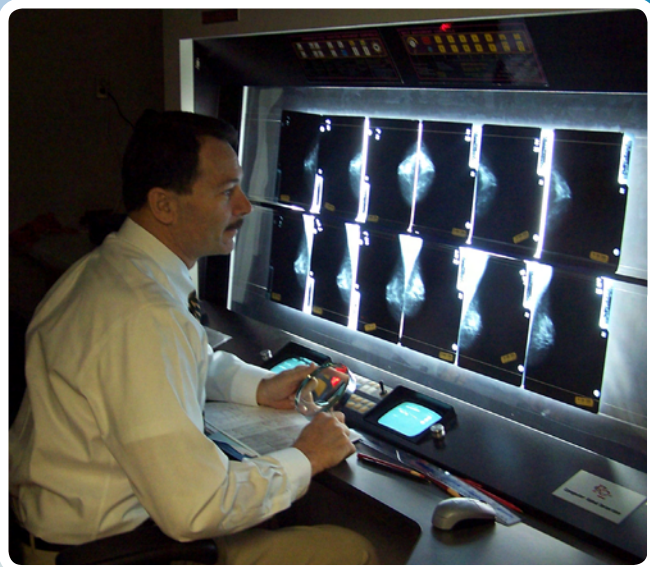


2013
NASH HEALTH CARE SYSTEMS

Cancer Program Annual Report



NASH HEALTH CARE
It's all about how we treat you.

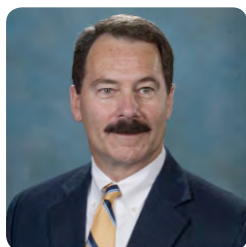
Message from Nash Health Care President and CEO, *Larry H. Chewning, III*



Nash Health Care System is constantly striving to expand the resources locally available to oncology patients we serve in our four county service area. Recent investments in technology devoted to the detection and treatment of cancer place us at the forefront of comprehensive community cancer centers. However, the best is yet to come. The recently announced affiliation relationship between NHCS and UNC Health Care creates an enormous opportunity to deliver the best in oncology services in our own back yard.

Larry Chewning
President and CEO
Nash Health Care

Chairman's Report - 2013, *Ivan Peacock, MD*



Ivan Peacock, MD
Cancer Committee
Chairman

It is my distinct pleasure to introduce this 2013 Annual Report of the Nash Health Care System community comprehensive cancer program. As the Chairman of the NHCS Cancer Committee for the past 10 months, I have developed abundant respect for the very complex medical process that is the comprehensive cancer program at Nash. I hope that this report is effective in providing you with an overview of the current cancer program activities, as well as informative in analyzing the cancer registry data for 2012.

I first must declare an earnest thank you to all of the medical staff and volunteers that comprise the Nash community comprehensive cancer program team. It is a very diverse, multi-dimensional, and extraordinarily talented team of professionals dedicated

to pursuing and diagnosing cancer; to staging disease and designing treatment plans; to coordinating and delivering cancer treatment; to supporting and sustaining the patient during treatment; to managing recovery and rehabilitation; and to restoring lost health and hope to patients and loved ones.

To coordinate and deliver comprehensive cancer care requires the services of a multidisciplinary team of administrators, physicians, surgeons, oncologists, radiologists, pathologists, nurses, navigators, nutritionists, social workers, psychosocial specialists, rehabilitation therapists, radiation therapists, laboratory technicians, genetic counselors, pharmacists, and hospice care specialists. Cancer patients must have access to this diverse array of professionals, as well as access to state of the art technology, in a systematized and synchronized manner to be effective; a colossal task to orchestrate!

This task is accomplished through the NHCS Cancer Committee which is comprised of representatives from the specialty services noted above. The committee meets quarterly to coordinate and administer the Nash cancer program which follows the national standards for cancer care promulgated by the Commission on Cancer, the national accrediting body for cancer centers. The Nash community comprehensive cancer program was reviewed in November 2011, by the Commission on Cancer, earning a three year accreditation with commendations in six out of nine eligible standards.

The Nash Comprehensive Cancer Operations Group, comprised of cancer leaders and administrators at Nash, provides additional strategic planning and coordination of hospital and

outpatient cancer services through monthly meetings.

I am honored to share in the commitment by Nash to building and sustaining the Comprehensive Cancer Program for our community.

