



# Cancer Program Annual Report 2018

\*Statistical Data for 2017



I am very pleased to present the 2018 University Health System Cancer Committee annual report, which highlights the exemplary efforts of our committee members to improve the care for cancer patients in Bexar County. This report highlights our progress, goals, and continuous commitment to cancer treatment, awareness, and education in our community

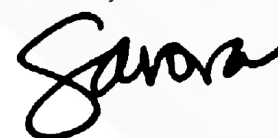
During the past calendar year, we have regained full accreditation by the American College of Surgeons Commission on Cancer (ACSCoC) by addressing the seven remaining deficiencies by December 2017. Our Tumor Registrar, Cynthia Evans, has been critical in this accomplishment. We are in a strong position for the next accreditation site review planned at three years, due October 2018. This past year, we have continued to improve cancer care through our cancer program goals and quality improvement projects. Dr. Kate Lathrop, medical oncologist, has been working with the emergency room to implement an identification care that identifies patients at risk for neutropenic fever, so these patients are triaged accordingly. Dr. Mio Kitano, surgical oncologist, has worked on a program for identifying surgical patients who are at risk for post-surgical venous thromboembolism (VTE), so that prophylaxis is initiated before discharge. Additionally, our robust Multidisciplinary Cancer Genetics Clinic has grown and patients have received prophylactic surgeries at UHS. Dr. Elizabeth Bowhay (hematologist) and Dr. Laura Tenner (medical oncologist) have worked with the committee to help establish Hematology/Oncology subcommittees for the Pharmacy and Therapeutics Committee at UHS, so these vital new treatments are available to patients in a timely manner.

For the upcoming year, we have the following specific goals:

1. Continue to improve standards that are high risk so we can demonstrate maintain our accreditation without contingency by the ACSCoC. Our committee is continuously working to prepare for our survey October 2018.
2. Continue to improve the integration of cancer services between the Mays Cancer Center and University Hospital, so that transition of care from inpatient to outpatient, and vice versa, is efficient for our patients. Dr. Kitano has taken the lead to improve peri-operative nutrition for high-risk surgical patients, so they receive optimal support as they prepare for surgery and heal from surgery.
3. Increase patient participation in cancer clinical trials. One of the goals this year to identify and address hurdles CareLink (county indigent program) patients have to enrollment onto clinical trials. Dr. Anna Taranova and myself along with others have been working on this endeavor.
4. Increase usage of cancer screening services in our community, which will hopefully downstage cancers in our community. We hope to build a liver cancer screening programs this year, and we are starting with Hepatitis C and cirrhosis screening at the downtown UHS campus. Success of this program will hopefully lead to programs at all outpatient clinic locations.
5. Improve documentation of recommendations from multidisciplinary tumor boards at Mays Cancer Center and UHS. We are continuing to work with tumor board leadership to improve standardization of documentation and communication of recommendations.
6. This year we hope to continue to grow our Survivorship Clinic for cancer survivors. We have two new physician assistants in Breast and Gastrointestinal Oncology Clinics who are helping with survivorship care plans for medical oncology patients, but this is a system wide effort among other specialties, including gynecology oncology and other oncology subspecialties.
7. Under the leadership of Dr. Laura Tenner and Social Worker LaTrecee Leeper, we have worked to implement a psychosocial distress screening assessment (ESAS) on every cancer patient at UHS as well as MCC. This will trigger timely palliative care consultations. Plans are to increase UHS participation to be hospital-wide as well as to outpatient clinics.

On behalf of the Committee, I would like to extend my appreciation to everyone throughout UHS involved in the care of the cancer patients. Our committee remains strongly committed to excellent and comprehensive care for our cancer patients, including superb patient care, high quality research and education for our community as well as healthcare workers.

Sincerely,



Sukeshi Patel Arora, MD  
 Medical Oncology  
 Chair, University Health System Cancer Committee

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# CANCER PROGRAM ADMINISTRATOR REPORT

University Health System, in collaboration with University of Texas Health Science Center, continues to advance cancer care in the area of treatment, clinical research and education. The Health System is committed to providing high quality, multi-disciplinary, patient-centered cancer care in accordance with the standard requirements by the Commission on Cancer, a quality program of the American College of Surgeons. This annual report serves the requirement of Standard 1.12 Public Reporting of Outcomes.

In 2016, the Health System opened a new 30-chair specialty infusion center on the first floor of the Rio Tower. Fifteen chairs are specifically for chemotherapy services. Significant safety improvement measures have been made to the chemo/bio-therapy administration process which include two-nurse verification on blood return and infusion rates at the bedside. The 16 bed Adult Oncology Unit on the 8th floor Sky Tower is providing care for the Pediatric Oncology Young Adult Patient. The Hematology/Oncology Unit has more than 18 nurses certified by the nursing oncology society to administer chemo and bio-therapy. Six are nationally certified oncology nurses. In fiscal year 2017, we hired 3 new tumor registrars and in early fiscal year 2018, a second genetic counselor assistant was added to increase access to this service. We also gained three new physicians in Surgical/Endocrine Surgery; Dr. Mio Kitano, Dr. Federico Tozzi and Dr. Maryam Elmi.

Since 2015, the Health System has received more than \$11.7 million in cancer screening funds from several funding sources such as CPRIT funds, Susan G. Komen, etc. In partnership with the American Cancer Society, the Health System employs a patient navigator. This staff member works at the Mays Cancer Center to assist newly diagnosed patients. More efforts have been placed on care coordination and patient navigation to assist all patients with access to timely care. For 2017, the Health System diagnosed 1,523 newly cancer related diagnosis.

Thank you,

Theresa De La Haya, RN, MPH  
Senior Vice President  
Cancer Program Administrator

# MISSION, VISION AND VALUES

## MISSION

The mission of University Health System is to improve the good health of the community through high-quality, compassionate patient care, innovation, education and discovery.

## VISION

We are leading the way to be one of the nation's most trusted health institutions.

## VALUES

Our patient care will be

- High quality and compassionate above all,
- Attentive, kind and helpful without exception, and
- Wise in the use of resources.



# CANCER REGISTRY REPORT 2018

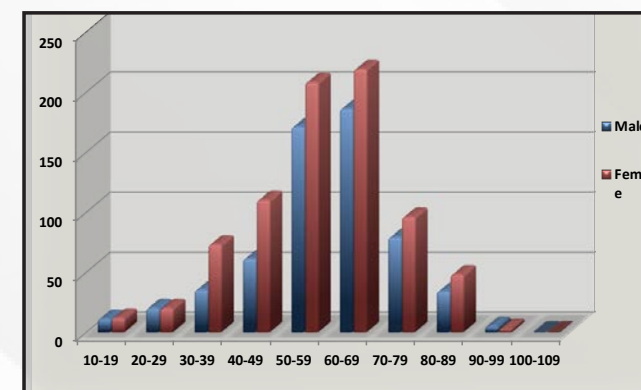
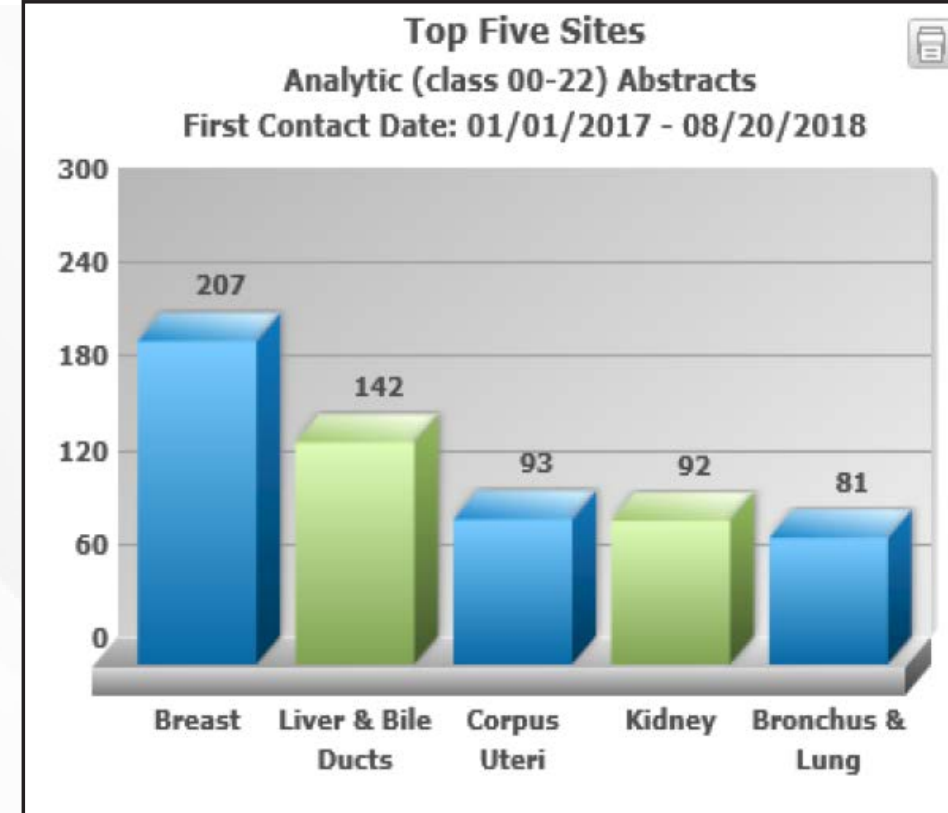
University Health System's Tumor Registry Department is an integral component of the cancer program and operates under the direction of the Cancer Committee. It is a data system designed for collection of persons with a diagnosis of cancer diagnosed and/or treated at University Health System. Data is collected according to the American College of Surgeons Commission on Cancer (CoC), as well as the Texas Department of State Health Services, Texas Cancer Registry (TCR). Some of the data collected includes patient demographics, primary site, histology, American Joint Committee on Cancer (AJCC/TNM) staging, first course of treatment, disease recurrence or progression, and survival information. All data is collected by Certified Tumor Registrars (CTR's) credentialed by the National Cancer Registrars Association (NCRA), and follows stringent cancer reporting guidelines and coding standards. The ultimate goal of the Tumor Registry is to provide medical staff at University Health System with data that will enable them to assess the results of their diagnostic efforts.

