celebrating survivorship

2015 CANCER PROGRAM ANNUAL REPORT
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Cancer Registrar

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Darlene Williams, RN
Clinical Trials Research Coordinator/Nurse Supervisor

Courtney Hickey
American Cancer Society Representative

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The CHRISTUS St. Michael Health System (CSMHS) Cancer Program in Texarkana began in 1989 and continues to expand nearly twenty-seven years later. With the goals of providing this community with the highest quality care, we continue to provide state-of-the-art in not only diagnostics and treatment, but also in screening and prevention programs.

2015 offered many salient features for the CSMHS Cancer Program. As an Accredited Cancer Program with the American College of Surgeons Commission on Cancer (CoC), CSMHS now follows the mandate to further develop the Survivorship Care Plan (SCP) which was initiated as a pilot program in 2012. In 2015, the program was able to track 10% of our eligible patients. Education and care plans were provided through the cancer treatment center. We are now using the Journey Forward Survivorship Care Plan Builder software which will implement essential components identified by the Commission on Cancer and Institute of Medicine.

Another important feature was the development of the Community Needs Assessment Program which also adheres to CoC requirements. This program serves to guide our activities and programs so as to best serve the needs of this community. The Community Needs Assessment Program was first developed here in 2012 and is updated every three years. Highlights of this program included development of the Community Profile Report of the Texarkana Affiliate of the Susan G. Komen Foundation. Next, a Cancer Prevention Report includes Tobacco Control Strategies and Obesity Control Strategies. In addition, a Diagnostic patient Navigation Resource Program has been developed along with Cancer-Related Community Resources. This Program also includes the CHRISTUS Colorectal Task Force goals and summary as well as the CSMHS Lung Nodule and Lung Cancer Screening Program. Through this program we have already identified several early stage lung cancers and provided comprehensive treatment and follow-up care.

Other notable features of our Cancer Program include an active bi-monthly Tumor Board in which multiple specialties are represented. Here, newly diagnosed cases are presented and discussed so as to optimize the diagnostic and multimodality treatment approaches. We are proud to have a number of enthusiastic physicians, practitioners, nurses and support staff in attendance including our new CHRISTUS Physician Group Hematologist Oncologist, Hesham Hazin, M.D. Stephanie Stewart has recently become a Certified Breast Navigator and assists as a Diagnostic Patient Navigator at the CHRISTUS Imaging Center. Tammie McKamie has been instrumental in the development of the CSMHS Genetics Counseling Program and has enrolled numerous patients in this important aspect of care.

It is an honor to serve as your Cancer Committee Chair and would like to offer my gratitude to the leaders who continue to keep this program. Particularly, I would like to thank Mr. Gary Upp and Mrs. Dianne Ketchum and your teams for their commitment and ongoing efforts for this program. I would also like to thank the many physicians, practitioners, nurses and staff members who show such knowledge and compassion in your respective fields. It is a privilege to work with you all. Let us continue to work together as we continually renew our program so that we provide the best care for the members of this beautiful community.

SUMAN K. SINHA, MD, MS, MBA, FCCP, FACP
DIRECTOR OF CHRISTUS PULMONARY SERVICES
CHRISTUS CANCER COMMITTEE CHAIR
The Commission on Cancer (CoC) of the American College of Surgeons (ACoS) initially submitted quality of care measures for breast and colorectal cancer to the National Quality Forum (NQF) in 2005. The CP3R version 3 currently reports estimated performance rates with 21 quality measures from nine primary sites including breast, colon, rectum, lung, cervix, gastric, endometrial, ovarian, bladder and melanoma. Specific criteria for each of the types of measures (accountability, quality improvement, and surveillance) can be found on the CoC website. The CP3R(v3) provides feedback to our programs to improve the quality of data across several disease sites.

Accountability Measure: Demonstrates good practice based on consensus. Commission on Cancer Standard 4.5 addresses compliance with quality improvement. Quality Improvement Measures: Considered standard of care based on clinical trial evidence. Commission on Cancer Standard 4.4. Surveillance Measure: Used at the community, regional, and/or national level to monitor patterns and trends of care in order to guide policymaking and resource allocation.

With breast cancer being the featured sites of this 2015 Annual Report, it was decided to identify the six breast measures the CHRISTUS cancer committee are currently tracking for quality.

