

PENROSE CANCER CENTER 2011 ANNUAL REPORT

CANCER CONNECTED

Penrose
Cancer Center

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“THE PENROSE CANCER CENTER OPENED IN 1941 AS THE PENROSE TUMOR INSTITUTE, THANKS TO THE GENEROUS SUPPORT OF SPENCER AND JULIE PENROSE. WE CONTINUE TO BE ONE OF THE LEADING COMMUNITY CANCER PROGRAMS IN THE NATION, PROVIDING THE LATEST TECHNOLOGY AND THE BEST MINDS IN THE FIGHT AGAINST CANCER. I’M ESPECIALLY PROUD OF OUR NEWLY DEVELOPED PARTNERSHIP WITH ROCKY MOUNTAIN CANCER CENTERS THAT WAS LAUNCHED IN JANUARY, 2011. THIS PARTNERSHIP HAS ALLOWED US TO PROVIDE A COMPREHENSIVE, INTEGRATED APPROACH TO CANCER CARE, WHICH TRULY BENEFITS OUR PATIENTS.”



Margaret Sabin
CEO, Penrose-St. Francis
Health Services

MISSION AND VALUES

THE PENROSE CANCER CENTER (PCC) will excel in providing information, treatment, and comfort to patients and families with cancer illnesses. PCC will integrate and support a community of cancer health professionals committed to evidence-based care, quality improvement, clinical research, community service, and multidisciplinary management. PCC will be guided by values of integrity, stewardship, spirituality, imagination, mutual respect, compassion, clinical research, communication, quality improvement and collaboration.



TO THE PENROSE CANCER CENTER COMMUNITY:

It is our pleasure to present the 2011 Penrose Cancer Center Annual Report. It has been a year of remarkable growth for our cancer program, with more achievements, collaborations, and innovations than can be detailed in this document. The successful partnership between Penrose Cancer Center (PCC) and Rocky Mountain Cancer Center (RMCC) continues to grow and develop. This, coupled with improved physician engagement, permitted PCC to serve nearly 2000 new cancer patients by the close of 2011, constituting a 50% increase compared to 2006 data.

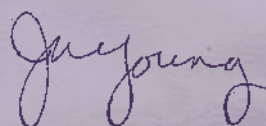
Ours is the second largest cancer program in the state of Colorado, and the only community cancer program of this size in the state of Colorado. Physician participation in multidisciplinary conferences has increased by 30% compared with the previous year. Penrose Cancer Center physicians have presented innovative clinical research at national meetings and have presented three educational conferences for physicians in southern Colorado. This year, PCC achieved the prestigious *Accreditation With Commendation* of the Commission on Cancer of the American College of Surgeons, and was the only Colorado recipient of the Outstanding Achievement Award in 2011. None of this could have been accomplished without the support of our community, our donors, visionary management leadership, the hard work and skill of our physicians, and, above all, our patients and their supportive families.

We have chosen to focus this year's report on our disease-specific multidisciplinary programs. This year, we will highlight our Thoracic Oncology, Head and Neck Cancer, and Urologic Oncology achievements. For the first time, we are presenting data comparing Penrose Cancer Center achievements to national benchmarks, and providing a snapshot of internal data illustrating our efforts to measure our efforts to improve and excel. In addition, we hope to highlight the benefits of care navigation and multidisciplinary collaboration to improve treatment outcomes.

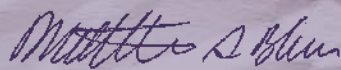
Penrose Cancer Center is still the only National Community Cancer Center Program (NCCCP) in the state. NCCCP is a program of the National Cancer Institute (NCI) designed to foster excellence in community based cancer programs like our own. We will present progress in clinical trials (research programs that further the goal of increasing cancer cures), multidisciplinary care, care navigation (specialized support for patients facing complex treatment courses), outreach to underserved populations in Southeastern Colorado, and support for survivorship (programming directed at patients and caregivers completing cancer treatment).

On behalf of all of the patients, families, physicians, and dedicated staff of Penrose Cancer Center, we wish to thank you for your interest and ongoing support of our vital mission in our community and our region.

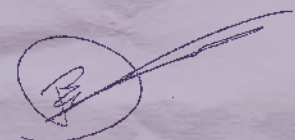
Sincerely yours,



James A. Young, MD
Penrose Cancer Center
Medical Director



Matthew Blum, MD
Penrose Cancer Center
Physician Advisory Board Chair



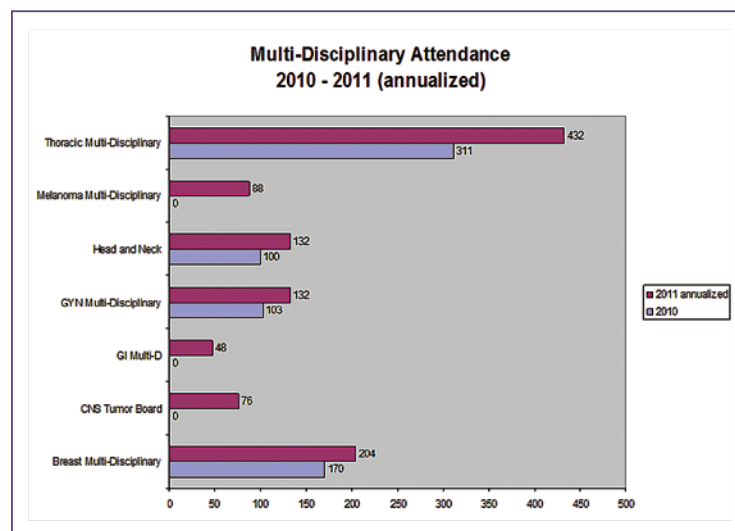
Dennis Bruens, MPA
Penrose Cancer Center
Director

