

WISCONSIN CLP TOOLBOX: CANCER FACTS, NEW STANDARDS AND ACCREDITATION TIPS ISSUE #2

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HELLO AGAIN!

My name is Amanda Kong and I am your State Chair for the Commission on Cancer. I am here to help you with any of your needs such as ideas for meeting accreditation standards, questions about cancer resources in the state and anything in between. If you have any suggestions or ideas for collaboration, please let me know.

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ISSUE 2- THE BIG ONE

- I hope you find this presentation useful! I received a little feedback from the last one that people like this format. Please let me know if you like it.
- They will be sent to your email so you can review them at your own pace
- There will be **THREE** components this time
 - **THE EDUCATIONAL COMPONENT:** The first will be facts related to cancer about the state of Wisconsin
 - **THE NEW STANDARDS :** straight from the CoC and hot off the presses
 - **THE PRACTICAL COMPONENT:** The third part will cover a topic of interest such as how to meet a standard, resources that available to you, etc...

IN THIS ISSUE...

- PART ONE
 - Cancer statistics: how does our state do?
- PART TWO
 - The New Standards
- PART THREE
 - An opportunity to help you meet Standard 7.3
 - One at your tumor board
 - One that improves the care in our state!

PART ONE

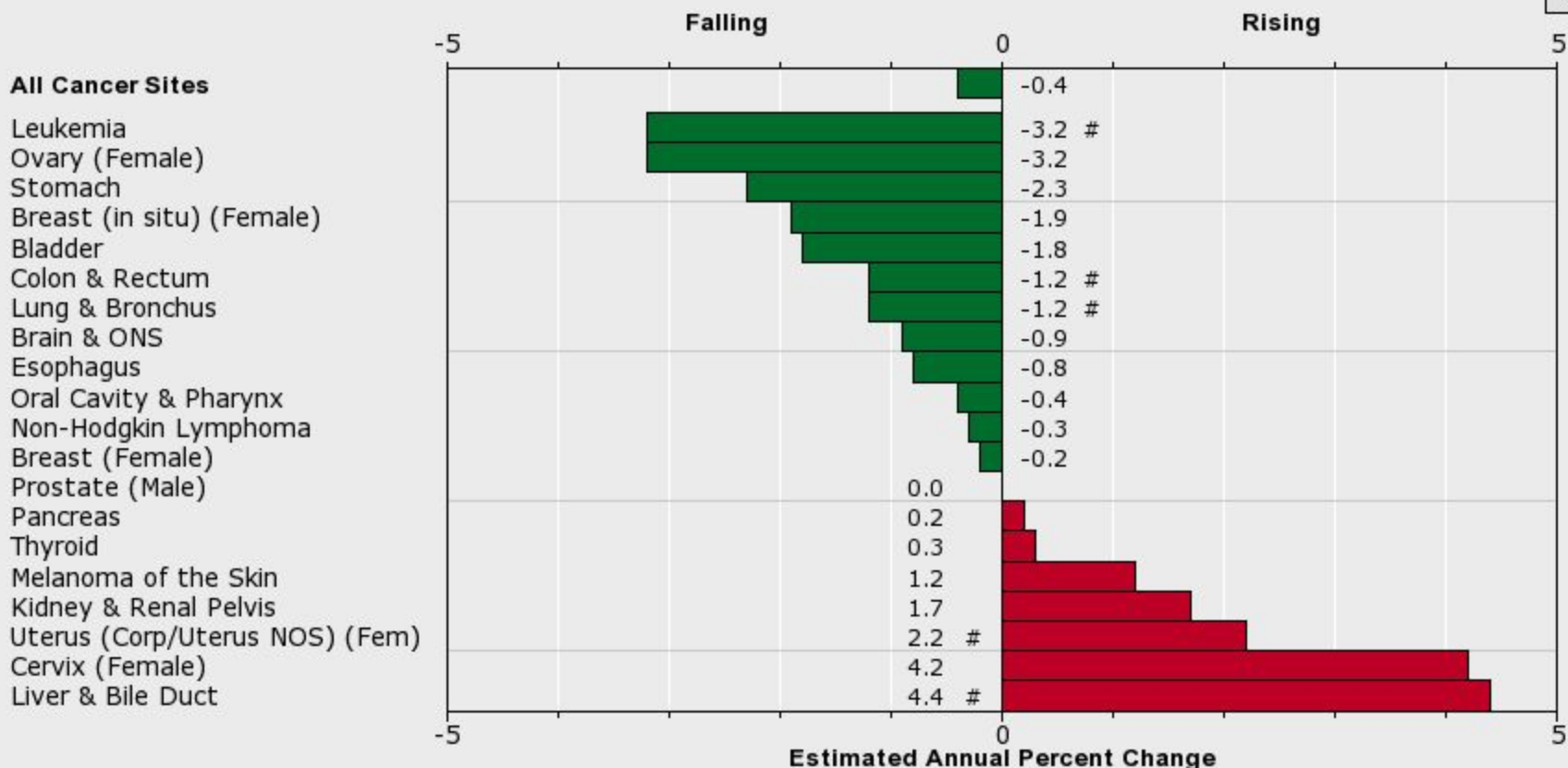
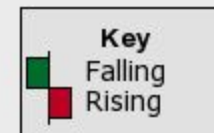
Cancer Statistics in Wisconsin

**HOW IS WISCONSIN
DOING?**

THE INCIDENCE OF CANCER TYPES IN WISCONSIN

Overall and by Gender and Age

5-Year Rate Changes - Incidence
Wisconsin, 2012-2016
All Ages, Both Sexes, All Races (incl Hisp)



Created by statecancerprofiles.cancer.gov on 10/27/2019 11:36 pm.

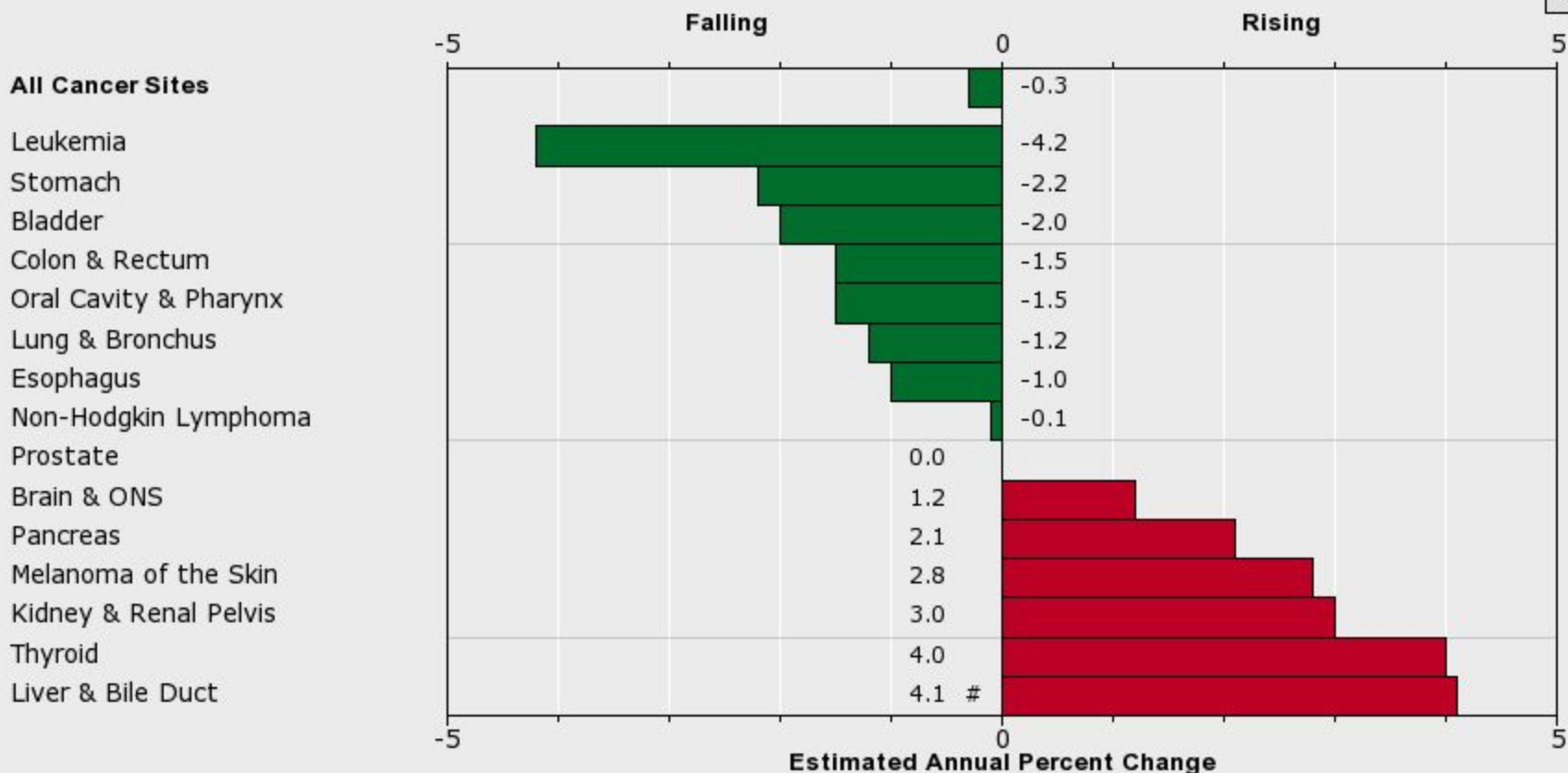
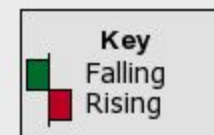
Source: Incidence data provided by the [National Program of Cancer Registries \(NPCR\)](http://www.npcr.org). EAPCs calculated by the National Cancer Institute using [SEER*Stat](http://seer.cancer.gov). Rates are age-adjusted to the [2000 US standard population](http://www.cdc.gov) (19 age groups: <1, 1-4, 5-9, ..., 80-84, 85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Population counts for denominators are based on Census populations as modified by NCI. The [1969-2016 US Population Data](http://www.cdc.gov) File is used with NPCR November 2017 data.

