Accredited Since 1984
The Foley Cancer Center has been honored to receive generous support from others over the years. Every gift helps to make a difference to those who need advanced, compassionate health care. We see gratitude on the faces of our patients and their families every minute of every day!

Gifts large and small have allowed us to change and improve the lives of our families, our friends and our neighbors.

Special thanks to the students at Christ the King School, the organizers and participants of the Mary Wells Heath 5K Memorial Run, the Rutland Rugby Club, Castleton State College and the Women’s Ice Hockey Team, the participants and organizers of the Alan Woodard Memorial Ride and the Jean Cooper Golf Tournament, the Women of the Cutting Edge Ice Hockey Tournament and Robert Isaac Tepper for the photo exhibit hosted on behalf of the Foley Cancer Center.

On behalf of our patients and their families, along with our physicians, nurses and clinical staff, thank you for your support.

The Rutland Health Foundation exists to improve the health status of the Rutland-area community by building financial support for Rutland Regional Medical Center and the Rutland Area Visiting Nurse Association & Hospice.
Chairman’s Report

The annual report last year focused attention on the general topics of cancer screening. Nationally, screening for cancers has become a “hot topic” of discussion. New technical developments have made DNA analysis easier and cheaper and the time from sampling to finding a result has shortened. Published studies of cancer screening, especially for breast and lung cancer, have created new data for discussion and analysis. Policy recommendations, made from analyzing these studies, have also changed how the medical community is considering and implementing screening practices. The topic of cancer screening is still quite controversial. The discussion that follows reviews some important considerations about cancer screening.

Screening tests for cancer can help find cancer at an earlier stage, before symptoms appear. This might make the cancer easier to treat and possibly easier to cure. Established screening tests include blood tests such as PSA for prostate cancer, diagnostic imaging tests, such as mammography for breast cancer, and even taking samples of tissue or cells such as PAP smears for cervical cancer. Of course these tests are used in addition to the very important “regular” physical examination and health history which occur in medical offices every day. Newer tests include tests of genes that might be linked to cancer, especially if there is a family history of certain cancer types such as colon cancer.

Most cancer screening tests carry very little if any physical risk. More important is the interpretation of the test results. Some tests may make it appear that a cancer is present when it is not (false positive). Or a cancer screening test can be normal when cancer is actually present (false negative). So interpretation of the screening test is critical.

Some cancers will never cause symptoms at all. And others may not be life threatening. However, the treatment for the cancer, once it is found, can have side effects. For example, major chest surgery is usually the treatment for a lung cancer found during screening. Policy makers have to weigh the risks and benefits of the treatments when creating policies that govern cancer screening recommendations.

Scientists with a variety of backgrounds collaborate with physician experts to review cancer screening studies to determine who has an increased risk of cancer. This leads to recommendations for screening tests only for those people with a documented high risk for certain cancers. Part of this analysis focuses on “risk factors” which are identified characteristics which increase the chance of cancer occurring. Just because a risk factor is present does not mean a cancer will occur. Some risk factors include a heavy smoking history, having several family members with the same type of cancer, cancers that have occurred at a young age in a family, and having had a cancer in the past.

In the United States and other countries around the world, large data bases exist which collect information on who gets cancer of all different types. In the United States, the two largest data collection repositories are the Surveillance, Epidemiology, and End Results (SEER) program and the National Cancer Database.

The “absolute risk” is a term that reflects the risk for anyone in the population in a certain group over a certain period of time. For example, if a group of 60-69 year old men are studied over a one year period, and 10 men are diagnosed with colon cancer, the absolute risk for this age group is 10 out of the total number of men studied. For large populations (states or countries) the risk rate is based on studying 100,000 people. The “relative risk” describes the risk related to a specific characteristic that is present in some members of a group. For example, in this same group of 60-69 year old men, smokers could be studied to see if they have a higher rate of colon cancer than the non-smokers. The rate of cancer detection in the smokers would be compared to the rate in the non-smokers. This ratio of cancers in smokers/ cancers in non-smokers is the relative risk. If the value is greater than “1”, then the risk factor (smoking in this example) is likely to increase the risk of getting cancer (colon cancer in this example).

