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Introduction

I am pleased to present our first collaborative Novant Health Cancer Annual Report.

Previously, the cancer centers in Winston-Salem and Charlotte published separate issues. This new all-inclusive report represents an important and exciting evolution that signifies the efforts made across our system to ensure the highest level of quality care, regardless where our patients seek care.

Cancer can be a truly intimidating adversary. Rare is the person whose life has not been touched by it. It is our mission to provide the compassion and comprehensive care our patients and their families deserve. I also am proud to say they have come to expect that level of care from Novant Health providers. Uniting our cancer programs under one brand only further ensures we will continue to honor that commitment.

The science and treatment of cancer are changing at a pace never before seen. Cancer care is increasingly becoming more personalized. And as one system, we have the ability to meet patient needs like never before.

From prevention to early detection through treatment to survivorship, Novant Health is committed to providing state-of-the-art care for our patients. Working collaboratively across regions, we can ensure that standard of quality exists each time we touch a patient.

As an example, Novant Health Rowan Medical Center earned its first three-year accreditation from the Commission on Cancer of the American College of Surgeons. The medical center joins Novant Health Forsyth Medical Center and Novant Health Presbyterian Medical Center in this prestigious recognition. This accreditation demonstrates the same commitment from leaders, physicians and team members to provide patient-centered, multidisciplinary care, including clinical trials, genetic counseling, patient navigation and survivorship. Congratulations.

Additionally, this past year has seen the highly successful implementation of our electronic health record. Having one online record for all cancer care within Novant Health further guarantees our patients will receive state-of-the-art, compassionate care within our communities.

We remain committed to this high-tech, high-touch care. As one program, we are truly pioneers with our innovative Choices and Champions initiative, which assists patients and their families with end-of-life decisions.

Novant Health has been a progressive leader in cancer care. Our navigator program has been a model for decades nationally. This past year saw the implementation of 3-D mammography to Winston-Salem and Charlotte breast centers.

In the coming year, we plan to add this advanced breast imaging technology to Novant Health Huntersville Medical Center, Novant Health Matthews Medical Center and Novant Health Imaging in Kernersville.

I am proud of the outstanding cancer program we have in our own community. To the clinicians, team members and volunteers who daily demonstrate their personal dedication to our patients, thank you.

Nick Chryssson, MD
Novant Health Oncology Council
New program highlights from 2014

3-D mammography brings enhanced level of breast care

In 2014, a total of 5,590 women took advantage of the newest breast imaging technology, 3-D mammography, at Novant Health locations in Charlotte and Winston-Salem. This technology, also known as breast tomosynthesis, enhances the view of breast tissue, and the two existing 3-D mammography units have been very well received by both patients and referring providers.

To meet the needs of our communities, we already have plans to add 3-D mammography to our breast centers at Novant Health Huntersville Medical Center, Novant Health Matthews Medical Center and Novant Health Rowan Medical Center. We are requesting additional units to expand access to women who visit Novant Health Breast Center — Forsyth, Novant Health Imaging Piedmont and Novant Health Imaging Kernersville.

Novant Health Rowan Medical Center earns cancer accreditation

The cancer center at Novant Health Rowan Medical Center received its first three-year accreditation with commendation from the Commission on Cancer of the American College of Surgeons. This accreditation represents the commitment of Rowan Medical Center leaders, physicians and staff to create a multidisciplinary cancer program that offers clinical trials, genetic counseling and patient-centered services, including psychosocial support, patient navigation and survivorship care planning.

Rowan Medical Center joins our other accredited cancer programs at Novant Health Forsyth Medical Center and Novant Health Presbyterian Medical Center. We’re proud to offer increased access to advanced-level cancer care to patients in their own communities.

Supportive & Palliative Care grows to meet needs of community

In 2014, Novant Health Supportive & Palliative Care made great steps toward creating a clearly defined service that meets the needs of patients and physicians in the communities we serve.

Dedicated inpatient programs exist at Novant Health Forsyth Medical Center and Novant Health Presbyterian Medical Center and feature robust teams of experts, including board-certified hospice and palliative medicine physicians and nurse practitioners, nurse navigators, nurses, licensed clinical social workers, counselors, chaplains and pharmacists.

These teams work alongside a patient’s primary physician, providing an extra layer of support and assisting with symptom management, emotional and spiritual support and decision-making and guidance for treatment choices. We are committed to reducing stress and improving quality of life for patients and families facing serious illness. In fact, Forsyth Medical Center was the first North Carolina hospital to earn advanced certification for palliative care programs by The Joint Commission in 2013.

And in December 2014, outpatient cancer patients gained access to new supportive and palliative care services with the addition of the Novant Health Supportive Care Clinic at Presbyterian Medical Center. This clinic allows us to establish goals of care with cancer patients and minimize side effects of treatment. We plan to expand this clinic to serve cancer patients in Winston-Salem and surrounding communities in 2015.
“We are committed to reducing stress and improving quality of life for patients and families facing serious illness.”

Geri Faulkner
Breast cancer survivor since 2013
Cancer incidence 2014

The Cancer Data Service, a support service for Novant Health Cancer Care, serves as the statistical database for the malignancies diagnosed and/or treated within Novant Health. The registry identifies, collects, manages and analyzes cancer data for use by physicians, hospital administrators and researchers.

The statistical analyses allow medical and allied health professionals to track trends in incidence and treatment outcomes. The registry maintains lifetime follow-up on patients.