In 2017, the Tumor Registry abstracted a total of 1745 cases of cancer, of which 1403 were analytic cases while 342 were non-analytic cases. Analytic cases are those which were newly diagnosed and received all or part of their first course of treatment at University Health System. These cases are required by the CoC and are submitted annually to the National Cancer Database. Non-analytic cases are required by the state cancer registry and include cases which are seen at University Health System which were originally diagnosed elsewhere but have persistent, recurrent, or metastatic disease during their visit at UHS. The five most prevalent cancers seen at UHS were breast, liver, corpus uterine, kidney, and lung. The Tumor Registry also performs follow-up or surveillance, in order to provide patient outcomes through ongoing monitoring of cancer status, and/or identify additional tumors.

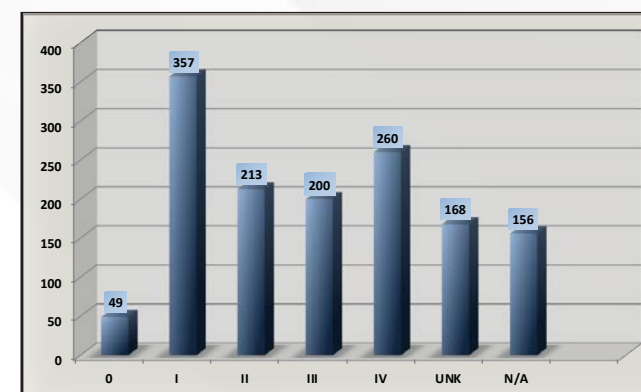
The CTR's are members of the National Cancer Registrars Association and the Texas Tumor Registrars Association and annually maintain certification status through various educational events. All registry staff (CTR and non-CTR) participates in ongoing educational events. This year the Tumor Registry's staff structure has changed and processes and procedures for coding and abstracting are continually being revised according to multiple national standard setter organizations. This transition will position the UHS Tumor Registry for future growth and development.

## UHS Tumor Registry Staff

Cynthia Evans BA, LVN, CTR – Tumor Registry Manager  
 Michael Gonzales – Health Information Specialist  
 Sarah Herrera, CTR  
 Deanna Rodriguez, CTR  
 Anna Burt, RHIT, CTR – UHS Independent CTR Contractor



Age Range	Male	Female
10-19	11	12
20-29	20	20
30-39	35	73
40-49	61	110
50-59	171	208
60-69	186	219
70-79	79	96
80-89	34	48
90-99	5	3
100-109	0	0
Totals	602	789



AJCC	Cases	Percent
0	49	3.49%
I	357	25.45%
II	213	15.18%
III	200	14.26%
IV	260	18.53%
UNK	168	11.97%
N/A	156	11.12%
Totals	1403	100.00%



Cancer Data Year 2017 ANALYTIC CASES

Primary Cancer Site

Primary Cancer Site	Total	Class Sex		American Joint Committee on Cancer (AJCC) Stage							Unk	N/A
		A	M	F	0	I	II	III	IV			
All Sites.....	1395	1395	603	792	48	356	213	200	260	164	154	
<b>Oral Cavity</b> .....	73	73	53	20	1	11	6	7	36	10	2	
Lip.....	1	1	1	0	0	0	0	0	0	1	0	
Tongue.....	14	14	8	6	0	4	2	2	4	2	0	
Oropharynx.....	8	8	8	0	0	0	0	2	4	2	0	
Hypopharynx.....	2	2	1	1	0	0	0	0	2	0	0	
Other.....	48	48	35	13	1	7	4	3	26	5	2	
<b>Digestive System</b> .....	334	334	215	119	2	78	68	58	75	44	9	
Esophagus.....	12	12	9	3	0	1	1	1	4	5	0	
Stomach.....	26	26	12	14	0	3	1	3	9	10	0	
Colon.....	44	44	23	21	2	1	11	9	19	2	0	
Rectum.....	33	33	20	13	0	7	3	10	7	6	0	
Anus/Anal Canal.....	7	7	3	4	0	0	2	4	1	0	0	
Liver.....	139	139	109	30	0	55	32	24	10	14	4	
Pancreas.....	48	48	27	21	0	8	5	12	21	2	0	
Other.....	25	25	12	13	0	3	6	2	4	5	5	
<b>Respiratory System</b> .....	107	107	57	50	0	17	7	20	50	9	4	
Nasal/Sinus.....	6	6	2	4	0	0	0	1	4	0	1	
Larynx.....	18	18	18	0	0	3	2	2	10	1	0	
Other.....	2	2	0	2	0	0	0	0	0	0	2	
Lung/Bronc-Small Cell.....	11	11	1	10	0	0	0	3	7	1	0	
Lung/Bronc-Non Small Cell.....	66	66	33	33	0	13	5	13	28	7	0	
Other Bronchus & Lung.....	4	4	3	1	0	1	0	1	1	0	1	
<b>Blood &amp; Bone Marrow</b> .....	39	39	19	20	0	0	0	0	0	0	39	
Leukemia.....	23	23	11	12	0	0	0	0	0	0	23	
Multiple Myeloma.....	12	12	7	5	0	0	0	0	0	0	12	
Other.....	4	4	1	3	0	0	0	0	0	0	4	
<b>Bone</b> .....	13	13	9	4	0	2	4	0	1	5	1	
<b>Connect/Soft Tissue</b> .....	27	27	11	16	0	3	2	8	4	8	2	
<b>Skin</b> .....	27	27	16	11	1	6	3	5	0	6	6	
Melanoma.....	22	22	12	10	1	6	3	4	0	6	2	
Other.....	5	5	4	1	0	0	0	1	0	0	4	
<b>Breast</b> .....	207	207	3	204	36	58	64	23	12	14	0	
<b>Female Genital</b> .....	178	178	0	178	0	88	16	30	26	16	2	
Cervix Uteri.....	45	45	0	45	0	8	9	12	10	5	1	
Corpus Uteri.....	101	101	0	101	0	68	4	10	8	10	1	
Ovary.....	26	26	0	26	0	10	2	7	6	1	0	
Vulva.....	5	5	0	5	0	1	1	1	2	0	0	
Other.....	1	1	0	1	0	1	0	0	0	0	0	
<b>Male Genital</b> .....	61	61	61	0	0	6	18	10	7	19	1	
Prostate.....	40	40	40	0	0	3	18	6	7	6	0	
Testis.....	17	17	17	0	0	3	0	2	0	11	1	
Other.....	4	4	4	0	0	0	0	2	0	2	0	
<b>Urinary System</b> .....	129	129	73	56	8	42	13	21	24	20	1	
Bladder.....	35	35	29	6	8	3	6	5	8	5	0	
Kidney/Renal.....	94	94	44	50	0	39	7	16	16	15	1	
Other.....	0	0	0	0	0	0	0	0	0	0	0	
<b>Brain &amp; Cns</b> .....	50	50	18	32	0	0	0	0	0	1	49	
Brain (Benign).....	8	8	4	4	0	0	0	0	0	0	8	
Brain (Malignant).....	14	14	7	7	0	0	0	0	0	0	14	
Other.....	28	28	7	21	0	0	0	0	0	1	27	
<b>Endocrine</b> .....	75	75	23	52	0	31	1	9	6	10	18	
Thyroid.....	57	57	15	42	0	31	1	9	6	10	0	
Other.....	18	18	8	10	0	0	0	0	0	0	18	
<b>Lymphatic System</b> .....	52	52	32	20	0	14	11	7	17	0	3	
Hodgkin's Disease.....	7	7	6	1	0	2	1	1	3	0	0	
Non-Hodgkin's.....	45	45	26	19	0	12	10	6	14	0	3	
<b>Unknown Primary</b> .....	16	16	10	6	0	0	0	0	0	0	16	
<b>Other/III-Defined</b> .....	7	7	3	4	0	0	0	2	2	2	1	

