

**CANCER PROGRAM
2016 ANNUAL REPORT
VA-New York Harbor Healthcare System**



CANCER PROGRAM ANNUAL REPORT

2016

MESSAGE OF THE CANCER COMMITTEE

The Cancer Committee at VA-New York Harbor Healthcare System (VA-NYHHS) is composed of specialists who are involved in all aspects of care for patients with malignant diseases. The committee meets quarterly and oversees a wide spectrum of cancer-related activities. The Cancer Committee consists of physician representatives from Medical Oncology, Surgery, Radiation Oncology, Urology, Gastroenterology, Pulmonary, Pathology, Palliative Care, Diagnostic Radiology and the Cancer Liaison Physician. Non-physician representation includes Social Work, Psychology, Cancer Registry, Nursing, and Quality Management.

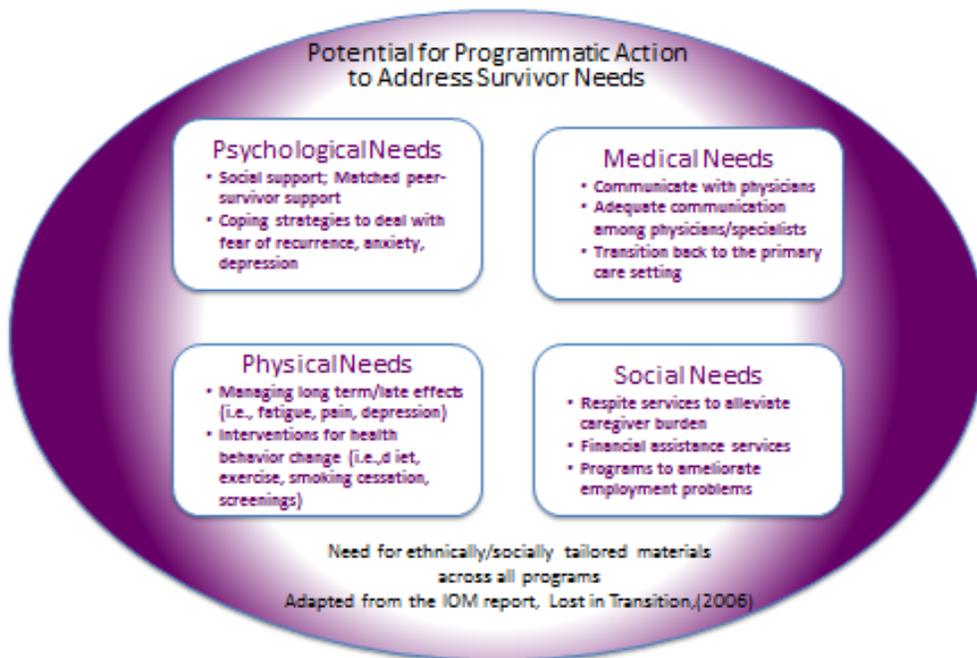
Since VA-NYHHS became accredited by the American College of Surgeons Commission on Cancer (CoC) in 1996, we have relied on CoC standards of care for the diagnosis and treatment of cancer, in conjunction with guidelines from other national cancer organizations and VA, to set the quality criteria for our cancer program.

In 2012, the CoC made substantial changes to its requirements for accredited cancer programs. Since that time, VA-NYHHS Cancer Committee has been re-evaluating patient care and programs in light of the 2012 CoC Cancer Program Standards: *Ensuring Patient Centered Care*. Three new standards introduced in 2012 challenged cancer programs to focus on the needs of individual patients and to have the new services in place by 2015.

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The new program requirements are disseminating cancer treatment summaries and survivorship plans to patients completing their initial course of treatment; screening oncology patients for psychosocial distress at least one time during their course of cancer treatment; and providing a navigation process addressing barriers to care for cancer patients. By 2015 the Cancer Committee had these practices in place, and in 2016 they were strengthened and broadened.

The figure below represents the holistic approach to cancer care which serves as the goal and the gold standard for VA NYHHS Cancer Program. Individual clinical interactions and cancer program design are challenged to demonstrate the prioritization of the cancer patient and appreciation of his or her experience as a whole person.



While concentrating on the planning and implementation of these new services, the Cancer Program broadened its scope in the following ways: in collaboration with the Salt Lake City VA, VA NYHHS now provides genetic counseling, testing and risk assessment for individuals at high risk of developing certain cancers; the VISN-wide Hepatocellular Cancer Program has expanded to other VA facilities; the No Veteran Alone Program provides volunteer companions to seriously ill patients; and a new Positron Emission Tomography (PET) has been installed in Nuclear Medicine to provide patients on-site access to this important staging modality.

Radiation Oncology Service recently dramatically improved the efficiency, precision and scope of services for radiation treatment of cancer patients at VA-NY Harbor by installing the Varian True Beam STX linear accelerator. This installation required years of planning and commitment by Radiation Oncology service. The linear accelerator is the most advanced technology available and provides very precise radiosurgery of brain, lung, spine and other sites of cancer.

Cancer Conferences (Tumor Boards) are an integral part of VA-NYHHS Cancer Program, providing an interdisciplinary forum to discuss the care and appropriate treatment options for patients with cancer. Cancer conference participants include board-certified medical oncologists, radiation oncologists, surgeons, diagnostic radiologists, pathologists, nurses, cancer registrars, quality management and the research coordinator. At each conference, discussion includes a review of the patient's medical history, radiology studies, pathology, AJCC staging, current methods of treatment and available clinical trials. Treatment recommendations based on multidisciplinary consensus and national treatment guidelines, such as National Comprehensive Cancer Network (NCCN), are formulated and documented in the electronic medical record.

Precision Oncology Program

In 2016, VA-New York Harbor Healthcare System began participating in the VA Precision Oncology Program. Initially, the program will focus on newly diagnosed non-small cell lung cancer. Specimens from non-small cell lung cancer tumors will be sent to qualified laboratories for multigene mutational analysis panels.

Through this program, we will also be able to offer Veterans the opportunity to participate in clinical trials of new drugs targeted to specific mutations and to add their data to repositories helping scientists make further breakthroughs. VA -NYHHS and VHA are at the threshold of this amazing opportunity. The hope and expectation is that the scope will expand to include many different types of cancer.

Recently developed reporting tools from the CoC are being used to provide feedback on quality indicators for care of patients with colorectal breast cancer and lung cancer: Cancer Program Practice Profile Reports (CP3R) and Rapid Quality Reporting System (RQRS). The CoC hosts the web-based CP3R site to offer cancer programs comparative information to assess their adherence to the standard of care for major cancers. This reporting tool provides a platform to promote continuous practice improvement to improve quality of patient care and permits hospitals to compare their care relative to that of other hospitals. The aim is to empower staff to work collaboratively to implement best practices that will improve cancer care.

The Rapid Quality Reporting System (RQRS) promotes evidence-based care for patients by actively monitoring compliance with National Quality Forum-endorsed measures and surveillance measures for patients on treatment for breast, colon and rectal cancers. RQRS monitors these measures in real-time and provides alerts to the cancer program that assist in meeting timeliness guidelines associated with quality cancer care.

VA-NYHHS also participates in the CoC-sponsored Facility Information Profile System (FIPS), a data-sharing system to connect cancer patients with CoC-accredited facilities. Through this program, patients have access to information about the resources and services provided, including board certified specialists, diagnostic and therapeutic services provided by surgical, medical and radiation oncology and programs for rehabilitation, support, research, prevention, screening and early detection. Through participation in FIPS, the NYHHS cancer program strives to increase its visibility to the public and promote quality cancer care.

The renovated Hospice and Palliative Care Unit at the St. Albans campus is an important part of the Cancer Program. The state-of-the-art, 15-bed unit provides a comfortable, home-like environment for terminally ill patients and their families and skilled, compassionate care provided by an interdisciplinary team. The Palliative Care service is active at all three campuses and offers symptom management to all patients and medical, nursing and psychosocial support to patients approaching the end of life.

Every June for the past twenty years, VA-NYHHS has proudly celebrated National Cancer Survivors Day, which represents the spirit and personal focus NYHHS Cancer Program aspires to create in clinical settings. As we incorporate new Commission on Cancer standards into standard practice, we are pleased and challenged to enter territory we have had in our sights for many years. We look forward to collaborating with the Commission on Cancer to develop and meet performance goals which improve the cancer patient's physical and mental health.

