

Cancer Program Annual Report

2014

This report is reflective of the 2013 Statistical Data for The Parrish
Medical Center Cancer Program

Parrish
Medical Center

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Chairman's Report

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



On behalf of the Cancer Committee of Parrish Medical Center (PMC), I am pleased to present the 2014 Cancer Program Annual Report. This report reflects the statistical data for the calendar year 2013.

In July 2013, PMC was granted a three-year accreditation from the American College of Surgeons Commission on Cancer (CoC). This accreditation is the seal of approval for cancer programs and formally acknowledges that PMC is providing high-quality cancer care to patients and our community.

The hospital voluntarily undergoes a rigorous three-year accreditation survey by CoC. Our cancer-care excellence has resulted in PMC being recognized as a CoC-approved Community Cancer program since 1989. Only 30 percent of all hospitals have earned this distinction. This approval helps ensure that our patients receive quality cancer care close to home. To maintain accreditation, we must annually meet the rigorous standard of the CoC.

The Cancer Program is governed by a multidisciplinary Cancer Committee which includes a board certified oncologist, radiation oncologist, pathologist, surgeons, radiologist and palliative care physicians, along with oncology nurses, nutritionists, social worker and other ancillary professionals who ensure PMC offers a coordinated, multidisciplinary, patient- and family-centered approach to cancer prevention and treatment. The committee is continually working to improve patient survival and outcomes, enhancing the quality of life for all cancer patients regardless of diagnosis. These goals are accomplished by emphasizing wellness, education, prevention, survivorship and monitoring comprehensive quality cancer care. As a healing environment, PMC provides for the physical, emotional and psychosocial care of the patient at every point in their treatment.

The Cancer Program and the community have advocated for innovative health initiatives and have helped to guide PMC's success in exceeding the national best-practice standards for excellence in cancer care.

I thank all of the dedicated healthcare providers and Cancer Committee members who make sure our objectives are met. It is a pleasure to work with these talented individuals in our shared mission of providing quality cancer care.

In 2014, the program received several recognitions and other achievements:

- To better serve women, PMC developed a Breast Imaging Center of Excellence. The center has earned more specialty Gold Seal of Approval® certifications from the Joint Commission than any other hospital in Central Florida. In March 2008, PMC received the Joint Commission Disease Specific Certification in Breast Cancer Care, making PMC one of only 10 certified organizations in the U.S. In 2014, a successful Intra-Cycle Monitor program report with the Joint Commission was completed.
- Voluntary participation in the National Consortium of Breast Centers Quality Measures for Breast Center Programs. Through PMC's participation, patients and families are assured that our center provides the services they need and is monitoring these services to provide each patient with the highest quality care.
- 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—and one of only two in Brevard County—to have been designated a Breast Imaging Center of Excellence.
- PMC has two Certified Breast Cancer Navigators (CBCNs). They provide educational and emotional support to patients with a cancer diagnosis. The navigators guide patients and their families through treatment options for a new diagnosis or recurrent cancer, reinforcing information given by their physicians and supporting the patient's decisions.
- Strong partnership with American Cancer Society.
- The Parrish Infusion Center specializes in intravenous treatments, with a number one goal of patient convenience. We work with an array of patients who are undergoing treatments such as chemotherapy, pain management or intravenous antibiotics. More than 120 patients were served in 2014.
- 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.
- PMC supports employees in promoting cancer risk reduction and access to high-quality cancer treatment. Employee Pink Parties are offered four times a year to encourage mammography screening; 179 care partners took part in the events.
- A Certified Cancer Registrar oversees and ensures quality in cancer program data and reports.
- PMC has a Lymphedema Therapy Program.

- PMC has implemented a low-dose CT lung screening program in Diagnostic Imaging for high-risk patients. Patients can self-refer if they have a strong family history of lung cancer, known chemical exposure or a suspicion of cancer. In 2014, 53 lung screenings were completed. Four patients were recommended for short-term follow-up.

PMC 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. Our culture is a reason why the Cancer Program is a service-line leader that provides safe, effective, superior care. In 2014, 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. PMC is in the top 30 percent of the centers reporting the length of time between screenings and biopsies. We have continued to improve outcomes by enhancing access to breast cancer services through ensuring that any woman with a positive breast finding will receive further diagnosis and treatment on a timely basis.

