment these with numerous other product safety features including wedge-free support, considerable software usability and human factor-related revisions, support for biometric authentication for both patients and users, and participation in a profession-wide universal error reporting registry initiative. Elekta is also embarking on safety-related research including an independent Failure Mode and Effect Analyses (FMEA) of our software and exploration of ways to better assure treatment quality directly at the point of delivery (portal dosimetry).

Managing complexity

so you can focus on what matters



Sophisticated therapies made easier

Radiotherapy techniques are becoming increasingly complex, requiring more time and energy to ensure safe delivery. By reducing the variables in planning, patient setup, treatment verification, and delivery, Elekta gives you greater confidence to define and raise the standard of human care. Visit us at **elekta.com/experience.**

Experience the Elekta Difference

ELEKTA

Media Relations

> Continued from page 1

had us take the lead. The resulting stories in both print and broadcast were as you'd expect: compelling and dramatic. Donations began to flow in immediately. But while factually accurate, the tones of the stories were a bit dismissive of their local cancer center's efforts for the man, almost as if they were washing their hands of the patient. Of course, nothing could be further from the truth, but, that's how the story played out anyway.

"Building a good relationship with the media [means] being accessible to them"

What should have happened was for the other center's media relations department to take the lead and guide interested local media through the story so they could control the message about what was really happening. Instead, they seemed to take a more passive approach and let the media concoct the story as they saw it. And therein lay the problem. After all, they had the local relationships, and they had the power, at least to a degree, to control some of the messaging. But they didn't, and the results weren't what they were expecting (it should be noted here that the result was something we weren't expecting either).

This case provides a classic example of what can happen when you don't take the reins on a story that is happening in your backyard. It wasn't a case of the story being pitched incorrectly, but rather a case of not leading the media through the story. And as we all know, a media story can be incredibly more influential than any ad campaign. It's the power of the objective, implied third-party endorsement. People just believe it because the media says so. So with that, here are five key points to always remember about media relations:

1. Craft your key messages carefully. Every good media relations program uses concise, crisp messages for story pitching. Make sure you know what yours are, and use them.

2. Build strong working relationships with key beat reporters and editors. If you can gain the trust of your local media (as well as national media), they will be more apt to listen to you. They'll also be more likely to call upon you as a source of information for all cancer-related stories, even if they don't necessarily have to do with your particular hospital or center. Building a good relationship with the media doesn't necessarily mean taking them to lunch or dinner, or trying to become friends with them–but rather being accessible to them. A great way of forging trust is to occasionally throw them a good story idea that may have nothing to do with your center/hospital. A reporter might see that as you simply being a friendly partner, increasing the likelihood of him/her reaching out to you in the future.

3. Be honest. Always. Never hide from the truth with reporters. Even if a story doesn't reflect positively on your institution, a good reporter will know

Continued on page 5 >

Media Relations

> Continued from page 4

when you're trying to "spin" something dishonestly to your advantage, and the repercussions of such a transgression can make a bad situation even worse. Not to mention the reporter will never trust you again. This isn't to say you shouldn't craft your responses in a thoughtful manner; just don't mislead.

"The more responsive you are, the stronger your relationships will become in the future."

4. Be proactive. Don't wait for a story to come to you. Instead, be on a constant search for positive and unique stories about patients treated at your institution that might attract the attention of a reporter, assuming, of course, you gain written approval from the patient well beforehand. Interesting clinical trials also make for good story fodder.

5. Be accessible. Nothing irritates a reporter more than not being able to reach an official source from the institution he/she is covering. Make sure all of your media contacts have your office number, cell number, pager number and email. The more responsive you are, the stronger your relationships will become in the future.

These are just a few of the basics, but they're good things to keep in mind as you chart your course for a strong media relations program. And remember, you won't always be able to control what's written, broadcast, blogged or posted about your organization. But by taking a few necessary steps and being thoughtful in your approach, you can count on your media strategy to become a shining star within your overall marketing plan.