Number of cases excluded: 8

This report Excludes CA in-situ cervix cases, squamous and basal cell skin cases, and intraepithelial neoplasia cases

# PHYSICIAN REVIEW: MONITORING COMPLIANCE WITH EVIDENCE-BASED GUIDELINES

Cancer Program – 2017  
Physician Review – CoC Standard 4.6

## METHODS:

PRIMARY SITE: COLON – Stage 4 Colon Cases

Diagnosis dates July 2014 to Dec. 2014 and Jan. 2015 to June 2015

Look at Diagnostic tests on path and first treatment for stage 4 colorectal cancer based on NCCN Guidelines.

Total colon cases diagnosed July 2014 to December 2014 – 32; 5/32 were stage 4 (16%)

Total colon cases diagnosed January 2015 to June 2015 – 26; 3/26 were stage 4 (12%)

Case	Diagnosis Date	Diagnostic Evaluation Per NCCN Guidelines				Evaluation		
		KRAS	NRAS	BRAF	MSI/MMR by IHC	First Course of Treatment	Treatment Concordant With NCCN Guidelines	Remarks
1	9/11/2014	Mutated	n/a	n/a	Intact MMR	hemicolectomy & chemo, multiple agents (no EGFR)	yes	
2	9/23/2014	Mutated	n/a	n/a	Intact MMR	chemo, multiple agents (no EGFR)	yes	
3	12/30/2014	Wild	Wild	Not done	Not done	Poor PS; hospice	Yes	Pt went to hospice so markers were not indicated
4	10/13/2014	Not done	Not done	Not done	Not done	total colectomy; lost to f/u (not seen as outpatient)	Yes	
5	10/27/2014	Mutated	n/a	n/a	Intact MMR	sigmoid resection only; chemo (no EGFR)	Yes	
6	5/8/2015	n/a	n/a	n/a	n/a	Lost to f/u	n/a	Path: Diagnosed at OSH; lost to f/u
7	5/26/2015	Not done	Not done	Not done	Not done	Lost to f/u	n/a	Pt lost to f/u; not seen at UT Cancer Center
8	6/18/2015	Wild	Wild	Wild	Not done	chemo, multiple agents (hospice after second line so didn't get EGFR)	Yes	

## SUMMARY:

Physician Reviewer: Sukeshi Patel Arora

Date Reviewed: 11/1/17

% of appropriate dx evaluation: 63%

% appropriate treatment: 100%

Date Presented to Cancer Committee: 11/2/17

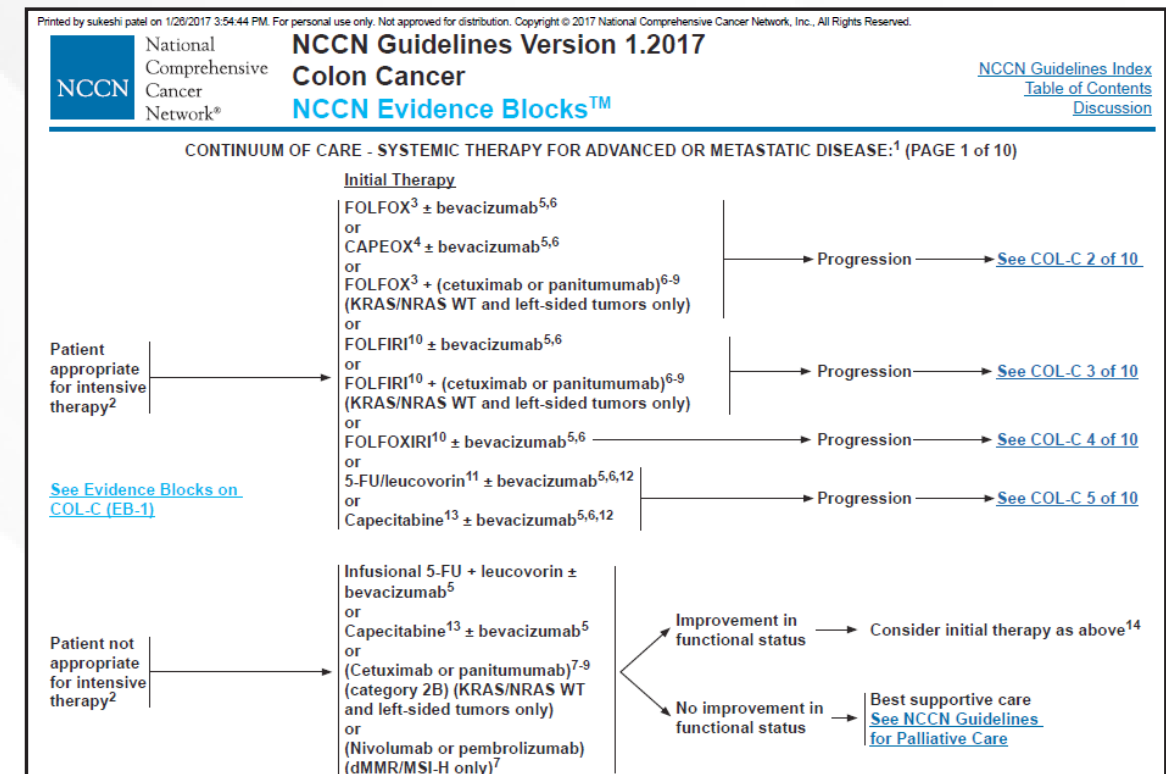
## ANALYSES:

1. Most patients did not have testing done because they were lost to follow-up and did not see oncologist in outpatient setting. Therefore, the ordering of these tests did not impact their care.
2. When KRAS mutated, further NRAS and BRAF testing is not recommended according to NCCN guidelines. We are 100 percent compliant with this.
3. When KRAS or NRAS mutated, EGFR Inhibitors are not given. We are 100 percent compliant with this.
4. Of the patients who had follow-up, appropriate testing was done according to NCCN guidelines.
5. Of the patients who had follow-up, appropriate treatment was given according to NCCN guidelines.

## RECOMMENDATIONS for improvements:

1. Physicians provide appropriate treatment according to NCCN Guidelines.
2. We need to be more consistent with MSI testing. In 2017, we have standardized ordering of RAS, BRAF, MSI for all pts with stage 4 colorectal cancer. Pathology department does reflex testing. If not done, physician will follow-up. MSI should be done routinely in all patients as this guides treatment and genetics testing (NCCN Guidelines).
3. At GI Tumor board, all new patients are presented. During this time, pathology and treating MD should review RAS, BRAF and MSI on all patients.

FOLLOW-UP: This is continuing to be reviewed by the GI Tumor Boards, during which all new patients are being reviewed.





