Message from the Medical Director

It takes a team to care for our cancer patients and their families at Marymount Hospital. Our cancer program, accredited by the Commission on Cancer since 1987, includes physicians, nurses, pharmacists, physical and occupational therapists, dieticians, chaplains, administrators, volunteers, social workers and respiratory therapists. Team members have unique, at times, overlapping responsibilities to address the multidimensional care needs of our patients. We all do what is needed to keep patients safe, achieve quality outcomes and provide an excellent experience. Patients First- Always and in all ways.

Our cancer program is integrated with the Cleveland Clinic Taussig Cancer Institute. Our patients and staff benefit from the collaboration. The collaboration leverages resources – access to specialists, diagnostic and treatment options and supportive services- all crafted to meet unique patient care needs. I believe progress in cancer care and service excellence can only be achieved with successful partnerships.

Our annual report celebrates this year’s work characterized by collaboration and integration. Lung cancer remains one of the top 3 cancer sites diagnosed at Marymount Hospital. We report on our new multidisciplinary pulmonary program. Lung cancer is one of the top five cancer sites diagnosed at Marymount Hospital. How we approach treatment is influenced by age, coexisting medical problems, disease state and patient preferences. The new program allows lung specialists to have timely access to patients who present with lung nodules in need of a thorough diagnostic evaluation. They are a great resource for our primary care physician partners. In treating cancer, staging is important because it directly affects the chance of being cured. When it comes to lung cancer, there are different types of diagnostic tests used to determine the stage. There are guidelines that determine and define stage I and II lung cancer. The good news is stage I lung cancer has a 80-85 percent cure rate. The lung program brings a resource to our community that facilitates an integrated and multidisciplinary approach to lung cancer care. The program will improve outcomes, decrease morbidity and reduce the cost of care for our lung cancer patients.

We pay tribute to the work done by our pastoral care team. The team reminds us daily to live our hospital’s mission- to provide excellent health care guided by Christian values of service, compassion, dignity and respect. Sister JoAnn Poplar’s story gives balance to the very technical stories covered in our report. Cancer care is about medical treatments and helping with the social, financial and emotional needs experienced by our patients and their families.

Our accredited community cancer program demonstrates commitment to our patients, community, providers, payers and policymakers. Through an evidence based and integrated approach to cancer care, we are able to deliver a quality cancer program for patients and their families. I believe excellent outcomes are only achieved when programs have a strong team. I am honored to lead our cancer program team.

Bachar Dergham, MD
Chairperson, Cancer Committee 2014
Physician Focus: Surgery for lung cancer at Marymount Hospital

Francis V. DiPierro, MD is the Division Head for Cardiothoracic Surgery at Marymount Hospital and staff Cardiothoracic Surgeon in the Department of Thoracic and Cardiovascular Surgery at the Cleveland Clinic. Dr. DiPierro is certified by the American Board of Thoracic Surgery and the American Board of Surgery. He specializes in surgical treatment of lung cancer, minimally invasive video assisted surgery for lung disease and pleural effusion, surgery for lymphadenopathy in the chest, and heart surgery including coronary artery bypass and valvular heart surgery.

Dr. DiPierro obtained his thoracic and cardiovascular surgery training at the Cleveland Clinic, receiving the Cleveland Clinic's prestigious Dr. Charles H. Bryan Award for Clinical Excellence in Cardiothoracic Surgery. Upon completing his training, Dr. DiPierro joined the medical staff of Eastern Maine Medical Center in Bangor, Maine, where he practiced cardiothoracic surgery for 12 years. While there, he participated in the multidisciplinary meetings of the thoracic oncology tumor board. He has returned to the Cleveland Clinic, joining the Cleveland Clinic Department of Thoracic and Cardiothoracic Surgery in 2012.

Dr. DiPierro is a native Clevelander. He attended Yale University where he graduated magna cum laude with Honors in Molecular Biophysics and Biochemistry. Dr. DiPierro earned his medical degree from the University of Chicago Pritzker School of Medicine, receiving the Association of Academic Surgery Surgical Student Award. He served his residency in general surgery at the Hospital of the University of Pennsylvania, and while there completed a post-doctoral research fellowship in cardiac mechanics and physiology.