With that, I'll leave you with one final thought:

In 1993, Al Ries, a well known ad-man, co-wrote a highly regarded book titled, *The 22 Immutable Laws of Marketing.* Concisely written and very readable, it soon became a favorite of marketing executives around the country, and its easy-to-digest gems about marketing, positioning and advertising were often preached to clients and C-level executives by advertising intelligencia everywhere. In short, it was one of those few business books that "made it" to become a part of everyday business vernacular.

But despite the word "marketing" in its title, the book really revolved around advertising. No surprise there; the author was an ad guy. However, fast forward several years to 2002, and the famous Ries came out with a new book: *The Fall of Advertising and the Rise of PR. Blasphemy!* How could the venerable Mr. Ries, creator of many successful advertising campaigns for Fortune 500 companies, make such an about-face? It was an affront to advertising professionals everywhere.

Well, here's how. He saw the light. ■

Cancer Program Success Questions

Cancer Registry *Class of Case* as a Decision-Support Resource

By Karen Gilden, Executive Vice President, The Oncology Group
and Marsha Fountain, RN, MSN, President, The Oncology Group

Analytic Cases

"Is Dr. Wayward a loyal supporter of our cancer program; or is he finding cancer among our patients and transferring them to the other community hospital for treatment?"

"How many patients leave our physicians and hospital, once cancer is diagnosed, to receive their treatment elsewhere?"

"How many patients seek breast cancer care at our institution, with our newly installed fellowship-trained breast surgeon, even when they receive their diagnosis at another local hospital?"

These questions represent some of the real-world questions c-suite executives often ask about their cancer programs. The answers to these questions are available immediately from their program's cancer registry Class of Case information. Class of Case information "most precisely describes the patient's relationship to the facility."[1]

In 2010, the Commission on Cancer revised the Class of Case categories, to provide substantive guidance for cancer registrars to more easily classify some cases. Class of Case information enables program and hospital administrators to answer such questions as how many (and what percentage of a year's cancer case volume) were:

- Cases diagnosed within the institution, but moved elsewhere for treatment (by either patient preference or physician referral);
- Cases diagnosed within the institution (by its physicians) and all or most of the first course of cancer treatment delivered by that institution's affiliated physicians; and,
- Cases which were diagnosed and treated entirely within a physicians' office practice.

The "new" (2010) Class of Case categories replaced the single-digit model used historically. The chart below provides an easy reference to the new two digit classification scheme for analytic cancer patients.

"The 'new' (2010) Class of Case categories replaced the single-digit model used historically."

Class of Case Two-Digit Classification System, Part I

ANALYTIC CASES	Class of Case Code	COMMENTS
Patients diagnosed at the reporting institution, but receiving their treatment elsewhere	00	Or, a decision not to treat was made elsewhere.
Patients diagnosed at the institution, or within a staff physician's office, and receiving all, or part of, their first course treatment there. Or a decision not to treat was made at the recording institution.	10	This is a "conversion" code that will be used less often after 2010, as it was replaced by more specific class of case codes 11, 12, 13 & 14. Replaces, in part, previous Class of Case 1 or 2 cancer cases (patients).
Patient diagnosed at a staff physician's office **AND part** of the first course of treatment was given at the reporting institution.	11	
Patient diagnosed at a staff physician's office **AND ALL** of the first course of treatment was given at the reporting institution.	12	
Patient diagnosed at the institution **AND part** of the first treatment course was given at the reporting institution.	13	
Patient diagnosed **AND received all** of their first treatment course at the reporting institution; or a no-treatment decision was made at the institution.	14	
Patients initially diagnosed elsewhere (e.g. at another, or competing, institution) but receiving all or part of their first course of treatment at this institution.	20	This is another "conversion" code that will be used less often after 2010, as it was replaced by more specific class of case codes 21 and 22. Replaces, in part, previous Class of Case 1 or 2 cancer cases (patients)
Patient diagnosed elsewhere **AND part** of their first course of treatment was done at this (reporting) institution.	21	
Patient diagnosed elsewhere **AND all** of their first course of treatment was completed at the reporting institution. Or a decision not to treat was made at the reporting institution.	22	

