Message from the Medical Director

Our cancer program at Marymount Hospital, accredited by the Commission on Cancer since 1987, continues to provide our community with the latest in cancer care. As a Cleveland Clinic hospital, we remain focused on providing integrated cancer care. We make sure our patients have access to medical specialists, effective diagnostic and treatment options and a network of supportive services.

To best serve our cancer patients and their families, our Hospital Cancer Committee conduct quality studies and improvements, review our alignment to national cancer guidelines, and evaluate our clinical services. Each committee member is passionate about cancer care. Our team is committed to offering quality care to our patients.

Over the past year, we have worked collaboratively to strengthen our cancer program. Our electronic medical records are continuously upgraded to provide clinicians with integrated patient information. We have added new clinicians to our cancer care team. Diagnostic tests to help us plan treatment for colon cancer patients have been standardized. We have also continued to work on integrating palliative care into our treatment plans for our high risk patients.

We moved about our work day with patients and their families guided by Marymount’s mission – to provide excellent health care guided by the Christian values of Service, Compassion, Dignity and Respect. I am honored to lead our cancer care team. I am proud to share a snap shot of our work and progress made in our cancer program. I hope you will find this information useful. We have great hope for advancements in cancer care and look forward to bringing our community the very best in cancer treatment.

Bachar Dergham, MD
Chairperson, Cancer Committee 2013
Dr. Lanea Keller is the Radiation Oncologist who joined our cancer program in 2013. She completed her specialized training in radiation oncology at the Fox Chase Cancer Center in Philadelphia after completing her internship at Resurrection Medical Center and medical education at Rush University in Chicago. She first discovered her love of oncology patients and radiation oncology as a Howard Hughes Medical Institute Research Scholar at the National Institutes of Health in 2005.

Dr. Keller has an unwavering commitment to delivering evidence-based oncologic care in a caring and compassionate environment. She forges a partnership with her patients and their families to achieve these treatment goals. Dr. Keller truly believes in spending enough time with her patients and sharing without restraint her reasoning and expertise behind her treatment recommendations. She is open to questions, no matter how technical or complicated, and she treats not only her patient’s, but also their family members, with consideration and hope.

Dr. Keller leads a team of professionals within the department that includes a medical physicist, dosimetrist, radiation therapists, and oncology nurse. Together her team operates the state of the art equipment to plan and deliver radiotherapy with the overwhelming compassion required to treat cancer patients and their support system. Dr. Keller is well connected with the physicians housed at the Cleveland Clinic (CCF) main campus and she works very closely with Marymount’s medical oncology team of Drs. Coffman, Dergham, and Kyei.

The Independence Radiation Oncology Department offers it’s cancer patients state-of-the art radiotherapeutic options including 3 dimensional conformal radiotherapy (3DCRT), intensity modulated radiation therapy (IMRT), and stereotactic body radiotherapy (SBRT). The department houses one of the most sophisticated modern linear accelerators, the True Beam, which has the capability for image guided radiotherapy (IGRT). Given this technical capability, Dr. Keller and her team can safely escalate dose to tumors while simultaneously reducing dose to nearby normal structures, thereby decreasing the risk of side effects and increasing the chance of cure. As a member of the Taussig Cancer Institute of the Cleveland Clinic, numerous clinical trials are available at the Independence site. Of great interest is a CCF prostate cancer trial that is open with Dr Keller where, for eligible patients, prostate
cancer is treated in five high dose radiation treatments, instead of the usual 40 treatments. Options like these may re-define the standard of care in the field of radiotherapy.

Radiation Oncology new facility at Independence Family Health Center
Multidisciplinary Cancer Conferences

Oncology Conferences are an opportunity for physicians to review and discuss treatment options available for specific cancer diagnosis. The conferences are multidisciplinary and include physicians from Medical Oncology, Radiation Oncology, Surgery, Radiology and Pathology. The specialists review diagnostic information and share ideas, discuss management, and review national treatment guidelines and the latest research findings, in order to create the best treatment plan or management plan for individual patients.

Cases presented at the Oncology Conferences are at least 15% percent of the annual analytic cases accessioned into the Cancer Registry database and include cases from the five major sites seen at Marymount Hospital. The Commission on Cancer requires that at least 80% percent of the cases are presented prospectively at cancer conferences. In 2013, we held 34 cancer conferences. 100% of the 142 cases were prospective case presentations. We believe this practice benefits patients treated at our cancer program.

