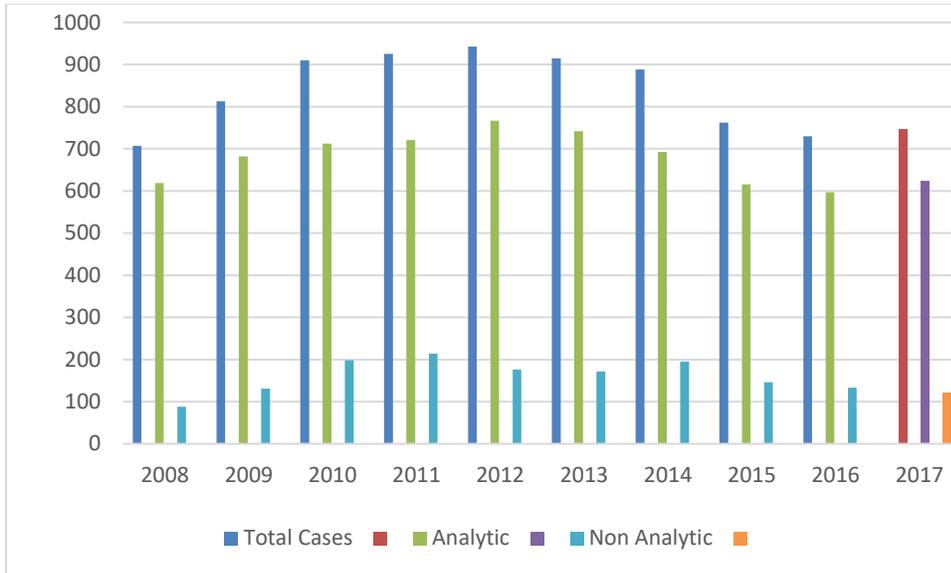




**VA PALO ALTO HEALTH CARE SYSTEM**

**VA Palo Alto Health Care System**  
**MULTIDISCIPLINARY CANCER PROGRAM**  
**Public Reporting of Outcome**  
**2018**

## 10 Years Incidence of Cancer Cases Accessioned at VAPAHCS



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Cases	707	813	910	925	943	915	888	762	730	747
Analytic	619	682	712	721	767	742	693	616	597	625
Non Analytic	88	131	198	214	176	172	195	146	133	122

Comparing frequency data of five most common cancer sites at VAPAHCS, Prostate and Lung cancers were consistently the highest over the period shown.

	2011	2012	2013	2014	2015	2016	2017
Prostate	193	157	174	143	127	138	123
Lung	139	148	133	124	101	96	98
Melanoma/Skin	98	102	108	101	87	70	88
Colorectal	48	51	52	51	47	43	37
Bladder	40	62	58	57	41	55	38

## Cancer Program Practice Profile Reports (CP3R)

The Cancer Care Committee ensures and monitors that patients treated at VA Palo Alto Health Care System receive care according to nationally accepted measures. The Commission on Cancer measures compliance with current CoC quality reporting tools—the Cancer Program Practice Profile Reports. Below is the summary CP3R performance grid that reports 2016 cases treated at VA Palo Alto Health Care System. We are proud that our program is exceeding and meeting all of the Estimated Performance Rate (EPR) of the Commission on Cancer (CoC).

Standard 4. 4 and 4.5

<b>ACoS-CoC NCDB Cancer Program Practice Profile Report (CP3R) 2016</b>		
<b>Measures</b>	<b>VA Palo Alto HCS 's Performance Rate</b>	<b>CoC Estimated Performance Rate (EPR)</b>
BCSRT: Breast radiation after breast conserving surgery	100%	90%
HT: Adjuvant hormonal therapy for hormone receptor positive breast cancer	100%	90%
nBx: Image or palpation-guided needle biopsy (core or FNA) is performed for the diagnosis of breast cancer	100%	80%
12RLN: At least 12 lymph nodes are removed and examined as part of primary colon cancer resection	100%	85%
LCT: Systemic chemotherapy is administered or recommended within 4 months prior to surgery or within 6 months postoperatively for surgically resected cases with pathologic, lymph node positive (pN1) and (pN2) NSCLC	100%	85%
LNoSurg: Surgery is not the first course of treatment for cN2, M0 cases	100%	85%
RECRTCT: Chemo and Radiation therapy is administered or recommended for resected rectal cancers	100%	85%

Results from the National Cancer Data Base quality measuring tool indicates that the performance rates of the VAPAHCS's cancer treatments quality measures are above the CoC Estimated Performance Rate (EPR)

Submitted by John Leppert, MD, Cancer Liaison Physician  
December 5, 2018

## Std 4.7 Studies of Quality

### Does Provider Documentation of Symptoms Improve Symptom Management in Thoracic Malignancies?

*Banks L, RNP, Patel M, MD, Das M, MD, Carevive Team Members (Birchard K, Wujcik D, and DiGiovanni, L)*

**Background:** Undertreated symptoms are common among patients with lung cancer and lead to increased use of acute care facilities. Studies show that better symptom management can improve patient quality of life. It is unknown, however, whether provider knowledge and documentation of patients' symptoms results in improved symptom management. Therefore, we conducted a randomized study to evaluate whether patient-reported symptoms improved provider documentation and symptom management among Veterans diagnosed with lung cancer.

**Methods:** All Veterans with lung cancer receiving ongoing treatment with chemotherapy or immunotherapy were randomized to either usual care or usual care enhanced with a lay health worker-led weekly telephonic symptom assessment. Symptoms rated at a 4 or greater on a scale from 0 to 10 with 10 being the worst possible were documented in the patient's chart and their provider notified. The patients' charts were reviewed retrospectively to determine if symptoms were documented and managed at the patient's next clinic visit.

**Findings:** Between July 01, 2017 and May 01, 2018, 37 Veterans were consented and enrolled in the study. Retrospective chart review was performed for 30 participants (usual care n = 15, intervention n = 15). Across both groups, median age was 68, majority were non-Hispanic White (67%), male (99%), and diagnosed with Stage IV disease. Provider documentation and management of symptoms did not improve in the intervention group when compared to the usual care group at baseline, 3 months, and 6 months ( $p = .41$ ,  $p = .50$ ,  $p = .51$ , respectively). The intervention group had a higher baseline symptom score ( $M = 24.07$ ,  $SE = 4.93$ ) than the usual care group ( $M = 21.33$ ,  $SE = 4.62$ ), but over time, the symptom score in the intervention group decreased, whereas, the usual care group increased which resulted in a significant difference at 6 months ( $p = .033$ ). When assessing if the groups differed based on their symptom scores, patients in the intervention group reported less severe symptoms at 3 and 6 months than the usual care group,  $F(1,4) = 39.44$ ,  $p = .003$ , partial Eta squared = .908. Post hoc analysis supported that there was not a significant change in symptom ratings across the two time periods ( $p = .503$ ) but that there was a significant difference between symptom severity in each group ( $p = .003$ ).

**Conclusions:** Patient-reported symptoms are important to ensuring timely interventions to decrease symptom burden. However, challenges remain in ensuring that symptoms that are reported result in a timely intervention by clinical providers. Weekly symptom assessment holds promise in reducing symptom severity, but more research is needed to ensure that providers document and intervene on symptoms reported by patients.