Registrar Jerri Linn Phillips, who is also Manager of Information Technology and Data Standards, for the National Cancer Data Base, at the Commission on Cancer, has created a decision flow-chart that explains how registrars can easily classify an analytic patient into one of the new (2010) class of case categories. (See "Figure 1" at http://health-information.advanceweb.com/Editorial/Content/PrintFriendly.aspx?CC=230823)

Continued on page 7 >

Class of Case > *Continued from page 6*

Non-Analytic Cases

The chart below provides an easy reference to the new two digit classification scheme for non-analytic cancer patients. Non-analytic cases are classified, in the "new" system, according to the reason a patient is non-analytic (to the reporting institution), or the reason a patient who never received care at this institution has had his/her case abstracted. Non-analytic cases are coded with two-digit numbers ranging from 30-49. It may be important to note that the Commission on Cancer does not require accredited institutions to abstract non-analytic cases. However, many community registries do abstract such cases; perhaps they are required to by their central registries, by the hospital, by their State Registry, or as a program or hospital institution decision.

Class of Case Two-Digit Classification System, Part II

ANALYTIC CASES	Class of Case Code	COMMENTS
Patient appeared in person at the institution		
Reporting hospital participated in the diagnostic workup (including a consult, or a staging workup, etc.) but the treatment was provided elsewhere.	30	
Reporting hospital provided in-transit care for a patient who was diagnosed elsewhere and received their 1ast course of treatment elsewhere.	31	In-transit care might include stent placement, for example.
Patient received diagnosis AND all of the first course of treatment elsewhere AND the patient presented at the reporting institution with disease recurrence or persistence.	32	Diagnosis and Treatment here Patient reports with recurrence or active disease (cancer).
Patient was diagnosed AND received all of the first course of treatment elsewhere AND presents at the institution with **disease history only.**	33	Patient presents to the institution with disease (cancer) history only.
CoC does NOT require case to be accessioned (e.g. a benign colon tumor) AND diagnosis and all of first treatment course was provided by the institution.	34	Diagnosis here & first course here. No requirement to abstract case.
Patient was diagnosed before the reporting institution's ACoS reference date AND diagnosis and all/part of the first treatment course were provided by the institution.	35	Case prior to institution's ACoS Reference Date. Institution provided diagnosis and first course.
CoC does NOT require the case to be accessioned (e.g. a benign colon tumor) AND the patient was diagnosed elsewhere, but the first course of treatment was provided at this reporting institution.	36	Diagnosis elsewhere; first course at reporting institution. No requirement to abstract case.
Patient diagnosed before ACoS reference date AND diagnosed elsewhere AND all or part of first course of treatment at the institution.	37	Case prior to ACoS Reference Date. Diagnosed elsewhere. First course (all or part) at this institution
Initial diagnosis at autopsy.	38	
Patient does NOT appear in person at the institution		
Patient diagnosed AND all of first course of treatment given at a single staff physician's office.	40	Single staff physician's office handles diagnosis and treatment.
Patient diagnosed AND all of first course of treatment given at two or more different staff physicians' offices.	41	Several staff physicians' offices handle diagnosis and first treatment course.
Case/Patient is diagnosed/treated in non-staff physician practice, or in non-AcoS- accredited facility, or case is being accessioned by the reporting institution for that "other" entity.	42	Example – when the hospital abstracts cases from an independent radiation therapy facility
Pathology or other lab specimens only	43	
Death Certificate only.	49	
Non-analytic case of unknown relationship to the reporting institution.	99	Can NOT be used by ACoS-accredited institutions for analytic cases.

It is common for academic centers to have a higher percentage of non-analytic cancer patients due to there being a referral center.

If a high number of non-analytic patients come from a certain area, it may be an opportunity to setup a new program or new services in that community. As well, a high number of non-analytic patients who are near the end of life may be able to support your palliative care program.

