



2012 ANNUAL CANCER REPORT



HEALING EXPERIENCES FOR EVERYONE ALL THE TIME®

2012 CHAIRMAN'S REPORT

Ashish Dalal, M.D. Board-Certified Medical Oncologist



On behalf of the multidisciplinary Cancer Committee of Parrish Medical Center (PMC), we are pleased to present 2012 Annual Report. This report reflects the statistical data for the calendar year 2011. Our cancer program provides a network of oncology services specializing in the prevention, diagnosis, treatment and management of patients with cancer. The hospital voluntarily undergoes a rigorous three-year accreditation survey by the American College of Surgeons Commission on Cancer (CoC). Due to our commitment of providing cancer care, PMC is recognized as a CoC approved Community Cancer program since 1989. Only 30 percent of all hospitals have earned this distinction. This approval helps to insure that our patients receive quality cancer care close to home. To maintain accreditation, we must continue to meet the rigorous standards of the Commission on Cancer on an annual basis. The CoC has recently updated the standards for cancer programs to focus on patient-centered needs and quality of care and outcomes, which encompasses our mission of “Healing Experiences for Everyone all the time”.

The Cancer Program is governed by a multidisciplinary Cancer Committee. The committee meets quarterly to plan, assess and implement all cancer-related programs and activities. The committee's goals ensure PMC offers a coordinated, multidisciplinary approach to cancer prevention and treatment. The Committee strives to continually improve patient survival and outcomes to enhance the quality of life for all cancer patients, regardless of diagnosis. These goals are accomplished by an emphasis on wellness, education, prevention, survivorship and monitoring comprehensive quality cancer care. As a healing environment PMC provides for the physical, emotional, and psycho-social care of the patient throughout the cancer disease continuum.

This report would not be complete without thanking the members of the Cancer Committee and the Cancer Registry for their help throughout the year and for their contribution to this annual report. Special thanks to Joan Galbicsek, the Cancer Registrar who is a vital organizing force and key component of the Registry's continued achievement. The cancer program and the community have advocated for innovative health initiatives and helped to guide the medical center's success in exceeding the national best-practice standards for excellence in Cancer Care.

Ashish Dalal, MD
Cancer Committee Chairman
Medical Oncology

In 2012 the Parrish Medical Center Cancer Care Program received several recognitions and other achievements:

CANCER CARE

- Parrish Medical Center has devoted significant resources to developing a Breast Center of Excellence. The program has the infrastructure and expertise to provide quality care. In March 2008, PMC received the Joint Commission Disease Specific Certification in Breast Cancer Care making us one of only ten organizations in the United States (U.S). This accreditation means we have met the highest national standards and guidelines known to significantly improve outcomes and satisfaction for patients undergoing treatment for breast care.
- Voluntarily participates in the National Consortium of Breast Centers Quality Measures for Breast Center Programs. Through PMC's participation, the community is assured that our center not only provides the services they need, but is actively monitoring these services to provide each patient with the highest quality care.
- Re-accreditation as a Breast Imaging Center of Excellence by the Commission on Quality and Safety and the Commission on Breast Imaging by the American College of Radiology in Mammography, Stereotactic Breast Biopsy, Breast Ultrasound and Ultrasound Guided Breast Biopsy. PMC in one of only 23 hospitals, clinics or health centers in Florida to have been designated a Breast Imaging Center of Excellence and is one of only two in Brevard County.
- New Toshiba Ultrasound Technology was installed. This technology provides improved image resolution and visualization and definition of lesions, cysts and subtle tissue characteristics while scanning at increased depth and on difficult-to-image patients
- Parrish Medical Center has the only Certified Breast Cancer Navigator (CBCN) in Brevard County. She provides educational and emotional support to patients with a cancer diagnosis and is able to guide the patient and family through treatment options for a new diagnosis or recurrent cancer, reinforcing information given by their physicians and supporting the patient's decisions. In 2012, the navigator has interfaced with 600 patients with suspicious findings. The ability to interface with the patients prior to further workup allows for improved quality of care and potentially impact clinical outcomes when timely intervention occurs.
- The Parrish Infusion Center specializes in intravenous treatments, and its number one goal is patient centered care. We work with an array of patients who are undergoing treatments such as chemotherapy, pain management or intravenous antibiotics.
- 2012 HealthGrades Gynecologic Surgery Excellence Award™. Parrish Medical Center is among the best 10% of hospitals. HealthGrades 2012 Trends in Women's Health in American Hospitals Report finds that collectively, from 2008–2010, if all hospitals in America performed at 5-star quality, women would have had nearly 32,000 fewer gynecologic surgery complications. Only hospital in Brevard County to earn award.
- College of American Pathology (CAP) certification since 1983. By maintaining the highest standards in lab services you can be confident that PMC is committed to quality patient care.

● **PALLIATIVE/SUPPORTIVE CARE**

The Palliative Care Program expanded services by the addition of a Palliative Care Coordinator, Masters prepared RN, who facilitates palliative care services to seriously and chronically ill patients hospitalwide. The goal of supportive and continuing care services is to ensure a complete range of services, and to address emotional and physical needs, as well as psychosocial services. Additionally, this service aims to support patients as well as their caregivers. Some of the successes include:

- Earlier referrals for hospitalized patient who may benefit from Palliative Care Services. Timeliness of referrals decreased from 4.37 days to 1.40 days from time of admission to time of palliative care referral.
- Number of referrals tripled with over 600 referrals made in 2012.
- Earlier referrals contributed to reduced hospital admit-to-discharge length of stay (from 10.83 days in 2011 to 5.06 days in 2012)
- 19% of Patient's served by PMC Palliative Care had Cancer as a primary or secondary diagnosis.
- 36% of cancer patients served by Palliative Care were assisted with transition to hospice services
- Hospice of St. Francis continued to support PMC with an Inpatient Hospice Program which serves families and patients who remained too unstable for transport out of the hospital.
- Collaborated with two local patient-centered medical homes to provide Advance Directive Discussions to patients.
- Presenting at local support groups to increase awareness of End of Life and the importance of having Advance Directives documented.
- Continued participation in the National Palliative Care Registry Database.
- Ongoing Process Improvement initiatives using Lean Six Sigma methodology and DMAIC processes.

