2013

Rex Cancer Center

Annual Report

Rex Cancer Care Committee

Rex Cancer Center

A COMPREHENSIVE COMMUNITY CANCER PROGRAM

Commission on Cancer™ ACCREDITED PROGRAM

Rex Cancer Center 2013 Annual Report

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At Rex, among the best ~ where there is teamwork & collaboration, wonderful things can be achieved

Organizational Mission, Vision, and Values

- **Mission:** To provide the best in healthy services by bringing together compassionate care and leading edge technology.
- **Vision:** To be the healthcare provider of choice in Wake and surrounding counties.
- **Values:** We value patient safety and outstanding care. We value superior service. We value a working partnership with our medical staff. We value our workforce. We value sound business practices. We value market –responsive growth and development

About the Organization

Rex Healthcare, a member of UNC Health Care, is a private, not-for-profit health care system with more than 5,400 co-workers. Rex Healthcare has 660 beds (433 general acute beds and 227 skilled nursing) and treats nearly 34,000 inpatients each year. Rex offers dedicated centers for cancer, surgery, heart and vascular, post-acute rehabilitation and skilled nursing care, wellness and women's care plus dedicated services for bariatric, heartburn, pain management, sleep disorders, diabetes education, wound and emergency care. Rex's medical staff includes more than 1,100 physicians and 1,700 nurses. Rex provides various health care services throughout Wake County with facilities in Apex, Cary, Garner, Holly Springs, Knightdale, Wakefield and downtown Raleigh.

Awards and Recognition

- Rex Oncologists recognized by Best Doctors in America and Business NC Magazine's Top Doctor
- Named a Top Performer by the Joint Commission Annual Report
- National Research Corporation Consumer Choice Award for the 10th consecutive year
- Recognized as 100 Great Hospitals by Becker's Hospital Review
- Top 50 N.C. Family-Friendly Companies by Carolina Parent Magazine in 2013
- Awarded "A" Hospital Safety Score by The Leapfrog Group in 2012 and 2013
- Honored in 2012 with the 100 Best Places to Work by Becker's Hospital Review
- Named the Best Places to Work list by Triangle Business Journal from 2010 to 2013
- Joint Commission recognition 2012 for heart attack, heart failure, pneumonia, surgical care
- National Research Corporation (NRC) named Consumer Choice Award winner 2004 to 2013
- Recognized by Metro Magazine 2012 Metro Bravo Awards
- Recognized National Best Organization 2012 for learning and development by Learning Elite
- Earned the Platinum Rule Award from Triangle Business Journal for Best Places to Work

Rex Cancer Center History

"As the treatment of cancer advances, so will Rex Hospital."

Those were the words of Rex Hospital Board Chairman Richard Urquhart Jr., on September 13, 1987, during the dedication ceremony of Rex Cancer Center. At that time, the concept of a freestanding building specifically dedicated to the treatment of cancer was innovative. Rex Cancer Center was one of only six cancer centers in the Southeast and one of only 100 in the country.

Rex continues its tradition of leadership and compassion today in the way it provides care for area cancer patients at our Raleigh campus, in north Raleigh at Rex Cancer Center of Wakefield and in Garner, Clayton and Smithfield. Although proud of our pioneering effort, our staff knows cancer treatment is about much more than a state-of-the-art facility.

It is about the patient. As a result, we provide programs that take care of patients' physical needs and their emotional and spiritual needs as well. These efforts have been recognized and applauded locally, regionally and nationally.

In 1991, the center received national accreditation from the American College of Surgeons (ACoS) Commission on Cancer (CoC) as a Comprehensive Community Cancer Center and maintained to date.

In July 2008, Rex Cancer Center was designated a Comprehensive Breast Center, making it the only center in the Triangle and one of three in North Carolina to receive full accreditation designation from the National Accreditation Program for Breast Centers (NAPBC). Both of these accreditations demonstrate the Rex commitment to providing the highest level of patient care and services in prevention, detection, diagnosis, treatment and recovery.

And the Story continues....

The Rex Cancer Center story is still being written by our patients, staff, physicians and community and is enriched daily by individual chapters of hope, survival and strength. We are growing to meet the needs of our patients and respond to the technological and medical advances that will eventually conquer this disease.

We look forward to the day when our final chapter is written, and a cure is found.

Until then....We have the Best Care Team Approach...

