

# 2015 Richard L. Roudebush VAMC Cancer Program Annual Report

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*A Summary of 2014 Cancer  
Data & 2015 Activities*

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## Introduction

The Richard L. Roudebush VA Medical Center (RLR VAMC) Cancer Program has been accredited by the American College of Surgeons Commission on Cancer (CoC) as an approved Veterans Affairs Cancer Program since 1995. The facility provides quality care to our Veterans through primary care and specialty clinics in conjunction with guidelines from national cancer organizations that set quality standards. As a tertiary care facility, Veterans are referred from the Danville, Fort Wayne and Marion VAMCs, along with Community Based Outpatient Clinics (CBOC) from as far away as lower Michigan/northern Indiana, south central Indiana, and central Illinois.

Multidisciplinary cancer conferences are held regularly as part of our quality cancer program. Cases are reviewed in an interdisciplinary forum from which diagnostic options, treatment options and treatment outcomes are discussed including the planning of end-of-life care when appropriate. To improve the quality of care available, expertise is drawn from both this VA Medical Center and our affiliate, Indiana University Medical Center (IUMC). Veterans may be referred to IUMC for specialized procedures or treatment when appropriate although most treatment modalities are provided within our facility.

## 2014 Cancer Committee Activities

The Cancer Committee is composed of representatives from each of the Medical Center specialties that participate in the care of cancer patients including the Allied Health departments. Emphasis is given to improving the availability of screening programs, cancer prevention, early diagnosis and prompt treatment of Veterans with cancer, both from the Indianapolis primary service area and from our referral medical centers. The committee oversees the various activities involved with the prevention and screening of cancers, the diagnosis and treatment of cancers, the psychosocial and nutritional support through survivorship and palliative care of Veterans with cancer.

## Cancer Committee Membership

The Cancer Committee met every other month in 2014 and 2015 to discuss the facility in terms of meeting our facility, CoC, and departmental goals and to ensure that the facility continues to meet the CoC standards to obtain accreditation. The 2014 team members included:

Helen Fosmire, MD, Chief of Radiation Oncology /Cancer Committee Chairperson

Clark Barco, DDS, Dental Service  
Debra Berg, NP, Oncology  
Thomas Birdas, MD, Thoracic Surgery/Cancer Registry Quality Coordinator  
Jacqueline Brumley, Cancer Care Center Unit Manager  
Rommel Dhadha, MD, Chief of Radiology  
Lisa Dovey RD, CSO, CNSC, Clinical Dietitian  
Andrew Eppstein, MD , General Surgery  
Chad Galer, MD, ENT/Cancer Liaison Physician  
Elizabeth Godby, RN, Performance Improvement/Quality Management Coordinator  
Mary McMullen, RN, Education Service  
Trent Miller, MD, Oncology  
Jane Murphy, MSN, Cancer Program Standards Coordinator  
Erin Newton, MD, Palliative Care  
Lyn Penton-Cooper, RN, Pulmonary  
David Plunkett, Staff Chaplain  
Amber Reguli, RHIA, CTR, Tumor Registry  
Jordan Schmitt, MD, Oncology  
Ronald Shapiro, MD, Radiation Oncology  
Kristen Strachman, LCSW , Social Worker  
Elliott Taylor, RN, Oncology Case Manager  
Cynthia Gilmour, RN, Gastroenterology  
Chris Wade, MD, Chief of Pathology and Laboratory  
Mary Ann Waterman, MS, Administrative Officer to Chief of Staff  
Rachel Bazzell, American Cancer Society

### Cancer Committee Activity

Many accomplishments and improvements occurred in 2014 & 2015 including:

- The streamlining the process for maintaining reproductive health, especially for Veterans in child-bearing ages, in anticipation of cancer treatments
- Modifications to cancer conference guidelines were made to provide a more efficient process to
  - forward cases for presentation
  - disseminate the case list to all potential attendees
  - describe expectations of the presenters and
  - standardize the follow up of conferences which include a conference note template containing the services that attended and provider confirmation of the conference content in CPRS.

- Review of the Thoracic Conference process to maximize provider time by separating the cases of diagnosed vs. non-diagnosed cases
- Continuing work on the navigation of Veterans with cancer through the various departments during workup, treatment, and subsequent follow up.
- Initiating implementation of a Distress Screening Tool to assess Veterans' responses to the cancer diagnosis and treatment plan
- Initiating implementation and distribution of the survivorship care plan which describes the follow up treatment plan.
- Improvement on the initiation of early palliative care for Stage IV lung cancer patients
- Improvement of potential delays in the Medical Oncology clinic

### Commission on Cancer (CoC) Quality of Care

The following information are indicators of the quality of care that the facility is evaluated on by the Commission on Cancer.

