Cancer Program
2016 Annual Report
(2015 Statistics)

Southern Arizona
Veterans Affairs
Health Care System

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Cancer Committee Members

Required Committee Membership:

(1) Dr. Felipe A. Maegawa , Surgeon, Surgical Care Line (SCL); Chairperson

(2) Dr. Margaret A. Rennels, Pathologist, Diagnostics Service Line (DSL); Vice Chairperson

(3) Dr. Maria C. Bishop, Medical Oncologist, Medicine Care Line (MCL)

(4) Maureen Price, RN, JD , Risk Manager; Cancer Program Administrator

(5) Joyce L. McDaniels-Higgs, RN, Oncology Nurse

(6) Stephanie Malone, RN, Palliative Care Professional, Rehabilitation & Transitional Care Line

(7) Sandra McDonald, Certified Tumor Registrar (CTR), Office of the Chief of Staff

(8) Carolyn Bernheim, RN, Clinical Surveillance Unit Coordinator

(9) Sharon P. Hammond, RN, Veteran Health Education Coordinator, Office of the Chief of Staff

(10) Elleen N. Martin, CCRP, Program Specialist, Research Service Line

(11) Dr. Michael Moore, Ph.D., Mental Health Care Line (MHCL)

AD Hoc Members:

(1) Elizabeth A. Wiseley, MS, RD, CDE, Clinical Care Support Service Line (CCSSL)

(2) Megan E. Banaszynski, PharmD, Oncology Pharmacist, CCSSL

(3) Tess Stanley, APN, Gastrointestinal Advisor Member, MCL

(4) Dr. Nickola Rogers, MD, Gynecology Advisory Member, SCL

Non-SAVAHCS Members

(1) Dr. Shona Dougherty, MD, Radiation Oncologist, Banner University Medical Center

(2) Nora McDonald, American Cancer Society Representative

Cancer Committee Report

The field of oncology has expanded exponentially over the past decades due to the better understanding of cancer biology and the advance in the technology of cancer management. With such large quantity and fast-growing knowledge in cancer medicine, a comprehensive multidisciplinary approach is essential to allow the cancer program of the medical center to provide high-quality cancer care to patients. The facility Cancer Committee is a multidisciplinary committee whose role is to monitor and improve the quality of cancer care at the Southern Arizona VA Health Care System (SAVAHCS). The committee was chaired for several years by Dr. Robert Krouse, a general surgeon. In May of this year Dr. Krouse left SAVAHCS and the chairmanship of the committee was turned over to Dr. Felipe Maegawa who is also a general surgeon.

The committee met on a regular basis throughout the year. Meeting frequency was increased from quarterly to bimonthly to improve the committee's ability to meet its goals. The overriding goal for the committee is to obtain accreditation from Commission on Cancer (CoC) which is a nationally recognized by organizations such as The Joint Commission, American Cancer Society, Centers for Medicare & Medicaid Services, National Quality Forum, and National Cancer Institute for having established performance measures for the provision of high-quality cancer care to patients. Accreditation by the CoC is re-evaluated every 3 years in order for the cancer program to maintain the accreditation. This continuous evaluation reaffirms the commitment of the cancer program to provide high-quality cancer care.

Cancer Conference Report

Cancer Conferences are held every Thursday afternoon as follows:

1st Thursday – Neurology and Ear, Nose, and Throat
2nd Thursday –Urology
3rd Thursday – Pulmonary
4th Thursday – General Surgery/Gastrointestinal

Attendees include physicians from surgery, pulmonary, radiation oncology, hematology/ oncology, radiology, and pathology as appropriate to the cases being discussed. At every conference, pathology, imaging, treatment options according to NCCN guidelines and prognostic factors are reviewed for new or challenging cases. A de-identified agenda with the patient initials, age, diagnosis, working AJCC stage, and the presenting physician is distributed before the conference. At the beginning of the year conferences were held three times a month. During the year it was decided that an additional conference each month would allow for the presentation of more cases, so a fourth Thursday conference was added and the schedule was adjusted accordingly.