Dr. DiPierro has published a number of scientific papers and abstracts in cardiothoracic surgery journals including the Annals of Thoracic Surgery and the European Journal of Cardio-Thoracic Surgery. He is a Fellow of the American College of Surgeons and a member of the Society of Thoracic Surgeons.

Empathy and excellence guide Dr. DiPierro’s interactions with patients. He puts himself in every patient’s shoes, and sets a goal to offer each patient the safest and most advanced care. He tries to communicate with patient and family so that they are all aware of the surgical management plan, and regularly communicates with the other physicians and with the nurses involved in the postoperative care so that the
management plan is coordinated. Postoperative care focuses on working toward early recovery and adequate pain control for incisions. Dr. DiPierro make himself available by phone call for the postoperative care staff for all questions and encourages his staff to call any time as needed.

Dr. DiPierro’s thoracic surgery team comprises a group of physicians with years of experience in the surgical management of lung cancer. The surgical and anesthesiology team members communicate about the operations so that the patient’s surgery is tailored to the particular patient’s needs. Every effort is made to put the patient at ease and to make sure that the patient is comfortable with the procedures that will be performed. Minimally invasive approaches to surgery are used when appropriate in order to make incisions only as long as the absolutely need to be and to help in recovery. When intraoperative decisions based upon preliminary pathologic findings need to be made, communication between pathologist and surgeon is excellent.

Dr. DiPierro collaborates with a team of specialist to address the multidimensional and complex needs of patients with lung cancer. For his patients with lung cancer, mesothelioma, and tumors of the mediastinum, treatment planning often starts with the multidisciplinary conference. The multidisciplinary team includes:

- Medical oncologists
- Radiation oncologists
- Pulmonary Medicine physician specialists and critical care specialists
- Interventional radiologists
- Pain Management specialists
- Critical care nurses

Other members of the lung team include: Respiratory therapists, physical and occupational therapists, social workers, chaplains and pastoral care staff.

In summary, Dr. DiPierro strives to provide a personalized, compassionate, coordinated, safe patient experience for his patients with lung cancer and other thoracic surgical diseases. Patient satisfaction and providing outstanding medical care are his goals.
Multidisciplinary Cancer Conferences

Cancer conferences review and discuss treatment options available for specific malignant processes. 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.

In 2014, under the direction of Dr. B. Dergham, Marymount Hospital cancer program had 35 cancer conferences. All of the 183 case presentations were prospectively reviewed. Cases presented at cancer conferences represent 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.

### 2014 Cancer Conference Case Mix Summary

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>40</td>
</tr>
<tr>
<td>Colon</td>
<td>18</td>
</tr>
<tr>
<td>Lung</td>
<td>29</td>
</tr>
<tr>
<td>Bladder</td>
<td>9</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>15</td>
</tr>
</tbody>
</table>

### 2014 Cancer Conference Attendance by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Attendance Rate(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>97</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>100</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>100</td>
</tr>
<tr>
<td>Radiology</td>
<td>100</td>
</tr>
<tr>
<td>Pathology</td>
<td>100</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

Cancer clinical trials advance evidence based medicine. Clinical trials are available in collaboration with Cleveland Clinic and the Case Comprehensive Cancer Center at Case Western Reserve University.

Patients diagnosed at Marymount are screened to determine eligibility in clinical trials. In 2014, our oncology physicians enrolled 2% of patients diagnosed with cancer at Marymount Hospital to a treatment, prevention, screening, or genetics clinical trial.

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 steadfast commitment to advance the science of cancer care.
Cancer Program Practice Profile Reports (CP³R)

The National Cancer Database (NCDB) records and stores data from cancer program nationwide. The repository allows cancer programs to compare patient characteristics, cancer types, treatments and outcomes with similar programs. The National Quality Forum (NQF) identified and endorsed quality metrics reported as indicators of quality oncology care. Commission on Cancer-approved programs access data and compare their performance on these indicators to other program.

The Commission on Cancer (CoC) measures cancer program performance with current CoC quality reporting tools—the Cancer Program Practice Profile Reports. The Web-based Cancer Program Practice Profile Reports offer Marymount Hospital cancer care team comparative information to assess adherence to and consideration of standard of care therapies for Breast, Colon, Gastric, Lung and Rectal Cancer.

