TURNING CANCER PATIENTS INTO CANCER SURVIVORS
Seattle Cancer Care Alliance (SCCA) is a unique convergence, combining the talents and resources of three world-renowned institutions: Fred Hutch, UW Medicine, and Seattle Children’s.

Our doctors and researchers are developing revolutionary new therapies, and refining every aspect of patient care to make it safer, more effective, and more patient-focused. These advances are the result of thoughtful convergences in both the lab and the clinic.

This exciting work is taking place in preclinical research in genomics and molecular biology. It occurs in SCCA’s multidisciplinary clinics, where doctors from all relevant specialties focus their expertise on each individual patient. We’re integrating new initiatives in palliative care, infection control, and personalized therapies. Our clinical pathways map these convergences to unify treatment approaches throughout SCCA, our network, and the community.

What we call *convergence* is remarkable and ongoing. We’re combining our strengths to help patients live better, longer, richer lives, and we are doing everything we can to promote their health, safety, and well-being. In these pages, we’ll share many of these successes with you.
We are more excited about the progress we are making in helping patients survive cancer than at any other time in SCCA’s history. Not since the days of E. Donnell Thomas, MD, and his first bone marrow transplantation have we seen advances with this much potential.

The area of clinical research we are so enthusiastic about is immunotherapy. We’re starting to reap the benefits from the convergence of two revolutions in biology. Such moments are uncommon in the history of mankind, so it’s worth reflecting for a few moments on the magnitude of the progress that has occurred in just the last decade.

The Convergence of Genomics and the Science of the Immune System

The first revolution stems from the exponential returns we’ve received from investments in the field of genomics. It was less than a dozen years ago, in 2003, when the Human Genome Project first sequenced the entire human DNA code—all three billion base pairs. That effort took more than 10 years and $1 billion. Today, we can do the same thing one million times more efficiently. In 2014 it took only 10 days to sequence a person’s entire genome, at a cost of less than $1,000.

For many types of cancer, doctors in our clinics can sequence the DNA of a patient’s tumor to identify the mutations that make it different from normal tissue. Based on this information, we can select therapies that target each patient’s specific genetic mutation. As such, advances in genomics are allowing us to match treatments to tumors with a level of precision unimaginable a decade ago.

The second revolution is in our understanding of the human immune system and its ability to sense incursions from countless types of bacteria and viruses and, within a few days, clear them from the body. While cancer, like bacteria and viruses, has differences from normal cells that our immune system should be able to detect, previous efforts to use the immune system to treat cancer have failed. To address this, we’ve been working—since the days of the first bone marrow transplants—to identify the mechanisms that enable the immune system to do its job. Increasingly, we can identify not only what functions specific genes control, but also how genes’ signals are transmitted along prescribed pathways via chains of proteins.

The convergence of these two revolutions—genomics and the molecular biology of the immune system—has given birth to the discipline of immunotherapy, where we are making gigantic strides.

Immunotherapy: Providing New Hope for Patients with Formerly Untreatable Cancers

In immunotherapy today, we’ve reached the point where we’re able to take immune cells from a patient and genetically manipulate them by adding an antibody receptor that sees the cancer. We harvest the patient’s cells, re-infuse those T-cells into the patient, and stand back and watch.

What we see, in many cases, is miraculous. As one patient participating in a clinical trial of this therapy for otherwise untreatable lymphoma said, “I could feel my lymph nodes melting away as if they were ice cubes.”

We wrote about this treatment, called chimeric antigen receptor (CAR) T-cell therapy, in last year’s report. Since then, our researchers have made exciting progress, which David Maloney, MD, PhD, will describe in these pages. Based on the laboratory work of Stanley Riddell, MD, the clinical team led by Dr. Maloney and Cameron Turtle, MD, PhD, has now treated nearly 30 patients with acute lymphoblastic leukemia, and we are seeing rapid complete responses in many cases. The results have been so encouraging that we are actively planning to open trials of CAR T-cell therapy for other cancers, including solid tumors such as breast and lung cancer.

Convergences are also occurring in other types of immunotherapy, including a recent initiative that combines tumor-infiltrating lymphocyte (TIL) therapy with the use of targeted checkpoint inhibitors. TIL is a T-cell therapy that we’ve used successfully against melanoma. It involves selecting T-cells that work best in fighting the patient’s specific tumor, growing
them in large numbers, and reinfusing them back into the patient. Some tumors have a receptor, PD-1, that turns off T-cells. Fred Hutch researchers contributed to the development of an antibody to PD-1 called pembrolizumab (Keytruda), which recently received U.S. Food & Drug Administration (FDA) approval for the treatment of melanoma. Now, Sylvia Lee, MD, is combining TIL with Keytruda, based on the hypothesis that the two should work well together. If the two therapies prove to have the expected synergistic effects, we will expand trials to other cancers in addition to melanoma.

Based on the remarkable progress we’re seeing at SCCA, we predict that, in five years, half of our patients who have metastatic disease will be treated with immunotherapy. It will become a mainstay, perhaps diminishing the need for traditional, more toxic therapies.

**Advancing Innovation, Improving Quality**

At SCCA, we’re constantly seeking to advance the standard of care, both through innovation and the quality of our patient care. That’s why we place so much emphasis on providing patients with access to clinical trials, which compare the current FDA-approved standard to new approaches that we hope will be even better. And, in many cases in which there is no standard therapy available, we provide patients with access to the most promising treatment under investigation.

As you might imagine, we constantly focus on quality as we monitor, measure, analyze, and improve our protocols. And, while all aspects of care are important, the quality measure that is most important to the majority of our patients is, quite simply, survival. Does getting treated at SCCA truly make a difference in their chances of surviving cancer?

The data show that the answer is “yes.” Every year that we’ve published this annual report, we’ve discussed five-year survival statistics that compare our patients’ outcomes to those of other hospitals and medical centers across the United States. Since 2002, when the data was first collected, we have been among the best places for patients to be treated. Better still, we’ve shown continuous improvement every year since then.

How does SCCA achieve these results? By maintaining a mindset that there is no detail too small when it comes to the health of our patients. One example is our dedicated infection control group, led by Steven Pergam, MD, MPH, which strives to ensure that our patients don’t get additional infections that could complicate their treatment. This is an area in which SCCA stands tall: Our infection rates are substantially lower. In fact, our own Sara Podczervinski, RN, MPH, CIC, was one of six winners, worldwide, of the 2014 Heroes of Infection Prevention Award.

We also try to do as much as we can to help patients after they complete treatment at SCCA—and elsewhere. It’s estimated that there are approximately 125,000 cancer survivors in Washington state alone. These people are coping with the side effects of their treatment as well as the risk of recurrence. Under the direction of Scott Baker, MD, MS, and Karen Syrjala, PhD, the SCCA Survivorship Clinic provides patients with a personalized Survivorship Care Plan that details all of their past test results and treatments and suggests strategies for ongoing health maintenance.

Everything we do at SCCA converges on survivorship. From preclinical research, to clinical trials and quality control, to post-treatment follow-up, everyone here focuses on delivering successful outcomes for our patients, their friends and families, and our community.

We would particularly like to thank our donors and volunteers who support us with their time and hard-earned dollars. Without your generosity, none of these exciting advances in our research labs and clinics would have been possible. Our donors and volunteers help us save lives every day, and we look forward to working with you in the coming years as we continue the fight against cancer.
At times, the fight against cancer can read like an espionage drama: *In a deadly betrayal, the disease recruits elements from within our own immune system. And, in order to save ourselves, we must master the secret codes that allow our agents to kill cancer...*

Specifically, through the convergence of genomics and molecular engineering, we’re building T-cells that grow specialized cancer-targeting receptors. We’re also expanding the universe of people who can safely receive a bone marrow transplant by deploying naïve cord blood stem cells that are stealthy enough to defeat the body’s autoimmune responses. And recent clinical studies in ultra-precise proton beam radiation are attempting to activate a hidden asset: the fact that radiation stimulates the body’s localized immune response against cancer cells.
Last year’s report introduced CAR T-cell therapy, a treatment that SCCA Executive Director Frederick Appelbaum, MD, characterizes as “the most amazing thing we’ve done since Dr. Don Thomas’ first bone marrow transplantation.”

Now, the early results from Phase I clinical trials are in, and were presented by Cameron Turtle, MD, PhD, at the American Society of Hematology (ASH) conference in December 2014. Patients’ responses included complete or partial remissions in six of nine patients with non-Hodgkin’s lymphoma and complete remissions in five of seven patients with acute lymphoblastic leukemia.

David Maloney, MD, PhD, is one of the lead investigators of CAR trials at SCCA. “We’re definitely seeing very encouraging anti-tumor activity,” he said, “but we still need to learn how to make these cells last a long time in the patients and to guarantee that they work in everybody.”

As generally the case with Phase I studies, the patients in Dr. Maloney’s trial are often virtually out of options for treatment. “Many of them wouldn’t be candidates for a bone marrow transplant—they’re too sick to even consider it,” he said.