MULTIDISCIPLINARY CONFERENCES

With the leadership of the NCI Community Cancer Centers Program contract, and with a growing wealth of outcomes research that demonstrates better patient satisfaction and cancer outcomes from multidisciplinary care, Penrose Cancer Center has expanded its multidisciplinary care programming. All multidisciplinary conferences are certified as continuing medical education for physician and nursing personnel.

Physicians with special training and expertise in select cancers come together with a wide array of support staff to share ideas, debate management, review national guidelines and the latest research, and formulate the best management plan for the individual patient. A nurse navigator, attached to each multidisciplinary program, is responsible for working directly with patients to assist them with prompt and accurate diagnostic evaluation and treatment.

NAME	BEGUN	FREQUENCY	PHYSICIAN LEAD
Breast MDC	10/99	weekly conference	Dr. Toni Green and Dr. Laura Pomeranke
Head & Neck CA MDC	1/98	monthly conference	Dr. Joel Ernster and Dr. Alan Monroe
Thoracic MDC	2007	weekly conference	Dr. Alain Eid and Dr. Matthew Blum
Gastrointestinal Tumor MDC	re-started in 2/11	bi-monthly conference	Dr. Ihor Fedorak and Dr. Brock Bordelon
GYN MDC	3/09	monthly conference	Dr. Dirk Pikaart
Melanoma MDC	10/10	quarterly conference	Dr. Brock Bordelon and Dr. Joel Ernster
CNS Tumor MDC	1/11	quarterly conference	Dr. Michael Brown
Malignant Heme MDC	9/11	monthly conference	Dr. Anthony DeCarolis



CANCER CENTER PHYSICIAN ADVISORY BOARD CONTACTS

NAME	ADDRESS	PHONE
<i>PAB Chair:</i> Blum, Matthew, M.D.	Colorado Springs Cardiovascular Thoracic Surgeons 2222 N. Nevada Avenue #4002 Colorado Springs, CO 80907	719-473-3550
<i>Medical Director:</i> Young, James, M.D.	Rocky Mountain Cancer Center at Penrose Cancer Center 2222 N. Nevada Avenue CC-201 Colorado Springs, CO 80907	719-577-1006
Chambers, William, M.D.	Colorado Surgical Associates 2222 N. Nevada Avenue, Ste 5017 Colorado Springs, CO 80907	719-635-2501
Cohn, Elliot, M.D.	Urological Associates 75 Printers Parkway #200 Colorado Springs CO 80910	719-634-1994
Ernster, Joel, M.D.	Colorado Otolaryngology Associates 303 N. Circle Drive #300 Colorado Springs CO 80909	719-867-7800
Garza, Austin, M.D.	Associates in Gastroenterology 2940 N. Circle Drive Colorado Springs, CO 80909	719-635-7321
Green, Toni, D.O.	St.Francis Medical Center #360 6011 E. Woodmen Road Colorado Springs CO 80923	719-571-8840
Monroe, Alan, M.D.	Penrose Cancer Center Radiation Oncology Services 2222 N. Nevada Avenue Colorado Springs, CO 80907	719-776-5281
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2011 PENROSE CANCER CENTER ANNUAL REPORT

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Bruens, Dennis Director	Penrose Cancer Center 2222 N. Nevada Ave. #CC-159 Colorado Springs, CO 80907	719-776-5272 or 719-314-5069 (cell)
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Gates, Lisa PCC Marketing Coordinator	Penrose Cancer Center 2222 N. Nevada Ave. #CC-159 Colorado Springs, CO 80907	719-776-5610