2013 Cancer program highlights

Acquisition of new advanced technology:

- On-Board Imager that provides complimentary imaging for the linear accelerator radiation treatment machine which will coordinate imaging and radiation treatment for more complex cancer
- Upgraded MRI machine with a large bore magnet (open) and new imaging technology that will improve diagnostic imaging of cancer disease
- Third mammogram machine added to the Nash Breast care Center to detect more breast cancer

Acquisition of new cancer detection and treatment expertise:

- Two new fellowship trained breast radiologists added to the Nash Breast Care Center who will further advance breast imaging and intervention at Nash
- A 3rd medical oncologist added to BWC that will facilitate cancer treatment
- Certification of Nash interventional radiologist to treat liver cancer with intra arterial catheter directed radionuclide microspheres

New Programs developed to promote excellence in cancer detection and treatment:

- Breast program leadership group established to pursue Center of Excellence accreditation for Nash Breast Care Center
- A weekly Breast Cancer Conference added for multidisciplinary review and discussion of breast cancer treatment
- Oncology lecture series for staff providing expert updates on cancer treatment
- Screening and testing program started to identify patients at high risk for breast and ovarian cancer
- Four cancer screening clinics held for colorectal cancer, breast cancer, skin cancer and prostate cancer

New Patient Education Outreach programs started:

- Breast Cancer Survivorship, Breast health, education, prevention, and living beyond breast cancer, expert panel 'Ask the Experts'
- New Cancer Patient Orientation, Look and Feel Better program, American Cancer Society trained volunteers

Risk Assessment and Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome in Triple Negative Breast Cancer Subjects - 2013, *Ivan Peacock, MD*

Introduction

In recent years the hereditary contribution to breast cancer has become increasingly apparent through the identification of several gene mutations that cause increased risk of breast cancer. The most well-known and studied of these mutations are the BRAC1 and BRAC2 gene mutations. The prevalence of hereditary cancer is known to be especially high in the Nash Healthcare service area and efforts to institute screening programs at Nash to identify these high risk patients are underway.

Women with the BRAC gene mutation have an estimated increased lifetime risk of breast cancer of up to 80% (compared to 8% for the unaffected population). Affected individuals diagnosed with breast cancer also have an estimated increased risk for a second contralateral breast cancer within 10 years of up to 30% (compared to 10% for unaffected individuals). Furthermore, women with the BRAC gene mutation have an increased risk for ovarian cancer estimated up to 60%.

Breast cancer that develops in association with the BRAC gene mutation tends to be triple negative subtype: negative for estrogen receptors; negative for progesterone receptors; and negative for human epidermal growth factor. Triple-negative breast cancers have a more aggressive course and poorer prognosis, with early metastasis and more limited treatment options.

The National Comprehensive Cancer Network (NCCN) has published specific criteria to identify individuals at risk for Hereditary Breast and Ovarian Cancer syndrome (HBOC). The presence of any one of these criteria should prompt further risk evaluation and genetic testing for the BRAC gene mutation. One of the testing criteria is a personal history of triple negative breast cancer diagnosed at age < 60 years.

The Nash Comprehensive Community Cancer Program (NCCCP) adheres to the national standards for cancer care promulgated by NCCN, as required by the Commission on Cancer, the accrediting body for the Nash cancer program. This review was undertaken to assess the Nash cancer program's adherence to the recommended NCCN guidelines for genetic testing by assessing compliance with the one specific testing criterion noted in the preceding paragraph.

Methods

From the Nash cancer registry, all patients 60 years or younger with triple negative breast cancer in 2012, were identified and compiled in an alphabetical listing. Representatives from the Myriad Genetics Laboratory, the leading provider of BRAC testing in the Nash area in 2012, provided a list of all subjects tested for BRAC during 2012 from the Nash area. The Myriad list identified the tested subjects only by initials and birth year. The two lists were carefully compared to identify which of the cancer subjects received BRAC testing by MYRIAD. The Nash cancer registrar further reviewed treatment records of the cancer subjects to identify any additional patients who may have been tested elsewhere, or were offered testing but chose not to complete the test.

Results

A total of 41 subjects were identified in the Nash Cancer Registry in the year 2012 with triple negative breast cancer age 60 years or younger. Thirteen of the 41 cancer subjects were identified as having been tested through comparison with the database provided by Myriad. Review of the treatment records of the remaining 28 cancer subjects (not on the Myriad list) identified an additional 18 subjects who were reported in the patient treatment record as tested,

or as offered testing. The total number of subjects with triple negative breast cancer 60 years of age or younger in 2012, who were tested for the BRAC gene mutation, or who were offered testing is 31 (75.6%). The total number of subjects with triple negative breast cancer 60 years of age or younger in 2012, for which no information could be identified to confirm that testing was performed, or that testing was offered, is 10 (24.4%)

Discussion And Conclusions:

The presence of the BRAC gene mutation in patients with breast cancer has significant implications for both the surgical and the medical management of the patient and should initiate discussions for risk-reducing mastectomy, risk-reducing salpingo-oophorectomy, risk reducing chemoprevention strategies, as well as ongoing surveillance options.

