The objective of the Bristol Hospital Cancer Program is excellence in oncology patient care.

This commitment to excellence is evident in the continued accreditation of the Bristol Hospital Cancer Program through the American College of Surgeons (ACoS).
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## 2014

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This annual report is produced and published by the Bristol Hospital Cancer Committee in conjunction with the American College of Surgeons (ACoS) Commission on Cancer. Bristol Hospital has received accreditation as a Community Hospital Cancer Program of the ACoS. Bristol Hospital is affiliated with the [Yale-New Haven Cancer Network](#).
CANCER COMMITTEE MEMBERS
2014

PHYSICIANS
Driola Brahaj, MD
Nasima Banerjee, MD
Chris Leary, MD
Allen Currier, MD
Stewart Bober, MD
Joseph Ravalese, MD
Douglas Housman, MD
Sai Varanasi, MD
James Sayre, MD

Chairperson - CoC CLP
Director, Pathology
Diagnostic Radiology
Diagnostic Radiology
Diagnostic Radiology
Radiation Oncology
Radiation Oncology
Beekley Breast Surgery
General Surgery

NON-PHYSICIANS
Mary Ann Cirone, RN, MS
Pauline Miller, MSW, LCSW, ACHP-SW
Kelly Michaud, RN
Candace Willig, RN
Kathy Albano, RN, BSN
Mary Jeanne Pierce, AS, CTR
Cathi Grady
Laurie Pirog, BS
Steve Burke, RPh
Kim Dompier, RD
Tricia Erickson, RD

Operations Manager, CCC
Social Work
Oncology Nurse Navigator
BSN Oncology
Breast Health Navigator
Cancer Registry Coordinator
Cancer Registry
Cancer Registry
Pharmacy Director
Dietician/Nutritionist
Dietician/Nutritionist
**CANCER COMMITTEE MEMBERS 2014**

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<td>Elizabeth Warner</td>
<td>Director of Rehab Services</td>
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<td>Sue Ann Maresca</td>
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<td>Chris Boyle, BAJ</td>
<td>Public Relations/Marketing</td>
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CANCER CONFERENCES 2013

CANCER CONFERENCE COORDINATOR REPORT

A total of 21 Medical Surgical Cancer Conference were convened in 2013.

A total of 75 prospective cases were presented.

The average % attendance:

- Medical Oncology 100.0%
- Radiation Oncology 95.2%
- Surgery 90.4%
- Pathology 100%
- Diagnostic Radiology 90.4%

Twenty two percent (22%) of the analytic caseload was presented, covering ten most frequently diagnosed cancers at Bristol Hospital.

References regarding stage of disease, prognostic indicators, and NCCN guidelines were an important part of the discussions.

If a patient is a candidate for a clinical trial it also is part of the discussion.

Adherence to conference policy is of prime importance.

Referrals to rehabilitation services, psychosocial and palliative care as well as genetic testing and counseling are addressed at The Interdisciplinary Team Meeting.

Analytic cases totaled 338.
35 of total presentations were breast primaries.

PRESENTATIONS
December 13, 2013 - NSC Lung Cancer Presentation by Dr. Driola Brahaj
December 27, 2013 - Head and Neck Cancer Staging Presentation by Dr. Valerie Vitale
As chairperson and liaison physician of our Cancer Committee, I am proud to present our accomplishments for this year and report them to the community.

In October 2012 Bristol Hospital Cancer Program was awarded Three-Year Accreditation with Commendation through 2015 by the Commission on Cancer (CoC) of the American College of Surgeons (ACoS) — a consortium of 42 national professional organizations that reflect the full spectrum of cancer care. The accreditation assures that the program meets the highest national standards for high quality, comprehensive and coordinated cancer care. We are looking forward to new survey of next year and we are working on meeting all the standards that measure and recognize the quality of our multidisciplinary care.

We strive every day to provide our patients with the best oncology care and this mission is realized with the strong collaboration between different disciplines and specialties: medical oncology, radiation oncology, surgery oncology, radiology department, pharmacy, oncology nursing staff and social worker.

All the specialists and the other health care professionals and supportive staff members involved in care of oncology patients continue to meet twice a month in our tumor boards and breast conference, and twice a year in gynecology conferences to discuss the new patients’ cases and the diagnostic and treatment plan. The outcome of the previous cases is discussed as well.

The NCCN guidelines are used during the case discussions and for diagnostic and treatment plans. These conferences provide physician education and at the same time provide excellent clinical care for our patients.

The conferences which emphasize the importance of AJCC staging in treatment of different solid tumors are organized every year.

Our patients are referred to tertiary centers for the consideration of participation in a clinical trial as we strongly believe that the ideal treatment for any patient with newly diagnosed malignancy is the enrollment in a clinical trial.

The team of medical oncologist, nurse navigator, social worker, physical therapist and the dietitian meets every week to discuss the patients’ new oncology diagnosis, the comorbidities, their psychological and social issues and physical therapy needs.

The skilled nursing staff is very involved not only in treatment of oncology patients, but in their education in regard to chemotherapy and targeted agents and their side effects as well.
The continued education of our oncology nurses is ensured by the participation and engaging discussions in Journal Club and the participation in nurses’ oncology Grand Rounds and other educational conferences.

The patient flow and the phone call system is managed very well by our triage nurse, Candice Willig.

The patients are consulted by the nurse navigator, Kelly Michaud and our social worker, Pauline Miller who address the patients’ needs and make their journey of cancer treatment and road to recovery as smooth as possible. The nurse navigator continues a survivorship care plan which guides our patients with the follow up plan after the cancer treatment is completed. The social worker continues to lead the supportive groups for the patients and their caregivers.

The collaboration between cancer center and the pharmacy department is stronger than ever. The members of Program of Process Improvement Task Force continue to meet on regular basis and the safety and easy navigation of chemotherapy template orders and the constant improvement of the format is discussed together with the new policies in administration of drugs.

The Tumor Registry staff continues to track the quality indicators and abstracts all the data of new diagnosed tumors with dedication and consistency. We could not have a successful cancer program without the wonderful work done by the Tumor Registry.

Our cancer program participated in numerous community outreach events including the American Cancer Society’s Relay for Life, which was a very successful one. We are also collaborating with Susan G. Komen foundation to provide of annual screening mammograms for women who are underserved in our community.

The new Beekley Breast Center, led by the new breast surgeon Dr. Sai Varanasi, continues to offer and provide the state-of-art care and treatment in breast disease.

I would very much like to thank the operative manager of our Cancer Center, Mary Ann Cirone for her great and tireless work. Her leadership and her dedication to the cancer program have made this year a very successful one.

I would also like to thank Bristol Hospital Administration for its great support.

Our Cancer Program continues to grow and our clinical and professional staff is committed to providing outstanding care and service to our patients.

Driola Brahaj, M.D.
Physician Study in Colon Cancer 2014

Colorectal cancer is one of the most common cancers worldwide. In the United States, approximately 96,830 new cases of colon cancer and 50,310 deaths (colon and rectal cancers combined) were estimated for 2014.

Surgical resection is the treatment of choice for patients with locally confined disease. Outcome prediction based on tumor stage, reflected by the American Joint Committee on Cancer, is currently regarded as the strongest prognostic parameter. Adjuvant treatment with chemotherapy, which is primarily based on 5-fluorouracil, has decreased tumor recurrence in AJCC Stage III patients, while neo-adjuvant chemotherapy and total mesorectal excision have improved local control in patients with rectal cancer. The indication for treatment with adjuvant therapy is mainly guided by the presence of regional lymph node metastasis.

The American Joint Committee on Cancer (AJCC) and a National Cancer Institute–sponsored panel recommend that at least 12 lymph nodes be examined in patients with colon and rectal cancer to confirm the absence of nodal involvement by tumor. This recommendation takes into consideration that the number of lymph nodes examined is a reflection of the aggressiveness of lymphovascular mesenteric dissection at the time of surgical resection and the pathologic identification of nodes in the specimen. Retrospective studies have demonstrated that the number of lymph nodes examined in colon and rectal surgery is associated with patient treatment decision and patient outcome.

A problem that was identified by the surveyor of American College of Surgeons on our last survey was that the number of dissected lymph nodes were not being adequately sampled in our cases of colorectal cancer.

We reviewed 45 cases (randomly chosen) of colorectal cancer diagnosed and treated in our institution from 2012 to 2014 to determine number of lymph nodes removed.

One case resulted to be Carcinoid Tumor of Rectum which was removed during the colonoscopy and another case resulted to be Carcinoid of Appendix for management of which the patient had appendectomy.

Seven cases resulted in Rectal Adenocarcinoma (including early stage and metastatic disease) and thirty-six cases resulted in Colon Adenocarcinoma.

Four patients with the diagnosis of colo-rectal cancer did not follow up with our surgical team.
One patient underwent removal of focal invasive carcinoma in a tubular adenoma during the colonoscopy and another patient underwent complete removal of rectal tumor via transanal excision.

Ten patients did not have surgical treatment as they were diagnosed with unresectable Stage IV Colo-Rectal Adenocarcinoma.

Of the twenty-eight patients who underwent surgical treatment at Bristol Hospital (including three patient with metastatic disease who had palliative and/or curative intent surgical resection), only in one case was noted that 7 lymph nodes were dissected; in one case 12 lymph nodes were dissected and in the other 26 patients more than 12 Lymph nodes were dissected.