The accountability measures are listed below:

- **BCSRT**: Breast radiation after breast conserving surgery
- **MAC**: Combination chemotherapy for hormone receptor negative breast cancer
- **HT**: Adjuvant hormonal therapy for hormone receptor positive breast cancer
- **MASRT**: Radiation therapy recommended or administered following mastectomy within 1 year of diagnosis for women with 4 or more positive regional lymph nodes

Quality Improvement measure:
- **NBX**: Image Guided Needle BX to establish diagnosis of cancer precedes surgical excision/resection

Surveillance Measure:
- **BCS**: Breast conserving surgery rate

The 2015 Annual Report is dedicated to the memory of Herbert B. Wren, Co-Founder of Joint Cancer Program in Texarkana. Dr. Wren was the Founding Chairman of the Joint Cancer Committee. Under the leadership and guidance of Dr. Wren, the program was established in 1989. sought and was granted its first Approval by the American College of Surgeons for a Commission on Cancer Accredited Cancer Program in 1991. Dr. Wren helped established the first Tumor Clinic in Texarkana in the early 1940’s. He was a visionary when he sought to establish a Regional Cancer Program in Texarkana in 1989. This Regional Program consisted of the two major facilities in Texarkana as well as nine area hospitals in Southeast Arkansas and Northeast Texas. The data from these hospitals was beneficial to the completion of the patients abstract since many of these patients were first diagnosed in the outlying hospitals. The 11-hospitalJoint Cancer Program in Texarkana was the first Regional Cancer Registry in Arkansas and the second Regional Registry established in Texas. Dr. Wren was a mentor to many and loved by all. He was dedicated to the mission of the cancer program in Texarkana.

We would also like to honor the memory of Mary Miller, Licensed Clinical Social Worker for the W. Temple Webber Cancer Center at CHRISTUS St. Michael Health System. Mary served on the Cancer Committee for CHRISTUS St. Michael for nearly 20 years. Her role at CHRISTUS was to provide referrals, resources and counseling to patients who needed her services. She coordinating the breast and cervical outreach programs which helped patients who were underinsured or uninsured receive the screenings and diagnostic breast health services they need. Mary served on the Susan G. Komen Board and the American Cancer Society Board of Directors for many years. Mary possessed a passion for the patients she served and her legacy will live on in their lives and the lives of her co-workers.

Source: cp3overview/CP3R Home/CoC Datalinks/CoC/www.facs.org
The W. Temple Webber Cancer Center at CHRISTUS St. Michael Health System continues to grow as we strive to offer best of class services for the care of our cancer patients. We are excited to make significant advances in both high quality personnel and expansion of services that enhance the patient experience.

One of our greatest achievements has been in the evolution of our CHRISTUS St. Michael Medical Oncology Clinic, located directly above the Cancer Center. Jayendra Patel, M.D., Medical Oncologist, retired in December 2015. In preparation for Dr. Patel’s upcoming retirement, we were very fortunate to attract and recruit Hesham Hazin, M.D., Hematologist and Medical Oncologist, in July 2015 from the Brooklyn, New York, area. Dr. Patel is still available on occasion to fill in for Dr. Hazin in times of need. Yolanda Bone, DNP, ARNP, FNP-BC, joined the Clinic in late January 2016. Yolanda’s primary role is to serve as our survivorship coordinator, working with both the patient and their primary care physician to assure the appropriate care continues once therapy is completed at the Cancer Center. She also helps manage patients coming to the Cancer Center for chemotherapy. The clinic is now a fully staffed Medical Oncology Clinic. We have also initiated a Nurse Triage Call Line to assist symptom management and other issues that may arise while at home. We want to provide our patients every opportunity to manage their care and decrease the number of times they need to leave home to seek emergency care.

In March 2015, the CHRISTUS St. Michael Outpatient Infusion Center opened. Previously, the Cancer Center provided other types of infusion therapy in addition to therapies treating cancer. We wanted to avoid compromising our cancer patients by exposing them to conditions that could have a negative effect on their health.

We eventually had to come up with a new alternative for non-cancer patients needing infusion therapies. The advantages of the Infusion Center are expanded hours, offering services 12 hours a day, seven days a week, to all patients not needing specific chemotherapy treatment.

