

# 2011 American Cancer Society Stewardship Report

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The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and service.

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# Letter from the Chair of the Board and President

To Our Readers:

***At the American Cancer Society, we are obsessed with numbers.*** Every percentage point in cancer statistics represents countless people touched by a cancer diagnosis – personally or through a loved one. Every dollar people contribute to the Society is an expression of trust and hope. Every vote by lawmakers; every research study; every point of contact with people who need help – they all correspond to years of hard work by millions of people. And that hard work gets us closer to the best numbers of all – more lives saved, and a world with more birthdays for everyone. We do not take numbers lightly.

Fifteen years ago, the Society set aggressive goals for the year 2015, to measurably reduce the impact of cancer, decreasing cancer mortality by 50 percent, reducing cancer incidence by 25 percent, and improving quality of life for people with the disease. We as a nation have made significant progress toward those goals:

- We celebrated in recent years as, for the first time, both incidence and death rates for all cancers combined were reported to be decreasing for both men and women.
- Since the decline in cancer deaths began in the early 1990s, we have helped avert more than 767,000 cancer deaths. Today, we are helping avert 350 cancer deaths each day.
- Overall five-year relative survival rates continue to improve – from 50 percent in the late 1970s to 66 percent today.
- The more than 11 million Americans who are cancer survivors are living proof of our progress.

Current trends point toward a 30 percent drop in cancer mortality by 2015. That translates to millions of cancer deaths avoided, but the American Cancer Society is not satisfied. We are on target in our goals regarding a few specific cancers – colorectal, breast, and prostate cancers – but if trends stay on their current path, we won't meet our overall goal of a 50 percent reduction. And, though we are making great progress in this country, our work here, and around the world – where cancer is a growing pandemic – is clearly far from finished.

Our chief executive officer has laid out a bold vision for our organization to save even more lives from this disease – potentially 1,000 lives per day in the United States and thousands per day worldwide – because our mission, and those who support it, deserve relentless action. That's why we're transforming our century-old organization to find new and better ways to tackle the challenges of fighting this disease. We're examining our operating model, which although it has evolved over time, has not fundamentally changed since the 1950s. And we're looking from every angle at how we do business to ensure we're having the greatest impact possible on this disease. We are proud to be part of an organization that constantly challenges itself to do what is best in the interests of those we serve and the mission we pursue – and we believe it is possible to achieve even greater progress toward our goals.

This report tracks progress on our goals thus far. It reports on the Society's cancer-fighting programs nationwide and on our focus in the areas that will have the greatest, and fastest, impact on saving lives from cancer. It discloses the numbers that add up to the business of fighting cancer: fundraising, expenditures, and more.

The resources entrusted to the Society to fight this disease are a signal to us of our duty to lead in public disclosure. Operating the world's largest voluntary health organization dedicated to fighting cancer is no small task, requiring a nationwide organizational structure. Yet we are as committed to providing the same – or greater – levels of ethical commitment, sound governance, and accountability as other organizations of our size, be they for-profit or nonprofit.

We hope as you study this report, you will feel a sense of our aspirational accountability and the organizational integrity we believe is the backbone of the Society and of the nonprofit sector. As part of the Independent Sector's Panel on the Nonprofit Sector, the Society helped develop a comprehensive report to Congress on strengthening transparency, governance, and accountability among nonprofit organizations. Releasing this report is an important sign of our own organization's commitment to those ideals.

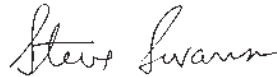
Our contributors are our investors in the fight against cancer. And we need your support in these tough economic times, more than ever, because cancer never sleeps. We want you to know how we are investing your dollars, and our pledge is to be accountable to you in this report. That is why we have modeled this document on similar reports released by many public companies in America. We hope it is helpful and informative. And, we hope you will contact us with any ideas or questions.

Thank you for your support as together, we are saving more lives from cancer every day and moving closer to a world where this disease can never steal another year of anyone's life – a world with more birthdays.

Sincerely,



Edward E. Partridge, MD  
President



Stephen L. Swanson  
Chair of the Board

# Report from the Chief Executive Officer

Dear Supporters,

We are at a critical point in our fight against cancer. There has perhaps never been a more exciting, or challenging, time to be involved in this fight, because we know how to bring cancer under control as a major public health problem – and save thousands of lives per day worldwide – if we do the right things.

Science has made significant progress in unraveling the mystery of cancer, but our world is not doing enough with what it knows. That is why it is so critical to us – and to you – that we do the right things with the resources you provide us.

While we're already saving 350 lives per day in our own country that would have otherwise been lost to cancer, the American Cancer Society is not content to rest on the laurels of that progress. We're working relentlessly to save more lives worldwide, seizing what is not only an incredible opportunity, but also a compelling duty. We believe it's possible to turn those 350 more lives per day into 1,000 lives per day saved from cancer in the United States – and we're working to make that a reality as quickly as possible in the coming years. Long term, we believe it's possible to see a world where people are celebrating even more birthdays every day – potentially 10,000 each day worldwide. To realize these goals, and to one day see a day where cancer can no longer steal another year of anyone's life, we must fight cancer on a global scale, where the disease has never been a greater threat, both as a cause of death and as an economic burden. The Society is a complex organization that does precisely that.

We are a nationwide organization with a strong local community presence and a growing global reach that works collaboratively around the world to reduce human suffering and help save lives.

By fighting for every birthday threatened by every cancer in every community, we have helped create a burgeoning cancer survivor population in this nation. To accelerate our progress and save even more lives, we are transforming our organization, working to bring cancer under control as early as possible in this century. We believe that is a possible dream, simply by applying what we already know about cancer. But what's more, it's a moral obligation, because of the nature of our cause. We are pursuing every avenue to make our own organization more efficient, effective, and as uncompromising as possible as we battle cancer. This disease is a fierce enemy – but we are fiercer.

Your support has made – and will make – our success possible. As a nonprofit business and voluntary health organization, we have always worked hard to focus our resources to save the most lives in the shortest amount of time. Once we challenged the nation to accelerate the war on cancer with our 2015 goals, we challenged ourselves to focus on ways our organization could play a unique role and make the greatest impact on the disease.

Our leadership roles (described in the business section of this report) provide that focus for the nationwide Society – our national headquarters, 12 Divisions, and our nonpartisan advocacy affiliate, the American Cancer Society Cancer Action Network<sup>SM</sup> (ACS CAN). They help our organization work toward achieving common goals while allowing for local flexibility to address discrete community challenges.

As we monitor the nation's progress against the disease, we measure ourselves against a rigorous set of established metrics. We are pleased to share our dashboard measurement instruments later in the report. These tools allow us to benchmark our success and challenges, adjust strategy, and continually evaluate the effectiveness of our programs.

The Society has been very successful raising money from committed individuals by leveraging our historic grassroots network of supporters. Many of our fundraising activities, like Relay For Life® events, raise more than money. Our Relay events alone allow us to reach 3.5 million people yearly in 5,100 communities nationwide and 19 other countries with lifesaving cancer information and opportunities to contribute to our patient support and advocacy work, doing so much to help people fight cancer on all fronts.

We are conservative in our policies – we uphold the highest levels of ethical accounting practices. As a result, the national Society holds the Better Business Bureau’s Wise Giving Alliance National Charity Seal.

While we have accomplished a great deal in the cancer fight, there is hardly a moment to pause and reflect on our milestones. Our sights are set on an ambitious goal, and we are moving forward relentlessly to reach it.

Thanks to our legion of supporters and our dedicated volunteers and staff, we have the potential to save millions of lives in the coming years. I invite you to take stock of our work toward our goals and the strategy behind them. We hope you will agree the Society spends its time and money efficiently and achieves measurable results as we continually challenge ourselves to be the best possible stewards of your trust and support. Should you have any questions or suggestions with respect to our mission, enterprise, reporting, or ways in which we can be more effective, please do not hesitate to contact us.

With gratitude,

A handwritten signature in black ink, appearing to read "John R. Seffrin". The signature is fluid and cursive, with the first name "John" being the most prominent.

John R. Seffrin, PhD  
Chief Executive Officer  
American Cancer Society, Inc.

# The Critical Point

The “critical point” referred to in the introductory letter from our CEO, John R. Seffrin, has to do with more than just the fight against cancer. There are new realities facing the Society and the entire nonprofit sector that have resulted in a convergence of concerns from all of our stakeholders, including regulatory groups and legislative bodies. This has surfaced a wide range of issues which can be distilled into one urgent and important imperative: the expectation that nonprofits demonstrate, explicitly and measurably, that they are being effective in fulfilling their missions.

The overarching issue of effectiveness has become a lens through which to look at virtually all aspects of how nonprofit organizations function today – and how well. The critical point both the Society and the sector have reached is about being sure that we understand and can meet those expectations, that we can stay aligned with what our stakeholders need, today and tomorrow, and that we can deliver on those expectations according to the highest possible standards of organizational governance, accountability, transparency, and stewardship of the resources entrusted to us.

These expectations start with the strategy for achieving the core mission. And it’s not just the strategy that is needed today, but also for the future. Stakeholders want to know the strategy is relevant to the problems we’re tackling and constantly evolving. It can’t exist in a vacuum from the trends, broad and specific, that most directly impact fulfilling the mission and the management of the organization.

Effectiveness is also about how well the organization is being managed, through good economies and bad, from top to bottom. That begins with raising the money needed to fulfill the mission and the spending of it on programs and services that help achieve the mission – and then everything else to support the organization, from paper clips to travel expenses.

But management effectiveness encompasses so much more about the organization and its ability to succeed in the best interests of its stakeholders. The degree of that effectiveness, and how it’s demonstrated, is an issue that corporations in the for-profit sector have had to face for decades – and even more so today. Although we may not be publicly traded, the nonprofit sector is publicly held – and it is only right that the same expectations apply today to the independent sector that have long applied to the corporate world. The Society not only welcomes these expectations – we also help develop best practices in nonprofit operations and governance.

Front and center in these converging trends is the subject of the salaries of the top nonprofit executives. How are those compensation levels determined? Are CEOs and other top executives worth every dollar they are paid? How is CEO performance measured? Could the same results in the mission be achieved at lower compensation levels for top management? These are just some of the questions about compensation – and they’re all important. No nonprofit organization can ignore them – and must continue to address these issues to reach maximum efficiency. These are also pressing issues among members of Congress who are mindful of their duty to protect the public interest – the public that provides donations to nonprofits and the public that is receiving their assistance as they fulfill their missions.

The Society acknowledges the importance of these issues and the trends they suggest. We believe our commitment to accountability, transparency, and best practices in corporate governance gives us the focus and discipline to address these issues head on and to read and understand the trends and adapt and evolve as needed. This willingness to change is not new to the Society. In our nearly 100-year history, while we have always remained focused on battling cancer, and changing as needed to win that fight, we have kept an eye on the shifting landscape and climate around us.

One such shift has been the new disclosure standards issued by the Internal Revenue Service for nonprofits. The “new” IRS Form 990 requires much more detailed information from organizations about compensation levels, how they are determined, and the various financial transactions that are entered into and with whom, among other information. The Society, of course, fully complied with these new disclosure requirements. This means that our National Home Office, and each of our operating Divisions, 13 at time of filing, filed separate Form 990s.

The critical point the Society is facing can be summarized purely and simply as the challenge to define and measure our overall effectiveness. We have included metrics for measuring that effectiveness in this report. We also believe this report itself is a measuring stick and therefore part of fulfilling our obligations to our stakeholders. At the same time, however, the Society, and the nonprofit sector as a whole, have a long way to go in demonstrating effectiveness at the level of interest and meaning that is and will continue to be expected of us. That means finding new, more precise, and meaningful metrics. We recognize that and will continue the work needed to not just meet, but to exceed those expectations.

# Battling Cancer

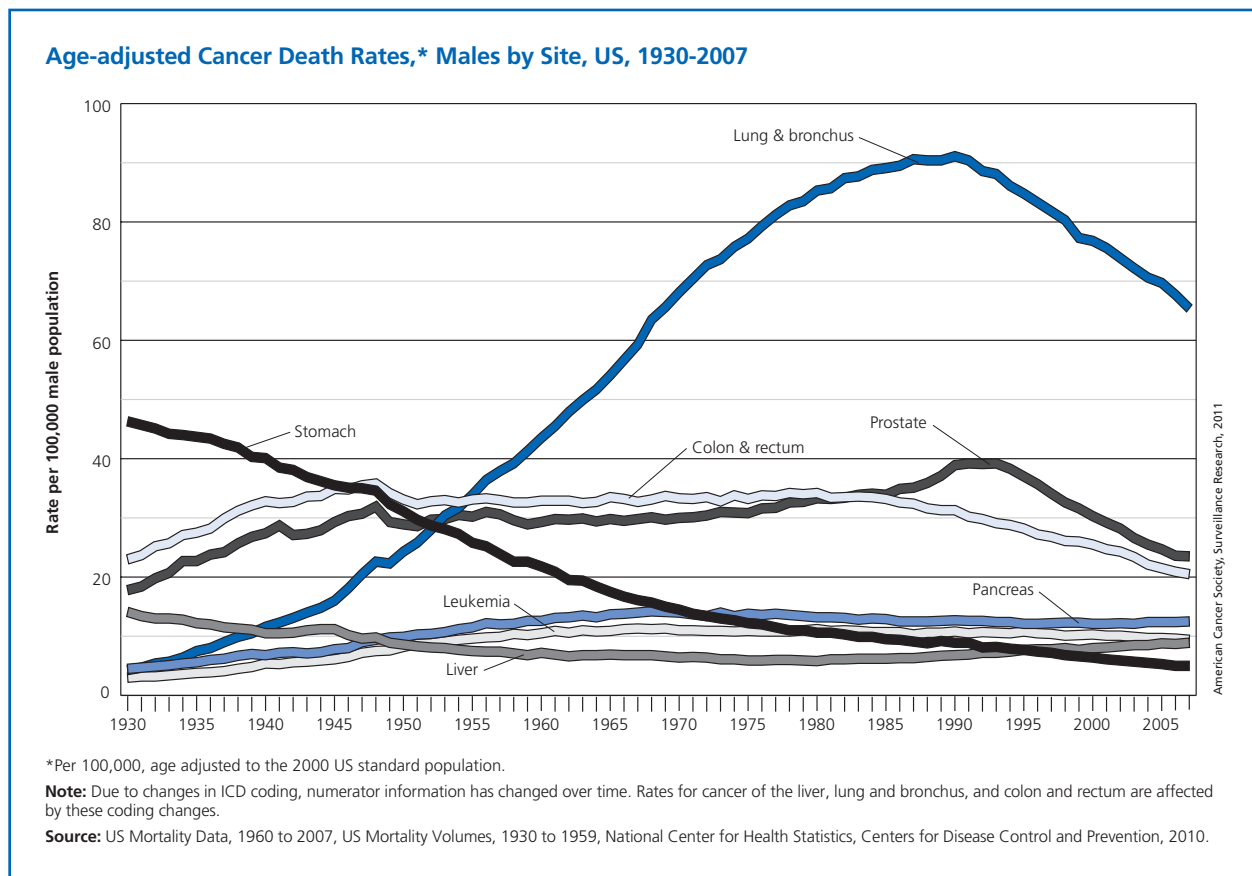
## THE FIGHT CONTINUES

It seems simple enough: Cancer develops when cells in a part of the body begin to grow out of control. Although there are many kinds of cancer, they all start with out-of-control replication, cell death, and loss of normal cell function. So the answer would seem obvious – just stop runaway cell replication. But the problem and the solution are much more complex. Cancer tops the list of Americans' health concerns because it is still a prevalent, and often deadly, disease.

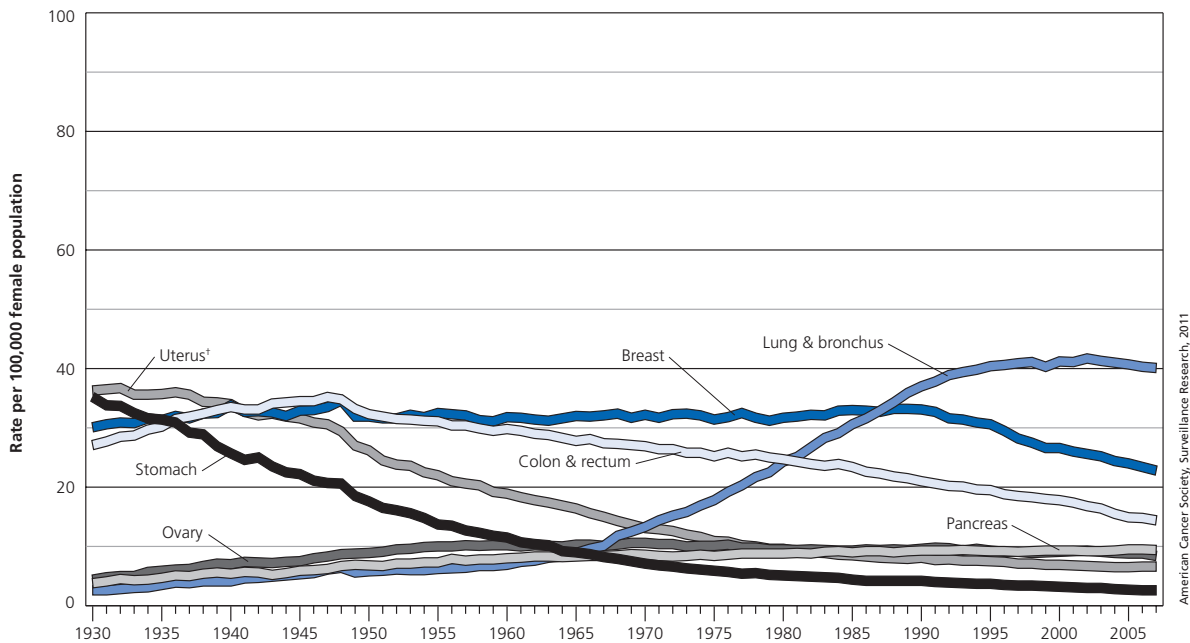
The good news is that science has made great headway in figuring out how to stop many cancers. When Congress and President Nixon declared war against cancer in 1971, pushing it to the forefront of our nation's public health priorities, cancer was largely a death sentence. Nearly four decades later, America's research investment has reaped remarkable returns.

Today, early detection can halt common cancers such as those of the cervix, breast, colon, and prostate, which represent more than half of all cancers. We now have strategies that can help prevent many cancers from starting at all. And the development of treatments such as Gleevec and Herceptin has shown how specific molecules can target and block cancer-causing abnormalities.

In fact, mortality rates have declined for almost all major cancers for both men and women:



### Age-adjusted Cancer Death Rates,\* Females by Site, US, 1930-2007



\*Per 100,000, age adjusted to the 2000 US standard population. †Rates are uterine cervix and uterine corpus combined.

**Note:** Due to changes in ICD coding, numerator information has changed over time. Rates for cancer of the lung and bronchus, colon and rectum, and ovary are affected by these coding changes.

**Source:** US Mortality Data, 1960 to 2007, US Mortality Volumes, 1930 to 1959, National Center for Health Statistics, Centers for Disease Control and Prevention, 2010.

Thanks to these advances, cancer survivorship has now become part of our vernacular. There are more than 11 million Americans alive today who have a personal history of cancer – twice the number of survivors as 30 years ago. We expect this number to double again in the next two decades.

Yet, despite this progress, cancer remains the leading killer in the United States for those under age 85 and accounts for one of every four deaths. This year, about 1,529,560 new cancer cases are expected to be diagnosed and approximately 569,490 Americans are expected to die of cancer – more than 1,500 people a day. In addition to lives lost, the National Institutes of Health estimated overall costs for cancer at \$263.8 billion in 2010, including \$102.8 billion in direct health expenditures. Moreover, medically underserved populations continue to bear a disproportionate cancer burden, underscoring the need that more research is required to address the health disparities gap.

