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.
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.

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.

Newly developed reporting tools from the CoC are being used to provide feedback on quality indicators for care of patients with colorectal and breast 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-endorse 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 last nineteen 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 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.
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**
Cancer patients followed in Brooklyn by the physicians in the Hematology, Medical Oncology and Radiation Oncology clinics who require hospitalization for management of cancer are admitted to the Oncology unit at Brooklyn. At the New York campus, Hematology/Oncology inpatients are admitted to the medical wards and are followed by the Hematology-Oncology fellow and the attending physician. Inpatients at the New York campus that require hospitalization for radiation or combined chemo-radiation treatments are transferred to the inpatient Oncology Unit at Brooklyn.

The Oncology Unit team, consisting of an attending oncologist and house officers, manages cancer patients with acute medical problems. The Palliative Care Team, consisting of a nurse practitioner and the physician Director of Palliative Care, work closely with the Oncology Unit team 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. A similar arrangement is planned for the Manhattan campus. 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.
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. The enormous impact of the Radiation Therapy Service on the quality of cancer care is indicated by the high percentage of NYHHS cancer patients whose treatment includes Radiation Therapy.

Since 2011, the service has been providing stereotactic lung radiotherapy for patients with unresectable lung cancer. This technique joined the range of therapy offered, which includes brachytherapy seed implants, high dose rate brachytherapy (where radiation is administered internally for a period of time) and conventional Radiation Therapy. Other forms of treatment include Intensity Modulated Radiation Therapy (IMRT) and Image Guided Radiation Therapy, (IGRT). IGRT is being used in the majority of patients, permitting more precise delivery of radiation to the tumor and reduced side effects. The service also continues to update its treatment planning software to improve the quality and timeliness of treatment planning.

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 was a very active year academically for the department with the publication of several articles in peer-reviewed journals and presentations at national meetings.

**Innovations**

With the use of the Varian True Beam STX linear accelerator, the Department of Radiation Oncology has dramatically improved the efficiency, precision and scope of patient services.

This innovative technology allows for extremely precise stereotactic radiosurgery of brain, lung, spine and other sites.
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 compiles comparative institutional data for research and education. 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 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 Intraperitoneal 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.

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.
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 3 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 traheo-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 electromagnetic 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 cyberknife radiation therapy, 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 2015, VA-NYHHS Hepatocellular Cancer (HCC) Team continued its commitment to standardize care for HCC patients and create 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 2015, VISN 3 joined with VISNs 4, 12, 1 and 6 to host a HCC seminar held in VISN 4 at Philadelphia VA. The meeting was available to VA nationwide via videoconference on the VA intranet. As in previous years, the seminar was attended by subject matter experts and clinicians treating hepatocellular cancer in these parts of the country. Participants shared the most up-to-date practices, as well as intellectual and procedural resources relating to the diagnosis and treatment of this disease.

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) 3 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 newly 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 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. At the New York campus, the hiring of two new oncology nurses fostered improved communication between disciplines and increased teamwork.

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.
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 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.

Psychotherapy, including cognitive-behavioral and supportive interventions, as well as VA evidence-based psychotherapy intervention using Acceptance and Commitment Therapy (ACT) is also made available. Pain management is offered using cognitive techniques such as relaxation training and guided imagery. In addition, outpatients can participate in a weekly cancer support group where psycho education is provided on topics related to cancer treatment, adjustment and coping skills.

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.
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. In 2010, the Pathology Service introduced the SurePath methodology for PAP smears which is more sensitive in detecting abnormal PAP and facilitates diagnosis in a number of ways.

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.

Policies and procedures are reviewed to ensure standards compliance. Medical records are reviewed on an ongoing basis to ensure appropriate documentation. Patient care rounds are performed on a routine basis to educate the staff on standard compliance.

The QM Specialist also monitors quality of care, utilization of patient care resources, patient safety and continuity of care. Admissions are reviewed utilizing Interqual criteria, to determine the appropriateness of admissions and length of stay on the inpatient Oncology Unit. The QM specialist is also actively involved in the timely coordination of patient care between the Brooklyn and New York campuses.

QUALITY MANAGEMENT

The Quality Management (QM) Specialist is an active member of the interdisciplinary cancer treatment team, the Cancer Committee and attends the Pulmonary, General and Cardiothoracic Tumor Boards.