Parrish Medical Center has a culture of quality improvement and service excellence. This environment inspires and challenges the cancer program to provide services that go beyond the standard of care, to be a service line leader that provides safe, effective, superior care. In 2012 the quality initiatives and goals focused on early detection, timeliness of services, treatment and supportive services. Ensuring patients get treatment according to national guidelines in a timely fashion is the key for improving quality of care and improved survival.

The following outcomes were achieved:

- Parrish Medical Center ranked in the top 25 percentile in timeliness of care among all other Clinical Breast Centers across the country that serves a similar size and population according to the National Quality Measures of the Breast Consortium. Timeliness of diagnostic mammography to definitive diagnosis has remained consistent from 4–6 average days. We have continued to improve outcomes by enhancing access to breast cancer services through ensuring that any women with a positive breast finding will receive further diagnosis and treatment on a timely basis.
- Improvement in timeliness between screening mammogram and diagnostic mammogram from 12 average days in 2010 to 6 average days in 2012.
- Improvement in timeliness between diagnostic mammogram and definitive diagnosis from 12 days

in 2010 to 7 average days in 2012.

- Achieved and maintained 100% adherence to treatment guidelines in patients receiving hormone therapy within 365 days.
- PMC's breast cancer program consistently performs above the ACR (American College of Radiology) benchmark of 50% in identifying early stage breast cancer. In 2012, 78% of breast cancers were staged Stage 0 or 1.
- Suzanne Comer OTR/L, CLT, a Certified Lymphedema Therapist joined the PMC team.
- Partnered with Helen Duane, a Licensed Clinical Social Worker, to ensure psychosocial support resources are available to all cancer patients.
- Recognizing that each person is unique, the cancer program strives to provide patient-centered care by developing a partnership with key community services that assist in providing the best quality care to the individuals we serve. These partnerships allow for care that reflects the individual's wishes, wants, and preferences and the insight gained through this process allows for programs, education, and support specific to the community needs. Patient services provided through partnerships for 2012 include:

The American Cancer Society (ACS) partnerships assist in leveraging resources and expertise to advance identified initiatives. The Cancer Care boutique provides a pampering environment with the resources to help cancer patients adjust to the psychosocial effects of cancer. Focus is on a patient's self-esteem and well-being by providing wigs, turbans, hats, bras, and prostheses. The boutique is available to patients with all types of cancer through the resources provided by the American Cancer Society. In 2012, over 144 patients were provided services through the ACS Cancer Boutique.

In 2012, the HOPE Award was awarded by the Florida Division of the ACS for exemplary and continuing volunteer service that enhances the quality of life of patients and their families.

- Look Good Feel Better
- Support Groups
 - Parrish Partners
 - I Can Cope – 3 trained facilitators
- Relay For Life
- Making Strides
- Expanded collaboration with local community providers by providing orthotic garments prior to planned surgery.

FUNDING

- Jess Parrish Foundation Gala raised \$20,000 for the PMC Cancer Care Program.
- Titusville Ladies Club raised over \$20,000 with the "Journey of the Traveling Bras" to assist women with breast cancer care.
- Funding was provided for breast screening through the generous donation of a local cancer survivor. The 2011 "All About You" event raised \$4,600 for the Breast Health Program at Parrish Medical Center. The donations benefited over 50 women in 2012.

- Provided \$5,000 in free screening mammograms. Funding provided for over 80 women.

COMMUNITY OUTREACH/EDUCATION

Provided 51 outreach events in 2012 and have served over 2,000 people. Focus has been on early detection and prevention.

- Provided “Food for Life” Cancer Project class offerings to educate survivors on better eating habits and ways to prepare foods to reduce the risk of cancer in 2012– January, May, September.
- “Whole Body Healing” 2012 Cancer Survivor Wellness Day Event was successful with over 100 participants. Lora A. Thompson, PhD, and Kathy Allen, M.A., RD, LD/N, CSO from Moffitt Cancer Center presented integrative therapies for the cancer survivor and their caregivers to address the mind, body, and spirit of the individual undergoing cancer treatment and follow-up care.
- In collaboration with the Titusville Art League, cancer survivors designed and created an inspirational ceiling tile painting displayed on the Oncology Unit. The project’s aim is to improve the quality of life for cancer patients and family members by providing an inspirational environment that encourages constructive responses to illness.
- Offered “Girls Night Out” to promote early detection with breast screening mammograms in May, July and October 2012. Over 120 women benefited from this endeavor.
- PMC and Dr. Miguel A. Medina joined efforts to volunteer in the Annual Men’s Health Summit providing free prostate screenings to 65 participants.
- Collaboration with community partners in the AME Churches has been successful in 2012 with reaching over 200 community members
 - Colorectal and Prostate Awareness & Screening to high risk populations: Mt. Moriah (#125), Harry T Moore Health Fair (#200).
- Dr. Miguel Pelayo provided education on prostate cancer in Spanish to 32 Latino participants.
- Parrish Medical Center offers Living Healthy workshops at no cost. Living Healthy is a Chronic Disease Self-Management Program (CDSMP) based on a proven model developed by the Stanford University Patient Education Research Center. Living Healthy is a six-week workshop for adults with chronic conditions. Caregivers and loved ones are also invited to attend. Workshops are offered in communities worldwide to improve health and reduce hospitalizations.
- Hope Floats, an event for Breast Cancer Prevention & Recovery was presented by Jenn Gibbons, the founder of ROW. ROW is a rowing team that gives breast cancer survivors the opportunity to interact, become active in their recovery, and gain support from fellow survivors.
- Emmi patient education videos were offered for oncology procedures and treatments. Emmi Videos are educational programs which walk you through medical procedures from beginning to end. The program helps you learn what to expect before, during and after a procedure.

RESEARCH

- PMC joined efforts to support the American Cancer Society's Cancer Prevention Study-3. CPS-3 will help researchers better understand the lifestyle, environmental, and genetic factors that cause or prevent cancer. PMC recruited over 250 participants to participate and to better understand the causes of, and ultimately determine ways to prevent cancer.
- Clinical Trials information and brochures are provided in the patient/family waiting areas including access to the ACS clinical trial matching website. Eligibility for clinical trials are further evaluated by attending physician and presented to patient if applicable.

