

“It’s cancer.”



2015 ANNUAL REPORT

MEMORIAL SLOAN KETTERING CANCER CENTER

IMPROVING PATIENT OUTCOMES



Memorial Sloan Kettering
Cancer Center

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Memorial Sloan Kettering
Cancer Center

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**IN 2015, MORE THAN 1.6 MILLION PEOPLE IN
THE UNITED STATES FACED A CANCER DIAGNOSIS.**

**AT MSK, WE'RE LEADING THE WAY IN SETTING
STANDARDS FOR THE DELIVERY AND QUALITY OF
CANCER CARE NATIONWIDE.**

Melanoma cells (orange) and their nuclei (blue)
alongside normal skin cells (green)

CONTENTS

Message from the Chairman and the President

04

OUTSMARTING CANCER

08

THE RIGHT TREATMENT AT THE RIGHT TIME

20

PATIENT COMFORT AND SATISFACTION

32

INCREASING AND IMPROVING ACCESS TO CARE

44

JOSIE ROBERTSON SURGERY CENTER

58

Statistical Profile

64

Financial Summary

66

Boards of Overseers and Managers

68

Leadership

69

The Campaign for
Memorial Sloan Kettering

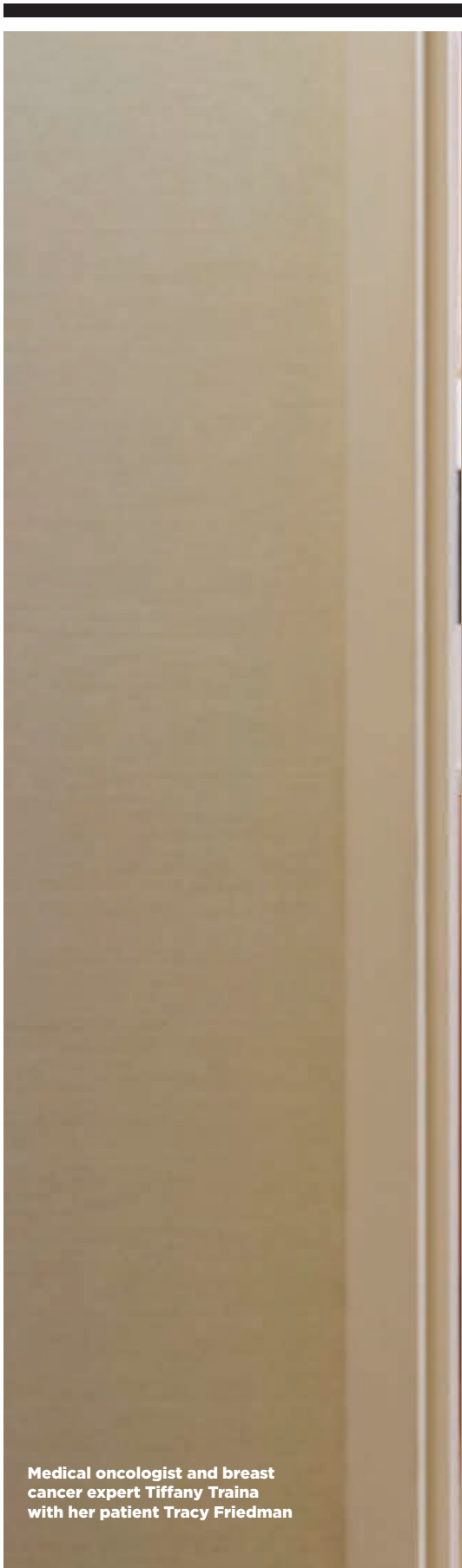
71

Donors to the Campaign for
Memorial Sloan Kettering

72

The Society of Memorial Sloan Kettering
Cancer Center

87



Medical oncologist and breast cancer expert Tiffany Traina with her patient Tracy Friedman



Message from the Chairman and the President



CRAIG THOMPSON
PRESIDENT AND
CHIEF EXECUTIVE OFFICER

DOUGLAS WARNER III
CHAIR, BOARDS OF OVERSEERS
AND MANAGERS

To enhance care delivery and extend our expertise to more patients, in 2015 Memorial Sloan Kettering embarked on a bold expansion of our facilities and implemented powerful new technologies that more efficiently and precisely attack cancer.

MSK is the nation's first cancer hospital. That legacy continues to drive our focus on generating meaningful discoveries that change our understanding of cancer as a disease and applying those insights to improve the effectiveness of cancer treatment. MSK's 2015 Annual Report takes improving outcomes as a broad theme because it touches every aspect of our work, from the bedside to the laboratory.

While the oncology community continues to make gains in cancer research and treatment, there are noteworthy gaps in achieving exceptional care for patients. The quality and cost of cancer treatment are inconsistent across the nation and survival rates vary widely. Indeed, an important recent study by researchers in Memorial Sloan Kettering's Center for Health Policy and Outcomes and other MSK colleagues showed that Medicare patients treated at freestanding cancer centers have significantly better outcomes than those treated at community-based hospitals. The need to develop more effective strategies to prevent, detect, and treat cancer remains urgent. But these findings remind us that we have an equally pressing imperative: to bring together patients, clinicians, insurers, and policy experts to develop new approaches to providing cancer treatment. We have an opportunity to dig more deeply into differences in care and to identify how to improve outcomes for people in the United States and around the world. To that end, MSK has joined with other dedicated cancer centers to lead a national conversation about quality care and outcomes.

MSK remains at the leading edge of immunoncology. From pioneering research into immune regulation, our physicians and scientists introduced the concept of immune checkpoint blockade therapy. Today, drugs that target immune checkpoints are unleashing the power of the immune system to detect and eradicate cancer. These same concepts have also led to the reengineering of patient T cells to specifically recognize tumors. And early in 2016, MSK became

a founding member of the Sean Parker Institute for Cancer Immunotherapy, which will accelerate the pace at which these new applications are developed.

MSK-IMPACT® — a test created by our genome scientists, bioinformaticians, and molecular pathologists — detects gene mutations and other aberrations in both rare and common cancers. Since 2014, the test has sequenced more than 10,000 patients' tumors. Data generated by this effort are enabling MSK scientists to better understand how specific mutations affect both cancer treatment and disease progression, thus changing how cancer is treated. A landmark study published in 2015 in the *New England Journal of Medicine* by MSK authors David Hyman and José Baselga illustrated how MSK-IMPACT data could be used to group patients whose tumors shared the same mutation — regardless of where their cancer originated. It represented the first “basket trial,” in which treatment was based on the mutation in a patient's tumor rather than on the site where that tumor developed. (To learn more, read “Outsmarting Cancer” beginning on page 8.)

Researchers are also combining this wealth of MSK-IMPACT genomic data with information about family history and inherited genetic mutations as part of the Robert and Kate Niehaus Center for Inherited Cancer Genomics. The goal of the Niehaus Center, led by Kenneth Offit, Chief of the Clinical Genetics Service, is to identify opportunities to diagnose hereditary cancers at their earliest, most curable stages — the equivalent of a cancer genomics prevention program.

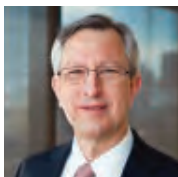
In late 2015, we began seeing patients at our magnificent new Josie Robertson Surgery Center, which has been specially designed to allow patients to return home either the day of or the day after a surgical procedure. You can read more about the facility, as well as the contributions our cadre of nurses made to its development, beginning on page 58.



KATHRYN MARTIN
Chief Operating Officer



JOSÉ BASELGA
Physician-in-Chief and Chief Medical Officer, Memorial Hospital



JOAN MASSAGUÉ
Director, Sloan Kettering Institute



JAMES D. ROBINSON III
Honorary Chair, Boards of Overseers and Managers

The MSK Cancer Alliance, formed in 2013 to forge partnerships between MSK and community oncology providers, is creating a new model for the delivery of — and patient access to — the highest-quality care. It's not even been three years and the Alliance now includes Hartford HealthCare, a multihospital system in Connecticut, and the Lehigh Valley Health Network in Pennsylvania. The Miami Cancer Institute, part of South Florida's Baptist Health System, is on track to become the third member.

On other fronts, MSK researchers have been hard at work learning more about how cancer develops and grows and revealing its vulnerabilities.

CRISPR/Cas9, a gene-editing technique that can target and modify DNA with extraordinary accuracy, was hailed by *Science* magazine as the most important breakthrough of 2015. Several MSK scientists are using this tool to understand cancer biology. Andrea Ventura of the Cancer Biology and Genetics Program at the Sloan Kettering Institute (SKI) published a paper in *Nature* in early 2015 in which he used CRISPR to engineer chromosomal rearrangements to create a specific lung cancer model that can be used preclinically to evaluate chemotherapeutics.

Cryo-electron microscopy — which uses electron beams to study molecules in atomic detail at cryogenic temperatures — is sending tremors through the world of structural biology. Nikola Pavletich, Christopher Lima, and Stephen Long of SKI's Structural Biology Program applied the revolutionary technology to provide new insights into molecules as diverse as the mTORC1 complex and cell membrane-spanning calcium channels. MSK will soon be installing a Titan Krios cryo-electron microscope that will advance research into the essential operating machinery of the cell and how molecules implicated in disease might be targeted with drugs.

Chemical biology is bringing new analytic techniques, molecular probes, and potential therapeutic leads to biomedical research and to cancer research in particular. To take full advantage of this, we created the Chemical Biology Program within SKI under the outstanding leadership of chemist Derek Tan in 2015.

To further the development of models for precision cancer treatment, Scott Lowe, Chair of the Cancer Biology and Genetics Program, and David Solit, Director of the Marie-Josée and Henry R. Kravis Center for Molecular Oncology, were awarded a five-year, \$10 million grant to support the use of genomic, computational, and animal modeling to more closely investigate specific cancers.

These are just a few examples that prove the adage that an organization is made stronger and more vibrant by the collective contributions of a diverse and talented staff. MSK itself received a significant honor reflecting the exceptional capabilities of our nurses. In early 2016, following a multiday site visit in December, the American Nurses Credentialing Center granted us Magnet recognition®, a distinction given to hospitals that demonstrate nursing excellence. This achievement confirms the superb performance of the entire nursing staff, led by Chief Nursing Officer Elizabeth McCormick, and marks the culmination of a years-long effort that involved MSK nurses at all levels.

MSK's staff of more than 14,000 men and women gives selflessly of themselves to ensure our success. Each year we welcome new members to our family; 2015 was no exception.

Renowned clinician and genitourinary cancer researcher Philip Kantoff was one of our most noteworthy recruits. Dr. Kantoff joined MSK as Chair of the Department of Medicine after holding several leadership positions at

Dana-Farber Cancer Institute and Harvard Medical School. He succeeded George Bosl, who served for 18 exemplary years as Chair.

We were delighted that Ned Groves came on board as Executive Vice President and Hospital Administrator. Previously, Mr. Groves served as Associate Director for Cancer Practice Administration and as Chief Operations Administrator for the Department of Oncology at the Mayo Clinic. He succeeded Kathryn Martin, now MSK's Chief Operating Officer.

We also note with sorrow the untimely death in May 2015 of Alan Hall, Chair of SKI's Cell Biology Program. He was a brilliant scientist with a deep and thoughtful intellect as well as a generous, good-humored, and respected colleague. He embodied the best that MSK has to offer and has been deeply missed. But his scientific contributions, the work of the many young scientists he trained, and his friendship to all remain an enduring legacy.

Our faculty was recognized with an abundance of awards in 2015, of which we'll mention just a few.

- Lorenz Studer, Director of the Center for Stem Cell Biology and Member of SKI's Developmental Biology Program, was named a MacArthur Fellow — one of just 24 people to receive a so-called “genius grant.”
- Maria Jasin, Member in the Developmental Biology Program, was elected to the National Academy of Sciences, joining 13 other MSK faculty members. The honor is one of the most prestigious a scientist can receive.
- Nikola Pavletich and Alexander Rudensky were both elected to the National Academy of Medicine. Dr. Pavletich is Chair of SKI's Structural Biology Program; Dr. Rudensky

is Chair of SKI's Immunology Program. They join 19 other distinguished MSK scientists as members.

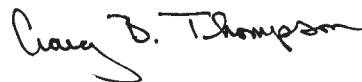
Our 2015 operating results were good. MSK's operating revenues increased by 8.4 percent. Our operating expense growth was 11.4 percent, an increase reflective of pre-operating costs related to our expansion of our ambulatory care facilities. MSK's operating expense growth during 2015 was also adversely impacted by the insolvency of a healthcare insurance company. (See page 66 for additional information on MSK's operating results.)

In the following pages, we introduce you to a range of innovative approaches we're taking to make care as accessible, coordinated, cost effective, and evidence based as possible to achieve the best outcomes for our patients.

By enhancing physician-patient communication, using patient feedback to improve care, illuminating the ways in which socioeconomic status affects treatment outcomes, and determining the right treatments for the right patients at the right time, we're charting new territory and setting standards for the future.



