2020 Cancer Program Reporting of Outcomes

*statistical data for 2019

CHI Memorial
Rees Skillern Cancer Institute
Leading Cancer Care

The Rees Skillern Cancer Institute at CHI Memorial is the leading provider of adult cancer services in the Chattanooga area. Our comprehensive program includes eight centers of excellence, each dedicated to a specific type of cancer and supported by interdisciplinary tumor boards, clinical trials and advanced technologies.

We’ve proudly served the Chattanooga, North Georgia and surrounding communities since 1952. The cancer program has consistently maintained accreditation with commendations from the American College of Surgeons, Commission on Cancer: program designation, “Comprehensive Community Cancer Program.”

Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.
Table of Contents

2 Centers of Excellence and Complete Services Listing
4 Message from Deb Moore, VP of Oncology Services at CHI Memorial
5 Digital Shift: Different Technologies, Same Effective Cancer Care
6 Rees Skillern Cancer Institute Medical Directors
8 2020 Cancer Committee
9 2021 Cancer Conference Schedule
10 Behind the Scenes in Cancer Care
11 Centers of Excellence Teams Add Value and Support
12 Genetics and Pancreatic Cancer
14 Reaching Out to Stop Lung Cancer
16 The Role of Palliative Care in Cancer Care
18 Working Together to Beat Cancer
20 Prehabilitation Offers Additional Support Prior to Cancer Treatment
21 Cancer Screening and Prevention Programs
24 Cancer Incidence
Rees Skillern Cancer Institute Centers of Excellence

Breast Center of Excellence –
  The MaryEllen Locher Breast Center
Colorectal Center of Excellence
Head & Neck Center of Excellence
Melanoma Center of Excellence –
  Elizabeth R. Smith Melanoma Program
Urologic Cancer Center of Excellence
Radiation Center of Excellence –
  H. Clay Evans Johnson Radiation Center
Pancreatic & Hepatobiliary Center of Excellence
Thoracic Center of Excellence
  Chest and Lung Cancer Center
  Buz Standefer Lung Center

Additional Services
  The Joe and Virginia Schmissrauter Center for Cancer Support
  High Risk Cancer and Genetics Center
  Survivorship Care
  Clinical Trials and Research
  Palliative Care
  Hospice Care
  Tumor Registry
  Mobile Coaches for Breast, Cervical and Lung Cancer Screening
Complete Service Listing

CHI Memorial offers a comprehensive range of services to meet all of your cancer care needs and concerns.

Colorectal Center of Excellence
3T MRI technology
capsule endoscopy
endorectal ultrasound
enhanced recovery after surgery (ERAS) protocols
endoscopic retrograde cholangiopancreatography (ERCP)
optical and virtual colonoscopies
robotic-assisted surgery

Gynecological Oncology Services
cervical screening outreach program
robotic-assisted surgery

Head and Neck Center of Excellence
oral cancer screening outreach program
robotic-assisted surgery

Lung Center of Excellence
cone beam CT
endo-bronchial ultrasound
fluoronavigational bronchoscopy
lung biopsies
lung cancer screening program
lung nodule clinic
mobile lung cancer screening program in
14 counties in Tennessee and eight in Georgia
PET scans
pulmonary rehab
respiratory testing
robotic-assisted surgery

MaryEllen Locher Breast Center
bone density tests
breast MRI
cancer risk counseling
community outreach

concurrent reconstructive and plastic surgery
2D & 3D mammography screening
mobile mammography services in north Georgia,
north Alabama, and 25 counties in Tennessee
stereotactic and ultrasound guided breast biopsies
whole-breast ultrasound diagnostics

Melanoma Center of Excellence
community outreach
skin cancer screening

Radiation Center of Excellence
image-guided radiation therapy (IGRT)
intensity-modulated radiation therapy (IMRT)
MammoSite treatments
Novalis Tx
TrueBeam STx

Urologic Center of Excellence
partial nephrectomy
robotic-assisted prostatectomy
targeted MRI/ultrasound biopsy
uro navigation

Holistic Support Services
genetic testing and counseling
oncology dietitians
oncology licensed clinical social workers
patient and family advisory counseling
RN navigation
second opinion services
spiritual care services
support groups and retreats
survivorship education and support from RNs,
dietitians, licensed clinical social workers and
chaplains and coordination with community
resources for survivorship including financial
counseling through the Chattanooga Tumor Clinic

* statistical data for 2019
I’m pleased to share with you CHI Memorial Rees Skillern Cancer Institute’s 2020 cancer annual report. Inside you’ll find stories about our team of professionals and how they persevered in difficult times to continue delivering the highest quality cancer care available in our community.

Much of the world was taken off guard by COVID-19, and the number of people who sought care – including all routine screenings – was negatively impacted. Our team quickly sprang into action, making the necessary adjustments to our schedules, workflows and spaces that would allow for the continued safe access to cancer screening and care. Additionally, our mobile mammography and lung coaches continued to take critical screenings to outlying communities that would otherwise not have adequate access.

Despite the unique challenges presented by the global pandemic, the need for innovative cancer care did not stop. In fact, the decrease in screenings has led to later stage cancer diagnoses, a result we are working hard to curtail by conducting reminder direct mail and text message campaigns and making screening event details available on our social media channels. We remain vigilant about identifying cancers earlier when they are most receptive to treatment.

The Rees Skillern Cancer Institute also established an information and referral network for cancer services called Cancer Connect, a one-stop resource for people seeking information on cancer care at CHI Memorial. Individuals can call 423.495.2222 to reach someone 24 hours a day who can offer support and guidance for all things cancer related – from help with scheduling and confirming appointments to questions about screenings to finding the right cancer specialist. Major cancer centers around the country offer this model of cancer support, and this is another way we’re making the process easier for our patients and providing the guidance and help our community needs.