As the studies move forward, Dr. Maloney and his colleagues will be working to minimize the incidence of complications. There are also initiatives to find additional antibodies that attack different targets. And plans are already in place to expand clinical trials to solid tumors, starting with lung cancer.

Dr. Maloney’s Journey: Monoclonal Antibody Pioneer Now Tackles T-Cells

CAR therapy marries the two most potent elements in the immune system—antibodies and T-cells—to destroy tumors. Over the last two years, researchers in the lab of Stanley Riddell, MD, have been able to genetically modify patients’ T-cells. A bioengineered virus is introduced, causing the T-cells to grow CD-19 antibody receptors. These receptors are specific for proteins associated with a number of blood cancers—non-Hodgkin’s lymphoma, chronic lymphoblastic leukemia, acute lymphoblastic leukemia, and other blood cancers. Thus, the modified T-cells gain the precision targeting ability of the antibody.

Dr. Maloney thinks it’s ironic that he’s now the lead investigator in SCCA’s clinical trials of an immensely promising immunotherapy based on T-cells because his career, until now, has focused on antibodies. Dr. Maloney’s experience in oncology began at Stanford in the 1980s, where he participated in some of the foundational work on monoclonal antibodies. He led the original clinical trials of rituximab, which became the first FDA-approved monoclonal antibody in 1997. Today, rituximab is a mainstay in the treatment of many blood cancers.

“T-cells have always had a lot of promise, but the native T-cell receptor is complex and does not recognize common targets on the tumor cell surface like an antibody can,” Dr. Maloney said. “So the idea of the CAR, using an antibody to provide that recognition, turned out to be the major key.”

You could even call it a convergence. “CAR T-cells are just kind of another step—a continuation of our work with antibodies. It’s been fun to be involved in both ends of immunotherapy, from the antibody side to the cellular T-cell side. Frankly, it’s very gratifying working with a great team to make this possible,” Dr. Maloney said.
Photographs of many former patients of pediatric oncologist Colleen Delaney, MD, MSc, sit on the bookshelves of her office. “They are the absolute motivation for what I do,” she said.

What Dr. Delaney has accomplished is remarkable. Early into a fellowship at Fred Hutch that began in 1999, she decided to pursue cancer research “to change things for a lot of people.” Dr. Delaney’s extraordinary advances in cord blood transplantation techniques are doing just that by opening the door to a wide array of new medical applications for cord blood therapies.

Dr. Delaney’s research is solving a huge challenge for many of the approximately 35 percent of patients who need a lifesaving transplant but can’t find a compatible donor—particularly ethnic minorities. Cord blood stem cells are derived from donated blood collected from the umbilical cord just after a baby is born. Because these cells come from an infant with a naïve immune system, they do not require as close a match to the recipient. In fact, nearly all patients without a suitable donor will be able to find a cord blood donor.

The challenge Dr. Delaney originally set out to solve was that the blood derived from umbilical cords contains only about one-tenth the number of blood-forming stem cells that conventional bone marrow or peripheral blood stem cell donors provide. This means that the process of engraftment, the incorporation of the transplanted cells by their recipient, takes an average of almost a month, as this relatively small number of cells becomes established and begins generating white blood cells.

During this delay in recovery, cord blood transplant patients were vulnerable to infections and other life-threatening complications of the transplant. “We wanted to develop a method that could expand the number of those proliferating cells to give to patients and help them recover their blood counts much earlier to reduce the risks,” Dr. Delaney said.

**Engineering a Protein to Trigger Stem Cell Proliferation**

Her first clinical study drew on her breakthroughs using a protein engineered in the lab of Irwin Bernstein, MD. Dr. Delaney had activated the cord blood stem cells, stimulating them to expand in number. Her trial with patients, launched in 2006, was a huge success. The patients participating were able to engraft in less than half the time—a median of 11 days compared to 26 days without the expanded cells—with fewer early complications.

Dr. Delaney was elated; she also realized this was just the beginning. To be truly responsive to patients’ needs, she knew she needed to create a process that “could be completed ahead of time, that we could offer to patients no matter where they are, and no matter their ethnicity or genetic make-up.”

**An ‘Off-the-Shelf’ Solution**

Her work in recent years has embraced this quest to create “what we call a universal donor,” Dr. Delaney said. The same process of cell expansion is used, but the cord blood derived stem cells are extracted within 36 hours of being donated, fresh from the delivery room. After they’re expanded ex vivo, “we have an off-the-shelf product,” Dr. Delaney said. “We can cryo-preserve them, and they go into a bank.”

In early December 2014, Dr. Delaney presented the results of a pilot study focused on this process at the ASH conference. “The results were unbelievably good,” she said. “These transplant patients didn’t graft...”
quite as quickly—but these are non-HLA-matched, third-party donor cells. And they had other, added benefits. There was less GVHD (graft-versus-host disease). There were fewer infections. And there were no cases of transplant-related deaths. These outstanding results led to the current randomized trial that we are doing now.

This randomized trial is now underway at six U.S. cancer treatment centers, with the goal of eventually enrolling 160 transplant patients. If these studies show similar outcomes, the potential benefits of this therapy could be phenomenal.

**Many Potential Treatment Applications**

In a different clinical study, Dr. Delaney’s off-the-shelf therapy has already helped non-transplant patients with acute myeloid leukemia reduce their rate of infectious complications. “We’re saying that if you’re getting intensive chemotherapy that’s going to leave you with a white blood cell count of zero, we could potentially give you these cells to prevent infections and toxicity,” Dr. Delaney said.

Dr. Delaney’s breakthrough work is inspiring new investigations by drug companies and in research labs all over the country—including her own. “We’re actively pursuing some of the more novel findings that have come from our trials,” she said. “We do a lot of translational work, seeing what happens with patients and taking these findings back to the lab.” One of the very surprising findings in the off-the-shelf pilot study was that the rates of severe, acute GVHD were lower when using a universal donor. “So we’re now back in the lab looking at immune tolerance.”

This landmark technique “is potentially going to be useful for many, many indications,” Dr. Delaney said. “That’s a very exciting thing to be thinking about.”
“STAY POSITIVE AND BE HAPPY.”
Aplastic Anemia Survivor: Kyra Diaz

Since being diagnosed in 2009 with severe aplastic anemia, Kyra Diaz has braved a series of demanding medical treatments to arrest and, ultimately, cure her disease. In October 2013, she received a cord blood transplant at SCCA that saved her life.

Now 11 years old, Kyra said there’s much about her treatments that she doesn’t remember. “I was in and out of the hospital a lot and I hated it,” she said. “It was a tough experience, but it made me more grateful. It gave me more experience with things that are hard, and that made me more tough and strong.”

Kyra’s treatment journey began when bruises on her legs led her parents, Ailiene and Mike, to seek medical care. In aplastic anemia, the bone marrow fails to make an adequate amount of new blood cells. A range of treatments are available to children with this disease, depending on the severity of their symptoms. Kyra received her treatment at Seattle Children’s from Akiko Shimamura, MD, PhD. For several years, she responded fairly well to a series of therapies, including blood transfusions and immunosuppressants.

But that progress didn’t last. By January 2013, Kyra was back to very low blood counts, and was experiencing a number of complications—her bone marrow was not producing enough red and white blood cells and platelets. A bone marrow transplant was Kyra’s best option to stay alive.

A Clinical Trial of One

Kyra is Filipino, and the national bone marrow donor registry’s limited ethnic-minority pool did not turn up a donor match for her. The most promising candidate, her younger sister Denise, was not a match either. Fortunately for the Diaz family, the answer to their prayers was right here in Seattle—but this involved creating a one-of-a-kind clinical trial for Kyra at SCCA.

The initial stumbling block for the Diaz family was that Dr. Colleen Delaney’s breakthrough clinical studies in cord blood transplants were not open to aplastic anemia patients. The Diaz family was planning a move to Maryland to enable Kyra to participate in a trial sponsored by the National Institutes of Health (NIH).

“Having to move to Maryland for the NIH trial made no sense,” Dr. Delaney said. “We had already established a successful double cord blood transplant process at the Hutch. I knew we could perform this with Kyra.”

To receive the go-ahead for Kyra’s treatment, Dr. Delaney submitted a single-patient Investigational New Drug application to the FDA. “This meant that Kyra was able to stay here for treatment,” Dr. Delaney said. “She did have some complications along the way. But she engrafted on day eight—an excellent result—and is now off all immunosuppression. She’s just a really amazing person. She’s back in the sixth grade, and was named Student of the Month at her school this past fall.”

Said her mom Ailiene, “Dr. Delaney makes miracles happen.”

Today, Kyra’s radiant face and quiet joyousness show no trace of what she has lived through while fighting for her life. What advice would she give to other patients facing a prolonged, life-threatening illness? “I’d say—stay positive,” Kyra said. “Because if you’re not believing you’ll get better, you’re putting yourself down even while everyone around you cares about you. And that doesn’t help anything. Stay positive and be happy.”
Ramesh Rengan, MD, PhD, joined SCCA to become medical director of SCCA Proton Therapy, A ProCure Center, in early 2013. A radiation oncologist, Dr. Rengan is internationally recognized for his work in treating melanoma and thoracic cancers. His expertise in the complex technology of proton therapy is a tremendous asset to SCCA.