### 2013 Summary of TMC Attendance by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>76.5% (increase from 2012 – 64.7%)</td>
</tr>
<tr>
<td>Rad Onc</td>
<td>100%</td>
</tr>
<tr>
<td>Med Onc</td>
<td>100%</td>
</tr>
<tr>
<td>Rad</td>
<td>100%</td>
</tr>
<tr>
<td>Path</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 2013 Case Mix Summary Top 5 Sites Presented

(142 Cases total)

<table>
<thead>
<tr>
<th>Site</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>23</td>
</tr>
<tr>
<td>Colon</td>
<td>16</td>
</tr>
<tr>
<td>Lung</td>
<td>45</td>
</tr>
<tr>
<td>Bladder</td>
<td>7</td>
</tr>
<tr>
<td>Prostate</td>
<td>2</td>
</tr>
</tbody>
</table>

The conferences are certified as continuing medical education for physicians and nurses. Multidisciplinary cancer conferences meet weekly on Wednesdays. Physicians are encouraged to contact the Cancer Registry at: 216-476-7305 to schedule case reviews.
Clinical Trial Accruals

Clinical trials in cancer advance evidence based medicine. Patients diagnosed at Marymount are screened to determine eligibility in clinical trials. In 2013, our oncology physicians enrolled 2% of patients diagnosed with cancer at Marymount Hospital to a treatment, prevention, screening, or genetic clinical trial.

The Commission on Cancer does not require community cancer programs to accrue patients to clinical trials. However, in 2015, the Commission on Cancer will require a minimum of 2% of patients be enrolled in clinical trials. Marymount Hospital cancer program continues to meet this requirement; demonstrating our commitment to quality care for our patients and advancing the science in cancer care.
Cancer Program Practice Profile Reports (CP³R)

The Cancer Committee ensures and monitors that patients treated at Marymount receive care according to nationally accepted measures. The Commission on Cancer (CoC) measures compliance with current CoC quality reporting tools—the Cancer Program Practice Profile Reports. The Web-based Cancer Program Practice Profile Reports (CP³R) offer Marymount Hospital cancer care team comparative information to assess adherence to and consideration of standard of care therapies for Breast, Colon and Rectal Cancer.

This reporting tool is reviewed at Cancer Committee providing a platform to have discussions that promote continuous practice improvement to improve quality patient care. Reports are used to identify problems in practice and delivery and to implement best practices that will diminish disparities in care across CoC-accredited cancer programs.

It is important to start treatment in a timely manner after a diagnosis of breast and colon care. A thorough review to determine factors contributing to treatment delay was completed for the cases that fell out. Findings revealed appropriate therapy was planned and recommended; however, patient-related issues such as refusal and illness contribute to the findings.

Below is the summary CP³R performance grid that reports 2011 cases treated at Marymount Hospital. We are proud that our program is exceeding or meeting all but two of the required performance expectations of the Commission on Cancer. We were slightly under the recommended performance rate for: radiation therapy for breast cancer and adjuvant chemotherapy for colon cancer patients. We continue to work on strengthening our performance for all measures.

Next Steps: Overall, adherence to the six published guidelines for breast, colon and rectal cancer was achieved. Continued evaluation of the CP³R reports will be a standing agenda item for the cancer committee.

In 2013, our Cancer Committee approved participation in the Commission on Cancer’s Rapid Quality Reporting System (RQRS). Optimizing the RQRS program will enable timely identification of patients who are at risk for not meeting treatment standards.
<table>
<thead>
<tr>
<th>Oncology Metric</th>
<th>Marymount Hospital</th>
<th>Performance Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation therapy is administered within 1 year of diagnosis form women &lt;70 years old receiving breast conserving surgery for breast cancer</td>
<td>83.3%</td>
<td>95% [CI: 62.2 - 99.5]</td>
</tr>
<tr>
<td>Combination chemotherapy is considered or administered within 4 months of diagnosis for women &lt;70 years old with AJCC T1c N0 M0 or Stage II or III ERA and PRA negative breast cancer.</td>
<td>100%</td>
<td>95% [CI: 53.5-100]</td>
</tr>
<tr>
<td>Tamoxifen or 3rd generation aromatase inhibitor is considered/administered within 1 year of diagnosis for women with AJCC t1c N0 Mo or Stage II or III breast cancer.</td>
<td>90.6%</td>
<td>95% [CI: 80.5 - 100]</td>
</tr>
<tr>
<td>Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.</td>
<td>71.4%</td>
<td>95% [CI: 80.5 – 100]</td>
</tr>
<tr>
<td>At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer</td>
<td>91.7%</td>
<td>95% [CI: 82.7 – 100]</td>
</tr>
<tr>
<td>Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer</td>
<td>100%</td>
<td>95% [CI: 100 – 100]</td>
</tr>
</tbody>
</table>

