



Edwards Comprehensive Cancer Center

2014 ANNUAL REPORT

KNOWLEDGE SAVES.



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Nehemiah, Coal Grove, OH.

We are proud of our record outcomes in cancer care and treatment. We are fully committed to putting our knowledge, experience and energy forward to ensure the best possible outcome for each patient. We understand our responsibility as the humble servants of those who seek our assistance.



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MANDATORY REPRESENTATION - PHYSICIANS

CHAIRMAN	Gerard Oakley, MD, Medical Director, ECCC
ACoS LIAISON PHYSICIANS	Mary Legenza, MD
	Amanda Arrington, MD
SURGERY	Jack Traylor, MD
MEDICAL ONCOLOGY	Maria Tria Tirona, MD
DIAGNOSTIC RADIOLOGY	Peter Chirico, MD
RADIATION ONCOLOGY	Grace Dixon, MD
PATHOLOGY	Linda Brown, MD

MANDATORY REPRESENTATION – NON-PHYSICIANS

CANCER PROGRAM ADMINISTRATOR	Chad Schaeffer, FACHE
ONCOLOGY NURSING	Molly Brumfield, RN, OCN
CANCER REGISTRY	Phyllis Edwards, RHIT, CTR, CCS, Cancer Registry Quality Coordinator
	Shelby Moore, CTR, CCS, Cancer Conference Coordinator
SOCIAL SERVICES	Michael Hanft, MSW, Psychosocial Services Coordinator
CLINICAL RESEARCH REPRESENTATIVE	Leann Ross, RN, BSN, OCN, CCRP, Clinical Research Coordinator
PERFORMANCE IMPROVE/QUALITY	
MANAGEMENT REPRESENTATIVES	Denise Gabel-Comeau, MHA, CPHQ, CCC-SLP
	Angie Hayes, MS R.T.(R)(T), CMD, Quality Improvement Coordinator
COMMUNITY OUTREACH COORDINATOR	Gigi Gerlach, RN, OCN, Community Outreach Coordinator
PALLIATIVE CARE SPECIALISTS	Charles McCormick, MD
	Sheila Stephens, DNP, MBA, AOCN
GENETIC PROFESSIONAL	Lisa Muto, MSN, WHNP-BC, OCN
REHAB REPRESENTATIVE,	
LYMPHEDEMA PROGRAM	Molly O'Dell, OTR/L, CDT

ADDITIONAL SPECIALTY MEMBERS

Specialty Physician Members:	
GYNECOLOGIC ONCOLOGY	Gerard Oakley, MD
SURGICAL ONCOLOGY	Amanda Arrington, MD
UROLOGY	James Jensen, MD
ORTHOPEDIC ONCOLOGY	Felix Cheung, MD
NEUROSURGERY	Terrence Julien, MD
Specialty Non-Physician Members:	
ADMINISTRATION	Hoyt Burdick, MD
SURVIVORSHIP COORDINATOR	Malinda Hanshaw, RN, OCN
PHARMACY	Chris Larck, PharmD
HOME HEALTH	Andra Hardin, RN, Director of Home Health
CLINICAL TRIALS NURSE	Teresa Giles, RN
TISSUE PROCUREMENT	Julie Morrison, MA
BREAST CENTER	Marsha Dillow, RN, MSN, CBCN
SITE NAVIGATORS	Margaret Ball, RN, MDC, Lung Cancer Nurse Navigator
	Jennifer Brown, RN, Colorectal Cancer Nurse Navigator
	Gigi Gerlach, RN, Breast Cancer Nurse Navigator
REGISTERED DIETITIAN NUTRITIONIST	Susan Hale, RDN, CSO, LD, CDE
AMERICAN CANCER SOCIETY	Mary Lough, ACS
MEDICAL ONCOLOGY FELLOWS:	I. Mehmi, MD
	M. Alsharedi, MD
	A. Raufi, MD
	Y. Khelfa, MD





Gerard J. Oakley, MD

*Medical Director, Edwards Comprehensive Cancer Center
Chairman, Oncology Committee*

"So how are you doing?"

This common phrase that we hear almost daily is usually in the place of a greeting, with no expectation of an in-depth response. One is expected to respond with a short answer and go on his or her way. But often we are faced with the need to critically assess how we are doing, personally, professionally and overall as a cancer center. The purpose of this year's annual report is just that— to review our processes and examine and report the outcomes of our efforts.

