CANCER PROGRAM ADMINISTRATION

2017 Annual Report

STATISTICAL DATA FOR 2016

Methodist DALLAS

Methodist Dallas Medical Center 2016 Volumes by Site and AJCC Stage Group

	CASES	SEX		AJCC STAGE GROUP DISTRIBUTION						
Primary Site	Total	Male	Female	Stg 0	Stg I	Stg II	Stg III	Stg IV	N/A	Unk
ORAL CAVITY & PHARYNX	31	19	12	0	9	5	3	12	0	2
Tongue	9	4	5	0	5	2	0	2	0	0
Salivary Glands	1	1	0	0	0	0	0	1	0	0
Floor of Mouth	1	0	1	0	0	0	0	1	0	0
Gum & Other Mouth	14	8	6	0	4	3	1	6	0	0
Tonsil	4	4	0	0	0	0	1	1	0	2
Hypopharynx	2	2	0	0	0	0	1	1	0	0
DIGESTIVE SYSTEM	466	291	175	6	116	108	82	65	43	46
Esophagus	22	17	5	0	5	5	9	1	0	2
Stomach	30	19	11	0	5	3	4	7	4	7
Small Intestine	11	5	6	0	0	0	1	2	7	1
Colon Excluding Rectum	70	45	25	1	8	11	22	16	2	10
Rectum & Rectosigmoid	29	17	12	0	2	6	5	5	3	8
Anus, Anal Canal & Anorectum	9	6	3	2	1	3	1	0	0	2
Liver & Intrahepatic Bile Duct	140	101	39	0	70	25	27	4	3	11
Gallbladder	5	2	3	0	0	1	3	1	0	0
Other Biliary	26	16	10	1	9	9	2	1	3	1
Pancreas	115	59	56	2	15	45	7	28	14	4
Retroperitoneum	2	1	1	0	1	0	1	0	0	0
Peritoneum, Omentum & Mesentery	1	0	1	0	0	0	0	0	1	0
Other Digestive Organs	6	3	3	0	0	0	0	0	6	0
RESPIRATORY SYSTEM	110	54	56	1	20	7	21	56	2	3
Larynx	5	3	2	0	2	0	1	2	0	0
Lung & Bronchus	105	51	54	1	18	7	20	54	2	3
BONES & JOINTS	2	0	2	0	0	1	0	0	1	0
SOFT TISSUE	3	2	1	0	0	1	0	0	1	1
SKIN:Melanoma/Other Non-Epithelial	13	12	1	0	2	4	2	4	0	1
BREAST	103	0	103	18	32	40	10	2	0	1
FEMALE GENITAL SYSTEM	39	0	39	1	13	6	3	6	3	7
Cervix Uteri	7	0	7	0	2	3	1	1	0	0
Corpus & Uterus, NOS	15	0	15	0	7	0	1	1	1	5
Ovary	15	0	15	0	4	2	1	4	2	2
Vulva	1	0	1	1	0	0	0	0	0	0
Other Female Genital Organs	1	0	1	0	0	1	0	0	0	0
MALE GENITAL SYSTEM	78	78	0	0	16	35	8	10	0	9
Prostate	70	70	0	0	14	35	8	9	0	4
Testis	7	7	0	0	2	0	0	0	0	5
Other Male Genital Organs	1	1	0	0	0	0	0	1	0	0
URINARY SYSTEM	60	37	23	11	22	2	10	10	1	4
Urinary Bladder	17	13	4	10	2	2	0	2	0	1
Kidney & Renal Pelvis	41	23	18	1	20	0	10	7	0	3
Other Urinary Organs	2	1	1	0	0	0	0	1	1	0
BRAIN/OTHER NERVOUS SYSTEM	40	13	27	0	0	0	0	0	40	0
Brain	9	2	7	0	0	0	0	0	9	0
Cranial Nerves Other Nervous System	31	11	20	0	0	0	0	0	31	0
ENDOCRINE SYSTEM	34	12	22	0	7	1	3	3	14	6
Thyroid	19	5	14	0	7	0	3	3	0	6
Other Endocrine including Thymus	15	7	8	0	0	1	0	0	14	0
LYMPHOMA	29	14	15	0	7	3	4	6	0	9
Hodgkin Lymphoma	5	1	4	0	0	0	2	1	0	2
Non-Hodgkin Lymphoma	24	13	11	0	7	3	2	5	0	7
MYELOMA	7	5	2	0	0	0	0	0	7	0
LEUKEMIA	13	9	4	0	0	0	0	0	13	0
Lymphocytic Leukemia	7	6	1	0	0	0	0	0	7	0
Myeloid & Monocytic Leukemia	5	3	2	0	0	0	0	0	5	0
Other Leukemia	1	0	1	0	0	0	0	0	1	0
MESOTHELIOMA	1	1	0	0	1	0	0	0	0	0
KAPOSI SARCOMA	1	1	0	0	0	0	0	0	1	0
MISCELLANEOUS	33	14	19	0	0	0	0	0	33	0
Total	1,063	562	501	37	245	213	146	174	159	8