While the new health care legislation will certainly help in providing coverage to these underserved populations, considerable work will still have to be done to close that gap. In our view, the reform legislation is not as much a solution as it is a blueprint for one. It will take months and years of hard work to build a system that works for people facing cancer and their families, and that effectively addresses cancer disparities.

And advocacy is only one of the ways the Society is working to reach medically underserved populations. We're also working through education programs, community outreach initiatives, and through collaborations with other organizations to ensure no communities have to face a disproportionate cancer burden.

Without some improvements very soon, changing population demographics will make the situation worse. Cancer can strike at any age, but it is a disease that disproportionately affects the elderly. More than 75 percent of all cancers are diagnosed in people 55 and older, while 70 percent of all cancer deaths occur in people 65 and older. Indeed, cancer is the leading cause of death for Americans aged 60-79. As the baby boomers reach retirement age, we will see the number of Americans older than 65 double in the next 30 years, translating to a dramatic increase in the number of new cancer cases.

The bottom line: though we are making great progress, it will require fast action to keep pace with growing needs.

## WHY WE STAND APART – WE SAVE LIVES

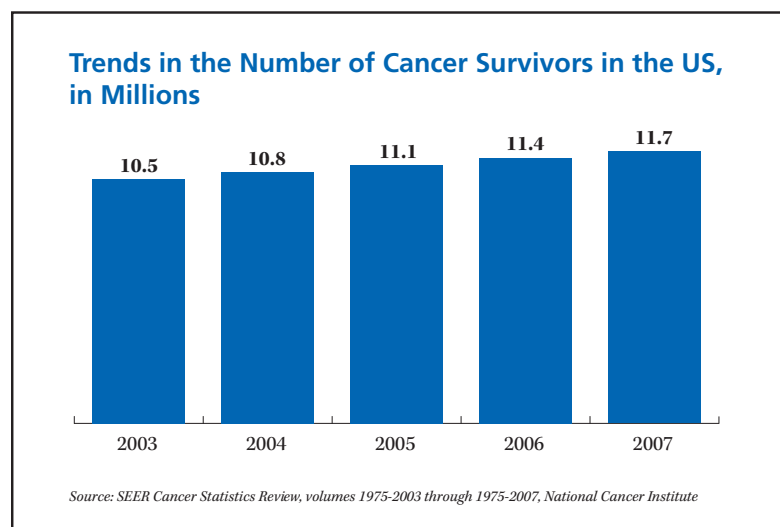
Most people know the Society for its groundbreaking research program, which has done so much to find cures and help us better understand cancer. Yet the organization has long been a visionary change agent on all fronts – and has truly transformed the landscape of the disease.

In less than 100 years, the American Cancer Society has turned cancer from a taboo topic into a rallying cry for change, ushering in an era where more people survive the disease than die from it in this country.

By taking what we've learned through research and translating it into action, we have contributed to a 16 percent decrease in the overall cancer death rate just between the early 1990s and 2006. That means that we helped avoid about 767,000 cancer deaths during that time.

Recent downturns in lung cancer mortality in America, for example, are possible in large part because of the Society. Beginning by confirming the link between smoking and lung cancer, the Society has worked tirelessly since the 1950s to educate people about the dangers of tobacco, de-normalizing its use with increased taxes and smoke-free laws that now cover most of the nation.

Lifesaving cancer screenings like the Pap test and the mammogram are also common practice today in part because of the Society's promotion. The tests have respectively moved cervical cancer from the second leading cause of cancer death in women to the thirteenth, and helped breast cancer death rates decline steadily each year.



## FIGHTING CANCER AROUND THE GLOBE

Because cancer knows no boundaries, the American Cancer Society's mission to eliminate cancer as a major health problem extends around the world. Better prevention, early detection, and advances in treatment have helped some high-income countries lower incidence and mortality rates for certain cancers. In low- and middle-income countries, however, cancer is a growing problem. In 2007, cancer accounted for 7.6 million deaths globally – *more than AIDS, malaria, and tuberculosis combined*, according to the World Health Organization. This figure is expected to rise to 12 million by 2030, largely due to the growth and aging of the population and the impact of unhealthy lifestyle behaviors. In 2010, the Society invested approximately \$7.2 million in global activities, with an additional \$6.1 million raised in restricted funding for global programs.

In collaboration with other cancer control organizations, the American Cancer Society advances its global mission through evidence-based programs to make cancer and tobacco control a priority on global health agendas. These programs include cancer advocacy and tobacco control measures such as increasing funding for tobacco control, increasing tobacco taxes, and creating smoke-free workplaces and public places globally. The Society's global program emphasizes issues where we can help determine and achieve a measurable impact, in regions where there is a clear need and the capacity for change.

# About the American Cancer Society

## WHAT THE AMERICAN CANCER SOCIETY DOES

It's clear that during the past century, the American Cancer Society has had a tangible effect on the fight against cancer, saving lives and serving as a round-the-clock resource for people facing the disease. How do we achieve measurable results? Across the board, the Society fights on all fronts to achieve victory against cancer, whether that means:

### ***Helping People Stay Well***

We're not just a disease-focused organization – we're a wellness-focused organization. The Society does so much to make sure people never get cancer and to help people everywhere live healthier lives, because we know that half of all cancers are preventable.

### ***Helping People Get Well***

Whether it's the middle of the day or the middle of the night, the American Cancer Society is there for people facing cancer and their loved ones. We help guide people through every step of a cancer experience, so they can focus on getting well.

### ***Finding Cures***

The Society has long been at the forefront of the scientific battle against this disease. It's one of the many – and most vital – ways we save lives: by funding and conducting research to help better understand, prevent, detect, and treat cancer.

### ***Fighting Back***

Across the nation, the American Cancer Society provides ordinary people an extraordinary opportunity to fight cancer in their communities and to work with lawmakers to make America a healthier place to live.

At the American Cancer Society, we don't just focus on one type of cancer or one way to combat the disease. Our work covers the entire spectrum of the cancer fight, from prevention and early detection, to support during treatment, to end-of-life care and quality of life after a cancer experience. We're not just a research-focused organization – although that's a key part of how we save lives. We're working as a global institution to bring cancer under control in this century.



## OUR HISTORY

When the Society was founded in 1913, cancer was a near-certain death sentence. Today, the hopeful side of cancer has never been more hopeful. Most people survive the disease. At the core of this radical transformation has been the American Cancer Society.

From the beginning, the Society was a visionary organization, bringing to light the radical idea that there was something people could actually *do* about cancer. Founded in 1913 as the American Society for the Control of Cancer by 15 prominent physicians and business leaders in New York City, the Society's founders knew they had to bring cancer into the mainstream of public discourse if progress was to be possible. They did that largely through education campaigns, working to inform both health practitioners and the public about the disease.

In 1936, the organization had perhaps its first truly transformational moment, when volunteer Marjorie G. Illig made an extraordinary suggestion: to create a legion of volunteers whose sole purpose was to wage war on cancer. The Women's Field Army, as this organization came to be called, was an enormous success, and became an incredible grassroots force driving the organization's mission, with members raising money and educating the public about cancer. Before the Women's Field Army was founded, there were 15,000 people active in cancer control throughout the United States. At its peak, the Women's Field Army alone counted more than 700,000 women among its members – and it had an additional volunteer base of more than 2 million women. More than anything else, it was the Women's Field Army that moved the American Cancer Society to the forefront of voluntary health organizations, setting the stage for the organization to become the leading health nonprofit in the nation.

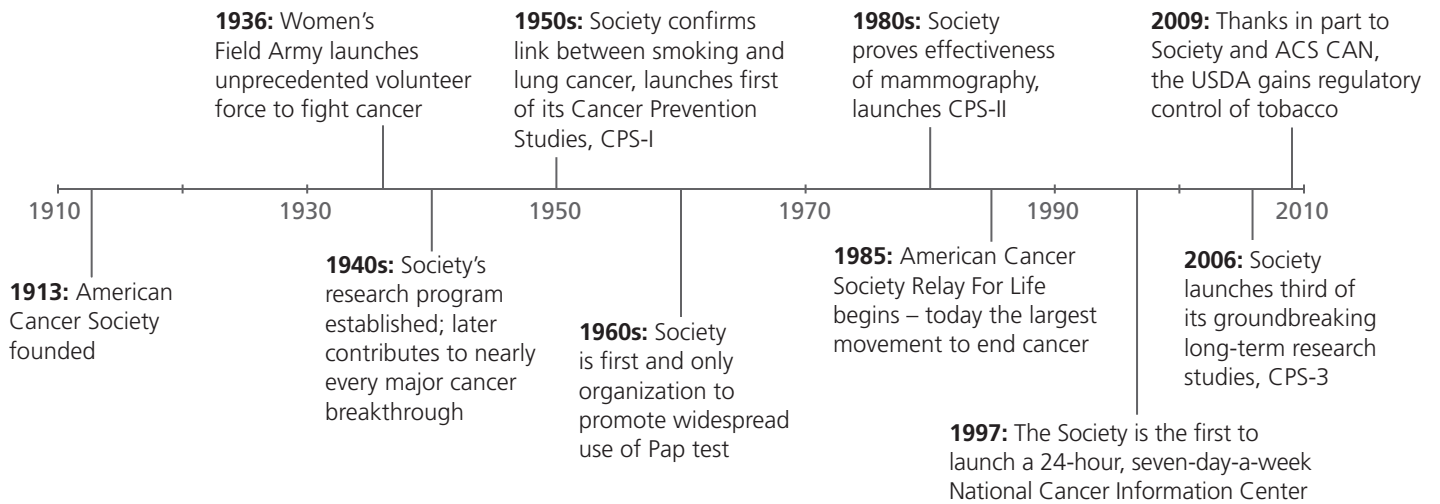
The post-World War II years saw another transformation at the Society – this one focused on cancer research. In 1945, the Society was reorganized, getting its current name and signaling a new era. Soon after, philanthropist Mary Lasker helped establish the Society's now groundbreaking research program, at a time when investigation into the disease in the United States was in its infancy. Throughout the next decades, the research program added accolade after accolade to its list of accomplishments, opening the modern era of chemotherapy for cancer treatment and confirming the link between smoking and lung cancer, among many other accomplishments. Today, the Society has invested more than \$3.5 billion in cancer research during its history – an incredible transformation considering that before the research program was created, the nation in total was spending less than a million dollars per year to investigate the disease.

In the 1960s and 70s, the Society began another era of transformation – one of working more closely with the government to fight cancer. The Society was instrumental in the development of the surgeon general's report on the link between smoking and cancer, which laid the groundwork for tobacco control progress – and for the corresponding lives saved – that continues today. That progress today has brought us victories like the 2009 federal move to give the US Food and Drug Administration regulatory control of tobacco products, a crucial change the Society long supported.

Our advocacy contributed to the passage of the National Cancer Act in 1971, which expanded the National Cancer Institute (NCI) and revolutionized the war on cancer. With the development of the NCI, the American Cancer Society also had to adapt to a new role – that of filling in the gaps of the federal government's focus in areas such as cancer prevention and education. Likewise, as federal funding for young investigators has diminished, the Society has allocated more research grants to that generation, helping promising young medical researchers enter the cancer field.

In 1985, one man, Dr. Gordy Klatt, raising money for the Society in Tacoma, Washington, helped again change the American Cancer Society, as he set in motion what would become Relay For Life, today the world's largest movement to end cancer. Relay For Life helped transform the Society from an organization that collected money and provided services locally, working centrally to do research, into a highly visible, national cancer control and change agency, empowering people in more than 5,100 communities nationwide and around the globe to end cancer.

Today, the Society keeps alive the visionary spirit that inspired its founders nearly 100 years ago. We are a billion-dollar organization that is looking ever forward, anticipating our next transformation and moving relentlessly toward a greater impact on the global cancer fight.

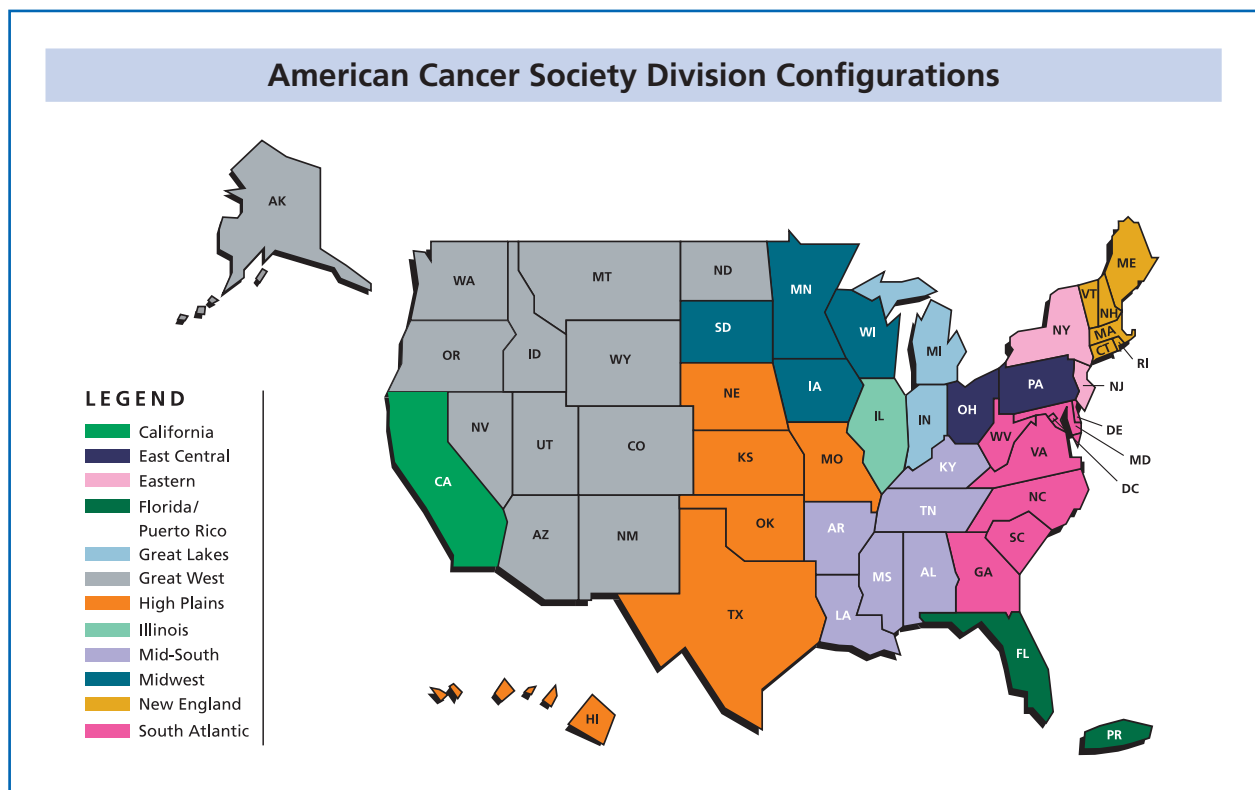


## ORGANIZATIONAL STRUCTURE

From the small nucleus of health activists in the early 20th century has grown a complex organization. Its goal remains the same, but its size and scope has grown. Strong volunteer and staff ranks nationwide that exemplify America's ethnic diversity share responsibility and decision-making. Today, the American Cancer Society's influence extends into more than 5,100 communities, marshaling the efforts of millions of volunteers. Its confluence of grassroots reach and worldwide eminence makes the Society a unique leader in the fight against cancer.

The American Cancer Society is comprised of 12 separately incorporated Divisions and a separately incorporated National Home Office (NHO), which coordinates with those Divisions in pursuit of common goals.

Our NHO has two governing bodies with distinctive roles, the National Assembly and the National Board of Directors. The voting members of both bodies are comprised entirely of volunteers from the medical and lay communities with representation from each of our Divisions.



## HOW WE FUNCTION

The National Assembly is responsible for electing the officers and members of the National Board of Directors. It also approves corporate bylaw changes and elects the committee that nominates the officers and members of the Board and other volunteer positions on the Assembly. In addition, it annually approves the Division of Funds Policy that controls what percentage of unrestricted funds raised by the Divisions is retained by the Divisions (approximately 60 percent) and what amount is sent to the NHO (approximately 40 percent) for extramural and intramural research and other nationwide programs, such as the National Cancer Information Center and the Web site cancer.org.

The National Board of Directors currently consists of 11 officers, 24 directors (12 from the medical community and 12 from the lay community) nominated by the Divisions, and eight directors at large. Directors are elected for a two-year term. The Board is responsible for setting policy, establishing long-term goals, monitoring general operations, approving Division charters, charter requirements, monitoring Division compliance, and developing and approving the national strategic plan. The national president is the chief medical and scientific volunteer leader, and the chair of the National Board is the lay volunteer leader. The chair and president are elected annually by the National Assembly. The National Board meets regularly throughout the year, and a typical agenda includes discussion and voting on our major goals and strategies and monitoring of the business operations of the Society.

The CEO of the NHO is selected by, and reports to, the National Board. The CEO is a paid employee and is responsible for the operation of the NHO, selection of key national staff officers, and coordination of the work of the NHO and the Divisions. The Board has established executive limitations that document key policies to which the organization should adhere, and the CEO provides periodic monitoring to the Board to confirm his compliance with those limitations.

The Society's 12 Divisions and the NHO work to ensure coordination of mission and adoption of best practices on both program delivery and income development through several mechanisms. Most fundamentally, each Division, while separately incorporated and governed, receives a charter from the national Society that is reviewed and revised every three years in a process that ensures the coordination of mission, uniform high standards, and consistency. In addition, the Division CEOs and key national staff officers meet regularly as the Nationwide Executive Team to make collective operational decisions and to coordinate the work of nationwide groups that focus on developing and sharing best practices.

# Strategic Plan

Delivering progress in the fight against cancer takes both great vision and careful planning.

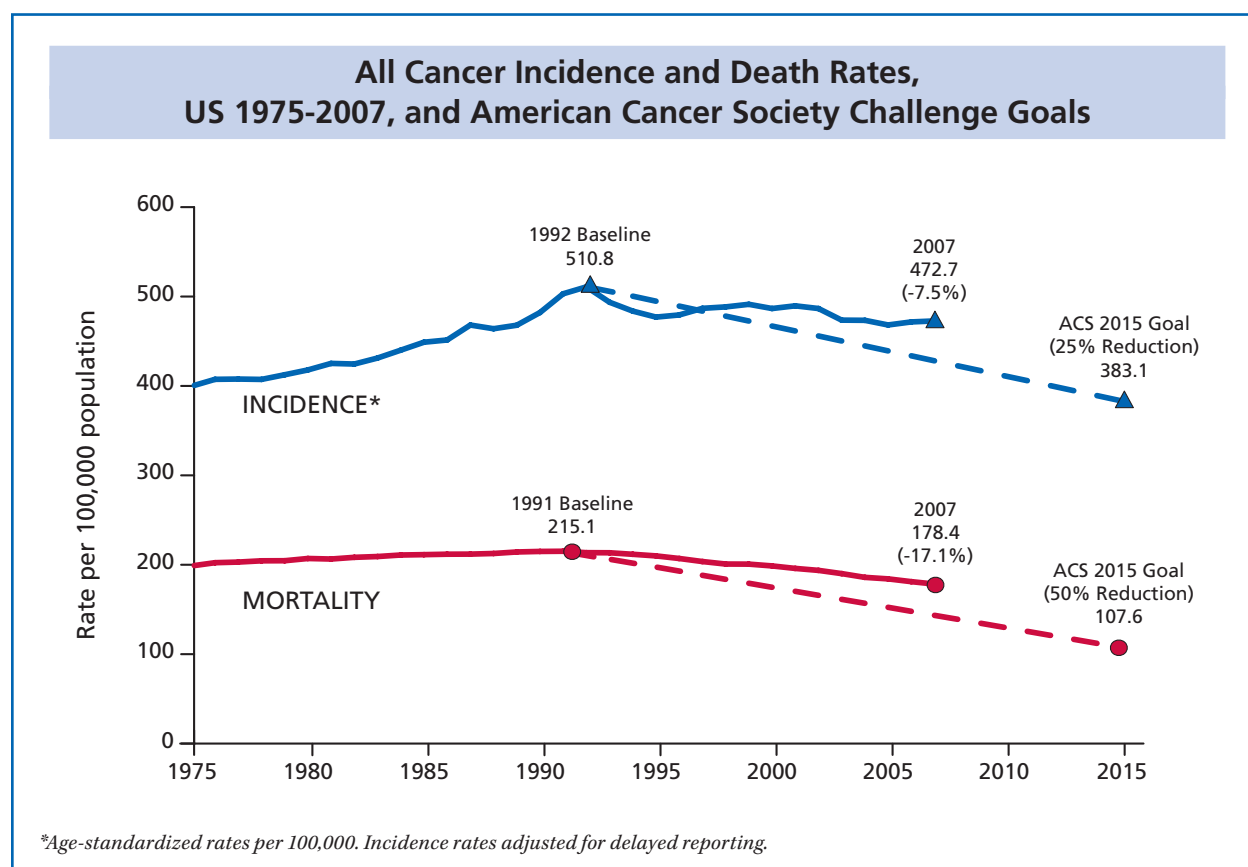
## 2015 CHALLENGE GOALS

In 1996, the American Cancer Society set its sights on the year 2015. We established long-term goals for the significant reduction of cancer mortality and cancer incidence rates and for the improvement of quality of life for cancer survivors and their caregivers. The Society sees these targets not as predictors, but as challenge goals for the nation. They clarify priorities and focus action on activities with the greatest potential to reduce cancer.

