Cancer Program

2018 ANNUAL REPORT

at Community Memorial Hospital

Community Memorial Hospital

Community Memorial Health System

MISSION

To Heal, Comfort and Promote Health for the Communities We Serve.

VISION

To be the regional, integrated health system of choice for patients, physicians, payers and employees. To be an indispensable community treasure.

VALUE

Integrity, Service, Excellence, Caring and Transparency.

Community Memorial Health System

From the Chairman and Medical Director

Lynn Kong, MD
Cancer Committee Chairman,
Community Memorial Health System

We are pleased to present to you the 2018 Annual Report from Community Memorial Health System.

What originated in 1902 as a single hospital in downtown Ventura, has today grown into an expansive healthcare system throughout Ventura County, California. In December 2018, the new 242 bed Community Memorial Hospital opened its doors in Ventura, with all private rooms and state of the art equipment. Ojai Valley Community Hospital continues to serve the Ojai Valley and the Continuing Care Center provides skilled nursing, rehabilitation and terminal care for those in need of additional assistance. The Centers for Family Health and Midtown Medical Group offer many outpatient family practice, internal medicine and specialty clinics throughout Ventura County.

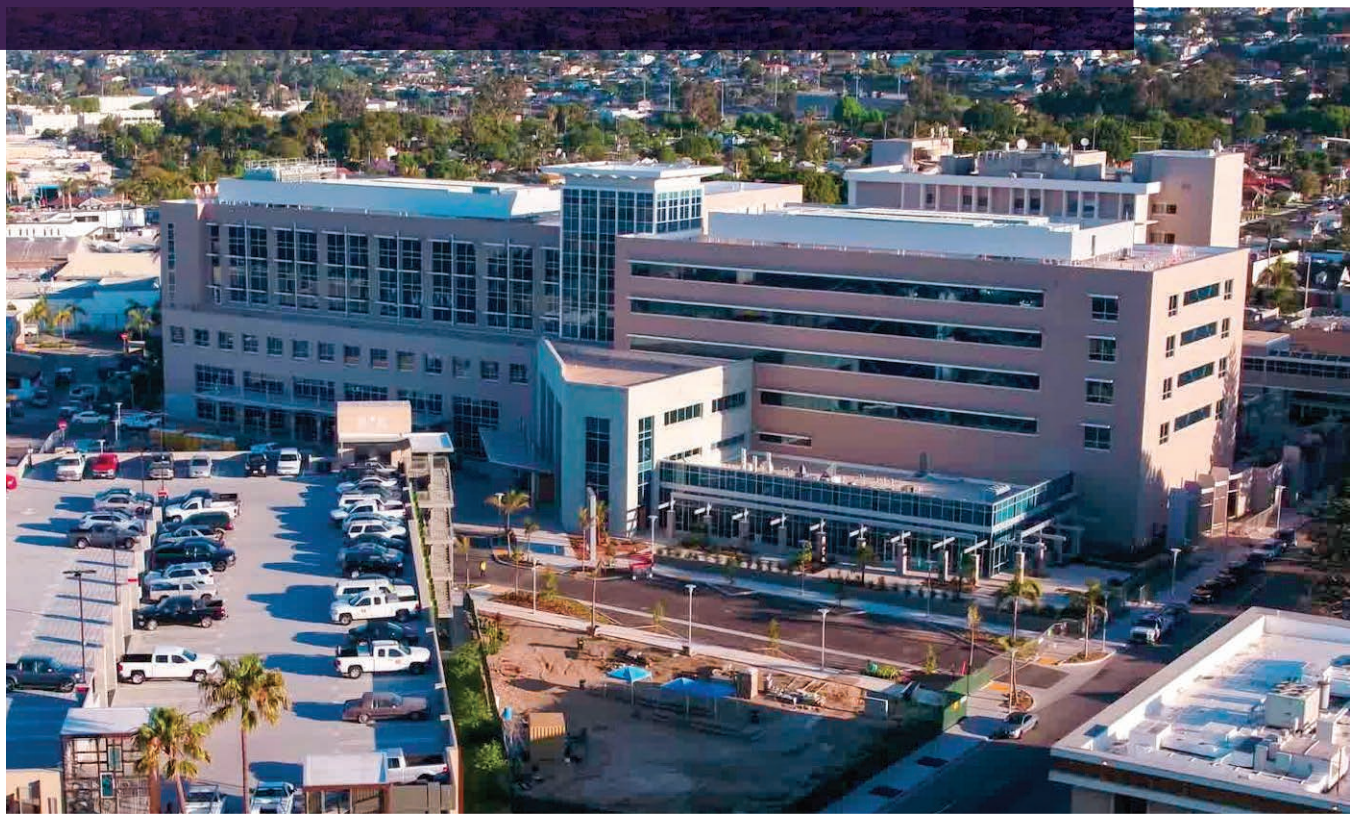
We are committed to providing patient-centered, personalized and evidence-based multidisciplinary care. Our focus on each patient includes prevention, screening and early detection, along with a compassionate diagnostic process, coordination of care, and extensive treatment options, including genomic testing for Targeted Therapy, Immunotherapy, Radiation, Palliative Care and Survivorship. In 2018, the FDA approved 19 new cancer drugs, 38 new indications for existing cancer medications and 4 biosimilar medications; most of these treatments are available locally with our oncologists. Clinical trials are available in the outpatient setting and provide access to exciting new treatments for cancer.

As our Residency program continues to grow, the residents in General Surgery, Family Practice and Internal Medicine have embraced cancer related research and quality improvement projects, as well as cancer screening and prevention in their outpatient clinics. Medical Oncology, Radiation Oncology and Palliative Care rotations are required for all Internal Medicine residents and are offered as electives to other residents and medical students. Residents and medical students also participate in our weekly tumor board.

The Cancer Resource Center continues to be a tremendous asset to our community. They provide navigation through the cancer process, education, support groups, rehab services, lectures, spiritual care, nutrition classes, yoga and other stress reduction methods. The staff is also responsible for coordinating our weekly multidisciplinary tumor board, cancer registry, outreach, the annual National Cancer Survivor Day celebration and our annual Cancer Symposium.

This report outlines the accomplishments of our program in the past year and highlights the dedication of our team in caring for patients and their families at every step along their cancer journey.

CMH Cancer Program



Community Memorial Hospital is closing in on completion of a 4 + year construction project, set to be completed at the end of December with a move in date set early in 2019. The hospital has changed considerably from what originated in 1902 as a single hospital serving its neighbors, to an expansive healthcare system that touches the lives of individuals throughout Ventura County, California and beyond.

Community Memorial Health System was established in 2005 when Community Memorial Hospital in Ventura merged with Ojai Valley Community Hospital. Our Health System is comprised of these two hospitals along with eleven family-practice health centers serving various communities within Ventura County. Big changes have been happening at Community Memorial Hospital with the construction of a brand new, state of the art facility. Many construction milestones were achieved throughout 2018 including the completion of a brand new parking garage and the beginning of a beautiful landscaping project that will create warmth and a welcoming atmosphere once open. We plan to start the move into the new Hospital in January of 2019 and to be fully operational by February of 2019.

Our health system is a community-owned, not for profit organization. As such, we are not backed by a corporate or government entity, nor do we answer to shareholders. Rather, we depend on—and answer to—the communities we serve. In that vein, it is incredibly important to us as a Health System to stay competitive and offer the best care possible, including specialty services that ordinarily a patient would have to travel a great distance to receive. Some of the specialty services that Community Memorial Hospital offers include: Brain surgery, Oncology services, and Cardio-Vascular and Stroke programs. We also have a robust Residency training program.

Guiding us on this esteemed mission is a volunteer and diverse Board of Trustees that represents a cross section of leaders in our community, and who govern Community Memorial Health System with a focus aimed on what is best for our citizenry.

In 2018, CMHS including Ojai Community Hospital had 14,889 total admissions, more than 69,000 patient days

and over 165,000 outpatient visits. CMH is an eight story, 242 bed state-of-the-art facility which provides a vast array of medical services and programs. We have 530 physicians on staff and over 2,000 employees and are one of Ventura County's largest employers. CMH also has 400 volunteers.

CMH is the regional leader in cardiac care with the lowest coronary artery bypass graft mortality rate in the county, as well as one of the lowest in the country, and has received

The Blue Cross/Blue Shield award of Distinction for cardiac care. CMH has the busiest orthopedic program in the county.

CMH is also a Primary Stroke Center and the leading birth facility in Ventura County with 2,639 births in 2018. Our Emergency Department, which is the designated critical heart patient receiving center, had over 58,471 visits in 2018. CMH has the region's leading surgical robotics program with over 800 procedures accomplished by the end of 2018 and has the most experienced DaVinci surgeons in Ventura County. 11,991 total surgical procedures and over 154,000 radiological procedures were performed during 2018. CMH also has an outstanding Palliative Care Program dedicated to helping patients and their loved ones cope with serious illness. This team includes Palliative Care physicians, Palliative Care nurses, Social Workers and a Chaplain. The Palliative Care department is making great strides and has established themselves as a leader in the field. Their current project is focused on integration into outpatient Oncology offices. CMH has an outstanding wound care center including hyperbaric medicine. The Breast Center has been designated as a Breast Imaging Center of Excellence by the American College of Radiology and CMH is also an accredited bariatric center.

CMH is accredited by Det Norske Veritas (DNV) and undergoes survey by this organization annually. DNV has extensive worldwide healthcare experience and has a reputation for quality and integrity in certification. CMH has been voted #1 by the community consistently for the last decade in the Consumer Choice and Ventura County Star polls.

2018 was a year of reflection and new budding ideas for continued growth for the CMH Cancer Program as well as within the Cancer Resource Center with the addition of new and improved program offerings for our patients. We continued to partner with the American Cancer Society, and local physicians to provide free programs, education, and support to cancer patients and their families while we chose to contract directly with staff to provide our support group services which proved to be an advantageous move.

Community Memorial Hospital has long been committed to assisting cancer patients from diagnosis through recovery and helping enhance the level of services provided, CMH is extremely proud to provide a wide range of services within the Cancer Program. Many of these services are provided at the CMH Cancer Resource Center.