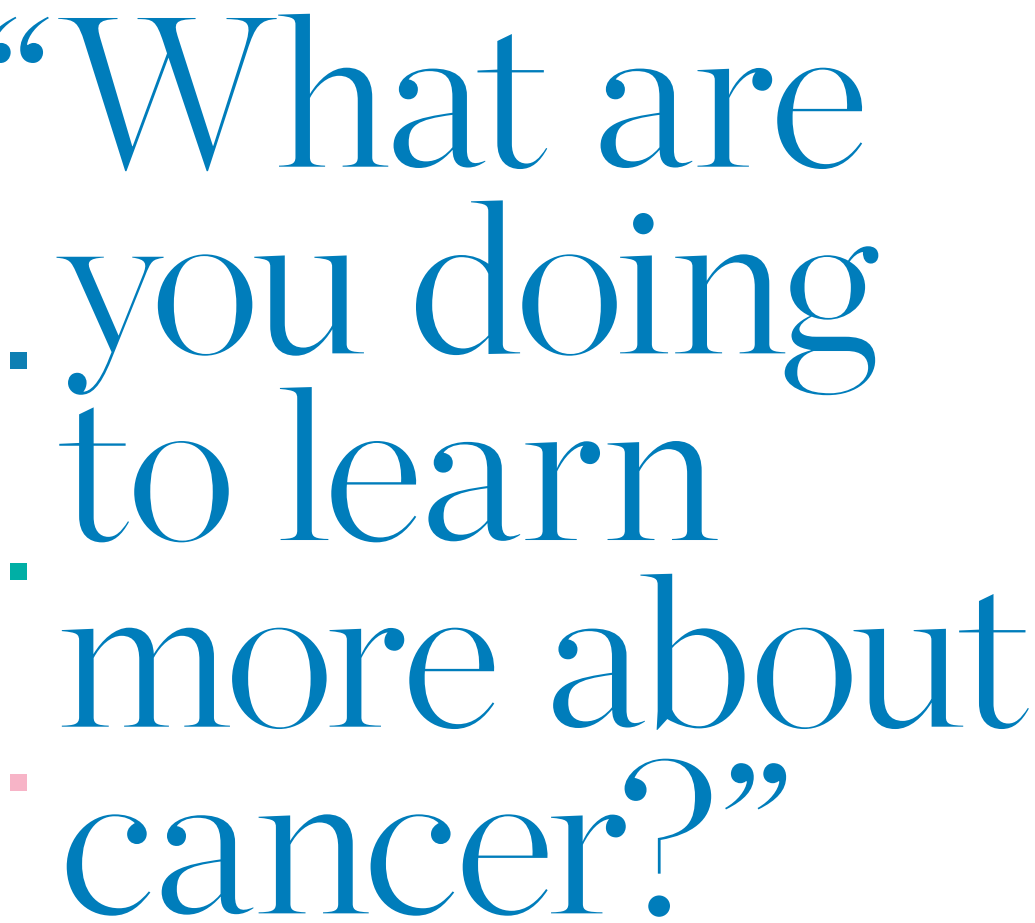
Douglas A. Warner III
Chair, Boards of Overseers and Managers



Craig B. Thompson
President and Chief Executive Officer



■ Research scholar Jie Su works in the laboratory of Sloan Kettering Institute Director Joan Massagué.

A decorative border of small, multi-colored squares (teal, blue, orange, brown, purple, pink, green) surrounds the central text.

“What are
you doing
to learn
more about
cancer?”

A close-up photograph of a female scientist with dark hair, wearing a white lab coat and white gloves. She is looking down intently at a small object in her hands, likely a pipette tip or a small vial. The background is a blurred laboratory setting with various pieces of equipment and shelves.

OUTSMARTING CANCER

Our laboratory-based and clinical research community is answering next-generation questions in cancer research and translating groundbreaking discoveries into more effective treatments for patients.

You don't smoke. You're not obese. You eat correctly. You exercise. You do everything you can to be a model citizen. And then you get cancer. Even with the best health practices, "we're only going to be able to prevent about 40 percent of cancers," says MSK Physician-in-Chief José Baselga. "We cannot escape the fact that the majority of cancers will occur because of the randomness of cell division."

So what do we do? To borrow from the old joke about how one gets to Carnegie Hall — practice, practice, practice — in cancer, the punch line is research, research, research. No one can predict when or where the next major advance will occur, but it will always have its genesis in scientific investigation.

Three of MSK's leaders — Dr. Baselga, Joan Massagué, Director of the Sloan Kettering Institute, and Charles Sawyers, Human Oncology and Pathogenesis Program Chair — have spent their lives gaining and sharing insights from their work in cancer biology and clinical and translational research. The multidisciplinary investigations in which they and their MSK colleagues engage are leading to the development of new cancer therapies and improved patient outcomes.

Prying Open Cancer's Black Box

Nine out of every ten people who die from cancer die not from the primary tumor but because it spread to vital organs somewhere else in the body. This process of metastasis has been cancer's black box. Little was known about its underlying causes.

According to Joan Massagué, an internationally recognized metastasis expert and Director of the Sloan Kettering Institute, in the past several years that black box has been opened wider than ever before — and MSK has played a key role in this. The Metastasis Research Center, which he directs, has brought together laboratories and scientists to facilitate metastasis study and treatment.

METASTASIS RESEARCH

JOAN MASSAGUÉ

DIRECTOR, SLOAN
KETTERING INSTITUTE





■ Research scholar Harihar Basnet (left) and hematology oncology fellow Karuna Ganesh (right) with Dr. Massagué in his lab

Our immune system detects and kills most tumor cells, but some escape detection and manage to infiltrate organs, where they live in the shadows — only to rear their heads years, even decades, later. The phenomenon is called latent (or dormant) metastasis.

In his own lab, he and his colleagues have probed the basic causes of metastasis in a number of different cancers — such as breast, lung, and kidney cancer — and identified genes and pathways that give tumor cells the specialized traits they need to invade specific organs, survive in them, and spawn new tumors.

“Tumors release cells the moment they begin to form,” Dr. Massagué explains. Our immune system detects and kills most of them, but some escape detection and manage to infiltrate organs, where they live in the shadows — only to rear their heads years, even decades, later. The phenomenon is called latent (or dormant) metastasis.

Unfortunately, it’s all too common for cancer to return after what appears to be successful treatment. Roughly 25 percent of women with HER2-positive breast cancer will experience a recurrence following surgery and chemotherapy. For lung cancer patients the numbers are even starker — half will see their cancer come back.

You Can’t Hide Forever

A recent study by Dr. Massagué and colleagues published in the journal *Cell* describes how they’ve created a new model to understand latent metastasis and how they’ve used it to kick in the door — for the first time — exposing the mechanisms that allow these cells to hole up, waiting to emerge when they think the coast is clear.

“Understanding latent metastasis is the biggest untapped opportunity to have a major impact on cancer and patient outcomes,” he says. “But it’s hard to find latent cancer cells in the body, much less to figure out what makes them tick.”

Srinivas Malladi, a postdoctoral fellow in Dr. Massagué’s lab who was the study’s first author, spent six years developing the model and putting it to use. He began with tumor cells taken from patients with early-stage breast and lung cancers, which he labeled with a fluorescent tag. He then injected these cells into mice



■ Research associate Srinivas Malladi (right) collaborates with Dr. Massagué on metastasis research.

and waited. For months. Nearly all the transplanted cells died. But a few survived, and Dr. Malladi discovered they were hiding out in the lungs and the kidneys. He called these persistent survivors latency competent cancer (LCC) cells. With these surviving cells in hand, Dr. Malladi began to investigate what made them so furtive and able to avoid detection. His first clue came when he looked at the proteins the cells made. He found that LCC cells behave a lot like stem cells, which divide periodically to repair our tissues. This stem-like quality helps to explain the LCC cells' ability to divide and seed distant organs.

Even more intriguing, though, he found that a proportion of these cells produce a protein that blocks cell division, forcing them into a state of suspended animation. This slowed-down growth is central to the cells' ability to survive in the body without detection.

Blinds Down, Lights Off

It's like evading the cops by pulling down the blinds in your apartment and turning off the lights: By not dividing, the LCC cells become less conspicuous to immune cells that patrol the body, looking for signs of trouble. When cells aren't dividing, they don't make the molecules that these immune cells detect, and so the immune cells ignore them. What's more, most chemotherapies kill only dividing cells, which means that non-dividing LCCs can survive treatment.

Taken together, this explains why a few LCC cells are able to survive. These cells may also acquire additional mutations over time, allowing them to escape immune patrols completely and cause a cancer recurrence.

The idea that our immune system holds latent cancer in check is not new. But up until now, the mechanism through which latent cancer and the immune system battle it out had remained mysterious.

Now, this work from Dr. Massagué's lab helps to clear up the mystery and suggests possible treatment options that may succeed where others have failed.

"Those of us who work on cancer and metastasis recognize we need all the help we can get — not only in terms of technology and resources but also in terms of sharing our knowledge," Dr. Massagué says. "For me, there's no better place than MSK for such sharing. Very few institutions in the world have the atmosphere it takes to address the broad and complicated questions we still face."



PRECISION MEDICINE

JOSÉ BASELGA

PHYSICIAN-IN-CHIEF

Listening to Biology

Something big is happening in precision cancer medicine and clinical trials that has far-reaching implications for the future of treatment and research.

“Precision medicine has emerged as an area of great promise in cancer treatment,” says José Baselga, MSK’s Physician-in-Chief. He is the leader of a landmark study published in 2015 in the *New England Journal of Medicine* showing one aspect of what this future looks like and demonstrating how it can work. The study, called a basket trial, showed that clinicians can design clinical trials based on genomics — the genetic mutations found in a tumor — rather than where in the body a cancer originated.

“As we’ve sequenced the genomes of more and more tumors, we have developed a catalog of genomic alterations, including

those that drive particular cancers,” he says. If clinicians are able to match a mutation with a therapy that attacks it, it would change the way we conduct most cancer clinical trials. Until now, trials were designed by the site of origin, so clinicians would offer one drug to a lung cancer patient, another to a breast cancer patient, and so on.

“But we really need to listen to the biology,” says Dr. Baselga. What the biology has been saying to investigators is that it may be possible to treat multiple tumor types with the same therapy — as long as those tumors share the same mutation. The approach is dramatically reshaping ideas about clinical research.

In addition to clarifying a treatment's effectiveness in different tumor types, these basket studies provide an important opportunity to test therapies for rare cancers, which are severely underrepresented in clinical trials. Patients with rare disorders can enroll if they have the mutation under study.

Written in Blood

Blood tells a story. From discovering what we ingest to monitoring the functioning of our organs, from learning how well a drug is working to detecting diseases before they manifest symptoms, a vial of blood discloses many tales.

Tumors shed their DNA, circulating their secrets into a person's blood. And now a breakthrough test called a liquid biopsy — a new alternative to tissue biopsy — holds the promise of a less invasive, more comprehensive way to deliver more-targeted cancer therapy and to monitor response to treatment.

Dr. Baselga has also been intimately involved in this work. Two 2015 MSK studies, one led by him and one that he co-authored with physician-scientist Sarat Chandralapaty, demonstrated the potential of the liquid biopsy, which uses blood samples drawn from cancer patients to analyze trace amounts of free-floating tumor DNA.

If its use is validated in larger studies, a liquid biopsy will offer several advantages over a conventional tumor biopsy and could contribute to better patient outcomes, both in treatment and quality of life. It requires just a simple blood draw, and since surgery isn't necessary, patients can be tested more frequently and with less discomfort and disruption of their daily activities. In addition, a liquid biopsy may provide a more global — and therefore more accurate — picture of the patient's cancer, by capturing cancer cells from different parts of the body, including the primary tumor and metastases.

"You can study the evolution of the tumor and whether it's responding to therapy in real time," explains Dr. Baselga. "If you're not getting the response you're looking for, you can modify your approach."

But it may also play a pivotal role in identifying cancers early. "In my mind, liquid biopsy is the most disruptive technology we've had in this field in years," he says. "I can envision a future in which people will go to their doctor once a year and have a test that looks for the presence of tumor DNA in their blood. This would lead to a paradigm shift in early diagnosis."

“

Hurdles remain in cancer research. But I'll take all the challenges because in my mind they pale in comparison to the opportunities.”

—JOSÉ BASELGA



■ Dr. Baselga meets with his patient Denise Albert.





DATA SHARING

CHARLES SAWYERS

CHAIR, HUMAN ONCOLOGY AND PATHOGENESIS PROGRAM

To the Moon — and Beyond

In January 2016, in his final State of the Union address, President Barack Obama announced the National Cancer Moonshot Initiative to improve cancer care and research. He appointed Vice President Joseph Biden to spearhead the effort. “The president’s call to action was a great opportunity for the entire oncology community to kind of hit ‘reset’ and ask, ‘How can we do this better?’” says Charles Sawyers, Chair of MSK’s Human Oncology and Pathogenesis Program.

There is a golden opportunity to make swift progress through sharing the clinical genetic sequencing data that cancer centers around the nation and the world are generating. Genes hold a vital key to our understanding of cancer and its underlying causes. A technology called next-generation sequencing, which significantly improves upon older gene-sequencing methods, is revolutionizing the way cancer research is conducted.

“The amount of information we’re getting is amazing,” says Dr. Sawyers. “But the quantity of data that genomic sequencing is producing has cancer researchers figuring out the best ways to analyze it all. We realized that to really leverage the information, we needed to band together.”

And so, well before the president issued his call to action, MSK and other cancer centers had already begun to craft a data-sharing effort: an unbiased, unaffiliated, nonprofit organization set up to convene the conversation and to house the data.

Summon the GENIE

The Genomics Evidence Neoplasia Information Exchange — Project GENIE — is an international initiative that includes MSK and six other leading cancer institutions, and is spearheaded by Dr. Sawyers. The American Association for Cancer Research, of which he is a past president, helped create the program.

- **Far right: Research associate Phillip Iaquina conducts experiments in Dr. Sawyers's laboratory. Below: Dr. Sawyers with research fellows Elizabeth Adams (left) and Ping Mu.**



“The need for Project GENIE is undeniable,” he says. “Numerous factors are driving an increase in the amount of genomic data available for analysis. In addition, it’s difficult for one institution to collect enough data to make statistically significant connections between a particular mutation and a specific cancer, especially for tumors and mutations that are rare. The numbers are just too small.” By aggregating existing and future genomic data from all seven participating institutions, it’s GENIE’s goal to address this problem.

There are many ways in which GENIE could affect patient outcomes, including:

- better predicting drug response and patient prognosis
- identifying new patient populations for previously FDA-approved drugs
- expanding the patient populations that may benefit from existing drugs
- identifying new drug targets and biomarkers

At the time GENIE was created, the database already held nearly 17,000 genomic records, and this number is growing quickly. Dr. Sawyers says that in the not-so-distant future, it’s likely that all cancer patients around the world could have their tumor genomically sequenced, and that their physicians could use a data registry to help make treatment decisions. “When this time comes, everyone involved in GENIE will know that he or she played a major role in bringing this new reality to life,” he says.



There is a golden opportunity to make swift progress through sharing the clinical genetic sequencing data that cancer centers around the nation and the world are generating. Genes hold a vital key to our understanding of cancer and its underlying causes.