In addition, the Cancer Data Service confidentially submits required datasets to the National Cancer Data Base of the Commission on Cancer. Select data are also submitted to the North Carolina Central Cancer Registry as required by law.
# Summary of cancer data

<table>
<thead>
<tr>
<th>Primary site</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sites</td>
<td>6174</td>
<td>2718</td>
<td>3456</td>
</tr>
<tr>
<td>Oral cavity</td>
<td>106</td>
<td>73</td>
<td>33</td>
</tr>
<tr>
<td>Lip</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tongue</td>
<td>45</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>Oropharynx</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hypopharynx</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>52</td>
<td>33</td>
<td>19</td>
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<tr>
<td>Digestive system</td>
<td>1056</td>
<td>555</td>
<td>501</td>
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<tr>
<td>Esophagus</td>
<td>54</td>
<td>41</td>
<td>13</td>
</tr>
<tr>
<td>Stomach</td>
<td>73</td>
<td>34</td>
<td>39</td>
</tr>
<tr>
<td>Colon</td>
<td>396</td>
<td>210</td>
<td>186</td>
</tr>
<tr>
<td>Rectum</td>
<td>182</td>
<td>97</td>
<td>85</td>
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<tr>
<td>Anus/anal canal</td>
<td>36</td>
<td>12</td>
<td>24</td>
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<tr>
<td>Liver</td>
<td>69</td>
<td>47</td>
<td>22</td>
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<tr>
<td>Pancreas</td>
<td>169</td>
<td>78</td>
<td>91</td>
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<tr>
<td>Other</td>
<td>77</td>
<td>36</td>
<td>41</td>
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<tr>
<td>Respiratory system</td>
<td>987</td>
<td>515</td>
<td>472</td>
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<tr>
<td>Nasal/sinus</td>
<td>3</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Larynx</td>
<td>47</td>
<td>37</td>
<td>10</td>
</tr>
<tr>
<td>Lung/bronchus</td>
<td>926</td>
<td>468</td>
<td>458</td>
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<tr>
<td>Other</td>
<td>11</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Blood and bone marrow</td>
<td>247</td>
<td>133</td>
<td>114</td>
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<tr>
<td>Leukemia</td>
<td>134</td>
<td>82</td>
<td>52</td>
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<tr>
<td>Multiple myeloma</td>
<td>75</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>Other</td>
<td>38</td>
<td>15</td>
<td>23</td>
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<tr>
<td>Bone</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Connect/soft tissue</td>
<td>29</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>Skin</td>
<td>118</td>
<td>70</td>
<td>48</td>
</tr>
<tr>
<td>Melanoma</td>
<td>112</td>
<td>65</td>
<td>47</td>
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<tr>
<td>Other</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Breast</td>
<td>1346</td>
<td>20</td>
<td>1326</td>
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<tr>
<td>Female genital</td>
<td>421</td>
<td>0</td>
<td>421</td>
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<tr>
<td>Cervix uteri</td>
<td>53</td>
<td>0</td>
<td>53</td>
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<tr>
<td>Corpus uteri</td>
<td>246</td>
<td>0</td>
<td>246</td>
</tr>
<tr>
<td>Ovary</td>
<td>86</td>
<td>0</td>
<td>86</td>
</tr>
<tr>
<td>Vulva</td>
<td>21</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Male genital</td>
<td>676</td>
<td>676</td>
<td>0</td>
</tr>
<tr>
<td>Prostate</td>
<td>639</td>
<td>639</td>
<td>0</td>
</tr>
<tr>
<td>Testis</td>
<td>32</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Urinary system</td>
<td>456</td>
<td>332</td>
<td>124</td>
</tr>
<tr>
<td>Bladder</td>
<td>259</td>
<td>205</td>
<td>54</td>
</tr>
<tr>
<td>Kidney/renal</td>
<td>170</td>
<td>112</td>
<td>58</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Brain and CNS</td>
<td>196</td>
<td>80</td>
<td>116</td>
</tr>
<tr>
<td>Brain (benign)</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Brain (malignant)</td>
<td>57</td>
<td>37</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>137</td>
<td>42</td>
<td>95</td>
</tr>
<tr>
<td>Endocrine</td>
<td>189</td>
<td>56</td>
<td>133</td>
</tr>
<tr>
<td>Thyroid</td>
<td>151</td>
<td>42</td>
<td>109</td>
</tr>
<tr>
<td>Other</td>
<td>38</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Lymphatic system</td>
<td>235</td>
<td>137</td>
<td>98</td>
</tr>
<tr>
<td>Hodgkin's disease</td>
<td>32</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Non-Hodgkin's</td>
<td>203</td>
<td>121</td>
<td>82</td>
</tr>
<tr>
<td>Unknown primary</td>
<td>85</td>
<td>43</td>
<td>42</td>
</tr>
<tr>
<td>Other/ill-defined</td>
<td>26</td>
<td>5</td>
<td>21</td>
</tr>
</tbody>
</table>
## Summary of cancer data (continued)

### Total 2013 analytic cases by market

<table>
<thead>
<tr>
<th>Market</th>
<th>Total analytic cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Winston-Salem market (GWM)</td>
<td>3,021</td>
</tr>
<tr>
<td>Novant Health Forsyth Medical Center</td>
<td>2014</td>
</tr>
<tr>
<td>Novant Health Medical Park Hospital</td>
<td>812</td>
</tr>
<tr>
<td>Novant Health Thomasville Medical Center</td>
<td>115</td>
</tr>
<tr>
<td>Novant Health Kernersville Medical Center</td>
<td>78</td>
</tr>
<tr>
<td>Novant Health Clemmons Medical Center</td>
<td>2</td>
</tr>
<tr>
<td>Greater Charlotte market (GCM)</td>
<td>2572</td>
</tr>
<tr>
<td>Novant Health Presbyterian Cancer Center</td>
<td>1916</td>
</tr>
<tr>
<td>Novant Health Matthews Medical Center</td>
<td>348</td>
</tr>
<tr>
<td>Novant Health Huntersville Medical Center</td>
<td>299</td>
</tr>
<tr>
<td>Novant Health Charlotte Orthopedic Hospital</td>
<td>9</td>
</tr>
<tr>
<td>Novant Health Rowan Medical Center (RMC)</td>
<td>491</td>
</tr>
</tbody>
</table>