Protons are charged particles that can be directed with great specificity at cancer cells, enabling radiologists to avoid destroying patients’ healthy adjoining cells. But this technology is also expensive. “That’s why there’s so much discussion around its cost and the potential evidence to justify that cost,” Dr. Rengan said.

Investing in Better Long-Term Outcomes for Patients

“There’s an increasing awareness that we can improve cancer care simply by reducing the side effects of treatment,” he said. “But when will we see the benefit of reducing that exposure of normal tissue to radiation?” With every disease and every patient, the goals and potential benefits are different. “With children, for example, you have to think of proton therapy’s selectivity as a certificate of deposit—one that may not mature for 30 to even 50 years from when you actually treat the patient.”

How do you keep track of someone for 30 years? “One of the things I’m very proud of,” Dr. Rengan said, “is that 95 percent of the patients treated at SCCA Proton Therapy are either enrolled in a clinical study or prospectively enrolled in a registry. We have a covenant with every patient that we are holding ourselves accountable for—that we will track and monitor their outcomes over the long term.”

Dr. Rengan was drawn to radiation oncology, he said, “because it sits at the intersection between cancer biology, technology, and clinical care in a way that’s unique in terms of any subdiscipline in medicine.” He earned his PhD in biological chemistry, focusing on immune cell biology. Coming to Seattle to treat patients at SCCA and conduct research at Fred Hutch “was a tremendous opportunity,” he said. “The Hutch is the world leader in investigating the ability to use the immune system against cancer.”

Taking Advantage of Proton Radiation’s Immune-System Stimulation Properties

Dr. Rengan couldn’t have found a better home for his own research interests, which include exploring convergences “between radiation, the immune system, and cancer progression—and how the immune system can be a tremendous ally as a weapon in treating cancer.” The linkage with radiation, he explained, “is due to the fact that radiation stimulates the body’s localized immune response against cancer cells.”

Currently, he and his colleagues are engaged in an ongoing clinical study at SCCA to test whether proton radiation can strengthen the body’s immune response for patients with advanced melanoma who don’t respond to treatment with ipilimumab (Yervoy). Ipilimumab is a monoclonal antibody that, in about 10 percent of melanoma patients, successfully activates the immune system to destroy cancer cells. The new approach utilizing protons is called RADVAX. “We’re excited about the fact that radiation could potentially be a real ally in stimulating these patients’ immune responses to their cancer.”
Prostate Cancer Survivor: William Kray

Bill Kray holds a PhD in organic chemistry. Before retiring in 2000, he enjoyed a wide-ranging career in both academic and industry settings—including analyzing lunar materials from the Apollo missions while working in the Space Science Laboratory at UC Berkeley.

In March 2013, Bill was diagnosed with inoperable, “fairly aggressive” prostate cancer. One year later, his testosterone-suppression therapy, Lupron, was proving inadequate in suppressing his tumor’s growth. He needed a more aggressive therapy. “Being research oriented,” Bill said, “I really investigated this. There are many modalities available to treat my disease. After all, it’s my body and I’ve got to live with it, whatever happens. I’m trying to stay healthy and live as long as I can.

“I made up my own mind,” Bill said. “Proton therapy was what I wanted to undergo; I knew enough about the technology to understand how it minimizes damage to the healthy tissue surrounding the tumor. Temporary side effects I can deal with, but long-term side effects are a whole different story.”

Currently, there are only 14 proton therapy centers in the United States. When Bill learned about SCCA Proton Therapy, A ProCure Center, he was glad of the opportunity to live at home in University Place, Wash., “a 95-mile round-trip drive for treatment.” His 44 treatment sessions began in September 2014 and were completed in mid-December. “I feel great,” he said. “Though I still feel a lack of energy due to the Lupron. The only real side effect I had was a little redness.”

Summing up his experience, Bill said, “I feel very fortunate in so many respects. I did not have metastatic disease. And in all my 75 years, I have never had such wonderful medical treatment as I received here at the proton center.” Bill’s conversations with Dr. Rengan were one of the highlights of his treatment. “I’ve learned a lot about the physiology of cancer cells,” he laughs. And, he said, he’s pleased to be monitored as part of SCCA’s ongoing research on proton therapy outcomes. “I told Dr. Rengan, ‘I’m a scientist—I’m all for research, where do I sign?’”
SCCA’s specialty disease-focused clinics provide patients with access to a multidisciplinary team of specialists on the same day—often within the space of a few hours. Bringing together expert points of view in a clinic setting allows us to deliver a high level of service to our patients. They receive a comprehensive treatment plan that includes the most appropriate therapy, including innovative clinical trials, as well as counseling on diet, tobacco cessation, and pain management.

SCCA offers multidisciplinary clinics focusing on a variety of cancer types, including breast, lung, colorectal, skin, cervical, prostate, and pancreas. Three of these clinics are highlighted here.
Colorectal Cancer Specialty Clinic: Comprehensive Screening and Access to Innovative Treatments

Headed by Alessandro Fichera, MD, director of the SCCA Colorectal Surgical Oncology Program, this clinic provides patients with the opportunity to see a multidisciplinary team of specialists in a single day. Not only does this save patients time and stress, but also, as Dr. Fichera pointed out, SCCA’s research capabilities “allow us to offer innovative treatments to patients, via clinical trials.”

The clinic meets three days per week, and the list of attending specialists is impressive. The team includes surgeons, medical and radiation oncologists, nutritionists, wound and ostomy practitioners, researchers, radiologists, social workers, genetic counselors, and palliative care specialists.

“In one day, the patients are seen based on their needs by a variety of different individuals,” Dr. Fichera said. “By the time they leave, they have a plan for treatment—a plan that may or may not involve surgery. It may involve additional therapy in preparation for surgery. If they come from far away, we are able to refer patients to centers in their area for chemotherapy or radiation therapy.”

The patients who come to the clinic are newly diagnosed with colon, rectal, or anal cancer; are experiencing a recurrence; or, in some cases, have metastatic disease. Thanks to advances in research, doctors at SCCA now recognize the diverse nature of colorectal cancers and can offer each patient a personalized treatment strategy specific to his or her actual tumor.

As a result, patients’ five-year survival rate at SCCA is better than national averages: 90 percent for stage I cancers and as high as 70 to 75 percent for stage III. “The key to success,” Dr. Fichera noted, “is working with a multidisciplinary team and getting the best treatment the first time.”

Dr. Fichera and the PROSPECT Trial: Seeking Reduced Side Effects for Patients

“While our knowledge is expanding, we still know only a very small part of this whole story about cancer,” Dr. Fichera said.

For colorectal cancer patients, recent advances in preventing local recurrences have come at the cost of increased toxicity. For example, Dr. Fichera noted that the standard of care for stage II and III rectal cancer is chemotherapy and radiation therapy followed by surgery. That’s why he is excited to be leading a clinical trial that investigates whether some patients might be treated just as well without radiation therapy.

“It’s called the PROSPECT trial,” Dr. Fichera explained, “and it’s near and dear to me. Our study patients receive more detailed and precise staging and restaging during treatment. In the experimental arm, they receive chemotherapy and then they get completely restaged to see if they have responded. If they have responded, they proceed to surgery, thus avoiding radiation altogether. If they have not responded, then they would receive radiation at that time.”

Dr. Fichera warns that it’s too early to draw conclusions. “This is a national multicenter cooperative group trial, which has treated 200 patients with a target of 1,000,” he said, “so we’re not there yet. But eventually we’ll have an answer to this very important question.”
Jeremy Lamb was the first patient Dr. Fichera enrolled in the PROSPECT clinical trial. At age 34, he was too young for routine colonoscopy screening. And, at the time, he didn’t realize he had a family history of cancer. It wasn’t until he’d experienced unusual bowel habits and bloody stools for six months that his wife Maria convinced him to get a colonoscopy.

The diagnosis was stage II, or possibly stage III, rectal cancer. Jeremy sought treatment at a medical center where his grandfather had battled esophageal cancer. But he didn’t feel comfortable. “They had no empathy,” he said. “It was all clinical.”

Thanks to a recommendation from his boss, he ended up at the SCCA Colorectal Cancer Specialty Clinic where, in addition to Dr. Fichera, he met medical oncologist Gabriela Chiorean, MD, and radiation oncologist Edward Kim, MD.

“It was amazing to get all that attention,” Jeremy said. “The other medical center made me wait two weeks between each scan. When I went to SCCA, my complete evaluation as well as meetings with all three doctors took four hours!”

Jeremy chose to participate in the PROSPECT trial, figuring he could always get radiation later if he needed it. As Dr. Fichera explained, “He was randomized to the experimental arm and avoided radiation. He also avoided any temporary ileostomy (an external bag to collect waste matter), had only one surgery, and recovered very promptly—without the morbidity of radiation therapy.”

Jeremy was pleased that he was spared the attachment of an external ostomy bag while waiting for his surgery to heal. “I didn’t have to do the radiation, which was fantastic,” Jeremy said. “The benefit was sparing me the long-term issues of radiation and, in my healing from surgery, I didn’t have to have an ostomy—either temporary or permanent—which is highly unusual.”