# QUALITY STUDY: NEUTROPENIC FEVER CARE COORDINATION

COC Standard 4.7

Neutropenic Fever Care Coordination

Drs. Kate Lathrop and Sukeshi Patel Aura

Marian Fagbemi, MS1

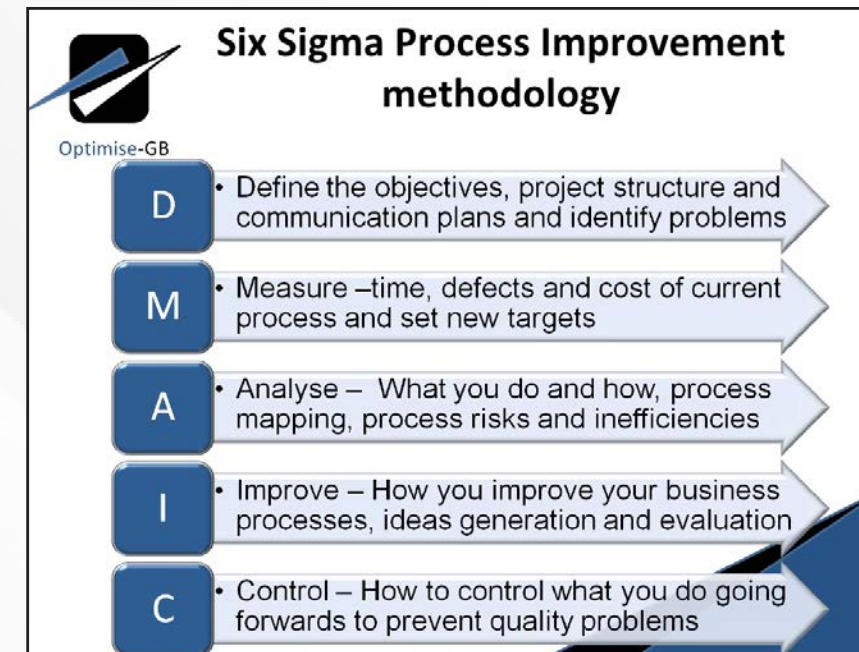
Heather Mendizabal, MS Public Health Candidate

## I. Background

- Chemotherapy decreases the production of neutrophils
- Neutrophils prevent bacterial infections
- Typical lifespan of a neutrophil is about 5-7 days
- Patients are at risk for serious bacterial infection during the period of “nadir” of the white blood cell count
- Often the only symptom is fever defined as greater than 38.0 degrees Celsius or 100.4 Fahrenheit.
- Limited symptoms can make triaging patients with neutropenic fever difficult as they do not meet traditional triage criteria for critically ill patients or a patient with urgent triage needs secondary to an expectation of rapid worsening of condition.
- With delay of care, patients are at risk for developing sepsis, multiorgan failure and death.

## II. Method: Six Sigma Process Improvement

<https://www.ahrq.gov/tools>



## III. Define the Problem

- Objective: Improve care of neutropenic patients with fever presenting for emergency care at University Hospital
- Project structure: Background research, IRB submission, chart review, data collection, data analysis, defining the team members, determining gaps in care, implementing corrective actions, post intervention surveillance.
- Identify problem: Prompt recognition of NF and initiation of treatment

## IV. Measure

- Data collection:
  - Chart review for 8 patients within University Health System (UHS) over a period of 3 months (7/5/17 – 9/6/17).
  - Patients who are  $\geq 18$  years of age, have had an encounter for neoplastic chemotherapy within UHS, and who have presented to the emergency room with febrile neutropenia (ICD 10 code D70.9 or D50.81).
  - Collected time of arrival to emergency room, time of vital signs taken, time of first contact with a provider, time of CBC draw, time of blood culture, time of antibiotic administration, and total time spent in the emergency room.
- Data analysis: Average times from patient check in at the ED
  - 8 minutes for a patient’s vital signs to be taken
  - 33 minutes to be seen by a provider
  - 90 min for resulted CBC,
  - 135 min for a blood culture
  - Average time before antibiotics were administered was 5 hours and 47 minutes, with a total emergency room stay average of 10 hours and 8 minutes.

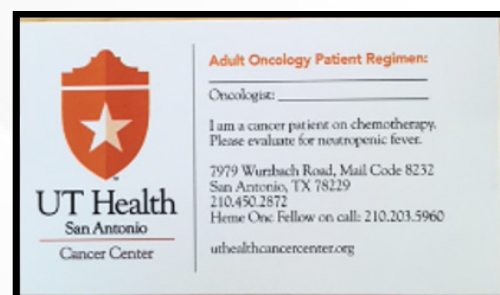
## V. Analyze and Identify Gaps

- Establishing a common algorithm for treatment
- Combined educational sessions with Hem-Onc and ED staff
- Shared patient outcome goals

National Comprehensive Cancer Network NCCN Guidelines Version 1.2018 Prevention and Treatment of Cancer-Related Infections		
<b>CLINICAL PRESENTATION</b>  Fever: • Single temperature equivalent to $\geq 38.3^{\circ}\text{C}$ orally or • Equivalent to $\geq 38.0^{\circ}\text{C}$ orally over 1-h period  Neutropenia: • $< 500$ neutrophils/mcL or • $< 1000$ neutrophils/mcL and a predicted decline to $\leq 500$ /mcL over the next 48 h	<b>INITIAL EVALUATION OF FEVER AND NEUTROPENIA</b>  • Complete H&P including supplemental history: ▶ Major comorbid illness ▶ Time since last chemotherapy ▶ Recent antibiotic therapy/prophylaxis ▶ Medications ▶ Use of devices • Epidemiologically relevant exposures (eg, marijuana use, cigarette smoking) • Laboratory/radiology assessment: ▶ CBC including differential, electrolytes, chemistry panel, and LFTs ▶ Consider chest x-ray and urinalysis	<b>MICROBIOLOGIC EVALUATION</b>  • Blood culture x 2 sets (one set consists of 2 bottles). Options include: ▶ One peripheral + one catheter (preferred) <sup>a</sup> or ▶ Both peripheral or ▶ Both catheter (if unable to obtain a peripheral blood) • Urine culture (if symptoms, urinary catheter, or abnormal urinalysis) • Site-specific culture: ▶ Diarrhea ( <i>Clostridium difficile</i> assay, enteric pathogen screen) ▶ Skin (aspirate/biopsy of skin lesions) ▶ Vascular access cutaneous site with inflammation (consider routine/fungal/mycobacterial) • Viral diagnostics: ▶ PCR- and DFA-based tests ▶ Vesicular/ulcerated lesions on skin or mucosa ▶ Throat or nasopharynx for respiratory virus symptoms, especially during outbreaks

## VI. Improve

- December 15 2017 – start of new triage system
  - Patients will be provided a card that identifies them as a patient at risk for neutropenic fever
  - This is “trigger” an up triage level for urgent evaluation, even in the setting of normal vitals
  - Modeled after “Code Howie” in pediatrics



## VII. Control

- Repeat analysis planned for March – May 2018
  - Expected outcomes include”
  - Decrease in time to lab draw for CBC, blood and urine cultures
  - Decrease time for antibiotic administration for patient with neutropenic fever
  - 100% notification of on call oncologist for coordination of additional outpatient vs. inpatient care.
  - Compliances with NCCN management guideline

# QUALITY STUDY: HOSPICE ENROLLMENT

2017 Studies of Quality – CoC Standard 4.7 – Dr. Kate Lathrop

“Hospice Enrollment and Enrolled More Than Seven Days Before Death” is a quality measure endorsed by ASCO’s Quality Oncology Practice Initiative (QOPI). For patients nearing end of life, particularly cancer patients, late referrals to hospice remain a quality-of-care issue. According to the National Quality Forum (NQF) report for National Voluntary Consensus Standards, Palliative Care and End of Life Care promotes measures that assess coordination of care, such as hospice referral. The consensus report states that referral to hospice is associated with less aggressive and less costly care for patients nearing end of life, and may extend survival for some patients. We sought to evaluate if our advanced cancer patients were receiving appropriate end of life care and if this standard was being achieved.

To address this question, we reviewed charts of University Hospital System patients from July 1, 2017 to Oct.1, 2017 who were admitted secondary to symptoms from advanced cancer where a referral to palliative care and potentially to hospice services would be appropriate. Chart review and patient selection was made by a faculty medical oncologist. In reviewing these charts, we collected data on date of palliative care consultation, whether hospice services were provided, date of hospice enrollment, and date of death is applicable. Our main outcomes measure was percentage of patient enrolled in hospice more than seven days prior to death as is the outline quality measure from ASCO. This study was reviewed by our institutional review committee and determined to be non-research quality improvement.

Our analysis concluded that on average, the time between hospital admission and palliative care consultations was 2.8 days. The average time between hospital admission and hospice enrollment was 9.1 days. The average time between hospital admission and death was 20.7 days. We also concluded that the average time between palliative care consultation and hospice enrollment was 6.6 days, and the average time to death after enrollment was 15.5 days. The study size was the main limitation of our study. Of the 31 patients identified as potential study subjects, only 11 subjects met all of the criteria for analysis.



