Annual Report for 2017

PROVIDENCE St. Mary Regional Cancer Center

Introduction

In November 2016, a surveyor from the Commission on Cancer (CoC) visited Providence St. Mary Regional Cancer Center (PSMRCC) to confirm that we are in compliance with the eligibility requirements and the standards of care. We are. In 2017, we received our accreditation from the Commission on Cancer that will stand for a three year period beginning 2016 and ending December 2018. We are proud to have earned the accreditation and see it continuing for additional three year periods.

The format for the PSRMCC Annual Report is grouped around the Standards from the Commission on Cancer. According to the CoC:

> The standards provide clear guidance to support the provision of high-quality care. Providing a high level of quality care requires coordination of care among many medical disciplines, including physicians ranging from primary care providers to specialists in all oncology disciplines. In addition, care requires input from many other clinical and allied health professionals, including nursing, social work, genetics, nutrition, rehabilitation, and others. Each standard is carefully reviewed for relevance, value to the program and to patients, and feasibility of implementation in community settings.

We truly believe those words to be the case for cancer care.

That being said, we are also extremely proud of the people who work for our cancer center and the compassionate care they continue to provide. From our patient handbook:

> Our Cancer Center is built on providing services, convenience, and comfort to our patients and their families. Cancer prevention, early detection, and treatment of cancer and blood diseases are important focuses of care within the clinical, education, and research setting at Providence St. Mary Regional Cancer Center.
>
> The Cancer Center offers complementary support programs and classes for patients and their families. It also houses Walla Walla's only American Cancer Society Cancer Resource Center, giving patients access to the latest in cancer-related medical information. Our physicians, oncology certified nurses, oncology social workers, rehabilitation therapists, and registered dietitians work together to coordinate your personalized care.

We strive to be the best for our patients and ourselves.

Program Management

Std 1.1, 2.2 – MD Credentials, nursing care
The providers and staff that care for our patients are well prepared to take care of our patients. The physicians are all board certified. The nurses that provide chemotherapy all have Oncology Nurse Certification (OCN) meaning they are better equipped to recognize problems and take action for the patients.

Std 1.2, 1.3, 1.4 – Cancer Committee meetings
In addition to providers and staff, there is an oversight committee comprised of physicians and staff that provides guidance to the Cancer Center. Four times annually, the committee comes together to hear

reports about program goals, continuum of care, outreach services that work to coordinate and improve care for our patients.

Std 1.5 – Program Goals – Genitourinary MDT, Handbook
Each year the Cancer Center picks one clinical goal and one programmatic goal with each designed to improve the delivery of care. For 2017, our clinical goal was to establish a multi-disciplinary team (MDT) focused on Genitourinary cancers. We brought together medical and radiation oncologists along with urologists and surgeons to work together to coordinate care for patients that present with various stages of genitourinary cancers. Pathologists present biopsy findings, care options are considered and then presented to patients at upcoming appointments. After a slow start, through September 2017, the Genitourinary MDT discussed over 80 patients with cancers such as prostate, bladder, testicular, and renal.

The programmatic goal was to resurrect, revise, and republish the patient handbook, *Patient and Family Information Guide to Services and Resources*, to provide important information to patients, especially new ones. The guide includes information on treatment, support services, housing and transportation, billing, and providers and caregivers in the Cancer Center. Patients will receive a guide at their first consultation. In addition, the handbook can be found on the Providence St. Mary Regional Cancer Center website.

Std 1.6, 1.7 – Cancer MDTs and 2016 data
In addition to the clinical goal to establish a GU MDT, the Breast Cancer MDT continued to operate weekly to present patients and follow the team meetings with clinical appointments with surgeons and oncologists, both medical and radiation. The Breast MDT discussed over 100 patients through September 2017.

A Lung MDT was also established in 2017. Over 70 patients were discussed through September 2017. As described earlier, medical and radiation oncologists along with pulmonologists and thoracic surgeons work together to coordinate care for patients that present with lung cancer.