One year after surgery, in December 2014, Jeremy was back in the clinic for his surveillance workup, which included a colonoscopy, a CT scan, and blood work. Dr. Fichera couldn’t have been more pleased with his progress. “At this point, it looks like I’m clean and clear,” Jeremy said. “There’s a relatively low risk of recurrence. And health-wise, I feel entirely back to normal, the way I used to. I’m feeling good.”
“IT WAS AMAZING TO GET ALL THAT ATTENTION.”
The Breast and Ovarian Cancer Prevention Program (BOCPP) at SCCA is a specialty clinic that allows patients to obtain the consensus opinion of a team of experts, including a medical oncologist, a genetic counselor, a nutritionist, and a gynecologic oncologist—in a single appointment.

Breast and ovarian cancers have well-understood genetic markers—BRCA1 and BRCA2—that enable the team to work up individualized risk assessments before patients ever get the disease. Thus, the role of the clinic truly is prevention, rather than early detection and treatment.

But a single genetic test can’t provide all the answers. As BOCPP Director Elizabeth Swisher, MD, explained, “It’s complicated. Our recommendations are tailored to each patient’s current exam, medical history, and incidence of cancer in the family, as well as the approach that’s most efficient for her—because the patient is part of that decision-making process.”

Dr. Swisher recalled that things were a lot simpler when the clinic got started, soon after the University of Washington’s Mary-Claire King, PhD, discovered BRCA1 in 1994. In those days, the main variables impacting the risk assessment were whether the patient had a BRCA1 or BRCA2 mutation, and how much, if anything, she knew about her family history of cancer. “Now we’re seeing a much bigger variety of genetic risk,” Dr. Swisher said. “Today we test for approximately 20 breast and ovarian cancer genes, and we have less-defined guidelines for treating patients with these rare mutations.”

It also takes experience to identify patients’ risk levels from family histories, particularly with small families or in cases in which men are the chief carriers of the mutation. Risk levels can change dramatically for the same person at different ages. The disease itself—breast or ovarian cancer—makes a difference, too.

The team assesses all of this information, and then presents its recommendation to the patient. “We try to create a plan that’s tailored to what the patient wants, because there are difficult choices involved,” Dr. Swisher said. “We want to take the worry out of it, so patients don’t end up feeling like everything they do is about cancer prevention.”

The issue here is that some cancer risks can be managed with chemoprevention drugs, such as tamoxifen, or with proactive screening followed by minimally invasive surgery if needed. The “worry-free” approach is prophylactic surgery, which means complete removal of the organs at risk. While some breast cancer risks can be managed via frequent screening, this approach generally doesn’t work for ovarian cancer because it is too lethal and too difficult to screen for effectively. At the same time, some patients assume that their risk is higher than it really is, so careful counseling is needed to ensure the appropriate strategy is pursued.

Dr. Swisher said she’s excited to be working in an environment that merges the leading-edge genomic research of UW Medicine and Fred Hutch with the hands-on clinical experience of SCCA. “We’re discovering new things in the lab and integrating them into patient care—now,” Dr. Swisher said. “Our clinic has the opportunity to be the leader in establishing the pathways for optimizing cancer prevention in patients who have various levels of risk.”
Lung cancer is the deadliest cancer. It is also one of the stealthiest. As David Madtes, MD, director of SCCA’s Lung Cancer Early Detection and Prevention Clinic, noted, “We know historically that 75 percent of lung cancers are not diagnosed until they are at an advanced stage. When patients start having symptoms, it’s often too late for the most effective treatments.”

The facts speak for themselves: Patients treated at SCCA for stage I lung cancer have a five-year survival rate of 60 percent. This declines to 4 percent for people whose disease has progressed to stage IV. “That’s why early detection is so important,” Dr. Madtes said. And that reality shapes the three-pronged approach taken by the Lung Cancer Early Detection and Prevention Clinic.

First is the low-dose computed tomography (CT) screening program for people who have a high risk of getting lung cancer. A recent study by the National Cancer Institute found a 16 percent reduction in lung cancer deaths for asymptomatic individuals at high risk for lung cancer who received a CT scan rather than a chest X-ray. As a result, SCCA encourages current or recent heavy smokers between the ages of 55 and 80 to get a CT scan.

Next comes the clinic’s core diagnostic capability. As Dr. Madtes explained, “Most patients who come to us already have a chest CT scan. These scans are very sensitive, but not very specific. When you see a nodule, it just tells you there is an abnormality.” Making the diagnosis of cancer requires expert analysis of the nodule. That’s where the clinic excels. Before actually meeting a patient, the clinic’s multidisciplinary Lung Nodule Board reviews his or her scan, as well as all available details about the patient’s risk profile.

“When we’re actually face to face with the patient, we’re prepared to recommend a plan tailored to that individual,” Dr. Madtes said. “This may be limited to active surveillance if the nodule is considered low or intermediate likelihood for cancer. Or, if it’s likely a lung cancer, we recommend advanced diagnostics, such as positron emission tomography [PET] scans, endobronchial ultrasound [EBUS], navigational bronchoscopy, or surgical biopsy and treatment via surgical resection—or, if that’s not possible, stereotactic radiation therapy.”

The clinic’s third key function is research. SCCA asks patients for a one-time blood draw and, for those who undergo lung surgery, a bit of spare cancer tissue. Researchers analyze the blood samples in an attempt to pinpoint biomarkers—similar to BRCA1 and BRCA2 in breast and ovarian cancer—that could help predict lung cancer risk. Dr. Madtes’ colleague, McGarry Houghton, MD, uses the tissue samples to investigate the immunobiology of lung cancers. To date, the clinic has collected more than 1,000 blood samples, and Dr. Houghton has performed immune profiles on nearly 50 lung cancer tissue specimens.

Dr. Madtes asked a pointed question: “Why isn’t there more advocacy for lung cancer?” His answer: “I think one reason is because we don’t have that many long-term survivors. But when we catch people early, we can get rid of the cancer with surgery, creating lung cancer survivors, and then they can become advocates, right? So that’s what we’re shooting for—more advocates.”
What does quality in cancer care look like? Does quality mean the availability of innovative treatments via an extensive arsenal of clinical trials? The presence of distinguished faculty who have won Nobel Prizes and other important recognitions? Certainly. But quality also encompasses the most basic aspects of treatment, like how we configure each clinic and schedule therapies to better support patients. Fostering a culture of great competence and compassion in our nursing staff. Attending to the broader needs—both physical and mental—of patients and their families. And paying attention to every minute detail in avoiding the spread of infections.

At SCCA, we are dedicated to enhancing quality on every front, bringing together resources from every discipline to improve the experience, health, and safety of patients in our care.
At SCCA, we know that protecting cancer patients from infections saves lives. Even a relatively benign respiratory virus can be life threatening to those whose immune systems are compromised.

“There’s no question that infections are one of the most common causes of death in cancer patients,” said SCCA Director of Infection Control Steven Pergam, MD, MPH. Dr. Pergam and his team—Sara Podczervinski, RN, MPH, CIC; Lois Helbert, RN; and Kim MacLeod—are pursuing every possible safeguard for patients through controlling and preventing infectious diseases. They’re also taking a leadership role in sharing their successes with other cancer treatment centers around the globe.

With this team’s effort—from food safety to hand hygiene to flu prevention—every detail matters. Dr. Pergam and team members educate staff, patients, and caregivers; research best practices and implement new protocols; consult with patient advocates; and stay alert to new and emerging pathogens. They’ve also enlisted SCCA nurses to brainstorm solutions to push the infection control bar ever higher.

And, every fall, they orchestrate a huge flu vaccination effort aimed at everyone who walks through the door.

“We Wanted to Change Their Minds”

During fall 2014, staff member vaccinations increased from 85 percent to more than 97 percent. And SCCA doubled the number of vaccines administered onsite to patients and quadrupled the number given to caregivers.

The team’s strategy focused on education and offering easy, streamlined access to vaccines. “Around the country, most centers are moving towards mandatory vaccinations for staff members,” Dr. Pergam said. “But instead of forcing our staff members to do this, we wanted to change their minds. We worked toward getting people to understand why vaccines are so important.” This was achieved by way of a new policy that requires staff members to take part in an education module.

For patients and their caregivers, education is just as critical, but identifying those who need vaccines and offering ready access to them made a huge difference as well. “This past year, we really engaged staff and changed our policies, including allowing vaccines to be given on every floor,” Dr. Pergam said.

His team also looked at caregiver vaccination data from the previous year. “Based on the numbers, we asked the SCCA administration for financial support to provide free vaccines to caregivers. They gave us nearly $20,000—and we used it all.”

Developing—and Sharing—Innovative Protocols

Dr. Pergam’s work in infection control is rooted in his ongoing research into infectious diseases. He gives the example of a protocol developed with Dr. Colleen Delaney’s cord blood transplant group.

