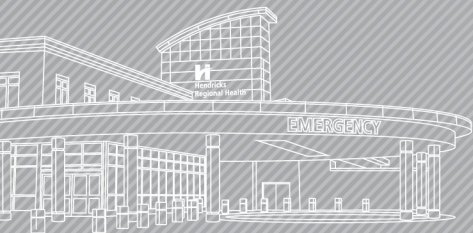


# **Hendricks Regional Health Quality Annual Report 2018 Standards 4.6, 4.7, 4.8**

Annual Reporting of Outcomes  
CoC Standard 1.12



# Cancer Care Committee 2018



Cancer Committee Chair/Radiation Oncology  
Cancer Liaison Physician  
Medical Oncology  
Radiologist  
Pathology  
Administration  
Social Work/Psychosocial Coordinator  
Quality Improvement Coordinator  
Certified Tumor Registrar  
Pharmacy/Clinical Research Coordinator  
Community Outreach Coordinator  
Cancer Conference Coordinator  
Oncology Nursing/Education  
Palliative Care  
Genetics  
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Lynn Turner, RN, MSN  
Angela Sanders, NP  
Jennifer Pierle, FNP-BC  
Danielle Thompson, RT(R)(M), BSHA

# Standard 4.6



## Monitor Compliance with Evidence-Based Guidelines

- Each calendar year, the cancer committee designates a physician member to complete an in-depth analysis to assess and verify that cancer program patients are evaluated and treated according to evidence-based national treatment guidelines.
- In 2018, Monet Bowling, MD analyzed the cancer program's adherence to the NCCN guideline recommending that Stage IV breast cancer patients be prescribed Denosumab.

# Standard 4.6



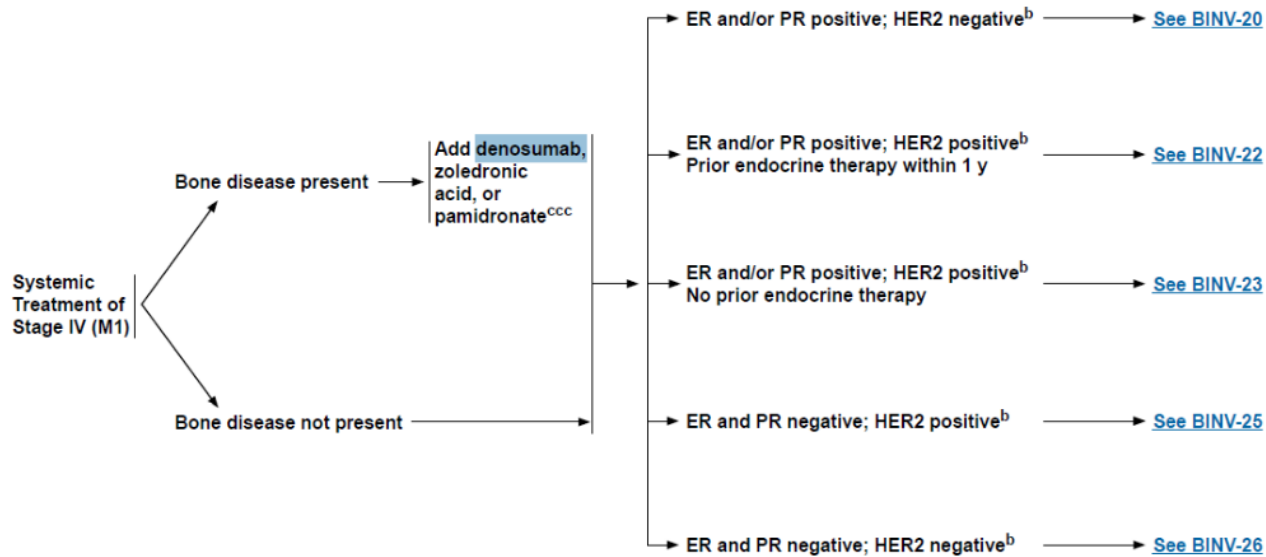
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## NCCN Guidelines Version 1.2018 Invasive Breast Cancer

[NCCN Guidelines Index](#)  
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[Discussion](#)

### SYSTEMIC TREATMENT OF RECURRENT OR STAGE IV (M1) DISEASE



<sup>c</sup>See Principles of HER2 Testing (BINV-A).

<sup>bbb</sup>The role and timing of surgical removal of the primary tumor in patients presenting with de novo stage IV (M1) is the subject of ongoing investigations and must be individualized. Performance of local breast surgery and/or radiation therapy is reasonable in select patients responding to initial systemic therapy.

<sup>ccc</sup>Denosumab, zoledronic acid, or pamidronate (all with calcium and vitamin D supplementation) should be given (category 1) in addition to chemotherapy or endocrine therapy if bone metastasis is present, expected survival is  $\geq 3$  months, and renal function is adequate. Patients should undergo a dental examination with preventive dentistry prior to initiation of this therapy. The optimal schedule for zoledronic acid is monthly x 12, then quarterly.

