Memorial Hospital of South Bend’s cancer program has taken steps to expand and strengthen its care capabilities in addressing all patient needs. Under the new leadership of long-time oncologist Thomas Reid, M.D., Ph.D., FACP, Memorial Regional Cancer Center has bolstered its services to include a more comprehensive team approach, a survivorship program, cutting-edge cancer research and additional multidisciplinary clinics.

Cancers, unlike some other diseases, can affect people in all facets of their lives. It’s not enough to just treat the disease anymore. Caring for the whole patient—physically, mentally, emotionally, spiritually and financially—is the cornerstone of Memorial’s oncology program.

“We reexamined how to best serve our patients in the areas of education, prevention, diagnosis, treatment and follow-up. Everything we are doing at the Center revolves around the patient,” Dr. Reid says.

**An Experienced Team**

The all-encompassing, patient-centered care begins with a team that includes specialists dedicated to guiding patients through diagnosis, treatment and follow-up. When a person enters the Memorial Regional Cancer Center, it opens the door to all of the Center’s services, programming and medical resources, setting in motion a coordinated and collaborative approach to cancer care.

**Being There for the Whole Journey**

The number of cancer survivors in the United States has increased from 3 million in 1971, to 9.8 million in 2001 to 11.7 million in 2007—an overall increase of 4 percent of the U.S. population, according to the Centers for Disease Control and Prevention. This improved survivorship rate is due to physicians’ ability to detect cancer earlier, diagnose it more accurately, treat it more effectively and provide better follow-up care. As a result, Memorial has expanded the scope of survivor care by implementing a program that begins at diagnosis and continues through the rest of the person’s life.

Patients are closely followed thanks to a more coordinated system that helps ensure all needs are being met, even long after treatment is completed. Coping with medication side effects, handling psychological or emotional concerns and adjusting to lifestyle changes are addressed as part of ongoing survivor care. This communication and support with the patient and the patient’s primary care physician help to smooth the transition and establish greater normalcy for those adjusting to life during and after cancer treatments.

A key facet of the survivorship program is also to help monitor and provide resources to children affected by cancer who are now adults. As one of only four pediatric oncology centers in Indiana, the Memorial Pediatric Hematology/Oncology Program has served more than 2,000 children throughout northern Indiana and southwest Michigan since its inception in 1992.

**Advances in Care**

While cancer research trials have long been a fixture at Memorial through the Northern Indiana Cancer Research Consortium, more resources are now being invested in

For more information, please call 574-647-1100 or visit qualityoflife.org/cancer
experimental drug therapies. Two such drug trials involve vaccine therapies for the treatment of breast and prostate cancers. These cutting-edge therapies are not found anywhere else in northern Indiana.

Making innovative therapies available goes hand-in-hand with the Center’s long-time focus on using the most advanced technology and procedures in diagnosing and treating cancer. Memorial’s radiation therapy program provides the region’s most comprehensive treatment for a variety of cancers, including breast and prostate. Led by radiation oncologists David Hornback, M.D., and Samuel McGrath, M.D., the radiation program features two linear accelerators—state-of-the-art machines (one in Mishawaka and one at Memorial) that provide highly targeted doses of radiation over a short period of time—as well as the region’s only stereotactic radiosurgery program.

**Meeting of the Minds**

Since cancers can be treated in multiple ways, Memorial is establishing multidisciplinary clinics that involve the collective expertise of physicians to treat several types of cancer. A dedicated group of specialists, including medical and radiation oncologists, interventional radiologists, surgeons, pathologists, radiologists, medical geneticists and others, regularly review new patient cases together to develop the most comprehensive treatment plan. This approach leads to faster treatments and ultimately to better outcomes.

While there is more work ahead, Memorial’s cancer leadership is excited about the initiatives that are placing the patient at the center of everything they do.
Memorial Cancer Registry is an integral part of the cancer program and operates under the leadership of the Director of Oncology Services and the Oncology Care Committee.

The purpose of the Cancer Registry is to ensure complete, timely and accurate data collection on all patients who have been diagnosed and/or treated for cancer at Memorial Hospital. The information collected is reported to the Indiana State Cancer Registry and National Cancer Data Base. This allows clinicians, researchers, and standard setters to provide the best treatments available, analyze outcome and end-results data, and to assess clinical standards and quality of patient care.