The Rex Cancer Specialty Center

Richard Gillespie, MD and **Alden Parsons, MD** of *Rex Thoracic Specialty*
Jeremiah Boles, MD and **Jeffrey Crane, MD** of *Rex Hematology Oncology*
William Hall, MD and **Patricia Rivera, MD** of *Rex Pulmonology*
John Fakiris, MD of *UNC/Rex Radiation Oncology* and **Jessie Weis, RN**, *Navigator*

The Rex Cancer Center is developing better ways of offering patient-centered, disease-specific care, through the creation of Rex Cancer Specialty Center. The Cancer Specialty Center is the epicenter for Thoracic, Gastrointestinal, and Breast Multidisciplinary Care programs. Each program has an expert team of specialists who believe in providing holistic care to the individuals they treat.

The Thoracic Multidisciplinary Care Program

The Thoracic Multidisciplinary Care (MDC) program was the first of its kind at Rex. The key concept is to provide continuity of care and minimize fragmentation among providers. The multidisciplinary program includes a medical record review by the treatment team and real time interpretations by our participating radiologist and pathologist. In addition to physician recommendations, the team also engages other medical disciplines to include social work, oncology certified dieticians, clinical research nurses, and palliative care nurse practitioners.

Facilitated by a specialized team, including a nurse navigator and a medical office assistant, a single point of contact is established for both patients and referring physicians across the organization to provide a seamless healthcare experience.

Our patient's treatment plan is created using the most current standards of best practice, clinical care and current clinical trials to best meet their medical needs. The patient discussion also includes identification of any financial concerns, transportation issues, nutritional concerns, and other possible barriers to care. Traditionally reserved for major academic centers, Rex is proud to bring this multi-disciplinary approach to the community hospital setting.

Our Teams of Experts Keep Patients at the Center of Our Care

Patient Navigator

The patient navigator's first encounter with patients is often right after their primary care physician has informed them that they have something suspicious on a diagnostic test, often a cat-scan. The primary care physician's office sends a referral either directly to Cancer Specialty Center or to one of our participating provider's offices. The MDC team reviews medical records, orders additional diagnostic tests, and attempts to streamline the evaluation process for the patient. This first patient interaction with the Thoracic MDC often begins as a voice over the phone. On the initial call, the navigator explains the MDC program, the need for any additional studies, and informs the patient about scheduled appointments.

Jessie Weis, R.N., B.S.N.
Thoracic Cancer Patient Navigator

Patient Navigation is valuable for our patients to have one dedicated person to communicate with or call on for questions. The navigator meets patients wherever they cross Rex's threshold: from diagnostic tests or at their initial appointment. From that point, the navigator helps guide the patient across the continuum of care. All patients diagnosed with a thoracic cancer that receive any part of their treatment within the walls of Rex have access to this resource.

Medical Office Assistant/ Administrative Staff

The medical office assistant (MOA) works closely with the entire team by providing a *concierge-like support service* to our patients, their families and referring physicians. From the time a referral is received, the MOA collaborates with the navigator and other team members to facilitate scheduling of all patient appointments. This process involves multiple steps that include obtaining medical records from other facilities, contacting insurance companies and working with other Rex departments. Handling all of these logistics ultimately results in the timely expedition of seamless care experienced by our patients and referring physicians.

Oncology Certified Registered Dietician

Rex Cancer Center is fortunate to have Registered Dieticians (RDs) on staff at multiple locations, providing expert dietetic advice and nutritional counseling to cancer patients treated at Rex. Their interventions can help improve quality of life and prevent nutritional imbalances that can occur during medical treatment. In addition to their routine duties, the dieticians participate in the Thoracic MDC and add their expertise when patients are discussed in case conference. Following case conference, the RDs meet with patients either with the rest of the team in the MDC clinic or by making arrangements to meet with them at another time.

Social Work

Social workers in the Thoracic MDC are specialty trained and help identify additional stressors in patients' lives that may compromise their care. In addition to the impact of a cancer diagnosis, patients may have difficulty with transportation to treatment or be unable to afford needed medications. They may have family concerns that prevent their caring for themselves while caring for others.

Addressing a patient's emotional health supports comprehensive patient care and relieves some of the pressure on the health care team, too, as questions are answered and resources are accessed to accommodate the patient's needs. The social work team is also available for conversations about advance directives, which may include a values discussion that helps family members address a range of concerns among themselves.

