2017 Richard L. Roudebush VAMC Cancer Program Annual Report

A Summary of 2017 Activities & 2016 Cancer Data
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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 Fort Wayne and Marion VAMCs, along with Community Based Outpatient Clinics (CBOC). The facility has recently merged into Region 10 which encompasses Michigan, Ohio and Indiana. The facility continues to receive consults from the Danville (Illinois) VAMC.

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.

2017 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 such as nutrition and pharmacy. 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 various activities involving the prevention and screening of cancers, the diagnosis and treatment of cancers, the psychosocial and nutritional needs through survivorship and palliative care of Veterans with cancer.

Cancer Committee Membership
The Cancer Committee met quarterly in 2017 to review and discuss the goals and quality standards set in place by our facility, its various departments and the CoC. As always, it is our mission to meet and exceed these benchmarks thus providing
outstanding care to our Veterans as well as to maintain our coveted CoC accreditation. The 2017 Cancer Committee team members are listed below with their CoC role included:

Helen Fosmire, MD, Radiation Oncology /Cancer Committee Chairperson/Cancer Conference Coordinator
Joseph Braun, MD, General Surgery/ Cancer Liaison Physician
Thomas Birdas, MD, Thoracic Surgery/Cancer Registry Quality Coordinator
Ronald Shapiro, MD, Radiation Oncology/Quality Improvement Coordinator
Jordan Schmitt, MD, Oncology/Clinical Research
Erin Newton, MD, Palliative Care
Jane Murphy, MSN, RN, Cancer Program Standards Coordinator/Community Outreach
Chris Wade, MD, Chief of Pathology and Laboratory
Aparna Velnati, MD, Radiology
Jennifer Ball MSN, RN, Cancer Care Center Unit Manager
Chad Galer, MD, ENT
Thomas Gardner, MD, Urology
Kimberly Lambert, CTR, Tumor Registry
Kristen Strachman, LCSW, Social Worker
Cynthia Gilmour, RN, Gastroenterology
Amber Hotz, RD, Clinical Dietitian
Susan Bullington, Pharmacy
Anne Sawrey, RN, Oncology, Nursing representative
Shanna Armstrong, RN, Oncology Case Manager
Harriet Ann Frame, RN, Performance Improvement
Clark Barco, DDS, Dental Service
Rachel Bazzell, American Cancer Society representative

Cancer Committee Activity
With the oversight of the Cancer Committee, many accomplishments and improvements occurred in 2017 including:

- The facility officially met all the American College of Surgeons Commission on Cancer (CoC) standards for accreditation and the facility is now accredited until 2019.
- The Urology Clinic has improved its access to transrectal ultrasounds (TRUS) for prostate cancer diagnoses and cystoscopies for bladder biopsies. The revisions have led to the program doubling their capacity for performing the procedures.
during the week. Wait times for cystoscopies were at six weeks and are now down to three weeks with same day capability. TRUS’s are down from six weeks to three weeks with some same day capability.

- Initiation of a Chest Conference Consult was implemented which included a review of the standard practices for diagnostic workup of lung cancer patients to ensure that the veteran was ready for treatment which improved timeliness to diagnosis and treatment by 12 days (27 days vs 39 days). The Lung Cancer team is continuing to focus on other processes that may lead to additional improvements.

- The Chest Conference Consult spawned a second improvement project regarding the process of submitting cancer cases to discuss at other cancer conferences. A formal consult is to be completed when providers wish to present their case at the General Tumor and Hepatobiliary Conferences. This improvement will streamline the process to avoid delays and duplication of efforts and closes the process in a more formal manner.

- A facility goal for 2017 included offering NETSPOT scans which are state-of-the-art scans for the identification of neuroendocrine tumors. The NETSPOT scans are more sensitive and specific for identifying neuroendocrine tumors. The implementation should improve timeliness for diagnosis of these tumors from 2-3 days to a 60-90-minute scan with immediate imaging available. Final preparations are under way to begin scanning in 2018.

- Another facility goal for 2017 was the implementation of aromatherapy on the inpatient oncology unit with the intent to spread the practice to the rest of the hospital. The response from the veterans and families have been overwhelmingly positive with 89% of veterans and families stating that they enjoyed the benefits and many plan on continuing aromatherapy after discharge.

- Quality improvements in 2017 included the implementation of clinical pathways for non-formulary drug use. The effort was to decrease the time for non-formulary drug approval in the process of providing chemotherapy. The effort to develop the pathways was divided among the medical oncologists and resulted in 19 clinical pathways. Timeliness for drug approval and administration decreased significantly with 28 cases delayed for non-formulary drugs in 2016 to nine in FY2017.
• Improvement on the treatment of the muscle-invasive bladder cancers continued through 2017. The evidence based practice (per NCCN) of offering neoadjuvant chemotherapy to muscle-invasive bladder cancer cases was not a consistent practice. The new process includes Urology Chief approval prior to the request for surgery on any muscle-invasive bladder cancer case that should be considered for neoadjuvant chemotherapy.

• The facility is continuing its participation in the VA National Precision Oncology Program which assists the facility in implementing best practices in precision oncology through genetic analysis of tumor samples and matching results to active therapies, both through standard care and within the context of clinical trials.