This report is reviewed at Cancer Committee. The review provides a platform for discussions about strategies to continuously improve quality patient care. Reports are used to identify improvement opportunities that will diminish disparities in care across CoC-accredited cancer programs.

The summary of the 2012 report, the most current report released by the NCDB, is presented below. The table provides a performance report for Marymount cancer program. A comparison is made to state and similar CoC cancer program types.
<table>
<thead>
<tr>
<th>Site</th>
<th>Measures</th>
<th>Performance Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>STATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program Type</td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer. (Surveillance)</td>
<td>64.8%</td>
</tr>
<tr>
<td></td>
<td>Image or palpation-guided needle biopsy (core or FNA) is performed to establish diagnosis prior to surgical treatment of breast cancer. (Quality Improvement)</td>
<td>83.5%</td>
</tr>
<tr>
<td></td>
<td>Radiation therapy is considered or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with ≥ 4 positive regional lymph nodes. (Accountability)</td>
<td>88.4%</td>
</tr>
<tr>
<td></td>
<td>Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. (Accountability)</td>
<td>92.2%</td>
</tr>
<tr>
<td></td>
<td>Combination chemotherapy is considered or administered within 4 months of diagnosis for women &lt;70 years old with AJCC T1c NO M) or Stage IB- III hormone receptor negative breast cancer. (Accountability)</td>
<td>88.6%</td>
</tr>
<tr>
<td></td>
<td>Tamoxifen or 3rd generation aromatase inhibitor is considered or administered within 1 year of diagnosis for women with AJCC T1c or Stage IB – III hormone receptor positive breast cancer. (Accountability)</td>
<td>96.9%</td>
</tr>
<tr>
<td>Colon</td>
<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. (Accountability)</td>
<td>89.3%</td>
</tr>
<tr>
<td></td>
<td>At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer (Quality Improvement)</td>
<td>87.5%</td>
</tr>
<tr>
<td>Rectal</td>
<td>Radiation therapy is considered or administered within 180 days of diagnosis for patients under the age of 80 with clinical or pathologic AJCC T4N0M0 or stage III receiving surgical resection for rectal cancer (Surveillance)</td>
<td>91.8%</td>
</tr>
</tbody>
</table>
2014 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. Accomplishing these goals strengthens our program and aligns our resources to meet patient care needs and practice standards.

Summary report 2014 Cancer Program Goals

Clinical Goal: Establish an on-site lung clinic service at Marymount Hospital.
In 2013, lung cancer accounted for 60/338 [18%] cancer diagnosis; the first half of 2014, lung cancer accounted for 13/128 [10%] cancer cases. On April, 2014, the Cleveland Clinic Respiratory Institute established out-patient pulmonary services at Marymount Hospital. Dr. DiPierro, leads the multidisciplinary team.

Programmatic Goal: Develop a procedure to facilitate optimal inter-disciplinary discussion of patient case presentations during MMH cancer conference using available technology upgrades
Multidisciplinary participation is vital for cancer conferences. With multiple demands, on-site participation of the specialist become challenging. Teleconferencing with specialist[s] allows interdisciplinary participation in prospective cancer conferences. Optimizing technology facilitated remote access to key specialists. The cancer program received upgrades to computer lap tops and telecommunication resources. Success is evident in the level of participation.

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

Study assistants: Ricci Grosick, CTR  
Patty Jurecko, 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. In 2014, we retrospectively reviewed treatment provided to 53 breast cancer patients diagnosed at Marymount Hospital between January 1-December 31, 2013. [Table 1] The review determined the degree to which evaluation and treatment of Stage 0-IV Breast Cancer conformed to evidence-based national treatment guidelines using AJCC stage and appropriate prognostic indicators. National Comprehensive Cancer Network (NCCN) Guidelines for Breast Cancer [v.3,2014] was used for this review.

Data from the Marymount Hospital cancer registry was reviewed to determine whether patients within the program are evaluated and treated according to NCCN guidelines.

Description of cases included in review:
Total number of breast cancer case diagnosed between 1/2013 through 12/2013: 53. See Table 1 for description of cases by stage.

The cases are evaluated based on the pTNM staging. The median age was 70 years old. The range was 44-89 years old.