■ Endocrinologist Michael Tuttle
with his patient Pamela Murphy

A decorative grid of small, colored squares is arranged in a 6x6 pattern around the central text. The colors of the squares include teal, blue, brown, orange, dark red, green, pink, purple, and light blue.

“Am I getting
the best
treatment?”



THE RIGHT TREATMENT AT
**THE RIGHT
TIME**

One size doesn't fit all. That's why at MSK we're committed to providing the right treatment for the right patient at the right time. It's what precision cancer medicine is all about.



LYMPHOMA

NANCY HUGHES

PATIENT

Most people’s first reaction to a cancer diagnosis is wanting to get rid of the disease as quickly as possible. When 47-year-old Nancy Hughes was diagnosed with follicular non-Hodgkin’s lymphoma in 2007, she went into fight mode — but her doctor had another idea.

MSK hematologic oncologist John Gerecitano instead recommended the “watch and wait,” or active surveillance, approach. Nancy, from Hampton Bays, New York, would be monitored regularly and put on chemotherapy only if her disease progressed.

As a result of decades of research, doctors now know that patients with certain types of cancer may not need immediate treatment. These patients are best served by active surveillance (also sometimes called watchful waiting). The approach usually involves regular testing to keep an eye on a tumor’s behavior over time. Only if symptoms develop or tests indicate the cancer is growing or changing is further treatment initiated.

“I remember thinking, This is insane. I have cancer, you have to get rid of it,” the mother of two recalls. “And I think that’s everybody’s initial response.”

That’s a reaction Dr. Gerecitano often finds himself receiving whenever he advocates a watch and wait approach for lymphoma patients. “This recommendation, especially in lymphoma, doesn’t mean we’re telling patients there’s no treatment for them,” he says. “We know from the data that harm will not come from waiting.”

Active surveillance is a common treatment strategy at MSK for lymphomas and other cancers that pose no immediate threat to a patient’s health.

“Some lymphomas can be treated like chronic conditions such as diabetes or high blood pressure, where we manage them over time,” says Dr. Gerecitano, who recently led a trial for venetoclax, a new FDA-approved lymphoma drug.

Even though that’s good news, many patients are skeptical about holding off on active treatment. “It causes understandable anxiety when you tell patients they have cancer but they should sit on the sidelines,” he says. “We live in a culture in which cancer is seen as an enemy that has to be actively fought.”

But the surveillance is called “active” for a reason. Usually, patients are first assessed every three to six months. Once doctors understand the disease’s growth pattern, they can sometimes space patients’ visits further apart — but they’re always carefully monitored.

At MSK, lymphoma experts typically recommend active surveillance for around 30 percent of patients. However, if and when a slow-growing lymphoma progresses, “it’s not one-size-fits-all,” says medical oncologist and lymphoma expert Alison Moskowitz. “Our choice of therapy depends on the individual patient and characteristics of the disease.”

When determining a treatment approach, Dr. Moskowitz and her colleagues are taking a mental look into each patient’s future. “We’re never thinking, OK, what am I going to do right now? We’re assessing our choices more broadly and long term,” she says. “We’re asking, ‘What am I going to do now, and then what am I going to do if I need to treat this person again? What are my next three steps?’ We want both to help prevent patients from developing treatment resistance and to ensure that they remain eligible for future therapies. Our goal is to deliver precisely the care our patients require — not too much, not too little, and only when they truly need it.”

“

When you go in for your appointments, those can be a little anxiety producing. But as time progresses it just gets easier to process.”

—NANCY HUGHES

■ Nancy’s physician,
John Gerecitano





It's not a simple matter to explain to a person with cancer that immediate treatment may not be necessary, or even desirable. It's a challenging conversation, says MSK urologic surgeon Behfar Ehdai. "A cancer diagnosis is a call to action for most people, and they're usually resistant at first to dealing with their disease in a non-interventional way," he explains.

Active surveillance is important in prostate cancer because the treatments physicians use can negatively affect a man's quality of life, so explaining the benefits is critical. Erectile dysfunction and urinary symptoms, including incontinence, are potential side effects of both surgery and radiation. "For the men we select for active surveillance, we're offering them the opportunity to live without these side effects by monitoring their cancer, but more importantly to find a point at which a change in their tumor would lead to curative treatment," Dr. Ehdai says.

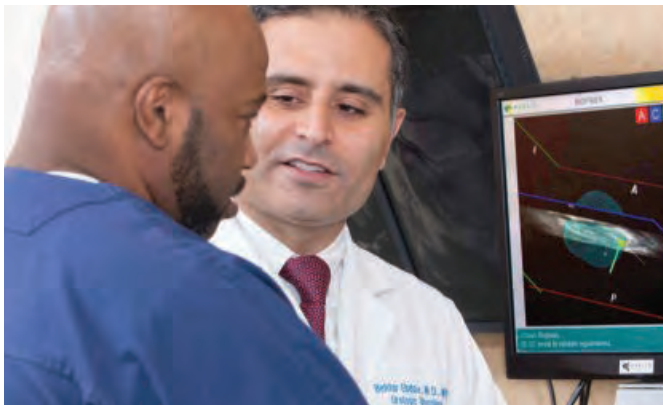
He and his colleagues recognized that improving their communication skills would help them increase the number of prostate cancer patients who would accept active surveillance as a treatment strategy. So they turned to an unusual source for assistance: a faculty member on the Negotiation, Organizations, and Markets Unit at the Harvard Business School.

To discover whether negotiation skills could play a role in physician-patient discussions, five surgical oncologists specializing in prostate cancer were recruited to participate in a one-hour training session with the Harvard consultant. The surgeons then applied the principles they'd learned during their training to patient conversations about active surveillance.

Among the behavioral science tools they were given is one that employs what's known as "social proof," highlighting for patients the choices that others in similar circumstances have made and their positive outcomes. Another is to talk about the natural history of prostate cancer — including its relatively long latency period — before even introducing a discussion of active surveillance. "This is very effective in overcoming patients' perceptions that active surveillance is not aggressive enough, or that the cancer can metastasize between medical appointments," says Dr. Ehdai.



Active surveillance is important in prostate cancer because the treatments physicians use can negatively affect a man's quality of life, so explaining the benefits is critical.



■ **Top: Clinical nurse Michael Manasia (left) consults with Dr. Ehdaie. Bottom: Ultrasound technologist Casey Colas (left) works with Dr. Ehdaie to image prostate cancer patients.**

The results after instituting the new techniques were impressive: The proportion of candidates for active surveillance who selected the option increased from 69 percent in the 24 months before the intervention to more than 80 percent in the 12 months afterward.

Dr. Ehdaie and his colleagues are completing the study, which will further evaluate the success of the approach, and the results of which they expect to publish. "Our goal is that these skills can be taught to surgeons by surgeons — and, we hope, at institutions beyond MSK," he says.

When a man comes to MSK with a prostate cancer diagnosis, his physician will first determine where he is in the course of his disease. This includes a review of his tumor pathology, including genetic testing to determine the risk of the tumor progressing in both the short and long term; the level of prostate-specific antigen (PSA) in his body; the

results of a digital rectal exam; and an advanced imaging study, such as an MRI. If the MRI shows suspicious findings, he may also undergo an MRI-guided biopsy. If, after all these tests, the physician determines that a patient is at low risk, he can join the active surveillance program.

Once in the program, "we do an examination of these men every six months and get a PSA level," Dr. Ehdaie explains. "Every 18 months, we get an MRI of the prostate. If there are no changes, we continue seeing these patients every six months for three years. At that point, a man will get another MRI and an MRI-guided biopsy. We continue the imaging every 18 months, but we're trying to minimize the number of biopsies a man has to undergo." Most patients will have biopsies only once every three years. Most importantly, only 40 percent of MSK's active surveillance prostate patients ever go on to need active treatment.

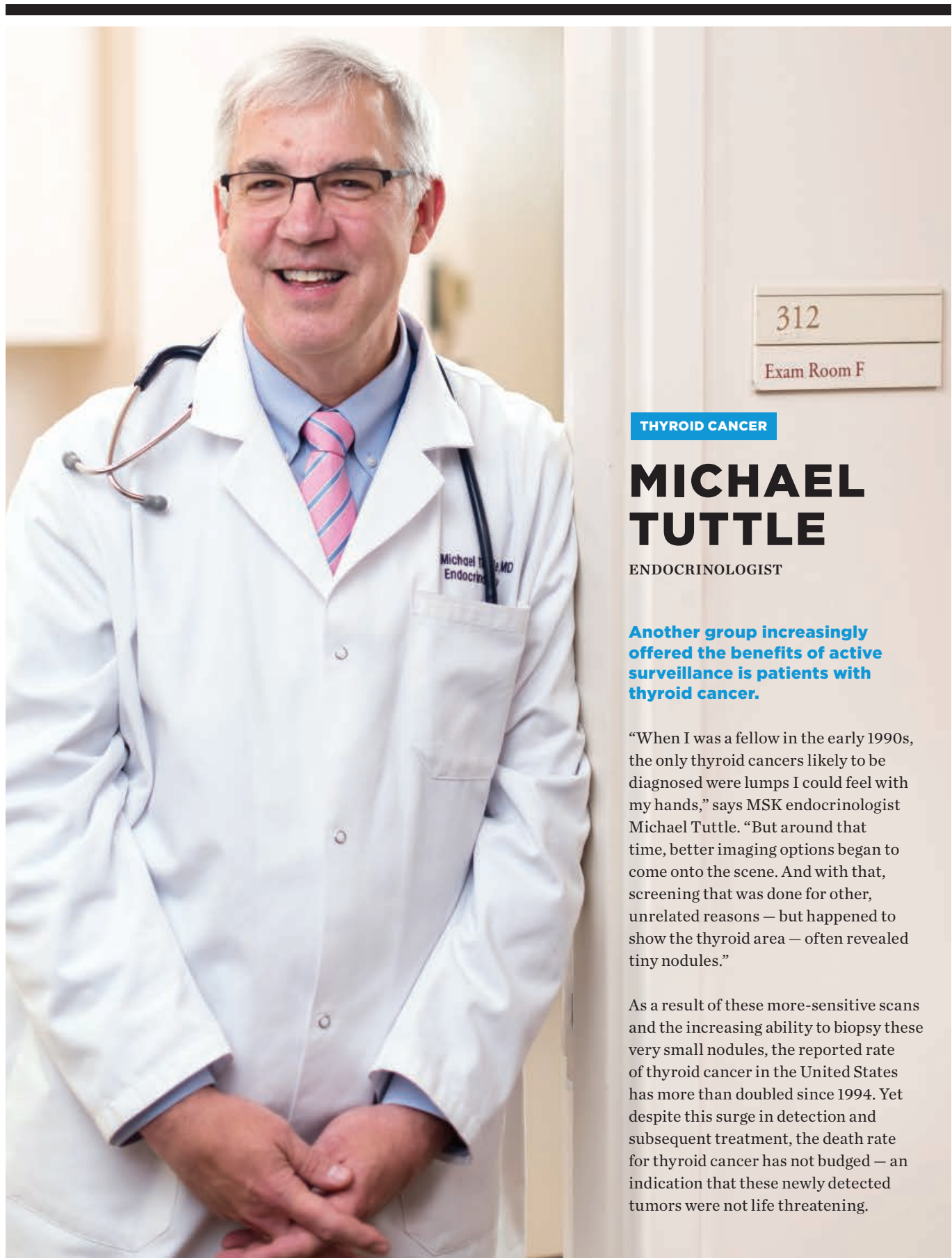
"We recently did a study in which we looked at what percentage of men with low-risk prostate cancer are offered and subsequently accept active surveillance at MSK. It turns out that 82 percent of our patients are and do, compared with a national average of about 40 percent in community health settings," he concludes.

82%

of MSK's patients with low-risk prostate cancer accept active surveillance, compared with a national average of about

40%

in community health settings



THYROID CANCER

MICHAEL TUTTLE

ENDOCRINOLOGIST

Another group increasingly offered the benefits of active surveillance is patients with thyroid cancer.

“When I was a fellow in the early 1990s, the only thyroid cancers likely to be diagnosed were lumps I could feel with my hands,” says MSK endocrinologist Michael Tuttle. “But around that time, better imaging options began to come onto the scene. And with that, screening that was done for other, unrelated reasons — but happened to show the thyroid area — often revealed tiny nodules.”

As a result of these more-sensitive scans and the increasing ability to biopsy these very small nodules, the reported rate of thyroid cancer in the United States has more than doubled since 1994. Yet despite this surge in detection and subsequent treatment, the death rate for thyroid cancer has not budged — an indication that these newly detected tumors were not life threatening.

“The majority of these very small thyroid cancers will never cause a problem,” Dr. Tuttle continues. “In fact, if the thyroid gland is very carefully examined, papillary thyroid cancer — the most common type of thyroid cancer — can be detected in more than 10 percent of healthy adults in the United States. But these tumors grow very slowly. They’re the same size in someone at 80 as they were at age 40.”

“All surgeries carry a level of risk,” says Dr. Tuttle. “Here at MSK, our complication rate is extremely low because our surgeons perform a high volume of thyroid operations.” Nationwide, however, about half of thyroid cancer removals are done by surgeons who perform fewer than ten a year. Patients whose thyroid is removed have to take hormones for the rest of their lives. “While most do fine,” he adds, “about 10 to 20 percent tell me they don’t feel good on the thyroid pills. They feel fatigued and have to work harder to function at their normal level.”

A new program at MSK gives certain patients with very early-stage thyroid cancer the option of choosing active surveillance in a program similar to what MSK’s prostate cancer patients are offered. If a person comes in with a small papillary thyroid cancer that appears to be confined to the gland and the thyroid cancer team feels that surgery is not required, that person is offered the opportunity to have an ultrasound exam every six months for two years instead of having the tumor removed.

“If after two years nothing has changed, we space out the ultrasounds to every nine to 12 months,” Dr. Tuttle explains. MSK physicians know that in the vast majority of cases, if thyroid cancer progresses, it’s going to happen slowly — in which case an operation will almost certainly be as effective in the future as it would have been at the time of diagnosis.