The CMH Cancer Program has been accredited by the American College of Surgeons (AC0S) Commission on Cancer (CoC) since 2008 and we have completed 4 consecutive accreditation cycles. Accreditation is an extremely high honor for a Cancer Program, and not one that every center achieves. In fact, CMH was the first accredited program in Western Ventura. Accreditation ensures that cancer patients at CMH receive the highest quality of care. The goal of the cancer program at Community Memorial Hospital is to provide high quality services to both the patient and their family. Our greatest asset is the compassionate, personalized care afforded our cancer patients. We will undergo the next accreditation process in September 2020.

Quality cancer care is a team effort. The spectrum of cancer care at Community Memorial Hospital is monitored by the cancer committee, a group of

physicians and departmental representatives involved directly or indirectly in the treatment of cancer patients. The committee ensures that consultative services are available to all cancer patients and their families.

Patient-oriented multidisciplinary cancer conferences are held weekly. Current case treatment and management options are discussed during these conferences, affording the cancer patient with a broad spectrum of comprehensive specialty input. The Cancer Registry maintains a database of the cancer patient's history, diagnosis, stage, and treatments for all patients diagnosed and/or treated at CMH. Treatment outcomes and survival statistics are maintained by conducting lifelong annual follow-up on all cases. The Cancer Registry data generates accurate and meaningful information to be used by the cancer committee, medical staff and hospital administration to improve quality care

Mandi Poltl
CMH Cancer Program Manager

2018 Cancer Registry Report

The American Cancer Society Cancer Facts & Figures 2019 estimated that 1,762,450 new cancer cases are expected to be diagnosed in 2019 in the United States. Of those cancer cases, an estimated 62.410 are expected to be diagnosed with a Head and Neck Cancer.

At Community Memorial Hospital, during 2018, a total of 753 cancer cases were entered into the cancer registry's database. Of those cases, 23 were newly diagnosed and/or treated Head and Neck cancers.

At Community Memorial Hospital, during 2017, a total of 741 cancer cases were entered into the cancer registry's database. Of those cases, 181 were newly diagnosed and/or treated Gynecological cancer cases.

With a reference date of January 1, 2006 the Community Memorial Hospital (CMH) Cancer Registry data base now has eleven years of complete data. This data includes information about the diagnostic work-up, primary site of origin, stage of disease at diagnosis, first course treatment and survival of all CMH cancer cases. The Cancer Registry data is available to CMH physicians to evaluate the effectiveness of early diagnosis, treatment and survival. Staff physicians are encouraged to access the data available in the Cancer Registry. Requests for data can be made by calling 805/652-5459.

The statistical data provided to our medical staff and hospital administrators is used for cancer program development, evaluation of patient outcomes and assessment of patient services. The cancer registry data is also required to be reported to the American College of Surgeons National Cancer Data Base, the California Cancer Registry and the National Cancer Institute's SEER Registry.

Community Memorial Hospital
2018 Top Ten Sites of Cancer

21% BREAST

17.6% PROSTATE

7.8% CORPUS UTERI

7.4% MELANOMA

6.8% LUNG

6% COLON

4.2% URINARY BLADDER

4% KIDNEY AND RENAL PELVIS

2.9% LYMPHOMA

2.5% OVARY

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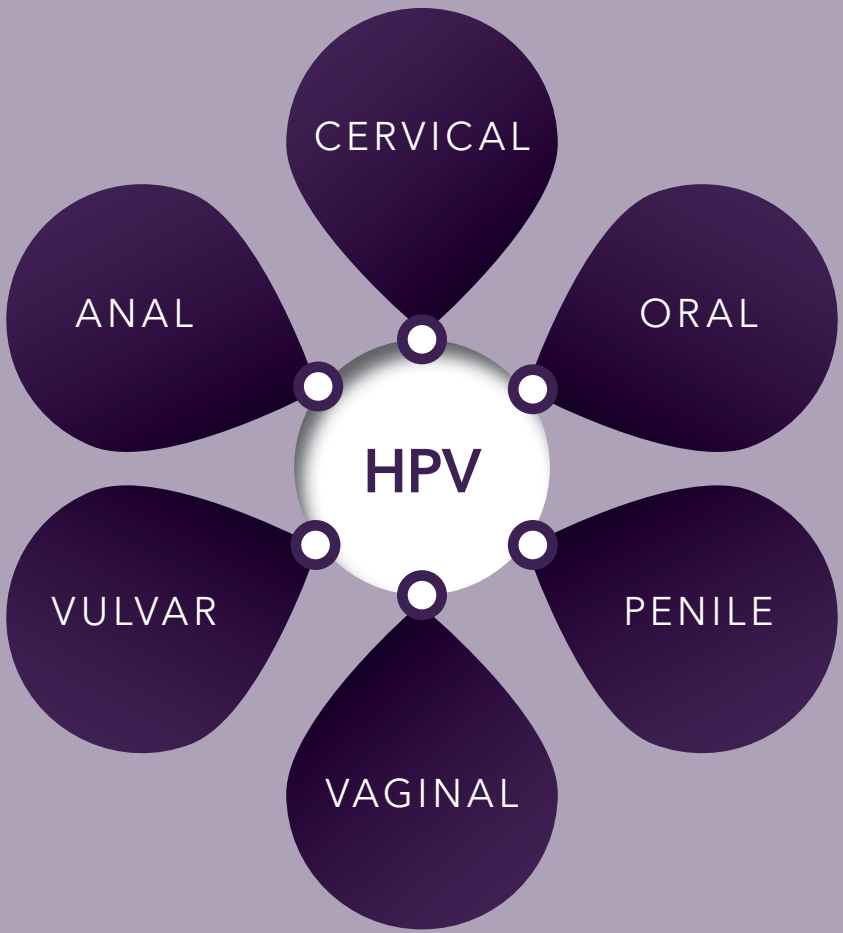
Natalie Santi, CTR
Program Registrar

Human Papillomavirus (HPV)

Human papillomavirus (HPV) is a well described risk factor for cervical cancer, oropharynx cancer, and anal cancer. HPV is a group of more than 150 related viruses. Some of them cause a type of growth called papillomas, which are more commonly known as warts. Cervical cancer: Virtually all cervical cancers are caused by HPV. Routine screening can prevent most cervical cancers by allowing health care providers to find and remove precancerous cells before they develop into cancer. As a result, cervical cancer incidence rates in the United States are decreasing.: Most oropharyngeal cancers (70%) in the United States are caused by HPV. The number of new cases is increasing each year, and oropharyngeal cancers are now the most common HPV-related cancer in the United States. Anal cancer: Over 90% of anal cancers are caused by HPV. The number of new cases and deaths from anal cancer are increasing each year Penile cancer: Most penile cancers (over 60%) are caused by HPV. Vaginal cancer: Most vaginal cancers (75%) are caused by HPV.. Vulvar cancer: Most vulvar cancers (70%) are caused by HPV

- HPV can infect cells on the surface of the skin, and those lining the genitals, anus, mouth and throat, but not the blood or internal organs such as the heart or lungs.
- HPV can spread from one person to another during skin-to-skin contact. One way HPV spreads is through sexual activity, including vaginal, anal, and even oral sex.
- Different types of HPV cause warts on different parts of the body. Some cause common warts on the hands and feet; others tend to cause warts on the lips or tongue.

(HPV) can cause several types of cancer



Head & Neck Cancers at CMH, 2018

HPV related is the most frequent Head and Neck cancer, with an estimated 63.220 nationally in 2019. Based on data from 2012 to 2016, about 44,000 HPV-associated cancers occur in the United States each year: about 25,000 among women, and about 19,000 among men. Cervical cancer is the most common HPV-associated cancer among women, and oropharyngeal cancers (cancers of the back of the throat, including the base of the tongue and tonsils) are the most common among men. At CMH, In 2018-, 23 analytic cases were recorded by the cancer registry. HPV related head and neck cancer is, most common. it is disease that most commonly occurs in Tabaco and heavy alcohol users, and Infection of HPV (Human Papilomavirus),. The disease generally is divided into two types of cancers: ***Almost all cancers in the larynx or hypopharynx develop from thin, flat cells called squamous cells.*** At CMH, Head & Neck cancers were diagnosed at a mean age of 61, and with a range in age from 31 to 93.

Comparision of HPV-Negative and HPV-Positive Head and Neck Cancers

CHARACTERISTICS	HPV-NEGATIVE	HPV-POSITIVE
Site	All site	Tonsil, BOT
Risk Factors	Tobacco/alcohol	Sexual Behavior
Confactors	Poor oral hygience	Marijuana use
Age	Older cohorts	Younger cohorts
Sex	3:1 men	3:1 men
Incidence	Decreasing	Increasing
Stage	Variable	Early T stage, advanced N stage
Histology	Keratinized	Basaloid/poorly differentiated
p53	Mutated	Wild type
p16	Decreased expression	Increased expresion

BOT = base of tongue; HPV = human papillomavirus.
Adapted from Gillisen et al. J Natl Cancer Inst. 2008,[8] with data from Urban et al. Cancer. 2014.[61]

Anal Cancer & HPV

Most squamous cell anal cancers are linked to infection with the human papillomavirus (HPV), the same virus that causes cervical cancer, as well as many other kinds of cancer. In fact, women with a history of cervical cancer (or pre-cancer) have an increased risk of anal cancer.

HPV is a group of more than 150 related viruses. They are called papillomaviruses because some of them cause papillomas, which are more commonly known as warts. There are many subtypes of HPV, but the one most likely to cause anal cancer is HPV-16. Other subtypes of HPV can cause warts in the genital and anal areas, but not cancer. The 2 types of HPV that cause most cases of anal and genital warts are HPV-6 and HPV-11. While anal warts themselves are unlikely to develop into anal cancer, people who have had anal warts are more likely to get anal cancer. This is because people who are infected with HPV subtypes that cause anal and genital warts are also more likely to be infected HPV subtypes that cause anal cancer.

HPV is passed from one person to another during skin-to-skin contact with an infected area of the body. HPV can be spread during sexual activity – including vaginal, anal, and oral sex – but sex doesn't have to occur for the infection to spread. All that's needed is for there to be skin-to-skin contact with an area of the body infected with HPV. The virus can be spread through genital-to-genital contact, or even hand-to-genital contact. An HPV infection can also spread from one part of the body to another. For example, an HPV infection might start in the genitals and then spread to the anus.

It can be very hard to avoid being exposed to HPV. It might be possible to prevent genital HPV infection by not allowing others to have contact with your anal or genital area, but even then there could be other ways to become infected that aren't yet clear.