Clinical Research

An integral part of the Thoracic Multidisciplinary Team Conference at Rex Cancer Center is the discussion of best possible treatment options for the patient. Treatment decisions are based on a review of the patient's clinical information, National Comprehensive Cancer Network (NCCN) guidelines, evidence from relevant studies, available Rex and UNC clinical trials, and consensus among case conference participants. With this information, physicians are able to discuss options with the patient in the Thoracic MDC.

Our research nurse team screens all patients discussed in conference for eligibility for clinical trials. The research nurses actively participate in the discussion as to patient's eligibility such as clarifying issues about diagnosis or staging, important medical history, prior therapies or oncologic history. If the patient is deemed eligible and he/she agrees to participate, the research nurse will discuss details of the trial.

Treatment Trials Currently Open for Lung and Esophageal Cancer

** Correlative / Companion Trails*

ECOG 5508:	Randomized Phase III Study of Maintenance Therapy with Bevacizumab, Pemetrexed, or a Combination of Bevacizumab and Pemetrexed Following Carboplatin, Paclitaxel and Bevacizumab for Advanced Non-Squamous NSCLC
LCCC 1210	A Phase II, Multi-Center Single Arm Study of the tolerability of weekly nab-paclitaxel as second line treatment for elderly patients with Advanced Lung Cancer (70 years or older)
RTOG 1010	A Phase III Trial Evaluating the Addition of Trastuzumab to Trimodality Treatment of HER2-Overexpresing Esophageal Adenocarcinoma
FDG Dynamic Scan Study *	Pilot Study for Monitoring Changes in ^{18}F-FDG Uptake to Predict Effectiveness of Oncotherapy (requires palpable lesions)
LCCC 0916 *	Carolina Senior - UNC Registry for Older Patients

As we look forward to 2014, Rex Thoracic Multidisciplinary Program and Research Department have been selected as a site for a pilot study for improving survivorship care through enhanced communication and coordination (LCCC 1325). Deborah K. Mayer, PhD, RN is the principal investigator and Jeffrey M. Crane, MD and Nirav Dhruva, MD are co-investigators. Rex Cancer Center as a community setting was chosen since it is more representative of where most cancer care is delivered. Target accrual is 60 patients with Stage I-III smoking related cancer (Small Cell Lung Cancer, NSCLC, Head and Neck Cancer, Pancreatic Cancer or Esophageal Cancer) who have completed treatment within the past 4 – 6 weeks.

As a Health eNC funded project and recommended by the Institute of Medicine, survivorship care plans (SCP) are tools to help provide information about the patient's cancer, treatment and follow-up plans. This has potential to help the patient and their doctor talk about and coordinate plans for care.

Clinical Trial Accruals

- *Rex Cancer Clinical Research program accrued 12.6 % of patients (analytic cases) in 2012 to a treatment, prevention, screening, or genetic clinical trial.*
- *The Commission on Cancer requires Comprehensive Community Cancer Programs (CCCP) to accrue patients to clinical trials. Minimum Requirement for a CCCP is 4% / Commendation = 6%.*

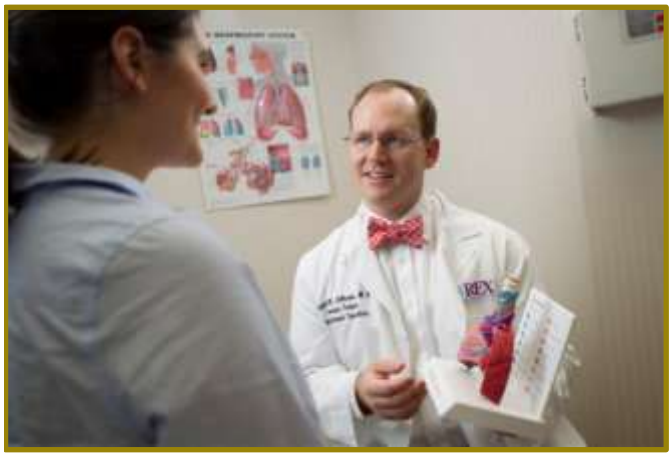
The Rex Cancer Clinical Research Program continues to meet and exceed this best practice requirement, demonstrating continual commitment to quality and advanced care.