An international panel of physicians that included Dr. Tuttle and MSK pathologist Ronald Ghossein recently determined

that a type of thyroid tumor that was classified as a cancer may not be a cancer at all. Their conclusion was published in the journal *JAMA Oncology* in April 2016. Once the diagnosis is confirmed by careful examination of the surgically removed thyroid nodule, these data confirm that no additional therapies are needed and exceptionally excellent outcomes can be expected in more than 99 percent of these patients.

Dr. Tuttle also points out that the American Thyroid Association guidelines, which he helped create, now recommend against taking biopsies of small thyroid nodules. “Even though you may know by looking at an ultrasound that the little spot you see is likely to be thyroid cancer, if you don’t stick a needle into it, you don’t turn your patient into a cancer patient,” he says. “The idea is that we want to decrease overdiagnosis. The message is, follow the guidelines. Don’t stick these little things. But even if you do, there’s almost never a reason to hurry into an operation.”

■ MSK patient Pamela Murphy sees Dr. Tuttle for periodic examinations.





BREAST CANCER

MONICA MORROW

CHIEF, BREAST SERVICE
DEPARTMENT OF SURGERY

The fact is that with an invasive breast cancer, a mastectomy does not lower the risk of the cancer recurring at a distant site in the body, or even in the breast itself.

Mastectomy rates are rising in the United States — despite the fact that breast-conserving surgery has now been established as a safe option for many patients. More than three-quarters of women with newly diagnosed, early-stage breast cancer are candidates for this minimally invasive operation, called a lumpectomy, followed by radiation. During a lumpectomy, surgeons remove the tumor along with an area of normal tissue surrounding it — known as the surgical margin — to reduce the chance of leaving cancer cells behind.

Despite evidence that lumpectomy is as effective in treating breast cancer as mastectomy, many women are still not choosing the approach. For a long time, it was thought that this was the fault of surgeons simply not offering women breast conservation as an option. But that turns out not to be true. “The use of mastectomy in the United States is very heavily driven by patient preference, not medical necessity or doctor recommendation,” says Monica Morrow, Chief of the Breast Service in the Department of Surgery. “Our studies show that patients are choosing mastectomy in spite of the fact that they’re being given medical information that less-radical surgery is safe and effective.”

The fact is that with an invasive breast cancer, a mastectomy does not lower the risk of the cancer recurring at a distant site in the body, or even in the breast itself. “For most women with invasive breast cancer, the risk of the cancer recurring in the area of the surgery is the same whether they have a lumpectomy or a mastectomy,” she explains. “It’s driven by the biology of the cancer, not by which operation a woman has.”

The rate of bilateral mastectomy — surgery to remove both breasts — is also increasing dramatically. A study of MSK breast cancer patients by Dr. Morrow and her colleagues revealed that of women who had cancer in one breast but opted to have both removed,



■ **Medical oncologist and breast cancer expert Tiffany Traina with her patient Tracy Friedman**

only about 11 percent had high-risk cancer. “We would like to understand — from the woman’s perspective — why more of them are choosing this option,” she says, “especially at a time when adjuvant therapies [radiation, systemic chemotherapy, hormone therapy, and targeted drugs] have made the risk of developing cancer in the opposite breast lower than it’s ever been.”

And then there’s ductal carcinoma in situ (DCIS). DCIS is the presence of abnormal cells inside a milk duct in the breast. Accounting for roughly 20 percent of breast cancer cases, it’s called “in situ” (meaning “in place”) because the cells have not left the milk duct to invade nearby breast tissue. In itself, it’s



Today’s treatments are more individualized because we understand so much more about the biology of the disease.”

—TIFFANY TRAINA

not harmful. However, current imaging, clinical, pathological, and molecular tests don’t give surgeons the information they need to reliably predict which cases will turn into invasive cancer. And local recurrence rates — the return of DCIS in the same breast — remain substantial. Therefore, surgery with or without radiation therapy is recommended for the treatment of DCIS. “Whether we do a lumpectomy or a mastectomy is based on how much DCIS is in the breast,” says Dr. Morrow. “A small DCIS can be treated with a lumpectomy, but more widespread DCIS requires a mastectomy.”

Many patients with early-stage invasive breast cancer have to sort through adjuvant therapy options with their oncologists. “Today’s treatments are more individualized because we understand so much more about the biology of the disease,” says medical oncologist Tiffany Traina.

For breast cancers that are driven by estrogen, which represents the vast majority, doctors now routinely test a series of genes within the tumor to help them estimate the risk of recurrence for that particular cancer over the next 10 years. But what’s even more informative is the predictive value of the assay they use.

Doctors can now also predict what the benefit of chemotherapy will be for a woman with breast cancer and use that information to make smarter treatment choices. “At MSK, we are incorporating these new insights into tumor biology to help make the best treatment recommendations for our patients,” Dr. Traina says. “My colleagues and I are always conscious of how we can minimize the side effects of treatment while maximizing the benefits.”



■ Eliana Ortega, OR assistant, and Gregory Craig, Manager of Perioperative Support Services, coordinate the day's surgeries in the main surgical center on the sixth floor of Memorial Hospital.



“I’m frightened.
Will you take
good care
of me?”





PATIENT COMFORT AND
SATISFACTION

Patients are at the center of everything we do. We're constantly striving to improve patient satisfaction because good patient experiences are associated with better treatment outcomes.

When it comes to assessing patient satisfaction — specifically, how MSK patients rate their experiences in the hospital or ambulatory care settings — Kathryn Martin goes right to the data. As MSK’s Chief Operating Officer and an experienced hospital administrator, she wants to know what patients think, and she actually believes they ought to be more demanding.

Each quarter, more than 3,000 MSK patients are asked to participate in external surveys administered by Press Ganey, a leader in the field. The surveys encompass both inpatient and outpatient environments; the questions cover topics that range from room décor and staff courtesy to waiting times and emotional support.

Yet Ms. Martin focuses her attention on one key factor: care coordination — how well a patient’s care is managed across the different sites of care and among healthcare providers. “Patients’ assessment of how well we do coordinating care is the single best predictor of how well they rate their overall experience and whether or not they’d recommend us to their family and friends,” she says.

“Our goal is to integrate clinical excellence with service excellence,” Ms. Martin amplifies. “These insights guide our thinking about how outstanding clinical care and a superior experience converge to make a meaningful difference for patients and their families.”

Ms. Martin is proud of MSK’s track record. For example, more than 95 percent of hospital patients routinely report that they would recommend MSK, putting us in the

upper ranks of all academic medical centers nationwide. Nonetheless, she sees room for improvement in how teams work together to coordinate patient care. “Patients want to feel like someone is in overall charge of their care and that all the staff they are in contact with are on the same page and wholly familiar with their particular needs,” she says. “We spend a great deal of time talking to our patients, but I always believe that we can and should do better.”

In addition to formal surveys, MSK seeks the patient perspective in a variety of other ways. Members of the Patient and Family Advisory Council for Quality (see opposite page) actively participate in hospital initiatives. Patient-reported outcomes and focused surveys have also been incorporated into the work of several disease management teams and the program at the Josie Robertson Surgery Center.



■ A meeting of the PFACQ. Top left: Kate Niehaus chairs the meeting. Top right: Rori Salvaggio, Director, Nursing, Ambulatory Services, and Michael Castellano, PFACQ patient advisor. Bottom right: Mr. Castellano.

Patient and Family Advisory Council for Quality: Putting Patients First

Members of MSK’s Patient and Family Advisory Council for Quality (PFACQ) – comprising current and former patients, family members, administrators, nurses, physicians, and patient representatives who meet monthly – are involved in numerous projects, quality improvement endeavors, and committees across the institution to ensure that patients’ and caregivers’ voices are heard.

Led by Chair Kate Niehaus, a former MSK patient, the council’s mission is to integrate the patient, family, and caregiver perspective into every aspect of MSK’s efforts to prevent, diagnose, treat, and cure cancer. In addition to their engagement with MSK initiatives, the group has initiated projects to

address times of tremendous stress for families and caregivers – particularly points of transition in care – for new patients, for those finishing treatment, and for those transitioning into hospice. In one example, the team is working to find ways to better integrate the patient-to-patient program, which connects former patients with current ones for support and guidance, throughout patients’ care at MSK.

“The experts at MSK provide excellent care,” says Ms. Niehaus. “But we have a separate expertise that they don’t have – we know what it is to be a patient or a caregiver. And we want to use our expertise to help MSK set the standard for patient-centered care.”



BREAST CANCER

**ANDREA
PUSIC**

PLASTIC AND
RECONSTRUCTIVE SURGEON

COLORECTAL CANCER

**LARISSA
TEMPLE**

SURGICAL ONCOLOGIST



“

**It's not enough
to save a life.
It's about the
quality of the life
you've saved.”**

—ANDREA PUSIC

Talking in PROSE

Plastic and reconstructive surgeon Andrea Pusic and colorectal surgical oncologist Larissa Temple are experts in patient-reported outcomes. They lead MSK's Patient-Reported Outcomes and Surgical Experience program, or PROSE.

PROSE was created to better understand how patients feel about their surgical treatment, care, and recovery. The program uses patients' feedback about things like pain, symptoms after surgery, and level of functioning to help doctors make better-informed decisions about care — and to help them really understand what it's like to be a patient. “There's been a sea change from the idea that surgeons always know best,” says Dr. Pusic.

“Patients today want to be engaged in decision-making,” adds Dr. Temple. “The tools we've developed are based on what we hear from patients during in-depth interviews — so patients have truly contributed to their creation.”

Cancer experts are increasingly focusing on asking similar questions of patients involved in clinical trials. Studies have shown that they generally underreport their side effects, for several reasons — they may be focusing on competing issues, such as test results, or are just reluctant to share their symptoms. As a result, quality of life can suffer. Researchers are looking for ways to scientifically evaluate side effects to improve care for these patients.

Recently a team funded by the National Cancer Institute and led by investigators at MSK and several other cancer centers worked with patients to develop a system for measuring their experiences during clinical trials. The group published an analysis of the tool's effectiveness in November 2015 in the journal *JAMA Oncology*.

It asks patients 124 questions about 78 potential side effects, including pain, fatigue, nausea, and skin problems — an unprecedented breadth of assessment, says Thomas Atkinson, head of MSK's Behavioral Research Methods Core Facility and one of the study's authors. “The largest stakeholder in clinical research is the patient,” he adds. “The majority of patients who participated in the study said that it helped them have better discussions with their doctors and nurses.”

“It's not enough to save a life,” Dr. Pusic concludes. “It's about the quality of the life you've saved.”



COMMUNICATIONS SKILLS

PATRICIA PARKER

DIRECTOR, COMMUNICATIONS SKILLS TRAINING AND RESEARCH PROGRAM

Learning to Have Difficult Conversations

It's not enough to walk the walk. You need to be able to talk the talk. And that's a gift that doesn't come easily or naturally to everyone — even doctors and nurses.

In 2005, MSK recognized that this issue needed addressing and established the Communications Skills Training and Research Program, or Comskil — the first structured communications initiative at a comprehensive cancer center. Comskil is designed to train physicians and other healthcare professionals to communicate in a patient-centered and effective way. The program began with attending physicians and oncology fellows and now

includes both inpatient and outpatient nurses as well as other clinician groups.

Comskil training allows learners to hone their skills with trained actors playing roles in different scenarios that can range from dealing with an angry patient to comforting bereaved parents. An MSK communications skills expert and a member from the learners' discipline who has received Comskil and facilitator training act as co-facilitators, with two or three trainees participating at a time.

Below, top and bottom: Patricia Parker meets with the Comskil faculty.



A Comskil Focus on Pediatric Oncology Nursing

Over the past decade, Comskil training has been available for all MSK physicians, clinical fellows, and nurses. But Joe and Robin Kanarek — who lost their young son, David, to acute lymphoblastic leukemia — saw an opportunity to extend Comskil training to pediatric nurse practitioners through their Kanarek Family Foundation.

More than 55 pediatric nurse practitioners have taken the training. Nurse practitioner Anne Casson, a member of MSK's Department of Pediatrics for 21 years, was David Kanarek's nurse before, during, and after a stem cell transplant that was performed to try to treat his leukemia. She's taken the Comskil training and is now a facilitator.

"None of us like having difficult conversations," she says. "But if a child relapses and parents need to make end-of-life decisions, you need to have an honest dialogue with families. In Comskil training you learn to use the word 'death,' which is not easy for many of us. Comskil has become a very important part of our ongoing MSK training."

"The Kanareks' commitment to nursing, palliative care, and pediatrics made this Comskil project come into focus and be executed rapidly," adds Julia Kearney, MSK pediatrician and child and adolescent psychiatrist. "Their dedication to the work is genuine, meaningful, and an inspiration to us."

“

Our program covers issues that include breaking bad news, shared decision-making, responding to patient anger, discussing palliative care, working with interpreters, and transitioning to survivorship.”

—PATRICIA PARKER

Before each scenario, facilitators give the actors instructions, such as the intensity of the emotions they'd like them to display. At the conclusion, trainees view themselves on video to learn where they can make improvements. Trainees also receive feedback from their co-trainees, the facilitators, and even from the actors.

“Our program covers issues that include breaking bad news, shared decision-making, responding to patient anger, discussing palliative care, working with interpreters, and transitioning to survivorship,” says Director Patricia Parker. Dr. Parker and her colleagues are also working on ways to expand their reach even further to offer training that meets the needs of anyone who interacts with patients.



SOCIAL WORK

**PENELOPE
DAMASKOS**

DIRECTOR, SOCIAL WORK

When Things Get Complicated, Call a Social Worker

Say the words “social work” and people may think of child welfare, substance abuse, or perhaps the criminal justice system. But few consider the role of the oncology social worker in a cancer hospital, despite the indispensable help they provide for patients and families.