*When there are an insufficient number of cases in a category of measure, Confidence Intervals are calculated to assure that the measure would meet the expected level of performance.
2013 Cancer Program Goals

Each year, the cancer committee sets a programmatic and a clinical goal. Annual goals provide direction for strategic planning of program activities. As we move towards accomplishing these goals, our program grows stronger and aligns to meet patient care needs and practice standards.

Clinical Goal

Our clinical goal focused on promoting a timely discussion about and/or referral to palliative care for patients diagnosed with stage III-B and IV lung cancer, stage IV pancreatic and colon cancer.

Significance. We believed this was a significant clinical goal. Members of the cancer committee continued to improve timely referral to palliative care by educating clinicians, cancer patients and families about the goals of palliative care.

Palliative care is care given to improve the quality of life of patients who have a serious or life-threatening disease, such as cancer. The goal of palliative care is to prevent or treat, as early as possible, the symptoms and side effects of the disease and its treatment, in addition to the related psychological, social, and spiritual problems. Research shows that palliative care and its many components are beneficial to patient and family health and well-being. A number of studies in recent
years have shown that patients who have their symptoms controlled and are able to communicate their emotional needs have a better experience with their medical care. Their quality of life and physical symptoms improve. In addition, many studies show patients are less able to adhere to their treatment and manage their illness and health when physical and emotional problems are present. Furthermore, patients who have serious illnesses and receive palliative care consultations have lower hospital costs than those who don’t. These consultations help determine treatment priorities and, therefore, help patients avoid unnecessary tests and procedures.

**Summary of Findings.** From the time period, June-Dec., 2013, there were 16 in-patients that had a diagnosis of Stage III-B lung cancer and IV lung, pancreatic and colon cancer. 56% of cases reviewed had discussions with their physician about and/or were referred to palliative care services.

Barriers and facilitators to the practice were identified. The barriers include: misconceptions held by attending physicians, patients and families about palliative care; palliative care service providers are often linked with hospice programs; age of patient; in-patient services not available; difficulty in managing patients’ and families’ fears and other feelings related to end of life;

Facilitators to the practice include: patients with more than one symptom to manage, repeated hospitalization over a short period of time, age of patient

**Next Steps:** Continue to educate patient, families and caregivers about the role of palliative care and pursue timely identification and access for patients who would benefit from the services.

**Programmatic Goal**

Our programmatic goal focused on adding standardized testing for resected colon cancer cases. Our goal was to routinely test resected colon cancer cases for microsatellite instability (MSI).

**Significance.** Determining the MSI status of a colorectal cancer has clinical use for identifying patients with HNPCC/Lynch Syndrome. In addition, MSI status, regardless of whether the causative defect is inherited or sporadic, may have use in prognostic and therapeutic decision-making. MSI-H colonic and gastric tumors are associated with favorable prognosis. There is also evidence to suggest that colorectal cancer patients with MSI-H tumors respond differently to fluorouracil-based chemotherapy
Summary of Findings. 89% [16/18] of resected colon cancer cases were tested for MSI. The two cases that fell out were very early in the implementation period. There were no further fall outs at later dates into the implementation.

Byron Coffman, MD
Bachar Dergham, MD
S. Elkhari, MD

Study assistants: Tracy Funk, RHIA, CTR
Ricci Grosick, CTR
Rosemary B. Field, MS, RN, AOCNS

Adherence to national treatment guidelines is integral to quality and outcomes evaluation of cancer treatment. Each year, physician members of our cancer committee complete a study to determine whether patients within the program are evaluated and treated according to evidence based treatment guidelines. This year, we completed a retrospective review of the treatment of ten patients with locally advanced rectal cancer diagnosed in 2012.