Table 1. pTNM Stage distribution of Breast Cancer Cases Diagnosed in 2013

<table>
<thead>
<tr>
<th>Stage</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>I</td>
<td>18</td>
</tr>
<tr>
<td>II</td>
<td>15</td>
</tr>
<tr>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>IV</td>
<td>1</td>
</tr>
<tr>
<td>No stage</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
</tr>
<tr>
<td>CHECKLIST</td>
<td>MET</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td><strong>Radiation</strong></td>
</tr>
</tbody>
</table>
| Received recommended treatment for stage 0  
[total cases: 11] | 11/11 | 9/9 | 9/9 | 2 cases did not have information to complete evaluation after the primary treatment [surgery] was completed. These cases were excluded from the review to determine concordance with indications for radiation and/or systemic treatment for Stage 0 breast cancer. | 100% |
| Received recommended treatment for Stage I  
[total cases: 18] | 18/18 | 17/18 | 18/18 | 3 patient chose not to get adjuvant chemotherapy offered with risk and benefits reviewed | 94% |
| Received recommended treatment for Stage II  
[total cases: 15] | 15/15 | 14/14 | 15/15 | For 1 case, medical records were not available to determine if radiation was refused, as such not included in the analysis for concordance with radiation therapy NCCN guidelines for Stage II breast cancer | 100% |
| Received recommended treatment for Stage III  
[total cases: 3] | 3/3 | 3/3 | 3/3 | 100% |
| Received recommended treatment for Stage IV  
[total cases: 1] | 1/1 | Palliative radiation to spine | 1/1 | recurrence | 100% |
OBJECTIVE: To ensure patient treatment plans meet NCCN guidelines. This study is different from CP3R because: it reviews appropriateness of treatment based on stage and prognostic indicators for all breast cancer cases diagnosed in 2013. In addition, the report provides a more timely report of concordance with NCCN guidelines [Breast Cancer Version 3.2014, 04/01/14].

MEASUREMENT: 100% Analytic Class of Case 11-22 Stage 0-IV Breast Cancer, diagnosed between: 1/1/2013 through 12/31/2013

METHOD: Retrospective chart review.

RESULTS: see Table 2: Summary of Findings, on page 12

Summary
Almost all breast cancer cases diagnosed in 2013 received appropriate evaluation and treatment that conformed to evidence based national treatment guidelines. Prognostic indicators were factored in treatment plans.

An opportunity for improvement was identified: improve practice to send patients for consultation with Radiation Oncologist to make final determination on the role of radiation therapy. The consistent presence of Radiation Oncologist and prospective case presentation at tumor conference will guide improvement in clinical practice.
2014 Cancer Program Community Events

Cancer Prevention and Risk Reduction Education Programs

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.

Four community health and education programs were offered. Attendance and the completion of standard evaluation form was the method of evaluation. For the 11.18.14, event at Garfield Heights, “Ask 3, Teach 3” teach back method was during the program to confirm that topics discussed was understood by the participants. Patients were given the speaker’s contact information for additional questions and concerns following the program.

Effectiveness evaluation: Attendance is nominal even with implementation all methods of communication to advertise community event using print materials and networks with identified community leaders and venues, such as libraries, community centers and churches. For 2015, we will explore more effective ways to bring our programs to the community.
Breast Cancer Screening

Based on a community needs assessment completed March 2012, our community outreach staff targeted marketing and access to breast cancer screening program offered to women in the catchment areas served by Marymount Hospital. The event was designed to provide clinical breast exams, education and facilitate access to mammography, if needed.

Dr. Shukri Elkhairi and Dr. Christian Massier conducted clinical breast exams. Oncology Clinical Nurse Specialist spoke individually to participants about breast cancer risk and breast cancer screening practices. Tiffany Williams, our partner from the American Cancer Society (ACS), reviewed and distributed ACS screening guidelines to keep for themselves and to take to friends and family. 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.
Tending the Spirit: Pastoral Care Services

I had the opportunity to visit an elderly woman, Virginia*, who was diagnosed with cancer. She was sedated and was on the ventilator but I was privileged to provide pastoral presence at her bedside. Chaplains often hear from patients of their awareness of people and conversations while they are sedated. Virginia’s husband and son were quietly sitting near her. Her husband was softly praying the rosary.