The Community Needs Assessment was completed in 2015. Performed every three years as a project of the CHRISTUS St. Michael Cancer Committee, the assessment takes a thorough look at the state of cancer care across the community. The report provides an in-depth analysis of the five major cancer types affecting our market by location, demographics, rates of occurrence, stage at time of diagnosis and survival rates. A collaborative approach was taken utilizing specialists from across our health care system, as well as taking advantage of our strong relationships with organizations such as the American Cancer Society and Susan G. Komen for a Cure. This year’s assessment included participation from cancer survivors, who provided their impressions of the quality of services offered and what we could do to improve their experience. The Community Needs Assessment has been posted on the CHRISTUS St. Michael website under Cancer Services.

At the W. Temple Webber Cancer Center and CHRISTUS St. Michael Health System, our patient satisfaction is our highest priority. As we continue to evolve, we always keep the patient’s needs at the forefront of our strategic planning process. Accomplishments achieved in 2015 are a great example of our commitment.

GARY UPP, MPSA
W. TEMPLE WEBBER CANCER CENTER DIRECTOR
Globally, breast cancer is the most frequently diagnosed malignancy in women, accounting for over one million cases each year. It is also the leading cause of cancer death in women worldwide. In the United States as well, breast cancer is the most common female cancer, and it is the second most common cause of cancer death in women. Once a diagnosis of breast cancer is established, it is important to accurately define the initial extent of disease since this information will affect treatment recommendations. This topic will review the clinical manifestations, differential diagnosis and staging following a diagnosis of breast cancer.

The factors that modify breast cancer risk include the diagnostic evaluation of women with suspected breast cancer, the treatment approach to in situ and invasive breast cancer, and the use of prognostic and predictive factors when making adjuvant treatment decisions are reviewed as separate topics.

In low and middle income countries, breast cancer is the most commonly diagnosed cancer. The incidence rates are highest in North America Australia/New Zealand and in western and northern Europe, and lowest in Asia and sub-Saharan Africa. These international differences are likely related to societal changes as a result of industrialization (eg, changes in fat intake, body weight, age at menarche, and/or lactation, and reproductive patterns such as fewer pregnancies and later age at first birth). Studies of migration patterns to the US are consistent with the importance of cultural and/or environmental changes. In general, incidence rates of breast cancer are greater in second-generation migrants and increase further in third- and fourth-generation migrants.

In the United States, breast cancer accounts for over 230,000 cases each year and is responsible for over 40,000 deaths. The incidence rates decreased from 1999 to 2007 by 1.8 percent per year. It is likely that two factors have contributed to this: the discontinuation of hormone replacement therapy (HRT) and the saturation/leveling of screening mammography rates. Of these factors, the discontinuation of HRT has probably had a greater effect. This was demonstrated in a report from the Women’s Health Initiative where a rapid decline in breast cancer incidence was noted in trial participants following discontinuation of HRT. Discontinuation of HRT was not accompanied by changes in mammographic utilization, suggesting that the latter did not play a role in the decline in incidence rates.

Breast cancer mortality rates have been decreasing since the 1970s. This decrease in mortality is likely due at least in part to improved breast cancer screening and adjuvant therapy. In countries with established breast cancer screening programs, most patients present due to an abnormal mammogram. However, up to 15 percent of women are diagnosed with breast cancer due to the presence of a breast mass that is not detected on mammogram (mammographically occult disease), and another 30 percent present with a breast mass in the interval between mammograms (interval cancers). In addition, women without access to screening mammograms and younger women under 40 years who may not be undergoing routine screening mammograms may present with a breast or axillary mass with or without skin changes.
When compared to Commission on Cancer (CoC) programs, CHRISTUS St. Michael at its best does a superior job in screening and detection of breast cancer or performs just as well, at worst. (See Graph 1) Early Stage 0 or DCIS, I & II are almost if not the same incidence of detection when compared to CoC programs – what is even more impressive is the ability to detect locally advanced diseases such as Stage III breast cancer. Detection prior to a Stage IV or metastatic disease is curable by means of a multi-modality approach of surgery, chemotherapy, hormonal and radiotherapy.

Racial disparities in breast cancer outcomes may be due in part to socioeconomic reasons, but may also relate to a more aggressive tumor biology among African Americans. Evidence suggests that African American women are more often diagnosed with the biologically aggressive basal-like subtype of breast cancer. For example, a genetic analysis of breast tumors from 870 women, approximately one-fifth of whom were African American, suggested greater intra-tumor genetic heterogeneity and more basal gene expression among tumors from African American women, even within the subset of triple-negative tumors. However, at this time, there is no evidence that African American women should receive different chemotherapy regimens than women of other races with the same biologic subset of breast cancer.