We were compliant with AJCC recommendations for lymph node examination in Colo-Rectal Cancer in all studied cases except one case where surgery was limited due to the small excision size.

We also looked at the period of time from the curative surgical treatment to initiation of adjuvant systemic chemotherapy (and/or radiation therapy) considering the impact that this has on patients.

Most clinical trials mandate that adjuvant systemic chemotherapy is started within 6 to 8 weeks after surgery. Timely access to adjuvant treatment is often cited and tracked as a quality indicator. Furthermore, beyond a certain time frame from surgery, such as the often quoted 12 weeks, it is uncertain whether the adjuvant benefit diminishes or is even lost entirely.

In a meta-analysis (JAMA; June 8, 2011, Vol 305 No.22) of the available literature on time to AC, longer time to AC was associated with worse survival among patients with resected colorectal cancer.

Of the twenty-five patients who underwent curative surgical treatment, two resulted to have Stage 0 (Tis; N0); three had Stage I disease; thirteen had Stage II disease and seven had Stage III (IIIA –IIIC) disease.

Two patients with Stage II disease were treated with adjuvant chemotherapy (based on NCCN guidelines risk factors) and six patients with Stage III were treated with adjuvant chemotherapy (one patient was lost to follow up after the curative surgical treatment).
All the patients who received adjuvant systemic therapy started it within 8 weeks (range from 4- weeks) except one patient (age 79 years old) who started it within 12 weeks from the curative surgical treatment.

In summary, the diagnosis and treatment of colo-rectal cancer in our institution is done according to AJCC recommendations and NCCN guidelines.

Respectfully submitted by Dr. Driola Brahaj and Dr. Nasima Banerjee.
Randomly Selected Bristol Hospital Colorectal Patients Treated and Diagnosed at Bristol Hospital Reviewed to Determine Number of Lymph Nodes Removed

- No surgical resection (17 patients)
- More than 12 lymph nodes dissected (25 patients)
- 12 lymph nodes dissected (1 patient)
- 7 lymph nodes dissected (1 patient) Fewer than 12 lymph nodes removed due to small incision size
QUALITY IMPROVEMENT
CANCER CENTER PROGRAM INITIATIVES
2014

The Cancer Care Center at Bristol Hospital has continued to serve the community offering consultative visits, second opinions and varied oncology services along with treatments that follow national guidelines and benchmarks. The Cancer Care Center also has a robust hematology practice.

The entire team is focused on making the patient and family experience more personal and is behind each patient every step of the way from our oncologists, oncology nurses, Nurse Navigator, Social Worker, Financial Assistance Counselor, to our support services and free events and support groups. The Cancer Care Center Physicians will make every attempt to schedule with any member of our community as expeditiously as possible.

The Cancer Care Center has had an exciting year developing new studies and enhancing quality services. The team recognized that the laboratory turnaround time was excessive with up to a 55 minute wait time for blood lab results prior to infusions. An extensive literature search was initiated and supporting clinical evidence-based medicine was found that patient satisfaction significantly increases with decreased turnaround time also known in literature as TAT. With exceptional help and enthusiasm from our laboratory services, we as a team, implemented a new service that has decreased the lab wait time to under 20 minutes and we give a tremendous thank you to all those who supported this effort.

Also, Pauline Miller LCSW, MSW has conducted at the time of consult, an interview reviewing the Distress Assessment. The staff at the Cancer Care Center during multiple meetings decided to put in place a “consult team”. Each new patient sees not only the physician but the oncology nurse navigator, the social worker, and the triage nurse.

With this team implemented, we have seen 100% success for each new patient being assessed with a Distress Assessment mandated by the NCCN for January 2015. We have kept data for over 12 months to accomplish this goal.

Also another quality goal initiative was to discuss with patients at the time of consult, challenging topics such as living will and advanced directives. This data has been monitored monthly for the same time frame and we have reached 100% for the last two months of 2014. The Advanced Directive is discussed by our triage nurse and a note is entered into the electronic medical record. Also being conducted weekly after initial consults are multidisciplinary team meetings every Tuesday. Presented are new patients or patients who may need additional discussion for treatment evaluation and supportive care.
The consultation project and treatment continuum plan was entered into the Magnet Project Document submitted by Bristol Hospital. Representatives from a number of disciplines attend.

The Cancer Care Center has updated all policies and procedures and has had all medication related policies approved by the Pharmacy and Therapeutics Committee. The Cancer Committee also reviewed additional policies this year. All the updated Cancer Care Center policies are located on the Bristol Hospital Intranet site.

A tremendous amount of work has been accomplished by each member of the team including our new social worker, Pauline Miller, the Cancer Registry staff, nurse navigator, clinical and non-clinical staff. Everyone plays a huge role in both helping patients and families with the process of diagnosis and treatment to discharge. It is truly extraordinary to see and measure quality outcomes along with measuring what team work can accomplish.

Respectfully submitted,

Mary Ann Cirone, RN., MS
Operations Manager
Cancer Care Center.
The Bristol Hospital Cancer Registry maintains a computerized database on all cancer cases that have been diagnosed and/or treated at this facility since its reference date of January, 1981. It is the function of the registry to identify, collect, analyze and store, each cancer diagnosis, in a sophisticated password protected database.

The data elements collected, such as primary site, histology, prognostic indicators, and clinical staging are all factors contributing to the patient’s treatment plan. All patients are provided with annual lifetime follow-up per state statute. Complete confidentiality of all medical information is maintained in compliance with HIPAA guidelines (the Health Insurance Portability and Accountability Act) and hospital confidentiality recommendations. The data is submitted quarterly to the Connecticut State Central Registry per state statute, whereby it is shared with SEER (Surveillance Epidemiology End Results), and the National Cancer Institute (NCI) where all national statistical data is compiled making it easily accessible to medical professionals and researchers throughout the world.

Annually the data is submitted to the National Cancer Data Base (NCDB) and the American Cancer Society (ACS) in compliance with the American College of Surgeons (ACoS) Commission on Cancer (CoC) requirements for an accredited Community Cancer Program (CCP). Data analysis is provided to physicians upon request.

The data is edited daily utilizing North American Association of Central Cancer Registries (NAACCR) extended edits as well as Gen Edits and routine visual and quality checks performed by staff physicians, all of which help to maintain high integrity of the data.

Information gathered from these records is valuable to researchers in determining who is at risk for certain cancers, what behaviors put people at risk, and what treatments are most successful.

Analysis of this data is crucial in our search for prevention, control, and new treatment modalities, and helps us to educate the public on ways to protect themselves from the disease.

Since the 1981 reference date, the Bristol Hospital Cancer Registry has accessioned 11,927 cases, 8,647 analytical cases. In 2013, 409 cases were accessioned of which 340 were analytic. Analytic cases are diagnosed at the accessioning facility and/or administered first course treatment after the registry’s reference date. Nonanalytic cases are patients who have been diagnosed elsewhere who present now at Bristol Hospital for treatment with recurrent or metastatic disease. The registry is presently following 2,421 cases.

The five most commonly diagnosed Primary Sites at Bristol Hospital were: Breast (79); Lung (52); Prostate (49), Hematopoietic & Lymphoid (49) and Colo/rectal (40).

Review of the Cancer Registry data noted 5 cases received no treatment of primary site. Two of these cases were ill defined sites, one case with 2 primaries (treatment for most aggressive cancer), one site diagnosed on CT scan only (patient wanted no treatment), and one
skin site no primary tumor treated lymph nodes only.

The Cancer Registry also reviewed class of case 00 (those cases who went elsewhere for treatment) total 23 cases. Primary site, why patient went elsewhere and where treatment was given was reviewed.

The Cancer Registry is maintaining 93% follow-up rate from reference year and a 98% follow-up rate for the last 5 years and 90% abstracting of cases within the six month time frame. Education is a prime importance for members of the cancer registry and training of non-CTR staff is ongoing.

The Cancer Registry hired a new member (Laurie Pirog) in April 2014. Laurie Pirog and Cathi Grady are being trained to become CTR’s. Cathi Grady is to be commended for the excellent job she does in maintaining our follow-up rates, minutes for the Cancer Committee, documentation of Tumor Boards and in training Laurie Pirog. The Cancer Registry staff also maintains other areas of the cancer program for accreditation. A certified cancer registrar is on staff from a consulting firm (Himagine Solutions).

The Cancer Center at Bristol Hospital will be surveyed for re-accreditation by the Commission on Cancer in October 2015.

Please see the following graphs of 2013 Cancer Registry Data.

Mary Jeanne Pierce, AS, CTR
Cancer Registrar
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<thead>
<tr>
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* Includes 1 or more lymphoma cases coded to non-lymphatic site.

Note: CIN III & Ca In-situ are no longer reportable

Abbreviations: Analytic N/A=Non-Analytic 0=Stage 0 I=Stage 1 II=Stage 2 III=Stage 3 IV=Stage 4 NA=Not applicable UNK=Unknown
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Range: 25 to 95
Mean: 65
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<tr>
<th></th>
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<th>Local</th>
<th>Dir Ext</th>
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<th>Both</th>
<th>NOS</th>
<th>Dis</th>
<th>Unk</th>
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<td>9</td>
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<td>72</td>
<td>61</td>
<td>50</td>
<td>20</td>
<td>202</td>
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</table>

S=Surgery  R=Radiation  C=Chemotherapy  H=Hormone  I=Immunotherapy  O=Other

General Summary Stage 2013

**Treatment Entire First Course**

There are several different first courses of treatment. These are the most common treatment modalities used in this hospital in 2013.
**General Summary Stage**

General summary stage is the extent of disease (SEER) which is done for all primary sites with the exception of unknown primaries.