Every one of our cancer experts at the Rees Skillern Cancer Institute is dedicated to providing the most compassionate service and the highest standard of care – and that means better outcomes for our patients. Our multidisciplinary team is focused not only on advanced detection and treatment technologies, but on providing the holistic support people need during treatment and into survivorship.

As we look to the future, we understand this work does not stop. But there’s a great opportunity for continued resilience, innovative thinking and increasing access to the services that are central to our mission of preventing and curing cancer. Thank you for your continued support.

Screening Information

Learn more about upcoming low-dose mobile lung CT screening events at memorial.org/lungscreening. To register or schedule the Breathe. Easy for an event, call 423.495.5864 (LUNG).

Mobile breast cancer screening information is available at memorial.org/mobilemammography.

Call 423.495.4040 or toll-free 866.591.2254 to schedule an appointment.

Follow us at Facebook.com/CHIMemorial for information about upcoming screening and support group opportunities.
Hard work and humility. That’s how the team at CHI Memorial’s Rees Skillern Cancer Institute approached 2020, arguably one of the most difficult years we’ve collectively experienced in our lifetime. Despite the challenges of COVID, the ravages of cancer didn’t stop. We quickly confronted the question: “How will we adapt and be nimble to continue serving our patients and their families well?”

Thanks to advancing technologies and loosening legislative restrictions around payments for virtual medicine, we quickly shifted certain aspects of cancer care to the digital space. Genetic counseling easily transitioned from in person to remote sessions; nurse navigators met with certain patients over Zoom; and the multidisciplinary tumor conferences began offering a remote option, expanding the potential number of experts who could weigh in on specific cancer diagnoses and treatment planning decisions. COVID and the need to connect virtually has introduced both the practicality and benefits of video visits for specific situations, and I expect these options to continue to grow.

While some aspects of medicine will always require direct examination that cannot be substituted, this year has proven there is always room for improvement and for implementing new solutions. We’ve shown that gathering data, connecting people to the resources they need, and collaboration between specialists to ensure the best possible approach to care can continue in light of extenuating circumstances. Not only have we survived this transition, we’ve thrived – by creating an environment that is keeping our team members, our patients and their families safe.

Lastly, I’m thrilled to announce that CHI Memorial has recognized by U.S. News and World Report for high performing in colon cancer and lung cancer surgery. This demonstrates how our hospital administration and leaders within the Rees Skillern Cancer Institute have simultaneously addressed the very difficult challenges presented by COVID-19 while also maintaining the high-quality cancer care that people have come to expect from our organization. That, combined with the commitment from the physicians who have willingly joined together to do more for our patients than ever before, is making a tangible difference in the care we provide every day. Seeing the teamwork and successes that have resulted in light of these difficulties makes me hopeful for a very bright future.
Advanced Training and Expertise
Rees Skillern Cancer Institute Medical Directors

CHI Memorial Rees Skillern Cancer Institute medical directors play a critical role in developing, shaping and implementing the clinical practice guidelines that drive quality improvements and help us continually elevate our level of care. As highly trained subject matter experts and leaders in their field of expertise, they play a vital role in clinical leadership – ensuring advanced treatments are available – while also advocating for each person at the highest level.

As engaged, passionate and dedicated professionals, our leadership team works together to develop, implement and adhere to the highest levels of care set forth in national clinical practice guidelines. We define ourselves by the ability to provide exceptional medical expertise, advanced cancer treatments and the support that begins with screenings and extends into survivorship.

Ted Arrowsmith, MD
Medical Oncology
MEDICAL SCHOOL, RESIDENCY, FELLOWSHIP
Medical Oncology
Vanderbilt University
Nashville, TN

J. Rob Headrick, MD
Thoracic Cancer
MEDICAL SCHOOL
University of Tennessee
Memphis, TN
RESIDENCY
University of Tennessee
Chattanooga, TN
FELLOWSHIP
Thoracic Surgery
Mayo Graduate School of Medicine, Rochester, MN

Peter Hunt, MD
Head, Neck & Melanoma
MEDICAL SCHOOL
Vanderbilt University
Nashville, TN
RESIDENCY
Baylor College of Medicine
Houston, TX
FELLOWSHIP
Head & Neck Oncology & Microvascular Reconstruction Surgery
Vanderbilt Medical Center, Nashville, TN
R. Hunter Jennings, MD
Pancreatic & Hepatobiliary Cancer
MEDICAL SCHOOL, RESIDENCY & FELLOWSHIP
Liver Transplantation & Surgical Critical Care
Emory University School of Medicine
Atlanta, GA

Jeffrey Mullins, MD
Urologic Cancer
MEDICAL SCHOOL
West Virginia University School of Medicine
Morgantown, WV
RESIDENCY
Johns Hopkins Hospital
Baltimore, MD
FELLOWSHIP
Research, Urology
Endourology
Johns Hopkins Hospital
Baltimore, MD

Eric Nelson, MD
Colorectal Cancer
MEDICAL SCHOOL
Loma Linda University
Loma Linda, CA
RESIDENCY
University of California Davis, CA
FELLOWSHIP
Colorectal Surgery
UT College of Medicine
Chattanooga, TN

Taylor Rowlett, MD
Radiology
MEDICAL SCHOOL
University of Louisville School of Medicine
Louisville, KY
RESIDENCY & FELLOWSHIP
Nuclear Medicine and Breast Imaging
Medical University of South Carolina
Charleston, SC

Sanford Sharp, MD
High Risk Genetics
MEDICAL SCHOOL
Vanderbilt University
Nashville, TN
RESIDENCY
Internal Medicine
University of Michigan Hospitals and Health Centers
Ann Arbor, MI
RESIDENCY
Anatomic & Clinical Pathology
University of Missouri
Columbia, MO
Vanderbilt University
Nashville, TN

Lanett Varnell, MD
Breast Imaging
MEDICAL SCHOOL
University of South Alabama College of Medicine
Mobile, AL
RESIDENCY
Diagnostic Radiology
Baptist Medical Centers
Birmingham, AL