### Five most prevalent cancer sites

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>GWM Total cases</th>
<th>% of Total volume</th>
<th>GCM Total cases</th>
<th>% of Total volume</th>
<th>RMC Total cases</th>
<th>% of Total volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>634</td>
<td>20.4%</td>
<td>633</td>
<td>24.6%</td>
<td>79</td>
<td>16.1%</td>
</tr>
<tr>
<td>Prostate</td>
<td>327</td>
<td>10.5%</td>
<td>260</td>
<td>10.1%</td>
<td>52</td>
<td>10.6%</td>
</tr>
<tr>
<td>Lung</td>
<td>522</td>
<td>16.8%</td>
<td>317</td>
<td>12.3%</td>
<td>87</td>
<td>17.7%</td>
</tr>
<tr>
<td>Colorectal*</td>
<td>283</td>
<td>9.1%</td>
<td>260</td>
<td>10.1%</td>
<td>49</td>
<td>10.0%</td>
</tr>
<tr>
<td>Gyn**</td>
<td>234</td>
<td>7.5%</td>
<td>174</td>
<td>6.8%</td>
<td>18</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

*Includes colon, rectum and recto sigmoid junction
**Includes cervix, uteri, other female gen, ovary, uterus NOS, vagina, vulva
Caseload by county
“In the most recent CP3R report, there were six breast cancer measures, two colon cancer measures, one rectal cancer measure, one gastric cancer measure and two lung cancer measures. Novant Health exceeded the benchmark in all areas where a benchmark is available.”
Ensuring quality cancer care

Novant Health’s unique oncology-specific quality outcomes program performs more than 120 quality studies each year. A majority of the studies are clinically based and have the potential to greatly impact patient care at Novant Health.

Novant Health Cancer Care’s cancer outcomes team focuses on monitoring adherence to nationally recognized care guidelines, such as the National Comprehensive Cancer Network (NCCN) as well as nationally published quality measures and benchmarks. Quality studies are performed, compliance rates are calculated, and the results are reported to physician advisory boards. When a need for improvement arises, process changes are implemented and improvements are tracked. In one of the studies completed in 2014, we assessed the appropriateness of antiemetic drugs being given with highly emetogenic chemotherapy treatments. Using the NCCN guidelines as a reference, the compliance rate was 100 percent for both the Forsyth-area and the Charlotte-area cancer facilities.

As part of our accreditation with the Commission on Cancer (CoC) of the American College of Surgeons, we are able to compare our quality with more than 1,500 commission-accredited cancer programs in the United States and Puerto Rico. By using the National Cancer Data Base, we can use comparative data to track our progress on important quality metrics, including survival data, time to treatment data as well as other important treatment measures provided in the Cancer Program Practice Profile Report (CP3R). In the most recent CP3R report, there were six breast cancer measures, two colon cancer measures, one rectal cancer measure, one gastric cancer measure and two lung cancer measures. Novant Health exceeded the benchmark in all areas where a benchmark is available. (See below.)

Our evidence-based quality program is a systemwide program focusing on assessing and improving patient care. Patients have told us that they want to know they made the right choice in choosing Novant Health for their cancer care and our consistent commitment to quality and outcomes can be part of their assurance. By monitoring patients across the care continuum, we are able to ensure we are providing the best care to our patients, in every dimension, every time.

Megan Tolley, MHSA
Cancer outcomes analyst

<table>
<thead>
<tr>
<th>Cancer site</th>
<th>Description</th>
<th>Primary measure steward</th>
<th>GWM* compliance rate</th>
<th>GCM* compliance rate</th>
<th>CoC standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Combination chemotherapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC T1cN0, or stage IB-III hormone receptor negative breast cancer.</td>
<td>Commission on Cancer</td>
<td>97%</td>
<td>97.2%</td>
<td>90%</td>
</tr>
<tr>
<td>GI</td>
<td>Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer.</td>
<td>Commission on Cancer</td>
<td>96.2%</td>
<td>94.7%</td>
<td>90%</td>
</tr>
<tr>
<td>Lung</td>
<td>Node positive (pN1) and (pN2) NSCLC*.</td>
<td>Commission on Cancer</td>
<td>100%</td>
<td>93.8%</td>
<td>(new measure)</td>
</tr>
</tbody>
</table>

*GWM = greater Winston-Salem market; GCM = greater Charlotte market; AJCC = American Joint Committee on Cancer; NSCLC = non-small cell lung cancer.
Perry Smith
Burkitt’s lymphoma cancer survivor since 2013
Survivorship

The National Cancer Institute defines cancer survivorship as “the physical, psychosocial and economic issues of cancer, from diagnosis until the end of life. It focuses on the health and life of a person with cancer beyond the diagnosis and treatment phases. Survivorship includes issues related to the ability to get health care and follow-up treatment, late effects of treatment, second cancers and quality of life. Family members, friends and caregivers are also part of the survivorship experience.” According to the American Cancer Society, there are now more than 13.7 million cancer survivors in the United States and that number is expected to grow to nearly 18 million by 2022. In addition, the five-year overall survival rate has increased to 68 percent.

Not so long ago, cancer care focused almost entirely on curing patients of the disease. Today, with treatment advances improving survival rates, the focus is expanding to include a spectrum of quality-of-life issues. Novant Health Cancer Care has made great progress in turning the attention toward the needs of our survivors by providing services that are evidence-based, adhere to national guidelines, and improve the survivor experience.

Novant Health cancer survivorship goals are:
- Prevention and surveillance of recurrent cancer, new or second cancers and late effects
- Interventions for consequences of cancer and its treatment (medical problems, psychological concerns, distress and/or practical concerns)
- Coordination of care between specialists and primary care providers
- Easy access to all cancer survivors
- World-class staff in knowledge, skills and compassion
- Convenient and affordable care to all cancer survivors
- Better health during and after treatment

Survivorship program enhancements for 2014 were implemented in radiation oncology, gynecologic oncology, medical oncology and outpatient infusion areas with easy referrals to our social work and counseling interventions. More than 160 Novant Health employees completed the STAR training and in-services, generating an increase in knowledge and skill for our employees and improving referrals to appropriate interventions for short- and long-term side effects.