STAFF EDUCATION

- Continue to meet the Oncology Nursing Certification Corporation Employer Award criteria for organizations that provide sustained support and recognition of oncology certified nurses.
- PMC has greater than 50% Oncology Certified Nurses on the oncology unit. Certification in oncology nursing demonstrates that the nurse has specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty to promote optimal patient care.
- PMC requires all nurses who administer chemotherapy to be certified by the Oncology Nursing Society Chemotherapy Course. We currently have 18 chemotherapy certified nurses.
- Cancer Conferences are an essential forum to provide multidisciplinary consultative services, as well as to offer education to physicians and allied health professionals.
- Oncology Grand Rounds provides education for physicians and health care providers to improve knowledge, competence and performance and enable the optimum provision of health care. Moffitt Cancer Center and MD Anderson specialized physicians presented in 2012.
- Palliative Care Series is offered quarterly and provides a learning opportunity for physicians, allied health professional and students who want to increase their understanding of palliative care and to improve the quality of palliative care services.

PARRISH MEDICAL CENTER

2011 SITE-SPECIFIC STUDY

BREAST CANCER



NAVIGATION

A diagnosis of cancer can be overwhelming for patients as well as their families. PMC patients and their families have a dedicated nurse who helps them through their cancer journey. As the patient's advocate, the navigator works with physicians and others involved in the patient's care to ensure the patient has access to education, support and resources needed to make informed choices.



Parrish Medical Center has the only Certified Breast Cancer Navigator (CBCN) in Brevard County. The navigator provides educational and emotional support to patients with a cancer diagnosis and is able to guide the patient and family through treatment options for a new diagnosis or recurrent cancer, reinforcing information given by their physicians and supporting the patient's decisions. In 2012, the navigator has interfaced with 600 patients with suspicious findings. The ability to interface with the patients prior to further workup allows for improved quality of care and potentially impact clinical outcomes when timely intervention occurs.

The patient navigator takes on the role of contacting the patient and discussing the resources available to help support them through their cancer journey. The patient navigator will serve as the patient's point of contact throughout treatment, available to answer questions about the diagnosis and physician orders, arranging access to community resources, and more.

While working with the newly diagnosed breast cancer patients is the main focus of breast health navigation, it is not the only function. The navigator is available to anyone with a breast health issue. Attending health fairs, talking with women's groups and spreading the importance of early detection are other key roles of navigation. Keeping other health care members up to date on current trends in breast care is yet another role of navigator.

The continuity of care for the breast cancer patient from suspicious finding throughout the entire plan of care is what sets PMC's navigation program apart from the rest. Since inception, the Breast Cancer Navigation Program has been enhanced and refined based on patient needs and wants. It now serves as a model for other programs.

For more information, contact the Breast Health Navigator at 321-268-6111, ext. 3544.

RADIOLOGY

As is the case with all cancers, early diagnosis is the key to a successful outcome. Early diagnosis is made possible through a large network of technologically advanced diagnostic centers. This network includes American College of Radiology accredited, all-digital diagnostic centers conveniently located throughout North Brevard. In 2012, PMC was re-accredited as a Breast Imaging Center of Excellence by the Commission on Quality and Safety and the Commission on Breast Imaging by the American College of Radiology in Mammography, Stereotactic Breast Biopsy, Breast Ultrasound and Ultrasound Guided Breast Biopsy. PMC is one of only 23 hospitals, clinics or health centers in Florida to have been designated a Breast Imaging Center of Excellence and is one of only two in Brevard County.



The Radiology Department provides services in diagnostic imaging, ultrasound, nuclear medicine, computerized tomography, magnetic resonance imaging, mammography and women's imaging and interventional radiology. The Women's Diagnostic Imaging Center performs digital mammography, bone density and ultrasound procedures. This is an integral part of the treatment for health prevention and intervention for the diagnosis of many cancer patients. In partnership for women's health, PMC performed 8,728 screening and diagnostic mammography exams and 216 mammography studies funded by grants and donations for women without health coverage in 2012.



PMC has digital diagnostic technology; doctors are able to see results immediately without having to wait for film to be developed. The images are superior and crystal clear, allowing for more-accurate and faster diagnoses. In 2012 new Toshiba Ultrasound Technology was installed. This technology provides improved image resolution and visualization and definition of lesions, cysts and subtle tissue characteristics while scanning at increased depth and on difficult-to-image patients. The images can be shared electronically among doctors and the hospital, which results in enhanced patient and physician experiences.

If a biopsy is needed for diagnosis, a needle biopsy is performed to successfully diagnose suspicious findings without requiring a traditional breast surgical biopsy, which is more invasive and is performed in the operating room. In 2012, one hundred thirty one stereotactic breast biopsies and 53 ultrasound breast biopsies were performed. Thirty eight core biopsies resulted in a positive diagnosis of breast cancer.

Our rates of detecting early stage breast cancer are higher than the average rate in the United States – 78% of our patients are detected at an early stage as compared to 56.39% for the United States. The women in our community have a greater awareness of the need for early detection and are getting their screening mammograms regularly. Our primary care physicians and gynecologists include regular mammograms as part of their patient's health maintenance. We attribute these successes to our reputation in the community and the efforts of a multidisciplinary team who works together to diagnose and initiate treatment in a timely manner.

PATHOLOGY

Changes in the breast can result in an abnormality that is either felt by examination or seen on mammogram. When a biopsy is performed, a pathologist's role is to carefully examine the tissue and classify it as benign or cancerous. If a cancer is found, it is further characterized to help make treatment decisions. Most breast cancers are carcinomas derived from breast ducts and lobules and are divided into invasive and noninvasive (carcinoma in-situ) types.



Noninvasive (in-situ) Carcinoma

In-situ carcinoma includes ductal (DCIS) and lobular (LCIS) types. These lesions have no ability to spread to other areas of the body. If left untreated, however, they may progress to invasive carcinoma. The pathologist evaluates the type and amount of carcinoma present, grade (low, intermediate, or high), and completeness of removal. All of these factors are used to determine the best plan for further treatment and follow-up.