2013 Clinical AJCC Staging

Clinical AJCC staging uses TNM system for most cancer sites in the staging process. Not all primary sites are staged using this method: for example, leukemia and multiple myeloma are systemic forms of cancer and would be staged by SEER extent of disease.

This method of staging is preferred by the American College of Surgeons (ACOS).
## BRISTOL HOSPITAL CANCER CARE CENTER
### TOP TEN SITES BY SEX
#### 2013

<table>
<thead>
<tr>
<th></th>
<th>Stomach</th>
<th>Colon</th>
<th>Rectum</th>
<th>Bronchus &amp; Lung</th>
<th>Hematopoietic &amp; Reticuloendo System</th>
<th>Skin</th>
<th>Breast</th>
<th>Prostate Gland</th>
<th>Bladder</th>
<th>Lymph Nodes</th>
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<td>4</td>
<td>13</td>
<td>9</td>
<td>19</td>
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<td>49</td>
<td>18</td>
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<td>151</td>
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<td>8.61</td>
<td>5.96</td>
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<td>9.93</td>
<td>0.66</td>
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<td>11.92</td>
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<td>78</td>
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<td>19.08</td>
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<td>32</td>
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<td>79</td>
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<td>17.7%</td>
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<tr>
<td>Total</td>
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<td>27.9%</td>
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![Bar chart showing the top ten sites by sex and count (N).](image-url)
## CANCER REGISTRY 2014

### Cancer Statistics, 2014

#### Estimated New Cases*

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<th></th>
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<th>Females</th>
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<tbody>
<tr>
<td>Prostate</td>
<td>233,000</td>
<td>Breast</td>
</tr>
<tr>
<td>Lung &amp; bronchus</td>
<td>116,000</td>
<td>Lung &amp; bronchus</td>
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<tr>
<td>Colorectum</td>
<td>71,830</td>
<td>Colorectum</td>
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<td>Urinary bladder</td>
<td>56,390</td>
<td>Uterine corpus</td>
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<td>Melanoma of the skin</td>
<td>43,890</td>
<td>Thyroid</td>
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<td>Kidney &amp; renal pelvis</td>
<td>39,140</td>
<td>Non-Hodgkin lymphoma</td>
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<tr>
<td>Non-Hodgkin lymphoma</td>
<td>38,270</td>
<td>Melanoma of the skin</td>
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<tr>
<td>Oral cavity &amp; pharynx</td>
<td>30,220</td>
<td>Kidney &amp; renal pelvis</td>
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<tr>
<td>Leukemia</td>
<td>30,100</td>
<td>Pancreas</td>
</tr>
<tr>
<td>Liver &amp; intrahepatic bile duct</td>
<td>24,600</td>
<td>Leukemia</td>
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<tr>
<td><strong>All Sites</strong></td>
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#### Estimated Deaths

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<td>86,930</td>
<td>Lung &amp; bronchus</td>
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<td>Colorectum</td>
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<td>Colorectum</td>
</tr>
<tr>
<td>Pancreas</td>
<td>20,170</td>
<td>Pancreas</td>
</tr>
<tr>
<td>Liver &amp; intrahepatic bile duct</td>
<td>15,870</td>
<td>Ovary</td>
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<td>Leukemia</td>
<td>14,040</td>
<td>Leukemia</td>
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<td>Esophagus</td>
<td>12,450</td>
<td>Uterine corpus</td>
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<td>Urinary bladder</td>
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<td>Non-Hodgkin lymphoma</td>
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<tr>
<td>Non-Hodgkin lymphoma</td>
<td>10,470</td>
<td>Liver &amp; intrahepatic bile duct</td>
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<tr>
<td>Kidney &amp; renal pelvis</td>
<td>8,900</td>
<td>Brain &amp; other nervous system</td>
</tr>
<tr>
<td><strong>All Sites</strong></td>
<td><strong>310,010</strong></td>
<td>All Sites</td>
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</table>

#### Ten Leading Cancer Types for the Estimated New Cancer Cases and Deaths by Sex, United States, 2014.

*Estimates are rounded to the nearest 10 and exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.

Source: CA - A Cancer Journal for Clinicians
BRISTOL HOSPITAL CANCER CARE CENTER
NUMBER OF CASES DIAGNOSED
YEARS 1981-2014
In 2013, the Bristol Radiation Oncology Centers saw a total of 120 patients in consultation. This represented no change in the patient volume as compared to 2012. A total of 2485 radiation treatments were administered during 2013 with an average of 9 patients treated on a daily basis. These numbers reflect approximately a 2% decrease in utilization compared to 2012.

In 2013, the brachytherapy program for prostate cancer at the Bristol Hospital campus, with its continued partnership of Oncology Med, Inc. (OMI), Bristol Urologic Associates and Bristol Radiation Oncology Center, treated a total of 4 patients (Iodine-125 radioactive isotopes). All implants were of “good quality” ($D_{90} \geq 80\%$) with the $D_{90}$ (the dose as a percentage of the prescription dose that covers 90% of the prostate volume) of 85% or greater. Unfortunately, Oncology Med, Inc. (OMI) sent notice November 6, 2013, that it will cease to provide brachytherapy services as of December 1, 2013. In 2014, the Bristol Radiation Oncology Center in conjunction with Bristol Hospital and Bristol Urologic Associates was able to provide continued prostate brachytherapy services for our community. (Details to be provided in the 2014 annual report)

The Quality Assurance Program in Radiation Oncology continued with monthly chart reviews of patients treated. These reviews were conducted by the radiation oncology physicians and staff. During 2013, a total of 118 radiation charts were reviewed and 99% of them met the 11 quality indicators.

The Bristol Radiation Oncology Center modernized its information technology with RadCalc® software by LifeLine Software, Inc. This provides fully automated independent dosimetric validation calculations for conventional and Intensity Modulated Radiation Therapy (IMRT) treatment planning systems. As a result of the Harold Leever Regional Cancer Center changing from Eclipse to Pinnacle 9.6 Treatment Planning System (TPS), Treatment Planning System Validation for the Bristol Radiation Oncology Center was required. This was completed successfully on October 21, 2013.

Respectfully submitted,

Joseph Ravalese III, M.D.
All Bristol Hospital Laboratory staff and members of Department of Pathology provided dedicated services for all Oncology patients. All pathologists were committed to coordinate care of patients by communication with physicians and other hospital/office-based healthcare providers. In April 2014, the lab was moved to a completely renovated, new location on Level D with significantly increased efficiency. All measures were taken to assure uninterrupted testing. Post-move validations were well planned. Further, turnaround time for many tests was significantly reduced as these tests were brought in house.

In 2013, the lab was re-inspected by the State of Connecticut Department of Public Health following relocation. Further, a full day inspection was performed by out-of-state inspectors representing the College of American Pathologists. Both these inspections were successful and re-licensure and full accreditation of the lab was granted.

In 2013, the External Proficiency Testing results showed greater than 99% accuracy including Anatomic Pathology and Clinical Laboratory Tests.

Dr.’s Normandin and Mandavilli coordinated all multidisciplinary tumor conferences to assure prospective review of cancer cases of all body sites, as required by the Commission on Cancer.

Dr. Curran provided strict surveillance for all blood transfusions. Dr. Curran as the Chairperson of the Blood Transfusion Committee and all members of this Committee were successful in significantly reducing the number of blood transfusions.

Supervision and continuing education for quality of tests in all Anatomic and Clinical Laboratory Sections was provided by the College of American Pathologists (includes subspecialty Board Certification in Cytopathology and Hematology).

Malignancies were diagnosed and reported according to the current and recognized standards provided by the College of American Pathologists, World Health Organization, American Joint Commission on Cancer (AJCC) and the International Federation of Gynecologists and Obstetricians.

All initial diagnoses of malignancy on biopsies were confirmed by review of tissue sections by a second pathologist. Pertinent breast core biopsies and any unusual/interesting cases were also reviewed by a second pathologist. Randomly selected negative cases were reviewed to screen for false negative cases. Policies were followed to assure receipt of reports of malignant cases at the time of initial diagnosis. Cytology/Histology correlation was excellent.
The average turn-around-time for surgical pathology cases was 1 to 2 days for greater than 90% of cases. In house interpretation of flow cytometry, molecular tests and fluorescent in situ hybridization tests were continued successfully by pathologists. Surveillance was provided for hematology/oncology cases in order to assure appropriate utilization of tests.

All members of the Department of Pathology appreciate the interactive working relationship amongst other departments at Bristol Hospital and affiliated organizations. It was a pleasure to provide services to patients, physicians and other health care providers of the community.

Respectfully Submitted:
Nasima Banerjee M.D. 3/24/14
Kim Dompier MS, RD, CD-N

Report for Outpatient Oncology
Clinical Nutrition Services 2014
Prepared September 2014

- Nutrition consults were generated by PCAs, RNs, MDs and inpatient RDs.

