Chairman’s Message

Michael Porter, MD (Cancer Committee Chair)

I am excited and privileged to begin my service as the Clinical Cancer Committee Chairperson. I am a Urologist who has been a full-time staff physician at the VA Puget Sound since 2005. I have served as the Chief of Urology since 2014, and the Associate Chief of Surgery since 2015. My clinical focus is on the surgical management of genitourinary cancers, with a special interest in bladder cancer. I have served as a physician member of the Clinical Cancer Committee since 2011. I assumed the role of Chairperson in July 2018, taking over for Dr. Daniel Wu, who served from 2017-2018 and remains a valuable member of the Cancer Committee. I hope everyone can join me in thanking Dr. Wu for his service to our community of cancer providers and patients, and for seeing the Cancer Committee through another successful accreditation cycle.

On that note, it has been an exciting year. The VA Puget Sound received a glowing report and full 3-year accreditation with 5 commendations after a site visit from the Commission on Cancer in June 2018. It is evidence of the excellent care that the VA Puget Sound provides to our Veterans with a diagnosis of cancer, and reflects the hard-work and dedication it takes by our community of cancer providers to meet the rigorous standards set by the Commission on Cancer. Dr. Wu and Sudarshana Das, Cancer Program manager, deserve special recognition and thanks for their efforts during the accreditation process. The year ahead proves to be exciting as well, as we continue to improve the world class cancer care we provide Veterans at the VA Puget Sound. Ongoing enrollment in clinical trials, completion of quality improvement projects, monitoring of cancer screening and prevention efforts, patient navigation and survivorship programs, and efforts to expand our collective clinical cancer expertise to other facilities in the Northwest Network are just a few examples of areas in which the Cancer Committee continues to advance this mission.

There are challenges ahead. We are currently recovering from a cancer database coding backlog that resulted from a contracted vendor falling behind on our timeliness requirements. We also face challenges coordinating the care we give with community providers who provide cancer care to our Veterans, a growing challenge in an era where community based care is more accessible to our patients than ever before. I am confident that we will meet these challenges, as this is one of the core purposes of maintaining an accredited cancer program- to solve problems that pose threats to the high-quality care that we provide.

We are one of a small handful of VA Hospitals in the nation that has a Commission on Cancer accredited program. This accreditation holds us to the highest standards, and demonstrates our commitment to providing the best care available to the Veterans we serve. In my 8 years working with the Clinical Cancer Committee, I have been impressed by the dedication and talent of the individuals who provide cancer care at the VA Puget Sound, and the commitment of hospital leadership to our program. I look forward to working with everyone in the year ahead to further our mission of maintaining a world class multidisciplinary cancer program.
Cancer Registry Report
Sudarshana Das, COC Cancer Program Manager
& Cancer Registry Manager

Recently, the Bureau of Labor Statistics announced the establishment of a special occupation code 29-9021 “Health Information Technologists and Medical Registrars” in the Standard Occupational Classification (SOC) system specifically for Cancer Registrars.

So, who are Cancer Registrars, and what are Cancer Registries?

According to NCRA\(^1\) (National Cancer Registrar Association) “Cancer Registrars are data information specialists that capture a complete history, diagnosis, treatment, and health status for every cancer patient in the U.S. Cancer registrars ensure that timely, accurate, and complete data are maintained on all types of cancer diagnosed and/or treated within a health care institution or within a defined population. The curated data provides essential information to researchers, healthcare providers, and public health officials to better monitor and advance cancer treatments, conduct research, and improve cancer prevention and screening programs.” Certified Cancer Registrars (CTRs) must undergo special training and achieve national level certification from NCRA for the purpose.

Cancer/Tumor Registry has been defined by NCRA as “information system that manage and analyze data on cancer patients and survivors. Cancer registries can be classified into three general types: hospital registries are the starting point for cancer surveillance and maintain data on all patients. Cases are reported to the central or state cancer registry; central registries that maintain data on all cancer patients within certain geographical areas; and special purpose registries maintain data on particular type of cancer, such as brain tumors.” Together, CDC’s NPCR\(^2\) and NCI’s SEER\(^3\) programs collect cancer data for 100% of the US population.”

Cancer Registry data are used for analyzing patterns, effectiveness and quality of care, survival and outcome related studies, devising early detection/screening cancer programs, and can help leadership in making informed decisions for hospital expansion, resource allocation and other business purposes.

The Department of Veterans Affairs (VA) requires each VA medical facility to maintain a cancer registry to identify and collect and report data on patients diagnosed and/or treated for cancer according to current VA Central Cancer Registry’s (VACCR’s) reportable list.

VA Puget Sound Cancer Registry is staffed by a facility employed cancer program manager to oversee the management and operations of the hospital cancer registry, while the bulk of the registry tasks are contracted out to vendor registry services awarded by Visn-20.

\(^1\) NCRA: a not-for-profit association body that represents cancer registry professionals, conducts stringent national level certifying exams, and maintains continuing education for its professionals.\n
\(^2\) NPCR: established by The Cancer Registries Amendment Act 1992 (Public Law 102-15) to provide grants to states without central cancer registries, or to enhance existing state population-based cancer registries.

\(^3\) SEER: a federally funded consortium of population-based cancer registries, established by the National Cancer Act 1971 to collect and publish information on cancer incidence, mortality, survival and trends over time in the US.
Cancer Registry Report (Continued)

VAPSHCS Cancer Registry Data, Finalized data CY 2017

Cancer data collection and abstraction at Registries is an ongoing process. Cancer registry data collection for complete calendar year 2018 is currently work-in progress, and finalized reports will be published and made available next year.

Finalized counts for CY 2017 shows total index caseload of 894 cases in the cancer registry database following reportability rules, including 755 analytic cases and 139 non-analytic cases.

The top seven ranking primary cancers seen at our facility in CY 2017 were Prostate, Lung, Liquid Tumors (Hematopoietic, Leukemia, Plasma Cell), Head & Neck (includes Larynx), Melanoma, Colorectal, and Bladder.

Analytic: Cancer patients diagnosed and/or received first course of treatment at VAPSHCS
Non Analytic: Cancer patients who came to VAPSHCS for subsequent treatment of cancer recurrences or persistent disease; Or, non-visit consults, 2nd opinion cases. pathology report review only, surveillance visits only, etc.
Trend analysis for past three accession years shows shift in analytic caseload versus non-analytic annual caseload due to election by veterans to receive care per Veteran’s Access, Choice and Accountability Act of 2014 (CHOICE Act).