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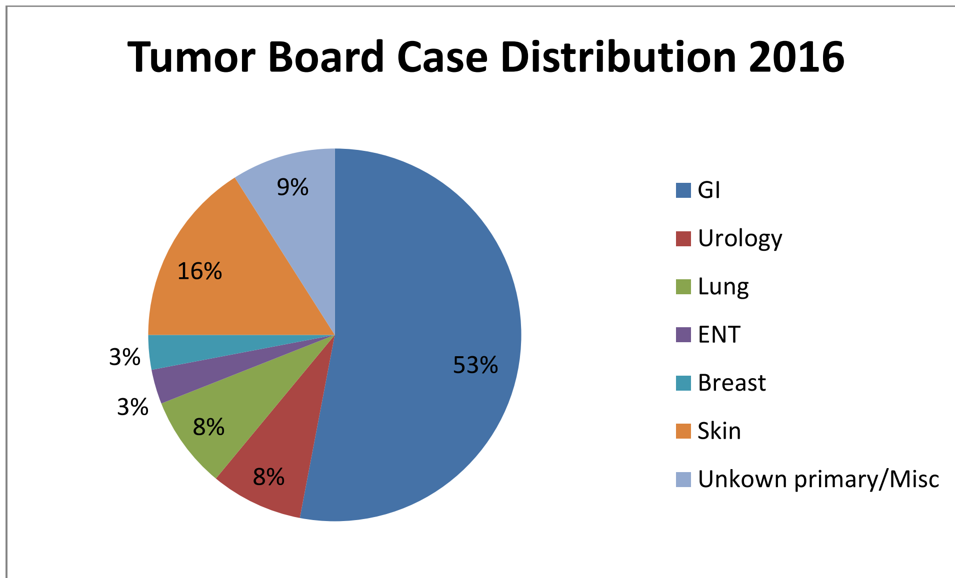
According to the Commission on Cancer Standards for approved cancer programs, 15% of the analytic case load (cases identified and treated at SAVAHCS) must be presented prospectively at the cancer conferences. In 2015, a total of 92 cases were presented at the conferences. This represents 13.9 % of the total analytic cases identified in 2015.

The following chart demonstrates the distribution of cases at the conferences.



Health Promotion and Disease Prevention

Veteran's Health Affairs (VHA) policy requires that each VA facility must have a program to educate veterans with respect to health promotion and disease prevention and to provide veterans with preventative medical care that includes screening, education, counseling, and other clinical services. In accordance with this policy, the SAVAHCS has clearly stated clinical guidelines for many aspects of care. Performance monitors have been developed to assess compliance with these guidelines. Providers are given regular feedback on their performance on selected clinical indicators in comparison to other providers.

Breast Cancer Screening – Mammograms are considered to be due annually for women over age 50.
Cervical cancer Screening – Women age 21-29 who are screened for cervical cancer in the past three years with a Pap test and women 30-64 who are screened for cervical cancer in the past 3 years with a Pap test or in the past 5 years with a Pap test AND a cervical HPV test.
Colon Cancer screening – Screening is done with 3 guaiac fecal occult blood testing during past year or fecal immunochemical-based FOBT (FIT) test in past year per manufactures guidelines.
. **Tobacco Screening** – Patients are screened annually for use of tobacco
Tobacco Counseling – Patient using tobacco are offered counseling, medications or referrals to cessation groups.

These algorithms are built into the reminder system to alert providers that screening is due. The following are data on performance indicators related to cancer prevention for patients assigned to primary care.

Colorectal Cancer Screening Age 50-75

	FY13	FY14	FY15	FY16
Num	534	550	558	562
Den	699	695	691	699
%	77%	80%	81%	82%

National FY16 - 82%

Breast Cancer Screening Women age 50-74

	FY13	FY14	FY15	FY16
Num	121	127	121	120
Den	134	143	146	148
%	91%	90%	82%	80%

National FY16 – 85%

Cervical Cancer Screening ages 30-64

	FY13	FY14	FY15	FY16
Num	144	153	130	165
Den	155	173	151	183
%	93%	92%	87%	90%

National FY16 - 87%

Cervical Cancer Screening ages 21-64

	FY13	FY14	FY15	FY16
Num	162	163	141	174
Den	181	183	163	193
%	92%	92%	88%	90%

National FY16 – 87%

Tobacco screening – Outpatient

	FY13	FY14	FY15	FY16
Num	1079	1079	1052	1103
Den	1080	1101	1062	1112
%	99%	97%	99%	99%

National FY16 – 99%

Patients using tobacco offered medication, counseling or referral to support groups

	FY13	FY14	FY15	FY16
Num	542	443	642	545
Den	700	531	645	577
%	77%	83%	99%	94%

National FY16 – 54%

Num = numerator
Den = Denominator

Patients at SAVHCS are offered a variety of health promotion classes to assist in achieving and maintaining wellness. Classes include Mindfulness Based Stress Reduction, Mind Body Skills Group (10 week program), Healthy Living Workshops, and Matter of Balance- Falls Prevention for adults over the age of 55. The Health Promotion Disease Prevention Program offers Gateway to Healthy Living which puts Veterans in contact with support groups/resources to assist them in meeting their health goals. Veterans are also educated about support groups offered through the American Cancer Society and the University of Arizona Cancer Center.