Rates are computed using cancers classified as malignant based on ICD-O-3. For more information see [malignant.html](http://www.cdc.gov)

Please note that the data comes from different sources. Due to [different years](http://www.cdc.gov) of data availability, most of the trends are AAPCs based on APCs but some are EAPCs calculated in [SEER*Stat](http://seer.cancer.gov). Please refer to the source for each graph for additional information.

- The annual percent change is significantly different from zero (p < 0.05).

5-Year Rate Changes - Incidence
Wisconsin, 2012-2016
All Ages, Males, All Races (incl Hisp)



Created by statecancerprofiles.cancer.gov on 10/27/2019 11:38 pm.

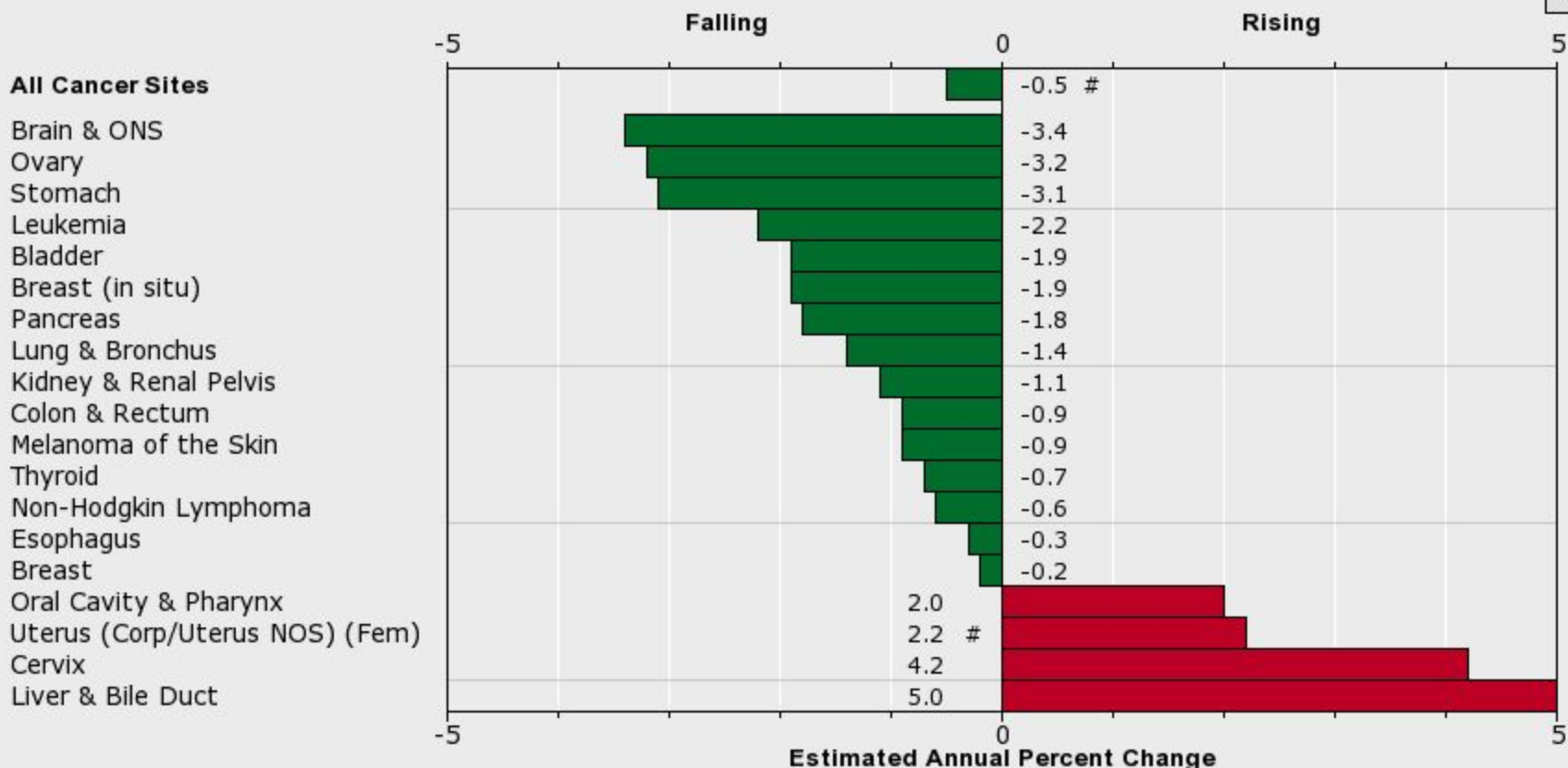
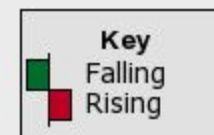
Source: Incidence data provided by the [National Program of Cancer Registries \(NPCR\)](#). EAPCs calculated by the National Cancer Institute using [SEER*Stat](#). Rates are age-adjusted to the [2000 US standard population](#) (19 age groups: <1, 1-4, 5-9, ... , 80-84,85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Population counts for denominators are based on Census populations as modified by NCI. The [1969-2016 US Population Data](#) File is used with NPCR November 2017 data.

Rates are computed using cancers classified as malignant based on ICD-O-3. For more information see [malignant.html](#)

Please note that the data comes from different sources. Due to [different years](#) of data availability, most of the trends are AAPCs based on APCs but some are EAPCs calculated in [SEER*Stat](#). Please refer to the source for each graph for additional information.

- The annual percent change is significantly different from zero (p<0.05).

**5-Year Rate Changes - Incidence
Wisconsin, 2012-2016
All Ages, Females, All Races (incl Hisp)**



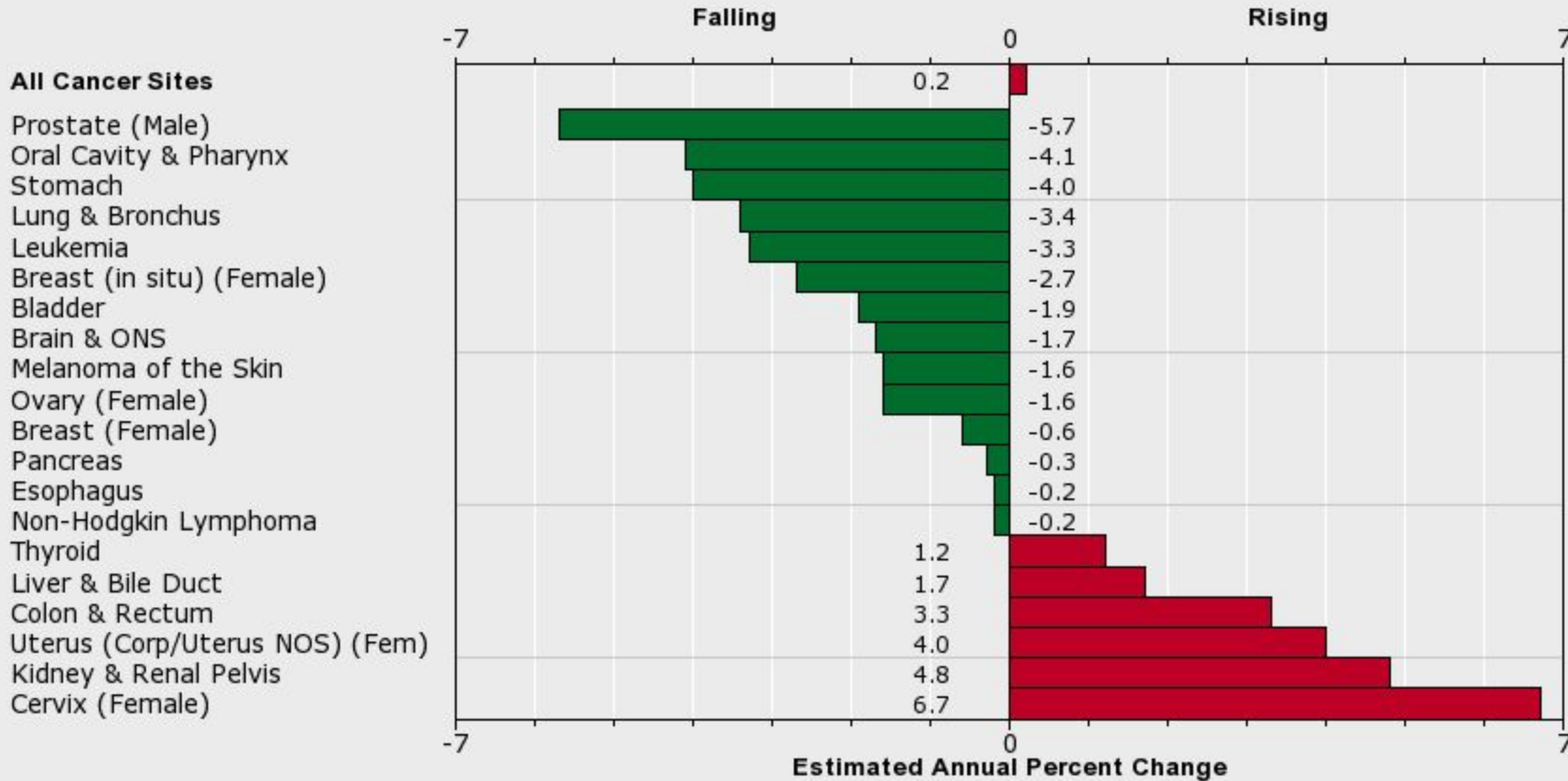
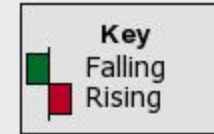
Created by statecancerprofiles.cancer.gov on 10/27/2019 11:37 pm.

