Premier Health

Premier Health

Cancer Report to the Community 2015

2014 Statistical Review

110 N. Main St.
Dayton, OH 45402

premierhealth.com/cancer

Premier Health

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Charles L. Bane, MD

Premier Health Cancer Institute

I would like to take this opportunity to welcome you to the third edition of Premier Health's Cancer Annual Report. Though the challenges within health care continue to grow and become more complex, the Premier Health Cancer Institute has remained steadfast in its commitment to pursue and develop technologies and treatments that will enhance and improve the patient experience and produce quality outcomes.

We are accomplishing this by viewing cancer and its treatment from a broad perspective, and a foundational understanding that such a complex disease requires a multidisciplinary approach. As a result, the Cancer Institute has combined the efforts of medical specialists from a variety of disciplines who have united to develop new levels of standardized care and quality metrics.

Our specialists continue to seek out ways to offer patients advanced treatment technologies, and enhance and improve the levels of communication between physicians and treatment facilities to provide the greatest impact across the whole spectrum of care.

This begins by emphasizing partnerships with primary care physicians to educate patients about cancer prevention and early screening strategies. Once cancer is detected, this multidisciplinary focus upon patient care continues throughout one's treatment and beyond. Our commitment to follow-up support allows our specialists to address a patient's long-term treatment effects, survivorship issues, advanced care planning, and even end-of-life care.

By addressing the full spectrum of cancer care, we are more empowered to help keep people healthy and treat them effectively when they need it most. As health care continues to evolve, the Premier Health Cancer Institute is embracing the opportunity we've been given to continue to partner with you to serve our community and bring high quality care and service to our community.

Together we can make a difference, one patient at a time.

Charles L. Bane, MD
Chair,
Premier Health Cancer Institute

Premier Health Service Integration Leadership

Cameron McGregor, MSN, RN, FACHE

The Premier Health Cancer Institute has the unique privilege of leading our organizational strategy for cancer care - from prevention, to post treatment care and everything in between.

We recognize that every decision made here will ultimately impact the patient and their family in some way, which is a responsibility we do not take lightly. These are our friends, family, and sometimes even ourselves. So how do we best serve them in the midst of one of life's greatest challenges? Above all, how do we do this with compassion, excellence, and innovation?

Our true measurement of success begins and ends with ensuring we are meeting our patients' needs. Driven by this powerfully simple philosophy, we designed a comprehensive care model that brings individualized treatment to the patient right in their own community.

Instead of requiring patients to follow a disjointed path on their journey or drive great distances for care, we have developed a way to deliver the care to the patient at one site and, when appropriate, one visit. By utilizing advanced treatment planning conferences that bring specialists and primary care physicians together from around the region, combined with providing necessary services at each of our Premier Health locations, we concentrate on care and allow our patients to concentrate on healing.

With access to over 100 clinical trials for all stages of cancer, our focus on cancer screening, prevention, and treatment is enhanced by the fact that each clinical process is led by a collaboration of Premier Health physicians and other clinicians in the region.

Such valuable tools and resources have made Premier Health facilities a destination for patients and their families in this region who no longer need to travel for the care they need. We remain committed to leading with care and advancing to new levels of research, prevention, diagnosis, and treatment for cancer.

It is our sincere privilege to partner with you to improve the health of the communities we serve.

Cameron McGregor, MSN, RN, FACHE
Vice President, Service Integration
Cancer Institute
Premier Health

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Premier Health Accomplishments and Activities

The Premier Health Cancer Institute continues to provide integrated, multidisciplinary oncology care by strengthening its comprehensive, system-wide approach to service delivery. This is accomplished through the collaborative efforts of its cancer programs at Miami Valley Hospital, Good Samaritan Hospital, Atrium Medical Center, and Upper Valley Medical Center.

Program Improvements

In an effort to continue providing consistent care across the system, physicians and operations staff joined together to expand upon national treatment guidelines. In addition to those for breast, lung, and neuro-oncology, the team is working to create unified, step-by-step processes for gastrointestinal and genitourinary cancers. These treatment algorithms outline the patient experience from screening and diagnosis through treatment.

In recognition of Skin Cancer Awareness Month, free skin cancer screenings were held system-wide. Screenings were offered through Premier Community Health, Wright State University Boonshoft School of Medicine, and Wright State Dermatology or a local dermatologist.

Fidelity Health Care, part of Premier Health, expanded offerings within its Expressions of Hope boutiques, located at Good Samaritan North Health Center and Miami Valley Hospital South. The boutiques serve a wide variety of clients, both male and female, with lymphedema and compression garments, stylish wigs and a wide array of fashion options for hats, scarves, and other head coverings. Expressions of Hope also provides products and services for mastectomy, lumpectomy, and reconstruction needs. In addition to expanding merchandise within the boutiques, Expressions of Hope also began offering monthly fittings for compression, full figure, and breast cancer patients at Atrium Medical Center and Upper Valley Medical Center, in an effort to expand their reach to additional women in need of these services.

Community Outreach

In recognition of Breast Cancer Awareness Month, Premier Health held four Brake for Breakfast events throughout the region. This event, which started at Good Samaritan Hospital in 2009, raises awareness about the importance of annual mammography and early detection of breast cancer. This year, more than 1,600 motorists stopped by one of the four locations to pick up a free breakfast and breast health information.

A second annual Shine a Light on Lung Cancer event was held during Lung Cancer Awareness Month to bring awareness and to celebrate survivors and others touched by the disease. The event included presentations by a physician and a lung cancer survivor, smoking cessation messaging, as well as a "lighting" ceremony for those who have been impacted by lung cancer.

Premier Health continues to be a strong supporter of local cancer awareness events. Event support ranges from monetary to on-site educational offerings, with the purpose of raising awareness throughout the region. Events supported include Volley for the Cure, Relay for Life, high school and college cancer awareness sporting events, and more. Through a partnership with the American Cancer Society, Premier offers programs such as Look Good Feel Better, Reach to Recovery, and Road to Recovery.

Patient Education

Physicians and staff throughout the system collaborated to develop comprehensive patient education books for breast cancer and lung cancer. These books are provided to patients free of charge and provide them with a wealth of information to help them through their cancer journey.

The Premier Health Cancer Institute also formally approved the adoption of a system level quality improvement function in order to provide oversite of the four cancer programs' quality goal outcomes each year.

Hospital-Specific Accomplishments

In addition to system-wide initiatives, each Premier hospital has a Cancer Committee designed to establish goals, make program improvements, conduct quality studies, and participate in local activities and events. While each hospital's cancer program accomplishes many things, we would like to share a sample of two highlights in 2015 from each of them.

Atrium Medical Center

- Launched a mobile mammography vehicle designed to increase screening mammography across the region.
- Hosted a lung cancer prevention event in an effort to further educate the general public and hospital staff about lung cancer, screening for the disease, and prevention information.

Good Samaritan Hospital

- Earned third re-accreditation from the National Accreditation Program for Breast Centers (NAPBC), and received the Outstanding Achievement Award from the Commission on Cancer.
- Implemented the following new technologies at Good Samaritan North Health Center to improve the likelihood of a more specific and targeted diagnosis: automated whole breast ultrasound (AWBUS) and cryo probe, which assists in getting more tissue for diagnosis.

Miami Valley Hospital

- Expanded neuro-oncology offerings with a designated clinical nurse specialist, and added weekly multidisciplinary treatment planning conferences and patient clinis at Miami Valley Hospital South.
- Added new medical imaging technology, including 3T MRI and UroNav Fusion Biopsy, to pinpoint specific areas of the prostate for biopsy.

Upper Valley Medical Center

- Added Star Gazer lighting to massage therapy rooms.
- Expanded massage therapy hours.

Lung Cancer Screening Option with Low Dose CT

Stephen Chambers, MD, FCCP, Pulmonary Medicine
Ronald Setzkorn, MD, Radiation Oncology

Lung cancer is the number one cause of cancer death in the United States, taking the lives of approximately 158,000 patients each year, and producing an overall survival rate of somewhere between 10 and 15 percent at five years. Though a few other forms of cancer may ultimately yield a grimmer prognosis, lung cancer's commonality continues to be cancer's most prolific killer in spite of ongoing research and treatment.

Traditionally, lung cancer has been difficult to treat quite simply because the symptoms do not typically present themselves at an early stage, and when they often do, the disease is more advanced and much less treatable as a result. As with most cancers, the odds of cure and survivability are greatly improved when the disease is caught in its earliest stages. However, up until very recently, accurate early detection tools and methods haven't existed, making it difficult to catch it before it advances further.

All of this began to change in 2014 as hospitals began using low-dose computed tomography (LDCT) to screen for lung cancer, based upon findings first published in 2012 in The Journal of the American Medical Association, and candidate criteria put forth by the U.S. Preventive Services Task Force. The use of this non-invasive technology is a significant discovery that is yielding tangible results in the fight against lung cancer.

For example, a 67-year-old patient who had been a one pack per day smoker for over fifty years was recently referred by her primary care doctor to have LDCT screening. The test revealed a 1.2cm nodule, and she was referred to a pulmonary specialist for further examination. A following PET scan and needle biopsy revealed a stage one malignancy, which was able to be surgically resected. Today the patient has a good prognosis for cure, which is a direct result of LDCT. The screening's out-of-pocket cost is notably low as well, at only $79, though some insurance plans may also provide coverage.

Both the U.S. Preventive Services Task Force and the National Comprehensive Cancer Network (NCCN) have guidelines for who qualifies to have LDCT screening. Premier Health follows NCCN guidelines, which suggest screening for patients between 55-74 years of age who have a 30-pack year smoking history (one pack per day for 30 years or two packs per day for 15 years) who currently smoke, or have quit smoking within the past 15 years.