#### *Rapid Quality Reporting System (RQRS)*

Promoting evidence-based cancer care is of key importance to improving the quality of care and patient outcomes. The Commission on Cancer (CoC) has developed the RQRS to facilitate real time quality improvement by encouraging evidence-based care in CoC-accredited programs for select quality measures. The RLR VAMC began participating in RQRS in November of 2013. The CoC utilized specific colorectal and breast cancer measures as their focus for 2014 and the facility receives notification if any case is at risk for falling out of compliance with the selected national treatment guidelines.

#### *Cancer Prevention & Screening Programs*

The Veterans Administration places a high priority on cancer prevention and screening programs targeted to the Veteran population as well as addressing the promotion of healthy habits. The VA follows the US Preventive Services Task Force recommendations for cancer screening and prevention to more effectively reach our specific Veteran population. The RLRVAMC met all of the Veterans Administration (VA) benchmarks up to the end of FY 2015 with the exceptions of breast and cervical cancer screening for which corrective action included Rapid Process Improvement Workgroups.

The facility also promotes activities that may reduce the Veterans' cancer risks such as alcohol cessation and weight reduction activities. This facility met the VA national standards and exceeded the benchmarks in most cases.

PERFORMANCE MEASURES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Cum	Target
Tobacco Use Screening (tob10)	100%	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	99.8%	MET=85%
Alcohol Use Screening (sub10)	98%	96%	100%	100%	98%	98%	100%	100%	98%	100%	100%	98.00%	MET=85%
Alcohol Use Brief Intervention Provided or Offered (sub20)	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	83%	99%	MET=85%
Alcohol Use Brief Intervention (sub30)	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	83%	99%	MET=85%
Breast Screen age 50 - 74 (p31h)	94.3%	96.6%	82.0%	82.4%	69.0%	83.7%	78.5%	61.7%	84.7%	97.0%	100%	84.0%	MET=85%
Cervical Cancer Screening (21-65) in past three years (P41h)	82.0%	79.1%	89.7%	92.4%	90.9%	92.8%	94.2%	87.5%	63.0%	89.0%	80.0%	86.0%	MET=86%
Cervical Cancer Screening (21-29) in past three years (P42)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	NA	100%	100.0%	NA	100%	100%	MET=85%
Cervical Cancer Screening (30-64) in past three years (P43h)	74.0%	74.3%	88.4%	92.2%	90.2%	92.1%	94.2%	85.5%	57.0%	89.0%	75.0%	84.0%	MET=86%
Colorectal Screen age 51 - 75 (p61h)	86.0%	90.6%	88.4%	78.0%	75.7%	86.2%	81.3%	93.0%	82.0%	79.0%	80% (recon)	85.0%	MET=81%
Provided with Brief Counseling. MH and Non-MH (Smg8)	92.3%	100.0%	86.1%	92.3%	88.9%	100.0%	100.0%	98.5%	88.0%	90.0%	87.0%	94.0%	MET=90%
Offered Referral to smoking Cessation Clinic to Assist with Cessation: MH and Non-MH (Smg9)	92.3%	100.0%	86.1%	92.3%	88.9%	100.0%	100.0%	98.5%	88.0%	90.0%	87.0%	94.0%	MET=90%

PERFORMANCE MEASURES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Cum	Target
Offered Medication to Assist with Cessation: MH and Non-MH (smg10)	95.5 %	100.0 %	86.1 %	92.3 %	85.8 %	100.0 %	100.0 %	98.6 %	88.0 %	90.0 %	87.0 %	94.0 %	MET=90 %
MOVE 5 Obese Pts Scrn & Offered Weight Mgmt MOV5	97.3 %	96.1 %	96.3 %	98.5 %	94.3 %	96.0 %	95.2 %	99.3 %	94.0 %	100.0 %	98.0 %	97.0 %	MET=90 %
Provided with brief Counseling for Tobacco Cessation (smg8s)	NA	NA	NA	NA	NA	100%	NA	NA	NA	NA	100%	100%	MET=84 %
Offered Referral for Tobacco Cessation (smg9s)	NA	NA	NA	NA	NA	100%	NA	NA	NA	NA	100%	100%	MET=93 %
Offered Medication to Assist with Cessation (smg10s)	NA	NA	NA	NA	NA	100%	NA	NA	NA	NA	100%	100%	MET=73 %

(September data not available at time of presentation to Cancer Committee)

## Service Reports

the following reports are provided by the respective services to highlight activities that have been improved or enhanced to provide excellent care to our veterans.

### Medical Oncology

The Medical Oncology service includes both Oncology and Hematology. In 2015, the service has added another oncologist with an emphasis on hematology. The service has also re-aligned navigators and case managers to maximize patient navigation opportunities among the subspecialties within the service.

The service participated in the national hematology/oncology telehealth collaborative which developed cancer templates for the electronic data collection of standard practices specific to cancer sites.