The Novant Health cancer survivorship program extends to Presbyterian Medical Center, Matthews Medical Center, Huntersville Medical Center, Forsyth Medical Center, Rowan Medical Center and Thomasville Medical Center and includes:

- Navigators
- Genetic counseling
- Multidisciplinary cancer clinic
- Smoking cessation
- Wellness (exercise, nutrition)
- Palliative care
- Hospice care
- Educational classes
- Individual or group counseling
- Case management
- Rehabilitation medicine (physical therapy, lymphedema)
- Integrative therapies
Clinical research update

Since the FDA’s 1997 approval of rituximab, the first targeted therapy for the treatment of non-Hodgkin lymphoma, and the decoding of the human genome in 2003, we have seen cancer research and development steadily move away from traditional chemotherapy-type drugs to what has now become known as “precision medicine.”

According to the National Cancer Institute (NCI), precision medicine is “the use of information about genes, proteins and other features of a person’s cancer to diagnose or treat their disease.” Also called targeted therapies, these treatments work extremely well in some forms of cancer and show a great deal of promise. They can be used alone or in combination with traditional chemotherapy drugs or regimens.

At Novant Health Cancer Care, we’re committed to being on the cutting edge of cancer therapy and offering our patients the most promising treatments available today. To do that, we’ve steadily grown our research program over the past two years, adding more targeted therapies to our portfolio of clinical trials.

From 2013 to 2014, we added targeted therapy trials for these cancers: breast, colorectal, glioblastoma, Hodgkin and non-Hodgkin lymphoma, non-small cell lung, and pancreatic. We also added a few NCI trials that required tissue samples from patients who have non-small cell lung or colorectal cancer. This tissue is analyzed for mutations for which there may be a clinical trial with a corresponding targeted therapy available.

We will continue adding targeted therapy trials in 2015 and in the years that follow. Our vision is to have a broad spectrum of clinical trials using the most current therapies in development, and our mission is to offer every patient who comes to us for help access to these novel therapies without leaving their own community.

Don McCall, RN, director
Novant Health clinical research

“We’re committed to being on the cutting edge of cancer therapy and offering our patients the most promising treatments available today.”
Ask the doctor: 3-D mammography

What role does 3-D mammography play in the cancer journey?

3-D mammography has moved us several steps forward in the early detection of breast cancer. It lets us see smaller breast cancers earlier than in the standard, two-dimensional mammogram, especially in women who have dense breast tissue. This often translates to improved outcomes and less-rigorous treatments.

What’s also great is that the experience for the woman is very similar to a standard mammogram. The mammography machine, instead of staying still, moves in an arc over the breast so it obtains arced or angled images. These additional images only add a few extra seconds to the entire mammogram experience.

How is Novant Health using 3-D mammography to improve or enhance patient care?

We as clinicians have witnessed firsthand the impact of 3-D mammography on breast cancer diagnosis and care. Our radiology team collaborates with primary care physicians, ob-gyns and oncologists to identify patients who are most likely to benefit from this enhanced screening so that they can receive the early detection care that’s right for them. And we’re adding 3-D mammography to additional Novant Health breast centers to ensure women have convenient access to this screening no matter where they live.

We’re also using 3-D mammography to decrease the anxiety and expense of being called back for additional images.

How can 3-D mammograms drive innovation in cancer care?

This technology has made mammography even more accurate, meaning it reduces the number of false positives on the screening while also detecting smaller, harder-to-find breast cancers.

It’s a new imaging tool that enables cancer to be caught at a more treatable stage, which is an innovation that speaks for itself. Additionally, earlier detection leads to less-aggressive treatments. This in turn leads to fewer side effects, which means improved quality of life.

Clinically speaking, right now, some of our biopsies are guided using mammography. In the future, we hope to use 3-D mammography to do biopsies so that we can more quickly and accurately target suspicious lesions.
What role does genetics play in the cancer journey?

Genetic testing allows us to identify genetic mutations that can increase a person’s risk to develop cancer. There are three components when it comes to cancer: the population, the individual and the malignant tumor. Knowing certain populations are more prone to have a genetic mutation helps identify the individuals who are at risk. For example, women who carry a BRCA1 or BRCA2 mutation are at increased risk of having breast and ovarian cancer, and certain BRCA1 and BRCA2 mutations were first identified in the Ashkenazi Jewish population. If a woman knows she carries a gene mutation, she can consider preventive measures. Her care team might also be able to modify her lifestyle, increase screening options or frequency, or offer medications to reduce the risk of developing a malignancy.

Some cancers are more difficult to treat than others and identifying the type of tumor you’re treating can help with outcomes. Within the tumor itself, genomic testing can identify mutations that affect how the patient might respond to chemotherapy. Some patients feel the toxic effects of chemo more than others, so being able to detect those genetic changes within a tumor lets us pursue the most accurate treatment.

How is Novant Health using genetics to improve or enhance patient care?

To help identify people who can benefit from this type of testing, genetic counselors have been added to the Novant Health care team. These counselors help to identify patients who are at risk to develop cancer and may have a genetic predisposition to develop multiple cancers. Genetic counselors work closely with these patients to educate them and to discuss options to reduce their risk to develop cancer. While these sessions prove immensely helpful for patients, they can also provide lifesaving information to family members as well. Inherited mutations account for about 5 to 10 percent of all cancers, according to the National Cancer Institute.

How can genetics drive innovation in cancer care?

Genetics can sometimes provide us with the right information that allows us to better treat the disease, and it allows us to do this on a case-by-case basis. We can identify single nucleotide polymorphisms, frequently called SNPs (pronounced “snips”), that helps us to customize cancer care. SNPs can increase the toxicity for certain chemotherapies. Being able to identify an abnormality guides us to use the right drug to treat the patients so they are less likely to have an adverse reaction to the chemo treatment.

“We also are using tumor genomic testing to provide better cancer care. By dissecting the tumor, we can look at the molecular makeup and tell what the risk of recurrence is.”