QM Specialists review the medical records of patients with lung, breast, colorectal and high risk locally advanced prostate cancers for compliance with the nationally recognized guidelines of The National Comprehensive Cancer Network. The results of these reviews are presented quarterly to the Cancer Committee and recommendations for corrective action are implemented.
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.
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 2014, 533 new analytical cases were added to the registry with a total number of 22,000 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.
The total number of analytical cases in 2014 is 533, an increase of 10% over last year’s total cases of 482. The figure above illustrates the site distribution for newly diagnosed malignancies in 2014. The five major sites are prostate, lung, bladder, colorectal and kidney. Prostate cancer is still the leading malignancy with 162 new cases in 2014, representing 30.4% of cases this year. Lung cancer is the second most common at 15.2%, with 81 new cases in 2014, compared to 74 new cases in 2013. This year, bladder cancer is third with 41 new cases. Colorectal (35 cases) and cancer of the kidney (including renal pelvis and ureter) are currently the fourth and fifth most common cancers.

Analysis of the ethnicity of the five most common sites in the cancer registry shows that 50% are Caucasian, 45% are African American and 5% are other ethnicities, representing Hispanic and Asian Americans. 47% of prostate cancer cases are seen in African Americans and 43% in Caucasians. Lung cancer is higher among African Americans with 49% versus 40% among Caucasians. Bladder cancer shows a higher rate in Caucasians with 71% cases versus 29% cases for African Americans.
QUALITY STUDY 2015

SHARING KNOWLEDGE AND EXPERIENCE:
CREATION OF A MULTIDISCIPLINARY AND MULTI-FACILITY TUMOR BOARD,
IMPROVING ACCESS, KNOWLEDGE AND QUALITY CARE IN HEPATOCELLULAR CARCINOMA

Each year, the Commission on Cancer requests accredited cancer programs such as ours to release a report to the general public which describes how quality was achieved for their patients or their programs. For this quality study we have chosen hepatocellular cancer, a type of cancer that is increasing in incidence in the United States.

Hepatocellular cancer is the fastest growing malignancy in the US and worldwide. Primary liver cancer is the third leading cause of cancer death in the world, behind lung and stomach cancer, accounting for approximately 700,000 deaths annually. The American Cancer Society estimates for primary liver cancer and intrahepatic bile duct cancer in the United States for 2015 are: 35,660 new cases (25,510 in men and 10,150 in women) will be diagnosed and 24,550 (17,520 men and 7,520 women) will die of these cancers. Liver cancer incidence rates are about 3 times higher in men than in women, and have doubled over the past two decades. From 2007 to 2011, the overall rate increased by 3.4% per year.

As seen in the table below, the number of patients diagnosed with hepatocellular cancer annually in VA-New York Harbor has been increasing over the past 10 years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>12</td>
</tr>
<tr>
<td>2005</td>
<td>23</td>
</tr>
<tr>
<td>2006</td>
<td>10</td>
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<td>2010</td>
<td>38</td>
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<tr>
<td>2011</td>
<td>30</td>
</tr>
<tr>
<td>2012</td>
<td>37</td>
</tr>
<tr>
<td>2013</td>
<td>31</td>
</tr>
</tbody>
</table>

Patients with hepatocellular cancer usually present with abdominal pain and vague symptoms such as weight loss and malaise. Hepatitis B and C are associated risk factors. In endemic areas of hepatitis B, such as the Far East and Sub-Saharan Africa, almost 90% of patients with hepatoma are positive for hepatitis B. However, at VA-NYHHS and in the United States in general, hepatitis C is the most common etiologic factor.

Since 2008, a Hepatocellular Cancer (HCC) Team has existed at VA-NYHHS consisting of members from Gastroenterology/Hepatology, Interventional Radiology, Medical Oncology, Surgery, Pharmacy and Radiology from both Brooklyn and New York campuses. The team soon expanded to include Social Work, Psychology and Palliative Care representatives. Awareness of the increasing frequency of this cancer and its particular characteristics led to the team’s formation. The status of HCC as the most rapidly increasing cause of cancer death in the United States is driven in part by Hepatitis C infected baby boomers. The cumulative number of cases of HCC in Veterans infected with Hepatitis C increased 20-fold between 2000 and 2008. The high incidence and low survival rates for HCC make it a disease worthy of attention.
In 2010 the VA-NYHHS HCC team took part in the Cancer Care Collaborative, a national VA project in which cancer programs across the country reviewed the processes involved in the delivery of care for one type of cancer, identified bottlenecks or inefficiencies in those processes, and then applied system redesign principles to improve care. The idea of reviewing cancer care delivery by cancer type grew from the recognition that delivery of care for each cancer type presents unique circumstances, problems and opportunities. For a number of reasons, this is particularly true for Hepatocellular cancer.

