

GCR Register

Georgia Cancer Registry

Spring 2019

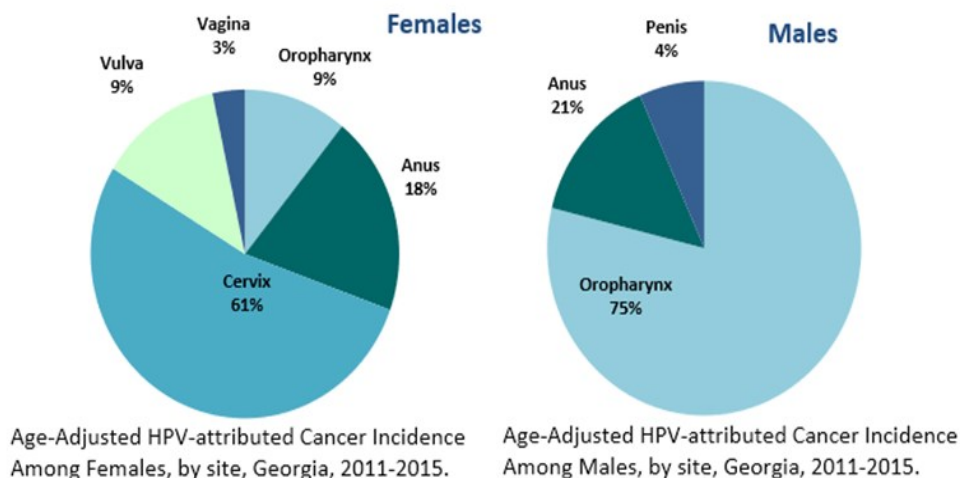
Cancers Attributable to Human Papillomavirus (HPV), Georgia 2011-2015

An HPV-attributable cancer is a cancer that is caused by HPV infection. HPV causes nearly all cervical cancers and can cause other cancers, such as cancers of the anus, oropharynx, penis, vagina and vulva. Each year in Georgia, there are 1,090 new cases of HPV-attributed cancers. Georgia's age-adjusted HPV-attributed cancer rate was 13.1/100,000 during 2011-2015.

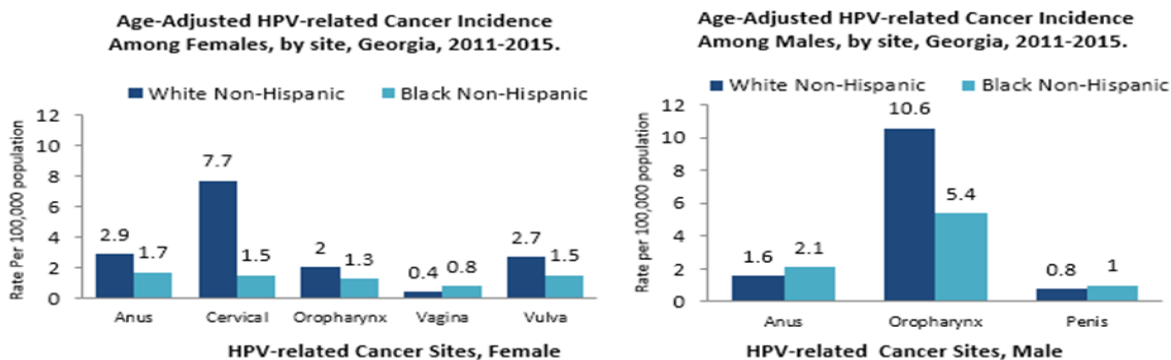
Number of new HPV-cancer cases, Georgia, 2011-2015

During 2011 to 2015, there were an average of 357 new cases of cervical cancer reported in Georgia, 394 new cases of oropharyngeal cancer and 208 new cases of anal cancer attributable to HPV.

Cervical cancer was the most common HPV-related cancer among female and oropharyngeal cancers (cancers of the back of the throat, including the base of the tongue and tonsils) were the most common among males.