Betsy Washburn, MD
Breast Cancer
MEDICAL SCHOOL & RESIDENCY
Medical College of Georgia
Augusta, GA
FELLOWSHIP
Breast Surgery
William Beaumont Hospital
Royal Oak, MI

J. Taylor Whaley, MD
Radiation Oncology
MEDICAL SCHOOL
University of Tennessee
Memphis, TN
RESIDENCY
University of Pennsylvania
Philadelphia, PA

* statistical data for 2019
2020 Cancer Committee

Bertrand Anz, MD, medical oncologist
John Boxell, MD, ret., cancer program advisor
Stephanie David, MD, cancer conference coordinator
John Fortney, MD, radiation oncologist
Rob Headrick, MD, thoracic surgeon
Peter Hunt, MD, head & neck surgeon
Hunter Jennings, MD, colorectal, pancreatic and hepatobiliary surgeon
Michael Lacombe, MD, diagnostic radiologist
Jeffrey K. Mullins, MD, director urologic oncology, surgeon
Ben Nadeau, MD, medical oncologist
Irina Perjar, MD, cancer conference coordinator
Gregory Phelps, MD, palliative care
Taylor Rowlett, MD, diagnostic radiologist
Sanford Sharp, MD, cancer committee chair, pathology, cancer registry quality coordinator
Betsy Washburn, MD, cancer liaison physician, breast surgeon representative
J. Taylor Whaley, MD, radiation oncologist
Keaona Adkinson, RN, outpatient infusion services coordinator
Penny Andrews, BSN, RN, FCN, OCN, clinical research coordinator
Marci Bradley, RN, CMSRN, OCN, oncology nurse navigator – breast
Clarissa Boyer, BSN, RN, CBCN, survivorship program coordinator
Allen Chandler, PA-C, palliative care
Rhonda Edwards, LCSW, ACSW, OSW-C, psychosocial services coordinator, mental health professional / clinical oncology social worker
Amy Fields, American Cancer Society representative
Karen Frank, DNP, RN, CPPS, MSHA, quality improvement coordinator
Mike Fuller, RN, OCN, oncology nurse navigator – urology and prostate
Tracy B. Gose, PT, DPT, CMP, CSCS, physical therapist

Lori Hammon, RN, BSHA, CPHQ, quality improvement coordinator
Tina Harris, MS, NP-C, AOCNP, managing director, Chattanooga Tumor Clinic
Terri Henderson, BSN, RN, OCN, BC, oncology nurse navigator – head & neck and melanoma
Brittany Hennessee, RT(R)(M), manager of breast services, MEL breast center
Mary Ellen Herring, CTR, tumor registrar, cancer registry quality coordinator
Sharon Hopper, RDN, LDN, registered dietitian
Betsy Kammerdiener, M.Div, BCC, director, mission integration
Nick Lockhart, PharmD, BCPS, pharmacy
Andrea Martin, breathe easy outreach coordinator
Mary Lynn Millsaps, MSW, LMSW, psychosocial services coordinator
Deb Moore, MSN, RN, MBA, vp oncology services, cancer program administrator
Greg O’Brien, sr. market development representative
Jeremy Posey, cancer conference scheduler
Betsy Quinn, MSN, RN, OCN, oncology nurse navigator – lung
Sherrie Sanders, BSN, RN-BC, OCN, oncology nurse navigator – pancreatic
Kim Shank, BSN, RN, OCN, oncology clinical services director, oncology nurse, colorectal nurse navigator
Jennifer Scollard, PT, DPT, rehabilitation services
Sentha Srinivasan, director of radiation oncology & lead physicist
Jennifer Stilts, CTR, tumor registrar
Madison Thomason, MS, CGC, genetic counselor
Casey Waddle, NP-C, survivorship clinic representative, oncology nurse navigator – breast
Hannah Walker, BSN, RN, OCN, oncology nursing unit director
C. Anice Watson, MS, CGC, genetic counselor
Ginger Whisman, BS, CCRC, clinical research coordinator
Melissa Harrington White, PT, DPT CCI, director of rehabilitation services and nutrition and weight management
# Rees Skillern Cancer Institute
## 2021 Cancer Conference Schedule

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**Start times:** All conferences start at 7:00 am.
Exceptions: GU: 7:15 am; Interstitial Lung: 11:45 am.

**Location:** All conferences currently held remotely on Zoom (until further notice).

Please contact Multidisciplinary Conference Coordinator Jeremy Posey with any conference related issues.
Email: Jeremy_Posey@memorial.org  P: (423) 495-2262  Fax: (423) 495-6158

*5/25/2021*

*statistical data for 2019*
CHI Memorial’s cancer registry team plays a pivotal – if often unseen – role in effective cancer care. The cancer registry is tasked with collecting cancer data – demographics, diagnostic information, treatments and outcomes – so that it can be studied by researchers and medical professionals to improve the quality and effectiveness of specific treatment plans. The highly detailed information collected can also be used by local physicians to understand what’s happening regionally with regards to cancer sites, staging and treatments offered.

“Certified tumor registrars (CTRs) are information specialists who go through extensive training and rigorous testing to accurately record and capture a complete history, diagnosis, treatment and health status for every patient under our care,” says Mary Ellen Herring, CTR, cancer registry lead. “This information is essential to researchers, healthcare providers and public health officials who use it to advance cancer treatments through monitoring, research and continuously updating cancer prevention and screening guidelines.”

Supporting Accreditation

CHI Memorial’s cancer registry consists of five certified tumor registrars, a multidisciplinary conference coordinator and one person dedicated to patient follow-up. As part of the Commission on Cancer certification, patients must be followed annually for the duration of their lives – asking how they are doing and if there are any changes to their cancer status.