Judith O. Hopkins, MD
Medical oncologist
We also are using tumor genomic testing to provide better cancer care. By dissecting the tumor, we can look at the molecular makeup and tell what the risk of recurrence is. It also helps us determine if an individual needs chemotherapy or if other treatment alternatives like lifestyle changes are an option. It can also allow us to tailor a treatment to make it more effective, improving the patient’s chance of being cured as well as decreasing the toxic side effects.

Additionally, genetics helps us clarify family history. If a genetic component can be identified within a family, then each of your first-degree relatives — parents, siblings and children — have a 50 percent chance of having that same genetic mutation. We are moving toward an era where we can take this information and try to potentially prevent some individuals from developing cancer.
“The research shows lung cancer screenings will save lives if we can get the right patients screened. Our No. 1 priority is to educate our primary care providers at Novant Health so they know it’s available for their at-risk patients.”

Ashley Burns
Lung cancer survivor since 2010
What role does lung cancer screening play in the cancer journey?

Lung cancer is the deadliest of all cancers in both men and women, causing about 160,000 deaths annually in the United States. Most lung cancers are diagnosed in advanced stage where curative therapy is not possible.

In fact, the five-year survival rate for lung cancer is only 17 percent.

In February 2015, the Centers for Medicare and Medicaid Services (CMS) approved low-dose spiral CT lung cancer screening. Historically, there was no approved screening procedure for lung cancer. However, the National Lung Screening Trial, which involved more than 50,000 patients, recently showed a 15 to 20 percent reduction in lung cancer deaths for those patients who underwent low-dose spiral CT screening. With this new technology, potentially 32,000 lives could be saved each year if we are able to screen everyone.

The spiral CT screening test can detect lung cancer at a much earlier stage, which will allow thousands of patients to be cured of this cancer and represents an important leap forward in lung cancer.

How is Novant Health using lung cancer screening to enhance patient care?

The research shows lung cancer screenings will save lives if we can get the right patients screened. Our No. 1 priority is to educate our primary care providers at Novant Health so they know it’s available for their at-risk patients. CMS covers this test as do most insurance companies. We also need to educate our local communities so they know we have a newly approved procedure that can detect lung cancer earlier.

But we know that change won’t come overnight, and that’s why we’re looking into innovative ways to meet consumers where they are in their healthcare journey. Some of our facilities have implemented a lung nodule evaluation program designed to detect nodules that are incidentally found during a CT scan. This program helps identify potential problems long before they are symptomatic, leading to earlier detection and perhaps even complete cancer avoidance. We’re also developing lung cancer risk clinics that — in addition to screenings — will offer smoking cessation programs to encourage individuals to make the changes necessary to reduce their risk of developing the disease.

How can lung cancer screening drive innovation in cancer care?

Spiral CT scans will be an innovative game changer for lung cancer. This newer technology can provide more rapid and accurate visualization of internal organs. The technology’s impact will be comparable to what colonoscopies did for colon cancer, mammograms did for breast cancer and what Pap smears did for cervical cancer — it has the potential to save thousands of lives across the country.

Ask the doctor: Lung cancer screening

Thomas H. Grote, MD
Medical oncologist
What role does navigation play in the cancer journey?

The navigator’s sole job is to help the patient maneuver the complicated maze of cancer care. The navigator is the one who guides the patient through the different meetings, appointments and treatments because the journey can easily become confusing and overwhelming.

Novant Health uses a multidisciplinary, patient-focused approach to provide a diagnosis and treatment plan for each individual. A patient can have many caregivers — the disease-specific specialist, radiation oncologist, medical oncologist, surgeon and pathologist. For those centers that use navigation, their patients will have one navigator by their side from the time of diagnosis to treatment to recovery to survivorship.

How is Novant Health using navigation to improve or enhance patient care?

The navigator serves as the patient advocate for the individual who has cancer. Every time that patient has a question, concern or problem, the assigned navigator will get the call. If it’s determined that the patient needs support services like rehab or counseling, the navigator can facilitate the referral. There are few questions that navigators can’t answer and for those they can’t, they’ll connect the patient with the resource or person who can.

Having a dedicated point of contact winds up being an invaluable resource for patients. They appreciate the navigator’s expertise, but perhaps even more importantly they gain strength from the emotional connection that is made during such a vulnerable time.

How can navigation drive innovation in cancer care?

Navigators drive patient satisfaction more than innovation. When it comes to navigation, it’s all about the human touch. It’s hard to improve upon personalized cancer care — having someone by your side as you wait for your latest body scan, someone to greet you when you arrive for chemotherapy or someone to call after hours.

Navigation also expedites care so the individual doesn’t get lost in the maze. We recently had a great example where a patient had visited the ER not once but twice over two months, and both times he was told he had a tumorous growth that needed immediate medical attention, but he wasn’t sure what next steps to take to seek care. Eventually, a navigator was able to find the individual. She then fast tracked the patient so a diagnosis was made within a week and treatment started within two weeks. This is the perfect example how a navigator takes the lead to coordinate care so diagnosis and treatment can be expedited.
“Navigators drive patient satisfaction more than innovation. When it comes to navigation, it’s all about the human touch. It’s hard to improve upon personalized cancer care.”
New cases
According to the American Cancer Society (ACS), an estimated 46,420 new cases of pancreatic cancer are expected in 2014. Approximately 22,890 (49 percent) of these cancers will be in females and 23,530 (51 percent) will be males. Pancreatic cancer frequently is diagnosed at later stages and, while it accounts for only 3 percent of all cancers in the United States, it accounts for 7 percent of cancer deaths.

Incidence rates have risen slightly over the last decade. The average lifetime risk of developing pancreatic cancer is 1 in 67 (1.5 percent). In 2014, it is estimated that there will be 39,590 deaths from pancreatic cancer: 19,420 women and 20,170 men.