In Georgia during 2011-2015, the incidence rate of HPV-related cancers varied by cancer site, sex, and race/ethnicity. Females had a higher incidence of HPV-related cancers of the anus than men. Men had a higher incidence of oropharynx cancers than women. Among women, White non-Hispanics had the highest incidence of HPV-related cancers of the anus, cervix, oropharynx, and vulva. Among men, Black non-Hispanics had the highest incidence of HPV-related cancers of the anus and penis, while White non-Hispanic men had the highest incidence of HPV-related oropharynx cancers.





Strategies We've Used to Deal with 2018 Changes

As a Cancer Registrar, one of the biggest attributes we all must have is the ability to adapt to change. We must recognize that is a constant. We have to be optimistic and maintain a positive attitude. With so many changes, of course there have been so many questions! These questions help to lead to much needed discussion in order to help us develop a plan of action to assist in adapting to the coming 2018 changes. At Northside Hospital we developed a few strategies while waiting for the V18 upgrade to our software.

While waiting for V18, it was decided that we should abstract each 2018 case as much as we possibly could and place the case on hold. In order to gather the information needed for the fields that were to be updated, a template was developed. This template covered the SSDI's, SEER EOD, AJCC Clinical and Pathological staging, as well as Prognostic Indicators when applicable. We were able to cut and paste the template into the additional text tab in our data management software and enter all of the data that would be needed later once the upgrade took place. In order to run a report to find these cases at a later date, we were able to flag them as 2018 cases in the abstract status section.

Once the V18 upgrade took place, a few abstractors were designated to take on the task of completing the incomplete 2018 cases. With a completed template in the Additional Text tab, the abstractors were able to complete the 8th edition AJCC staging, SSDI and any other necessary fields, then re-run and clear edits. Once completed, the state reporting status and the abstract status could be updated and await submission to the State.

Currently, our 2018 Data Entry team completes approximately 20-30 abstracts per day. Breast patients are priority, due to the time-sensitive data needed for RQRS, COC and NAPBC surveys, and also for Genetics who ask for real time monthly reports in order to identify patients who are eligible to receive genetic counseling resources. At this rate, the data entry project is projected to wrap up in approximately 13 weeks.

