2016 Public Reporting of Outcomes Standard 1.12

Roland Matthews MD, Director GCCE
Sheryl Gabram MD, Deputy Director GCCE
Pooja Mishra FACHE, Executive Director GCCE
## Top 5 Primary Sites

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>155</td>
<td>139</td>
<td>202</td>
<td>194</td>
<td>207</td>
<td>168</td>
</tr>
<tr>
<td>Lung</td>
<td>143</td>
<td>134</td>
<td>187</td>
<td>162</td>
<td>172</td>
<td>173</td>
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<tr>
<td>Prostate</td>
<td>104</td>
<td>98</td>
<td>104</td>
<td>103</td>
<td>116</td>
<td>128</td>
</tr>
<tr>
<td>Colon</td>
<td>52</td>
<td>64</td>
<td>61</td>
<td>64</td>
<td>79</td>
<td>59</td>
</tr>
<tr>
<td>Endometrium</td>
<td>26</td>
<td>39</td>
<td>35</td>
<td>41</td>
<td>37</td>
<td>40</td>
</tr>
</tbody>
</table>
Total Patient Cases
2009-2015

- 2009: 1005
- 2010: 1068
- 2011: 1216
- 2012: 1363
- 2013: 1318
- 2014: 1453
- 2015: 1301
Cancer Committee

- 29 members representing: Medical, Surgical and Radiation Oncology, Tumor Registry, Pathology, Radiology, Oncology Nursing, Social Work, Administration, Quality Management, Clinical Research, Rehabilitation, Genetics, Pharmacy, Nutrition, Survivorship, Palliative Care and American Cancer Society.

- Subcommittee Coordinators:
  - Quality Improvement-- *Sheryl Gabram-Mendola, MD*
  - Cancer Conference-- *Sherita Hearn, CTR*
  - Community Outreach- *Djuana Stroud, MPH*
  - Quality Control Cancer Registry - *Roland Matthews, MD*
  - Clinical Research-- *Leon Bernal-Mizrachi, MD/ Michelle Knight-Johnson*
  - Psychosocial Services – *Makeeta Rayton*
# Cancer Program Practice Profile Report (CP3R) Accountability Measures

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Measure</th>
<th>Expected Performance Rate</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>BCSRT</td>
<td>90%</td>
<td>Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer</td>
</tr>
<tr>
<td>Breast</td>
<td>HT</td>
<td>90%</td>
<td>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</td>
</tr>
<tr>
<td>Breast</td>
<td>MASRT</td>
<td>90%</td>
<td>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</td>
</tr>
<tr>
<td>Year</td>
<td>BCSRT</td>
<td>HT</td>
<td>MASRT</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>2011</td>
<td>89.5%</td>
<td>81.8%</td>
<td>71.4%</td>
</tr>
<tr>
<td>2012</td>
<td>87.0%</td>
<td>89.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>2013</td>
<td>89.5%</td>
<td>93.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>2014</td>
<td>92.9%</td>
<td>86.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>2015</td>
<td>85.3%</td>
<td>91.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Primary Site</td>
<td>Measure</td>
<td>Expected Performance Rate</td>
<td>Measure Description</td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
<td>---------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Breast</td>
<td>nBX</td>
<td>80%</td>
<td>Image or palpatation-guided needle biopsy (core or FNA) is performed to establish diagnosis of breast cancer</td>
</tr>
<tr>
<td>Gastric</td>
<td>15RLN</td>
<td>80%</td>
<td>At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer</td>
</tr>
<tr>
<td>Colon</td>
<td>12RLN</td>
<td>80%</td>
<td>At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer</td>
</tr>
<tr>
<td>Lung</td>
<td>NoSurg</td>
<td>80%</td>
<td>Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is considered for surgically resected cases with pathologic, lymph node-positive (pN1) and (pN2) NSCLC (</td>
</tr>
<tr>
<td>Lung</td>
<td>LCT</td>
<td>80%</td>
<td>Surgery is not the first course of treatment for cN2, M0 lung cases</td>
</tr>
<tr>
<td>Rectum</td>
<td>RCRTCT</td>
<td>80%</td>
<td>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 considered; for patients under the age of 80 receiving resection for rectal cancer.</td>
</tr>
</tbody>
</table>
### Quality Improvement Measures