These strategic goals for 2015 include:

- Reduce the age-adjusted cancer mortality rate by 50 percent.
- Reduce the age-adjusted cancer incidence rate by 25 percent.
- Measurably improve quality of life (physical, psychological, social, and spiritual) from time of diagnosis through balance of life for all cancer survivors.

“Age-adjusted” means the mortality and incidence rates are adjusted in order to account for the increasing average age of our population, which would otherwise skew the statistics because cancer incidence increases with age. Thus, if we achieve these age-adjusted goals, in absolute numbers cancer incidence and mortality reductions will still appear significantly less than these percentages because of our aging population.



The Society recognizes that we cannot achieve these goals alone. In order to accomplish our objectives, we are committed to collaborating with other organizations with similar goals and with federal and state governments. We believe we have a responsibility to act as a catalyst, engaging our collaborators to address gaps in cancer control.

## OUR FOUR LEADERSHIP ROLES

With the 2015 goals firmly in mind, the American Cancer Society continued to evaluate its optimal role. We asked ourselves: How can one organization with finite human and financial resources best use its assets to achieve its goals?

Starting in February 2003, the Society began a nationwide process to align its mission activities and strategic priorities to have an even greater impact on the disease. As a result, the Society identified four leadership roles that would have the greatest potential impact in the cancer world:

1. Make available high-quality, timely, clear information, especially to newly diagnosed cancer patients and their caregivers, to support better decision-making.
2. Use our scientific credibility and unique position to support innovative, high-impact research through both direct funding and our ability to influence the amount and direction of research funding from other sources.
3. Improve the quality of life of cancer patients, caregivers, and survivors by assisting primarily with service referral, community mobilization, collaboration, advocacy, and where appropriate, directly providing services.
4. Prevent and detect cancer as early as possible.

In addition, the Society identified two “pillars” of action that support all four leadership roles. Those pillars are:

- Advocate effectively at all levels of government for policies that will help us win the fight against cancer.
- Eliminate disparities in the prevention, detection, and treatment of cancer as well as in quality of life.

Those four leadership roles guide our actions in the fight against cancer. As the landscape of cancer changes, along with the larger economic, social, and public policy world in which we wage the fight against the disease, we have sought to clarify these leadership roles further in order to be continually more effective in our mission. We’ve done this by defining criteria that helps us to prioritize our work and therefore better use our resources.

The three core criteria pose the key, practical questions that sharply focus our work: first, the effect of the disease on people; second, our capacity to deliver services and resources to them; and third, the effect this all has on our ability to achieve our mission. When, for instance, we consider the effect of the disease, we ask what the strength of the existing science is to address the need. When we consider our capacity to deliver resources, we do so in a way that we know is most likely to achieve a successful outcome. And when we consider the effect on mission, we ask what financial resources will be required and what overall financial impact this expenditure will have on the organization. The result of this process is that it has made our actions, and the outcomes, even more powerful.

## PLANNING FOR THE FUTURE

Our strategic planning has two time frames: intermediate, or planning to impact our work in the next three to five years, and long term. In both cases we remain fixed on our 2015 goals and the continuous improvement in fulfilling our four leadership roles.

### Intermediate

The American Cancer Society has brought together the organization’s thought leaders to institute a strategic planning initiative on the mission-signature strategies, to further sharpen our focus on our mission and fine-tune our operations. This initiative seeks to identify the Society’s programs and services that have the greatest impact in achieving our 2015 goals, to maximize the organization’s growth potential, and to identify areas for operational improvement, all within the next three to five years.

Central to these signature strategies are the shifts we must engineer in our mindset about “return on investment.” Staying within our four leadership roles, we want to achieve a clearer “line of sight” between the actions we take with our programs and their specific impact. It’s a shift, in a sense, from measuring the volume of our activities to measuring the impact those activities will have on larger cancer outcomes.

For instance, within the Information and Quality of Life leadership role, we are establishing population-based monitoring to measure drivers of quality of life and then encouraging participation in decision-making to help ensure healthy living. This will not only transform our work and enhance our current measurement systems, but it will also have benefits for the whole cancer-fighting community.

## The Long Term

Long term, we are systematically transforming both our organization and the disease we fight, with the Society leading a global movement to save potentially thousands more lives per day from cancer around the world. As our Board chair and president noted in their opening letter, our century-old organization has not changed its fundamental operating model in more than 50 years. While we have accomplished tangible, lifesaving results with this model, the world of today demands new thinking – and our mission demands we undergo a deliberate organization-wide transformation to save more lives – so we can deliver on our mission faster and better. Although our mission statement will remain the same, this may mean we will narrow the focus of the Society’s work so we can pinpoint the areas in which we can have the most impact. It means we are examining new and innovative ways to take the fight against cancer to the next level, looking internally to our own programs as well as externally at how we can reach across sectors to increase our collaborative efforts. It means fundamentally, we are taking a hard look at how we do business, how we are structured, and asking ourselves how we can save more lives – and we are acting on what we find.

The results of this transformation will make the Society an organization that makes decisions more quickly, has more streamlined systems of governance, a laser focus on mission, and overall more innovative, customer-centric approaches to our work. It will make our organization ever more efficient and effective so that we continue to have the most impact with every donor dollar. These are not just plans we are talking about as an organization; we are actively transforming to take the American Cancer Society from a *good* organization to a *great* one. Overall, we believe by strategically reinventing the Society we will create an organization that is better poised to save more lives from cancer worldwide – and one that is ever more relevant to the constituents we serve. That means the Society will continue to be *the* place people turn when dealing with cancer or when they want to fight back to end the disease.

As the burden of cancer grows worldwide, and particularly in challenging economic times, this work has never been so important, as people facing cancer have turned to us more than ever in recent years. We have not let them down – we continue to be there for people facing the disease, when and where they need help – as we will continue to be for years to come.

## Futuring Initiative

The American Cancer Society National Board of Directors has historically engaged in futuring activities to anticipate changes in the world and to guide our organization accordingly. The National Board launched its most recent futuring initiative in 2007 to anticipate and prepare for global changes that may occur by the year 2020 and beyond so that the Society can continue to lead the fight against cancer and make the greatest impact on the disease well into the future.

In February 2008, the National Board of Directors received the culmination of the most recent futuring initiative including:

- The major trends that will shape the world and cancer by the year 2020
- The implications for the Society of those trends on mission delivery, mission support, its people, and the organization as a whole
- A set of potential 2020 visions and aspirations for what the organization might achieve to maintain its leadership position given future trends
- Several near-term initiatives to set the organization on a path to successfully meet the 2020 trends
- A proposed process for the Board to continue its futuring work on an ongoing basis

The National Board of Directors sequenced the strategic discussion of the long-term visions and aspirations through 2009. These discussions helped chart a path for the organization’s future and more specifically shape the evolution of the Society’s leadership roles and the areas of the cancer fight on which we focus our work.

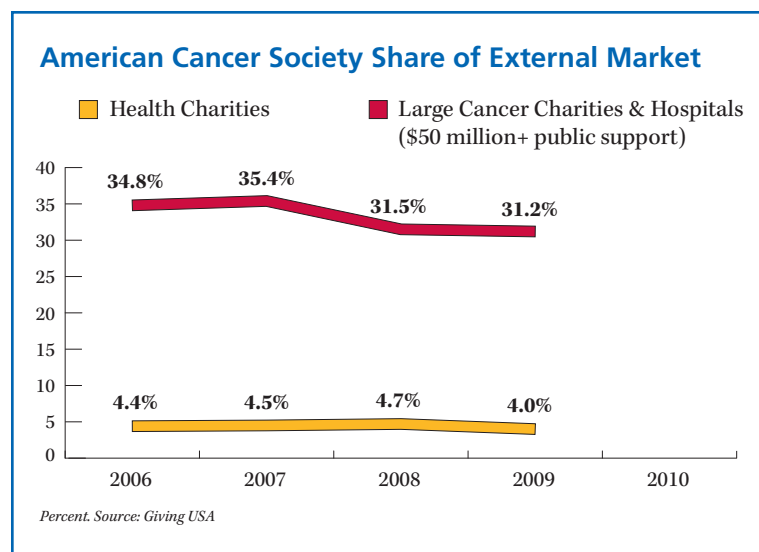
# Financial Stewardship

## OUR SHARE OF THE HEALTH SECTOR

The American Cancer Society continues to be the largest health charity, and in 2008 through 2010 moved ahead of the Red Cross to become the largest secular charity in public support (excluding organizations that focus on donated goods, and pass-through organizations like the United Way). Fundraising dollars exceeded \$1 billion for the first time in 2007 and again in 2008, but retreated below that level during the recession (\$898 million in 2009, and \$903 million in 2010) due primarily to a market-driven decline in the size of planned gifts received.

The Society has performed well in recent years compared to the charitable health sector as a whole. Since the inception of the Integrated Fundraising Plan in 2003 through 2008, the Society grew at an annual rate of 3.8 percent, outpacing the charitable health sector at 1.8 percent annual growth. The Society approximately doubled the rate of health sector growth in every one of these years, and did so again in 2008 despite public support for the Society being down 3 percent (the health sector declined 6.5 percent). Market share improved during each of these years, but dropped to 4.0 percent in 2009.

To be more specific, the Society has lost market share in the increasingly competitive cancer philanthropy space during the past decade, as the organization's growth has been outpaced by rising niche brands who are also friends and collaborators in mission. From 2003 to 2009, the Society's share of the cancer marketplace declined about 30 percent. Market share data is not yet available for 2010. Maintaining and increasing our market share to ensure the Society remains relevant to our constituents is one of the larger goals of the organization's transformation work mentioned in the previous section.

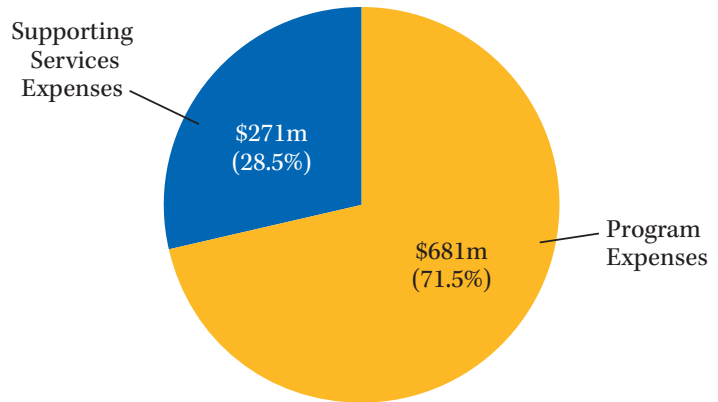


## SPENDING THE MONEY

The Society is not an endowment that has been underwritten in perpetuity by a single wealthy benefactor, individual, family, or corporation. We are funded, primarily, from the money we can raise each year. While we have investments, cash reserves, and other assets underpinning the organization for the future, the Society is funded mostly by donations averaging well under \$100. With nearly a billion dollars in annual resources, the Society has continued to show strong fundraising success, even in these tough economic times. At the same time, each year we spend virtually every dollar we raise from public support and other sources of income on achieving our mission.

As part of our commitment to best practices in financial stewardship, the Society is acutely mindful of our obligation to spend the money entrusted to us wisely. Given our role in fighting cancer across the full spectrum of the disease, and increasingly around the world, the demand for the dollars donors have given to us is significant.

Broadly speaking, our expenses fall into two categories: first, program services such as cancer research, prevention, detection, and treatment, and patient support; and, second, supporting services such as management compensation, general infrastructure, and the cost of fundraising. The pie chart on the right shows the general breakdown of monies in those two areas for our most recent fiscal year of financial reporting, the period ending August 31, 2010.

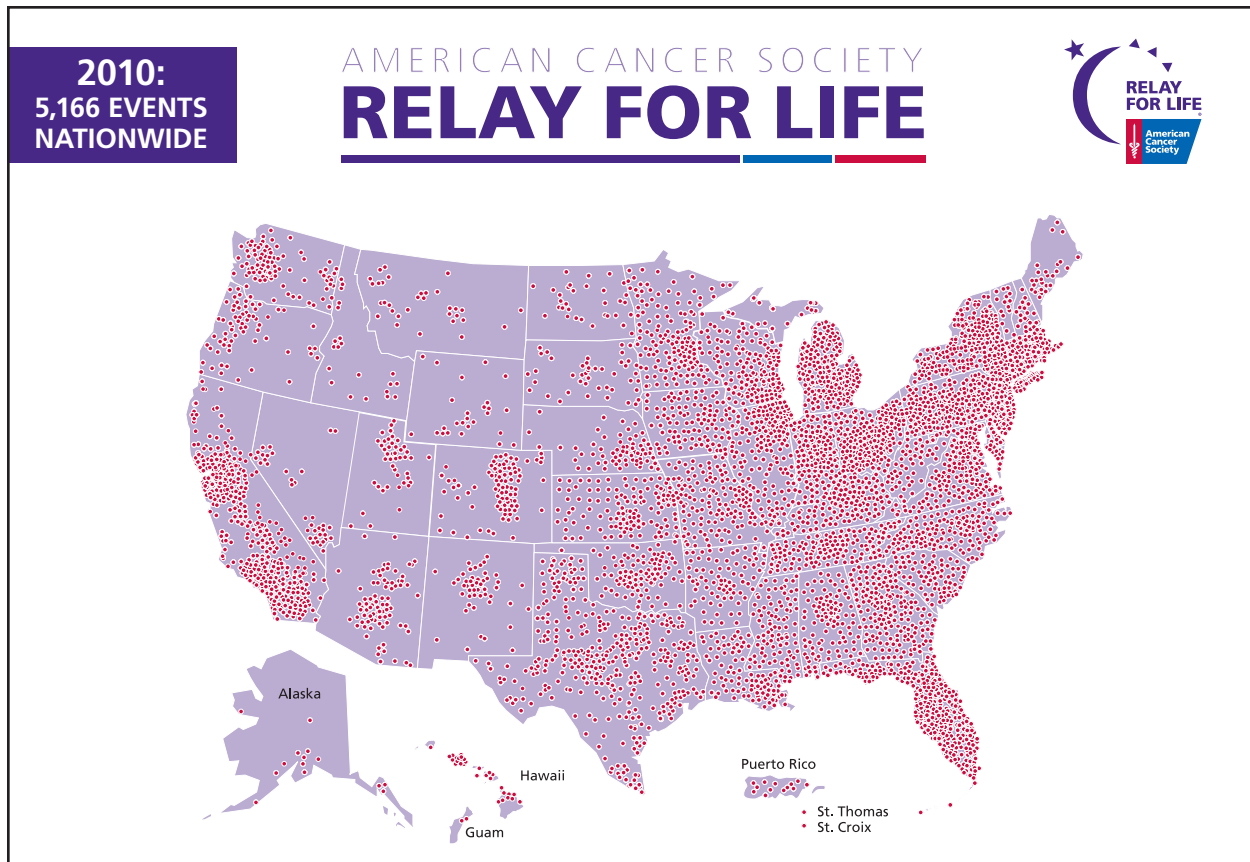


A deeper analysis of this spending is contained in the Financial Report section on page 42.

## FUNDRAISING

The American Cancer Society enjoys a historic strength in mobilizing communities to fight back against cancer through grassroots fundraising – raising small gifts through millions of individual donations from private supporters. In the past decade, the Society has made strong and deliberate efforts to broaden its portfolio of fundraising approaches to capitalize on market opportunities, minimize risk, and improve fundraising efficiencies.

In 2010, more than 6.9 million donors comprised of individuals, corporations, and foundations made approximately 9 million gifts. More than 6.6 million of these donors were individuals with an average gift size of \$67.



## Relay For Life

The American Cancer Society Relay For Life is the world's largest movement to end cancer and the largest global awareness and fundraising event of its kind. This community-based event gives everyone the chance to celebrate the lives of people who have battled cancer, remember loved ones lost, and fight back against the disease. Relay For Life is a significant opportunity to reach and engage more than 3.5 million people – 1 in every 100 Americans – in more than 5,100 communities in the United States as well as 19 other countries with lifesaving messages about staying well and getting well from cancer, finding cures, and fighting back.

## Special Events

The American Cancer Society manages a variety of fundraising activities that appeal to constituents based on their personal interests and passions (e.g., cancer type, athletics/sports, social activities, honoring/remembering loved ones, etc.). Priority activities include Making Strides Against Breast Cancer®, distinguished events (galas and golf tournaments), Daffodil Days®, Coaches vs. Cancer®, and the Society's newest program, DetermiNation®. Some recent special event highlights for the Society include:

- Making Strides Against Breast Cancer, the Society's premier event that raises funds and awareness to fight breast cancer and save lives, continues to provide more than \$50 million to the income portfolio.
- The Society launched the DetermiNation program in 2009. Income from endurance events increased more than 60 percent in 2010 as the Society pursues aggressive growth in events.

## Major Gifts

The American Cancer Society's Major Gifts initiative develops meaningful long-term relationships with high-net worth individuals and foundations, and provides them a platform for realizing their personal vision of fighting cancer as they invest in the Society's most compelling mission opportunities to save lives.

In February 2010, the Bill & Melinda Gates Foundation awarded the Society a \$7 million, five-year grant to lead and coordinate the African Tobacco Control Consortium, a global coalition of public health-oriented organizations focusing on using evidence-based approaches to stem the tobacco epidemic in sub-Saharan Africa.

## Planned Giving Resources

Planned giving develops meaningful personal relationships with individuals of capacity and their financial advisors, enabling them to leverage their assets and make ultimate gifts to save lives from cancer. Through its planned giving program, the American Cancer Society serves as a philanthropic advisor to donors and their financial advisors and uses direct response strategies to build awareness of planned giving opportunities among a broader audience.

In 2010, the Society received \$113.8 million in charitable legacy and bequest income. The organization continues to leverage best practices to further refine nationwide benchmarks for planned giving staff productivity measurement. The Society received the largest gift in its history in 2009, when a \$25 million new gift commitment (expectancy) was secured. Partnerships with Relay For Life and Making Strides Against Breast Cancer generated more than 20,000 event participants requesting information for including the Society in their future estate and financial plans.

## Corporate & Systems Initiative

The American Cancer Society Corporate & Systems Initiative develops relationships with major US employers (e.g., Fortune 1,000 companies), health care, government, and school systems to create mutually beneficial relationships through a coordinated account management process. It offers companies and other systems customized mission and income offerings to help employees stay well and get well, and offers them avenues to help the Society find cures and fight back against cancer. Companies and other systems can address health care costs and stimulate giving through payroll deduction programs, event sponsorships, matching gifts, cause marketing relationships, and corporate philanthropy.

