Turning Cancer Patients into Cancer Survivors
SCCA is the clinical intersection of three participating institutions: Fred Hutchinson Cancer Research Center, UW Medicine, and Seattle Children’s. The result is an unprecedented collaboration among a cadre of physicians and scientists, translating scientific discoveries into cancer prevention, diagnosis, treatment, and cure.

Our four institutions form a comprehensive cancer research and care delivery system—focused on patients and their families. We continue to coordinate our resources to make the system even stronger, bringing groundbreaking research to SCCA patients more quickly and effectively.

Robert Bakemeier, Board Chair
It was a vision so powerful, it now seems inevitable: Bringing together the research and treatment expertise of doctors and scientists from three world-class institutions to form a new entity dedicated to turning cancer patients into cancer survivors. Since SCCA opened its doors in 2001, we’ve treated more than 160,000 patients. Every day, more cancer survivors walk out of these doors. Each of them has a unique story to tell.

This 2012 annual report is a look at what we believe is a new era of Precision Medicine. As the pace of medical breakthroughs accelerates, so does our ability to target therapies to individual patients’ biology and the genetic signature of their disease. This report will share many of the innovations we’re bringing into the clinic, and introduce you to several of the doctors whose brilliance and devotion make this possible.

In these pages, you’ll also hear from our patients, community partners, and leaders. We are a growing, thriving community, proud of how far we’ve come—and committed to furthering our knowledge of cancer and giving our patients access to the most targeted and effective therapies available.
At a time when the population is aging, every passing year brings increased risk that more people will be stricken with cancer. On the positive side of the ledger, each year also brings advances in medical knowledge and technological capabilities at a pace that—even here at SCCA, where much of this innovation is centered—is positively breathtaking. Just in the past 12 months, we can point to significant new accomplishments across the continuum of cancer care.

We’ve improved our ability to assess an individual patient’s risk for cancer thanks to advancements in genomics and genomic screening. We’re also intensifying our research into ways to improve the odds that a person can avoid cancer beyond current lifestyle modification strategies.

For those with cancer, our knowledge of the disease now extends to the ability to differentiate between individual tumors of the same type. Credit goes to our partners at UW Medicine and Fred Hutchinson Cancer Research Center for this breakthrough diagnostic test called UW-OncoPlex. UW-OncoPlex identifies genetic variants, which allows us to target the individual’s specific disease-type with the treatment regimen that will be most effective.

When it comes to treatments, two new options that we’re adding to our arsenal—adoptive immunotherapy and proton radiation—are highly targeted approaches. In immunotherapy, our scientists are now able to take out T-cells—specifically the central memory T-cells that are most responsible for immune function—and genetically re-engineer them, putting in a receptor that binds to a specific type of tumor. Similarly, radiation from proton beams is far more targeted than conventional X-rays. There is an obvious benefit for children and young adults: reducing their total radiation exposure lowers the risk of secondary cancers later in life. We’ll be researching the benefits for both children and adults with a variety of cancers in our new facility, SCCA Proton Therapy, A ProCure Center, which will open its doors in March 2013.

We use the term “Precision Medicine” to describe this set of innovations. As cancer doctors, we want to increase the degree of precision at every point of contact with our patients: Identifying genetic risk factors helps us get better at preventing cancer. Understanding the biology of each patient’s specific disease is a powerful diagnostic tool. Precisely targeting molecules makes us both more lethal in destroying tumors and less apt to cause unwanted side effects and recurrences.

Precision Medicine also has the potential to reduce the cost of cancer care across the entire population, chiefly through the introduction of standardized treatment protocols for each disease. We call these “Clinical Pathways.” The traditional model allows for considerable variation in treatment, based on each physician’s individual experience. (Incidentally, this individual element is one of the reasons why we avoid the currently popular term “personalized medicine.”) In contrast, the discipline of Precision Medicine is based on evidence gathered from many doctors in different clinics. For each separate tumor type and stage, we’re working to identify the best therapy that is associated with the least toxicity—and, to the extent possible, at the lowest cost. We are hard wiring these Clinical Pathways into our system to provide patients with the most effective treatments, while eliminating waste, decreasing the chance for error, reducing costs, and increasing overall efficiency.
Is there evidence that Clinical Pathways make a difference? We think our patients’ survival rates make a compelling case. Since 2002, SCCA has topped the National Cancer Data Base rankings for aiding patients in surviving a wide range of cancers. The data for breast cancer patients are instructive. For women with Stage III breast cancer, 89% of SCCA patients were alive after five years, compared to 64% of those treated at other types of facilities. We assume that a large part of this differential is explained by our patients’ access to clinical trials and our highly specialized teams of world-class doctors.

But when we look at the survival rates for stage I breast cancer, the results continue to show a surprisingly large gap—given that the treatments are relatively straightforward. SCCA patients achieved a 99% five-year survival rate, compared to 94% at other academic/research hospitals, and 88% at Community Cancer Centers. We attribute this difference to SCCA’s standard of care that optimizes every detail of the treatment. In other words, Clinical Pathways.

That’s why we tell people in our community, “If you have cancer, it really matters where you’re treated first.” It’s important to get the right diagnosis the first time and to have a full range of treatment options. Precision Medicine enables us to provide therapy that responds to the patient’s biology and targets his or her cancer. Then we reduce the complications. We help to keep the person in less pain, with less toxicity, less time away from work, and less time away from family.

That said, it’s also part of SCCA’s mission to help improve the standard of care throughout our community. In November, we launched a new initiative with EvergreenHealth in Kirkland, Washington. This partnership takes our clinical care network to the next level as we actually embed an SCCA clinic—staffed with 50 of our employees, including six doctors providing hematology and medical oncology services—inside EvergreenHealth.

This letter provides a snapshot of recent developments that excite us most. In the body of the report, we’ll discuss community benefits and provide a more personal perspective on the doctors driving the innovations that make Precision Medicine possible. As many of you know, Fred Hutch founder E. Donnall Thomas passed away in October; a section of the report describes how his scientific legacy and character continue to inform our work. And, as further tribute to Don’s spirit and outlook, you’ll meet a few of the patients who are the real heroes of this story. Cancer survivors are a unique breed. Their courage, patience, and passion for life make them role models for all of us.
The recent passing of Don Thomas at age 92 has provided an opportunity for all of us at SCCA, and many in the broader community as well, to reflect on his life and accomplishments. Brilliant, sublimely stubborn, with the ability to inspire and lead teams of talented colleagues, Don’s influence continues as a key factor in SCCA’s ongoing success.

The story of the challenges Don had to overcome in order to make bone marrow transplants work has been told many times. It’s often seen as a tale of a visionary’s perseverance against the odds and in spite of the skepticism of his peers. That’s true enough. But it’s also a fact that the scientific principles Don uncovered—specifically, his pushing out the boundaries of our knowledge of the workings of the immune system—are a priceless legacy.