We chose to concentrate our efforts on issues that the American College of Surgeons' Commission on Cancer has identified as important in their accreditation review of the cancer center. To that end, this year's report outlines the numerous prevention and screening activities that the Edwards Comprehensive Cancer Center has sponsored or participated in. Information is also included regarding our ongoing quality improvement measures. As medicine in general, and specifically cancer management, has evolved into a process reliant on evidence-based decisions and treatments, national guidelines have been designed as a guide for treatment decisions. In that these guidelines represent the accumulated experience with the spectrum of cancer, our compliance with these guidelines is measured and reported. Throughout the year, every year, the Cancer Center identifies areas where efforts to improve the quality of care for our patients are needed, and makes appropriate improvements. Results of some of these improvements over the past year are reported. At the Cancer Center, we are constantly striving to improve our service to you, our patients. Our goal is to be the best we can be and provide the highest quality of care to all patients in all circumstances.



While the purpose of this report is to examine outcomes, be certain that the Cancer Center has not lost awareness of our duty to ensure that the methods we use to achieve these outcomes keep patient care and patient satisfaction as our primary focus. Through constantly striving to improve care, ensuring access to state-of-the-art treatment and offering a comprehensive approach to care, the beneficial outcomes that we all desire will naturally follow. Through the close association and collaborative efforts of the clinicians and researchers of the Edwards Comprehensive Cancer Center, new and innovative approaches to cancer management are being developed within the McKown Translational Genomic Research Institute.

It is with great pride and humility that we share this report outlining the Edwards Comprehensive Cancer Center's continuing fight against cancer in our region. We are proud of our record on outcomes in cancer care and treatment. We are fully committed to putting our knowledge, experience and energy forward to ensure the best possible outcome for each patient. We understand our responsibility as the humble servants of those who seek our assistance.

Patients with urologic malignancies are treated by the region's most experienced urologic surgeon who specializes in minimally invasive surgery. Tumors and malignancies of the bladder, kidney or other area of the urologic system can often be addressed surgically with the *daVinci*[®] Robotic surgery platform, offering manifold benefits over conventional surgery. Improved outcomes, decreased in-hospital times and quicker recoveries



are only some of the benefits of minimally invasive surgery. Women with gynecologic malignancies are comprehensively treated in the Gynecologic Oncology Center. Minimally invasive surgery is also a mainstay for management in this specialty, allowing improved outcomes, decreased pain and more rapid recovery and return to usual activities. Close coordination with radiation therapy and in-depth discussions of treatment planning at multidisciplinary conferences promote optimized outcomes.

Specialized programs addressing gastrointestinal malignancies, lung nodules and cancers, led by dedicated patient navigators, have broadened the spectrum of patients served through the ECCC. Other programs designed to provide expanded community access to early breast cancer and cervical cancer detection continue to bring care to many who otherwise might not receive it. Dedicated Social Services staff, Nutritional Support staff, and an active Genetic Diagnostic Program address specific needs and concerns. Our Infusion Center provides access to chemotherapy and other infusion-related treatment modalities in a warm, nurturing environment, creating a level of comfort for individual patients that is unsurpassed.

The Edwards Comprehensive Cancer Center, as our name implies, is truly dedicated to providing all-encompassing and far-reaching care for the total patient. It is in this way that we strive to be the best we can be — the best anyone can be. We realize the great responsibility our patients have entrusted us with — their health and indeed even their lives — and we view this as an opportunity to provide for them the best that medicine has to offer, in their community, in a warm and welcoming environment. Our goal is to treat every patient as we would want to be treated ourselves; our dream is to deliver successful treatment to all of our patients with as minimal a level of discomfort and inconvenience as possible, and to create results that produce not just survival, but prosperity.

I am pleased to have this opportunity to be included in this, our eighth Annual Report of the Edwards Comprehensive Cancer Center. I am proud to be a member of the Edwards Comprehensive Cancer Center, and I am very proud of the accomplishments and progress we have made over the past few years. At the same time, I am aware that there is still much to accomplish. We are constantly searching for new and better ways of doing things, new treatments, new technologies, and we will continue our commitment to excellence. I personally wish to thank all of our patients, their families and loved ones for their trust and support. We promise that we will continue to strive and to do all things possible to ensure your successful outcome. We relish the opportunity to serve you and will remain ever aware of the great responsibility that that entails.