Invasive Carcinoma

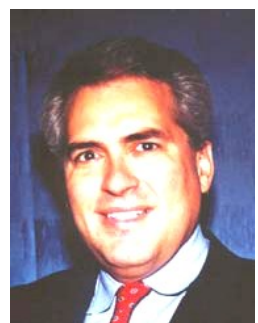
Surgery for invasive carcinoma may involve a partial or complete mastectomy with or without axillary lymph node sampling. The pathologist's role is to assess characteristics of the tumor, called pathologic staging. Important features that contribute to staging are tumor size, grade, invasion of adjacent structures, and proximity of the tumor to the tissue edges. If lymph nodes have been removed, these are also carefully examined for the presence of metastatic tumor cells. Pathologic staging is essential for deciding what other therapy (chemotherapy, radiotherapy, further surgery) will benefit the patient most.

Ancillary Studies

Some medical therapies for cancer depend on special characteristics of the tumor cells. Hormonal therapies target the growth-promoting effect of estrogen. Antibodies against the growth-promoting protein HER2 impair its function. Pathologists determine whether a patient's breast cancer cells express estrogen receptor, progesterone receptor, and HER2 so that the correct therapy can be used. Other tests may be performed to estimate how likely a tumor is to metastasize. Pathologists have an integral role in ensuring the proper tissue is tested and in helping to interpret the results.

SURGERY

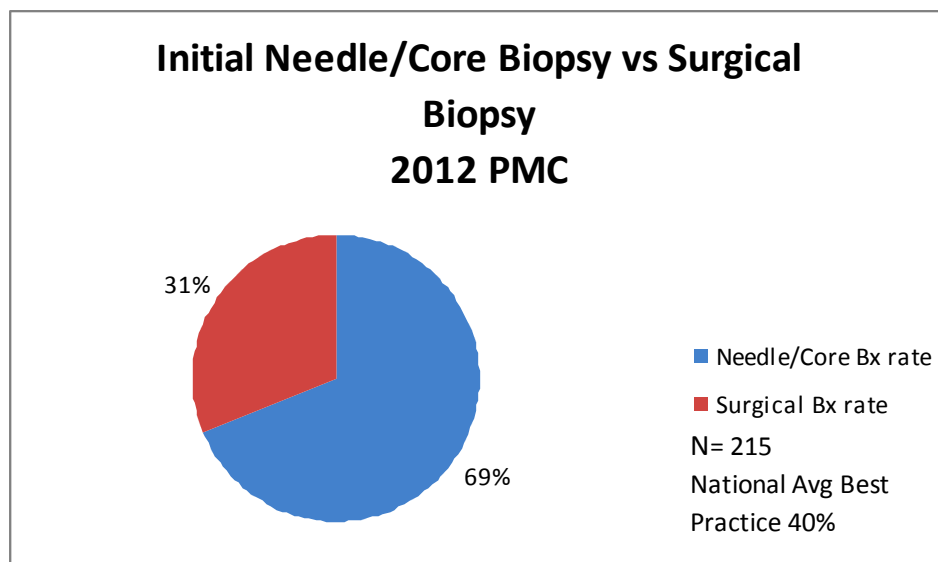
The mainstay of treatment begins with a biopsy to complete the diagnosis of cancer and prescribe the best, most effective course of treatment. Proper care of patients undergoing breast biopsy requires complete cooperation and communication by the entire healthcare team. The team includes a variety of professionals, but centrally involved are radiologists, surgeons, pathologists, and medical oncologists.



Understanding the value and limitations of various diagnostic biopsy maneuvers fosters efficiency in determining optimal patient management. Currently in the US, most initial biopsy procedures are performed by radiologists or by surgeons using image directed, minimally invasive technology. Your physician will recommend the most minimally-invasive procedure

possible depending on the size and location of your mass. Having an expert opinion about the type and grade of cancer will affect your treatment from the very beginning.

Every breast biopsy is precisely targeted to disrupt only the suspicious breast tissue, leaving the rest of the breast intact. In fact, 90 percent of breast biopsies can be obtained in a minimally-invasive manner without an incision or general anesthesia. According to the NCCN guidelines (version 1.2012 for Breast Screening and Diagnosis) a tissue biopsy should be performed by fine needle aspiration or core biopsy (by needle or vacuum) for initial diagnostic approach for palpable or occult lesions. Open surgical biopsy as an initial approach should be avoided as it does not allow for treatment planning and is associated with high re-excision rate. In 2012 at PMC, 69% of all patients receive a needle or core biopsy prior to any surgical treatment. While needle or core biopsy is considered the initial route of biopsy, it can be contraindicated in some patients. Some patients are not able to tolerate the position for the testing and others have tumors located in areas of the breast where needle biopsy or stereotactic procedures cannot be accomplished.

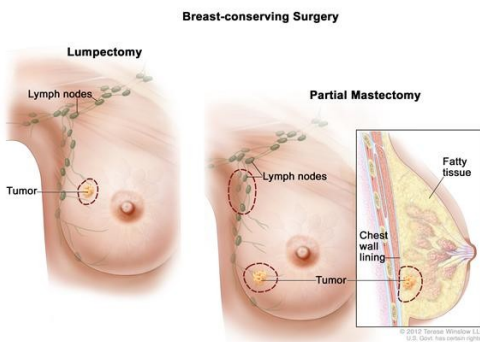


Surgery is a vital component of breast cancer treatment, and it continues to evolve. Most women with a new diagnosis of breast cancer are able to undergo breast-preserving surgical treatment without sacrificing the opportunity for survival as compared to those who undergo mastectomy. While breast conserving surgery (BCS) is the optimal choice for most women with early stage disease, the location of the tumor and patient co-morbidities can preclude BCS as a surgical recommendation.

Although these treatments are not appropriate for all patients, the physician will help you understand the advantages and disadvantages and determine which options may be right for you. We embrace an individualized approach to the surgical treatment of breast disease – both benign and malignant. Our surgeons understand that each diagnosis is unique, and work with each patient to identify a treatment plan that will achieve the best clinical outcome as well as the highest quality of life post-treatment. Procedures may include:

Mastectomy: This surgery removes one or both breasts. The entire breast is removed, along with any affected lymph nodes.