Cytomegalovirus (CMV) is a viral infection that’s typically latent in normal adults. But in high-risk, immunocompromised patients it can be deadly. Cord blood transplant patients are among the most vulnerable. “Together, our teams developed a protocol, instituted it, and decreased the risk of CMV disease for these patients by a substantial amount,” he said. Then they shared their results. “We’ve seen many other cancer centers model their CMV prevention program on our protocol.”

Infection control frequently relies on classic investigative techniques. “When you see a problem, you identify it, look for a root cause—and then try to fix that. When we develop these strategies, we disseminate them,” Dr. Pergam said. “That’s the way things get better. And we want to make everyone better.”
Increasingly, palliative care is an integral part of treatment for SCCA patients, thanks to the energy and vision of Elizabeth Trice Loggers, MD, PhD. Dr. Loggers joined SCCA in 2009 to treat adult sarcoma patients, and has served as SCCA’s medical director for Palliative Care since 2011. Her work in the latter role is helping SCCA caregivers address how patients and their families can get the support they need during cancer treatment—from the very beginning of their treatment here.

Palliative care is not just for patients contending with metastatic cancer or end-of-life concerns. Its reach is much broader and deeper. Palliative care focuses on preventing, managing, and relieving cancer symptoms, as well as any side effects of treatment, regardless of the severity of a patient’s diagnosis. It also carries the larger goal of supporting each patient’s quality of life.

"There’s probably some lack of appreciation of the depth and breadth of services that are available here at SCCA," Dr. Loggers said. "One of our goals has been to make sure that patients are aware of the range of resources that we’ve offered for years.”

Dr. Loggers said she’s seeing great strides made at SCCA in this regard. She credits "the hard work and leadership of Moreen Dudley,” SCCA’s director of supportive care, radiation therapy, and specialty clinics, for many of the initiatives that are currently making a difference for patients by providing high-quality patient resources.

Wide-Ranging Initiatives that Support Patients and their Families

Dr. Loggers, Dudley, and others engaged in this effort are enlarging the conversation about palliative care among doctors and caregivers. Increasingly, doctors are inviting palliative care specialists to take part in multidisciplinary meetings and patient consults, and embedding the spectrum of palliative care planning into SCCA’s pathways. “There’s always more that we can do to improve the experience of treatment,” Dudley said.

A pilot study of early palliative care for high-risk transplant patients was conducted to see how these consults may effect patients over the long run. “Can we improve patients’ survivorship for those who survive, as well as end-of-life for those patients who die, with an early palliative care consult?” Dudley asked.

"We definitely see the volume of palliative consults increasing,” Dr. Loggers said. "More and more practitioners are talking about palliative care, thinking about it actively, and improving their own primary palliative care skills. That’s really critical: It’s not just recognizing where you may need a specialist. There are many things that caregivers can do, including bringing up advance care planning and talking about symptom management. I definitely think the culture is changing, that doctors are more aware of palliative care and that they’re referring more frequently.”

Meaningful Conversations About End-of-Life Issues

This team also partnered with Chief Quality Officer and Vice President of Quality, Safety, & Value Barbara Jagels on an initiative to share data relating to patients’ end-of-life care outcomes with the clinical teams that treated them. This is important feedback for treatment providers; it allows them to reflect on how care may be improved in the future. Next, these groups will partner to track completion of advance care planning documents and durable power of attorney; when the right kind of planning is implemented, patients and their families typically fare better. Specifically, completion of these documents may help reduce visits to the emergency room and hospitalizations and improve the quality of end-of-life care.

“There can be very important, meaningful preparatory conversations happening all along the way that will make the end
Introducing our New Chief Nurse Executive: Dr. Angelique Richard

In September, SCCA welcomed Angelique Richard, PhD, RN, as chief nurse executive (CNE) and vice president of clinical operations. In this role, she is responsible for overseeing all aspects of nursing practice at SCCA.

Dr. Richard brings 29 years of experience as a registered nurse and extensive experience in health care leadership to this new role. Prior to joining SCCA, she served as the chief nursing officer and vice president of patient care services at Presence Healthcare – Saint Francis Hospital and chief nurse officer at the University of Connecticut Health Care System.

In her role at SCCA, Dr. Richard leads patient care delivery, ensures staff accountability for providing a patient-centered clinical practice environment, and oversees general clinical quality and patient safety. Two goals she plans to pursue are the exploration of the Magnet designation, a nursing quality designation for excellence held by 7 percent of hospitals nationally and internationally, and striving for SCCA to become a national and international leader in oncology nursing care and practice.

What has the SCCA community so excited is the level of passion Dr. Richard brings for advancing nursing and patient-centered care. “This is my dream position,” Dr. Richard said. “It marries two worlds I love: oncology and executive leadership with the opportunity to collaborate with extraordinary nurses and providers, fulfilling a mission dedicated to the cure and care of cancer patients.”

A Brief Introduction to Palliative Care at SCCA

SCCA’s Supportive and Palliative Care Service is open to all SCCA patients. Anyone coping with a serious illness can benefit from a consultation.

Patients typically get the most benefit when they begin the process in the early stages of their treatment. Potential benefits include:

- Gaining relief from pain and other symptoms and addressing the emotional and existential concerns that can accompany a serious illness.
- Talking through their treatment choices to gain a deeper understanding of their options.
- Gaining a clear picture of their hopes for the future.
- Preparing for future decision making—both on a spiritual level and in more concrete ways, such as completing advance health care directives, living wills, and durable powers of attorney for health care.

For many SCCA patients, palliative care consults have been useful in helping them recognize and draw from their personal strengths. Communicating their values and wishes also helps families and care providers better understand what’s important to them, which in turn enables caregivers to provide better support.

of life better and bereavement for surviving caregivers better,” Dr. Loggers said. “And we’re seeing all of this improving for our patients and their families.” Her own motivation to become an oncologist and palliative care specialist was inspired by her father’s experience of losing his mother to breast cancer when he was 16.

“I observed in him all of that lack of good bereavement. He carried it like a bad scar. That really affected me as a young person—to see how much he distrusted physicians. For me, he was the living memory of that suboptimal care. That’s a large part of the reason why I chose this work. So that we could say: ‘We can do this better in the next generation. Whatever the outcome, you don’t have to be scarred by the experience. It can be transformational.'”

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The clinical pathways program is a multiyear effort at SCCA to formally define treatment recommendations for a large majority of our patients. Since 2011, John Harlan, MD, and program manager Venus Chan have been working systematically with disease-group teams across SCCA.

For each type and stage of cancer, a multidisciplinary team of experts studies the national guidelines, updated with evidence from the latest research. The team then refines and focuses the guidelines: in effect, tailoring them for SCCA. The result is a roadmap for treating each disease.

Clinical Pathways:

1. Are driven by quality and outcomes—not cost. As Dr. Harlan explained, “The overall goal of the program is to continuously assure the best outcomes and the highest quality by using the most effective and least toxic therapies for a particular cancer diagnosis. Only if more than one regimen showed comparable efficacy and toxicity, with no reduction in quality or outcomes, would cost to the patient or payer be considered.”

2. Prioritize innovation. Patients come to SCCA because they recognize the value of the research contributions of Fred Hutch and UW Medicine. Clinical trials are the way we advance the standard of care. With this in mind, we design all pathways with a clinical trial as the initial option. Clinical trials are always on the pathway as the first priority.

3. Incorporate personalized medicine. “Ten years ago, a clinical pathway diagram would have been much smaller and less busy-looking,” Dr. Harlan said, with reference to the dazzling breakthroughs in immunotherapy. “The fact that there are apparent complexities is a reflection of the progress that’s been made in individualizing and tailoring therapy to the patient’s cancer.” Specifically, all viable precision medicine options are incorporated into SCCA’s pathways when appropriate for specific tumors.

4. Enable patients’ providers to stay in synch. Chan pointed out that quality cancer care involves collaboration between specialists from medical oncology, surgery, and radiation oncology, as well as input from pharmacy, nursing, radiology, and pathology. “Within our system,” she said, “we need to communicate between our campuses and also with our Network Members in their local communities. Pathways enable streamlined discussions of a patient’s treatment, because the doctors are looking at the same roadmap.”

5. Promote a holistic approach to care and treatment. SCCA is expanding the role of symptom management and supportive care throughout a patient’s treatment. “Palliative care includes chaplaincy, nutrition, physical therapy, and social work. Evidence shows that these elements improve quality of life, patient satisfaction, and even survival outcomes in some cases,” Chan said.

Finally, Dr. Harlan and Chan both emphasized that pathways do not interfere with the fundamental doctor-patient relationship. “Pathways are not prescriptive, there’s always the clinician’s judgment,” Dr. Harlan said. “And the content is not static, it is reviewed regularly.” Chan concurred: “We expect that a reasonable percentage of cases will not be covered by the guidelines. Our doctors always have the autonomy to choose what they believe will be best for the patient. Pathways do not restrict a doctor’s—or a patient’s—choice.”
SCCA is Ranked Among the Top Cancer Treatment Centers in the U.S. by Two Important Measures of Patient Survival

When the milestone of survival is measured, more of our patients are living longer than those treated at other cancer centers—across many types of cancers.