Chad Schaeffer, FACHE

Executive Director, Edwards Comprehensive Cancer Center

You might notice that our Cancer Program Annual Report has a slightly different look this year. That is because we have decided to change our focus away from a report that provides a very detailed listing of our programs and services that were offered in the previous year. Instead, we have re-designed the Edwards Comprehensive Cancer Center Annual Report to be a more succinct summary of our accomplishments and outcomes.

To that end, this Annual Report is more specifically designed to clearly meet **Standard 1.12, Public Reporting of Outcomes**, of the American College of Surgeons' Commission on Cancer's (CoC) accreditation standards. Under this standard, each year, the Oncology Committee develops and disseminates a report of patient or program outcomes to the public. This usually involves the reporting of outcomes of the efforts of various cancer program initiatives usually involving quality improvements.

This year, we have compiled a report that focuses on the outcomes in the following CoC standards:

- Standard 4.1 Prevention Programs
- Standard 4.2 Screening Programs
- Standard 4.5 Quality Improvement Measures
- Standard 4.6 Monitoring Compliance with Evidence-Based Guidelines
- Standard 4.7 Studies of Quality
- Standard 4.8 Quality Improvements

While Standard 1.12 only requires that we report on one area, the Oncology Committee felt it was important to report to the public how we have performed in a number of areas.

We hope that you will enjoy this newly designed Annual Report format and that it will be an easier, quicker read. We are very proud of the accomplishments we have made in 2014, and we hope that you benefit from hearing about them!



Nadim Bou Zgheib, MD
Gynecologic Oncologist

Overview

Annually, more than 15,000 women die from ovarian cancer. Survival rates have remained steady near 40% for years, primarily due to the lack of a reliable early detection test. More than 70% of patients diagnosed with ovarian cancer present with advanced stage disease, which is associated with a poor survival. However, patients diagnosed with early stage ovarian cancer have an excellent survival rate, reaching up to 90% for patients with stage 1 disease. Many women diagnosed with ovarian cancer recall having symptoms prior to diagnosis; other patients may have minimal or no symptoms. A subset of patients with early ovarian cancer, as well as many patients with more advanced stage disease, present with vague symptoms such as bloating, pelvic or abdominal pain, difficulty eating or early satiety and/or urinary symptoms. While it is uncertain that early identification of ovarian cancer based on symptoms will lead to earlier stage diagnosis or improved survival, there may be benefit to a careful evaluation of patients who present with frequent symptoms that are new and otherwise unexplained. Currently there are several screening investigations for early ovarian cancer, including one trial open at the ECCC, attempting to identify early detection strategies that exploit molecular markers of cancerous and normal tissue.

Work-up and Diagnosis

Ovarian cancer is further grouped into histological types as follows: serous, mucinous, endometrioid, clear cell, transitional cell tumors, carcinosarcoma, mixed epithelial tumor, undifferentiated carcinoma and others. In stage distribution, serous carcinoma is found predominantly with stage III or IV most commonly identified at presentation. In the era of frequent imaging tests, incidental ovarian masses, especially ovarian cysts, are being found more and more frequently in postmenopausal women. Transvaginal ultrasound is the preferred imaging modality to evaluate the ovaries; however, it should be performed by a sonographer who has extensive experience in the evaluation of ovarian size and morphology. Suspicious pelvic masses are usually enlarged, and/or presenting with complex features such as irregularity, multiple septations, papillations or projections into the cyst, and solid areas. The risk of malignancy in a postmenopausal woman with a unilocular mass without solid components is <1% increasing to 8% in a multilocular mass and 70% in a mass with solid components. The findings of bilateral masses, fixed immovable masses or elevated tumor markers (CA125) should raise the suspicion of ovarian malignancy. Moreover, elevations between 35 and 65 U/ml are associated with a cancer risk of 50 to 60% in the presence of complex pelvic mass. In a postmenopausal patient with suspicious pelvic masses, a CA-125 >65 U/ml is virtually diagnostic of malignancy with a specificity of 98%. Studies have shown that a referral to a gynecologic oncologist is most likely to result in superior patient outcomes, secondary to more comprehensive staging and optimal removal of the pelvic masses.