Cancer Registry Report

Sandra Mc Donald, CTR
Marian Stephens, CTR

The Cancer Registry is a systematic collection of data about cancer and tumor diseases. This data is collected by Cancer Registrars. They capture a complete summary of the patient history, diagnosis, treatment, and status for every cancer patient in the United States and other countries. The cancer registry at SAVAHCS has a reference date of 1999. The Cancer Registry is an integral part of the Commission on Cancer (CoC) Accredited Cancer Program at SAVAHCS.

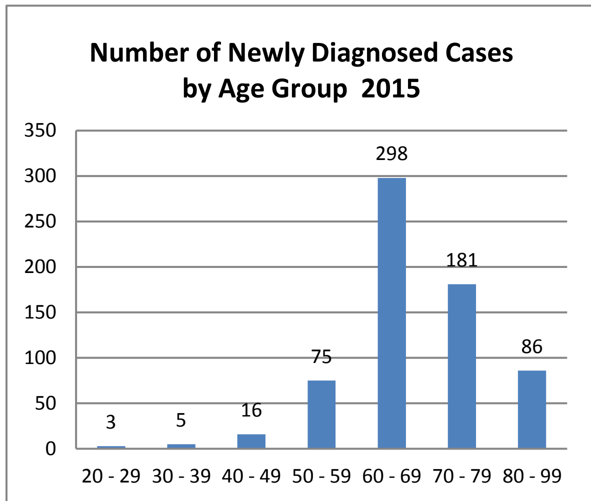
One of the functions of the registry is to provide lifelong patient follow up to obtain end results on the quality and length of survival. According to the CoC, a 90% follow up rate must be maintained for all eligible analytic cases for patients diagnosed with in the last 5 years and an 80% follow up rate must be maintained for all eligible analytic patients from the cancer registry reference date (date the facility registry started). At SAVAHCS, the follow up rates are 94% and 95% respectively which is well above the required minimums. The Cancer Registry can be utilized by physicians and others for conducting research projects or completing studies of quality. As more physicians recognize the value of the registry data, more requests for data are submitted.

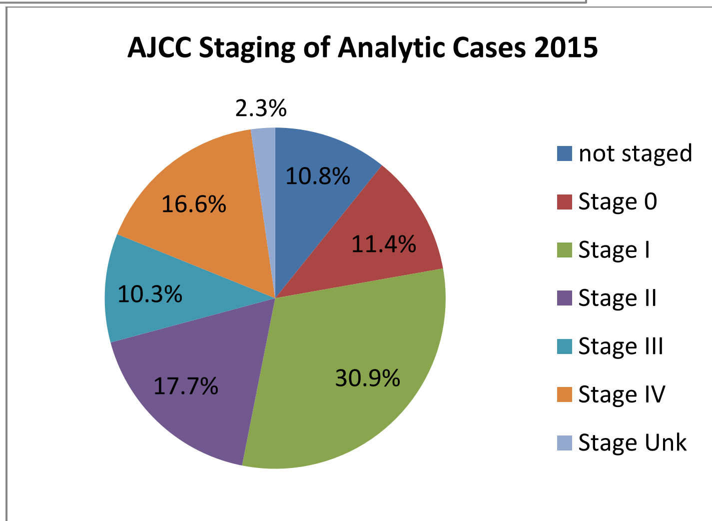
Continuing education for the registry staff is a CoC requirement. All staff must attend a combination of local, regional and national conferences. The SAVAHCS registry staff attended the Arizona State Cancer Registry Conference, the National Cancer Registrar Association (NCRA) annual meeting, as well as the Arizona State funded North American Association of Central Cancer Registries (NAACCR) webinar series. Continuing education standards for the CoC meet the necessary continuing education requirements to maintain Certified Tumor Registry states as well.

The Cancer Registry at SAVAHCS added 664 caes to its database in 2015. Thirty cases (4.5%) were Class 00 – diagnosed at SAVAHCS but treated elsewhere. Five hundred and twenty-eight cases (79.5%) were Class 10-14 – diagnosed at SAVAHCS and all or part of treatment was provided at SAVAHCS.

Sixty-three cases (9.5%) were Class 20-22 – diagnosed elsewhere but treated at SAVAHCS for all or part of first course of treatment. An additional 43 non-analytic cases were abstracted.

Out of the 621 analytical cases, 67 cases (10.0%) did not have an American Joint Committee on Cancer (AJCC) staging designation, i.e. unknown primary, leukemia, myeloma, brain, and others. Staging for the other 597 cases is as follows: In Situ or Stage 0: 71 cases (11.4%); Stage I: 192 cases (30.9%); Stage II: 110 cases (17.7%); Stage III: 64 cases (10.3%); Stage IV: 103 cases (16.6%); and Unknown Stage: 14 cases (2.3%).