In 2014:

- Timeliness between screening mammogram and diagnostic mammogram was an average of six days.
- Timeliness between diagnostic mammogram and definitive diagnosis was an average of 12 days.
- Our rates of detecting early-stage breast cancer are higher than the average rate in the United States – 77 percent (stage 0, I, II) of our patients are detected at an early stage as compared to 87 percent for the U.S. We have 16 percent unknown rate compared to two percent for all other hospitals.
- Eighty-nine percent of colon cancer patients have at least 12 regional lymph nodes removed and pathologically examined for resected colon cancer.
- Eighty-five percent of all patients receive a needle or core biopsy prior to any surgical treatment; the national best practice is 40 percent.

At the PMC, 100 percent of women with Stage 0, I, or II elected for breast-conserving surgery in 2013; the national best practice is 56.6 percent.

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 enable care that reflects the individual's wishes, wants and preferences. The insight gained through this process allows for programs, education and support specific to the community needs.

Patient services provided through partnerships for 2014 include:

- The American Cancer Society (ACS) partnerships 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 ACS. In 2014, the Cancer Boutique served 78 patients. Most were either uninsured or had Medicaid coverage only. For Brevard County, there were 141 patients referred to ACS; 20 of these patients were uninsured or had Medicaid coverage only. ACS received a total of 274 service requests from our North Brevard Community. PMC is the largest-referring facility in the county, ensuring these patients receive the services they need.
 - Support Groups
 - Look Good Feel Better
 - Parrish Partners
 - Cancer Boutique
 - Relay for Life
 - Making Strides

Stewardship

- Jess Parrish Medical Foundation (JPMF) provided \$35,000 in free screening mammograms. More than 50 patients were served in 2014.
- Great Outdoor residents raised and donated more than \$600 for the Cancer Boutique. Cancer Boutique offers wigs, turbans, bras and prosthesis at no cost to the patient.
- The Titusville Fire & Emergency Services presented JPMF with a check for \$1,500. Proceeds will benefit cancer care programs at PMC.

Community Outreach

- 2014 Survivors Day. More than 100 cancer survivors and their families attended “Survivors Rock,” a ‘50s fun-filled themed event. Guest speakers shared their stories, bringing inspiration, joy and hope.
- Through round-table discussion with community partners, the Florida Department of Health Brevard County (FDOH Brevard) and the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP), we are able to provide services to uninsured and underinsured women in our community. The goal is to communicate, develop and coordinate services by providing screenings, diagnostics and follow-up mammograms. We also support our employees in promoting cancer risk reduction, as well as access to high-quality cancer treatment. Employee Pink Parties are offered on a regular basis to encourage mammography screenings. More than 179 care partners took part in the events.
- Provide Food for Life series focused on enhancing the health and helping to fight chronic diseases while supporting your overall wellness goals through a healthy diet.



Ashish Dalal, MD
Cancer Committee Chairman
Medical Oncology

Site study: Bladder cancer

An estimated 74,000 new cases of urinary bladder cancer will be diagnosed in the U.S. (56,320 men and 17,680 women) in 2015 (NCCN, 2015). Bladder cancer is the sixth most common cancer in the U.S., but the third most common in North Brevard. It is three times more prevalent in men than in women.

Approximately 80 percent of bladder cancer cases are diagnosed in individuals over the age of 60, representing the second most prevalent cancer in men 60 years old or older. Globally, the incidence of bladder cancer varies approximately ten-fold, with Western European and North Americans having the highest, and Eastern European and Asian countries the lowest rates. (NCCN, 2015)

The bladder is a hollow organ in the lower part of the abdomen. Bladder cancer can be divided into three categories that differ in prognosis, management and treatment and are named for the type of cells that become malignant (NCI, 2014).

Site	Analytic	Non-analytic
Lung & Bronchus	59	17
Breast	52	3
Urinary Bladder	29	1
Prostate	19	7
Rectum	13	0