In 2013, the Oncology Cancer Committee elected to participate in the Rapid Quality Review System (RQRS) provided by the Commission on Cancer’s (CoC) National Cancer Data Base. The purpose of RQRS is to assist CoC accredited cancer programs in promoting evidence-based cancer care at the local level for breast and colorectal cancer patients.

In addition to collecting cancer data, Memorial Cancer Registry coordinates multiple site-specific multi-disciplinary cancer conferences where diagnostic procedures are reviewed and treatment options are discussed by a multidisciplinary group of specialty physicians. The site specific conferences include breast, lung, gastrointestinal, urology, gynecology, neurosurgery, head and neck, hematologic and pediatric oncology. In 2012, 64 conferences were held at Memorial Hospital with 262 of Memorial Hospital analytic cases presented, 99% of which were prospective case presentations.

Since the Cancer Registry’s reference year of 1985, the department has collected data on over 30,000 cases and continues to maintain a successful follow-up rate of 92% on eligible cases, exceeding the requirement of the Commission on Cancer. In 2012, 1168 new cancer cases were added to the cancer registry data base which includes 1037 analytic cases (diagnosed and/or receiving first course of treatment at Memorial) and 131 non-analytic cases (first course treatment elsewhere).

Figure 1 illustrates 2012 analytic primary diagnostic site distribution with figures 2 and 3 showing the top five sites for male and female respectively. Figure 4 demonstrates the service area for 2012.

Memorial Cancer Registry continues to strive for excellence. The associates of the Cancer Registry department participates in continuing education annually, works closely with physicians and physician offices to ensure accurate data is collected, and collaborates with other local as well as state registries.

Reference: 1. American College of Surgeons, Rapid Quality Reporting System (RQRS)
Standard 4.7 Studies of Quality

Each year, the Cancer Center’s Quality Improvement coordinator, under the direction of the cancer committee, develops, analyzes, and documents the required studies that measure the quality of care and outcomes for patients with cancer.

Studies of Quality #1
According to National Cancer Data Base Completion report for cases diagnosed in 2010 (most recent year available), Memorial’s Cancer Registry reports a higher percentage of cases with a cancer status coded as unknown than the national benchmark (National Cancer Data Base, benchmark 15%).

Clinic notes and follow-up letters received from physician offices for cases diagnosed January 1 through June 30, 2012 (excluding cases diagnosed at Memorial but treated elsewhere) were reviewed to study this issue.

What were the study findings: Decrease of unknown cancer status by 23% (46% down to 23%)

What action was taken at the completion of the study: Implementation of a template for physicians to complete cancer status documentation on all Memorial Hospital Radiation Oncology and Medical Oncology follow up and office notes.

This study was reviewed by Memorial’s Oncology Care Committee on December 18, 2013.

Studies of Quality #2
Use of Prophylactic Cranial Irradiation Following Response to Initial Therapy in Those with Small Cell Lung Cancer: A Quality Improvement Study (Standard 4.7) from 2012-2013 at Memorial Hospital of South Bend.

Background:
In December of 2012, data was presented highlighting the rates of prophylactic cranial irradiation (PCI) administration in those with limited and extensive stage small cell lung cancer (SCLC) meeting National Comprehensive Cancer Network (NCCN) criteria for treatment. While most patients were ineligible for such therapy, rates of PCI delivery remained suboptimal amongst eligible individuals with a favorable response to first line treatment. After presentation of this data and the accompanying Category 1 evidence to support PCI use, new cases of small cell lung cancer were reviewed to assess whether trends in overall management had changed.

Study Objectives:
To determine whether individuals are being appropriately staged with imaging in the form of a brain MRI or head CT with contrast, and whether PCI is being routinely offered in those without central nervous system involvement when appropriate, concordant with NCCN guidelines.

Study Population:
All cases of SCLC diagnosed and/or treated at Memorial Hospital from October 2012-July 2013. Case review was performed by one physician, SM.