By vigilantly adhering to these guidelines, primary care physicians have a tremendous opportunity to have a significant impact upon a patient's health and length of life. If caught at stage one, the opportunity to have the cancer resected using robotic surgical methods is much greater, and a patient's five year survival rate is between 75 to 85 percent. In contrast, the five year survival rate is virtually non-existent for those whose cancer is discovered at stage four.

Above all, encouraging and assisting individuals to stop smoking is the best advice since prevention is the key to optimal lung health. Prevention will always top good detection and treatment.

For more information about Premier Health's LDCT screening program, visit **premierhealth.com/lung**.

Screening and Treatment Options for Prostate Cancer

Erik Weise, MD, Urology
Shane Smith, MD, Neuroradiology

For decades, prostate cancer screening recommendations have indicated that men with no previous history or increased risk should start being screened at age 50, and then periodically tested until the point of 10-year life expectancy. Recommendations shift to age 40 and 45 for African American men or for those who have a known family history of the disease. These recommendations, which are still maintained by the American Cancer Society and others, have not been without controversy. Other societies have, in fact, put forth more lukewarm recommendations that have added to this debate.

Many urologic oncologists have acknowledged that harm can come as a result of screening; however it is crucial to understand that screening ultimately

saves lives and that the real problem rests with patient overtreatment, not the screening itself. Early detection, which involves a digital rectal exam (DRE) and prostate-specific antigen (PSA) test, may lead to screening via needle biopsy which has the inherent benefit of alerting clinicians to cancer treatment where a patient would be helped, as well as a risk of diagnosing cancer where a patient might be harmed from treatment.

Ideally, physicians must resolve to aggressively diagnose, while making a judicious examination of available data to wisely recommend the treatment or non-treatment of the cancer. Doctors should begin having conversations about screening's potential advantages and disadvantages and sharing various recommendations with patients who are in their 40s and 50s. Decisions can then be made depending upon a patient's individual desires and needs.

Thankfully, our ability to diagnose and treat prostate cancer has improved dramatically within the past decade. Until recently, if a patient had a clinical or lab finding he would undergo a standard transrectal ultrasound guided biopsy for random sampling of the prostate gland resulting in numerous biopsies but no specific target area.

Today, a newly developed technology known as UroNav combines a 3T MRI with a surgeon's ultrasound images which can be fused in real time to diagnose a suspicious lesion. Because it provides detail of the anatomy, the surgeon can view the exact location to target.

Surgery to remove the prostate has changed significantly as well. In the late 1990's, surgical robotics transformed the way prostatectomies were performed. Instead of invasive surgery, this precise and less invasive method has become the standard of care. Today patients undergoing this procedure typically leave the hospital the next day, have their catheter removed within a week, and are fully recovered within about three weeks.

Radiation treatments (external beam or seed implants), are optional for low to moderate risk cancers; however, side effects can take years to develop and can be severe in some cases. Though outcomes are typically good up front they are likely not as durable for a decade or more. As a result, surgery tends to be the better option for the young and healthy and radiation the better option for older individuals who may have other health issues.

PROSTATE CANCER
BY THE NUMBERS

OTHER THAN SKIN CANCER, **PROSTATE CANCER** IS THE MOST COMMON CANCER IN AMERICAN MEN. THE AMERICAN CANCER SOCIETY'S ESTIMATES FOR PROSTATE CANCER IN THE UNITED STATES FOR **2015** ARE:

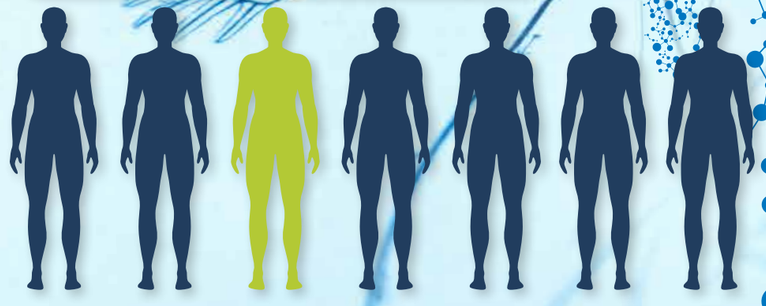
NEW CASES OF PROSTATE CANCER

220,800

DEATHS FROM PROSTATE CANCER

27,540

ABOUT **1** MAN IN **7** WILL BE DIAGNOSED WITH PROSTATE CANCER **DURING HIS LIFETIME.**



Prostate cancer occurs mainly in older men. **About 6 cases in 10 are diagnosed in men aged 65 or older**, and it is rare before age 40. The average age at the time of diagnosis is about 66.

Prostate cancer is the second leading cause of cancer death in American men, behind only lung cancer. **About 1 man in 38 will die of prostate cancer**.

Prostate cancer can be a serious disease, but most men diagnosed with prostate cancer do not die from it. In fact, more than **2.9 million men in the United States who have been diagnosed with prostate cancer at some point are still alive today**.

New Technologies Improve the Odds for Beating Breast Cancer

Diane Anderson, DO, Co-Medical Director, Samaritan Breast Center
Thomas Heck, MD, Co-Medical Director, Samaritan Breast Center
John Weske, MD, Medical Director of Medical Imaging, Atrium Medical Center

New, advanced technology is making it easier to detect breast cancer early, when it's most treatable. Women in the greater Dayton region benefit from Premier Health's investment in 3-dimensional (3D) mammography, a mobile mammography vehicle, and Automated Whole Breast Ultrasound (AWBUS).

Premier Health is the first health system in Dayton to offer 3D mammography, also known as tomosynthesis. It's an advanced form of mammography that, studies show, can find more invasive cancers and may reduce callbacks for additional images. Using 3D mammography, radiologists can get a clearer image of breast tissue, giving them a better opportunity to detect breast cancer at its earliest stage.

In 3D mammography, imaging equipment moves in a slight arc over the breast, taking multiple images of the breast from several angles to form a 3D image. Radiologists can manipulate the 3D image to better visualize fine details within the breast tissue. This can result in finding cancers that might be missed with traditional 2D mammography, where images are taken from the top and side of the breast to produce a flat image.

However, up to 40 percent of women age 40 and over in southwest Ohio are not getting annual mammograms, according to Susan G. Komen for the Cure, Greater Cincinnati Affiliate. The new mobile mammography coach from Premier Health and Atrium Medical Center takes mammography to busy women. They can make an appointment for their screening mammogram at a location close to home or work. The mobile coach offers traditional 2D and new 3D mammography with the same quality as Premier Health's breast centers. Premier Health is the only Dayton-based health system offering mobile mammography.

For some women, including those with dense breast tissue and/or breast implants, mammography is not a perfect breast examination. Automated Whole Breast Ultrasound (AWBUS), when used with screening mammography, can find more cancers in women with dense breast tissue than mammography alone. As of March 2015, Ohio law requires hospitals and breast centers to notify a woman if her test results show dense breast tissue.

On mammograms, dense breast tissue looks white, and so do breast masses or tumors. As a result, dense tissue can hide tumors. Breast implants compress the natural breast tissue, making it difficult to evaluate tissue against the chest wall or under the arm.

AWBUS is a screening study used in addition to mammography. It uses sound waves to examine all of the breast tissue, including lower lymph nodes under the arm, inner breast tissue between the breasts, outer breast tissue under and around the breasts, and tissue under the collar bone. The exam is reproducible in the future to track any changes in the breast. If any possible issues are discovered, traditional breast ultrasound can be ordered for a targeted area. AWBUS is available at Samaritan Breast Center, the first location in Dayton to offer it. Other Premier Health sites will offer this technology in 2016.

For women with breast cancer, early detection is key to good results. Dayton-area women can count on these new technologies to help them beat breast cancer. To learn more about these technologies, visit **premierhealth.com/mammo.**

What's in a Name: CyberKnife vs. TrueBeam

Gregory Rasp, MD, Radiation Oncology

Branded technologies such as CyberKnife and TrueBeam are truly innovative in their scope and application, but both are rooted in a tool that was originally invented in the 1950's. Radiosurgery, as it is known, was originally created to treat brain tumors and was only available for limited use due to the expensive nature of the equipment at the time. In the decades since, it has been developed to utilize more rapid techniques which have allowed for treatment for other parts of the body.

Essentially, radiosurgery employs the precise application of high-intensity radiation to a targeted area of the body in the attempt to eradicate a tumor in just a few treatments. It is commonly used today to treat tumors of the brain, liver, lung, prostate, and less commonly, tumors of the pancreas or spine. Each of these areas typically offers a more defined target than other cancers, and allows for a shorter course of treatment with fewer side effects.

Though CyberKnife and TrueBeam draw from the same technology, there are some notable differences between the two. First, TrueBeam uses a more modern way of locating and tracking a tumor by using a CT scan, as opposed to CyberKnife's use of an X-Ray. Secondly, TrueBeam also has a much higher output of radiation per second, which translates into a much shorter period of time that a patient has to spend on the table. This feature also offers a greater amount of targeted precision, while delivering the treatment at a much lower cost.

Thirdly, TrueBeam has very fine architecture which allows clinicians to control the shape of the beam to treat more complicated shapes and preserve healthy tissue. CyberKnife simply does not have this capability. As a result, TrueBeam allows many patients to avoid open surgery which can turn their recovery time into a matter of hours instead of weeks. It also provides an effective alternative when surgery isn't an option due to certain health restrictions, and it offers a significant improvement over traditional radiation. For example, prior to TrueBeam, the cure rate for a stage I lung cancer using traditional radiation might have been around 20 percent. With TrueBeam that statistic improves to nearly 85 percent.