Risk factors
Smoking is considered one of the most important risk factors for pancreatic cancer. The risk of developing pancreatic cancer is about twice as high among smokers as compared to those who have never smoked. Cigar, pipe and smokeless tobacco products all increase risk.

Obesity and exposure to certain chemicals are also risk factors for pancreatic cancer. Obese people are about 20 percent more likely to develop the cancer. In addition, certain pesticides, dyes and chemicals used in metal refining may increase the risk of developing pancreatic cancer.

Pancreatic cancer is more common in people who have diabetes. The risk is found mostly in people with type 2 diabetes. It is unclear if people with type 1 diabetes are at higher risk for this type of cancer.

Some risk factors that cannot be changed include age, gender and race. According to the ACS, about two-thirds of pancreatic cancer patients are at least 65 years old. Almost all of them are over age 45. Men are 30 percent more likely to develop this cancer, and African-Americans have a higher rate of pancreatic cancer as well.

Symptoms
Many symptoms of pancreatic cancer can also be caused by other conditions, so it’s important that patients discuss any symptoms with their healthcare providers. However, early pancreatic cancers may not cause any signs or symptoms.

The most common symptom associated with pancreatic cancer is jaundice, which may present as dark urine, light-colored stools and itchy skin. Other common symptoms include diarrhea, poor appetite/weight loss, nausea and vomiting. Less often, people may notice diabetic-type symptoms, such as extreme thirst, frequent urination, sweating and weakness. In rare cases, deep vein thrombosis formation may signal pancreatic cancer.

Diagnosis
Although pancreatic cancer may be discovered incidentally on imaging tests or lab work, if symptoms are present, a doctor will start with an abdominal exam. In addition, imaging tests, such as computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) and ultrasound, may be helpful in imaging the pancreas and adjacent structures. Endoscopic ultrasound (EUS) is more accurate than abdominal ultrasound or CT but is also invasive, requiring insertion of a flexible tube to look inside the digestive tract. Blood tests may also be helpful to identify specific tumor markers and to assess liver function.
Treatment
Pancreatic cancer is treated based on stage of disease and the overall health of the person. Treatment options include surgery, ablation, radiation therapy and chemotherapy or other drugs.

Pancreatic cancers usually are divided into those that are resectable or are unresectable. If resectable, meaning they have a reasonable chance of removing the cancer, then surgery and chemotherapy with or without radiation therapy may be recommended. For unresectable cancers, meaning the tumor has grown too far into surrounding tissues to be completely removed by surgery, then the standard treatment is chemotherapy or chemotherapy with radiation therapy. In cases that are unresectable, surgery may be performed to relieve or prevent symptoms, such as bile duct blockage or blocked intestines.

Survival
Survival rates for pancreatic cancer depend on the stage of disease at diagnosis and the general health of the patient. For 2003-2006, the National Cancer Data Base (NCDB) reports five-year observed survival rates for stage I pancreatic cancer to be 63 percent; stage II rates to be 20 percent; stage III rates to be 2.5 percent; and stage IV rates to be 1.6 percent. The overall five-year observed survival rate for pancreatic cancer is 5.6 percent.

Novant Health Cancer Center cases and outcomes
In 2013, 74 patients were diagnosed with pancreatic cancer at Novant Health Derrick L. Davis Cancer Center (NHDLDCC). Of those 74 patients, 52.7 percent of patients were female and 47.3 percent were male, which is similar to national data reported by ACS. The median age of pancreatic cancer patients diagnosed at NHDLDCC was 71 years, with 31 percent being younger than 65 and 69 percent being 65 or older.

Using 2011 pancreatic cancer data for comparison, many similarities are found between NHDLDCC and the NCDB — the data source that accredited cancer programs use for national comparisons. NHDLDCC patients were similar in age to patients diagnosed with pancreatic cancer reported in the NDCB for 2011 (see figure 1). Eighteen percent of NCDB patients were less than 60 years of age, which was slightly lower than the rate seen for NHDLDCC patients (24 percent).

Patient gender is also similar at NHDLDCC when compared to patients reported in the NCDB. Females made up the majority of patients diagnosed. NHDLDCC rate by gender was 56 percent female while NCDB rates were 51 percent (see figure 2).

In 2013, 74 patients were diagnosed with pancreatic cancer at Novant Health Derrick L. Davis Cancer Center (NHDLDCC)
The five-year observed survival rates for pancreatic cancer patients diagnosed at NHDLDCC from 2003 to 2006 is slightly lower than the patients reported in the NCDB for the same time period (see figure 3). Overall survival rate was 4.3 percent for patients diagnosed at NHDLDCC.

**Commission on Cancer standard 4.6 study results**

As part of our commitment to providing the highest quality care, a physician member of the NHDLDCC cancer committee performed a study to assess that nationally recognized treatment guidelines are being used in the formulation of the first course of treatment for patients with newly diagnosed pancreatic cancer. The initial treatment of patients diagnosed during 2013 was reviewed. A total of 28 patients received treatment: 12 were female (43 percent) and 16 were male (57 percent). Patient age ranged from 47 to 86 years with eight (28.6 percent) less than 65 years of age and 20 (71.4 percent) greater than or equal to 65 years. Distribution of AJCC stage was as follows: 7 percent were stage I; 46 percent were stage II; 4 percent were stage III; and 43 percent were stage IV.

Initial treatment included surgery in 11 patients and chemotherapy in four patients of the stage I or II cases. Chemotherapy was the initial treatment for all of the stage III and IV cases. With reference to NCCN guidelines version 2.2014 for initial treatment of pancreatic carcinoma, all cases were managed in accordance with evidence-based national guidelines.