“We follow approximately 19,000 patients a year and currently keep a 90% follow up rate on analytic patients that have been diagnosed in the last five years. This follow up is important because we want to know how they’re doing and to provide accurate information to both the Georgia state cancer registry and the Commission on Cancer, which is then used by the American Cancer Society, university researchers and others to evaluate treatments and outcomes,” Herring says.

Herring also points out that accreditation isn’t required for all cancer centers, but that CHI Memorial Rees Skillern Cancer Institute chooses to submit to the certification process which demonstrates an overall commitment to maintaining the highest possible level of care. CHI Memorial is one of approximately 1,500 COC accredited programs in the United States.

“The entire team at Rees Skillern Cancer Institute is focused on providing the latest and most effective treatments for cancer – and we are proud to be part of that effort,” says Herring. “Cancer care and research is always changing, and it’s exciting to help these leaders go in the direction that’s most beneficial to our patients in terms of quality of life and survival. This is our job, but we are also personally invested in making a difference for people living with cancer.”
Centers of Excellence Teams Add Value and Support

A center of excellence refers to the multidisciplinary approach and access to all available treatment options for specific cancer types. It sets apart organizations that demonstrate excellence in patient-centered, coordinated care for people undergoing cancer treatment. CHI Memorial Rees Skilern Cancer Institute includes eight centers of excellence, supported by tumor boards, clinical trials, advanced technologies and team members who work together to continuously improve quality of care.

“Each of our centers of excellence teams are headed by a medical director and a nurse navigator and include surgeons, pathologists, radiation and medical oncologists, as well as dietitian and social work support,” says Kim Shank, BSN, RN, OCN, oncology clinical services director and GI-colorectal nurse navigator. “These multidisciplinary committees meet quarterly and set goals for quality, volume and budget and ensure our programs are operating based on national standards and guidelines. We’re also looking for potential barriers to access and at processes that are delaying timeliness. Tracking our progress is one way we ensure we’re meeting our own standards for high quality care.”

PEG Process Quality Improvement

The Head and Neck Center of Excellence committee, in collaboration with nurse navigators, dietitians and social workers in the Center for Cancer Support, identified ongoing concerns with PEG tube insertions, including education, supplies, order sets, ED admissions and physician calls. The team developed a series of educational tools including two hands-on mannequins, training manuals for staff and outpatient areas where patients are admitted or recovered. The tools include a patient education video, a speech and swallow prescription for specific physician orders, and a dietitian referral process to order tube feeding recommendations.

“Dr. Marcus Wagner, Dr. Peter Hunt and nurse practitioner Brooke Houston have been instrumental in this work, and it is an ongoing process that we continue to refine and improve,” says Terri Henderson, BSN, RN, OCN, head and neck nurse navigator.

Other process improvements include:

- Working closely with speech language therapists to have a modified barium swallow study performed within two to three weeks of initiating treatment, or sooner if indicated.
- Developing a food diary and cookbook for individuals receiving radiation or chemotherapy.
- Developing a template for tube feeding recommendations to standardize the order process.

“We continuously work with our GI partners to have oncology patients consulted and evaluated within two to three weeks of beginning treatment to give us a baseline if a PEG needs to be inserted. Close follow up continues by the speech language therapist, nurse navigator and dietitian during and after treatment,” says Henderson. “Nutrition management is an essential part of the care for people with head and neck cancer. While great progress has been made, a well-coordinated team that spans all related disciplines provides the best opportunity for high quality care and optimal outcomes for these unique patients.”

* statistical data for 2019
Pancreatic cancer doesn’t discriminate – celebrities, a supreme court justice, and a local state representative have been recently affected by this silent and often deadly disease. Pancreatic cancer is the fourth leading cause of cancer death simply because it’s not often found until a later stage, when treatment is less effective. Fortunately, the role of genetic testing is expanding rapidly in pancreatic cancer treatment and in identifying those at high risk.

“A significant number of patients will have a positive family history for pancreatic cancer – roughly 10 to 15 percent,” says Hunter Jennings, MD, pancreatic cancer surgeon. “It’s important to identify these individuals for two reasons – there are specific genetic mutations that can be targeted with chemotherapy and family members can begin screening much earlier and make lifestyle decisions based on this new information.”

National Comprehensive Cancer Network guidelines recommend that every person diagnosed with pancreatic cancer should be offered genetic counseling and testing, regardless of whether or not they have a strong family history of the disease. The detailed personal and family medical history gathered can help gauge the degree of suspicion for a hereditary cancer that could be due to an underlying genetic mutation present at birth.

“Knowing whether there’s a genetic component to a pancreatic cancer diagnosis means a person’s family can implement earlier and more frequent screenings with the hope of catching cancer in an early stage when better outcomes are more likely. In some cases, there may be preventative surgeries or medications to help lower a person’s cancer risk,” says Madison Thomason, MS, CGC, licensed, certified genetic counselor with CHI Memorial High Risk Genetics. “Although some people may be hesitant to have genetic testing, shedding light on why a person developed this condition can be mentally and emotional helpful. My goal is for patients and families to understand that this information can be powerful and potentially lifesaving.”

Genetic Testing Impacts Surveillance and Treatment Decisions

In addition to providing valuable information to family members, genetic testing offers other benefits to the patient and treating physician – including deeper insight into the best approach to treatment.
“We’re understanding more and more how genetic counseling impacts surveillance, early detection and potentially even treatment decisions if and when cancer is found. It gives us an opportunity to be proactive rather than reactive,” says Julie Koffron, MD, pancreatic surgeon on staff at CHI Memorial. “Individuals with a strong family history, especially those with an identifiable genetic disorder, will have more opportunity to find premalignancy or even very early-stage cancers that could increase their chances of cure.”

Coordinated Pancreatic Cancer Care
There’s no doubt that pancreatic cancer is a difficult disease to treat. That’s why CHI Memorial Rees Skillern Cancer Institute offers a multidisciplinary approach to surveillance and treatment that brings together the brightest minds in genetic testing, surgery, chemotherapy, radiation and other support teams to provide the very best care.