Since 2002, SCCA has been near the top of the National Cancer Data Base (NCDB) Survival Reports for aiding patients in surviving a wide range of cancers.

And, in the most recent multiyear study by the Center for International Blood and Marrow Transplant Research (CIBMTR), the Fred Hutch Bone Marrow Transplant Program at SCCA was recognized for outperforming its expected one-year survival rate for patients undergoing allogeneic transplants.

National Cancer Data Base Survival Reports

The NCDB reports compare SCCA patient survival rates to survival rates for patients treated at other academic medical centers, large community hospitals, and small community hospitals. The data shows that, in general, SCCA patients have better outcomes than patients treated elsewhere.

The NCDB tracks the outcomes of 70 percent of all newly diagnosed cancer in the United States from more than 1,500 commission-accredited cancer programs. It has been collecting data from hospital cancer registries since 1989 and now contains almost 30 million records.

“The CIBMTR’s findings reflect the extraordinary and long-standing dedication by the staff of the Hutch and SCCA to improve the outcomes of our patients by continually refining transplantation to be a safer and more effective treatment.”

— Dr. Fred Appelbaum

The most recent NCDB data includes patients who were diagnosed between 2003 and 2006 and then followed for five years. Patient survival rates are categorized by stage of diagnosis. 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.

Center for International Blood and Marrow Transplant Research Findings

Doctors from the Fred Hutch Bone Marrow Transplant Program at SCCA have performed more than 14,000 bone marrow transplants—more than any other institution in the world. We were also one of 13 U.S. centers whose patients achieved higher-than-expected survival rates in a recent CIBMTR study.

To compare transplant centers, the CIBMTR independently examined the survival rates of 20,875 transplants for its 2014 Transplant Center-Specific Survival Report. These transplants were performed to treat blood cancer and took place at U.S. centers in the National Marrow Donor Program’s (NMDP) network over a three-year period.
To bring lifesaving cancer therapies to as many patients as possible, SCCA relies on the combined energies, abilities, and resources of a broad community of people.

Our community includes SCCA’s current and former patients and their families. Our researchers, doctors, nurses, and other caregivers. Hundreds of volunteers, who share more than 1,300 hours of their time each month. SCCA’s many impassioned donors and fundraisers. And our SCCA Network partners across Washington state and in Montana, Oregon, and Alaska.

We are grateful to all who came together and took part in these efforts.
“The hallmark of compassionate care is doing what is best for the people you treat,” Matthew Lonergan, MD, said.

Dr. Lonergan is a medical oncologist who serves as medical director of SCCA at EvergreenHealth in Kirkland, Wash. “The goal of our practice here in Kirkland,” he said, “is to be mindful of the needs of people who are struggling with the daily logistics of cancer treatment—and not force them to cross a bridge and go downtown. We’re enabling them to be treated closer to home.”

Dr. Lonergan completed his fellowship in hematology and oncology at the University of Washington in 2000; two years later, he joined a private practice in Kirkland. But what he missed in private practice was the ability to consult with world-class experts on every aspect of cancer treatment. “At SCCA, you have multiple doctors and researchers who know more than you about individual parts of a patient’s treatment—and you can benefit from their perspectives on how that person should be treated,” Dr. Lonergan said. A conversation he shared with SCCA Medical Director Marc Stewart, MD, led to his practice joining SCCA as an affiliate in 2012.

SCCA was the only choice for Dr. Lonergan and his oncologist partners, he said. “Other institutions in the area are treating cancer, but they have multiple interests. SCCA is the only institution in this area that’s dedicated to cancer. We wanted an organization that was absolutely committed to our same purpose. SCCA is never going to take cancer out of their name. We worked to structure a model for SCCA in Kirkland, making use of the advantages that SCCA offers, along with those of EvergreenHealth.”

Halvorson Cancer Center is a partnership between SCCA and EvergreenHealth. He and his partners “are truly part of the community,” Dr. Lonergan said. “We treat the teachers who take care of our kids, we treat the people who deliver our mail—we see them at fundraisers and in the grocery store. We’re often fairly involved in our patients’ lives because these patients live in our own community.”

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Caring for Patients in Their Community: SCCA at EvergreenHealth in Kirkland

New SCCA Clinic on the Campus of UW Medicine’s Northwest Hospital & Medical Center

SCCA expanded treatment accessibility for cancer patients in the north Puget Sound region with the opening of SCCA Medical Oncology at UW Medicine’s Northwest Hospital & Medical Center in September 2013. This clinic is pursuing a model similar to that established by the Halvorson Cancer Center in Kirkland: bringing the highest level of cancer care to patients in their communities.

“At SCCA, we pride ourselves on providing world-class cancer care for our patients,” said Norm Hubbard, SCCA executive vice president. “We made a concerted effort to expand this care in a new and innovative way to the north end community.”

The clinic joined SCCA Radiation Oncology, which has provided services at Northwest Hospital for the past several years.
When a family member is fighting cancer, financial hardship typically adds to the burden. "The Family Assistance Fund was created to help take away significant financial obstacles for families—so that patients can get treatment," said Debbie Fraley, SCCA’s Housing & Family Assistance coordinator.

Often, a cancer diagnosis results in the loss of income for patients and caregivers, but needs vary from family to family. For most recipients, Fraley explained, a grant from the fund can help defray housing and transportation expenses so the family can afford to travel to and live in Seattle for an extended treatment stay. Some families have expressed that, without the fund’s support, they would not have been able to come to receive treatment at SCCA.

"We’re focused on supporting families struggling with expenses that they just can’t sustain," she said. The fund has paid for families’ Cobra insurance payments and often helps with a weekly check for groceries. The fund also has a petty-cash system, designed to pay for more immediate needs like a meal, parking, or a utility bill. On average, the fund receives 15 to 20 applications each month and provides support to more than 500 individual patients and families each year.

In recent years, these requests have continued to rise. "The Family Assistance Fund is more critical than ever," Fraley said.

For requests beyond a few dollars, the fund’s application process is based on formal eligibility criteria. "What we are looking for is a demonstrated, substantial financial need," she explained. "Many families may be living here for months during treatment. The fund can’t replace 100 percent of the need for anyone, but we really do our best to make a difference and help everyone we can.

"It’s been very gratifying to see the growth and impact of the fund over the years," she concluded. Contributions come from many sources; all make a difference. "One early gift came along with a letter from an eight-year-old boy, whose uncle was treated here. He sold berries by the side of the road to raise $64 for the fund. This gift was a product of his hard work—and his heart."
SCCA House, located just a few minutes from the SCCA clinic at South Lake Union, was created to offer affordable, safe, and convenient housing for patients and their families who travel to Seattle from all over the globe for treatment. It’s a comfortable retreat, as well as a place to connect with other patients and caregivers.

“SCCA House is an extraordinary resource,” SCCA Executive Vice President Norm Hubbard said. “Our goal is to help reduce the stress on patients and their families already coping with a serious illness.”

Completed in late 2009, SCCA House provides 80 guest suites of three different sizes that accommodate patients’ varying needs. The rooms include ample storage for longer stays, well-equipped kitchenettes, and large windows to let in natural light. There’s a terrace patio and rooftop garden. A dedicated shuttle bus transports patients to and from SCCA and a local grocery store.

SCCA House’s shared spaces foster community gatherings. There’s a large living room area, along with an ample communal kitchen and dining room. SCCA House also has media and wellness rooms, a classroom, a meditation room, and a resource center. Every aspect of the building was designed to protect patients’ health. Indoor air is filtered through a system rated higher than what’s used in typical hospital laboratories.

SCCA is committed to keeping this housing affordable to families. Many with demonstrated financial needs receive housing assistance grants for their stay there through the Family Assistance Fund.

Individuals, businesses, and local fundraisers help defray the costs of maintaining this community both through their dollars and through their time. Volunteers host movie nights, fill the pantry, and cook meals for guests on a regular basis, often taking patients’ minds off of their treatment, if only for a moment. Monetary contributions help keep SCCA House stocked with all the comforts of home and accessible to those who might not otherwise be able to come to Seattle for extended treatment.

Hit Fore the House Raises Funds for SCCA House: “It’s a Gift to Ourselves”

For the past three years, the women supporting Hit Fore the House, an annual golf tournament in Kent, Wash., sponsored by the Women’s Division of the Meridian Valley Country Club, have been creatively dreaming up new ways to raise funds for SCCA House with their annual golf tournament and auction. Last year, they began selling tee shots—by some of the club’s biggest hitters—to tournament participants. “That was a real hit,” 2014 Chair Nancy McElheran said. “We’re doing all we can to pull in donations.” And it’s working! In just three years, this growing event has raised over $25,000 for the SCCA House. Several of the women engaged with Hit Fore the House are cancer survivors. “We chose SCCA House because we wanted to make sure all the funds we raise go directly to this housing, to be used by the people who really need it,” McElheran explained. “SCCA House is part of our community, and it fills an important role,” she said. “This event is fun for us to do. We think of it as a gift to ourselves.”
“I CAN’T SAY ENOUGH GOOD THINGS—IT MADE SUCH A HUGE DIFFERENCE.”
The Massey Family Finds a Refuge in SCCA House

The Massey family has faced more hardships than many, “You count your blessings,” Pamella Massey said. Pam was diagnosed with stage I breast cancer in late September. Sixteen years ago, her son Jacob was born with spina bifida; since that time, he has faced significant medical challenges.