In an effort to thank the Veterans for their service and to develop partnerships, the Cancer Care Center staff is now quarterly organizing and serving dinner to those Veterans who were staying at the Veteran's house. The dinner themes are a wonderful event that is enjoyed by staff and Veterans alike.

### *Radiation Oncology*

The Radiation Oncology department continues to see an increase in workload with a 10% increase in the total number of encounters (12,175). A total of 257 Veterans received treatment in 2015.

The department has expanded their ability to treat Veterans with the start of the stereotactic body radiation therapy (SBRT) program for liver and lung cancers which were previous referred to outside medical facilities.

Staff has also improved Veteran care by creating an orientation video on the process of radiation therapy for Veterans with head and neck cancer so that the Veteran can better understand the complex process of diagnosis and treatment.

### *Research*

Clinical trials are highly encouraged by national treatment guidelines to increase the knowledge on effective treatments for all types of cancers. The use of Y-90 in the treatment for hepatocellular cancer has been in progress through 2015.

The facility has had an ongoing clinical trial on the use of colonoscopy versus FIT (Fecal Immunochemical Test) for the past 3 years to screen for colorectal cancers which has garnered a significant number of participants.

The facility, with the assistance of Dr. Jordan Schmitt, has worked to improve the availability of clinical trials. Clinical trials have been approved to start in 2016 which will allow Veterans to participate in potentially groundbreaking new treatments.

### *Social Services*

Social work remains an integrated discipline within the VA cancer care program in addressing the psychosocial needs of our Veterans with cancer and their caregivers. This includes support to address the many stressors, potential barriers in accessing care and overall adjustment to one's life threatening illness.

In 2015, our program has been able to sustain and spread the Commission on Cancer (CoC) Program Standard of screening for psychosocial distress in all new Veterans diagnosed with cancer who are receiving care within the Oncology, Hematology and Radiation Oncology clinics. This includes the utilization of the distress thermometer as recommended per the NCCN clinical practice guidelines. The purpose of the distress screen is to identify the potential psychological, behavioral, social, physical and financial concerns that may be a barrier for a Veteran in the management of his/her cancer. The goal is to improve access and link Veterans and their caregivers to the appropriate psychosocial supportive services on-site or by referral. Outcomes are monitored per the Oncology Social Worker to determine the most appropriate interventions, provision of identified support and compliance with the CoC accreditation program standard.

An exciting update for 2015, was the addition of a second full-time dedicated Hematology/Oncology Social Worker to assist in addressing the complex psychosocial needs of our Veterans affected by cancer. The goal for 2016 will be to continue to enhance the supportive programs available within our cancer care center while continuing to address the social work needs along the cancer continuum.

### *Nutrition Service*

The nutrition service is a vital piece of the puzzle in the treatment of cancer patients. The dietitian works closely with oncology social workers to respond to Veterans' nutrition related problems identified through the Cancer Distress Screening tool. Veterans who report symptoms related to nutrition that are causing distress are brought to the dietitian's attention for evaluation. Veterans may not necessarily present with weight loss initially but are experiencing symptoms that place them at risk.

An excellent example of early intervention is esophageal cancer. Prior to esophageal resection and following neoadjuvant chemotherapy/radiation, Veterans are prescribed an immune modulating formula prior to surgery to improve outcomes. The introduction of this process has strong data to support the use of this product for improved healing, reduction of infections and recovery from surgery.

Another example is the treatment of colon cancer patients. The dietitian had staffed the general surgery clinic when Veterans are being evaluated for surgical resection for colon cancer. An immune modulating formula is prescribed prior to surgery to

enhance post-operative recovery. These Veterans may not be seen pre-operatively in oncology so this is an improvement that enhances the care of the Veteran with cancer.

## Tumor Registry Report

### Cancer Conferences

The following are the schedules for Cancer Conferences:

Tumor Cancer Conference meets every Thursday at 7am in A-7095.

Chest (Thoracic) Cancer Conference meets every Thursday at 2pm in A-7095.

Liver Cancer Conference meets on the first and third Tuesday of the month at 7am in A-7095.

Breast and Gynecologic Cancer Conference meets on the first Wednesday of the month at 12 noon in A-7095. This conference focuses on ensuring that each Veteran is meeting the standard of care for timeliness of treatment with breast and gynecologic cancers. Most Veterans with these types of cancer receive diagnostic and surgical treatment outside of the facility so confirming appropriate follow up is critical to ensuring great patient care. Below are the attendance rates for the required services in each conference with the exception of the Breast and Gynecologic Conferences which are not tracked.