Registrar Jerri Linn Phillips, who is also Manager of Information Technology and Data Standards, for the National Cancer Data Base, at the Commission on Cancer, has created two graphics (see Figures 2 and 3, at http://health-information.advanceweb.com/Editorial/Content/PrintFriendly.aspx?CC=230823) that further describe how registrars can easily classify a non-analytic patient into one of the new (2010) class of case categories. ■

Reference

1 Commission on Cancer. FORDS Manual (Facility Oncology Registry Data Standards), 2010, P 97.

President's Message

William Laffey
System Director, Cancer Services
Aurora Health Care

So who are some of your most important work partners?? Who helps make your job easier and more rewarding and, at the same time, makes you look good as a leader??

Might it be your cancer registry professional who abstracts, collects and interprets data allowing you to determine whether your outcomes compare to benchmarked standards or your competitors? Maybe it's your coding department which does its best to maximize your center's reimbursement. Or perhaps the nurse navigator who works diligently to ensure that every patient has an outstanding experience.

You can add to the list as well as I can: radiation oncology manager, nutrition specialist, cancer rehab professional, social worker, financial counselor, spiritual care advisor, support group leader. And let's not forget the physicians and volunteers!

After you've put some serious thought into the original question, I'd ask you to do two things. First, provide an individual 'thank you' to everyone on your list. Send a note, make a phone call, or, best of all, walk around and tell them personally. Second, find someone in that group who might benefit from becoming an ACE member. Our organization is growing in size and diversity. Continue to assist by talking to at least one person in your own organization about the benefits of membership.

For an added incentive, please refer to our "ACE Member – Get a Member" Campaign where you can receive an unlimited number of American Express gift cards for your efforts. You should also consider this as a final reminder to submit your dues and maintain your own active ACE membership.

As I once again remind you to attend our 2012 annual meeting in Savannah, I want to thank our **Education Committee** for putting together a terrific program. I've seen the final draft agenda and there are sessions and speakers you definitely won't want to miss. Our **Vendor Relations Committee** is doing an excellent job helping obtain sponsors and exhibitors to keep our costs down. You can do your part by contacting that committee with the names of any vendor or supplier with whom you have a positive relationship and who might benefit from joining our group of business supporters.

By the time you read this, the Board will have conducted its mid-year meeting and will have received recommendations from our ad hoc credentialing work group, chaired by Wendy Austin. You'll hear about our next steps following discussion at the board meeting.

All the best, until we see each other in Savannah in January! ■

ACE Welcome New Members

Since July 7, 2011

■ **Jennifer Bolduc,** BS, CTR
Project Manager
ICFI
20 Jenness St
Rochester, NH 03867
(603)817-7769
jlrbolduc@aol.com

■ **Stacy Goetz**
Pocono Medical Center
231 East Brown Street
East Stoudsburg, PA 18302
570-476-3488
sgoetz@pmchealthsystem.org

■ **Terry Hamilton,** PHR
Human Resources Specialist
Seattle Cancer Care Alliance
P.O. Box 19024
Seattle, WA 98109
206.667.5630
tjhamilt@fhcrc.org

■ **Debra Ishihara-Wong,** RN, APRN, MN
Director of Cancer Center & Oncology Services
The Queen's Medical Center
1301 Punchbowl Street
Honolulu, HI 96813
808-537-7574
dwong@queens.org

■ **JoAnn Lovins**
Director, Oncology
Poudre Valley Health Systems
Poudre Valley Hospital
1024 S. Lemay Ave
Fort Collins, CO 80550
970-495-8382
jl8@pvhs.org

■ **Kelly McCormick-Sullivan,** MA, MS
President & CEO
Pluta Cancer Center
125 Red Creek Drive
Rochester, NY 14623
585-487-1674
kmccormick@plutacancercenter.org

■ **Joseph Mirro,** MD
CEO/CMO
West Michigan Cancer Center
200 N. Park Street
Kalamazoo, MI 49007
269-373-7456
jmirro@wmcc.org

Incorporating Genetics Into Your Cancer Center

By Stephanie A. Cohen, MS, CGC, LGC, St. Vincent Hospital Center for Cancer Care, Indianapolis, IN

"The new standard outlines what is meant by a qualified provider to offer genetic risk assessment and testing services."