By analyzing the makeup of the demographic population that CHRISTUS St. Michael served from 2003 through 2013, (Graph 2) it is clear that there was a larger African American population compared to CoC programs which is a great benefit since higher mortality rates occur more frequently in African American females compared to Caucasians. When integrating the data of demographics & stage (Graph 3) we were able to detect early stage II & locally advanced stage III breast cancer in African American females at a higher incidence than Caucasian females.

With regards to treatment, the widespread application of adjuvant systemic therapy has reduced mortality from breast cancer in the Western world. Unfortunately, many patients are not treated appropriately, with some overtreated (when they would have been cured solely with local therapy) and others undertreated (eg, not treated in the adjuvant setting or treated with drugs that are ultimately not active). It would be of great value to have reliable prognostic factors that could help select those patients most at risk for recurrence. In addition, clinically applicable predictive factors would aid in the personalization of adjuvant therapy by identifying which therapies would be most likely of benefit to patients and which patients would not benefit, potentially sparing them from the unnecessary exposure to potentially toxic and expensive therapies. By definition, prognostic factor is capable of providing information on clinical outcome at the time of diagnosis, independent of therapy. Such markers are usually indicators of growth, invasion and metastatic potential. By contrast, a predictive factor is capable of providing information on the likelihood of response to a given therapeutic modality. Such markers are either within the target of the treatment or serve as modulators or epiphenomena related to expression and/or function of the target. Although they can be separately classified, several factors in breast cancer are both prognostic and predictive (eg, the presence of overexpression of the human epidermal growth factor-2 receptor [HER2]).
Nodal involvement (i.e., the number of ipsilateral axillary nodes with metastatic tumor growth) is a strong and independent negative prognostic factor. Among women with no evidence of metastatic disease (M0), the five-year survival rate for those who present with localized (i.e., breast only) versus regional disease (i.e., pathologic node involvement) is 99 and 85 percent, respectively. Even small tumors (<2 cm) have a worse prognosis in the presence of pathologic node involvement. In one series involving almost 25,000 cases, the five-year relative survival was 96, 86 and 66 percent if patients were pathologically node-negative, had one to three nodes involved, or had greater than four nodes involved, respectively.

Our last graph reveals the observed survival by stage at CHRISTUS St. Michael, which appears to be comparable if not better in regards to survival.

With the review of the data compared to CoC Programs CHRISTUS St. Michael Health System has not only provided state of the art technology when diagnosing/detecting breast cancer but are offering some of the most exclusive treatments in the greater Ark-La-Tex area.

Not only are the treatments becoming relatively safe and efficacious our prognostic modalities at our disposal are able to deliver the appropriate treatment to one of the most common female malignancies.

HESHAM HAZIN, MD
MEDICAL DIRECTOR,
W. TEMPLE WEBBER CANCER TREATMENT CENTER
CHRISTUS ST. MICHAEL HEALTH SYSTEM
CHRISTUS CANCER PROGRAM LIAISON
CHRISTUS Incidence Rates by Site and Race, Y2010-2014

- Lung
- Colon
- Breast
- Prostate
- Bladder

CHRISTUS 5 Major Sites Distribution by AJCC Stage at Diagnosis, Y2015

- Breast
- Lung & Bronchus
- Colorectal
- Prostate
- Bladder
As an Accredited Cancer Program with the Commission on Cancer, CHRISTUS St. Michael Health System (CSMHS) was given the responsibility for developing the process to disseminate a Survivorship Care Plan (SCP) to patients with cancer who have completed cancer treatment at our facility. Standard 3.3 focuses on the subset of survivors who are treated with curative intent and have completed active therapy (other than long-term hormonal therapy). The process is monitored, evaluated, and presented to the cancer committee annually.

The pilot program was developed in 2012 and began by looking at the best practices of creating and delivering these SCP’s to patients and to their Primary Care Physicians (PCP). The SCP originates in the cancer registry and is distributed to the Nurse Navigator of the W. Temple Webber Cancer Center at CHRISTUS to complete and deliver to the eligible patients.