In March 2016, we held a campaign for increasing Veteran awareness of colon cancer prevention. The Super Colon event brought together a group of talented individuals that resulted in a multicolored display of creative thinking and design. Our mascot, Super Colon Hero, was awarded the 2016 American College of Gastroenterology (ACG) Scopy Award. The Scopy Award was introduced by the ACG to recognize the achievements of ACG members in community engagement, education and awareness efforts for colorectal cancer prevention.

In all of its activities, the Cancer program seeks to make the cancer patient and his family the focal point for the organization and delivery of services, ensuring compassionate, technologically advanced and holistic patient care.



Colon Cancer Screening Awareness

HEMATOLOGY/ONCOLOGY

In recent years increased understanding of the molecular basis of many tumors allows for individualized medical treatment for an increasing number of cancer patients. This trend synchronizes with the practitioner's heightened awareness of the need to attend to the whole patient, including his psychological and social needs.

Outpatient Oncology

Outpatient clinic appointments are held throughout the week for Hematology and Oncology patients and are staffed by physicians, nurse practitioners, and nurses. Each patient is screened by the clinic nurse and evaluated for referral to the dietitian, social worker or psychologist who is available to see urgent referrals immediately. The chemotherapy infusion center is supervised by Oncology trained nurses at each campus, and is in session Monday through Friday. Both campuses have modern and attractive chemotherapy suites, designed with the patient's safety and well-being in mind.

Inpatient Oncology

When oncology patients require hospitalization, the Hematology/Oncology consultation service assists in managing their care. The Hematology/Oncology clinicians have a strong partnership with the Palliative Care Service, consisting of a nurse practitioner and the physician Director of Palliative Care. Both teams work closely to manage symptoms, participate in family meetings and provide emotional and spiritual support to patients and families. The clinical pharmacist is available to review and discuss medication management. Interdisciplinary rounds, conducted twice weekly, include the participation of the attending physicians in Oncology and Palliative Care, the house officers, nurses, social workers, the pharmacist, dietitian, psychologist, chaplain, and the Quality Management specialist.

At the time of discharge, all patients receive counseling regarding medications, clinic follow-up with an oncologist and instructions on how to contact their physician, pharmacist, dietitian, social worker, and psychologist.

Two Palliative Care suites are available in Brooklyn to provide a comfortable environment for family to visit and stay with patients who have terminal illness. The close collaboration between the Oncology and Palliative Care Teams at both campuses provides high quality care by assuring physical comfort, emotional support and spiritual support for the patient and his family.

RADIATION ONCOLOGY

VA-NYHHS Department of Radiation Oncology, on-site at the Brooklyn campus, is accredited by the American College of Radiology and continues to upgrade its technology to offer the most advanced treatment strategies for the management of malignant diseases. Radiation Therapy Service plays an important role in the VA NYHHS Cancer Program since treatment for a great many NYHHS cancer patients includes Radiation Therapy.

For the past 5 years, the service has been providing Stereotactic Body Radiation Therapy (SBRT) for patients with unresectable lung cancer. Now, in 2016, Stereotactic Body Radiation Therapy (SBRT) and Stereotactic Radiosurgery (SRS) are increasingly provided to lung, prostate, liver and brain cancers. With conventional therapy, radiation is delivered in relatively small doses over several weeks. With SBRT and SRS, we are able to deliver a greater dose of radiation over the course of far fewer treatments, yet with milder side effects than the conventional method.

All treatments are available to both inpatients and outpatients, as clinically appropriate. Two nurses are dedicated full-time to the nursing and educational needs of the Radiation Oncology patient. The Radiation Oncology Service collaborates closely with the medical and surgical oncology staff in the diagnosis and treatment of cancer patients, participates actively in cancer conferences, engages in research and provides educational programs for residents and medical students. 2015 and 2016 were very active years academically for the department with the publication of several articles in peer-reviewed journals and presentations at national meetings.



SURGICAL ONCOLOGY

Surgical Oncology at VA-NYHHS continues to grow in caseload and sophistication. Surgical Services at the New York and Brooklyn campuses confer with one another to ensure patients benefit from the expertise of the entire surgical staff through participation in Cancer Conferences and as members of the Hepatocellular Cancer Team. Each campus has its particular areas of interest and experience.

VA-NYHHS participates in the National Surgical Quality Improvement Program which is the primary tool for the measurement and analysis of quality surgical outcomes to enhance high quality, safe and timely surgical care. Although surgery is often the definitive treatment for cancer, multidisciplinary partnerships are imperative not only for cure, but also to improve the quality of life for all cancer patients.

VA-NYHHS Surgical Service continues to expand oncology-related services through advances and innovations in surgical approaches, resident and student oncology education and research.

The planned redesign of the Surgery Department will include five new operating rooms with high definition monitors and state-of-the-art laparoscopic towers.

The Surgical service provides advanced laparoscopic surgery for colorectal cancer as well as state-of-the-art surgical care for oncology-related nephrectomy, prostatectomy, endocrine tumors and radiofrequency ablation of liver tumors. The Service also provides high quality surgical care for patients with primary and secondary liver tumors including, but not limited to, routine and complex liver resections, laparoscopic resections of liver tumors, and radiofrequency ablation. The Service provides treatment for a broad range of complex gastro-intestinal malignancies, such as esophageal, gastric, duodenal, biliary, pancreatic and colorectal cancers. The service uses minimally invasive approaches when appropriate for all GI malignancies and performs complete cytoreductions and peritoneal perfusions (HIPEC) for patients with peritoneal carcinomatosis. All cases treated by the Surgical Service are discussed at the multidisciplinary Tumor Board meetings and the combined Surgery/GI conferences.

Breast Health Center

The Center continues to expand, offering consultations in the Women's clinic every other week. A surgical attending, radiologist and cytopathologist meet with women who have suspicious breast masses and provide expert evaluation and counseling. Enhanced, on-site breast imaging services have also been added. This clinic was developed to improve access for women to timely services for the evaluation of breast neoplasms.

The New York campus is the referral center for plastic reconstructive, microvascular reconstructive, neurological and thoracic surgery in addition to full service general, urology and head and neck surgery services.

General surgery

Surgeons are skilled in new minimally invasive surgical procedures for treating tumors of the esophagus, pancreas, liver, colon and rectum. In addition, Hyperthermic Intra-peritoneal Chemotherapy (HIPEC) is offered for selected cases of colorectal cancer and mesothelioma.

SURGICAL ONCOLOGY (continued)

Special expertise in hepatobiliary, gastroesophageal and colorectal surgery is supplied by surgical oncologists. Cases are managed by the surgical service in cooperation with medical gastroenterology. Oncology cases are discussed weekly for evidence-based treatment planning during both the interdisciplinary Tumor Board (surgical, radiation and medical oncology, diagnostic and interventional radiology, pathology and gastroenterology) and the interdisciplinary VA-NYU Gastrointestinal Conference. Gross and histopathology of all cancer cases are discussed with the surgical pathologists in a weekly case review and staging conference.

Neurological Surgery

Brain and spinal cord tumors are staged with neuroradiology and neurology at the weekly combined VA-NYU Neurosurgery Conference. In addition to staff neurosurgeons, experts in all phases of neurosurgical oncology are available to discuss patients. Skull base tumors, including pituitary and acoustic, are operated jointly with the ENT skull base/neuro-otology group.

Cancer of the Head and Neck

The management of malignancies of the head and neck is increasingly multidisciplinary, with surgery and radiotherapy as mainstays of treatment and chemotherapy as adjuvant. The head and neck surgery service at the New York campus is a tertiary referral service offering the entire spectrum of diagnostic and therapeutic procedures to head and neck and endocrine patients. The outpatient clinic is equipped for outpatient procedures and ultrasound guided biopsies. A dedicated speech and swallow therapist is part of the management team and provides care to all head and neck cancer patients. The entire gamut of head and neck cancer procedures are performed at the New York campus, including: trans-oral minimally invasive laser surgery, free flap reconstruction and endoscopic skull base surgery. The center is equipped to perform the most complex surgeries in collaboration with neurosurgery and thoracic surgery. All patients treated at the New York campus are presented at a multidisciplinary tumor board conference and receive recommendations from all modalities.

The head and neck service collaborates closely with thoracic and gastrointestinal surgery and is the referral center for Brooklyn patients, as well as patients from VISN 2.