As this technology continues to advance we are continuing to invest in tools that allow us to maximize its potential. We have recently purchased and begun to utilize a Six-Dimensional (6D) couch which allows us to even more safely and accurately deliver targeted radiation with the freedom to adjust the patient seamlessly on six axes. This enhancement further reinforces TrueBeam's ability to provide improved treatment delivery to patients, in a more comfortable setting, and at a much lower cost.

Advancements in the Fight against Colon and Liver Cancers

James Ouellette, DO, FACS, Vice Chair, Premier Health Cancer Institute
Shannon Kauffman, MD, Interventional Radiology

Perhaps one of the greatest advancements in the fight against colon cancer hasn't actually involved the treatment of the disease at all. In recent years there has been an increased awareness that colon cancer is one of the few that may be completely preventable, simply by following proper screening guidelines. Vigilant efforts to screen patients have also led to the early detection of the disease, which is so vital for treatment success.

Just as prevention and detection methods have evolved, so has the technology to treat colon cancer. Perhaps the most dramatic change in these methods has been the use of laparoscopic surgical techniques, which are much less invasive than previous open surgical methods that did not provide as much precision and naturally led to much longer recovery times.

Medications have also improved greatly, and it is not beyond our ability to cure single liver metastases with a combination of minimally invasive surgery and medication. When colon cancer spreads to the liver it is possible for up to 50 percent of patients to live for five years or more.

Now, a variety of ablation tools may also be used as an exception to, or in conjunction with, open or laparoscopic surgical procedures to treat a limited number of lesions.

Ablation is broken down into three basic categories:

- Heat mediated (radiofrequency (RF) ablation and microwave ablation)
- Cold mediated (cryoablation)
- Electrical (NanoKnife, which is also known as irreversible electroporation)

The choice to use a specific ablation tool largely depends upon the type and location of the tissue being treated. For example, RF or microwave ablation, which uses extreme heat, would be used in treatment of the liver. Cryoablation which uses extreme cold, is used in the treatment of bone and soft tissue. NanoKnife, which uses electricity, is intended to be used in areas next to critical structures.

Today's surgeons have the ability to use each of these technologies directly themselves or collaborate with an interventional radiologist who utilizes minimally invasive image-guided procedures (CT or X-Ray) to administer treatment where open or laparoscopic surgery is not feasible.

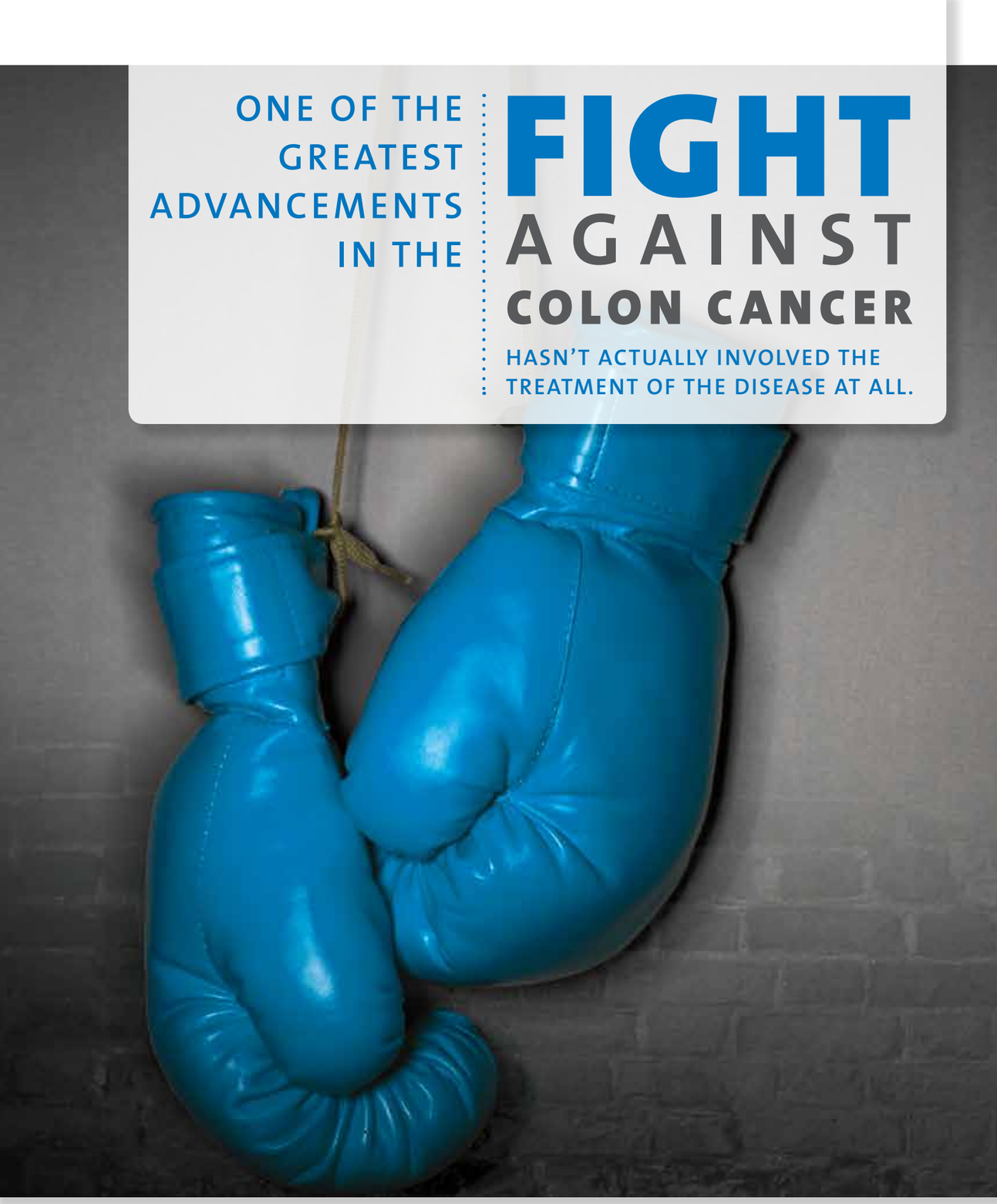
An example of this type of treatment is through the use of radioembolization, or Y90, to treat multiple lesions on the liver. With Y90, the interventional radiologist delivers tiny microspheres containing high-dose radiation directly to the liver through a catheter in the artery above the hip joint, allowing for selective radiation therapy. There are certain scenarios when this therapy not only helps shrink tumors, but allows for the growth of healthy tissue which eventually allows the cancerous portion to be resected.

This multi-specialty approach has proven to be an invaluable method to achieve improved outcomes, and will be essential as new tools and technologies are developed. In the meantime, primary care physicians have a tremendous opportunity to add to these existing efforts by continuing to spread awareness among their patients along with their encouragement to obtain regular colon screenings.

ONE OF THE GREATEST ADVANCEMENTS IN THE

FIGHT AGAINST COLON CANCER

HASN'T ACTUALLY INVOLVED THE TREATMENT OF THE DISEASE AT ALL.



SCREENING

Colon cancer is one of the few that may be completely preventable, simply by following proper screening guidelines.

American Cancer Society Recommendations for colorectal cancer early detection:

BEGINNING AT AGE 50

BOTH MEN AND WOMEN AT AVERAGE RISK FOR DEVELOPING COLORECTAL CANCER SHOULD USE ONE OF THE SCREENING TESTS BELOW:

TESTS THAT FIND POLYPS AND CANCER

5 YEARS

- Flexible sigmoidoscopy
- Double-contrast barium enema
- CT colonography (virtual colonoscopy)

10 YEARS

- Colonoscopy

TESTS THAT MAINLY FIND CANCER

EVERY YEAR

- Guaiac-based fecal occult blood test (gFOBT)*,**
- Fecal immunochemical test (FIT)*,**