Expansion took place in 2016 with the hiring of a Nurse Practitioner to lead the Survivorship Program. Prevention and management of late term and/or long term effects will be assessed for oncology rehabilitation services by the survivorship nurse practitioner. Upon completion of treatment, a survivorship visit will be scheduled for the patient to meet with the nurse practitioner. The treatment summary will be reviewed and needs will be assessed. In addition, education will be provided to the patient regarding follow up care, proper nutrition, exercise and screenings. It is the goal of the survivorship program to provide the patient with education, reassurance, support and access to services towards wellness.
Here at CHRISTUS St. Michael we provide education, screening, and breast navigation to all women/men in the community we serve. Currently we receive two grants to assist women/men who are uninsured or underinsured through our breast and cervical outreach program receive breast and cervical services.

This program educates the community about early detection and the importance of mammography and pap testing. In 2013 the hospital expanded breast navigation services to all women/men receiving breast imaging services. A pilot program was initiated to help decrease wait times from screening to diagnostic imaging. The goal was to reach the top 25% of breast centers according to National Quality Metrics for Breast Cancer (NQMBC). The pilot program was a success.

The Breast Navigation program was expanded to all patients receiving breast services at CSM Imaging Center.

Once breast navigation was implemented the average wait time decreased from 12 days to an average of 3 days. Patients who require further diagnostic intervention meet with the navigator the same day and education is provided based on the radiologist recommendations.

The navigator schedules and coordinates the plan of care to ensure the patient receives results as quickly as possible. The navigator received certification in breast navigation in March of 2015. The programs provided here at CHRISTUS allow us to meet the needs of the community we serve.

Stephanie Stewart, RN, BSN, CN-BN

<table>
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<tr>
<th>20-29</th>
<th>30-39</th>
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<td>14%</td>
<td>23%</td>
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<td>18%</td>
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<td>25%</td>
<td>19%</td>
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CHRISTUS Case Distribution by Age and Gender, Y2015

Male  298  Female  354  Total analytic:  653  Total all cases:  806

Oral Cavity & Pharynx: 9 (3%) [4%]
Lung & Bronchus: 90 (30%) [14%]
Pancreas: 9 (3%) [3%]
Kidney & Renal Pelvis: 10 (3%) [5%]
Urinary Bladder: 17 (6%) [7%]
Colon & Rectum: 45 (15%) [8%]
Prostate: 32 (11%) [26%]
Non-Hodgkin Lymphoma: 11 (4%) [5%]
Melanoma of the Skin: 6 (2%) [5%]
Leukemia: 7 (2%) [4%]

All Other Sites: 62 (21%)
National Male All Other Sites= 21%

Thyroid: 8 (2%) [6%]
Lung & Bronchus: 66 (19%)
Pancreas: 9 (3%) [3%] [13%]
Breast: 141 (40%) [28.6%]
Kidney & Renal Pelvis: 7 (2%) [3%]
Ovary: 6 (2%) [3%]
Uterine Corpus: 11 (3%) [7%]
Colon & Rectum: 31 (9%) [8%]
Non-Hodgkin Lymphoma: 9 (3%) [4%]
Melanoma of the Skin: 6 (2%) [4%]
Leukemia: 7 (2%) [3%]

All Other Sites: 62 (18%)
National Female All Other Sites= 21%

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Despite the many available resources for cancer care, Texarkana faces certain barriers in providing low-cost community-level colorectal cancer screening opportunities. While several health care organizations have a patient navigator, more lay and professional navigators are needed to assist patients and their families to access cancer screenings, diagnostic and surgical services. Funding for cancer screenings, diagnostic services and treatment is limited to only a few of the major cancer sites. There is a lack of community awareness on certain cancer sites, therefore, more education is needed.

To address one of the gaps, the CHRISTUS St. Michael Cancer Committee chose to impact screening rates and to reduce the stages of colorectal cancers seen locally in our community. Their goal was to educate physicians and health professionals by offering basic information on colorectal cancer screening and national guidelines from the American Cancer Society to identify primary risk factors for colorectal cancer, along with graphs depicting CHRISTUS ST. Michael AJCC Stage distribution of colorectal cancer at time of diagnosis. Comparing local data to national averages and including a three-year trending of colorectal cancer incidence by stages at CHRISTUS St. Michael was one of four essential strategies that can be used to help improve cancer screening rates within primary care practices. Handy small pocket tri-folds that outline the most current recommendations for colorectal screening from the American Cancer Society were distributed.