Table 1: Parrish Medical Center 2013 Cancer Cases

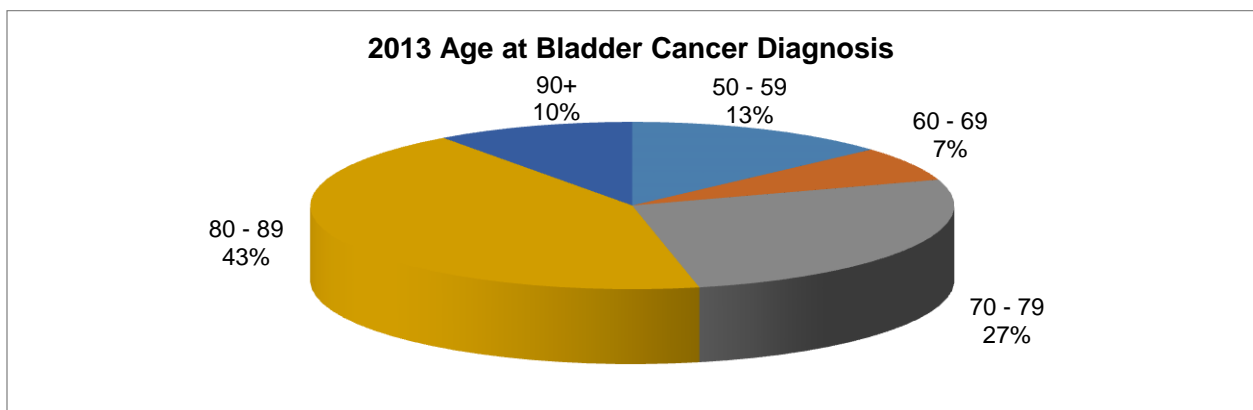


Table 2: Parrish Medical Center 2013 Age at Diagnosis of Bladder Cancer

Signs and symptoms of bladder cancer

The signs of bladder cancer include blood in the urine, frequent painful urination and low back pain. (NCI, 2014). These are nonspecific symptoms and are similar to symptoms found in other non-cancerous diseases such as urinary tract infection, interstitial cystitis, prostatitis, and kidney stone passage.

Tests to detect and diagnose bladder cancer

1. Physical exam and history
2. Internal exam
3. Urinalysis and urine cytology
4. Cystoscopy
5. Intravenous pyelogram
6. Biopsy

Risk factors for bladder cancer

1. Smoking and any type of tobacco product use
2. Family history of bladder cancer
3. Genetic mutations
4. Exposure to paints, dyes, metals, or petroleum products
5. Past treatment with radiation therapy to the pelvis or certain chemotherapy, such as cyclophosphamide or ifosfamide
6. Drinking water that has high levels of arsenic or chlorine
7. History of bladder infections, including bladder infections caused by *Schistosoma haematobium*
8. Long-time use of urinary catheters
9. Age

Overall, the most significant risk factor is cigarette smoking, accounting for approximately 50 percent of cases diagnosed in the U.S. (NCI, 2014)

Classifications of bladder cancer

More than 90 percent of urothelial tumors originate in the urinary bladder, 8 percent originate in the renal pelvis and the remaining 2 percent originate in the ureter and urethra. Urothelial (transitional cell) carcinomas, the most common histologic subtype in the U.S., may develop anywhere transitional epithelium is present, from the renal pelvis to the ureter, bladder and proximal two-thirds of the urethra. The distant third of the urethra is dominated by squamous epithelium. The diagnosis of squamous cell tumors, constitutes 3 percent of the urinary tumors diagnosed in the U.S., requires the presence of keratinization in the pathologic specimen. Of the other subtypes, 1.4 percent are adenocarcinomas and 1 percent are small-cell tumors. Adenocarcinomas often occur in the dome of the bladder in the embryonal remnant of the urachus. Urothelial tumors have been reclassified by World Health Organization (WHO) into 13 histologic variants based on differentiation patterns. The most common variants are squamous, glandular, sarcomatoid and micropapillary. (NCCN, 2015)