Genetic testing has gained much visibility and continues to grow in importance to the care of patients in a cancer center. Results of genetic tests can guide treatment, management and screening. There are more than 20 cancer genetic syndromes with commercial testing available, and this list is growing rapidly.

The 2012 Commission on Cancer (CoC) Standards as proposed will require cancer genetic risk assessment, genetic counseling and genetic testing to be provided on site or by referral by a qualified genetics professional (Standard 2.4). Additionally, the new standards outline the necessary components of risk assessment, which are quite lengthy and do require a health-care professional to spend a significant amount of time to cover (Figure 1). These new guidelines are expected to be released in their final version July 1, 2011 to be implemented by January 1, 2012.

Figure 1: 2012 Proposed minimum standards for pre- and post-test counseling

Pretest counseling

- Collect 3-4 generation pedigree to document family medical history
- Evaluate the patient's risk for cancer and the likelihood for a cancer susceptibility gene mutation, based on the family history.
- Perform psychosocial assessment
- Educate patient about suspected hereditary cancer syndrome, including inheritance patterns, penetrance, variable expressivity and heterogeneity
- Obtain informed consent if genetic testing is performed

Post-test counseling

- Disclose results
- Discuss results, significance and impact of the test results, including management options
- Discuss informing relatives, future contacts and available resources

The new standard outlines what is meant by a qualified provider to offer genetic risk assessment and testing services. A board-certified genetic counselor would be a qualified professional according to these standards. Genetic counselors obtain a specialized Masters degree by training in genetics, psychology, social work and medicine. The American Board of Genetic Counselors (ABGC) provides certification to genetic counselors who have graduated from an accredited genetic counseling training program. A list of board certified genetic counselors is available through the ABGC website at www.abgc.net. Eleven states also currently require licensure (a listing is maintained on the NSGC website at http://www.nsgc.org/Advocacy/tabid/126/Default.aspx), and more states are in the process of passing laws. A physician who is boarded in genetics by the American Board of Medical Genetics would also fit as a qualified professional.

Continued on page 10 >

ACE Member {Get-A-Member} Campaign Starts Now!

Refer a **NEW** ACE Member to attend the ACE Annual Meeting and get a reward!

Successful referrals will receive a $25 AmEx gift card*. Referral deadline is October 31, 2011. These are the rules:

- Your name must appear on the new member's online application and your ACE membership dues must be current.
- The new referral must be registered and in attendance at the ACE 18th Anual Meeting in Savannah.
- Claim your gift card at the Annual Business Meeting during the ACE 18th Anual Meeting in Savannah.

ACE Association of Cancer Executives | 18TH ANNUAL MEETING | JANUARY 18–21, 2012 Savannah, Georgia HYATT REGENCY SAVANNAH

*One gift card per referral. No limit on how many cards one person can receive. Please contact ACE HQ with any questions: Association of Cancer Executives | www.cancerexecutives.org (202) 521-1886 | Email: info@cancerexecutives.org |

Genetics

> Continued from page 8

Nurses may be able to fulfill this role if they have received specialized training and credentialing. There is a credential for a Genetics Clinical Nurse, available through the Genetic Nursing Credentialing Commission. The requirements for this credential include 5 years of experience in clinical genetic nursing and more than 50% of the nurse's practice in genetics. The complete credential requirements are available on their website at http://geneticnurse.org/home.html. There are currently just 15 GCNs listed on the organization's website.

An advanced practice nurse (with a masters or doctorate) may serve as a qualified professional to provide cancer genetic risk assessment if they have specialized education in cancer genetics. Certification by the Oncology Nursing Certification Corporation is preferred. Finally, a board-certified physician who provides cancer risk assessment on a regular basis may be considered a qualified professional.

"Board certified genetic counselors bring many unique skills to a cancer program."