<table>
<thead>
<tr>
<th></th>
<th>nBx</th>
<th>15RLN</th>
<th>12RLN</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>92.2%</td>
<td>No Patients Fit Criteria</td>
<td>88.2%</td>
</tr>
<tr>
<td>2012</td>
<td>85.0%</td>
<td>No Patients Fit Criteria</td>
<td>87.5%</td>
</tr>
<tr>
<td>2013</td>
<td>95.9%</td>
<td>100.0%</td>
<td>87.0%</td>
</tr>
<tr>
<td>2014</td>
<td>98.0%</td>
<td>57.1%</td>
<td>89.7%</td>
</tr>
<tr>
<td>2015</td>
<td>100.0%</td>
<td>No Patients Fit Criteria</td>
<td>91.3%</td>
</tr>
<tr>
<td>Standard</td>
<td>Study Topic</td>
<td>Evaluation Criteria (Data Needed)</td>
<td>Person(s) Responsible</td>
</tr>
<tr>
<td>----------</td>
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<td>-----------------------</td>
</tr>
<tr>
<td><strong>1.5 Annual Goals and Objectives</strong></td>
<td>Programmatic</td>
<td>HDR Brachytherapy Suite in Rad/Onc by 4th Qtr 2015</td>
<td>Treat at least 3 patients by 4th Quarter</td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td>Improve Throughput (Cycle Time) in Cancer Center by 4th Qtr 2015</td>
<td>by 90 minutes Med/Onc Rad/Onc Surgery</td>
</tr>
<tr>
<td><strong>4.7</strong></td>
<td>Studies of Quality</td>
<td>Identify tools and resources needed to expand the NeuroOncology Program</td>
<td>Pull Historical Data from 2007 - 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Determine the impact of the lung cancer screening program</td>
<td>2008-2013 Data</td>
</tr>
<tr>
<td><strong>4.8</strong></td>
<td>Patient Improvements</td>
<td>Implementation of a Survivorship Care Program in the Cancer Center</td>
<td>Measure patients enrolled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time to treatment (or discussion) for node positive colon cancer</td>
<td>&gt;90% of patient have had treatment started or discussion less than 120 days</td>
</tr>
</tbody>
</table>
2015 Quality Improvements

• Lung Cancer Screening Program
• Survivorship Program
• American Society of Clinical Oncology - Quality Oncology Practice Initiatives
• Cycle Time
Early Detection - Lung Cancer

Estimated new cases, 2016
By cancer type, both sexes combined

- Breast: 249,260
- Lung and bronchus: 224,390
- Prostate: 180,890
- Colorectum: 134,490
- Urinary bladder: 76,960
- Melanoma of the skin: 76,380

Estimated deaths, 2016
By cancer type, both sexes combined

- Lung and bronchus: 158,080
- Colorectum: 49,190
- Pancreas: 41,780
- Breast: 40,890
- Liver and intrahepatic bile duct: 27,170
- Prostate: 26,120

American Cancer Society – Cancer Statistics Center
Lung Cancer - Key Strengths at Grady

- Physician Champion – E. Flenaugh MD
- 4D Electromagnetic Navigation Bronchoscopy
- Multidisciplinary tumor board conference
- Stereotactic Body Radiation Therapy: J. Shelton MD
- Medical Oncology Aerodigestive Clinic: R. Pillai MD and M. Moore MD
- Thoracic Oncology: B. Keeling MD
- Survivorship Clinic and Smoking cessation program
- Clinical Trial (RTOG)
Overall Malignancy: Consistent w/ reported malignancies for multiple studies (NLST, Baaklini, Becker)
Lesion Size: 22.1mm +/- 10mm

Grady’s Ability to Diagnose Cancer

<table>
<thead>
<tr>
<th>Patients</th>
<th>TNS Completed</th>
<th>Overall Malignancy</th>
<th>Overall TNS Diagnostic Yield</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>43/44 97.7%</td>
<td>16/41 39%</td>
<td>37/41 90.2%</td>
</tr>
</tbody>
</table>

Initial Experience Using 4D Electromagnetic Navigation Bronchoscopy System With Tip Tracked Instruments For Localization of Peripheral Lung Nodules
E L Flennaugh, K H Mohammed

Citation
- All tissue diagnosed as inflammation resolved with antibiotics
- Follow Up ENB 10 months later, no malignancy, CT Stable
- Loss in Follow Up: 1 Patient
Grady Has a Thoracic Surgical Oncology Service