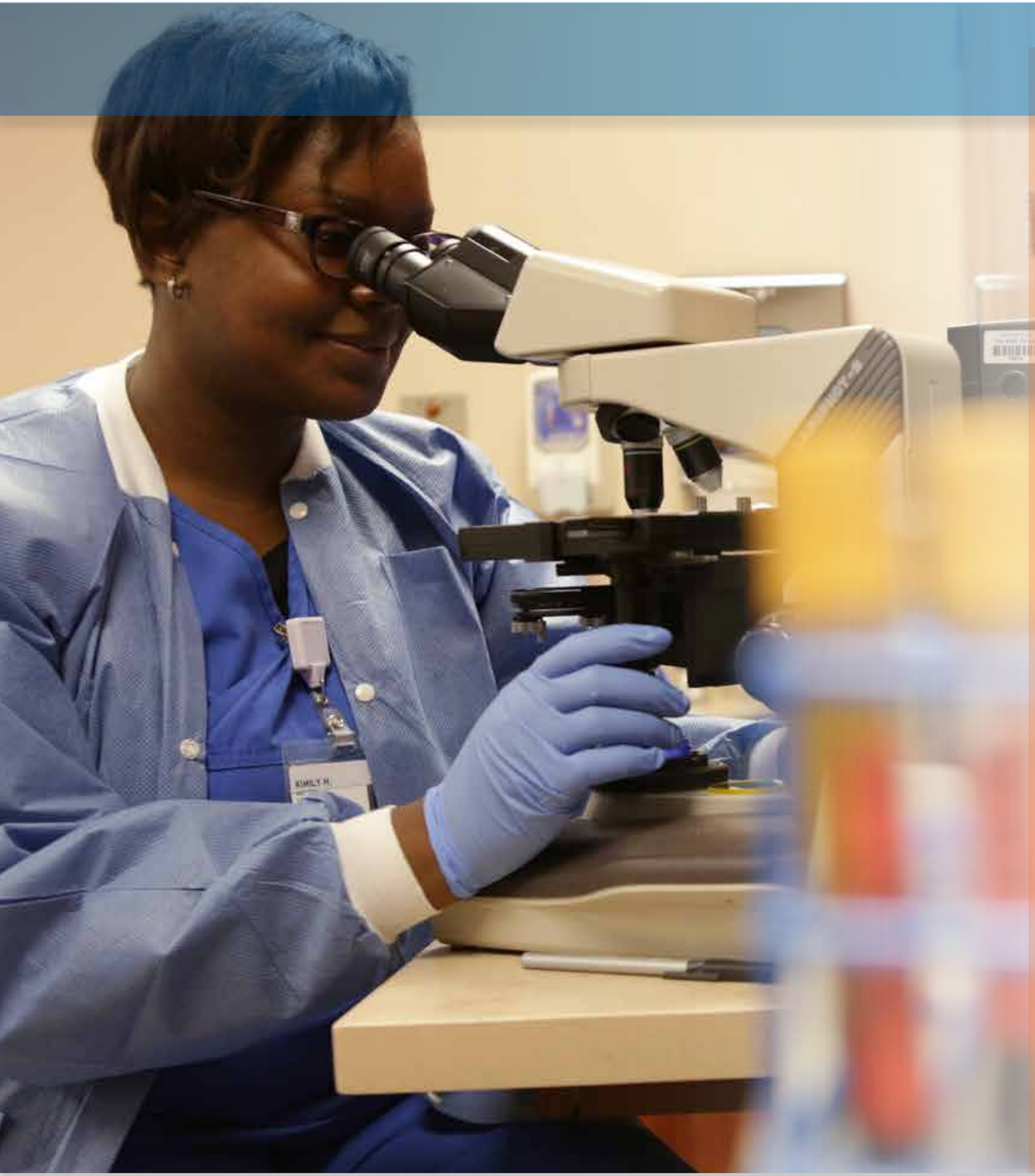
3 YEARS

- Stool DNA test (sDNA)*

HIGH RISK= HISTORY

If you are at an increased or high risk of colorectal cancer, you should begin colorectal cancer screening before age 50 and/or be screened more often. The following conditions make your risk higher than average:

- A personal history of colorectal cancer or adenomatous polyps
- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- A strong family history of colorectal cancer or polyps
- A known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC)



Local Clinical Trials Expand Cancer Care Options

Charles Bane, MD, Chair, Premier Health Cancer Institute
Loren Friedman, MS, Director of Clinical Trials,
Wright State University and Premier Health Clinical Trials Research Alliance

The optimal treatment for cancer is not yet defined, so research is essential to develop new ways to prevent, detect and, treat this disease. Here in the greater Dayton region, patients with cancer have access to clinical trials that make new therapies available.

Premier Health collaborates with the Dayton Clinical Oncology Program (DCOP) and the Clinical Trials Research Alliance, based at Wright State University, to offer eligible patients a wide variety of clinical trials, close to home. Treatment trials test new cancer drugs, approaches to surgery or radiation therapy, new combinations, or even new methods such as gene therapy. Prevention trials test new approaches such as medicines, vitamins, minerals, or other supplements that may lower the risk for certain types of cancer. Other trials explore ways to improve comfort and quality of life for patients with cancer. Clinical trials are available for all stages of cancer.

Many of the cancer clinical trials are funded by the National Cancer Institute (NCI), the largest sponsor of cancer research in the world. Founded in 1982, DCOP is a charter member of NCI's Community Oncology Research Program. Through DCOP, Premier Health physicians can enroll eligible patients with cancer in approximately 100 studies, including some funded by pharmaceutical companies.

The innovative Clinical Trials Research Alliance brings together the strength of Wright State University Boonshoft School of Medicine and Research Institute with Premier Health's physicians, hospitals and outpatient centers. Formed in 2012 to focus primarily on industry-related studies, CTRA has developed the infrastructure required to support clinical trials throughout the region. Because managing administrative requirements to ensure data accuracy and protect patient safety is labor intensive, CTRA frees investigators to spend more time doing clinical work and research. With the input of local physicians and community groups, CTRA tracks drugs in development and contacts potential study sponsors proactively to bring relevant studies to Dayton-area patients.

One of the most exciting new aspects of cancer care is personalized medicine. Sophisticated testing of individuals helps to determine what's driving a person's cancer and the effective treatment approach, so treatment can be tailored to that specific tumor. Some of the newest cancer treatments are targeted therapies, such as pills or new types of chemotherapy, that are designed to turn off the cancer "switch" without damaging normal tissues. Coming to the greater Dayton region are personalized medicine trials that will help us to understand what the cancer "switch" is, what turns it on, and what turns it off.

We're proud that patients in our region can receive many newer treatments for cancer without traveling long distances for care at a stressful time in their lives. As Premier Health enrolls even more patients in clinical trials — and collaborates to bring additional trials to the Dayton area — we contribute to advancing care for all cancer patients.

Advance Care Planning Restores Patient Choice in End-of-Life Care

Chirag Patel, MD, Medical Director, Innovative Care Solutions
Abi Katz, DO, Medical Director of Premier Health Advanced Illness Management

Despite all the ways that medicine has evolved, death is still a reality for patients, their loved ones and the physicians who treat them. Too often we've seen patients die in the intensive care unit on life support systems with their family members under stress because they didn't know their loved one's wishes for the end of life.

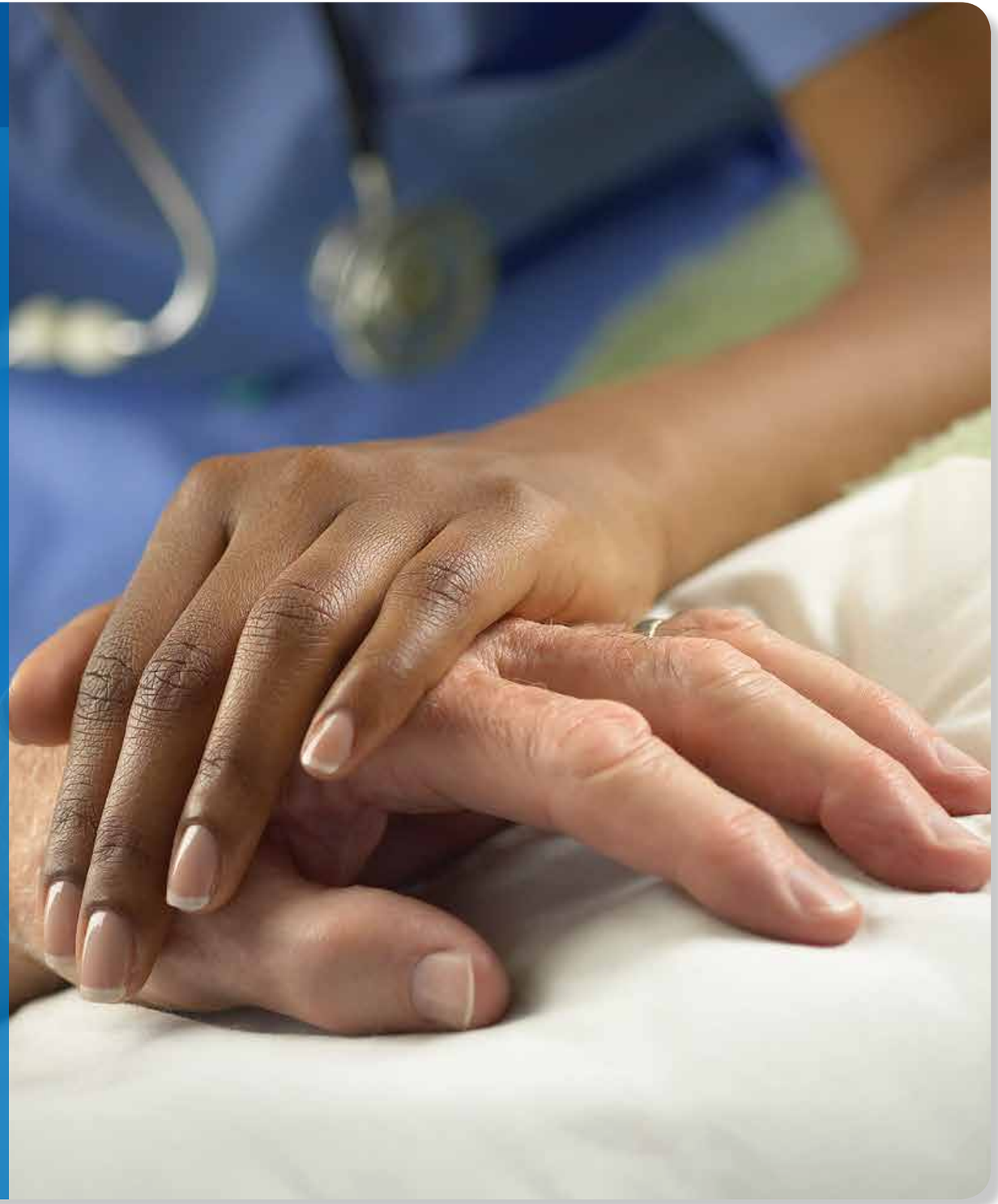
We believe that the voice of the patient can and should return to the process of dying, making the end of life as personal and meaningful as all the years that precede it. In a nationally recognized community project in LaCrosse, Wisconsin, called Respecting Choices, 96 percent of adults die with a completed advance directive. In Wisconsin and here in southwest Ohio, experience shows that empowering the patient to take control is comforting for everyone, including health care professionals. Despite the grief and emotion surrounding death, there's also a great sense of relief that a person's end-of-life wishes can be fulfilled.

Advance care planning is one of the most effective tools to transform the process of dying. The key to making those plans is an ongoing conversation among the patient, family and physicians. Especially in oncology, advance care planning starts with talking about what matters most to the patient and family so that, over time, they can make thoughtful decisions that are right for them. Because defining one's end-of-life wishes is an iterative conversation, the earlier it's started, the better.