*Includes patients initially diagnosed and/or receiving all or part of 1st course treatment at Methodist Dallas Medical Center

1257 198420595 1217

CANCER PROGRAM ADMINISTRATION

2017 Annual Report

Continued

Health care is continuously evolving; becoming better with every new medication, every upgrade to healthcare technology and every new medical discovery. It takes constant work and engagement of multiple physicians and allied health workers to stay abreast of changes in cancer care. This is why it is important for cancer programs to always remain current on national treatment guidelines, standards for quality care and medical technology, and to understand the limitless benefits of interdisciplinary care.

Prashant Kedia, MD, performs hospital's first photodynamic therapy procedure.

A 60-year-old female patient with cholangiocarcinoma presented in the GI lab with two stents in her common bile duct. She was scheduled for an ERCP (endoscopic retrograde cholangiopancreatography), which allowed gastroenterologist Prashant Kedia, MD, on the medical staff at Methodist Dallas Medical Center, to access her duct to perform photodynamic therapy (PDT).

Two days before the May 24 procedure, the patient was brought to the Methodist Dallas GI lab for education and supplies, including a sun hat, gloves, and sunglasses as a special precaution. She then received an infusion of PHOTOFRIN® (porfimer sodium), which made her highly photosensitive as it was absorbed into the tumors in her bile duct. Dr. Kedia used the Optiguide™ fiber optic diffuser with a laser light source to activate the medication and destroy the tumors. PDT with PHOTOFRIN shrunk the tumors and minimized the blood flow to the cell.

The multidisciplinary process involved many departments within the hospital, including pharmacy, supply, 7 Schenkel Tower, biomedical, laser safety, compliance, legal, and the GI lab.

Methodist Health System Launches a New Mobile Mammography Unit

Since 1991, Methodist Health System Mobile Mammography Unit has been serving communities in the Dallas area with breast cancer screenings. With an understanding that the best way to beat breast cancer is to detect it at an early stage, the mobile mammography unit sets out to serve women in the community up to six days per week at local churches, health fairs, clinics and businesses. Nearly 3,500 women are provided with a screening mammogram each year.

Right on time for breast cancer awareness month, Methodist Health System re-launched a brand new mobile mammography unit in October 2017. The new unit is equipped with digital mammography, but was built for a future upgrade to 3D mammography. The vehicle, manufactured by Farber Specialty Vehicles, is wheel chair accessible and surround video monitoring makes it a safe and comfortable environment for both patients and staff. With a retractable awning, a short wait time during hot summers makes the experience even better for women who are receiving their mammogram.

In October 2017, over 400 women received a mammogram on the new mobile mammography unit and one breast cancer was detected as result of the service.

Standard 4.7 – A Study of Palliative and Advance Care Directives: an Integrative Approach for Unresectable Pancreatic Cancer Patients – by Elaina Vivian, MPH

The clinical course of pancreatic cancer usually is aggressive, with high symptom burden and potential for a substantial deterioration in quality of life. Given that, palliative care to focus on distressing symptoms and quality of life is an important adjunct in the management of this condition. In addition, having advanced directives in place is a part of good healthcare planning.