Infection with HPV is common, and in most cases the body can clear the infection on its own. But in some people the infection doesn't go away and becomes chronic. Chronic infection, especially with high-risk HPV types, can cause certain cancers over time, including anal cancer. Since the cause of many cases of anal cancer is unknown, it's not possible to prevent this disease completely. But there are things you can do that might lower your risk of anal cancer.

Infection with HPV increases the risk of anal cancer. HPV infection can be present for years without causing any symptoms, so the absence of visible warts can't be used to tell if someone has HPV. Even when someone doesn't have warts (or any other symptom), he (or she) can still be infected with HPV and pass it on to somebody else.

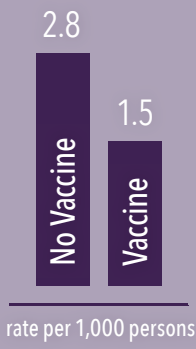
Important symptoms of anal cancer include:

- Rectal bleeding
- Rectal itching
- A lump or mass at the anal opening
- Pain or a feeling of fullness in the anal area
- Narrowing of stool or other changes in bowel movements
- Abnormal discharge from the anus
- Swollen lymph nodes in the anal or groin areas

Benefits TODAY from the HPV vaccine

In just 5-6 years after HPV vaccine became available, studies found ...

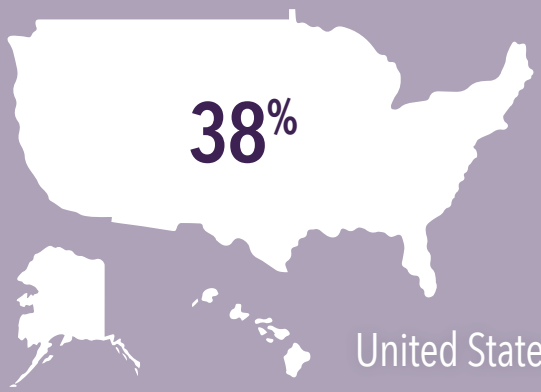
64%
DROP
in cancer-causing
HPV Infections
in girls aged 14-19



47%
LOWER
risk of
Cervical Pre-Cancer

61%
DROP
in treatment of
Genital Warts

But rates of HPV vaccination in U.S. lag behind other countries



Get Kids
11-12 years
Vaccinated!

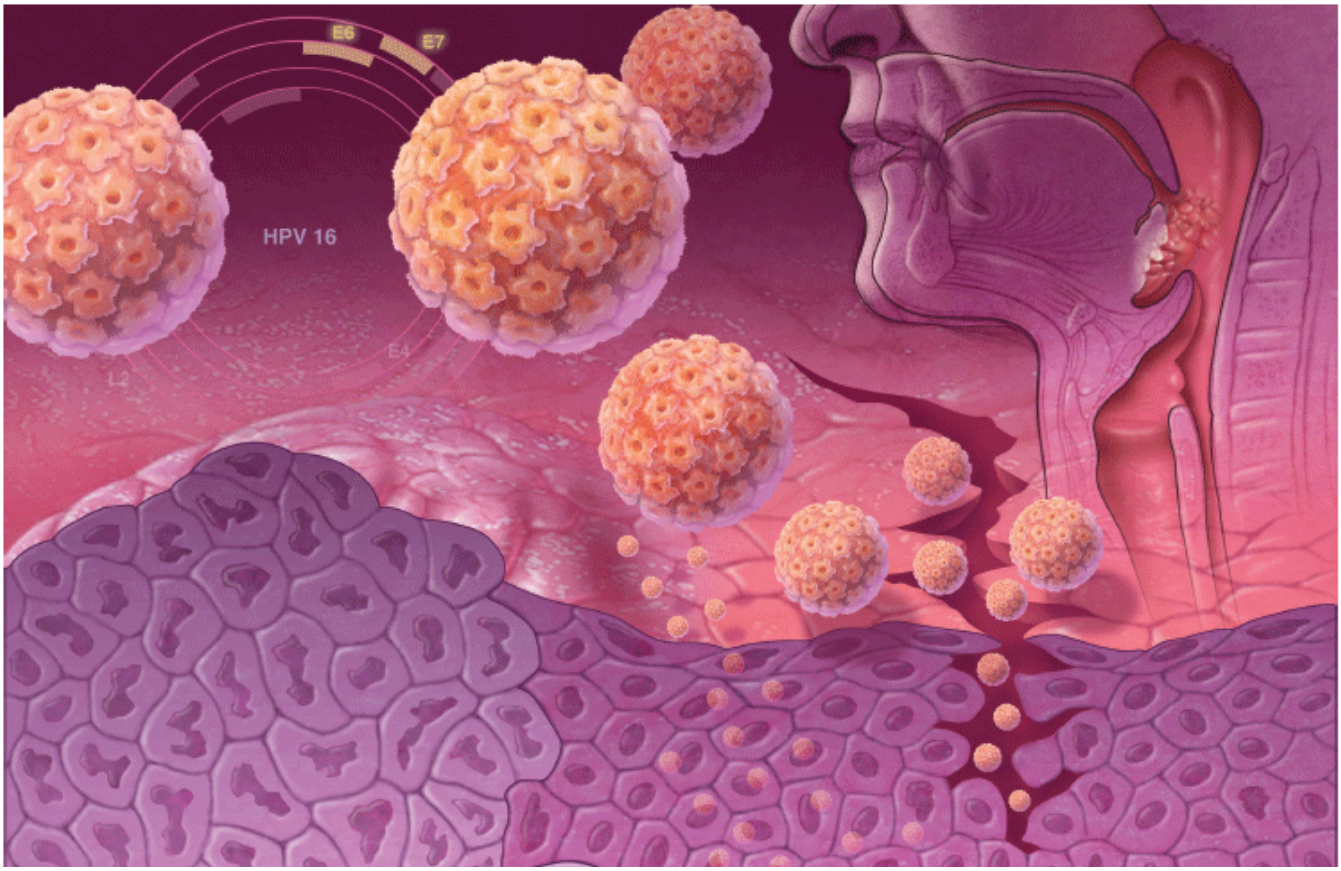


Figure 1. Human papillomavirus (HPV) is a sexually transmitted virus and may be contracted by unprotected oral sex. This virus, mainly the HPV 16 subtype, is responsible for 70% of oropharyngeal cancer cases in the United States. The virus infects basal cells deep within the tonsillar crypts. Expression of viral E6 and E7 oncoproteins leads to malignant transformation in a susceptible host. HPV-positive oropharyngeal cancer patients are typically middle-aged, nonsmoking white men, althhough women can also be affected.

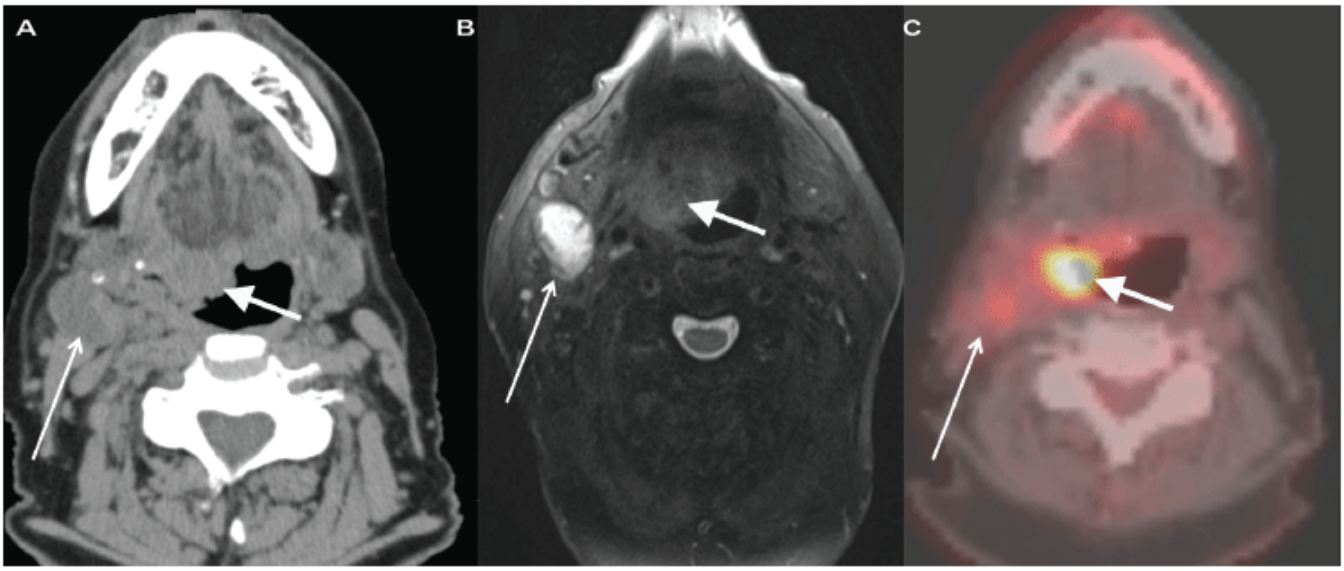
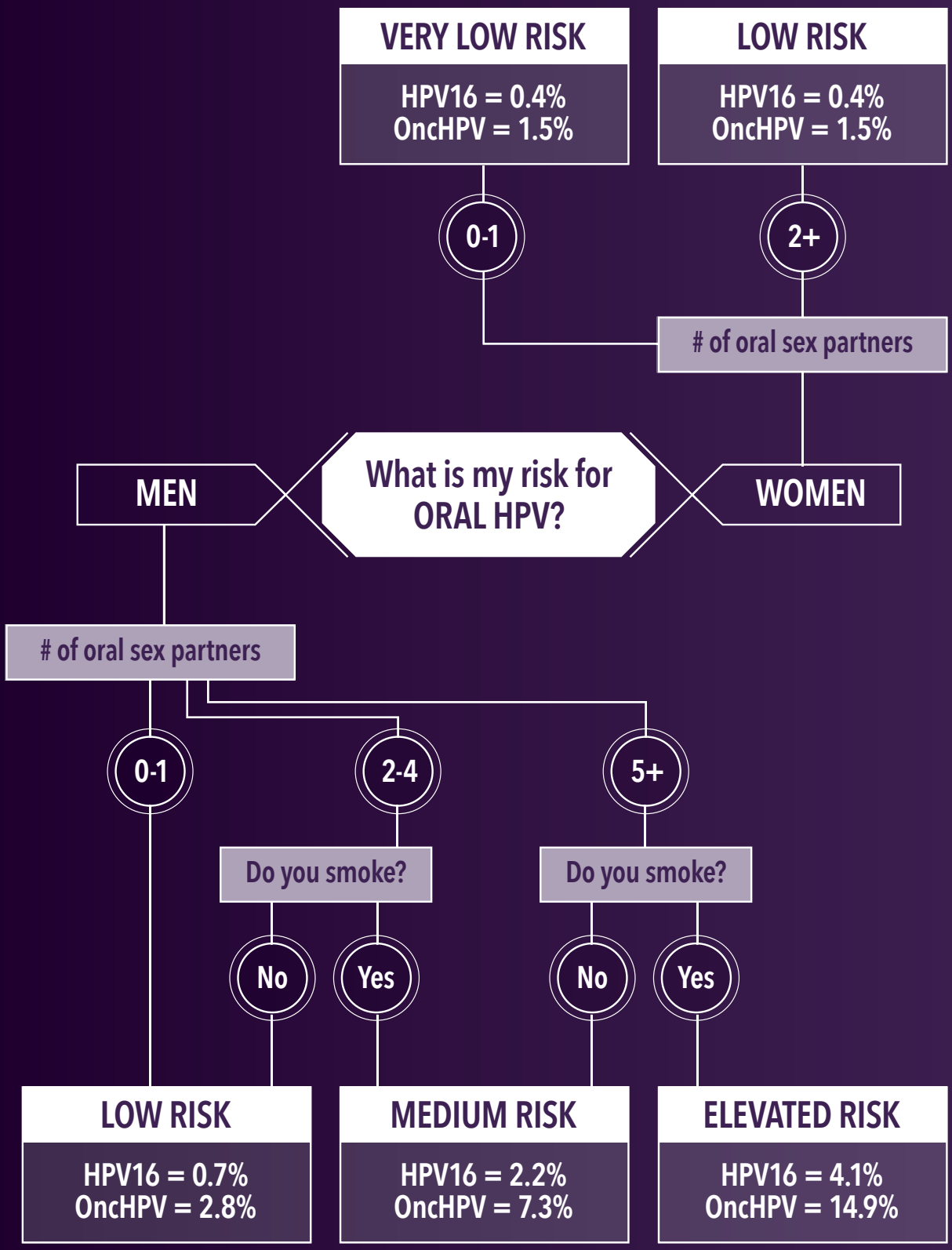