I introduced myself and we sat quietly for a bit. Then her husband, Tom, spoke of their faith and the life together he had shared with Ginny for more than fifty years. He told of their struggles as a newlywed couple, challenges they faced to make ends meet during the depression and of raising a family. He counted his blessings in their long life together. Their son Michael was very supportive. Mike brought his father every day to visit his mother and he would return after work to be at his mom’s side.

A few days later I again found Tom again sitting at his wife’s bedside. He was crying quietly. Slowly he started to share his struggle. He wanted so much to help her yet it seemed there was nothing he could do for her. She was not getting better and he felt helpless. As he watched her get weaker day by day, he dreaded the day when he would be faced with the question of withdrawing life support. It felt wrong. I listened to his heart and his mind, we talked about his questions, and then we prayer together as he had asked. He found comfort and support in his faith.

As I continued my pastoral journey with this family I reflected on how being a chaplain is like a sacred dance. A Chaplain moves together in changing combinations with patients and family members as their needs unfold. When we enter their hospital room it is truly Holy and sacred ground. Through interaction with patients or families we enter into their time and space of life, whether it is patients talking about present day experiences or those reflecting on their life journey as it slowly comes to an end. This is never “ordinary” time for them.

Ginny remained on a ventilator and never made eye contact with me. I got to know her through the pastoral journey with her family. I supported them when it became clear that the goal of care for Ginny needed to change. The clinical staff could not help her heal. Our goal became keeping her comfortable and supporting her spiritual needs in the time left before her death. I walked with Tom and Michael as they came to the decision to compassionately wean her from the ventilator. She began hospice care, and was even able to go home where she died peacefully surrounded by her husband and two sons.

I saw Tom and Michael again when they attended the Memorial Mass we offer for families each quarter. They appreciated the Mass very much and also expressed their appreciation for hospice during Ginny’s final days. Their struggle with grief had led them from praying for a miracle to praying for what was best for her. When it came time, they realized they did not want us to prolong her dying. All that could be done that would help her had been done. They turned to hospice in peace.

*Sister Jo Ann Poplar, SSJTOSF

*All names have been changed
Cancer Cases Diagnosed and/or treated at Marymount Hospital, 2013

- **Breast**, 19%
- **Lung**, 18%
- **Colon**, 12%
- **Rectum**, 4%
- **Pancreas**, 2%
- **Other**, 0%
- **Non-Hodgkin’s**, 6%
- **Hodgkin’s**, 1%
- **Unknown Primary**, 2%
- **Thyroid**, 4%
- **Brain**, 1%
- **Kidney**, 1%
- **Bladder**, 1%
- **Prostate**, 4%
- **Corpus Uteri**, 4%

Legend:  
- **Bladder**  
- **Brain**  
- **Breast**  
- **Colon**  
- **Corpus Uteri**  
- **Hodgkin’s Disease**  
- **Kidney**  
- **Lung**  
- **Non-Hodgkin’s**  
- **Other**  
- **Pancreas**  
- **Prostate**  
- **Rectum**  
- **Thyroid**  
- **Unknown Primary**
2014 Cancer Program Committee

Bachar Dergham, MD  
Co-Chair, Cancer Committee  
Cancer Conference Coordinator  
Hematology/Medical Oncology

Laura Rabinowitz, MD  
Co-chair, Cancer Committee  
Pathology

Shukri Elkhairi, MD  
Surgery

Lenea Keller, MD  
Radiation Oncology

Byron Coffman, MD  
Cancer Liaison Physician  
Hematology/Medical Oncology

Mark Kyei, MD  
Community Outreach Coordinator  
Hematology/Medical Oncology

Aju Thomas, MD  
Radiology

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Psychosocial Services Coordinator  
Case Management

Donna Koterba, MSN, RN  
Cancer Program Administration  
Administration

Cathleen Hugney, RN, CCRP  
Clinical Trials Research Coordinator  
Clinical Trials

Patty Jurecko, CTR  
Oncology Data Services

Leonard Bernstein, MD  
Urology

Marianne Douglas, MS, CCC-SLP  
Rehabilitation Services

Francis Dipierro, MD  
Thoracic Surgery

Julie Michael, PharmD, BCPS  
Pharmacy

Holly Piechtu, RD, LD  
Food and Nutrition Services

Joseph Rinderknecht  
Pastoral Care Services

Tiffany Williams  
American Cancer Society