Prognosis

Prognosis in ovarian cancer is influenced by several factors, but multivariate analyses suggest that the most important favorable factors include younger age, good performance status, cell type other than mucinous and clear cell, lower stage, well-differentiated tumor, smaller disease volume prior to any surgical debulking, absence of ascites, smaller residual tumor following primary cytoreductive surgery and/or intraperitoneal chemotherapy. The residual tumor size after cytoreductive surgery and adjuvant chemotherapy are the only two modifiable factors influencing the prognosis in ovarian cancer. This underlines the importance of referring patients with ovarian cancer to a gynecologic oncologist who is specifically trained to achieve optimal cytoreductive surgery and use the appropriate type and route of adjuvant chemotherapy, which result in an improved overall survival. More so, there are multiple randomized clinical studies confirming that patients with ovarian cancer who received intraperitoneal chemotherapy lived longer. In a Gynecologic Oncology Group (GOG) trial, patients with stage 3 C ovarian cancer optimally debulked and treated with intraperitoneal adjuvant chemotherapy survived on average 16 months more longer than similar patients treated with intravenous chemotherapy. The substantial impact on overall survival was found to be associated with an increased toxicity the fact that prevented intraperitoneal chemotherapy becoming standard of care for adjuvant treatment of patients with ovarian cancer. However, several modifications of the GOG intraperitoneal chemotherapy regimen have been described in the literature,



Gynecologic oncologists Gerard Oakley, MD, and Nadim Bou Zgheib, MD, are committed to providing the latest in diagnostic and treatment services for women with possible pre-cancerous conditions or malignancies of the reproductive tract.

including the regimen used at ECCC, which has been reported to be much more tolerated than the GOG regimen and more convenient for the patients. Comprehensive care of patients with ovarian cancer is required to optimize patients' outcome and improve overall survival.

Importance of Genetic Testing

Approximately 5% to 10% of ovarian cancers are familial, and three distinct hereditary patterns have been identified: ovarian cancer alone, ovarian and breast cancers, or ovarian and colon cancers. Women with a mutation in the BRCA 1 or 2 genes have a much higher risk to develop ovarian cancer than the general population, reaching around 50% in their lifetimes. The NCCN issued guidelines in 2013 recommending that patients with ovarian cancer should be offered genetic testing. These recommendations were strengthened by the NCCN in 2014. This recommendation is a category 2A, which indicates that based on lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate. This has the benefit of better informing the patients regarding their risk of developing other cancers associated with hereditary breast and ovarian cancer syndrome, which will lead to establishing a much more comprehensive screening strategy and medical care tailored for each individual patient. More so, identifying patients with a genetic predisposition for ovarian cancer has a great implication for their family members' medical status.



Leann Ross, RN, BSN, OCN, CCRP
ECCC Clinical Research Supervisor

Clinical Trials at the Edwards Comprehensive Cancer Center

Clinical trials are an essential component of the cancer program at the Edwards Comprehensive Cancer Center (ECCC), providing advanced treatment options for adult and pediatric patients. There are three primary components of the ECCC research program: clinical trials, translational research and procurement of tissue for research.

Clinical trials for the adult population are accessed through membership with the Alliance for Clinical Trials in Oncology. An affiliation with Nationwide Children’s Hospital in Columbus, Ohio provides access to pediatric trials sponsored by the Children’s Oncology Group (COG), an NCI -supported program dedicated exclusively to research and treatment of childhood and adolescent cancers. The ECCC clinical trials menu also includes select trials sponsored by the pharmaceutical industry and investigator-initiated pilot trials conducted in collaboration with Marshall University researchers.

Outcome: In 2014, the ECCC had 107 clinical trial enrollments.

Clinical trials are an indispensable weapon in the fight against cancer, and provide patients with valuable treatment options that may not be available to them otherwise. A list of clinical trials currently enrolling at the ECCC is available on our website at <http://edwardsccc.org/>.



Gerard Oakley, MD, and Clinical Trials Supervisor Leann Ross, RN, BSN, OCN, CCRP, confer about a patient.

STANDARD 2.2 ONCOLOGY NURSING



Molly Brumfield, RN, BSN, MBA, OCN

Manager of Medical and Surgical Programs

The oncology nurses at Cabell Huntington Hospital and the Edwards Comprehensive Cancer Center provide care to cancer patients of all ages, from pediatrics to geriatrics, in both the outpatient and inpatient acute care settings. Nurses go through specialized education and training in general cancer diagnoses, the safe handling and administration of chemotherapy, radiation and many other diagnostic and therapeutic procedures. Certification in oncology occurs when nurses meet specific eligibility requirements and pass a very difficult, rigorous multiple-choice examination, formally recognizing this specialized knowledge, skills and experience.