“Our priority is to find pancreatic cancer early, and genetic testing is playing a prominent role in that effort. This cancer is very complex and requires advanced care by a number of specialists who are working together as a team,” says Dr. Jennings. “CHI Memorial Rees Skillern Cancer Institute adheres to the most up to date national guidelines, provides nuanced assessment of pancreatic cancer risk and offers the same level of advanced treatment that’s available in large, tertiary medical centers – with the goal of helping people with pancreatic cancer live longer and improve their quality of life.”
Can Lung Cancer Be Found Early? Yes.

Lung cancer is an unrelenting and often silent disease – especially in the early stages. Identifying patients who are at highest risk remains challenging because lung cancer doesn’t show symptoms until it has progressed to a later stage. This is one of the reasons it’s by far the leading cause of cancer death among both men and women.

The prevalence of lung cancer in our community shouldn’t be underestimated. To counter this deadly disease, CHI Memorial launched the most advanced mobile health coach – the Breathe. Easy. – equipped with the safest technology to perform computed tomography (CT) to screen for lung cancer. This second-generation mobile lung screening coach offers updated CT technology including calcium scoring capabilities and a redesigned layout to increase access. Remote connectivity means patients are linked to our team and rapid diagnosis – even in rural areas where access to this lifesaving technology is limited.

“There’s been a huge team effort to design, test and create a fully functioning mobile lung cancer screening coach that makes screening easier than ever before – and that can be reproduced for communities all across the country,” says Rob Headrick, MD, lung cancer surgeon with CHI Memorial Chest and Lung Cancer Center. “Working with a team of pathologists, radiologists, pulmonologists, nurse navigators and support staff, we can provide the highest quality, evidence-based approach to diagnosis and treatment of lung cancer – and save lives.”

The Breathe. Easy. mobile lung CT coach serves 14 counties in Tennessee and eight counties in North Georgia, with plans to expand to the Northeast Alabama area later this year.
Early Detection Makes a Difference

Lung cancer is the second leading cause of death in Tennessee, CHI Memorial is bringing access to this lifesaving screening to the people who need it most. Low-dose CT lung cancer scans have shown to improve survival by 20 percent according to The National Lung Screening Trial (NLST) by the National Cancer Institute (NCI). Since the rollout of the Breathe. Easy. lung coach prototype in 2018, 77% of the cancers found were in the early stages of the disease.

“National trials have predicted that finding cancer earlier leads to better outcomes and survival, and the opposite used to be true – that the majority of lung cancers found were late stage with a poor prognosis,” says Betsy Quinn, MA, MSN, RN, OCN, lung, heme/lymph and esophageal nurse navigator. “Our goal with CT lung screening and within the Lung Center of Excellence is to continue increasing screening volumes – both on and off the Breathe. Easy. mobile coach – so that more lung cancers can be diagnosed early when more treatment options are available.

Those who are at highest risk for lung cancer and are ideal candidates for lung cancer include anyone age 50 and older who have smoked for 20 years (one pack per day). Medicare, Medicaid and commercial insurance will cover most screenings, and a doctor’s referral is required.

To register for a low-dose CT lung screening or to schedule the Breathe. Easy. mobile coach for an event, call 423.495.5864 (LUNG).

Our Top Priority? Getting more people screened earlier for lung cancer when there’s a greater likelihood of successful treatment.
Palliative care is the specialized medical care for people with serious illness that emphasizes providing patients with the relief from the symptoms, pain and stress of a life-limiting diagnosis. Palliative care is often recommended for people with cancer but is also appropriate for illnesses associated with a 50% mortality at five years— including COPD, advanced stage solid tumor cancers, heart failure, advanced dementia and end stage renal disease.

“Palliative care emphasizes comfort, communication and coordination, and focuses on relieving the symptoms of pain, nausea, fatigue, insomnia and constipation that often come with illness or aggressive treatments. As experts in communication with patients, their families and the cancer care team, palliative care specialists help identify a person’s goals around their care and support treating physicians by offering expertise in pain and symptom management,” says Greg Phelps, MD, palliative care physician with Hospice of Chattanooga.

Palliative care is different than hospice in that it can be engaged during life threatening illnesses much earlier in acute care when curative treatment is still ongoing. Hospice is a Medicare benefit that can be engaged during the last six months of life when curative care is no longer pursued. One way to determine if a person would benefit from palliative care is to ask whether you would be surprised if the patient died within 18 months or before adulthood. Other triggers for palliative measures include complex care requirements like functional dependency, home support for a ventilator, antibiotics, feeding or oxygen; or if they are declining in function, feeding tolerance or experience unintended weight loss, among others.

“There’s always need for more education about what palliative care is, certainly from the patient perspective. I try to help them understand that our purpose is not to stop curative treatment, but to walk alongside them, help improve their quality of life, and ensure they are getting what they need out of their medical care,” says Maribeth Bosshardt, MD, palliative care physician with Tennessee Oncology. “We have the extra time to spend with our patients to better understand their physical, psychosocial and emotional needs, which leads to better outcomes.”
For individuals with cancer and a high symptom burden and/or unmet physical or psychosocial needs, the American Society of Clinical Oncology recommends that outpatient cancer care programs provide and use palliative care clinicians to deliver palliative care services to complement existing program tools.

Studies of palliative care continue to show that patients receiving these specialized services live longer than matched patients outside of hospice and suffer less – including less pain, depression, dyspnea and lower rates of PTSD, stress and depression. The goal is to improve value and outcomes without increasing costs.

“I begin with asking my patients the top one or two symptoms that are negatively impacting their quality of life, and let that information drive our discussions. Cancer related pain, anxiety and depression are the most common side effects that can overshadow a person’s entire life,” says Dr. Bosshardt. “With the expertise to aggressively manage pain and other potential side effects from intensive treatment for cancer, we are helping people live longer, fuller and more active lives that are aligned with their personal goals of care.”