Outreach & Support

About 30 patients and family members participated in Living With and Beyond Lung Cancer: Updates in Treatment and Management on November 14, 2013. Dr. Alden Parsons addressed current practice, possible new screening guidelines, and answered questions on a range of topics. Participants acknowledged that sharing their experiences with others in the room was also useful.

Rex Cancer Center continues its commitment to education and outreach activities supporting all kinds of cancer throughout the year. Brothers and Sisters of Rex raise awareness about breast, prostate and colorectal cancer in the community. These specially trained volunteers provide current health information and support resources for prevention and early detection among local citizens at workshops, health fairs, businesses, churches, service groups and other community events.

In addition, Rex co-sponsors programs with the Leukemia and Lymphoma Society, Komen Foundation and the American Cancer Society. Survivors' Day in June also drew 500 participants. Rex and the Rex Cancer Center team supported 70 programs including health fairs, conferences, education and outreach. These community and population specific programs connected with over 10,000 participants in 2013!



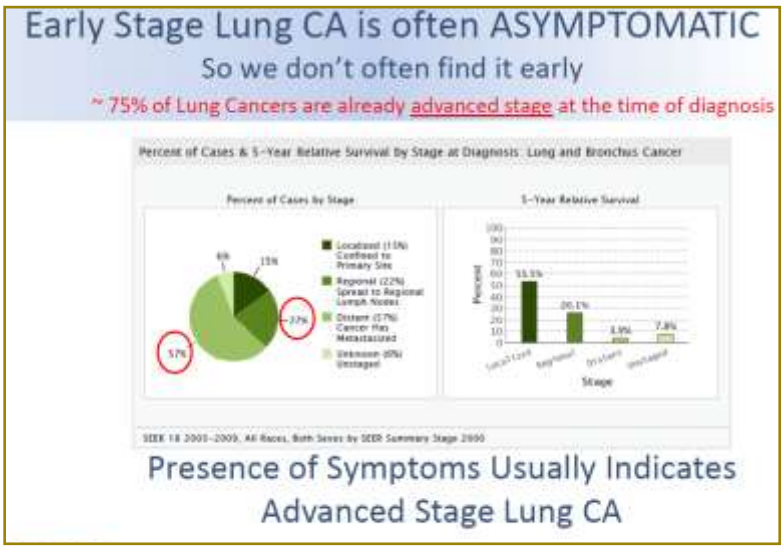
"The Thoracic Oncology Multidisciplinary Program sets a standard for cancer care in North Carolina. The comprehensive discussions in a collaborative atmosphere allow us to offer patients the highest level of care possible in any medical setting. In addition to championing excellent patient care, our program has also helped develop the personal relationships between physicians in all of the different cancer care specialties. This allows for the sharing of ideas and elevates our individual abilities and experiences to another level."

Dr. Richard Gillespie,
Rex Thoracic Surgical Specialty

Site Specific Study 2013: Lung Cancer

Introduction

Lung Cancer currently stands out as the highest mortality rate of any malignancy, and in fact claims as many lives as the next four leading types of cancers combined *(colorectal, breast, pancreatic and prostate).*



High mortality in lung cancer patients is primarily asymptomatic, with few signs and symptoms until it reaches advanced stages. The majority of patients with lung cancer (75%) are not diagnosed and present for treatment until they are Stage III or IV, making survival rates significantly lower.

The U.S. Preventive Services Task Force (USPSTF) recently finalized recommendations for annual screening for lung cancer in high risk individuals.

This recommendation is based largely on the recent National Lung Screening Trial (NLST) randomized controlled trial in the New England Journal of Medicine. The NLST demonstrated a 20% risk reduction in lung cancer deaths in patients who were screened by low dose CT scan (LDCT) based on the criteria which are now recommended by the USPSTF and the National Comprehensive Cancer Network (NCCN) and other major chest organizations.