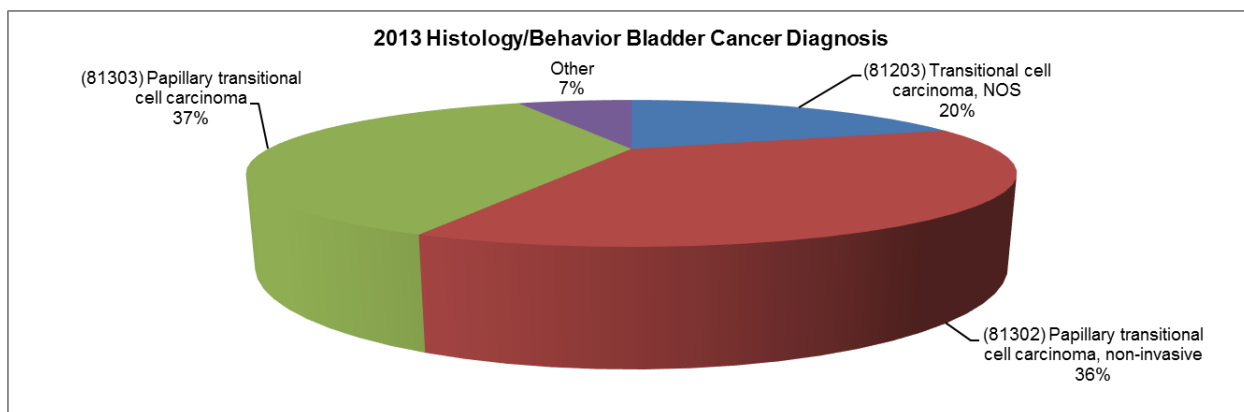


Table 3: Parrish Medical Center 2013 Histology Bladder Cancer Diagnosis

Diagnosis and treatment

The diagnosis of bladder cancer is often delayed due to the similarity of symptoms to those of benign disorders (e.g. urinary tract infection, interstitial cystitis, prostatitis, passage of kidney stones). Furthermore, the symptoms are often intermittent. The most common presenting symptom is hematuria (blood in urine). This is typically intermittent, painless and present throughout voiding. Constitutional symptoms due to bladder cancer can include fatigue, weight loss, anorexia (loss of appetite) and decreased performance status. These are usually signs of advanced or metastatic disease and denote a poor prognosis. The majority of bladder cancers are transitional cell carcinoma (91 percent). Other malignant cell types include adenocarcinoma (6 percent), squamous cell carcinoma (2 percent) and small cell carcinoma (1 percent). Cystoscopy forms the mainstay of diagnosis and staging of bladder cancer. The cystoscope is inserted into the bladder for visual inspection. Biopsy specimens are

taken from visible tumors. Additionally, biopsy specimens from grossly normal bladder epithelium as well as prostatic urethra are obtained to assess possible further spread of cancer. Urine is obtained for cytology and a bimanual examination under anesthesia is also performed to assist in staging the malignancy. Additional diagnostic studies utilized to evaluate the extent of bladder cancer include intravenous pyelogram (IVP), ultrasound, chest X-ray, CAT scans, bone scans and MRI studies. (NCCN, 2015)

A patient's prognosis and treatment recommendations are based on the stage of the cancer. Early noninvasive cancers are usually treated with transurethral resection of the bladder (TURB). This may be followed by immune therapy with bladder instillation of BCG or mitomycin. A more advanced invasive bladder cancer is usually treated with total cystectomy (total removal of bladder). Patients are frequently recommended to have neoadjuvant (presurgery) chemotherapy to downstage (shrink) the cancer prior to surgery. Clinical trials report that preoperative chemotherapy with cisplatin and Gemzar improve resectability and five-year survival. (NCCN, 2015)

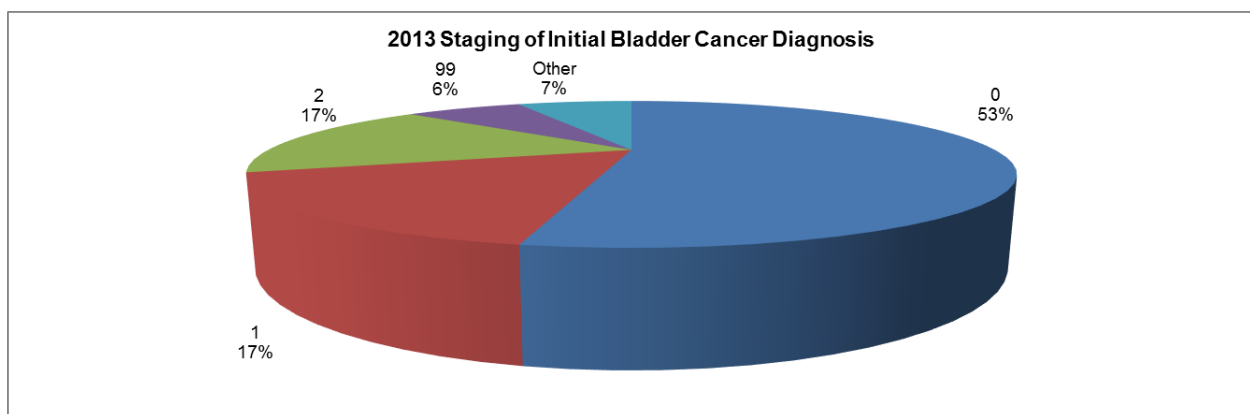


Table 4: Parrish Medical Center 2013 Stage of Initial Bladder Cancer Diagnosis

Four standard types of treatment are used

Surgery:

1. Transurethral resection with fulguration.
2. Radical cystectomy: Surgery to remove the bladder and any lymph nodes and nearby organs that contain cancer.
3. Partial cystectomy: Surgery to remove part of the bladder.
4. Urinary diversion.