Patients with a BRCA mutation may choose mastectomy over lumpectomy plus contralateral prophylactic mastectomy. Patients who choose breast conservation should consider more vigilant surveillance, including alternating breast MRI and mammography at six month intervals. Affected women who choose breast conservation treatment may consider tamoxifen therapy which has been found to reduce the risk of recurrent breast cancer by at least 50%. In addition, prophylactic oophorectomy has been shown to reduce the risk of breast cancer by more than 50% in premenopausal women with BRCA2 mutation, with less benefit to those patients with a BRCA1 mutation.

Nash Breast Care Center (NBCC) has been developing a screening and testing program to identify patients at risk for HBOC syndrome utilizing the NCCN guidelines for approximately eighteen months. Additionally, NBCC and NCCCP have sponsored numerous education and outreach programs for physicians and patients to increase awareness of HBOC syndrome and its implications. Discussions of HBOC syndrome and genetic testing have become commonplace in the Tumor Board and Breast Conferences.

This review utilized a narrow focus to assess adherence to a single NCCN criterion for risk assessment and genetic testing for HBOC syndrome. The observed compliance of 75.6% for genetic testing of patients with a personal history of triple negative breast cancer diagnosed at age < 60 years is creditable considering the early stage of development of the education and screening programs at Nash, which were just starting in 2012. The compliance for testing will likely increase in 2013 as this program matures. The actual compliance could be higher than 75.6% considering that there may be incomplete documentation in the patient treatment record that risk assessment was performed and that testing was offered, but declined. Similarly, genetic testing may have been performed by another company or institution, and not documented properly in the treatment records for easy abstraction. Additionally, those patients diagnosed near year's end may not be tested until early 2013, and therefore not reported on the annualized Myriad list. A second look at the compliance for genetic testing could be conducted in 2014 to assess the effectiveness of the current education and screening program.

Acknowledgements

I would like to thank Penny Hearn, Chris Wood, Kathy Vick, and Donna Baber for their assistance in preparing this report. Information for this report was obtained from the Nash Tumor Registry; the 2013 National Comprehensive Cancer Network Guidelines for HBOC testing criteria, Version 1.2013; the American Society of Breast Surgeons Position Statement on BRAC Genetic Testing dated September 30, 2012; and Myriad Genetics, Inc..

SIR - Microspheres at Nash Health Care Systems, *Tillman Bailey, MD*



Tillman Bailey, MD

In 2012, Nash Healthcare began offering Selective Internal Radiation Therapy (SIRT), using SIR-Spheres® microspheres, for patients with metastatic liver cancer. SIR-Spheres® microspheres are the only fully FDA-approved microsphere therapy for colorectal cancer that has spread to the liver. Dr. Tillman Bailey, Interventional Radiologist, leads the program at Nash Healthcare.

Up to 60% percent of the nearly 150,000 Americans diagnosed with colorectal cancer every year will see their cancer spread to the liver, and most liver tumors cannot be surgically resected.

Metastatic liver cancer is often fatal, with up to 90 percent of patients dying from liver failure. Microspheres therapy has

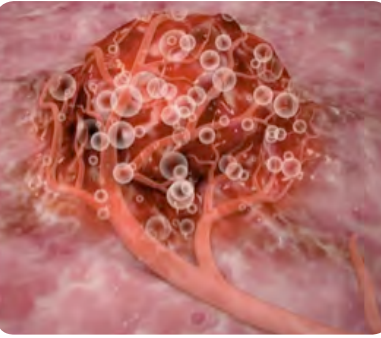
emerged as a treatment option for patients with colorectal cancer that has spread to the liver.

SIR-Spheres® microspheres are microscopic radioactive spheres that can be delivered by the millions directly to the tumor site. The microspheres contain the radioactive isotope yttrium-90, which delivers beta radiation to the tumor. The microspheres selectively target liver tumors with a dose of internal radiation up to 40 times higher than conventional external radiotherapy while sparing healthy tissue. The microspheres emit beta radiation for a period of about two weeks.

The SIRT procedure allows the radiation source to be placed directly into the liver tumor by using the tumor's blood supply. The normal liver tissue takes about 90% of its blood supply from the portal vein that flows from the intestine while liver tumors receive about 90% of their blood supply from the hepatic artery. SIR-Spheres® microspheres are targeted directly at the liver

tumors via the hepatic artery, so exposure to the remaining healthy liver tissue is minimized.