**Figure 3: 2003–2006 5-year observed survival rates from NCDB**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>63%</td>
</tr>
<tr>
<td>II</td>
<td>20%</td>
</tr>
<tr>
<td>III</td>
<td>2.5%</td>
</tr>
<tr>
<td>IV</td>
<td>1.6%</td>
</tr>
<tr>
<td>Overall</td>
<td>5.6%</td>
</tr>
</tbody>
</table>
Austin Wilson
Rhabdomyosarcoma survivor since 2013
New cases
According to the American Cancer Society (ACS), an estimated 96,830 new cases of colon cancer are expected in 2014, with males having a greater lifetime risk of developing colon cancer than females. Colon cancer death rates have steadily decreased over the past 20 years thanks to screening and early detection advancements. Even so, colon cancer is the second leading cause of cancer death when both sexes are combined, and is estimated to claim 50,310 lives in 2014.

Risk factors
Age is a primary risk factor for colon cancer. According to the ACS, 9 out of 10 people diagnosed with colon cancer are age 50 or older. Lifestyle factors such as smoking, drinking alcohol, obesity, limited physical activity and type 2 diabetes are also considered risk factors. A personal or family history of colorectal polyps or colorectal cancer also poses risks. According to the ACS, 5 to 10 percent of people who develop colorectal cancer have inherited genetic mutations, which can lead to developing cancer at a younger age. ACS data shows that Ashkenazi Jews have one of the highest colorectal cancer risks of any ethnic group in the world, and African-Americans have the highest colorectal cancer incidence and mortality rates of any race in the United States.

Symptoms
Symptoms of colon cancer can include:
• A change in bowel habits (e.g., diarrhea, constipation, narrowing of the stool) that lasts for a few days
• Feeling as if a bowel movement is needed but no relief once having one
• Rectal bleeding, dark stool or blood in the stool
• Abdominal pain and cramping
• Weakness and fatigue
• Unintended weight loss

Diagnosis
Screening tests such as flexible sigmoidoscopy, colonoscopy, double-balloon enteroscopy and CT colonography can find colon cancer early and even help prevent it. While these tests look for polyps and cancer, fecal occult blood tests and fecal immunochemical tests look for signs of cancer in the stool. Beginning at age 50, people with an average risk of colon cancer should begin screening.

Treatment
Colon cancer is treated based on the patient’s stage of disease. Stage 0-I cancers are treated with polypectomy or colectomy. Stage II cancers with high-risk features are treated with a colectomy, and — due to risk factors — may require chemotherapy as well.
Once colon cancer has spread to the lymph nodes, as is the case with stage III patients, both surgery and chemotherapy are indicated. Surgery is unlikely to cure stage IV cancer that has spread to other organs but is still often used along with chemotherapy.

Radiation therapy is used in colon cancer post-surgery if there is a concern for cancer cells being left behind and is also indicated for symptom relief in stage IV patients.

**Novant Health Rowan Medical Center cases and outcomes**

In 2013, 33 patients were diagnosed and treated with colon cancer at Novant Health Rowan Medical Center (NHRMC). Of those patients, 45 percent were female and 55 percent were male. The median age of colon cancer patients diagnosed at NHRMC was 69 years, with 97 percent being 50 or older.

Using 2012 colon cancer data for comparison, many similarities were found between NHRMC and the National Cancer Data Base (NCDB). NHRMC patients were similar in age to patients diagnosed with colon cancer reported in the NCDB. (See figure 1.) Ninety-three percent of NCDB patients were over 50 years of age; similarly, 97 percent of NHRMC patients were over 50 years of age.

Patient gender varied only slightly between databases, with the NCDB reporting an even split between males and females and NHRMC reporting their rate by gender as 45 percent female. (See figure 2.)

2013 census data shows the Rowan County population is 80.3 percent Caucasian and 16.5 percent African-American. NHRMC data report the incidence of colon cancer cases as 79 percent Caucasian and 21 percent African-American. These data support ACS statistics revealing a higher incidence of colon cancer in African-Americans. NCDB 2012 data shows a different composition, with Caucasians accounting for 81 percent of colon cancer diagnoses and African-Americans accounting for 11 percent. These numbers do not correlate with ACS data. (See figure 3.)
A greater percentage of colon cancer patients were diagnosed as stage I at NHRMC (33 percent) when compared to the NCDB (20 percent). (See figure 4.)

**Commission on Cancer standard 4.6 study results**

As part of our commitment to providing the highest quality of care, a physician member of the Novant Health Rowan Medical Center cancer committee performed a study to assess if nationally recognized treatment guidelines are being used in the formulation of the first course of treatment for patients with newly diagnosed colon cancer. The initial treatment of patients diagnosed during 2013 was reviewed. There were a total of 27 cases: 13 were female (48 percent) and 14 were male (52 percent). Patient age ranged from 41 to 90 years, with 26 (96 percent) being 50 years of age and older.

Distribution of American Joint Committee on Cancer stage was as follows: 33 percent were stage I; 21 percent were stage II; 24 percent were stage III; and 21 percent were stage IV. Initial treatment included surgery in all cases. With reference to National Comprehensive Cancer Network Guidelines version 2.2014 for initial treatment of colon cancer, all cases were managed in accordance with evidence-based guidelines.

**Figure 4: 2013 NHRMC stage vs. 2012 NCDB**

![Graph showing stage distribution for NHRMC and NCDB](image)

Gregory Mitro, MD
Radiation oncologist

“As part of our commitment to providing the highest quality of care, a physician member of the Novant Health Rowan Medical Center cancer committee performed a study to assess if nationally recognized treatment guidelines are being used in the formulation of the first course of treatment for patients with newly diagnosed colon cancer.”
Novant Health Cancer Center cases and outcomes

In 2013, 164 patients were diagnosed and treated with colon cancer at Novant Health Charlotte-area cancer facilities: Novant Health Presbyterian Medical Center, Novant Health Huntersville Medical Center and Novant Health Matthews Medical Center. Of those patients, 48 percent were female and 52 percent were male. The median age of colon cancer patients diagnosed in greater Charlotte was 66 years, with 88 percent being 50 or older.