**CLASS CATEGORY CASELOAD TREND LAST 3 ACCESSION YEARS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Analytic</th>
<th>Non-analytic</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>813</td>
<td>183</td>
</tr>
<tr>
<td>2016</td>
<td>782</td>
<td>222</td>
</tr>
<tr>
<td>2017</td>
<td>757</td>
<td>240</td>
</tr>
</tbody>
</table>

References:
   Release of VA data to State Central Registries
3. NCRA, https://www.ncra-usa.org/
   ViewPublication.asp?pub_ID=2858
8. Previous VAPSHCS Annual Reports
## Cancer Registry Report (Continued)

<table>
<thead>
<tr>
<th>PRIMARY SITE:</th>
<th>CASELOAD CY 2017</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>W:White, B:Black, Oth:Other race</td>
<td>TOT# ANAL</td>
<td>NON W B OTH W B OTH</td>
<td>RACE</td>
</tr>
<tr>
<td>H&amp;B (incl Larynx)</td>
<td>TOT# ANAL</td>
<td>NON W B OTH W B OTH</td>
<td>RACE</td>
</tr>
<tr>
<td>MALE</td>
<td>FEMALE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NON W B OTH W B OTH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>MALE</td>
<td>FEMALE</td>
</tr>
<tr>
<td>Peripheral Nervous System</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Connective/Subcutaneous</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Breast(excl skin)</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Male Genital</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Urinary Organs</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Respiratory (exc Larynx)</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Bones/Joints/Articular</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Skin(excl reproductive)</td>
<td>TOT# ANAL</td>
<td>NON W B</td>
<td>OTH W B O</td>
</tr>
<tr>
<td>Grand Total</td>
<td>894</td>
<td>755</td>
<td>139</td>
</tr>
</tbody>
</table>

**Notes:**
- MALE
- FEMALE
- TOT# ANAL: Analytic, NON: Nonanalytic
- W:White, B:Black, Oth:Other race
- TONGUE, BASE: 3 3 3
- TONGUE, OTHER/NOS: 9 9 5 3 1
- THYMUS: 3 3 3
- Eye & Central Nervous System TOT# ANAL NON W B OTH W B OTH
- TESTIS: 4 4 1 3
- Connective/Subcutaneous: 1 1 0 0 0 0 0 0 1
- PROSTATE GLAND: 222 178 44 76 15 131
- Male Genital: 1 1 1
- Male Genital, Other/Other: 228 182 46 77 15 136 0 0 0
- Hematopoietic, Ret & Lymph | TOT# ANAL | NON W B | OTH W B O |
- Hematopoietic/Reticulo | TOT# ANAL | NON W B | OTH W B O |
- Lymph Nodes | TOT# ANAL | NON W B | OTH W B O |
- Skin(excl reproductive) | TOT# ANAL | NON W B | OTH W B O |
Hospital & Specialty Medical Care - Oncology Division  
Daniel Wu, MD, PhD

The VA Puget Sound Oncology Division provides initial medical diagnosis, medical treatment, and follow-up care for Veterans diagnosed with cancer. The division works closely with surgical subspecialties and Radiation Oncology to offer multidisciplinary care; and with social work, nursing, dietary, chaplaincy, and other allied healthcare services to provide holistic care. Care and treatment for cancer patients is frequently coordinated through a multidisciplinary Tumor Board. In this forum, individual cases and therapeutic options are reviewed by representatives from all services and a consensus recommendation is rendered. Oncology nurse coordinators from the Oncology Division ensure follow-up, coordinates diagnostic and therapeutic recommendations, and maintains contact with the patient. In addition, a well-staffed Cancer Care Clinic provides ongoing chemotherapeutic, transfusion, and supportive services for patients undergoing treatment.

The Oncology Division provides care in both inpatient and outpatient settings. Patients are evaluated and followed at four weekly subspecialty outpatient clinics staffed by attending physicians who are also faculties of the University of Washington and fellow physicians from the Fred Hutchinson Cancer Center. Chemotherapy and treatment related care is provided in the newly remodeled Cancer Care Clinic that operates five days per week and staffed by two physician assistants, two nurse practitioners, three to four RNs, and one clerk. This unit provides all of the outpatient chemotherapy for VA Puget Sound Health Care System patients and also offers a convenient location for outpatient procedures, such as bone marrow aspirates and physical examinations, outside of the regular outpatient clinic hours. A full-time clinical pharmacist manages chemotherapy for both inpatients and outpatients, and ensures safety of drug administration.

Recently, the Division has added a four member cancer navigation team to support patients who must travel great distances or are challenged with difficult personal issues. This navigation team, consists of a nurse practitioner, a nurse coordinator, a social worker and a clerk, maintains contact with the patient and provides throughout his/her cancer care journey. The navigation team also ensures seamless transition of the patient back to the referral facility and provider. Additionally, the team will provide survivorship counseling to patients, who have completed treatment.

The Marrow Transplant Service remains a marquee program of the VA Puget Sound Oncology Division. The Marrow Transplant Unit (MTU) is one of only three such units nationwide under the national VA program. The MTU performs approximately 50-60 transplants per year on patients referred from both remote and regional sites. The MTU works in close collaboration with the Fred Hutchinson Cancer Research Center, and the treatment and experimental protocols for transplantation are shared between the two institutions. After the acute transplant phase, the MTU performs outpatient follow-up on transplanted patients as well as annual long-term follow-up. The MTU is a discrete physical patient care unit with integrated outpatient and inpatient care, and a dedicated nursing and clerical support staff. The unit operates full-time and manages transplant patients 24/7.

As always, the Oncology Division supports the overall direction of the VA Puget Sound Cancer Committee, a multidisciplinary committee that maintains accreditations and promotes cancer care activities of the institution. As a part of the mission to provide Veterans with cutting edge cancer care, the Oncology Division also actively maintains a clinical research program. We provide clinical trial participation opportunities so that patients can have access to novel drugs and advanced oncological concepts. Our clinical research program participates in a number of studies through national cooperative programs and pharmaceutical sponsors; and is staffed with three clinical research coordinators. The Oncology Division additionally maintains a local cancer registry under a certified Cancer Registrar; and undergoes regular clinical and system improvement evaluations under a full-time quality improvement coordinator.

The Oncology Division is a central part of the VA Cancer Program, which has received continuous distinction as a comprehensive cancer center designated by the Commission on Cancer. The marrow transplant unit has been awarded multiple achievements and certificates of excellence by the National Marrow Donors’ Program. The entire Oncology team strives daily to provide superior care to our Veterans whom have served this country with honor.
Tumor Board Activities for 2018
Victoria Campa (Compiled data is from 1/3/18 through 12/5/18)

The VA Puget Sound Health Care System Tumor Board is held every Wednesday from 1:00 p.m. to 2:00 p.m. in Building 100, Room BD-152. Tumor Boards provide clinical information, pathologic staging, and treatment recommendations for the patient’s disease.