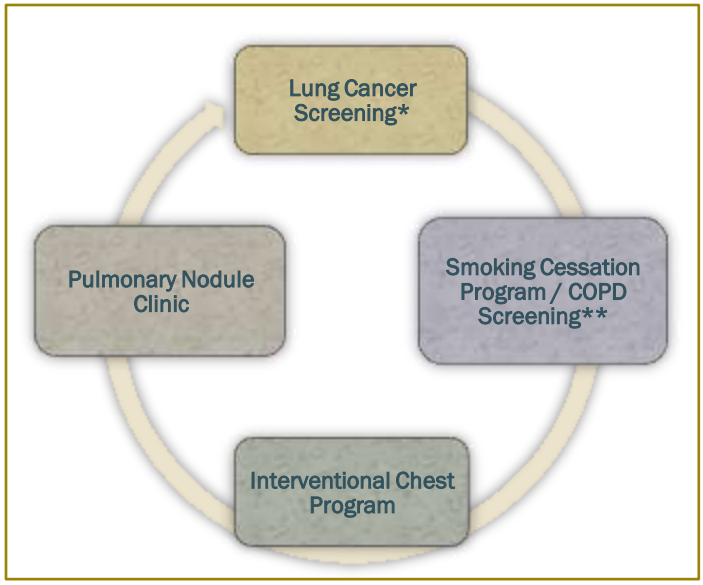
The goal of screening is earlier detection of lung cancer, allowing treatment at an earlier stage, which is more likely to be successful, and potentially curative.

The full impact from both clinical and cost standpoints is yet to be determined, but many health care systems including Rex are developing comprehensive lung screening programs.

The incorporation of a smoking cessation program and an organized programmatic approach to screening is thought by many to be key to the effectiveness of a LDCT lung screening program in any given community.

Rex has many lung center elements effectively in place, with further development in the months ahead in 2014.

Lung Center Components



** Approved by the USPSTF **Collaboration with UNC Program*

Lung Cancer – Rex Patient Population Data

The following data represents 1,147 analytic cases from the *Rex Cancer Center Tumor Registry* from 2008 to 2012 specific to Lung Cancer. Analytic cases by definition are cases diagnosed and/or receiving all or part of the first course of therapy at Rex.

Lung Cancer Stage	2008	2009	2010	2011	2012	Grand Total	% Total
0		1	1	1	1	4	0.3%
1	56	53	47	43	50	249	21.7%
2	16	14	14	23	30	97	8.5%
3	54	64	59	51	46	274	23.9%
4	96	88	85	102	89	460	40.1%
Unk/NA	*23*	*16*	*8*	*7*	*9*	*63*	*5.5%*
Total	245	236	214	227	225	1147	

As seen in national and regional data, patients diagnosed at Rex also present predominantly in the advanced stages of lung cancer.

Although minor variations are noted in patient volume between calendar year 2008 to 2012, the majority of lung cancers identified at Rex are Stage 4 (40.1%) followed by Stage 3 (23.9%). Cumulatively, advanced stage (3, 4) combined are 70% of patients diagnosed at Rex. Inversely, early stage disease (1, 2) makes up only 30% of patients diagnosed.

Once again, the data supports the need and goal of early screening and detection of lung cancer, supporting earlier treatment and potential for more successful and potentially curative outcomes.

Lung	FEMALE	MALE	Total
0	2	2	4
1	130	119	249
2	39	58	97
3	120	154	274
4	192	268	460
Total	513	634	1147

In review of all cases from 2008 to 2012, 55.3% of those diagnosed are male, with 44.7% female.

Little variation is noted in each stage of disease at presentation, with slightly higher volume of males at Stage 4 (42.3%) versus females Stage 4 (37.4%).

Lung	WHITE	BLACK	OTHER	Total
0	4			4
1	215	31	3	249
2	86	11		97
3	224	45	5	274
4	372	78	10	460
Total	954	172	21	1147

In review of cases all cases in distribution by race, 1.8% are other (non-white / non-black), with 15% black, and 83.2% white,

White: 63.5% of cases at Stage 3 and Stage 4 combined

Black: 71.5% of cases at Stage 3 and Stage 4 combined

Other: 71.4% of cases at Stage 3 and Stage 4 combined

In review of all cases by distribution by age range, the largest group is ages 65-74 (35.7%), followed by ages 75-85 (25.6%) Only 20 total cases are identified in ages 27-44, (1.7%), with 60% at Stage 4 lung cancer.