Board certified genetic counselors bring many unique skills to a cancer program. Hiring a genetic counselor to be on-site allows for program development and keeps services "in-house". Attendance at tumor boards can improve the detection of individuals who may benefit from a genetic risk assessment and benefit patients and physicians alike. Finally, the presence of a genetic counselor on-site allows for education of medical staff and increased visibility of your cancer program.

Although ideally suited to perform this role, we all recognize that board-certified genetic counselors are not highly accessible in every community. As of July 1, 2011, there are 637 members of the Cancer Genetics significant interest group of the National Society of Genetic Counselors (www.nsgc.org). The limited availability of certified genetic nurses and advanced practice nurses with experience in cancer genetics makes it unlikely that these individuals will routinely be offering genetic risk assessment. Finally, physicians, though perhaps well-qualified, often do not have the time to meet the guidelines of what should be included in the genetic counseling session.

Some alternatives to hiring a genetic counselor or genetics nurse may include using telephone-based genetic counselors, such as those employed by DNA Direct, using web- or video-based genetic counseling with a remote site or collaborating with a genetics center to offer some basic services locally and triaging more complicated cases to a board-certified genetic counselor. The benefit of using a telephone-based genetic counseling service is that the staff is board-certified and licensed, if necessary. This contractual agreement may be less expensive than hiring a genetic counselor to be on-site if patient volume is low. The down-side is that there is no program development or access to other health-care professionals within your cancer center. Web-based genetic counseling, or telegenetics, may offer the ability to reach a wide geographic area. If you are from a hospital-system with multiple sites, this would allow a "shared" board-certified genetic counselor in one location to serve many different sites efficiently without losing time traveling. Hiring a board-certified genetic counselor and then setting up a collaborative approach using locally-trained nurses or medical staff allows for triaging cases so that access can be improved while keeping services within the local communities. This strategy allows a smaller site the ability to have some oversight by a highly trained professional and frees up time for the genetic counselor to focus on the most complex cases. Multiple sites can be served by this approach, again improving accessibility.

Another important note is the need for cancer genetics service providers to receive on-going education. Genetics is an ever-changing field, with new advances occurring on a daily basis. For genetic counselors, board certification requires on-going education at the rate of 125 contact hours every 5 years and licensure in most states is in line with this requirement. Without this ongoing training, regardless of specialty, there is a risk of a gap in knowledge leading to below-standard care.

In summary, these new CoC standards are aimed to improve access to quality genetics services that affect management and treatment, which ultimately will improve patient outcome and satisfaction. ■

ASSOCIATION of CANCER EXECUTIVES

ACE Update is published by
Association of Cancer Executives (ACE)
1025 Thomas Jefferson Street NW
Suite 500 East | Washington DC 20007
202.521.1886 | Fax: 202.833.3636
www.cancerexecutives.org
© 2011 ACE. All rights reserved.

JOIN A COMMITTEE!
To learn more about ACE Standing Committees visit
www.cancerexecutives.org or send an email to:
info@cancerexecutives.org

YOUR FEEDBACK IS IMPORTANT TO US!
ACE appreciates suggestions to better serve you.
E-mail your questions or comments to:
info@cancerexecutives.org

Update on the Cancer Program Standards 2012 Project and CoC Resources to Support the New Standards

By Connie Bura, Administrative Director of Cancer Programs, American College of Surgeons

The Commission on Cancer's (CoC) new standards for accreditation – ***Cancer Program Standards 2012: Ensuring Patient-Centered Care*** – are scheduled for implementation in 2012 by hospital cancer programs participating, or interested in participating, in the CoC's accreditation program.

The CoC standards and survey process have routinely been reviewed and revised every five to seven years in an effort to remain relevant and to reflect current cancer care practices. The current standards have been in place since 2004 and a Steering Committee was convened in 2009 to begin the review and revision process. The main goal of the revision process has been to define standards that focus on the entire continuum of care in order to embrace and address needs of the whole cancer patient. The Steering Committee included broad representation from all disciplines and organizations committed to improving, and providing optimal, cancer patient care. It has been important to the CoC to ensure that the accreditation process remains valuable to institutions, providers, quality improvement organizations, and the public, and that the new patient-centered standards increase the level of service provided to patients.