To quickly recap, in the 1950s, Don’s goal of using bone marrow transplants to cure leukemia was hampered by the patient’s body rejecting the graft or the graft rejecting the host. The transplant was only tolerated in identical twins, so the challenge was learning how to expand the set of compatible donors. Don struggled for over a decade, working with mice and dogs to develop rudimentary tissue typing methods. The advancement of our understanding of histocompatibility is considered one of his major achievements.

By 1967, Don and his team extended their knowledge of tissue typing to humans. They learned how to select compatible donors; give the right dose of therapy to wipe out the bone marrow; and administer specialized medicines to prevent graft-versus-host disease. In March 1969, he successfully transplanted a patient with advanced leukemia, using bone marrow from a matched sibling donor. That was the first example of using the power of the human immune system to eradicate a malignancy. In 1975, he joined the Fred Hutchinson Cancer Research Center and, by 1979, performed the first successful bone marrow transplant on a leukemia patient from an unrelated donor.

Over the next three decades, Don continuously improved every aspect of the process—from fine-tuning the combination of chemotherapy drugs to control graft-versus-host disease to outlining a comprehensive protocol for nurses helping to keep patients safe from infections, despite their weakened immune systems. (The development of new second- and third-line antibiotics is another important part of Don’s legacy.)

Thanks to Don’s work, there are 65,000 transplants performed worldwide each year, with the total number now exceeding one million. Twenty million people have volunteered as bone marrow donors, and doctors can treat more than 40 different diseases.
Don’s legacy to SCCA includes both his actual medical breakthroughs and his unceasing passion for improvement. This is evident in his Nobel Prize acceptance lecture, delivered in December 1990. After discussing the development and current status of the bone marrow transplantation protocol, he turned to the future. Monoclonal antibodies, recombinant molecular biology, retroviral vectors, he said then, all have promise to reduce relapse rates or prevent graft-versus-host disease. It didn’t stop there. Twenty-two years later we are still carrying out Don’s agenda: Targeting a molecule, targeting a population, targeting a tumor physically. Everything we do in Precision Medicine is an outgrowth of Don’s initial big idea.

Truly, Don’s perseverance, commitment to patients, and groundbreaking medical achievements continue to inspire, guide, and sustain SCCA today.
Precision
Talking with doctors and researchers about the treatment innovations they are bringing to SCCA patients, you can’t help but notice a growing sense of optimism. Everyone seems to have an inspiring story to tell. Whether it’s long-awaited research results, new diagnostic tools, or new clinical techniques—many of our recent clinical accomplishments are pushing the boundaries of cancer treatment.

In almost any other field, the people involved would be high-fiving, fist-pumping, and dancing in the streets. But cancer doctors know that they’re battling a formidable enemy, capable of mutating and putting up new defenses—just as victory seems certain. That said, Precision Medicine is generating excitement throughout our faculty and the medical community worldwide. Please read on to learn more about several of these developments, and how they are giving patients new ways to win the battle with cancer.
UW-OncoPlex pinpoints cancer’s Achilles heel

One of the biggest breakthroughs of the year at SCCA is the launch of a long-wished-for diagnostic tool called UW-OncoPlex. Driven by high-powered “next generation” genetic sequencing, UW-OncoPlex allows doctors to predict which of the available therapies will be most effective for an individual patient’s cancer.

Developed by Dr. Colin Pritchard and his team in the Clinical Molecular Genetics Laboratory at UW Medicine, UW-OncoPlex analyzes 194 different genes for “driver mutations” that are associated with specific types of cancer.

The diagnostic power of UW-OncoPlex stems from the fact that it is evaluating the genetics of the patient’s tumor cells—not healthy tissue. A mutation that appears on the UW-OncoPlex panel points to a known subtype of the disease, whether it’s melanoma, lung cancer, sarcoma, gastrointestinal/colon cancer, or leukemia. Armed with this information, doctors can choose the therapy that’s known to work best to destroy or control the patient’s tumor type.

For example, in lung cancer, UW-OncoPlex can identify mutations in three different tumor genes—each with FDA-approved therapies that promote tumor shrinkage two to three times better than chemotherapy. Plus, UW-OncoPlex can identify mutations in over 20 more genes that qualify patients for investigational drugs. The patient benefit is significant, says Dr. Renato Martins, Medical Director, Thoracic/Head and Neck Oncology at SCCA: “Patient responses can last between nine and 14 months, which used to be the time lung cancer patients survived—period. In some cases, the disease has remained under control for much longer than 14 months and for these patients it’s a huge improvement in expected outcomes.”

Dr. Robin Jones is excited about the potential of UW-OncoPlex to drive innovation in his area of specialization: sarcoma. “Sarcoma actually consists of 60 to 70 different histological subtypes,” he explains. “Historically, these have been treated with exactly the same systemic therapy. Yet it’s clear they are completely different diseases.” He points to the success in identifying the driver mutation for gastrointestinal stromal tumor (GIST) as “the paradigm for targeted treatment in solid tumors.”

The promise of targeted therapies is two-fold: More effective treatment with fewer side effects. UW-OncoPlex fits this profile nicely. Says SCCA Director Fred Appelbaum, “First, our doctors can save patients from being exposed to toxic chemotherapy, when we know, thanks to UW-OncoPlex, that it would have little chance of helping them. Second, UW-OncoPlex allows us to prescribe therapies that are more likely to help at the time when they will do the most good—early in the course of the disease.”

Even when there’s no approved drug available, says Dr. Pritchard, UW-OncoPlex can help doctors and patients choose a clinical trial that’s likely to be most effective. And the number of driver mutation genes in the panel will continue to expand.
Robin Jones finds himself in the right place, at the right time, to work on his specialty: the treatment of sarcoma. Dr. Jones trained in London at the Royal Marsden Hospital, working initially on breast and colorectal cancer. Then, he “became fascinated by the fact that many sarcomas are treated with exactly the same systemic therapy, despite the clear differences in biology between different subtypes. In fact, sarcoma has 60 to 70 different histological subtypes: It’s clear that they’re completely different diseases.”

Dr. Jones met Drs. Ernest Conrad and Janet Eary at a conference; they convinced him that working at SCCA would give him an opportunity to develop “improved treatments and improved ways of designing clinical trials for these diseases.”

Precision Medicine is a natural fit for sarcomas—it provides tools that are particularly well suited to address their heterogeneity. For example, SCCA currently has immunotherapy trials in progress for two histological subtypes of sarcoma: synovial and myxoid/round cell liposarcoma. Says Dr. Jones, “We are using our growing understanding of the biology of these diseases to have a more targeted approach to treatment… and we are starting to see success.”

Because of its ability to pinpoint tumor subtypes, SCCA’s new diagnostic tool, UW-OncoPlex, could open pathways for the treatment of different sarcomas—including the very rare ones. He notes that gastrointestinal stromal tumor has been the paradigm for targeted treatment in solid tumors with characteristic driving mutations. “Only now are we starting to unravel the underlying molecular drivers of diseases,” Dr. Jones says. “It’s a good time to be involved with the care and research of sarcomas and SCCA is a good place to be doing this research.”