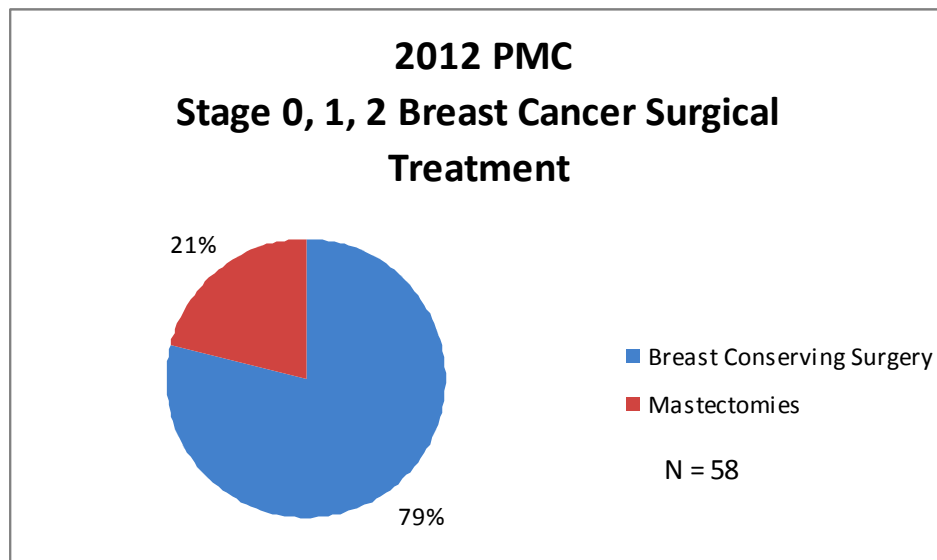
Breast conserving surgery is an attempt to save as much healthy breast tissue as possible. These procedures are best for treating early stage (I and II) breast cancer.



Breast conserving techniques include:

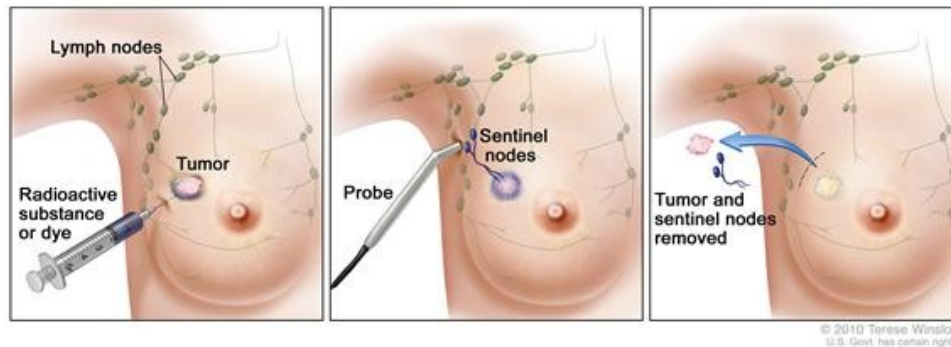
Lumpectomy: The tumor and a small margin of healthy breast tissue are removed.

Partial mastectomy: The tumor is removed, along with a margin of healthy breast tissue. The lining of the chest muscles and any affected lymph nodes under the arm are removed also.



There were 58 patients diagnosed with Stage 0, I, or II breast cancer at the PMC in 2012. In fact 78% of all breast cancer cases diagnosed were early stage and 100% of these patients received a lumpectomy, mastectomy or mastectomy with reconstruction. All patients received axillary staging. While breast conserving surgery (BCS) is the optimal choice for most women with early stage disease, the location of the tumor and patient co-morbidities can preclude BCS as a surgical recommendation. In addition, women with breast cancer are given options for treatment and may elect to have a more aggressive surgery even when BCS is the recommendation. At the PMC, 79% of women with Stage 0, I, or II elected for BCS in 2012.

Many patients with breast cancer require evaluation of lymph nodes underneath the arm (axillary lymph nodes) to assess whether cancer has spread from the breast. We continue to provide sentinel lymph node biopsy as a low-risk, state-of-the-art alternative to removal of all lymph nodes under the arm.



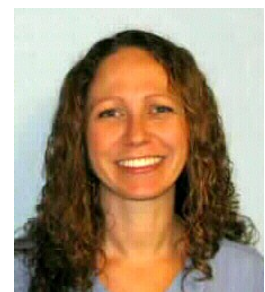
Sentinel lymph node (SLN) is performed by injecting blue dye and/or radiolabeled colloid into the skin and breast tissue around the area of the tumor or the subareolar area which permits identification of one or more sentinel lymph nodes in the majority of patients, and the status of the sentinel nodes accurately predicts the status of the remaining axillary lymph nodes. While some patients still require removal of a larger number of lymph nodes, which is called an axillary node dissection, recent data suggest that not all women with positive lymph nodes require axillary node dissection. In carefully chosen women with cancer that has spread to the lymph nodes, axillary node dissection can be reserved, and successful therapy can be accomplished with radiation treatment, leaving the lymph nodes in place. This option reduces the pain and the low, but real, risk of lymphedema that can accompany axillary node dissection.

If a patient is going to have a mastectomy, breast reconstruction (surgery to rebuild a breast's shape after a mastectomy) may be considered. Our breast cancer surgeons assist with coordinating care for reconstructive options for a natural appearing reconstructed breast, keeping in mind the other treatments that many patients require. Deciding which reconstruction method is best for you will be discussed during your consultation with the plastic surgeon, who will consider your personal preferences, as well as body shape, prior surgeries, current medical condition and cancer treatment needs. All reconstructive options have both risks and benefits, and each option usually requires multiple procedures to reach a final result.

In summary, the major goal in our surgical management of breast cancer is to limit a woman's exposure to pain, disability, altered body image and inconvenience, while optimizing her opportunity for cancer cure. Finding the right balance for each patient remains our primary focus.

REHABILITATION

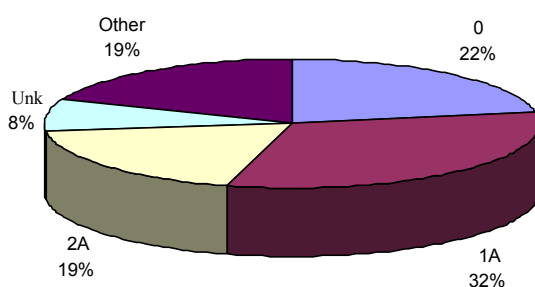
The Parrish Medical Center Rehabilitation Department supports the Cancer Program through participation in the multi-disciplinary Oncology team. The Rehabilitation representatives are also active participants on the Cancer Committee. Our therapists work closely with the nursing and case management staff to assist in meeting the needs of our patients. Occupational therapists, Physical therapist and Speech-Language Pathologists evaluate and treat patients who are referred to therapy services by their physicians. The goal of the rehabilitation services is to improve functional abilities and the quality of our patients lives.



