NEW YORK - PRESBYTERIAN QUEENS

Standard 1.12: 2018 Public Reporting of Outcomes

Standard 4.1 Cancer prevention

Prevention & Early Detection

Community Need addressed: Lung cancer represents about 15% of our newly diagnosed cancers, second only to breast cancer however local death rates for lung cancer is the highest at nearly 25%. In Queens, this is largely attributed to smoking among our recent immigrant and undocumented populations. Second hand smoke is also a cause for concern. After review of our local data the Committee has voted to focus on lung cancer for our prevention and screening efforts in 2018.

Activities: NYPQ provided screening and referral of eligible patients for CT Lung Cancer Screening for community providers. The program was developed by the Department of Cardiothoracic Surgery provides screening for eligibility, insurance preauthorization, scheduling of tests, follow up of test results, sending results to the provider and arranging post-test referral and care, as necessary

Cancer Site for 2018: Lung

Date Held: The programs were held throughout the year

Number of participants: 20 lung prevention programs with 1,189 participants

Guidelines Used: NCI; NCCN; ASCO

Discussion: The lung cancer screening events were well received and successfully reached over 1100 people in Queens. NYPQ is committed to formally expand the program going forward. We needed our clinical providers, community based organizations, and volunteers from NYPQ to join us in reaching the community. We had to ensure this was a collaborative event so that anyone in need of lung cancer screening would be able to access services across our Borough. Our goal was to direct referral to anyone in need of lung cancer screening. staff hours, meeting space, small media, money) were needed for the activity. Going forward, we look to expand the program by linking CT lung cancer screening to smoking cessation and counseling.

Summary: These programs were highly effective in reaching out to a highly diverse population according to age, race and ethnicity, taking into account the unique demographic diversity of the Borough of Queens. The educational events were very useful in educating the public, many of whom are medically underserved, about the need for lung cancer screening, how to evaluate their own risk and providing information and how to obtain screening services

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Additional Educational Activities for 2018: - Educational workshops to date were 71

Cancer Sites: Breast, Colon, Cervix

Date Held: The programs were held throughout the year

Guidelines Used: NCI; NCCN; ASCO

Ms. Xouris Reported the following: In 2018 from January to September 30th screenings were performed as follows:

Site	Screening	# of Screenings Performed	Cancers Found
Breast	Mammograms	2,153	Invasive breast cancer 12 , Other carcinoma in-situ, including ductal = 11
Cervix	Pap& Pelvic	920	Invasive Cervical cancer = 0 CIN III , severe Dysplasia, Carcinoma insitu = 4
Colorectal	Colonoscopies FIT KITS	35 356	Colorectal cancer = 0 Adenomatous polyp = 12

Discussions/Summary:

We began planning this activity last March, following the success of the Prevent Cancer Foundation's Super Colon at the Queens Mall. We knew this event was worth repeating and began plans to do it again almost immediately. Planning event for over a year, with most implementation in last 4 months leading up to event.

Personnel were the greatest resources needed to have a successful event. We needed our clinical providers, community based organizations, and volunteers from NYPQ to join us in reaching the diversity of the Queens Mall shoppers. We had to ensure this was a collaborative event so that anyone in need of colorectal cancer screening would be able to access services across our borough. Our goal was to distribute FIT kits, or provide direct referral to anyone in need of colon cancer screening. It would not have worked if only one provider (NYPQ) was there. Once we knew that our partners shared our enthusiasm for this event, and staff were dedicated to it, financial support became the next vital resource. Renting the Prevent Cancer Foundation Colon and space at Queens Mall is truly expensive.

If there were costs related to this activity, what funding sources were used (e.g., NYSDOH/CSP infrastructure funds, partner funds, etc.?)

We used our COLA funds provided by NYS to finance most of this day. COLA funds covered the cost of space, colon, giveaways, photographer and advertisement. Each clinical provider and community-based organization at the event incurred cost related to staffing the event as well as cost related to site specific giveaways.

The evening before the Super Colon was scheduled, March 2nd, 2018, New York experienced the brunt of a northeast winter storm, culminating in 50-60 mile an hour winds. All trains from Virginia were canceled due to the high winds. Many bridges were closed too, unsafe due to the excessive winds. The Prevent Cancer Foundation (PCF) called us the night before the big event telling us that their staff could not make it to our area due to the bad weather and that the event had to be canceled. After much negotiating on our end we were able to locate PCF staff person in the Brooklyn area who was able to attend our event the next morning and take responsibility for

setting up the Super Colon display. The event took place the next day and it was extremely successful due to teamwork and perseverance.