Do screening tests reduce the risk of dying from a cancer? If a cancer is discovered at an earlier time (especially before symptoms appear) will the chance of dying from the cancer be lower? Screening studies do look very carefully at this issue. Very large studies which are often difficult to design and sometimes difficult to interpret try to answer this very important question. Certain factors may complicate the issue by causing some survival times to look like they are getting better when then may not be. Controversy over the tests, the frequency of doing the tests, which groups of people to screen, and how to pay for these tests are only a part of the discussion. As with many important issues in medicine, careful review and analysis of the data will lead to a better understanding of how best to screen for cancer. And, even more important, new techniques of screening, especially using analysis of DNA, will probably give new meaning to the value of screening for cancer.

Talk with your doctor or health care provider about your health and any new symptoms you may have. Screening for cancer is an important part of the discussion you should have at least once each year.

Allan Eisemann, MD
2013 has passed into the history of the Foley Cancer Center; next year is the 25th year of our department which started as the Community Cancer Center, in October of 1989.

In Radiation Oncology, we have upgraded our GE Lightspeed CT with precision lasers to become a true CT simulator. This upgrade gives us the precision which we have enjoyed with the Lightspeed CT, but now with the additional capabilities of performing an entire simulation on the CT live, with the patient still in the room. In the past, we would obtain the CT data, with targeting marks placed on the patient, and later, complete the treatment plan on the Varian Eclipse system in Radiation Oncology, after the patient has left the department. Now, we can analyze the CT, with the patient still in the imager, set ports, export targeting data to the laser system, and mark the patient, all in one procedure. This increases our capabilities in the delivery of precision radiation therapy.

We have also instituted peer review of all new cases, within the first week of treatment, and often prior to treatment. As a physician, working for the University of Vermont, and Fletcher Allen Health Care, (and in my 23rd year here at Rutland Regional Medical Center), I collaborate on this peer review with my colleagues at Fletcher Allen and Central Vermont Hospital, to give our patients the benefit of the oversight which assures them of state of the art treatment.

Nationally, radiation oncology is supporting efforts to ensure quality radiation oncology services, across the country. As a member of the Quality Committee for the American Society of Radiation Oncology (ASTRO), we are influencing this quality with templates and guidelines on the delivery of radiation for several disease sites, as a member of the Government Relations Committee, we are influencing the government regulators to ensure radiation oncology is delivered nationwide in a safe and efficient manner, and as a member of the Health Information sub-committee, we are influencing the documentation and delivery of radiation for years to come. Rutland Regional Medical Center, with Cerner and Varian’s assistance has supported this endeavor.

Finally, in 2013 we have been certified in radiation oncology by the Joint Review Committee on Education in Radiologic Technology for the clinical curriculum for radiation oncology students. Now, not only are we a Joint Commission on the Accreditation of Health Care Organizations, hospital, a American College of Surgeons accredited cancer center, but now an accredited teaching organization.

We look forward to our 25th anniversary next year.

Richard Lovett, MD
2013 was a quiet year in the Tumor Registry. There were no major changes in coding, abstracting, or reporting rules. Software upgrades were kept to a minimum, only two this year. The first software upgrade we wait for each year allows us to run new reports, edit data, and submit cases to the NCDB (National Cancer Database) based on new edits and dates they require. The submittal for recent cases that were required to be submitted to the NCDB included 1,911 cases. All cases must be error free in order for us to meet quality guidelines.

The NCDB is sponsored by the American College of Surgeons and the American Cancer Society. The data is collected from more than 1,500 hospital registries nationwide that are accredited through the Commission on Cancer. Registry software pulls cases for submission that include cases from the most recently completed year of data and all previous year’s cases that have had changes made in the past year. A change can be as simple as updating the patient’s vital status to entering more treatment data that was not known at the original submission.

The NCDB collects data on the majority of patients diagnosed with a malignancy each year; around 70% of newly diagnosed cases are reported to the NCDB. The database has over 30 million historical records stored. The data is available to hospitals who are interested in tracking comparative benchmarks. Reports can be made to compare data across a hospital’s state, region, or even nationally. This can help an organization looking at quality improvement initiatives, quality assurance for the work they do, and also surveillance measures.