Certification assures the public that a nurse has completed all criteria to earn a specific credential. It establishes minimum competency standards and recognizes those who have met these standards. Patients can feel more confident in their caregivers when they receive care from a certified nurse. Certification is also strongly recommended by accreditation agencies such as the Joint Commission, the American Nurses Credentialing Center's Magnet Recognition Program and the American College of Surgeons Commission on Cancer.

Outcome: This past year, three more nurses have earned their certification in oncology. Overall, fifty-one percent of our nurses are now certified, thereby giving us commendation level for this standard during our most recent Commission on Cancer survey.



Patients can feel more confident in their caregivers when they receive care from a certified nurse.





Marsha Dillow, RN, MSN, CBCN

*Director, Cabell Huntington Hospital Breast Health Center
& ECCC Diagnostic Breast Center*

Standard 4.1 Prevention Programs

Standard 4.1 states “Each year, the cancer committee provides at least one cancer prevention program that is targeted to meet the needs of the community and should be designed to reduce the incidence of a specific cancer type.” This year, the Cancer Committee set a goal to increase patient knowledge about cancer preventive screenings that are recommended to the public based on gender and age. A small team was formed to develop educational tools that could be placed throughout the cancer center to increase patient awareness on these preventive screenings.



Outcome: A poster (shown to the left) was developed that lists both preventive screenings for cancer as well as overall health screenings. These posters were placed in each exam room in the cancer center for patients to review, and larger posters were placed on each floor of the cancer center to make these recommendations available to patients and families so that they can be better prepared to discuss their individual needs with their healthcare provider.

Standard 4.2 Screening Programs

Standard 4.2 states “Each year, the cancer committee provides at least one cancer screening program that is targeted to decreasing the number of patients with late-stage disease.” In 2014, two screening programs that focused on four cancers were held at the Edwards Comprehensive Cancer Center.

- **Uterine Cancer.** The first program was held on March 14, 2014 and provided free uterine cancer screenings. **Outcome: Approximately 45 women received services with one uterine cancer being diagnosed.**
- **Breast Cancer.** The second program was held on October 17, 2014 and provided free clinical breast exams. **Outcome: More than 60 women participated. All patients who met criteria were referred for mammograms and one breast cancer was detected.**

Both of these programs enabled these cancers to be found early before these patients presented with late-stage disease.

- **Colon Cancer.** In addition, as part of an effort to increase colon screenings, all patients seen at the Breast Health Center and the Edwards Comprehensive Cancer Center are now asked if they have had a colonoscopy in the last year. **Outcome: The number of patients receiving colonoscopies increased from 32 in 2013 to 66 in 2014.**
- **Lung Cancer.** Patients are now asked during their visits if they have a history of smoking and if so, if they would like to see our lung navigator. **Outcome: This year, 332 patients have been screened by the lung navigator and actual CT scans have been performed on 72 patients.**

All of these efforts work together to ensure screening guidelines to detect cancers at an early stage are provided to all patients throughout the organization.

**CANCER PROGRAM OUTCOMES REPORT (STANDARD 1.12)
STANDARDS 4.4 AND 4.5 ACCOUNTABILITY & QUALITY IMPROVEMENT MEASURES**



Phyllis Edwards, RHIT, CTR, CCS
Cancer Registry Manager

The Cancer Registry at the Edwards Comprehensive Cancer Center submits data annually to the National Cancer Data Base (NCDB). The data elements required for submission to NCDB are utilized by the Commission on Cancer in evaluating and assessing quality measures that have been developed to ensure patient-centered treatment outcomes. The quality measures are endorsed by the NQF (National Quality Forum).

Five of the eight measures proposed by the CoC (four breast cancer, three colon cancer and one rectal cancer) were reviewed by NQF and were determined to meet the evaluation criteria. Five met criteria for the accountability measures, meaning that these measures can be used for such purposes as public reporting, payment incentive programs and the selection of providers by consumers, health plans or purchasers. Quality improvement measures are intended to be used for internal monitoring of performance within an organization or group so that analyses and subsequent remedial actions can be taken, as appropriate. Surveillance measures can be used at the community, regional and/or national level to monitor patterns and trends of care in order to guide policymaking and resource allocation.