Despite the weather we had a great turnout. Over 1,300 men and women over the age of 50 walked through the Super Colon and learned the importance of colon cancer screening. Once again, the Prevent Cancer Foundation invited all of our clinical participants to join them at the 2018 Dialogue for Cancer being held in Virginia. They again waived registration fees for anyone interested in attending.
Another great success was having Senator Leroy Comrie and his team attend our event and speak to the crowds. He stressed his continued support for the CSP, and encouraged all to be screened. He commented on the uniqueness of so many clinical providers working together, not competing for those in need of screening.
Events such as this bond our partnership, another success achieved. Working together on a level playing field such as the Queens Mall demonstrates our shared commitment to the people of Queens.

We learned we are resourceful and capable. The show must go on! We learned not to give up when feeling rejected, but to persevere!

We held a debriefing with all staff following our Super Colon. There is not much we would do differently. We felt this year went much smoother than last, despite the weather.

Although our providers and CBO's would like this to be an annual event, the cost may be too great. A decision to repeat this activity will be based on available funding next year.

Standard 4.4 & 4.5 Accountability Measures

BCSRT - Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer (Accountability)
Expected (Estimated Performance Report) EPR – 95%

2013 – 92(92- 99.8) 2014 94.7% (90.2. -99.2%)
2015 – 86.4 (79.2- 95.2%) 2016 99.2%(84.4 -96%)

HT - Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or stage IB-III hormone receptor positive breast cancer (Accountability)
Expected (Estimated Performance Report) EPR – 95%

2013 98.4% (96.2 -100%) 2014 95.8% (92.2 -99.4%)
2015 91% (85.7 -96.3%) 2016 97.6% (94.9 – 100%)

MASTRT - Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with >= 4 positive regional lymph nodes (Accountability)
Expected (Estimated Performance Report) EPR – 95%

2013 82.4% (64.3 -100%) 2014 86.7% (69.5 – 100%)
2015 75% (50.5- 99.5%) 2016 100% (100- 100%)

MAC - Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0, or stage IB - III hormone receptor negative breast cancer (Accountability)
Expected (Estimated Performance Report) EPR – Not Applicable

2013 92.3 (82.1 -100) 2014 85.3% (73.4 -97.2%)
2015 95.2% (86.1 -100) 2016 100% (100 -100%)

ACT - Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer (Accountability) Not Applicable

2013 – 100%(100- 100) 2014 100% (100 -100)
2015 90% (76.9 -100) 2016 87.5%(71.3 -100)

Standard 4.5 – Quality Improvement

nBx - Image or palpation-guided needle biopsy (core or FNA) is performed to establish diagnosis of breast cancer. Expected (Estimated Performance Report) EPR – 95%

2013	91.6% (87.9 -95.3)	2014	94.7.1% (91.8 -97.6)
2015	97.2% (95-99.4)	2016	8.9% (88.6- 95.5)

12RLN - At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer (Quality Improvement)
Expected (Estimated Performance Report) EPR – 95%

2013	98.4% (95.3 -100)	2014	96.8% (93.2 -100)
2015	95.8% (91.8 -99.8)	2016	90.1% (84- 96.2)

G15RLN - At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer (Quality Improvement)
Expected (Estimated Performance Report) EPR – 95%

2013	80% (64.3 -95.7)	2014	92.3% (82.1 -100)
2015	75% (53.8 -96.2)	2016	75% (53.8 -96.2)

LCT - Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is recommended for surgically resected cases with pathologic lymph node-positive (pN1) and (pN2) NSCLC (Quality Improvement)
Expected (Estimated Performance Report) EPR – 95%

2013	92.9% (79.4 -100)	2014	87.5% (64.6 -100)
2015	100% (100 -100)	2016	100% (100 -100)

LNoSurg - Surgery is not the first course of treatment for cN2, M0 lung cases (Quality Improvement)
Expected (Estimated Performance Report) EPR – 85%

2013	78.6% (57.1 -100)	2014	87.5% (64.6 -100)
2015	80% (44.9 -100)	2016	100% (100 -100)

RECRTCT - Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or Postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is recommended; for patients under the age of 80 receiving resection for rectal cancer (Quality Improvement)
Expected (Estimated Performance Report) EPR – 85%

2013	100% (100-100)	2014	93.3% (80.6 -100)
2015	88.9% (68.4 -100)	2016	75% (45 -100)

Standard 4.6 Monitoring Compliance with Evidence-Based Practice

STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines

STUDY TOPIC: Adherence to National Comprehensive Cancer Network (NCCN) Guidelines for prostate cancer

OBJECTIVE: To ensure patient treatment plans meet NCCN guidelines

MEASUREMENT: 2017 Prostate (Analytic Class of Case 11-22) All stages

METHOD:
2017 prostate cancer retrospective chart review Stages 1 – Stage 4) 110

RESULTS:
Distribution of cases by AJCC staging

STAGE	No. Patients	NCCN Compliance
Stage 1	21	21
Stage 2A	25	25
Stage 2B	30	30
Stage 3	27	27
Stage 4	7	5*
Total	110	108

- Notes: Stage 4 category - 2 patients were lost to follow-up after initial diagnosis.