• Patient with 42 pk-yr Smoking History
  – Low Dose Chest CT 03/15
  – Right Upper lobe 2.1 solitary lung nodule

• Navigation Bronchoscopy 04/15
  – Lesion targeted and mapped
  – Real time image guided lung biopsy
  – Pathology: Non small cell lung cancer

• Curative Surgical Resection 06/15
  – PET Scan = No evidence of metastasis
  – 2.2 cm lesion with negative margins
  – Pathology: Mucinous AdenoCarcinoma
  – Stage I (T1b N0 M0)
Grady Has Stereotactic Body Radiation Therapy

- Patient with severe Chronic Obstructive Pulmonary Disease (COPD) requiring home O2

- 42 pk-yr Chronic Smoker
  - Low Dose CT on 7/14
  - Right lower lobe 10 x 9 mm nodule
  - Pathology: AdenoCA Stage I (T1 N0 M0)

- COPD: non-surgical candidate

- Navigation Bronchoscopy
  - Lesion targeted and mapped
  - Fiducial Markers Placed
  - SBRT with curative intent
Grady Has Created a Stage Shift

![Bar chart showing the distribution of stages over time.]

- **4 year average (2010-13 n=569; ~141/yr)**
  - Stage I: 10%
  - Stage II: 15%
  - Stage III: 30%
  - Stage IV: 55%
- **2014 Average (n=153)**
  - Stage I: 15%
  - Stage II: 10%
  - Stage III: 25%
  - Stage IV: 50%
GHS Impacts Medical Practice

• Grady is a Center of Excellence for Navigation Bronchoscopy for Lung Cancer Screening
  – E. Flenaugh MD: partnered with Johns Hopkins LEAP Study to establish training and credentialing of physicians for this new procedure technology.
  – Hosted physicians from other institutions, including Emory and MD Anderson Cancer Center, to showcase and train in this procedure

• Future Plans: Lung Nodule Clinic, Merck Grant
CoC Standard 3.3
Survivorship Care Plan

The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the cancer committee and documented in minutes.

- A survivorship care plan is prepared by the principal provider(s) who coordinated the oncology treatment for the patient with input from the patient’s other care providers.
- The survivorship care plan is given to the patient on completion of treatment.
- The written or electronic survivorship care plan contains a record of care received, important disease characteristics, and a follow-up care plan incorporating available and recognized evidence-based standards of care, when available.
Survivorship Program

• Implemented in 2014  P. Kim NP
  (breast patients identified through weekly conference list and referrals)

• Survivorship 2015 Statistics:
  – # COC Analytic Cases: 804
  – # NAPBC Analytic Cases: 162
  – # Survivorship Care Plans: 96
    12% ACS CoC cases (Met the 10% Requirement for 2015)
    58% NAPBC cases (Met the 50% Requirement for 2015)

• Grady News
  The New You Survivorship Support Group
  16 May 2016 1:00 pm
  The New You Survivorship Support Group is designed to assist survivors to cope with the various physical and emotional changes that have occurred as a result of treatment. Group meets the third Monday of every month. Location: Georgia Cancer Center for Excellence 9E002 Contact: Patricia Kim NP (404) 489-9003
2016 Survivorship Plan

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th># Analytic Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>162</td>
</tr>
<tr>
<td>Colorectal (January-June)</td>
<td>70</td>
</tr>
<tr>
<td>GYN (July-December)</td>
<td>60</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>292</strong></td>
</tr>
</tbody>
</table>

- **COC Goal= 201 Care plans** (25% of 804 total analytic cases)
- **Grady Goal= 210 Care plans**
CCF Receives Grant from Stavros Niarchos Foundation to Provide Quality Care Improvement to Four Underserved Communities

FEBRUARY 23, 2016

The Conquer Cancer Foundation, the philanthropic arm of ASCO, has received a grant of nearly half a million dollars from the Stavros Niarchos Foundation to enhance the quality of cancer care available in select underserved communities over the next 3 years.

ASCO’s Quality Training Program and Quality Oncology Practice Initiative (QOPI®) will serve as the foundation for quality improvement and support in four selected communities in Atlanta, Dallas, Fort Worth, and New York. Chosen for their commitment to caring for underserved populations as well as their willingness and commitment to engage in quality improvement, one oncology practice in each of these four communities has been selected to participate in this quality-improvement opportunity. Participation will be supported by the Conquer Cancer Foundation through the Stavros Niarchos Foundation grant.