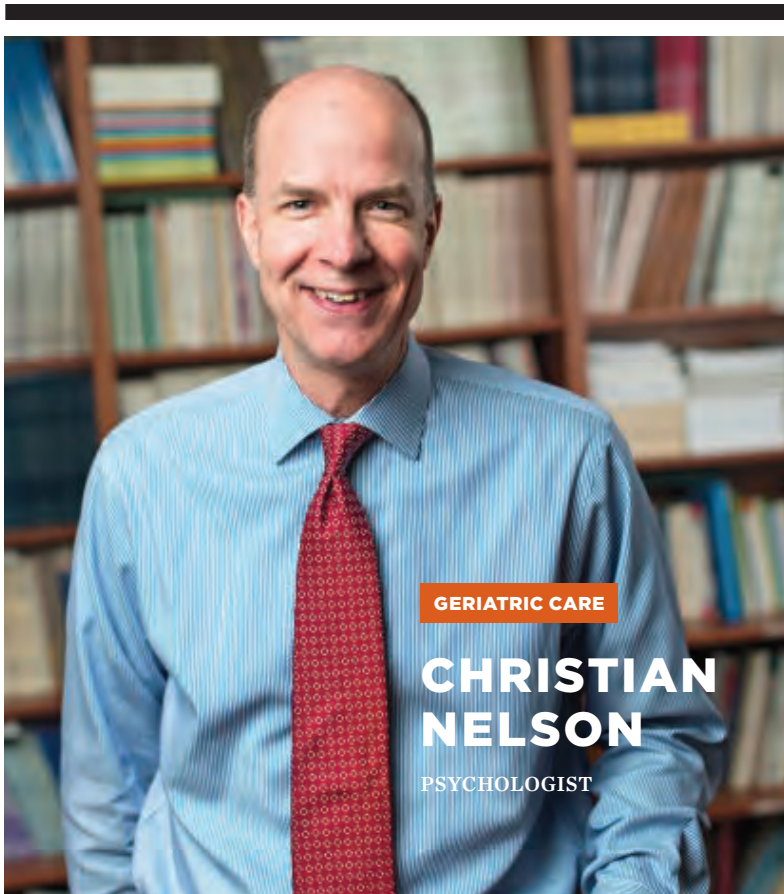
“Each stage along the road of cancer treatment can represent a new crisis,” says Penelope Damaskos, Director of MSK’s Department of Social Work. “Social work runs the gamut, from helping people cope with the diagnosis and adjust to living with illness to assisting and supporting them in practical issues.”

A social worker is trained to help people deal not only with how they feel about a situation but also with what they can do about it. Dr. Damaskos explains, “Our aim is that every patient who comes through our doors has an opportunity to get help to better manage and understand the impact cancer has on their lives.”

MSK’s social workers can intervene in almost any aspect of a patient’s life. On the practical side, they have funds available to provide nontreatment

financial assistance to people who may need it. For example, some patients need help getting to their appointments or temporary housing near the hospital. A patient who may require help with rent, utilities, or childcare can also look to social workers. (The lion’s share of these funds is provided by The Society of Memorial Sloan Kettering, a volunteer organization that offers a range of enhancements to MSK’s patient care and research programs.)

MSK’s social workers offer counseling as well. If a patient or family is experiencing an emotional crisis, their doors are open. “We help patients and families at this extremely vulnerable moment in their lives,” Dr. Damaskos says.



Older Patients, Unique Needs

Age is the single biggest risk factor for developing cancer. Older adults with cancer often have a different set of concerns than other adults, which can affect both their outcomes and how they cope with the disease.

MSK's Geriatrics Service in the Department of Medicine addresses the special challenges of treating cancer in older patients and serves as the focal point for ongoing clinical research.

In 2015, MSK established a geriatric education initiative to instruct physicians in how to most effectively treat cancer in older patients. The new program was made possible by a grant from the US Health Services Resources Administration. MSK was the only cancer hospital to receive one of these grants.

"Physicians are thinking about older adults and cancer very differently than they did years ago," says MSK clinical psychologist Christian Nelson, who works with the 65+ Program, a multidisciplinary initiative comprising experts from various fields, including

physical therapy, psychiatry, pharmacy, and social work. "We now commonly offer cancer treatment to people in their 80s and even 90s." He points out that the age of the average cancer patient today is over 65, as is the average age of survivors.

The treatment preferences of older adults can differ from those of younger cancer patients. "In my experience, older adults may come in wanting to know even more than younger people about the range of treatment options," Dr. Nelson says. "They are often more concerned with their quality of life as opposed to extending the length of that life."

Interestingly, levels of emotional distress may be lower in older adults. "One reason is simply where they are in their lives," he says. "The other reason is better coping skills: Older patients have experienced more ups and downs."

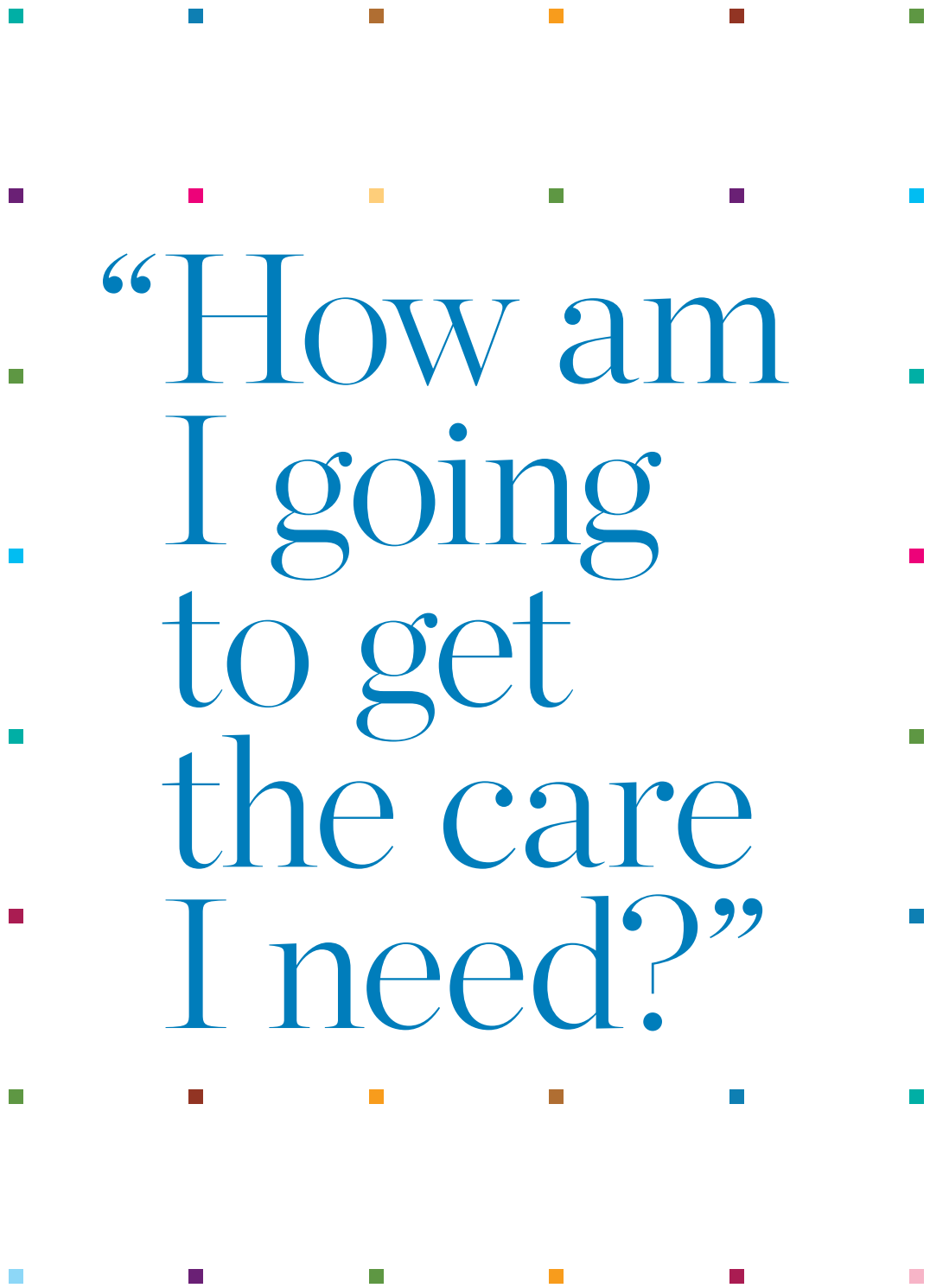
However, older adults with cancer often face situations that affect them more profoundly than younger patients. They may be at an increased risk of social isolation due to circumstances such as living alone or acting as the primary caregiver for an aging spouse or partner. Suddenly, the caregiver needs care.

Dr. Nelson co-facilitates a support group for older patients called the Vintage Readers Book Club. "Because most of the members are vintage," Dr. Nelson smiles. "Jimmie Holland [the first Chair of MSK's Department of Psychiatry and Behavioral Sciences and a pioneer in psycho-oncology] has really taken the lead in this. Our readings have been very eclectic and range from Martin Luther King Jr.'s 'Letter from Birmingham Jail' to Cicero's essay on aging. The idea is to give members another way to connect."

"It's a privilege to care for and work with older adults," says Dr. Nelson. "I often think I learn more from them than they learn from me."



■ **Internist Deborah Korenstein with nurse practitioners Rosanne Sharp (left) and Maureen Reidy (right)**

A decorative border of small, multi-colored squares (teal, blue, brown, orange, purple, green, pink) surrounds the central text.

“How am
I going
to get
the care
I need?”

**INCREASING AND IMPROVING****ACCESS
TO CARE**

Providing access to cancer care is a complex challenge. At MSK, we turn challenges into opportunities. From screening for financial distress and connecting with the medically underserved to forming alliances with community-based providers, we're extending care and improving outcomes for more patients than ever before.



A Conversation with Peter Bach

Physician Peter Bach is Director of Memorial Sloan Kettering's Center for Health Policy and Outcomes. He and his colleagues collaborate on research and analysis that embrace a wide range of cancer types and issues. Their aim is to contribute to the development of approaches that will improve patient outcomes. Here, he talks about measuring the complex and often profound impact treatments can have on patients and the ways in which we can better provide cost-effective cancer care.



Looking at hospital-specific cancer survival is the start of a very large effort to bring transparency to performance and to cost. It may be uncomfortable, but it's vital."

—PETER BACH



■ Scientist Elena Elkin works with Dr. Bach on projects aimed at understanding patterns, delivery, and outcomes of cancer treatments.

What do we mean when we talk about outcomes as they relate to cancer?

In the broadest sense, cancer outcomes — and research to enhance those outcomes — encompasses the entire trajectory of the illness and evaluates all aspects of care. We consider a range of questions: How long do people live? How well do they live? Have we cured their cancer? How long do patients go on before the disease relapses or recurs? Also vital to outcomes research are the issues that surround making cancer care more efficient and cost effective.

Obviously, the most important of these is patient survival. Most of what we do in cancer is aimed at prolonging life. But quality of life is also extremely important. As we work to extend life, we want to do it in the safest way we can and with minimal side effects, so people can continue to live their lives as normally and comfortably as possible.

Finally, the reality of caring for people with cancer is also the reality of taking care of those who are dying. While this is not the outcome we wish for our patients, some of them will experience it, so end-of-life care is very much on the agenda of outcomes research.

One big focus of outcomes is overall survival rates, which may be quite different depending on where a patient is treated.

True. Research has shown that cancer survival outcomes can vary widely depending on where a patient receives care. But it's been difficult to assess hospitals by long-term survival rates without including disease-stage information.

However, a study my colleagues and I published in October 2015 in *JAMA Oncology* found that readily available, unbiased Medicare claims data may be sufficient to calculate long-term survival rates at hospitals, eliminating the need to know the stage of individual patients' cancers.

What did you discover?

In a nutshell, we found that there were large survival differences between different types of hospitals that treat Medicare patients with cancer. We discovered that patients treated at specialized cancer centers, including MSK, had a 9 percent higher survival rate over five years compared with cancer patients treated at community hospitals.

So that 9 percent represents deaths that might be prevented?

Yes. The degree of survival gap between hospital types is substantial and represents potentially preventable deaths. If more research confirms this survival gap, our next step will be to figure out the mechanics underpinning it.

Can where you're treated affect your chances for survival?

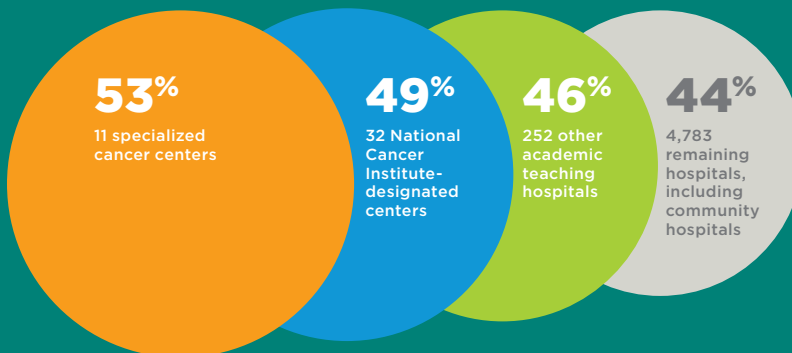
Yes.

A recent MSK study of 750,000 patient treatment records from 2006-2011 showed that patients treated at specialized cancer centers had a

9% higher survival rate

over five years than those treated at community hospitals, regardless of tumor type or stage.

FIVE-YEAR SURVIVAL RATES BY HOSPITAL CATEGORY:



Dr. Bach and his colleagues are now studying the factors behind these differences.

The MSK study was conducted by a multidisciplinary clinical and administrative team including Dr. Bach; David Pfister, Chief of MSK's Head and Neck Oncology Service; Elaine Duck; Elena Elkin; Ushma Neill; Mark Radzyner; and David Rubin.

You've received a great deal of press attention for the stance you've taken against the high cost of cancer drugs.

Right now we have a pricing system that has no checks in place. Pharmaceutical companies are allowed to charge whatever they like.

As a consequence, we've had more-rapid rises in pricing and spending on drugs than in any other category of healthcare. A few decades ago we used to be alarmed when cancer drugs cost \$1,000 a month. Now we're seeing drugs that cost \$10,000 or \$20,000 a month.