The first phase of planning focuses on acute care. Patients consider what they want to have happen if they experience a catastrophic event or neurological impairment and designate someone to make health care decisions on their behalf. As the illness progresses, patients' goals often change. What matters to them may shift, affecting their preferences for what happens next. Finally, near the end of life, patients, families and physicians must balance treatment options with patients' priorities and the dying experience they hope to have.

As physicians, we can play an important role in turning the often taboo topic of end-of-life planning into a normal part of our ongoing interaction with our patients. Certainly these conversations take time, which can be difficult in a busy physician practice. In recognition of the importance of this work, in 2016 Medicare will begin paying physicians and other qualified health care professionals for advance care planning as a separate service.

Here in the greater Dayton region, Premier Health is helping to restore the voice of the patient to end-of-life care. Innovative Care Solutions, a palliative medicine team, includes physicians, advance practice nurses, and RNs that are available to patients and physicians in nearly all Premier hospitals. An order for this service can be requested at any time by the provider to support the patient and their family in beginning this discussion. To continue the conversation and care, Fidelity Health Care offers Premier Health Advance Illness Management, as well as home-based palliative care, to assist patients in formulating questions to bring back to their physicians for discussion. Together, we can help patients and their families make informed health care choices to live — even at the end of life — as they desire.



Cancer Program Practice Profile Reports (CP3R) 2014

The estimated performance rates shown below provide cancer programs with an indication of the percentage of patients treated according to the recognized standards of care.

Each year more measures are added for review. You will note that not all measures show that 100% of patients were treated according to the standard. There are many reasons for this. There may have been health conditions to resolve before a certain treatment could begin, an emergency surgery that did not allow for the full collection of lymph nodes, or a patient may have chosen to delay treatment until after a special event.

The Commission on Cancer does not expect that programs will achieve 100% compliance on all measures for these reasons. It is, however, each program's responsibility to review the cases that did not meet the standard and determine if there are ways to improve the likelihood that patients will receive the recommended care, or that the situations described above were unavoidable.

MEASURES	Performance Rates 2014 AMC	GSH	MVH	UVMC
BREAST				
Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer. **(BCS)**	65.9%	63.7%	59.6%	75.0%
Image or palpation-guided needle biopsy (core or FNA) of the primary site is performed to establish diagnosis of breast cancer. **(nBx)**	100.0%	98.5%	91.2%	82.9%
COLON				
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)**	100.0%	100.0%	81.8%	100.0%
At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. **(12RLN)**	100.0%	87.5%	91.7%	75.0%
ENDOMETRIUM				
Endoscopic, laparoscopic, or robotic performed for all Endometrial cancer (excluding sarcoma and lymphoma), for all stages except stage IV. **(ENDLRC)**	85.7%	80.0%	68.3%	0.0%
LUNG				
Surgery is not the first course of treatment for cN2, M0 lung cases. **(LNoSurg)**	100.0%	90.9%	94.3%	100.0%
CERVIX				
Radiation therapy completed within 60 days of initiation of radiation among women diagnosed with any stage of cervical cancer. **(CERRT)**	50.0%	100.0%	50.0%	0.0%
Chemotherapy administered to cervical cancer patients who received radiation for stages IB2-IV cancer (Group 1) or with positive pelvic nodes, positive surgical margin, and/or positive parametrium. **(CERCT)**	100.0%	100.0%	100.0%	100.0%

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Head and Neck											
Tongue	20	17	3	2	6	0	2	9	0	1	0.54%
Salivary Gland	3	2	1	0	0	1	0	1	0	1	0.08%
Floor of Mouth/Gu Head and Neck											
Tongue	20	17	3	2	6	0	2	9	0	1	0.54%
Salivary Gland	3	2	1	0	0	1	0	1	0	1	0.08%
Floor of Mouth/Gum/Other	10	7	3	2	2	2	2	2	0	0	0.27%
Nasopharynx	7	3	4	0	1	1	2	1	0	2	0.19%
Tonsil	21	16	5	0	0	0	4	15	0	2	0.56%
Oropharynx	10	6	4	0	0	1	2	5	0	2	0.27%
Hypopharynx	5	2	3	0	1	1	1	2	0	0	0.13%
Digestive System											
Esophagus	33	26	7	0	3	8	10	8	2	2	0.88%
Stomach	52	37	15	0	8	14	15	11	0	4	1.39%
Small Intestine	18	12	6	0	3	2	7	5	0	1	0.48%
Colon	208	96	112	7	53	55	44	47	2	0	5.57%
Rectosigmoid Junction	28	17	11	0	7	5	13	3	0	0	0.75%
Rectum	70	44	26	0	10	17	26	14	0	3	1.87%
Anus/Anal Canal/Anorectum	13	2	11	1	4	2	5	0	1	0	0.35%
Liver	54	44	10	0	14	11	6	10	3	10	1.45%
Intrahepatic Bile Duct	12	6	6	0	5	2	0	2	2	1	0.32%
Gallbladder	10	3	7	0	0	2	3	5	0	0	0.27%
Other Biliary	16	7	9	0	5	5	0	2	1	3	0.43%
Pancreas	83	46	37	0	7	24	4	46	0	2	2.22%
Retroperitoneum	6	5	1	0	1	0	5	0	0	0	0.16%
Peritoneum/Omentum/Mesentery	6	1	5	0	0	0	2	2	1	1	0.16%
Respiratory System											
Nose/Nasal Cavity/Middle Ear	5	1	4	0	1	0	1	2	1	0	0.13%
Larynx	42	30	12	1	14	6	8	9	2	2	1.12%
Lung/Bronchus	644	331	313	4	126	56	148	302	3	5	17.25%
Trachea/Mediastinum/Other	2	2	0	0	1	0	0	0	1	0	0.05%
Bones and Joints	4	4	0	0	3	0	0	1	0	0	0.11%
Soft Tissue Including Heart	26	16	10	0	6	6	8	1	1	4	0.70%
Skin											
Melanoma	125	73	52	31	51	17	17	6	0	3	3.35%
Other Non-Epithelial Skin	6	4	2	0	1	1	0	0	3	1	0.16%
Breast	740	7	733	140	304	183	71	36	2	4	19.82%

Premier Health

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Female Genital System											
Cervix	28	0	28	0	8	9	6	5	0	0	0.75%
Corpus & Uterus	127	0	127	2	93	3	22	6	1	0	3.40%
Ovary	51	0	51	0	9	4	15	22	0	1	1.37%
Vagina	3	0	3	1	0	0	0	1	1	0	0.08%
Vulva	19	0	19	4	11	1	2	1	0	0	0.51%
Other Female Genital Organs	2	0	2	1	0	0	1	0	0	0	0.05%
Male Genital System											
Prostate	342	342	0	0	47	218	32	40	2	3	9.16%
Testis	14	14	0	0	4	4	2	0	0	4	0.37%
Penis	4	4	0	0	0	2	0	2	0	0	0.11%
Urinary System											
Bladder	182	150	32	103	32	20	14	10	0	3	4.87%
Kidney/Renal Pelvis	182	104	78	1	107	7	31	28	1	7	4.87%
Ureter	12	8	4	3	4	0	3	2	0	0	0.32%
Other Urinary Organs	4	2	2	1	1	0	0	0	2	0	0.11%
Brain and CNS											
Brain	60	33	27	0	0	0	0	0	60	0	1.61%
Cranial Nerves/Other Nervous System	47	20	27	0	0	0	0	0	47	0	1.26%
Endocrine											
Thyroid	71	21	50	0	45	6	12	4	0	4	1.90%
Other Endocrine including Thymus	16	4	12	0	0	0	0	3	13	0	0.43%
Lymphoma											
Hodgkin's	17	9	8	0	2	4	4	6	1	0	0.46%
Non-Hodgkin's	119	68	51	0	37	21	30	25	3	3	3.19%
Myeloma	33	19	14	0	0	0	0	0	33	0	0.88%
Leukemia											
Acute Lymphocytic Leukemia	1	1	0	0	0	0	0	0	1	0	0.03%
Chronic Lymphocytic Leukemia	14	8	6	0	0	0	0	0	14	0	0.37%
Other Lymphocytic Leukemia	1	1	0	0	0	0	0	0	1	0	0.03%
Acute Myeloid Leukemia	31	20	11	0	0	0	0	0	31	0	0.83%
Chronic Myeloid Leukemia	6	3	3	0	0	0	0	0	6	0	0.16%
Other Leukemia	4	4	0	0	0	0	0	0	4	0	0.11%
Mesothelioma/Kaposi Sarcoma											
Mesothelioma	2	2	0	0	0	0	1	1	0	0	0.05%
Kaposi Sarcoma	1	1	0	0	0	0	0	0	1	0	0.03%
Miscellaneous	62	27	35	0	0	0	0	0	62	0	1.66%
Total:	**3734**	**1732**	**2002**	**304**	**1037**	**721**	**581**	**703**	**309**	**79**	**100%**