- Nutrition counseling from BH Registered Dietitians is provided as a complementary service for Cancer Care Center (CCC) patients.

- Patient counseling for CCC patients was provided on-site, in the Radiation Oncology office and via phone for patient convenience.

- Inpatient RDs continued to assess and counsel CCC patients in the acute care setting and coordinate follow-up care as indicated with the outpatient CCC RD.

### Patient Contact Summary

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<th># of RD Contacts</th>
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<tbody>
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<td>2013</td>
<td>84</td>
</tr>
<tr>
<td>2012</td>
<td>146</td>
</tr>
<tr>
<td>2011</td>
<td>71</td>
</tr>
<tr>
<td>2010</td>
<td>42</td>
</tr>
</tbody>
</table>

RD CCC Interventions:

- Attended weekly CCC multidisciplinary rounds

- Attended quarterly Cancer Committee meetings

- Maintained supply of a variety nutrition supplement for patient samples.

- Educated Radiation Oncology staff on services for home tube feeding.

- Provided nutrition literature for CCC Cancer Survivor Day.

KD -9/14
**INTRODUCTION:**

2013 was a very busy year for the Hospice program of Bristol Hospital. Hospice experienced turnover in staffing which resulted in recruitment of a stronger, more experienced team of professionals. Referrals to the hospice program continue to come from Bristol Hospital, the Bristol Hospital Cancer Center, community physicians and skilled nursing facilities. The majority of patients were served in their own home but hospice services were also provided in skilled nursing facilities or very short term as an inpatient at Bristol Hospital. Special Touch patients were also served by the hospice team and many of them transitioned to the hospice program. The following is a summary and analysis of care and services provided over the past year.

**ACCOMPLISHMENTS:**

The managers and staff of the Hospice program are proud of their many accomplishments of 2012 including (but not limited to):

- **The recruitment of highly qualified, compassionate staff:**
  
  In 2013, we had the second year of significant turnover of the hospice nurses which impacts the program directly. The positive note is one hospice nurse returned after a one year absence and another nurse was hired from an inpatient oncology unit. An additional hospice nurse position was added and all three positions have been filled and the staffs have been with the program for more than six months and still going strong. The Agency does recognize the stress and burnout of nurses caring for patients and families at the end of life and we have revamped the program to offer more support and smaller caseloads.

- **Service of Remembrance** - The annual service of remembrance was held in May 2013 and had a very nice turnout. This service offers family, friends and members of the community an opportunity to reflect on their loved ones life and death in a supportive environment. A power point photo presentation was played during the presentation. Approximately 50 attendees were present at the event.

- **Lights of Love** - The annual “Lights of Love event” was a dinner held at Nuchi’s in December 2013. This event has been successful in raising funds that help to support the uninsured and/or under insured hospice and special touch patients. These funds are also used to provide extra services such as meals, financial assistance, alternative therapies, bereavement support and other items to Hospice families.
Support Groups: Ongoing groups are offered at eight week intervals throughout the year with good attendance and feedback.

Community Education: The community was educated through in-services that were provided at various facilities and throughout the hospital.

Clinical Education: Annual Hospice education is provided to inpatient staff as well as to local skilled nursing facilities. This was well attended and received very favorable feedback.

Committee Involvement: Hospice was represented on many hospital committees including Quality, Safety, Ethics, Emergency Preparedness, Infection Control, JCAHO, and Fall Prevention and Med reconciliation. Department specific committees include utilization review, clinical record review, and therapy and clinician interdisciplinary meetings.

JCAHO survey: Preparation for the next survey is ongoing and includes committee work, chart review, policy review and education to the staff such as a review of the National Patient Safety goals. Feedback from the surveyor was incorporated into the clinical practice specifically addressing infection control, oxygen safety, and the bereavement risk tool and benchmarking the hospice quality data.

QUALITY PROGRAM:

The quality committee has integrated the Hospice QAPI requirements into the program. The hospice program continues to participate in a National quality study and benchmarks against the national database through the National Hospice and Palliative Care organization. The quality study for 2013 was management of pain symptoms within 48 hours. The results in 2013 were close to 100% for each quarter measured. Hospice patient satisfaction surveys continue to be very positive. Currently the hospice patient satisfaction is conducted by mailing a survey to the bereaved families. Starting in 2015, Strategic Healthcare Programs (SHP) will administer the surveys per Medicare requirements.

OBQI/OBQM – Outcome audits obtained from the OASIS data (for our palliative care program as part of the home care) we send to the State is analyzed and any adverse events are reviewed for opportunities to improve. These State reports are a retrospective review of care already provided. A particular focus has been on falls, wound infections, and development of UTI’s. The Agency has a contract with Strategic Healthcare Programs for outcomes and benchmarking reports allows drill down to specific patients, services and providers.
**PROGRAM EVALUATION:**

The hospice program was reviewed by the Professional Advisory Committee at the semi-annual meetings. (see PAC minutes.) The Hospice program provided care to 286 patients in 2012. The program provided 4,084 patient days at the routine level of care, 211 inpatient days and we provided 24 hours of continuous care at home.

**DOCUMENTATION OF CLINICAL COMPETENCE**

- Criteria-based position descriptions are reviewed annually and revised as necessary.
- Performance-based performance appraisals, including self-evaluations, and observation of staff on patient home care visits, were completed on each staff member on their anniversary date annually.
- Performance evaluations, performance improvement activities, as well as aggregated data from completed competency skills checklists helped to identify the educational needs of the department.
- Educational Offerings this year included (but is not limited to) Health Stream computerized education system for completion of mandatory education requirements.
- Hospice training was provided for hospital, home care, and long-term care staff. There was also education provided at IDT, classes were held on pain management, OASIS documentation and diagnosis coding.
- Classes were attended at the CT Council for Hospice and Palliative Care Conference, Home Run (Information Services) Update, CAHC for updates on Medicare and Home Health Care, KCI for Wound Vac system, and other topics, Home Health Aide offerings include all the mentioned as well as HHA specific topics.

**PROCESS AND OUTCOME AUDITS:**

Quarterly process and outcome audits were performed per State regulations (Home Care and Hospice combined). See Home Care Annual Report 2013 for quarterly results.

**FINANCIAL REVIEW:**

Hospice reimbursement is based on specifically defined levels of care. The majority of patients were served at the routine level of care either at home or in a skilled nursing facility. The in-patient level of care is utilized when the patient’s condition is unstable and requires closer monitoring. General
inpatient days were less than 10% of the days on hospice services. Medicare regulations state that no more than 20% of total days may be general inpatient or respite. Medicare was the primary payer followed by commercial health plans for the hospice patients. Palliative care patients are seen under the home care program (see homecare annual report statistics).

The Hospice program serving the dually eligible patients provided services including room and board at all local skilled nursing facilities. The reimbursement for room and board is funded by Medicaid and then hospice in turn reimburses the facility. The reimbursement for hospice services which includes clinical services, medications and DME is primarily paid for by Medicare. This pass through of funds allows for clients to enroll in hospice and utilize both the Medicare and Medicaid funds available.

Donations to the Hospice program go to the Development fund and are accessed for patients who are uninsured or under insured. Funds were used to provide direct patient care, meals for hospice families, and community education as well as to provide non-traditional alternative treatments for comfort measures i.e. massage therapy.

TOWNS SERVED:

Clients were serviced in their homes in the following towns:

- Bristol
- Farmington
- Forestville
- Harwinton
- Terryville
- Thomaston
- Burlington
- Plymouth
- Southington
- New Britain
- Plainville
- Unionville
- Wolcott

Demographics:

Clients are primarily English speaking, Caucasian, average age is between 75-85 years old, approximately 55% are referred by Bristol Hospital which is an increase from 2012 and the remainder is referred by other hospitals, physicians’ offices, skilled facilities and other community entities. The most common admission diagnoses were malignant neoplasm primarily with lung cancer followed by end stage heart failure. Approximately 53% of patients admitted to the Hospice program had a cancer diagnosis. Patients with non-cancer diagnoses most commonly had respiratory failure, end stage Alzheimer’s or dementia, cardiac disease or neurological disorders. This hospice program will continue to educate the community in the benefits of hospice for patients of any age with a life limiting condition.

More females (63%) are admitted to the agency than men; most patients live with a competent
caregiver, require some or no assist for ambulation and are discharged from the agency due to improvement in condition. The majority of patients are discharged with their condition improved and goals met.

**Goals Achieved in 2013**

- Recruitment and retention of professional staff
  1. Provided education and training to new staff using CAHC resources
  2. Evaluated software to improve assessment tools for clinicians
  3. Added additional staff as needed to meet program needs

- Increased referrals from Bristol Hospital and the community
  a. Continued development of liaison nurses to work with both internal and external referral sources
  b. Ongoing education and bereavement support in the community

- Sustained growth in Hospice Census
  1. Utilized liaison staff to increase visibility of Hospice program
  2. Provided educational events in the community

Respectfully Submitted,

Ann S. Burch, R.N., M.A.
Director of Clinical Operations
Bristol Hospital Home Care and Hospice
Library Services works to locate and provide knowledge-based information to physicians, nurses, the cancer program leadership, tumor registry personnel, social workers, other health care personnel, and patients. Information provided supports diagnosis, therapy decisions, and overall patient care and well-being. Library Services staff collect current oncology resources, provide oncology-related information services, and maintain positive ongoing professional relations with the rest of the health care team.