A working draft of the standards was released to all CoC-accredited cancer programs in February 2011 and select new standards were pilot tested between January and June 2011 at 50 cancer programs surveys representing facilities from all accreditation categories. The purpose of the pilot was to assess programs' ability to comply with the newly proposed standards. Pilot results were primarily positive, with most programs currently meeting most of the new standards, or able to meet with minimal effort beginning in 2012 and beyond.

The pilot survey results and feedback from CoC-accredited programs on the working draft were reviewed by the Leadership Team in June. The Leadership team made final modifications to the standards, defined the commendation criteria for select standards, and confirmed the requirements for NCI-designated comprehensive cancer centers. Final approval of the standards resides with the CoC's Accreditation Committee, which will be meeting in July 2011. This work will culminate in the final release of the standards in late August to include a comprehensive manual available as a PDF download from the CoC Website (www.facs.org/cancer) or for hard-copy purchase from the CoC for $50.00.

Major highlights include:

- Creation of 12 eligibility requirements that form the basic structure, resources, and services provided by cancer programs seeking CoC accreditation.
- Categories for accreditation were refined based on the scope of cancer

Continued on page 11 >

ACE Thanks Our 2011–2012 Corporate Sponsors

PLATINUM

ELEKTA

VARIAN medical systems

GOLD

Oncology Solutions

GE Healthcare

SILVER

CHAMPS Oncology

Radiation Business Solutions

The Oncology Group

BRONZE

Integrated Healthcare Strategies

Contact ACE HQ to learn more about our Corporate Sponsorship Opportunities

Update on CoC Cancer Program 2012 Standards

> Continued from page 80

program services, resources, and cancer caseload. Category names have been changed to more accurately represent the nature of the cancer program.

- 34 total standards will be announced, including several new standards focused on patient-centered care and quality and outcomes.
- New patient-centered standards address genetic assessment and counseling, palliative care services, patient navigation, psychosocial services, distress screening, and survivorship cancer plans.
- New quality and outcomes standards address clinical trial accrual, quality of care metrics, studies of treatment planning, studies of quality, and improvements in patient care.

"The CoC has been working on the development and dissemination resources to support cancer program implementation of the new standards"

- The following standards will be phased in, with programs required to demonstrate compliance by 2015:
  - Patient navigation
  - Psychosocial distress screening
  - Survivorship care plans
  - Clinical trial accrual
  - Cancer registrar credentials
- Cancer programs scheduled for survey in 2012 will be required to demonstrate compliance with the current 2009 standards representing cancer program activity from 2009, 2010, and 2011. At the time of survey, surveyors will discuss the new standards with the cancer committee, including current implementation strategies.
- Cancer programs will need to begin working with the new standards in 2012 and demonstrate compliance beginning with 2013 surveys.

Resources to Support the New Standards

The CoC has been working on the development and dissemination resources to support cancer program implementation of the new standards.

The following resources will be accessible from the CoC Website at www.facs.org/cancer:

- **Webinar Series:** Scheduled for release in September 2011
  - Webinar Series – Part 1: Supporting Cancer Program Operations to include Eligibility Requirements, Categories for Accreditation, Awards, and the Outstanding Achievement Award, Cancer Committee Leadership Role, and What to Expect on Survey Day/Survey Process, and Quality Centered Standards to include Clinical Trial Accrual, QI and Quality Studies, and Accountability and QI Measures.
  - Webinar Series – Part 2: Supporting Patient Centered Standards to include Patient Navigation, Psychosocial Distress Screening, Survivorship Cancer Plans, Cancer Risk Assessment and Genetic Testing, and Palliative Care Services.
- **Video Vignettes:** Scheduled for release in late 2011
  - 5-minute video presentations on each standard.
  - What is the standard and its definition?
  - Compliance criteria (i.e., documentation).
  - Strategies/best practices for compliance.
  - What doesn't meet the standard?
  - Resources to support the standard.
- **Workshops:**
  - Survey Savvy, September 15–16, 2011 in Los Angeles, with two additional workshops planned for 2012.
- **Best Practices Repository:** Scheduled for release in September 2011
  - Specific examples and resources from accredited cancer programs and organizations to assist CoC-accredited programs with implementation and compliance for each standard.
- **CAnswer Forum:**
  - Repository of questions and answers about cancer program and data standards.
  - Registered users can post and respond to inquiries about the CoC standards.