# of <b>Tumor</b> Conferences (80% attendance required)	% Prospective	Surg Attendance	Med Onc Attendance	Rad Onc Attendance	Radiology Attendance	Pathology Attendance
46	100% (# of cases=159)	91%	100%	98%	98%	93%

# of <b>Chest</b> Conferences (80% attendance required)	% Prospective	Surg Attendance	Med Onc Attendance	Rad Onc Attendance	Radiology Attendance	Pathology Attendance
48	99% (# of cases=85)	94%	100%	91%	96%	100%

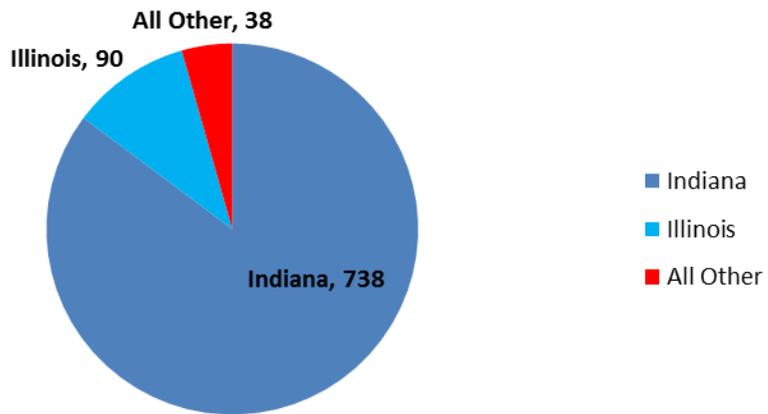
# of Liver Conferences (65% attendance required)	% Prospective	Surg Attendance	Med Onc Attendance	Rad Onc Attendance	Radiology Attendance	GI Attendance
23	100% (# of cases =75)	74%	100%	70%	100%	74%

### *2014 Cancer Population Distribution*

While the vast majority of our Veterans are residents of Indiana, the facility also treats a significant number of Veterans from the state of Illinois. Illiana Veterans receive most of their cancer treatment at this facility. The Northern Indiana facilities have fee for service arrangements for both Radiation and Medical Oncology when the Veteran prefers to be treated locally. However, if the Veteran chooses to be treated at this facility, accommodations are made. A distribution map is attached displaying the counties in Indiana and Illinois that had five or more patients from their corresponding county.

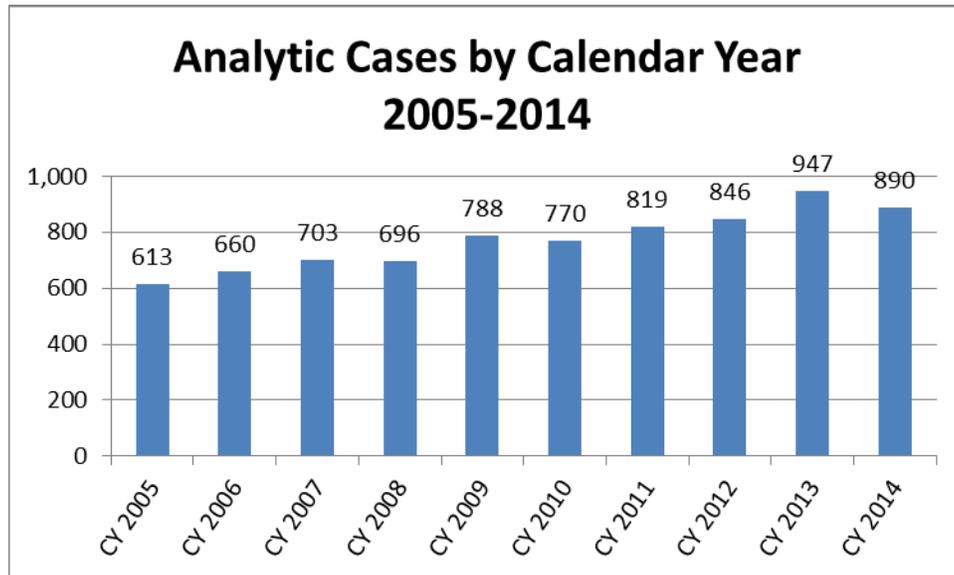
Veterans from other states including California, Florida, Georgia, Michigan, New York, Ohio, Oklahoma, South Carolina, Tennessee and the Virgin Islands were also treated at this facility for various reasons, many involving the need for temporary relocation to obtain family support. Our Veteran House provides overnight accommodations as needed for those Veterans undergoing invasive procedures or diagnostic testing as well as surgery and cancer treatments. The Veteran House also provides a place for family members to stay close to their loved ones in a time of potential crisis.