Lung	27-34	35-44	45-54	55-64	65-74	75-84	85-95	Total
0					3	1		4
1		1	14	45	101	76	12	249
2		2	11	17	42	16	9	97
3		2	27	68	88	72	17	274
4	2	10	45	98	163	116	26	460
Total	2	18	104	246	410	294	73	1147

National Cancer Data Base – Survival Comparatives: 2003 to 2006

The NCDB Survival Reports are unadjusted five-year observed survival rates *(not case-mix / risk adjusted).* Rates are calculated by the actuarial method, compounding survival in one-month intervals from the date of diagnosis. Survival rates are not displayed when fewer than 30 cases are available, (QNS) due to statistical limitations. Reports provide programs with their observed overall and AJCC stage stratified survival rates (with 95% confidence intervals) by type of cancer, supplemented with a comparison to the aggregate survival of all cases reported to the NCDB from CoC accredited programs. *(NCDB, 2014)*

Note: 2003 to 2006 – Latest available released data from NCDB /Jan 2014)

ALL- NSCLC	NCDB	0 yr	1 yr	2 yr	3 yr	4. yr	5 yr	95% CI
Occult	265	100.0	45.9	29.2	19.1	14.9	12.7	*8.6 - 16.7*
Stage 0	671	100.0	53.7	39.8	30.2	25.9	23.1	*19.9 - 26.4*
Stage I	70773	100.0	81.5	68.5	59.4	52.5	**46.8**	*46.4 - 47.2*
Stage II	23375	100.0	68.1	48.9	38.6	32.1	**27.6**	*27 - 28.2*
Stage III	89157	100.0	47.1	26.5	18.3	13.9	**11.2**	*11 - 11.5*
Stage IV	135732	100.0	23.3	9.8	5.6	3.7	**2.7**	*2.6 - 2.8*

REX -NSCLC	Rex	0 yr	1.yr	2 yr	3 yr	4 yr	5 yr	95% CI
Stage I	118	100.0	79.8	60.5	57.3	51.7	**47.7**	*37.6 - 57.7*
Stage II	32	100.0	52.9	41.5	37.3	28.4	**17.1**	*3.6 - 30.5*
Stage III	128	100.0	51.9	27.5	15.9	11.6	**10.2**	*4.4 - 15.9*
Stage IV	210	100.0	23.8	8.6	4.9	4.3	**4.3**	*1.5 - 7.1*

ALL -SCLC	NCDB	0 yr	1 yr	2 yr	3 yr	4 yr	5 yr	95% CI
Occult	57	100.0	48.5	21.6	15.1	10.8	10.8	*3.1 - 18.5*
Stage 0	97	100.0	34.0	15.9	13.8	10.4	5.8	*1.6 - 9.9*
Stage I	3419	100.0	66.0	41.3	30.9	25.8	**21.8**	*20.4 - 23.3*
Stage II	2240	100.0	61.4	34.0	24.6	19.2	**16.9**	*15.3 - 18.5*
Stage III	18303	100.0	49.6	23.4	14.8	11.4	**9.5**	*9.1 - 10*
Stage IV	37215	100.0	22.6	5.8	2.9	2.0	**1.6**	*1.5 - 1.8*

REX- SCLC	REX	0 yr	1 yr	2 yr	3 yr	4 yr	5 yr	95% CI
Stage I	5	*QNS-Insufficient cases to display survival information*						
Stage II	2	*QNS-Insufficient cases to display survival information*						
Stage III	27	*QNS-Insufficient cases to display survival information*						
Stage IV	61	100.0	23.0	1.9	1.9	0.0	**0.0**	0 - 0

ALL- Other	NCDB	0 yr	1 yr	2 yr	3 yr	4 yr	5 yr	95% CI
Occult	62	100.0	38.7	20.8	12.2	10.4	7.8	*1.6 - 14*
Stage 0	83	100.0	57.4	41.2	31.9	29.2	29.2	*19.5 - 38.9*
Stage I	3084	100.0	60.2	40.3	29.1	22.8	**18.4**	*17 - 19.9*
Stage II	825	100.0	41.6	24.6	15.9	13.0	**10.4**	*8.3 - 12.6*
Stage III	5040	100.0	28.7	15.2	10.1	7.7	**6.2**	*5.6 - 6.9*
Stage IV	16061	100.0	12.8	5.8	3.5	2.4	**2.0**	*1.7 - 2.2*

REX- Other	REX	0 yr	1 yr	2 yr	3 yr	4 yr	5 yr	95% CI
Stage I	2	*QNS-Insufficient cases to display survival information*						
Stage II	1	*QNS-Insufficient cases to display survival information*						
Stage III	2	*QNS-Insufficient cases to display survival information*						
Stage IV	18	*QNS-Insufficient cases to display survival information*						

Cancer Program Practice Profile Reports: CP3R

The Cancer Program Practice Profile Reports (CP3R) represents the core quality measures across oncology programs. The public/private partnership led by the National Quality Forum (NQF) in coordination with the Commission on Cancer, brought together payers, consumers, researchers, and clinicians to endorse and disseminate performance measures for breast and colorectal cancer.