In 2014, new measures were added to CP3R (Cancer Program Practice Profiles Report). The current CP3R provides estimated performance rates with 12 new measures: six breast, two colon, one rectal, one gastric and two lung measures.

In compliance with CoC Standard 4.4 (Accountability Measures) and Standard 4.5 (Quality Improvement Measures), during the fourth quarter Oncology Committee meeting, Dr. Legenza, Cancer Liaison Physician, reviewed the five accountability measures and four quality improvement measures and the estimated performance rates for Cabell Huntington Hospital and the Edwards Comprehensive Cancer Center (see the graph below) with the Committee. An action plan has been developed to address the quality improvement measures that drop below the CoC requirement.

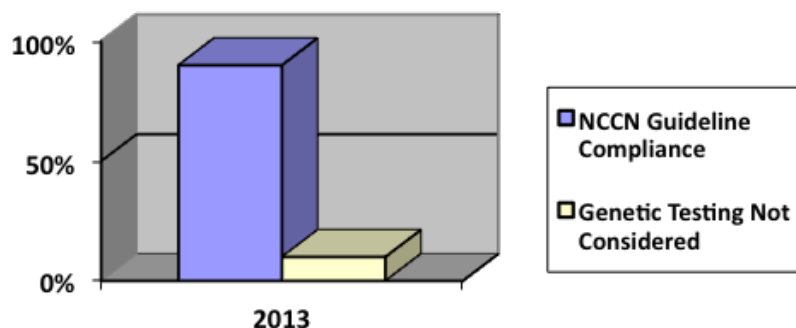
Primary Site	Measure Type	Measure Specifications	CoC Requirement	CHH/ECCC estimated performance rate
Breast				
nBx (NEW)	Quality Improvement	Image or palpation-guided needle biopsy (core of FNA) is performed to establish diagnosis of breast cancer	80%	84.9%
MASTRT (NEW)	Accountability	Radiation therapy is considered or administered following any mastectomy within one year (365 days) of diagnosis of breast cancer for women with greater than or equal to four positive regional lymph nodes	90%	100%
BCSRT	Accountability	Radiation is administered within one year (365 days) of diagnosis for women under the age of 70 receiving breast conservative surgery for breast cancer	90%	96%
MAC	Accountability	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0 or stage IB – III hormone receptor negative breast cancer	90%	91.7%
HT	Accountability	Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or Stage IB-III hormone receptor-positive breast cancer	90%	100%
Colon				
ACT	Accountability	Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.	90%	100%
12RL	Quality Improvement	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	85%	72.7%
Gastric (NEW)				
G15RLN	Quality Improvement	At least 15 regional nodes are removed and pathologically examined for resected gastric cancer	Not applicable	No data available
Lung (NEW)				
LCT	Quality Improvement	Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is considered for surgically resected cases with pathologic, lymph node-positive (pN1) and (pN2) NSCLC	Not applicable	100%



CHH 2013 COMPLIANCE WITH NCCN GUIDELINES FOR OFFERING OVARIAN CANCER PATIENTS GENETIC TESTING

A chart audit was conducted on CHH ovarian cancer patients who were diagnosed in 2013. A total of 10 charts were reviewed out of a total of 23 patients, representing 43% of all ovarian cancer patients.

Ovarian Cancer Patients Offered Genetic Testing



Outcome: The audit's outcome revealed that 9 out of the 10 patients either received genetic testing or were at least considered, indicating a compliance rate of 90%.

Standard 4.6: Monitoring Compliance with Evidence-Based Guidelines

The role of this standard is to ensure that evaluation and treatment conform to evidence-based national treatment guidelines. Each year, a physician member of the cancer committee performs a study to examine the evaluation and treatment of patients and ensure that it is compliant with evidence-based national guidelines. The study must determine that the diagnostic evaluation is adequate and the treatment plan is concordant with a recognized guideline. Any problems identified with the diagnostic evaluation or treatment planning process could serve as a source for a performance improvement.