While 2017 data is still accumulating, the following represents our data for 2016:

			Sex of Patient				**AJCC STAGE**			
PRIMARY SITE	**#**	**%**	**MALE**	**FEMALE**	**0**	**I**	**II**	**III**	**IV**	**UNK***
Buccal Cavity & Pharynx	14	3.3	9	5	0	2	3	1	6	2
Esophagus	8	1.9	7	1	0	1	1	3	2	1
Stomach	0	0	0	0	0	0	0	0	0	0
Small Intestine	2	0.5	0	2	0	0	2	0	0	0
Colorectum	25	5.9	11	14	0	2	11	7	3	2
Anus, Anal Canal, Anorectum	3	0.7	2	1	0	1	1	1	0	0
Liver	8	1.9	6	2	0	1	2	3	1	1
Gallbladder & Biliary Tract	0	0	0	0	0	0	0	0	0	0
Pancreas	7	1.6	4	3	0	0	4	0	3	0
Other Digestive Organs	2	0.5	0	2	0	0	0	0	1	1
Nasal Cavity & Sinuses	0	0.0	0	0	0	0	0	0	0	0
Larynx	3	0.7	3	0	0	1	1	0	1	0
Lung & Bronchus	50	11.8	27	23	0	10	3	11	26	0
Trachea, Pleura & Other	0	0.0	0	0	0	0	0	0	0	0
Bones & Joints	0	0.0	0	0	0	0	0	0	0	0
Soft Tissue	2	0.5	2	0	0	1	0	1	0	0
Melanoma of Skin**	9	2.1	5	4	1	3	1	1	2	1
Other Skin	2	0.5	0	2	0	0	0	1	1	0
Breast	80	18.8	2	78	12	36	26	5	1	0
Cervix, Invasive	2	0.5	0	2	0	1	0	1	0	0

PRIMARY SITE	#	%	Sex of Patient MALE	FEMALE	AJCC STAGE 0	I	II	III	IV	UNK*
Corpus Uteri	15	3.5	0	15	0	9	2	3	1	0
Ovary	4	0.9	0	4	0	1	0	1	2	0
Other Female Genital Sites	2	0.4	0	2	0	0	0	2	0	0
Prostate	47	11.1	47	0	0	8	24	3	12	0
Testis	6	1.4	6	0	0	4	0	1	0	1
Other Male Genital Sites	0	0	0	0	0	0	0	0	0	0
Urinary Bladder	21	4.9	19	2	15	3	1	0	2	0
Kidney, Renal Pelvis & Ureter	16	3.7	10	6	1	9	0	3	3	0
Other Urinary Organs	0	0.0	0	0	0	0	0	0	0	0
Eye	0	0.0	0	0	0	0	0	0	0	0
Brain & Other Nervous System	15	3.5	9	6	0	0	0	0	0	15
Thyroid	18	4.2	5	13	0	11	1	6	0	0
Other Endocrine System	1	0.2	1	0	0	0	0	0	0	1
Lymph Nodes	24	5.6	15	9	0	6	2	4	12	0
Blood System	34	8	17	17	0	0	0	0	0	34
Other Ill-Defined & Unknown	5	1.8	3	2	0	0	0	0	0	5
PSMMC 2016 Cases	425	100%	210	215	29	110	85	58	79	64
PSMMC Total %			49%	51%	7%	26%	20%	14%	19%	15%

The data shows that our top three cancers in 2016 were breast, lung, and prostate and correspond to the establishment of our multi-disciplinary teams. Other cancers are covered in our general tumor conference twice a month.

Std 1.9 – Clinical Trials

Providence St. Mary Regional Cancer Center has a robust clinical trials program. We are an affiliate member of the Southwest Oncology Group (SWOG), and participate in selected trials sponsored by SWOG, other National Cancer Institute-sponsored cooperative groups, and leading pharmaceutical companies. All patients are reviewed for eligibility and with assent are enrolled in appropriate clinical trials. Through September 2017, twenty new patients were put into a clinical trial. It is important to know that everyone who participates in a clinical trial at Providence St. Mary receives treatment. There is no “placebo group.” The trials all test the best known treatment against a promising new treatment.

Clinical Services

Std 2.3 – Genetic Counseling

PSMRCC has offered genetic testing for several years. Genes can contribute to the development of certain types of cancer. Approximately 30 percent of cancers are hereditary and 5 to 10 percent are caused by a single gene. In 2017, PSMRCC partnered with Myriad to add tele-genetics to the care provided patients. All new patients have an initial telephonic screening and based on the results will meet with Cancer Center personnel to view a video and then call a genetics counselor for additional risk assessment. Based on the information provided, the patient may receive a recommendation for further testing. The new process provides a larger screened population to decrease the risk of hereditary cancers.