### 2014 Patient Distribution at Diagnosis



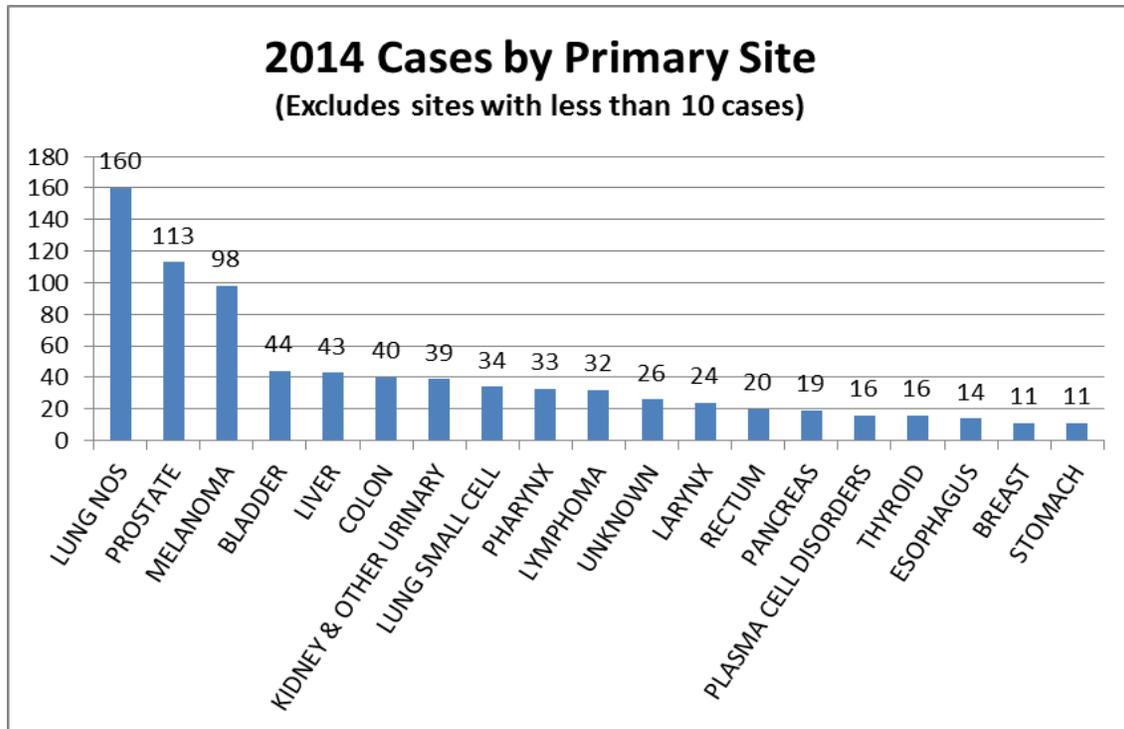
### *Cancer Volume: Past 10 years*

The cancer cases for the past 10 years have been increasing steadily. The graph below shows the number of analytic cases (cases that were either diagnosed and/or treated at this facility).



### *2014 Analytic Cases*

In 2014, the Tumor Registry had 890 analytic cases and 13 non-analytic cases. The following statistics are of the analytic cases only. The graph below indicates the number of cancers identified in 2014 by primary site.



### Top 20 Leading Cancer Sites

The following grid is a summary of the top 20 cancers over the past five years ranked highest to lowest. Lung and prostate cancers continue to top the list for this facility.

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
<b>LUNG (<i>not</i> small cell)</b>	165	162	168	182	160
<b>PROSTATE</b>	87	121	123	149	113
<b>MELANOMA</b>	54	59	57	109	98
<b>COLON</b>	52	53	54	38	40
<b>BLADDER</b>	37	35	38	41	44
<b>KIDNEY &amp; OTHER URINARY</b>	44	37	31	33	40
<b>PHARYNX</b>	28	28	22	41	33
<b>LIVER</b>	35	31	38	26	43
<b>LUNG SMALL CELL</b>	27	28	26	24	34
<b>LARYNX</b>	22	31	29	27	24
<b>LYMPHOMA</b>	26	32	26	28	33
<b>RECTUM</b>	19	19	19	23	20
<b>ESOPHAGUS</b>	20	14	16	16	14
<b>UNKNOWN</b>	15	18	28	17	26
<b>PANCREAS</b>	22	17	23	37	19
<b>LEUKEMIA</b>	21	8	13	3	1
<b>ORAL CAVITY</b>	11	19	5	18	8

	<b>CY 2010</b>	<b>CY 2011</b>	<b>CY 2012</b>	<b>CY 2013</b>	<b>CY 2014</b>
<b>PLASMA CELL DISORDERS</b>	13	11	14	13	20
<b>STOMACH</b>	9	12	12	16	11
<b>THYROID</b>	11	21	20	16	16

## Lung Cancer Review

According to the American Cancer Society, the top three cancers nationally for 2016 include breast, lung and bronchus, and colorectal cancer for women and prostate, lung and bronchus, and colorectal cancers for men.