Radiation therapy both external and internal:

1. **External Beam Radiation Therapy (ERBT)** is a type of radiation therapy that directs a beam of radiation from outside the body at cancerous tissues inside the body.
 - ERBT delivers high-energy rays to tumors, using a special X-ray machine, a linear accelerator. This machine allows radiation to be delivered from any angle and shapes the radiation beams to the contour of the tumor.
 - ERBT can target the tumor more effectively and decrease the typical side effects of radiation treatment.
 - ERBT is generally administered daily over six-to-eight weeks.
 - ERBT is an outpatient procedure. It is painless and does not carry the standard risks or complications associated with major surgery.
 - ERBT poses no risk of radioactivity to you or others with whom you have contact.
2. **Internal Radiation (Brachytherapy):**
 - The doctor places a small container of radioactive substance into the bladder through the urethra or through an incision in the abdomen.
 - Patient stays in the hospital for several days during treatment to protect others from radiation exposure.
 - Once the implant is removed no radioactivity is left.

Chemotherapy: Central or intravesical: There are two types of chemotherapy that may be used to treat bladder cancer. The type depends on the stage of the cancer.

1. **Intravesical chemotherapy** (local) is usually given by a urologist. Drugs are delivered into the bladder through a catheter that has been inserted through the urethra.
 - Local treatment only destroys superficial tumor cells that come into contact with the solution.
 - It cannot reach tumor cells in the bladder wall or cells that have spread to other organs.
 - Mitomycin and thiotepa are drugs most often used for intravesical chemotherapy
 - Doxorubicin, gemcitabine and valrubicin are also used.
2. **Systemic chemotherapy** (whole body) chemotherapy is usually prescribed by a medical oncologist. It gets into the bloodstream to reach cancer cells throughout the body.
 - It can be given intravenously or orally.
 - A common combination of drugs is MVCA and it has been the standard for years. It is combination of four drugs, methotrexate, vinblastine, doxorubicin and cisplatin.
 - New combination of gemcitabine and cisplatin may also be used and has fewer side effects.

Biologic or immunotherapy is used to boost the body's natural defenses to fight cancer. It uses materials made either by the body or in a laboratory to improve, target or restore immune system function.

1. Bacillus Calmette-Guerin (BCG) is the standard immunotherapy for bladder cancer.
 - A. It is a weakened bacterium which is similar to the bacteria that cause tuberculosis.
 - B. It is placed directly into the bladder through a catheter.
 - C. BCG attaches to the inside lining of the bladder and stimulates the immune system to destroy the tumor.
 - D. BCG can cause flu-like symptoms, a burning sensation and bleeding in the bladder.
2. **Interferon** is another type of immunotherapy that can be given as intravesical therapy.

Summary

Urothelial tumors represent a spectrum of disease with a range of prognoses. After a tumor is diagnosed anywhere within the urothelial tract the patient remains at risk for developing a new lesion at the same or a different location; and with a similar or more advanced stage cancer. Continued monitoring for recurrence is an essential part of management because most recurrences are superficial and can be treated endoscopically. Within each category of disease, more refined methods to determine prognosis and guide management, based on molecular staging, are under development with the goal of optimizing each patient's likelihood of cure and chance of organ preservation.

For patients with more extensive disease, newer treatments typically involve combined modality approaches using recently developed surgical procedures or three-dimensional treatment planning for more precise delivery of radiation therapy. Although these are not appropriate in all cases, they offer the promise of improved quality of life and prolonged survival. (NCCN, 2015)

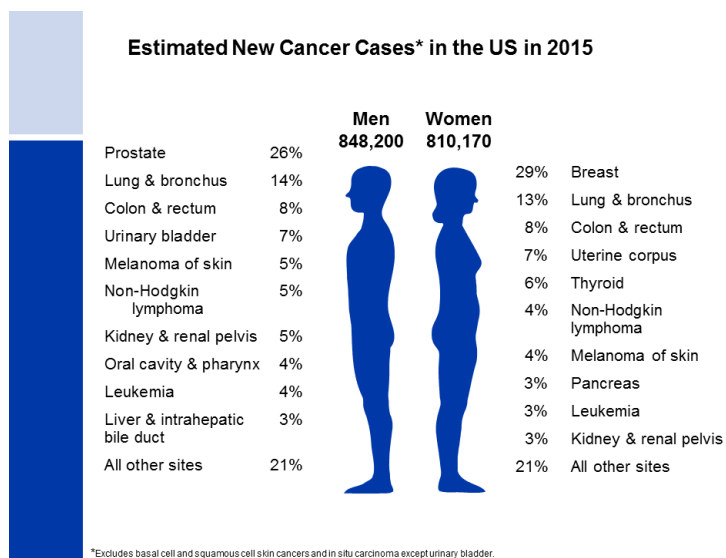


Table 5: Estimated New Cancer Cases in the US in 2015. (ACS, 2015)