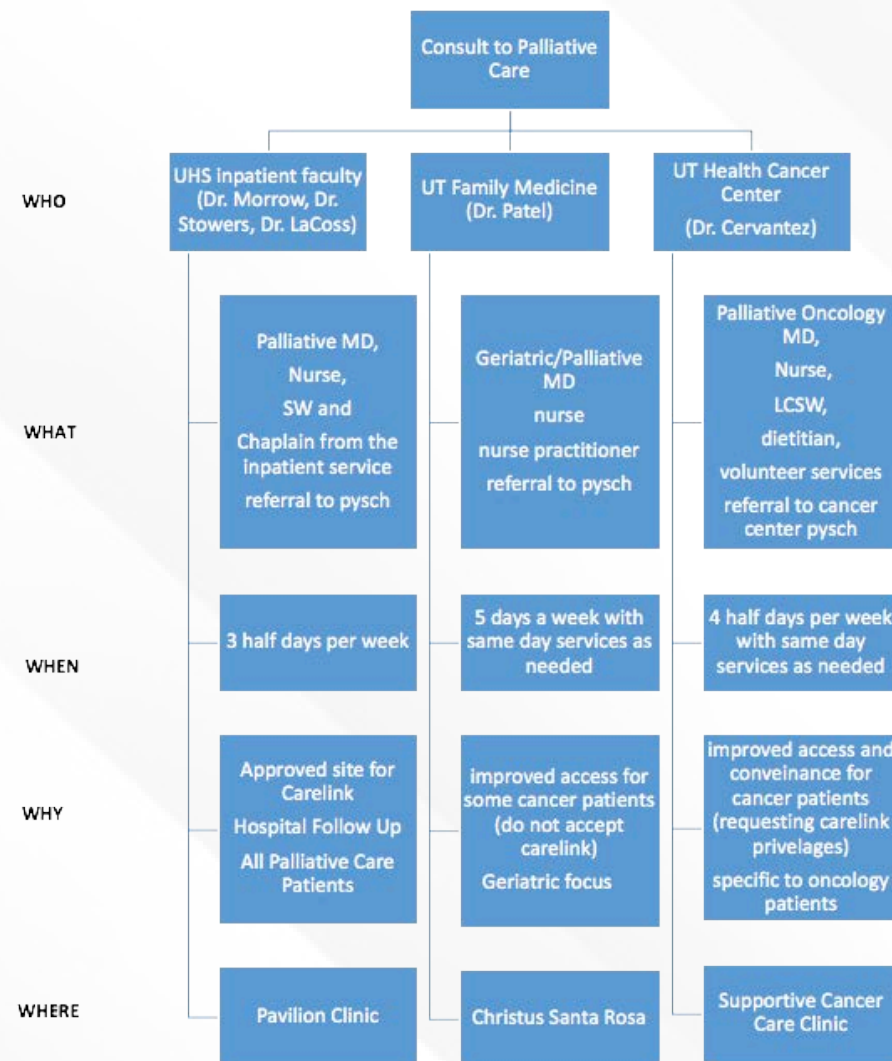
Thus, we currently are meeting the suggested ASCO's Quality Oncology Practice Initiative (QOPI) standard of enrollment of enrollment into hospice more than 7 days prior to death for our patients with advanced cancers. This achievement is likely secondary to a very active inpatient palliative care service that is available at our institution. However, this study also points to potential areas of improvement. Particularly, the six-day period between palliative care consultation and enrollment into hospice may represent a lack of advanced end of life care planning prior to admission for an acute medical issue. We are hopeful that this will be addressed through a new outpatient Supportive Cancer Care clinic located at our cancer center and directed by a physician who is dual trained in medical oncology and hematology as well as palliative medicine. This is a multidisciplinary clinic that includes physicians, social workers, nutritional services, pharmacy support, and advanced oncology nursing support. We anticipate this service line will help integrate our inpatient and outpatient palliative care services and hopefully allow more opportunity for advance care planning and communication among providers with the ultimate goal to provide seamless and high quality end of life care for our patients with advanced malignancy. Specifically, with the addition of the new Supportive Cancer Care clinic, there will be three pathways for the cancer center referrals to palliative care in association with UT Health. They are outlined below.

# CANCER CONFERENCES

Multidisciplinary Cancer Conferences bring together providers, administrators, and support staff to improve care for our patients. University Health System's partnership with UT Health San Antonio Mays Cancer Center provides multidisciplinary discussion through daily cancer conferences. Each case discussion includes medical history, radiologic and pathologic findings, staging, prognostic indicators, discussion of national treatment guidelines, treatment planning, possible clinical trial availability and psychosocial issues.

2017 UHS/MAYS CANCER CENTER TUMOR BOARDS							
TUMOR BOARDS	TOTAL NUMBER OF MEETINGS FOR 2017	TOTAL NUMBER OF CASES PRESENTED FOR 2017	Prospective Cases Presented	STAGING and Guidelines Discussed	Options for Clinical Trial Discussed	Adherence to Policy	Multidisciplinary Attendance
BREAST	48	378	320	YES	YES	YES	YES
GI	45	127	127	YES	YES	YES	YES
GU	23	124	124	YES	YES	YES	YES
HEME PATH	38	74	74	YES	YES	YES	YES
HEAD AND NECK	0	0	0	N/A	N/A	N/A	N/A
LIVER	36	206	206	YES	YES	YES	YES
NEURO-ONCOLOGY	22	110	110	YES	YES	YES	YES
PANCREAS	43	180	180	YES	YES	YES	YES
SARCOMA	45	159	159	YES	YES	YES	YES
THORACIC	43	158	158	YES	YES	YES	YES
GYN		0	0	N/A	N/A	N/A	N/A
Total	343	1516	1496	YES	YES	YES	YES

\*Data Collected from Mays Cancer Center Tumor Board Staff, CME Department.



## 2018 COC Nursing Report by Geary Lynn Delgado, RN, BSN, CPN

The University Health System oncology nurses and other members of the Oncology Department family are a unique network of professionals that come together to provide a lasting sense of healing and community for our oncology patients.

In addition to the Oncology Nursing Society-certified and specially trained oncology nursing staff, our community includes physicians, social workers, a physical therapist, dietitians, and support staff that utilizes an array of methods to ensure the highest level of care for our patients. We do this by providing a top-down approach that supports our patients along their journey from the moment they walk through the door.

The oncology nurses at University Health System participate and coordinate events that benefit our patients, such as the 2018 Bone Marrow Donor Registry Drive which was held at University Hospital in May 2018.

Our oncology nurses receive annual training and have specialized skill sets, including training in the administration of chemo and biotherapy, and management of the symptoms and side effects that patients experience as a result of cancer and chemotherapy. In the Oncology Department at University Health System, we believe that integrating the community at large including, family, friends and other familiar support systems allows our patients to rest easy with the knowledge that we are here to assist them in all facets and stages of their care.

## Clinical Research Enrollments

### Standard 1.9: Clinical Research Accrual

Anna Taranova, MD, MS, CCRP, Executive Research Director, UHS

Deidre Winnier, PhD, Director of Clinical Research, UHS

Tiffany Mince, MHIM, RHIA, Assistant Director of Research Compliance, UHS

In order to achieve Standard 1.9: Clinical Research Accrual; a research coordinator must document and report annually, research study enrollment information to the cancer committee with regards to how many cancer patients are enrolled within Clinical Research Trials, this may include both Clinical as well as Observations studies.

The annual average analytic caseload for University Health System in 2015 was 1,350. In order to achieve 6 percent, which is the minimum for compliance, 81 patients required to be enrolled. To receive commendation percentage, patient accruals would require 8 percent, totaling 108 patients. Actual University Health System patients enrolled in clinical trials totaled 127. This total was reported to the Health System's Cancer Committee on Sept. 1, 2016.

The annual average analytic caseload for University Health System 2016 is 1,275. In order to achieve 6 percent, which is the minimum for compliance, 77 patients required to be enrolled. To receive commendation percentage, patient accruals would require 8 percent, or 102 patients. Actual University Health System patients enrolled in clinical trials totaled 212. This total was reported to the Cancer Committee on Dec. 1, 2016.

The annual average analytic caseload is for University Health System in 2017 is 1,403. In order to achieve 6 percent, which is the minimum for compliance, would require 84 patients need to be enrolled. To receive commendation percentage, patient accruals would require 8 percent, or 112 patients Actual University Health System patients enrolled in clinical trials totaled 227. This total was reported to the Cancer Committee on Dec. 7, 2017.



Since 2015, the University Health System Clinical Research Department has received the commendation percentage regarding Standard 1.9: Clinical Research Accrual, as each year the patients enrolled on clinical trials has been over the commended 8 percent of the analytic caseload.