We're developing an approach to pricing drugs based on their value, as defined by questions such as how much benefit they give patients, how much they contribute to survival, and what side effects they cause. Does a drug have a favorable profile? If it does, perhaps it should garner a somewhat higher price — but if it doesn't, it shouldn't.

Soaring drug costs are a serious problem. Here's just one example: There are people in this country who are not getting Gleevec® [a drug used to treat chronic myelogenous leukemia and several other types of cancer] because the price is so high. This, in the wealthiest nation on earth, is somewhere between embarrassing and heartbreaking.

Can you discuss what is known as comparative effectiveness research and how it benefits patient outcomes?

The whole idea of comparative effectiveness research is to identify ways in which you can do something that's easier on a patient or less expensive — or both — and get the same quality outcomes as doing something more expensive or difficult.

For example, we can compare different surgical approaches for the same disease, or different radiotherapy approaches, or different approaches to diagnostic testing. These are all areas in which we can employ comparative effectiveness research to learn if we're able to achieve the same outcomes at a lower cost, or even improve them.

Much of what you've talked about relates to issues of transparency.

It does. It's part of our mission at MSK and it's the right thing to do. Looking at hospital-specific cancer survival is the start of a very large effort to bring transparency to performance and to cost. It may be uncomfortable, but it's vital.



**KATHRYN
MARTIN**

CHIEF OPERATING OFFICER



We absolutely believe that cost-effective patient care is the highest-quality care.”

—KATHRYN MARTIN

Cancer Care Cost and Value

Having the best care isn't worth much if patients can't afford to access it. “What we're really talking about is giving good value,” says MSK Chief Operating Officer Kathryn Martin when asked about outcomes. “We spend a lot of time trying to communicate this to patients, referring physicians, insurance companies, and large employers — better outcomes at a hopefully lower cost, but at the very least no higher cost. This is a critical distinction between MSK and many other oncology providers.”

The economic burden of cancer on patients is a subject about which Ms. Martin is passionate. “If someone comes through our doors and says that he or she has a financial problem,” she says, “we'll do everything possible to make sure that lack of money is not a barrier.”

In fact, the stress of what is sometimes called financial toxicity can be as significant as the physical toxicities of cancer treatment and can contribute to worse clinical outcomes and reduced quality of life. That's why providing high-quality cancer care now includes assessing patients for financial distress. “As part of our screening tool for every new patient, our nurses ask, ‘Would you like to speak to someone about your ability to pay for treatment?’ and ‘Do you need help with transportation to medical appointments or temporary lodging during treatment?’” Ms. Martin explains.

If patients reveal they can't afford treatment they are referred to MSK's Financial Assistance Program,

where patients with incomes up to five times the federal poverty level are eligible for help. Last year more than 1,000 patients had their bills reduced or eliminated because they could not afford to pay. Patients who are struggling with non-treatment-related costs such as rent, transportation, or childcare are referred to MSK's Department of Social Work. Using gifts from The Society of MSK and other generous donors, in 2015 social workers were able to help more than 1,700 patients who were having trouble making ends meet. (To read more about social work, see page 42.)

MSK staff are engaged in many other efforts to reduce the cost of care and, in turn, the financial burden on patients. Ms. Martin makes the point that “the cost question” does not in any way conflict with patient care. Indeed, she says, “They're totally aligned. We absolutely believe that cost-effective patient care is the highest-quality care.”



MEDICAL TESTING

**DEBORAH
KORENSTEIN**

INTERNAL MEDICINE SPECIALIST

Changing the Culture

One way to cut costs without compromising outcomes is through the prudent use of medical tests. “The overuse of testing is usually framed as a cost problem,” says MSK internal medicine specialist Deborah Korenstein. “But to me, it goes much deeper. It’s really a fundamental quality-of-care issue, because everything you do — whether it’s prescribing a drug or a diagnostic test — runs the risk of harm. And if we’re not doing something that potentially benefits patients, then we’re simply exposing them to potential harm.”

For a number of years, Dr. Korenstein has been involved nationally in designing ways to measure how much unnecessary care doctors are giving to patients and trying to tease out why they do it. She observes that the cultural landscape of medicine contributes to the problem. “Traditionally, doctors have subscribed to the idea that something is better than nothing,” she says. “There was a sense that to be a heroic doctor meant to go above and beyond for your patient. However, there has never really been an acknowledgement or a quantification of the potential harms of that approach.”

Yet another barrier to changing medical practice is that when doctors are trained, “we’re taught not to miss anything,” she says. “Young doctors will generate long lists of what could possibly be wrong with a patient even though out of 25 things on the list, 21 of them are

virtually impossible. And senior doctors grill junior doctors, ‘Did you do this? Did you order that?’ No one will ever get in trouble for having done too much or ordering too many tests.”

These factors can become magnified in cancer. “There’s the feeling that patients with cancer are very sick and extremely vulnerable,” Dr. Korenstein says. “People are worried about them — and that’s totally legitimate. But it cuts both ways: The harms of doing unnecessary things may be increased in cancer patients precisely because they are so vulnerable.”

She has recently initiated a project at MSK that addresses the overuse of laboratory testing in hospitalized patients. To launch it, she created a survey of staff who care for MSK’s inpatients, including floor nurses, nurse practitioners, physician assistants,

■ **Dr. Korenstein (pictured below with nurse practitioners Maureen Reidy, left, and Rosanne Sharp) is undertaking a study aimed at curbing excess lab testing.**



doctors in training, and attending physicians. Two key questions she asked were whether patients typically received unnecessary lab tests and whether staff would be comfortable with less testing. “Across the board, the majority of people said they would be comfortable doing less,” she says. And the most common reasons respondents gave for not actually reducing the number of tests? Habit.

Now Dr. Korenstein is working with a multidisciplinary committee to pilot a project on one service in Memorial Hospital to see if it can help cut down on excess lab testing. It’s an intervention that is strikingly simple: The group has created a small poster that hangs in the nurses’ station reminding clinical staff to consider what they’re ordering. Every week, she will send the staff a report of their “most popular tests,” as she puts it, and will track what happens. “The message is not ‘Don’t do it,’” she explains. “It’s ‘Think about it and only do the things your patient really needs.’”

She talks compellingly about what’s known as “anxiety due to uncertainty” and how this may affect medical decision-making. “Uncertainty is a huge part of being a doctor — you rarely know anything with 100 percent certainty,” she says. “And people who are more uncomfortable with uncertainty usually do more testing.”

Since arriving at MSK about a year ago, Dr. Korenstein says she is optimistic about the future. “Everyone has been so welcoming and open to the idea of trying to implement positive change.”



“

Traditionally, doctors have subscribed to the idea that something is better than nothing.... However, there has never really been an acknowledgement or a quantification of the potential harms of that approach.”

—DEBORAH KORENSTEIN



IMMIGRANT HEALTH

FRANCESCA GANY

CHIEF, IMMIGRANT HEALTH AND
CANCER DISPARITIES SERVICE

Going Where People Work, Play, and Learn

Internist Francesca Gany, Chief of MSK's Immigrant Health and Cancer Disparities (IHCD) Service, doesn't spend a lot of time in her office. That's because her most important work is done in the community, connecting immigrants, minority community members, and the medically underserved with the healthcare system in an effort to eliminate cancer and health disparities.

Immigrants and minorities have disproportionately high rates of many types of cancer, but many do not have the resources to access quality care. Lack of access to health information and services has been shown to have a negative impact on treatment outcomes for the medically underserved. "The work of our service is to identify the causes of health disparities in these populations and to develop, implement, and test interventions to overcome them," Dr. Gany says. The service also conducts outreach and education, delivers services to underserved communities, and trains practitioners and scientists who are members of those communities.

It comes as no surprise that the economic issues of cancer and its treatment can be staggering. But what may be eye opening is that among these problems is food. "Food is huge," says Dr. Gany. "We've found that 60 percent of patients served by the Integrated Cancer Care Access Network are food insecure. The program gives immigrants with cancer access to quality care, services, and resources that help ease the financial burden of treatment, including indirect costs such as transportation, childcare, and food. This means patients may not be traveling to medical appointments so they can have that transportation money to feed their kids. Or their hourly jobs give them only enough money to feed their families. Or they're barely eating. These



We've found that 60 percent of patients served by the Integrated Cancer Care Access Network are food insecure.... These patients very often have worse treatment outcomes than those who have enough to eat."

—FRANCESCA GANY



■ Community outreach assistant Anuradha Hashemi (left) and internal medicine specialist and public health researcher Abraham Aragonés work with Dr. Gany on the Immigrant Health and Cancer Disparities Service.

patients very often have worse treatment outcomes than those who have enough to eat."

That's why IHCD established its Food to Overcome Outcome Disparities Program. The program distributes nourishing food to patients and their families through pantries located in Manhattan, Brooklyn, Queens, and the Bronx.

And then there's a population that few consider, except on a cold, rainy day or after a late night at the theater: taxi drivers. There are more than 100,000 in New York City and almost all of them face similar health issues: obesity; a sedentary lifestyle behind the wheel; insulin resistance, which can lead to

type 2 diabetes; and the heightened cardiovascular and cancer risks that accompany these conditions.

The Immigrant Health Service has a grant from the National Institute on Minority Health and Health Disparities to improve the health of New York City cab drivers. Dr. Gany and her colleagues have partnered with the South Asian Council for Social Services and have worked with an advisory board of taxi drivers, community partners, and an external advisory committee to assess drivers' health priorities, identifying barriers to healthcare and finding ways to reduce health disparities in this community.

Individual Concerns, Personalized Programs

Each ethnic group has its own distinct set of health and cancer issues. IHCD has several programs that tackle some of the most pervasive of these concerns.

The Arab Health Initiative runs a breast cancer education and referral program that aims to disseminate culturally sensitive information about breast cancer to Arab-American women. In women diagnosed with breast cancer, IHCD staff helps them access healthcare services and provides psychosocial support.

The South Asian Health Initiative works to increase awareness and treatment of the most common health problems affecting the South Asian immigrant community, including oral cancer, diabetes, high blood pressure, and high cholesterol.

Ventanillas de Salud (Health Windows) was created by the Mexican Consulate as a venture between government and private organizations to eliminate barriers to healthcare in New York City's growing Mexican-American population. "There's a high incidence of cervical cancer in the Mexican-American community, and we currently have an initiative around cervical cancer and HPV vaccination," says Dr. Gany. "We're finding that we can increase HPV vaccination rates among the children of these immigrants and have gotten it up to about 70 percent — much higher than the national average."

Their findings have informed the development of comprehensive driver-centric health interventions, such as using air filters to remove particulate matter in taxis; pedometers — in a project called Step On It — to increase driver activity levels; and healthcare coverage and access navigators to help drivers obtain and keep health insurance coverage. "Another of our goals is to make sure that every driver has a primary care physician," says Dr. Gany. "Many of them don't. And if a driver has a colonoscopy and is found to have cancer, we're going to connect him or her with the appropriate care."



MSK CANCER ALLIANCE

RICHARD BARAKAT

DEPUTY PHYSICIAN-IN-CHIEF,
REGIONAL CARE NETWORK AND
MSK CANCER ALLIANCE

Improving Outcomes by Expanding Care and Research

Currently, community oncologists deliver the vast majority of cancer treatment. But advances in fighting the disease can take years to be adopted by local physicians. In 2013, the MSK Cancer Alliance was formed to forge partnerships between MSK and community oncology providers, creating a transformative new model for the delivery of — and patient access to — the highest-quality care.

The MSK Cancer Alliance now includes Hartford HealthCare, a multihospital system in Connecticut; Lehigh Valley Health Network in Pennsylvania; and the newest member, the Miami Cancer Institute, part of South Florida’s Baptist Health System. “Initially we thought of the Alliance as an opportunity to raise the standard of cancer care in the community for people who would not otherwise have access to the expertise of a comprehensive cancer center,” says Kathryn Martin, Chief Operating Officer. “But as the Alliance has evolved, we’ve come up with several other goals — and an important one is research, because with the advent of precision cancer medicine, our clinical care and research efforts are more closely aligned than ever.”



■ **Top left: Senior Vice President of Strategic Planning and Innovation Wendy Perchick at the Lehigh Valley Health Network-MSK Cancer Alliance announcement. Top right: MSK President and CEO Craig Thompson addressing the audience at Hartford HealthCare in Connecticut. Bottom, from left: MSK medical oncologist Tiffany Traina, Ms. Perchick, and Dr. Barakat at the Lehigh Valley Hospital announcement.**

“These are living, breathing, dynamic partnerships with a robust sharing of ideas and expertise,” says Richard Barakat, Deputy Physician-in-Chief for MSK’s Regional Care Network and the MSK Cancer Alliance. He and his colleagues have studied how Alliance members treat the six most common cancers to determine if MSK’s and members’ practices are in sync. “If they aren’t, we’ve come up with mitigation plans so that ultimately we’re all practicing in similar ways,” he explains. “We also have the ability for our disease management teams to work together. For example, Hartford, Miami, and Lehigh doctors will present cases at our tumor boards. What patients are getting is several healthcare systems interacting with MSK experts to decide the most-effective treatment approaches.”

And, like Ms. Martin, he points to a revolution in personalized cancer medicine, with more patients required to fulfill a burgeoning research agenda. “Right now, we have about 800 clinical trials ongoing at MSK,” he says. “The Alliance is about taking these cutting-edge trials and opening them up to the community.” Not only will trials be available to many more patients who need them, but also, says Dr. Barakat, “by increasing the numbers of patients enrolled on these trials, we’re actually going to be able to answer the most burning questions in cancer much faster. We’ll be studying outcomes very closely, and our knowledge base is going to increase exponentially.”

“

The MSK Cancer Alliances are living, breathing, dynamic partnerships.”

—RICHARD BARAKAT

Even before they enter the thoughtfully designed building on the day of their surgery, patients at the Josie Robertson Surgery Center (JRSC) have already embarked on a journey in which every step has been scrupulously planned to be as safe, smooth, and pleasant as possible.