The Cancer Care Collaborative directed the team to carefully study the processes involved in treating HCC. By examining the HCC continuum of care in detail, and dividing it into care segments, the team was able to achieve tighter timelines and improved efficiency for numerous tasks: the transplant package completion time was reduced from 145 to 30 days by creating a transplant order set in CPRS; the number of cases with documented staging prior to treatment increased; the length of time from diagnosis to treatment shortened; the percentage of cases with advance directives in place increased. Related improvements involved the assignment of a dedicated social worker to the Liver team, and including space for a social worker and palliative care representative nearby HCC medical staff. An Advance Directive reminder was created in CPRS for clinicians managing patients with HCC. New formats for the HCC tumor board agenda and the tumor board note required data fields, information and staging systems specific to HCC patient care, including Childs Pugh, MELD, ECOG performance status, TNM and Barcelona staging. Having all this information in a predetermined format facilitated efficient decision making and discussion documentation.

Also in 2011, because HCC usually develops in a cirrhotic liver, a cirrhosis database was created and our baseline HCC screening rates evaluated. As our screening rates were around 60%, a clinical reminder for HCC screening was developed indicating the due date for the patient’s next abdominal ultrasound. Responsibility for fulfilling the reminder was assigned to Primary Care, so that it was subject to the widest provider audience.

In 2012 the team turned its attention to the development of a VISN 3-wide hepatocellular tumor board to standardize care across all VISN 3 facilities, improve access to care and timeliness of care. Streamlining of local processes and focusing on the specialized considerations of HCC diagnosis and treatment inspired the ambition to affect broader change. Team members wanted to offer a consistent approach to HCC patients within the New York-New Jersey area, known as VISN 3, eliminate disparities in care and offer the most informed interdisciplinary clinical evaluations regardless of the patient’s home campus. The centerpiece for this unified approach to HCC in VISN 3 was the creation of a VISN-wide Tumor Board which would meet weekly to evaluate all potential HCC cases.

Because each VA traditionally operates independently and autonomously, this level of collaboration beyond facility borders activated dormant institutional muscles. For example, to a large degree, the foundation for the tumor board was the agreement by all the VISN radiologists to adopt a new common protocol for communicating their evaluations of liver tumors. Efforts to convince the VISN 3 radiologists to accept and adopt specialized LI-RADS (Liver Imaging Reporting and Data System) templates for potential HCC cases were successful. As of 2014, all reports on these cancers in VISN 3 reflected this uniform reporting format.

This is an extremely important change because uniformity of radiologic evaluations fosters consistent treatment. In HCC, imaging is the single conclusive diagnostic tool, rather than imaging supported by pathology, which is the case with most cancers.
Another vital interconnecting piece in constructing the VISN 3 Tumor Board was the HCC Cancer Care Tracking System (CCTS), developed in the West Haven Connecticut VA in VISN 1. The HCC team contacted, visited and developed relationships with West Haven VA cancer staff, who generously shared the results of their own innovative efforts. CCTS is a web-based program linked to the electronic record which uses natural language processing to identify potential liver malignancies in Radiology reports even if LI-RADS fails or is absent. This tracking system software was put in place at all VISN 3 hospitals. It is operational in three hospitals. There is one nurse in New York reviewing the tracker results continuously for potential HCC cases. Depending on the volume of cases, additional nurses may be hired.

Further ground was broken when the interdisciplinary tumor board included expert representatives from all five campuses. This necessitated coordinating with telehealth and information technology to set up telehealth equipment at each campus to enable providers at separate hospitals to view the imaging with radiology and discuss the patients among all disciplines every week.

A time for the HCC tumor board had to be established which allowed for weekly attendance by all the specialists at the various hospitals. Clinicians and support staff had to make schedule adjustments and commit to weekly attendance and punctuality. The agenda had to be assembled in advance and available to the team for preview on a shared network file. During the tumor board, the cases are reviewed and discussed, with didactic commentary, by the diverse team from the various facilities. Educational credit, through the TMS program, is available for registrants.

In addition to the fundamental adjustments required by Radiology and the enabling telehealth technology, creating one HCC tumor board across VISN 3 required consensus on other tools and processes. The hospitals had to agree on a tumor board agenda format which included all the data elements relevant to HCC diagnosis. Along the same lines, they had to agree on a consistent format for the content of the note in the patient record which documented the tumor board discussion.