2012 CANCER COMMITTEE MEMBERS

Toni Green, DO, Chair

General Surgeon
Board Certified

Alan Monroe, MD

Radiation Therapy
Board Certified

Jeffrey Ross, MD

Radiology
Board Certified

Cosimo Sciotto, MD

Pathology
Board Certified

Daniel K. Smith, MD

Otolaryngology
Board Certified

William Timmins, MD

Medical Director, Palliative Care
Board Certified

James A. Young, MD

Medical Oncology
Board Certified

Charles Zinn, MD

Internal Medicine/Med. Onc.
Board Certified

Jameson Smith, Executive VP/COO

Chief Operating Officer
Penrose Hospital

Dennis Bruens, MPA

Director
Penrose Cancer Center

Kate Crow, MS

Genetic Counselor

Carolyn Cusic, RN, BSN, OCN

Clinical Manager
Oncology Inpatient Unit

Judy De Groot, RN, MSN, AOCN

Lead Nurse Navigator

Jodi Harr, CTR, CCRP

Manager, Cancer Registry
Clinical Research & IRB

Sherry Martin, MSW, LCSW

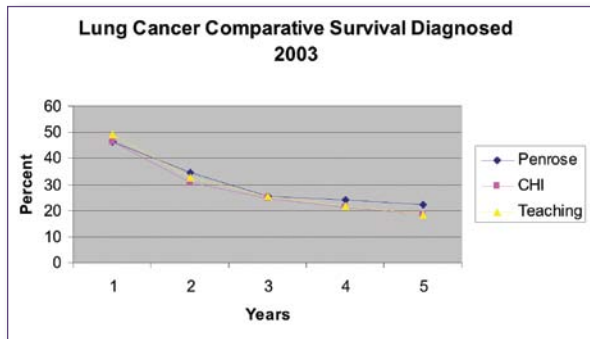
Oncology Social Worker



Matthew Blum, M.D.

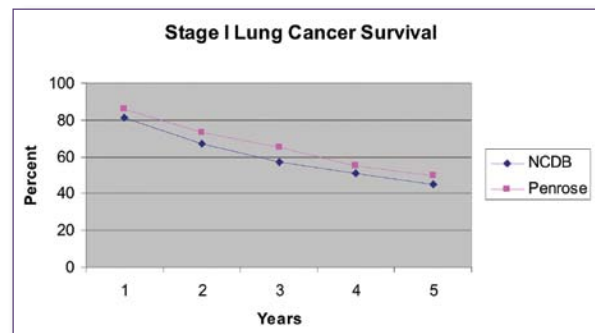
THORACIC ONCOLOGY PROGRAM

The Penrose Cancer Center Multidisciplinary Thoracic Oncology Program was initiated in 2009. A multidisciplinary group meets weekly, and includes representation from thoracic surgery, pulmonary medicine, radiation oncology, medical oncology, clinical trials nurses, nurse care navigators, radiology, pathology, genetics, smoking cessation counselor and other disciplines. At each conference, cases of patients with newly diagnosed chest cancers (lung, thorax, esophagus) are presented anonymously to the group. A comprehensive, individualized plan of evaluation, treatment and followup is developed by the group, with emphasis on using evidence-based guidelines. At Penrose Cancer Center, we have a firm belief that rigorous pre-treatment multidisciplinary review constitutes better care for the patient.

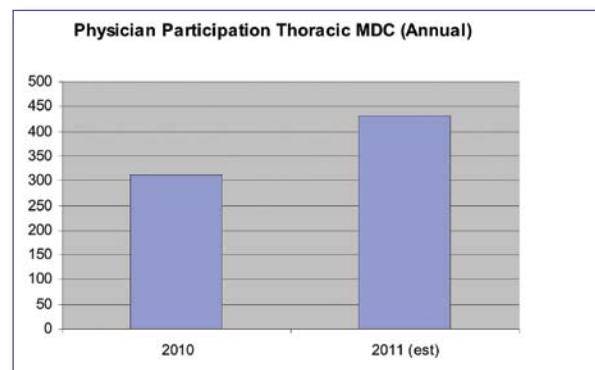


Lung cancer is one of the most difficult diseases to treat, and carries a very high risk of recurrence. PCC lung cancer treatment outcomes for 2003, the last year for which complete 5 year survival data are available, demonstrates equivalence of PCC outcomes with those of a comparable group of community (CHI) hospitals and for academic (Teaching) medical centers.

Stage I lung cancer is the most curable stage of the disease. For the years 2000-2010, PCC survival rates for Stage I disease were 46%, which is slightly higher than collected data from other NCDB cancer centers around the nation. Of a total of 565 patients treated over this decade, 474 were treated with surgery, and 91 treated with radiation therapy. The latter group tended to be older and more ill, and a number were treated with a focused form of radiotherapy called SBRT (stereotactic body radiotherapy).