In conclusion, the benefits of the proposed standards have:

- Established minimum thresholds for all CoC-accredited cancer programs through new eligibility criteria
- Increased depth through the addition of standards to address the full continuum of care
- Increased focus on cancer committee leadership through expanded coordinator and CLP roles
- Increased focus on the quality of care through performance metrics and quality improvement activities.

With the new patient-centered focus of the standards, the CoC hopes to see the results of this work have a far reaching and significant impact on the care of cancer patients throughout the United States. ■

ACE Members on the Move

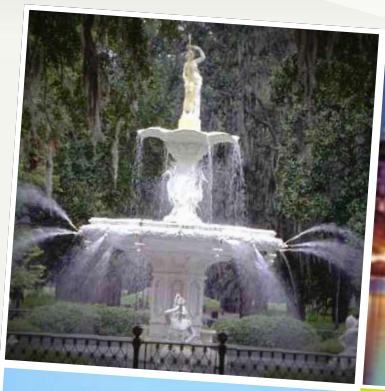
Effective in April 2011, **Matt Sherer** has taken a new role as the Oncology Service Line Administrator with Tallahassee Memorial Healthcare, Inc. in Tallahassee, Florida. Matt is responsible for all oncology services within the organization which include radiation oncology, medical oncology, infusion, tumor registry, navigators, clinical research, and inpatient unit. Previously, Matt was the Administrative Director with the John B. Amos Cancer Center in Columbus, Georgia. ■

Share Your News!

Achievements
Program Changes
Staff Honors
Events
Transitions
New Facilities

Announce it in *ACE Update!*
Send your news and press releases to:
info@cancerexecutives.org
– attention *ACE Update.*

Join your colleagues in Savannah in 2012



ASSOCIATION of CANCER EXECUTIVES

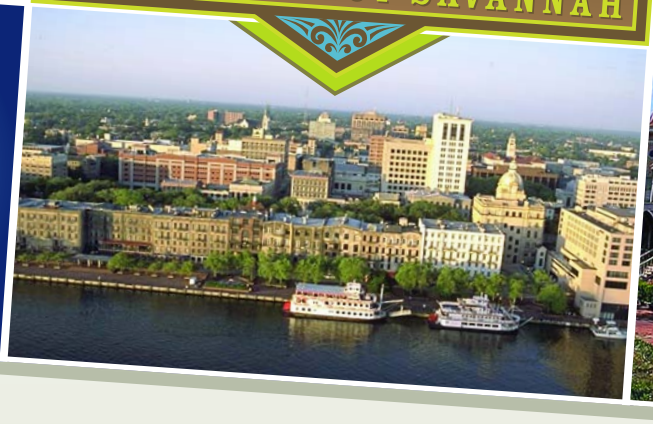
18th ACE ANNUAL MEETING

*Savannah * Georgia*

JANUARY 18—21, 2012

HYATT REGENCY SAVANNAH

THE MUST-ATTEND EVENT *of the* YEAR *for* ALL ONCOLOGY ADMINISTRATORS



Come to Savannah in January and learn how to effectively steer your cancer center through today's emerging challenges. **If you are an oncology administrator, this is the event that you do not want to miss.**

- ✔ Educational sessions with expert speakers and continuing education credit
- ✔ Great networking opportunities
- ✔ Latest technologies and services in EXPO Hall
- ✔ Walk away with tools and strategies that you can implement right away!

EXHIBITOR & SPONSORSHIP OPPORTUNITIES AVAILABLE!

For details contact ACE at (202) 521-1886 or info@cancerexecutives.org

Registration information is coming soon! | Stay tuned at **www.cancerexecutives.org**