- Accountability: Four of the measures are accountability measures, measures applicable for purposes as public reporting, payment incentive programs, selection by consumers, health plans, purchasers.
- Quality: The measures relating to regional lymph node examination and radiation therapy for are quality improvement measures and are intended to be used for internal monitoring, PI.
- Surveillance: Surveillance measures can be used at the community, regional, and/or national level to monitor patterns and trends of care in order to guide practice change where appropriate, policymaking, and resource allocation. *(NCDB, 2013)*

	American College of Surgeons National Cancer Data Base	Rex Cancer Program			Comparatives	
	Cancer Program Practice Profile Reports CP3R Breast & Colorectal Measures 2009 to 2011	2009	2010	2011	South Atlantic Region	All CoC COMP Programs
BREAST	Radiation tx is adm within 1 yr of dx for F<70 receiving breast conserving surgery	89.5%	92.5%	**90.1%**	**90.1%**	**91.5%**
BREAST	Combination chemo is considered or adm within 4 mths of dx for F<70 w/ AJCC T1c N0 M0, or Stage II or III ERA and PRA-	91.5%	93%	**94.2%**	**91.2%**	**92.5%**
BREAST	Tamoxifen or 3rd gen AI is considered or adm within 1 yr of dx for F w/ AJCC T1c N0 M0, or Stage II or III ERA and/or PRA+	90.8%	86.5%	**94.5%**	**87.7%**	**89.2%**
COLON	Adjuvant chemo is considered or adm within 4 mths of dx for pts <80 w/ AJCC Stage III (lymph node+)	78.9%	80%	**100%**	**89.5%**	**90.2%**
COLON	At least 12 RLN are removed and pathologically examined	92.5%	96.7%	**100%**	**86.8%**	**87.4%**
RECTAL	Radiation tx is considered or adm within 6 mths of dx for pts <80 w/ AJCC T4N0M0 or Stage III receiving surgical resection *(* Volume /# QNS)*	100%	100%	*** 85.7%**	**93.4%**	**93.2%**

Rex's performance meets or exceeds the defined Confidence Interval and comparative groups given the number of cases classified for the measure by the NCDB*

In addition, 2014 expansion of the CP3R/RQRS brings additional focus with and national comparatives in multiple areas and key performance metrics further expanding the quality measures:

- Non-Small Cell Lung Cancer Measure *(All new -4 measures)*
  - A total of at least 10 lymph nodes are removed and pathologically examined for resected NSCLC (pathologic stage IA, IB, IIA, IIB).
  - Surgery is not the first course of treatment for cN2, M0 cases.
  - Compare NSCLC Resection Rate to All NCDB: Path T by Type Resection
  - Systemic chemotherapy is considered or administered within 4 months preop or day of surgery to 6 months postop or surgically resected cases with (pN1) and (pN2) NSCLC.

Other changes and additions to measures and monitoring for 2014 include 3 new in Breast, 3 new in GI (Esophagus, Gastric, and Rectal), and GYN, with GU in consideration.

Rex Cancer Center – Analytic Cases 2013

Analysis of Rex Healthcare Cases for 2012:
Source: Rex Cancer Center Tumor Registry ~ 2068 Total Analytic Cases

REX ANALYTIC CASES 2012 *Distribution: Volume by Site, Sex, Stage*

PRIMARY SITE		SEX		AJCC STAGE				
	TOTAL	Male	Female	0	I	II	III	IV
BREAST	594	4	590	113	253	143	38	14
PROSTATE	225	225	0	0	52	123	32	15
LUNG/BRONCHUS	227	117	110	1	47	32	47	86
COLON/RECTAL	167	75	92	3	42	28	56	24
URINARY SYSTEM	132	93	39	42	51	10	11	9
SKIN- MELAMONA	96	58	38	25	49	10	2	3
BLOOD & BONE MARROW	92	47	45	0	0	1	0	1
GYN	89	0	89	6	40	4	21	10
LYMPHATIC SYSTEM	83	44	39	0	19	13	17	27
PANCREAS	67	36	31	0	6	14	5	34
THYROID	57	16	41	0	43	2	8	3
TOTAL VOLUME *(All Sites)*	2068	863	1205	195	650	403	271	274