Source: Incidence data provided by the [National Program of Cancer Registries \(NPCR\)](#). EAPCs calculated by the National Cancer Institute using [SEER*Stat](#). Rates are age-adjusted to the [2000 US standard population](#) (19 age groups: <1, 1-4, 5-9, ..., 80-84,85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Population counts for denominators are based on Census populations as modified by NCI. The [1969-2016 US Population Data](#) File is used with NPCR November 2017 data.

Rates are computed using cancers classified as malignant based on ICD-O-3. For more information see [malignant.html](#). Please note that the data comes from different sources. Due to [different years](#) of data availability, most of the trends are AAPCs based on APCs but some are EAPCs calculated in [SEER*Stat](#). Please refer to the source for each graph for additional information.

- The annual percent change is significantly different from zero (p<0.05).

**5-Year Rate Changes - Incidence
Wisconsin, 2012-2016
Ages <50, Both Sexes, All Races (incl Hisp)**



Created by statecancerprofiles.cancer.gov on 10/27/2019 11:46 pm.

Source: Incidence data provided by the [National Program of Cancer Registries \(NPCR\)](#). EAPCs calculated by the National Cancer Institute using [SEER*Stat](#). Rates are age-adjusted to the [2000 US standard population](#) (19 age groups: <1, 1-4, 5-9, ..., 80-84, 85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Population counts for denominators are based on Census populations as modified by NCI. The [1969-2016 US Population Data](#) File is used with NPCR November 2017 data.

Rates are computed using cancers classified as malignant based on ICD-O-3. For more information see [malignant.html](#)

Please note that the data comes from different sources. Due to [different years](#) of data availability, most of the trends are AAPCs based on APCs but some are EAPCs calculated in [SEER*Stat](#). Please refer to the source for each graph for additional information.

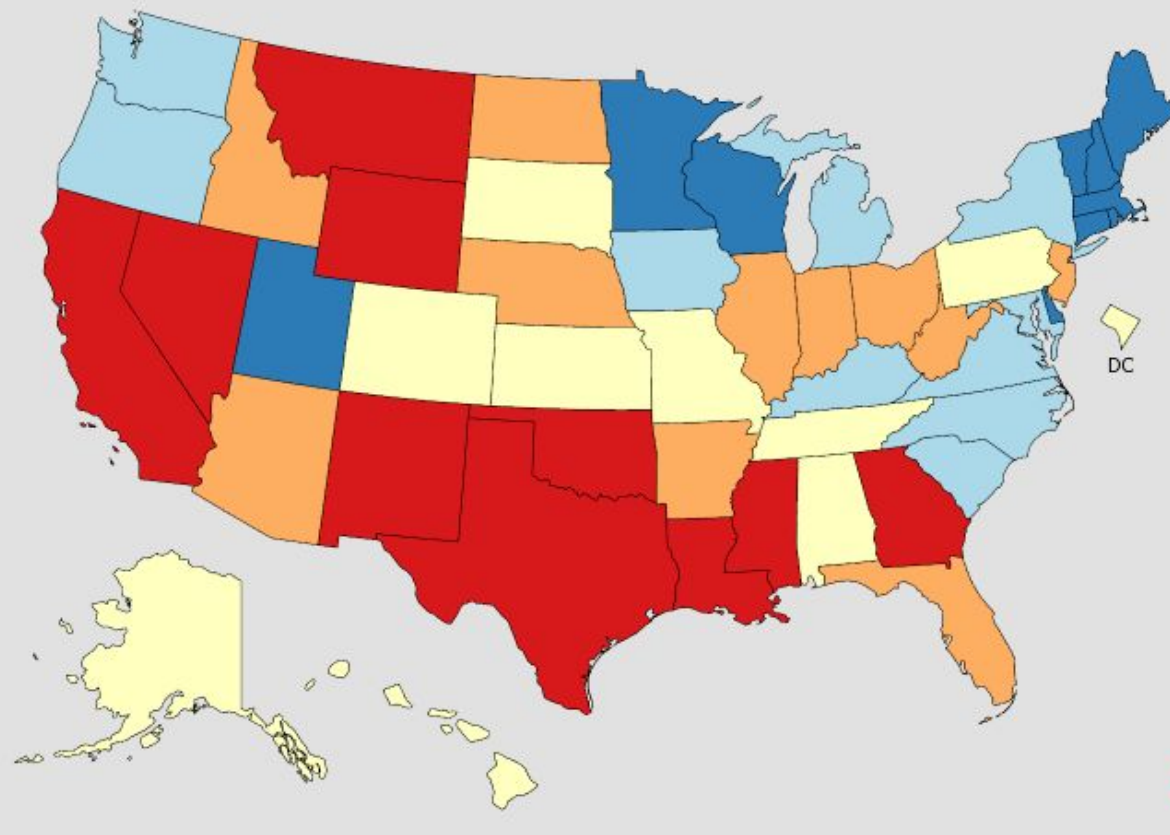
WHAT IS THE BRFSS?

- Behavioral Risk Factor Surveillance System
 - Started in 1984 by the CDC
 - Covers all 50 states, District of Columbia, Puerto Rico, US Virgin Islands, Guam, American Samoa, and Palau
- Health related telephone surveys that collect state data about US residents
 - Cross-sectional telephone survey that state departments conduct monthly over the phone with a standardized questionnaire
 - Health-related risk behaviors
 - Chronic health conditions
 - Use of preventive services

SCREENING FOR YOUR COLON

- **USPTF recommendations:**
 - Starting at age 50 years and continuing until 75
 - Decision to screen for those 76 to 85 is an individual one, taking into account the patient's overall health and prior screening history
- **American Cancer Society**
 - Average risk of colon cancer □ screen starting at 45
 - People in good health with life expectancy >10 years should continue screening through age 75
 - Ages 76 through 85, screening should be based on a person's preferences, life expectancy, overall health and prior screening history
 - Those over 85 should not have screening

**Screening and Risk Factors for United States by State
(Directly Estimated 2016 BRFSS Data)
Ever Had Colorectal Endoscopy (Sigmoidoscopy or Colonoscopy)
All Races (includes Hispanic), Both Sexes, Ages 50+**



Notes:

Note: Alaska, DC, Hawaii and Puerto Rico are not drawn to scale.

BRFSS Survey Data is the source for this data collected by the Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the [Centers for Disease Control and Prevention](https://www.cdc.gov). Data for the US is a median and not a percent.