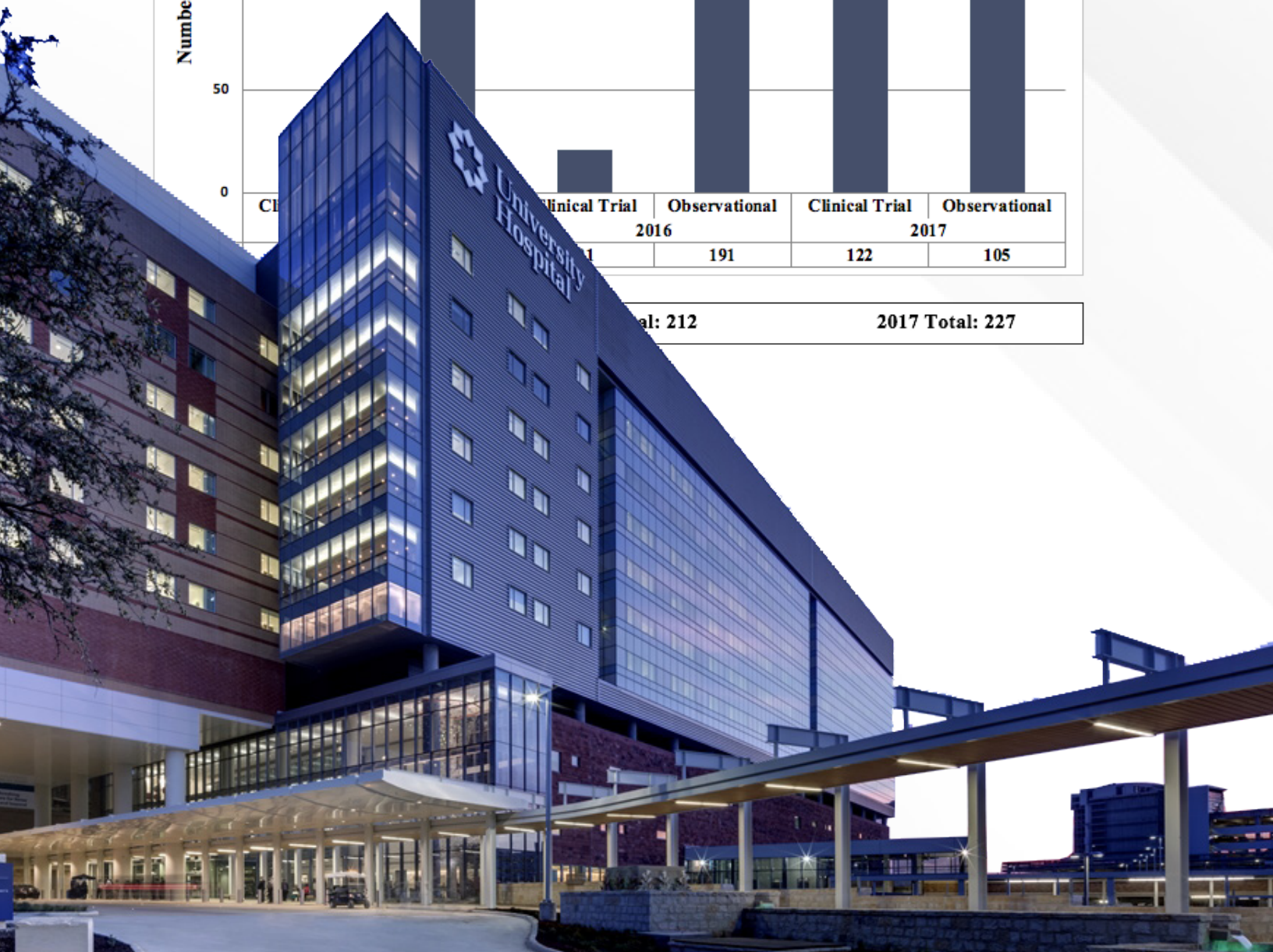
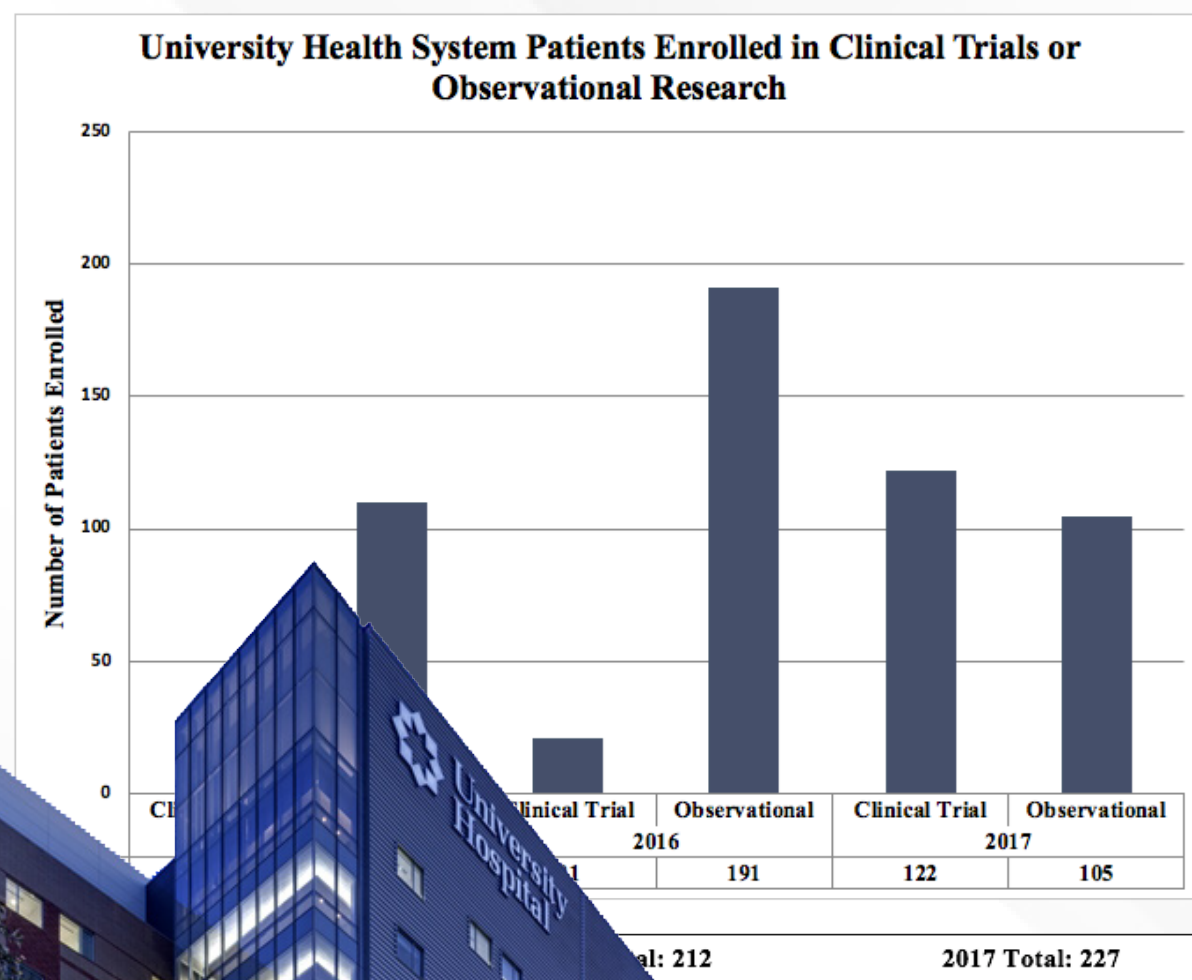
## SOCIAL SERVICES

Psychosocial Care Report 2018 by La Trecee' Leeper, LMSW, Psychosocial Distress Coordinator

La Trecee' Leeper, LMSW at University Health System provides psychosocial support to patients and families. She works with patients and families to identify stressors in their immediate family and provides resources to address the stressors identified. She collaborates with physicians, nurses and other support staff closely to further identify patients in need of psychosocial support. Psychosocial screenings are conducted during the Initial Discharge Assessment by the social worker and acute signs of distress are addressed within 24 hours.

### Concrete Services:

- Financial: Assessment of all financial needs. Coordinates with Med Data regarding MCD/SSI assessments. Referrals to CareLink for unfunded in county residents, coordinates the completion of application and gathering of documents for review.
- Transportation: Referral forms completed and sent to American Cancer Society and Thrive Well for assistance.
- Housing: Advocacy letters to support housing applications, assisted living/skilled nursing facility referrals, rental assistance program referrals provided.
- Family: Letters to the Mexican Consulate, Jail or Prison system provided.
- Food: Referrals to SNAP, Meals on Wheels and various Food pantries provided.
- Employers: Aides in the completion of FMLA or Leave of Absence forms.
- Hospice: Discuss hospice benefits with patients and families.
- Addresses all psychosocial needs with the patients and their families.
- Works closely with the pharmacy regarding medication securing for patients that are affordable.