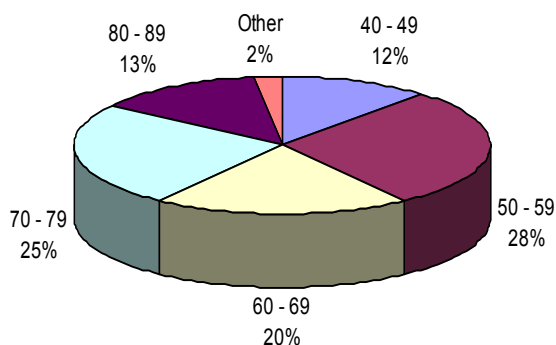
In addition, Parrish Medical Center has Certified Lymphedema Therapists (CLT) on staff to work with both inpatient and outpatients. These therapists have completed a specialized training course to receive their certification in the treatment and management of lymphedema. The lymphedema therapists provide hands on treatment including skin care, manual lymph drainage, compression, therapeutic exercise as well as patient education for the self management of their condition. The certified therapists have also played an important role in assisting breast cancer survivors gain access to properly fitted compression garments.

For more information, contact the Lymphedema Therapist at 321-268-6111, ext. 7715.

2012 Staging of Breast Cancer Diagnosis at PMC



2012 Age at Breast Cancer Diagnosis



CANCER LIAISON PHYSICIAN

Germaine Blaine, MD, MPH, is a board-certified medical oncologist at the Cancer Care Center of Brevard. In addition to her busy oncology practice, she voluntarily serves as the cancer liaison physician (CLP) for the hospital's cancer program.



As CLP, Dr. Blaine provides leadership and supervision in monitoring and overseeing activities to improve the quality of the hospital's cancer program. This includes evaluating and analyzing Parrish Medical Center's cancer program performance using National Cancer Data Base (NCDB) data and regularly reporting here analysis of NCDB data to the hospital's cancer committee at large. The CLP serves as the official physician liaison to the Commission on Cancer, the entity overseeing accreditation for the hospital's cancer program.

CANCER REGISTRY REPORT

The Cancer Registry is the cornerstone of the cancer program at PMC with the focus to exceed the expectations of the American College of Surgeons Commission on Cancer standards and fulfill the Cancer Committee's vision. The Registry collects, manages, and analyzes statistical data on all cancer patients diagnosed and/or treated at Parrish Medical Center.

The Cancer Registrar at PMC's Oncology Program is a Certified Tumor Registrar (CTR) who continually participates in ongoing cancer-related education at the local, state and national levels to maintain and increase knowledge of various treatments and to keep abreast of changes in state laws and/or statutes.

The registrar is responsible for submitting accurate and timely data to the Florida Cancer Data System (FCDS) and the National Cancer Database (NCDB) who use this data to determine future therapies, cancer patient survival rates, and efficacy of current therapies.

The goals for the registry are to collect cancer and vital data for the life of the patient, complete all cases within six months from the date of first contact, assist with the annual report, provide supportive documentation for compliance with CoC standards, coordinate bi-monthly Cancer Conferences and participate in Cancer Program committees and activities.

2011 REGISTRY DATA SUMMARY

Registry Data Activity

The registrar provides data reports for the Cancer Conferences and Cancer Committee. This data is used by PMC staff to evaluate clinical outcomes, needs assessment for future staffing and equipment, develop therapeutic protocols for treatment, clinical trials feasibility, and quality assurance studies.

Follow-Up Rate

Follow-up is important for tracking of vital status and cancer status. The registry maintains lifetime follow-up on all analytic patients entered into the database. This includes tracking and updating any additional treatments received, monitoring current cancer status and documenting last date of contact with the patient.

The registrar is currently following 2,503 patients annually with a follow-up rate of 91.24% (target 80%) since the reference date of 1997. The follow-up rate for the last five years is 90.29% (target 90%).

Cancer Conference Activity

The Cancer Conference are held twice-monthly to provide a forum in which experts from varied oncology disciplines are able to collaboratively discuss the clinical stage of disease, the different treatment options mandated by national treatment guidelines as well as available clinical trials when applicable.

There were a total of 18 Cancer Conferences in 2011 with a total of 50 cases presented. Forty-eight of those cases were prospective.

Quality of Data in the Cancer Registry

The Cancer Registrar continually strives for data quality through a variety of monitoring systems. In 2011, a minimum of 10% of the newly diagnosed cases were reviewed by the Cancer Liaison who verified the accurate recording of class of case, primary site, histology, stage of disease, collaborative stage, first course of treatment, and timeliness.

In addition to the CLP review, the Cancer Registry software has extensive built-in validation edits at the time of data entry that contribute to high quality data.

Incidence

A total of 444 cases were entered into the data base for 2011. Of the total cases, 336 were analytic – which are all reportable cases first diagnosed and/or receiving all or part of their initial treatment within PMC and 108 were non-analytic cases that include patients who received at treatment elsewhere and are being seen at PMC for subsequent treatment for progression, metastatic disease or recurrent disease. The five most frequent analytical sites were Breast, Bronchus/Lung, Colon, Prostate and Urinary Bladder.

Table I: Analytical and Non-Analytical cases by Sex and Race

Table II: PMC Top 5 Sites for 2011.

Table III: Top 5 Sites Distribution by Stage

Table I

Sex Distribution	Analytic (336)	Non-Analytic (108)
Male	163	64
Female	173	44
Total	336	108

Race Distribution	Analytic	Non-Analytic
White	314	97
Black	18	8
Other	4	3
Total	336	108

Table II

Site	Analytic	Non-Analytic
Lung	71	29
Breast	64	5
Colon	29	2
Prostate	23	5
Bladder	21	2

The CoC standards require that all analytical cases (sites and staging schemata) be staged by the managing physician caring for the patient utilizing the AJCC Staging criteria from the AJCC Staging Manual 7th Edition. The staging is a tool used to determine treatment plans for the patient. Table III shows the staging for the top five sites at PMC.

The table below defines our top 5 cancer sites and the stages at which they were diagnosed.