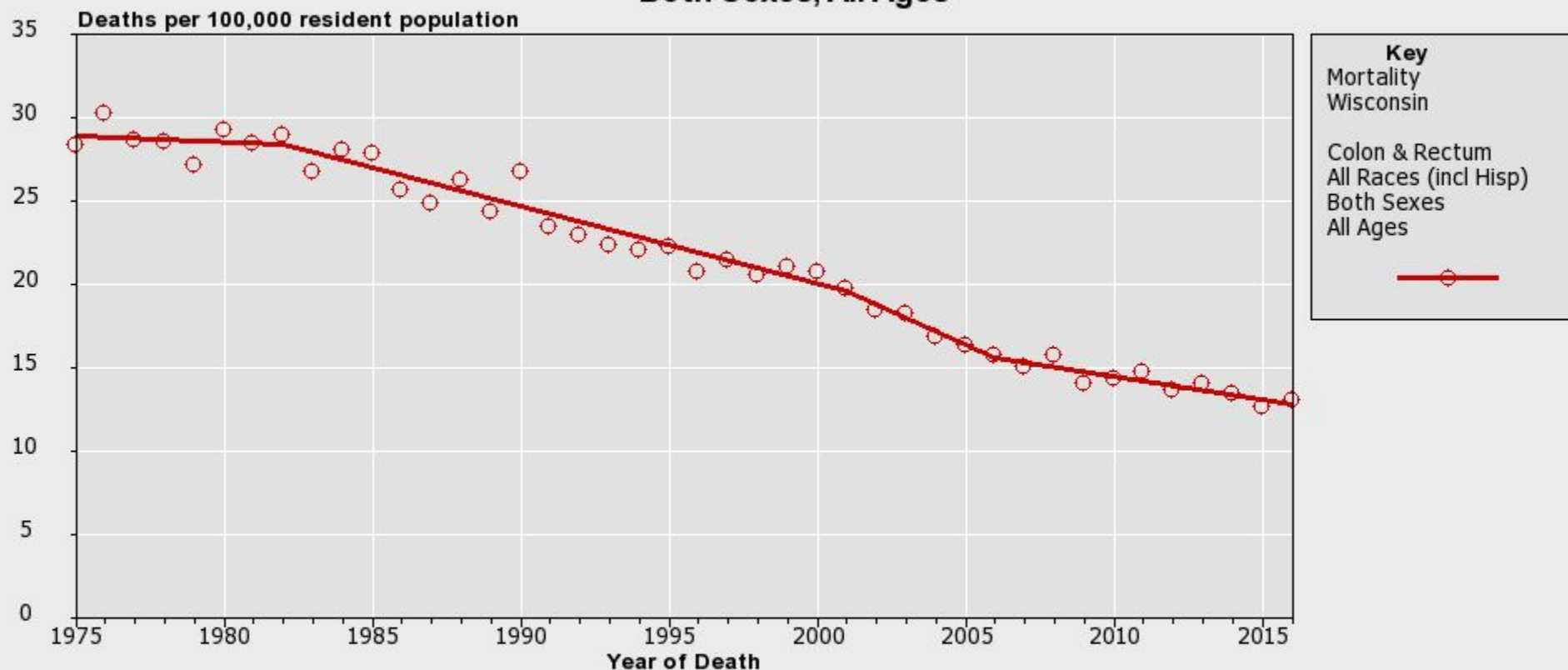
BRFSS Prevalence estimates presented here may vary from other published estimates due to differences in the methodology used to generate estimates. Data for the United States does not include data from Puerto Rico

Historical Trends (1975-2016)

Mortality, Wisconsin

Colon & Rectum, All Races (incl Hisp)

Both Sexes, All Ages



Notes:

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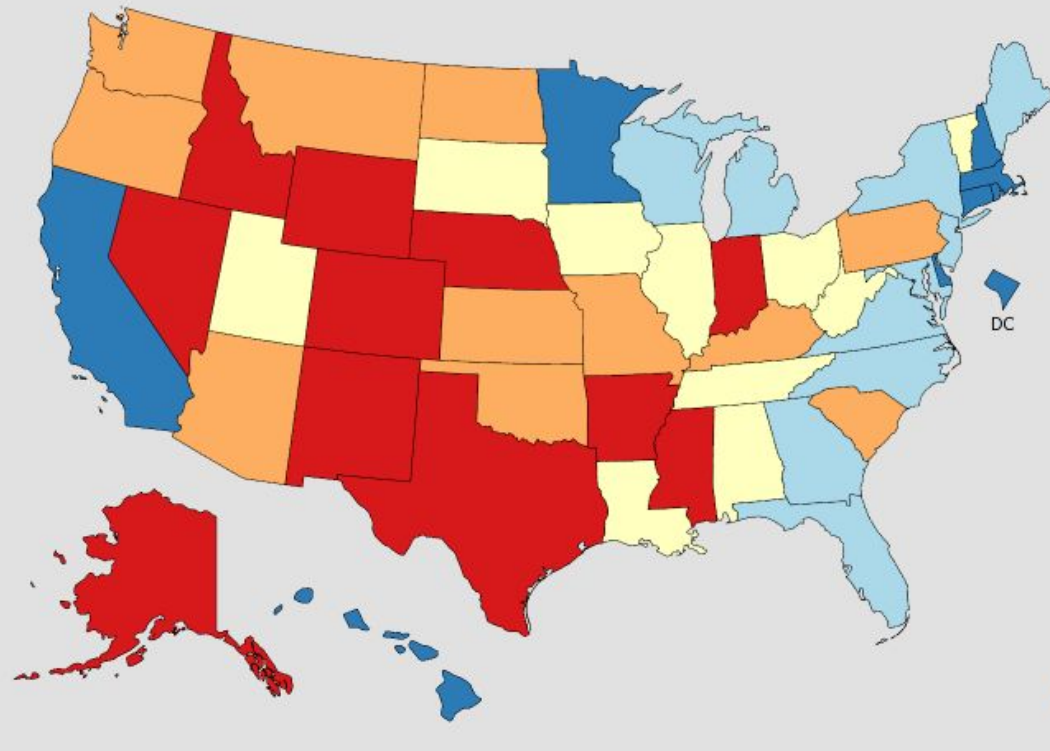
Regression lines calculated using the [Joinpoint Regression Program \(Version 4.7.0.0\)](#).

Source: Death data provided by the [National Vital Statistics System](#) public use data file. Death rates calculated by the National Cancer Institute using [SEER*Stat](#). Death rates (deaths per 100,000 population per year) are age-adjusted to the [2000 US standard population](#) (19 age groups: (<1, 1-4, 5-9, ..., 80-84, 85+). Population counts for denominators are based on Census populations as modified by NCI. The US populations included with the data release have been adjusted for the [population shifts due to hurricanes Katrina and Rita](#) for 62 counties and parishes in Alabama, Mississippi, Louisiana, and Texas. [1969-2016 US Population Data](#) File is used with mortality data.

BREAST SCREENING GUIDELINES

- This is controversial because it depends who you ask. The following data is for those who should be screened no matter which guideline you follow.
- Here are links to some of the guidelines:
 - USPSTF:
<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening>
 - American Cancer Society:
<https://www.cancer.org/latest-news/american-cancer-society-releases-new-breast-cancer-guidelines.html>
 - American College of Radiology/ Society of Breast Imaging:
[https://www.jacr.org/article/S1546-1440\(09\)00480-3/abstract](https://www.jacr.org/article/S1546-1440(09)00480-3/abstract)

**Screening and Risk Factors for United States by State
(Directly Estimated 2016 BRFSS Data)
Had a Mammogram in Past 2 Years
All Races (includes Hispanic), Female, Ages 50-74**



Had a Mammogram in Past 2 Years
(Percent of Respondents)

Quantile Interval

- 64.14 to 73.61
- > 73.61 to 76.74
- > 76.74 to 78.70
- > 78.70 to 81.75
- > 81.75 to 86.27