These group of patients benefit from neoadjuvant chemoradiotherapy (chemotherapy and radiation therapy completed before surgery) to facilitate a margin-negative resection. Data from the Marymount Hospital cancer registry was reviewed to determine whether patients within the program are evaluated and treated according to NCCN guidelines.

Significance. Patients with clinical stage T3 or T4, cT3NO diagnosed by TRUS or MRI or high risk rectal tumors with a >5 mm depth of extramural tumor invasion may benefit from neoadjuvant chemoradiation treatment before surgical resection. Cases during tumor conference generated discussion regarding NCCN guidelines. Medical oncologist and surgeons were interested in determining treatment patterns for the low volume of rectal cancer patients diagnosed at Marymount Hospital.

Findings: In 2012, there were ten rectal cancer cases. The findings are reported based on cases with pathologic staging only [n=4] and cases with clinical staging [n=6]. Two of the ten cases were excluded from the evaluation.

The remaining eight cases were reviewed to determine if there would have been a benefit to use neoadjuvant chemotherapy and/or radiation therapy. Six out of eight cases received chemotherapy and radiation therapy before definitive surgical resection. One of eight cases received radiation therapy only before definitive surgical resection. There was only one case who did not receive neoadjuvant chemotherapy because the patient refused all adjuvant treatment. This patient case was also not seen by a medical oncologist.

Analysis: 75% of patients diagnosed at Marymount Hospital with rectal cancer received neoadjuvant chemotherapy prior to surgical resection. We were unable to access records to determine the reason why radiation therapy was the only modality used only prior to definitive surgical resection. For the case that fell out, we were unable to access records to determine the reason why radiation therapy was the only modality used prior to definitive surgical resection. This patient was treated in an outside health care system that ended their contract with Marymount.
Cancer care reaches beyond the confines of our hospital. Marymount Hospital reaches out to our community to provide programs and services that help families and friends. Serving our community means increasing their awareness and knowledge about the warning signs of cancer, cancer risk reduction strategies, adhering to cancer screening guidelines and improving access to early screening services. Our goal is to partner with our community to improve health practice that promote healthy lifestyles to reduce risk for cancer and identify it early for the best treatment outcomes.

### 2013 Cancer Prevention Programs

<table>
<thead>
<tr>
<th>Name of Prevention Program</th>
<th>Date</th>
<th>Number of Participants</th>
<th>Evidence based guideline or intervention used</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting risk reduction behaviors for breast, lung and skin cancer</td>
<td>Nov. 12, 2013</td>
<td>21 Garfield Heights Middle School 8th grade students in health education class</td>
<td>ACS guidelines for breast cancer screening and behaviors to reduce risk for lung and skin cancer</td>
<td>Knowledge of participants: Average test score: 89% Action plan follow-up completed: 10% [2/21]</td>
</tr>
<tr>
<td>Life After Breast Cancer: An educational event focused on survivorship issues and update on latest breast cancer treatment</td>
<td>Oct 26, 2013</td>
<td>57 Breast cancer survivors</td>
<td>NCCN guidelines</td>
<td>Attendance: 57</td>
</tr>
<tr>
<td>Name of Prevention Program</td>
<td>Date</td>
<td>Number of Participants</td>
<td>Evidence based guideline or intervention used</td>
<td>Evaluation</td>
</tr>
<tr>
<td>----------------------------</td>
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</tr>
<tr>
<td>Maple Heights Health and Wellness Fair</td>
<td>August 17, 2013</td>
<td>Promote risk reduction and early detection practices with focus on: breast cancer early detection and breast, lung cancer risk reduction. Smoking cessation was highlighted.</td>
<td>ACS guidelines</td>
<td>Attendance:46</td>
</tr>
<tr>
<td>Garfield Heights Health and Wellness Fair</td>
<td>May 4, 2013</td>
<td>Promote risk reduction and early detection practices with focus on: breast and skin cancer early detection reduction.</td>
<td>ACS guidelines</td>
<td>Attendance:30</td>
</tr>
<tr>
<td>Senior Healthcare Information Expo</td>
<td>April 2, 2013</td>
<td>156 participants Promote risk reduction and early detection practices to seniors</td>
<td>ACS guidelines</td>
<td>Attendance: 175</td>
</tr>
</tbody>
</table>

**Breakfast with a Doc: Breast Cancer Awareness**

Based on a community needs assessment completed March 2012, our community outreach staff targeted marketing and access to an educational program offered to underserved minority women in the catchment areas served by Marymount Hospital. The education program was designed to provide education and identify women who would benefit from breast cancer screening.