Atrium Medical Center

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Head and Neck											
Tongue	2	2	0	0	1	0	1	0	0	0	0.42%
Salivary Gland	0	0	0	0	0	0	0	0	0	0	0.00%
Floor of Mouth/Gum/Other	1	0	1	0	0	0	0	1	0	0	0.21%
Nasopharynx	1	0	1	0	0	0	0	1	0	0	0.21%
Tonsil	0	0	0	0	0	0	0	0	0	0	0.00%
Oropharynx	3	2	1	0	0	1	0	2	0	0	0.64%
Hypopharynx	2	2	0	0	0	1	0	1	0	0	0.42%
Digestive System											
Esophagus	6	5	1	0	0	1	3	2	0	0	1.27%
Stomach	4	3	1	0	0	2	2	0	0	0	0.85%
Small Intestine	5	2	3	0	0	0	3	2	0	0	1.06%
Colon	42	22	20	2	14	14	9	3	0	0	8.90%
Rectosigmoid Junction	4	3	1	0	1	0	3	0	0	0	0.85%
Rectum	3	2	1	0	0	1	1	1	0	0	0.64%
Anus/Anal Canal/Anorectum	2	0	2	0	0	0	2	0	0	0	0.42%
Liver	5	4	1	0	0	1	1	2	1	0	1.06%
Intrahepatic Bile Duct	1	1	0	0	0	0	0	0	1	0	0.21%
Gallbladder	2	0	2	0	0	2	0	0	0	0	0.42%
Other Biliary	0	0	0	0	0	0	0	0	0	0	0.00%
Pancreas	11	5	6	0	1	1	2	7	0	0	2.33%
Retroperitoneum	2	2	0	0	0	0	2	0	0	0	0.42%
Peritoneum/Omentum/Mesentery	1	0	1	0	0	0	0	1	0	0	0.21%
Respiratory System											
Nose/Nasal Cavity/Middle Ear	0	0	0	0	0	0	0	0	0	0	0.00%
Larynx	8	6	2	0	0	2	2	4	0	0	1.69%
Lung/Bronchus	98	45	53	2	18	5	25	47	0	1	20.76%
Trachea/Mediastinum/Other	1	1	0	0	1	0	0	0	0	0	0.21%
Bones and Joints	1	1	0	0	1	0	0	0	0	0	0.21%
Soft Tissue Including Heart	0	0	0	0	0	0	0	0	0	0	0.00%
Skin											
Melanoma	8	5	3	1	2	1	3	1	0	0	1.69%
Other Non-Epithelial Skin	1	1	0	0	0	0	0	0	1	0	0.21%
Breast	94	3	91	16	36	25	11	5	0	1	19.92%

Atrium Medical Center

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Female Genital System											
Cervix	6	0	6	0	1	2	2	1	0	0	1.27%
Corpus & Uterus	11	0	11	0	10	0	1	0	0	0	2.33%
Ovary	3	0	3	0	0	0	1	2	0	0	0.64%
Vagina	0	0	0	0	0	0	0	0	0	0	0.00%
Vulva	2	0	2	0	1	0	1	0	0	0	0.42%
Other Female Genital Organs	0	0	0	0	0	0	0	0	0	0	0.00%
Male Genital System											
Prostate	40	40	0	0	8	20	6	4	0	2	8.47%
Testis	1	1	0	0	1	0	0	0	0	0	0.21%
Penis	1	1	0	0	0	1	0	0	0	0	0.21%
Urinary System											
Bladder	28	23	5	16	5	3	2	1	0	1	5.93%
Kidney/Renal Pelvis	19	13	6	0	12	1	4	2	0	0	4.03%
Ureter	2	1	1	1	1	0	0	0	0	0	0.42%
Other Urinary Organs	0	0	0	0	0	0	0	0	0	0	0.00%
Brain and CNS											
Brain	3	1	2	0	0	0	0	0	3	0	0.64%
Cranial Nerves/Other Nervous System	0	0	0	0	0	0	0	0	0	0	0.00%
Endocrine											
Thyroid	11	5	6	0	7	2	1	1	0	0	2.33%
Other Endocrine including Thymus	0	0	0	0	0	0	0	0	0	0	0.00%
Lymphoma											
Hodgkin's	1	0	1	0	0	0	1	0	0	0	0.21%
Non-Hodgkin's	16	10	6	0	4	3	6	2	0	1	3.39%
Myeloma	2	2	0	0	0	0	0	0	2	0	0.42%
Leukemia											
Acute Lymphocytic Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Chronic Lymphocytic Leukemia	3	2	1	0	0	0	0	0	3	0	0.64%
Other Lymphocytic Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Acute Myeloid Leukemia	3	2	1	0	0	0	0	0	3	0	0.64%
Chronic Myeloid Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Other Leukemia	2	2	0	0	0	0	0	0	2	0	0.42%
Mesothelioma/Kaposi Sarcoma											
Mesothelioma	0	0	0	0	0	0	0	0	0	0	0.00%
Kaposi Sarcoma	0	0	0	0	0	0	0	0	0	0	0.00%
Miscellaneous	10	4	6	0	0	0	0	0	10	0	2.12%
Total:	**472**	**224**	**248**	**38**	**125**	**89**	**95**	**93**	**26**	**6**	**100%**

Good Samaritan Hospital

Site Summary Table for New Cases 2014

SITE	Total Cases	GENDER Male	GENDER Female	AJCC STAGE GROUP 0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Head and Neck											
Tongue	4	3	1	0	0	0	0	4	0	0	0.38%
Salivary Gland	1	1	0	0	0	1	0	0	0	0	0.09%
Floor of Mouth/Gum/Other	3	3	0	0	2	0	1	0	0	0	0.28%
Nasopharynx	2	1	1	0	0	0	2	0	0	0	0.19%
Tonsil	10	8	2	0	0	0	4	6	0	0	0.94%
Oropharynx	1	1	0	0	0	0	0	1	0	0	0.09%
Hypopharynx	2	0	2	0	1	0	0	1	0	0	0.19%
Digestive System											
Esophagus	6	4	2	0	1	3	1	1	0	0	0.57%
Stomach	10	8	2	0	1	3	3	3	0	0	0.94%
Small Intestine	2	2	0	0	0	1	1	0	0	0	0.19%
Colon	53	24	29	2	13	13	9	16	0	0	5.00%
Rectosigmoid Junction	5	3	2	0	0	1	3	1	0	0	0.47%
Rectum	22	12	10	0	3	3	13	3	0	0	2.08%
Anus/Anal Canal/Anorectum	7	0	7	1	2	1	2	0	1	0	0.66%
Liver	4	4	0	0	2	1	0	1	0	0	0.38%
Intrahepatic Bile Duct	2	0	2	0	0	1	0	0	0	1	0.19%
Gallbladder	2	0	2	0	0	0	0	2	0	0	0.19%
Other Biliary	4	1	3	0	1	2	0	1	0	0	0.38%
Pancreas	18	10	8	0	1	6	2	9	0	0	1.70%
Retroperitoneum	2	2	0	0	0	0	2	0	0	0	0.19%
Peritoneum,/Omentum/Mesentery	0	0	0	0	0	0	0	0	0	0	0.00%
Respiratory System											
Nose/Nasal Cavity/Middle Ear	1	0	1	0	1	0	0	0	0	0	0.09%
Larynx	15	10	5	1	6	2	5	1	0	0	1.42%
Lung/Bronchus	247	125	122	0	57	23	63	104	0	0	23.32%
Trachea/Mediastinum/Other	1	1	0	0	0	0	0	0	1	0	0.09%
Bones and Joints	1	1	0	0	1	0	0	0	0	0	0.09%
Soft Tissue Including Heart	4	2	2	0	2	1	1	0	0	0	0.38%
Skin											
Melanoma	15	10	5	3	5	2	3	1	0	1	1.42%
Other Non-Epithelial Skin	3	2	1	0	1	1	0	0	1	0	0.28%
Breast	261	1	260	56	101	69	24	11	0	0	24.65%

Good Samaritan Hospital

Site Summary Table for New Cases 2014

SITE	Total Cases	GENDER Male	GENDER Female	AJCC STAGE GROUP 0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Female Genital System											
Cervix	4	0	4	0	1	1	0	2	0	0	0.38%
Corpus & Uterus	10	0	10	1	7	0	2	0	0	0	0.94%
Ovary	4	0	4	0	0	1	1	2	0	0	0.38%
Vagina	0	0	0	0	0	0	0	0	0	0	0.00%
Vulva	4	0	4	0	3	0	0	1	0	0	0.38%
Other Female Genital Organs	0	0	0	0	0	0	0	0	0	0	0.00%
Male Genital System											
Prostate	110	110	0	0	18	76	6	10	0	0	10.39%
Testis	3	3	0	0	0	3	0	0	0	0	0.28%
Penis	1	1	0	0	0	1	0	0	0	0	0.09%
Urinary System											
Bladder	63	55	8	39	12	6	3	3	0	0	5.95%
Kidney/Renal Pelvis	30	18	12	0	13	2	7	8	0	0	2.83%
Ureter	2	1	1	1	1	0	0	0	0	0	0.19%
Other Urinary Organs	1	1	0	1	0	0	0	0	0	0	0.09%
Brain and CNS											
Brain	7	5	2	0	0	0	0	0	7	0	0.66%
Cranial Nerves/Other Nervous System	14	6	8	0	0	0	0	0	14	0	1.32%
Endocrine											
Thyroid	3	1	2	0	2	0	1	0	0	0	0.28%
Other Endocrine including Thymus	7	1	6	0	0	0	0	2	5	0	0.66%
Lymphoma											
Hodgkin's	6	3	3	0	1	0	2	3	0	0	0.57%
Non-Hodgkin's	30	18	12	0	10	3	6	10	1	0	2.83%
Myeloma	14	8	6	0	0	0	0	0	14	0	1.32%
Leukemia											
Acute Lymphocytic Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Chronic Lymphocytic Leukemia	5	2	3	0	0	0	0	0	5	0	0.47%
Other Lymphocytic Leukemia	1	1	0	0	0	0	0	0	1	0	0.09%
Acute Myeloid Leukemia	10	7	3	0	0	0	0	0	10	0	0.94%
Chronic Myeloid Leukemia	2	1	1	0	0	0	0	0	2	0	0.19%
Other Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Mesothelioma/Kaposi Sarcoma											
Mesothelioma	2	2	0	0	0	0	1	1	0	0	0.19%
Kaposi Sarcoma	0	0	0	0	0	0	0	0	0	0	0.00%
Miscellaneous	18	7	11	0	0	0	0	0	18	0	1.70%
Total:	**1059**	**490**	**569**	**105**	**269**	**227**	**168**	**208**	**80**	**2**	**100%**