### *Lung Cancer Risk Factors:*

According to the Surgeon General, lung cancer is associated with patients with active or previous smoking history as well as exposure to second hand smoke.<sup>1</sup>

### *Military Service and Smoking*

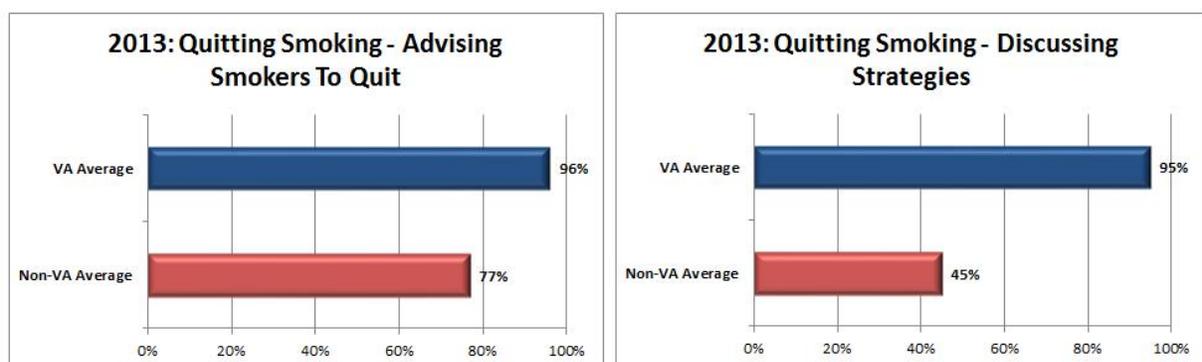
In 2007, among U.S. adults who currently did not smoke, 52.1% were former smokers. Among 2012 VA enrollees, 70% identified as former smokers who no longer smoke.<sup>2</sup>

The CDC indicates that, in the United States, cigarette smoking prevalence is higher among people currently serving in the military than among the civilian population. Cigarette smoking prevalence is even higher among military personnel who have been deployed.

- In 2011, 24.0% of all active-duty military personnel reported currently smoking cigarettes, compared with 19.0% of civilians.
- During 2007–2010, male Veterans aged 25–64 years were more likely to be current smokers than nonVeterans (29.0% versus 24.0%).<sup>3</sup>

### *Smoking Cessation Efforts*

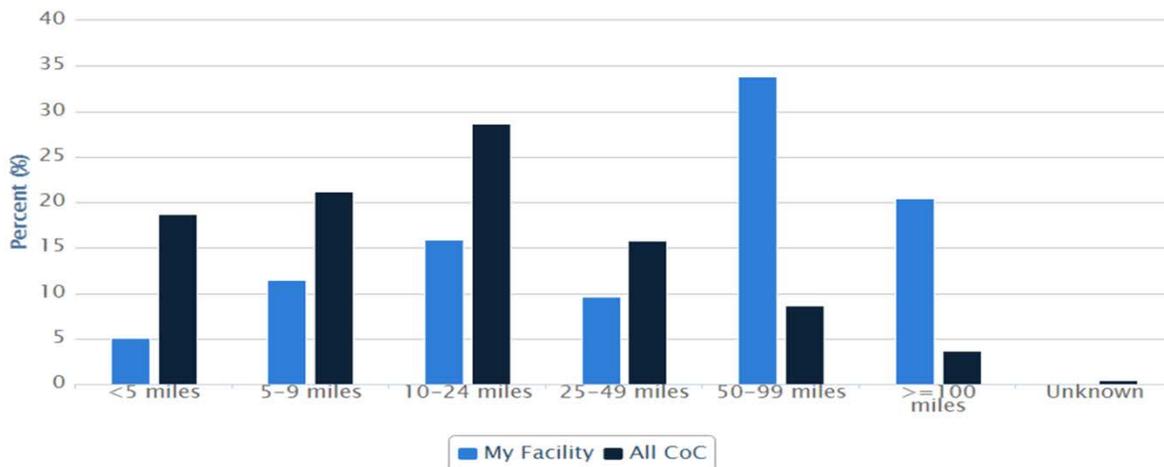
The graph below shows the national VA scores compared with non-VA hospital scores for encouraging Veterans to quit smoking and discussing non-medication strategies to quit smoking.



### Distance Traveled for Veterans with Lung Cancer

(2013 data)

In an NCDB report on 2013 cancer data, the comparison between our VAMC and other CoC accredited hospitals shows the distance traveled for the treatment of lung cancer is significantly higher. In fact, the majority of Veterans travel 50 or more miles for treatment. This places greater emphasis on combining resources to meet the needs of the Veteran in as few visits as possible.