To date, over 25,000 patients have been treated worldwide with SIR-Spheres® Microspheres. SIRT is only suitable for patients with liver tumors where either the liver is the only site of disease or the liver is the major site of disease. SIRT has no effect on tumors outside the liver. Before SIRT can be offered as a treatment option for patients, there are a number of other factors that have to be considered. Most importantly, patients need to have a sufficiently healthy liver that is working satisfactorily. This is usually determined by a simple blood test. Nearly all of the patients who receive this treatment will return home the same day.

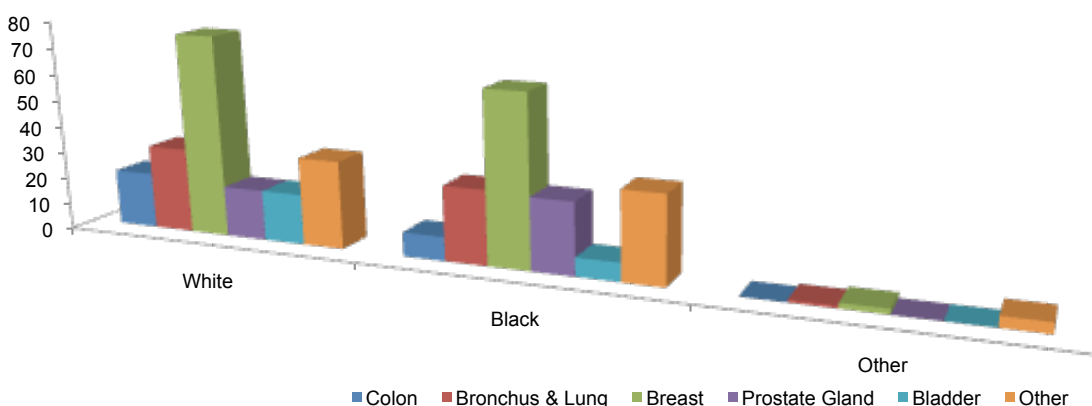


Clinical data shows that when used in combination with chemotherapy, SIR-Spheres® microspheres may shrink patients' liver tumors more than chemotherapy alone, improve quality of life, and increase life expectancy. For a small number of patients, treatment can cause sufficient shrinkage of the liver tumor to permit its removal by surgery at a later date. In patients whose liver tumors are no longer responding to chemotherapy, SIR-Spheres® microspheres have also been used successfully to shrink these tumors and extend patients' survival. There are many publications in the scientific literature on the use of SIR-Spheres® microspheres in the treatment of patients with liver metastases.

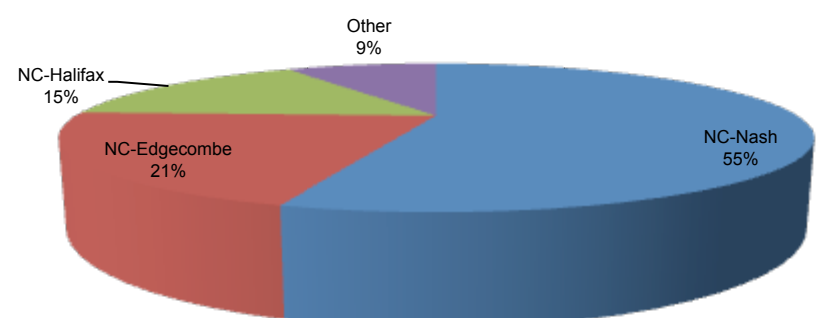
Cancer Incidence by Body System and Sex 2012