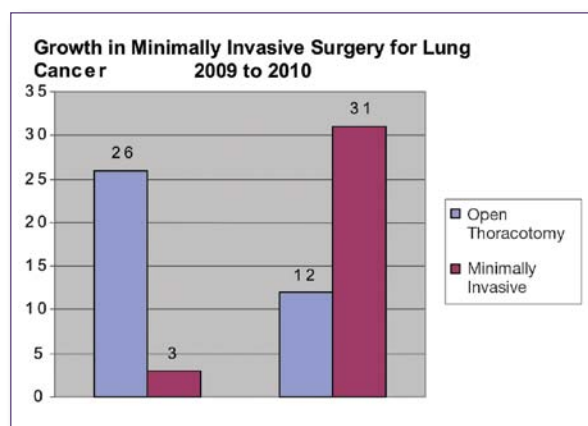
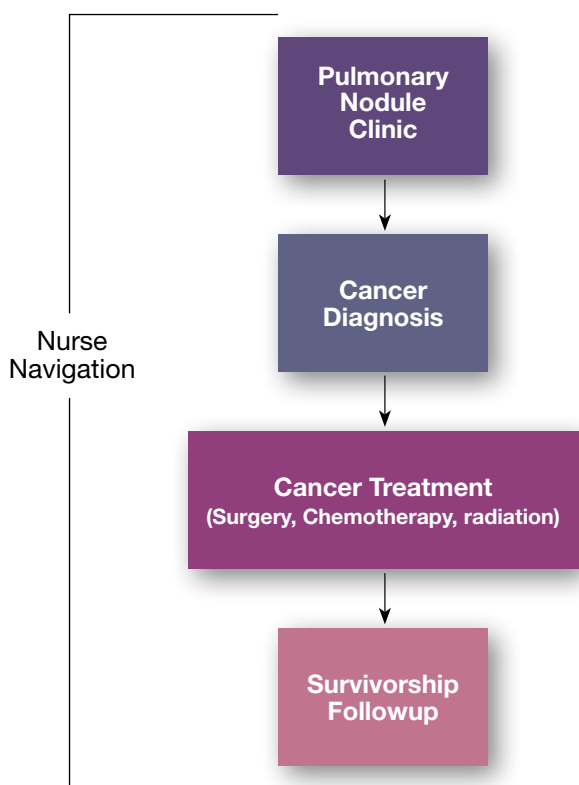
Physician participation in the Thoracic MDC conferences has grown by about 38% from 2010 to 2011, and averages about nine physicians per conference.



The Thoracic MDC program includes two care navigators. These oncology nurses are specially trained to assist with prompt “navigation” of patients and families through the diagnosis and treatment phase of their illness. This program was initiated with the goal of minimizing delays in obtaining diagnosis and starting appropriate therapy. In addition to navigation during cancer treatment, the navigators help coordinate followup of nodules suspicious for lung cancer through the Pulmonary Nodule Clinic. In the second quarter of 2011, 66 patients with lung nodules were navigated through the process of diagnosis and planning of followup, with a total of 302 patients being followed. In addition, 69 patients with thoracic cancers were in various stages of diagnosis and treatment during the same time period.

As illustrated in the chart at the bottom of this page, care navigation and improved multidisciplinary collaboration have resulted in reduction in the time of first contact to treatment from 45 days in 2009, to 20 days in late 2011.

Innovations in treatment have also improved the care and outcomes of Penrose Cancer thoracic oncology patients. Traditional thoracic surgery is associated with a large incision, longer hospital stays, and more complications. “Minimally invasive” surgery employs sophisticated instruments and operator skill that result in small incisions, more prompt recovery, and fewer complications. Penrose Cancer Center is the only provider of advanced minimally-invasive thoracic surgery in southern Colorado, and the change in patterns of care is illustrated below.



From 2009 to 2010, total thoracic surgery volume increased from 137 to 285 patients annually (over 100%), and total lung cancer resections increased from 29 to 43 patients during the same time frame.

	2009	2010	JAN-JUN 2011	JUL-SEPT 2011
First Contact to Diagnosis (days)	18	16	18	9
Diagnosis to Treatment (days)	27	19	15	11

(THORACIC ONCOLOGY Continued)

The use of minimally invasive surgery has decreased the average postoperative length of stay for lobectomy from 7.35 days in 2006 to 3.85 days in 2010. The Penrose thoracic surgery program participates in the Society of Thoracic Surgery (STS) database. This database allows comparison of the quality of surgical care by comparing the Penrose program to the other major thoracic surgery centers in the United States and Canada. There were no deaths after lobectomy at Penrose in 2010-2011, and complication rates were substantially below the STS averages.

Cyberknife radiation therapy is a new technique to target small lung lesions for treatment. Selected patients not suitable for surgery have been treated in this fashion. This sophisticated targeted therapy, sparing damage to surrounding tissues, may be given in five days or less, and is associated with minimal pain and risk.

A major focus of Penrose Cancer Center programming is clinical trials, designed to test new methods

of treatment in order to improve outcomes. In 2011, a total of 26 clinical trials, covering virtually all stages of thoracic cancer, were open to patients of the thoracic oncology program.

At Penrose Cancer Center, all patients completing therapy for a thoracic cancer are provided with a treatment summary, recommendations for follow-up care, and survivorship support.

As part of the PCC commitment to medical community outreach and education, members of the thoracic oncology program presented a half-day, didactic program on the management of pulmonary nodules and lung cancer. This program was designed for primary care physicians and physician-extenders in Southeastern Colorado and was broadcast to St. Mary Corwin Hospital in Pueblo.

For 2012, the PCC thoracic oncology program has goals of increasing clinical trials participation, implementing a plan for low dose CT imaging screening of patients at high risk for lung malignancy, and extending its reach of thoracic oncology excellence into Southeastern Colorado.



HEAD AND NECK ONCOLOGY



Joel A. Ernster, M.D.

The Penrose Cancer Center (PCC) Head and Neck Multidisciplinary program is the oldest of the Penrose disease specific MDC oncology programs, dating to approximately 2000. Patients with malignancies of the head and neck region are some of the most demanding in terms of complexity of care, coordination of various disciplines, support requirements during treatment, and rehabilitation after treatment. In 2011, PCC added a nurse navigator to the Head and Neck program, with the goal of improving the experience for patients and families, assist with coordination of complex care, and improve patient outcomes.