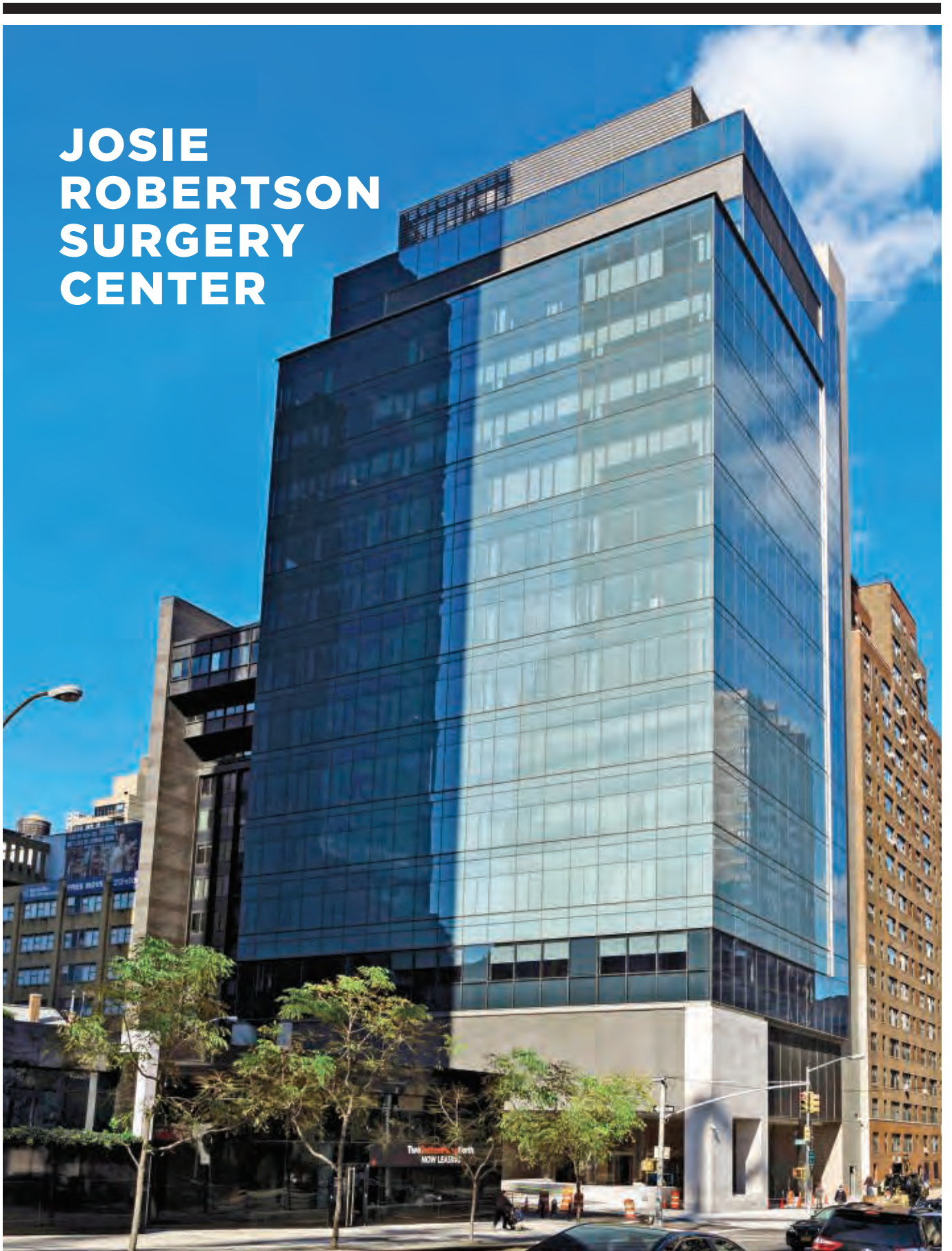
“This unrivaled facility is the result of years of research by our experts that’s now been translated into the most effective and personal outpatient surgical care,” says Brett Simon, Director of the JRSC.

“Our goal is to offer our patients an unmatched experience while they are with us at the JRSC and then enable them to return home and resume their daily activities,” Dr. Simon says. “Designing a way to get them to that point safely and quickly is a significant advance in cancer care pioneered at MSK.”

For example, as patients approach the day of their procedure, an online patient portal enables them to communicate directly with medical staff, with a mobile device app planned to be available soon. They also receive notifications from the staff to familiarize them with the facility and instruct them on preparing for their operation.

The center was established with a gift of \$50 million from the Robertson Foundation, established in 1996 by the late Josephine (Josie) Robertson and her husband, legendary investor Julian H. Robertson, Jr., and their family.

JOSIE ROBERTSON SURGERY CENTER





■ From left: The Josie Robertson Surgery Center offers gathering spaces for patients and their caregivers to relax before and after surgery; breast surgeon Carol Brown meets with a patient.

A Comfortable and Serene Setting

When patients arrive at the Josie Robertson Surgery Center on the day of their surgery, a concierge greets them in the lobby. Floor-to-ceiling windows let in abundant natural light and offer sweeping views of the East River. Once they're checked in, a real-time location system gives patients the flexibility to move around, and staff can still find them when needed.

Specially designed areas allow family members and caregivers to rest, eat, read, go online, play games to let off steam, or just have a quiet moment. A patient and caregiver waiting area on the third floor includes a café, tables with board games and crossword puzzles, and an Xbox station for playing video games. Tables and chairs, clustered in small groups called campsites, enable people to be together while they wait to see their loved one.

Each short-stay patient room is private, with its own bathroom, and includes bedside tablets equipped with video conferencing technology to allow patients to continue securely



■ From left: Rebecca Twersky, Josie Robertson's Chief of Anesthesia; and Vincent Laudone, Chief of Surgery.

“

The operating rooms at the Josie Robertson Surgery Center feature state-of-the-art equipment incorporating the most-advanced technology available.”

—VINCENT LAUDONE

Sophisticated Surgical Technology

The 12 operating rooms at the Josie Robertson Surgery Center have been equipped to perform specific surgeries, including robot-assisted procedures. Some of the most common operations performed here include breast surgery with immediate reconstruction and prostate, kidney, ovarian, uterine, and thyroid surgery.

“The operating rooms at the Josie Robertson Surgery Center feature state-of-the-art equipment incorporating the most-advanced technology available,” says urologic surgeon Vincent Laudone, Chief of Surgery.

He explains that surgical lights automatically adjust to eliminate shadows in the operating field and are temperature-adjusted to maintain accurate tissue color. Wide-screen, super-high-definition monitors are employed for laparoscopic and robotic surgery and can be used in all procedures to visually consult with onsite pathologists.

communicating with their doctors, caregivers, and family and friends after surgery. If a patient needs to stay overnight, these rooms include sleeper sofas or chairs to accommodate a caregiver.

In addition, the center has been designed to inspire patients to get out of bed as soon as they can. Central gathering areas outside the patient rooms encourage them to socialize, relax, or have a buffet-style snack. In the corridors, artwork and inscriptions on the walls serve as walking milestones, so patients can track their progress in the hours following their operation.

Diligent Follow-Up

After surgery, patients are closely monitored as they recover in the facility and are then deemed ready to be sent home. But the JRSC's commitment to patient care doesn't end there. On the day after their discharge, all patients receive a phone call from a nurse checking on the progress of their recovery.

Medical staff then continues to check in electronically with patients on a daily basis to ensure that their recovery is going smoothly, answer questions, and address any issues that may arise. This daily symptom reporting also gives JRSC physicians, nurses, and clinical staff information that will help them learn from and reevaluate procedures, such as changing pain medication prescriptions or altering how anesthesia is given.

“The increased attention to follow-up at Josie Robertson really stands out,” says Rebecca Twersky, Chief of Anesthesia at the JRSC. “After patients go home, we check in with them constantly to guide their recovery. Then, using data from these interactions, we see how we can improve our care and enhance outcomes.”



■ Above left: Clinical nurses Tamara Strah (left) and Amy Pippin were among the nurses who made vital contributions to the care delivery systems at the JRSC. Above right: Notes from staff members congratulating one another on providing exceptional patient care.

Nurses Help Create a New Patient Experience

Even before the Josie Robertson Surgery Center was on the drawing board, nurses were collaborating on and contributing to the processes that would, several years later, be in place there.

Michelle Burke, Nursing Director of Perioperative Services, along with William Hoskins, recently retired as MSK’s Executive Director of Surgical Activities, launched a pilot program called Ambulatory Extended Recovery (AXR) to critically evaluate post-surgical recovery. AXR looked at surgical patients who currently had three-, four-, or five-day hospital stays and who might be moved to an ambulatory extended recovery program that would get them home in 24 hours or less.

“We focused on the surgical services we anticipated moving to the JRSC,” says Ms. Burke. “We began with breast, plastic surgery, and some head and neck surgeries. Then we determined that gynecologic and urologic surgeries, with their laparoscopic and robotic techniques, could also lend themselves well to this effort.”

The AXR pilot began on several Memorial Hospital inpatient units. “We developed criteria for patients we felt we could accept into the program,” says Ms. Burke. “We looked for people who did not have a lot of comorbidities, such as heart disease, that might preclude them from being in the program. We also assessed social support: Did a patient have someone at home who could care for them after the operation? For those patients we felt would do well, we developed a different methodology for caring for and educating them.”

This included putting patients on a track requiring them to achieve specific post-surgical milestones by certain times to see whether they could return home within 24 hours. Ms. Burke and her colleagues also developed a comprehensive home follow-up program. The pilot lasted approximately four years, when it began to transition over to the JRSC.

The structure of the nursing teams delivering care at the JRSC is different than what a patient or caregiver may encounter almost anywhere else. For example, the presurgical nurse personally escorts the patient to the operating room and introduces him or her to the OR nurse. “This adds a level of comfort because the patient has already developed a relationship with that nurse,” explains clinical nurse IV Amy Pippin, who has worked at MSK for ten years.

Cross-Training — and We Don’t Mean the Gym

Another enhancement in JRSC nursing is what’s known as cross-training. All perianesthesia nurses are trained in both preoperative and postoperative patient care. “Every JRSC nurse has knowledge and skills to work preop, postop, and extended stay, which offers more flexibility for staffing because nurses are able to practice in any area of the facility as needed,” says Ms. Pippin. “Each nurse understands the entire process from beginning to end.”

Cross-trained nurses also benefit patients in other ways. Each nurse is able to anticipate her or his patients’ needs at any point during their stay. Patients can feel secure in that knowledge, and it also reduces anxiety for waiting family members. In certain cases, it may even be possible for a patient to have the same nurse before and after surgery.

In another innovation, patients are moved to one room to recover comfortably after surgery, rather than first having to go to a recovery room — also called a post-anesthesia care unit — and then being transported to yet another room once they’re awake. Not moving a patient more than once after surgery makes for a better, more comfortable experience, is more efficient, and reduces the potential for errors from handoffs of care from one team to another.

It’s All about the Patient

While there are many new processes in place at the JRSC, the quality of nursing care is the same high quality as patients experience in Memorial Hospital. “We all share the same values, beliefs, and ethics and take a team approach to looking after our patients,” says clinical nurse IV Tamara Strah, who has worked at MSK for 14 years and was previously an OR nurse in MSK’s Surgical Day Hospital. “We already have the culture. We’re just bringing it to the JRSC.”

“Our hope is that patients and caregivers have a warm feeling that we’re at Josie to dedicate all our time and attention to them,” concludes Marcia Levine, Nursing Director of Perioperative Services at Josie Robertson. “Everyone at the JRSC plays an integral role in patient care — providing feedback, measuring progress, and offering ideas about how to continuously improve our quality of care and patient outcomes.”

“

Our hope is that patients and caregivers have a warm feeling that we’re at Josie to dedicate all our time and attention to them.”

—MARCIA LEVINE

- Most of the approximately 200 pieces of art at the JRSC are inspired by views of the East River from the building. The works blend different textures and media and combine flow, color, and light to foster a healing environment.