CONCLUSIONS:

Retrospective chart review revealed the following:

1. 98.1% of the patients received the recommended treatment by stage per NCCN guidelines

Standard 4.7 Studies of Quality

Study 1. Survey lung cancer tumor tissue diagnosed in 2017 to determine if EGFR testing was performed which will guide the use of targeted therapy.

Standard 4.7 Quality Study: EGFR Analysis

Quality Assurance Study-Review of EGFR analysis performed on 2017 Lung Cancer Surgical specimens.

Purpose: To determine if EGFR mutation analysis is done routinely on Lung Cancer surgical specimens. Understanding the EGFR mutation will guide the use of targeted therapy, thereby improving the quality of care.
Methods: Review Lung Cancer surgical specimens from surgical resections with Adenocarcinoma histologies performed in 2017 to determine if EGFR mutation analysis was performed. Data obtained from cancer registry.

Results: Total of 33 surgical specimens with adenocarcinoma histology were identified. 30 (+1%) of these specimens had EGFR testing done.

Total # of Lung Surgery Cases 2017	33
EGFR analysis Performed	30
Percentage of EGFR test performed	91%

Conclusion: Based on the survey, 91% of Lung Cancer surgical specimens in 2017 were tested for EGFR mutation and needs to be improved to 100%

Standard 4.7 Studies of Quality – Interval between date surgery was booked and the date surgery was performed for Ovarian Cancers in 2017.

Purpose: To look at the interval between the date of surgery booked and the date surgery was performed for all ovarian cancers in 2017. The goal being an interval of <2 weeks which is best practice because this shortened interval will positively impact health outcomes.
Method:

11 ovary cases that had surgery at our facility in 2017 were analyzed for surgery booked to surgery dates.

Results:

SURGERY BOOKED	DATE OF SURGERY	Days	Weeks
7/19/2017	7/20/2017	1	0
12/7/2017	12/11/2017	4	1
6/15/2017	6/26/2017	11	2

3/8/2017	3/20/2017	12	2
4/24/2017	5/8/2017	14	2
3/24/2017	4/10/2017	17	2
7/5/2017	7/24/2017	19	3
7/5/2017	7/24/2017	19	3
4/24/2017	5/18/2017	24	3
2/27/2017	4/3/2017	35	5
2/13/2017	3/20/2017	35	5
		191	27
		17	2

The average interval time between the surgeries booked to the surgery date is exactly 2 weeks

Conclusion: The goal is exactly 2 weeks.

Improvement 1 –
Revised the policy for blood transfusion limiting transfusion to one unit PRBC for all cancer patients as per evidence based medicine (unless otherwise indicated Ex: active bleeding)
Purpose: Reduce the number and frequency of blood transfusions for cancer patients (unless otherwise indicated as in active bleeding) as per evidence based medicine.

Methods: Reviewed all cases of blood transfusion occurring in the outpatient chemo therapy treatment unit for cancer patients in 2017.

Results:
Transfusions per patient in outpatient chemo unit in 2017 compared to 2018. An improvement of 1.5 units (61% reduction) after policy was implemented.

Improvement 2 –
Roll over study – to increase the referrals of colon cancers for Genetic Counseling & Testing.

Purpose: Roll over study from 2017 – To increase the referrals of colon cancers for Genetic Counseling & Testing.

Standard 4.8 Quality Improvement Study

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, implements two cancer care improvements. One improvement is based on the results of a quality study completed by the cancer program that measures the quality of cancer care and outcomes. One improvement can be based on a completed study from another source. Quality improvements are documented in the cancer committee minutes and shared with medical staff and administration.

One quality improvement is implemented as a result of data collected from a quality study conducted by the cancer committee

Purpose: Roll over study from 2017 – To increase the referrals of colon cancers for Genetic Counseling & Testing.

Method:

1. GC tumor board presence at GI tumor board
2) Genetics presentation at GI tumor board to remind them of criteria
3) Have an RA look at all colon cases to sift through which ones that are a) under 50 or b) MMR absent in the tumor.
The RA will then give us a list and we will reach out to the surgeons
4) Disseminate ACMG guidelines to GI's, PA's and medical staff to remind them of criteria

Results:

NCCN guidelines	# of patients	# of patients genetic counselling
Patients under the age of 50	8	7
Patients with IHC positive	7	6

Conclusion: Of the patients qualified for GCT approximately 86% were referred. Continuing physician education, tumor board attendance etc… is necessary for continued quality improvement.