The Tumor Board is composed of a multidisciplinary group of attending physicians, fellows, residents, physician assistants, nurses, medical students, and other health care professionals. Staff representatives from Medical, Surgical, and Radiation Oncology act as discussants. All surgical subspecialties are represented. Images and micrographs are presented by staff physicians from Diagnostic Radiology and Pathology. The conference provides a forum to disseminate the most current information on cancer management. The discussants review data from current publications and determine eligibility of patients for cooperative group trials sponsored by the Southwest Oncology Group (SWOG) as well as in-house clinical trials. The conferences provide continuing medical education and provide a convenient forum for expeditious management decisions of complex patients.

In 2018, there were 47 conferences for the year. All the major cancer sites were represented in the cases discussed. The average attendance at each conference was 22. Attendees can receive one credit hour continuing medical education category 1 per session, which can be applied toward re-licensure requirements in Washington State.

All requests for Tumor Board submission shall be ordered online in CPRS on the order tab. The requesting service must complete the consult template and include a reason for the request. All consult requests will be coordinated through Victoria Campa, Tumor Board Coordinator, Oncology Section (6-4757).

**Tumor Board 2018 - Distribution of 342 Total Cases (1/3/18 – 12/5/18)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEAD &amp; NECK</td>
<td>90</td>
<td>26.3%</td>
</tr>
<tr>
<td>MUSCULOSKELETAL</td>
<td>6</td>
<td>1.8%</td>
</tr>
<tr>
<td>SKIN</td>
<td>6</td>
<td>1.8%</td>
</tr>
<tr>
<td>BREAST</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>GENITOURINARY</td>
<td>23</td>
<td>6.7%</td>
</tr>
<tr>
<td>OPHTHALMIC</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>LYMPHOID NEOPLASMS</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>CENTRAL NERVOUS SYSTEM</td>
<td>5</td>
<td>1.5%</td>
</tr>
<tr>
<td>NON-CANCEROUS</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>OTHER</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>20</td>
<td>5.8%</td>
</tr>
<tr>
<td>DIGESTIVE</td>
<td>63</td>
<td>18.4%</td>
</tr>
<tr>
<td>THORAX</td>
<td>123</td>
<td>36.0%</td>
</tr>
</tbody>
</table>
Cancers of the digestive system constitute a significant portion of the cancers diagnosed and treated at the VA Puget Sound Health Care System (VAPSHCS). Increased awareness and compliance with colorectal cancer screening, as well as the rising incidence of hepatocellular carcinoma, esophageal and pancreatic adenocarcinoma, have resulted in ever-increasing numbers of procedures performed for the screening, surveillance, diagnosis, and treatment of these cancers at our facility.

Procedures offered at the VAPSHCS include liver biopsy, esophagogastro-duodenoscopy (EGD), sigmoidoscopy, colonoscopy, capsule endoscopy, and endoscopic retrograde cholangiopancreatography (ERCP). Endoscopic ultrasound (EUS) is also available to Veterans needing tissue acquisition for the diagnosis of cancer, as well as for cancer staging. Other procedures include endoscopic palliation of malignant obstruction (e.g. esophageal, duodenal, biliary or colonic obstruction), in addition to percutaneous endoscopic gastrostomy for nutritional support. There are now eleven full-time staff gastroenterologists/hepatologists, three nurse practitioners, and a superb team of nurses on staff at the Seattle and American Lake campuses. Gastroenterology and Hepatology providers participate in weekly multidisciplinary conferences for the management of malignancies (e.g. Tumor Board and Liver Tumor Conference).

All staff physicians at the VAPSHCS hold faculty positions at the University of Washington and the Gastroenterology team also includes fellows, residents and medical students from the University. Members of our Gastroenterology Section are also actively involved in research relevant to cancer, including basic (e.g. DNA methylation & carcinogenesis), translational (e.g. screening tools), and clinical (e.g. screening, diagnostic and treatment strategies) research. They also collaborate with the research programs of many other departments within the VAPSHCS, the Fred Hutchinson Cancer Research Center and the University of Washington.
The multidisciplinary Urologic Oncology program is designed to help patients with genitourinary cancers of all types and give them the opportunity to discuss their therapeutic options with a broad range of care providers who treat patients with this disease, including urologists, radiation oncologists, medical oncologists endocrinologists, advanced registered nurse practitioners, specialty trained nurses, and physical therapists. By providing this type of integrated patient care, doctors hope to help patients make informed decisions and receive the best possible treatment. The multidisciplinary team offers some of the most advanced treatment options available for prostate cancer, including nerve sparing prostate surgery, brachytherapy (radiation implants), adjuvant chemotherapy, the latest options in hormonal therapy, and advanced disease chemotherapy studies. The center is one of a select few VA centers in the country utilizing the DaVinci robotic system to perform prostatectomies. We also offer cutting edge treatment options for kidney and bladder cancer, including robotic partial nephrectomy, laparoscopic nephrectomy, energy based ablative techniques for small renal tumors, radical cystectomy with urinary diversion for muscle invasive bladder cancer, and adjuvant therapies for non-muscle invasive bladder cancer including chemotherapy placed into the bladder. Finally, we offer continuing care of urologic cancer survivors which includes management of long term side effects of cancer therapy including erectile dysfunction and urinary symptoms. We are a cancer referral center for all of VISN 20 and also provide comprehensive care for cancers that are more uncommon in the Veteran population, including testis and penis cancer. The Program actively participates in cutting edge research, and offers ongoing trials in bladder cancer treatment and active surveillance of localized prostate cancer and precision oncology studies of germline and somatic sequencing paired with relevant clinical trials for advanced prostate cancer. For information, contact the Oncology Department at (206) 764-2709 or the Urology Department at (206) 764-2265

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**Tobacco: How the VA Can Help Veterans Quit**

*Michele Meconi, ARNP, CDE*

**Tobacco Use Rates among Veterans**

Veterans have much higher rates of tobacco use compared to nonveterans. Current use of tobacco products was higher among persons aged 18-25 years. A 2017 survey of Veterans enrolled in VA health care found 15.9% of those who responded are current smokers. That is an increase from 2016 (14.9%), but still far lower than what was seen just 12 years ago in 2005 (22.2%).[i] The survey also found that current smokers were more likely to be female (16.9%) than male (15.5%) and more likely to have OEF/OIF/OND status. Because Veterans have higher rates of smoking than nonveterans and smoking is the leading cause of preventable death, the importance of VA’s tobacco cessation efforts is vital to the overall health of many Veterans in our care.

**Negative Health Effects of Tobacco Use**

The U.S. Surgeon General advises that smoking can harm almost every organ in the body. Using tobacco exposes you to harmful chemicals that can:

- Lead to problems with your teeth, gums, and mouth.
- Decrease the effectiveness of medications for depression, anxiety, and psychotic disorders.