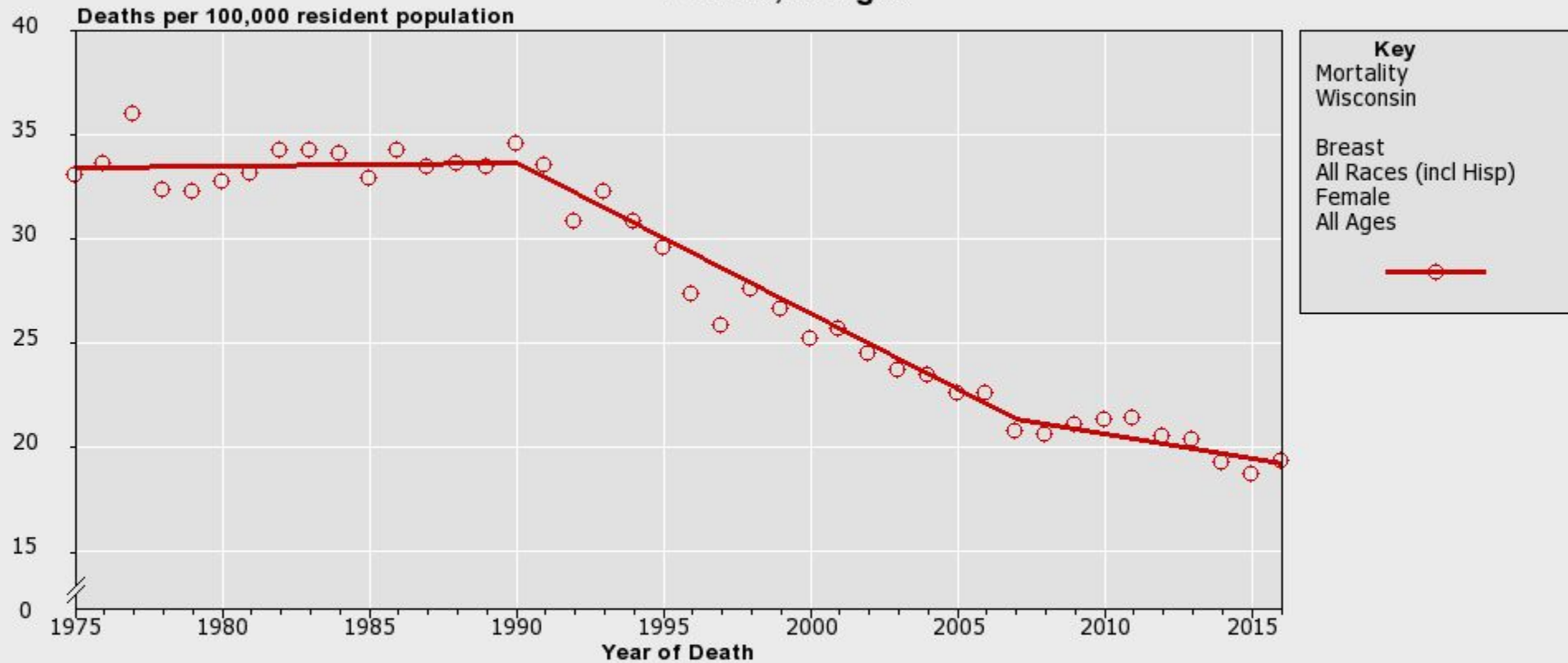
United States
Percent (Median)
77.6

Healthy People 2020
Goal C-17
81.1%

Notes:
 Note: Alaska, DC, Hawaii and Puerto Rico are not drawn to scale.
 BRFSS Survey Data is the source for this data collected by the Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the [Centers for Disease Control and Prevention](#). Data for the US is a median and not a percent.
 BRFSS Prevalence estimates presented here may vary from other published estimates due to differences in the methodology used to generate estimates.
 Healthy People 2020 Goal C-17 : Increase the proportion of women who receive a breast cancer screening to 81.1.
[Healthy People 2020](#) Objectives provided by the [Centers for Disease Control and Prevention](#).
 Data for the United States does not include data from Puerto Rico

Historical Trends (1975-2016)

Mortality, Wisconsin Breast, All Races (incl Hisp) Female, All Ages



Notes:

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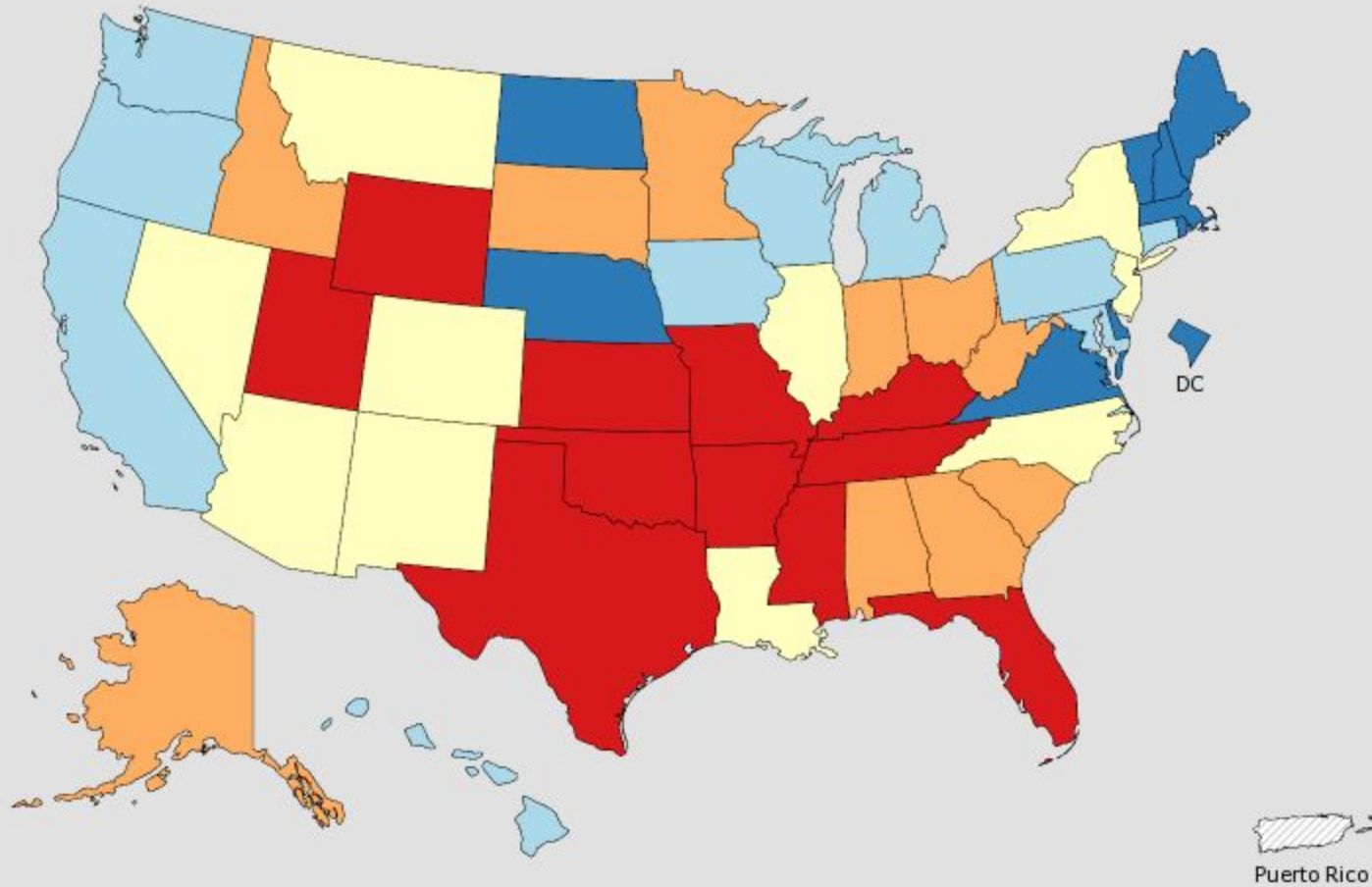
Regression lines calculated using the [Joinpoint Regression Program \(Version 4.7.0.0\)](#).

Source: Death data provided by the [National Vital Statistics System](#) public use data file. Death rates calculated by the National Cancer Institute using [SEER*Stat](#). Death rates (deaths per 100,000 population per year) are age-adjusted to the [2000 US standard population](#) (19 age groups: (<1, 1-4, 5-9, ..., 80-84, 85+). Population counts for denominators are based on Census populations as modified by NCI. The US populations included with the data release have been adjusted for the [population shifts due to hurricanes Katrina and Rita](#) for 62 counties and parishes in Alabama, Mississippi, Louisiana, and Texas. [1969-2016 US Population Data](#) File is used with mortality data.

HPV VACCINATION GUIDELINES

- Age 9-14
 - 2 doses with the second dose given 6-12 months after the first dose
 - First dose before 15th birthday
- Age 15-26
 - 3 doses with second dose given 1-2 months after first dose and third dose given 6 months after first dose
- For details
 - <https://www.cdc.gov/hpv/hcp/schedules-recommendations.html>

**Screening and Risk Factors for United States by State
(2017 National Immunization Survey)
Percent who received 2+ doses of HPV Vaccine
All Races (includes Hispanic), Both Sexes, Ages 13-17**



Percent who received
2+ doses of HPV
Vaccine
(Percent of Respondents)

Quantile Interval

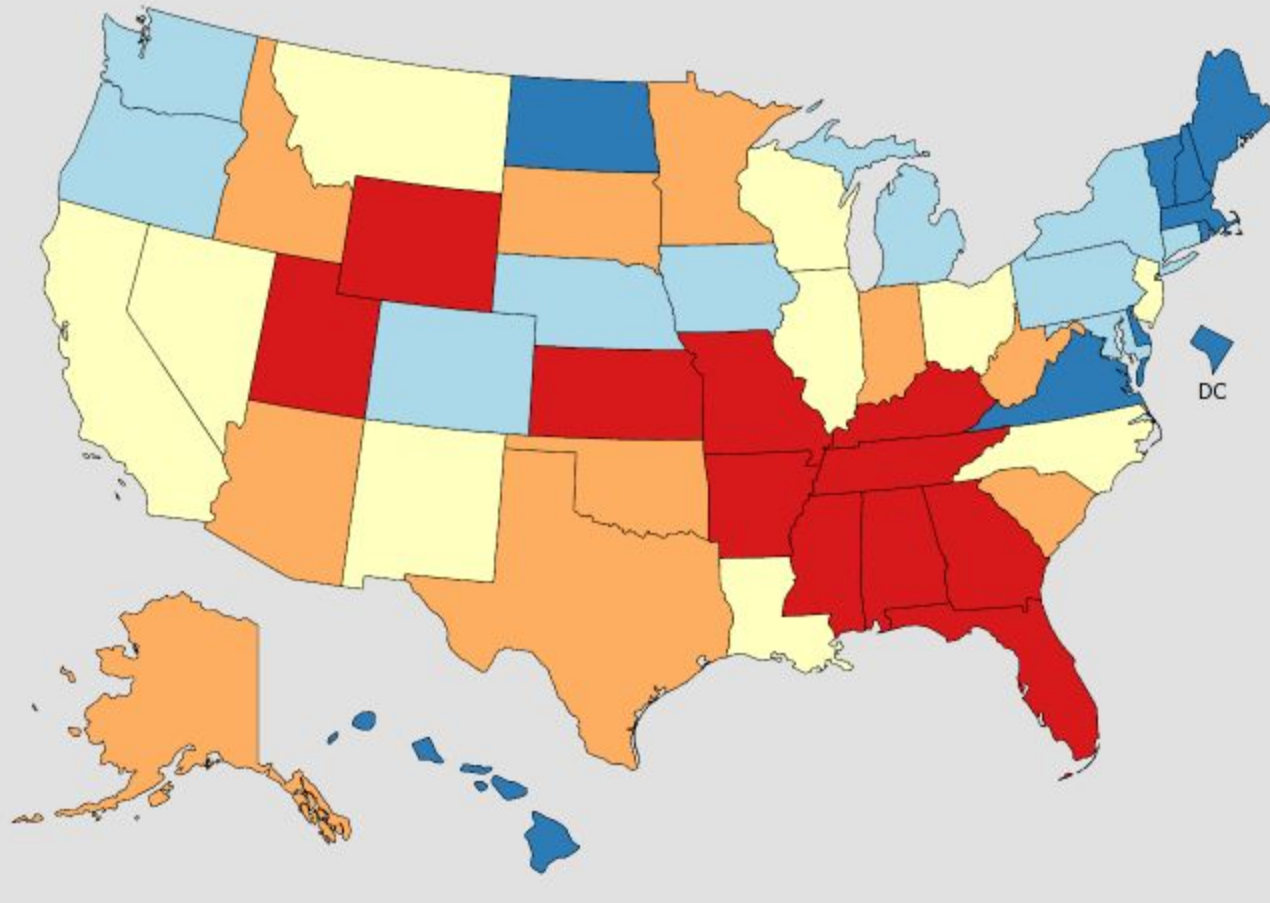
- 35.3 to 46.2
- > 46.2 to 51.2
- > 51.2 to 57.3
- > 57.3 to 61.8
- > 61.8 to 80.7
- Data Not Available ◇