Two automated clinical reminders relating to HCC had been established by the VA-NYHHS HCC team. These are messages which communicate to the patient’s providers the need to provide care or offer services. For patients identified by ICD-9 code as cirrhotic, a reminder is sent to the PCP notifying them of the need for HCC screening by abdominal ultrasound every 6 months. The other automated reminder is that an advance directive be completed within 90 days of HCC diagnosis. These reminders had to be accepted and established in the other three VISN hospitals so that all patients received the same standard of care.

In September of 2012, 2013, 2014 and 2015, the V03 HCC team conducted “Liver Cancer Summits” which were all day educational seminars with nationwide leaders in HCC from an array of disciplines. Subjects discussed ranged from the pros and cons of screening, to various surgical and radiation procedures, transplantation, the role of imaging, the importance of staging, systemic therapies and palliative care. All the summits received full Employee Educational System accreditation, with the first two taped for subsequent and wider viewing; the last two summits were broadcast live nationally via telehealth and Lync systems.

In September of 2014, the VISN 3 team organized an all-day national summit for VISNs 1, 4 and 12 to share the lessons learned in VISN-wide team and tumor board creation as part of their national spread initiative. Thanks to sustained support from information technology and telehealth, the summit was available nationwide on VA website. This summit addressed the structural underpinnings for a VISN HCC tumor board and included best practices and innovations in the treatment of HCC as described by clinical leaders.
The 2015 summit was held in Philadelphia, in VISN 4, and, as in the previous year, was available nationwide via VA website. In 2015 the HCC team used a VA Public Health grant to develop a public education tool on hepatitis which is available as an application on VA website.

Team goals for 2016 include: implementation of the tumor tracking software in four of the five VISN 3 hospitals; use of the psychosocial distress monitor in CPRS to screen HCC patients for distress; earlier introduction of palliative care in the treatment process (included in the education tool discussed above); expanded use of My HealtheVet to increase patient participation in treatment decisions; inclusion of upstate New York, VISN 2, in the HCC team. There is another grant for next year which will concentrate on preventive care and early diagnosis of HCC. This effort will include extending the HCC team’s reach to primary care PACT teams and endocrinologists, taking into account the important role of metabolic syndrome as etiology for liver cancer.

In this way, VA-NYHHS sustains and shares the tradition of constant performance improvement, education at the cutting edge of knowledge, and continuous system redesign of Hepatocellular treatment processes, always putting the patient at the center of the team.
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, as one way that biological variation among people presents itself is responsiveness to drugs. 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.
The Cancer Program’s major community outreach event is the annual Cancer Survivors Day Celebration, now in its 19th year. In June of each year, we invite patients and staff from both the New York and Brooklyn campuses and all cancer survivors, to join together for an afternoon of celebration. The event always includes a talk by one of our Cancer Survivors, refreshments, and entertainment generously provided by very talented performers.

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 treatment and prevention as part of the VA-NYHHS family of services.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>April</td>
<td>Colorectal Screening Month</td>
</tr>
<tr>
<td>June 3</td>
<td>National Cancer Survivors Day</td>
</tr>
<tr>
<td>June 4</td>
<td>Women’s Health Day</td>
</tr>
<tr>
<td>July 12</td>
<td>Living With Cancer</td>
</tr>
<tr>
<td>Oct. 9</td>
<td>VA Breast Cancer Awareness Day</td>
</tr>
<tr>
<td>Nov. 19</td>
<td>Great American Smoke Out at VA</td>
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</table>
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. In common with most other programs working on this standard, we believe that the Cancer Survivorship Treatment Summary and Care Plan should be in our electronic medical record. This allows the document to be available not only for the patient but for all treating providers to consult.

“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.”
- Siddhartha Mukherjee

The Emperor of All Maladies: A Biography of Cancer
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.

Last year, 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.

![Distress Thermometer](image-url)
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 of the armed forces 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 4/2011 and 2/2014 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 Louisa Daratsos, PhD, LCSW, at 718-836-6600, x6366.

   *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”.

Potential for Programmatic Action to Address Survivor Needs

Psychological Needs
- Social support; Matched peer-survivor support
- Coping strategies to deal with fear of recurrence, anxiety, depression

Medical Needs
- Communicate with physicians
- Adequate communication among physicians/specialists
- Transition back to the primary care setting

Physical Needs
- Managing long term late effects (i.e., fatigue, pain, depression)
- Interventions for health behavior change (i.e., diet, exercise, smoking cessation, screenings)

Social Needs
- Respond to care provider burden
- Financial assistance services
- Programs to ameliorate employment problems

Need for ethnically/socially tailored materials across all programs
Adapted from the IOM report, Lost in Transition (2006)