* statistical data for 2019
After a cancer diagnosis, the care a person needs for other medical conditions doesn’t stop when treatment begins. Because people in active treatment are seeing many specialists and are in and out of doctors’ offices, they don’t always think about maintaining an active relationship with their referring physician. What’s more, cancer treatments are increasingly effective for many cancer types – and that means more people than ever before are living as cancer survivors. Developing open communication between the oncologist, primary care provider or physician, the patients and their family is critical to maintaining a person’s overall health.

“Primary care physicians have always played an important part in oncology care and continuing to improve the communication between specialists is top of mind for our administrative team as well as our Patient Family Advisory Council which has stressed the importance of PCPs staying well informed as a person goes through active treatment and beyond,” says Kim Shank, BSN, RN, OCN, oncology clinical services director and GI-colorectal nurse navigator. “These physicians are our eyes and ears in the community, and they know their patients well – encouraging screenings and following up on symptoms that often lead to the initial diagnosis.”

“The responsibility of a primary care physician never really stops because someone gets cancer. In fact, the relationships we’ve fostered over the years is valuable because our patients often look to us for information they can trust and the reassurance they’re doing the right thing. We also are there to answer questions and interpret information about the diagnosis and recommended treatment plan,” says Jeffrey Jump, MD, primary care physician with CHI Memorial Integrative Medicine Associates – Chattanooga. “Fortunately cancer treatments are becoming more successful with newer immunotherapies and there’s a shift to the concept of managing some cancers like you do other chronic diseases. It’s more critical than ever before that we play an active part as they are going through treatment and when they transition back into our care.”

Working Together to Beat Cancer

Kim Shank, BSN, RN, OCN, oncology clinical services director and GI-colorectal nurse navigator, leads the online Patient Family Advisory Council. The group transitioned from in-person meetings to Zoom during the COVID-19 pandemic.
Improving Care Coordination

Experts as well as patients and families agree that oncologists and PCPs working together toward meeting a patient’s physical and emotional needs is a great benefit to all involved. Dr. Jump notes that one interesting aspect of cancer care is that sometimes the roles of the oncologist and PCP overlap, which can be a good thing when there’s open communication about a person’s care and how to create the most positive patient experience and outcome.

“Oncologists are involved day to day when questions or concerns come up about side effects from chemotherapy or radiation, but I’m also here to help address those issues if necessary and consider how they may impact a person’s long-term health,” Dr. Jump says. “Because every person is different, we can play as large or small a role as determined by their treatment plan and their body’s unique response.”

“Our primary care physicians are our first line of defense against cancer because they are uniquely positioned to know their patients’ health status, recommend lifesaving screenings and play an integral role in caring for other health needs outside of direct cancer treatments,” says Deb Moore, vice president, oncology services. “And it’s our job to ensure we are providing the appropriate education on national guidelines, thoughtfully communicating about patient needs, and working hand in hand to provide the continuity of care necessary for people to live a full and active life during cancer treatment and into survivorship.”

Patient Family Advisory Council

CHI Memorial’s patient family advisory council (PFAC) was created to provide a voice for patients, families and caregivers and to identify gaps and determine which services are valued most in order to optimize and personalize cancer care. One recent goal was to have medical oncology and primary care physician representation on the committee, which has been valuable as the team worked on other enhancements, including:

- bridging the information gap between inpatient and outpatient oncology patients.
- enhancing the value of survivorship and survivor care plans.
- improving summary updates for primary care.
- creating educational videos about stress management, fear of recurrence, dietary information and cooking demonstrations and of survivors and physicians sharing their experiences.

If you’d like to participate in the patient family advisory council or have questions, please call 423.495.2222.

* statistical data for 2019
Prehabilitation Offers Additional Support Prior to Cancer Treatment

CHI Memorial Rees Skillern Cancer Institute launched the Pre-Surgery Rehabilitation Program in 2020, offering a new emphasis within cancer rehabilitation services that helps prepare patients physically for primary cancer treatment, identify impairments and provide targeted interventions. Cancer prehabilitation occurs on the continuum of care between cancer diagnosis and the beginning of acute treatment. Generally referred to as pre-hab, the program has shown to improve pulmonary function prior to surgery, decrease post-operative complications, decrease length of hospital stay and improve functional capacity or tolerance to chemotherapy.

“Prehabilitation for bladder cancer is all about preparing a patient for their treatment. The multidisciplinary program involves urology, medical oncology, a nurse navigator, nutrition and physical therapy. It builds a treatment team around each person and empowers them to be an active participant in their care,” says Jeffrey Mullins, MD, urologist with CHI Memorial Urology Associates. “Our patients who have participated in this program are stronger going into surgery, leave the hospital more quickly, and return to normal life sooner.”

Individuals referred for pre-hab receive a baseline screening and evaluation by a physical therapist. Standardized tests are used to determine physical performance ability – including a 6-minute walk, strength tests, range of motion, grip strength as well as endurance and aerobic capacity. Physical therapy sessions are scheduled three times weekly for 10-12 visits.

“When someone has cancer, the disease process itself, not to mention surgery, chemotherapy, and/or radiation can negatively affect a person’s health both physically and mentally. Our multidisciplinary pre-habilitation team is here to address these issues prior to surgery,” says Tracy Gose, DPT, physical therapist with CHI Memorial physical therapy. “Physical therapy allows us to objectively obtain the patient’s baseline functional level and establish an exercise program tailored to improve endurance, balance and strength prior to surgery. Improvement in these areas make a positive impact on patients’ overall recovery and is an encouragement to them as well.”

Individuals with any type of cancer are eligible for prehabilitation; or they may take advantage of the cancer rehabilitation services available throughout the course of their treatment and beyond.

