

2017 Public Outcomes Report: Oncology Committee

The Commission on Cancer (CoC) is a group of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education and the monitoring of comprehensive quality care.

The Oncology Committee met four times in 2017. Committee membership is defined by the CoC and required members, or their designated alternate, and are required to attend at least three of four meetings. The required members are:

- Bhanu Vakalankka, MD, medical oncologist, cancer committee chair
- Mary Cameron, MD, internal medicine, cancer liaison physician
- Henry Busch, MD, general surgeon
- Margaret Ruocco, MD, pathologist
- Timothy McKone, MD and James Leenstra, MD radiation oncology
- Stephen Hite, MD, radiologist
- Amy Selly, RN, advanced oncology certified nurse practitioner, community outreach coordinator
- Sharon Miller, BSN, RN, oncology certified nurse, clinical research coordinator
- Jean Brazil, social worker, psychosocial services coordinator
- Rhonda Mulder, quality improvement coordinator
- Shanda Phippen, MS, CGC, genetic counselor
- Erin Ferris, BSN, RN, oncology certified nurse, cancer program administrator, patient care manager, cancer conference coordinator
- Leann Osada, certified tumor registrar, cancer registry quality coordinator.

The committee also includes representation from Administration, Nutrition Services, Pharmacy, Lab, Courage Kenny Rehabilitation Institute®, Diagnostic Imaging, and the American Cancer Society (ACS).

2017 PROJECTS

The Commission on Cancer standards and eligibility requirements need to be met annually. The following outlines some of the projects completed by the Oncology Committee in 2017.

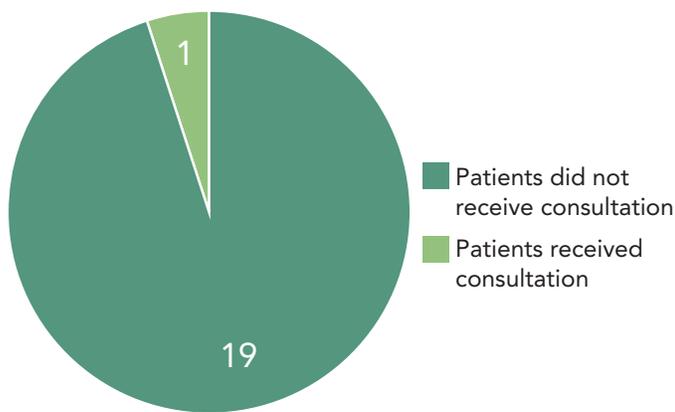
- Multidisciplinary tumor conferences are held monthly and are attended by members of the committee listed, in addition to primary care providers, infusion nurses and support staff. Tumor conferences enable the multidisciplinary team to collaborate and discuss diagnoses and optimal treatment plans for patients.
- A colon and breast cancer prevention event focused on screenings and based on community need was held on Saturday, Sept. 30, 2017 from 9 a.m. to 3 p.m. at District One Hospital in partnership with the Minnesota Department of Health's Sage Program and the ACS. The objective of the event was to increase the number of people screened for colon cancer and increase the number of women screened for breast cancer.
 - Eligibility for free mammograms and breast exams was determined by Sage based on access to Medicare or insurance. An invitation was mailed to 1,070 eligible women and flyers and social media posts invited the public to the event.
 - Normal mammogram results were communicated through the radiology department and any abnormal results were communicated through Sage protocol.
 - Maxfield Richardson, DO, led a discussion about colon cancer prevention.

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- A quality study was done to determine the number of oncology patients who received a palliative care consult in 2015 and 2016.
- The study indicated 19 of 20 randomly audited stage 4 oncology patients did not receive a palliative care consultation.
- Palliative care is an essential component of cancer care, with a focus on improving quality of life. To improve access to palliative care, a palliative care program was implemented in September of 2017 and is led by an oncology nurse practitioner.

2015-2016

Palliative care consultation random audit



- A quality improvement project was completed to increase baseline bone density completion prior to initiation of aromatase inhibitor medication in estrogen positive breast cancer patients and to increase two-year follow-up bone density completion of all patients on aromatase inhibitor medication used as treatment of estrogen positive breast cancer. The process includes:
 - The imaging history is reviewed.
 - The date of most recent bone density is identified.
 - Provider to order bone density if following are indicated:
 - Patient has estrogen positive breast cancer.
 - Initiate aromatase inhibitor is planned within the next 0-6 months.
 - It has been two years or greater since previous bone density or less than two years and elevated risk factors for bone loss since prior bone density.
 - It has been two years since prior bone density and patient is currently on aromatase inhibitor.

2008 (3rd quarter) – 2017 (2nd quarter)	# of patients	% of total
Total number of patients started on aromatase inhibitor medication	37	
Patients with initial bone density <=2 years prior to aromatase inhibitor	23	62%
Patients with follow-up bone density <=2 years after starting aromatase inhibitor	10	27%