Data Reviewed:
- Initial evaluation including (but not limited to):
  - H&Ps
  - Pathology report(s)
  - Chest/Upper Abdomen CT(s)
  - Brain MRI or CT(s)
  - PET-CT(s)
  - Bone Scan(s)
- Additional work-up performed

- Stage at time of diagnosis
- Recommended treatment
- Treatment received
- Response to treatment
- Performance status
- Neurocognitive Function

Findings:
Case review was performed on 16 patients diagnosed and/or treated for SCLC within a ten month span during 2012-2013. Ten individuals had extensive stage disease while 6 had limited stage disease. Three patients had brain metastases at diagnosis, excluding them from consideration for PCI. Eleven of the sixteen patients had either an MRI or contrast-enhanced CT scan of the brain as part of their staging work-up. Amongst the five patients without CNS imaging, 3 had extensive stage disease and began chemotherapy while one had limited stage disease but received systemic therapy alone (due to prior receipt of XRT to the thorax). The other individual was assumed to have limited stage disease, began concurrent treatment and subsequently underwent an MRI revealing brain metastases during the first cycle of chemotherapy. Combined modality treatment continued,
with whole brain radiotherapy being administered around the
time of cycle 5.

Of the remaining 13 patients without brain metastases
identified at the outset, seven patients appeared eligible for
PCI. Prophylactic treatment was not discussed with two of these
patients. PCI was mentioned to the remaining five patients,
with one patient eventually receiving whole brain treatment to
an appropriate dose. One patient never received treatment for
undocumented reasons, one was of poor compliance and lost
to follow up, one patient refused whole brain treatment, and
one patient was not offered therapy due to their age, ("PCI not
indicated at the age of 71").

The remaining 9 patients included in this updated analysis
would not have been eligible for prophylactic treatment.
Again, three had brain metastases identified during their
staging work up, two discussed PCI with their practitioner but
unfortunately developed progressive metastatic disease, and
four patients expired either pretreatment or during the course of
chemotherapy.

Conclusions:
This updated analysis redemonstrates that the majority of
patients with small cell lung cancer will not be eligible for PCI,
reflective of the aggressive natural history of this disease process.
Five of the seven patients eligible for prophylactic treatment
had documentation that a discussion took place regarding this
treatment. Additionally, PCI was discussed with two patients who
unfortunately developed progressive disease and in turn were
not eligible. These results are encouraging. That being said,
only one patient ended up receiving whole brain radiation as a
preventive measure, a treatment that has been well documented
to improve survival. Similarly poor rates of administration were
noted during our last analysis (2/13). We remain cognizant
of the limitations of a retrospective chart review, including
identification of case specifics that might have contributed to
the decision not to offer or administer prophylactic treatment.
However, there remains significant room for improvement
within our oncologic community to improve adherence to
NCCN guidelines by ensuring that not only a discussion takes
place, but that patients go on to receive prophylactic cranial
irradiation. It is incumbent upon all of us to appropriately stage
the CNS at diagnosis, become familiar with evidence based
eligibility criteria and therapeutic advantages of prophylactic
treatment, as well as provide a fair discussion of the side effect
profile of PCI.

Standard 4.8 Quality Improvements

Annually, the quality improvement coordinator, under the
direction of the cancer committee, implements 2 patient care
improvements. One improvement is based on the results of
a completed study that measures cancer patient quality of
care and outcomes. One improvement can be identified from
another source or from a completed study. Improvements are
documented in the cancer committee minutes and shared with
medical staff and administration.

S4.8 Quality Improvements

- (Improve 4.7 #1 – Decrease “unknown cancer status”) Add
  specific dictation options to RO and MO follow-up notes to
  improve response rate and decrease number of cancers with
  unknown status.

- Hiring of dedicated oncology outpatient social worker
  (Completed Q1 2013)

- Implementation of new software – Medical Oncology EMR
  (ARIA) (To be completed by Q4 2013)

- Addition of Ra-223 injections (Xofigo) 3rd Q 2013 for bone
  metastasis of prostate cancer (Completed 2013)
The Prostate Cancer Clinic

Providing Same-Day Treatment Options and One-on-One Access to Specialists

There are many options available for the treatment of prostate cancer. To help decide which treatment is best for your patients, Memorial Regional Cancer Center’s Prostate Cancer Clinic brings patients and family members together with medical oncologists, urologists and radiation oncologists to discuss the different treatment options in one convenient visit. The team of multispecialty, board-certified physicians reviews each case and works together with the patient to coordinate a comprehensive care plan.