This past Christmas, Pam, her husband Rob, and their sons Nathan, Jacob, and Zachary stayed at SCCA House for two and a half weeks while Pam underwent radiation therapy at SCCA. “We brought all of our traditions with us,” Pam said. “SCCA House is amazing. I can’t say enough good things—it made such a huge difference. Staying in a hotel would have been incredibly difficult on so many levels,” she said. “After I learned that I would not need chemotherapy I wasn’t concerned about my immunological status, but we always take precautions for Jacob. And we also needed handicap accessibility for a 450-pound wheelchair.”

“I Want to Go to Seattle”

Last summer, Jacob was hospitalized at Seattle Children’s several times, including a six-week stay following emergency surgery on his brain stem. “I had postponed my mammogram because he was in the hospital,” Pam explained. But when her family was finally able to return home to Lewiston, Idaho, she made the appointment.

“Thank goodness they did a 3D mammogram,” she said. “You could not see my tumor on the 2D. But the 3D picked it up. It didn’t have any vessels or nerves. It was very tiny and very early. But right at that point I said, ‘I want to go to Seattle.’ Because of Jacob. His health was still tenuous. His needs are unique—and we live in a very small area. What we’ve learned over the years is that larger tertiary care hospitals have more advanced medicine.”

Pam chose SCCA for her treatment. Thanks to responsive scheduling from Jacob’s many care teams, she was able to schedule a week of his appointments with specialists at Seattle Children’s in late October between her first consultation with her surgeon, Sara H. Javid, MD, and her lumpectomy. “This is how phenomenal SCCA and Children’s are,” Pam said.

Pam’s lumpectomy turned up no cancer in her lymph nodes. Her subsequent six-week course of radiation therapy aimed to destroy any remaining cancer cells. Because of the tumor’s location in her left breast near her heart, this therapy, under the care of Christine Fang, MD, utilized a technique called Calypso breath-hold. The technique makes use of complex technology that enabled Dr. Fang to avoid exposing Pam’s heart to the radiation beam path while Pam held her breath.

Resting in her room after a morning treatment in early January, Pam said she values the flexibility of SCCA House’s living areas. “There are lovely spaces to meet up with people,” she said. “But because I came to this very tired and Jacob has been so sick, I was looking for peace and quiet. I found that here, too.”
Your gift to SCCA helps us transform patients’ lives. Our vision is to advance the standard of care for cancer patients everywhere.

**SCCA Donors Provide Critical Funding for:**
- Advancing SCCA’s breakthrough clinical studies
- Helping SCCA provide supportive care services to our patients and families
- Providing a home away from home at the SCCA House
- Sustaining SCCA initiatives that promote cancer prevention and survivorship
- Supporting SCCA’s areas of greatest need

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

You can also join the SCCA community by becoming a volunteer or hosting a fundraising event.

We’re committed to reaching as many patients as we can; your generosity helps make this possible.

To learn more about giving and volunteer opportunities, including making memorial and tribute gifts and participating in SCCA community events, please visit our website at [www.seattlecca.org/donate](http://www.seattlecca.org/donate) or contact us at (877) 308-3117.

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### 2015 Cancer Care Champions

SCCA’s Cancer Care Champions recognition program acknowledges generous donors who give $1,000 or more annually to our programs. We would like to recognize our Cancer Care Champions for 2015 who gave $1,000 or more in 2014. On behalf of our patients, our staff, and our partners, thank you for your support. For more details please contact champions@seattlecca.org or (206) 288-2070.

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Kathy and Steve Berman*
Ms. Roxanne Bevins
Betty Bottler*
Bill and Toni Boyd*
Lisa and Dirk Brandenburg*
Dianne Breen
In Memory of Diane K Bridges
Steve and Steph Briscombe
David C. Brown*
Dr. S. Lori Brown and Mr. Chris Green*
Dr. David Byrd*
John Caraher
Ms. Sara Carter
Ross and Julia Case
2015 Cancer Care Champions (continued)

Dr. and Mrs. Mike Casey*
Mike and Karen Chadduck*
Manisha and Devindra Chainani*
Ms. May Lee Chung
William and Paula Clapp
Columbia Athletic Club*
Compendium*
Mr. and Mrs. Philip R. Compton
Dr. and Mrs. Steven Connelly*
Mr. and Mrs. Bryan Conner*
The Columbia Foundation*
Dr. Shannon Corbin and Mr. Jonathan Tingstad*
Howard and Sarah Date*
The Delman Family*
Ms. Michelle Desmond
Mr. Charles Divelbiss
Kathleen K. Dorcy
Employees Community Fund of The Boeing Company*
Mr. and Mrs. Robert C. and Vera Ellen Fahl*
Janice L. Ferguson*
Bob and Micki Flowers
Mr. Jay M. Ford
Mr. Cay Fortune
Mr. Steve Francks
Mr. Phillip F. Frink
Mr. and Mrs. John T. Garland
Kent Gavin*
Deborah and Mark Gentzen*
Janice A. and Robert L. Gerth*
Mr. and Mrs. Ralph and Bea Gilfilen*
Mrs. Linda Glein
Glein Family Foundation
Kari Glover and Thad Alston
Mr. Daniel Gover
Greenbaum Home Furnishings*
Mark Groudine and Cynthia Putnam*
Mr. Salvador O. Gutierrez
Mark and Dana Hagenbaugh*
Mr. and Mrs. Jon K. Hahn
Matt and Julia Hanrahan
Mrs. Shanon Hardie
Mit and Maureen Harlan*
Brian and Kristin Hartnett*
Mr. and Mrs. Thomas F. Herche
Mr. and Mrs. Russell P. Herwig
Norman E. Hubbard*
Tom and Julie Hull*
Independent Brewers United Corporation
The Jagels Family*
In Memory of Don Jasper
John Kasonic Family*
The Kemper Freeman Foundation*
Mr. and Mrs. Alfred L. Kerns
Edward B. “Ted” Kibble*
Mr. Thomas D. Kite
Kitsap County Deputy Sheriff’s Guild
Kitsap Destruction Derby Association*
Mr. Art Klepen
Katherine Kreager
Walter and Wilma Laity*
Mr. and Mrs. Kenneth D. Lawson*
Tom and Janet Leeds*
LeRoss Family Foundation*
Ms. Susan Lichtenberg
Mr. and Mrs. Harry A. Linker*
Eric Lippke*
Torii Locke
Kristine A. Logan*
The Lookout Foundation Inc.*
Low Pressure Promotions LLC*
Mr. and Mrs. Jeffrey A. Lubetkin*
James and Lisa Magnusson

OncoScan, a new whole-genome testing platform, is used to help doctors guide therapy decisions and understand the risk of recurrence.
David and Ruth Mahan*
Mrs. Gail Masonbrink
Kristen Mattoni*
Jeremy and Linda Mattox*
Caron and Richard McCune*
Kimberly McNally and Mark Sollek, MD*
Mr. and Mrs. Michael Meiser
Mr. Rick Meyer
Danny and Suzanne Meyer
Terry Meyer Open Golf Tournament
Robert Middelburg*
Bliss N. Miller
Jean Marie Miller
Wendy and Paul Mitsuyama*
Robert and Gwen Moore
Michael Mulhern
Shan and Lee Mullin*
Ms. Shera I. Myers
National Comprehensive Cancer Network
The Newsome Family*
Emily Ngo
The Family of Betty G. Olson
Tom and Miggie Olsson*
Mr. Richard John Omata
Mr. and Mrs. Brian O’Neill
Mr. and Mrs. Ostermann
Paragon Products, LLC
The Barbara Parker Family
Chuck and Lynn Patten*
Pemco Foundation Inc
Performance Wheel*
Drs. Carl and Jeannette Pergam*
Dr. Steven Pergam*
Doug and Cassie Picha*
Mr. and Mrs. James C. Pigott
Mr. Larry Pihl
Ollie and Nancy Press
Portland General Electric Co.
Jay and Julia Portnoy*
Elisabeth N. Power
Puget Sound Speed-Crabbing
Dr. Mark Rachesky
Brooks and Suzanne Ragen*
Angelique Richard RN, PhD and Family
Mr. Stephen Richards
Team R4C – Riding for Cures*
Bruno and Jackie Rudolf*
Run Sasha Run
Mr. Rodney Ryan
Robert and Helen Saito
School Employees Credit Union of Washington
Seattle Police Employees Charity Fund
Mr. and Mrs. Howard Seelig*
Wayne and Davy Sellman
Mr. and Mrs. Shahryar Shahrivar*
Moreen Shannon-Dudley
Martin and Kari Shelley*
Paramjit Singh and Harmeet Kaur
Eugene Skiffington*
David G. Smith*
The Lester and Bernice Smith Foundation
Karen Marcotte Solimano and James P. Solimano*
Alexander C. and Tillie S. Speyer Foundation*
Mrs. Johnese Spisso and Dr. Ross Hartling*
Kenneth Sroufe Memorial Golf Tournament*
Mr. and Mrs. Brien Stafford
Dr. and Mrs. F. Bruder Stapleton*
In memory of John and Louise Steegstra*
Jim Stratton
Mr. John W. Stroh, Jr.
Ms. Elizabeth Stolpe
Tim and Kara Sullivan*
Jan Supler and Laura Burns
Myra Tanita*
True Fabrications Inc
Twin County Credit Union
Frank and Betty Vandermeer*
VitalSource Staffing, LLC*
Mrs. Keith A. Vormsberg*
Ms. Carey Wakeley
Washington State Combined Fund Drive*
Mr. Boyce C. Watson
Mr. William E. Whitaker
Mr. James Williams
Mr. Matt Williams
Stephen and Marcia Williams
Keith and Debbie Winkle*
Lee G. Woods
Mr. and Mrs. Richard Yarmuth*
Richard B. Zalewski
Jeff and Jane Zimmerman
SCCA devotes more than 9 percent of its operational costs to benefit our community (per the calculations of the IRS Schedule H). For the fiscal year 2014, this amounted to more than $40.9 million. During this period, SCCA funding for uncompensated care alone totaled more than $26.4 million.