Urology

At the multidisciplinary urologic oncology conference, all options for care, including minimally invasive and open techniques including nerve sparing prostatectomy are discussed. Patients with prostate cancer are evaluated and followed longitudinally. The robotic da Vinci surgical system is an available option, enabling surgeons to perform operations through a few small incisions which allow the surgeon's hand movements to be translated into smaller, precise movements of tiny instruments inside the patient's body.

THORACIC ONCOLOGY

Pulmonary Service continues its interdisciplinary work in conjunction with the other key specialties to develop Thoracic Oncology at the Brooklyn campus.

The Interventional Pulmonary program continues to develop innovations to improve the treatment and quality of life for patients with unresectable, relapsed and refractory lung cancer, as well as those with certain non-malignant conditions. These innovations include new techniques and new equipment to achieve:

- earlier diagnosis
- more precise staging
- better quality of life

These techniques include the use of Endobronchial Ultrasound (EBUS) which was initiated in 2008. EBUS is a sensitive modality for staging lung cancer. This approach increases the accuracy of cancer staging and is also used to investigate lung nodules which are difficult to assess by more traditional methods. EBUS also offers a reliable way to evaluate invasion of bronchial and vascular structures in a less invasive manner than surgery.

The Thoracic Oncology program also addresses

problems such as central airway obstruction and the related complications of bleeding and post obstructive pneumonia. Rigid bronchoscopy is routinely employed for placement and retrieval of airway stents used to establish and maintain airway patency. These advanced stents include the aero covered Self Expanding Metallic Stents (SEMS) and silicone stents. Medical authorities consider aero stents to be the state-of-the-art.

Other treatments such as balloon bronchoplasty and tumor ablation are also used to treat airway obstruction to improve shortness of breath, decrease the risk of pneumonia, and improve quality of life. These methods have the advantage of providing immediate relief of obstruction even in patients receiving other treatments such as chemotherapy and radiation therapy.

Pulmonary Service continues to offer Pulmonary Interventional Consultations to other facilities in VISN 2 for the management of thoracic oncology patients and non-malignant airway disease. It is expected that the need for consultative services will grow as both primary therapy for lung cancer and

palliative techniques improve and expand. Life-threatening complications of malignant diseases such as trachea-esophageal fistula are now referred to Pulmonary Interventional Service rather than proceeding to surgery.

A combined thoracic surgery video-conference is held weekly for multidisciplinary case management. Thoracic oncology cases, including pulmonary, esophageal and mediastinal cancers, are discussed at this conference.

Innovations

New technology, **Bronchoscopic electro-magnetic navigation**, provides the ability to diagnose lung nodules without invasive surgery.

In addition, this new technology permits the placement of markers to aid in delivery of more precise treatment by stereotactic body radiotherapy, sparing normal healthy lung tissue and reducing complications.

HEPATOCELLULAR CANCER TEAM

Hepatocellular cancer is the most common type of liver cancer globally, the fastest growing cancer in the United States and the eighth leading cause of death. This trend is expected to continue until the peak of the hepatitis C epidemic in 2020.

In 2016, VA-NYHHS Hepatocellular Cancer (HCC) Team continued its commitment to standardize care for HCC patients and created a network of VISNs engaged in VISN-wide HCC Tumor Boards.

Interdisciplinary teams created from disciplines across the VISN, including medical oncology, nursing, gastroenterology, hepatology, surgery, radiology, palliative care, social work, telehealth, information technology and cancer registry were sustained and collaborated on patients whose cases were brought before them.

VA-NYHHS innovations in HCC treatment are now provided in VISNs across VA and include weekly VISN-wide Tumor Boards conducted using video technology to discuss cases, view radiology and pathology and make recommendations for therapeutic intervention; a standardized Tumor Board Note template which includes all necessary items for decision making and treatment.

In September 2016, VISN 2 South hosted the VA Liver Cancer Summit. As in previous years, the seminar provided updates on HCC care and facilitated collaboration and innovation, promulgating best practices in HCC management nationwide. The annual seminar is a venue for interactive discussion by VA and non-VA subject matter experts and includes faculty from VISNs 1,2,4,6,12 and 16.

Accomplishments

Standardization for:
 • Staging
 • Terminology
 • Documentation
 • Radiographic Imaging

Spread of VISN-wide Tumor Boards to VISNs 1, 4, 6 and 12.

Sustained relationships within and across VA Medical Centers and networks.



PALLIATIVE CARE

As a member of the Veterans Integrated Service Network (VISN) 2 Palliative Care program, the New York Harbor Palliative Care Service shared in the recognition by the American Hospital Association's 2010 Circle of Life Award. This prestigious award recognizes programs that provide excellent end of life care and that serve as innovative models of delivery of palliative care for the nation.

The Palliative Care service continues to be active on all three campuses, Brooklyn, New York and St. Albans, with the goal of providing expert care to all patients in need of symptom management and to patients who are approaching the end of life. We participate in the VISN 2/3 Hospice Veterans Partnership, working closely with our partners in the local hospice organizations.

Papillon de Vie—Butterflies of Life is the name of the renovated state of the art 15 bed dedicated Hospice and Palliative Care (HPC) Unit had its opening celebration in April, 2012.

The mission of the HPC Unit is to provide personalized care to each Veteran. The Veteran's and family's preferences for care are clarified and honored to maintain the comfort and dignity of each Veteran while caring for his or her emotional, spiritual, physical and psychological needs in a beautiful, home-like environment. Veterans' families are welcomed and accommodated on the unit.

An interdisciplinary team of highly trained staff provide patients with holistic, compassionate, and integrative care, including Reiki and aromatherapy.

No Veteran Alone Program guarantees that no Veteran dies alone. With collaboration of the nursing team and trained volunteers, every Veteran is provided with reassurance, care and companionship during his or her final hours.

Semiannual Memorial Services are held for staff and the family of patients who died within the past year. During these services, patients are remembered and honored for their military service.



Papillon de Vie
Butterflies of Life
Hospice and Palliative Care
Unit at St. Albans campus

PATIENT SERVICES

Patient Services includes nursing, social work, clerical support, pharmacy, nutrition and pastoral care.

Operations are organized on a patient-centered care model which aligns services around patients rather than in individual departments. Programs for care are decentralized from the departmental level and grouped along diagnostic categories, such as Oncology.

The Oncology Patient Care Team Coordinators at each campus are registered nurses who are responsible for the direct supervision of inpatient and outpatient oncology nursing, including Radiation Therapy and chemotherapy, and coordination with the allied health and other support staff in all assigned areas.

Oncology Nursing

The nursing staff continues its commitment to excellent care with a focus on the relief of the symptoms of cancer as well as the comfort of patients and their families.

The staff provides a compassionate environment for the patients' physical and emotional comfort.

Assignment to both inpatient and outpatient settings has established cross-coverage, increased sharing of knowledge and more consistent care.

All nursing practices are based on Oncology Nursing Society (ONS) standards of practice with specific nursing competencies for chemotherapy and radiation therapy. Oncology Nurses are responsible for the safe delivery of all chemotherapeutic agents in the hospital, including the outpatient and inpatient settings. Nursing ensures that prior to receiving chemotherapy, patients are educated about specific regimens, anticipated side effects and suggested coping measures for side effects.

Both campuses have modern and renovated chemotherapy suites, designed for the comfort and safety of inpatients and outpatients.

Oncology Nurses work closely with Radiation Oncology, Medical Oncology, Pharmacy, Pastoral Care, Nutrition and Quality Management, Social Work and Psychology. Nursing Team Leaders participate in the weekly meetings with representatives from each service

Ongoing educational opportunities for nurses in oncology and palliative care are met with enthusiasm. The ELNEC (End of Life Nursing Education Consortium) course which addresses critical aspects of

end-of-life care has been attended by nursing and nurse aides from all three campuses. Oncology Nursing Society membership remains strong. All nursing service oncology policy and procedures are followed, updated annually and are based on ONS standards.

Social Work Service

Oncology Social Workers collaborate with the interdisciplinary treatment team to provide comprehensive psychosocial oncology services in all clinical areas that treat patients with cancer, including the Palliative Care Service.