United States
Rate (95% C.I.)
53.2 (51.9 - 54.5)

Notes:

Note: Alaska, DC, Hawaii and Puerto Rico are not drawn to scale.
The [National Immunization Survey - Teen](#), Hyattsville, MD: Centers for Disease Control and Prevention.
◇ [Data not available](#)
for this combination of geography, statistic, age and race/ethnicity.
Data for the United States does not include data from Puerto Rico

**Screening and Risk Factors for United States by State
(2017 National Immunization Survey)
Percent who received 3+ doses of HPV Vaccine
All Races (includes Hispanic), Both Sexes, Ages 13-17**



Percent who received
3+ doses of HPV
Vaccine
(Percent of Respondents)

Quantile Interval

- 23.2 to 33.0
- > 33.0 to 37.8
- > 37.8 to 43.1
- > 43.1 to 47.9
- > 47.9 to 70.5

 Data Not Available ◊

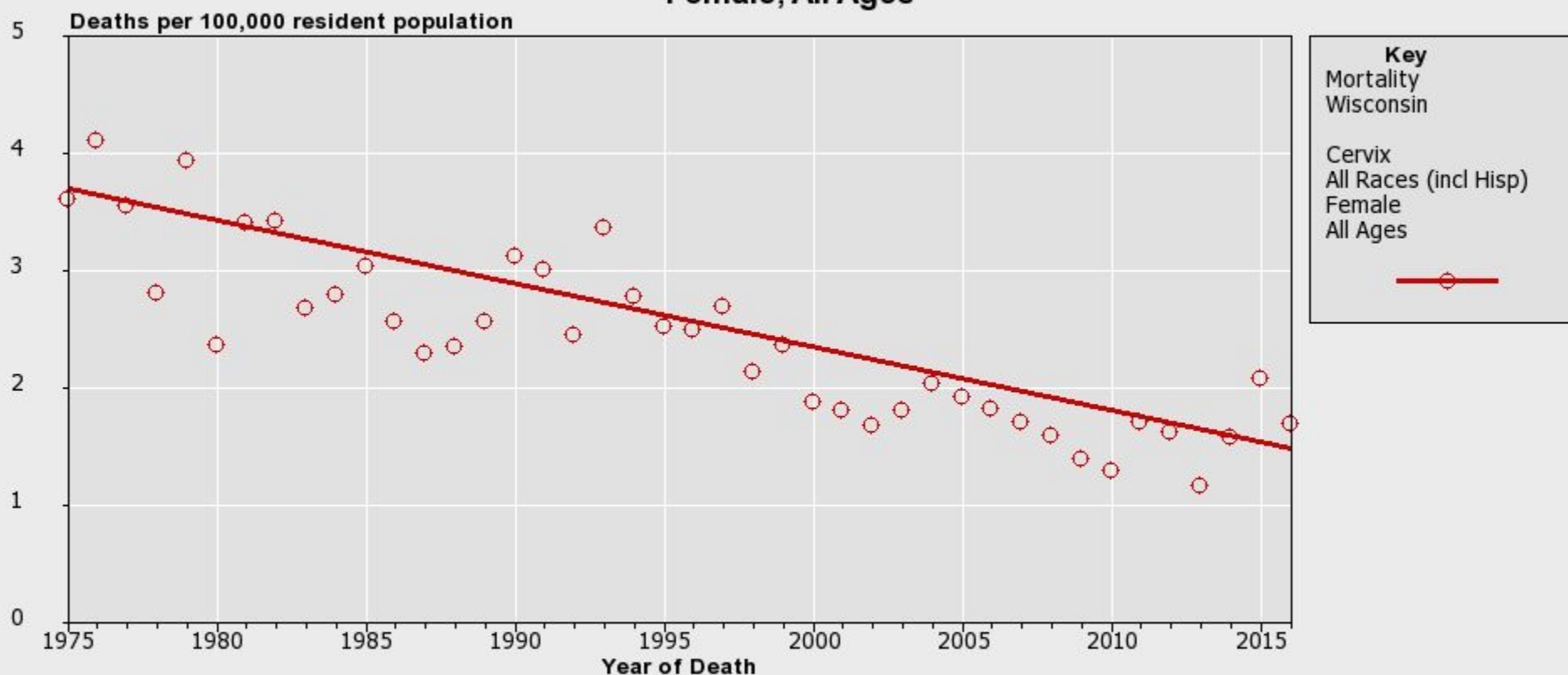
United States
Rate (95% C.I.)
39.3 (38.0 - 40.6)

Notes:

Note: Alaska, DC, Hawaii and Puerto Rico are not drawn to scale.
The [National Immunization Survey - Teen](#), Hyattsville, MD: Centers for Disease Control and Prevention.
◊ [Data not available](#)
for this combination of geography, statistic, age and race/ethnicity.
Data for the United States does not include data from Puerto Rico

Historical Trends (1975-2016)

Mortality, Wisconsin Cervix, All Races (incl Hisp) Female, All Ages



Notes:

Created by statecancerprofiles.cancer.gov on 10/27/2019 11:54 pm.

Regression lines calculated using the [Joinpoint Regression Program \(Version 4.7.0.0\)](#).

Source: Death data provided by the [National Vital Statistics System](#) public use data file. Death rates calculated by the National Cancer Institute using [SEER*Stat](#). Death rates (deaths per 100,000 population per year) are age-adjusted to the [2000 US standard population](#) (19 age groups: (<1, 1-4, 5-9, ..., 80-84, 85+)). Population counts for denominators are based on Census populations as modified by NCI. The US populations included with the data release have been adjusted for the [population shifts due to hurricanes Katrina and Rita](#) for 62 counties and parishes in Alabama, Mississippi, Louisiana, and Texas. [1969-2016 US Population Data](#) File is used with mortality data.

SUMMARY

- **INCIDENCE OF CANCER**

- The incidence of breast and colon cancer are going DOWN
- The incidence of pancreas, thyroid and especially cervix, uterine and bile duct cancer are going UP
- For those under age 50, the incidence of colon, cervix, kidney and uterus cancer are going UP

SUMMARY

- HOW ARE WE DOING WITH SCREENING AND VACCINATIONS?
 - Colon Cancer
 - With screening colonoscopies, we are doing great!
 - Mortality is also improving
 - Breast Cancer
 - Our mammography rates are not bad but we have room for improvement
 - The good news is mortality is improving
 - HPV vaccination
 - For those receiving 2 doses, our rates are not bad but we have room for improvement
 - For those receiving 3 doses, we need to improve our rates

PART TWO

THE NEW STANDARDS

These will affect your nursing, surgical and pathology teams

There are several more changes but these are the BIG ones. I can send you all the standards if you need them.

PHASE-IN STANDARD
4.2 Oncology Nursing Credentials

Documentation

Submitted with Pre-Review Questionnaire

- A roster of nursing certification status for all nurses providing direct oncology care and documentation of 36 cancer-related continuing education nursing contact hours for each nurse providing direct oncology care who does not hold a cancer-specific certification
- A policy and procedure that states that oncology nursing competency will be evaluated each year per hospital or facility policy

Measure of Compliance

Each accreditation cycle, the program fulfills the compliance criteria:

1. All nurses providing direct oncology care hold a cancer-specific certification or demonstrate ongoing education by earning 36 cancer-related continuing nursing education contact hours.
2. Programs have in place a policy and procedure that ensures oncology nursing competency is reviewed each year per hospital policy.