The Health Sciences Library is open to patients and the community and holds current texts both for general cancer medicine and for multiple specialties. Oncology journals provide access to information on new developments in the field. For cancer patients, a consumer health collection located in the library offers books for borrowing, and staff is ready to assist with online searching. There is also a brochure (see next page) designed for patients and the community which details the accessibility of the library to all.

Literature searches are conducted on all topics requested by all other members of the health care team. Information is obtained both online and from in-house resources. Articles unavailable through the hospital collection are obtained via an international electronic interlibrary loan system. Bibliographies may be compiled for specific conferences or other educational events sponsored by the Center.

The Library Services department is staffed by a librarian, masters-prepared in library science and has earned membership status in the Academy of Health Information Professionals.

Lori Bradshaw, MSLIS, AHIP
Library Services
Brochure for Cancer Resources
(Outside and inside of bifold)

Using Bristol Hospital Library Services, you can:

- Learn how to improve health through better nutrition.
- Look up recommended treatments for specific conditions.
- Find out about support organizations.
- Use materials written in non-technical language.
- Locate medical information on top Internet websites.

Bristol Hospital Library Services
41 Brewster Road
P.O. Box 977
Bristol, CT 06010
860-585-3239

"May anyone use the library at Bristol Hospital?"

Yes. Just call 860-585-3239 and leave a message. Or send an email message to BHlibrary@bristolhospital.org. A friendly library staff member will return your call, arrange a convenient time for you to visit, and help you find information on your topic.

"What kind of information is available?"

There are up-to-date books and professional journals used regularly by hospital doctors, nurses, counselors, and other caregivers. Visitors are invited to use all of the materials in the library. In addition, there is a collection of books chosen especially for health care consumers. These consumer health books may be checked out.

"I am writing a paper for school. May I do research at the library?"

Yes. Library staff will be happy to help you find appropriate materials and provide you with a quiet place for study.

"What about computers?"

Computer workstations are freely available, supplying you with Internet access and standard desktop applications.

Location of Bristol Hospital Library Services

The Library Services department is on Level D of Building 3 of the hospital. It can be reached by taking a main hospital elevator to Level E and following the signs. The library is conveniently located near the Medical Office Building on 25 Newell Road and can be reached from that entrance, as well.

Library Hours

Call 860-585-3239 for hours.

Library Staff

A masters-prepared librarian with additional training in medical librarianship directs Library Services. You will be given courteous help in finding the information you need.
Eligibility Requirements:

E9: Clinical Trial Information
- Society Clinical Trials Matching Service information is shared with patients per their request.
- Society resources available for patients include Exploring the Options: Clinical Trials video, Is a Cancer Treatment Clinical Trial the Right Choice for Me? brochure, Clinical Trials Matching Service flyer, Clinical Trials Matching Service poster, and Clinical Trials: What You Need to Know guide.
- Society resources available for clinicians include Raising Awareness About Clinical Trials: A Video for Clinicians video and Referring Your Patient To a Clinical Trial brochure.

E10: Psychosocial Services

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>NUMBER OF REFERRALS January – October 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of patients served and provided with information</td>
<td>8</td>
</tr>
<tr>
<td>Look Good ...Feel Better participants</td>
<td>10</td>
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</table>

Look Good Feel Better Detail for 2014(LGFB)

<table>
<thead>
<tr>
<th>MONTH</th>
<th># PARTICIPANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>JANUARY</td>
<td>3</td>
</tr>
<tr>
<td>MARCH</td>
<td>3</td>
</tr>
<tr>
<td>MAY</td>
<td>Cancelled</td>
</tr>
<tr>
<td>JULY</td>
<td>2</td>
</tr>
<tr>
<td>OCTOBER</td>
<td>2</td>
</tr>
<tr>
<td>NOVEMBER</td>
<td>0 (participants were no-shows)</td>
</tr>
<tr>
<td>TOTAL FOR 2014:</td>
<td>10</td>
</tr>
</tbody>
</table>

E12: Nutrition Services
- Society Nutrition for the Person With Cancer During Treatment: A Guide for Patients and Families provided to patients upon request.
Program Management Standards:

Standard 1.8: Monitoring Community Outreach
- Society staff partner can help the community outreach coordinator network and connect with other community organizations involved in outreach efforts and documenting joint initiatives.

Standard 1.9: Clinical Trial Accrual
- Society resources noted previously for E9: Clinical Trials Information also support accruals to clinical trials.

Standard 2.3: Risk Assessment & Genetic Counseling
- Society resources include Genetic Testing: What You Need to Know guide and Heredity and Cancer booklet.
- Patients may also call The ACS 800# to speak with a Cancer Information Specialist and learn more about genetic testing.

Standard 2.4: Palliative Care Services
- Society website (cancer.org) contains 70,000+ cancer-related resources and supportive services available from the Society, local, and national organizations.
- Website includes information on various physical side effects that can be caused by different cancer treatments. You will also find information on different feelings people with cancer commonly experience during and after treatment, as well as suggestions for healthy ways to deal with these common feelings.
- The book Caring for the Patient with Cancer at Home is also available to patients and their caregivers.
- Our easy-to-read Getting Help tear-sheet series cover a variety of cancer treatment side effects and are available in English and Spanish.
- Other Society resources include When the Focus is on Care: Palliative Care and Cancer book, Cancer-Related Pain: A Guide for Patients and Caregivers guide, Pain Control: A Guide for Those With Cancer and Their Loves Ones guide, patient/caregiver communication worksheets (Pain Diary, Chemotherapy Side Effects, Radiation Side Effects), and I Can Cope online classes (Managing the Effects of Illness and Treatment, Managing Cancer-related Fatigue, Relieving Cancer Pain, Communicating Concerns and Feelings).

Continuum of Care Standards:

Standard 3.1: Patient Navigation Process
- Reach to Recovery, Road to Recovery, Look Good...Feel Better all offered on-site.
- Society website (cancer.org) contains 70,000+ cancer-related resources and supportive services available from the Society, local, and national organizations.
- Patients and caregivers can also call out 800# any time, 365 days a year to speak to a Cancer Information Specialist about all aspects of cancer care and treatment.

Standard 3.2: Psychosocial Distress Screening
- Reach to Recovery, Road to Recovery, Look Good...Feel Better all offered on-site.
- Society website (cancer.org) contains 70,000+ cancer-related resources and supportive services available from the Society, local, and national organizations.
● Patients and caregivers can also call out 800# any time, 365 days a year to speak to a Cancer Information Specialist about all aspects of cancer care and treatment.
● Other Society resources include Distress in People With Cancer guide and coping checklists for patients and caregivers.

Standard 3.3: Survivorship Care Plan
● Society website (cancer.org) provides links to Survivorship: During and After Treatment (where various topics on cancer survivorship and survivor care plans can be found) and the National Cancer Survivorship Resource Center.

Patient Outcomes Standards:

Standard 4.1: Prevention Programs and Standard 4.2: Screening Programs
● ACS materials are shared at hospital-led education programs. I.e. The Parents Guide to Skin Protection will be shared at the July skin cancer screening event.
● Society website (cancer.org) provides the following information for healthcare professionals outlining our prevention and early detection screening guidelines, fact sheets, cancer presentations, Easy Reading for Patients: Tobacco Cessation and Cancer Screening, Asian Pacific Islander Cancer Education Materials, ColonMD: Clinicians’ Information Source, ProstateMD: Clinicians’ Information Source (resources to help promote colorectal and prostate cancer screening), and Cancer Facts & Figures.

Standard 4.3: Cancer Liaison Physician Responsibilities
● CLP Toolkit is a web-based orientation and training module for newly appointed CLPs.
● Other Society resources include ACS-CoC Collaborative Action Plan which documents opportunities for the Society’s collaboration with CoC-accredited programs and ACS Cancer Committee Reporting Template, a worksheet documenting collaborative activities for the cancer committee available on the facs.org website.

Other Collaborative Opportunities
● Materials provided for Cancer Education programs throughout the year for health fairs.
● Smoking cessation recommendations were shared at health fairs,
● Information included for nutritional consultations for patients at weekly multi-disciplinary team meetings.
● Materials and screening guidelines provided for skin cancer screenings, including the American Cancer Society presentation on skin cancer awareness.
What's new from the Society?

Patient Information Guides – cancer.org
The Society’s medical content team publishes a number of free patient information brochures that are available on cancer.org. Listed below are guides that your cancer program can print and distribute to patients and families.

Understanding Chemotherapy: A Guide for Patients and Families

Understanding Radiation Therapy: A Guide for Patients and Families
http://www.cancer.org/treatment/treatmentsandsideeffects/treatmenttypes/radiation/understandingradiationtherapyaguideforpatientsandfamilies/index

Chemotherapy Side Effects Worksheet


Nutrition for the Person With Cancer During Treatment: A Guide for Patients and Families

Nutrition for Children With Cancer

Genetic Testing: What You Need to Know

Cancer-Related Pain: A Guide for Patients and Caregivers
A patient video and companion patient guidebook with pain diary.