Oncology Social Workers provide assistance to patients under the policies and procedures of the Community and Social Services division of Patient Services. The Oncology Program Social Workers are PhD or Masters level practitioners, holding state licenses appropriate to their position and are dedicated to advancing their practice by attending continuing education programs that enhance clinical practice, skills and knowledge of community resources. They adhere to the Codes of Ethics of the National Association of Social Workers (NASW) and the Association of Oncology Social Work (AOSW) and demonstrate competencies in accordance with the

PATIENT SERVICES

standards for healthcare social workers of NASW.

Oncology Social Workers provide assessment, counseling, case management, continuity of care/discharge planning, psycho-education, community liaison and end-of-life care for patients and their families affected by cancer. Oncology Social Workers strive to establish and maintain therapeutic relationships with patients and their caregivers to decrease the anxiety associated with the initial news of a cancer diagnosis. By offering individualized plans of care including assessment, supportive counseling and referrals for tangible services such as transportation, homecare and specialized support groups, oncology social workers intervene in practical ways to improve patient and family coping at a particularly stressful time in their lives. Oncology Social Workers assure appropriate representation of patient and caregiver perspectives in interdisciplinary team meetings, in program planning venues and in staff education activities.

Psychosocial distress screening and patient navigation interventions for new cancer patients is a joint pilot project with Psychology Service.

Since 2012, Oncology Social Workers have increased their engagement with the care teams and the patients by taking the lead in assessing Vietnam Era patients for Agent Orange exposure. Awareness of the relationship between cancer and environmental exposure is a developing area of practice. Social workers knowledgeable in this area are helping Veterans receive treatment for illnesses resulting from exposures during their service. Oncology Social Workers also contribute to patient participation in cancer clinical trials by handling the insurance documentation required for enrollment in off-site clinical trials.

As the Veteran population ages, there is a need for consultation with geriatricians and palliative care specialists to develop an understanding of the psychosocial needs of older patient with cancer. It is important as well to help these individuals define their quality of life, and help them achieve it

Pastoral Care

The primary role of the Chaplain is to provide for the spiritual and, when appropriate and requested by the patient or caregivers, religious care within the holistic approach of the care team. The Chaplain visits the patient and assesses their spiritual and religious needs and, if requested by the patient, offers prayers and religious rituals according to the patient's faith tradition. The chaplain visits the patient before and after surgery and on a regular basis during a patient's stay in the hospital. The Chaplain is available when the patient becomes discouraged or when an event occurs that affects the patient's hope for recovery. The chaplain also assists the patient in coping with the lifestyle limitations and difficult choices that lie before him/her. Staff and team members make good use of the Chaplains' expertise as pastoral, spiritual and religious needs arise.

A VA training program for clinical pastoral education program was initiated at New York Harbor in 2001. This program has improved staff awareness of patients who appreciate spiritual and/or religious support. Chaplains and pastoral education residents contribute their spiritual sensibilities to the care inpatients and outpatients receive in the Cancer Program.

PHARMACY SERVICE

Pharmacy service has dedicated full-time pharmacists at each campus for the preparation of chemotherapy. Each is assisted by a full-time pharmacy technician. The pharmacists screen patient charts for height, weight, allergies, concurrent therapy and pertinent laboratory values and all physician orders for appropriateness of dose, indication and duration of therapy. The pharmacist is a resource for drug information for both medical and nursing staff and acts as a liaison between the medical staff and the pharmaceutical companies, consulting with them regarding new therapies, administration of medications and new indications for an approved drug. A recent trend has been a greater use of oral chemotherapy as maintenance therapy for select disease states. By close contact and communication with the medical and nursing staff, the pharmacists contribute significantly toward the safe, efficient and cost-effective administration of chemotherapeutic agents to our patients.

The clinical pharmacist performs many functions for cancer inpatients. The pharmacist not only provides medication counseling to all inpatients at the time of discharge but also improves medication distribution by facilitating drug approvals and one-time drug requests, monitoring missed doses, reviewing and overseeing physician orders and monitoring the use of opioids. The pharmacist is also a resource for information about medications, drug interactions, adverse effects and dosage and participates in interdisciplinary rounds, assists in the preparation of pharmacologic guidelines for oncology patients and provides lectures to the nursing staff on topics related to the care of cancer patients.

DIAGNOSTIC RADIOLOGY AND NUCLEAR MEDICINE

The Radiology and Nuclear Medicine Services are essential in detecting, evaluating and monitoring patients with cancer. Services provided by these departments include the performance and interpretation of conventional radiographic examinations, fluoroscopic studies of gastrointestinal and genitourinary tracts, CAT scans, ultrasound examinations, magnetic resonance imaging (MRI), mammography, angiography and radionuclide studies. In 2015 a Positron Emission Tomography (PET) was installed at the Brooklyn campus. Installation of the PET/CT Discovery 710 by General Electric is the latest example of the constantly improving technology which characterizes Radiology and Nuclear Medicine at VA NYHHS.

Planning for, procuring, installing and placing into operation the PET Scan was a process that began in 2012, was a Cancer Program goal in 2013 and 2014, and was finally realized in 2015. Prior to this year, PET Scans were obtained by sending outpatients to non-VA contracted facilities.

Advantages to PET Scan on-site include:

- 1- Ease and convenience for patients
- 2- Automatic capture and inclusion of PET images within the VA Imaging System
- 3- Easy access to PET data for clinical decision-making
- 4- Availability of PET technology for inpatients
- 5- Better coordination of care among cancer treating specialties

Interventional Radiology offers biopsies, aspiration and drainage of pleural, biliary and genitourinary tracts, long-term peripherally inserted central catheter (PICC) placement, percutaneous feeding tube placement, tumor embolization and intra-arterial chemotherapy access for hepatocellular cancers.

All Radiology exams are captured digitally since the implementation of Picture Archive Communications System (PACS) in 2005. This technology facilitates rapid interpretation and dissemination of all patient imaging exams.

PET Scan at the Brooklyn campus, VA-NYHHS



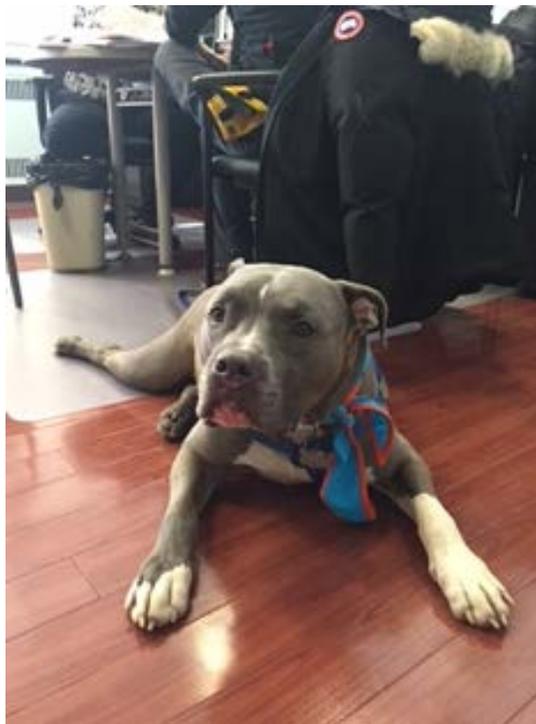
PSYCHOLOGY

The psychologist participates on the interdisciplinary treatment team. Through health and behavior interventions, psychology fellows, under the supervision of the psychologist, work with the oncology physicians and nurses to monitor at-risk patients and support their compliance with medical treatment. The psychology fellows perform clinical assessments and provide interventions with the goals of supporting medical decision-making, assisting with patient compliance, providing education, and support groups. The psychology service also assists in the management of potential crisis situations as they arise in the context of medical therapy. Psychology also conducts a weekly cancer support group for outpatients where psycho-education and support is provided on topics related to cancer treatment, adjustment and coping skills. Many of the participants are long terms attendees and have become good friends.

Psychology service introduced Pet Therapy to the VA-NYHHS Cancer Program in 2012 and by now several generations of therapy dogs have joined. Both our psychologist and therapy dog were highlighted in the February 29, 2016 New York Times article, *Turning your Pet into a Therapy Dog*. Valerie Abel, the psychologist who coordinates the Pet Therapy Program said, "The presence of therapy dogs makes such a difference. Many ask when they'll next be back. A big dog can put his head on a patients' bed and you can actually see them relax."