Through its employer relationships, the Society secured 48 members for its Relay For Life National Team Program, which garnered the organization more than 7,800 teams and an estimated \$19 million in Relay fundraising and corporate gifts. In fiscal year 2010, more than 4 million individuals were affected by workplace mission offerings (e.g., the American Cancer Society Quit For Life® program, an Alere Wellbeing tobacco cessation program, and Active For Life<sup>SM</sup>, a corporate wellness program aimed at increasing physical activity) at more than 1,500 worksites.

### **Corporate Marketing Alliances**

Through its Corporate Marketing Alliances program, the American Cancer Society works to create mutually beneficial marketing collaborations with targeted corporations that support Society cause branding platforms, extend the reach of Society mission messages, and generate significant revenue through sponsorship, cause marketing promotions, and licensing.

### **Direct Response Marketing**

Through an integrated set of direct response strategies, the direct response marketing team aims at strengthening mass market constituent relationships to improve donor retention, constituent loyalty, and gift size and frequency of support. The direct response group focuses on market segmentation, acquiring and reactivating donors, testing multi-channel opportunities, and improving constituent giving relationships.

### **E-revenue**

The goal of the American Cancer Society's e-revenue strategy is to build a powerful online competency that is constituent-focused while providing income growth opportunities to all major Integrated Fundraising Plan initiatives. E-revenue creates dynamic new fundraising opportunities by leveraging technology to access a broader group of potential donors, increase the efficiency of fundraising, achieve higher levels of giving, and improve ease of data capture and subsequent constituent relationship management. In 2010, total e-revenue increased by 16.8 percent from the prior year, now representing 14.8 percent of public support.

# Achieving Organizational Excellence

## MANAGING IN A RECESSION

Being a financial leader also means being a leader in organizational stewardship – especially when times are tough. The economic times in which we find ourselves are unlike any the American Cancer Society – or indeed, the nonprofit sector as a whole – has seen in our century-long history. Throughout this recession we are also mindful of the fact that it's during periods of such hardship that people facing cancer need us even more. We have therefore used this as an opportunity to challenge ourselves at all levels of the organization to do more with less – without losing focus on our mission. This has renewed our management discipline to achieve a higher level of organizational efficiency and will enable the Society to emerge from this recession even stronger.

## ACHIEVING OPERATIONAL EFFICIENCIES

Ensuring our operations are as efficient as possible is an ongoing obligation for the Society to which we have been committed since our inception as an organization. We have made strides in this area in recent years, beginning in 2001, when we merged services such as data, donations, invoice processing, and purchasing into a state-of-the-art Shared Services Center shared by our then 17 Divisions and our national headquarters that has helped us save tens of millions of dollars by capitalizing on economies of scale. From 2006-2008 alone, this saved us nearly \$40 million.

In 2007, when our national headquarter operations in Atlanta grew beyond its building capacity, we took the opportunity to merge our National Home Office, our South Atlantic Division, and our Atlanta Metro Unit into one facility, increasing collaboration and cutting costs by allowing these offices to share meeting, technology, and staff resources.

Then, in January 2009 we convened staff leaders from our national office and throughout the nation to take a hard look at how and where we spend our resources, and what we could do in the short term to improve operational efficiencies and effectiveness across every area of the Society. We engaged outside organizational efficiency experts to help us delve deeper into our business processes nationwide.

This stage in our ongoing pursuit of efficiencies started with an in-depth operational analysis at the National Home Office level, and with select functions among the Divisions. The scope of the analysis looked at every major function of the organization engaged in our mission, from support (management, governance, finance, etc.) to mission enablers (e.g., call centers, our advocacy arm, and Relay For Life) and patient/research-facing work. In all, that scope encompassed some \$680 million in spending and we concluded that savings of approximately \$40 million were achievable over the next two to four years, especially by streamlining our nationwide procurement strategy for outside vendor supplies and services. Also notable in the actions from this analysis will be the consolidation of our information technology service and our talent learning and development capabilities across the country, which will preserve time and resources for our Divisions.

## WORKFORCE MANAGEMENT

Companies and organizations across the nation have made reductions in their workforce to cope with these lean times, and the American Cancer Society has been no different. We've made difficult decisions since the recession began, consolidating and cutting positions when budget forecasts necessitated it.

Our National Home Office and many of our affiliated Divisions instituted reductions in force, hiring freezes, and some Divisions used furlough days and other means to help trim spending. Executive leadership at the national office also chose to freeze its own salaries. In total, the Society has affected a 14 percent reduction in force over the past two years.

Throughout this process, our dedicated staff at all levels of the organization has taken on additional duties, devoting more time and energy to their work as resources have been tight. The spirit of teamwork throughout this difficult time has been remarkable – and our staff has proven again and again their fierce determination to our mission. We also found new ways to bring employees and volunteers together, using technology to work more often in a virtual space and create innovative ways to connect people across the nation. This helped us tighten travel budgets, as did a nationwide consolidation of many of our travel services among our Divisions and national office.

# Fulfilling Our Mission

The Society achieves its leadership roles and focus areas through its research, education, advocacy, and patient support programs.

The Society works tirelessly to educate the public, the media, and health professionals about the steps people can take to stay well, programs and resources the Society offers to help people with cancer get well, the progress toward and action needed to find cancer's causes and cures, and ways everyone can fight back against the disease.

## LEADERSHIP ROLE – INFORMATION

### Finding Cancer Early, When It Is Most Treatable

#### ***Focus Areas:***

1. Being a trusted provider of unbiased, general information.
2. Being a trusted provider of interactive, personal information and guidance.

The best defense against cancer is finding it early – when it is easiest to treat.

To help the public and health care professionals make informed decisions about cancer screening, the American Cancer Society publishes a variety of early detection guidelines. These guidelines are assessed regularly to ensure the recommendations are based on the most current scientific evidence. The Society currently provides screening recommendations for cancers of the breast, cervix, colon and rectum, and endometrium. We also provide information and guidance on testing for early prostate cancer and general recommendations for a cancer-related component of a periodic checkup to examine the thyroid, mouth, skin, lymph nodes, testicles, and ovaries.

Throughout its history, the American Cancer Society has launched a number of aggressive public awareness campaigns targeting the general public and health care professionals. Campaigns to increase the usage of Pap testing and mammography have contributed to a 70 percent decrease in cervical cancer incidence rates since the introduction of the Pap test in the 1950s and a steady decline in breast cancer mortality rates since 1990. From 2003 through 2006, the Society focused its efforts on encouraging adults aged 50 and older to get tested for colon cancer, resulting in increased awareness and intent to get screened.

As Society researchers began to confirm the link between cancer outcomes and insurance status, the organization launched a pioneering effort in 2007 to raise awareness about lack of access to quality health care as a significant barrier to progress against cancer. This effort surfaced tens of thousands of devastating stories of people facing cancer with inadequate insurance or with no insurance at all. The Society and ACS CAN are working in partnership to increase funding for programs that provide access to breast and cervical cancer screenings to low-income, underinsured, and uninsured populations, and to support similar programs for colon cancer so that everyone has the opportunity to stay well.

In addition to the Society publishing public information through pamphlets, books, and online at [cancer.org](http://cancer.org), we also publish numerous information sources for health care professionals, including three clinical journals: *Cancer*, *Cancer Cytopathology*, and *CA: A Cancer Journal for Clinicians*. More information on the Society's books and journals is available at [cancer.org/bookstore](http://cancer.org/bookstore).

## LEADERSHIP ROLE – QUALITY OF LIFE

### Helping People Get Well

#### *Focus Areas:*

1. Refer patients and caregivers to optimal local services via multiple channels.
2. Influence investment by local communities in high-impact quality of life services and policies through community mobilization, collaboration, and advocacy.
3. Where necessary, directly provide services where the Society is uniquely able to do so.

Whether it's the middle of the day or the middle of the night, the American Cancer Society is here to guide and support people through every step of a cancer journey. The Society offers a comprehensive suite of support programs and services to help people get well, and is the only cancer organization that stands ready to assist the more than 1.5 million cancer patients diagnosed each year, and the more than 11 million cancer survivors – as well as their family and friends – 24 hours a day, seven days a week.

Providing information to help make informed decisions or free services like transportation to and from cancer treatment or a free place to stay while receiving treatment far from home, the American Cancer Society is available around the clock to help people focus on getting well.

### **National Cancer Information Center (1-800-227-2345, cancer.org)**

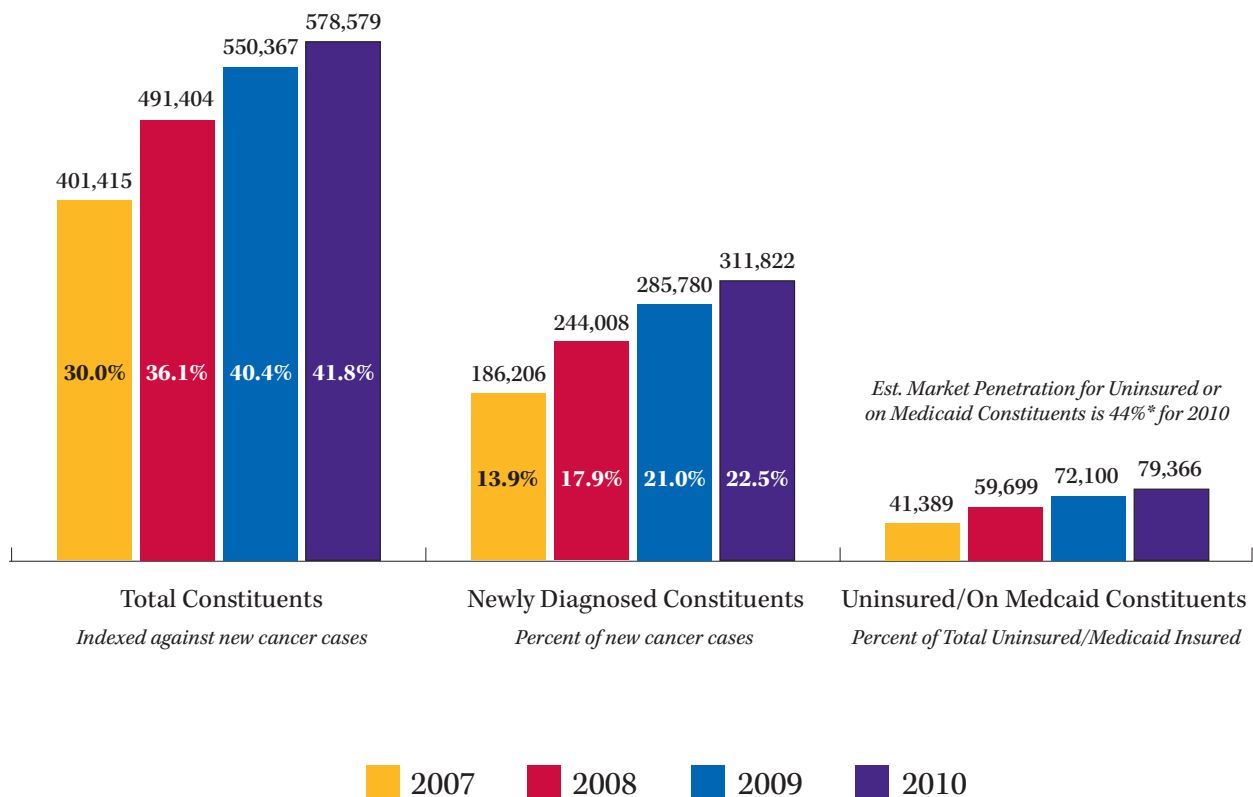
The Society's greatest expenditure in its patient support portfolio, as well as the most heavily used channel to serve constituents, is its National Cancer Information Center (NCIC) located in Austin, Texas. A primary gateway to the American Cancer Society and its resources, the NCIC provides consistent, high-quality, unbiased cancer information to constituents 24 hours a day, seven days a week, 365 days a year. Through the NCIC, the Society reaches people with the cancer information they need, when they need it, and helps constituents make informed decisions about their health and cancer care. Answering approximately 800,000 calls annually, the Society's highly trained Cancer Information Specialists provide the utmost quality service by assisting with information requests, service referrals, and by helping patients and caregivers navigate the cancer experience.

The NCIC also processes donations and gathers vital information from constituents to help support Society goals. The NCIC creates efficiency for the organization by centralizing nationwide information delivery while allowing Division and field staff and volunteers to focus on local delivery of services. Cancer Information Specialists are also responsible for responding to inquiries for information and assistance at cancer.org, the Society's comprehensive Web site, which receives almost 20 million visitors each year, or almost 180 people every five minutes. In FY2010, traffic to cancer.org increased 1.09 percent from 2009.



## 2010 Nationwide Mission – Information and Quality of Life Leadership Roles

### Number of Constituents Served with Patient-related Information or Patient Programs and Market Penetration



\* Uninsured or Medicaid Insured estimated new cancer incidence developed by American Cancer Society Research department.

Source: Siebel Service Requests and Activities, Fiscal Year.

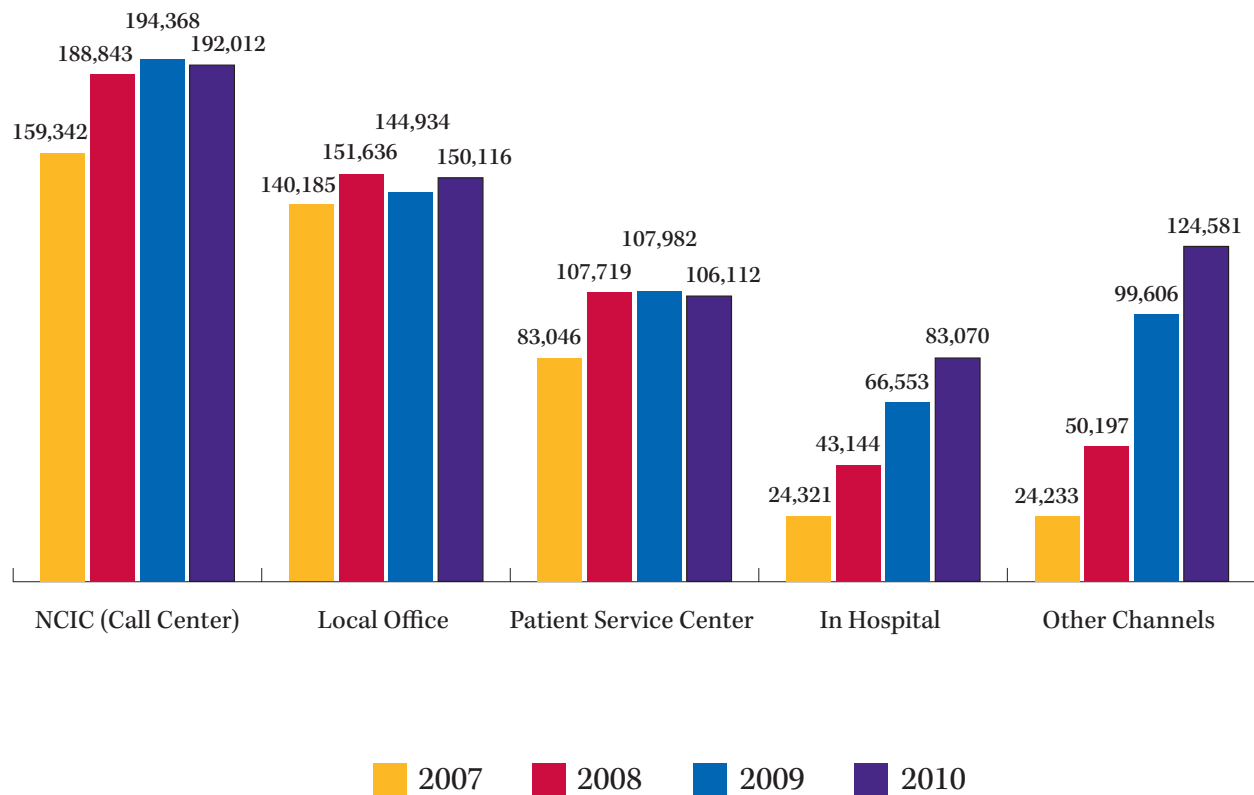
Total Constituents = Patient, caregiver, or friend calling as a result of someone's cancer diagnosis.

The American Cancer Society served more than 578,000 unique constituents with patient-related information or programs in FY2010, an increase of more than 28,000 constituents from the prior fiscal year, or an increase of 5 percent. There were also sizable increases among constituents who were newly diagnosed, up 9 percent, and constituents who were uninsured or on Medicaid, up 10 percent. These increases reflect a combination of improvements in outreach and data capture.



## 2010 Nationwide Mission – Information and Quality of Life Leadership Roles

### Constituents Served with Patient-related Information by Channel



Source: Siebel Service Requests: Fiscal Year.

Other Channels include: Customer Service, Event, Fax, NHO, Other, Physicians' Portal, Web, Volunteer Resource Center, Quit For Life, Patient Navigator Program staff portal, and hospital-based navigation.

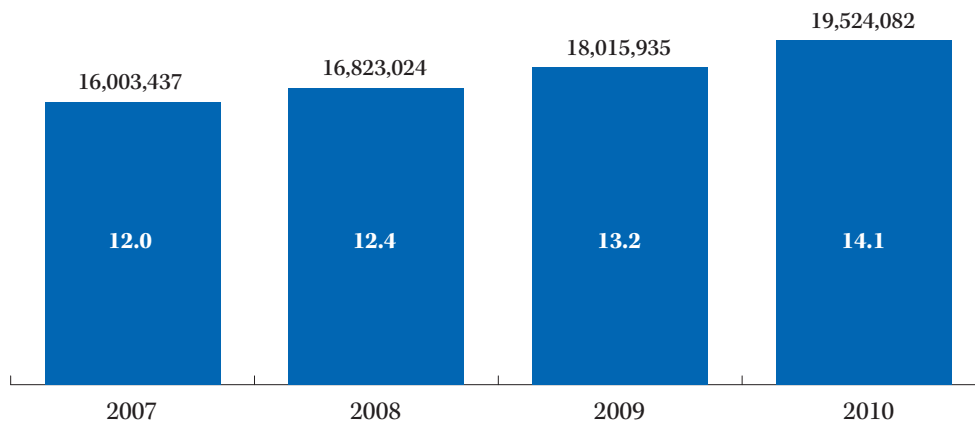
The categories of local office, in hospital, and other channels each experienced growth compared to the prior fiscal year. Growth in the other channels category was driven by new innovations such as a fax process from referral organizations and volunteer resource centers. There was a slight decrease in volume of service through the NCIC.



# 2010 Nationwide Mission – Information and Quality of Life Leadership Roles

## Online Measures

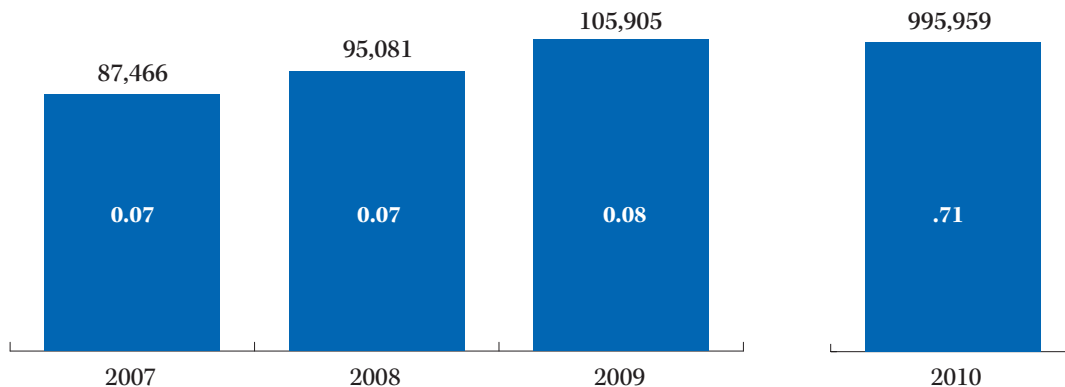
### Cancer.org Total Visitors Indexed against New Cancer Cases



*i.e., For FY2010 there were 14.1 visitors for every one new cancer case.*

Unique visitors to cancer.org grew by 8 percent compared to the prior year, increasing the rate of visitors to 14.1 for every one new US cancer case (visitors include anyone utilizing cancer.org as a trusted resource).