If you smoke cigarettes, you are about 25 times more likely to develop lung cancer than a person who doesn’t smoke, and nine out of 10 lung cancer deaths are due to smoking. It is estimated that more than 1.5 million people in the United States are living with cancer other than lung cancer that is due to cigarette smoking.
How the VA Can Help Veterans Quit (Continued)

VA Tobacco Cessation Efforts
It is important to note that tobacco use rates among Veterans in VA care have greatly decreased in the past decade, and there is still much work to be done. In addition, the VHA has developed tobacco cessation policy and programs as well as clinical resources for providers. We believe these resources can support efforts to bring the tobacco use rate down among Veterans in our care.

Quitting tobacco is a process that often takes many attempts. With tobacco use disorder being a chronic condition that often requires repeated interventions, all VA health care providers are encouraged to address tobacco use with their patients. Within the last two years, close to 60% of VA enrollees who smoked cigarettes made a quit attempt, yet were unsuccessful. More than anything, this shows that Veterans want to quit smoking, and that a huge percentage of current smokers has been in the “action” stage of quitting tobacco, but likely need the support of counseling and medication offered through VA. VA knows that with its support and resources, along with your desire and strength, you can quit and stay quit.

For VA health care providers, this represents a great opportunity to talk to our patients about their tobacco use and help them with this behavioral change through counseling, medication, and coming up with a quit plan. If you’re ready to quit tobacco, your VA health care team is ready to work with you to create a quit plan that’s right for you. Quitting isn’t easy, but you can do it. There are more former smokers today than current smokers — and VA has more treatment options available than ever before. Every day, Veterans just like you make one of the most important choices that they can for their health. They decide to quit using tobacco.

Important Benefits of Quitting Tobacco
There are many reasons to quit tobacco. Within five years of quitting smoking, your chance of getting cancer of the mouth, throat, esophagus, and bladder is cut in half. Ten years after quitting smoking your risk of dying from lung cancer drops by half. When a person living with cancer quits smoking, they can improve the course of their cancer and their chance of survival.

The benefits of quitting tobacco — for your physical and mental health — can begin almost immediately. Your heart rate and blood pressure will both drop, and within days you will notice a better sense of taste and smell, as well as breathing.

Quitting can also:
• Reduce stress and improve your mental health.
• Help you save money.
• Boost the effectiveness of some anxiety and depression medications.
• Make it easier to stop using drugs and alcohol.
• Increase your energy.
• Reduce your risk for cancer.
• Lower your blood pressure and cholesterol.
• Improve your lung function, skin, and night vision.
• Strengthen your immune system, muscles, and bones.
• Limit the exposure of loved ones and pets to secondhand smoke.

Tobacco Cessation Resources

Research shows that a person has the best chance of quitting tobacco for good when they use tobacco cessation medication and take part in tobacco cessation counseling. Tobacco contains nicotine, a highly addictive chemical. Using smoking cessation medications for the first few months while you’re quitting can help you manage nicotine withdrawal symptoms and cope with the urge to smoke.

Medications
There are several different types of medication, including:
• Nicotine Replacement Therapy (NRT): The nicotine patch, nicotine gum, and nicotine lozenges give your body medicinal nicotine to reduce your withdrawal symptoms.
• Bupropion (Zyban®): This pill helps reduce your urge to smoke. It can be combined with a single type of NRT.

(Continued on next page)
How the VA Can Help Veterans Quit (Continued)

- Varenicline (CHANTIX®): This pill blocks the effects of nicotine on your brain, making smoking less enjoyable and reducing your withdrawal symptoms. It should not be combined with any other smoking cessation medication.

Counseling
Tobacco cessation counseling is when you talk with a health care provider or a counselor about your tobacco use and work on ways to get tobacco out of your life. This type of counseling can help you break your tobacco habit and the daily patterns you have developed over the years.

Counseling is available in person or over the phone. You can talk with your health care provider or a counselor one-on-one, or participate in group counseling sessions. An important part of counseling is figuring out what triggers your tobacco use; common triggers include drinking coffee or alcohol, and feeling bored. Your counselor will help you find ways to avoid or cope with your triggers so that you don’t start using tobacco again.

Contact your VA health care provider and let them know you are quitting tobacco. They can offer you counseling and the right smoking cessation medication for you.

Learn more at www.publichealth.va.gov/smoking/quit.

Other VA Tobacco Cessation support options include the following:

A Self-Management Workbook to Help You on Your Journey to Quitting

This workbook is intended to be utilized by Veterans participating in cessation programs. It provides information about the harmful effects of tobacco, preparing to quit tobacco, tips and strategies for success, as well as other VA resources that can be accessed to accompany this mini-workbook.

Visit www.publichealth.va.gov smoking/quitline.asp to learn more.

Smokefreevet Text Service
SmokefreeVET is a free text messaging service that sends daily support, advice, and encouragement directly to your mobile phone. You will receive 1-5 messages per day and can receive additional quit support by texting keywords such as URGE, STRESS, or SMOKED.

Sign up for the program in English by texting the word VET to 47848 from your mobile phone or by visiting www.smokefree.gov/VET. For Spanish, text VETespanol to 47848 or visit www.smokefree.gov/VETespanol.

For more information and to watch a short video about the program, go to www.publichealth.va.gov/smoking/smokefreevet.asp.

Stay Quit Coach App
The Stay Quit Coach app was specifically designed to help Veterans with Post-Traumatic Stress Disorder (PTSD) quit smoking. It has been shown to double quit rates for Veterans with PTSD.

Use the Stay Quit Coach mobile app to:
- Create a custom quit plan that takes into account your personal reasons for quitting, such as coping with symptoms of PTSD;
- Learn more about the risks of smoking, the benefits of quitting smoking, and how to cope with urges to smoke;
- Access support contacts and hotlines that can help you stay smoke-free;
- Receive motivational messages and reminders to take any medications; and more.

Quitline
Tobacco quitlines can double your chance of quitting, compared to getting no support at all. And they’re great for Veterans with busy schedules or Veterans who can’t attend counseling in person. Call VA’s smoking quitline toll free at 1-855-QUIT-VET (1-855-784-8838). A counselor will answer your call in less than a minute and begin helping you create your own personal quit plan. Your counselor will ask you about your tobacco use, quitting history, and motivations to quit. Any information you share during the call will be kept private.

A recent Veteran caller said, “You know what? This is actually going to work!” Let it work for you too, and call 1-855-QUIT-VET (1-855-784-8838) Monday through Friday from 6AM to 6PM Pacific Time. Counseling is available in English and Spanish.
Stay Quit Coach is available for free on the Apple iTunes store. Learn more at mobile.va.gov/app/stay-quit-coach.

You’re Not Alone: Join an Online Support Community
On the SmokefreeVET Facebook page [www.facebook.com/smokefreevet] Veterans can share stories, offer and receive tips and encouragement, find resources to help them as they quit, and get the latest news on the benefits of living a tobacco-free life.

Tobacco Cessation Counseling at your VA Puget Sound Clinic
There are many local tobacco cessation resources, including group options at the main facilities as well as the CBOCs or through telehealth options.