“Sarcomas comprise about one percent of all solid tumors—split into 60 or 70 different diseases. That shows how rare sarcomas are and how challenging it is to treat them. I’m excited to see both the scope of our treatment expanding and the improvement in results.”
Immunotherapy comes of age

Immunotherapy is the holy grail of Precision Medicine. For most diseases, the body’s immune system functions effectively to target bacteria, viruses, and other invaders, with minimal side effects. Unfortunately, cancer knows how to trick our natural defenses into leaving it alone. The goal of immunotherapy is to turn the tables on cancer, activating the body’s own immune system to fight and destroy cancer.

At SCCA, immunotherapy research is advancing on multiple fronts. One outstanding example is a recent Phase I study of “PD-L1 antibody,” a monoclonal antibody that blocks a signaling mechanism tumors use to dampen the body’s natural immune response. The clinical trial included patients with eight types of cancer; a significant majority were non-small-cell lung cancer and melanoma patients. The New England Journal of Medicine published the study in June 2012, to wide acclaim. SCCA melanoma specialist Kim Margolin, MD, and her colleagues are excited about the results: This new agent produced solid remissions in 17% of patients with advanced melanoma. “The PD-1 antibody is fully human, which means it does not cause allergic reactions,” says Dr. Margolin. And, because its action is so specifically targeted, “it doesn’t seem to bother other body tissues.”

The PD-L1 antibody may have an even greater impact on the outlook for lung cancer patients. Drs. Renato Martins and Laura Chow co-authored the paper and reported that the results were “phenomenal.” That’s because non-small-cell lung cancer had never before responded so positively to immunotherapy (in contrast to melanoma or renal-cell cancer, which are typically more responsive). PD-L1 represents an important potential breakthrough because, in Dr. Martins’ words, “for some patients, it may be the difference between a life expectancy of two months and having a complete response and living a normal life.”

Some of the biggest successes have been in melanoma, with several immunotherapy treatment options in promising clinical trials: Sylvia Lee, MD, and her group are working on tumor-infiltrating lymphocyte (TIL) therapy. This technique involves removing a piece of melanoma tissue from a patient, isolating the T-cells and replicating them into the billions, and then infusing them back into the patient to destroy the cancer. Dr. Paul Nghiem’s group is the first to develop an immunotherapy for a rare form of skin cancer, called Merkel cell carcinoma. And Dr. Margolin continues to collaborate in the study of various cytokines such as interleukin-2 and interleukin-15. These are growth and stimulation factors for white blood cells with antitumor activity. Frequently used as front-line therapies for metastatic melanoma, cytokines continue to play an important role in combination with newer antibody, T-cell, and vaccine immunotherapies.
Matt Flood is a very strong man. Before his diagnosis of melanoma in 2005, he worked for 21 years in the Tacoma fire department in a demanding role as a first responder to medical emergencies. Off-duty, he stayed active, playing basketball competitively and working on home remodeling projects.

Matt believes his physical and mental discipline has been key in his fight with cancer. Initially, a couple of routine surgeries and treatment with high dose interferon seemed to produce a complete response.

But in 2009, when he went back for his annual screening, Matt received some stunning news: His cancer had returned. He learned that the survival range for someone who’s in stage 4A is four to nine months.

Matt and his wife Anne didn’t waste any time. They researched their treatment options, deciding that SCCA offered leading-edge therapies that were the most promising—less than an hour’s drive from home.

At the time, Matt’s best odds were with high-dose interleukin-2, which had only a six percent chance of success. It made him “sick as a dog.” He gained 40 pounds in one week, had atrial fibrillations, and the skin peeled from his entire body—twice. The treatment did produce a remission, which lasted only three months.

Dr. John Thompson, Matt’s SCCA oncologist, suggested a clinical trial involving T-cell therapy plus an investigational drug, ipilimumab, which has since been approved. Two studies were available, and the first didn’t work. Matt’s cancer continued to progress.

Dr. Thompson moved quickly to enroll Matt in the clinical trial managed by Dr. Aude Chapuis. This time the immunotherapy treatment worked as hoped. His body is now successfully fighting off the cancer—with no serious side effects. Says Matt, “Dr. Thompson has been a godsend. I am very grateful to everyone at SCCA; it’s impossible to pay back the debt I owe them.”
We’ll conclude this partial list with two new approaches to fighting leukemia. Dr. Stanley Riddell and his fellow researchers reasoned that, unlike many immunotherapies, a normal human immune response can last a lifetime. Thus, they set out to identify and use “central memory T-cells” that have longer staying power. Dr. Riddell says the approach holds promise for fighting different types of leukemia, including chemotherapy-resistant acute lymphoblastic leukemia in children, and breast, ovarian, and skin cancers.

And, at Seattle Children’s, Dr. Rebecca Gardner recently made news with a new technique for treating childhood leukemia. It involves inserting a new gene into the patient’s T-cells that re-trains them to fight the disease. Dr. Gardner says, “The hope is to refine this therapy to be highly effective and minimally toxic.” As such, it has the potential to be a much easier-to-tolerate alternative to the current standard of care, which is a bone marrow transplant.

“At SCCA, therapies that will become the standard of care years from now are available today as clinical trials.”

Renato Martins, MD, MPH
There’s poetic justice in the story of Eva Borsi’s battle with lung cancer. According to the risk factors, she never should have gotten the disease in the first place. She never smoked, doesn’t eat meat, and exercises regularly. Yet suddenly, at the age of 46, she was diagnosed with stage IV lung cancer.

Eva’s doctor immediately referred her to SCCA, where medical oncologist Laura Chow treated her with some of the strongest chemotherapy drugs available. While successful in knocking back the cancer, the treatment was also having a toxic effect on Eva’s body. She was always tired, with high blood pressure and swelling in her eyes and legs. Worse, her liver and kidneys were being damaged.

Dr. Chow suggested that Eva try a different approach—an immunotherapy drug, MDX-1105, in clinical trials for patients with many kinds of cancer. Here’s where Eva’s luck started changing. She believes she was the last lung cancer patient accepted for that trial. And, better still, the drug started helping her right away. “For me it’s like a miracle drug,” says Eva. “Physically speaking, there is no sign of cancer. I ride a bike. I go to the gym. I ski. I run. I live just like I did before—if not better.”

Eva’s immunotherapy treatment began in October 2011. She will continue to receive infusions every two weeks until August 2013. “The hypothesis,” says Eva, “is that by then, my body will have trained itself to block the proteins” that keep the immune system “from recognizing the cancer cells. So even without the infusions, my body will kill the cancer.” Sometimes there is justice in the world. The woman who never should have gotten cancer—but did—is also the woman who probably shouldn’t be surviving—but now is stable and living a healthy life.

“If anyone comes to the crossroads where they need to decide whether to participate in a clinical trial, I would highly encourage them to give it a try. You have nothing to lose but so much to gain.”
90% of bone marrow transplant patients can now find donors

Thanks to developments in our Alternative Donor Program, SCCA is providing bone marrow transplants to more patients in need of this life-saving treatment. That's great news, particularly for African Americans, Hispanics, and other non-Caucasian or mixed-ancestry individuals, whose search for a suitable donor often comes up empty.