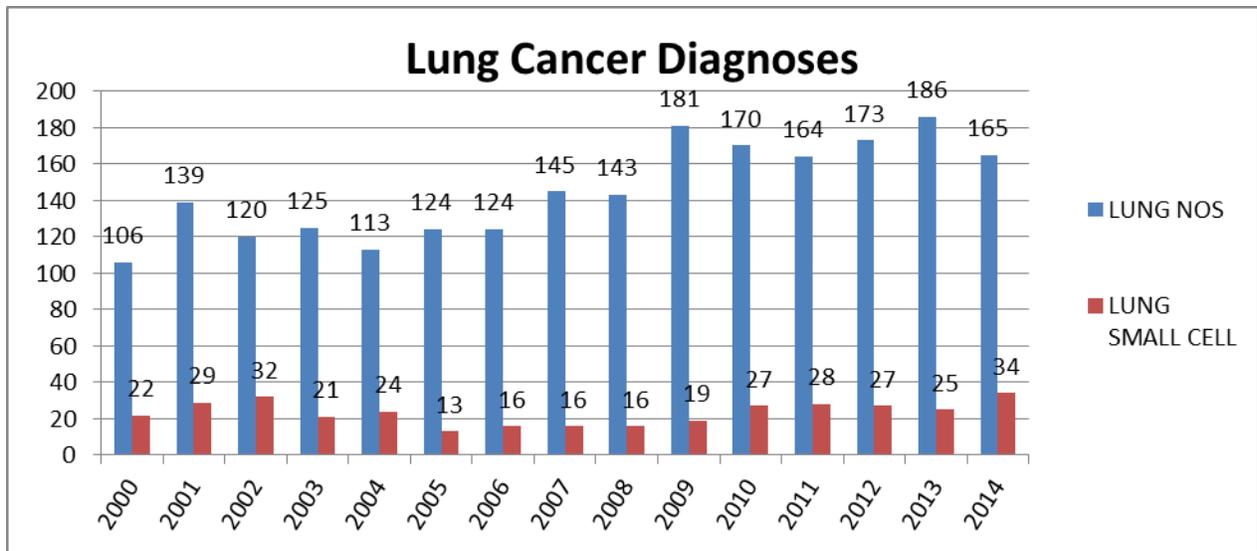


	<5 miles	5-9 miles	10-24 miles	25-49 miles	50-99 miles	>=100 miles	Unknown
<b>My Facility</b>	5.1 % (n=8)	11.5 % (n=18)	15.9 % (n=25)	9.6 % (n=15)	33.8 % (n=53)	20.4 % (n=32)	0 % (n=0)
<b>All CoC</b>	18.7 % (n=24144)	21.2 % (n=27311)	28.6 % (n=36953)	15.8 % (n=20381)	8.6 % (n=11129)	3.7 % (n=4836)	0.4 % (n=476)

### Lung Cancer Diagnosis & Treatment

#### Overall Lung Cancer Cases 2000-2014

The data below demonstrates the volume of lung cancer patients in the past 14 years. Lung cancer has remained in the top five cancer sites reported at this facility.



### *2014 Total Facility Lung Cases by AJCC Clinical Stage*

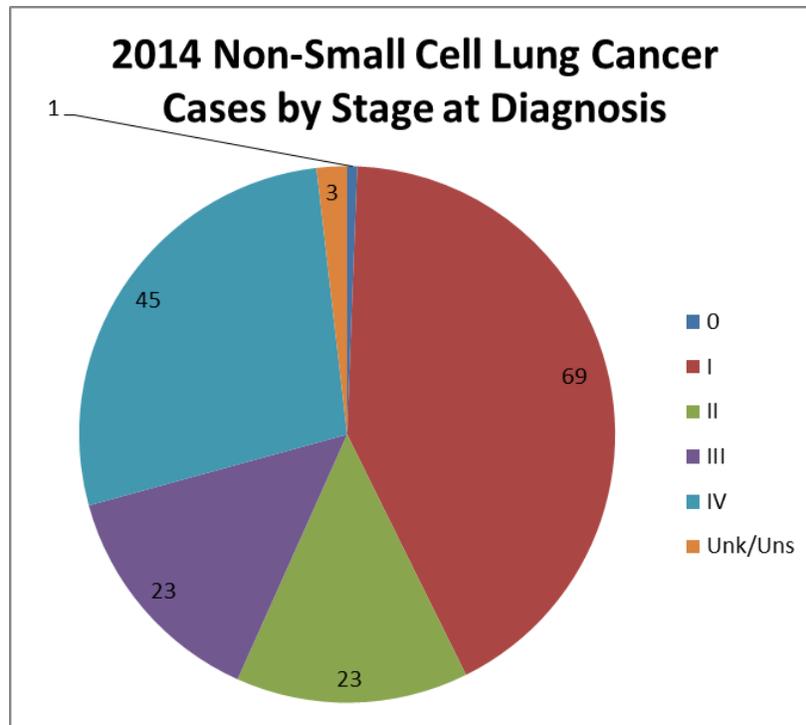
Staging for non-small cell lung cancer is based on amount of involvement of the cancer within the lung, spread to lymph nodes or other organs. According to lungcancer.org, the stages of non-small cell lung cancer are described as:

**Stage I:** The cancer is located only in the lungs and has not spread to any lymph nodes.

**Stage II:** The cancer is in the lung and nearby lymph nodes.

**Stage III:** Cancer is found in the lung and in the lymph nodes in the middle of the chest, also described as locally advanced disease.