**Pain Control: A Guide for Cancer Patients and Their Loved Ones**

**Pain Diary**

**Caring for the Cancer Patient at Home**

**Distress in Patients With Cancer**

**National Cancer Information Center Update:**
The American Cancer Society’s National Cancer Information Center (NCIC) was opened in January 1997 to address the cancer information needs of the public. Cancer Information Specialists at the NCIC are available 24/7, 365 days a year to provide referrals to local and national resources, cancer information, clinical trials information, and assistance with health insurance questions.

The NCIC includes staff with varying roles and specialties to meet the varied needs of our constituents:

- **Cancer Information Specialists** provide cancer information and resource referrals for patients, family and the general public.
- **Spanish Cancer Information Specialists** are available Mon – Fri, 7 am to 7 pm to assist Spanish-speaking callers. Answering machines are available during off periods and messages are returned promptly the next day. A translation service is utilized for any language other than English or Spanish.
- **Oncology Nurse Information Specialists** serve as a second level of support to the Cancer Information Specialists to aid callers who may have complex or unique information needs.
- **Clinical Trials Specialists** provide information on clinical trials and can match callers to clinical trials
- **Health Insurance Assistance Specialists** provide constituents with personalized assistance regarding insurance-related questions. Specialists can assist callers with specific questions regarding their health insurance, coverage dynamics, and state programs.

NCIC staff have access to many sources of information which they use to assist callers:

- **The Document Search** contains cancer-related information that is developed, maintained, and updated by a medical editorial board. Information available through this database includes cancer sites, prevention and early detection, treatment information, and other topics. Our specialists use these documents to answer questions and can also send documents to callers via regular mail or email.
• **The Resource Search** links to a database of over 65,000 national and community resources. The six priority program areas of the database, which reflect our most popular telephone inquiries, includes ACS Programs and Services, Financial Assistance, Patient Housing, Smoking Cessation, Support Groups and Transportation.

• Healthcare providers, patients, and families can contact the National Cancer Information Center at **1.800.227.2345**

acs.whatnext.com.

• Developed with the participation of the American Cancer Society, WhatNext is an online network that connects cancer patients, survivors, and their caregivers with peers and resources to assist them on their journey to get well. WhatNext encourages those with experience to give back by sharing their cancer journey and insights, so others can get a better idea of what they might expect as they move through their own journey.

• WhatNext is intended to complement the Society’s Cancer Survivors Network (CSN) and Circle Of Sharing™. The Cancer Survivors Network is an online community created by and for people with cancer and their caregivers to provide peer support in a safe and welcoming environment. Circle of Sharing is a secure online tool that allows people with cancer to securely store and update their personal cancer information, including diagnosis, staging, treatment regimen, and side effects in a personal health record using Microsoft HealthVault technology.

**How WhatNext Works**

• Individuals can join the WhatNext site directly by visiting acs.whatnext.com. WhatNext is a public Web site and all information entered is publicly available, except the user’s email address and password.

• WhatNext uses unique technology to match newly diagnosed patients, survivors, and caregivers based on their specific cancer-related situations. Members receive recommendations to add other members who have entered similar cancer information as peers. WhatNext also recommends American Cancer Society content and resources for members based on the information they have entered about their cancer experience as well as their location. If a member has a question, they can use the “Ask Network” feature to post their question to the network. Once a question is posted, all members of the network have the ability to answer the question.
Cancer Advocacy Update State Update - 2014 State Legislative Outcomes

Lung Cancer and Tobacco Control

- **Medicaid Smoking Cessation**: We were pleased to support a proposal within the state budget that continued funding of $3.4 million for coverage of smoking cessation services through Medicaid, including counseling, Nicotine Replacement Therapies and Prescription medications.

- **Tobacco Control Program Funding Allocation Authority**: ACS CAN supported bill language that would expand the allocation authority of the Tobacco and Health Trust Fund (THTF) from $6 million annually to up to $12 million in unobligated funds annually. Additionally, the bill language restored THTF activities and tobacco control allocations for 2016, which had been suspended as part of the 2014-2015 state budget.

- **Electronic Cigarettes**: We strongly opposed language that attempted to restrict youth access to E-Cigarettes but that did not define E-Cigarettes as a tobacco product. This omission essentially exempts these products from tobacco control laws and smoking restrictions that have been proven to reduce exposure to the harmful effects of nicotine and tobacco.

- **Tobacco Control Program Funding**: ACS CAN opposed state budget proposals that redirected a total of $25 million in critical funds, including $10 million per year for ten years starting in 2016, from the Tobacco Settlement Fund to pay for a variety of non-tobacco related programs. Despite our objections, this significant re-direction of funds was included in the budget; however we secured commitments from the Administration and Legislative Leadership to look at more appropriately and adequately funding tobacco control programs during the 2015 Legislative session.

Expanding Cancer Prevention, Treatment and Survivorship

- **Breast and Cervical Cancer Early Detection Program (BCCEDP)**: ACS CAN advocated for, and the Legislature supported, funding of $2,213,575 for the BCCEDP. Thousands of underserved women across the state will continue to have access to this valuable, lifesaving program in 2015.

- **Step Therapy**: We believe treatment plans should be between a doctor and a patient, not left up to an insurance company. Insurance companies currently require patients to try a lower-cost medication for a period of time before gaining coverage for a higher-cost medication. However this can lead to treatment delays and other complications. We worked with proponents and advocates to pass legislation that would prohibit the use of step therapy for more than 60 days. At that time, all effective medications would become available. The bill also establishes an override process through which providers can stop the step therapy regimen if there are clear indications it is not effective.

- **Chronic Care Treatment**: We supported legislation that requires the Commissioner of the Department of Public Health, in consultation with local health departments and others to develop a statewide Chronic Care Treatment Plan.

Improving Quality of Life

- **Palliative Care Education and Resources**: In 2013, ACS CAN introduced legislation to create a Palliative Care Advisory Council (PCAC), taking a first step toward improved coordination, education and availability of palliative care for anyone at anytime during the course of a serious or chronic illness. In 2014, we built on that success by continuing to expand education and access to resources on palliative care through the PCAC page on the Department of Public Health’s website.
Obesity Prevention

- **Nutritional Standards for Children and Students**: ACS CAN supported legislation that would have established basic nutritional standards at childcare facilities, limiting access to some types of juices containing high levels of sugar, addressing milk fat content and providing that water be made available to children when they need it.

American Cancer Society Cancer Action Network (ACS CAN)

- ACS CAN is the nation’s leading advocate for public policies that are helping to defeat cancer. The organization ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.
- As the Society’s advocacy affiliate, ACS CAN works to encourage elected officials and candidates to make cancer a top national priority.

Why ACS CAN?

- Defeating cancer is as much a matter of public policy as scientific discovery. Lawmakers play a critical role in determining how much progress our country makes toward defeating cancer.
- ACS CAN gives a voice to those impacted by the disease as they encourage lawmakers at all levels of government to join the fight to make cancer a national priority.
- ACS CAN’s work has resulted in enormous progress through increased funding for cancer research and prevention programs, stronger tobacco control policies nationwide, and improved access to the full range of cancer care for people diagnosed with the disease and their families.
- By focusing national attention on the cancer fight, raising funds, educating voters, and rallying others to join the fight, ACS CAN unites and empowers people with cancer and their families to help save lives.

What does ACS CAN do?

- ACS CAN’s work helps advance the Society’s mission to defeat cancer by helping to protect and increase public investment in groundbreaking medical research, and by improving access nationwide to the latest prevention and early detection measures, treatments, and follow-up care that are proven to save lives.
- Like the Society, ACS CAN follows the science when supporting evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.
- ACS CAN utilizes its expert lobbying, policy, grassroots, and communications capacity to amplify the voices of patients in support of laws and policies that save lives from cancer.
- Through Cancer Votes, ACS CAN’s voter education program, ACS CAN is working to make sure candidates for public office are aware of the impact cancer has on the people they represent and why they should make the fight against the disease a priority once they’re in office.

What does ACS CAN not do?

- ACS CAN does not endorse candidates or political parties, and it is not a political action committee (PAC).
- The organization does educate voters by serving as a trusted source of information about candidate positions on cancer-related concerns and on key issue campaigns across the country that impact those affected by cancer.
- Like cancer itself, ACS CAN is nonpartisan.
What issues does ACS CAN work on and why?

- **Cancer research funding** – A strong and sustained federal investment in cancer research funding will yield scientific breakthroughs that save lives.
- **Strong smoke-free laws and higher tobacco taxes** – These measures are proven to reduce tobacco use, the largest preventable cause of disease and premature death in the United States.
- **Lifesaving screening programs** – Programs that increase access to proven cancer screenings, especially among medically underserved populations, save lives and are good for the economy.
- **Access to quality, affordable health care** – More than 300,000 people in the United States die from cancer each year because they lack access to affordable, adequate, quality care and treatment, and millions of others are forced to skip lifesaving care or spend their savings to pay for it.
- **Nutrition and physical activity** – An estimated one out of every three cancer deaths in the United States is linked to excess body weight, poor nutrition, or physical inactivity.

ACS CAN Membership

- There is a $10 or more annual membership fee to join.
- Contributions or gifts to ACS CAN are not deductible as charitable contributions for tax purposes; they support our citizen-based advocacy and lobbying efforts.
- You will receive a membership card and eNewsletter along with a Legislative Toolkit which includes a personalized listing of elected officials and instructions for taking action.