“ASCO continuously strives to reduce disparities in cancer care, and one of the ways we do so is by improving access to high-quality care,” ASCO President Julie M. Voso, MD, MBA, FASCO, said. “This support from the Stavros Niarchos Foundation will enable ASCO to bring the Quality Training Program, QOPI, and its additional quality-improvement resources to four oncology practices that would otherwise not have the financial resources to participate in these programs.”

As part of the grant, practices will receive an on-site assessment, assistance in identifying achievable improvements, targeted toolkits, and hands-on quality improvement training. They will each partner with a mentor practice that will assist with specific areas of quality improvement. Outcomes of the project will be reported at the ASCO Annual Meeting, the ASCO Quality Care Symposium, and in the Journal of Oncology Practice. The four participating practices are:

- Georgia Cancer Center for Excellence at Grady – Atlanta, Georgia
- Ralph Lauren Center for Cancer Care and Prevention – New York, New York
- Parkland Health and Hospital System – Dallas, Texas
- JPS Center for Cancer Care – Fort Worth, Texas

“Improving the quality of health care services as well as access to those services are important elements in the Stavros Niarchos Foundation’s health grant making efforts,” Roula Sillas, program coordinator for Health and Sports at the Stavros Niarchos Foundation, said. “This program addresses both of these issues by supporting clinicians to maximize their resources in order to deliver the best care and to share those learnings and best practices with the larger community of cancer care providers and, ultimately, with patients with cancer across the nation.”

ASCO’s Quality Training Program is a 6-month structured education and training program based on improvement science, focusing on process analysis, rapid cycle improvement, quantitative and qualitative methods, and creating and managing effective teams.

QOPI is an oncologist-led, practice-based quality assessment program designed to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. QOPI provides a standard methodology, robust library of quality metrics for oncology, and a collection tool to reliably and routinely assess care, inform quality improvement activities, and demonstrate quality to patients and external stakeholders. Early adopters of QOPI are well-positioned to meet external reporting requirements for payers and the government and participate in new payment models focused on quality.

To learn more about QOPI and ASCO’s full range of initiatives to improve the quality of cancer care, please visit ASCO’s Institute for Quality.
Georgia Cancer Center for Excellence is funded by Niarchos Grant to participate in ASCO QOPI and pursue QOPI certification.

Participation in Quality Training Program – 2 year program, comprehensive education and training for GCCE interdisciplinary team. A structured and facilitated improvement project selected by each oncology team to solve a problem in the organizations clinical setting, with guidance of experienced coaches.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Study Topic</th>
<th>Evaluation Criteria (Data Needed)</th>
<th>Person(s) Responsible</th>
<th>Summary of Progress</th>
<th>Timeframe for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 Annual Goals and Objectives</td>
<td>Programmatic</td>
<td>Decrease Overall DNKA rate by 10% to = 32%</td>
<td>Workbench Report Ambulatory Report</td>
<td>Cancer Center Administration</td>
<td>Reported June 2016</td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td>Improving Access to Care in Infusion Center</td>
<td>Review data, address barriers, adjust as needed</td>
<td>Cancer Center Administration</td>
<td>Reported June 2016</td>
</tr>
<tr>
<td>4.7</td>
<td></td>
<td>Evaluation of Migration Patterns in Cancer Center</td>
<td>Pts receiving treatment outside of Grady by Cancer Site, Insurance Status, County at Diagnosis</td>
<td>S. Hearn</td>
<td>July 2016</td>
</tr>
<tr>
<td>Studies of Quality</td>
<td></td>
<td>Screening vs Diagnostic Colonoscopy Colorectal Diagnosis</td>
<td>Age at Dx, Stage at Dx, Survival Data</td>
<td>Russell</td>
<td>September</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Converting Radiation Oncology Consults to Treatment Summaries</td>
<td>80% of patients start treatment within 14 days from Consult</td>
<td>S. Daniel</td>
<td>September</td>
</tr>
<tr>
<td>4.8</td>
<td>Patient Improvements</td>
<td>Evaluating tracking program for CT Lung Screening</td>
<td>Submitting proforma evaluating lung screening volume</td>
<td>Radiology E. Flenaugh</td>
<td>October</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advanced Imaging Software (VARIAN) for SBRT</td>
<td>New Software</td>
<td>Shelton</td>
<td>October</td>
</tr>
</tbody>
</table>