This has truly been a team effort from the very beginning. A lot of thought and hard work went into this project and it truly shows. Everyone's contribution to the project proves that we are all strong team players and connoisseurs of excellence. We have worked through the 2018 challenge in abstraction and with this experience, we are prepared to take on the future challenges to come.

~~~*Jessica Smith, Northside Hospital*





**AJCC**  
American Joint Committee on Cancer



**From the Standard Setters**  
**2018 Implementations and Timeline Version 1.9**  
**August 2, 2018**

**AJCC 8<sup>th</sup> Edition Chapter Updates to Histologies (Complete)**

Update: AJCC Final Histology and Topography Codes have been posted. Link to the AJCC Histology and Topography Code Supplement:

<https://drive.google.com/file/d/1GG4WdS5n6BAG0VpWgt4bGs0HhLVgOMj1/view>

**New and Revised Site-Specific Data Items (Complete)**

Update: All SSDIs have been approved by UDS and included in Volume II. SSDI & Grade manuals have been posted. Link online coding tool, SSDI and Grade Manuals:

<https://apps.naaccr.org/ssdi/list/>

**ICD-O-3 Histology Revisions (Complete)**

Update: Changes were reviewed and approved by CMB on 7/26/17; guideline and code tables released on 1/10/18; site/histology validation list and excel file released 1/17/2018). Link to ICD O 3 Histology Revisions:

<https://www.naaccr.org/2018-implementation/#Histology>

**Solid Tumor Rules**

Update: Final rules have been posted for General Instructions and all sites as of January 22, 2019. Link to Solid Tumor Rules:

<https://seer.cancer.gov/tools/solidtumor/>

**SEER Hematopoietic and Lymphoid Neoplasm Database (Complete)**

Link: [https://seer.cancer.gov/tools/heme/Hematopoietic Instructions and Rules.pdf](https://seer.cancer.gov/tools/heme/Hematopoietic%20Instructions%20and%20Rules.pdf)

**SEER Summary Stage 2018 and SEER EOD 2018 (Complete)**

Update: Released as part of SEER\*RSA on March 20, 2018

Link to NCI SEER RSA: <https://staging.seer.cancer.gov/>

**CoC 2018 STORE Manual**

Link: <https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals>

**Standards Volume II, Version 18 (Complete)**

Link to Standards Volume II, Version 18: <https://www.naaccr.org/data-standards-data-dictionary/>

**FREESTUFF****FREESTUFF**

## Casefinding Exercises Now Available in SEER\*Educate

Mary Potts, RHIA, CPA, CTR  
Director, Information Services  
Fred Hutchinson Cancer Research Center, Cancer Surveillance System  
**Learn by Doing: Casefinding**



**When it comes to  
casefinding, we could all  
use a good map.  
A guided tour would be  
even better.**

Under the Training Menu in SEER\*Educate is a new Casefinding Page with 300 pathology reports for training in the application of SEER's reportability rules using additional references of Solid Tumor Rules, Heme Rules, and ICD-O-3 codes. This selection of pathology reports is based on the **types of actual reports** that both trainees and sometimes experienced staff at our registry misclassified as to the potential number of primaries (0 for not reportable and then 1, 2, or 3 for reportable primaries).

These pathology reports are not intended to be trick questions, but are intended to challenge people. After you declare the number of potentially reportable primaries, you are prompted to code the primary site(s), if any. These exercises provide many opportunities for students and registry staff to practice primary site coding in addition to learning casefinding and how to apply the Solid Tumor Rules and Heme Rules.

Casefinding is always done in context of a facility's reporting requirements for State reporting, CoC reporting (if the facility is ACoS-approved), and per the facility's own Cancer Committee requests. For this purpose, we created SEER\*Educate Memorial Hospital. This hospital registry uses a Casefinding Overview document, General Guidelines document, and then a Facility-Specific Path Casefinding Rules document, and these documents are available on the Casefinding Page. Each user needs to read these documents before starting these exercises and then reference the documents as needed throughout the exercises.

The National Cancer Registrars Association (NCRA) recognizes 9 practicum hours for the casefinding requirement for students who complete a set of 100 path reports achieving 85% accuracy across the cases. Although users can immediately repeat a test to improve one's score, we recommend cycling through all 100 in a set before repeating any tests to improve your actual understanding of the casefinding guidelines, reportability rules and resources, and primary site coding. We will be adding 100 path reports per month to the Casefinding Page for February, March, and April for a total of 600 reports to practice on.  
(continued next page)