The key to a successful bone marrow transplant is “histocompatibility.” That means finding a donor whose tissue type is close enough to that of patients’ so that their immune systems will not see each other as “foreign” and attack each other. Until recently, the sources were either a matched sibling or an unrelated person located through the National Bone Marrow Registry's database of 15 million potential donors. Together, these have provided matches for only 65% of patients.

That remaining 35% of patients that can not find donors has been a huge motivator for SCCA doctors and researchers with our Alternative Donor Program. Their efforts with two new transplant techniques now mean that 90% of our patient searches results in a donor. One technique works with donors among family members who are “haploidentical” or “half-matched” with the patient. These typically are parents, children, or siblings who are not identical matches. Advances in drug therapies now control the adverse immune responses (graft-versus-host disease) that used to prevent these family members from serving as donors.

The second new technique relies on blood saved from umbilical cords and placentas following childbirth. Cord blood is unique because its immune cells haven’t been educated against foreign invaders such as bacteria and viruses. Says SCCA’s Dr. Colleen Delaney, one of the primary researchers in this technique, “Cord blood transplants have the advantage of allowing greater tissue-matching disparity.” As a result, “you open up transplantation to patients who need it but can’t get it.”

“Translating laboratory findings to the patient bedside is no small feat. And when the time finally comes and a patient agrees to take a step forward with a new treatment, the feeling is without description—excitement, anxiety, and hope. Then, when the treatment works, there isn’t anything more gratifying.”

Colleen S. Delaney, MD, MSC
Cord blood transplant recipient Jessie Quinn is a trailblazer: She was the first to participate in a clinical trial that is making this alternative transplant a more effective option for adults. The trial, based on Dr. Colleen Delaney’s technique, built on her original umbilical cord blood expansion trial. In addition to two “unmanipulated” cords, a third unit, composed of expanded, washed stem cells, was added.

Jessie was diagnosed with acute myelogenous leukemia (AML) in March 2010. Her doctor told her that she’d need a bone marrow transplant to survive. “I already knew I was going to have a hard time finding a donor,” she says. Her ancestry is half African-American. A dozen years earlier, Jessie had signed up to be a donor in the National Marrow Donor Program after learning that African-American and biracial donors are underrepresented in the registry. When NMDP searched for a potential donor in 2010, her name was the only viable match in the system.

A scientist herself, Jessie arranged to meet with Dr. Delaney when she traveled to SCCA to explore getting a stem cell transplant. “We talked about how she was building on her other research into cord blood stem cells, and I thought her ideas were brilliant and interesting,” Jessie says. “I’d never had an opportunity to be ‘part of the experiment’ and there was something about participating in this that felt right to me.”

Jessie’s transplant was performed at SCCA in September 2010. SCCA physicians routinely use a combination of two cord blood units in performing this transplant in adults to extend the number of stem cells; Dr. Delaney’s study added a third, “manipulated” cord. The goal was to achieve quick engraftment of the cells along with cord “competition”—which is positioned to reduce the risk of relapse for transplant patients.

“It was a difficult, long, but fairly uneventful recovery, which is really one of the best things you can hope for,” Jessie says. Now, more than two years later, her physical strength has returned. She is working again, and spending as much time with her young daughter as she can—time she feels she lost during her illness.

Jessie says the message she wants to give people who aren’t likely to find a perfect donor match is to never give up. “If someone says they’re out of options, that’s probably not the case.” She is the living proof.
Treating—and curing—rare genetic disorders

Treating patients with Fanconi anemia (FA) and sickle cell disease (SCD) is another important addition to SCCA’s world-leading capabilities in bone marrow transplants.

FA is a very rare, inherited blood disorder that prevents the bone marrow from making adequate new blood cells. Children who inherit FA have a higher risk of birth defects, growth problems, hearing loss, and abnormal hearts and gastrointestinal tracts. They are also at risk for non-blood cancers and other serious health problems. SCCA’s Fanconi Anemia Center is one of the few places in the U.S. where patients contending with FA can receive comprehensive care, including access to the newest specialized treatments.

Although every patient with FA is different, for some of these children, transplants offer the chance for a complete cure. FA patients require special care before and after transplant; SCCA doctors have developed several low-dose conditioning therapies. And they are successfully utilizing haploidentical transplants for children with FA.

SCD is a group of genetically inherited disorders that includes sickle cell anemia. This disease affects hemoglobin, which carries oxygen in the blood. Many children with SCD face a life of tremendous pain, along with the potential for organ dysfunction and stroke. Since transplants themselves pose risks to any patient, they are not a solution in all cases, but, says SCCA’s Dr. Michael Bender, “They absolutely should be considered more often.”

With a successful transplant, says Dr. Bender, “these children are cured. They no longer need the sickle cell treatments. The pain is gone. The lung disease and the neurological disease do not get worse. As we make these transplants safer and identify appropriate patients sooner, many more patients will benefit.”

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Michael A. Bender, MD, PhD
As a young girl, Tola Oriade, now 16, often felt hemmed off from a normal life. “I was kind of weak, and couldn’t do a lot of things that my friends were doing—like going to the beach, playing soccer, going for a swim,” she says. Diagnosed with sickle cell disease (SCD) at birth, Tola couldn’t risk getting too hot or too cold, getting injured—or getting sick. What was innocuous for most kids might trigger a life-threatening complication.

What began as a grave event for Tola—a serious case of pneumonia at seven—ultimately led to a transformative cure: A bone marrow transplant. For people with SCD like Tola, a successful transplant is a complete cure. Up until that time, her mother Bosede recalls, “We thought Tola had a very mild case of SCD, because she was very healthy. Most patients usually have pain crises. She never got sick until she was seven; but once it started it was very bad.”

Also called sickle cell episode, a pain episode occurs when sickle-shaped red blood cells stick to other blood cells and the blood vessel wall, forming a “sludge” that blocks the blood vessels. This may cause excruciating pain, organ damage, and other serious complications, and can occur anywhere in the body.

“At first we thought the pneumonia was an aberration. But a year after that, Tola had a stroke,” says Bosede. It affected the right side of Tola’s brain. Follow-up tests confirmed that she had previously suffered a series of mini-strokes. Another stroke could prove fatal.

One of Tola’s doctors, SCCA Pediatric Oncology/Hematology Specialist M. A. Bender, MD, suggested the family explore having Tola undergo a transplant to cure her disease. With two siblings at the time, there was a better chance that one of Tola’s sisters would be her perfect donor match than seeking a public one. Luckily, this perfect match was found in her older sister, Abi, who is now 18. “I was happy to save my little sister’s life—I felt like a hero,” Abi recalls.

Says Tola’s father Caleb, “a bone marrow transplant is not a walk in the park. It was a long and difficult process, with many complications.” But for Tola and her family, it was worth the risks and temporary hardships. Tola’s recovery process took about a year. Now living with her family in Virginia, she says her two favorite pursuits are drawing and dancing—especially hip-hop and jazz dances. Tola dreams of someday working as a graphic designer or a cartoon animator. “I feel blessed,” she says.
Since SCCA opened in 2001, our vision has been to give cancer patients the best possible options for surviving cancer. From the start, we believed that combining world-class medical expertise and a standard of care that targets and enhances every aspect of cancer treatment would make a big difference for our patients.