Figure 2. Imaging Studies of HPV-Positive OPSCC—HPV-positive base-of-tongue SCC (large arrowhead) with a level II cystic node (small arrowhead) is seen on (**A**) CT of the head and neck, (**B**) MRI (T2 phase), and (**C**) PET/CT (note that cystic metastatic nodes may not be significantly PET-avid). CT = computed tomography; HPV = human papillomavirus; MRI = magnetic resonance imaging; OPSCC = oropharyngeal squamous cell carcinoma; PET = positron emission tomography; SCC = squamous cell carcinoma.

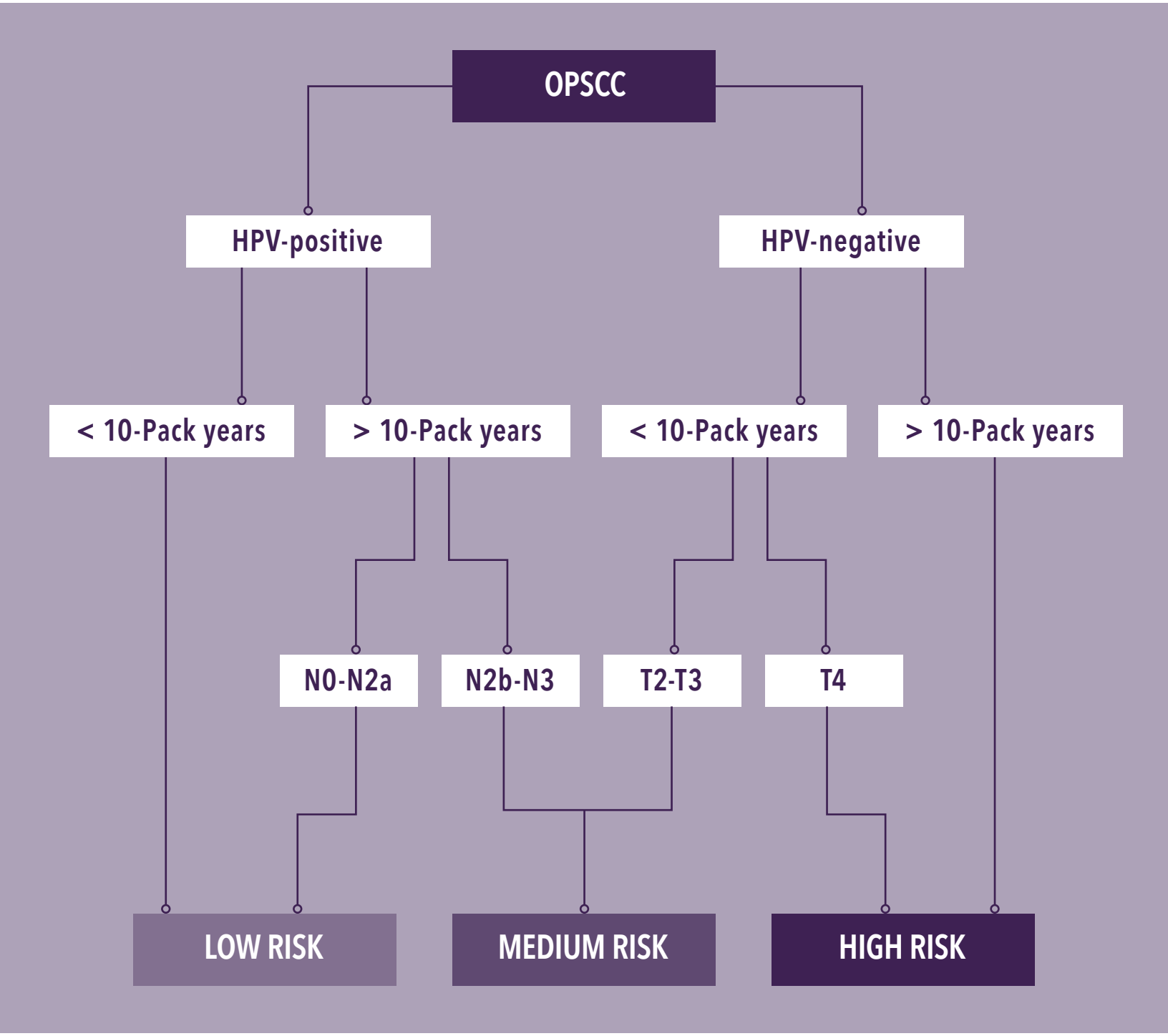

What is my risk for ORAL HPV?
MEN
WOMEN
# of oral sex partners
0-1
2-4
5+
Do you smoke?
No
Yes
VERY LOW RISK
HPV16 = 0.4%
OncHPV = 1.5%
LOW RISK
HPV16 = 0.4%
OncHPV = 1.5%
2+
LOW RISK
HPV16 = 0.7%
OncHPV = 2.8%
MEDIUM RISK
HPV16 = 2.2%
OncHPV = 7.3%
ELEVATED RISK
HPV16 = 4.1%
OncHPV = 14.9%

Summary: Management and Treatment Options in HPV-OPSCC

PHASE	RECOMMENDATIONS
Diagnostic phase	› U/S-guided needle biopsy improves yeild in cystic nodes › p16 testing of needle aspirate may point to oropharynx as potential site of primary tumor › Palatine or lingual tonsillectomy for diagnosis is preferred over random biopsies when exact primary site is unclear › PET/CT may be helpful in pinpointing the primary site; it should be done before biopsy
Tharapeutic phase	› AJCC stage-dependent treatment › No modifications based on HPV status at this time; deintensification of treatment is under active study › Refer patient to a clinical trial if possible
Surveillance phase	› No modification recommendations based on HPV status to date › Most recurrances occur within 2 years › Lungs are most common site of distant metastases › HPV status is favorable prognostic indicator in the recurrent/ metastic setting

AJCC = American Joint Committee on Cancer; HPV = Human Papillomavirus;
OPSS = oropharyngeal squamous cell carcinoma; PET/CT = positron emission tomography/ computed tomography; U/S = ultrasound

Risk Stratification for Oropharyngeal Squamous Cell Carcinoma (OPSCC)



In a large retrospective analysis of the impact of HPV on outcomes in OPSCC, patients were divided into risk-of-death categories (low,moderate, and high) based on their HPV status, tumor burden, and tobacco use. HPV = human papillomavirus; Adapted from Ang et al. N Engl J Med. 2010.[34]

Cervical Cancer

At CMH, In 2018-, 17 analytic cases were recorded by the cancer registry. (of those X were HPV +)