**Report submitted on December 15, 2014 by:**
Sue Ann Maresca, Senior Director for Community Engagement
Direct Line: 203-379-4780
Email: sue.ann.maresca@cancer.org
24/7 Cancer Information Line: 1-800-227-2345
Rehabilitation services for patients with cancer diagnoses can include Physical Therapy, Occupational Therapy, and Speech Pathology at a variety of Bristol Hospital outpatient sites in Bristol. Specialty lymphedema services through a certified lymphedema therapist (CLT) have been available for many years at Rehab Dynamics 2 at The Bristol Hospital Wellness Center on Clark Avenue. Aline Mellon, PT, CLT has moved her practice into The Center for Wound Care and Hyperbaric Medicine at Bristol Hospital. She is currently seeing returning and new patients at this recently built site with access off of the Bradley Street entrance to Bristol Hospital. Improved communication to referring physicians and hospital departments as well as the beautiful new building are some of the immediate benefits. Patients have transitioned well and have commented positively on the ease of parking and overall access to the building.

Lymphedema is a swelling that occurs often in an arm or a leg from a blockage of the lymphatic system. This can result in increasing edema and in a decreasing ability to function because of the edema. The treatment provided involves learning to manage this condition and to decrease the swelling through massage-type techniques on the tissues affected to aide in the fluid returning to the body and being excreted. Then the reduction in the size of the limbs can be retained through compression wraps/stockings. The edema can be caused by any condition that negatively impacts the lymphatic system including surgery or trauma or body pressure on the nodes. In the United States, the number one cause of lymphedema is breast cancer treatment due to tissue removal during surgery and radiation therapy. Symptoms can arise soon after surgery or years later.

Referrals to lymphedema therapy for patients with cancer related diagnoses have more than doubled in 2014 compared to 2013 data. Patient satisfaction scores specifically regarding patients responding positively to the question “Would you recommend us to your family or friends?” in 2014 are greater than 99%. The evidence based outcomes tool being used with patients with lymphedema (The Lymphedema Quality of Life tool) demonstrates dramatic differences in patients perceived ability to function before and after this therapy with many reporting being able to perform tasks and that they have not been able to do in years.

We look forward to continuing to grow in 2015 and working with The Cancer Care Center and the Beekley Center for Breast Health and Wellness to streamline processes that make this program Everyday Extraordinary.
As I’ve said so many times before, and as you’ve consistently heard from everyone who is and has been connected with the Cancer Care Center... we’re all in this together. “Why? “one might well ask. “Why are we in this together? “ Isn’t life hard enough without having to... you know... share each other’s burden? Why would an able-bodied and able-minded person choose to be and stay involved with this nasty thing known as cancer? Undoubtedly, there are more fun things to do. But, the truth is, that most people become involved in care because they themselves have experienced care. Good care. Care during challenging times in their own lives. Care that was honest, empathetic, and compassionate. Care which has been transformative and healing... a life-changing experience! This is why we become involved, and stay involved, despite the oft-times ugly nature of cancer.

Some people flee, while others lean into the storm... either way is okay. We do what we can do, and how we do it is ever-unfolding to us practitioners of the “caring arts”. Are you a care-giver? Are you an artist? Are you a practitioner of the “caring arts”? Never heard of that one before? Good, because I just came up with it. And, it fits. Just as good medicine is never purely a science, what makes it good is when a practitioner transcends the science, and the practice of medicine becomes an art. It is when the science of medicine moves beyond the dimensional confines of height and width... and begins to embody that realm known to us as depth! I believe the same thing happens when we... partners, spouses, children, siblings, friends and colleagues... become an integral part of one’s journey through illness, especially catastrophic illness (and we all know what that is), as we become, evolve, and grow into a practitioner of the art of caring. Can you relate to this? Is this mere hyperbole, or does it have resonance, application, and depth for you?

So, what about this “we’re all in this together” stuff? No one can operate or exist in a void while we deal with this reality known as cancer. Even though at times we feel all alone and left behind due to our place in the system (whether one is the patient, or one is the “other”)... we are but one piece of the jumble. And where one person is affected, there are others who are affected by this, and yet there are others who are affected by how we have been affected. (Basic law of physics: for every action, there is a re-action.) And at some point, we begin to realize that ready or not, like it or not, willing or not, we are all in this together. At the very least, there is cold comfort in knowing this. At the very best, it brings us comfort and strength.
And if we are fortunate (note that did not use the word *lucky*), we will be touched by and ministered unto by one who cares, and who happens to do a particularly fine job of caring. And we, in the midst of our own desert experience will find a newly revealed direction to where we need to go. And in time… we will understand that we, too, are in this together, and we will find our place in the journey, *our own self* a practitioner of the art of caring.

**Rev. J. Richard Fowler, Chaplin**
Bristol Hospital Cancer Care Center patients are provided with emotional support, psychotherapy, crisis intervention, education, advocacy and referral to community resources. Patients are followed by the Cancer Care Center’s Oncology Clinical Social Worker throughout their ongoing care, and if an inpatient stay is necessary the Oncology Clinical Social Worker visits with the patient and family for emotional support and assistance with care planning, psychotherapy, crisis intervention, education, advocacy and referral to community resources. Patients are followed by the Cancer Care Center’s Oncology Clinical Social Worker throughout their ongoing care, and if an inpatient stay is necessary the Oncology Clinical Social Worker visits with the patient and family for emotional support and assistance with care planning.

The Bristol Hospital Cancer Care Center’s Oncology Clinical Social Worker Pauline Miller M.S.W., L.C.S.W., ACHP-SW joined the Cancer Care Center in July 2014 and has over 20 years’ experience in Oncology, Hospice and Palliative Care. Pauline Miller has been on board with the Cancer Care Center full time to meet the demands of increasing number of new patients, to support Beekley Center for Women’s Health and Wellness, and works collaboratively with the Nurse Navigator Kathy Albano RN, BSN from Beekley Center for Breast Health and Wellness.

The “Circle of Hope” and the “Cancer Caregivers” support groups continue each month. A new addition to the support group service is one for those patients who have been newly diagnosed with cancer. The three support groups are titled, “Circle of Hope, Survivor Support Group”, “Comforting Conversations” and “Cancer Caregiver Support”.

The Bristol Relay for Life was held in June 2014 and included representation from the Bristol Hospital Team coordinated by the Bristol Hospital Cancer Care Center’s Oncology Nurse Navigator and Operations Manager. Both Drs. Brahaj and Khubchandani spoke at this event and to date over $95,000 was raised for this Relay Year.

Other community events included the following:

The social worker participates in various committees such as: the Beekley Center for Breast Health and Wellness, the Hospice Care planning team, Bristol Hospital Ethics Committee to ensure smooth coordination of services and quality of care. The social worker also coordinates with the American Cancer Society, Cancer Care Inc., The Leukemia
Lymphoma Society and many other community organizations to offer education, volunteer services and community resources. A weekly interdisciplinary team meeting is facilitated by the social worker to discuss new consultations, patients beginning new treatments, patients completing treatments. Also, inpatients, patients with complicated plans of care, patients with challenging behaviors, on-call issues, patients who might benefit from access to complementary services.

Bristol Hospital Cancer Care Center implemented a policy of distress screening in accordance with National Comprehensive Cancer Network and The Commission on Cancer guidelines. This has helped us to reach more patients and attend to their psychosocial needs. The NCCN guidelines require that in January 2015 a mandatory Distress Assessment is conducted for each newly diagnosed patient. Through the process of group planning and evolution, this assessment is completed at each new consult time for any new patient. The NCCN has yet to establish the percentage of patients to capture for compliance but the Cancer Care Center has set the compliance percentage at 95% internally. Data has been tracked for this initiative since August 2013 and just recently, in October and November 2014 the Cancer Care Center has reached the 100% mark. The Cancer Care Center staff has also submitted this data capture for Magnet Project Submission by Bristol Hospital.

See attached graph representing this and advanced directive data in the addendum section of this report.

Pauline Miller M.S.W., L.C.S.W., ACHP-SW
Bristol Hospital Cancer Care Center  Data August 2013-December 2014

Goal 95% Distress Tool

Goal 98% Advanced Directives

Blue Reflects Percentage of Distress Tools Completed per Actual Consults Seen by MD
(0-100% by Month)

Red Reflects Percentage of Advanced Directives Completed per Actual Consults Seen by MD
(0-100% by Month)
The Patient Navigation process serves the Cancer Care Center’s patients with the main goal of being the liaison between the patients and their health care providers. The navigator’s responsibilities are to coordinate timely care, serve as the patient advocate, and keep track of the patients throughout the continuum of care. The navigator also includes the patients’ family members and other support system involved and emotionally supported as well.

A new cancer diagnosis can be very overwhelming for a patient. The Patient Navigator reaches out the patient 24 to 48 hours before the patient’s first consultation with the oncologist. The patient is informed of the navigator’s role at that time, reassuring the patient that they will be supported from the very beginning of their cancer care. The patient is informed of what to expect at the initial consultation with the oncologist. This includes a detailed history, physical examination, review of medications, diagnosis, treatment plan and future coordination of care. The patient is instructed to bring a list of medications and have someone accompany them to their appointment.

The main barriers in access to health care are addressed either prior to or at initial consultation. These include lack of insurance coverage, lack of financial resources, lack of transportation, lack of knowledge and/or understanding of need for health and preventative care, and a regular source of care such as a primary care provider. After assessing the patient’s need, support is provided.