Each new patient admitted to inpatient and outpatient oncology service receives a screen for psychosocial distress. For those who show a need for further psychological services, there is an initial health and behavior assessment for hospital depression and anxiety, cognition and quality of life. Psychologists routinely screen and assess patients for suicide risk, depression, alcohol and substance use and PTSD. These disorders may be related to their medical conditions or pre-existing mental health issues.

Psychology has partnered with Social Work to design and implement new patient-centered services such as monitoring cancer patients for psychosocial distress and offering navigation through the cancer experience.



Pootie, Pet Therapy Dog

ANATOMIC PATHOLOGY

Anatomic Pathology offers the latest technology and evaluation in surgical pathology, cytopathology, immunopathology, dermatopathology, and electron microscopy.

By providing detailed analysis and discussion of selected tumors, Pathology makes an essential contribution to the weekly Tumor Board conferences.

The pathologist's presentation of the histology and cytology of the tumors, with reference to staging and prognostic indicators, add an important contribution to treatment planning.

Immunohistochemistry, immunofluorescence, and flow cytometry are important contributors to the diagnosis. The laboratory offers over 100 antibodies to aid in identification of tumors, leading to improved classification of unknown primary cancers.

The electron microscopy laboratory allows pathologists to study cancers on an ultrastructural basis and has been very useful in the evaluation of poorly differentiated malignancies. Cytopathology services include fine needle aspirations of

lymph nodes and subcutaneous nodules performed by a board certified cytopathologist. Since 2010, the Pathology Service has been using the SurePath methodology which is more sensitive in detecting abnormalities and facilitates diagnosis in a number of ways.

QUALITY MANAGEMENT

The Cancer Quality Improvement (QI) Coordinator, an active member of the Cancer Committee, and the QI Specialist, who attends and participates in General, Pulmonary and Thoracic Tumor Boards, provide QI skills and guidance to the Cancer Program. The QI Coordinator monitors and reports to the Cancer Committee at least 2 quality improvement activities each year, including corrective actions if indicated.

The QI Coordinator leads the Cancer Committee in developing, analyzing and documenting two studies that the CoC requires every year that measure the quality of care and outcomes for cancer patients.

A significant role of the QM specialist is to ensure program compliance with accrediting agencies such as the Commission on Cancer of the American College of Surgeons and the Joint Commission. This is done by serving as the facility experts on accrediting agency standards and methods required for full compliance with the standards.

Completion of a study of quality must provide data results that serve as the first step in the QI process. One QI each year is the result of data collected from a Quality Study conducted by the Cancer Committee. The second improvement can be based on any study or relevant data source.

The QI staff supports the Cancer Program's compliance with nationally recognized guidelines such as those of the national Comprehensive Cancer Network, the Joint Commission on Accreditation of Hospitals and the College of American Pathology.

PHYSICAL MEDICINE AND REHABILITATION

The Physical Medicine and Rehabilitation (PM&R) Service supports the cancer program by minimizing impairment and reducing activity limitations of cancer patients through a coordinated, interdisciplinary approach to patient care. The PM&R Service is integrated across all campuses of VA New York Harbor Healthcare System and encompasses physiatry, physical therapy, occupational therapy, kinesiotherapy, and vocational therapy staff. This core group of clinicians works closely with recreation therapy, psychology, neuropsychology, speech pathology and audiology, nursing and social service staff to form a dynamic extended rehabilitation team. As more patients become cancer survivors, the role of PM&R in the lives of survivors

continues to expand.

We have introduced and continue to develop our new specialty programs available to cancer patients that address pelvic floor dysfunction, lymphedema, and vestibular issues. An interventional pain management service provides new alternatives in the treatment of malignant and non-malignant pain.

The PM&R Service works also closely with the Prosthetics and Sensory Aids Service to provide veterans in the cancer program and others with the proper adaptive equipment and assistive devices. Through the Housing and Structural Alterations Program, Veterans are provided with financial assistance to obtain

necessary home modifications such as ramps. Through the Major Medical Equipment Committee, Veterans are provided with high-quality equipment as clinically necessary.

Patients receive both inpatient and outpatient therapy services. Patients who require bedside services are seen regularly on the inpatient units. All other patients are seen in the designated therapeutic areas to encourage independence, socialization and psychological well-being.

As an integral part of the care of patients in the cancer program, the PM&R team works to improve both the functional status and the quality of life of Veterans with cancer.

AUDIOLOGY AND SPEECH PATHOLOGY

The Audiology and Speech Pathology Service provides diagnostic and rehabilitation services to patients with communication and swallowing disorders. Such disorders include hearing loss, dizziness, aphasia, dysphagia, laryngectomy, glossectomy, confusion and dementia, dysarthria, memory disorders,

and problems with voice production. Patients with neurogenic and mechanical swallowing disorders are also managed. The Service provides comprehensive hearing evaluation services, auditory brainstem response evaluations, and vestibular assessments. Prostheses, such as hearing aids, assistive listening devices

and electrolarynxes, are provided to eligible Veterans. Fiberoptic evaluations of swallowing disorders are conducted with Otolaryngology Service and videofluoroscopic studies of swallowing disorders are conducted with Radiology Service.

AUDIOLOGY AND SPEECH PATHOLOGY (CONTINUED)

In addition to individual services, there are several support programs including the Communication/Stroke and Laryngectomy groups. Families of patients with swallowing disorders are provided counseling about how to

maximize the nutritional content of the patient's recommended diet and assure that the rehabilitative swallowing techniques taught to the patient are used in the home setting. Family members are also counseled

about communication disorders, teaching them the best methods to help the patient communicate effectively.

CANCER REGISTRY

The Cancer Registry is a vital part of the Cancer Program and coordinates the collection, management, analysis and dissemination of information on cancer patients who are diagnosed and treated at the VA-NYHHS. Our registry has a reference date of January 1, 1984 and was computerized in 1990.

The Cancer Registry is staffed by two Certified Tumor Registrars and is supervised by the Cancer Committee. In 2011, the registry began to participate in the CoC's Rapid Quality Reporting System (RQRS), which provides the facility rapid case specific feedback for certain treatment milestones in real-time to allow for adjustments in the patient's treatment.

In 2015, 535 new analytical cases were added to the registry with a total number

of 23,000 cases since its reference date. The data is electronically stored and submitted to the National Cancer Data Base (NCDB), allowing comparison with other hospitals and national data.

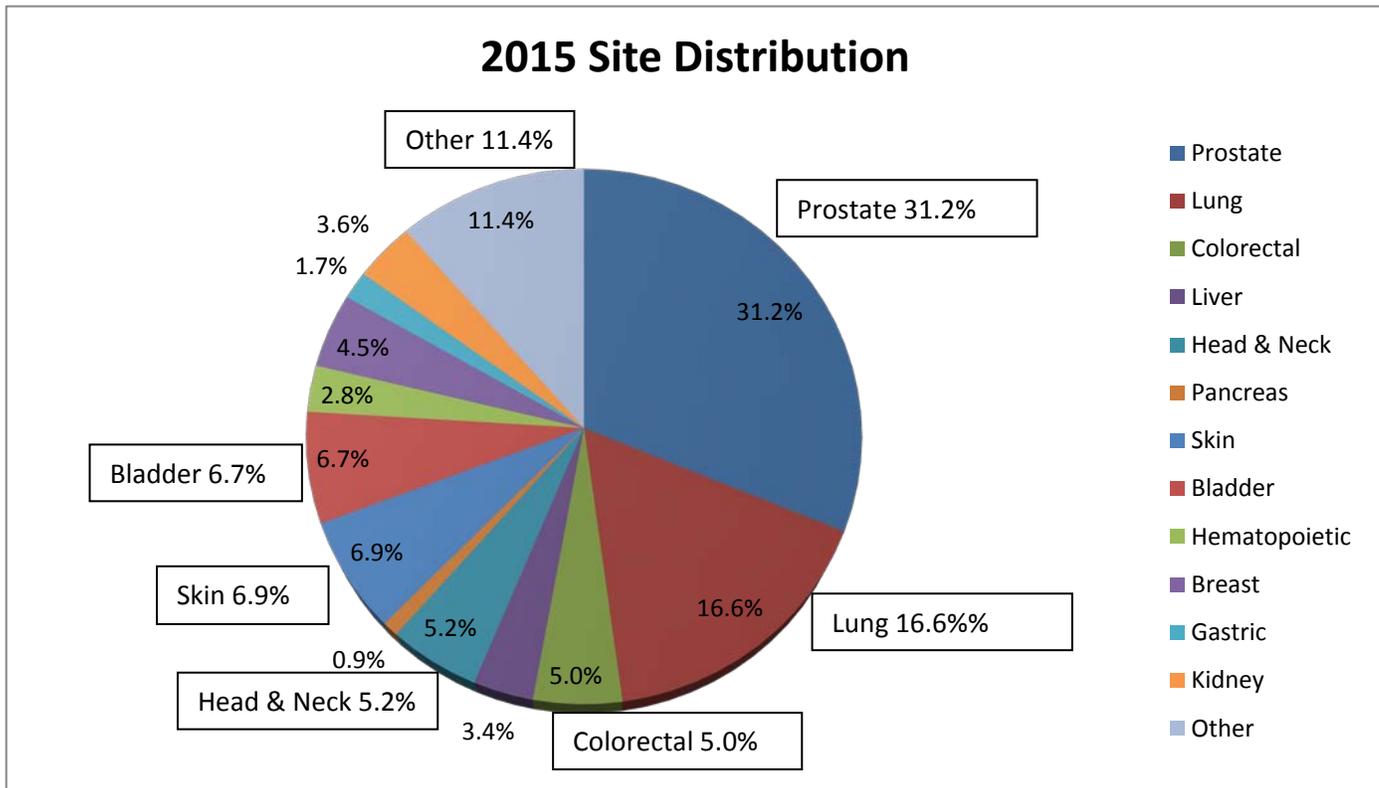
Annual follow-up of patients is an important function of the registry and the procedure for follow-up is based on guidelines recommended by the Commission on Cancer. Tracing and surveillance of registered cancer patients assures continuity of care, early detection of recurrent or new primary tumors, and appropriate patient follow-up. Our follow-up tracking and surveillance rate for all eligible patients in the registry from the reference date meets the CoC standard of 80%. The registry is also required to track follow-up rates for