Cancer Liaison Report

Germaine Blaine, MD, MPH, is a board-certified medical oncologist at the Cancer Care Center of Brevard. In addition to her oncology practice, she voluntarily serves as the Cancer Liaison Physician (CLP) for PMC'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 PMC's Cancer Program performance using National Cancer Data Base (NCDB) data and regularly reporting her 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

According to the National Institutes of Health, cancer is the second-leading cause of death among Americans. Doctors, researchers and public health officials are working to improve cancer prevention and treatment, ultimately hoping to find a cure for cancer. The starting point for the work of doctors, researchers and public health officials is the Cancer Registrar.

Throughout America, and in our community, cancer registrars gather information from every cancer patient on all aspects of their disease. As each patient's data becomes combined with that from other patients and from other communities, the entire medical community can understand more about cancer.

The cancer registry is the cornerstone of the cancer program at PMC with the focus to exceed the expectations of the CoC standards and fulfill the Cancer Committee's vision. The registry collects, manages and analyzes statistical and quality data on all cancer patients diagnosed and treated at PMC.

The cancer registrar at PMC's Cancer Program is a Certified Tumor Registrar (CTR) who 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 statutes, assist with the annual report, provide supportive documentation for compliance with CoC standards and submits accurate and timely data to the Florida Cancer Data System (FCDS) and the National Cancer Database (NCDB). These organizations use the data to determine future therapies, cancer patient survival rates and efficacy of current therapies.

2014 Registry Data Summary

Registry data activity

The registrar provides data reports for the Cancer Committee. This data is used by PMC's staff to evaluate clinical outcomes, 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.

Cancer conference activity

Cancer conferences provide our cancer specialists with a forum to collaboratively discuss the clinical stage of the disease, and the different treatment options mandated by national treatment guidelines on an individual patient in order to provide excellence in patient care.

PMC cancer conferences are held twice-monthly. The cancer coordinator coordinates the meetings and gathers the information required for discussion, including medical history, pertinent pathology and radiology material for review. Multidisciplinary cancer conferences are attended by surgeons, medical oncologists, radiation oncologists, pathologists and radiologists. Both prospective and retrospective cases are discussed.

The American College of Surgeons requires that the number of cases presented annually is proportional to 10 percent of the analytic caseload. There were a total of 15 cancer conferences in 2014 with a total of 45 cases presented.

Quality of data in the cancer registry

The cancer registrar's quality efforts employ a variety of monitoring systems. In 2014, a minimum of 10 percent of the newly diagnosed cases were reviewed by the cancer liaison physician 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 421 cases were entered into the data base for 2013. Of the total cases, 332 were analytic – which are all reportable cases first diagnosed or treated at PMC; 89 were non-analytic cases that included patients who received a 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, urinary bladder and prostate.

Sex Distribution	Analytic (332)	Non-Analytic (89)
Male	165	53
Female	167	36

Race Distribution	Analytic (332)	Non-Analytic (89)
White	310	87
Black	18	
Other	4	2

Table 6 Analytical and Non-analytical Cases by Sex and Race

Site	Analytic	Non-Analytic
Lung/ Bronchus	59	17
Breast	52	3
Bladder	29	1
Prostate	19	7
Rectum	13	0