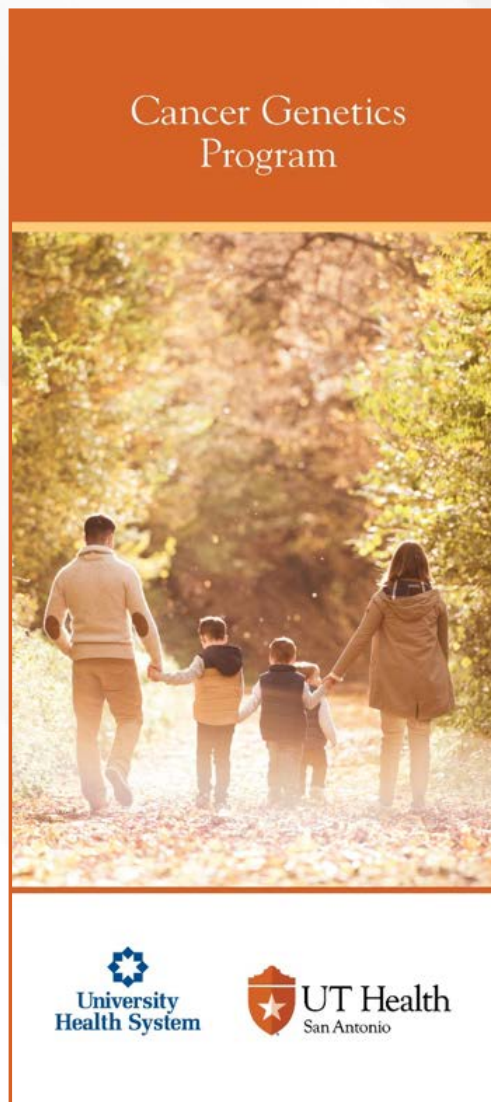
## Cancer Genetics Program

To keep with the mission of providing comprehensive care to patients, genetic counseling is offered at UT Health by a board certified genetic counselor, Anusha Vaidyanathan. The staff at the cancer genetics clinic includes surgical oncologists, medical oncologists, genetic counselors, radiologists, plastic surgeons, gastroenterologists, endocrinologists and gynecologic oncologists. This clinic aims to provide tailored cancer risk assessment and management recommendations to individuals and families in San Antonio. Hereditary cancers occur due to changes (mutations) in specific genes passed down through generations. Individuals with these changes, along with their family members, may be at higher risk of developing specific cancers during their lifetime.

## Services

Our genetic counselor conducts a detailed genetics evaluation, educates patients and family members on hereditary cancer disorders, promotes informed decision making, coordinates genetic testing and, interprets test results for patients and medical providers. Positive genetic test results can change medical interventions and available treatment options to improve outcomes. Individuals with a positive result meet with several staff physicians to determine further screening and management options.

The Genetics program in 2017 evaluated more than 350 patients. Of these patients, 87 percent met current guidelines for genetic testing. A 10 percent positive genetic mutation rate for was observed in our patient population.



## Quality:

The genetic counselor is part of several professional societies such as National Society of Genetic Counselors (NSGC) and Texas Society of Genetic Counselors (TSGC). Additionally, participation in Cancer genetics webinar series, annual conferences as well as quarterly meetings with South Texas Genetic Counselors help our cancer genetics staff stay abreast of the most current literature and recommendations for hereditary cancer conditions.

In keeping with providing quality care to all individuals, the genetics clinic uses telephone Spanish translators for Spanish speaking patients to promote patient autonomy and facilitate better communication. All patients seen at the clinic are also evaluated for psychosocial well-being in addition to hereditary cancer syndromes. In addition to clinical work, educational opportunities including meeting with a genetic counselor and shadowing have been made available to high school and undergraduate students interested in pursuing genetic counseling as a career. The genetic counselor participated at the colon cancer awareness event "Give Cancer the Boot" which took place in March and provided information to the public on hereditary colon cancer disorders.

## Growth

In the past year, efficient workflows for patient care have been established to reflect the recent changes in National Comprehensive Cancer Network guidelines for genetic testing. The year has also seen an addition of a Genetic Counseling assistant to the clinic staff. This position has allowed for an increase in the number of patients seen by the genetic counselor per week.

The genetics grand rounds brings together medical oncologists, surgical oncologists and genetic counselors to discuss treatment and follow up for complex diagnoses. The cancer genetics program is committed to collaborating with multiple oncology divisions to remain at the forefront of screening for hereditary cancer conditions.





## Outpatient Rehabilitation Report 2017

### Breast Cancer Program

Reeves Rehabilitation Center – Ambulatory provides the following rehabilitation services for breast cancer patients referred to the department:

1. Preoperative education class or one on one session addressing the following:
  - a. Education regarding possible post operative musculoskeletal complications of pain, swelling and range of motion.
  - b. Education about lymphedema
  - c. Taking preoperative girth measurements of arm(s) that might be affected with surgery
  - d. Provide written home exercise program for shoulder range of motion
  - e. Issue home use pulley system to assist with shoulder range of motion
  
2. Post operative evaluation and treatment for:
  - a. Shoulder pain and/or range of motion related concerns
  - b. Lymphedema

Referrals received	85
# of patients scheduled	66 (78%)
# of patients who arrived for scheduled visit	58 (88%)
# of patients who no showed for scheduled visit	8 (12%)
# of patients not scheduled	19 (22%)

Main reasons for not scheduling patients: Patient denial, unable to reach patients, denied by insurance plan, and deceased.

In 2017, 85 patients were referred from the Cancer Therapy Research Center (CTRC) for Occupational Therapy services. The following describes department follow through with the 85 referrals:

The therapy clinic continues regular communication with the clinic via electronic medical record and other means to ensure efficient care delivery and improve patient outcomes.

Please direct any ambulatory rehabilitation services related questions to Amit Mehta, Executive Director bulatory Rehabilitation and Orthopedics, at 210-358-1056.





# COMMUNITY OUTREACH

University Health System Community Outreach and Prevention Programs work in partnership with UT Health and under the guidance of the Commission on Cancer Committee. This department plays an important role in the community to help educate and reach the people with the most need in Bexar County.

Our outreach services work with patients individually to assist with any needs to include financial concerns, paperwork and assisting in scheduling appointments. This department offers support with connecting patients to various resources in the community to include organizations such as American Cancer Society. University Health System also offers various navigation programs to include an onsite patient navigator employed by American Cancer Society housed at the Mays Cancer center to assist in navigating patients once diagnosed.

In the past year after the discussion and approval by the CoC committee it was decided to focus on outreach and education for colorectal cancer screenings.

## • Highlights:

- The colorectal screening program follows U.S. Preventive Services Task Force recommendations
- Evidence-based program evolved from recognized need for screening to reduce mortality due to colorectal in Bexar County
- As of December 2013, only 3 percent of CareLink\* men and women had a known colonoscopy

## • Focus for 2017 year:

- Colorectal screenings
- Cancer Prevention Research Institute of Texas (CPRIT) grant to provide 980 screenings until June 2018
- 2017 goal is to complete 520 screenings
- Program components
  - Patient navigation for University Health System patients
  - Funding for screening for CareLink patients
  - Funding for transportation for University Health System patients

\*CareLink is a financial assistance program offered by University Health System to Bexar County residents.

Total of four screening events held from May 16, 2017 to Oct. 27, 2017 with a total attendance of 29. Two patients identified with unknown cancer stage and 1 identified with localized tumor. Some of the common barriers identified are financial, scheduling and transportation issues. This was addressed by integrating the family into the decision-making process, and providing cultural and social support for procures and assisting the patient to understand the scheduling process.

Other outreach events include participating in Komen Walk for the Cure, American Cancer Society Relay for Life, and Real Men Wear Gowns colorectal education segment on the local news channel.





# PALLIATIVE CARE SERVICES

From an internally maintained databases, there were a total of 794 of 1,236 inpatient consults for Palliative Care in 2017 based on non-overlapping search terms. These terms included:

447 CA + 132 omas + 33 HCC + 25 mass + 11 BC + 80 carc + 1 VHL + 10 ALL + 10 SCC + 26 RCC + 7 AML/CML + 4 NSCL + 1 histio + 1 lymphoproliferative + 1 esophagectomy + 5 tumor.


That's 794 unique cancer patient consults representing 794 unique admissions and 64% of Palliative Care inpatient consultations. The search terms are not reliable for distinguishing the volume or percentage of types of cancer ("CA" is pretty vague).

The most common reason for consultation is cancer pain, which is about 60%. The next most common reason at about 30% is other symptoms including N/V and dyspnea. "Goals of care" represent the rest. However, "goals of care" is frequently a secondary indication for consultation.