Stage 0	Carcinoma in-situ (no potential for metastasis)
Stage I	Smaller & less deeply invasive with negative nodes
Stage II & III	Increasing tumor size or nodal extent
Stage IV	Metastasis present at diagnosis

STAGING AT DIAGNOSIS

Table III

Site	Number of Cases	Stage 0	Stage I	Stage II	Stage III	Stage IV	UNK
Lung	100	1 / 1%	3 / 3%	3 / 3%	21 / 21%	38 / 38%	34 / 34%
Breast	69	19 / 28%	26 / 38%	13 / 19%	4 / 6%	3 / 4%	4 / 6%
Colon	31	0	6 / 19%	10 / 32%	6 / 19%	6 / 19%	3 / 10%
Prostate	28	0	7 / 25%	11 / 39%	0	2 / 7%	8 / 29%
Bladder	23	10 / 43%	4 / 17%	3 / 13%	0	1 / 4%	5 / 22%

Body System Site Group Report – 2011

	Count	%		Count	%
Tongue	3	0.7%	Breast	68	15.3%
Salivary Glands	1	0.2%	Cervix Uteri	1	0.2%
Floor of Mouth	1	0.2%	Corpus & Uterus, NOS	6	1.4%
Gum & Other Mouth	2	0.5%	Ovary	7	1.6%
Tonsil	3	0.7%	Vulva	1	0.2%
Oropharynx	2	0.5%	Prostate	28	6.3%
Hypopharynx	1	0.2%	Testis	3	0.7%
Esophagus	8	1.8%	Penis	1	0.2%
Stomach	4	0.9%	Urinary Bladder	23	5.2%
Colon Excluding Rectum	31	7.0%	Kidney & Renal Pelvis	10	2.3%
Rectum & Rectosigmoid	11	2.5%	Brain	7	1.6%
Anus, Anal Canal & Anorectum	2	0.5%	Cranial Nerves Other Nervous Sys.	6	1.4%
Liver & Intrahepatic Bile Duct	4	0.9%	Thyroid	4	0.9%
Other Biliary	1	0.2%	Other Endocrine incl. Thymus	3	0.7%
Pancreas	13	2.9%	Hodgkin Lymphoma	3	0.7%
Retroperitoneum	1	0.2%	Non-Hodgkin Lymphoma	18	4.1%
Other Digestive Organs	1	0.2%	Myeloma	8	1.8%
Larynx	2	0.5%	Lymphocytic Leukemia	9	2.0%
Lung & Bronchus	100	22.5%	Myeloid & Monocytic Leukemia	5	1.1%
Trachea, Mediastinum & Other	1	0.2%	Other Leukemia	1	0.2%
Soft Tissue	3	0.7%	Miscellaneous	27	6.1%
Skin excl. Basal & Squamous	10	2.3%	Total	444	100.0%

2012 COMMUNITY OUTREACH

Event Name	Date	Focus/Topic	Population Served	# of Attendees
Look Good...Feel Better	Monthly	Survivor Support	Survivors	23
N. Brevard Senior Health Fair	1/13	Cancer Prevention Awareness	Community	150
MLK Health Fair	1/16	Cancer Prevention/Awareness	AA Community	75
Reiki Therapy Instructor Course	1/18	Complementary Therapy	Community	10
Parrish Partners	Monthly	Survivor Support	Survivors	200
Food for Life Series (4 classes ea.)	Quarterly	Cancer Prevention	Survivors	346
Astronaut HS Health Fair	4/12	CP3 Study Recruitment	Community	100
Harry T. Moore	4/21	Prevention/Awareness	Community	200
CP3 Study	4/27–4/28	Cancer Prevention Study	Community	254
Casting for Recovery	4/27–4/28	Breast Cancer Support	Survivors	14
Relay for Life	5/5–5/6	Survivor Celebration	Survivors/Families	100/500
Girls Night Out	5/10	Breast Cancer Screenings	Community	56
Men's Health Summit	6/9	Prostate Cancer Screenings	AA/Latino Men	65
Teachers' Girls Night Out	7/18	Breast Cancer Screenings	Community	7
Mt. Moriah	8/18	Prostate/Colon Screenings	AA Community	125
Latino Outreach	8/18	Prostate Cancer Prevention	Latino Community	46
2012 Wellness Center	9/15	Complementary Therapy	Survivors	100
Central Florida State Prison	10/11	Breast Cancer Awareness	Prison Officers	100
Employee Mammo Day	10/18	Breast Screenings	Care Partners	66
Making Strides	10/20	Sleep Better/Feel Better	Community	800
City of Titusville	10/30	Prostate/Colon Screenings	Community	80
Hope Floats	11/1	Cancer Survivor Support	Survivors	80
Gift of Light	12/2	Cancer Prevention/Awareness	Community	200

* AA – African American

2012 CANCER EDUCATION SEMINARS

February 21	“New and Emerging Therapeutic Options in Metastatic Melanoma-Progress and Challenges for Personalizing Patient Care Melanoma” Jeffrey S. Weber, MD, PhD
March 20	“Parkinson’s Disease End of Life” Elizabeth Galfo, MD Palliative Care Series
April 25	“Integrating Care & Research in Brain Cancer” Peter Forsyth, MD Moffitt Grand Rounds
May 15	“Personalizing Non-Small Cell Lung Cancer Treatment Using Histology-Based Approaches” Anne S. Tsa, MD University of Texas-MD Anderson CBCE
June 19	“End of Life Care for Patients with Multiple Sclerosis/Amyotrophic Lateral Sclerosis” Elizabeth Galfo, MD Palliative Care Series
July 18	“Minimally Invasive Surgery in Gynecologic Oncology” Sachin Apte, MD Moffitt Grand Rounds
August 21	“Heparin Induced Thrombocytopenia” Ashish Dalal, MD
September 18	“Domestic Violence – Elder Mistreatment” Elizabeth Galfo, MD Palliative Care Series
October 2	”Botanicals and Biological in Cancer Prevention Treatment and Survival” Magi Kumar, PhD, RD, FADA Moffitt Grand Rounds
December 18	“Lynch Syndrome” Cristi Radford, MS, CGC President of Lynch Syndrome International – Ambry Genetics

2013 CANCER COMMITTEE GOALS

Cancer Program Goals 1.5

1. Clinical Goal: Standard 3.2
 - a. Develop and implement a process to ensure at least 60% of patient admitted for cancer diagnosis have a psychosocial distress evaluation.
 - b. Develop and implement a process to increase breast screening to 8000 per fiscal year. (FY 2012 #6881 or 37% community impact)
2. Programmatic Goal: Standard 1.9
 - a. Develop and implement a process for clinical trial accruals to include 2% of annual analytic cases.
 - b. Develop and implement a process to provide cancer risk assessment and genetic counseling by a qualified genetic professional.