We continue to place a high priority on research, along with the continuing education of our health professionals.

In contributing to our community, much of what we do at SCCA can’t be quantified, including the thousands of hours our professionals devote to volunteer efforts. From the Family Assistance Fund to subsidizing health and nutrition programs, we’re dedicated to our patients’ health and survivorship, and committed to helping to ease the financial strains that cancer treatment places on families.

### Community Benefit Allocations

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncompensated Care</td>
<td>64%</td>
</tr>
<tr>
<td>Community Health Improvement Services &amp; Community Benefit Operations</td>
<td>9%</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>10%</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>1%</td>
</tr>
<tr>
<td>Research</td>
<td>14%</td>
</tr>
<tr>
<td>Cash &amp; In-Kind Contributions for Community Benefit</td>
<td>2%</td>
</tr>
</tbody>
</table>

### Uncompensated Patient Care to SCCA Patients

$26.4 million

### Community Health Improvement Services and Community Benefit Operations

$3.87 million

### Health Professions Education

$3.94 million

### Subsidized Health Services

$.28 million

### Family Assistance Fund

$322,508

### Research

$5.68 million

### Cash and In-Kind Contributions

$.76 million

### Number of Patients Seen by MammoVan

4,976

### Hours Contributed by SCCA Volunteers

16,279
## Financial Overview

### Statement of Operations

<table>
<thead>
<tr>
<th>Fiscal Year (in Thousands)</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Revenue</strong></td>
<td>$393,731</td>
<td>$435,228</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td>363,819</td>
<td>408,155</td>
</tr>
<tr>
<td><strong>Income from Operations</strong></td>
<td>29,912</td>
<td>27,073</td>
</tr>
<tr>
<td><strong>Non-operating Income</strong></td>
<td>(23,334)</td>
<td>7,689</td>
</tr>
<tr>
<td><strong>Net Income</strong></td>
<td>$ 6,578</td>
<td>$ 34,762</td>
</tr>
</tbody>
</table>

### Balance Sheet

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td>$295,071</td>
<td>$345,655</td>
</tr>
<tr>
<td><strong>Assets Whose Use is Limited</strong></td>
<td>9,643</td>
<td>9,767</td>
</tr>
<tr>
<td><strong>Property, Plant, &amp; Equipment, Net</strong></td>
<td>109,337</td>
<td>109,085</td>
</tr>
<tr>
<td><strong>Other Assets</strong></td>
<td>26,934</td>
<td>24,392</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$440,985</td>
<td>$488,899</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td>$ 56,431</td>
<td>$ 71,055</td>
</tr>
<tr>
<td><strong>Long-term Liabilities</strong></td>
<td>101,492</td>
<td>99,653</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>283,062</td>
<td>318,191</td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Net Assets</strong></td>
<td>$440,985</td>
<td>$488,899</td>
</tr>
</tbody>
</table>

### Key Statistics

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Treatment Episode</strong></td>
<td>6,667</td>
<td>6,584</td>
</tr>
<tr>
<td><strong>Patient Visits</strong></td>
<td>82,598</td>
<td>77,177</td>
</tr>
<tr>
<td><strong>Operating Margin</strong></td>
<td>7.6%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

### Operating Expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>24%</td>
</tr>
<tr>
<td>Purchased Services</td>
<td>34%</td>
</tr>
<tr>
<td>Supplies</td>
<td>27%</td>
</tr>
<tr>
<td>Depreciation, Amortization, &amp; Interest Expense</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Revenues

<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Patient Service Revenue</td>
<td>91%</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>7%</td>
</tr>
<tr>
<td>Non-operating Income</td>
<td>2%</td>
</tr>
</tbody>
</table>
“Seattle Cancer Care Alliance is a unique organization that leverages the cancer-fighting capabilities of Fred Hutch, UW Medicine, and Seattle Children’s. We are a cancer-focused clinic and patients come here from all over the world to access the innovative treatments developed by researchers at the Hutch and the University of Washington. That’s because our five-year survival rates are higher, for most cancers, than any place else across the United States.”

— Carl Behnke, Board Chair

SCCA Executive Management Team

Fred Appelbaum, MD
Executive Director and President: responsible for general administration and management of SCCA operations; Deputy Director and Executive Vice President, Fred Hutch

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

David Ackerson
Chief Information Officer and Vice President: responsible for Information Technology, Clinical Information Systems, Information Security, Health Information Management, Enterprise Project Management, and Decision Support

Debby Gentzen
Chief Strategy Officer and Vice President: responsible for Strategy, Business Development, Marketing, Public Relations/Media, the SCCA Network, Program Management, Proton Therapy, and Research Integration

Barbara Jagels, RN, MHA
Chief Quality Officer and Vice President of Quality, Safety, & Value: responsible for Quality Measurement, Patient Relations, Patient Experience, Infection Prevention, Patient Safety, Regulatory Affairs, Risk Management, and Cell Therapy Processing Quality Assurance

Angelique Richard, PhD, RN
Chief Nurse Executive and Vice President of Clinical Operations: responsible for nursing, infusion, imaging, pharmacy, supportive care, radiation therapy, specialty clinics, clinical laboratories, and SCCA satellite clinics

F. Marc Stewart, MD
Medical Director and Vice President: oversees clinical care and conducts quality monitoring of medical practice on behalf of SCCA; responsible for SCCA outpatient clinics

Jonathan Tingstad
Chief Financial Officer and Vice President: responsible for Finance, Revenue Cycle and Payor Relations, Patient Accounting, Clinical Research Billing, Facilities, and Patient Access

Governance

Member Representatives

Gary Gilliland, MD, PhD
President and Director, Fred Hutch

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’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. 2014 SCCA Board members include:

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

Richard McCune  
*Vice Chair; Chair, Board Governance Committee; Fred Hutch Board of Trustees; Partner, KPMG LLP (retired)*

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

Mike Delman  
*Treasurer; Chair, Board Finance, Investment & Audit Committee; Seattle Children’s Board of Trustees; Corporate Vice President, Microsoft (retired)*

Robert Bakemeier  
*Immediate Past Chair; Seattle Children’s Board of Trustees; President, Bakemeier Law Firm*

Lisa Brandenburg  
*President, Seattle Children’s Hospital*

Robert Flowers  
*Seattle Children’s Board of Trustees; Senior Vice President, Washington Mutual (retired)*

Karen Glover  
*Global Integration Partner, K&L Gates (retired)*

Mark Groudine, MD, PhD  
*Executive Vice President and Deputy Director, Fred Hutch; Professor, Radiation Oncology, UW School of Medicine*

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

Linda Mattix  
*Chair, Board Development Committee*

Shan Mullin  
*Chair, Board Facility Committee; Partner, Perkins Coie LLP*

Brooks Ragen  
*Chair, Board Integrity Committee; Vice Chairman, Private Wealth Management, Robert W. Baird & Company*

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

Bruder Stapleton, MD  
*Chief Academic Officer & Senior Vice President, 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, Fred Hutch*

JoAnn Taricani, PhD  
*Associate Professor and Chair, Division of Music History, UW School of Music*

Richard Yarmuth  
*Partner, Yarmuth Wilsdon PLLC*

**Community Committee Members**

The following volunteers from the community also serve on SCCA Board committees:

Sue Albrecht  
*Board Development Committee*

Jim Hughes  
*Board Integrity Committee; Owner, Flatiron Properties, Property Management & Investments*

Jonelle Johnson  
*Board Development Committee; Consultant, Nordstrom*

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

Cilla Joondeph  
*Board Patient Quality, Safety & Service Committee*

Robert MacAulay  
*Board Facility Committee; Principal, Meriwether Partners LLC (retired)*
SCCA unites doctors from Fred Hutch, UW Medicine, and Seattle Children’s. Our goal, every day, is to turn cancer patients into cancer survivors. Our purpose is to lead the world in the prevention and treatment of cancer.