Std 2.4 – Palliative Care

Palliative care is a specialty focused on the relief of physical, emotional, and spiritual suffering for those affected by life-limiting or complex chronic illnesses. In 2017, there were no changes to the service provided, however there was a change in providers.

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Continuum of Care

Std 3.1, 3.2, 3.3 – Navigation, Psycho/Social, Survivorship
Navigation continues to be a key aspect of patient care at PSMRCC. The 2017 addition of the new multi-disciplinary conferences put pressure on our navigator. As a result, through a grant from Every Woman Can, a position was created for a Breast Advocate. The position is designed to focus on patients with Breast Cancer (the largest cancer diagnosis). In this regard, the Advocate will work with PCPs to support patients who have positive results from mammograms and will need further care. The Advocate will guide the patient through biopsy to confirm or refute the preliminary positive result from the mammogram.

Another addition to PSMRCC in 2017 is the ability to increase our "touch points" regarding patient stress/distress as they journey through treatment. Traditionally, the social worker attempts to measured patient distress at the initial chemo treatment for medical oncology patients and at the CT simulation for radiation oncology patients. In November 2017, a software product, TONIC, will give the ability to capture distress at first consult and multiple times during their treatment time. It will act as a set of emotional "vital signs" and permit comparisons across their journey.

Survivorship continues to meet goals of transitioning patients from the rigors of treatment to the post treatment phase of the cancer journey. Many times patients feel lost as they stop coming to the Cancer Center – a loss of family. Survivorship eases that transition. As of September 2017, ninety-five care plans have been presented compared to fifty-six in 2016.

Patient Outcomes

Std 1.8, 4.1, 4.2 – Screening, Prevention
An important part of any cancer program is to provide screening opportunities to discover cancer, hopefully in its early stages.

Skin Screening Clinic May 2017 - The Walla Walla County melanoma skin cancer incidence rate is 22.6 compared to the US incidence rate of 20.3. Due to this higher incidence rate Providence St. Mary Regional Cancer Center provides an annual free skin screening clinic. This has proven effective as Walla Walla County is the only county in Washington State with a classification of decreasing skin cancer rates.

23 patients attend the clinic
14 had abnormal exams by the dermatologist requiring further evaluation

As a total, 61% of the patients participating were identified with abnormalities requiring further care.

Prostate Screening Clinic October 2017

28 men attended the clinic
22 had a physical exam/blood draw
Out of the 22 blood draws, 3 test results were abnormal
Out of the 28 physical exams by our urologist, 3 were abnormal

However, the 3 patients with abnormal physical exams, were not the same 3 patients with abnormal PSA's. Total of 6 patients with abnormal results

Prevention is also critical to support those whose habits can lead to cancer. In 2017, the Cancer Center revised and resurrected the smoking cessation curriculum. The classes were offered twice, in June and in November. For the two classes, ten people signed up with four attending.

Std 4.3, 4.4, 4.5 – Accountability and Quality Improvement Measures

Updated results from the Cancer Program Practice Profile Reports for year 2015 were available for review. Congruent with previous reports from the Committee, estimates for our practice of breast cancer evaluation and management continues to equal or exceed performance rates set by the Commission on Cancer and are listed below in table form:

Measure	***Coc Std/%***	***2012***	***2013***	***2014***	***2015***
BCSRT	4.4 / 90%	100.00	91.70	100.00	97.20
HT	4.4 / 90%	93.80	94.60	100.00	95.30
MASTRT	4.4 / 90%	100.00	100.00	100.00	100.00
nBx	4.5 / 80%	89.70	86.00	84.10	92.20
BCS	Not Applicable	66.70	57.10	69.60	75.00
MAC	Not Applicable	100.00	100.00	100.00	100.00

BCSRT: 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)

HT: Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or stage IB-III hormone receptor positive breast cancer (Accountability)

MASTRT: Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with >= 4 positive regional lymph nodes (Accountability)

nBX: Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer (Quality Improvement)

BCS: Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer (Surveillance)

MAC: Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0, or stage IB - III hormone receptor negative breast cancer (Accountability)

That performance was mirrored by results from compliance standards governing colorectal cancer which are displayed below which also meet or exceed CoC expectations:

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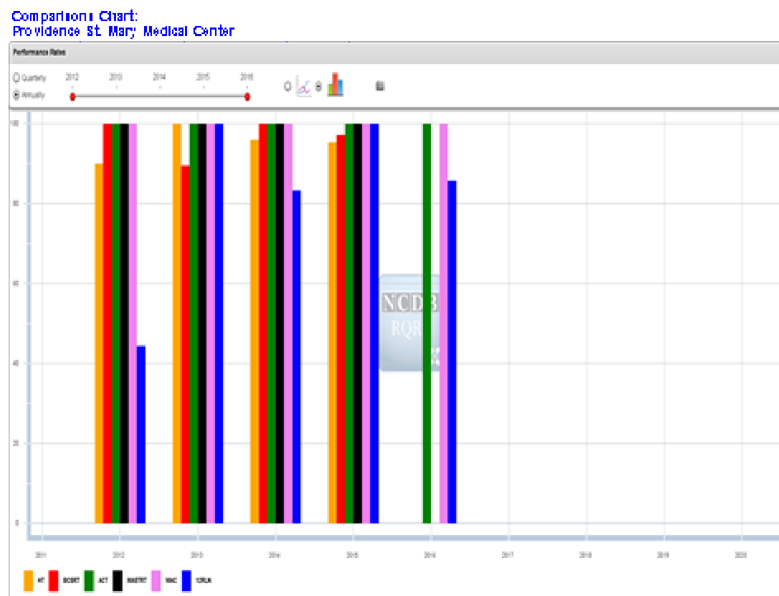
Measure	CoC Std / %	2012	2013	2014	2015
12RLN	4.5 / 85%	50.00	100.00	83.30	100.00
ACT	Not Applicable	100.00	100.00	100.00	100.00

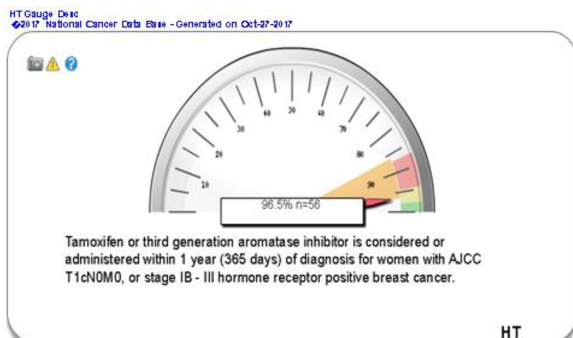
12 RLN: At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer (Quality Improvement)

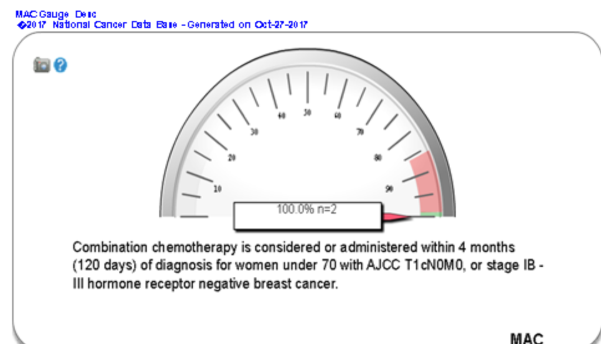
ACT: Adjuvant chemotherapy is recommended, or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer (Accountability)

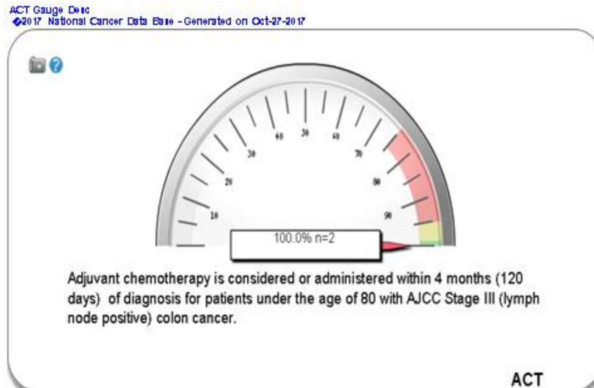
This information is also available in chart form covering a 5 year period from 2012 through 2016 as seen below:

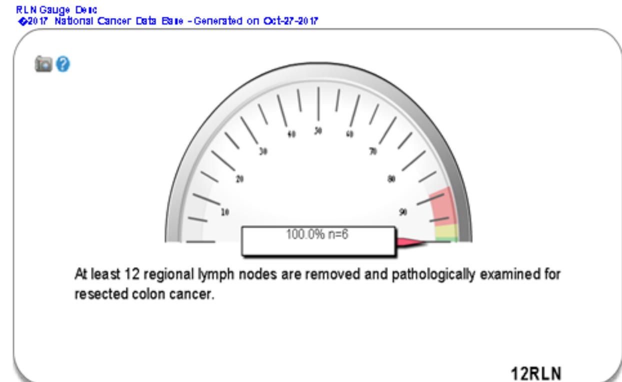


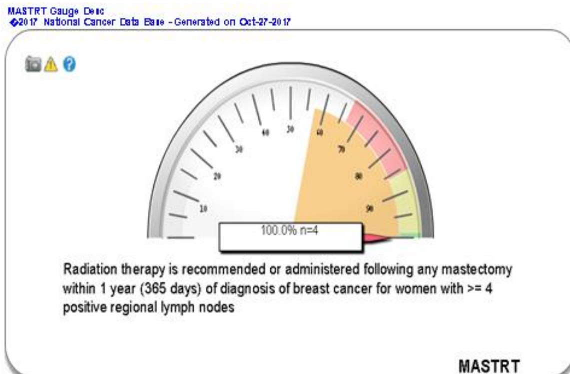
Review of the Rapid Quality Reporting System data (RQRS) from the CoC Data Links covering a large portion of cases submitted from Providence St Mary for year 2017 is presented below for six key measures:

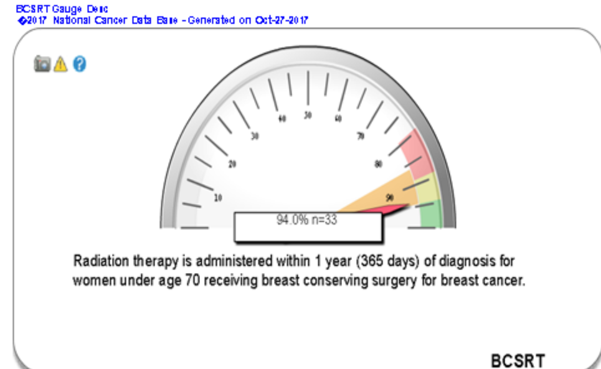












From the above it thus appears that evaluation and management of breast and colorectal cancer are fully compliant with standards being set by the Commission on Cancer.

Std 4.6 – Monitoring Compliance with Evidence-Based Guidelines

To assess the Cancer Center's compliance with evidence-based guidelines, a study of patients with non-small cell lung cancer treated in year 2016 was performed. Guidelines taken from the National Comprehensive Cancer Network (NCCN) for management of lung cancer were used to assess compliance with both pretreatment evaluation as well as subsequent cancer treatments employed. A total of ten cases spanning the spectrum of clinical and pathologic stages of lung cancer were chosen for review.

Of those ten patients there were five males and five females, ages ranging from 57-84 years with median age of 76 years. Combined clinic-pathologic staging ranged from stage IA through stage IV broken out as follows:

Stage I: cT1a cN0, M0; cT1a N0 M0
Stage II: cT3, N0 M0
Stage IIIA: cT2 N2 M0
Stage IIIB: pT1b pN3 M0
Stage IV: cTx N3 M1b; cT2 N2 M1b; cT4 N1 M1b; cT2 N0 M1b; cT3 N3 M1a

A pathologic diagnosis of cancer was achieved in all ten cases reviewed, 7 attributable to adenocarcinoma histopathology, and 3 being squamous. Of those ten pathologic diagnoses, 9 were established by image-guided biopsy, 1 by endoscopic bronchial ultrasound (EBUS).

Staging modalities employed included PET/CT scan used in 7 of 10 cases, MRI used in 3 of 10 cases, bronchoscopy in 1 of 10 cases and mediastinoscopy in 1 of 10 cases. For patients with advanced stage disease, molecular testing was performed in 3 of 5 cases.