During the last Joint Commission review of the pancreatic program, the surveyor identified an opportunity to improve referrals to palliative care services and execution of advanced directives among unresectable pancreatic cancer patients. Therefore, as study was conducted to further identify the root cause of these problems. The study was conducted based off of the following causes for review:

Updated ASCO and NCCN Recommendations, 2017

- Every patient with pancreatic cancer should be offered information about clinical trials, which include therapeutic trials in all lines of treatment as well as palliative care, biorepository/biomarker, and observational studies.
- The goals of care (to include a discussion of an advance directive), patient preferences, as well as support systems should be discussed with every patient with metastatic and locally advanced pancreatic cancer and his or her caregivers.

Barriers to Services

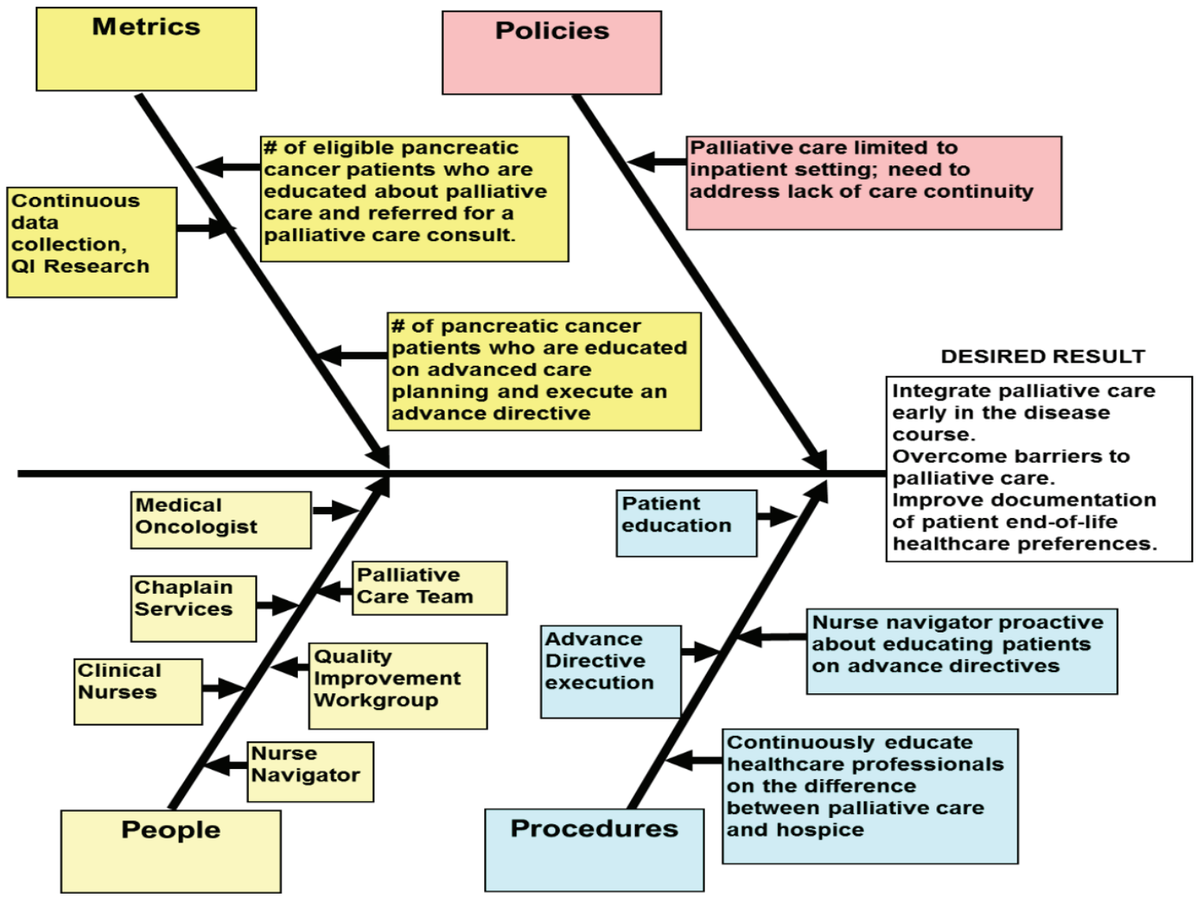
- There is confusion about the definition of palliative care. Patients and healthcare professionals alike often associate this term with end of life and death.
- Beyond admission, there is little discussion with patients about advance directives.