In 2014, the following table lists the physician members who performed a study to examine the adherence to national guidelines, the study method, and outcome for each:

Lung Cancer	Outcome/Improvements Suggested
<p>Physician: Andrew Freeman, MD Radiation Oncologist</p> <p>Method: Random Chart Audit</p> <p>Study: Compliance with NCCN guidelines for work-up of lung cancer</p>	<p>Appropriate workup was performed in all patients (100% compliance). However, documentation of important prognostic factors and smoking cessation/counseling were missing in some patients. We should improve documentation and consider adding the values specifically into our consultation templates for patients diagnosed with lung cancer. Treatment recommendations are generally in concordance with published guidelines.</p>
<p>Prostate Cancer</p> <p>Physician: Andrew Freeman, MD Radiation Oncologist</p> <p>Method: Random Chart Audit</p> <p>Study: Compliance with NCCN guidelines for work-up of prostate cancer</p>	<p>TNM and group staging, DRE findings, PSA and Gleason score were documented in 100% of patients. Imaging studies including bone scan, CT of the A/P, and MM of the pelvis were ordered appropriately in concordance with NCCN guidelines 100% of the time. A minority of patients who were referred to urology from an outside medical facility received inappropriate imaging.</p>
<p>Ovarian Cancer</p> <p>Physician: Nadim Bou Zgheib, MD Gynecologic Oncologist</p> <p>Method: Random Chart Audit</p> <p>Study: Compliance with NCCN guidelines for offering ovarian cancer patients genetic testing</p>	<p>We need to be sure to appropriately document the reasons that a patient is not being referred when applicable. A compliance rate of 90% was documented for 2013.</p>



Angela Hayes, MS, DMD
*Radiation Therapy Manager &
Quality Improvement Coordinator*