In the outpatient setting, we saw about 475 patients, most of whom had cancer, about 75%.

The Palliative Care inpatient consultation service available every day of the year for patients with cancer and other conditions. Our clinic is available 3 half-days per week.

Cancer patients can rely upon comprehensive and expert supportive care from a highly-trained team of interdisciplinary professionals. We have 3 doctors who rotate inpatient and outpatient, 2 APRNs who provide inpatient consultation M-F, and interdisciplinary team members available inpatient and outpatient as needed, including 2 Palliative Care chaplains, a dedicated Social Worker, a team nurse, an Advance Care Planning facilitator who is also Clinic Manager, an Operations Manager, and a Nurse Director. We also have a Pediatric Palliative Care team that includes 2 doctors, an APRN Director, a Child Life specialist, and a chaplain. The Pediatric team is not represented in the above data. They offer inpatient consultation every day and a Complex Care Clinic during the week.




UT MEDICINE  
**CTRC**  
HEALTH SCIENCE CENTER  
SAN ANTONIO

**Delays in Treatment for Colorectal Cancer Patients in an NCI-designated Cancer Center, Serving a Hispanic Majority Community**

Tamna Wangjam, MD<sup>1</sup>, Sherri L. Rauenzahn, MD<sup>1</sup>, Praveena Iruku, MD<sup>1</sup>, Stephanie P. Lindauer, MD<sup>1</sup>, Matthew J. Butler, MD<sup>1</sup>, Annie Hung, MD<sup>1</sup>, Kinan Yarta, MD<sup>1</sup>, Jessica T. Jones, MD<sup>1</sup>, Brandon Konkel, MD<sup>1</sup>, Andrew McCracken, MS<sup>2</sup>, Sukeshi R. Patel, MD<sup>1</sup>.

<sup>1</sup>University of Texas Health at San Antonio/ Cancer Therapy and Research Center, <sup>2</sup>Research & Information Management, University Health System, San Antonio, TX



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### INTRODUCTION

- Timeliness of cancer treatment is an important aspect of health care quality.
- Colorectal cancer (CRC) care requires the coordinated multidisciplinary effort of various aspects of the health care system, which can lead to delays between initial diagnoses to definitive therapy.
- Little is known about the time from diagnosis to cancer-directed treatment, neither about the factors that cause delays or its effect on patient outcomes.
- Delays to curative surgery beyond 12 weeks are associated with increased mortality in CRC.
- Longer time to adjuvant chemotherapy is associated with worse survival among patients with resected CRC.

### OBJECTIVE

The objective of our study is to identify delays in initiation of CRC treatment and its causative factors in our patient population.

### METHODS

- We retrospectively reviewed the medical records of CRC patients who were either initially diagnosed or had initial surgical resection at University Hospital and had further treatment at Cancer Therapy and Research Center, between 7/1/2010 and 12/22/2014.
- Data were collected on patient and disease characteristics, treatment timelines and outcomes, till pre-specified data cut-off date of 8/1/16.

### RESULTS

- Of 256 patients treated for CRC, majority were males (59%), Hispanic (59%), uninsured (34%), had non-metastatic disease (70%).

Characteristic	Count (n)	Percentage (%)
Age <55	96	37.5%
Age ≥55	160	62.5%
Gender Male	151	59.2%
Gender Female	104	40.8%
Ethnicity Hispanic/Latino	151	59.2%
Ethnicity White, Caucasian	79	31.0%
Ethnicity African American	15	5.9%
Marital Status Single, never married	80	31.4%
Marital Status Married	104	40.8%
Marital Status Separated	13	5.1%
Marital Status Divorced	34	13.3%
Marital Status Widowed/Widower	24	9.4%
Insurance at diagnosis Self-pay	86	34.1%
Insurance at diagnosis Carelink	86	34.1%
Insurance at diagnosis Medicaid	35	13.9%
Insurance at diagnosis Medicare	35	13.9%
Insurance at diagnosis Private insurance	37	14.7%
Insurance at diagnosis TRICARE/VA Health Benefits	3	1.2%
Primary language English	193	75.7%
Primary language Spanish	59	23.4%
Primary language Neither English or Spanish	4	1.6%
Primary language Not recorded/Unknown	3	1.2%
Site of CRC Colon	99	39.6%
Site of CRC Sigmoid	61	24.4%
Site of CRC Rectal	71	28.4%
Site of CRC Recto-sigmoid	15	6.0%
Site of CRC Unknown/not clear	4	1.6%
Clinical cancer stage at diagnosis Non-metastatic	175	69.7%
Clinical cancer stage at diagnosis Metastatic	76	30.3%

### CONCLUSION

Hispanic patients were more likely to have a longer time from diagnosis to treatment compared to non-Hispanic patients. The factors for such disparities in health care quality and their effect on survival needs to be explored further in larger studies.

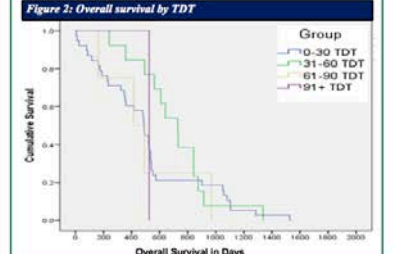
### ACKNOWLEDGEMENT

Abstract Number: 178  
The authors would like to thank all participants & staff involved in this project.  
For additional information, please contact: Tamna Wangjam, MD at [Wangjam@utcrca.edu](mailto:Wangjam@utcrca.edu) University of Texas Health at San Antonio, SA, TX.

### Figure 1: TDE percentage of Non-Hispanic and Hispanic Patients

Time from diagnosis	Non-Hispanic (%)	Hispanic (%)
0-30 Days from diagnosis	44.30	55.7
31-89 Days from diagnosis	36.60	63.4
≥90 Days from diagnosis	23.10	76.9

### Figure 2: Overall survival by TDT







# CANCER COMMITTEE MEMBERS

**Sukeshi Patel Arora, MD**  
Committee Chair

**Pamela Otto, MD**  
Cancer Liaison Physician

**Kenneth Kist, MD**  
Cancer Liaison Physician (A)

**Kate Lathrop, MD**  
Medical Oncology

**Sukeshi Patel Arora, MD**  
Medical Oncology (A)

**Edward Kost, MD**  
Surgery, GYNONC

**Mio Kitano, MD**  
Surgery (A)

**Philip Valente, MD**  
Pathology

**Daniel Mays, MD**  
Pathology (A)

**Pamela Otto, MD**  
Diagnostic Radiology

**Kenneth Kist, MD**  
Diagnostic Radiology (A)

**Zheng Shi, MD**  
Radiation Oncology

**Richard Crowover, MD**  
Radiation Oncology (A)

\*(A) – Alternate Member

**Theresa De La Haya**  
Sr. Vice President  
Cancer Program Administrator

**Eric Dahl BSN, RN**  
Cancer Program  
Administrator (A)

**Geary L. Delgado, BSN, RN,  
CPN**  
Oncology Nurse

**Eva Eastham, RN**  
Oncology Nurse (A)

**La Trecee Leeper, LMSW**  
Social Worker  
Psychosocial Services Coordinator

**Regina Reed**  
Social Worker (A)

**Cynthia Evans, BA, LVN, CTR**  
Certified Tumor Registrar  
Cancer Registry Quality Coordinator

**Deanna Rodriguez, CTR**  
Cancer Registry Quality Coordinator  
(A)

**Jason Morrow, MD**  
Palliative Care

**Erin Perez**  
Palliative Care (A)

**Anusha Vaidyanathan,  
MS, CGC**  
Genetics Counselor

**Deanna Rodriguez, CTR**  
Cancer Conference Coordinator

**Sarah Herrera, CTR**  
Cancer Conference  
Coordinator (A)

**Katherine Diaz**  
Community Outreach Coordinator

**Anna McAndrew**  
Community Outreach (A)

**Carol Mancinas**  
Quality Improvement Coordinator

**Kristi Hill-Herrera**  
Quality Improvement Coordinator  
(A)

**Anna Taranova, MD**  
Clinical Research Coordinator

**Tiffany Mince, RHIA, BSHIM**  
Clinical Research  
Coordinator (A)

**Leticia Puente**  
Oncology Patient Navigator

**Amit Mehta PT, DPT, MBA**  
Rehabilitation Services

**Simone Lewis**  
American Cancer Society

**Bob Pfenning**  
Pastoral Care

**Gary Hill**  
Pharmacist

**Eileen Lundin**  
Cancer Survivor/Advocate

**Sandi Stanford**  
Cancer Survivor/Advocate





# University Health System