Commission on Cancer (CoC) Quality of Care

The CoC has standards that relate to specific quality indicators which the facility is evaluated on and compared with other CoC accredited facilities. The metrics have been identified by the CoC to evaluate if a facility is providing high quality care for various primary sites and include specific treatment or surgical recommendations. As seen in Table 1, the facility met all the benchmarks in 2014.

Table 1

<table>
<thead>
<tr>
<th>Breast:</th>
<th>% required</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer (Accountability)</td>
<td>90%</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with &gt;= 4 positive regional lymph nodes (Accountability)</td>
<td>90%</td>
<td>no data</td>
<td>no data</td>
<td>100</td>
</tr>
<tr>
<td>Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer (Quality Improvement)</td>
<td>80%</td>
<td>100</td>
<td>no data</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rectum:</th>
<th>% required</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or Postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is recommended; for patients under the age of 80 receiving resection for rectal cancer (Quality Improvement)</td>
<td>85%</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
Lung:

<table>
<thead>
<tr>
<th>% required</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery is not the first course of treatment for cN2, M0 lung cases (Quality Improvement)</td>
<td>85%</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is recommended for surgically resected cases with pathologic lymph node-positive (pN1) and (pN2) NSCLC (Quality Improvement)</td>
<td>85%</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Colon:

<table>
<thead>
<tr>
<th>% required</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer (Quality Improvement)</td>
<td>85%</td>
<td>93.1</td>
<td>88.5</td>
</tr>
</tbody>
</table>

Gastric:

<table>
<thead>
<tr>
<th>% required</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer (Quality Improvement)</td>
<td>80%</td>
<td>0*</td>
<td>60*</td>
</tr>
</tbody>
</table>

*Pathology was unable to complete a thorough review of older cases to determine if more lymph nodes were available in 2012 and 2013 cases reviewed.

**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 activities 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 continued to focus on specific colorectal and breast cancer measures in 2017 and our facility submits cases monthly to be included in the quality measures. The facility then receives notification if any case is at risk for falling out of compliance with the selected national treatment guidelines. The certified tumor registrars (CTR) are extremely diligent on submitting cases monthly within two months of diagnosis. Currently the facility is meeting all the criteria required as national treatment guideline recommendations.

**Cancer Prevention & Screening Programs**

The Veterans Health Administration, as well as the CoC, places a high priority on cancer prevention and screening programs targeted to the Veteran population as well as addressing the promotion of healthy habits. As part of the RLRVAMC program, a Cancer Resource Fair was held demonstrating many prevention, screening, treatment,
palliative care and survivorship activities that are available to veterans. As part of the screening program, a nurse practitioner was available to do melanoma screenings if requested. The facility was also able to get access to an inflatable colon as a loan from St. Francis in Lafayette, Indiana. The inflatable colon demonstrated the various stages of colon cancer and was a big hit with the veterans, visitors and staff.

2016 Cancer Data

*Cancer Volume: Past 10 years*

The cancer cases for the past 10 years have been increasing steadily. Figure 1 shows the overall number of cancer cases and the facility reached a new high of 973 analytic cases in 2016.
**2016 Analytic Cases Only**

The primary sites for 2016 are displayed in Figure 2. The facility’s top five primary sites mirrors the national VA which includes prostate, lung, colorectal (combined nationally), urinary and bladder cancers as well as skin melanomas.

![Figure 2]
**Top 5 Leading Cancer Groups**

A summary of the top five groups affected by cancer over the past five years ranked highest to lowest in Figure 3. The top five groups have remained constant for the past five years.

![Top 5 Cancers by Group](image)

*Figure 3*

Urologic cancers represent the highest volume and the majority are prostate and bladder cancers which require surveillance over several years. Lung cancer cases are second followed by gastrointestinal. Head and neck primary sites were combined to display the high volume of cases that require a significant amount of planning and scheduling for the Veterans’ diagnostic workup and treatments.

**Cancer Population Distribution**

The residence of Veterans with cancer served by our facility have remained constant with most Veterans originating from Indiana (Indiana=893, Illinois=106) but the distance traveled may vary considerably within Indiana. The most recent data available on the distance traveled is from 2014 (see Figure 4). The number of Veterans by county for 2016 is displayed in Appendix B.
Cancer Distress Screening

As part of the CoC standards, the facility is required to evaluate the distress of Veterans who are diagnosed and treated for their cancer here. The majority of the screenings take place prior to chemotherapy or radiation therapy (see Figure 6). A potential goal for 2018 may be to spread the screening to other high volume areas that may benefit from social work presence.
The Distress Screening Tool (DST) identifies the personal issues or concerns that the Veteran may have after learning they have cancer. The self-administered screening evaluates the Veterans’ emotional, physical, family and practical issues they may be experiencing at that time. A clinically significant score is 4 or above and percentage of clinically significant scores in 2016 are displayed in Figure 7. The top 10 issues identified on the distress screening tool are displayed in Figure 8.
The Cancer Care Center which includes Medical Oncology, Radiation Oncology, Medical and Surgical Clinics, Social Work, Nutrition, Radiology and Tumor Registry continue to provide excellent quality care and are deeply committed to providing the best care for our Veterans who are dealing with cancer. The information provided in this report is evidence that the whole facility shares in this commitment as well.
Glossary of Terms:

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

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

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
Appendix A

Red = >20 cases

Green = 10-20 cases

Blue = less than 10 cases