When creating a report one can choose the year or years the data needs to be pulled from, the primary site of the malignancy, and the case type. Data comes from 2000 – 2010 and can include all or just a portion of those years depending on what the report needs to compare. There are over 30 primary sites/types of malignancies to choose from. Case types include class of case which is useful to know where the patient was diagnosed and/or originally treated. Up to three variables can be chosen for each report depending on the data that is being viewed. Examples of variables include age at diagnosis, stage at diagnosis, and first course of treatment.

The number of items to choose from gives organizations good way to compare data that are otherwise not available to them in report form. Now that is not to say, that everything an organization would want to compare is included in the data choices but the great majority of topics are. The Tumor Registry here at Rutland Regional Medical Center makes use of these reports on a regular basis. We pull data multiple times a year to compare our data to other hospitals that are similar in size to ours. We find the data useful and the reports are easy to create.

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>2013</th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
<th>2009 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORAL CAVITY &amp; PHARYNX</td>
<td>9</td>
<td>9</td>
<td>4</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>DIGESTIVE SYSTEM</td>
<td>66</td>
<td>64</td>
<td>67</td>
<td>63</td>
<td>68</td>
</tr>
<tr>
<td>RESPIRATORY SYSTEM</td>
<td>56</td>
<td>63</td>
<td>52</td>
<td>67</td>
<td>78</td>
</tr>
<tr>
<td>BONES &amp; JOINTS</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>SOFT TISSUE</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>SKIN EXCLUDING BASAL &amp; SQUAMOUS</td>
<td>8</td>
<td>5</td>
<td>12</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>BREAST</td>
<td>51</td>
<td>83</td>
<td>63</td>
<td>75</td>
<td>66</td>
</tr>
<tr>
<td>FEMALE GENITAL SYSTEM</td>
<td>19</td>
<td>24</td>
<td>20</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>MALE GENITAL SYSTEM</td>
<td>26</td>
<td>27</td>
<td>51</td>
<td>36</td>
<td>58</td>
</tr>
<tr>
<td>URINARY SYSTEM</td>
<td>31</td>
<td>22</td>
<td>23</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>BRAIN &amp; OTHER NERVOUS SYSTEM</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>ENDOCRINE SYSTEM</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>LYMPHOMA</td>
<td>26</td>
<td>23</td>
<td>16</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>MYELOMA</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>LEUKEMIA</td>
<td>12</td>
<td>10</td>
<td>14</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>MISCELLANEOUS</td>
<td>16</td>
<td>20</td>
<td>22</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>336</strong></td>
<td><strong>360</strong></td>
<td><strong>359</strong></td>
<td><strong>364</strong></td>
<td><strong>404</strong></td>
</tr>
</tbody>
</table>
Medical Oncology Unit

The Medical Oncology Unit, the 5th Floor, has had a productive and busy 2013. This past year, we have continued our partnership with the Studer Group to strengthen our patient centered care processes. Nurse Leader Rounding in patients gives us the opportunity for us to ensure that every patient receives the care and comfort they deserve. The nurse leader, who may be a manager or a charge nurse, visits with each patient and asks them several key questions to make sure their needs are being met. Using this information, we can respond and hopefully make anything that isn’t right, right.

We also have continued to grow our Patient Callback program. Each patient who is discharged home is called back in 24 to 72 hours to ensure they had a positive hospital experience and make sure they have their medications; they are not having any adverse symptoms that require attention or any other issues or complements we can use to improve our care. This allows us the opportunity to make sure our patients continue to heal even after their discharge from our hospital.

In June we were very pleased to open our Dayroom Program. The Dayroom is located on the 5th floor and is open to all inpatients that are deemed medically stable enough to enjoy a family style room with activities, meals, movies, music or socialization to make their recuperation more enjoyable and therapeutic. For our patients with any type of anxiety or altered thought process, the Dayroom program tailors activities suited to their needs while helping them use energy during the day for a more restful sleep at night. With assistance from the Volunteer Program we are able to offer pet therapy, Reiki, musical performances as well as special help and activities.