In 2011, approximately 100 patients will be navigated through treatment. By far the largest disease subset is cancer of the oropharynx, totaling about 32 patients for the year. The majority of patients diagnosed with this disease will have Stage IV, or evidence of spread beyond the organ of origin (usually base of tongue or tonsil).

In recent years, our understanding of the epidemiology of oropharynx cancer has improved, and a major contribution was made by Penrose Cancer Center physicians. Dr. Joel Ernster and Dr. Cosimo Sciotto collaborated on research that demonstrated an increase in the incidence of this disease in the 1990's, principally in male non-smokers, and occurring in the age 50-70 year time frame. These researchers also demonstrated a link between this increase of oropharynx cancer and the presence of a virus (HPV or human papilloma virus) in the tissue specimens.

Penrose Cancer Center has also been a leader in the development of non-surgical therapy of oropharynx cancer. This treatment, a combination of chemotherapy and radiation therapy, has been refined over the years and is associated with an 80-90% probability of cure. However, the treatment is highly complex and demanding for patients and their families and is associated with significant risks. In many cancer centers, delays in starting treatment may be 30 to 60 days in order to accomplish the various consultations and preparations required for therapy of this disease. Patients commonly require dental work in advance of therapy to minimize risk of dental infection and damage. Because tissues of the throat become inflamed and painful from treatment, patients have difficulty with nutrition and require intensive nutrition support during treatment. In addition, they require rehabilitation support to regain and maintain normal swallowing function after therapy.

For all Penrose head and neck cancer patients, the interval between referral and initiation of therapy during 2011 was approximately 15 days. Average weight loss during therapy was 5.5% of baseline weight, better than our program goal of limiting weight loss to 10% of total weight. A total of 10 hospitalizations were required (13% of patients treated), and six emergency room visits were observed (8% of patients treated).



The following fictional narrative is an example of the typical patient experience at Penrose Cancer Center:

J.D., a 55 year old healthy civil engineer with no evidence of cigarette smoking, noted a painless mass, about 2 in. in diameter, in his neck. His wife confirmed the abnormal swelling, became concerned and contacted their family physician, who made a referral to an otorhinolaryngology (ENT) specialist, who saw the patient the next day. The ENT specialist used a special instrument to visualize the base of tongue and tonsil and identified a suspicious ulcer on one tonsil. A small needle was introduced into the neck mass to obtain diagnostic material.

Within 48 hours, Penrose pathologists reported that tumor cells were present with evidence of HPV infection. The ENT specialist saw the patient and explained that the cancer, while serious, was curable and that he did not require radical surgery. The Penrose Head and Neck nurse navigator was present for the initial visit, and immediately coordinated a number of special services.

The patient saw his dentist to confirm that no extractions were needed and to get advice on oral health. Arrangements were made to see a swallowing specialist for baseline assessment, a gastroenterologist for placement of a gastrostomy tube (feeding tube through the abdominal wall and into the stomach), and a dietician for education regarding nutrition support during therapy. In addition, within days, the patient was seen by a medical oncologist and radiation oncologist to learn more about details of treatment, an intensive 6 week course of weekly chemotherapy and daily radiation treatments.

During therapy, which was started two weeks from the date the neck mass was detected, J.D. was seen weekly by his team of physicians and his care navigator. He was able to contact his navigator directly to obtain answers to questions or assistance with symptom management. Weekly progress was monitored by weight and laboratory studies. While J.D. lost nearly 15 pounds of weight during treatment, and was temporarily unable to work due to fatigue and discomfort, he had progressive and total shrinkage of the mass during therapy. Three months after therapy, he was back at work full time, swallowing and maintaining his nutrition, and scans showed no evidence of tumor.

J.D. and his family credit care navigation and multidisciplinary coordination of his complex care for his excellent outcome.

UROLOGIC ONCOLOGY

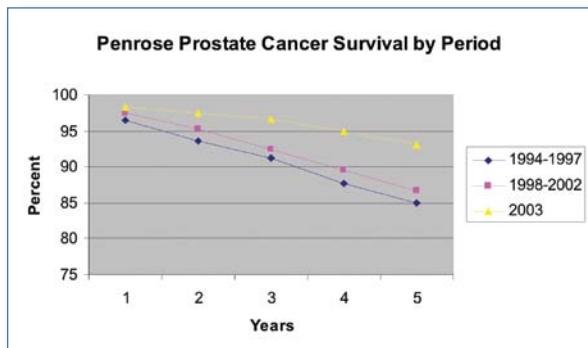


Elliot J. Cohn, M.D.

Prostate cancer is, by far, the most common urologic cancer in the United States, and the most common cancer affecting men. Prostate cancer is also the most common cancer treated at Penrose Cancer Center, with 300 new cases annually in recent years, making Penrose Cancer Center the leading center for prostate cancer treatment in Southern Colorado.