### Cancer Survivors Network<sup>SM</sup> Total Registered Indexed against New Cancer Cases



*i.e., For FY2010 there were .71 registered visitors for every one new cancer case.  
Online data not included in patient information totals above. Source: Google Analytics.*

The number of registered users of Cancer Survivors Network in 2010 cannot be compared to past years, as a new reporting system is being used. The new system follows the same methodology as cancer.org.

## Hope Lodge®

When a person diagnosed with cancer must travel far from home for the best available treatment, where to stay and how to afford accommodations are immediate concerns, and can sometimes affect treatment decisions. American Cancer Society Hope Lodge facilities provide free, high-quality, temporary lodging for patients and their caregivers close to treatment centers, thereby easing the emotional and financial burden of finding affordable lodging. Hope Lodge facilities cater to patients who live 35 or more miles (or more than an hour) from their treatment center. Equally as important, they provide a supportive, nurturing environment key to the healing process and getting well. Hope Lodge facilities help patients and caregivers better navigate the cancer experience by providing information and ready access to the full spectrum of American Cancer Society programs and services. In 2010, the Society operated 31 Hope Lodge locations across the United States and served nearly 33,000 patients and caregivers. The Society was able to provide more than 240,000 room nights at an estimated savings of more than \$23 million to guests, versus staying at a hotel.

## Patient Navigator Program

Learning how to navigate the cancer journey and the health care system can be overwhelming for anyone, but it is particularly difficult for those who are medically underserved, those who experience language or health literacy barriers, or those with limited resources. The American Cancer Society Patient Navigator Program was designed to reach those most in need. Specially trained American Cancer Society patient navigators are located in cancer treatment facilities (host sites) and, working in cooperation with host site staff, connect patients with information, resources, and support to decrease barriers and ultimately to improve health outcomes.

The Society collaborates with a variety of organizations, including the National Cancer Institute's Center to Reduce Cancer Health Disparities, the Center for Medicare and Medicaid Services, numerous cancer treatment centers, and others to implement and evaluate its program. Currently, the Society's Patient Navigator Program is the largest oncology-focused patient navigator program in the country, with 140 program sites located nationwide in a variety of publicly and privately funded institutions. In 2010, our navigators helped more than 83,000 patients through their cancer experience.

## Transportation

Cancer patients cite transportation to and from treatment as a critical need, second only to direct financial assistance. Through its Road To Recovery® program, the American Cancer Society matches cancer patients with specially trained volunteer drivers. This program offers patients an additional key benefit of companionship and moral support during the drive to medical appointments. The Society's transportation grants program allows hospitals and community organizations to apply for resources to administer their own transportation programs. In some areas, primarily where Road To Recovery programs are difficult to sustain, the Society provides transportation assistance to patients or their drivers via pre-paid gas cards to help defray costs associated with transportation to treatment. Extensive evaluation has shown that these programs are highly effective in helping patients maintain their treatment schedules – a key to getting well. In 2010, the Society helped 15,139 constituents get to and from their cancer treatment through its Road To Recovery program.

Throughout the country, the Society offers a variety of programs to provide people facing cancer with the information, day-to-day help, and emotional support they need to focus on getting well. For a complete list of these programs, visit [cancer.org](http://cancer.org).



## 2010 Nationwide Mission – Information and Quality of Life Leadership Roles

### Constituents Served by Patient Programs – Details

#### All Access to Care Programs – Detail

	<b>FY2007</b>	<b>FY2008</b>	<b>FY2009</b>	<b>FY2010</b>
<b>Programs</b>	<b>Number Served</b>	<b>Number Served</b>	<b>Number Served</b>	<b>Number Served</b>
Hope Lodge	6,132	7,469	9,012	9,681
Hope Lodge – Caregiver	n/a	3,104	5,964	8,483
Hope Lodge Van	n/a	719	1,204	1,314
Lodging	3,548	4,112	4,309	4,640
Road To Recovery	12,809	13,944	13,662	15,139
Transportation Assistance	27,280	38,285	43,475	50,340

The Society served more than 250,000 unique constituents with patient programs in 2010, an increase of 4 percent compared to the prior year.



# 2010 Nationwide Mission – Information and Quality of Life Leadership Roles

## Constituents Served by Patient Programs – Details

### All Patient Support Programs – Detail

	FY2007	FY2008	FY2009	FY2010
Programs	Number Served	Number Served	Number Served	Number Served
Camp	2,550	2,886	3,637	4,883
I Can Cope®	10,235	9,333	11,677	11,732
Look Good...Feel Better®	35,233	40,508	46,160	48,193
Man To Man®	8,341	8,390	8,059	7,486
Reach To Recovery®	27,698	26,198	24,148	21,481
Support Group	10,362	9,401	7,816	7,418

Patient support programs saw a marginal increase in the number of constituents served compared to the prior year. The top programs utilized by constituents continue to be Look Good...Feel Better and Reach To Recovery. However, declines in the support group Man To Man and Reach To Recovery categories diminished the overall growth of this focus area.

## LEADERSHIP ROLE – RESEARCH

### Finding Cures

#### *Focus Areas:*

1. Extramural funding of innovative and high-impact research.
2. Intramural funding to conduct, collaborate, and publish high-impact research, assisting both internal and external cancer control strategies.
3. Influence the amount and direction of funding and policy changes that support research.

The aim of the American Cancer Society's research program is to determine the causes of cancer and to support efforts to prevent, detect, and cure the disease. The Society is the largest source of private, nonprofit cancer research funds in the United States, second only to the federal government in total dollars spent.

In 2010, the Society spent an estimated \$148.6 million on research and health professional training and has invested more than \$3.6 billion in cancer research since the program began in 1946.

The Society's comprehensive research program consists of the Extramural Grants department (funding to outside research institutions) as well as the Intramural Research department (research conducted by Society researchers), with programs in epidemiology, surveillance research, health services research, behavioral research, international tobacco control research, and statistics and evaluation.

#### *Extramural Grants*

The extramural program supports investigator-initiated projects taking place in leading centers across the country, as well as training grants in selected health professions. Applications for grants are subjected to a rigorous external peer review, which ensures that only the highest-quality applications receive funding. The Society focuses most of its efforts toward supporting researchers in the early part of their careers, demonstrated by redefining our target grantees for the Research Scholar Grant as those within the first six years of their independent academic appointments. The success of the Society's research program is exemplified by the fact that the organization supported 44 Nobel Prize winners early in their careers.

#### *Epidemiology*

As a world-class program on epidemiologic research of cancer, the Society's intramural epidemiology research program has examined cancer risk factors in the general population and monitored trends in cancer incidence, mortality, and survival in the United States for more than 60 years. Over the years, Society researchers have conducted three large prospective studies to identify factors that cause or prevent cancer:

- Hammond-Horn study (188,000 men followed from 1959-1972 in 25 states)
- Cancer Prevention Study I (CPS-I, one million people followed from 1959-1972 in 25 states)
- Cancer Prevention Study II (CPS-II, an ongoing study of 1.2 million people enrolled in 1982 in 50 states)
- Recruitment into a new Cancer Prevention Study (CPS-3) that includes an ethnically and geographically diverse population of 300,000 adults began in 2006.

The Cancer Prevention Studies have provided unique contributions both within the American Cancer Society and in the global scientific community. These contributions allow the Society to focus its resources on factors most important in preventing cancer and promoting health. In particular, the data collected in these studies provided a unique picture of the progression of the tobacco epidemic and the emergence of the obesity epidemic over the last half-century. Some other key findings from these studies include:

- Cigarettes with reduced yield of tar and nicotine do not reduce the risk of lung cancer.
- Obesity is associated with increased death rates from at least 10 cancer sites, including colon and postmenopausal breast cancer.
- Discovery of the link between aspirin use and lower risk of colon cancer opened the door to research on chronic inflammation and cancer.

- Relationships of other potentially modifiable factors such as physical inactivity, prolonged hormone use, and certain dietary factors with cancer risk.
- Air pollution, especially small particulates and ozone, increase death rates from heart and lung conditions. CPS-II findings helped to motivate the Environmental Protection Agency to propose more stringent limits on air pollution.

### ***Surveillance Research***

The Surveillance Research mission is to analyze and disseminate population-based information on cancer occurrence, its causes, prevention, early detection, treatment, and survival, and thereby, to strengthen the scientific basis for cancer prevention and control. This is achieved through three approaches, each targeting a specific audience: *Facts & Figures* publications target the media, Society staff and volunteers, cancer control advocates, and health educators; the *Cancer Statistics* article targets clinicians; and research papers target public health experts and scientists.

*Cancer Facts & Figures*, the principal service publication, has been published annually for nearly 60 years. *Cancer Facts & Figures* is complemented by a special section and stand-alone publications focusing on specific topics to satisfy the need of staff, volunteers, and advocates for more in-depth information. Six supplemental publications focus on specific topics related to risk factors and early detection (*Cancer Prevention and Early Detection* [CPED]), major subpopulations (*Cancer Facts & Figures for African Americans* and *Cancer Facts & Figures for Hispanics/Latinos*), major cancer sites (*Breast Cancer Facts & Figures* and *Colorectal Cancer Facts & Figures*), and the global burden of cancer (*Global Cancer Facts & Figures*). CPED is published annually; the other *Facts & Figures* are published every two or three years. All *Facts & Figures* are available at [cancer.org/statistics](http://cancer.org/statistics). Surveillance Research also provides frequently used current statistics in a scripted PowerPoint slide set to assist Society staff and volunteers, and educators in making presentations to diverse audiences.

*Cancer Statistics* is a companion publication to *Cancer Facts & Figures*. Published annually in *CA-A Cancer Journal for Clinicians* since 1970, it targets clinicians for a wider application of evidence-based interventions. *Cancer Statistics* is one of the most widely cited articles in scientific journals because it reports the expected number of cancer cases and deaths in the current year.

Surveillance Research studies largely focus on disparities. Eliminating health disparities among subgroups of the US population (race/ethnicity, socioeconomic position, geographic location, sex, or sexual orientation) is an overarching goal of Healthy People 2010 and it is a Society 2015 goal. The program has two areas of emphasis: 1) Major risk factors (smoking, obesity, sun exposure) and 2) common cancers including lung, colorectal, female breast, and prostate, which account for more than 50 percent of the total cancer deaths and have known interventions. Surveillance researches disparities by socioeconomic status, racial and ethnic groups, and geography (state or country) using publicly available population-based cancer occurrence data and survey data.

### ***Health Services Research***

Interest in developing a Health Services Research (HSR) program within the American Cancer Society National Home Office began in the late 1990s, motivated by several factors including increasing disparities in the quality and outcomes of cancer care. Success in founding the HSR program was achieved in 2006. Since then, the group has developed into a highly productive multidisciplinary research team consisting of both clinician and non-clinician staff.

The primary objective of the HSR program is to support the Society mission by performing high-quality and high-impact research that provides evidence for Society policy and program initiatives. Additional, related objectives include identifying critical gaps in evaluating and improving quality of cancer patient care, and taking leadership in policy and technical initiatives to address these gaps. The HSR program is uniquely positioned to respond rapidly to critical information needs by Society personnel as well as national and international policy-makers. The HSR program analyzes cancer treatment patterns and outcomes and has examined the role of health insurance in explaining disparities in access to care, quality of care among patients with access, and outcomes such as morbidity and mortality.

Health Services Research has primarily involved the use secondary data sources. The National Cancer Data Base (NCDB), jointly sponsored by the Society and the American College of Surgeons, is key to HSR research on the impact of insurance on cancer status, treatments, and outcomes as well as for broader surveillance of cancer incidence/prevalence and treatment patterns. Other databases used include linked SEER-Medicare data, linked state registry and Medicaid enrollment data, and Medical Expenditure Panel Survey Data linked with National Health Interview Survey Data.

### ***Behavioral Research Center***

The American Cancer Society was one of the first organizations to recognize the importance of behavioral and psychosocial factors in the prevention and control of cancer and to fund extramural research in this area. In 1995, the Society established the Behavioral Research Center as an intramural department. The center's research has focused on five aspects of the cancer experience: prevention, detection and screening, treatment, survivorship, and end-of-life issues. It also focuses on special populations, including minorities, the poor, rural populations, and other underserved groups. The center is developing research projects designed to prevent and control tobacco use and research that explores individual and community-level factors affecting health behaviors among diverse cultural, racial, and socioeconomic groups.

### ***International Tobacco Control Research***

The predecessor of the International Tobacco Control Research Program (ITCRP), the International Tobacco Surveillance unit, was created in 1998 to support collaborative international tobacco surveillance efforts involving American Cancer Society, the World Health Organization (WHO) Tobacco Free Initiative, and the Centers for Disease Control and Prevention's (CDC) Office of Smoking and Health. In 2006, Dr. Hana Ross was recruited as program director. Dr. Ross brought a wealth of expertise as one of the world's leading experts in the economics of tobacco control and longstanding partnerships with multiple organizations and individuals conducting tobacco control research. The program emphasis shifted to a greater focus on primary collection and analysis of economic data. The work is done in collaboration with national investigators and serves to build capacity for collection and analysis of economic data to provide the evidence base for tobacco control in low- and middle-income countries.

The mission of ITCRP is to conduct research on the economic aspects of tobacco control and public policies that influence the global tobacco epidemic. Three objectives support the mission statement:

1. To conduct original research on tobacco control policies with a particular focus on economic policies including the impact of taxes and prices on smoking behavior, the impact of other policies to reduce the demand for tobacco products, and the linkage between tobacco use and poverty on a national, regional, and global scale.
2. To increase capacity of researchers in low- and middle-income countries to collect and analyze economic and policy data relevant for national, regional, and global tobacco control.
3. To promote collaboration and coordination among researchers, advocacy organizations, and funders engaged in international tobacco control research, programs, and policy initiatives.

### ***Statistics and Evaluation Center***

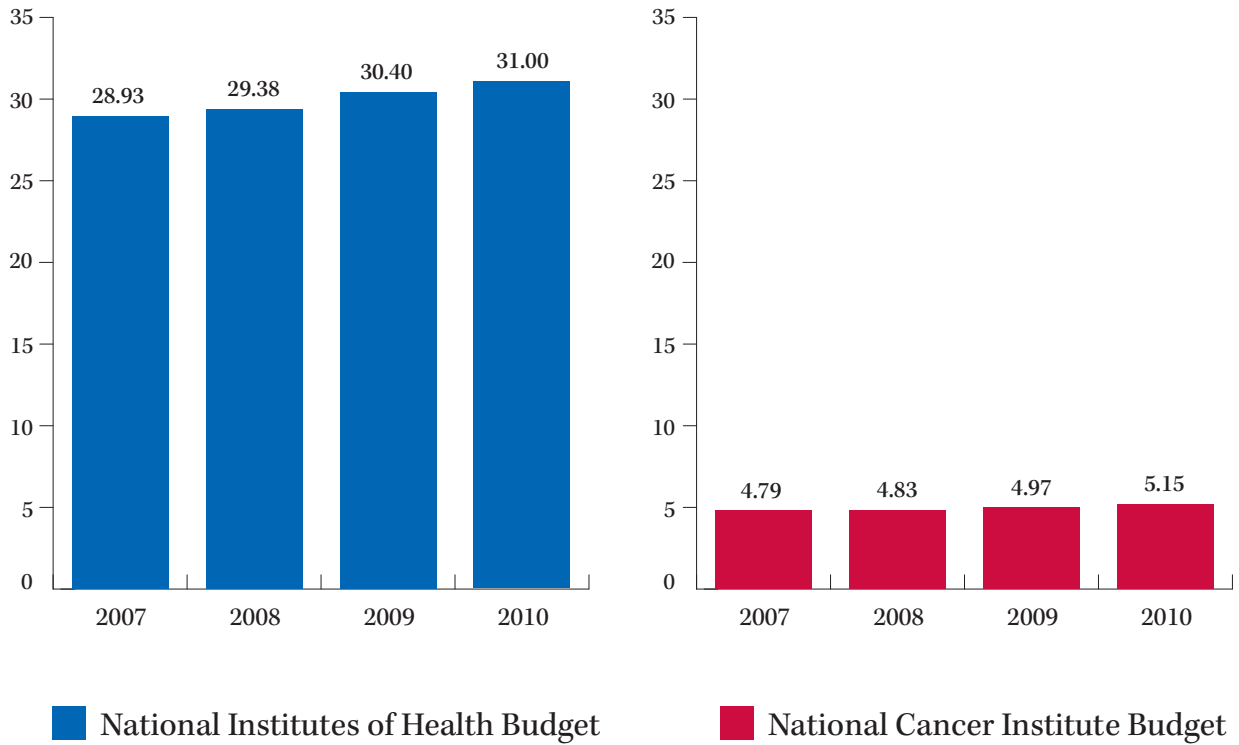
In August 2005, the American Cancer Society inaugurated the Statistics and Evaluation Center (SEC), a resource that provides consultation to investigators in the Research department, Health Promotions experts at the National Home Office, and mission delivery staff throughout the Society. The SEC has three main responsibilities: to assist Society researchers in the design, analysis, and preparation of manuscripts for publication in peer-reviewed scientific journals; to function as part of the Society team that evaluates selected mission delivery interventions; and to conduct methods research on cancer-related problems for publication in peer-reviewed journals.

The center's researchers engage in original research on predictive modeling for cancer control and advocacy and in developing optimal and ethical cancer study designs that minimize the required number of patients to be accrued for the study.



# 2010 Nationwide Mission – Research Leadership Role

## Federal Research Budgets, in Billions



Source: American Cancer Society Cancer Action Network<sup>SM</sup>.

The Research leadership role focuses on influencing the amount and direction of funding for cancer research, with research advocacy being one of the Society's key strategies. Funding for the NIH increased \$600 million in 2010, to \$31.0 billion. Funding for the NCI increased \$181 million, to \$5.15 billion.

Please Note: Dollar figures do not include any additional funding through the American Recovery and Reinvestment Act of 2009.

## LEADERSHIP ROLE – PREVENTION AND EARLY DETECTION

### Helping People Stay Well

#### *Focus Areas:*

1. Prevent and detect colorectal cancer as early as possible.
2. Reduce tobacco use to prevent lung and other cancers.
2. Prevent and detect breast cancer as early as possible.
3. Improve nutrition and physical activity to decrease the incidence of overweight-/obesity-related cancers.

### Steps to Help Prevent Cancer

The American Cancer Society saves lives by helping people everywhere take steps to prevent cancer or detect it early, when it's most treatable. Whether it's helping people to quit smoking, providing information on cancer screening tests, or through simple tips to live a healthier lifestyle, we transfer our cancer knowledge into helping people stay well.

We help people quit smoking through our American Cancer Society Quit For Life® Program operated by Alere Wellbeing. This state-of-the-art telephone and Web-based coaching service links callers with trained coaches who help develop a quit method that fits each person's unique needs. Together with Alere Wellbeing, the American Cancer Society has helped 1 million tobacco users.

The American Cancer Society works across the nation with its nonprofit, nonpartisan advocacy affiliate, the American Cancer Society Cancer Action Network (ACS CAN), to create healthier communities by protecting people from the dangers of secondhand smoke. More than 79 percent of the US population is now covered by a 100 percent smoke-free workplace and/or bar and/or restaurant law, meaning the majority of Americans can breathe easier where they live, work, and play. In 2010, four states – Kansas, Wisconsin, South Dakota, and Michigan – passed and implemented comprehensive smoke-free laws.