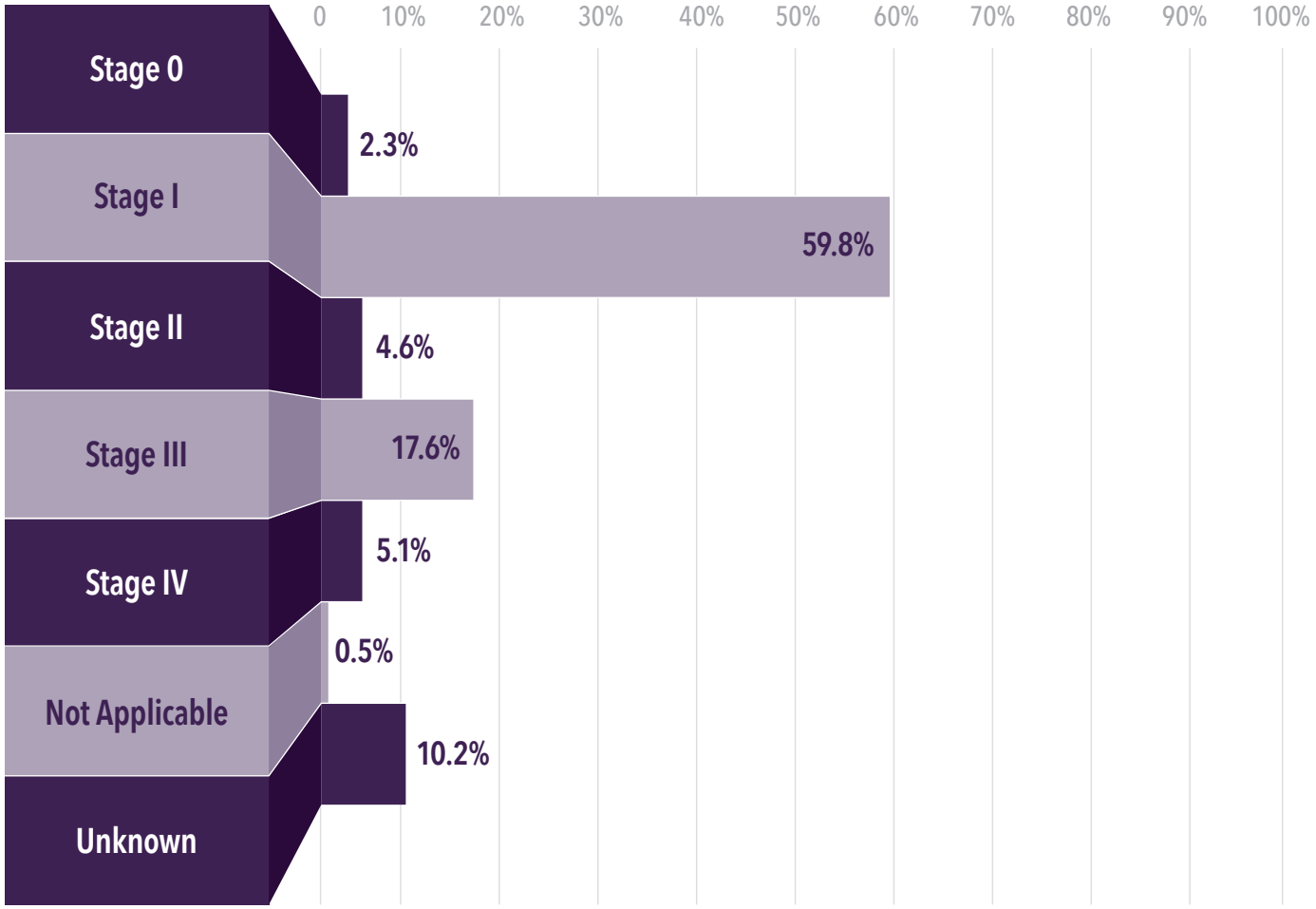
Certain types of HPV may cause warts on or around the female and male genital organs and in the anal area. These are called low-risk types of HPV because they are seldom linked to cancer.

Other types of HPV are called high-risk types because they are strongly linked to cancers, including cancer of the cervix, vulva, and vagina in women, penile cancer in men, and cancers of the anus, mouth, and throat in both men and women.

Infection with HPV is common, and in most people the body can clear the infection by itself. Sometimes, however, the infection does not go away and becomes chronic. Chronic infection, especially when it is caused by certain high-risk HPV types, can eventually cause certain cancers, such as cervical cancer.

Although there is currently no cure for HPV infection, there are ways to treat the warts and abnormal cell growth that HPV causes.

CMH Cervical Cancer Cases by AJCC Stage at Diagnosis 2013-2018



CMH 6th Floor Nursing

JODY MCDONALD, BSN, RN
6th floor Medical/Oncology Clinical Manager

CMH Ocean Tower 6 East and 6 West are 30 bed units. 6 East is our dedicated Oncology unit. Our nurses care for a diverse group of patients, with our primary focus on caring for the Oncology patient population in our community. Our team provides care in every phase of their treatment. As of October 2019 we have 25 nurses who are ONS Chemotherapy certified and have achieved competency for safe administration. In addition, 3 of our leadership nurses became OCN certified (Oncology Certified Nurse). These nurses have advanced clinical assessment skills paired with an empathetic nature to ensure our Oncology patient population is provided the highest level of care. Our staff works very closely with the Palliative Care Team, whose office is also located on 6 East, this team approach with Palliative and the nursing staff allows open communication with the patients and families so that their treatment goals can be identified and met. This collaboration helps us support our patient's physical, emotional, spiritual and cultural needs.

6th floor nurses continue to educate and be a resource for staff throughout the hospital regarding cytotoxic precautions. These precautions are needed to protect themselves as well as others when caring for patients who are receiving chemotherapy and for the 5 days post administration. The education also includes how healthcare workers can best protect themselves from exposure to potentially hazardous materials and waste. We also have a chemotherapy nurse on the linen task force to ensure safe handling of potentially contaminated linens and a lead chemo nurse and manager attending Cancer Committee.

Each year we provide an annual Chemotherapy workshop for all certified chemotherapy nurses and any other nurses interested in attending for informational purposes. This workshop along with mentoring will ensure the competency of our nurses administering chemotherapy. Our goal is to continually deliver the highest quality of care. These care models are derived from evidence based practice guidelines from the ONS and ASCO.

With the opening of the CMH Ocean Tower in December 2018, we now can offer all of our patient's private rooms. This has helped facilitate more opportunities for family to be at the bedside to support their loved one and foster a patient/family centered care environment. This will also allow us more opportunities to provide a calm, quiet and healing environment that is essential to their recovery.

Community Outreach

2018 Year-End Report Based on Screening and Prevention Activities at CMH

PURPOSE

To evaluate current Community Outreach, Screening and Prevention strategies and activities in order to ensure that the planning and execution of these activities is in line with the written standards developed by the COC.

EVALUATION OF PROGRAM DATA

In 2017, the committee agreed that a needs assessment is the best way to research and evaluate data in order to establish beneficial screening and prevention activities for CMH patients which will also help to establish beneficial Community Outreach activities for the population served.

The Cancer Committee analyzed several different annual reports from local County agencies and compiled data for a needs assessment. Ventura County has several organizations that currently poll and compare County wide data and we decided to incorporate portions of these findings into our needs assessment for comparison purposes on a broader scale. Utilizing the County data also highlighted trends in certain screenings and preventions and provided a comparison of neighboring Counties. The committee voted to move ahead with this method for an assessment, which will be conducted every 3 years based on the timeline of the agencies currently polled.

In 2018, CMH in joint effort with other not-for-profit health systems, Camarillo Health District and the County of Ventura, produced a Public Needs Assessment in order to gauge current offerings in the community and compare them to needs that Community Members are highlighting.

BREAST SCREENING NEEDS BASED ON POPULATION DATA

The committee analyzed County data available through Health Matters in Ventura County as well as Ventura County Public Health. The data compiled was put into comparison slides of eligible patients that underwent mammography screening at CMH.

Ventura County has a fairly high screening rate for mammography at 77.2% however, the goal for screening is 81.1% by 2020 which the county and CMH are both falling short of meeting. Only 8% of the age eligible patients that presented to CMH during the 2017 calendar year underwent a screening mammogram.

While the CMH Cancer Registry has not entirely completed compiling 2018 numbers as of yet, it is expected that they will reside in a similar range. 8% initially seems extremely low, but it must be taken into account that this does not include patients screening elsewhere in Ventura County such as through the Dignity Health System, Kaiser Health System, UCLA and various smaller entities such as Rolling Oaks Ventura and Oxnard locations; Grossman Imaging; Ventura County Medical Center, Pueblo Radiology; Palms Radiology; Los Robles Hospital; Santa Paula Hospital; RadNet and Conejo Medical.

The CMH Breast Center offers a low cost screening event throughout the month of October every year to celebrate Breast Cancer Survivorship but to also ensure that patients in need of screening, but prohibited from seeking it due to cost are able to receive screening. In 2018, the cost for traditional 2D mammography was $65; $90 for 3D breast Tomosynthesis and $150 for ABUS. ..\..\ Standards Section 4\2018\4.2 screening\6915_mammo_ flyer_2018.pdf

The Community Memorial Hospital Cancer Committee analyzed the data for screenings provided through the Breast Center and determined that screening mammography continues to be a priority in this community. The committee also concluded that future activities should be developed in order to reach the goal of 81.1% screened by 2020 as well as broaden the reach to minority populations within the County.

Analysis of ethnicities screened at CMH showed that the White/Caucasian population is head and shoulders above other ethnicities for screening. Only 1% of the Black eligible population underwent screening at CMH and the same is true for the Asian population. The committee would like to investigate this further in the future to determine if there is a lack of screening in particular ethnicities within the Ventura County population or if these other ethnicities are represented elsewhere in Ventura County via off site screening centers.

RESULTS OF THE CMH BREAST CENTER'S LOW COST SCREENING MONTH (OCTOBER):

- 57 women participated during the month of October for low cost breast screening.
- There were 57 mammograms; 54 of which were scored a BIRAD, 1 or 2 and 5 were scored a BIRAD, 0. 2 of the BIRAD, 0 patients did not return for follow up and 1 rescored as a BIRAD 4, which was determined to be a fibroadenoma on biopsy. 2 of the BIRAD 0 patients returned for follow up and had normal results.

- Only 4 of the patients that presented for the screening recorded that they had insurance; 2 were HMO and 2 were Kaiser Patients; 2 had "other" insurance.
- There were 6 ABUS screenings; 5 of which had a BIRAD 1 or 2 and 1 had a BIRAD 0. That patient returned and had a normal follow up screening.
- Of the ABUS patients, 2 recorded having insurance; 1 had HMO and 1 had "other" insurance.

LUNG SCREENING NEEDS AND RESULTS BASED ON POPULATION DATA:

According to Ventura County statistics, a significant percentage of the population in various age groups continue to smoke and or use other tobacco products. Roughly 14% of adults age 18-24 are reported smokers; 13% age 25-44 adults are reported smokers and about 12% adults age 45-64 are reported smokers. For this reason, Low Dose CT screening has become a top priority at CMH and an offering that we present to our qualifying patients.

Per the California Health Interview Survey (2015), 12.7% of Ventura County adults are current smokers. This is above both the Healthy People 2020 target (12.0%) as well as the Let's Get Healthy California target of 9.0%. The percentage of adults who smoke ranges from 8.9% in Thousand Oaks/Westlake Village (91362) to 14.9% in Port Hueneme (93041).

Research into County Statistics showed that males were more likely to die from lung cancer than females, but females were more likely to die from lung cancer than breast cancer in Ventura County. White (Non-Hispanic) females were more likely to die from breast cancer than Hispanic females, and Hispanic males were more likely to die from prostate cancer than White (Non-Hispanic) males.