An example of the detail provided in the rationales is shown below. Reading the rationales and learning the concepts that are repeated throughout these exercises is the transferable skill students and registrars need to acquire to perform highly accurate casefinding.

### Example Answer/Rationale for a Pathology Report

Log in or sign up at **SEER\*Educate** today by visiting <https://educate.fredhutch.org/> and **Learn by Doing!**

**CORRECT****CRITICAL (2.00/2.00)**

**Data Item:** Potentially Reportable

**Response:** ☒ 1 

**Correct Answer:** 1

**Rationale:**

This case is potentially reportable for one primary per the Final Diagnosis, Diagnosis Comment, and the information in the Clinical Data section of the pathology report.

The Final Diagnosis of the right oophorectomy was positive for adenocarcinoma with mucinous and goblet cell features consistent with metastatic appendiceal adenocarcinoma. The Clinical Data section of the pathology report states the patient has a history of metastatic appendiceal carcinoma involving the left ovary. The Diagnosis Comment specifies, "The morphologic features are consistent with metastatic adenocarcinoma from patient's known appendiceal primary."

The metastatic adenocarcinoma ex goblet cell carcinoid seen within the right ovary would not be a separate reportable primary. The 2018 Solid Tumor Rules do not apply to metastatic disease; therefore, the patient has only one reportable appendiceal primary.

This case needs to be investigated further to confirm that the patient's appendiceal adenocarcinoma ex goblet cell carcinoid has been included in the cancer registry if appropriate.

**Note:** Central registries are required to follow back to facilities or physicians for any pathology report that mentions a reportable disease currently exists or that indicates the patient had a reportable disease diagnosed in the past if the case is not reflected in the central registry database.

**CORRECT****(1.00/1.00)**

**Data Item:** Primary Site(s)

**Response:** ☒ C181

**Correct Answer:** ☒ C181

**Rationale:**

**C181 (Appendix).** The appendix was specified as the primary site of the patient's adenocarcinoma ex goblet cell carcinoid per the Final Diagnosis, Diagnosis Comment, and the Clinical Data section of the pathology report. Primary site is assigned based on the site of tumor origin, not the site of metastatic deposits. Code the primary site to C181 (Appendix).

SEER\*Educate is funded by Surveillance, Epidemiology and End Results (SEER) of the National Cancer Institute (NCI) and the Fred Hutchinson Cancer Research Center. (NCI Contract Number HHSN261201800004I)



## Grade 2018 Coding Exercises Now Available in SEER\*Educate

Mary Potts, RHIA, CPA, CTR

Director, Information Services

Fred Hutchinson Cancer Research Center, Cancer Surveillance System

**Learn by Doing: 2018 Grade Site-Specific Coding Guidelines**



With diagnosis year 2018, we now have to code three Grade fields instead of one. In fact, Grade now has its very own manual.

To support the people preparing for the March CTR exam window, we have released Grade exercises on five high volume primary sites and one historically challenging primary site.

**During April and May, Grade exercises for additional sites will be released.**

| NCRA Title                             | Pending NCRA Approval | Requested CE's | Start Date | End Date   |
|----------------------------------------|-----------------------|----------------|------------|------------|
| SEER*Educate—Grade 2018 Breast         |                       | 1.5            | 01/01/2019 | 12/31/2021 |
| SEER*Educate—Grade 2018 Bone           |                       | 0.75           | 01/01/2019 | 12/31/2021 |
| SEER*Educate—Grade 2018 Bladder        |                       | 0.75           | 01/01/2019 | 12/31/2021 |
| SEER*Educate—Grade 2018 Colon & Rectum |                       | 0.75           | 01/01/2019 | 12/31/2021 |
| SEER*Educate—Grade 2018 Lung           |                       | 0.75           | 01/01/2019 | 12/31/2021 |
| SEER*Educate—Grade 2018 Prostate       |                       | 0.75           | 01/01/2019 | 12/31/2021 |

Log in or sign up at **SEER\*Educate** today by visiting <https://educate.fredhutch.org/> and **Learn by Doing!** SEER\*Educate is funded by Surveillance, Epidemiology and End Results (SEER) of the National Cancer Institute (NCI) and the Fred Hutchinson Cancer Research Center. (NCI Contract Number HHSN261201800004I)



## QA Corner

### Exploring EOD

Answer the following questions as related to SEER EOD. 2018 SEER EOD Introduction and General Instructions may be downloaded as a PDF document within SEER Educate at:

<https://educate.fredhutch.org/LandingPage.aspx>

1. As of what diagnosis date will EOD 2018 be implemented?
2. What are the three main data items in EOD?
3. True or False. EOD 2018 is fully compatible with the AJCC TNM staging manual, 8th Edition.
4. The cortex is the \_\_\_\_\_ of an organ.