This past August we initiated Hourly Rounding. During day hours, we round on our patients to make sure they are safe and comfortable. We make sure that our patients pain is managed, that they have everything they need within reach, and any personal needs along with their position that may need attention to remain comfortable. Our goal is to anticipate patient needs before our patients become uncomfortable or do not have what they need.

We continue to enjoy a very robust relationship with the Foley Cancer Center team as well as the Palliative care team. We partnered for education and were able to provide several of our team with ELCNE Palliative care education over two days. We also partnered for a night of fun and team building bowling event and most recently Romp to Stomp! We are looking forward to providing great care together to our patients in 2014.

Pharmacy Program

Keeping abreast of new developments in chemotherapy treatments for cancer care is a constant challenge, and 2013 has proven to be another year of new and innovative drug treatment regimens. The pharmacy department in the FCC has provided many educational sessions on new treatments to help familiarize the clinical staff with these new therapies. Clare Coppock, Oncology Pharmacist and Leonard DeLorenzo, PA, presented a lecture on Chronic Myelogenous Leukemia at the Spring Meeting of the Vermont Society of Health-System Pharmacists in Burlington.

Four students from the Albany College of Pharmacy each spent 6 weeks in the FCC pharmacy learning all aspects of oncology care. These students each spent time interviewing patients about all of the medications they are taking (medication reconciliation). They were able to use the pharmacist’s drug expertise to help the patients use their medications as intended for best patient outcomes. Many of these consultations resulted in communication with the primary care provider to adjust a patient’s medications. The students also provided many of the educational sessions to the clinical staff.

The pharmacists and technicians continue to work with the providers and nurses to provide safe and effective chemotherapy treatments to all patients treated at the Foley Cancer Center.

Pharmacy Program cont’d

2013 was a year of growth for hospice with an ADC of 35. Census varied from the low 30’s to the 40’s. Hospice admitted 201 patients and discharged 2011. The comfortable dying measure data which is submitted to CMS showed that 34 patients out of 200 had pain on admission. Pain was resolved in 17. Staffing was fairly stable with the addition of a per diem staff that later increased her hours.

The Trillium singers were active with sings 2-3 times a month and urgent sings as needed. Bereavement support groups were held on a regular basis; attendance varied.

There were two volunteer trainings done during the year in the spring and the fall with good attendance. In addition, there were Reiki trainings held which added to the services that we can provide.

Also, contacts were in place with local restaurants that provided meals or what is known as Dinners with Love to clients on a weekly basis.

Our first Death Café was held in the fall in Rutland. The chaplain conducted several memorial services for patients as well as funeral services.

Hospice Program
Marrow Donor Program

At our November meeting, Golden Swab Awards were presented by Jennifer St Peter, Account Executive, Be The Match at Rhode Island Blood Center and Kerry Ellis, Program Coordinator for the Marrow Donor Program at Rutland Regional Medical Center. These awards are presented yearly and are in appreciation of contributions to, and support of, the Be The Match Program. 2013 recipients were:

- Lois Wenger, a marrow donor who is now a volunteer. Lois speaks with groups about her donation and recently wrote a book about her experience, A Match For Mary.
- The Fretta Family. Chris Fretta was diagnosed with Non-Hodgkins Lymphoma in 2009. While he continues to do well and does not need a transplant at this time, he and his entire family have become advocates and volunteers for us – helping organize marrow drives and sharing their story to encourage others to join the registry.
- The Packard Family. 16 year old race car drive Emily Packard and her parents have become tireless volunteers supporting the program in numerous ways from having the Be The Match logo on her race car to organizing donor drives to leading the Leukemia & Lymphoma Society’s Light The Night walk in Burlington.
- The Red Knights. The motorcycle group consisting of active and retired firefighters annually organizes a benefit ride in support of the program. This year they had over 300 riders from around the world and raised over $2,300!
- David Cranmer. David received a marrow transplant from his brother 13 years ago and has been an advocate ever since. David is the Coordinator for Vermonters Taking Action Against Cancer (VTAAC), a volunteer and speaker for our program.