The risk factors associated with the development of lung cancer include tobacco smoking, contact with second-hand smoke, contact with radon, asbestos or other cancer-causing agents, history of lung disease, and family history of cancer (National Comprehensive Cancer Network, 2017).

The U.S. Preventive Services Task Force (USPSTF) recommends annual

Screening for lung cancer with low-dose computed tomography (LDCT) for adults aged 55-80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.

CANCER PREVENTION ACTIVITIES

The committee assessed the number of melanoma and other skin cancers in the community and determined that skin cancer awareness and prevention is lacking and should have more focus. In partnership with the CMH Marketing Department and several Community Physicians, a Men's Health Symposium was presented to the Community on 9/15/18 with a strong focus on skin protection in the sun, incorporating yearly skin checks through a Dermatology office into a person's care routine and general preparedness for living in a sunny climate where daily skin protection utilizing an SPF 30 or higher is highly recommended. Vendor booths were set up at this event and free SPF sun screen and lip balm were given free of charge to participants. Also provided were step by step skin check cards with graphics demonstrating how to check one's self for suspicious skin lesions. (Power point presentation hyperlink here)

In 2018, roughly 70 patients were diagnosed with Melanoma skin cancer. Of those 70 patients, 12 had previously been diagnosed with a different skin cancer. It is important to note that the CMH registry only has data on previously diagnosed skin cancers for a patient if it is documented in their History and Physical and/or they were treated at our facility. This number could be much higher.

Under the licensing of the American Lung Association, CMH continues to provide smoking cessation classes as a prevention for patients identified as a current smoker. This is a referral based program with a $50 fee associated. In an effort to be conscientious of the potential financial barriers that patients may be facing, CMH has partnered with Ventura County Public Health Department to also refer patients to their grant funded, smoking cessation program which can be offer to patients free of charge. Together, we have been able to provide the education and support necessary to quit smoking to 237 patients.

COMMUNITY OUTREACH ACTIVITIES AT CMH 2018:

- The Men's General Prevention Symposium held in Camarillo on 09/15/18 reached 116 unique constituents. Prevention and sun safety information and materials were covered.
- 72 participants completed several 8 week exercise programs held throughout the year. This is a collaboration between CMH and the YMCA's Live Strong program. 3 separate sessions were held during 2018.

- National Cancer Survivor's Day held at the Cancer Center reached 50 patients. This was celebrated on June 1, 2018.
- The Nutritional series with Oncology certified Dietician, Susan Speer, MS, RD, CDE held one Friday per month reached 120 patients during 2018.

ANALYSIS AND PRESENTATION OF SCREENING AND PREVENTION ACTIVITIES TO THE COMMITTEE:

- The Community Outreach Coordinator, Evelyn Scott, RN, recommended future screening and prevention activities to focus on for 2018 based on the data that was compiled for the deficiency resolution. Breast screening and LDCT screening for lung remain top priority for the committee based on the information provided. Skin cancer prevention as well as a future focus on colorectal screening is recommended going forward.
- Evelyn Scott has begun conversations with the Centers for Family Health and Dermatology in order to design a future skin cancer screening clinic for the community.
- Based on the data collected for the deficiency resolution from the 2017 Cancer Program Survey, Community Outreach Coordinator, Evelyn Scott, RN made recommendations for future screening and prevention activities in 2018. While the data revealed that breast and LDCT screening should remain a priority, it is recommended that the committee focus its efforts on skin cancer screening and prevention moving forward.
- Evelyn has initiated a conversation with the Centers for Family Health Dermatologist in an effort to facilitate a free skin cancer screening event for the community in the future.
- Evelyn has initiated conversations with the Centers for Family Health Dermatologist and the CMH marketing team to discuss the possibility of hosting an educational presentation to the community focusing on skin cancer prevention. This educational piece should be offered to the community free of charge. The purpose of the presentation would be to educate the community about the risks of skin cancer as well as prevention methods.

COMMUNITY OUTREACH COORDINATOR'S RECOMMENDATIONS:

Based on the CMH Community Needs Assessment as well as the data provided by Health Matters in Ventura County, it is the recommendation of the Community Outreach Coordinator that CMH continue to focus its screening efforts on mammography screening.

Due to the high number of community members that continue to smoke along with the number of lung cancer cases diagnosed and treated at CMH, it is the recommendation of the Community Outreach Coordinator that the committee evaluate and modify the current Low Dose CT screening process. The goal of the evaluation would be to streamline the screening processes and improve patient participation in the CMH Low dose CT screening. The Community Outreach Coordinator recommends that a multidisciplinary team become involved in the review and planning of treatment following each Low Dose CT screening. This multidisciplinary team should include a Chief Medical officer, a Radiologist and a Thoracic Surgeon. Additionally, the necessity to maintain the CMH smoking cessation program should be evaluated. It is the recommendation of the Community Outreach Coordinator that a direct referral process to the Ventura County Public Health Department smoking cessation classes be considered. The overall goal would be to improve patient participation in a smoking cessation program.

Based on the data from the CMH Cancer Registry as well as the community response to the Skin Cancer presentation at the Men's Symposium, it is the recommendation of the Community Outreach Coordinator that the committee consider focusing its screening and education efforts more specifically on skin cancer awareness and prevention. The goal would be to educate community members on the importance of utilizing an SPF 30 or higher sunscreen daily as well as the importance of obtaining a yearly skin screening with a physician. Additionally, the committee should consider providing the community with an annual skin screening at no cost. This is a screening service that has not previously been provided and could be of great benefit to the community due to the large number of skin cancer cases treated and diagnose in Ventura County.

“You have **CANCER** ...”

Some of the most devastating words an individual will ever hear. There are so many questions and so many unknowns. Patients are no longer in control of their own destinies. How do patients and their loved ones pick up the pieces of their lives after this? How do they put their worlds back together?

This is where my role as the Cancer Patient Nurse Navigator comes into play.

I am able to offer our patients the knowledge and resources that come with 30+ years of Oncology Nursing experience. My background in oncology nursing is varied and includes acute care, outpatient clinic, nursing education and the pharmaceutical industry.

My goal is to walk with patients on this often times scary path, just as I would with any member of my family.

Deb Lawry, RN
Nurse Navigator

My role allows me to:

- Provide guidance and support for patients and their families through each step of the cancer journey from diagnosis through treatment completion and survivorship
- Guiding patients and families through the healthcare system including attending physician appointments at patient's request
- Educating patients on communication with their family and their healthcare team
- Educating patients and family regarding diagnosis, treatment and survivorship
- Provide patients with the tools and information they need to make informed decisions and actively participate in their own care
- Advocate for patients and act as a liaison between the patient and the medical team to make sure their questions and concerns are addressed
- Provide referrals to resources as needed

During 2018 I was able to provide guidance and resources to 506 patients. Over the next year, I will continue working with our LCSW Lyndsay, to continue outreach processes to market our CRC to the community.

During this year, we have also been able to successfully establish new support groups and programs based on patient needs.

It is a privilege to work with our cancer patients and I am truly excited to be a part of the Cancer Resource Center.

The Oncology Rehabilitation and Lymphedema Program

Claudia Steele-Major, PT, CLT
Lymphedema Therapist,
Rehabilitative Services, CMH

The Oncology Rehabilitation and Lymphedema Program at the Cancer Resource Center is a partnership between the Rehabilitation Department and the Coastal Communities Cancer Center. Physical Therapy, Occupational Therapy, and Speech Therapy services are providing rehabilitation to oncology patients through the continuum of care from diagnosis through treatment, and all stages of survivorship. Survivorship care addresses late effects of cancer treatment such as fatigue, deconditioning, speech and swallowing difficulties, lymphedema, and mobility restrictions. As such, we have developed a collaborative relationship with the Live Strong at the YMCA Program to allow patients to transition into community exercise programs upon completion of rehabilitation.

The majority of patients seen at the Lymphedema Program are patients with lymphedema because of lymph node removal surgery and/or radiation treatment e.g. breast cancer, melanoma, head-and neck cancers, gynecological cancers, and others.

Lymphedema presents as swelling in the region where lymph nodes have been removed. This chronic swelling can be successfully treated with Complete Decongestive Therapy, the standard of care for lymphedema. Through manual lymphatic massage, compression therapy, exercise, and education in self- care the patient and caregivers learn to reduce swelling, prevent infection, and exacerbation of this condition. Great emphasis is put on functional rehabilitation of the affected area to improve quality of life, return to prior activities of daily living, and resume occupational and recreational tasks.

In 2018, we saw an increase of patient referrals with head-and neck cancer. Beside lymphedema of the head, neck, or face functional impairments may include trismus, facial muscle weakness, limited ROM of the neck and shoulder girdle, pain, and connective tissue restrictions. Swallowing- and speech difficulties, as well as cognitive impairments, fatigue and general debility due to weight loss often require interventions of the entire rehabilitation team to restore our patients' functional abilities to prior levels.

While our program primarily serves outpatients coming to our clinic, we are also available for inpatient consultations on the oncology floor as needed.

Nurses Knowledge of Lymphedema Prevention Strategies After Axillary Surgery and Effect of Evidence-based Education

Norair Adjamian, DO, Graal Diaz, PhDsc, Constanze Rayhrer, MD
Community Memorial Hospital, Ventura, California

INTRODUCTION

Traditional recommendations for arm care after axillary lymph node surgery are touted as measures to prevent lymphedema in patients after surgery. These recommendations include avoiding blood draws, blood pressure measurements, and intravenous infusions. Evidence based information has recently been made available regarding the unnecessary nature of these precautions but has not been widely adopted. Post educational surveys were given to gauge the effectiveness of our education.

PARTICIPANTS

Nurses and nurse technicians were invited to one of two educational lectures. In each of these lectures, a pre lecture survey of ten questions was given to attendees. A lecture was given reviewing recent evidence based literature regarding IVs, blood draws and blood pressure measurements performed on arms not affected by lymphedema after axillary surgery, and a post lecture survey was given. Our surveys consisted of questions assessing knowledge regarding current practices, knowledge of an existing arm care protocol at the hospital, source of their education, extra work precautions created, perceived impact on patients, efficacy of the education we provided and attendees job type.