PHASE-IN STANDARD
4.8 Survivorship Program

Documentation

Submitted with Pre-Review Questionnaire

- Policy and procedure defining the survivorship program requirements
- Cancer committee minutes that document the required yearly evaluations of the survivorship program

Measure of Compliance

Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee identifies a survivorship program team, including its designated coordinator and members.
2. The survivorship program is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes.

These will be phased in 2021....

5.3 Breast Sentinel Node Biopsy

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients with breast cancer of epithelial origin who underwent nodal staging in a curative setting.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. All sentinel nodes for breast cancer are identified, removed, and subjected to pathologic analysis.
2. Operative reports for patients undergoing breast sentinel node biopsy includes required minimum elements in synoptic format.

PHASE-IN STANDARD

5.4 Breast Axillary Dissection

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients with breast cancer of epithelial origin who underwent axillary dissection with diagnostic or therapeutic intent.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Axillary dissections for breast cancer remove level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and latissimus dorsi, while preserving key neurovascular structures.
2. Operative reports for patients undergoing axillary dissection include the required minimum elements in synoptic format.

5.5 Primary Cutaneous Melanoma

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients who underwent a curative-intent wide local excision for primary cutaneous melanoma.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Clinical margin width for wide local excision of invasive melanoma is 1 cm for melanomas less than 1 mm thick.
2. Clinical margin width for wide local excision of invasive melanoma is 1 to 2 cm for melanomas 1 to 2 mm thick.
3. Clinical margin width for wide local excision of invasive melanoma is 2 cm for melanomas greater than 2 mm thick.
4. The clinical margin width for wide local excision of a melanoma in situ is at least 5 mm.
5. Operative reports for patients undergoing a wide local excision of a primary cutaneous melanoma include the required minimum elements in synoptic format.

5.6 Colon Resection

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients who underwent resection for colon cancer.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s).
2. Operative reports for patients undergoing resection for colon cancer include the required minimum elements in synoptic format.

5.7 Total Mesorectal Excision

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic pathology reports for rectal cancer patients with middle and low rectal cancers.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Total mesorectal excision is performed for all patients undergoing radical surgical resection of mid and low rectal cancers and results in a complete or near complete mesorectal excision.
2. The quality of TME resection (complete, near complete, or incomplete) is documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format.

5.8 Pulmonary Resection

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic pathology reports for curative intent pulmonary resections.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.
2. The nodal stations examined by the pathologist must be documented in curative pulmonary resection pathology reports in synoptic format.

PART THREE

TWO, yes TWO!!

Opportunities to Meet Standard 7.3 for Accreditation

(note 7.3 is part of the 2020 Standards and was previously 4.7 & 4.8)

WHAT IS STANDARD 7.3?

- Standard 7.3 (new and was previously standard 4.7 and 4.8)
 - One quality improvement initiative based on an identified quality-related problem is initiated each year. The QI initiative documentation includes how it measured, evaluated, and improved performance through implementation of a recognized, standardized performance improvement tool
 - Status updates are provided to the cancer committee two times. Reports are documented in the cancer committee minutes
 - A final presentation of a summary of the quality improvement initiative is presented after the QI initiative is complete. The summary presentation includes all required elements

MEETING STANDARD 7.3- TWO OPPORTUNITIES

- Alliance Dissemination & Implementation Committee
 - Alliance Tumor Board Video Pilot
 - goal of this effort is to provide communities a package that will enable learning about Alliance trial results and making decisions about how to incorporate the trial findings into their current practice
 - Each package will include a short video (10 minutes) describing the trial and multidisciplinary aspects as well as a discussion guide to help decide how this should be implemented locally
- Wisconsin Surgical Collaborative

THE ALLIANCE TUMOR BOARD VIDEO PILOT SERIES



ALLIANCE VIDEO PILOT SERIES

- The Alliance Dissemination & Implementation Committee is hoping to have communities:
 - watch the video and go through the discussion guide
 - then give feedback about how effective they felt this approach would be for dissemination of future trial results
 - looking for communities that have an organized multidisciplinary tumor board and who have not incorporated the trial results in a standard fashion (i.e. everyone in the community has agreed on who is eligible, technical aspects, etc)
- **CoC sites can use this for Standard 7.3 credit**



Tumor Board Video Pilot

Alliance ACS Dissemination & Implementation
Committee

Alliance Tumor Board Video

Pilot

STUDY GOALS

- Disseminate trial data:
 - Accurately
 - Reflects multidisciplinary perspective
- Facilitate discussion that relates the data to the local community
 - Accounts for local resources & patient population
- Social reinforcement of practice change
 - Leverages Tumor Board setting to reinforce

ALLIANCE TUMOR BOARD VIDEO PILOT

Package – Borderline Resectable Pancreas Cancer Management

- 10 minute video featuring surgery, medical oncology, and radiation oncology which defines borderline resectable pancreas cancer, the relevant literature, and ongoing trials
- Discussion guide to facilitate discussion about the trial
- Summary statement that could be distributed to other clinicians in the community

WHAT'S INVOLVED

- Tumor board attendees fill out a 3 question survey at a tumor board
- Sites are sent link to a 10 minute video that can be shown during tumor boards
- Tumor board attendees fill out a 3 question survey after seeing the video
- 4-5 stakeholders are sent a link to a longer survey that takes 10-15 minutes to complete

INTERESTED?

- Recruiting pilot sites for pancreas (available early 2020) packages
 - Email ascaudle@mdanderson.org if interested



THE WISCONSIN SURGICAL COLLABORATIVE

SURGICAL COLLABORATIVE OF WISCONSIN

- SCW is a practice change community that aims to optimize quality and reduce costs by improving surgical care and fostering provider professional development across practice settings
- Objectives
 - Ensure equal access to high-quality surgical care in communities across Wisconsin
 - Promote appropriate utilization of surgical care and control costs
 - Provide a performance improvement platform for Wisconsin surgeons

SCW CURRENT PROJECTS

- Reduce rates of repeat operations for women with breast cancer
- Increase adoption of enhanced recovery protocols for colorectal procedures
- Change approach to surgical pain management to reduce postoperative opioid use and overprescribing
- Working together to provide high-quality pediatric surgical care
- Rural task force

THE PROBLEM

- Surveys of surgeons have found the definition of “adequate margin” ranges from “ink negative” to >1cm, leading to significant variability in re-excision lumpectomy rates (0-70%)
- 80% of women with Stage I-II breast cancer are eligible to undergo lumpectomy followed by radiation
- A repeat operation is needed if “adequate margins” are not achieved
 - Increased cost and nonfinancial consequences
 - Delays in time to treatment
 - Missed work
 - Increased travel
 - Another surgical recovery with post-operative pain and risk of infection/healing problems
 - Potentially worse cosmetic outcomes

SSO ASTRO MARGIN GUIDELINE

In patients with invasive cancer, there is no benefit to re-excision to wider margins than those that are ink free

Ann Surg Oncol (2014) 21:704–716
DOI 10.1245/s10434-014-3481-4

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – GUIDELINE AND META-ANALYSIS

Society of Surgical Oncology–American Society for Radiation Oncology Consensus Guideline on Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Stages I and II Invasive Breast Cancer

Meena S. Moran, MD¹, Stuart J. Schnitt, MD², Armando E. Giuliano, MD³, Jay R. Harris, MD⁴, Seema A. Khan, MD⁵, Janet Horton, MD⁶, Suzanne Klimberg, MD⁷, Mariana Chavez-MacGregor, MD⁸, Gary Freedman, MD⁹, Nehmat Houssami, MD, PhD¹⁰, Peggy L. Johnson¹¹, and Monica Morrow, MD¹²

Reducing Repeat Operations for Women with Breast

SSO/ASTRO Guidelines on Margins for BCS

Margin Status	Stage I or II Invasive Breast Cancer (+/- DCIS)	DCIS Alone (no invasion)
Positive Margin (tumor on ink)	Re-excise	Re-excise
Close Margin (<2mm)	No further surgery	Re-excise
Negative Margin (2mm or greater)	No further surgery	No further surgery

Stage I and II Invasive Breast Cancer (+/- DCIS). A positive margin, defined as ink on invasive cancer or ductal carcinoma in situ (DCIS), is associated with two-fold increase in IBTR. This increased risk is not nullified by: delivery of a boost dose of radiation, delivery of systemic therapy (endocrine therapy, chemotherapy, or biologic therapy), or favorable biology. Wider margin widths do not significantly lower this risk. The routine practice to obtain wider negative margin widths than no ink on tumor is not indicated.

DCIS (No invasive cancer). Margins of at least 2 mm are associated with a reduced risk of IBTR relative to narrower negative margin widths in patients receiving WBRT. The routine practice of obtaining negative margin widths wider than 2 mm is not supported by the evidence.

HOW WILL SCW HELP REDUCE THE RATE OF REPEAT BREAST CONSERVING PROCEDURES?

- Provide reports of surgeon and hospital performance for reoperation rates after initial lumpectomy for breast cancer using existing claims/billing data, benchmarked against other providers in the state
- Distribute a comprehensive toolkit to assist in identification and implementation of evidence-based options, tailored to each practice setting
- Assist with the identification of key factors that influence performance and capacity for practice change, thus helping hospitals implement strategies that reflect their resources and other contextual factors
- Provide a platform for collaborative learning through webinar sessions and in-person meetings
 - Opportunities for interactive problem solving and brainstorming between interested surgeons
 - Overview of specific topics, prioritized by participating hospitals
 - Case studies of solutions from hospitals within SCW
- Provide interested hospitals with guidance on limited, tailored primary data collection

WHAT IS THE BENCHMARK (TARGET GOAL) ENDORSED BY AMERICAN [ASBRS] AND EUROPEAN [EUSOMA] SURGEONS?