The most current research supports this belief—and our dedication in applying it. Patients who have chosen to come to SCCA for treatment have experienced better outcomes compared to patients who are treated at other cancer centers.

The patient data shown at right is the most recent available from the National Cancer Data Base (NCDB).* Some of these patients were treated more than a decade ago; their treatment was based on the standard of care at that time. We are confident that future findings will reflect ever-improving advances in survival, as our commitment to Precision Medicine enables us to get the most effective treatments to patients as soon as they walk through our doors.

SCCA patients’ five-year survival rates are highest among all cancer treatment programs nationwide

SCCA has stood at the top of the NCDB rankings for aiding patients in surviving a wide range of cancers since 2002. When the milestone of survival is measured, more of our patients across virtually all types of cancers are living longer than those who were treated at other cancer centers. This includes other academic medical centers like SCCA, as well as community hospitals large and small.

Our success in helping people live longer can be attributed to everything we do here at SCCA—from pursuing exacting safety protocols to the profound clinical advances pushed forward by our doctors and researchers. Many of these efforts are described in this annual report. We strongly believe that where a patient chooses to go for initial cancer treatment has a significant impact on his or her ability to survive this disease.

The NCDB tracks the outcomes of 70% of all newly diagnosed cancers in the U.S. from more than 1,500 accredited cancer programs. The NCDB, founded in 1989, now contains more than 26 million records from hospital cancer registries across the U.S. Examples of the NCDB’s most recent data are shown at right, in survival rates for Stage II prostate cancer and Stage I lymphoma.

To learn more about the methodology applied by the NCDB and to see the survival data on SCCA patients across a wide range of cancers, please visit our website at www.seattlecca.org/survivalrates.

* This information was collected by the NCDB for patients who were diagnosed either between 1998 and 2002 or between 2003 and 2004 and then followed for five years. We’ve used the latest data set wherever possible.
**Stage II Prostate Cancer**

SCCA patients are represented by the green line. On average, their average five-year survival rate was 98% from the time they were first diagnosed by SCCA. Note that only patients who received all of their care from SCCA are included.

Patients from all types of treatment centers — Community Cancer Centers, Comprehensive Community Cancer Centers, and Academic/Research Hospitals — are represented by the orange line. Their combined five-year survival rates were 91%.

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**Stage I Lymphoma**

SCCA patients are represented by the green line. On average, their five-year survival rate was 94% from the time they were first diagnosed by SCCA. Note that only patients who received all of their care from SCCA are included.

Patients from all types of treatment centers — Community Cancer Centers, Comprehensive Community Cancer Centers, and Academic/Research Hospitals — are represented by orange, blue, and brown lines. Their five-year survival rates, on average, were between 69 and 73%.
In March, after four years of partnering, planning, and building, SCCA Proton Therapy, A ProCure Center will be up and running on the Northwest Hospital & Medical Center campus. SCCA doctors are excited to have the opportunity to utilize proton therapy in treating patients with tumors in sensitive, hard-to-reach locations—and in treating children, who are acutely sensitive to radiation side effects. An advanced form of radiation treatment, proton therapy can be calibrated with great precision to selectively kill cancer cells.

For patients with certain types of tumors, proton therapy can offer significant advantages. Compared to standard X-ray treatment, the accuracy of the delivery of proton therapy reduces damage to the healthy tissues and organs surrounding tumors. Other benefits include fewer side effects, including a decreased risk of developing secondary tumors (cancers that result from radiation treatment).

Clear benefits for children
We are especially excited about proton therapy’s treatment potential for children with tumors. Children are more prone to secondary cancers than adults. The risk of secondary cancers is correlated with the amount of irradiated tissue. Since proton therapy is more efficient in sparing normal tissue, it reduces the likelihood that children undergoing this treatment will have to face recurrent cancers later in their lives. And studies show that using proton therapy to treat pediatric tumors provides excellent results.
Christine Fang feels very strongly about safeguarding her patients’ quality of life while pursuing treatment approaches that can save their lives. A radiation oncologist who specializes in treating women with breast and gynecologic cancers, Dr. Fang joined the SCCA medical team in 2011 and is rapidly making a difference in the lives of many patients here.

“Weighing the risks and benefits of radiation treatment for cancer,” she points out, “is a judgment call that radiation oncologists have to make every day. Treating cancer is our primary objective, but a very close second is making sure that we protect everything else around it.” Last year, she led SCCA’s efforts in developing the Calypso breath-hold technique to help protect breast cancer patients’ sensitive organs—particularly the heart—during radiation therapy.

Calypso utilizes transponders to alert radiation therapists when patients make subtle movements during their therapy. This technology has been used successfully in radiation treatment of prostate cancer for several years; along with the SCCA radiation oncology team, Dr. Fang is developing investigational protocols with the goal of optimizing the use of Calypso in breast cancer patients.

During 2010, Dr. Fang completed a fellowship in proton therapy at MD Anderson Cancer Center in Texas. She’s excited about exploring its benefits, including reduced irradiation of healthy tissues in treating women with breast cancer at SCCA’s new proton therapy center. Proton therapy has been relatively underutilized in treating breast cancer—particularly later-stage cancers. Dr. Fang is the SCCA principal investigator in a multi-institutional trial that will study proton therapy in treating stage III breast cancer. She will also be launching clinical trials for patients with earlier stage cancers.

“As we increase the number of cancer survivors that win the fight against cancer, we cannot forget that they are often left with lasting side effects from treatment. I believe that in addition to improving cure rates, a critical part of our role as physicians is to understand the factors that negatively impact patients’ long-term quality of life. We must continually strive to eliminate the ‘badges’ of our patients’ survivorship.”
Proton therapy can also be beneficial in treating a broad range of cancerous—and some benign—tumors in adults, including those of the brain, central nervous system, gastrointestinal tract, head and neck, lung, prostate, breast, as well as sarcomas.

**Bringing answers to patients**

As an institution dedicated to building on our knowledge and bringing answers to our patients, we view the new SCCA Proton Therapy Center as a tremendous opportunity. Our doctors plan to take the lead in active clinical investigations that will help define the role of proton therapy in future cancer treatment. Because proton therapy is an emerging technology, there is much that remains unclear about its cost-benefit profile relative to other radiation therapies—and its overall efficacy.

This new facility will enable Pacific Northwest patients to remain closer to home. In the past, those who could benefit from proton therapy were forced to travel to other parts of the country for a multi-week course of treatment. Because of the significant investment required in building and operating a proton therapy facility, this treatment is currently available in only about a dozen sites in the U.S.

The SCCA Proton Therapy Center is made possible through a financial and operating partnership between SCCA and ProCure, which currently operates three other proton therapy facilities in the eastern U.S. To learn more about this precise technology and our new facility, please visit our website at www.sccaprotontherapy.com.

“Proton radiotherapy is the most precise form of radiotherapy available today—and will improve the outcomes for a large number of cancer patients.”