Patient Outcomes Goals

1. Prevention Programs: Standard 4.1
 - a. Offer at least one series of the Cancer Project Food for Life program.
 - b. Offer a community opportunity to participate in the Cancer Prevention CPS3 Trial through collaboration with the ACS. (current goal)
 - c. Build on current successes by increasing virtual colonoscopy education in Titusville Family Practice by 10%.
2. Screening Programs: Standard 4.2
 - a. Offer at least one prostate cancer screening event.
 - i. Men's Health Summit
 - b. Offer at least two breast cancer screening programs.
 - i. Girls Night Out
 - c. Offer at least one colon screening event.
3. Quality Report: Standard 4.3
 - a. Quarterly Registry Quality Report is shared with the Cancer Committee at least four times a year.
4. Accountability Measure: Standard 4.4
 - a. Use Breast e-QuIP data to monitor and evaluate breast indicators to maintain at least a 90% performance rating
 - i. Radiation Therapy is administered within one year of diagnosis for women under 70 receiving breast conserving surgery for breast cancer. (BCS/RT)
 - ii. Combination chemotherapy is considered or administered within four months of diagnosis for women under 70 with AJCC Stage IC, II, or III hormone receptor negative breast cancer. (MAC)

- iii. Tamoxifen or third generation aromatase inhibitor is considered or administered within one year of diagnosis for women with AJCC Stage IC, II or III hormone receptor positive breast cancer. (HT)
 - iv. Adjuvant chemotherapy is considered or administered within four months of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. (ACT)
- 5. Quality Improvement Measure: Standard 4.5
Use Colon e-QuIP data to monitor and evaluate colon indicators
 - a. Improve lymph node (at least 12) removal for pathological review to at least 80% performance rate.
- 6. Assessment of Evaluation and Treatment Planning: Standard 4.6
 - a. A study is performed by a MD member of the cancer committee of at least 10% (random) of annual analytic case load is completed and reviewed for concordance with the evidence-based national treatment guidelines.
- 7. Studies of Quality: Standard 4.7
 - a. Navigation Quality Study completed and outcome shared with Cancer Committee for further performance improvements opportunities can be implemented.
 - b. Complete DMAIC for Colon Cancer Screening
 - c. Complete DMAIC for Breast Cancer Screening
- 8. Quality Improvement: Standard 4.8
 - a. Improve Patient Navigation Program based on results from qualitative findings.
 - b. Improve colon cancer screening rates
 - i. Develop and implement a process to ensure at least 80% of positive iFOBTs are followed up by direct notification to patient.
 - ii. Increase Colon Cancer Screening to 28 per month.
 - iii. Partner with Primary Care Practices to provide early detection and screening initiatives through virtual education and colon risk assessments evidenced by completion of 10 per month.
 - c. Improve timeliness of screening to diagnostic mammogram to 90% or greater.

2012 Cancer Committee Membership

Cancer Committee Chairman

Cancer Liaison Physician

Administration

General Surgery

Radiation Oncology

Pathology

Radiology

Hospice of St. Francis

Quality Improvement

Oncology Nursing

Quality Risk Management

Tumor Registrar

Palliative Care

Psychosocial Services

Service & People Excellence

Food & Nutrition

Rehabilitation Dept.

Pharmacy

Laboratory

Home Health

Pastoral Services

American Cancer Society

Oncology

Case Management

Service & People Excellence

Ashish V. Dalal, MD

Germaine Blaine, MD, MPH

Chris McAlpine, VP

John M. Zambos, MD

James Giebink, MD

Edward Jones, MD

Richard Mayer, MD

Elizabeth Galfo, MD

Gloria Velez, ARNP, MSN, AOCN

Marsha Richardson, RN, MSN, CBCN, ONC

Anna Maynard, RN

Joan Galbicsek, TR

Terry Donovan, RN, MSN

Helen Duane, LCSW

Alexandra Gutierrez, RN, MSN

Kate Schindler, RD, LDN, CDE

Louise Andrews, PT

Jeff Ruff, PhD

Rene Pulido, MT

Adeline Todd, RN

Rev. Jerald Smith, D.Min.

Gina Becker

Kathy Myer, RN, MSN

Susan Rothell, MSW, LCSW

Mathew Hagggar, MS



Glossary of Terms

Analytic – A cancer that is reportable to the FCDS and NCDB; cases that are initially diagnosed and/or received all or part of the first course of treatment at PMC.

American College of Surgeons (ACoS) – Dedicated to improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment.

Commission on Cancer (CoC) – Sets standards for quality multidisciplinary cancer care delivery primarily in hospital settings; surveys hospitals to assess compliance with those standards; collects standardized and quality data from approved hospitals to measure treatment patterns and outcomes; and uses the data to evaluate hospital provider performance.

National Cancer Data Base (NCDB) – Nationwide oncology outcomes database for over 1,500 hospitals in 50 states. The NCDB was founded as a joint project of the ACoS, Commission on Cancer and the American Cancer Society.

Non-Analytic – Cancer cases primarily diagnosed and treated elsewhere, and/or receiving subsequent care at PMC.

References

National Cancer Data Base (NCDB) Commission on Cancer
American Cancer Society, Cancer Facts & Figures
National Comprehensive Cancer Network, NCCN Guidelines
Centers for Disease Control and Prevention

AWARDS & ACCREDITATIONS

Commission on Cancer



American College of Radiology Accreditation



College of American Pathologists



The Joint Commission



CMS – Centers for Medicare and Medicaid Services, ranked Parrish Medical Center Number 1 in Central Florida for clinical care, patient hospital experience, and low cost.

PMC ranked as the Number 5 independent public hospital in the U.S. and in the top six percent of the 2,985 hospitals analyzed by CMS. This Hospital Compare data is important to everyone, not only those on Medicare or Medicaid



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