patients diagnosed within the last 5 years. Our follow-up rate for these patients also meets the Commission on Cancer's standard of 90%.

Utilization of the cancer registry data is monitored by the physician supervisor and is another important function to promote clinical research and continuous analysis of the data. Utilization of this data contributes to the effectiveness of patient care and the Cancer Committee encourages frequent use of the Cancer Registry database.

SUMMARY OF THE CANCER REGISTRY DATA FOR 2015

Selected data of the Cancer Registry of VA-NYHHS for 2015 is presented below.



The total number of analytical cases in 2015 is 535, similar to the number of cases in 2014 (533). The figure above illustrates the site distribution for newly diagnosed malignancies in 2015. The five major sites are prostate, lung, melanoma, bladder and head & neck. Prostate cancer is still the leading malignancy with 167 new cases in 2015, representing 31.2% of cases this year. Lung cancer is the second most common at 16.6%, with 89 new cases in 2015, compared to 81 new cases in 2014 and 74 in 2013. This year, for the first time, skin cancer is among the top 5 sites with 37 new cases. 82% of these skin cancers are Stage 0 or I melanoma. Bladder cancer and head & neck cancer (including laryngeal) are currently the fourth and fifth most common cancers at VA-NYHHS. For the first time in many years, colorectal cancer is not in the top 5 sites and this may reflect our effective colorectal screening program.

Analysis of the ethnicity of the five most common sites in the cancer registry shows that 50% are Caucasian, 43% are African American and 7% are other ethnicities, representing Hispanic and Asian Americans. This year, the majority of prostate cancer cases were seen in African Americans (59%) and 31% in Caucasians. Lung cancer is higher among Caucasians (57%) than African Americans (36%). As in national series, bladder cancer shows a higher rate in Caucasians (64%) versus 36% for African Americans.

Outcomes Report on Accountability and Quality Improvement Measures

Quality Measure Reports: These reports reflect our Cancer Program's degree of compliance with Accountability Measures and Quality Improvement Measures established by the Commission on Cancer. Accountability measures are considered the current standard of care based on clinical trial evidence. Quality Improvement Measures demonstrate good practice based on consensus and usually not based on clinical trial evidence. The outcomes of these measures are reported below for 2013-2014 and if compliance is less than expected, the Cancer Committee has reviewed the cases and actions taken are indicated.

Breast Cancer Accountability Measures

- 1. Post breast conservation surgery irradiation:* Radiation is administered within one year (365 days) of diagnosis for women under age 70 receiving breast conservation surgery for breast cancer. Compliance: 100% CoC Standard 90%

Quality Improvement Benefits: Improving the utilization of radiation with breast conservation surgery for breast cancer and optimizing the reduction of the risk of local recurrence.

Summary of Evidence: There is extensive evidence from randomized clinical trials demonstrating the impact of radiation with breast conservation surgery. It reduces the risk of local recurrence in the breast and may have a small impact on survival. The limitation for the purpose of a measure for provider accountability to women under the age of 70 is because of high-level evidence that women with small, estrogen receptor positive cancer (the majority of women over age 70 with breast cancer) gain only a very small reduction in local recurrence and no difference in lifetime mastectomy rate and no difference in survival.
- 2. Adjuvant hormonal therapy:* Tamoxifen or third generation aromatase inhibitor is considered or administered within one year (365 days) of diagnosis for women with AJCC T1c or Stage II or Stage III hormone receptor positive breast cancer. Compliance: 88% CoC Standard 90%

Quality Improvement Benefits: Improve the utilization of hormone therapy for women with estrogen receptor positive breast cancer.

Summary of Evidence: There is extensive evidence that hormone (endocrine) therapy with hormone receptor positive breast cancer reduces the risk of local recurrence, contralateral breast cancer, distant recurrence, and death. Measure specifies use of Tamoxifen or third-generation aromatase inhibitor rather than specifying Tamoxifen for premenopausal and aromatase inhibitor for postmenopausal because of (a) difficulty in clearly identifying from records or administrative data the menopause status, and (b) variation in appropriate use of Tamoxifen in postmenopausal women and some reasonable use of aromatase inhibitor in premenopausal women with the use of ovarian suppression.

3. *Radiation therapy* is considered or administered following any mastectomy within one year (365 days) of diagnosis of breast cancer for women with 4 or more positive regional lymph nodes. Compliance: 100% CoC standard 90%

Breast Cancer Quality Improvement Measure

1. Image or palpation-guided needle biopsy (core or fine needle aspiration) is performed to establish diagnosis of breast cancer. Compliance: 100% for patients who had palpable lesions prior to surgery. Two patients did not have palpable masses or evident on imaging prior to surgery. CoC Standard 80%

Colorectal Cancer Quality Improvement Measure

1. *Colon cancer*: At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

Compliance: 93% CoC Standard 85%

Quality Improvement Benefits: Improved survival for patients with a greater number of lymph nodes resected; greater accuracy of staging for patients and consequently appropriate postsurgical care.

Summary of Evidence: The American College of Pathologists (1999) recommended that a minimum of 12 lymph nodes be examined to accurately identify AJCC stage III colon cancer. The AJCC (5th edition) indicated that it was desirable to obtain at least 12 lymph nodes in radical colon resections (1997). In its 6th edition, the AJCC modified this recommendation to obtain at least 7 to 14 lymph nodes but included rectal resections among the procedures associated with this numeric recommendation. By its 7th edition, citing data from NCI/SEER, the AJCC clearly noted the positive relationship between the number of nodes pathologically examined and patient survival.

2. *Rectal cancer*: Preoperative chemotherapy and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or postoperative chemotherapy and radiation are administered within 180 days of diagnosis for clinical AJCC T1-N0 with pathologic AJCC T3N0, T4N0 or Stage III; or treatment is considered for patients under the age of 80 receiving resection for rectal cancer.

Compliance: 100% CoC Standard 85%

Lung Cancer Quality Improvement Measure

1. Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to six months postoperatively or it is considered for surgically resected cases with pathologic, lymph nodes positive (pN1) and (pN2) non-small cell lung cancer. (LCT)
Compliance: 100% CoC Standard 85%
2. Surgery is not the first course of treatment for Cn2 M0 lung cancer cases
Compliance: 100% CoC Standard 85%

CLINICAL CANCER RESEARCH

Participation in clinical cancer research is one of the features of a state of the art cancer program and is a requirement for accreditation status with the Commission on Cancer of the American College of Surgeons. The Commission requires this standard to assure patients and their families the opportunity to participate in recent advances in cancer treatment and to encourage cancer research.