Note: All recommendations are category 2A unless otherwise indicated.  
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

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BINV-19

# Standard 4.6



## Results

- 12 patients were diagnosed with stage IV breast cancer in the years 2016 and 2017.
- Of these patients, 2 were prescribed Denosumab or 16.6%.
- If this becomes a treatment requirement for stage IV patients, the cancer care committee will re-educate the medical oncologists on the use of this drug.

# Standard 4.7



## Studies of Quality

- Each calendar year, the cancer care committee, under the guidance of the Quality Improvement Coordinator, develops, analyzes, and documents the required number of studies (based on program category) that measure the quality of care and outcomes for cancer patients.
- Hendricks Regional Health is required to perform at least two studies.
- In 2018, the cancer care committee chose the following Studies of Quality:
  - Outside Pathology Slide Review
  - DVT/PE Study

# Standard 4.7



## Outside Pathology Slide Review

- This quality study looked at slides of patients who have a confirmed malignancy from an outside facility and seek further treatment at HRH. This is done to confirm the diagnosis and to look for discrepancies between the two diagnoses. The pathologist also looked at minor versus major discrepancies. A major discrepancy was defined as a discrepancy that affects the patient's treatment. We identified 33 patients that we discussed during tumor board that fulfilled the criteria. The outside slides were reviewed and diagnoses were documented in our EMR systems. We first confirmed that all patients had malignancy. Then we compared our diagnoses with the outside diagnoses.
- **Conclusions & Recommendations:** It was concluded that there were no major discrepancies identified, but there were 4 minor discrepancies, including: (one case of each)
  - Margin status, though remaining negative, was closer than original measurement
  - Change in nuclear grading, but not overall tumor grading
  - Change grading of the glandular differentiation, but not overall tumor grading
  - Identified previously undocumented in situ component in excision for invasive carcinoma.
- It was decided to continue outside pathology evaluations on malignant cases due to the fact that this is the current standard of care and that we did find some minor discrepancies.

# Standard 4.7

## DVT/PE Study



- This quality study looked at the number of cancer patients who developed DVT/PE while on treatment and compared those numbers to state and national benchmarks. Review of Cancer patient data at HRH is somewhat limited due to multiple EMR systems that are being used among Practitioners.
- Patient claims were analyzed from December, 2015-September, 2018 to ensure a large enough sample size. Additionally a Crimson Benchmark of Top Decile-Medium Sized Hospitals was used for comparisons sake.
- Conclusions and Recommendations: One case was found coded with an active PE in a colon cancer patient. No cases were found in breast or lung cancer patients. This gave the study a 1.7% incidence. The cohort performance for this measure was 1.81%, favorable to HRH.
- Because when compared to top decile, medium sized hospitals HRH currently performs under benchmark (favorable), it is recommended that there does not exist a quality improvement opportunity for the reduction of PE within this cohort.



# Standard 4.8



## Quality Improvements

- Each calendar year, the cancer care committee, under the guidance of the Quality Improvement Coordinator, implements two cancer care improvements.
- In 2018, the cancer care committee chose the following Quality Improvements:
  - Increased Acuity in Outpatient Radiation Oncology
  - Analysis of Chemotherapy Use in the Last 14 and 30 Days of Life

# Standard 4.8



## Increased Acuity in Outpatient Radiation Oncology

- A quality improvement study was conducted to determine what could be done by the cancer center staff to help with the increased acuity that was seen in their patient population in early 2018. The cancer center staff performed a retrospective chart review of 10 high acuity patients. Focus was on the patient demographics, barriers to care, co-morbidities, and other factors leading to increased acuity level. The cancer center staff evaluated equipment and resources required to care for higher acuity patients.
- **Conclusions and Recommendations:** Barriers possessed by the 10 reviewed patients require preparation for a higher acuity patients. These preparations include increased social support and nurse navigation, and improved equipment and supplies to meet the needs of a higher acuity population. The cancer center nurses will continue to proactively monitor patient acuity levels as well as maintain up-to-date knowledge of current patient barrier trends and current literature for addressing high patient acuity. The cancer center staff will increase referrals to social services and nurse navigation. New equipment and supplies was ordered to care for high acuity patients.

# Standard 4.8



## A CASE STUDY OF INCREASED ACUITY IN OUTPATIENT RADIATION ONCOLOGY Elizabeth Allen RN, BSN Theresa Scheumann RN, BSN Edna Wilson RN, BSN, OCN Hendricks Regional Health Cancer Center



### CLINICAL PROBLEM/SIGNIFICANCE

- In first quarter 2018, there was a significant increase in patient acuity level at the HRH Cancer Center.
- High patient acuity brought multiple challenges for the nursing staffing, as they worked to acquire the equipment, supplies and time necessary to care for patients.
- The nurses questioned, what are the factors that increased patient acuity and was this the new norm?
- Lastly, if this is the new norm, what do the nurses need to do in order to assure the best possible patient outcomes?