“This multidisciplinary approach to cancer care and survivorship has been evolving over the last decade and having another individual team member of the cancer program like Tracy who is invested in our patients’ outcome has been key,” says Jill Tichy, MD, medical oncologist with Tennessee Oncology. “Anyone who seems to be struggling with tiredness, weakness, general deconditioning or other concerns as a result of cancer treatment can benefit from this focused therapy. The communication and feedback have been invaluable, and my patients have come back so thankful for the additional support.”

“The Rees Skillern Cancer Institute aims to treat the whole patient with a comprehensive treatment team, and this patient first, multidisciplinary program is one more way to offer support and to fight cancer from every side,” says Dr. Mullins. “We are all working together to provide the highest quality care, and we believe this approach will be a game-changer for our patients.”
Cancer screening and prevention is a priority for Rees Skillern Cancer Institute, as evidenced by our increasing opportunities to engage individuals in their community or on site at our hospital or other centers. Our aim is to increase cancer awareness through cancer signs and symptoms education, pointing individuals to available resources and addressing common barriers to care. These barriers include diverse misconceptions about the benefit of screenings, attitude, negligence, fear, lack of awareness or resources, or not enough paid time off work.

Commission on Cancer standards 4.1 and 4.2 address cancer prevention programs and screenings by encouraging participation in community events or occasions to provide education and screenings for the well-being of all members of our community.

Each outreach program offered by Rees Skillern Cancer Institute provides one-on-one engagement, clinically accurate literature, relevant educational giveaways and effective communication tools. What’s more, our mobile health coaches bring necessary screenings to underserved populations, while creating a foundation of trust within our community.
### MaryEllen Locher Breast Center

#### Mobile Mammography / Breast Center Outreach

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On average, MaryEllen Locher Breast Center distributes more than 70,000 pages of educational material each year with around 10,000 of that being distributed through the Outreach Program.

### Elizabeth R. Smith Melanoma Program

#### Skin Disease and Oral, Head and Neck Cancer Outreach

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Lung Disease Outreach and Smoking Cessation

2019 Low Dose CT Lung Screening

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</table>

Low Dose CT Lung Screenings Growth 2015 - 2019

<table>
<thead>
<tr>
<th>Year of Screening</th>
<th>Number of Patients Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>478</td>
</tr>
<tr>
<td>2016</td>
<td>711</td>
</tr>
<tr>
<td>2017</td>
<td>876</td>
</tr>
<tr>
<td>2018</td>
<td>1889</td>
</tr>
<tr>
<td>2019</td>
<td>2295</td>
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</table>

27 people completed Freedom from Smoking classes at CHI Memorial Chattanooga, CHI Memorial Family Practice Associates – Ooltewah, CHI Memorial Community Health – Hixson, CHI Memorial Family Practice Associates – LaFayette.

Special projects included promotion of cessation classes and implementation of classes at satellite clinics.

* statistical data for 2019
Cancer Incidence

### Cancer Incidence at CHI Memorial Rees Skillern Cancer Institute

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Breast</td>
<td>355</td>
<td>361</td>
<td>416</td>
<td>409</td>
<td>422</td>
<td>434</td>
<td>390</td>
<td>393</td>
<td>413</td>
<td>420</td>
</tr>
<tr>
<td>Lung</td>
<td>405</td>
<td>368</td>
<td>338</td>
<td>379</td>
<td>404</td>
<td>438</td>
<td>423</td>
<td>458</td>
<td>422</td>
<td>401</td>
</tr>
<tr>
<td>Prostate</td>
<td>295</td>
<td>331</td>
<td>314</td>
<td>256</td>
<td>291</td>
<td>349</td>
<td>340</td>
<td>322</td>
<td>272</td>
<td>313</td>
</tr>
<tr>
<td>Colorectal</td>
<td>236</td>
<td>214</td>
<td>216</td>
<td>213</td>
<td>182</td>
<td>179</td>
<td>190</td>
<td>201</td>
<td>210</td>
<td>210</td>
</tr>
<tr>
<td>Melanoma</td>
<td>151</td>
<td>127</td>
<td>119</td>
<td>126</td>
<td>102</td>
<td>126</td>
<td>75</td>
<td>111</td>
<td>143</td>
<td>83</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>118</td>
<td>104</td>
<td>92</td>
<td>118</td>
<td>94</td>
<td>96</td>
<td>105</td>
<td>104</td>
<td>75</td>
<td>73</td>
</tr>
<tr>
<td>Bladder</td>
<td>95</td>
<td>89</td>
<td>85</td>
<td>111</td>
<td>99</td>
<td>107</td>
<td>136</td>
<td>131</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td>Kidney</td>
<td>72</td>
<td>88</td>
<td>75</td>
<td>95</td>
<td>81</td>
<td>89</td>
<td>82</td>
<td>110</td>
<td>127</td>
<td>125</td>
</tr>
<tr>
<td>Pancreas</td>
<td>43</td>
<td>56</td>
<td>63</td>
<td>55</td>
<td>73</td>
<td>72</td>
<td>58</td>
<td>83</td>
<td>63</td>
<td>70</td>
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<tr>
<td>Corpus Uteri</td>
<td>31</td>
<td>22</td>
<td>40</td>
<td>53</td>
<td>56</td>
<td>51</td>
<td>54</td>
<td>60</td>
<td>53</td>
<td>59</td>
</tr>
</tbody>
</table>

### CHI Memorial Body System Cancer Sites 2019

- **Leukemia** - 1.4%
- **Endocrine system** - 1.8%
- **Others** - 2.7%
- **Lymphoma** - 3.1%
- **Oral Cavity & Pharynx** - 3.8%
- **Skin** - 4.0%
- **Female Genital System** - 5.2%
- **Urinary System** - 10.4%
- **Male Genital System** - 14.1%
- **Digestive System** - 17.5%
- **Respiratory System** - 18.2%
- **Breast** - 17.9%
- **Digestive System** - 17.5%
## 2019 Tumor Site Origins (Analytic Cases)