Cancer Research at VA-NYHHS is involved in cooperative group treatment and prevention studies sponsored by the National Cancer Institute (NCI), Eastern Cooperative Oncology Group (ECOG), and Radiation Therapy Oncology Group (RTOG). In addition, we have access to other cooperative group trials through the CTSU (Clinical Trials Support Unit).

Sponsored by the NCI, the CTSU allows sites access to protocols without the requirement of group membership.

In 2015, VA-NYHHS oncology opened a new study on non-small cell lung cancer. This study, Adjuvant Lung Cancer Enrichment Marker Identification and Sequencing Trial, is an example of research in personalized medicine. Personalized medicine uses predictive tools to evaluate health risks and to design personalized health plans to mitigate risks, prevent disease and treat it with precision when it occurs. Another trial, this one interdisciplinary, opened in 2015, the Observational Study of Dental Outcomes in Head and Neck Cancer Patients. We recently applied to the Hope Foundation and received funding to support NYHHS cancer research in 2016.

The increased integration of psychosocial care within Oncology over the last several years has resulted in a number of local VA-NYHHS clinical trials examining the impact of psychosocial care on cancer patients. These trials have been a significant source of patient accrual.

Treatment guidelines developed as a result of clinical trials are made available for clinicians across the country and around the world so they can deliver the best treatment for their patients. Today, there are more than 10 million cancer survivors in the United States, in large part because of the work that has been done in clinical trials.

COMMUNITY OUTREACH

The Cancer Program's major community outreach event is the annual Cancer Survivors Day Celebration, now in its 20th year. Every June, we invite cancer survivors, their families, patients and staff from the New York and Brooklyn campuses, to join together for an afternoon of celebration. The event includes a talk by one of our Cancer Survivors, refreshments, and entertainment generously provided by talented performers.



Our 2016 Cancer Survivor Speaker and his granddaughter

In March 2016, we held a campaign for increasing Veteran awareness of colon cancer prevention. The Super Colon event brought together a group of talented individuals that resulted in a multicolored display of creative thinking and design.

Our mascot, Super Colon Hero, was awarded the 2016 American College of Gastroenterology (ACG) Scopy Award. The Scopy Award was introduced by the ACG to recognize the achievements of ACG members in community engagement, education and awareness efforts for colorectal cancer prevention.

Throughout the rest of the year, staff of Cancer Program plays a part in planning or promoting a variety of community outreach activities. Our goal is to make sure that NYHHS community outreach includes a message about the availability of cancer screening, prevention and treatment as part of the VA-NYHHS family of services.



SURVIVORSHIP

“Patients completing primary treatment should be provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained.”

- Cancer Patient to Cancer Survivor: Lost in Transition, Institute of Medicine, 2005

The Institute of Medicine and National Research Council 2005 report titled *From Cancer Patient to Cancer Survivor: Lost in Transition* suggested that treatment summaries and care plans would help cancer survivors who may otherwise get lost in the transitions from the care they received during treatment through subsequent phases of their lives or stages of their disease. The purpose of this standard is to have cancer programs develop and implement a process to monitor the dissemination of a Survivorship Care Plan as a part of the standard care of the cancer patient.

The following excerpt from the August 2011 American College of Surgeons (ACoS) Commission on Cancer (CoC) report on the Rapid Quality Reporting System provides the context for both the challenge and the importance of this new initiative.

“The organization of cancer makes quality evaluation in cancer a different challenge than, for example, cardiac care. Quality initiatives in cardiac care can focus primarily on single episodes of inpatient care. Quality evaluation in cancer care cannot be limited to the inpatient setting. Cancer care is the sum of multiple episodes of care, often spread over weeks or months, administered by a number of providers across different specialties.”

Oncology- Hematology departments do not single-handedly provide cancer treatment. At best, these departments lead Cancer Programs by example and act as home base for integration and coordination of patient care across settings and treatments. Just as sports teams rely on game plans and diversified businesses use mission statements, cancer patients and their providers benefit from a unifying document recording the relevant past and projecting the possible future.

Since 2012, the Cancer Committee has been striving to meet this challenge, and we continue to do so. The Cancer Survivorship Treatment Summary and Care Plan are in the electronic medical record, allowing the document to be available not only for the patient but for all treating providers.

“The story of cancer ... is the story of patients who struggle and survive, moving from one embankment of illness to another. Resilience, inventiveness and survivorship – qualities often ascribed to great physicians- are reflected qualities, emanating first from those who struggle with illness and only then mirrored by those who treat them.”

*The Emperor of All Maladies:
A Biography of Cancer
- Siddhartha Mukherjee*

SCREENING FOR PSYCHOSOCIAL DISTRESS

The 2012 Standards of the Commission on Cancer include screening patients for distress and psychosocial health needs as a critical first step to providing quality cancer care. The Institute of Medicine (IOM)'s 2007 report, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, emphasized the importance of this intervention. The National Comprehensive Cancer Network (NCCN) states that *distress should be recognized, monitored and documented and treated promptly at all stages of the disease*. The IOM report emphasizes that cancer patients registering distress in the initial review need referrals for appropriate follow up and re-evaluation. Thus, the goal of the Cancer Committee is to develop a process to: 1) incorporate the screening of distress into the standard care of oncology patients; 2) provide patients with appropriate resources and referral for psychosocial needs.

In 2011, we adapted the National Comprehensive Cancer Network’s Distress Thermometer for use in our electronic medical record and began screening new patients in the Medical Oncology clinic at the Brooklyn campus. The clinic nurse administers the psychosocial monitor and appropriate follow-up is provided by the psychologist and social worker. In 2014, we began to administer the distress screen in the Radiation Oncology Department and in Oncology at the New York campus.

In 2015, VA-NYHHS Psychology Service conducted an IRB-approved study in the Oncology outpatient clinic to measure the impact of this encounter on patients, including their receptivity to this intervention initially and to subsequent psychosocial follow-ups. The evidence indicates that the introduction of psychosocial care at an early point in medical treatment is feasible, convenient for patients and helpful in normalizing the psychosocial dimension as part of the cancer experience.

NCCN Practice Guidelines in Oncology - v.1.2010 Distress Management

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress 10
9
8
7
6
5
4
3
2
1
0
No distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems	YES	NO	Physical Problems
<input type="checkbox"/>	<input type="checkbox"/>	Child care	<input type="checkbox"/>	<input type="checkbox"/>	Appearance
<input type="checkbox"/>	<input type="checkbox"/>	Housing	<input type="checkbox"/>	<input type="checkbox"/>	Bathing/dressing
<input type="checkbox"/>	<input type="checkbox"/>	Insurance/financial	<input type="checkbox"/>	<input type="checkbox"/>	Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Changes in urination
<input type="checkbox"/>	<input type="checkbox"/>	Work/school	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
		Family Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with children	<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with partner	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Ability to have children	<input type="checkbox"/>	<input type="checkbox"/>	Feeling Swollen
		Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Getting around
<input type="checkbox"/>	<input type="checkbox"/>	Fears	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Memory/concentration
<input type="checkbox"/>	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores
<input type="checkbox"/>	<input type="checkbox"/>	Worry	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest in usual activities	<input type="checkbox"/>	<input type="checkbox"/>	Nose dry/congested
<input type="checkbox"/>	<input type="checkbox"/>	Spiritual/religious concerns	<input type="checkbox"/>	<input type="checkbox"/>	Pain
			<input type="checkbox"/>	<input type="checkbox"/>	Sexual
			<input type="checkbox"/>	<input type="checkbox"/>	Skin dry/itchy
			<input type="checkbox"/>	<input type="checkbox"/>	Sleep
			<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands/feet

Other Problems: _____

PATIENT NAVIGATION

Since 2007, the VA-NYHHS Cancer Program has partnered with Voluntary Service to develop and manage a Navigators Program at the Brooklyn campus. Our navigators are Veterans who have experienced cancer either as a patient or as caregiver. They provide peer support to other Veterans with cancer with the goal of lessening the anxiety of receiving cancer care and providing a friendly presence in clinics and chemotherapy areas and through their presence, assist patients as they move through the cancer treatment continuum. As valuable as these volunteers are, the new navigation standard from the Commission on Cancer to be effective in 2015 definitely required more structure.