| Primary Site | Total | % | Male | % | Female | % | Primary Site | Total | % | Male | % | Female | % |
|---------------------------------|-------|-------|------|-------|--------|-------|------------------------------|------------|-------|------------|-------|------------|-------|
| ORAL CAVITY & PHARYNX | 12 | 2.5% | 6 | 3.0% | 6 | 2.1% | BREAST | 143 | 29.3% | 0 | 0.0% | 143 | 49.8% |
| Tongue | 4 | 0.8% | 2 | 1.0% | 2 | 0.7% | Breast | 143 | 29.3% | 0 | 0.0% | 143 | 49.8% |
| Salivary Glands | 1 | 0.2% | 0 | 0.0% | 1 | 0.3% | FEMALE GENITAL SYSTEM | 16 | 3.3% | 0 | 0.0% | 16 | 5.6% |
| Gum & Other Mouth | 1 | 1.2% | 1 | 0.5% | 0 | 0.0% | Cervix Uteri | 1 | 0.2% | 0 | 0.0% | 1 | 0.3% |
| Tonsil | 3 | 1.6% | 2 | 1.0% | 1 | 0.3% | Corpus & Uterus, NOS | 9 | 1.8% | 0 | 0.0% | 9 | 3.1% |
| Oropharynx | 1 | 0.2% | 0 | 0.0% | 1 | 0.3% | Corpus Uteri | 7 | | 0 | | 7 | |
| Hypopharynx | 1 | 0.2% | 0 | 0.0% | 1 | 0.3% | Uterus, NOS | 2 | | 0 | | 2 | |
| Other Oral Cavity & Pharynx | 1 | 0.2% | 1 | 0.5% | 0 | 0.0% | Ovary | 5 | 1.0% | 0 | 0.0% | 5 | 1.7% |
| DIGESTIVE SYSTEM | 84 | 17.2% | 45 | 22.4% | 39 | 13.6% | Vulva | 1 | 0.2% | 0 | 0.0% | 1 | 0.3% |
| Esophagus | 3 | 0.6% | 2 | 1.0% | 1 | 0.3% | MALE GENITAL SYSTEM | 49 | 10.0% | 49 | 24.4% | 0 | 0.0% |
| Stomach | 9 | 1.8% | 6 | 3.0% | 3 | 1.0% | Prostate | 46 | 9.4% | 46 | 22.9% | 0 | 0.0% |
| Small Intestine | 6 | 1.2% | 5 | 2.5% | 1 | 0.3% | Testis | 3 | 0.6% | 3 | 0.6% | 0 | 0.0% |
| Colon Excluding Rectum | 30 | 6.1% | 9 | 4.5% | 21 | 7.3% | URINARY SYSTEM | 40 | 8.2% | 25 | 12.4% | 15 | 5.2% |
| Cecum | 7 | | 2 | | 5 | | Urinary Bladder | 26 | 5.3% | 19 | 9.5% | 7 | 2.4% |
| Ascending Colon | 7 | | 3 | | 4 | | Kidney & Renal Pelvis | 14 | 2.9% | 6 | 3.0 | 8 | 2.8% |
| Hepatic Flexure | 1 | | 0 | | 1 | | BRAIN & OTHER NERVOUS SYSTEM | 11 | 2.3% | 5 | 2.5% | 6 | 2.1% |
| Transverse Colon | 2 | | 1 | | 1 | | Brain | 4 | 0.8% | 4 | 2.0% | 0 | 0.0% |
| Splenic Flexure | 1 | | 0 | | 1 | | Cranial Nerves Other | 7 | 1.4% | 1 | 0.5% | 6 | 2.1% |
| Descending Colon | 2 | | 1 | | 1 | | Nervous System | | | | | | |
| Sigmoid Colon | 8 | | 2 | | 6 | | ENDOCRINE SYSTEM | 10 | 2.0% | 2 | 1.0% | 8 | 2.8% |
| Large Intestine, NOS | 2 | | 0 | | 2 | | Thyroid | 10 | 2.0% | 2 | 1.0% | 8 | 2.8% |
| Rectum & Rectosigmoid | 12 | 2.5% | 8 | 4.0% | 4 | 1.4% | LYMPHOMA | 18 | 3.7% | 11 | 5.5% | 7 | 2.4% |
| Rectosigmoid Junction | 1 | | 1 | | 0 | | Hodgkin Lymphoma | 1 | 0.2% | 1 | 0.5% | 0 | 0.0% |
| Rectum | 11 | | 7 | | 4 | | Non Hodgkin Lymphoma | 17 | 3.5% | 10 | 5.0% | 7 | 2.4% |
| Anus, Anal Canal & Anorectum | 4 | 0.9% | 2 | 1.0% | 2 | 0.7% | NHL Nodal | 14 | | 7 | | 7 | |
| Liver & Intrahepatic Bile Duct | 4 | 0.9% | 4 | 2.0% | 0 | 0.0% | NHL Extranodal | 3 | | 3 | | 0 | |
| Liver | 3 | | 3 | | 0 | | MYELOMA | 7 | 1.4% | 2 | 1.0% | 5 | 1.7% |
| Intrahepatic Bile Duct | 1 | | 1 | | 0 | | Myeloma | 7 | 1.4% | 2 | 1.0% | 5 | 1.7% |
| Gallbladder | 2 | 0.4% | 2 | 1.0% | 0 | 0.0% | LEUKEMIA | 8 | 1.6% | 4 | 2.0% | 4 | 1.4% |
| Pancreas | 13 | 2.7% | 7 | 3.5% | 6 | 2.1% | Lymphocytic Leukemia | 2 | 0.4% | 1 | 0.5% | 1 | 0.3% |
| Other Digestive Organs | 1 | 0.2% | 0 | 0.0% | 1 | 0.3% | Myeloid & Monocytic | 6 | 1.2% | 3 | 1.5% | 3 | 1.0% |
| RESPIRATORY SYSTEM | 72 | 14.8% | 43 | 21.4% | 29 | 10.1% | Leukemia | | | | | | |
| Nose, Nasal Cavity & Middle Ear | 1 | 0.2% | 1 | 0.5% | 0 | 0.0% | Acute Myeloid Leukemia | 3 | | 1 | | 2 | |
| Larynx | 11 | 2.3% | 8 | 4.0% | 3 | 1.0% | Chronic Myeloid Leukemia | 3 | | 2 | | 1 | |
| Lung & Bronchus | 60 | 12.3% | 34 | 16.9% | 26 | 9.1% | MESOTHELIOMA | 2 | 0.4% | 0 | 0.0% | 2 | 0.7% |
| SOFT TISSUE | 1 | 0.2% | 1 | 0.5% | 0 | 0.0% | Mesothelioma | 2 | 0.4% | 0 | 0.0% | 2 | 0.7% |
| Soft Tissue (including Heart) | 1 | 0.2% | 1 | 0.5% | 0 | 0.0% | MISCELLANEOUS | 12 | 2.5% | 7 | 3.5% | 5 | 1.7% |
| SKIN EXCLUDING BASAL & SQUAMOUS | 3 | 0.6% | 1 | 0.5% | 2 | 0.7% | Miscellaneous | 12 | 2.5% | 7 | 3.5% | 5 | 1.7% |
| Melanoma -- Skin | 1 | 0.2% | 0 | 0.0% | 1 | 0.3% | | | | | | | |
| Other Non Epithelial Skin | 2 | 0.4% | 1 | 0.5% | 1 | 0.3% | TOTAL | 488 | | 201 | | 287 | |