George Laramore, MD, PhD
Medical Director, SCCA Proton Therapy, A ProCure Center
Sunil Hingorani is a researcher and medical oncologist who has focused his work exclusively on giving patients with pancreatic cancer a fighting chance. “The median survival for patients after diagnosis is four to six months,” he says. “It is a fast-moving, hard-to-detect disease, and typically remains hidden until it’s too late. Almost always, by the time I meet a patient for their original diagnosis, the cancer has already spread beyond the possibility of surgery.”

Someday soon, thanks to Dr. Hingorani’s breakthrough research efforts, pancreatic cancer patients may be able to count on a more targeted approach to destroying their tumors—and extending their lives. The resistance of pancreatic cancer to chemotherapy stems in part from the unique biological barrier these tumors build around themselves.

Using a genetically engineered mouse model that he developed, Dr. Hingorani and his team utilized an enzyme called PEGPH20 to penetrate these tumors’ defenses. When combined with a chemotherapy agent, this approach resulted in a 70% increase in survival time after the start of treatment. “This represents the largest survival increase we’ve seen in any of the studies done in a preclinical model, and it rivals the very best results reported in humans,” he says.

Some SCCA patients diagnosed with pancreatic cancer are taking part in a clinical trial that is testing this treatment approach in humans. Although results in mice don’t always translate into similar results in people, Dr. Hingorani is hopeful—and impatient to find answers. 40,000 people lose their lives to pancreatic cancer in the U.S. every year. And his own father was his first patient. “That’s why I study this and only this cancer,” he says. “It’s more of a case of the cancer choosing me.”

Someday soon, thanks to Dr. Hingorani’s breakthrough research efforts, pancreatic cancer patients may be able to count on a more targeted approach to destroying their tumors—and extending their lives.
SCCA enters its second decade on a solid foundation. As the only National Cancer Institute-designated comprehensive cancer center in the Northwest, we are clearly addressing a huge unmet need. And the public response—approximately 160,000 patients cared for since 2001—has been gratifying.

We also recognize that everything in our world is changing: medical science, patient demographics, how we deliver care, and how we as a society pay for it.

**Leveraging our legacy**

As leaders in cancer care innovation, we are actively seeking solutions: How can we continue to thrive in this new environment? How can we continue to make SCCA’s care more cost effective and more accessible?

To define our direction more effectively, the leadership group—consisting of the CEOs and Board leadership from the Hutchinson Center, UW Medicine, Seattle Children’s, and SCCA—is now meeting quarterly. The agenda always includes a discussion of how the four institutions can knock down barriers and collaborate more effectively.

**Process improvements and Clinical Pathways**

These sessions have already resulted in the adoption of continuous process improvements, which make planning and implementation of decisions work more smoothly. For example, we developed strategies for using our clinical facilities more efficiently, and we’re beginning to reap the benefits.

Within the clinics, we’re instituting a best practices program we call Clinical Pathways. For each disease, we identify the best science and the most effective treatments. Then our physicians write guidelines on how a particular cancer ought to be addressed throughout the institution. This is another aspect of Precision Medicine, as Clinical Pathways uses evidence to target the treatment approach that’s likely to work best, when delivered compassionately and respecting each patient’s individuality.

**Serving the greater community at EvergreenHealth**

Cancer patients are starting to get the message that it really matters where they are treated first. That’s why we wanted to expand from our single location in Seattle. SCCA at EvergreenHealth is located “across the bridges” in Kirkland, Washington. Now patients can receive SCCA’s leading-edge cancer treatments and participate in clinical studies without having to travel to downtown Seattle.

We’ve long provided training to doctors through the SCCA Network, which extends from Anchorage, Alaska to Bozeman, Montana. SCCA at EvergreenHealth takes this concept one step further. SCCA doctors and staff are housed within another institution. As a result, patients receive SCCA-specific benefits including:
latest chemotherapy treatment and biologic therapies, new drugs and alternative treatments that are under investigation, and SCCA’s excellent record of success in helping patients survive cancer. As SCCA Executive Vice President Norm Hubbard says, “We’re partnering with EvergreenHealth in a deep and rich way with the goal of improving cancer care in our region.”
Cancer has a devastating impact on patients, families, and communities. At SCCA, we see our role as much broader than providing the highest standards of care in cancer research and treatment. Our community-focused programs and efforts are aimed at reducing the burden of cancer.

Many of our initiatives seek to help relieve patients’ financial and logistical burdens on an individual basis, from underwriting uncompensated care, to making short-term housing available to those who travel to Seattle for extended treatment. Other SCCA programs promote better health in the community at large, including SCCA’s mobile breast imaging MammoVan, and the SCCA Survivorship Program.

SCCA’s vision also includes shifting the “business as usual” cancer paradigm. We seek ways to educate people about preventing cancer, and support research into how cancer treatment providers and researchers can use their dollars more wisely and efficiently. In this section, we’re spotlighting two efforts that are targeting cancer prevention and healthcare economics in important and inventive ways.

**HICOR is dedicated to helping communities and families make better decisions about cancer treatment and research**

Dr. Scott Ramsey and his team at Hutchinson Institute for Cancer Outcomes Research (HICOR) are tackling Precision Medicine head on—but from a health economics perspective. The issue they’re targeting is fundamental: How, as a community, can we make the best use of our healthcare and cancer research dollars?

Established in 2012, the Institute is the first of its kind among comprehensive cancer centers. “Cancer care in the United States is in crisis,” says Scott Ramsey. “Costs are rising at an unsustainable rate, putting tremendous strains on patients and the healthcare system.” Included in this assessment are the constraints placed on medical researchers, as limited funding challenges their ability to pursue clinical studies.

**At the crossroads of medicine and economics**

A physician, cancer researcher, and PhD economist, Scott Ramsey works at the crossroads of disciplines that can benefit from more precise measurement of treatment effectiveness and costs. The Institute’s work aims to break down the data system silos that currently exist, easing information gaps among doctors, healthcare institutions, patients and their families, researchers, research funders, and health insurers.

Medicine and economics, he says, inform each other in critical ways. “Cancer is so costly, and many treatments offer patients very little, either in terms of survival or quality of life. Our mission is to improve cancer care delivery and reduce the costs of cancer care for communities. We’re very much focused on looking at the entire enterprise of cancer care—what’s currently being done and what can be done to make this process more efficient and effective.”
The Institute is focusing on a number of research areas, including:

- Outcomes research in cancer treatment—including identifying costly procedures that don’t have evidence to support their value
- Conducting cost-effectiveness and comparative effectiveness studies of clinical trials in cancer prevention, early detection, and treatment
- Finding better ways to track cancer care in the community to identify variation and reduce wasteful or harmful care
- Developing methods to report on quality and costs to health insurers, clinicians, and patients

Helping cancer patients and their families get information about quality, cost-effective care is fundamental to the Institute’s work. “If you get cancer, where do you go to get information about who’s the best person to take care of you? Right now you can look at advertisements, but that’s not data,” says Scott Ramsey. “We’d like to change that.”