Who is eligible?

- Untreated, biopsy-proven localized prostate cancer.
- Elevated PSA level measured within the last six months.
- Increasing PSA watched over several months.

It is our goal to make the entire referral process as seamless as possible. All it takes is a single call to Memorial Regional Cancer Center’s main number: 574-647-1100.

Early Stage Lung Cancer Screening

Memorial Regional Cancer Center and the Thoracic Oncology Clinic have initiated a Low-Dose Lung CT Scan Program to help people at risk of having lung cancer gain access to lifesaving treatment. The use of a low-dose CT scan can be an effective screening tool for early-stage lung cancer in patients with the following criteria:

- Individuals with no signs or symptoms connected with underlying cancer
- Individuals between the ages of 55 and 74 with a lengthy smoking history or a former smoker

For just $99, the program includes a low-dose lung CT scan, preliminary lung function testing and smoking cessation classes. For more information, please call Memorial’s Health Discovery Center: 574-647-1801.

Two Locations in 2014

Beginning January 2014, the Memorial Regional Cancer Center will begin providing its full range of hematology and oncology services in two locations; Memorial Hospital campus and Day Road campus in Mishawaka. Services available at the new Mishawaka location include:

- Chemotherapy
- Radiation Therapy
- Infusion Therapy
- Lymphedema Therapy
- Radiology / PET/CT
- Anti-coagulation Clinic
- Complementary Services
- Survivorship Services

Memorial Hospital of South Bend
615 N. Michigan Street
South Bend, IN 46601

MRCC at Mishawaka (Cancer Care Partners)
301 East Day Road
Mishawaka, IN 46545

Both locations can be reached by calling the Cancer Center’s main line 574-647-1100.
We are pleased to announce the addition of Ivan Bedoya, M.D. to the Memorial Regional Cancer Center. Dr. Bedoya completed his Internal Medicine residency at the Jewish Hospital of Cincinnati in 2010 and his Hematology/Oncology fellowship in 2013 at the University of Cincinnati Medical Center. Dr. Bedoya will join Dr. Thomas Reid in the Hematology/Medical Oncology Center of MRCC on January 2, 2014, practicing mainly at the Day Road campus.

David Hornback, M.D.
David Hornback, M.D., received his medical degree and completed his residency in radiation oncology at Indiana University School of Medicine, and served his internship through the Transitional Residency Program at St. Vincent Hospital & Healthcare Center.

Dr. Hornback specializes in stereotactic radiosurgery, high and low dose rate brachytherapy and prostate seed implants. He has extensive clinical research experience and maintains memberships in a number of professional associations, including the American Society for Therapeutic Radiology and Oncology, the American Society of Clinical Oncologists and the American Medical Association.

Samuel McGrath, M.D.
Dr. McGrath, is board certified radiation oncologist who has been practicing at Memorial Hospital of South Bend since 2010. He completed his internship and residency at William Beaumont Hospital in Royal Oak, Michigan. While at William Beaumont, Dr. McGrath had the opportunity to train under several nationally renowned radiation oncologists, acquiring valuable experience with advanced treatment planning and delivery techniques, including radiosurgery, brachytherapy and IMRT/IGRT. He received his medical degree from Wayne State University School of Medicine in Detroit, Michigan, graduating with highest distinction as a member of the Alpha Omega Alpha national medical honor society. Prior to this, he completed his bachelor’s degree in chemistry at Indiana University, Bloomington, where he graduated summa cum laude and as a member of the Phi Beta Kappa honor society. Dr. McGrath has published on a variety of topics, including prostate, breast and lung cancer. He is an active member of the American Society of Therapeutic Radiology and Oncology and treats all solid tumors at both the South Bend and Mishawaka offices.

Dr. Reid received his medical degree from Uniformed Services University of the Health Sciences in Bethesda, Md. He completed his internship and residency in Internal Medicine and fellowship in Hematology-Medical Oncology at the Walter Reed Army Medical Center, District of Columbia. He received a PhD in biochemistry at Purdue University.

From 1991 to 2004, Dr. Reid was at the Walter Reed Army Institute of Research; including three years as Chief of Blood Research. From 2004 to 2008, Dr. Reid was Chief of Hematology-Medical Oncology at the Walter Reed Army Medical Center. After 27 years in the Army Medical Corps, he retired in 2008 as a full Colonel.