The Society and ACS CAN also work to curb tobacco use by raising tobacco taxes. Since 2002, 47 states, the District of Columbia, and several US territories have increased tobacco taxes. In 2010, Guam and six states – New York, New Mexico, Utah, South Carolina, Washington, and Hawaii – increased their taxes.

For the majority of Americans who don't smoke, the most important ways to reduce cancer risk are to maintain a healthy weight, be physically active on a regular basis, and eat a mostly plant-based diet that limits saturated fat.

Our guidelines for proper nutrition and physical activity and cancer screenings help doctors and all Americans understand how to reduce cancer risk and what tests they need to find cancer at its earliest, most treatable stage. People can visit [cancer.org](http://cancer.org) to create a personalized health action plan based on their age and gender that provides individualized cancer screening and healthy lifestyle recommendations. In addition, the Society provides tips, tools, and online resources to help people set goals and stay motivated to eat healthy and maintain an active lifestyle.

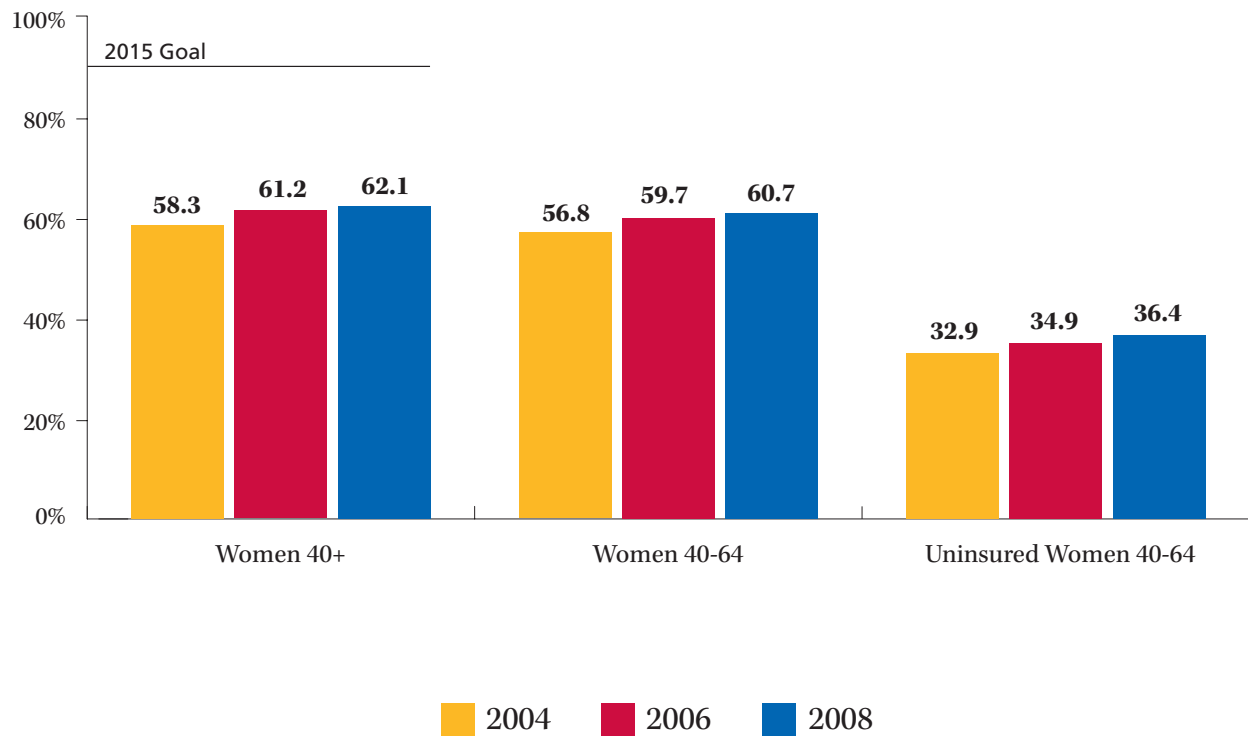
We offer many programs for companies to help their employees stay well and reduce their cancer risk. These include Freshstart®, a group-based tobacco cessation counseling program designed to help employees plan a successful quit attempt by providing essential information, skills for coping with cravings, and group support; Active For Life, a 10-week online program that uses individual and group strategies to help employees become more physically active; and Meeting Well, a planning tool to help companies organize meetings and events with good health in mind.

The Society accumulates scientific evidence on diet and cancer and synthesizes this evidence into clear, informative recommendations for the general public. The Society publishes these guidelines on nutrition and physical activity for cancer prevention to promote healthy individual behaviors, environments that support healthy eating and physical activity habits, and, ultimately, to reduce cancer risk. These guidelines form the foundation for the Society's communication, worksite, school, and community strategies designed to encourage and support people in making healthy lifestyle behavior changes.



## 2010 Nationwide Mission – Prevention and Detection Leadership Role

### Recent Mammography Screening Rates for Women



*Note: No data updates for 2010.*

*Source: BRFSS. Mammography within the past year.*

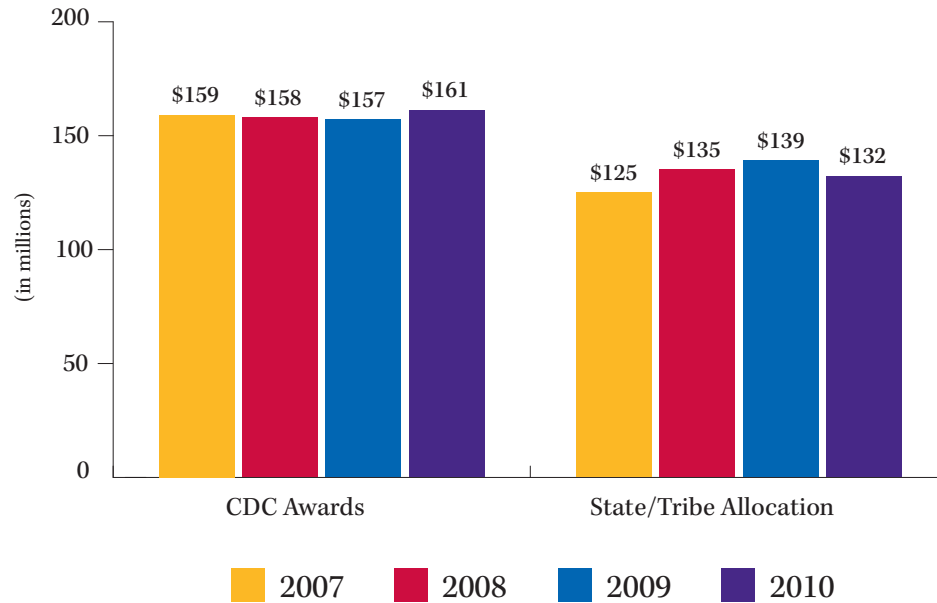
Recent mammography screening rates have not changed significantly during the last three Behavioral Risk Factor Surveillance Surveys (BRFSS) among the general population of women or among uninsured women. The screening rate among the uninsured women 40-64 remains slightly above half the rate among the general population.



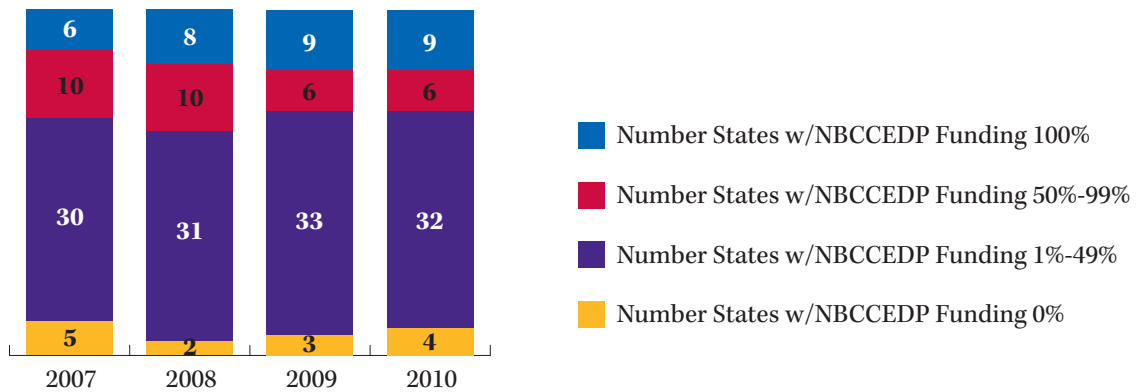
# 2010 Nationwide Mission – Prevention and Detection Leadership Role

## National Breast and Cervical Cancer Early Detection Program Funding

### CDC and State Funding Levels



### State Funding as Percentage of CDC Award



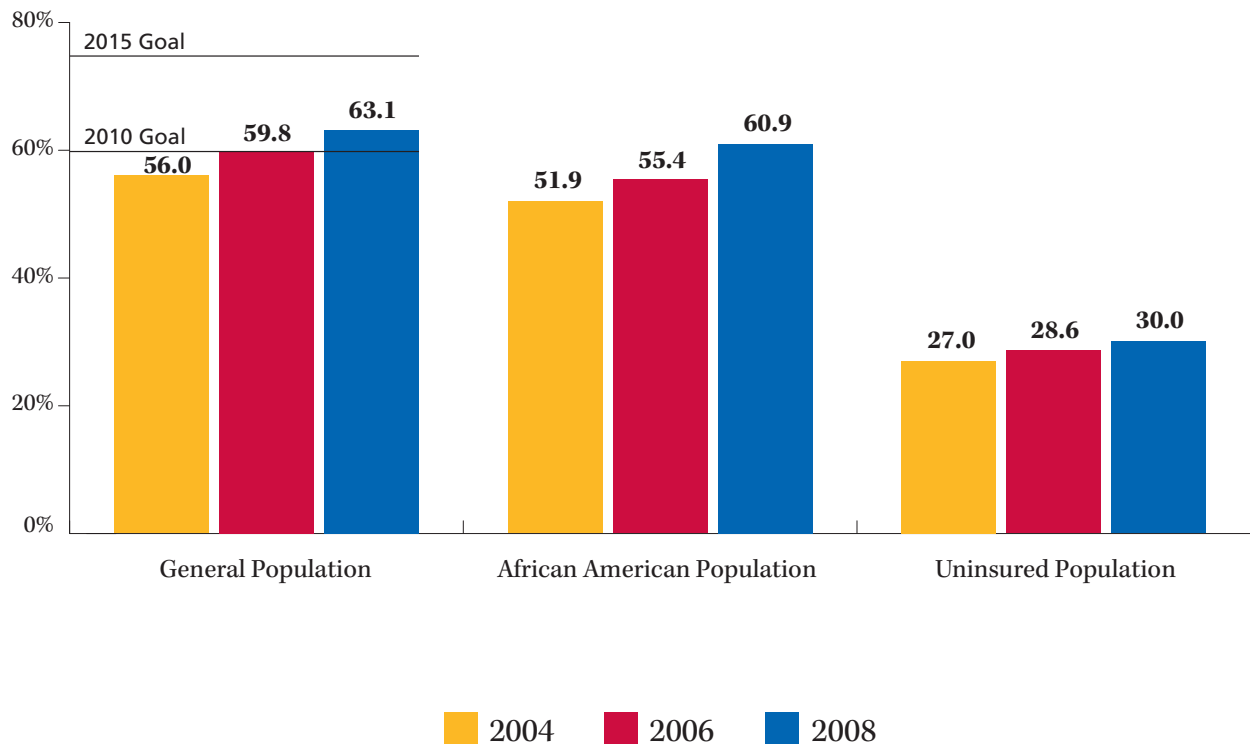
Source: CDC.

CDC funding for the NBCCEDP program in states, tribes, and territories increased slightly in FY2010, by ~\$4 million, to \$161 million. The total amount of funding by states declined almost \$7 million to \$132 million. The number of states at 50 percent or more of the CDC award remained at 15 in FY2010.



## 2010 Nationwide Mission – Prevention and Detection Leadership Role

### Colorectal Cancer Combined FOBT or Endoscopy Screening Rate Among Adults 50+



Note: No data updates for 2010.

Source: BRFSS. Screening rate for Fecal Occult Blood Test (FOBT) within the past year or sigmoidoscopy/colonoscopy within the past 10 years.

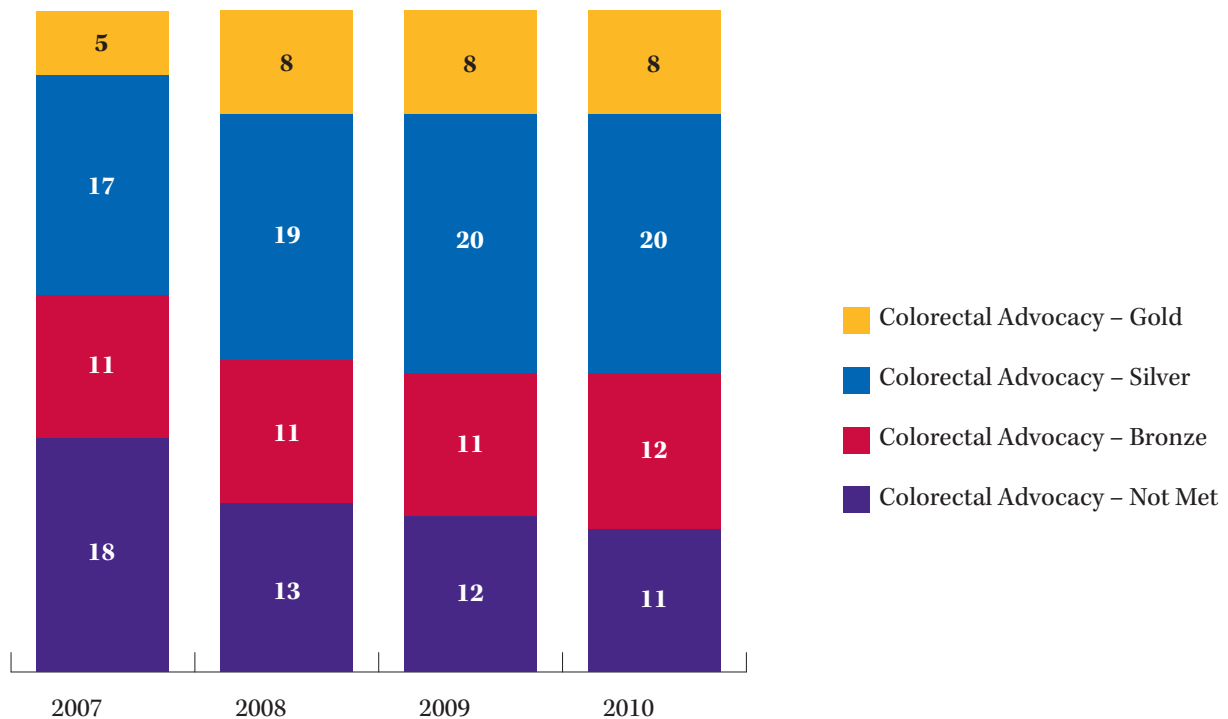
Colorectal cancer combined screening rates for FOBT or endoscopy increased among the general population (from 59.8 percent to 63.1 percent) and the African American population (from 55.4 percent to 60.9 percent), both above the national 2010 goal.

During the same time period, there was no significant change in screening rates among uninsured adults. For each year measured, rates for this group have been less than half the levels of the general population.



## 2010 Nationwide Mission – Prevention and Detection Leadership Role

### Number of States Achieving Colorectal Screening Coverage Advocacy Ratings



Source: American Cancer Society Cancer Action Network.

Criteria: Gold: Coverage for State employees, Medicaid, Medicare, Uninsured, Private insurers. Silver: Coverage in 4 categories.

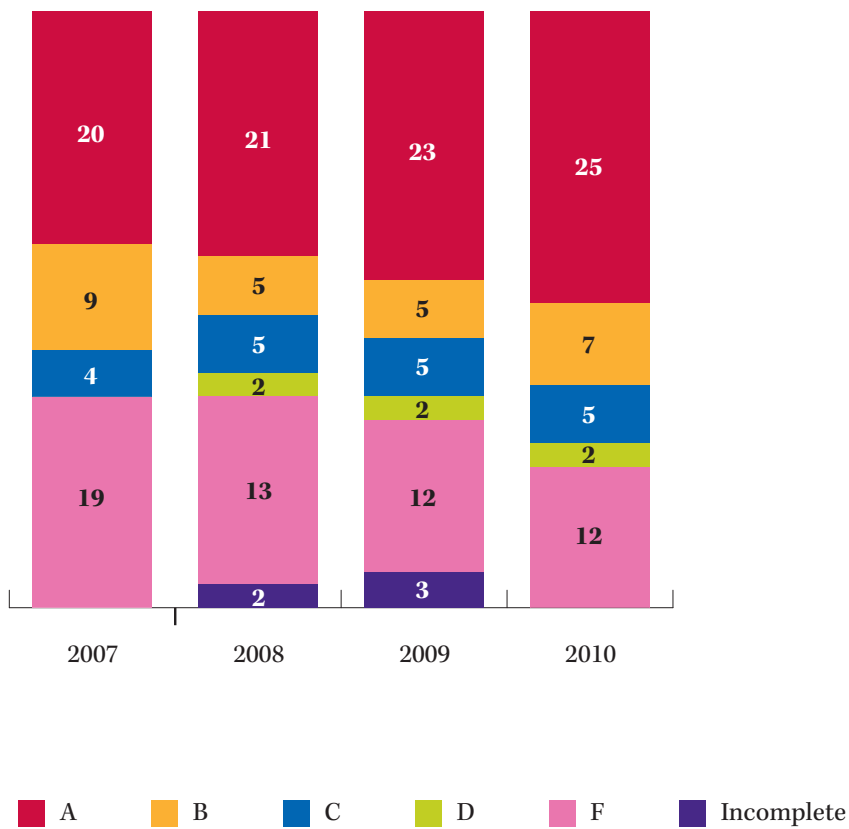
Bronze: Coverage in 3 categories.

Eight states maintained gold status, compared to the previous fiscal year; 20 states achieved a silver status, and 12 states achieved bronze status, up from 11 in the prior fiscal year.



# 2010 Nationwide Mission – Prevention and Detection Leadership Role

## State Smoke-free Laws Grade



Source: American Lung Association

An incomplete grade is given to states where a smoke-free law has been passed, but not implemented.

In 2010 a total of 25 states received a grade of 'A' and more than half of the states now have either an 'A' or 'B' grade.

## SUPPORTING PILLARS

### Fighting Back

The American Cancer Society works every day to empower individuals and communities across the nation to fight back against cancer. At its core, the Society is a vigilant grassroots force of passionate volunteers who tirelessly seek to save lives, whether it's by fighting for smoke-free laws, increased funding for cancer research, avenues to improve access to quality health care, or through inspiring community events.

For more information on American Cancer Society events in communities across the nation and around the world – such as our Relay For Life and Making Strides Against Breast Cancer events, as well as our DetermiNATION program – that give people from all walks of life a chance to fight back against cancer, please see page 19.

### *Advocacy – American Cancer Society Cancer Action Network*

Cancer is more than just a scientific and medical challenge – it is also a matter of public policy. In a world of competing policy concerns, government support for proven solutions in the fight against cancer is never guaranteed. The American Cancer Society and ACS CAN work in partnership to ensure that elected officials nationwide make the fight against cancer a top national priority. The Society granted more than \$14 million in 2010 to ACS CAN to support applied policy analysis, direct lobbying, grassroots action, media outreach, and litigation for the purpose of accomplishing the Society and ACS CAN's shared advocacy goals.

With funds granted by the Society as well as financial support from ACS CAN members, corporate donors, and other charitable organizations, including Society Divisions, ACS CAN leads a nationwide grassroots movement in support of laws and policies that help people fight cancer. ACS CAN volunteer advocates work to encourage lawmakers and policymakers to support necessary investments in research and prevention, strong tobacco control measures, improved access to care, and better quality of life for cancer patients.

ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit [acscan.org](http://acscan.org).