A Texarkana’s Colorectal Task Force was created to address the Prevention Programs (Standard 4.1) of the Commission on Cancer (COC) to identify risk factors and use strategies to modify attitudes and behaviors to reduce the chance of developing cancer. One of the efforts in 2016 is for the American Cancer Society to send out a letter of invitation to Primary Care Physicians (PCPs) on behalf of the Colon Cancer Task Force to attend the July 2016 5th Friday Educational Conference. The conference will be hosted at CHRISTUS and the topic is “Colorectal Screening Guidelines and Methodologies”. The Task Force appreciates the Gastroenterology physicians in Texarkana, Brian So, M.D. and Jay Boehmke, D.O. for their support and guidance for the improvement of patients lives by providing prevention activities and education in our community.
CHRISTUS St. Michael Health System, as a designated Lung Cancer Screening Center with the American College of Radiology (ACR), began to see more referrals to its lung cancer screening program in 2015, but not as many as expected. The 2015 year showed slow growth which can be attributed to the continued debate over coverage by providers. With the announcement that Center for Medicare and Medicaid Services had agreed to cover the exam starting in January 2016 and more and more private insurers offering coverage, the growth in patient participation in 2016 looks very promising.

CHRISTUS St. Michael has purchased the software technology, Invivo DynaCAD- a computer aided detection tool for radiologists and Invivo DynaLync- a robust patient monitoring and tracking system. This new software will allow for direct upload to the National Low Dose Lung Cancer Screening Patient Registry with the ACR. The ACR opened this new registry at the end of 2015.

“We recognized early on the responsibility of having a quality screening program and the need for a tool to assure all patients were tracked and monitored appropriately versus a manual process that would demand many staff hours.”

Patient participation was mostly seen in the last quarter of 2015. A total of 55 patients were registered in the program in 2015, with a 25% abnormal rate. The lung cancer screening registry denotes an abnormal as a CT low dose lung screening result of a category 3 or 4. There were no diagnoses of cancer in the registered patients in 2015.

LISA PATTERSON, BS,CNMT, RT (N)
the case presentations brought before the CHRISTUS St. Michael Tumor Board physicians are in the best interest of the patient, providing a forum for patient consultation and contributing to a learning experience for all. These conferences are coordinated through the cancer registry staff. Moderators for these meetings are Howard Morris, MD and Hesham Hazin, MD.

Discussion on the case presentation precedes the review of diagnostic studies and pathology. The moderator allows for a consultative dialogue and discussion of treatment plan options. Discussion occurs on AJCC stage including prognostic factors. The NCCN guidelines were viewed at these meetings 95 percent of the time to allow participants the opportunity to see the national recommendations for treatment planning using evidence-based guidelines.

Tumor boards also give the opportunity for options on clinical trial participation. A Clinical Nurse Navigator/Cancer Genetic Educator is available for consultative services to give physicians the opportunity to refer their patients for evaluation. Identifying these patients early would allow for modification of medical management to help prevent second primary cancers.

Cancer Conferences (Tumor Board meetings) are hosted on the second and fourth Fridays of each month. Twenty-one cancer conferences were hosted at CHRISTUS in 2015 with a total of 346 physicians and 183 allied health professionals in attendance. Ninety-five percent of our cases were presented prospectively where treatment management of the patient can effectively be impacted by discussions.

Educational Conferences are hosted on the fifth Friday in the calendar year. All of these meetings are approved for one hour of continuing medical education through the University of Arkansas for Medical Sciences. Appreciation is given to the moderators, radiologist, pathologist and physicians who present their patients in this multidisciplinary setting.

### 2015 5th Friday Educational Cancer Conferences

- “Interventional Pulmonology (IP) and the Multiple Disciplinary Thoracic Oncology Program” Gordon Downie, M.D. PH. D. FCCP
- “Focus on Multiple Myeloma” A. Keith Stewart, MD, ChB
- “Colorectal Health Symposium” Jay Boehmke, DO, Brian So, MD, J.D. Patel, MD. Mark Sutherland, MD, Tammy McKamie, MSN, RN, OCN, GCN
- “Ethical Principles in Healthcare” Jim Pomeroy, MAHCM
- “Update on Navigational Bronchoscopy & Photo Dynamic Therapy” Suman Sinha, MD, MS, MBA, FCCP, FACP/Gordan Downey, MD, PH.D., FCCP
CHRISTUS Treatment Assessment Studies
monitoring compliance with evidence based guidelines