Tobacco Cessation Events
You have likely seen many of these tobacco cessation resources at health fairs, stroke fairs, diabetes fairs, and patient education fairs where you have the opportunity to speak to our dedicated doctors and nurses. Our Healthy Living Team reaches out to help motivate and encourage Veterans to quit tobacco. We asked Veterans visiting our Tobacco Cessation booth whether our efforts were effective. As a result of visiting our tobacco cessation booth patient reported the following:
1) 94% reported they were more likely to review information and resources about quitting tobacco.
2) 88% reported they would be more likely to think about what quitting tobacco might be like.
3) 81% reported they would consider moving toward quitting tobacco.
4) 87% reported they would be more likely to talk about quitting tobacco with their health care team.
5) 67% reported they would be more likely to make a plan for quitting tobacco.
6) 64% reported they would be more likely to set a date for quitting tobacco.

Not everyone is ready to quit right now and that’s okay. Our goal is to provide those who use tobacco with information to at least think about quitting. That’s the first step. We will support Veterans’ efforts to quit using tobacco in any way we can at VA Puget Sound. Your health care team will ask you about tobacco use at least once a year. If you do use tobacco, our clinical staff are trained to guide you toward resources to help you quit whenever you are ready.


History: In 2005 (1), the Fleischner Society, an international society of individuals interested in lung disease, published a set of guidelines for the management of small lung nodules detected on computed tomographic (CT) examinations. The goal of the guidelines was to provide a sensible and homogeneous pathway for management of the numerous small pulmonary nodules identified by CT and to reduce patient anxiety, unnecessary patient radiation exposure, healthcare cost and time expenditure. Prior to this, follow-up management was erratic and at the discretion of the radiologist/pulmonologist/clinician caring for the patient. The initial set of guidelines were applied to indeterminate, small lung nodules, those without benign characteristics and of completely solid nature.

VA Puget Sound Health Care System (VAPSHCS): 2011 (6 years after publication of original 2005 FSG) – Our facility evaluated the CT reports of 153 cancer-free patients with lung nodules to see if they recommended management in accordance with FSG. To isolate reports containing lung nodules only, not nodules in other organs, or “nodular opacities” of infection/inflammation, the reports underwent screening by a natural language processing program (WEKA tool) – a program that was being developed by Dr. Steven Zeliadt’s research group (VAPSHCS/UWMC). Results were then manually reviewed and if lung nodules were not present, reports were excluded. The 153 reports indicated above were the end results.

Nodules were categorized as 1) very small (≤4 mm); 2) stable or benign; and 3) indeterminate requiring additional surveillance. A radiologist specializing in thoracic imaging reviewed recommendations and clinical indications included in the text report and classified follow-up recommendations as appropriate, inappropriate or incomplete.

Focusing on 139 patients with small and/or stable nodules, our review found that 43% of very small nodules or clearly benign or stable nodules (categories 1 and 2) received appropriate recommendation from the radiologist in the CT report. 9% had inappropriate follow-up recommendation. The remaining 47% had incomplete or vague follow-up recommendations.

Among the 14 (9%) of patients with indeterminate nodules (category 3), 43% had appropriate follow-up recommendation included in report, 43% had incorrect recommendation with follow-up interval not appropriately specified and 14% had incomplete recommendations.

2013 – The 2nd version of FSG was published and included management suggestions for lung nodules that were not completely solid, but part-solid or fully ground-glass.

Implementation: In March of 2017, the latest (3rd) version of the FSG was published (3). Revisions were based on experience with prior versions of FSG, as well as lessons learned from National Lung Screen Programs. The guidelines were not to be applied to individuals younger than 35 years, to patients with known malignancies or immunocompromised states, or in the presence of active infections; which are all variables that significantly affect the likelihood of malignancy. The recommended surveillance was more sophisticated than the original FSG. Management strategies differed depending on whether the patient was at high or low risk for lung cancer; whether nodules were solid, part-solid, or purely ground-glass, and whether they were solitary or multiple. Additionally, flexibility in the recommended period of time until the next CT scan was added allowing the radiologist, clinician and patient some input based on his/her concern for malignancy.

To educate our radiologists on applying the latest FSG, 2 power-point presentations were made available to the attending radiologists in the VAPSHCS Body Imaging section. The first presentation explained CT technique, described nodule types, CT findings suspicious for malignancy, how nodules are measured, what nodules should be reported, and the new FSG. The 2nd power-point was a self-assessment that included 35 test cases with images and possible follow-up approaches. The test cases were selected to represent both common presentation of nodules as well as to highlight instanc-
es when FSG would indicate additional follow-up is not necessary. Answers with associated with FSG recommend-ed follow-up and clinical reasoning for follow-up were immediately available. Body Imaging attendings were asked to review the power-point presentations. Scores from the self-assessment were not collected. The 2017 FSG was posted on the wall in the reading room above the workstations of the Body Imaging section.

Results: To learn whether our radiologists were compliant with the new FSG, another group of CT reports was sampled. In December of 2017, chest CT reports (with lung nodules identified by WEKA tool) were pulled for the months of April, May, and June of 2017. These reports were not as highly selected as the original 2011 set, so some differences in the report pools between the 2 groups would be expected. 285 reports were selected from 377. Excluded reports (92) included those that were dictated by non-PSVA radiologists who did not undergo training, reports from patients with a known malignancy or immunocompromised state if identified in the body of the dictated report (not FSG candidates). The nodules were not sub-categorized into very small, stable or benign, or indeterminate since that status was not always available to the radiologist or to us. Individuals who may have had a malignancy or immunocompromised state, but could not be identified as such by review of the radiology report (clinical history was not made available) were included. The same chest radiologist reviewed these 285 reports and classified follow-up recommendations made by the interpreting radiologists as appropriate, inappropriate, or missing/vague. 43% (123/285) were appropriate, 23% (66/285) were inappropriate, 34% (96/285) were vague or missing.

Following the FSG training, one radiologist expressed concern with recommending specific follow-up management in accordance with FSG because of a lack of radiologist knowledge of patient risk-factors (smoking status, pack-years of smoking, carcinogenic exposures, etc.) for lung cancer. Results above show the percentages of appropriate, inappropriate and vague or missing recommendations made by all radiologists in 2017 (2017 all), without the one radiologist in 2017 (2017 [-1rad]) and all radiologists in 2011 (2011 all).

<table>
<thead>
<tr>
<th></th>
<th>2017 (all)</th>
<th>2017 [-1 rad]</th>
<th>2011 (all)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appropriate</strong></td>
<td>43%</td>
<td>47%</td>
<td>47%</td>
</tr>
<tr>
<td><strong>Inappropriate</strong></td>
<td>23%</td>
<td>26%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Vague/Missing</strong></td>
<td>34%</td>
<td>27%</td>
<td>41%</td>
</tr>
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(Continued on next page)
The findings were examined by month following the FSG training (2017) to see if improvement occurred with practice.