### Eliminating Cancer Disparities

One of the overarching themes of the American Cancer Society's 2015 challenge goals is eliminating disparities in the cancer burden between different segments of the US population. The causes of these health disparities are complex and interrelated, but likely arise from education, housing, and overall standard of living; economic and social barriers (such as a lack of health insurance) to high-quality cancer prevention, early detection, and treatment services; and the impact of racial and ethnic discrimination on all of these factors. Recent immigrants may also have unique risk factors related to their country of origin, as well as language and cultural barriers. Biologic or inherited differences associated with race are thought to make a minor contribution to the disparate cancer burden between racial/ethnic groups.

The American Cancer Society works aggressively to eliminate cancer disparities through a multi-layered approach of research, collaborations, community outreach, and public policy changes. As of January 2011, the Society had 89 grants in effect totaling just over \$72 million to support cancer disparities research. The Society has forged several strategic collaborations with organizations such as the National Medical Association and Phi Beta Sigma Fraternity, Inc., that will help the Society effectively reach and address health issues affecting minority communities.

The American Cancer Society and ACS CAN support important legislation and public programs that reduce cancer disparities and improve access to quality care for all Americans. ACS CAN is actively engaged in a number of efforts at the federal and state levels, including:

- Increasing federal and state funding that supports the National Breast and Cervical Cancer Early Detection Program, which provides free or low-cost breast and cervical cancer screening and follow-up treatment for low-income, uninsured, and underinsured women, with a high priority on reaching racial and ethnic minority women. Current funding allows the program to serve fewer than one in five eligible women aged 50 to 64 nationwide.
- Supporting the Colorectal Cancer Early Detection, Prevention, and Treatment Act, which will help increase access to colorectal cancer screening and treatment services for low-income, uninsured, and underinsured individuals age 50 to 64 (the pre-Medicare population) and those most at risk, such as African Americans.
- Funding the Patient Navigator, Outreach, and Chronic Disease Program, which would provide trained patient navigators to help minority and other medically underserved patients overcome barriers to quality health care and get the care they need. Congress appropriated \$5 million for fiscal year 2010 to ensure that the program gets off the ground; however, more funds are needed to ensure patient navigators are placed in additional medically underserved communities.

The Society is also actively engaged in a variety of targeted community outreach initiatives to provide cancer information, education, and support to minority communities.

# Financial Report

## COMBINED FINANCIAL STATEMENTS, FISCAL YEARS 2010 AND 2009 (in thousands)

ASSETS	August 31	
	2010	2009
Cash and cash equivalents	\$ 117,968	\$ 112,123
Temporary Investments, at fair value	844,921	784,250
Securities lent under securities lending program	107,821	163,253
Collateral received under securities lending program	109,992	166,450
Receivables, net	52,978	65,494
Prepaid expense and other assets	31,309	30,770
Gift annuity investments, at fair value	34,838	34,925
Legacies and bequests receivable	85,410	88,916
Beneficial interests in trusts	284,980	270,257
Fixed assets, net	345,596	353,992
Investments, at fair value	88,546	90,501
Total assets	\$ 2,104,359	\$ 2,160,931
<b>LIABILITIES AND NET ASSETS</b>		
Research and other program awards and grants payable	\$ 212,571	\$ 217,339
<b>Accrued expenses:</b>		
Accounts payable and other accrued expenses	67,537	84,450
Accrued retirement plan benefits	231,396	180,273
Post-retirement medical, dental, and life insurance accrual	57,716	56,472
Total accrued expenses	356,649	321,195
Gift annuity obligations	25,926	26,230
Payable under securities lending program	109,992	166,450
Other liabilities	26,108	27,464
Debt	65,715	67,851
Total liabilities	796,961	826,529
<b>Commitments and contingencies</b>		
<b>NET ASSETS:</b>		
Unrestricted:		
Available for program and supporting activities	531,951	556,585
Net investment in fixed assets	277,303	281,719
Total unrestricted	809,254	838,304
Temporarily restricted	258,137	273,416
Permanently restricted	240,007	222,682
Total net assets	1,307,398	1,334,402
Total liabilities and net assets	\$ 2,104,359	\$ 2,160,931

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	
				2010	2009
<b>REVENUE, GAINS, AND OTHER SUPPORT</b>					
<b>Support from the public:</b>					
Contributions	\$ 134,967	\$ 52,986	\$ 592	\$ 188,545	\$ 186,811
Special events	454,908	70,429	63	525,400	523,865
Other special fundraising events	297	-	-	297	534
Legacies and bequests	78,870	30,594	4,358	113,822	135,600
Change in value of split-interest agreements	(119)	5,537	77	5,495	(32,857)
Contributed services, merchandise, and other in-kind contributions at fair value	22,665	27,273	-	49,938	59,698
Contributions raised indirectly from federated and other fundraising organizations	12,930	6,773	-	19,703	23,972
Total support from the public	704,518	193,592	5,090	903,200	897,623
<b>Investment income (losses):</b>					
Interest and dividends, net	15,310	3,278	1	18,589	29,561
Net realized and unrealized investment gains (losses)	6,168	907	355	7,430	(15,038)
Net unrealized gains (losses) on perpetual trusts	-	-	11,649	11,649	(42,401)
Total investment income (losses)	21,478	4,185	12,005	37,668	(27,878)
<b>Exchange transactions:</b>					
Income	91,680	-	-	91,680	97,903
Expenses	(91,095)	-	-	(91,095)	(95,423)
Net exchange transactions	585	-	-	585	2,480
Grants and contracts from government agencies	8,824	2,356	-	11,180	19,388
Other revenue (losses)	2,937	885	(127)	3,695	296
(Loss) gain on disposal of fixed assets	(169)	-	-	(169)	5,142
Total revenue, gains, and other support	738,173	201,018	16,968	956,159	897,051
<b>NET ASSET RESTRICTION TRANSFERS</b>					
Satisfaction of activity restrictions	190,860	(190,860)	-	-	-
Revision of donor restriction	145	(502)	357	-	-
Satisfaction of equipment acquisition restrictions	6,711	(6,711)	-	-	-
Expiration of time restrictions	18,224	(18,224)	-	-	-
Total net asset restriction transfers	215,940	(216,297)	357	-	-

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total			
				2010	%	2009	%
<b>EXPENSES</b>							
<b>Program services:</b>							
Research – support provided to academic institutions and scientists to seek new knowledge about the causes, prevention, and cure of cancer, and to conduct epidemiological and behavioral studies	148,644	-	-	148,644	16%	149,829	15%
Prevention – programs that provide the public and health professionals with information and education to prevent cancer occurrence or to reduce the risk of developing cancer	148,982	-	-	148,982	16%	177,849	17%
Detection/treatment – programs that are directed at finding cancer before it is clinically apparent and that provide information and education about cancer treatments for cure, recurrence, symptom management, and pain control	112,262	-	-	112,262	12%	129,396	13%
Patient support – programs to assist cancer patients and their families and ease the burden of cancer for them	270,652	-	-	270,652	28%	275,377	27%
Total program services	680,540	-	-	680,540	72%	732,451	72%
<b>Supporting services:</b>							
Management and general – direction of the overall affairs of the Society through executive, financial, and administrative services	68,373	-	-	68,373	7%	62,948	6%
Fundraising – programs to secure charitable financial support for programs and supporting services	202,210	-	-	202,210	21%	222,280	22%
Total supporting services	270,583	-	-	270,583	28%	285,228	28%
Total program and supporting services expenses	951,123	-	-	951,123	100%	1,017,679	100%
Net decrease in retirement plan liability	32,040	-	-	32,040		134,604	
CHANGE IN NET ASSETS	(29,050)	(15,279)	17,325	(27,004)		(255,232)	
NET ASSETS, beginning of year	838,304	273,416	222,682	1,334,402		1,589,634	
NET ASSETS, end of year	\$ 809,254	\$ 258,137	\$ 240,007	\$ 1,307,398		\$ 1,334,402	

	Program Services				Supporting Services		Total	
	Research	Prevention	Detection/ Treatment	Patient Support	Management	Fundraising	2010	2009
<b>EXPENSES</b>								
Salaries	\$ 16,346	\$ 64,589	\$ 50,602	\$ 107,282	\$ 32,245	\$ 97,012	\$ 368,076	\$ 409,974
Employee benefits	4,394	20,217	15,590	33,248	9,572	28,679	111,700	88,943
Payroll taxes	1,259	5,355	4,195	9,050	2,750	7,992	30,601	32,577
Professional fees	6,893	11,474	8,169	12,332	2,845	12,871	54,584	60,686
Supplies	142	1,169	895	2,130	394	1,672	6,402	7,522
Telephone	773	3,170	2,240	5,369	1,015	3,696	16,263	17,501
Postage and shipping	302	4,870	2,270	5,594	2,707	6,447	22,190	21,637
Occupancy	1,936	7,124	5,232	16,741	4,232	9,362	44,627	45,724
Equipment rental, maintenance, and information processing	941	2,341	1,683	3,646	1,316	2,856	12,783	13,012
Printing and publications	3,957	10,167	7,238	15,126	2,600	11,302	50,390	57,148
Meetings and conferences	1,548	3,055	2,452	4,098	1,315	3,881	16,349	19,667
Travel	1,028	4,610	3,192	5,888	977	5,365	21,060	29,115
Special assistance to individuals	-	3	302	28,042	-	6	28,353	26,959
Awards and grants for program services, net of cancellations	105,167	2,970	2,679	4,369	2	27	115,214	121,957
Membership dues and subscriptions	241	329	182	285	198	276	1,511	1,704
Depreciation and amortization	1,718	4,543	3,301	10,279	1,672	5,893	27,406	27,798
Interest expense	2	74	54	2,317	137	124	2,708	2,880
Contributed services and other in-kind contributions	1,818	882	428	1,933	784	526	6,371	18,344
Miscellaneous	179	2,040	1,558	2,923	3,612	4,223	14,535	14,531
<b>Total program and supporting services expenses</b>	<b>\$ 148,644</b>	<b>\$ 148,982</b>	<b>\$ 112,262</b>	<b>\$ 270,652</b>	<b>\$ 68,373</b>	<b>\$ 202,210</b>	<b>\$ 951,123</b>	<b>\$ 1,017,679</b>

<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>	<b>2010</b>	<b>2009</b>
Change in net assets	\$ (27,004)	\$ (255,232)
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:		
Depreciation and amortization	27,594	27,875
Net unrealized (gains) losses on perpetual trusts	(11,649)	42,401
Net realized and unrealized investment (gains) losses	(7,430)	15,038
Change in value of split-interest agreements	(5,495)	32,857
Loss (gain) on disposal of fixed assets	169	(5,142)
Other gains	-	21
Net change in retirement plan liability	32,040	134,604
Support from the public restricted for long-term investment	(5,090)	(7,177)
Support from the public restricted for fixed asset acquisition	(3,102)	(5,572)
Changes in assets and liabilities:		
Receivables, net	12,516	12,520
Prepaid expenses and other assets	(521)	2,090
Legacies and bequests receivable	3,506	8,676
Beneficial interests in trusts and gift annuities, net	5,722	2,506
Research and other program awards and grants payable	(4,768)	(12,348)
Accrued expenses	(8,163)	(9,952)
Other liabilities	(1,008)	(4,398)
Net cash provided by (used in) operating activities	7,317	(21,233)
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Purchase of fixed assets	(19,781)	(29,912)
Proceeds from disposal of fixed assets	678	9,213
Support from the public restricted for fixed asset acquisition	3,102	5,572
Purchase of investments	(570,070)	(667,205)
Proceeds from maturity or sale of investments	574,154	720,573
Net cash (used in) provided by investing activities	(11,917)	38,241
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>		
Payments on debt	(2,136)	(5,383)
Proceeds from issuance of debt	-	1,102
Increase (decrease) in bank overdrafts	11,577	(8,265)
Payments on capital lease obligations	(568)	(628)
Payments to annuitants	(3,518)	(3,598)
Support from the public restricted for long-term investment	5,090	7,177
Net cash provided by (used in) financing activities	10,445	(9,595)
<b>NET CHANGE IN CASH AND CASH EQUIVALENTS</b>	<b>5,845</b>	<b>7,413</b>
<b>CASH AND CASH EQUIVALENTS, beginning of year</b>	<b>112,123</b>	<b>104,710</b>
<b>CASH AND CASH EQUIVALENTS, end of year</b>	<b>\$ 117,968</b>	<b>\$ 112,123</b>
<b>SUPPLEMENTAL CASH FLOW INFORMATION</b>		
Interest paid	\$ 2,667	\$ 2,834
<b>NON-CASH INVESTING AND FINANCING ACTIVITIES</b>		
Fixed assets acquired through capital lease	\$ 220	\$ 124
Collateral received and payable under the securities lending program	\$ (56,458)	\$ 3,845

# MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL RESULTS

## Results from Operations – Revenue

Combined revenue from operations for the last two years in the period ending August 31 was as follows (in thousands):

	2010	2009
Support from the Public	\$903,200	\$897,623
Investment Income (Losses)	37,668	(27,878)
Grants and Contracts from Government Agencies	11,180	19,388
Other Income	4,111	7,918
Total Revenue	\$956,159	\$897,051

Total revenue for fiscal year 2010 was \$956 million, \$59 million more than prior year or a 7 percent increase; the overall charitable sector results also demonstrated increases during 2010 as the country and sector recovered from the economic crisis of the past few years. Fiscal year 2010 marked the second consecutive year since fiscal year 2005 that the organization did not surpass \$1 billion in total revenue, partially as a result of the economic conditions and the resulting impact on both the markets and our constituents. The Society has also seen erosion of total revenue over the years as more cancer organizations have entered the fundraising space and niche organizations have grown.

Support from the public increased \$6 million or 1 percent from prior year mostly driven by planned giving results. The charitable sector typically lags both entering and exiting a recessionary period, therefore we were not surprised that after a year of steep declines, our public support financial results flattened out during fiscal year 2010 with a continued increase in event participation.

Within support from the public, special events continue to dominate the financial results. Our signature event, Relay For Life, fared relatively well in the spring and summer months, increasing less than 1 percent from prior year but rebounding from a 5 percent decline in the prior year, resulting in a net revenue amount of \$388 million. The Relay For Life revenue base is very broad over events (more than 5,100 events) and constituents (more than 3 million participants) and therefore tends to withstand external circumstances better than other special events. Consistent with other special event results, Relay For Life participation increased from the prior year, although revenue was relatively flat. The Society continues to utilize Relay For Life as an efficient vehicle to build awareness, deliver prevention and detection messaging, and develop capacity in the communities that we serve. Making Strides Against Breast Cancer, a \$50 million special event that raises awareness and funds to fight breast cancer, declined 1 percent from the prior year amid increases in participation. Endurance events, primarily events under the DetermiNation platform, continued to perform exceedingly well in fiscal year 2010, achieving a 63 percent increase in revenue, including two new DestiNation sites. The Society has recently invested in this area in a very targeted and accelerated manner, and while the overall DetermiNation revenue is not material to total revenue, we anticipate double-digit growth to continue. Golf events and galas, traditionally hit hardest during difficult economic periods, increased by more than 1 percent as the organization instated events that had been canceled in fiscal year 2009 and new events that had been deferred in the prior year. Capital campaigns experienced a 42 percent decline from prior year, mainly due to campaigns that were concluding and the lack of new campaign launches to replace the previous activity. As with many other charitable organizations, the Society is reassessing the feasibility studies supporting any anticipated capital campaign as the campaign landscape is vastly different than prior to the economic downturn. Employee giving, including United Way and Combined Federal Campaign relationships, continues to experience a decline – 11 percent from fiscal year 2009 to 2010 – as the employee giving environment continues to be intensely competitive and as employees pulled back on their giving due to their own personal financial situations. Direct marketing, both mail and telemarketing, also showed a minimal decline – 1 percent – in fiscal year 2010. Planned giving results (legacies and bequests and change in value of split-interest

agreements) increased by 13 percent from the prior year, mostly driven by market values of beneficial interests in trusts or deferred gifts. The Society was the beneficiary of a few significant legacies in fiscal year 2009, which did not recur in fiscal year 2010 and were offset by the increase in market values. The planned giving units continue to log future gifts, although not accruable under generally accepted accounting principles, but accretive to the significant planned giving pipeline of future revenue. Contributed services and merchandise decreased 20 percent from fiscal year 2009, mostly due to donated advertising by certain corporate partners that did not recur from the prior year.

Investment income components had mixed results with interest and dividends declining by 37 percent from fiscal year 2009 due to the historically low interest rates. The Society's operating portfolio is currently focused on short- and intermediate-term products, and interest income decreased as interest rates declined during the past few years. Net realized and unrealized investment results swung from a loss position in fiscal year 2009 to a gain position in fiscal year 2010, producing a net gain of \$22 million from prior year. Net unrealized losses on perpetual trusts in fiscal year 2009 also moved to net unrealized gains in fiscal year 2010, contributing to a \$54 million increase from the prior year due to the underlying market value of the assets in those trusts. The Society is not a trustee on these trusts and therefore does not have the control of the investment decisions surrounding these assets, but rather reports our proportionate share of the current value.

Grants and contracts from government agencies decreased by 42 percent from the prior year due to a collaboration with Alere Wellbeing to leverage our brand and their delivery model for a more efficient and effective tobacco cessation model. Alere Wellbeing is now the contracting entity with states and employers for cessation services; contracts were still in transition from the Society to Alere Wellbeing during fiscal year 2010.

Other revenue decreased \$4 million due to non-recurring gains on disposal of fixed assets from certain property sales during fiscal year 2009.

<b>Total Public Support Net Income (in millions)</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
Total public support	\$969	\$1,039	\$1,008	\$898	\$903
Relay For Life	\$375	\$406	\$409	\$386	\$388
Other community-based events (Making Strides Against Breast Cancer, Daffodil Days, others)	\$73	\$83	\$90	\$91	\$89
Distinguished events (gala and golf)	\$53	\$57	\$57	\$48	\$49
Direct response strategies (direct mail, telemarketing)	\$69	\$72	\$70	\$65	\$64
Employer-based strategies – independent payroll deduction campaigns	\$14	\$21	\$22	\$20	\$19
Major gifts/campaigns	\$62	\$69	\$65	\$49	\$45
Planned giving (legacies, bequests, others)	\$171	\$193	\$157	\$103	\$119
United Way/Combined Federal Campaign	\$31	\$29	\$25	\$22	\$18
Memorials	\$33	\$31	\$31	\$29	\$28
Contributed services and other in-kind contributions	\$63	\$51	\$45	\$60	\$50
Other	\$25	\$27	\$37	\$25	\$34

## Results from Operations – Expenses

Combined program and supporting services expenses for the last two years in the period ending August 31 were as follows (in thousands):

<b>Program Services</b>	<b>2010</b>	<b>2009</b>
Research	\$148,644	\$149,829
Prevention	148,982	177,849
Detection/Treatment	112,262	129,396
Patient Support	270,652	275,377
Total Program Services	\$680,540	\$732,451
<b>Supporting Services</b>	<b>2010</b>	<b>2009</b>
Management and General	\$68,373	\$62,948
Fundraising	202,210	222,280
Total Supporting Services	\$270,583	\$285,228

Total program expenses for fiscal year 2010 were nearly \$681 million, \$51 million less than the prior year or a 7 percent decline. This decline in program expenditures is compared with a 17 percent decrease in total revenue in the previous year, which demonstrates a fundamental business challenge for the Society; as economic conditions worsen, our constituents' needs do not decrease and in some instances, actually increase. Additionally, it typically takes a full business cycle to realize and report the impact of significant cutbacks. Total supporting services expenses were nearly \$271 million, which was a significant decrease, 5 percent, from the prior year.