Miami Valley Hospital

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Head and Neck											
Tongue	12	10	2	2	4	0	0	5	0	1	0.62%
Salivary Gland	1	0	1	0	0	0	0	1	0	0	0.05%
Floor of Mouth/Gum/Other	6	4	2	2	0	2	1	1	0	0	0.31%
Nasopharynx	3	1	2	0	1	0	0	0	0	2	0.16%
Tonsil	9	7	2	0	0	0	0	7	0	2	0.47%
Oropharynx	6	3	3	0	0	0	2	2	0	2	0.31%
Hypopharynx	1	0	1	0	0	0	1	0	0	0	0.05%
Digestive System											
Esophagus	15	13	2	0	1	4	3	5	0	2	0.78%
Stomach	32	22	10	0	6	7	9	7	0	3	1.67%
Small Intestine	10	8	2	0	3	0	3	3	0	1	0.52%
Colon	85	37	48	1	18	22	19	25	0	0	4.42%
Rectosigmoid Junction	13	8	5	0	5	4	3	1	0	0	0.68%
Rectum	36	24	12	0	6	13	9	6	0	2	1.87%
Anus/Anal Canal/Anorectum	2	0	2	0	1	0	1	0	0	0	0.10%
Liver	44	36	8	0	11	9	5	7	2	10	2.29%
Intrahepatic Bile Duct	9	5	4	0	5	1	0	2	1	0	0.47%
Gallbladder	6	3	3	0	0	0	3	3	0	0	0.31%
Other Biliary	10	5	5	0	3	3	0	1	0	3	0.52%
Pancreas	51	29	22	0	5	15	0	29	0	2	2.65%
Retroperitoneum	2	1	1	0	1	0	1	0	0	0	0.10%
Peritoneum/Omentum/Mesentery	4	0	4	0	0	0	2	1	1	0	0.21%
Respiratory System											
Nose/Nasal Cavity/Middle Ear	4	1	3	0	0	0	1	2	1	0	0.21%
Larynx	16	12	4	0	6	2	1	4	1	2	0.83%
Lung/Bronchus	257	143	114	2	49	27	48	128	0	3	13.38%
Trachea/Mediastinum/Other	0	0	0	0	0	0	0	0	0	0	0.00%
Bones and Joints	1	1	0	0	1	0	0	0	0	0	0.05%
Soft Tissue Including Heart	19	13	6	0	4	4	6	1	0	4	0.99%
Skin											
Melanoma	99	56	43	25	43	14	11	4	0	2	5.15%
Other Non-Epithelial Skin	2	1	1	0	0	0	0	0	1	1	0.10%
Breast	314	1	313	56	135	76	28	16	0	3	16.35%

Miami Valley Hospital

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Female Genital System											
Cervix	16	0	16	0	5	5	4	2	0	0	0.83%
Corpus & Uterus	94	0	94	1	69	3	14	6	1	0	4.89%
Ovary	43	0	43	0	9	3	12	18	0	1	2.24%
Vagina	3	0	3	1	0	0	0	1	1	0	0.16%
Vulva	12	0	12	3	7	1	1	0	0	0	0.62%
Other Female Genital Organs	2	0	2	1	0	0	1	0	0	0	0.10%
Male Genital System											
Prostate	172	172	0	0	17	110	20	24	0	1	8.95%
Testis	9	9	0	0	2	1	2	0	0	4	0.47%
Penis	2	2	0	0	0	0	0	2	0	0	0.10%
Urinary System											
Bladder	81	65	16	44	12	10	9	4	0	2	4.22%
Kidney/Renal Pelvis	124	70	54	1	77	4	20	17	1	4	6.45%
Ureter	7	5	2	1	1	0	3	2	0	0	0.36%
Other Urinary Organs	3	1	2	0	1	0	0	0	2	0	0.16%
Brain and CNS											
Brain	47	25	22	0	0	0	0	0	47	0	2.45%
Cranial Nerves/Other Nervous System	33	14	19	0	0	0	0	0	33	0	1.72%
Endocrine											
Thyroid	50	13	37	0	30	4	9	3	0	4	2.60%
Other Endocrine including Thymus	8	2	6	0	0	0	0	1	7	0	0.42%
Lymphoma											
Hodgkin's	7	4	3	0	1	2	1	3	0	0	0.36%
Non-Hodgkin's	65	36	29	0	17	15	17	13	1	2	3.38%
Myeloma	16	8	8	0	0	0	0	0	16	0	0.83%
Leukemia											
Acute Lymphocytic Leukemia	1	1	0	0	0	0	0	0	1	0	0.05%
Chronic Lymphocytic Leukemia	6	4	2	0	0	0	0	0	6	0	0.31%
Other Lymphocytic Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Acute Myeloid Leukemia	17	11	6	0	0	0	0	0	17	0	0.88%
Chronic Myeloid Leukemia	2	2	0	0	0	0	0	0	2	0	0.10%
Other Leukemia	1	1	0	0	0	0	0	0	1	0	0.05%
Mesothelioma/Kaposi Sarcoma											
Mesothelioma	0	0	0	0	0	0	0	0	0	0	0.00%
Kaposi Sarcoma	1	1	0	0	0	0	0	0	1	0	0.05%
Miscellaneous	30	15	15	0	0	0	0	0	30	0	1.56%
Total:	**1921**	**905**	**1016**	**140**	**556**	**361**	**270**	**357**	**174**	**63**	**100%**

Upper Valley Medical Center

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Head and Neck											
Tongue	2	2	0	0	1	0	1	0	0	0	0.71%
Salivary Gland	1	1	0	0	0	0	0	0	0	1	0.35%
Floor of Mouth/Gum/Other	0	0	0	0	0	0	0	0	0	0	0.00%
Nasopharynx	1	1	0	0	0	1	0	0	0	0	0.35%
Tonsil	2	1	1	0	0	0	0	2	0	0	0.71%
Oropharynx	0	0	0	0	0	0	0	0	0	0	0.00%
Hypopharynx	0	0	0	0	0	0	0	0	0	0	0.00%
Digestive System											
Esophagus	6	4	2	0	1	0	3	0	2	0	2.13%
Stomach	6	4	2	0	1	2	1	1	0	1	2.13%
Small Intestine	1	0	1	0	0	1	0	0	0	0	0.35%
Colon	28	13	15	2	8	6	7	3	2	0	9.93%
Rectosigmoid Junction	6	3	3	0	1	0	4	1	0	0	2.13%
Rectum	9	6	3	0	1	0	3	4	0	1	3.19%
Anus/Anal Canal/Anorectum	2	2	0	0	1	1	0	0	0	0	0.71%
Liver	1	0	1	0	1	0	0	0	0	0	0.35%
Intrahepatic Bile Duct	0	0	0	0	0	0	0	0	0	0	0.00%
Gallbladder	0	0	0	0	0	0	0	0	0	0	0.00%
Other Biliary	2	1	1	0	1	0	0	0	1	0	0.71%
Pancreas	3	2	1	0	0	2	0	1	0	0	1.06%
Retroperitoneum	0	0	0	0	0	0	0	0	0	0	0.00%
Peritoneum/Omentum/Mesentery	1	1	0	0	0	0	0	0	0	1	0.35%
Respiratory System											
Nose/Nasal Cavity/Middle Ear	0	0	0	0	0	0	0	0	0	0	0.00%
Larynx	3	2	1	0	2	0	0	0	1	0	1.06%
Lung/Bronchus	42	18	24	0	2	1	12	23	3	1	14.89%
Trachea/Mediastinum/Other	0	0	0	0	0	0	0	0	0	0	0.00%
Bones and Joints	1	1	0	0	0	0	0	1	0	0	0.35%
Soft Tissue Including Heart	3	1	2	0	0	1	1	0	1	0	1.06%
Skin											
Melanoma	3	2	1	2	1	0	0	0	0	0	1.06%
Other Non-Epithelial Skin	0	0	0	0	0	0	0	0	0	0	0.00%
Breast	71	2	69	12	32	13	8	4	2	0	25.18%