top cancer sites ~ By Race 2012



county at diagnosis ~ 2012



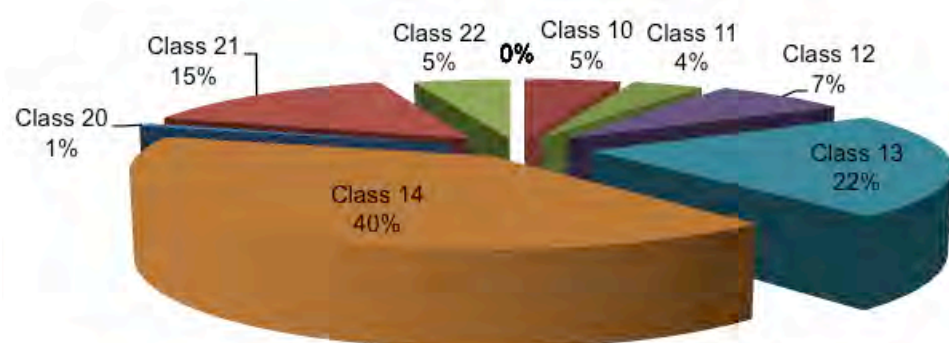
Tumor Registry Class of Case... What does it mean? *Lisa Gimber, RHIT, CTR, Cancer Registry*

When reporting a case to the National Cancer Database or the North Carolina Central Cancer Registry, a registrar reports patient demographic information, cancer identification, diagnostic procedures, cancer-directed treatment, and survival. The collection of information is reported in a standardized manner.

Class of Case divides cases recorded in the database of the facility into two categories; analytic and non-analytic. Analytic data includes cancer cases diagnosed at Nash Health Care (the accessioning facility) and/or administration of any of the first course of therapy at another institution, or are diagnosed at autopsy or by death certificate only. Analytic cases are those required by the Commission on Cancer (CoC) to be abstracted. Non-analytic cases are not required to be abstracted by the CoC, but can be required by the central registry or the hospital's cancer committee. Non-analytic cases are not usually included in routine treatment or survival statistics.

In 2010, the Commission on Cancer of the American College of Surgeons introduced the first major changes to the Class of Case data item in the decades since the item went into use. Beginning in 2010, Class of Case is used to define the data items that must be completed in order to assign a date to the new data item, Date Case Completed – CoC. Class of Case is also attractive to hospital administrators and central registries for defining the types of contact patients have with individual hospitals. The revisions to the item were made with each of these uses in mind.

Nash Health Care 2012 Class of Case



The new analytic Class of Case codes are:

| Class | Description |
|--|--|
| Initial diagnosis at reporting facility | |
| 00 | Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere |
| 10 | Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS |
| 11 | Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility |
| 12 | Initial diagnosis in staff physician's office AND all of first course treatment or a decision not to treat was done at the reporting facility |
| 13 | Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility |
| 14 | Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility |
| Initial diagnosis else where | |
| 20 | Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS |
| 21 | Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility |
| 22 | Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility |

Source: Facility Oncology Registry Coding Standards (FORDS): Revised for 2010.