Ann Surg Oncol (2015) 22:3174–3183
DOI 10.1245/s10434-015-4759-x

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

CrossMark

EUROPEAN JOURNAL OF CANCER 46 (2010) 2344–2356

ORIGINAL ARTICLE – BREAST ONCOLOGY

Toolbox to Reduce Lumpectomy Reoperations and Improve Cosmetic Outcome in Breast Cancer Patients: The American Society of Breast Surgeons Consensus Conference

Jeffrey Landereasper, MD, FACS¹, Deanna Attai, MD², Dunya Atisha, MD³, Peter Beitsch, MD, FACS⁴, Linda Bosserman, MD, FACP⁵, Judy Boughey, MD, FACS⁶, Jodi Carter, MD, PhD⁶, Stephen Edge, MD⁷, Sheldon Feldman, MD, FACS^{8,9}, Joshua Froman, MD¹⁰, Caprice Greenberg, MD, MPH¹¹, Cary Kaufman, MD, FACS¹², Monica Morrow, MD, FACS^{13,14}, Barbara Pockaj, MD, FACS¹⁵, Melvin Silverstein, MD, FACS^{16,17}, Lawrence Solin, MD, FACP, FASTRO¹⁸, Alicia Staley¹⁹, Frank Vicini, MD²⁰, Lee Wilke, MD, FACS¹¹, Wei Yang, MBBS, FRCR²¹, and Hiram Cody III, MD, FACS^{13,14}

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available at www.sciencedirect.com

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journal homepage: www.ejconline.com

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ELSEVIER

Position Paper

Quality indicators in breast cancer care

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^a Eusoma, Florence, Italy

10% is the target goal



THE TARGET GOAL IS NOT ZERO.

**REOPERATIONS IN PATIENTS WITH
POSITIVE LUMPECTOMY MARGINS IS
“GOOD” CARE**

**REOPERATIONS IN APPROPRIATE
PATIENTS REFLECTS HIGH QUALITY CARE,
BECAUSE TO DO SO, DECREASES
THE RISK OF SUBSEQUENT
IN-BREAST-TUMOR-RECURRENCE**

MEETING COC STANDARD 7.3

- SCW can help fulfill these measures!
- Opportunity to meet **Standard 7.3**
 - Measure quality of care and outcomes for cancer patients with SCW benchmark data
- Performance reports distributed
- Complete action plan with toolbox measures
- Implementation of a correction or performance improvement that comes as a result from participation in the SCW helps fulfill **Standard 7.3**



SAMPLE DRAFT REPORTS AND ACTION PLANS

Reducing Repeat Operations for Women with Breast Cancer Prioritization of Initiative Guideline Components



CURRENT RATE _____ GOAL RATE _____ SCW established goal rate is 10%

Definitions as you complete the action plan worksheet

Strength of Evidence: Approach to assessing strength of evidence adapted from guideline issuing agencies. High-level evidence represents strong to strong-moderate strength of recommendation based on a combination of expert consensus and high quality evidence of effectiveness in peer-review journals. Moderate evidence represents moderate to moderate-weak evidence of effectiveness, including majority and not uniform consensus. Low strength of evidence reflects weak or insufficient evidence.

Determine Priority: Answering these questions will help you determine an activities priority and if a particular activity is worth doing

Aim/Desired Outcome: This is what you're hoping to achieve by accomplishing your plan or your goal.

Characteristics about your practice that will help or hinder your ability to implement: These are problems, attitudes, and challenges that you should think about and address to achieve success (barriers) or resources in-hand (facilitators). These could include people, time, materials, and know-how that already exist within your program and could be used to accomplish your tasks. This is an opportunity to identify resources that are needed in order to accomplish your tasks.

Determination of Success – How will the team know if the aim is achieved? - This is a simple way of keeping track of progress toward an aim/desired outcome. It should be easily tracked, and commonly understood. It data should be regularly checked to avoid wasting time on strategies that do not achieve your aim/desired outcome. Successful programs check in on average of every two weeks. For example, if you have a goal of increasing physical activity you need to:

- 1) Understand how many minutes of physical activity is currently happening on average throughout the program
- 2) Introduce your task/strategy for achieving your increased minutes of physical activity
- 3) Re-measure the amount of time of physical activity occurring in the program after your strategy has been rolled out
- 4) If your goal has not been reached, try a new strategy



SCW Confidential Performance Report for Hospital X
Quality Initiative: Reducing Repeat Operations for Women with Breast Cancer
Reporting Period: January-December 2017



Reducing Repeat Operations for Women with Breast Cancer

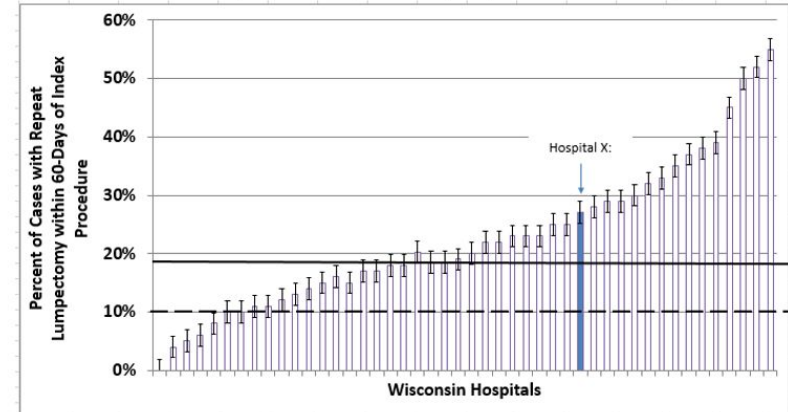
Table 1. Unadjusted and risk- and reliability-adjusted re-excision and mastectomy rates

	Hospital X	Participating Hospitals (n=)	All WI Hospitals (n=)
60-Day Re-Excision Rate			
Unadjusted			
Risk- and Reliability-Adjusted			
Mastectomy as First Operation			
Unadjusted			
Risk- and Reliability Adjusted			

Table 2. Case volume, sociodemographics and clinical characteristics

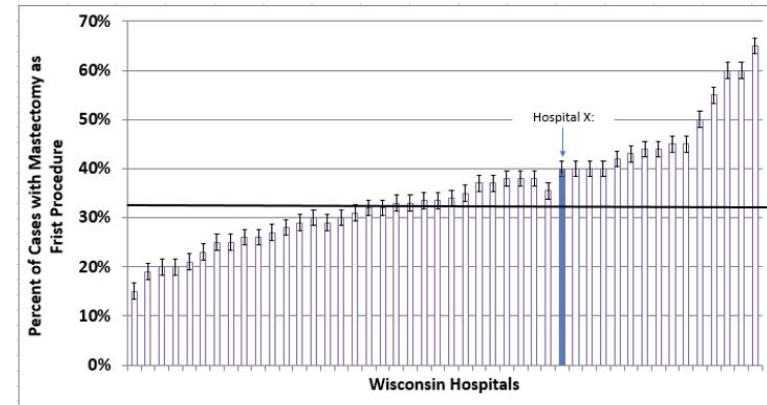
	Hospital X	Participating Hospitals (n=)	All WI hospitals (n=)
Number of Index Lumpectomy Procedures			
Number of Mastectomy Procedures (as First Operation)			
Number of Repeat Procedures			
Mean age (SD)			
Payer			
Private insurance			
Medicare			
Medical assistance/Badgercare			
Self-pay			
Other			

Figure 1. Risk- and reliability-adjusted hospital 60-day reoperation rates following lumpectomy



Black line: Statewide median hospital-level re-excision rate. Black dashed line: Target re-excision rate (European Society of Breast Surgeons, American Society of Breast Surgeons). Each bar represents a hospital in Wisconsin. Error bars represent confidence intervals around each hospital estimate. Your hospital's performance is represented by the solid blue bar.

Figure 2. Risk- and reliability-adjusted hospital mastectomy rates



Black line: Statewide median hospital-level re-excision rate. Each bar represents a hospital in Wisconsin. Error bars represent confidence intervals around each hospital estimate. Your hospital's performance is represented by the solid blue bar.

WHAT IS REQUIRED FOR PARTICIPATION?

- Sign Participating Hospital/Facility Agreement
 - <https://www.scwisconsin.org/join/become-a-member/>
- Receive and review benchmarked performance reports
- Participate in webinar sessions and in-person meetings
- Agree to complete surveys and interviews to track progress
- IT'S FREE!! <https://www.scwisconsin.org/>

INTERESTED? CONTACT ONE OF US!

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THANK YOU!

- If you have a moment, please provide me with any feedback on the format or content
- I am interested in helping you improve cancer cancer in the state of Wisconsin!
- Email me: akong@mcw.edu OR call me: 414-955-1441
- Happy Holidays!