<table>
<thead>
<tr>
<th>Month</th>
<th>% appropriate</th>
<th>% missing/vague</th>
<th>% inappropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>48%</td>
<td>28%</td>
<td>24%</td>
</tr>
<tr>
<td>May</td>
<td>40%</td>
<td>37%</td>
<td>23%</td>
</tr>
<tr>
<td>June</td>
<td>40%</td>
<td>37%</td>
<td>23%</td>
</tr>
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</table>

Of the reports when follow-up recommendations were inappropriate, 58% (38/66) recommended follow-up when no follow-up was indicated. Of reports where follow-up was vague or missing, 59% (57/96) did not require follow-up.

National benchmarks: Looking at the literature on compliance with FSG, in 2010 (5 years after release of the initial Fleischner recommendations) a survey was conducted of 7,000 randomly selected members of the largest Radiology Society in the world to assess their awareness and use of the FSG. Surveys were returned by 834 (12%) members, and 649 (79%) reported they were aware of the FSG. (4) 490 members (78%) used those or similar guidelines in their practices. Three scenarios for nodule management were assessed by responding members. Management of those scenarios were consistent with FSG in 35% to 61% of responses. The conclusion of this report was that there is high awareness and adoption of FSG, but radiologists show varying conformity with the recommendations.

Another survey published in 2012 showed comparable results with adherence to FSG in 34% of reports 7 years after the original Fleischner article. (5)

A review conducted by MacMahon (6) explored potential reasons for incomplete compliance with FSG:
1. Medicolegal considerations (6) – legal vulnerability of recommending no follow-up for a lesion that later turns out to be malignant. Follow-up examinations that confirm stability are unlikely to be medicolegal issues.
2. Financial (6) – more exams, more income.
3. Pressure by patient or clinician to follow more closely than necessary (6).
4. Remembering to use FSG, remembering to remind residents/fellow to use.
5. Difficulty remembering specific guideline recommendations (5)

In addition to these reasons, our study identified additional potential reasons stated by radiologists that are unique to the updated FSG.

6. Practice needed to unlearn old FSG recommendation, make correct follow-up recommendations based on changes made in 2017 FSG regarding nodule size and timing of subsequent CT scans.
7. Patient risk factors, highlighted by updated FSG, are often not provided by ordering clinician/patients

Another study (7) that focused on improving FSG compliance showed nearly twice the level of FSG adherence (82%). That achievement was credited to the radiology department stressing use of FSG to reduce patient radiation exposure and health care costs. Small laminated cards having the FSG were attached to every workstation at that facility.

In addition, the increase in complexity in the 3rd iteration of the FSG itself may have contributed to the greater proportion of inappropriate recommendation observed in the follow-up period. Research in behavioral economics has demonstrated that as decision-making becomes more complex (e.g., more options are available or more variables need to be evaluated) individuals are more likely to experience choice overload. One way they deal with choice overload is to revert to prior habits or defaults. (https://www.behavioraleconomics.com/mini-encyclopedia-of-be/choice-overload/). Faced with flexibility in the recommended follow-up time period and uncertainty about patient risk factors, it might be expected that radiologists reverting to decision defaults would recommend more frequent follow-up than appropriate.

Summary: Following educational steps, a self-assessment tool, and posting FSG on-site above the work area for the Body Imaging section, we were able to implement the use of the 2017 Fleischner Society Guidelines for management of small lung nodules with adherence in accordance with reported benchmarks for previous editions of FSG.

Corrective Action Plan:
Although we achieved adherence at about 45%, there is significant room for improvement.
1. Our department should make further efforts to highlight FSG, including promoting their use through posting and discussion at faculty meetings, educating and reminding students to use FSG, and sending reminders to each Body Imaging attending, resident and fellow at the beginning of each rotation (every 4 weeks).
2. Our department should work with Primary Care, Pulmonary and other ordering providers to ensure patient risk-factors for cancer are included in CT orders. This issue can be addressed for FSG candidates as well as potential Lung Screen candidates through several paths:
   a. Patient questionnaire
   b. CPRS pulled data
   c. Referring clinician questionnaire

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3. Recurring review: Our faculty is motivated to improve adherence to the new FSG and will prioritize recurring reviews. When the Diagnostic Imaging Service is fully staffed, we will routinely sample sets of CT reports from all Body Imaging attending physicians for review of adherence to FSG and feedback will be provided to the radiologist.

4. Although financial incentives have been highlighted as a concern in other settings, this likely does not affect our department because the attending physicians are salaried and there are not financial incentives to recommended additional imaging at the time of exam interpretation and reporting.

References:

Radiation Oncology
Tony Quang, MD, JD, Adam Tazi, PhD, and Kent Wallner, MD

The VA Puget Sound Health Care System is a radiation oncology referral center in the Veterans Affairs system, which is the first radiation oncology facility in the State of Washington accredited by the American College of Radiology. It provides cancer care for patients from the VA Northwest Health Network 20 which serves Alaska, Idaho, Oregon and Washington. We deliver state of the art clinical care to patients.

We seize every opportunity to implement technological advances. We are currently preparing to upgrade our linear accelerators and standard operating procedures in anticipation of offering SBRT (stereotactic body radiotherapy) and SRS (stereotactic radiosurgery) treatments. This effort is spear-headed by our interdisciplinary team of radiation oncologists—Tony S. Quang, MD, JD and Kent E. Wallner, MD, physicists Adam Tazi, PhD and Carl Bergsagel, MS, dosimetrists David Cain, CMD, ARRT(T), and Blake Webb, CMD, ARRT(T). Moreover, Melissa Mitchell, CMD, ARRT(T) has served as liaison between dosimetry and treatment delivery; Karina Dean, ARRT(T) is developing standard operating procedures to improve workflow between CT simulation and treatment delivery; and Janyce Short, ARRT(T) has focused on informatics to better navigate MOSAIQ.

While IMRT (intensity-modulated radiotherapy) continues to be used to treat head and neck, prostate, lung, and rectal cancers, VMAT (volumetric-modulated arc therapy), a faster and better technique of radiation therapy delivery, has been commissioned and added to the treatment planning tool box. In fact, VMAT has been in clinical use for more than 1.5 years.

As part of external peer review for quality assurance measurements and dosimetry review of our radiation treatment machines and planning system, we recently had an onsite visit on October 24 – 26, 2018, by IROC (Imaging and Radiation Oncology Core) from MD Anderson Cancer Center in Houston, Texas. IROC provided the service under a grant from the National Cancer Institute and a contract with the Department of Veterans Affairs. Because of this affiliation IROC obtained confirmatory machine data

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and reviewed our calculational procedures to ensure accuracy. The outcome of the review included a few excellent recommendations and the finding that there were no items missing in our current quality assurance program. Because of Dr. Adam Tazi’s leadership, our physics program is second to none.