RESULTS

A total of 47 pre-educational and 47 post-educational surveys were returned. Forty respondents were nurses, and seven were scrub technicians. Seventy-two percent of participants reported direct involvement in managing patients who have undergone lymph node sampling. Pre-survey results indicate that 94% of participants refrain from blood pressure cuffs, blood draws, or needle sticks on the effected extremity. Fifty-five percent report no knowledge or are unaware of an existing hospital protocol. Following our educational lecture, survey results showed that 100% of the participants found the lecture informative, with 83% endorsing hearing the information for the first time. Eighty-five percent reported a need for an updated hospital protocol. Ninety-six percent of the participants believed that adopting the recommendations in the lecture would improve patient care and quality of life.

CONCLUSION

In our community hospital, current practices include avoiding blood pressure measurements, blood draws, and needle sticks to the extremity that has undergone lymph node sampling. Forty three percent of the participants learned such practices while on the job. While 32% of respondents were unaware of an official hospital protocol, 45% of respondents reported being aware that there was a protocol when, in fact, there is none. Most nurses or nurse techs at our institution were unaware of new data available regarding management of the ipsilateral arm after lymph node surgery. One hundred percent of the survey participants found our in-service lecture informative, and 83% reported hearing the information for the first time, indicating this type of education is a timely educational opportunity. Ninety-six percent of survey respondents felt that adopting new evidencebased patient management strategies would improve patient care and subsequently improve patients' quality of life.

Molecular Testing of Non-Small Cell Lung Cancer Patients

STD 4.7 2018

Lynn Kong MD, Mandi Poltl CTR, Meeae Kwon MD

Purpose

In 2013, the College of American Pathologists released guidelines for molecular testing of advanced non-small cell lung cancer (NSCLC). Subsequently, we initiated a quality improvement project to ensure testing of all advanced stage adenocarcinoma patients diagnosed at CMH. This study was performed as a follow up study to assess the success of the quality improvement study.

Methods

Patients with NSCLC diagnosed in 2016 and 2017 were identified through the cancer registry and selected for adenocarcinoma histology. Inpatient and outpatient records were reviewed for clinical staging. CMH pathology records were reviewed to confirm stage and presence of molecular testing for ALK and EGFR.

RESULTS

Fifty eight (58) patients were identified by the cancer registry. One was deemed ineligible due to histology (carcinoid). Staging could not be determined on one patient. Patients were categorized by stage and year of diagnosis. Presence or absence of ALK/EGFR mutation analysis was confirmed and recorded by stage and year of diagnosis. All data is presented in the table below.

Stage	2016	ALK/EGFR	2017	ALK/EGFR	TOTAL	% TESTED
IA	5	3	3	0	9	33%
IB	4	2	6	3	10	50%
IIA	5	5	2	1	7	86%
IIB	0	0	0	0	0	0%
IIIA	3	2	1	1	4	75%
IIIB	1	1	0	0	1	100%
IV	14	13	11	9	25	88%
Unknown	1	1	0	0	1	100%
Total	33	27	24	14	57	72%

CONCLUSION

The majority of patients with advanced stage NSCLC are tested for ALK and EGFR mutations at the time of diagnosis in accordance with our in house work flow. Three patients with stage IV disease were not tested. Review of their medical records revealed:

1. 71 yr old, molecular testing requested but not performed due to insufficient tissue
2. 89 yr old, elected hospice
3. 85 yr old, elected supportive care

Surprisingly, many patients with early stage NSCLC were also tested. Education is planned regarding the indications for molecular testing. In addition, the 2018 CAP guideline updates for ROS testing will be incorporated into the CMH NSCLC workflow for molecular testing.

REFERENCES

1. Lindeman NI, Cagle PT, Aisner DL et al. Updated molecular testing guideline for the selection of lung cancer patients for treatment with targeted tyrosine kinase inhibitors: guideline from the College of American Pathologists, the International Association for the Study of Lung Cancer, and the Association for Molecular Pathology [published online January 22, 2018]. Arch Pathol Lab Med. doi: 10.5858/arpa.2017-0388-CP
2. Neal I. Lindeman, MD; Philip T. Cagle, MD; Mary Beth Beasley, MD; Dhananjay Arun Chitale, MD; Sanja Dacic, MD, PhD; Giuseppe Giaccone, MD, PhD; Robert Brian Jenkins, MD, PhD; David J. Kwiatkowski, MD, PhD; Juan-Sebastian Saldivar, MD; Jeremy Squire, PhD; Erik Thunnissen, MD, PhD; Marc Ladanyi, MD. Molecular Testing Guideline for Selection of Lung Cancer Patients for EGFR and ALK Tyrosine Kinase Inhibitors. Arch Pathol Lab Med. 2013;137:828–860; doi: 10.5858/ arpa.2012-0720-OA

2018 SITE TABLE

SITE GROUP	TOTAL CASES	CLASS			CLASS			STAGE							
		Analytic	NonAn	Other	M	F	Other	Stage 0	Stage I	Stage II	Stage III	Stage IV	Unknown	Not Applicable	Missing
TOTAL SITES	850	732	117	1	381	466	3	45	242	101	96	96	112	37	3
TONGUE	5	3	2	0	4	1	0	0	1	1	0	0	1	0	0
FLOOR OF MOUTH	1	1	0	0	1	0	0	1	0	0	0	0	0	0	0
TONSIL	2	2	0	0	2	0	0	0	1	0	0	0	1	0	0
ESOPHAGUS	4	4	0	0	4	0	0	0	0	0	0	2	2	0	0
STOMACH	5	4	1	0	2	3	0	0	0	1	0	2	1	0	0
SMALL INTESTINE	4	4	0	0	2	2	0	0	1	0	1	1	0	1	0
COLON	51	44	7	0	26	25	0	0	7	10	5	12	7	2	1
RECTUM & RECTOSIGMOID	15	13	2	0	8	7	0	0	1	2	3	3	3	1	0
LIVER	2	0	2	0	1	0	1	0	0	0	0	0	0	0	0
GALLBLADDER	1	1	0	0	0	1	0	0	0	0	0	0	1	0	0
BILE DUCTS	2	1	1	0	1	1	0	0	1	0	0	0	0	0	0
PANCREAS	11	9	2	0	6	5	0	0	0	0	1	6	1	0	1
LARYNX	2	1	1	0	1	1	0	0	0	1	0	0	0	0	0
LUNG/BRONCHUS-SMALL CELL	7	6	1	0	3	4	0	0	0	0	1	4	1	0	0
LUNG/BRONCHUS-NON SM CELL	58	39	19	0	32	25	1	0	4	2	7	21	5	0	0
HEMERETIC	13	6	7	0	5	8	0	0	0	0	0	2	0	4	0
MYELOMA	2	1	1	0	1	1	0	0	0	0	0	0	0	1	0
OTHER HEMATOPOIETIC	1	1	0	0	1	0	0	0	0	0	0	0	0	1	0
BONE	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0
SOFT TISSUE	2	2	0	0	1	1	0	0	0	0	0	0	0	2	0
MELANOMA OF SKIN	63	63	0	0	36	26	1	20	28	5	2	6	2	0	0
OTHER SKIN CA	5	5	0	0	3	2	0	0	3	0	0	0	1	1	0
BREAST	179	173	6	0	0	179	0	14	93	31	13	5	16	1	0
CERVIX UTERI	19	17	2	0	0	19	0	0	6	3	3	4	1	0	0
CORPUS UTERI	66	65	1	0	0	66	0	0	36	3	12	3	11	0	0
UTERUS NOS	2	2	0	0	0	2	0	0	0	0	0	2	0	0	0
OVARY	21	17	4	0	0	21	0	0	6	0	6	1	3	1	0
VULVA	2	2	0	0	0	2	0	0	1	0	1	0	0	0	0
OTHER FEMALE GENITAL	11	11	0	0	0	11	0	0	0	0	3	2	3	3	0
PROSTATE	150	106	43	1	150	0	0	0	11	28	28	10	28	0	1
TESTIS	8	7	1	0	8	0	0	0	5	0	0	0	2	0	0
PENIS	3	2	1	0	3	0	0	0	1	1	0	0	0	0	0
BLADDER	36	34	2	0	25	11	0	10	9	7	2	2	4	0	0
KIDNEY AND RENAL PELVIS	34	31	3	0	22	12	0	0	11	1	3	3	13	0	0
BRAIN	5	5	0	0	2	3	0	0	0	0	0	0	0	5	0
OTHER NERVOUS SYSTEM	3	3	0	0	2	1	0	0	0	0	0	0	0	3	0
THYROID	15	13	2	0	6	9	0	0	11	1	0	0	1	0	0
OTHER ENDOCRINE	5	4	1	0	0	5	0	0	0	0	0	0	0	4	0
HODGKIN'S DISEASE	2	2	0	0	1	1	0	0	0	2	0	0	0	0	0
NON-HODGKIN'S LYMPHOMA	25	20	5	0	17	8	0	0	4	2	5	5	4	0	0
UNKNOWN OR ILL-DEFINED	7	7	0	0	5	2	0	0	0	0	0	0	0	7	0

2018 Cancer Conferences

The CMH Cancer Program holds Cancer Conference (Tumor Board) once weekly on every Wednesday of the month at noon in the CMH Board room. Continuing Medical Education (CME) credit for physicians, established in 2016, allows all physicians to obtain educational credits when attending. During the cancer conference, specific cases undergo physician review with a multidisciplinary team, thus enabling the physicians coordinating the patient's care to optimize his or her management. Resident physicians are also encouraged to attend and present cases in order advance their education.

THE DISCUSSIONS INCLUDE:

- Reviewing pertinent patient data including history, clinical findings, as well as pathologic and radiographic data.
- Interdisciplinary patient management options based on current standard of care
- References to the national guidelines i.e. NCCN
- Results of completed clinical trials and the relevance to the patient
- Availability of open clinical trials
- Prognostic Markers when available
- Genetic Testing when available
- AJCC staging

After discussion, consensus recommendations regarding the patients' management are made and subsequently implemented by the involved physicians.

During the year 2018, 196 cases were presented at Cancer Conference. These cases comprised a wide range of cancer diagnoses. This total represents approximately 24% of CMH's annual caseload.