2012 Community benefits in brief

SCCA devotes approximately nine percent of its operational costs to benefit our community (per the calculations of the IRS Schedule H). For the fiscal year 2012, this amounted to close to $31 million. During this period, SCCA funding for uncompensated care alone totaled more than $19.7 million. We have also continued to invest significantly in education for our health professionals (about $3.7 million) and research (more than $4.1 million). So much of what we do at SCCA to give back to our community goes beyond the expected, including the volunteer efforts made by our professionals, the health and nutrition programs we subsidize, and our Family Assistance Fund, which helps ease the financial strains that cancer treatment places on families.

Community benefit allocations

- Uncompensated care
- Community health improvement services and community benefit operations
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions for community benefit
MoDAWGS in Movember means many mustaches grown in November—to raise awareness of the issues surrounding men’s health, particularly prostate cancer. The Movember movement was launched in 2003 by two “mates” in Australia and caught fire here in the U.S. in recent years. Two years ago, SCCA’s Dr. Jonathan Wright was inspired to bring the Movember message to our community in greater Seattle.

The MoDAWGS team is the result of his creative organizing efforts. Originally made up of caregivers for prostate cancer patients, including urologists, medical oncologists, and researchers who study and treat this cancer at SCCA, UW Medicine, Fred Hutchinson Cancer Research Center, and VA Puget Sound Health Care System, the group quickly spread beyond those ranks, inspiring an extended community of supporters to ‘grow a mo.’

The point is to “generate talk about men’s health,” says Jonathan Wright. “Everyone knows that men don’t like going to the doctor. So when someone says to you, ‘What’s up with the mustache?’ you can say, ‘It’s about men’s health—did you see your doctor today?’

Early detection and preventative care are saving lives

“It’s early detection for cancer,” he says. “For young men, it’s testicular cancer; for older men, it’s prostate cancer. Early detection saves lives. But at the same time, most men won’t have cancer. You’re going to find the high cholesterol, obesity, pre-diabetes, and high blood pressure that a doctor can treat. And that will help their lives as well.”

Women, aka “Mo Sistas,” have been welcomed into the MoDAWGS mix. “Women can’t grow mustaches so we had buttons made,” he says. “All the women in the clinic were wearing these, and we printed business cards to help break the ice with patients.”

The monies raised by MoDAWGS last November were sent on to the Movember charity, which distributes funding worldwide for prostate cancer-related research and education efforts. Some of these funds ultimately make their way back here to support research at the Hutchinson Center and SCCA.

But the real point for Jonathan Wright and MoDAWGS is the message. And MoDAWGS (obviously) has its lighter side. “We were at our end-of-the-month party and you’d look around and think: This is what the ’70s looked like,” he laughs. “It was an absolute sea of mustaches.”
Jonathan Wright embraces the balance his work as a urologic oncologist provides. “We treat the disease and care for the patient,” he says.

Born and raised in Yakima, Washington, Dr. Wright says he always thought he’d return to his hometown to be a family doctor before he discovered urologic oncology. His specialty enables him to build the relationships with patients he had envisioned. “We do the screening, diagnostic testing, counseling, treatment, and follow-up. So you truly become each patient’s doctor.” His expertise includes surgical approaches—including minimally invasive robotic surgery—to cancers of the bladder, prostate, kidney, penis, and testicles.

Urologic oncology is a field that demands a different answer for each patient. These cancers vary widely in their genetic make-up, tumor characteristics, and prognoses. Dr. Wright’s research aims to define more precisely the cancers his patients bring into the clinic, so he can offer them more effective responses—and outcomes.

With muscle-invasive bladder cancer, for example, “we know that a third of patients will have a great response to chemotherapy” prior to surgical removal of their bladder. For those who don’t, he and other collaborators are working on circulating tumor cells and targeted testing of biopsy tissue, searching for a correlation between tissue types and responses, “so that we can get a better treatment for them.” This ultimately involves “clinical trials with newer agents that we’re defining or testing in the lab with some of our researchers.”

For bladder cancers that are non-muscle-invasive, Dr. Wright is searching for better screening and surveillance techniques for patients living with this cancer. “We’re now looking at urine cells in 3D to see if we can get a more precise understanding of them.” In his work with prostate cancer patients, one of his studies is examining the correlation between obesity and adverse prostate cancer outcomes. “What aspect of obesity drives this? Because if we can find that out, we can target it.”

“.... if we can find that out, we can target it.”
There are so many ways for you to contribute to the critical work at SCCA. Your generosity makes our vision of turning cancer patients into cancer survivors possible.

Your gift to SCCA will help us to:

- Support SCCA's areas of greatest need
- Advance specific types of cancer research
- Help SCCA provide supportive care services, beyond treatment, to our patients and families
- Provide a home away from home at the SCCA House

Every gift can be made as a memorial or tribute to a loved one, doctor, nurse, or other caregiver.

You can also join the SCCA family by becoming a volunteer, or hosting a fund-raising event benefiting SCCA.

We’re committed to reaching as many patients as we can. With your help and generosity, we can accomplish so much more.

To learn more about giving opportunities and SCCA’s vision, please visit our website at www.seattlecca.org/donate or contact us at (877) 308-3117.
**Safeway’s giving initiatives for breast cancer are helping to save lives in the Pacific Northwest**

Every year since 2001, Safeway’s October in-store fundraising efforts have raised millions of dollars for breast cancer research, education, and prevention nationwide. In the Pacific Northwest, the Safeway dollars that are raised here, stay here. Many dimes, quarters, and dollars given at check stands in our regional supermarkets are earmarked for the important breast cancer-related work performed at SCCA and at two of our three founding institutions, Fred Hutchinson Cancer Research Center and UW Medicine.

Since the launch of Safeway’s breast cancer initiative, more than $8,000,000 has been raised for breast cancer research, prevention, early detection, and care across the Alliance.

Some of the work Safeway has supported includes:

- Clinical trials of potential new breast cancer treatments, along with prevention and survivorship strategies
- Pilot breast cancer research projects, including getting novel studies performed by junior investigators off the ground
- Support for the SCCA Women’s Wellness Clinic

The MammoVan, a mammography clinic on wheels, is an early detection community resource that wouldn’t exist without Safeway’s support. Safeway purchased the van and continues to support its ongoing operations. The MammoVan screens more than 4,000 women each year; in 2013, Safeway will invest in a state-of-the-art digital breast tomosynthesis (DBT) unit. Since the “birth” of the MammoVan, Safeway has invested more than $2,000,000 in its screening programs. To show our gratitude for their commitment to women of our region, in December of 2011 we named the SCCA Breast Imaging Lobby, the Safeway Breast Imaging Lobby.