Statistical Profile

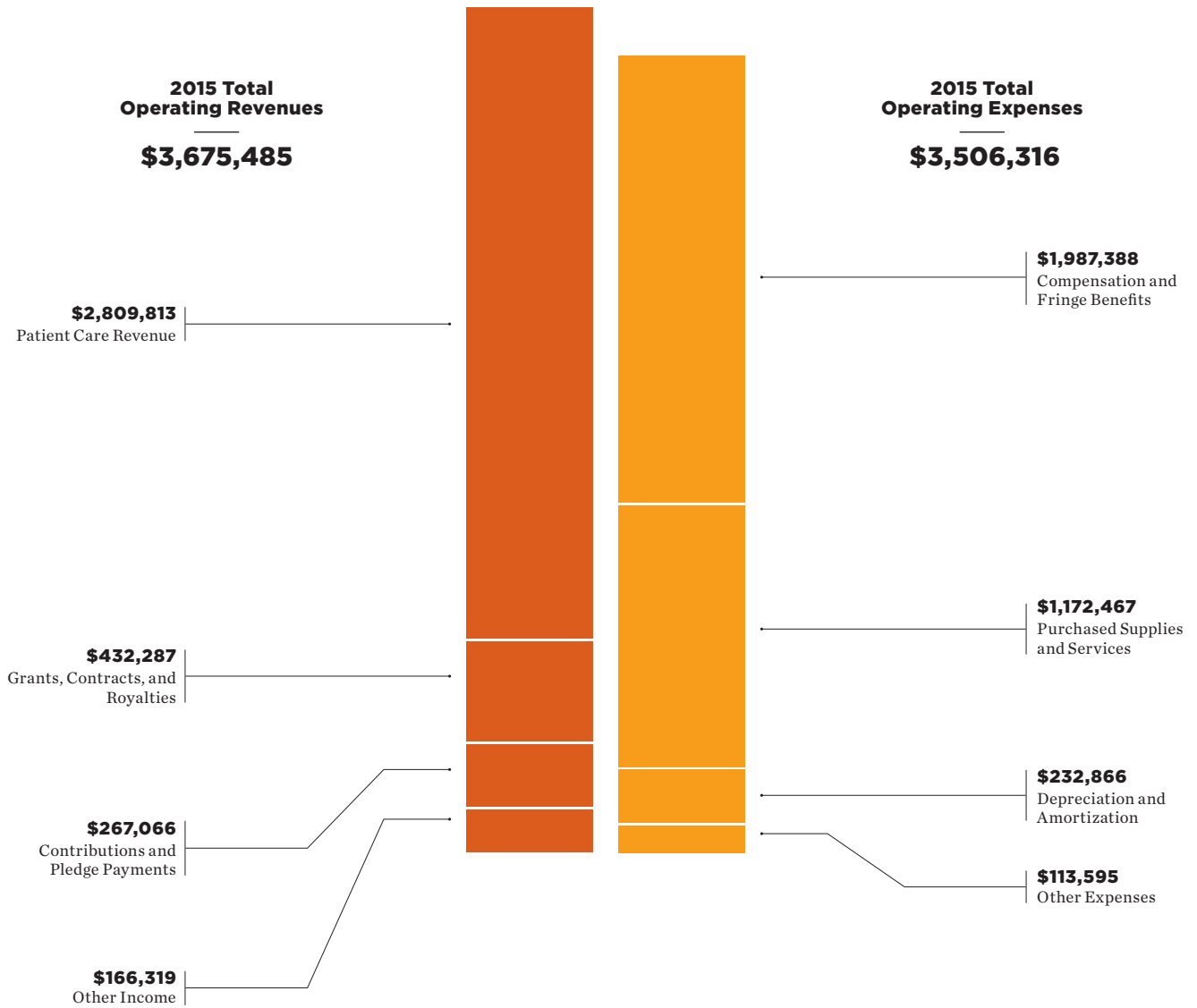
	11	12	13	14	15
Patient Care					
Patient Admissions: Adults	22,983	23,139	20,773	20,640	21,064
Patient Admissions: Children	1,503	1,459	1,553	1,504	1,403
Total Admissions	24,486	24,598	22,326	22,144	22,467
Total Patient Days	140,990	149,368	144,345	146,855	151,827
Average Patient Stay (days)	5.8	6.1	6.5	6.6	6.8
Bed Occupancy Rate ⁽¹⁾	82.2%	87.0%	83.0%	84.3%	90.9%
Outpatient MD Visits: Manhattan	432,802	436,510	463,724	480,260	489,897
Outpatient MD Visits: Regional Network	103,098	104,964	108,198	113,699	136,506
Total Outpatient Visits	535,900	541,474	571,922	593,959	626,403
Screening Visits	20,518	15,519	12,826	10,282	22,403
Surgical Cases	19,374	19,691	20,465	20,420	21,368
Radiation Treatments and Implants: Manhattan	60,393	60,289	61,335	62,375	60,804
Radiation Treatments and Implants: Network	51,615	50,476	53,660	55,229	58,041
Total Radiation Treatments and Implants	112,008	110,765	114,995	117,604	118,845
Diagnostic and Interventional Radiology Procedures	377,360	391,187	416,360	435,501	466,848
Clinical Investigation Protocols ⁽²⁾	552	657	735	776	879

(1) Based on adjusted bed count
 (2) Excludes studies closed to accrual

	11	12	13	14	15
Staff					
Sloan Kettering Institute Members	143	149	143	140	140
Hospital Attending Staff	834	876	935	995	1,033
Registered Nurses	2,018	2,133	2,221	2,373	2,605
Administrative and Support Staff	8,989	9,281	9,707	10,223	10,965
Total Staff*	11,950	12,402	12,975	13,699	14,711
Volunteers	1,058	1,018	1,004	902	967
Education					
Residents and Clinical Fellows — Positions	440	445	464	465	464
Residents and Clinical Fellows — Annual Total	1,676	1,682	1,691	1,674	1,723
Research Fellows	321	320	323	351	355
Research Scholars	131	124	133	110	98
Research Associates	82	89	91	95	110
Graduate Research Assistants	29	39	41	47	47
PhD Candidates	225	222	227	239	265
MD/PhD Candidates	21	21	19	18	20
Registrants in CME Programs	2,533	3,968	3,681	5,614	3,581
Medical Observers	526	566	630	579	574
Medical Students	419	431	392	505	548
Nursing Students	142	178	179	257	312
Social Work Students	6	6	7	7	4
Radiation Oncology Technology Students	14	13	15	15	15
Physical Therapy Students	4	7	2	6	5
Occupational Therapy Students	3	4	2	3	2

*In 2015, 32 staff members held appointments in both the Institute and the Hospital.

Financial Summary



	11	12	13	14	15
Operating Revenues (in thousands)					
Patient Care Revenue	\$ 2,141,421	2,201,941	2,367,731	2,560,457	2,809,813
Grants and Contracts	190,948	185,160	202,061	229,562	234,402
Contributions	128,354	128,253	138,343	168,797	137,538
Net Assets Released from Restrictions – Pledge Payments	64,798	86,820	79,199	103,112	129,528
Royalty Income	77,510	78,350	94,058	162,710	197,885
Other Income	48,351	51,167	57,150	62,643	66,032
Unrestricted Investment Return Allocated to Operations	104,699	75,877	82,028	87,917	90,648
Transfer of Board-Designated Annual Royalty Annuitization	46,417	51,709	57,495	15,885	9,639
Total Operating Revenues	\$ 2,802,498	2,859,277	3,078,065	3,391,083	3,675,485
Operating Expenses (in thousands)					
Compensation and Fringe Benefits	\$ 1,466,667	1,582,212	1,689,501	1,782,477	1,987,388
Purchased Supplies and Services	835,621	879,219	924,691	1,062,603	1,172,467
Provision for Bad Debts and Assessments	18,285	17,541	19,969	35,859	64,194
Depreciation and Amortization	195,461	210,810	210,373	217,342	232,866
Interest Expense	57,098	54,894	55,039	50,147	49,401
Total Operating Expenses	\$ 2,573,132	2,744,676	2,899,573	3,148,428	3,506,316
Income from Operations	\$ 229,366	114,601	178,492	242,655	169,169
Philanthropic Revenue	\$ 301,374	231,159	380,500	376,533	276,747
Capital Spending	\$ 223,251	258,613	315,282	473,859	710,873
Balance Sheet Summary					
Assets	\$ 6,790,005	7,795,606	8,481,418	8,963,268	9,592,021
Liabilities	2,848,843	3,562,546	3,337,444	3,596,860	4,058,058
Net Assets	\$ 3,941,162	4,233,060	5,143,974	5,366,408	5,533,963

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as of March 31, 2016

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The Campaign for Memorial Sloan Kettering

As it enters its final year, the Campaign for Memorial Sloan Kettering has maintained its strong forward momentum, with nearly 1 million gifts received in 2015. As of December 31, the Campaign had recorded a total of \$3.83 billion in gifts and pledges, putting it \$333 million above its goal of \$3.5 billion. The Campaign is on track to pass the \$4 billion mark by the time it concludes at the end of 2016.



Douglas A. Warner III Louis V. Gerstner, Jr. Craig B. Thompson



Left: Julian Robertson and Douglas Warner at the December 9 dedication of the Josie Robertson Surgery Center. Right: Equinox Instructor JJ Hendershot leading a Cycle for Survival event in New York City.

A record-setting \$96.2 million in cash receipts for the month of December brought the year to a resounding close. It was the Campaign's second consecutive record-setting December.

Key to such strong ongoing achievement are the farsighted donors who have been so consistently generous in support of MSK and its mission. Special recognition is also due to the leadership provided by the Campaign's co-chairs, Douglas A. Warner III and Louis V. Gerstner, Jr., who have guided the historic fundraising effort from its earliest days. Through their work with potential donors, as well as in their collaborative efforts with MSK President and CEO Craig B. Thompson and their colleagues on the Board, they have helped to ensure that the Campaign embodies MSK's highest aspirations even as it generates the funds needed to meet top institutional priorities.

During the course of the Campaign, MSK has built one of the nation's most productive and highly efficient fundraising operations. Under the direction of Anne M. McSweeney and Richard K. Naum, MSK's Development Office now has in place the solid foundations required for long-term fundraising success.

Of the many contributions received in 2015, several stood out as exemplifying the spirit of thoughtful generosity that inspires donors at every level. These include a commitment of \$35 million from the Parker Institute for Cancer Immunotherapy; a pledge of \$15 million from Board member David M. Rubenstein in support of

the David M. Rubenstein Center for Pancreatic Cancer Research, which brings his total support for the initiative to \$25 million; \$10 million from Robert and Kate Niehaus to create the Robert and Kate Niehaus Center for Inherited Cancer Genomics; a commitment of \$5 million from Nassef Sawiris to establish the Sawiris Family Initiative in Blood Cancer Research; and \$5 million from the Debra and Leon Black Family Foundation for the Acral Melanoma Initiative.

Memorial Sloan Kettering also benefited enormously from the thousands of volunteers who put their energy and enthusiasm to work for the institution by participating in athletic fundraising events. Nearly 950 runners ran in the 2015 TCS New York City Marathon as members of Fred's Team, raising a total of more than \$5.3 million for research. And Cycle for Survival continued to grow at a rapid pace, with 21,000 cyclers taking part in events across the nation in 2015. In its first nine years, Cycle for Survival raised \$76.5 million and supported more than 100 clinical trials and research studies focused on rare cancers.

The Campaign for Memorial Sloan Kettering has spanned a critical period in the fight against cancer, one marked by exciting scientific breakthroughs and innovative approaches to treatment. Fueled by the support of thousands of benefactors, MSK's physicians and scientists are intensifying their efforts on every front, making a real difference in the lives of patients and paving the way to even greater future progress.

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The Society of Memorial Sloan Kettering Cancer Center

“The Society has been part of the Memorial Sloan Kettering team for nearly seven decades. We are privileged to fund projects that strengthen and enhance the mission of this extraordinary institution,” says Society President Lavinia Branca Snyder.



The Society plays a central role at Memorial Sloan Kettering. We are grateful for their longstanding support of innovative research, for programs that enhance our patients' well-being, and for public education initiatives that promote the understanding of cancer prevention, detection, and treatment.”

—CRAIG B. THOMPSON

Supporting Research

One of The Society's central missions is the funding of nascent research that is often too early to receive support from conventional sources. The Society has helped launch innovative investigations of young scientists and has provided an opportunity for established researchers to explore leading-edge ideas.

In 2015, The Society's Special Projects Committee funded the research of five MSK scientists. Their projects included an investigation that modeled pancreatic cancer through gene editing in human embryonic stem cells; inducing cell death with the use of nanoparticles as an anticancer strategy; and employing genetically engineered mouse models of glioblastoma to gain insights into tumor development that can inform the development and assessment of therapies for this deadly brain cancer.

The Society's Research Grants support the clinical and translational research projects of junior investigators, many of which go on to become permanent programs and features of MSK. In 2015, the grant program funded nine proposals. These included a study focused on investigating the molecular mechanism

underlying a novel group of aggressive kidney cancers; a project exploring changes in the tumors and blood of patients with Merkel cell carcinoma, a rare skin cancer; and a study to examine methods to sensitize ovarian cancers to checkpoint blockade immunotherapy.

The Society also supports research through the Associates Committee Fall Party, which in 2015 raised funds to help launch the Pain and Palliative Care Team in MSK's Department of Pediatrics.

The Society Campaign (formerly known as the Annual Appeal), a tradition since 1946, supports research and patient care programs through a personal letter-writing campaign. This year, the Campaign raised crucial funds for precision medicine, which seeks to understand the molecular makeup of each patient's tumor to inform the best therapeutic strategy.

Funds raised through the Winter Lunch and Bunny Hop concluded the Associates Committee's fundraising for the pediatric sarcoma initiative led by pediatric oncologist and sarcoma expert Paul Meyers.



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Supporting Patient Care

When Society members are asked to define one of the key aims of the organization, the words “patient care” echo again and again. The group has a long-standing commitment to enhancing the patient experience by providing activities and events outside of the treatment routine.

Patient programs that support artistic expression and special projects that improve the patient environment — including visits from Big Apple Circus clowns to the Department of Pediatrics, flowers in waiting areas, and festive holiday activities throughout the year — are just a few of the ways The Society enriches the days of MSK’s patients.

For decades, some of the most celebrated Society traditions have centered on making the winter holiday season a joyful time for Memorial Hospital inpatients. The Society sponsors parties for both children and adults, complete with overflowing gift bags.

And, at one of the year’s most anticipated events, more than 200 pediatric patients — from toddlers to teens — can be counted on to party up a storm at the

25th annual Pediatric Prom in May. The event, hosted by The Society’s Children’s Committee, enables children and young adults who are being treated for cancer to celebrate with family, friends, and Department of Pediatrics’ medical and support staff.

To increase accessibility and encourage support for its mission, The Society introduced its newest donor group, The Society Circle, in 2014. In 2015, it continued to support The Society’s mission.

Supporting Education

The educational programs sponsored by The Society are conducted in cooperation with the professional staff of MSK. The annual Health Education Seminar (HES) is central to The Society’s commitment to providing public education on the prevention, early detection, and treatment of cancer.

In 2015, the HES featured advances in precision imaging in cancer, focused on the Department of Radiology’s development of new molecular probes for multi-modality imaging, including MRI, PET, and optical, as well as innovative translational research in molecular imaging.

Among its other activities, The Society’s Social Services Committee funds the Fellowship Program for oncology social work, which annually allows four individuals interested in pursuing careers in social work to intern at MSK. This year, the Fellowship Program provided specialized on-the-job learning opportunities and stipends for four social work interns in their second-year masters program for a ten-week period during the summer.

1. Left to right: Former Society President Martha Vietor Glass; artist Solange Knowles, who served as a special guest DJ for the Spring Ball; and MSK Physician-in-Chief José Baselga.

2. 2015 Society Research Grants Program award recipients with MSK Physician-in-Chief José Baselga (center), Society Treasurer Victoria Greenleaf Kempner (far left), and Mrs. Glass (far right).

3. Caroling and celebrating at the 2015 adult patient holiday party.

4. Santa peruses the Christmas wish list of an MSK pediatric patient.

5. Left to right: Honorary Miracle on Madison Chair Sandra Lee, Society President Lavinia Branca Snyder, and Madison Avenue BID President Matthew Bauer at the 29th annual Miracle on Madison Avenue shopping event benefiting The Society of MSK on December 5.



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