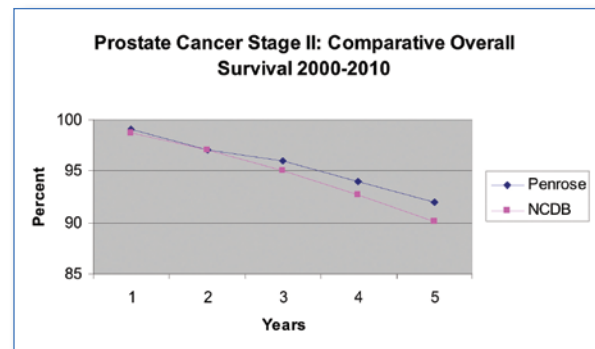
Patients treated at PCC for prostate cancer in 2003, the last year for which complete 5-year survival data are available, achieved 93% 5-year survival. This compared favorably with data from university and teaching hospitals (90%) and a set of comparable Catholic community hospitals (86%).

Furthermore, PCC demonstrated continued improvement in prostate cancer 5-year survival for time periods 1994-97 (85%), 1998-2002 (92%) and 2003 (93%).



For the most common stage of prostate cancer (Stage II), PCC 5 year survival for all patients diagnosed 2000-2010, was 92%. This compared favorably to a national database of cancer programs (National Cancer Database-NCDB), with 5-year survival of 90%

For Stage II patients, there are two very effective treatments, surgical prostatectomy and radiation therapy. For the period 2000 to 2010, a total of 887 Stage II patients had surgery as their initial treatment, and 845 patients had radiation therapy as their initial treatment. Patients age 70 or over comprised 41% of the radiation therapy group and 18% of the surgery group.



Penrose Cancer Center offers the latest generation of treatment technologies for prostate cancer. In recent years, the DaVinci robotic system is the predominant surgical technique. With this technique, the surgeon performs the dissection robotically, employing small incisions, offering the advantage of more precise dissection with a goal of minimizing side effects. Urologic surgeons from Urological Associates and Pikes Peak Urology are among the most experienced in the state, with over 200 robotic prostatectomies performed annually. Average duration of hospital stay has progressively improved to 1.0 days, with average operating time of approximately 3 hours.

(UROLOGIC ONCOLOGY Continued)

For patients electing radiation therapy, PCC offers the most experienced physicians, multidisciplinary care, and the latest technology. In addition to conventional IMRT (intensity modulated radiation therapy), delivered with image guidance to offer precise external beam treatment, PCC has the state's largest experience with HDR (high dose rate brachytherapy). HDR offers focused high dose internal treatments that can be completed as an outpatient with minimal complications.

Anuj Peddada, MD and colleagues have published a large experience in HDR brachytherapy for patients with large prostate glands, as well as patients with prior TURP (transurethral resection of the prostate), establishing a new option for these patients increasingly adopted nationwide. In addition, PCC offers real time intraoperative transperineal permanent seed prostate brachytherapy as a definitive single treatment for patients with favorable risk disease. PCC also

offers CyberKnife radiosurgery, a non-invasive treatment option permitting extreme precision and short duration therapy in low and intermediate risk prostate cancer patients electing this approach. The radiation oncology department has a full time prostate cancer nurse navigator able to coordinate all aspects of care.

PCC volunteer physicians and personnel, in collaboration with Peak Vista Clinic, Rocky Mountain Cancer Centers, the Man to Man Support Group, and Memorial Health System, led an annual free prostate cancer screening event in September 2011. A total of 133 patients, approximately 50% of whom had no insurance or access to routine health care, received prostate cancer screening with PSA testing and DRE (digital rectal examination). A total of 45 were found to have an abnormal DRE, and 10 were found to have an abnormal PSA. To date, a number of patients have been referred for urologic evaluation, and at least one patient has been diagnosed with cancer.

Doctors Who Perform DaVinci Robotic Prostatectomies:

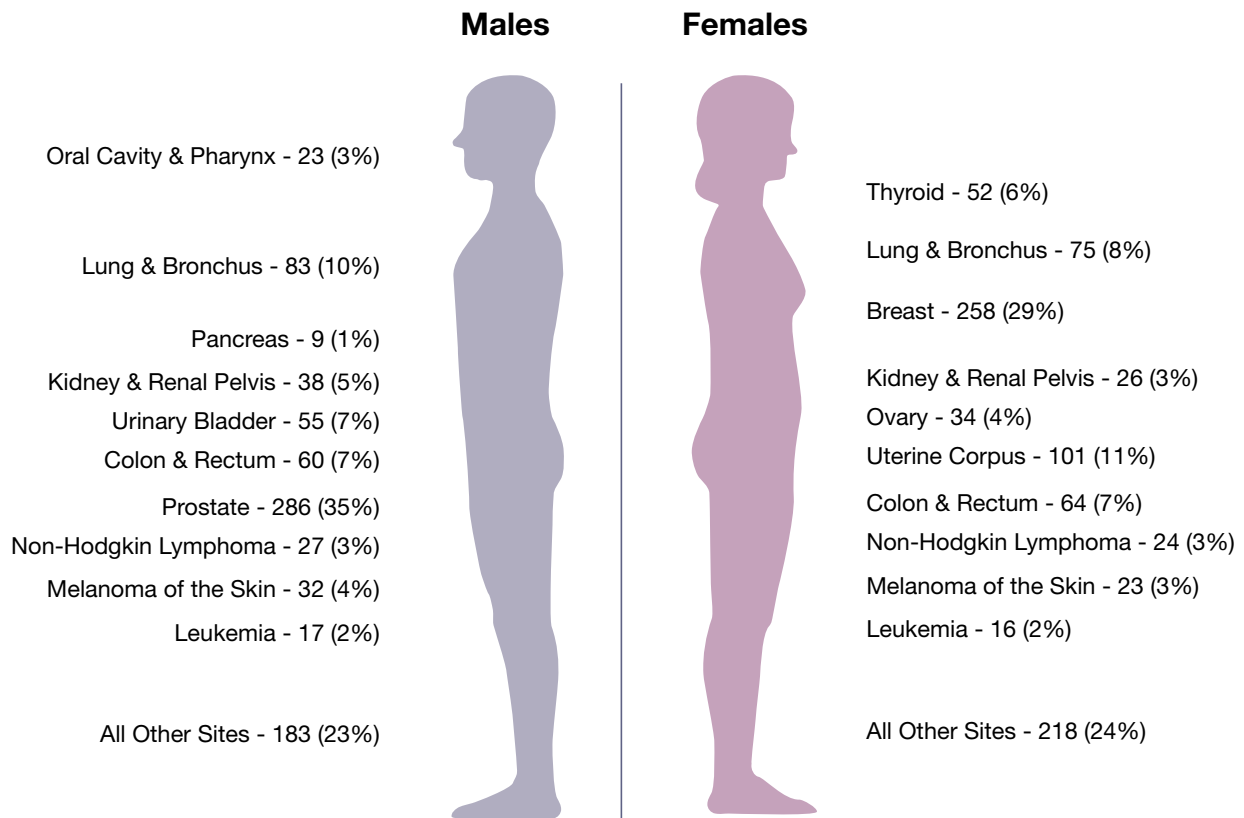
Jeff Ferguson	Urological Associates
J. Erik Derksen	Urological Associates
Benjamin Coons	Urological Associates
James Tomasch	Urological Associates
James Simon	Urological Associates
Gary Bong	Pikes Peak Urology

SUMMARY BY BODY SYSTEM AND SEX REPORT (2010 DATA)

	TOTAL	%	MALE	%	FEMALE	%
ORAL CAVITY AND PHARYNX	37	2.2%	23	2.8%	14	1.6%
Lip	1	0.1%	0	0.0%	1	0.1%
Tongue	13	0.8%	9	1.1%	4	0.4%
Salivary Glands	4	0.2%	2	0.2%	2	0.2%
Floor of Mouth	2	0.1%	1	0.1%	1	0.1%
Gum & Other Mouth	4	0.2%	1	0.1%	3	0.3%
Nasopharynx	2	0.1%	1	0.1%	1	0.1%
Tonsil	7	0.4%	5	0.6%	2	0.2%
Oropharynx	2	0.1%	2	0.2%	0	0.0%
Hypopharynx	2	0.1%	2	0.2%	0	0.0%
DIGESTIVE SYSTEM	223	13.1%	112	13.8%	111	12.5%
Esophagus	14	0.8%	11	1.4%	3	0.3%
Stomach	14	0.8%	9	1.1%	5	0.6%
Small Intestine	6	0.4%	3	0.4%	3	0.3%
Colon Excluding Rectum	95	5.6%	44	5.4%	51	5.7%
Rectum and Rectosigmoid	29	1.7%	16	2.0%	13	1.5%
Anus, Anal Canal & Anorectum	6	0.4%	4	0.5%	2	0.2%
Liver & Intrahepatic Bile Duct	17	1.0%	11	1.4%	6	0.7%
Gallbladder	2	0.1%	0	0.0%	2	0.2%
Other Biliary	2	0.1%	2	0.2%	0	0.0%
Pancreas	32	1.9%	9	1.1%	23	2.6%
Retroperitoneum	1	0.1%	1	0.1%	0	0.0%
Peritoneum, Omentum & Mesenter	4	0.2%	1	0.1%	3	0.3%
Other Digestive Organs	1	0.1%	1	0.1%	0	0.0%
RESPIRATORY SYSTEM	174	10.2%	95	11.7%	79	8.9%
Nose Nasal cavity & Middle ear	4	0.2%	4	0.5%	0	0.0%
Larynx	11	0.6%	7	0.9%	4	0.4%
Lung & Bronchus	158	9.3%	83	10.2%	75	8.4%
Pleura	1	0.1%	1	0.1%	0	0.0%
BONES & JOINTS	3	0.2%	2	0.2%	1	0.1%
Bones & Joints	3	0.2%	2	0.2%	1	0.1%
SOFT TISSUE	10	0.6%	4	0.5%	6	0.7%
Soft Tissue (including Heart)	10	0.6%	4	0.5%	6	0.7%
SKIN EXCLUDING BASAL AND SQUAMOUS CELL	59	3.5%	35	4.3%	24	2.7%
Melanoma - Skin	55	3.2%	32	3.9%	23	2.6%
Other Non-epithelial Skin	4	0.2%	3	0.4%	1	0.1%
BREAST	260	15.3%	2	0.2%	258	29.0%
Breast	260	15.3%	2	0.2%	258	29.0%
FEMALE GENITAL SYSTEM	189	11.1%	0	0.0%	189	21.2%
Cervix Uteri	22	1.3%	0	0.0%	22	2.5%
Uterus, NOS	101	5.9%	0	0.0%	101	11.3%
Ovary	34	2.0%	0	0.0%	34	3.8%
Vagina	4	0.2%	0	0.0%	4	0.4%
Vulva	13	0.8%	0	0.0%	13	1.5%
Other Female Genital Organs	15	0.9%	0	0.0%	15	1.7%
MALE GENITAL SYSTEM	293	17.2%	293	36.0%	0	0.0%
Prostate	286	16.8%	286	35.2%	0	0.0%
Testis	5	0.3%	5	0.6%	0	0.0%
Penis	2	0.1%	2	0.2%	0	0.0%
URINARY SYSTEM	138	8.1%	97	11.9%	41	4.6%
Urinary Bladder	66	3.9%	55	6.8%	11	1.2%
Kidney & Renal Pelvis	64	3.8%	38	4.7%	26	2.9%
Ureter	5	0.3%	3	0.4%	2	0.2%
Other Urinary Organs	3	0.2%	1	0.1%	2	0.2%
BRAIN & OTHER NERVOUS SYSTEM	66	3.9%	25	3.1%	41	4.6%
Brain	24	1.4%	14	1.7%	10	1.1%
Cranial nerves Other Nervous System	42	2.5%	11	1.4%	31	3.5%
ENDOCRINE SYSTEM	91	5.3%	34	4.2%	57	6.4%
Thyroid	75	4.4%	23	2.8%	52	5.8%
Other Endocrine including Thymus	16	0.9%	11	1.4%	5	0.6%