One of the Standards of the Commission on Cancer (CoC) was the development of a *Treatment Assessment Planning Study* each year. The cancer committee reviewers accomplished an evaluation of a site of cancer treatment to determine adherence to the National Comprehensive Cancer Network (NCCN) Guidelines for standard of care monitoring. The following studies were accomplished using Cancer Registry data to ensure patient treatment met the NCCN guidelines. **In 2014** the CHRISTUS Stage IV Non-Small Cell Lung Cancer Patients (NSCLC) were reviewed for pre-assessment and treatment concordant with NCCN guidelines and correct staging by the AJCC 7th Edition Staging Manual. The NCCN Guidelines for Stage IV cases were found to be very complex with many different combinations of distant metastatic sites. In order to appropriately determine if treatment administered matched the guidelines, we first reviewed the number of stage IV cases given a subcategory of M1A or M1B or if MD staging, which was stage IV or extensive metastatic disease. The results of this study revealed a need for more education in the staging of AJCC Stage IV lung cancers M1A & M1B subcategories. A discussion now occurs at tumor board meetings in an effort for this committee to provide complete staging of these cancers. Recommendation was to increase the utilization of Endobronchial Ultrasound (EBUS) to assist with complete MD Staging. As an improvement, a Lung Cancer Educational Conference was hosted in November to inform the medical staff of local and national lung cancer statistics and to familiarize the systematic use of AJCC clinical staging of NSCLC for reliable evaluation of treatment planning. **In 2015** a colon cancer treatment assessment study was completed with a retrospective study of 2014 colon patients to determine if treatment administered matched NCCN treatment recommendations by stage at diagnosis and treatment administered. See results below:

<table>
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<th>2015 Colon Cancer Pre-Assessment Work-Up</th>
<th>Colonoscopy</th>
<th>Path Review</th>
<th>PRE-Op CEA</th>
<th>Family HX</th>
<th>Chest or ABD/Pelvic CT</th>
<th>Total Cases</th>
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<td>Stage 3</td>
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<th>2015 Colon Cancer Treatment</th>
<th>Pathologic Stage</th>
<th>1st Course Treatment</th>
<th>Concordant with NCCN</th>
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<td>Stage T1-T4 NO</td>
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Under the leadership and guidance of the Commission on Cancer Standards for Approval, the entire interdisciplinary team involved with treating cancer at CHRISTUS St. Michael Health System utilizes the resources found in the Cancer Registry as a source for monitoring quality trends effecting patient care decisions and for improved patient navigation.

These monitoring processes allow our institutions to look at local data and identify problematic areas for improvement to meet breast quality measures set forth by the National Quality Metrics for Breast Cancer (NQMBC) guidelines, for benchmarking surgical procedures and obtaining breast conserving surgery/mastectomy rates, sentinel lymph node resection and needle core biopsy before an open procedure rates in their efforts to improve patient care and outcomes.

Cancer Registrars bridge the gap by capturing a complete summary of the patient’s disease from diagnosis throughout their lifetime. The primary responsibility of the cancer registrar is to ensure that timely, accurate, and complete data is incorporated and maintained on all types of cancer diagnosed and/or treated at our facility. Information entered into the cancer registry database is a summary of the cancer patients history, diagnosis and treatment and their current vital status. It takes dedicated staff to coordinate the regulatory requirements for a CoC Approved Cancer Program.

The Cancer Registry staff have completed their twenty-sixth year of partnering with CHRISTUS St. Michael in an effort to maintain accreditation. The cancer registrars are members of both Texas and Arkansas Cancer Registrar’s Association as well as the National Cancer Registrar’s Association (NCRA).

The Cancer Registry staff accessioned 653 newly diagnosed cases in 2015 with an additional 153 nonanalytic or recurrent cases being collected. Our staff has collected data over the past twenty-six years on 18,280 CSMHS patients and 19,532 total primaries. Of this number, we have 3,571 living patients. We have a reference year follow-up rate of 94 percent and a 5-year follow up rate of 95%. A 80% reference year and a 90% 5-year rate is the required percentage by the CoC.

All the successes of the cancer program in Texarkana would not be possible without the support and leadership of the CHRISTUS St. Michael Cancer Committee and administration. Appreciation is given to all cancer committee members, tumor board moderators and physicians who present at these meetings. A special appreciation is given to Donna Marlar, CTR and Christy Dabbs, CTR for their dedication to this profession by performing their cancer registrar’s duties in an exemplary way.

DIANNE KETCHUM, CTR, OWNER
CANCER REGISTRY SERVICES OF TEXARKANA, LLC

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