We continue to perform rigorous continuous quality improvement including interdisciplinary chart rounds, morbidity and mortality conferences, outcomes studies, focus studies, and peer review. Drs. Quang and Wallner are active participants at weekly Tumor Board meetings. Dr. Wallner runs monthly journal clubs teaching residents at University of Washington Medical Center. Drs. Quang and Wallner continue to be Visiting Oncology Lecturers at Bellevue College teaching clinical oncology to radiation therapy students. Students from this training program have consistently over the years scored in the 90th to 95th-percentile on their board examinations.

As an international authority on prostate brachytherapy, Dr. Wallner has pioneered a specialty clinic, which continues to offer seed implant to prostate cancer patients in the country. We have integrated brachytherapy with an interdisciplinary prostate cancer program that includes IMRT/VMAT with placement of gold seed fiducials for IGRT (image-guided radiotherapy). Moreover, using a shorter course—hypofractionated radiation therapy treatment has allowed patients to complete their treatment quicker so they can go back home. Patients have tolerated this regimen exceptionally well and have expressed high satisfaction with the convenience.

Furthermore, Dr. Quang remains as a Board Member to the Association of VA Hematology/Oncology, an organization with members who are interested in advocating and promoting cancer care of Veterans. At the last annual meeting in Chicago, Illinois in September 2018, he served as one of the moderators for the scientific poster session. He continues to provide our VA with up-to-date scientific and best clinical practice expertise in his respective roles as Surveyor for the American College of Radiology. Dr. Quang also serves on the American Society for Radiation Oncology (ASTRO) Bylaws Committee. Dr. Quang serves as a Board member to the Washington State Medical Associations and joined the Committee on Universal Healthcare.

The VA Puget Sound Radiation Therapy Department has maintained its position as a nationally visible center drawing referrals from other VA facilities throughout the United States. Our department continues to successfully implement technological advances and upgrades to offer state of the art cancer care. Our expansion of cutting edge technology, continued innovation efforts, and our commitment to quality assurance through the implementation of a robust continuous quality improvement has positioned our department to offer our patients the best of care for now and well into the future. With costs continuing to increase in health care, which affects access to care, it is now more important than ever to reaffirm our commitment to our Veterans.
Annual Palliative Care Report 2018
Alice Foy, ARNP, CHPN

Palliative Care Service Growth Summary:
The Seattle VA Palliative Care consultation service continues to expand at a rapid pace. The majority of new growth is in the outpatient clinic and we have enjoyed getting to know and work with Veterans outside of the hospital setting. Consults and follow-up requests from Oncology services, including Radiation Oncology, continues to be our top source of referrals, and we often see Veterans during their appointments with other specialty providers. Our local Cancer Navigation team continues to be instrumental in identifying and facilitating additional support for Veterans with a cancer diagnosis who may benefit from enhanced palliative specialty care. This care includes complex symptom management, helping patients to identify and address their goals of care, as well as finding additional services and programs to help individuals maintain as much independence and functioning as possible while they receive important treatments.

The following services continue to be offered: Acute care consultation, outpatient consultation, non-visit consults, and hospice in the VA Community Living Center. We also continue to partner with community based palliative and hospice agencies to ensure that care is being provided for Veterans with advanced illness. We are able to see new clinic patients within a month and can often accommodate urgent visits within days. We have also been able to utilize non-VA community based palliative care services to meet growing needs and distance challenges for our Veterans outside of King County. American Lake has recently added a new MD and ARNP for their Palliative Care consultation service and are now able to see Veterans in clinic on Monday and Wednesday at that location.

Education:
Our teaching program continues to grow and we look forward to a robust palliative fellowship program again next year. We now also have an active CLC hospice rotation for 4th year Medical Students as well.

Advanced planning initiative:
We continue to implement The Life-Sustaining Treatment Decisions Initiative (LSTDI,) a VA nationwide quality improvement project to improve patient-centered care for Veterans with serious illness. The project promotes proactive goals of care conversations with patients who are at high risk of a life-threatening clinical event. Most of the Oncologists and Palliative Physicians have already completed this training which is an important part of ensuring that Veteran and family goals are understood and honored at all stages of an illness.

Special Projects:
The palliative care team is collaborating on a very important project to develop a better symptom management pathway for Veterans experiencing Head and Neck cancer. Tamarind Keating, ARNP of the Cancer Navigation Team, is leading our efforts to identify the best and most effective ways to address the very complex symptoms, particularly pain, that these individuals experience during and after the treatment process. Because we feel that this project has valuable and important implications for both the local and national level in ensuring quality care for Veterans, the Palliative Care team has made the focal point of their FY 2019 “Smart Goal” to support all cancer team efforts in creating a comprehensive plan to deliver effective symptom management.
The surgical oncology program provides comprehensive evaluation and treatment for tumors of the upper and lower gastrointestinal tract, hepatobiliary system, pancreas, breast, melanoma, soft tissue sarcoma, and endocrine system. Together with Drs. Lorrie Langdale, Roger Tatum, Dana Lynge, Edgar Figueredo, and Deborah Marquardt; our section provides surgical expertise covering a broad range of procedures, including sentinel lymph node mapping, minimally invasive and robotic surgery, and complex oncologic resections including esophagectomy, hepatic resection, pancreaticoduodenectomy and total mesorectal excision with anal sphincter preservation. We work in tandem with colleagues in Medical and Radiation Oncology to offer personalized combined modality protocols. Our goals are to provide state-of-the-art solid tumor treatment in a multidisciplinary environment, enroll patients in cancer clinical trials, conduct innovative cancer research, and provide education and mentorship to our students, residents, and fellows affiliated with the University of Washington and Fred Hutchinson Cancer Research Center.

The Cancer Telemedicine Program based at the VA Puget Sound is broadcast twice monthly and serves to advise and coordinate multidisciplinary oncology care throughout the Veterans Integrated Service Network (VISN) 20. Originally conceived as the Northern Alliance Cancer Center and funded by the VA New Clinical Initiatives Program and VACO Transformational Initiatives Program, the VA Cancer Telemedicine Program has matured into a vital clinical program for the region. Providers at regional VA facilities throughout the VISN 20 present cases in a live interactive format to the multidisciplinary tumor board in Seattle staffed by surgical and medical oncologists. Participation in this program facilitates patient referral, minimizes consultation delays, avoids unnecessary patient travel, coordinates outpatient studies, and provides multidisciplinary evaluation of all cancer patients. The program’s success ensures that all veterans within the VISN 20 have access to state-of-the-art multidisciplinary cancer care.