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LYMPHOMA	63	3.7%	35	4.3%	28	3.1%
Hodgkin Lymphoma	12	0.7%	8	1.0%	4	0.4%
Non-Hodgkin Lymphoma	51	3.0%	27	3.3%	24	2.7%
MYELOMA	15	0.9%	8	1.0%	7	0.8%
Myeloma	15	0.9%	8	1.0%	7	0.8%
LEUKEMIA	33	1.9%	17	2.1%	16	1.8%
Lymphocytic Leukemia	14	0.8%	9	1.1%	5	0.6%
Myeloid & Monocytic Leukemia	18	1.1%	7	0.9%	11	1.2%
Other Leukemia	1	0.1%	1	0.1%	0	0.0%
MESOTHELIOMA	3	0.2%	3	0.4%	0	0.0%
Mesothelioma	3	0.2%	3	0.4%	0	0.0%
MISCELLANEOUS	47	2.8%	28	3.4%	19	2.1%
Miscellaneous	47	2.8%	28	3.4%	19	2.1%
TOTAL	1704	100.0%	813	100.0%	891	100.0%



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NCCCP PROGRAM AT PENROSE CANCER CENTER

Penrose Cancer Center is the only cancer center in Colorado selected by the NCI to participate in the NCI Community Cancer Centers Program (NCCCP).

Clinical Trials

- Accrued more than 300 patients on the various clinical trials available
- Working closely with University of Colorado on a Survivorship Trial
- Continued collaboration with the Colorado Cancer Research Program (CCRP). Penrose Cancer Center received the award for being the top accruing site within CCRP
- Penrose Cancer Center has an offering of 75 clinical trials open at this time

Quality of care

- Disease specific navigators available for Breast, GYN, Prostate, Head and Neck, GI, Lung and Hematology
- The Pulmonary Nodule Clinic is following more than 350 patients who presented with a nodule in their lungs
- Participated in the Quality Oncology Practice Initiative
- Increased the participation in the multidisciplinary conferences in multiple disease sites
- Started multidisciplinary conferences for GI, Hematology and Neuro

Outreach and Education

- Participated in multiple community education health education events, attended by more than 17,000 people total
- Participated in the community wide skin and prostate screenings
- Hosted the only Head and Neck Cancer Screening in the State of Colorado, attended by more than 160 people
- Reached out to various rural areas of El Paso and Teller counties, providing education on cancer related topics
- Developed programming specifically for the Latino population through a collaborative effort, using a Spanish language soap opera as a vehicle for education on colorectal cancer and screening
- Educational Programs targeted to physicians
 - Paul Anderson Lecture Series – Dr. Graham Warren – Interactions between Tobacco Use and Cancer Treatment
 - From Screening to Treatment: New Developments in the Multidisciplinary Approach to Lung Cancer
 - Prostate Cancer: Current Concepts in Screening and Treatment

Survivorship and Palliative Care

- Increased number of treatment summaries for patients and primary care physicians
- Unique Survivorship Navigator program
- Worked with Pikes Peak Hospice on providing on-site palliative care services
- Held the annual survivorship retreat for cancer survivors in collaboration with the Penrose-St. Francis Spiritual Care Department
- Increased survivorship group offerings and attendance
- Developed Integrative Therapies program with weekly one-hour sessions



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NCI COMMUNITY
CANCER CENTERS
PROGRAM

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