During the education program, the Oncology Clinical Nurse Specialist spoke individually to participants about breast cancer.

Mark Kyei, MD
screening practices. The goal was to identify patients at risk who would benefit from breast cancer screening. Participants were given ACS screening guidelines to keep for themselves and to take to friends and family.

Financial counselors were available on site to direct patients to funding sources, if financial barriers were identified to breast cancer screening services. Participants were also informed about community based resources available to address financial barriers to access screening services. MMH continues to be a BCCP partner. The BCCP program provides low income women with mammography screening services, referrals and follow-up.

<table>
<thead>
<tr>
<th>Name of Screening Program</th>
<th>Date</th>
<th>Number of Participants</th>
<th>Evidence based guideline or intervention used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitating breast cancer screening</td>
<td>Oct 26, 2013</td>
<td>10</td>
<td>ACS guidelines for breast cancer screening</td>
</tr>
</tbody>
</table>

**Evaluation:** One participant needed to complete her yearly screening mammogram. The participant had an appointment. Otherwise all participants were up-to-date on their screening. None of the participants identified barriers to obtaining their regularly scheduled mammograms.
Cancer Program Total Case Volume, 2009-2011

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon</td>
<td>78</td>
<td>63</td>
<td>67</td>
</tr>
<tr>
<td>Rectum</td>
<td>9</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Lung, Bronchus Non-Small Cell Carcinoma</td>
<td>65</td>
<td>57</td>
<td>46</td>
</tr>
<tr>
<td>Breast</td>
<td>77</td>
<td>93</td>
<td>79</td>
</tr>
<tr>
<td>Prostate</td>
<td>46</td>
<td>37</td>
<td>27</td>
</tr>
<tr>
<td>All Other Sites</td>
<td>183</td>
<td>168</td>
<td>171</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>458</td>
<td>433</td>
<td>402</td>
</tr>
</tbody>
</table>

Summary of Cancer Cases Diagnosed and/or Treated at Marymount Hospital in 2011
2013 Cancer Program Leadership

B. Dergham, MD  
*Cancer Committee Co-chair*  
*Cancer Conference Coordinator*

L. Rabinowitz, MD  
*Cancer Committee Co-chair*  
*Pathologist*

S. Elkhari, MD  
*General Surgeon*

L. Keller, MD  
*Radiation Oncologist*

A. Mastroianni, MD  
*Radiation Oncologist*

B. Coffman, MD  
*Medical Oncologist*  
*Cancer Physician Liaison*

Mark Kyei, MD  
*Medical Oncologist*  
*Community Outreach Coordinator*

Aju Thomas, MD  
*Diagnostic Radiologist*

R. Grosick, CTR  
*Certified Cancer Registrar*  
*Cancer Registry Quality Coordinator*

P. Shell, RN  
*Quality Improvement Coordinator*

R. Field, MS, RN, AOCNS  
*Oncology Clinical Nurse Specialist*

S. Conard-Scott, BSN, RN  
*Nurse Manager, Oncology Unit*

A. Blaha, MSW  
*Social worker*  
*Psychosocial Services Coordinator*

D. Koterba, BSN, RN  
*Cancer Program Administrator*

R. McBride, RN  
*Clinical Research Coordinator*

C. McBride, RN  
*Clinical Research Coordinator*

Additional Cancer Program Members

**Cancer Registry**

T. Funk, RHIA CTR/Cancer Registry

**Medical Specialty Representatives**

L. Bernstein, MD  
*Urology*

D. Waite, MD  
*Thoracic Surgery*

**Clinical Services**

M. Douglas, MS, CCC-SLP  
*Rehabilitation Services*

M. Kravitz, RD  
*Nutrition Services*

J. Michael, PharmD  
*Pharmacy Services*

Sister B. Gulick  
*Pastoral Care*

**Community Partner**

T. Williams  
*American Cancer Society*