Nash Tumor Registry Staff
Pictured from left to right: Beth Pearsall, Cancer Conference Coordinator, Kathy Vick, RHIT, CTR, Lisa Gimber, RHIT, CTR, and Donna Baber, CTR

Class of Case 11 and 12 are distinguished from 13 and 14 by whether the case was initially diagnosed by a staff physician in his or her office or at the hospital. A staff physician is a physician who is employed by the reporting facility, is under contract with it, or has routine practice privileges there. Clinics are considered part of the hospital if they operate under the hospital's administration, whether they are located in the hospital building or elsewhere. A clinic located in the hospital, but not under its administration is not considered part of the hospital.

The new non-analytic Class of Case codes are:

| Class | Description |
|--|---|
| Patient appears in person at reporting facility | |
| 30 | Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup |
| 31 | Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care |
| 32 | Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence |
| 33 | Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only |
| 34 | Type of case not required by CoC to be accessioned AND initial diagnosis AND part or all of first course treatment by reporting facility |
| 35 | Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility |
| 36 | Type of case not required by CoC to be accessioned AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility |
| 37 | Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility |
| 38 | Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death |
| Patient does not appear in person at reporting facility | |
| 40 | Diagnosis AND all first course treatment given at the same staff physician's office |
| 41 | Diagnosis and all first course treatment given in two or more different staff physician's offices |
| 42 | Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity |
| 43 | Pathology or other lab specimens only |
| 49 | Death certificate only |
| 99 | Non-analytic case of unknown relationship to facility |

Source: Facility Oncology Registry Coding Standards (FORDS): Revised for 2010.

The concepts of class of case and analytic/non-analytic classes in CoC program cancer registries were developed long before hospital registries were computerized. The categories initially developed anticipated neither the variety of locations where an individual patient may receive diagnostic and treatment services nor the extent of analytic cases that now characterize the data collected by hospital registries. The revised analytic codes retain the original principle that analytic cases are those for which the facility bears early responsibility for the management and outcome of the patient's disease. They also provide additional detail necessary for contemporary administrative and analytic purposes.

Cancer Liaison Physician's Report - 2013, *Laura Jacimore, MD*



Laura Jacimore, MD
Cancer Liaison Physician

Over the past year, the Cancer Committee at Nash Health Care realized several goals designed to advance hospital initiatives benefiting our cancer patients. Several of these notable examples are to follow.

The committee recommended and approved the creation of a CME lecture every other month. This was accomplished through the cancer program's clinical trial affiliate relationship with the University of North Carolina Lineberger Cancer Center in Chapel Hill, North Carolina. Dr. Keith Amos, a surgical oncologist at UNC, was our first speaker and discussed the topics of "Neoadjuvant Chemotherapy from a Surgeon's Perspective, Surgical Management of the Axilla in 2012, and Breast MRI in Breast Cancer: Pros and Cons".

As part of this CME series, the cancer program at Nash implemented a telemedicine virtual tumor board as another tool that our local physicians can utilize to assist in the care of our patients.

As part of the Commission on Cancer's CP3R quality guidelines, the program received a 100% compliance rating for radiation being administered within 1 year of diagnosis for women under the age of 70 undergoing breast conserving surgery for breast cancer. This was well above the state benchmark for this measure of 94.8% and the community hospital cancer program average of 90.8%.

Nash's cancer program also received a 100% compliance rating for adjuvant chemotherapy being considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. The North Carolina benchmark for this measure was 98.3%

A new and important service was created for the cancer patients at Nash Health Care in 2012. Delphine Wiggins, MSW, was hired as the new outpatient oncology social worker. She fills an extremely important role for our patients and the cancer program at Nash. As the psychosocial representative on the cancer committee, she is available for our patients and their families as they navigate through the complex continuum of cancer care, both physically and emotionally.

The Nash Breast Care Center continued to see exponential growth in 2012, with a near 30% increase in volume. With this was the staff addition of Dr. Todd A. Goodnight, a breast and chest imaging trained radiologist. In the summer of 2013, the center will welcome Dr. Kenneth L. Crosby to the staff. He is currently completing a breast imaging fellowship at the University of North Carolina, Chapel Hill and is board certified in psychiatry, neurology, and radiology.

In 2012, the cancer program has seen many improvements that will facilitate and improve care of the cancer patients at Nash and in the surrounding communities. The members of the cancer committee look forward to further advancements in 2013 that will benefit our patients and continue to enhance the quality of cancer care at Nash Health Care System.