At the first consultation, the patient meets with the nurse navigator, as well as the oncologist, social worker and triage nurse. The nurse navigator provides copies of all reports including biopsy and pathology reports, CT scans and MRI results. Chemotherapy education and medication instruction are provided to each patient, and printed materials on the diagnosis and treatment plan are also given to each patient. A port demonstration is given, if necessary. Advance Directives are discussed. The patient is given a calendar of future appointments and contact information for the Cancer Care Center’s team members. A list of online resources and support groups is also provided to each patient.

The nurse navigator follows the patients through the continuum of care, including surgical, chemotherapy, radiation, follow up visits, inpatient admissions, visiting nurses, Special Touch program and/or Hospice. The nurse navigator serves as the key contact for each oncology patient, as well as the physicians, office staff, social worker, nutritionist.

If applicable, patients are provided with an individualized Survivorship Care Plan upon completion of chemotherapy and radiation treatment plans. Eligible patient
include all patients without metastatic disease who have completed treatment. The care plan is also mailed to the patient's primary care provider.

The Navigation Program is continually evolving to include more resources as made available to each patient. The navigator assists with such programs as the Look Good/Feel Better program with the American Cancer Society which offers wig referrals for patients, massage referrals to Beekley, hats, scarves, blankets, etc. Since January 2014 to date, more than twelve patients have benefited from the program.

Kelly Michaud, RN
Oncology Nurse Navigator
The Cancer Care Center had two patients on onsite research protocols.

1) National Surgical Adjuvant Breast and Bowel Project, NSABOP B-42 HIC Protocol Number: 0907005410

A clinical Trial to Determine the Efficacy of Five Years of Letrozole Compared to Placebo in Patients Completing Five Years of Hormone Therapy Consisting of an Aromatase Inhibitor (AI) or Tamoxifen Followed by an AI in Prolonging Disease-Free Survival in Postmenopausal Women with Hormone Receptor Positive Breast Cancer.

The patient completed treatment with Letrozole vs placebo at the end of December 2014. The patient will have a six month toxicity follow up in June 2015.

2) Southwest Oncology Group, SWOG S0307, HIC Protocol Number: 903004856

Phase III Trial of Bisphosphonates as Adjuvant therapy for Primary Breast Cancer. The primary purpose of this study is to see if patients who receive bisphosphonates as adjuvant therapy for early breast cancer have an increase in disease-free survival.

The patient began Zometa therapy on February 2, 2010. Total duration of the therapy was 36 months. Patient has completed the active treatment phase on October 16, 2012. The patient will continue six month follow ups for five years post completion of therapy.

So far in the year of 2014 we referred 6 patients to Yale Medical Center and Massachusetts General for Clinical Trials.

1. Phase I/Ib Study of AZD9150 (ISIS-STAT3Rx) in Patients with Advanced/Metastatic Hepatocellular Carcinoma.

Investigation of the safety and tolerability of AZD9150 when given intravenously to patients with hepatocellular carcinoma and determine a recommended phase II dose and schedule (RP2D) by evaluating dose limiting toxicities occurred during cycle 1. Time frame: Assessed up to 12 months.

The patient began AZD9150 treatment on May 1, 2014 at Yale.
2. A Phase I, Open-label, dose-escalation study of the safety and pharmacokinetics of MPDL3280A.

Investigation study of the safety and pharmacokinetics of MPDL3280A when given intravenously as a single agent to patients with locally advanced or metastatic solid tumors or hematologic malignancies.

The patient began MPDL3280A therapy at Yale on October 8, 2014 and received two cycles. Restaging scans were conducted after the two cycles and disease progression was evident. Therefore, protocol therapy was stopped on December 1, 2014.

3. A Phase II Study: MK-3475 in Melanoma and NSCLC Patients with Brain Metastases

The purpose is of this clinical trial is to study the activity of MK-3475 in the untreated brain metastases from melanoma or non-small cell lung cancer.

The patient began MK-3475 therapy at Yale on July 2, 2014 for 8 weeks of systemic therapy and then every 8 weeks thereafter with 4 week scans to determine response and safety. This study is expected to end in March 2018.

4. Phase 1/2, Study of ISIS 4811464, an antisense Oligonucleotide Inhibitor of STAT, Administered to Patients with Advanced Cancers

A Phase 1/2, open-label, dose escalation, dose expansion study for the treatment of patients with advanced cancers. Eligible patients with DLBCL of other advanced lymphomas will be enrolled into the dose-expansion cohort.

The patient began ISIS 4811464 therapy on May 1, 2014 at Yale. This patient was removed as a candidate from the clinical trial due to disease progression in July 2014.

5. Phase II Open-Label Trial of AUY922, an HSP90 Inhibitor, in Patients with ALK-Rearranged Advanced NSCLC and Acquired Resistance to Prior ALK Tyrosine Kinase Inhibition

A Phase II clinical trial, which tests the safety and effectiveness of an investigational drug to learn whether the drug works in treating a specific cancer that have become resistant to drugs like Crizotinib by stopping cancer cells from growing abnormally. This study tests that safety of AUY922 and determines how well AUY922 treats participants with advanced, ALK-positive NSCLC.

The patient began AUY922 therapy on April 9, 2014 at Massachusetts General. Due to other medical complications that were considered life threatening, the patient’s
performance status was diminished and the clinical trial was discontinued on June 26, 2014.

6. **Study Title:** S1206, “A Dose Finding Study Followed by Phase II Randomized, Placebo Controlled Study of Veliparid (ABT-888) Added to Chemoradiotherapy with Carboplatin and Paclitaxel for Unresectable Stage III Non-Small Cell Lung Cancer (NSCLC), (NCI Study Number 8811)”

Part I of the study involves a standard dose of radiation therapy five days a week for 6 weeks with investigational drug, Veliparib on day 1 of the study. This is given alongside Paclitaxel and Carboplatin weekly during the 6 weeks of radiation. A rest period of 4 to 6 weeks follow. If the tumor has not worsened, an additional 2 cycles (or 6 weeks) of Veliparib and chemotherapy is administered as consolidation therapy. On the first day of each cycle, Paclitaxel and Carboplatin is administered.

The patient began S1206 Study on November 24, 2014 at Yale.

Thirteen subjects (7 males and 6 females) have been enrolled through Bristol Hospital in the National Quality of Life Study of Cancer Survivors (SCS-1) at Yale Cancer Center since 2004.

Cancer Care Center continues to provide patient information regarding clinical trials. Several sources of information are available to the patients:

- Brochures and Pamphlets
- Internet sites
- Patient Library
- Physicians
- Clinical Research Nurse
Bristol Hospital would like to recognize and thank the individual Cancer Committee members and the departments which they represent, for their time and many valued contributions to the Bristol Hospital Cancer Program throughout the years 2013-2014.
### Frequently Called Numbers 2014

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<td>Bristol Hospital Main Number (Brewster Road)</td>
<td>(860) 585-3000</td>
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<tr>
<td>Patient Information</td>
<td>(860) 585-3255</td>
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<td>Business Office - Cashier</td>
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<td>Business Office - Patient Records Mgr.</td>
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<td>Administration</td>
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<td>Cancer Registry</td>
<td>(860) 585-3173</td>
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<td>Counseling Center (440-C No. Main Street)</td>
<td>(860) 583-5858</td>
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<td>(860) 585-3431</td>
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<td>Development Foundation</td>
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<td>Emergency Department (24-hour)</td>
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<td>(860) 585-3217</td>
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<td>MedWorks (975 Farmington Avenue) [Occup. Health]</td>
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<td>Radiology Center (25 Collins Road)</td>
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<td>Volunteer Services</td>
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<td>Wellness Center</td>
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<td>Women’s Health Resource (25 Collins Road)</td>
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ONCOLOGY RELATED
INTERNET WEBSITE ADDRESSES
1-800 NUMBERS
2014

AMERICAN COLLEGE OF SURGEONS
http://www.facs.org/cancer/

AMERICAN COLLEGE OF SURGEONS - PATIENT EDUCATION
http://www.facs.org/patienteducation/

AMERICAN CANCER SOCIETY
http://www.cancer.org

NATIONAL CANCER INSTITUTE
http://www.cancer.gov
1-800-CANCER

NATIONAL COMPREHENSIVE CANCER NETWORK
http://www.nccn.org

NATIONAL LIBRARY OF MEDICINE - NATIONAL INSTITUTES OF HEALTH
http://MEDLINEplus.gov
http://ClinicalTrials.gov

COMMISSION ON CANCER - ACCREDITED CANCER PROGRAMS
http://www.facs.org/cancerprograms/usn08

CANCERWATCH CLINICAL TRIALS LISTING SERVICE
http://www.cancer.gov/clinicaltrials

CANCERWATCH
http://www.cancerwatch.org

CANCER CLINICAL TRIALS HELP

CENTERWATCH
http://www.centerwatch.com

CENTERS FOR MEDICARE & MEDICAID SERVICES
http://cms.hhs.gov/ClinicalTrialPolicies

PEDIATRIC SITES:

CURESEARCH
http://www.childrensoncologygroup.org/

THE LEUKEMIA & LYMPHOMA SOCIETY
http://www.LLS.org
1-800-955-4572

To speak to an Information Specialist or to order a fact sheet or booklet.