Research, prevention, and detection/treatment all experienced decreases from the prior year as the Society realized the budget reductions executed in the prior year in order to preserve and continue our significant community presence and broad mission delivery for our constituent base. Prevention declined 16 percent due to the transition of our tobacco cessation services to Alere Wellbeing, in addition to advocacy efforts that were focused on research in fiscal year 2010 rather than prevention in fiscal year 2009. Detection/treatment decreased 13 percent in fiscal year 2010, primarily due to certain non-recurring contributed advertising around detection and a change in the nature of the calls received at our National Cancer Information Center. Patient support also decreased slightly as cutbacks were comprehensive and affected all program service categories.

Management and general expenses increased as reductions in force were executed around the country in order to respond to the substantial revenue decline from 2009; these cost savings will be realized in future years. Offsetting the increased expenses were continuous improvements of our Shared Services Business Center and efficiencies in our independent audit. Fundraising costs declined during fiscal year 2010 due to an enhanced focus on portfolio management and lower cost strategies. Cost per dollar raised decreased from \$0.25 to \$0.22 as public support was flat to prior year and fundraising costs declined.

## Liquidity and Cash Flows

Cash and cash equivalents, temporary investments, and securities lent under securities lending program increased by 1 percent from prior year, ending at \$1 billion. The primary sources of cash that contributed to the \$6 million net increase were net proceeds from operations and the major use of cash during the fiscal year was purchase (or building) of fixed assets.

The Society invests operating funds in both short- and intermediate-term investments as selected, monitored, and evaluated by senior leadership, our investment advisors, and volunteer investment committee. Due to the short-term nature of the investments and a low-risk strategy, the Society did not incur any substantial losses during the market downturn. During 2010, the team reevaluated the strategy for operating funds and moved to a tiered structure approach, introducing longer-term products, which will enhance the asset return without incurring additional risk. Also as a strategy to maximize return, certain of the fixed-income securities in the

portfolio are included in a securities lending program, which is administered with a large investment custodian and collateralized at 102 percent. The Society has never experienced a loss or lack of liquidity with regard to the program; however, it is evaluating the risk versus return, especially in light of the last few years when many organizations suffered losses and illiquidity in their securities lending program. The Society is currently in the process of evaluating the endowment and long-term portfolio investment policy statements.

During fiscal year 2010, the Society completed an important process of evaluating and revising its internal policy with regard to minimum and maximum liquidity levels to ensure continued financial health and continuation of quality program delivery to our constituents.

# Management and Leadership

## GOVERNANCE STANDARDS AND PRACTICE

As described in the Organizational Structure section, the American Cancer Society is comprised of a National Home Office and 12 separately incorporated Divisions. Each of the Divisions is chartered by the NHO, through its Board of Directors, and is required to sign a charter agreement that sets forth certain mission-critical policies that the Divisions are required to follow. The Divisions certify compliance with the mission-critical policies on a quarterly basis, and report financial information to the NHO's Board of Directors. Failure by a Division to comply with a mission-critical policy or breach of the charter agreement could result in sanctions to the Division up to and including revocation of the charter.

To preserve the public's trust and protect the Society's strong reputation, the national Society has adopted most if not all of the recognized governance best practices for nonprofit organizations, and has gone a step further by adopting many of the relevant governance practices used by publicly traded for-profit companies as well. The Society has established charters for several Board committees, including the Audit Committee, Finance Committee, Compensation Committee, and Governance Committee.

The Audit Committee assists the Board in overseeing accounting and internal control processes. The Finance Committee assists the Board in overseeing the financial performance and strategy of the Society. The Compensation Committee oversees executive compensation. The Compensation Committee's charter provides a road map for compliance with IRS procedural requirements on compensation and transactions with insiders. The Governance Committee's charter also follows the new for-profit practices that require the committee to consist of only independent directors. All Divisions have adopted this charter for their respective Compensation Committees as a requirement of their charter agreements.

Tax and financial information for the national Society is publicly available on cancer.org and on the Form 990s, which are filed annually with the IRS. The NHO Board of Directors and the Board of Directors for each Division review the information provided in their respective Form 990s prior to filing with the IRS.

## ETHICS POLICIES

The Society's written Code of Ethics contains a mechanism for managing and disclosing conflicts of interest, as well as a confidentiality agreement for staff and certain volunteers. In addition, the Society has implemented a whistleblower policy and nationwide hotline (1-866-813-8313) to address suspected violations of law or misconduct. Each of the Divisions has adopted these policies and reports to NHO on their compliance with these policies as part of the requirements of the charter agreement.

These governance practices reflect the American Cancer Society's commitment to the highest standards of organizational integrity.

## EXECUTIVES AND COMPENSATION

### Executive Compensation

#### *Overview and Guiding Principles*

The Society requires top executive talent with a wide range of management skills, education, experience, and leadership abilities to lead the national organization, as well as the chartered Divisions. The Society recognizes both its legal obligation to pay only reasonable compensation and benefits to its executives, as well as its need to pay competitively in order to assure it can attract and retain the requisite executive leadership required to carry out the organization's mission.

The Society fundamentally believes that nonprofit executive compensation should be market-based and performance-tested. The Society views the market as other nonprofit health and social welfare agencies regardless of size, other nonprofits of comparable size, and other large non- and for-profit organizations that could compete for and be a source of executive talent. The Society relies on independently derived and reliable sources of compensation data, as well as the reasoned opinion of an independent, nationally recognized compensation consultant, as the basis of compensation comparisons and compensation policy. The current compensation consultant is Mercer LLC.

### ***The Role of the Board of Directors and the Compensation Committee***

The National Board of Directors is responsible for the administration of the Society's compensation program. The Board of Directors has chartered a Compensation Committee of independent directors, which exercises the Board's authority to assure and document the reasonableness of the compensation and benefits provided to the chief executive officer and other executives with substantial authority over the Society's affairs and finances, such as the chief operating officer and the chief financial officer.

The committee also conducts an annual review of the chief executive officer's total compensation. In that review, committee members measure the compensation against defined goals and compare it with market-based data provided by an independent, qualified compensation consultant. This review may result in an adjustment of the CEO's compensation and benefits in order to conform to market-based data and to reflect performance outcomes, all according to standards of reasonableness and IRS guidelines.

With respect to other executives with substantial authority over the Society's affairs and finances, the committee reviews and approves the ranges of compensation and benefits for these executives based on recommendations provided by an independent, qualified consultant, and in accordance with the same standards of reasonableness and IRS guidelines. The committee documents its deliberations and decisions and submits a report to the Board at least annually.

The Society has adopted a set of key principles that guide its executive compensation decision-making process, as follows:

- It will uphold competitive, yet reasonable compensation policies and practices relative to the market and that comply with IRS guidelines.
- It will expect vigorous goal-setting tied to the strategic, mission-related, and financial objectives of the organization and will objectively evaluate executive performance against these objectives.
- It will pay for expected performance and reward the achievement of high performance outcomes.
- It will require timely and accurate documentation of executive compensation decisions, regularly inform the Board of its actions, and make available compensation information related to reviewed executives.
- It will completely and accurately disclose the total compensation paid to executives on the annual Form 990, which will be provided to the Board for its review prior to filing with the Internal Revenue Service.

### ***Primary Program Components***

Total compensation for executives is made up of the following components: base salary, annual incentives, standard benefits, and supplemental retirement benefits.

- Base salary ranges are based on the median value in the market for comparable positions, as established through generally accepted compensation methods, and through the use of available surveys provided by outside consultants, and/or other appropriate forms of data.
- Incentive compensation is the primary tool to reward outstanding executive performance for certain key executives. Incentive compensation is used to focus performance on specific outcomes of particular benefit to the organization and to achieving its mission, and thus to reward and help retain certain key executives for the achievement of outstanding results.

- The Society provides executives market-competitive total benefits. Executives receive the benefits made available to all employees, which include:
  - Participation in a qualified defined benefit (pension) plan
  - Participation in a qualified defined contribution plan (403(b) plan – similar to traditional 401(k) plan)
  - Comprehensive medical, dental, and vision insurance
  - Life insurance for the executive and his or her family
  - Flexible spending accounts for health care and dependent care
  - Health and wellness programs
  - An employee assistance program
  - Short- and long-term disability insurance
  - Paid holidays
  - Vacation, sick, and personal time

### ***Retirement Plans and Other Benefits***

In 2008, the Society redesigned its retirement plans to combine the pension benefit (defined benefit) with the 403(b) benefit and added an employer match (defined contribution.) The decision to change the Society's retirement benefit structure was based on market studies and reflects the desire to continue to attract top executive management talent from an increasingly mobile workforce, while minimizing the long-term financial risks and costs associated with maintaining a pension-only retirement plan. Existing employees were given the option to remain in the existing pension plan without a 403(b) match or elect the new combined plan. All employees hired after January 1, 2008, are automatically enrolled in the combined plan.

- In addition to the benefits listed above, eligible executives may be considered for participation in a supplemental retirement plan. The plan restores the earned pension benefit that an executive would lose based on compensation limitations imposed by the Internal Revenue Code on the qualified pension plan. Some Society executives also participate in a salary deferral plan known as a 457(b) plan. The 457(b) plan allows the participating executive to set aside a portion of his or her salary, on a pre-tax basis and at no additional cost or risk to the Society, for future payment. Participation in the plan is generally available only to the Society's senior executives.
- The Society does not provide executives-only perquisites such as a car allowance, club dues, leased vehicles, or reimbursement of professional advisory services.
- The Compensation Committee may also authorize unique program components that support the achievement of the Society's mission. These unique components could be selectively applied, for example, individual retention agreements or special severance arrangements.

Below is a link to NHO's Form 990, which provides information about the compensation of NHO's executives:

[cancer.org/AboutUs/WhoWeAre/FinancialInformation/IRSForm990s/index](http://cancer.org/AboutUs/WhoWeAre/FinancialInformation/IRSForm990s/index)

# NATIONAL BOARD OF DIRECTORS

## National Officers

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Second Vice President	Tim E. Byers, MD, MPH
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Secretary	Lila R. Johnson, RN, MPH, CHES
Immediate Past Chair	George W. P. Atkins
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## Directors

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Susan D. Henry, LCSW – Mid-South	2012
Jeffrey L. Kean – California	2012
Robert R. Kugler, Esq. – Eastern	2011
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#### LAY

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Sandra Millon Underwood, RN, PhD, FAAN	2012
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Kevin J. Cullen, MD	2011
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## NATIONAL ASSEMBLY MEMBERS

Full Name	Assembly Position
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Willie H. Goffney, MD, FACS	Board Member Delegate
Jeffrey L. Kean	Board Member Delegate
Cynthia M. LeBlanc, EdD	Board Member Delegate
Marjorie Kagawa Singer, RN, MN, PhD, FAAN	Board Member Delegate
Clifford C. Eke Jr., MD, FACS, FICS	Division Delegate
George A. Fisher, MD, PhD	Division Delegate
Carol Jackson	Division Delegate
Paul J. Murata, MD, MSPH	Division Delegate
Carolyn Rhee	Division Delegate
Charles G. Smith, Esq.	Division Delegate
Carolyn Pesnell Amory	Honorary Life Member
Sally West Brooks, RN, MA	Honorary Life Member
Helene G. Brown	Honorary Life Member
Jennie R. Cook	Honorary Life Member
George Good	Honorary Life Member
Larry Hagman	Honorary Life Member
Thomas D. Hobday Jr.	Honorary Life Member
Ann Jillian	Honorary Life Member
Allan K. Jonas	Honorary Life Member
Robert J. Schweitzer, MD	Honorary Life Member
Stephen F. Sener, MD	Past Officer Delegate
<b>East Central Division</b>	
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Enrique Hernandez, MD	Board Member Delegate
Gary M. Reedy	Board Member Delegate
Stephen L. Swanson	Board Member Delegate
Gary Allison	Division Delegate
Patrick J. Fahey, MD	Division Delegate
Z. Charles Fixler, MD, FACP	Division Delegate
Thenice P. Gall	Division Delegate
Carmen E. Guerra, MD, MSCE, FACP	Division Delegate
Samuel W. Monismith, DED	Division Delegate
Valeriy Moysaenko, MD, FACS	Division Delegate
George H. Musekamp III	Division Delegate
Regina "Jean" Nagy	Division Delegate
Peter C. Olden, MHA, PhD	Division Delegate
Chand Rohatgi, MD	Division Delegate
Barbara J. Wilinski	Division Delegate

<b>Full Name</b>	<b>Assembly Position</b>
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**East Central Division (continued)**

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Frank B. Fisher . . . . .	Honorary Life Member
Mary A. Simmonds, MD, FACP . . . . .	Honorary Life Member
Robert C. Young, MD . . . . .	Honorary Life Member
Richard C. Wender, MD . . . . .	Past Officer Delegate

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Marguerite K. Schlag, RN, EdD . . . . .	Division Delegate
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Mrs. Elmer H. Bobst . . . . .	Honorary Life Member
Matilda Raffa Cuomo . . . . .	Honorary Life Member
George Dessart . . . . .	Honorary Life Member
Norma J. Hayman . . . . .	Honorary Life Member
George J. Hill, MD . . . . .	Honorary Life Member
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John M. Montgomery, MD, MPH, FAAFP . . . . .	Division Delegate
Eric Sandler, MD . . . . .	Division Delegate
John F. Windham, Esq. . . . .	Division Delegate
Victor A. Marcial, MD . . . . .	Honorary Life Member
Barbara Weintraub . . . . .	Honorary Life Member

**Great Lakes Division**

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Douglas K. Kelsey, MD, PhD . . . . .	Board Member Delegate
Maryjean Schenk, MD, MPH, MS . . . . .	Board Member Delegate
Maria J. Worsham, PhD, FACMG . . . . .	Board Member Delegate
Raymond Y. Demers, MD, MPH . . . . .	Division Delegate
Frank P. Lloyd Jr., MD, FACS . . . . .	Division Delegate
Joseph R. Mahoney, CPA . . . . .	Division Delegate

<b>Full Name</b>	<b>Assembly Position</b>
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**Great Lakes Division (continued)**

James E. Montie, MD .....	Division Delegate
Gregory L. Pemberton .....	Division Delegate
Peter S. Sheldon, Esq. ....	Division Delegate
Thomas G. Burish, PhD .....	Past Officer Delegate

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Pamela K. Meyerhoffer, FAHP .....	Board Member Delegate
Robert E. Youle .....	Board Member Delegate
Deborah J. Barnard .....	Division Delegate
Wil Counts, RPh, PhD .....	Division Delegate
Patricia J. Crome, RN, MN .....	Division Delegate
John W. Hamilton, DDS .....	Division Delegate
Marianne B. Kipper, PhD .....	Division Delegate
Brian A. Marlow, CFA .....	Division Delegate
Harmon J. Eyre, MD .....	Honorary Life Member
Gordon R. Klatt, MD .....	Honorary Life Member
H. Fred Mickelson .....	Honorary Life Member
Van Velsor Wolf .....	Past Officer Delegate

**High Plains Division**

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Jack W. Steinmeyer .....	Division Delegate
Thomas J. Williams .....	Division Delegate
B.L. Aronoff, MD .....	Honorary Life Member
Dileep G. Bal, MD, MS, MPH .....	Honorary Life Member
Gerald D. Dodd, MD .....	Honorary Life Member
G. Robert Gadberry .....	Honorary Life Member
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Myles P. Cunningham, MD	Honorary Life Member
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Kathleen L. Horsch	Honorary Life Member
Gerald C. Mueller, MD, PhD	Honorary Life Member
Henry C. Pitot, MD, PhD	Honorary Life Member
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<b>Full Name</b>	<b>Assembly Position</b>
<b>New England Division</b>	
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Vincent T. DeVita Jr., MD . . . . .	Board Member Delegate
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David M. Zacks, Esq. . . . .	Honorary Life Member
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Anna Johnson-Winegar, PhD . . . . .	Past Officer Delegate

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### Past Presidents

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1996	Dr. Raymond Lenhard Jr.	Maryland	
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1987	Dr. Virgil Loeb Jr.	Missouri	Deceased
1986	Dr. Charles A. LeMaistre	Texas	
1985	Dr. Robert J. McKenna	California	Deceased
1984	Dr. Gerald P. Murphy	New York	Deceased
1983	Dr. Willis J. Taylor	Washington	Deceased
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1981	Dr. Edward F. Scanlon	Illinois	Deceased
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1977	Dr. R. Lee Clark	Texas	Deceased
1976	Dr. Benjamin F. Byrd Jr.	Tennessee	Deceased
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1974	Dr. Justin Stein	California	Deceased
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1970	Dr. Jonathan E. Rhoads	Pennsylvania	Deceased
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1967	Dr. Ashbel C. Williams	Florida	Deceased

1966	Dr. Leonard W. Larson	North Dakota	Deceased
1965	Dr. Murray M. Copeland	Texas	Deceased
1964	Dr. Wendell G. Scott	Missouri	Deceased
1963	Dr. I. S. Ravdin	Pennsylvania	Deceased
1962	Dr. Thomas Carlile	Washington	Deceased
1961	Dr. John W. Cline	California	Deceased
1960	Dr. Warren H. Cole	Illinois	Deceased
1959	Dr. Eugene P. Pendergrass	Pennsylvania	Deceased
1958	Dr. Lowell T. Coggeshall	Illinois	Deceased
1957	Dr. David A. Wood	California	Deceased
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1952	Dr. Charles C. Lund	Massachusetts	Deceased
1951	Dr. Guy Aud	Kentucky	Deceased
1950	Dr. Alton Ochsner	Louisiana	Deceased
1949	Dr. C. C. Nesselrods	Kansas	Deceased
1948	Dr. Edwin P. Lehman		Deceased
1943-1946	Dr. Frank E. Adair	New York	Deceased
1941-1943	Dr. Herman C. Pitts	Rhode Island	Deceased
1937-1941	Dr. John J. Morten Jr.		Deceased
1937	Dr. Frederick F. Russel		Deceased
1936	Dr. Robert S. Greenough	Connecticut	Deceased
1933-1935	Dr. Burton T. Simpson	New York	Deceased
1931-1933	Dr. George M. Bigelow		Deceased
1931	Dr. Jonathan M. Wainwright		Deceased
1924-1930	Dr. Howard C. Taylor	New York	Deceased
1922-1924	Dr. Edward Reynolds	Massachusetts	Deceased
1918-1922	Dr. Charles A. Powers	Colorado	Deceased
1913-1918	Dr. George C. Clark		Deceased

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2009	Van Velsor Wolf	Arizona
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2005	Thomas G. Burish, PhD	Virginia
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2003	David M. Zacks	Georgia
2002	H. Fred Mickelson	Oregon
2001	John C. Baity, Esq.	New York
1999	John R. Kelly, PhD	Mississippi
1998	Francis Coolidge	Massachusetts
1997	Jennie R. Cook	California

1996	George Dessart	New York	
1994-1995	Larry K. Fuller	Texas	Deceased
1992-1993	Stanley Shmishkiss	Massachusetts	
1990-1991	John R. Seffrin, PhD	Georgia	
1988-1989	Kathleen J. Horsch	Wisconsin	
1986-1987	Don Elliot Heald	Georgia	Deceased
1983-1985	G. Robert Gadberry	Missouri	
1981-1982	Allan K. Jonas	California	
1978-1980	Hon. Joseph H. Young	Maryland	
1976-1977	Thomas P. Ulmer	Florida	Deceased
1974-1975	W. Armin Willig	Kentucky	
1972-1973	Charles R. Ebersol	Connecticut	Deceased
1968-1971	William B. Lewis	New York	Deceased
1967	Travis T. Wallace	Texas	Deceased
1963-1966	Francis J. Wilcox	Wisconsin	Deceased
1960-1962	Rutherford L. Ellis	Georgia	Deceased
1953-1959	Governor Walter J. Kohler Jr.	Wisconsin	Deceased
1950-1952	General William J. Donovan	New York	Deceased
1947-1949	Eric A. Johnston		Deceased
1946	Ted R. Gamble		Deceased
1945	Eric A. Johnston		Deceased
1944	Dr. Herman C. Pitts	Rhode Island	Deceased
1949-1955	Elmer H. Bobst (Honorary Board Chair)		Deceased









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