Nash Community Comprehensive Cancer Program - CME Education Series

In 2012-2013, the Nash Cancer Program instituted a regular Continuing Medical Education series through its partnership with the UNC Lineberger Comprehensive Cancer Program in Chapel Hill NC. Since its implementation physician speakers from UNC have given lectures on topics related to breast, head and neck cancers. We look forward to continued collaboration between UNC and Nash Health Care to sustain this effort. Lectures given to NHCS physicians between September 2012 and September 2013 include:

- **Neoadjuvant Chemotherapy from a Surgeon's Perspective; Surgical Management of the Axilla** - Dr. Keith Amos, Assistant Professor of Surgery, Division of Surgical Oncology, UNC-CH
- **Rx in the Elderly and Sick; Current concepts in Axillary Management for Breast Cancer Patients** - Dr. Lisa Carey, Physician in Chief - NC Cancer Hospital, Division of Hem/Onc - Chief, UNC-CH and Dr. David Ollila, Associate Director of NC Cancer Hospital, Dept of Surgery - Professor, UNC-CH
- **The Metabolic Effects of Obesity and Gynecologic Cancers** - Dr. Victoria Bae-Jump, Assistant Professor of GYN ONC, Dept of OBGYN, UNC-CH
- **Breast Masses in the Pregnant and Lactating Patient** - Dr. Cherie Kuzmiak, Director of Breast Imaging & Associate Professor of Radiology, UNC-CH
- **Updates in the Treatment of Head and Neck Cancer** - Dr. Neil Hayes, Associate Professor, Division of Hem/Onc, Dept of Medicine, Dept of Otolaryngology/Head and Neck Surgery, UNC-CH

Nash Health Care's Oncology Unit

The Oncology Unit is a 17 bed unit. The philosophy of the Oncology Unit is centered around the concept of the inherent worth of the individual. Because the impact of cancer and its treatment extends beyond the individual into the heart of the family, care in the Oncology Unit is also family-centered. Further, recognizing that the needs of the patient and family will change across the continuum of cancer, the nursing staff believes that care should be dynamic and highly individualized in order to help the patient and family respond to the challenges they face.

The Oncology staff is required to attend a comprehensive course designed to prepare the professional nurse to practice Oncology nursing and to obtain certification in chemotherapy administration. Certification in Oncology is strongly encouraged.

Scheduling is flexible to meet the needs of the patients and the staff. The 12-hour shift pattern allows for minimal, if any, shift rotations, such enhanced life-planning for the staff member. Those staff members choosing to work straight PM shifts do not rotate and enjoy the generous PM shift differential offered by NHCS. Week-End Option is also available on the unit.



Nash Oncology Unit Staff
Pictured from left to right: Kimberly Hamiel, Erica Moore, Latisha Richardson, Mary Ricks, Chris Cherry, Nurse Manager, Linda McCoy, Enola Hicks, Felicia Hunter, in front Amanda Matthews

oncology unit goals

1. To provide comprehensive diagnostic and multi-modality treatment options to oncology patients in order to return the patient to optimal level of functioning and quality of life within the constraints of the disease process.
2. To ensure continuity of care across the health-illness continuum of cancer by working collaboratively with The Nash Cancer Treatment Center (Radiation Therapy), Pastoral Care, Care Managers, hospice, home health, and other health care providers to assist in the provision of quality care.
3. To provide continuous support to the families of the center's patients through such mechanisms as support groups and educational interventions.
4. To enhance the understanding of all aspects of cancer and its treatment by offering prevention, detection, and educational programs to patients, their families, and our community by actively participating in community cancer services organizations.

Social Work Services at Nash Cancer Treatment Center



Outpatient Social Work services may be accessed by contacting Delphine Wiggins, MSW at (252) 962-8908 or dcwiggins@nhcs.org.

A diagnosis of cancer can affect many areas of a person's life, causing him or her to feel overwhelmed. Nash Cancer Treatment Center hired its first Outpatient Oncology Social Worker in November 2012 to assist cancer patients with access to various non-medical services during all phases of their treatment journey.

Our Outpatient Oncology Social Worker can help patients understand how best to communicate with their medical treatment team as well as give them advice on talking to family members, friends, and co-workers about their cancer experience.

Help is also available to assist patients in:

- Access to information to help patients and their families fully understand their cancer diagnosis and treatment options
- Support to help cope emotionally with a diagnosis of cancer
- Understanding benefits and insurance coverage
- Apply for programs that offer financial assistance
- Connecting to support groups, educational programs and counseling for patients and their families
- Coping with emotions associated with cancer: sadness, anger, worries, and fears
- Reducing stress through relaxation techniques
- Understanding how cancer affects intimacy, fertility and self body image
- Exploring complementary and alternative medicine options
- Evaluating clinical trials
- Understanding survivorship issues/life as a cancer survivor
- Planning for advanced directives: Living Wills, Healthcare Power of Attorney
- Accessing transportation to and from cancer treatment
- Accessing medication assistance programs