### LITERATURE REVIEW

- A review of the literature identifying barriers to cancer treatment revealed:
- 50 to 80 % of cancer patients are diagnosed in advanced stages (Sparla, 2016; Cazap, 2016)
  - Median age of patient is 56 years old (pre-retirement) (Sparla, 2016; Bourdeanu, 2013)
  - 21% experienced a delay in referral to Oncologist (Bourdeanu, 2013)
  - Cost / Finances : No insurance/ underinsured, loss of income and transportation cost. (Noted in every article)
  - Inconvenient physician office hours / patient unable to get time off from work for doctor appointments (Bourdeanu, 2013).
  - Lack of social services and oncology nurse navigators to guide patient through the healthcare system and financial resources ("Why research on cancer health disparities", 2017)

### CLINICAL QUESTIONS

- Are there consistent barriers that contributed to the increased patient acuity at HRH Cancer Center and does it match the literature?
- What changes in equipment, supplies and resources are needed to care for these higher acuity patients at HRH Cancer Center?

### METHOD

- In a retrospective chart review, we examined 10 high acuity patients' charts in a three month period: 12/2017 – 2/2018
- We focused on demographics, barriers to care, diagnosis, co-morbidities or any factor that increased their acuity level.
- We compared the literature to our data to ascertain possible future trend
- We also examined equipment and resources that needed adjustment to provide patients with the best possible outcomes

### DATA ANALYSIS

#### Description of Case Study Patients

80 % female
50% with 2 or more Serious Co-Morbidities
80% with two or more Barriers

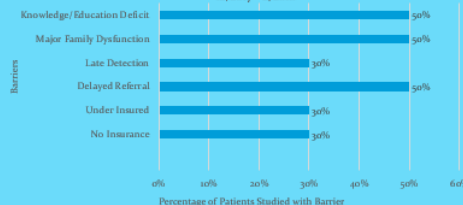
Age Range of 10 Patient in Case Study  
Hendricks Regional Health Cancer Center  
12/2017 - 2/2018



Cancer Diagnosis of 10 Patients in Case Study  
Hendricks Regional Health Cancer Center  
12/2017 - 2/2018



Barriers Assessed for 10 Patients in Case Study  
Hendricks Regional Health Cancer Center  
12/2017 - 2/2018



### CANCER CENTER IDENTIFIED BARRIERS

- Lack of financial resources (i.e., medication/living expenses)
- Difficulties getting transportation to appointments.
- Lack of equipment / difficulty obtaining supplies
- Complex transfers and coordination of care from outside facilities
- Increased caregiver strain (pre-retirement age)
- Delayed referrals (patients diagnosed at later stages)
- Lack of knowledge in patient and outside care providers about cancer
- Inadequate nursing time to address the needs of high acuity patients.

### CONCLUSION/DISCUSSION

- The literature review supported the barriers identified at HRH Cancer Center.
- The barriers identified in these ten patients requires preparation for a higher acuity patient.
- These preparations include both increase social support, navigation for patients/families and improving equipment and supplies needed for the higher acuity patient

### IMPLICATIONS FOR CANCER CENTER PRACTICE

- Cancer Center nurses need to continue to review the literature and pay attention to trends in patient barriers.
- HRH Cancer Center nurses will increase referrals to Social Services and Oncology Nurse Navigators
- New Equipment/supplies ordered to prepare for patients:
  - Continuous vital sign machine
  - Automated medication administration machine for medication access,
  - Emergency prep trays for : dressing supplies, urinary catheters and trach care/suction .

# Standard 4.8



## Analysis of Chemotherapy Use in the Last 14 and 30 Days of Life

- The initial quality study was presented August 2016 and looked at time frame between a patient's last chemotherapy treatment and death. We looked at 72 qualifying oncology patients that incurred cancer related death in 2017 at Hendricks Regional Health and evaluated treatment timelines with proximity to death (See Table 1). Out of 26 (36.1% of all patients) patients who received chemotherapy and died within 30 days, fifteen of them were under hospice care (58%). A significant improvement is exhibited between 2016 (20%) to 2017 (58%) in patients who received chemotherapy within 30 days of death and was on hospice care at our clinic. Out of 14 patients (19.4% of all patients) who received chemotherapy and died within 14 days, three patients were under hospice care (19.1%). A decline was seen in the patients who received chemotherapy within 14 days of death and under hospice care from 2016 (36.6%) to 2017 (21.4%) with an equivalent patient population percentage to compare. Overall 39 out of 72 patients (54.2%) were on hospice care in 2017 at their time of death regardless of relation to treatment in our analysis.
- Our data describes two divergent pathways for end of life care. One path starts with early conversations about end of life care that involves earlier and greater use of hospice care and less aggressive treatment. The other path involves end of life discussions that begin in the last 30 days of life or never take place, which is accompanied by aggressive treatment and less and delayed hospice care.
- Conclusions and Recommendations: We have improved significantly in addressing end-of-life discussions. With the addition of our Palliative Care team, it could be expected that these numbers will still continue to improve and that end-of-life discussions will occur earlier in treatment.