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>420</td>
<td>17.9</td>
</tr>
<tr>
<td>Lung</td>
<td>401</td>
<td>17.1</td>
</tr>
<tr>
<td>Prostate</td>
<td>313</td>
<td>13.3</td>
</tr>
<tr>
<td>Colon</td>
<td>146</td>
<td>6.2</td>
</tr>
<tr>
<td>Kidney &amp; Renal Pelvis</td>
<td>125</td>
<td>5.3</td>
</tr>
<tr>
<td>Urinary Bladder</td>
<td>104</td>
<td>4.4</td>
</tr>
<tr>
<td>Oral Cavity/Pharynx/Tonsil</td>
<td>88</td>
<td>3.8</td>
</tr>
<tr>
<td>Melanoma</td>
<td>83</td>
<td>3.5</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>73</td>
<td>3.1</td>
</tr>
<tr>
<td>Pancreas</td>
<td>70</td>
<td>3.0</td>
</tr>
<tr>
<td>Corpus Uteris / Uterus, NOS</td>
<td>65</td>
<td>2.8</td>
</tr>
<tr>
<td>Rectum / Rectosigmoid</td>
<td>64</td>
<td>2.7</td>
</tr>
<tr>
<td>Thyroid</td>
<td>41</td>
<td>1.7</td>
</tr>
<tr>
<td>Esophagus</td>
<td>37</td>
<td>1.6</td>
</tr>
<tr>
<td>Leukemia</td>
<td>32</td>
<td>1.4</td>
</tr>
<tr>
<td>Stomach</td>
<td>28</td>
<td>1.2</td>
</tr>
<tr>
<td>Liver &amp; Intrahepatic Bile Duct</td>
<td>26</td>
<td>1.1</td>
</tr>
<tr>
<td>Larynx</td>
<td>25</td>
<td>1.1</td>
</tr>
<tr>
<td>Ovary</td>
<td>24</td>
<td>1.0</td>
</tr>
<tr>
<td>Myeloma</td>
<td>20</td>
<td>0.9</td>
</tr>
<tr>
<td>Cervix Uteri</td>
<td>16</td>
<td>0.7</td>
</tr>
<tr>
<td>Testis</td>
<td>15</td>
<td>0.6</td>
</tr>
<tr>
<td>Ureter &amp; Other Urinary</td>
<td>15</td>
<td>0.6</td>
</tr>
<tr>
<td>Anus</td>
<td>10</td>
<td>0.4</td>
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<tr>
<td>Vulva</td>
<td>10</td>
<td>0.4</td>
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<tr>
<td>Small Intestine</td>
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<td>0.4</td>
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<tr>
<td>Mesothelioma</td>
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<td>0.4</td>
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<tr>
<td>All Other</td>
<td>77</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2346</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*statistical data for 2019*
2019 Stage of Disease at Diagnosis

**Lung**
- Stage 1: 36%
- Stage 2: 10%
- Stage 3: 17%
- Stage 4: 28%
- Other: 9%

**Melanoma**
- Stage 1: 52%
- Stage 2: 18%
- Stage 3: 9%
- Stage 4: 6%
- Other: 2%

**Breast**
- Stage 1: 57%
- Stage 2: 14%
- Stage 3: 7%
- Stage 4: 4%
- Other: 4%

**Prostate**
- Stage 1: 21%
- Stage 2: 27%
- Stage 3: 18%
- Stage 4: 9%
- Other: 25%

**Bladder**
- Stage 1: 14%
- Stage 2: 7%
- Stage 3: 4%
- Stage 4: 4%
- Other: 15%

**Colon**
- Stage 1: 16%
- Stage 2: 26%
- Stage 3: 33%
- Stage 4: 17%
- Other: 8%
Residence by County at Time of Diagnosis 2019

<table>
<thead>
<tr>
<th>County at Diagnosis</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN-Hamilton</td>
<td>1,179</td>
<td>50.3%</td>
</tr>
<tr>
<td>GA-Walker</td>
<td>257</td>
<td>11.0%</td>
</tr>
<tr>
<td>TN-Bradley</td>
<td>173</td>
<td>7.4%</td>
</tr>
<tr>
<td>GA-Catoosa</td>
<td>143</td>
<td>6.1%</td>
</tr>
<tr>
<td>TN-Marion</td>
<td>92</td>
<td>3.9%</td>
</tr>
<tr>
<td>TN-Rhea</td>
<td>89</td>
<td>3.8%</td>
</tr>
<tr>
<td>GA-Dade</td>
<td>81</td>
<td>3.5%</td>
</tr>
<tr>
<td>GA-Whitfield</td>
<td>70</td>
<td>3.0%</td>
</tr>
<tr>
<td>AL-Jackson</td>
<td>39</td>
<td>1.7%</td>
</tr>
<tr>
<td>TN-Grundy</td>
<td>33</td>
<td>1.4%</td>
</tr>
<tr>
<td>TN-Mcminn</td>
<td>21</td>
<td>0.9%</td>
</tr>
<tr>
<td>TN-Polk</td>
<td>21</td>
<td>0.9%</td>
</tr>
<tr>
<td>TN-Bledsoe</td>
<td>20</td>
<td>0.9%</td>
</tr>
<tr>
<td>GA-Murray</td>
<td>16</td>
<td>0.7%</td>
</tr>
<tr>
<td>TN-Henderson</td>
<td>16</td>
<td>0.7%</td>
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<tr>
<td>TN-Sequatchie</td>
<td>13</td>
<td>0.6%</td>
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<tr>
<td>GA-Gordon</td>
<td>12</td>
<td>0.5%</td>
</tr>
<tr>
<td>GA-Chattooga</td>
<td>11</td>
<td>0.5%</td>
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<tr>
<td>AL-De Kalb</td>
<td>10</td>
<td>0.4%</td>
</tr>
<tr>
<td>TN-Meigs</td>
<td>7</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,346</strong></td>
<td><strong>100.0%</strong></td>
</tr>
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*statistical data for 2019*