For patients with stages I-IIIA disease, treatment consisted of stereotactic body radiation (SBRT) in two cases and chemoradiotherapy in two cases. One patient with stage IIIB disease also received treatment with chemoradiotherapy. No patient underwent attempted thoracotomy for cancer resection. For patients with stage IV lung cancer, one patient received palliative chemotherapy and three patients were either initially or subsequently referred to hospice. One patient with an isolated skeletal metastasis was treated with initial radiation to the bone followed by chemoradiotherapy. She remains I remission over one year from time of diagnosis.

As an overall assessment of guideline compliance, there was generally fair to good utilization of comprehensive staging of lung cancer relying chiefly on PET/CT scan, but with much less utilization of bronchoscopy, EBUS or surgical staging with mediastinoscopy, reflecting the diminished access to these modalities.

Treatment of localized lung cancer with curative intent was fully concordant with guideline recommendations and reflected the Center's expertise with both SBRT and chemoradiotherapy. For advanced stage disease, there was similar adherence taking note of the provider's consistent use of molecular testing to assess for eligibility for targeted therapeutics.

In year 2016 there was no platform available for consistently achieving coordinated, prospective treatment planning among providers with specialized diagnostic or treatment expertise, other than ad hoc interactions. This deficiency likely accounts in part for the limited use of surgical consultation for evaluated patients. This has now been addressed as part of a year 2017 quality improvement program sponsored by the Cancer Committee, specifically designed to address this shortcoming with the establishment of the thoracic interdisciplinary conference held bi-monthly in the Cancer Center.

Std 4.7, 4.8 – Research and Improvements – Advanced Care and Lung Cancer

Study of quality – Advanced Care

As reported at the last meeting, (8/02/17), one area of study was to look at advance care directives and goal of care conferences with new cancer center patients.
We highlighted the hypothesis, methodology employed to collect the date and compare it to the national bench mark.

Quality improvement – Advanced Care

The goal in mind would be to have significant increases in the number of new cancer center patients with adv. care directives. Based on the comparisons, the following were recommended.

- Creation of a subcommittee, for advance care planning, led by Lisa Schumann.
- Effort made to educate caregivers about the importance this initiative.
- Members subsequently attend a ½ day symposium on "advance care planning re-imagined"
- Continued education post symposium. Subsequent meetings to be held with caregivers/providers imparting information gained by subcommittee.
- Subcommittee also to work with Providence in developing a three step approach, in ensuring that all new patients have an advanced care plan documented.

- Collection of date in the first quarter of 2018 for the 4th quarter of 2017.
- Comparison of date collected the 4th quarter 2016, to data collected the 4th quarter 2017.
- Show how both periods related to the national benchmark. (Note improvements).

<u>Study of quality – Lung Cancer</u>

A research project started with the hypothesis that our patients are like any other person with a lung cancer diagnosis across the national cancer database. We reviewed the NCDB data to determine if our Cancer Center had outcomes equal to the national average. The data collected for 2016, showed that our center was falling short in catching lung cancer at an early stage. The survival of patients diagnosed here, were noticeably less than the national average.

<u>Quality improvement – Lung Cancer</u>

The overall information gathered from the collected data, suggested an important need to address tobacco cessation, lung cancer screening and comprehensive integrated disease managements. To rectify the discrepancy, the following actions took place:

- There was a successful launch of the thoracic multidisciplinary conference in 2017.
- Lung cancer screening. (This started July 2015. To date, a total of 118 screening studies conducted). We will include highlighted numbers captured in 2016 to this year's numbers, in our 2018 report.
    1. LRAD 1=45 cases
    2. LRAD 2= 56 cases
    3. LRAD 3=10 cases
    4. LRAD 4=6 cases
    5. One + case of invasive squamous carcinoma diagnosed 10/23/17

- Smoking cessation number for 2016 and 2017
- Collection of data in the first quarter of 2018 for 2017.
- Comparison of data collected in 2016, to data collected in 2017(post implementation of multi directional strategy)
- Show how both periods related to the national benchmark.

Summary

As was stated in the introduction, in 2017, Providence St. Mary Regional Cancer Center received its accreditation from the Commission on Cancer that will stand for a three year period beginning 2016 and ending December 2018. This annual report is designed to demonstrate PSMRCC continues to meet and exceed the standards set by the Commission on Cancer.

In addition, this annual report is a way to demonstrate to our patients that we strive to be the best because our patients deserve the best.