According to the Commission on Cancer, the accrediting institution for cancer programs including VA NYHHS, patient navigation in cancer care

refers to individualized assistance offered to patients, families and caregivers to help overcome healthcare system barriers and facilitate timely access to quality medical and psychosocial care.

Effective in 2015, cancer programs were expected to establish a process to deliver patient navigation services to cancer patients.

At VA-NYHHS, we used the Distress Thermometer developed by the National Comprehensive Cancer Network (NCCN) was used during the years 2012, 2013 and 2014 to assess the needs of new oncology patients at the VA NYHHS Brooklyn campus. The data gathered from 396 Veterans on their practical, family, emotional, physical and spiritual problems provided valuable information that forms the basis of this needs assessment.

The experience of a cancer diagnosis and treatment is sometimes referred to as a “teachable moment” wherein the illness experience creates receptivity to behavior change and healthier lifestyle choices. In the course of helping patients with the difficulties arising from cancer, clinicians and cancer programs have the opportunity to direct attention to issues affecting the overall quality of life.

Data from Veterans (n=396) who were administered the NCCN Distress Thermometer between April 2012 and February 2014 was used to assess their needs. Veterans received screening at one of two points of entry for oncology services: 1) outpatient triage prior to initial medical oncology consultation; and 2) admission to the acute inpatient oncology unit.

Numerous problems were reported by patients. Nearly half of the Veterans reported worry, 40% reported fatigue and sleep problems, and one third reported depression, pain, nervousness, sadness and fear as significant concerns.

Six of the top 12 concerns reported by Veterans were directly related to mental and behavioral health assessment (worry, depression, nervousness, sadness, fears, and loss of interest) and the remainder were concerns about physical symptoms of fatigue, pain, tingling hands and feet, changes in urination and breathing. Several of these physical symptoms (fatigue, sleep and pain) require a team approach to assessment and management (medical, social work, mental and behavioral health).

Using this information, a patient education tool was developed and a process put in place. A sample of the Cancer Navigation Plan is shown below.

Sample Cancer Navigation Plan in the Electronic Medical Record

LOCAL TITLE: IDN: CANCER NAVIGATION PLAN
 STANDARD TITLE: HEMATOLOGY AND ONCOLOGY TREATMENT PLAN NOTE
 DATE OF NOTE: AUG 17, 2015@14:52 ENTRY DATE: AUG 17, 2015@14:52:45
 AUTHOR: SOCIAL WORK OR PSYCHOLOGY STAFF EXP COSIGNER: SUPERVISOR
 URGENCY: STATUS: COMPLETED

NEW YORK HARBOR HEALTHCARE SYSTEM
 CANCER NAVIGATION PLAN

My distress score today was: 6 Date of Screen: 8/17/15

What does this score mean?

Your score indicates that you are experiencing some distress that may be affecting your life quite significantly. It could be worth discussing this with your health care team and finding ways to get additional support. A starting point may be to look at the information below.

Things that help me when I am distressed:

- 1. I walk to get my mind off things.*
- 2. I talk to my brother or daughter for support.*
- 3. I use distraction (TV) to occupy my mind.*
- 4. I try not to dwell on things.*

EMOTIONAL PROBLEMS:

*Worry
 Nervousness
 Fears*

Plan: Patient may try and drop-in to see Dr. Doe in 8- 224 (Extension 6722) when at VA next Wednesday.

I have a Mental Health Provider: No. I will reach out if I want a psychiatrist in future.

*Would you like to attend a VA support group or be contacted about resources by the American Cancer Society?
 No*

PALLIATIVE CARE:

*Have you heard of Palliative Care?
 No*

Palliative Care is a service that specializes in symptom management and making sure that patient goals are always considered in treatment plans. Palliative Care is available at any time during your cancer treatment. Ask your oncology doctor if you become interested at a later date.

Palliative Referral was not made at this time.

PRACTICAL PROBLEMS:

Transportation

The following information is supplemental to consultation with Oncology Social Work, available by contacting ____.

**Transportation
 Access-A-Ride- Call 877-337-2017 for information and application*

**Financial/Insurance- Single Stop
 Room 5-310 Mon-Thurs 9am-4pm 718-836-6600, x4418 or x3169*

**Housing- Single Stop
Room 5-310 Mon-Thurs 9am-4pm*

**Medicaid- Single Stop Room 5-310 Mon-Thurs 9am-4pm*

**VA Benefits- pensions, co-pay status
<http://www.benefits.va.gov> for information about application process
and to apply on-line; You may also contact the Veterans Service Organization (VSO)
of your choice, such as American Legion, Disabled American Veterans, Order
of the Purple Heart.*

Plan and/or referrals for practical problems: Patient will call SWS when able to. He declined to see SWS today.

*Contact Information:
Social Work: (718)836-6600 x6366
Psychology: (718)836-6600 x4795
VA Suicide Hotline (24/7): 1(800)-TALK (8255)*

*/es/ MARY JANE DOE
PSYCHOLOGY FELLOW*

At VA-NYHHS, the navigation discussion takes place in the outpatient oncology clinics. This is also the setting for the administration of the Distress Monitor, which may occur the same day or at a later point in the patient's care. For patients scoring 4 or higher on the Distress Screen, either a social worker or a psychologist meet with each new oncology patient and discuss the patient's distress score, and develop a plan to deal with their distress. The plan is documented in the patient record and is provided to the patient. Patients requiring or requesting further psychosocial support are given appointments with the administering clinician or referrals to other clinicians.

VA -NYHHS Cancer Program is committed to attending to all needs of the patient – psychological, physical, medical and social – during treatment and as a cancer survivor as outlined in the 2006 Institute of Medicine report, “Lost in Transition”.

FOREVER PROUD

"Hit me like a ton of bricks," Vietnam Marine Corps Veteran Robert Hall, 67, told his Primary Care Physician Dr. Sabrina Felson. He was explaining how he felt recently, hearing from his oncologist there was a bad prognosis for his GI cancer. Dr. Felson said that no one can know exactly how long a patient has to live. She reminded Mr. Hall that he would be meeting with members of the Harbor's Palliative Care team in upcoming weeks and



that the goal now was to make every day the best day possible, and to maintain his control in shaping what time he did have left here. He is clear about his main priority, which is quality time with his family, particularly Jayden, his 11 month old curious and spirited grandson. His daughter, Monique, says that when Jayden sees his grandfather, he is "all gums, he's so excited." Jayden is also soothed by Mr. Hall's calm voice, and Monique says appreciatively, "Jayden is a handful, but when my dad lies down next to him Jayden just falls asleep."

Daughter and grandson have recently moved in to stay with and tend to Mr. Hall during his illness. "Somehow, he caught on to calling me Bobbie," said Hall, sharing photos of his dimpled grandson with Dr. Felson, who has been his PC physician for ten years, and to Navy Veteran Penelope Bennett-Kone, Primary Care Program Support Assistant, who is very protective of Mr. Hall and enjoys talking with him on his frequent visits. Asked about his memories of Vietnam, Mr. Hall says, "I remember a lot of things about Vietnam." He held up his hand and flicked his fingers, to describe the "star shells," flares that were set off at the airstrip where the new troops' plane landed. "To welcome you to war," said Dr. Felson. He said he will never forget the smell of death. He kept a lot of war details private according to his daughter, who does remember hearing stories about "wet socks and rain, and bullets flying over your head."

Mr. Hall was injured by friendly fire (81 mortar) and medivacked to navel hospitals, first in Vietnam and then to Japan before returning to the States. He has received 100 percent service connected disability status. When asked what Monique admires about her father she says "Everything! I admire anyone who can protect people and put other lives first. That's an unselfish person." Mr. Hall, like many of his fellow Vietnam Veterans, struggled with drugs and alcohol when he returned home. It was the unexpected and tragic death of his son at age 13 that pulled Mr. Hall back into the fold of his family, and into the welcoming arms of the church he'd grown up in, where he now serves as Deacon and sings in the choir. Monique says you "can't walk the streets of Harlem with him cause he stops to talk to everyone. Everybody knows him. You run outside for five minutes and it takes three hours."

Dr. Felson said that for Mr. Hall, like many of the Vietnam Veterans she sees, "Their grandchildren are so important. That is their legacy. We hope Jayden--who reminds Monique of both her father and departed brother--walks the streets of Harlem with the same love and respect that his grandfather garners with his patience, bravery and kindness."

Robert Hall died on October 21, 2016. VA-NYHHS was honored to provide his care.