Upper Valley Medical Center

Site Summary Table for New Cases 2014

SITE	GENDER			AJCC STAGE GROUP							
	Total Cases	Male	Female	0	I	II	III	IV	None N/A	Unknown	% of Occurrence
Female Genital System											
Cervix	2	0	2	0	1	1	0	0	0	0	0.71%
Corpus & Uterus	12	0	12	0	7	0	5	0	0	0	4.26%
Ovary	1	0	1	0	0	0	1	0	0	0	0.35%
Vagina	0	0	0	0	0	0	0	0	0	0	0.00%
Vulva	1	0	1	1	0	0	0	0	0	0	0.35%
Other Female Genital Organs	0	0	0	0	0	0	0	0	0	0	0.00%
Male Genital System											
Prostate	20	20	0	0	4	12	0	2	2	0	7.09%
Testis	1	1	0	0	1	0	0	0	0	0	0.35%
Penis	0	0	0	0	0	0	0	0	0	0	0.00%
Urinary System											
Bladder	10	7	3	4	3	1	0	2	0	0	3.55%
Kidney/Renal Pelvis	9	3	6	0	5	0	0	1	0	3	3.19%
Ureter	1	1	0	0	1	0	0	0	0	0	0.35%
Other Urinary Organs	0	0	0	0	0	0	0	0	0	0	0.00%
Brain and CNS											
Brain	3	2	1	0	0	0	0	0	3	0	1.06%
Cranial Nerves/Other Nervous System	0	0	0	0	0	0	0	0	0	0	0.00%
Endocrine											
Thyroid	7	2	5	0	6	0	1	0	0	0	2.48%
Other Endocrine including Thymus	1	1	0	0	0	0	0	0	1	0	0.35%
Lymphoma											
Hodgkin's	3	2	1	0	0	2	0	0	1	0	1.06%
Non-Hodgkin's	8	4	4	0	6	0	1	0	1	0	2.84%
Myeloma	1	1	0	0	0	0	0	0	1	0	0.35%
Leukemia											
Acute Lymphocytic Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Chronic Lymphocytic Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Other Lymphocytic Leukemia	0	0	0	0	0	0	0	0	0	0	0.00%
Acute Myeloid Leukemia	1	0	1	0	0	0	0	0	1	0	0.35%
Chronic Myeloid Leukemia	2	0	2	0	0	0	0	0	2	0	0.71%
Other Leukemia	1	1	0	0	0	0	0	0	1	0	0.35%
Mesothelioma/Kaposi Sarcoma											
Mesothelioma	0	0	0	0	0	0	0	0	0	0	0.00%
Kaposi Sarcoma	0	0	0	0	0	0	0	0	0	0	0.00%
Miscellaneous	4	1	3	0	0	0	0	0	4	0	1.42%
Total:	**282**	**113**	**169**	**21**	**87**	**44**	**48**	**45**	**29**	**8**	**100%**

Cancer Committee Members

Atrium Medical Center

Ryan Steinmetz, MD, Chair
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Nurse Manager,
Medical Oncology Medical Surgical Unit

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Vice President of Operations

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Nutritional Services

Michael Bonar, MD
Pathology

Lisa Boster, RHIT, CTR
Cancer Registry

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Medical Oncology

Judith Burichin, MD
OB/GYN

Ravi Cherukuri, MD
Radiology

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Research/Clinical Trials

Melissa Cottman, RT
Imaging Manager

Mark Curtis, MSN, CNS-BC, ACHPN, LMT
Palliative Services

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Oncology Service Line Director

Karen Feldmeyer, MSA, RD, LD
Patient Services Manager/Nutrition Services

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Research/Clinical Trials

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Compton Infusion Center, Manager

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Radiation Oncology

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Pharmacy

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Clinical Nurse Specialist 4 North

Tia Leedy
Outpatient Oncology Social Services

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Administrative Director, Nursing Operations.

Gloria McIntosh, RHIT, CTR
Cancer Registry

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Beth Mullins, RHIA, CCS, CTR
Medical Records Manager

Marilyn Noll, MT (ASCP)
Director of Outpatient and Ambulatory Services

Mary Noll, RT
Radiation Oncology Manager

Alan Prok, MD
Pathology

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Rehabilitation/Lymphedema Services

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Director, Quality Innovation

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Jules Sherman, DO
Palliative Medicine

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Medical Director, Laboratory Services

Patrick Allan, MD
Pulmonologist

Diane Anderson, DO
Radiologist, Co-Medical Director
Samaritan Breast Center

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Medical Oncologist & Medical Director,
Oncology Services

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Certified Genetic Counselor

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Howard Gross, MD
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John Haluschak, MD
Medical Oncologist

Dianah Hurd, CTR
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Oncology Social Worker

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Medical Oncologist

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Brenda McCracken, BS, CTR
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Theodore Payne, MD
Radiologist

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Clinical Trials Research Nurse

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Pathologist

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Cancer Liaison Physician

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Interventional Radiology

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Administrative Coordinator

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Surgical Oncologist

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Inpatient Medical Oncology

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Radiology Special Procedures

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Interventional Radiology

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Gynecology Oncology

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Medical Social Worker

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Mark Monsour, MD
Urologist

James Ouellette, DO, FACS
Surgical Oncologist

Jose Rodriguez, MD, FACS
Cardiotheracic Surgery

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Surgery, Medical Director
High Risk Breast Cancer Center

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Genetic Counselor
High Risk Breast Cancer Center

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Clinical Pharmacist
Hematology and Oncology

Burhan Yanes, MD
Medical Oncologist
Medical Director - Oncology

Miami Valley Hospital South

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Director Clinical Operations
Miami Valley Hospital South

Joann Ringer
COO, Miami Valley Hospital South

Upper Valley Medical Center

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Pathologist

Wincha Chong, MD
Diagnostic Radiologist

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CTR, Cancer Registry Quality Coordinator

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VP, CNO

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General Surgeon

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Community Outreach Director

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Oncology CNS/Manager
Quality Management Representative

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Stewart Lowry, MD
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Pathologist

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Clinical Research Representative

Tarek Sabagh, MD
Cancer Liaison Physician/Medical Oncologist

Pam Wilson
LSW- Social Services

Amy Yoder
Cancer Conference Coordinator

Thomas Zaugg
Pharmacy

Cancer Committee Chairs

Premier Health has taken an integrated, comprehensive approach to cancer services. This brings together a collaboration for the four Premier Health hospitals and the committee chairs for the hospitals.

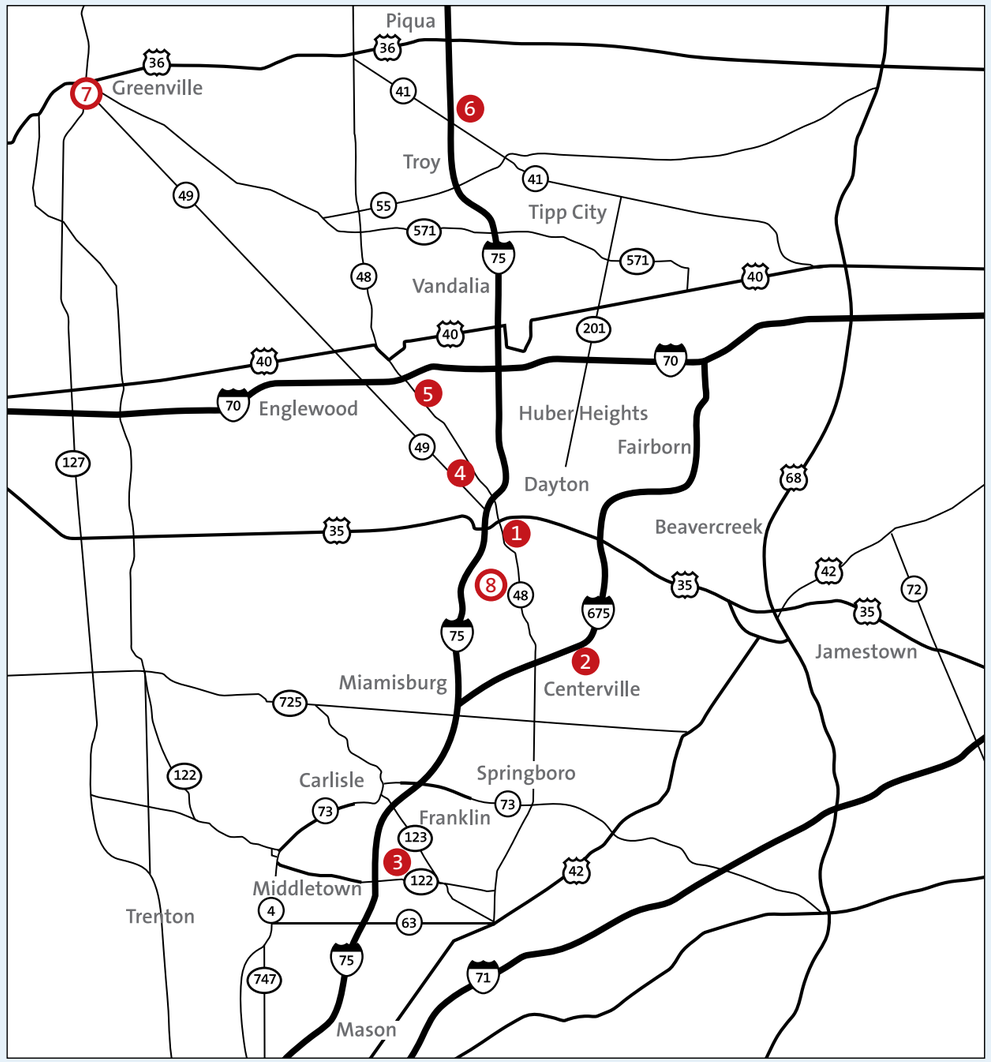
Mark A. Marinella, MD
Miami Valley Hospital

Gregory M. Rasp, MD
Good Samaritan Hospital

Ryan Steinmaetz, MD
Atrium Medical Center

Ronald K. Setzkorn, MD
Upper Valley Medical Center

Premier Health offers multiple cancer centers across the region that are conveniently located for you and your family.



Premier Health Cancer Center Locations:

1. **Miami Valley Hospital**
   One Wyoming St.
   Dayton, OH 45409

2. **Miami Valley Hospital South**
   2400 Miami Valley Dr.
   Centerville, OH 45459

3. **Atrium Medical Center**
   One Medical Center Dr.
   Middletown, OH 45005

4. **Good Samaritan Hospital – Dayton**
   2222 Philadelphia Dr.
   Dayton, OH 45406

5. **Good Samaritan North Health Center**
   9000 N. Main St.
   Dayton, OH 45415

6. **Upper Valley Medical Center**
   3130 N. County Rd.. 25A
   Troy, OH 45373

7. **Wayne Cancer Center***
   1111 Sweitzer Street
   Greenville, OH 45331

8. **Greater Dayton Cancer Center***
   3120 Governor's Place Blvd.
   Kettering, OH 45409

*joint venture with Premier Health

premierhealth.com/cancer