A comparison was done of Novant Health’s greater Charlotte colon cancer data to that of the National Cancer Data Base (NCDB). Greater Charlotte data indicates 12 percent of patients were diagnosed at less than 50 years of age. (See figure 1.) Only 7 percent of NCDB patients were under 50 years of age at diagnosis. However, recently reported figures in the *Journal of the American Medical Association Surgery* show a higher incidence of colon cancer diagnoses in a younger population. The study reported from the University of Texas MD Anderson Cancer Center in November 2014 indicates that the incidence rate of colorectal cancer diagnosed in patients under the age of 34 is increasing across all stages.

While patient gender reported in the NCDB is evenly split between males and females, the greater Charlotte rate by gender is 52 percent male. (See figure 2.)

In the greater Charlotte area, African-American patients represented 24 percent of colon cancer diagnoses, as compared to 11 percent in the NCDB. The majority of diagnoses occurred in the Caucasian population. (See figure 3.)
Greater Charlotte and the NCDB report similar trends in stage at colon cancer diagnosis. (See figure 4.)

The five-year observed survival rates for colon cancer patients diagnosed at greater Charlotte from 2003 to 2007 are slightly higher than the patients reported in the NCDB for the same time period. Overall survival rates were 61.1 percent for patients diagnosed at greater Charlotte Novant Health facilities, compared to 56.1 percent in the NCDB. (See figure 5.)
Commission on Cancer standard 4.6 study results

As part of our commitment to providing the highest quality of care, a physician member of the greater Charlotte Novant Health cancer committee performed a study to assess if nationally recognized treatment guidelines are being used in the adjuvant treatment of colon cancer patients. The study included the adjuvant treatment of 91 patients diagnosed with stage I to III cancer in 2013, of which 43 were female (47 percent) and 48 were male (53 percent). The median patient age was 66, with 89 percent being 50 years of age and older. Distribution of American Joint Committee on Cancer stage was as follows: 32 percent were stage I; 34 percent were stage II; and 34 percent were stage III. Treatment for all stage I cases included surgery alone, which is also the recommendation set forth in the National Comprehensive Cancer Network (NCCN) Guidelines version 3.2014. Adjuvant treatment of stage II colon cancer is somewhat controversial. NCCN guidelines indicate clinical trial, observation and chemotherapy as options in the adjuvant treatment of stage II colon cancers. Physicians consider multiple risk factors for recurrence when selecting adjuvant treatment. This study indicates that in greater Charlotte, 74 percent of patients had surgery alone, and 26 percent had surgery followed by chemotherapy. Guidelines for stage III colon cancer designate chemotherapy as the appropriate adjuvant treatment in that population. In this review, 77 percent of the stage III patients received adjuvant chemotherapy. Five patients (16 percent) had chemotherapy recommended; however, those patients elected observation as their postoperative treatment course. Two stage III patients (7 percent) were not given chemotherapy due to age and other comorbidities. When analyzing care in accordance with NCCN guidelines, appropriate care was given to the medically fit patients in this population.

“This study indicates that in greater Charlotte, 74 percent of patients had surgery alone, and 26 percent had surgery followed by chemotherapy. Guidelines for stage III colon cancer designate chemotherapy as the appropriate adjuvant treatment in that population.”
Lee Pennington
Testicular cancer survivor since 2014
Improving patient care

Continuing medical education
With a focus on providing the highest level of care to our patients, we prioritize making education and training opportunities available to physicians, nurses and staff.

Novant Health Cancer Care hosts an annual educational symposium for physicians around the region. Nationally recognized speakers provide a forum in which participants can learn and ask questions about the latest evidence-based information.

Along with the lectures, our faculty provides case presentations to the audience to enhance learning through real-life situations. The symposium takes place in Charleston, South Carolina, and focuses on a specific tumor site each year. In 2014, 100 participants, including 38 physicians, earned 8.5 CME credit hours while discussing innovations in gastrointestinal cancer care.

Cancer conferences and clinics
Cancer conferences provide a forum for multidisciplinary case consultations with physicians in oncology-related specialties. Multiple general and tumor-site specific conferences are held monthly at Novant Health Forsyth Medical Center, Novant Health Presbyterian Medical Center and Novant Health Rowan Medical Center. Physicians located at our community hospitals participate through video conference.

Each conference is designated for up to one hour Category I credit of AMA Physician’s Recognition Award.

Multidisciplinary cancer clinics are offered at Presbyterian Medical Center and are similar in nature to the cancer conferences, with the exception that the patient is involved in the conversation. Specific clinics are held each month for breast, colorectal, thoracic and urologic cancers.

Between our cancer conferences and clinics, we provided 426 continuing medical education hours in 2014.
Prevention and early detection

Our prevention and early detection program exists to promote healthy lifestyles through education and community awareness. Thanks to partnerships with local agencies and community groups, in 2013 we were able to touch hundreds of lives with messages about the importance of prevention and early detection for breast, prostate, colorectal, cervical, lung and skin cancer.

We’re firm believers that screenings can save lives. Every year, we commit to making screening services readily available to our community, with the goal of impacting those who couldn’t find the time or resources to schedule an appointment on their own.

We’re deeply appreciative of our physician and community partners whose collaboration makes it possible to extend prevention and diagnostic care to those in need. Among others, Susan G. Komen for the Cure, National Breast Cancer Foundation, the Avon Foundation, Colon Cancer Alliance, American Cancer Society and Cancer Services, Inc. of Forsyth County have provided essential dollars and resources to support our efforts.

<table>
<thead>
<tr>
<th>Results from our early detection programs</th>
<th>Number screened</th>
<th>Number diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin cancer screening</td>
<td>314</td>
<td>26</td>
</tr>
<tr>
<td>Colonoscopy screening</td>
<td>26</td>
<td>1</td>
</tr>
<tr>
<td>Prostate cancer screening</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>Mammography screening</td>
<td>1,062</td>
<td>21</td>
</tr>
</tbody>
</table>

1,054 Diagnostic procedures  117 Biopsies

“We’re firm believers that screenings can save lives. Every year, we commit to making screening services readily available to our community, with the goal of impacting those who couldn’t find the time or resources to schedule an appointment on their own.”