5. \_\_\_\_\_ is a term used in staging to indicate contiguous growth of tumor from the primary into an adjacent organ or surrounding tissue.
6. In most cancer sites ITCs (isolated tumor cells) typically do not show evidence of \_\_\_\_\_.
7. In medicine, \_\_\_\_\_ describes disease that is limited to a certain part of the body.
8. The \_\_\_\_\_ is the central portion of an organ, in contrast to the outer layer.
9. What is the term for the functional portion of an organ, in contrast to its framework or stroma?
10. In oncology, \_\_\_\_\_, describes the body area right around a tumor.
11. The \_\_\_\_\_ are the cells and tissues that support, store nutrients, and maintain viability within an organ.
12. True or False. When considering involvement the list of ambiguous terms constituting involvement in EOD takes highest priority.
13. True or False. The list of ambiguous terms in EOD is the same list used for determining reportability as published in the SEER or STORE Manuals.
14. For all sites, EOD is based on a \_\_\_\_\_ clinical and operative/pathological assessment.
15. EOD should include all information available within \_\_\_\_\_ months of diagnosis in the absence of disease progression or upon completion of surgery (ies) in first course of treatment, whichever is longer.
16. Information for EOD from a surgical resection after neoadjuvant treatment may be used, but ONLY if the extent of disease is \_\_\_\_\_ than the pre-treatment clinical findings.
17. Should the medical record documentation or documented TNM information take precedence when there is a discrepancy?
18. What is the priority order for assigning the highest applicable codes in the EOD data items?
19. True or False. In situ tumors with nodal or metastatic involvement should be coded as localized in EOD.
20. If direct extension of the primary tumor into a regional Lymph node is shown, code the involved node(s) in \_\_\_\_\_.

## Answers and Rationale



1. As of what diagnosis date will EOD 2018 be implemented? 1/1/2018
2. What are the three main data items in EOD? EOD Primary Tumor, EOD Regional Nodes, and EOD Mets.
3. True or False. EOD 2018 is fully compatible with the AJCC TNM staging manual, 8th Edition. True, Thorough review of EOD 2018 was completed by NCI SEER staff, SEER\*Educate Staff, and contractors.
4. The cortex is the external or outer surface layer of an organ.
5. Direct extension is a term used in staging to indicate contiguous growth of tumor from the primary into an adjacent organ or surrounding tissue.
6. In most cancer sites ITCs (isolated tumor cells) typically do not show evidence of metastatic activity.
7. In medicine, localized describes disease that is limited to a certain part of the body.
8. The medulla is the central portion of an organ, in contrast to the outer layer.
9. What is the term for the functional portion of an organ, in contrast to its framework or stroma? Parenchyma
10. In oncology, regional describes the body area right around a tumor.
11. The stroma are the cells and tissues that support, store nutrients, and maintain viability within an organ.
12. True or False. When considering involvement the list of ambiguous terms constituting involvement in EOD takes highest priority. False. The clinician's definitions/descriptions and choice of therapy have priority over these lists because individual clinicians may use these terms differently.
13. True or False. The list of ambiguous terms in EOD is the same list used for determining reportability as published in the SEER or STORE Manuals. False. These are not the same terms for determining reportability. Please refer to the appropriate SEER or STORE manual for reportable terms.
14. For all sites, EOD is based on a combined clinical and operative/pathological assessment.
15. EOD should include all information available within 4 months of diagnosis in the absence of disease progression or upon completion of surgery(ies) in first course of treatment, whichever is longer.
16. Information for EOD from a surgical resection after neoadjuvant treatment may be used, but ONLY if the extent of disease is greater than the pre-treatment clinical findings.
17. Should the medical record documentation or documented TNM information take precedence when there is a discrepancy? Use the medical record documentation when there is a discrepancy between the T, N, or M information. Query the physician if possible. If there is doubt that the documentation in the medical record is complete, code the EOD corresponding to the physician staging.
18. What is the priority order for assigning the highest applicable codes in the EOD data items? Pathology, Imaging, Physical Exam
19. True or False. In situ tumors with nodal or metastatic involvement should be coded as localized in EOD. False, code EOD Primary Tumor as in situ and EOD Regional Nodes or Mets as appropriate.