From 2011 to 2012, he was Chief, Hematology-Medical Oncology and Oncology Program Director at MedStar Good Samaritan and MedStar Union Memorial Hospitals in Baltimore, Md. In Baltimore and at Walter Reed, he served as Principal Investigator for the cancer clinical trials cooperative group, Cancer and Leukemia Group B (CALGB). Dr. Reid also served as co-chair of the Clinical Research Committee at the Lombardi Cancer Center, Georgetown University Medical Center. His special interests include cancer clinical trials (adult solid tumors and lymphomas, supportive care, cancer vaccines, translational research), cancer epidemiology, cancer genetics, cancer survivorship and coagulation (bleeding and clotting) and hematologic disorders.
Prostate Cancer

**Stage of Prostate Cancer Diagnosed in 2010**
Memorial Hospital of South Bend, South Bend IN vs. Community Hospitals in ACS Division of Great Lakes
All Diagnosed Cases

<table>
<thead>
<tr>
<th>STAGE</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>UNK</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Facility</td>
<td>131</td>
<td>65</td>
<td>13</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>128</td>
<td>499</td>
<td>43</td>
<td>42</td>
<td>30</td>
</tr>
</tbody>
</table>

**First Course Treatment of Prostate Cancer: Diagnosed in 2010**
Memorial Hospital of South Bend, South Bend IN vs. Community Hospitals in ACS Division of Great Lakes
All Diagnosed Cases

<table>
<thead>
<tr>
<th>FIRST COURSE TREATMENT</th>
<th>Surgery Only</th>
<th>Radiation Only</th>
<th>Radiation &amp; Hormone Therapy</th>
<th>Hormone Therapy Only</th>
<th>Other Specified Therapy</th>
<th>No 1st Course Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Facility</td>
<td>73</td>
<td>24</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>210</td>
<td>217</td>
<td>127</td>
<td>47</td>
<td>81</td>
<td>60</td>
</tr>
</tbody>
</table>
Cancer Liaison Report June 19, 2013
Oncology Care Committee Meeting

Mark Thompson, M.D.
Pancreatic Cancer
Mark Thompson, M.D.

Lung Cancer
### Age Group of Lung, Bronchus Non-Small Cell Carcinoma Cancer Diagnosed in 2000 to 2010

**Memorial Hospital of South Bend, South Bend IN**

**vs. Community Hospitals in All States**

**All Diagnosed Cases**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>My (N)</th>
<th>Oth. (N)</th>
<th>My (%)</th>
<th>Oth. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td></td>
<td>17</td>
<td></td>
<td>0.01%</td>
</tr>
<tr>
<td>20 - 29</td>
<td>2</td>
<td>123</td>
<td>0.15%</td>
<td>0.06%</td>
</tr>
<tr>
<td>30 - 39</td>
<td>11</td>
<td>1015</td>
<td>0.92%</td>
<td>0.52%</td>
</tr>
<tr>
<td>40 - 49</td>
<td>77</td>
<td>9488</td>
<td>5.76%</td>
<td>4.82%</td>
</tr>
<tr>
<td>50 - 59</td>
<td>203</td>
<td>29049</td>
<td>15.19%</td>
<td>14.76%</td>
</tr>
<tr>
<td>60 - 69</td>
<td>420</td>
<td>57129</td>
<td>31.44%</td>
<td>29.04%</td>
</tr>
<tr>
<td>70 - 79</td>
<td>419</td>
<td>67823</td>
<td>31.36%</td>
<td>34.47%</td>
</tr>
<tr>
<td>80 - 89</td>
<td>195</td>
<td>30034</td>
<td>14.6%</td>
<td>15.26%</td>
</tr>
<tr>
<td>90 and over</td>
<td>9</td>
<td>2077</td>
<td>0.67%</td>
<td>1.06%</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td>1</td>
<td></td>
<td>0%</td>
</tr>
</tbody>
</table>

**Col. TOTAL**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>My</td>
<td>1336</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oth.</td>
<td>196756</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My (%)</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oth. (%)</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Insurance Status by Stage of Lung, Bronchus Non-Small Cell Carcinoma Cancer Diagnosed in 2000 to 2010