In October, Kerry Ellis, Program Coordinator, attended the National Marrow Donor Program’s Annual Council Meeting in Minneapolis, Minnesota. The yearly conference brings together professionals involved in transplantation from around the world and provides updates on the state of transplant science, the registry, new initiatives, and educational workshops. A highlight of this year’s meeting was a first time meeting between a transplant patient and the donor who saved her life and a keynote presentation from Ethan Zohn, winner of the television show Survivor, Non-Hodgkins Lymphoma survivor, and 2 time marrow transplant recipient.

In FY13 (October 2012-September 2013) we added 745 new potential donors to the Be The Match registry. 23 donors registered through our program were called for additional testing as possible matches for a patient in need. Of those, 4 were found to be the best match for the patient and went on to donate. They donated to a 9 year old male with AML, a 67 year old male with AML, a 68 year old male with AML, and a 58 year old with CLL.

Clinical Trials

The Foley Cancer Center continues to offer Clinical Trials to our eligible patients. Over the spring and summer months we participated in an exciting study looking at developing a blood test to help diagnose breast cancer. We partnered with the Breast Care Program to help identify these patients and were able to accrue 8 patients. Two new metastatic breast cancer studies were opened through pharmaceutical companies.

Several changes have occurred with the National Cancer Institute (NCI) Cooperative Group Studies. The Institute Of Medicine recommended decreasing the number of funded cooperative groups and putting in place a committee to help prioritize clinical trials and reduce the number of competing studies. Without competing studies accrual time to clinical trials can be increased. In 2014 there will be a re-application process for funding. As a result many of the Cooperative Groups have been working together to combine their resources. Rutland Regional Medical Center was formerly an affiliate member of the Radiation Therapy Oncology Group (RTOG) through Dartmouth Hitchcock Medical Center. We now belong to NRG which is a combination of the National Surgical Adjuvant Breast and Bowel Program (NSABP), the Radiation Therapy Oncology Group (RTOG), and the Gynecological Oncology Group (GOG) Cooperative Groups. This allows us to continue participation in the Clinical Trials Support Unit (CTSU) which gives us access to other Cooperative Group Phase III studies.

In addition the NCI Central IRB (NCICIRB) has changed to an independent review model. This makes for an easier approval processes and may allow us to open and maintain more clinical trials.

We continue to follow 16 patients on clinical trials with no delinquencies. We currently have 7 clinical trials available. These can be viewed on the RRMC website at www.RRMC.org.

Members of the research staff are also involved in assisting our Departmental Leader in coordinating the ACOS survey data and managing quality improvement studies.
2013 Cancer Program Committee Members

J.C. Biebuyck, MD
MaryLou Bolt
Kathleen Boyd, RN
Nina Buss, Ladies First
Maureen Chamberlain, MS, RHIA
Clare Coppock, RPH
David Cranmer – VTAAC
James F. Cromie, MD
Leonard DeLorenzo, PA
Rebecca Denofer, RN
Kelly Doaner
Carol Egan, CNO
Loreen Eddy, CBEC,CBPN-IC
Allan Eisemann, MD
Kerry Ellis
Kim Flory-Lake
Holly Fox, OCN
Amanda Freund, MS
Karen Alcorn, RN
Jessica Greco, MSW
Samantha Helinski, RN, BSN, CWOCN
Jill Jesso-White
Priscilla Latkin
Chrissy Littler
Rick Lovett, MD
Sharon Mallory
Sheela Martel, OCN
Linda McKenna, PA, Director
Tony Masuck, MD
Jessica Rappeno, RN BSN, OCN,CHPN
Suzanne Redden, MD, Hospitalist
Barb Robinson, VP
Leigh Sampson
Julie Scott, RN
Bridget Tarbell, CTR
Howard Weaver, MD
Eva Zivitz, CHPN

Our mission is to improve the outcomes of our patients with cancer, ease their pain and suffering, help patients and families live a better quality of life despite these challenges, and provide a compassionate, understanding, and safe environment.

Foley Cancer Center
A Department of Rutland Regional Medical Center