Table 6 2013 Top 5 Cancer Sites for PMC

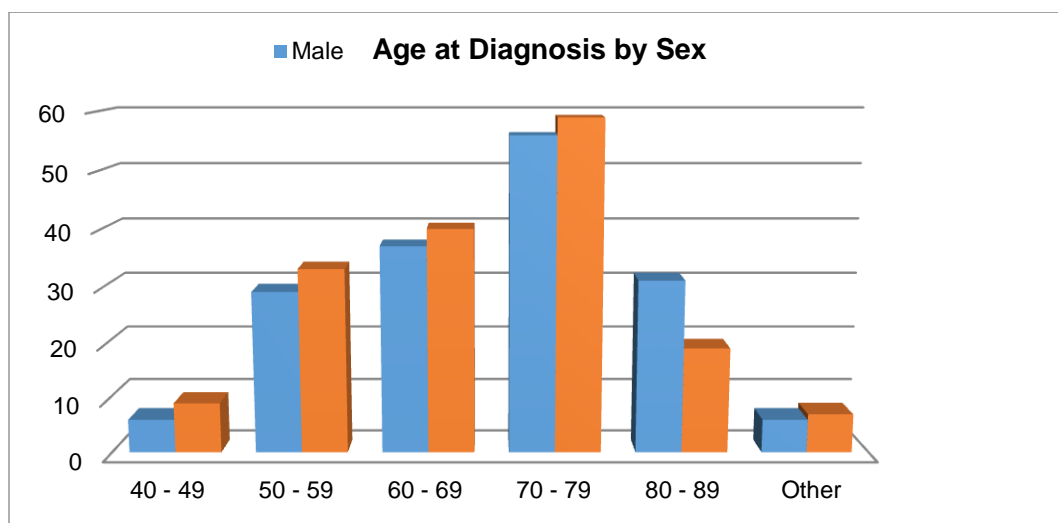


Table 7: Parrish Medical Center 2013 Age at Diagnosis by sex (all Cancers)

2014 Community outreach

Event Name	Date	Focus/Topic	Population Served	# of Attendees
Look Good...Feel Better	Monthly	Survivor Support	Survivors	20
Parrish Partners	Monthly	Survivor Support	Survivors	92
Food for Life Series (4 classes)	Quarterly	Cancer Prevention	Survivors	109
Employees' Mammo Day	Quarterly	Breast Screenings	Care Partners	178
MLK Health Fair	1/19	Cancer Prevention/Awareness	AA Community	60
Knight's Enterprise	7/22	Prevention/Awareness	Community	75
Relay for Life	5/02	Survivor Celebration	Survivors/Families	300
2014 Survivor Celebration	09/20	Survivor's Rock	Survivors	104
Making Strides	10/25	Survivor Celebration	Community	1,000
City of Titusville		Prostate/Colon Screenings	Community	65
Men's Health Awareness St. James Missionary Baptist Church	11/9	Prostate & Colon Screening	AA Community	15
Gift of Light	12/14	Cancer Prevention/Awareness	Community	>1,000

2014 Cancer education seminars

Mar. 18	Interpreting and Applying New Data in CML Strategies for Optimizing Patient Outcomes Dr. Pinalla-Ibarz (Moffitt)
Apr. 15	Lung Cancer and AJCC Staging Dr. Pedergast (SCCC)
Jun. 17	Navigation HER-2 Positive Breast Cancer Dr. Regan(Emory University)
Aug. 19	Management of Prostate Cancer Dr. Cynthia Bryant (SCCC)
Sep. 16	Prognostication: What is the Trouble Dr. Zeini (Hospice St. Francis)
Nov. 18	Targeted Therapies in NSCLC Dr. Ross(Cancer Care of Brevard)

2014 Cancer Committee program goals

2014 Cancer program goals

1. Clinical Goal:
Develop a relationship with Mayo for e-consults to assist with evaluation, diagnosis and treatment of unusual cancer presentations.
2. Programmatic Goal:
Initiate application process for National Accreditation Program for Breast Centers (NAPBC).

2014 Patient outcome goals

3. Prevention Programs: Standard 4.1
 - Offer nutrition counseling at least twice a year.
 - Promote safe sun education and practices during outdoor events.
 - Promote Colon Cancer Awareness Month in Parrish Medical Group (PMG) Patient-Centered Medical Homes (PCMH).

4. Screening Programs: Standard 4.2

- Evaluate efficacy of prostate screening events.
- Men's Health Summit
- Offer at least two breast cancer screening programs.
- Mammo Day
- Offer at least one colon screening event.

5. Quality Report: Standard 4.3

- Quarterly registry quality reports are shared with the Cancer Committee.

6. Accountability Measure: Standard 4.4

- Use Breast e-QulP data to monitor and evaluate breast indicators to maintain at least a 90 percent performance rating.
- Radiation therapy is administered within one year of diagnosis for women younger than 70 receiving breast conserving surgery for breast cancer. (BCS/RT)
- Combination chemotherapy is considered or administered within four months of diagnosis for women younger than 70 with AJCC Stage IC, II or III hormone receptor negative breast cancer. (MAC)
- 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)
- 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)

7. Quality Improvement Measure: Standard 4.5

- Use Colon e-QulP data to monitor and evaluate colon indicators.
- Improve lymph node (at least 12) removal for pathological review to at least 80 percent performance rate.