**All Diagnosed Cases - Community Hospitals in All States - Data from 449 Hospitals**
### Insurance Status by Stage of Lung, Bronchus Non-Small Cell Carcinoma Cancer Diagnosed in 2000 to 2010

All Diagnosed Cases - Community Hospitals in All States - Data from 449 Hospitals

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>Stage 0</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>OC</th>
<th>UNK</th>
<th>Totals N</th>
<th>%b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Insured</td>
<td>5639</td>
<td>2.87%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Insurance</td>
<td>17849</td>
<td>9.07%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managed Care</td>
<td>32897</td>
<td>16.76%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>9998</td>
<td>5.08%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>43261</td>
<td>21.99%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare w/ Supplement</td>
<td>80223</td>
<td>40.77%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Affairs</td>
<td>964</td>
<td>0.49%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRICARE/Military</td>
<td>1454</td>
<td>0.74%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian/Public Health Service</td>
<td>201</td>
<td>1.01%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Status Unknown</td>
<td>4180</td>
<td>2.13%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>415</td>
<td>0.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Observed Survival For Lung, Bronchus - Non-Small Cell Carcinoma

'C340','C341','C342','C343','C348','C349'

Cases Diagnosed in 2003 - 2006 Data from 1484 Programs [National]

WARNING: The information within this graphic is not to be used for clinical decision making.
Observed Survival for Lung, Bronchus - Non-Small Cell Carcinoma

'C340', 'C341', 'C342', 'C343', 'C348', 'C349'

Cases Diagnosed in 2003 - 2006

Data from 1 Programs []

WARNING: The information within this graphic is not to be used for clinical decision making.

Cumulative Survival Rate

Years from Diagnosis

©2013 National Cancer Data Base (NCDB), Commission on Cancer (CoC)

Designed and developed by James M. Banasiak [banasiak@facs.org]

- Stage I
- Stage III
- Stage IV
Dr. Mark Thompson discussed Memorial Hospital’s performance statistics utilizing National Cancer Data Base data from 2011 (most recent information available), comparing Memorial Hospital performance rates to other facilities within the Indiana, Midwest Region, American Cancer Society Division, Commission on Cancer (CoC) Program Type and all CoC Approved Programs. Memorial Hospital performance rates meet and in some instances exceed the benchmarks set by the Commission on Cancer.

The following measures were discussed and presented to the committee:

- Radiation following Breast Conserving Surgery (BCS/RT) measure, Performance Rate: 95.5% Combination chemotherapy for breast (MAC) measure, Performance Rate: 100%
- Hormone Therapy for breast (HT) measure, Performance Rate: 96.8%
- Adjuvant Chemotherapy for Colon (ACT) measure, Performance Rate: 88.9%
- 12 Regional LN removed for Colon (12RLN) measure, Performance Rate: 85.3%
- Adjuvant Radiation for Rectal (AdjRT) measure, Performance Rate: 100%

Accountability and Quality Improvement Measures

Cased Diagnosed in 2011 and Reported to the National Cancer Data Base (NCDB)

(Most recent data available from the NCDB)

<table>
<thead>
<tr>
<th>Select Breast &amp; Colorectal Measures</th>
<th>Estimated Performance Rates (click for more information)</th>
<th>Case Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. (BCS/RT)</td>
<td>95.5%</td>
<td>BCS</td>
</tr>
<tr>
<td>Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women with AJCC T1c NO MO, or Stage I or III ERα and/or PRa negative breast cancer. (MAC)</td>
<td>100%</td>
<td>MAC</td>
</tr>
<tr>
<td>Taxane or oral generation non-anthracycline-based chemotherapy is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c NO MO, or Stage II or III ERα and/or PRa positive breast cancer. (HT)</td>
<td>96.8%</td>
<td>HT</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. (ACT)</td>
<td>88.9%</td>
<td>ACT</td>
</tr>
<tr>
<td>At least 12 regional lymph nodes are removed and histologically examined for resected colon cancer. (12RLN)</td>
<td>85.3%</td>
<td>12 RLN</td>
</tr>
<tr>
<td>Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 with clinical or pathologic AJCC T4NO0M0 or Stage III resectable surgical resection for rectal cancer. (AMRT)</td>
<td>100%</td>
<td>Adj R1</td>
</tr>
</tbody>
</table>