A medical record review demonstrated lack of documentation of referrals to palliative care and execution of advanced directive among this patient population. A root cause analysis was performed and is demonstrated in the fish bone diagram below.

1257 198420595 1217

2017 Annual Report

Continued



Opportunities for improvement were identified as the following:
For Referrals to Palliative Care Services:

- Due to the delicate nature of palliative care conversations with patients and their families, nurse navigators need to identify unresectable pancreatic cancer patients and positively prime them on palliative care services.
- Medical oncologist should further discuss palliative care with patient and family and refer for a consult during admission, or document why a referral was not made.
- All multidisciplinary team members need to be educated on the measure. Importantly, all direct patient care staff should continue to be educated on the difference between palliative care and hospice since this has been identified as a barrier for patients.

For Execution of Advanced Directives (AD):

- Nurse navigator needs to positively prime patients regarding AD, beyond the survey on admission/registration
- Medical Oncologists need to also speak to patients further about ADs
- Need support of Chaplain services to help execute ADs
- Important to offer ADs to cancer patients prior to surgery

The study concluded that palliative care services was not being routinely consulted for unresectable pancreatic cancer patients, and that patients who did not have advance directives on file were not receiving additional information or support in order to execute an advanced directive.

NAPBC Re-Accreditation

Methodist Dallas received reaccreditation by the American College of Surgeons, National Accreditation Programs for Breast Centers in August 2017. The surveyor, Dr. Dava Gerard, highlighted the breast program's study of late-stage breast cancer diagnosis among African American women as a very good study that addressed a community disparity, and noted "This program provides excellence in diagnosis and care of the breast cancer patients and is fortunate to have a strong BPL composed of individuals focused on providing patient centered care and addressing the challenges of their community".

NAPBC® NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS | A QUALITY PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS

Overcoming the Unthinkable

Robert Valentine is a 57 year old Dallas resident. He is the father of 7 children and enjoys working in the yard and using his physical ability to do home repairs. Mr. Valentine received a Low-dose computed tomography test (LDCT) at Methodist Dallas in September 2016. After his physician referred him to the smoking cessation program offered through the cancer program, he began his cessation journey. Mr. Valentine started the 4 class course in January 2017 and set a goal to quit smoking after the NFL Super Bowl game in February.

The program known as the Freshstart Smoking Cessation program is sponsored by the American Cancer Society and offers free 1 on 1 counseling services, 24 hours a day to any person who enrolls in one of its courses. The group based course taught by Maiya Bangurah Community Outreach Specialist for the Cancer Program, was Mr. Valentines second attempt in 44 years to quit smoking.

To date he has not smoked in 9 months and is very proud of his accomplishment. Mr. Valentine states that his motivation to quit smoking was his grandchildren who consistently reminded him of his promise to quit smoking. He also states that continuous prayer and motivation from his "prayer warriors" have helped him stay grounded and focused on accomplishing his goal. He reports that he now has more energy and has seen a tremendous change in his breathing and overall physical health. His journey to become smoke free has been challenging, but has allowed him the chance to live a better.

Methodist Dallas Cancer Program is located on the campus of Methodist Dallas Medical Center at 1441 N. Beckley Ave., Dallas, Texas 75203.

For more information, call 214-947-1766 or visit MethodistHealthSystem.org/Cancer.

1257 198420595 1217