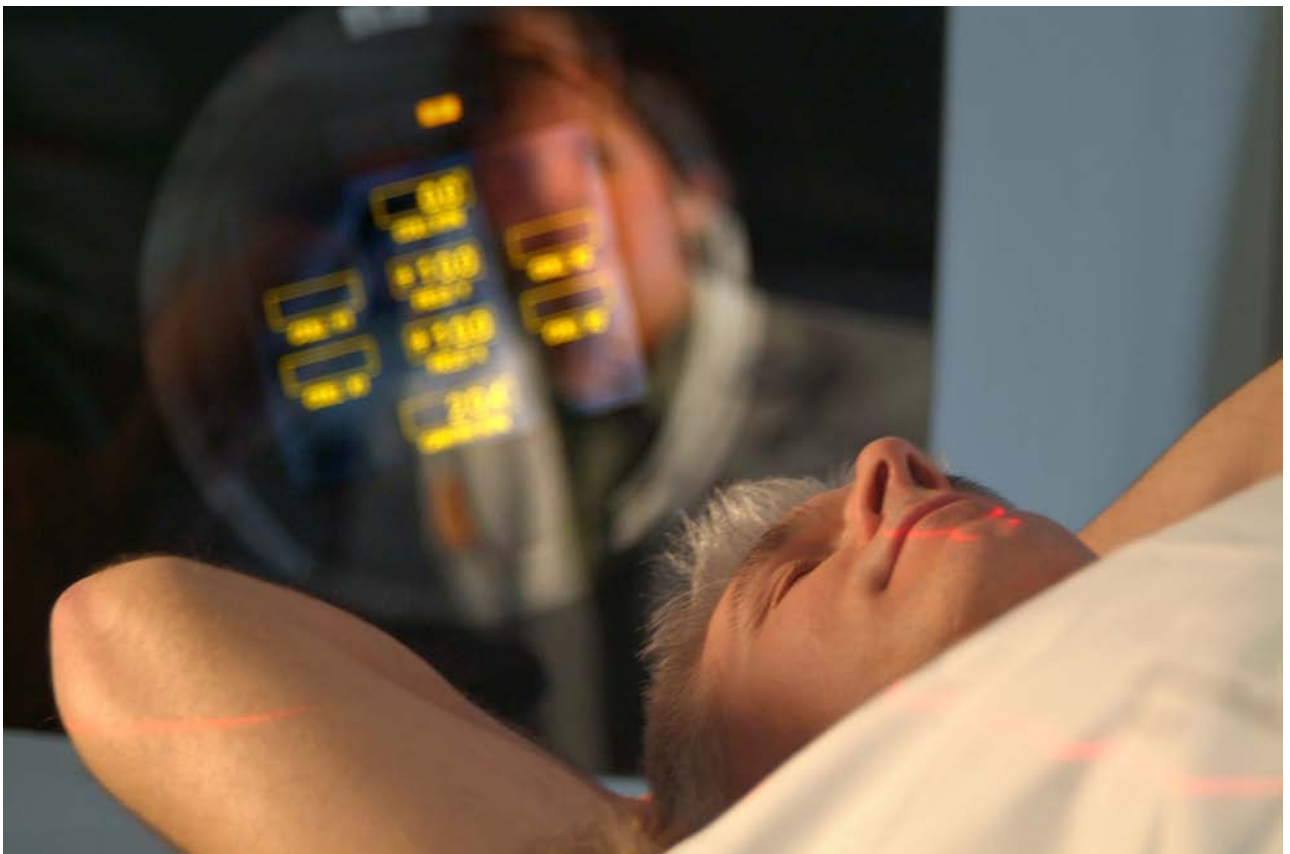
Standard 4.7 Studies of Quality

In September 2014, the Radiation Oncology Department implemented a revised time-out procedure. The revision was made based on American College of Radiology (ACR) recommendations. The change focused on more patient involvement in the process.

Standard 4.8 Quality Improvements

Through the Radiation Oncology Department's own quality improvement committee, it was determined that once the appropriate patient involvement was complete, the therapist would verify the time-out procedure through a check box. The check box is built into the electronic medical record in a way that will not allow the therapist to turn the machine on until the time-out is acknowledged.

Outcome: Eighty new patient starts were evaluated for appropriate time-out documentation from September 1, 2014 to December 5, 2014. Seventy-seven were compliant and three were not, resulting in a compliance rate of 96.25%. The department will continue to intermittently monitor time-out to ensure compliance.



ABOUT US

The Edwards Comprehensive Cancer Center houses the James F. Edwards Adult Cancer Clinic, which includes an adult oncology center with infusion stations, exam/consultation rooms, minor procedure rooms, a diagnostic breast center and physician offices, and the Joan C. Edwards Children's Cancer Clinic, which includes the children's oncology/hematology treatment center with infusion stations, pediatric oncology clinics and physician offices. Patients are offered state-of-the-art technology for delivering cancer treatment, including PET/CT scanning, image-guided radiation therapy, 3D mammography, stereotactic breast biopsy and the *da Vinci*® Surgical System. Services include:

Breast Oncology
Clinical Trials
Comprehensive Lung Nodule Program
Gynecologic Oncology
Multidisciplinary Lung Cancer Program
Orthopedic Oncology
Radiation Oncology
Survivorship Program

Cancer Risk Assessment
Colorectal Cancer Program
Genetic Testing
Medical Oncology
Neuro-Oncology
Pediatric Oncology
Surgical Oncology
Urologic Oncology

On the third floor is the Charles H. McKown, Jr., MD, Translational Genomic Research Institute (TGRI), which allows scientists to work in close proximity to clinicians, fostering collaboration. This facility supports the Marshall University Joan C. Edwards School of Medicine and clinical researchers by enabling them to conduct a greater number of investigator-initiated clinical trials and rapidly translate genome-based laboratory research into clinical applications that will improve patient care.

Patient Support

Key support staff available to patients include a licensed social worker, a registered dietitian nutritionist and an occupational therapist specializing in lymphedema. Support groups are offered for breast cancer, gynecologic cancer and ostomy patients. Furry friends from the Pet Therapy Program frequently visit patients to bring comfort and help reduce feelings of stress and anxiety. Representatives from the Arts in Medicine Program at the Huntington Museum of Art offer a positive distraction for patients and their family members while undergoing cancer treatment. Look Good Feel Better meets at the ECCC every other month to help patients manage appearance-related side effects of cancer treatment. A light-filled Resource Room offers patients access to books, periodicals and the Internet to conduct personal research.

Community Outreach & Education

Annual Cancer Survivors' Day Celebration
Annual Colors of Cancer 5K Run/Walk
Annual Breast Cancer Survivors' Dinner
Relay for Life
Senior Saturday, church/community health fairs and mall events
Free/reduced-cost cancer screenings (breast, lung, pelvic, prostate, skin)
Tobacco cessation resources
CME programs for physicians, nurses, healthcare providers and allied health personnel



Annual Colors of Cancer 5K Run/Walk, Nov. 1, 2014.



Annual Breast Cancer Survivors' Dinner, Oct. 7, 2014.



Annual Survivors' Day Celebration, June 1, 2014.