**Stage IV:** This is the most advanced stage of lung cancer, and is also described as advanced disease. This is when the cancer has spread to both lungs, to fluid in the area around the lungs, or to another part of the body, such as the liver or other organs.



The graph above demonstrates the stage of lung cancer the Veteran presents with prior to any treatment. Early detection is key as symptoms of lung cancer may not appear until the cancer is at an advanced stage. The 45 to 50% 5-year survival rate with stage I lung cancer drops to 1% with stage IV disease.<sup>5</sup>

To further define the stage, the American Joint Committee on Cancer (AJCC) separates the extent of disease into the T, N and M subcategories for staging. The T typically describes the primary tumor involvement, the N describes the lymph node involvement and the M describes the spread of disease outside the regional area. The 'c' before each T, N, and M indicates the extent of spread before treatment and the 'p' indicates the extent of spread after the primary cancer has been removed.

The table below demonstrates this facility's compliance with the NCCN guidelines on 2013 and 2014 cases regarding the appropriate treatment of non-small cell lung cancer cases with positive lymph nodes which is that surgery is not the first course of treatment.

	Total cases applicable	Total Cases w/o Surgery as First Course	% Compliant
<b>2013 Total cN2 M0 cases</b>	17	17	100%

	<b>Total cases applicable</b>	<b>Total Cases w/o Surgery as First Course</b>	<b>% Compliant</b>
<b>2014 Total cN2 M0 cases</b>	8	8	100%
	25	25	100%

The second lung measure evaluated on 2013 and 2014 lung cancer cases addressed the treatment of lymph node-positive (pN1) and (pN2) non-small cell lung cancer after surgery was performed. The measure follows the NCCN guidelines on the administration of chemotherapy or the consideration of chemotherapy within 4 months prior to surgery or within 6 months after surgery.

	<b>Total cases Applicable</b>	<b>Total Cases Met Criteria for Inclusion/Consideration of Chemo</b>	<b>% Compliant</b>
<b>2013 Total pN1-2 M0 cases</b>	3	3	100%
<b>2014 Total pN1-2 M0 cases</b>	9	9	100%
	12	12	100%

As the data shows, the facility was compliant with following national guidelines for the treatment of lung cancer in specifically staged Veterans.

As special thanks to Dr. Thomas Birdas who graciously assisted in the review.

## References:

1. Retrieved from [Surgeon General report on health effects of smoking](#)
2. Retrieved from [US Dept. of Veterans Affairs: Tobacco Use Among Veterans](#)
3. Retrieved from [CDC Cigarette Smoking Among Military Service Members](#)
4. Retrieved from [US Dept of Veterans Affairs Discussing Strategies for Quitting Smoking](#)
5. Retrieved from [American Cancer Society: Non-small Small Cell Lung Cancer Survival](#)



## Glossary of Terms:

**Analytic Case:** Cancer patients diagnosed and/or received first course of treatment at RLRVAMC.

**Caseload:** the number of new cancer cases annually entered into a registry

**CTR (Certified Tumor Registrar):** the credentials granted to a person who has passed the cancer registry certification examination by the NCRA, and signifies specialized knowledge and education for accurate collection, recording and analysis of cancer data into registry databases.

**CoC (Commission on Cancer):** a division of the American College of Surgeons consisting of professional organizations involved in cancer control and improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and monitoring of comprehensive quality care.

**First Course of Treatment:** Cancer directed treatment planned and administered, usually started within four months of diagnosis or as determined by the managing physician.

**NCCN (National Comprehensive Cancer Network):** a not-for-profit alliance of 26 of the world's leading cancer centers devoted to patient care, research, and education

**NCDB (National Cancer Database):** a nationwide oncology outcomes database for more than 1,400 CoC-approved cancer programs in the United States and Puerto Rico. Approximately 75 percent of all newly diagnosed cases of cancer in the United States are captured at the institutional level and reported to the NCDB.

**NCRA (National Cancer Registrars Association)** is a not-for-profit association with a primary focus of education and certification, representing Cancer Registry professionals and Certified Tumor Registrars (CTRs).

**Non-Analytic Case:** Cancer patients who were both diagnosed and received first course cancer treatment at outside facility, and presented to RLR VAMC either for treatment of cancer recurrences, persistent disease, or surveillance/follow-up