8. Assessment of Evaluation and Treatment Planning: Standard 4.6

- A study is performed by a physician member of the Cancer Committee of at least 10 percent (random) of the annual analytic case load is completed and reviewed for agreement with the evidence-based national treatment guidelines.

9. Studies of Quality: Standard 4.7

- Complete DMAIC for Navigation Quality Study for further performance improvements.
- Complete a DMAIC for psychosocial services offered to newly diagnosed cancer patients.

- Complete DMAIC for timeliness from diagnostic mammography to definitive diagnosis.

10. Quality Improvement: Standard 4.8

- Improve patient navigation program based on results from DMAIC.
- Develop and implement a process to ensure that 50 percent of patients admitted with a new cancer diagnosis have a psycho-social evaluation.
- Develop and implement a process to ensure at least 50 percent of patients diagnosed with breast cancer have a genetic risk assessment questionnaire completed by a qualified genetic professional.

2014 Cancer Committee membership

The Cancer Committee is composed of representatives of primary and specialty care physicians, as well as team members involved in the care of cancer patients. The multidisciplinary committee meets at least quarterly to review and evaluate the quality and direction of the cancer program.

Cancer Committee Chairman
 Cancer Liaison Physician
 Administration
 General Surgery
 Radiation Oncology
 Pathology
 Diagnostic Radiologist
 Community Outreach Coordinator
 Quality Improvement
 Oncology Nursing
 Quality Risk Management
 Certified Cancer Registrar
 Palliative Care
 Psychosocial Services
 Communication & Service Excellence
 Food & Nutrition
 Rehabilitation Department
 Pharmacy
 Laboratory
 Pastoral Services
 Case Management
 Home Health
 American Cancer Society
 Communication & Service Excellence
 Oncology
 Rehabilitation

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 Jo Connell
 Shannon Luker, RN / Terrilyn Holtkamp, RN
 Norise Whitman / Suzanne Comer, OTR/L

Glossary of terms

Analytic – A cancer that is reportable to the Florida Cancer Data System and National Cancer Data Base. Cases that are initially diagnosed 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 multi-disciplinary cancer care 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.

Florida Cancer Data System (FCDS) – A statewide Florida cancer registry which has been collecting data since 1981. The database contains over 2,700,000 cancer incidence records.

National Cancer Data Base (NCDB) – Nationwide oncology outcomes database for more than 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 or receiving subsequent care at PMC.

References

National Cancer Data Base (NCDB) Commission on Cancer, 2015

American Cancer Society, Cancer Facts & Figures, 2014

National Comprehensive Cancer Network, NCCN Guidelines, 2015

Centers for Disease Control and Prevention, 2014

Florida Cancer Data System and Office of Vital Statistics, 2014

PMC benchmarks

Patient treatment and survival outcomes presented in this publication have been compared to state and national statistics for comparable healthcare institutions.

The statistical data presented by Parrish Medical Center in this report have been benchmarked against data collected by the following sources:

Commission on Cancer



SEER



FCDS



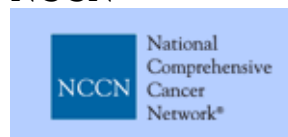
American Cancer Society



NCDB



NCCN



Awards and accreditation



Commission on Cancer

The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.



American College of Radiology

The Breast Imaging Center of Excellence (BICOE) designation is awarded to breast imaging centers that achieve excellence by seeking and earning accreditation in all of the ACR's voluntary breast-imaging accreditation programs and modules, in addition to the mandatory Mammography Accreditation Program.



College of American Pathologists

The CAP Laboratory Accreditation Program is an internationally recognized program and the only one of its kind that utilizes teams of practicing laboratory professionals as inspectors. Designed to go well beyond regulatory compliance, the program helps laboratories achieve the highest standards of excellence to positively impact patient care.



Joint Commission

Joint Commission accreditation means your organization complies with the highest national standards for safety and quality of care and is committed to continually improving patient care.

In 2013

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

Parrish Medical Center also ranks as the #5 independent public hospital in the U.S., and in the top 6 percent of the 2,985 hospitals analyzed by CMS. This hospital compared data is important to everyone, not only those on Medicare or Medicaid.

Received The Joint Commission award for top performer on key quality measures