REX ANALYTIC CASES 2012 *Distribution: Percent by Site, Sex, Stage*

PRIMARY SITE		SEX		AJCC STAGE				
	TOTAL	Male	Female	0	I	II	III	IV
BREAST	594	0.7%	99.3%	19.0%	42.6%	24.1%	6.4%	2.4%
PROSTATE	225	100.0%	0.0%	0.0%	23.1%	54.7%	14.2%	6.7%
LUNG/BRONCHUS	227	51.5%	48.5%	0.4%	20.7%	14.1%	20.7%	37.9%
COLON/RECTAL	167	44.9%	55.1%	1.8%	25.1%	16.8%	33.5%	14.4%
URINARY SYSTEM	132	70.5%	29.5%	31.8%	38.6%	7.6%	8.3%	6.8%
SKIN- MELAMONA	96	60.4%	39.6%	26.0%	51.0%	10.4%	2.1%	3.1%
BLOOD & BONE MARROW	92	51.1%	48.9%	0.0%	0.0%	1.1%	0.0%	1.1%
GYN	89	0.0%	100.0%	6.7%	44.9%	4.5%	23.6%	11.2%
LYMPHATIC SYSTEM	83	53.0%	47.0%	0.0%	22.9%	15.7%	20.5%	32.5%
PANCREAS	67	53.7%	46.3%	0.0%	9.0%	20.9%	7.5%	50.7%
THYROID	57	28.1%	71.9%	0.0%	75.4%	3.5%	14.0%	5.3%
TOTAL VOLUME *(All Sites)*	2068	41.7%	58.3%	9.4%	31.4%	19.5%	13.1%	13.2%

Submitted by K. Foote, CTR / C.Jones, CPHQ

The Rex Cancer Center Annual Report 2013 is presented on behalf of the Rex Cancer Care Committee and contributors:

Required Roles	Member	Supporting Roles	Member
Chairman	Jeffrey Crane, MD	Family Practice	Douglas Hammer, MD
ACoS CLP	David Eddleman, MD	Thoracic Surgeon	Alden Parsons, MD
Radiology	Kirk Peterson, MD	Surgeon	Matthew Strouch, MD
Pathology	Keith Volmar, MD	Registered Dietitian	Patty Cepull, RD
Surgery	Yale Podnos, MD	Pharmacy outpatient	Donna Quinn, RPH
Hematology/Oncology	Jeremiah Boles, MD	Pharmacy inpatient	Jeff Gross, RPH
Radiation Oncology	Pete Hoffman, MD	Rehab Services	Nancy Reifsteck, OTR
Cancer Services, Director	Vickie Byler, MSN	Mgr. OSS Services	Emmeline Madsen, MHA
Tumor Registry	Kathleen Foote, CTR	Radiation Oncology	Fred Fangman
Oncology Nurse Mgr	Claudia Hepburn, RN OCN	American Cancer Society	Pat Curl
Social Work	Kimberly Fradel, MSW	Med Oncology -Wakefield	Claudia Hepburn, RN OCN
QI Coordinator	Cynthia Jones, CPHQ	Pastoral Care	
Oncology Research	Nancy Burns, RN OCN	Inpatient oncology	
Hospice Unit /Hospitalist	Meena Mohan, MD		
Palliative Care Team	Toni Miller, NP		
Genetics Counselor	Catherine Fine		

Feature Contributors

- **Alden Parsons, MD** — *Rex Thoracic Surgical Specialists, Medical Director*
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- **Reynaldo Garcia, RN** — *Rex Clinical Research*
- **Cynthia Jones, BSHA, CPHQ** — *Rex Cancer Quality Program Coordinator*
- **Rose Auman, MSW** — *Rex Cancer Center Outreach Coordinator/ Annual Editor**

Resources & References

- Commission on Cancer, American College of Surgeons, Cancer Program Standards 2012: *Ensuring Patient-Centered Care*
- Commission on Cancer, American College of Surgeons, Quality Tools for Cancer Programs:
  - *NCDB Survival Reports (Survival)*
  - *Cancer Program Practice Profile Reports (CP3R)*
  - *Rapid Quality Reporting System (RQRS)*