20. If direct extension of the primary tumor into a regional Lymph node is shown, code the involved node(s) in EOD Regional Nodes.





## ***Welcome to our New CTR's!!***

### **Piedmont Hospital welcomes Adrienne Pendergast**

Adrienne Pendergast received her CTR certification in December 2018. She also holds a bachelor's degree in Physical Therapy, having practiced in the past. She is currently working in the Oncology Analytics department at Piedmont Healthcare and is excited to continue learning and growing within the field.

### **Winship Cancer Institute welcomes LaToya Thompson**

LaToya Thompson is a new CTR currently employed at the Winship Cancer Institute of Emory University, Atlanta, GA. She attended Chamberlain College as a nursing student prior to the career path change to become a Cancer Registrar. LaToya is very passionate about Cancer Registry work and all the possibilities that are offered in this field. Her destiny was and still remains to be able to help any stranger she meets that needs a helping hand. She is adamant about being able to help anyone that crosses her path, if she can.

### **Winship Cancer Institute welcomes Barbara Watkins**

Barbara Watkins had been working in the Medical Records field over 23 years when she was introduced to the Cancer Registry. She holds a degree in Health Information Management with an RHIT certification.

In October 2018 she passed her CTR exam.

Barbara and her high school sweetheart just celebrated their 31<sup>st</sup> anniversary. Her greatest joy is to spend time with her three wonderful grandsons, family and reading.

### **University Health Care System welcomes Laura Willis**

Hello! My name is Laura Willis. I'm originally from Augusta, GA and I am a new employee at University Hospital. Actually, I am returning to my roots at UH since it is where I was hired with my first real job as a Unit Secretary way back in 1994 ("real" job to me since it had benefits).

I graduated from the Medical College of GA in 2001 obtaining a B.S. in Allied Health Science with focus in Health Information Administration. My first job after college was at Palmetto Health Baptist in Columbia, SC as a Cancer Data Analyst. I received my RHIA and my CTR in 2002. After leaving Palmetto Health in 2005, I have worked at Lexington Medical Center, S.C. Central Cancer Registry and Regional Medical Center (all in S.C.). Most recently, I worked for Registry Partners as a Project CTR over the last three years.

I have been married for over 20 years to my wonderful husband, Adrian. I have two amazing daughters, Kearnan (10) & Evelyn (7). I love spending time with family, watching movies and listening to music. I am also a complete Disney World parks fanatic! My family is so great about giving me Disney gift cards for my thrill addiction. Once the gift cards pile up, I'm off to Orlando whenever I can get down there. I'm always looking for travel buddies!

## Educational Opportunities.....



“Jumping Into the Deep End”  
March 22, 2019  
Macon GA

### GCR to Host Educational Workshops

The Georgia Cancer Registry (GCR) will host a FREE Educational Workshop in Macon at Springhill Suites on Friday, March 22, 2019. Contact Debbie Chambers at [Debbie.Chambers@dph.ga.gov](mailto:Debbie.Chambers@dph.ga.gov) to register. Seating will be limited to 30. Encore presentations of this workshop will be held Monday, April 1, 2019 at Northeast GA Medical Center’s Braselton Campus (seating limited to 20) and again at Emory University on Thursday, April 11, 2019 in room 2001 in the Claudia Nance Rollins Building to accommodate training for the registry community who are unable to attend in Macon.

Contact Robin Billet at [rbillet@emory.edu](mailto:rbillet@emory.edu) to register for the Emory location and LeRue Perry at [LeRue.Perry@dph.ga.gov](mailto:LeRue.Perry@dph.ga.gov) to register for the Braselton location. Parking in Macon is free. Registrants will be responsible for any parking charges at the other locations.

It is the goal of GCR to offer as much education as possible to our state registry community to meet the challenging demands of the new data requirements beginning with diagnosis year 2018. Participants are encouraged to bring a laptop; we have been promised wireless internet! In the event of interrupted or no internet access, download the 2018 SEER Manual, 2018 STORE Manual, EOD, Summary Stage, and SSDI’s for p16+ oropharynx and kidney parenchyma. Solid Tumor Rules for these sites should also be downloaded from the SEER website. Look for more information coming soon!!



Save the Date  
November 4-6, 2019  
2019 GATRA Annual Educational  
Conference

Lake Blackshear Resort & Golf Club