Here at SCCA, we want to thank Safeway’s far-sighted management, enthusiastic employees, and generous customers for their contributions to our work in preventing cancer, seeking cures for breast cancer—and turning breast cancer patients into survivors.
Gifts from SCCA donors in 2012

$1,000,000 and up
Norcliffe Foundation

$100,000 – $249,999
AEG Live
The Madhouse Project
The Safeway Foundation
Swim Across America

$50,000 – $99,999
Drive Fore the Cure Northwest Foundation
Muckleshoot Tribe of Indians

$25,000 – $49,999
Microsoft Corporation

$10,000 – $24,999
The 5th Avenue Theatre
Chin-Ley/Reche Associates
Edmonds School District No. 15
Jacobs Johnson Foundation
Liberty Mutual
Perkins Coie LLP
Sterling Realty Organization

$5,000 – $9,999
Carl and Renée Behnke
Costigan Integrated
FBI Agents Association
Employees Community Fund of The Boeing Company
Gary E. Milgard Family Foundation
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LeRoss Family Foundation
Low Pressure Promotions, LLC
Messenger Signs
Mr. and Mrs. John H. Mills
Morgan Stanley Smith Barney Global Impact Funding Trust, Inc
Bud Mount
Rona Consulting Group
United Way of King County

“Your donations will be invested carefully, and will make a tremendous difference.”

Robert Bakemeier, Board Chair
$1,000 – $4,999
Alderbrook Ladies Golf Club
First Mates
Allflight Corporation
Association of Community Cancer Centers
Auburn School District #408
Mr. Robb Bakemeier and Mrs. Karen Rosengren
Bank of America
Mr. and Mrs. Steve W. Berman
Bill & Melinda Gates Foundation
Mr. Bill Blackburn
Bluebills Heritage Chapter
Ms. Linda K. Bonet
Breast Cancer Emergency Fund
Carillon Point Account
Dr. Shannon Corbin and Mr. Jonathan M. Tingstad
Custom Craft LLC
Mr. and Mrs. Donald A. Dick, Jr.
Donna's Tournament
Mr. and Mrs. Stanley Edmond
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Dr. Sherman S. Ely, D.D.S.
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Ms. Janice L. Ferguson
Fraternal Order of Eagles Prairie Aerie #4144
Freestone Capital Management Charitable Foundation
Ms. Leslie Freund
Michael and Lynn Garvey
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Vanguard Charitable Endowment Program
Ms. Leah Wiiest
David and Jace Williams
Woodland Park Zoo Society

*Gifts made during the SCCA fiscal year 2012: July 1, 2011 – June 30, 2012.*
### Fiscal Year (in thousands) 2012

#### Statement of Operations

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#### Balance Sheet

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#### Key Statistics

- Treated Patients: 5,599
- Patient Visits: 72,300

#### 2012 Revenue

- Net Patient Service Revenue: 90%
- Other Operating Revenue: 7%
- Non-Operating Income: 3%

#### 2012 Operating Expenses

- Compensation: 27%
- Purchased Services: 34%
- Supplies: 7%
- Depreciation, Amortization, and Interest Expense: 8%
- Other: 24%
Member Representatives

Larry Corey, MD  
President and Director, FHCRC;  
Professor, UW Department of Laboratory Medicine

Thomas Hansen, MD  
Chief Executive Officer, Seattle Children’s

Paul Ramsey, MD  
Chief Executive Officer, UW Medicine;  
Executive Vice President for Medical Affairs and Dean of the School of Medicine, University of Washington

SCCA Executive Management Team

Fred Appelbaum, MD  
Executive Director and President:  
Responsible for general administration and management of SCCA operations;  
Director, Clinical Research Division and Member, FHCRC; Professor and Head, Division of Medical Oncology, UW School of Medicine

Norm Hubbard  
Executive Vice President: Responsible for overall strategic leadership and management of SCCA

David Ackerson  
Chief Information Officer and Vice President: Responsible for Information Technology, Clinical Information Systems, Information Security, Health Information Management, Project Management, Continuous Performance Improvement, and Decision Support

Madeline Buelt, MSN, RN  
Chief Nurse Executive and Vice President of Operations: Responsible for the administrative and clinical operations of SCCA

Debby Gentzen  
Chief Strategy Officer and Vice President: Responsible for Strategy, Business Development, Marketing, the SCCA Network, Program Management, and Radiation Therapy

F. Marc Stewart, MD  
Medical Director and Vice President: Oversees clinical care and conducts quality monitoring of medical practice on behalf of SCCA

Jonathan Tingstad  
Chief Financial Officer and Vice President: Responsible for Finance, Revenue Cycle and Payor Relations, Patient Accounting, Facilities, and Patient Access
SCCA’s affairs are governed by an 18-member Board of Directors. Each member institution appoints six of the 18 directors, with at least four of the six directors required to be community representatives. 2012 SCCA Board members include:

Robert Bakemeier  
*Chair;* Chair, Board Compensation Committee; Chair, Board Executive Committee; Seattle Children’s Board of Trustees; President, Bakemeier Law Firm

Carl Behnke  
*Vice Chair;* Chair, Board Governance Committee; President, REB Enterprises, Inc.

Kimberly McNally, MN, RN  
*Secretary;* Chair, Board Patient Quality, Safety & Service Committee; President, McNally & Associates

Bob Gerth  
*Treasurer;* Chair, Board Finance, Investment & Audit Committee; Partner, Deloitte & Touche LLP (retired)

Brooks Ragen  
*Immediate Past Chair;* Chair, Board of Directors, McAdams Wright Ragen & Manzanita Capital

Lisa Brandenburg  
President, Seattle Children’s Hospital

Mike Delman  
Seattle Children’s Board of Trustees; Corporate Vice President, Microsoft (retired)

Mark Groudine, MD, PhD  
Executive Vice President & Deputy Director, FHCRC; Professor, Radiation Oncology, UW School of Medicine

Jonelle Johnson  
Chair, Board Facility Committee

Rich Jones  
UW Medicine Board; President and CEO, Washington Society of Certified Public Accountants; Partner, Ernst & Young (retired)

Robert MacAulay  
Principal, Meriwether Partners LLC (retired)

Ruth Mahan  
Chief Business Officer, UW Medicine; Vice President for Medical Affairs, University of Washington

Linda Mattox  
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Richard McCune  
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Shan Mullin  
UW Medicine Board; Partner, Perkins Coie LLP

Johnese Spisso  
Chief Health System Officer, UW Medicine; Vice President for Medical Affairs, University of Washington

Bruder Stapleton, MD  
Chief Academic Officer & Senior VP, Seattle Children’s; Ford/Morgan Professor & Chair, Department of Pediatrics, UW School of Medicine; Associate Dean, UW School of Medicine

Myra Tanita  
Executive Vice President and Chief Operating Officer, FHCRC
SCCA Board Chair Robert Bakemeier has served on the Board of Trustees since 2007. The son of an academic oncologist, Robb says he’s seen tremendous progress made in fighting cancer—during his entire lifetime. We are deeply grateful for Robb’s service and wise counsel.

“As SCCA Board members, we frequently see patients and their families dealing with the trauma of cancer. We also see so much promise, so much horsepower and resources in the pioneering treatment approaches made available to patients. This is a truly remarkable place to contribute and volunteer.”

Robert Bakemeier, Board Chair
SCCA unites doctors from Fred Hutchinson Cancer Research Center, UW Medicine, and Seattle Children’s. Our vision is to lead the world in preventing and treating cancer—and to give our patients the best possible options for surviving this disease.