In 2018, there were also four educational conferences held. The Cancer Committee is strongly considering pursuing Breast Center Accreditation, which would change the format of the Cancer Conference going forward. In order to be compliant with accreditation standards for breast center specific measures, the conference would have to have at least two breast specific meetings to discuss breast cancer cases and treatment options for those. The committee has also decided to dedicate one conference per month to lung cancer. These changes should take effect in 2020. While our standards and format for case presentation will not change, the ratio of site-specific cancer

Jeffrey Rodnick, M.D
Cancer Conference Coordinator, Cabrillo Radiation

NUMBER OF CASES BY SITE PRESENTED TO THE CMH CANCER CONFERENCE IN 2018

Site	Totals Jan - Dec
Gallbladder	2
Prostate	10
Breast	68
Lung	7
Colon/appendix	12
Skin (SCC)/ (BCC)	21
Uterus/endo	3
Lymphoma- B cell/non and Hodgkin	6
Bladder	4
Kidney	2
Unknown/unclear site	5
Rectum/Anus	6
Salivary/buccal/submandibular	1
Esophagus	1
Soft tissue	3
Cervix	1
Merkel cell	5
Melanoma	25
Liver	2
Pancreas	4
Testicle	1
Meningioma	1
Sarcoma	4
Total	**194**

Oncology Patient Navigation & Social Services

A diagnosis of cancer can be all encompassing in its effect on a person's life. It can affect the emotional, financial and social/resource needs of the patient and their loved ones. If these challenges are not addressed, a patient may face barriers to achieving their treatment protocol and may feel overwhelmed by the challenges they face.

To assist in addressing these and other psychosocial concerns, we provide psychosocial services though the services of a Cancer Center Social Worker. The social workers goal is to help patients, their families and their extended support team starting at diagnosis and continuing through cancer treatment and survivorship.

Lyndsay Heitmann, LCSW
Cancer Program Social Worker

These services look different for each person and are tailored to fit each individual need, but some of the more commonly sought out services are as follows:

- Providing resources and referrals for diverse needs such as financial resources, caregiver resources, housing, transportation etc.
- Providing support groups so patients can hear from and share with others with similar circumstances
- Assisting the patient with adjustment through diagnosis, treatment process and after in survivorship
- Educating patients on communication with their family (especially in age appropriate ways for children) and their medical team
- Providing instruction in the completion of Advanced Healthcare Directives, Five Wishes and POLST forms
- Helping patients apply for insurance, understand their insurance benefits and appeal insurance denials
- Making sure patients are receiving the disability accommodations they are entitled to
- Researching which programs a patient or family member may be eligible for to replace lost income such as FMLA and disability
- Supporting patients who want to go back to work in finding jobs and job training

In 2018, I made contact with 382 new patients and had over follow up contacts with over 1,250 patients and families. I am very proud of the work we do here and consider it a privilege to walk through this journey with so many patients and families.

Palliative Care Services

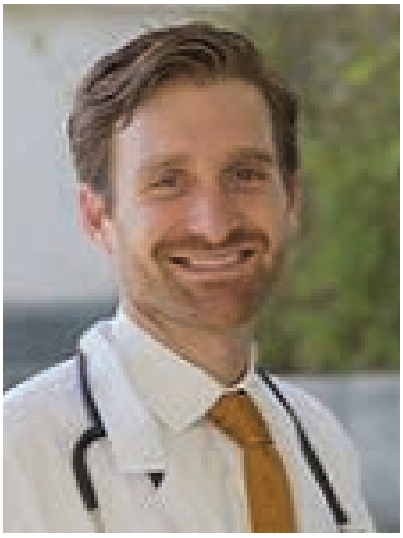
The Palliative Care Services experienced tremendous growth and success over this past year. We have increased our overall inpatient coverage to 5.2 % of all admissions as well as expanding our outpatient service with community physician engagement. The service also has expanded their outreach into the community in multiple avenues including in services, education and participation in local as well as National projects.

Charles Pankratz, M.D.
Medical Director Palliative Care Services

Palliative Care aims to relieve suffering and improve quality of life for patients and their families with advanced illness. Unlike Hospice, Palliative Care can be provided as part of acute care plan, simultaneously with all other treatments. In the inpatient setting, The PC team increased their value to the organization with a direct cost savings totaling $1,699.00 using the Palliative Care Impact Calculator for Direct Cost savings. This cost savings is reflected at the same time as maintaining a patient centered approach to care with Physician and patient/family satisfaction rates of 98% and 94% respectively. Families have also maintained a 94% confidence that they would recommend our service to others.

The outpatient service has seen similar results in excellence focused on patient centered care. The maintained quality of service while focusing on evidence based practice. During this time of expansive growth, we maintained our goal of 100% discussion reflected in completion of advance care planning documents, advance directives and POLST forms.

Diana Jaquez, R.N., OCN, CHPN
Director Palliative Care Services



Colin Scibetta, M.D.
Palliative Care Services

In 2018, we were fortunate to have a new Physician join our team. Dr Colin Scibetta, MD is certified as a diplomate in Hospice and Palliative Medicine. Dr Scibetta has been a welcomed by CMH as he brings a fresh perspective and knowledge base in Palliative Care to improve our approach and innovation in practice.

This year our service goals remain on the Triple Aim of access to care, excellence in service and patient centered cost savings. The Palliative Care team actively participates in community, regional and national projects with data submission as national competencies and goals for excellence in patient outcomes are developed. Many of our team members continue to show their dedication to advancing the specialty as instructors for advance courses in palliative care for Nurse Practitioners and Social Workers through the California State University San Marcos.

We continue to look for new ways to best position the service to meet the needs of our patients and community. In 2018, we have new projects and pilots in the works with new contracts ready for implementation. We have looked beyond the physical building at possible alternative locations that may allow access for those patients that otherwise may not have the chance to receive our care. Early integration into the Oncologist office may allow patients to receive early services with the goal of initiating future care planning. This planning has been seen to lower utilization of unnecessary hospitalizations and ED usage at the end of life as it focuses on honoring patient's goals and wishes for their treatment. We have also initiated a plan to see patients that have been discharges from CMH in the Skilled Nursing facility for continued care planning and expectations of rehabilitation conversations that may clarify goals and decrease the need for unnecessary hospital readmission

The Palliative Care team looks forward to our continued participation in the CMH Cancer Committee. We look toward the future as we strive to integrate Palliative care into the patient centered plan of care. Our sights are on meeting the patients "where they are" as we pilot projects to identify the best process to reach the patients while maintaining quality outcomes.

Cancer Resource Center 2018 Statistics

2018 Patients Served	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2018
INFORMATION AND REFERRALS					
Telephone Requests	Too many to track				0
Walk In Requests	200	366	320	323	1209
Other Assistance (Mandi)	16	9	3		28
New Referrals	183	205	214	195	797
Social Services	326	313	349	290	1278
Patient Navigator	512	472	599	468	2051
Wig/Hat Bank	39	27	40	40	146
Spanish (Calls, Walk ins, One on One)	1	1	6	8	16
EDUCATIONAL SESSIONS					
English					0
Spanish					0
SUPPORT GROUPS/PROGRAMS					
Restorative Yoga	35	40	42	31	148
Level I Yoga - Tuesdays	53	57	58	59	227
Level I Yoga - Fridays	74	70	79	55	278
General Cancer Support Group	93	80	102	54	329
Breast Cancer Support Group	72	86	58	59	275
Reiki	150	135	169	171	625
Reflexology	10	12	10	10	42
Nutritional Consults with Susan Speer	32	34	33	31	130
Head and Neck Cancer Support Group	11	20	11	8	50
Ostomy Support Group	14	17	25	9	65
Look Good Feel Better - ACS		3	1	0	4
Art Class	19	18	15	9	61
National Cancer Survivor's Day Celebration		50			50
Annual Cancer Symposium					0
Auxiliary Member Workshop		18			18
ACS Lunch and Learn			9		9
MONTHLY TOTALS	**1925**	**2111**	**2251**	**1901**	**8188**

Cancer Commitee

The CMH Cancer Committee is comprised of physicians from various specialties, allied healthcare professionals and supportive services professionals. The Committee meets bi-monthly to assess, plan and implement cancer related programs and activities for our community.

The multidisciplinary Cancer Committee is composed of both medical staff members and hospital personnel with a full range of specialty skill sets invoked in the diagnosis, treatment, rehabilitation and support of cancer patients. The committee is responsible for reviewing and maintaining the standards of care for cancer patients at Community Memorial Hospital to meet the accreditation requirements of the American College of Surgeons.

2018 Cancer Committee MEMBERS

LYNN KONG, M.D.
CHAIR, CANCER COMMITTEE
HEMATOLOGY/ONCOLOGY

JEFFREY RODNICK, M.D.
RADIATION ONCOLOGY

NATALIE SANTI, CTR
CANCER REGISTRY

THOMAS FOGEL, M.D.
CANCER LIAISON PHYSICIAN
RADIATION ONCOLOGY

JAMES WOODBURN III, M.D.
GENERAL SURGERY

REVEREND CURTIS HOTCHKISS
SPIRITUAL SERVICES

KEVIN CHANG, M.D., PH.D.
CLINICAL TRIALS COORDINATOR
HEMATOLOGY ONCOLOGY

CLAUDIA STEELE-MAJOR, PT, CT-LANA
REHABILITATION SERVICES

DIANA JAQUEZ, R.N. MSN, OCN
PALLIATIVE CARE SERVICES

IVAN HAYWARD, M.D.
RADIOLOGY

CINDY DEMOTTE
VP QUALITY SERVICES

JODY MCDONALD, R.N.
ONCOLOGY NURSING

BRIAN NADAV, M.D.
RADIOLOGY

JENNIFER GIRTSMAN, R.D.
DIETARY/NUTRITION

CYNTHIA FAHEY, R.N.
VP, NURSING

JAMES HORNSTEIN, M.D.
FAMILY PRACTICE

LYNDSAY HEITMANN, LCSW
SOCIAL SERVICES

DEB LAWRY, R.N.
NURSE NAVIGATOR

CHARLES PANKRATZ, M.D.
PALLIATIVE CARE SERVICES

MANDI POLTL
CANCER PROGRAM MANAGER

GENE DAY, PHARM.D.
PHARMACY

Community Memorial Health System

COMMUNITY MEMORIAL HEALTH SYSTEM
147 North Brent Street | Ventura, California 93003
805/948-5011 | cmhshealth.org

CMH CANCER RESOURCE CENTER
2900 Loma Vista Road, #105 | Ventura, California 93003
805/948-5459 | cmhshealth.org/cancer