### News from GATRA

GATRA is a non-profit professional organization for cancer registrars and other allied health professionals interested in cancer data. Founded in 1976, GATRA is dedicated to promoting the professional development of individuals in the cancer registry profession, providing educational programs, publishing newsletters with pertinent information of interest, and lastly promoting the ideals of the cancer registrar as a professional member of the healthcare team, offering greater service to physicians, health care administrators, and ultimately the cancer patient.

GATRA is a growing association with over 450 members.

GATRA is only as dynamic as its members, so if you are not a member then please consider joining today. All information can be found on its website, [gatravweb.org](http://gatravweb.org). Contact GATRA’s President, Colleen Vann @ [cvann@phoebehealth.com](mailto:cvann@phoebehealth.com) with questions, comments, concerns, or ideas. You can always support GATRA by selecting the association as your charity when you make purchases through AmazonSmile.

## And More Educational Opportunities.....



| <b>Date</b>        | <b>Title</b>                 | <b>Hosted by</b>                                                                     |
|--------------------|------------------------------|--------------------------------------------------------------------------------------|
| <b>March 7</b>     | <b>Boot Camp</b>             | <b>Medical Center Navicent, Macon</b><br><b>Georgia Center for Cancer Statistics</b> |
| <b>April 4</b>     | <b>Hema/Lymph Neoplasms</b>  | <b>Georgia Center for Cancer Statistics</b>                                          |
| <b>May 2</b>       | <b>Neuroendocrine Tumors</b> | <b>Georgia Center for Cancer Statistics</b>                                          |
| <b>June 6</b>      | <b>Ovary</b>                 | <b>Georgia Center for Cancer Statistics</b>                                          |
| <b>July 11</b>     | <b>Registry Operations</b>   | <b>Medical Center Navicent, Macon</b><br><b>Northside Hospital, Atlanta</b>          |
| <b>August 1</b>    | <b>Solid Tumor Rules</b>     | <b>St. Joseph Candler, Savannah</b><br><b>Georgia Center for Cancer Statistics</b>   |
| <b>September 5</b> | <b>Coding Pitfalls</b>       | <b>Medical Center Navicent, Macon</b><br><b>Georgia Center for Cancer Statistics</b> |

For information on Macon and Savannah hosted webinars, contact:

Debbie Chambers @ [debbie.chambers@dph.ga.gov](mailto:debbie.chambers@dph.ga.gov)

For information on GCCS and Atlanta hosted webinars, contact:

Robin Billet @ [rbillet@emory.edu](mailto:rbillet@emory.edu)



On December 31, 2018, Carol Crosby retired as the Southwest Regional Coordinator for the Georgia Cancer Registry. Carol started her Cancer Registry career in the 70's at Phoebe Putney Medical Center in Albany. She then worked with the Georgia Department of Public Health for more than 20 years as a contractor and later as full time employee.

I have enjoyed working with Carol and felt sad when she decided to retire from our group. Through the years Carol taught me a lot, and I am very appreciative of all the knowledge I received from her. I hope the Georgia Cancer community appreciates the casefinding manual she developed that is still used statewide.

Carol was very generous with her time, the first few months when I was hired, Carol traveled from southwest Georgia to educate and assist me in structuring the Georgia Comprehensive Cancer Registry. Our first Georgia Comprehensive Cancer Registry training was hosted by Phoebe Putney as Carol was the Cancer Registrar for Phoebe at that time. Carol took time to introduce me to all the cancer registrars in the state at that time. Carol was dedicated to her career and focused on getting cancer data reported in her region completely, timely and accurately.

Time has passed so quickly and now she has decided to dedicate her time to her family and of course to be spoiled by her grand kids. She and her husband will be moving closer to them in North Georgia.

Carol, we wish you only the best of times; we love you and we miss you!

~Rana, Sheree, Debbie, Robin and LeRue





**LAST BUT  
NOT LEAST**

Since Carol Crosby retired on December 31, 2018, her region has been divided between Sheree Holloway, SE GA Regional Coordinator and Debbie Chambers, Central GA Regional Coordinator. The division is as follows:

**Sheree Holloway**

Colquitt Regional Medical Center  
John D. Archbold Memorial Hospital  
South Georgia Medical Center  
Tift Regional Medical Center  
Brooks County  
Cook Medical  
Dorminy Medical  
Grady General  
Irwin County  
Miler County Mitchell County  
Phoebe Worth Medical

[sheree.holloway@dph.ga.gov](mailto:sheree.holloway@dph.ga.gov)

**Debbie Chambers**

Crisp Regional  
Phoebe Putney Memorial Hospital  
Phoebe Sumter  
Piedmont Columbus- Midtown  
St Francis Hospital  
Donaldsonville Hospital  
Lifebright Community Hospital of Early  
Memorial Hospital & Manor  
Southwest Ga Regional Medical Center  
Albany Pathology

[debbie.chambers@dph.ga.gov](mailto:debbie.chambers@dph.ga.gov)