In 2015, 664 cases were added to the data base. This includes cases that were diagnosed elsewhere but treated at SAVAHCS (non-analytic cases).

Site	Cases	Site	Cases
Prostate	145	Plasma Cell Disorders	6
Lung NOS	81	Anus	5
Melanoma	65	Extrahepatic Bile Duct	4
Bladder	46	Nasal Cavity/Sinus/Ear	4
Kidney	31	Skin	4
Liver	23	Soft Tissue	4
Leukemia	26	Testis	4

Colon	22	Thyroid	4
Pancreas	21	Uterus	4
Breast	18	Cervix	3
Oral Cavity	17	Endocrine	3
Unknown	17	Lip	2
Lung Small Cell	16	Ampulla of Vater	2
Rectum	15	Nervous system, other	3
Lymphoma	15	Bone	1
Pharynx	14	Digestive	1
Stomach	11	Female Genitals	1
Larynx	9	Small Intestine	1
Esophagus	8		
Hemato/Reticulo	8	Total # of Cases for 2015	664

Studies of Quality

During the year, a study of quality was done looking at timeliness of care for patients diagnosed with lung cancer. In 2010, the VA conducted a nationwide study on the quality and timeliness of cancer care in the VA. Twenty-three quality indicators were examined including diagnosis, treatment, management, supportive care, end of life care, and timeliness of care. Based on the results, a VA wide Lung Cancer Collaborative was started.

SAVAHCS was asked to participate in the collaborative in 2011. The team decided to look at timeliness of care for patients diagnosed with lung cancer. Baseline data from the national study was as follows: the median time from suspicion to the diagnosis of lung cancer was 32 days with a range of 11-75 days. The median time from diagnosis to treatment was 35 with a range of 19-48 days. A review of patients treated at SAVAHCS found that the average time from initial suspicion to initial diagnosis of lung cancer was 54 days and the average time from diagnosis of lung cancer to first course treatment was 61 days.

In order to assess current timeliness, data analysis was done for timeliness of care for patients who were diagnosed with lung cancer from July-2015 to April 2016 in two cohorts. The following definitions were established:

a. Date of initial suspicion – Date on which the first imaging study showing a suspected or known lung nodule or mass was obtained where the radiologist recommended additional imaging, biopsy or bronchoscopy.

b. Date of initial diagnosis – Date pathology report compete after either lung biopsy or bronchoscopy.

c. Treatment Date – Date of initial treatment reported in Cancer Registry abstract (chemotherapy, radiation therapy or surgery)

The same time periods for care were utilized as in the 2011 study - timeliness from initial suspicion to initial diagnosis of lung cancer and timeliness from diagnosis to first course of treatment.

From July 2015-November 2015, 14 cases of lung cancer were diagnosed. The average number of days from suspicion to diagnosis was 137 days. The average was affected by four patients who had provider related long delays between an image showing a possible or probable nodule and definitive imaging and biopsy. An additional study was done on this cohort to examine the average time from diagnosis to first treatment. The average time form diagnosis to treatment was 57 days. Three of the 14 patients opted for comfort care so were not included in the average.

The second cohort included patient diagnosed between December 2015 - April 2016. During this time 19 cases of lung cancer were diagnosed. The average time for this group was 98 days. One patient in this cohort, delayed diagnosis by repeatedly cancelling her appointment for a lung biopsy. There were four patients in this cohort that had delays in diagnosis similar to those seen in the first cohort.

The following chart is a comparison of studies done in 2011 (Lung Cancer Collaborative) and 2015/16:

	Exec summary - 2010	SAVAHCS Collaborative 2011	7/15- 11/15	12/15-4/16
Days from Initial Suspicion to Diagnosis	32 Range 11-75	54	137	98
Days from Diagnosis to First Treatment	35 Range 19-48	61	57	

SAVAHCS did a root cause analysis on the care on one of the patients with a delay in diagnosis early in 2015. The team proposed the formation of a special unit called the Clinical Surveillance Unit. The purpose of this unit is to monitor abnormal imaging reports suggestive of pulmonary malignancy or the presence of lung nodules and track these patients to be sure none are lost to follow-up. The unit was formed in August of 2015 and a data base for tracking purposes was created. The CSU began tracking patients in October of 2015 and is now tracking over 1800 patients with lung nodules and intervened over 1200 times to ensure that the patient accomplished the next step of care in the evaluation or diagnosis of their lung nodule.