For further information, please contact our Cancer Telehealth Coordinator, Lisa Mandell, R.N., J.D. e-mail: Lisa.Mandell@va.gov
Cancer Care Navigation Team and Survivorship Clinic

Lynsi Slind, RN, MN, Tamarind Keating, ARNP, Ana Fisher, LICSW OSW-C, Werk Demisse, MSA

A multidisciplinary team partnering with Veterans with cancer to identify and eliminate barriers to care and improve patient outcomes. Cancer patient navigation was developed in the 1990s as a method to address health disparities that impact cancer prevention, detection, diagnosis, treatment and survival. Poverty, lack of insurance, distance from a treatment facility and other factors may be barriers that prevent patients from getting necessary and timely care. By partnering with vulnerable patient populations to identify and address these barriers, navigation programs have been able to improve screening rates, timeliness of care, compliance, patient satisfaction and survival rates. These programs have been implemented in cancer centers across the country and patient navigation is now a standard of care for programs accredited by the Commission on Cancer.

The VA Puget Sound Cancer Care Navigation Team (CCNT) was established as part of a network of Cancer Care Navigation Teams across VISN20 with additional sites in Idaho (Boise), Oregon (Portland, White City and Roseburg), and Washington (Spokane, and Walla Walla). In Seattle, CCNT includes a nurse practitioner, registered nurse, social worker and program support assistant.

Veterans with cancer may experience a number of barriers to receiving the care they need, including a lack of social support or caregiver, difficulty with transportation or travel, coordinating appointments with multiple services, distress, poor nutrition, and low health literacy. When a Veteran is referred to CCNT, our staff conduct a comprehensive assessment for distress and barriers to care and individualize a plan of care for each Veteran. We provide patient education regarding their diagnosis and treatment and resources available from the VA. We assist with schedule coordination to reduce additional trips to our facility and counsel Veterans regarding the costs of their care with referrals to eligibility and community sources of financial support when available.

For Veterans referred from another VA facility, CCNT conducts a history and physical exam to document and address other health conditions that may be relevant during an extended stay away from home. Veterans receive ongoing support through their treatment and a written treatment summary at the end, detailing their cancer diagnosis, treatment, complications and follow-up plan. This information is sent to home providers via interfacility consult.

For Veterans who are within the VA Puget Sound catchment that report significant barriers in traveling to Seattle for cancer-related treatment that cannot be resolved by CCNT, a formal review process is in place to review named barriers or “geoburden” for consideration of the Veteran receiving their cancer care locally. CCNT completes a thorough geoburden assessment and presents this information to VISN20 Cancer Interdisciplinary Purchase Care Team for review based on established care routing business rules. Upon approval of local cancer care, CCNT continues to assist the Veteran in setting up care in the community to assure it is timely.

The Cancer Survivorship Clinic counsels Veterans regarding their diagnosis and treatment and related potential late health effects. A survivorship care plan is detailed for the Veteran and their health care providers and resources are provided to assist Veterans in managing some of the unique aspects of physical and psychosocial health following cancer treatment. The Cancer Survivorship Clinic is meeting the goal set forth by the Commission on Cancer that our facility provide this care to more than 50% of all eligible cancer patients each year.

To date, the VA Puget Sound Cancer Care Navigation Team has enrolled over 2000 Veterans in navigation services. Approximately 50% of these patients are referred from VA facilities across VISN 20 while the other 50% come from the VA Puget Sound catchment area. We have received over 1700 consults from 320 VA providers, including specialty and primary care providers, nurses, dieticians, and coordinators. Over 400 Veterans have been seen in the Cancer Survivorship Clinic.

To refer a Veteran to CCNT: Submit a consult to Cancer Care Navigation Team in the CPRS consult menu or call: 206-277-4593
Speech Language Pathologists (also known as Speech Therapists) are actively involved in the care of patients if speech/communication, swallowing, and/or cognition are affected by cancer. We work with patients at the onset of cancer diagnosis, throughout the course of their treatment, and years after the completion of their treatment for ongoing therapy or management of any difficulties that may continue. We primarily work with patients who are diagnosed with head and/or neck cancers, but we can work with patients with other types of cancer too.

Speech Language Pathologists are specialists that help educate you and your family about ways to minimize the side effects of head and neck cancer, both from the tumor itself, or the side effects of treatment. Speech Language Pathologists can help manage the symptoms that you are experiencing whether you undergo surgery, radiation, chemotherapy, or even if no treatment course is pursued.

Because the cancer and/or its treatment often affect the ability to talk and eat, the Speech Language Pathologist evaluates for any chewing, swallowing, speech/communication, language, or cognitive difficulties and provides education and therapy as needed.

Some examples of the areas in which Speech Language Pathologists help cancer patients and their families:
- Difficulty eating or drinking (dysphagia), such as difficulty chewing, difficulty swallowing, or other complications arising from the tumor or surgery.
- Prevention of swallowing problems mentioned above that may occur from the treatment (radiation or chemotherapy).
- Changes in your voice or speech production.
- Evaluating and managing cognitive (memory, attention) changes.
- Management of your stoma and alternative communication options/methods following Total Laryngectomy Surgery.

When you meet with a Speech Language Pathologist, they may help you with the following:
- Understand the muscles, anatomy, and sequence involved in eating, drinking, and talking.
- Understand more about your surgery or treatment and how it may affect your ability to eat, drink, or communicate.
- Learn the short and long term effects of chemotherapy and radiation on speech and swallowing and ways to minimize any adverse effects.
- Evaluate for any difficulties you may already have with talking and eating, as well as monitor you for any changes in these abilities as you progress with therapy. We can do this both clinically and instrumentally with a variety of evaluation methods.
- Teach you ways to minimize effects of surgery or treatment on your swallow function, such as compensatory strategies or diet modifications.
- Teach you exercises to maximize short and long term range of motion, strength, and overall function to combat effects of surgery and/or treatment.
- Teach you ways to compensate for any speech or voice changes, including use of compensatory strategies, compensatory tools, or other alternative methods of communication that may be used in the short and long term. Tools and devices include simple “low tech” options, such as writing pads or picture boards, as well more “high tech” options such as alternative communication devices, voice amplifiers, tablet applications, etc.

Ideally, patients should expect to see a Speech Language Pathologist whenever they are experiencing changes in their swallowing, communication, or cognition – and this may occur even prior to their diagnosis. However, once diagnosed, Speech Language Pathologists like to see patients at the following times:
- Prior to surgery to discuss changes in swallowing, speech/communication, or cognition and ways to immediately compensate for changes.
- Following surgery to help manage any changes (whether in acute care or in the outpatient setting).
- Prior to initiating radiation therapy and throughout your treatment.
- Intensive treatment or occasional follow-up after treatment, depending on your needs.

Swallowing and communication are extremely important aspects of the human condition that we often take for granted until changes occur; our goals as Speech Language Pathologists are to help you understand how your cancer diagnosis and treatment can impact talking, eating, and thinking, but more importantly to maximize your quality of life during your treatment and for the remainder of your life.
A newly expanded paradigm for health care called Whole Health is being tested at the U.S. Department of Veterans Affairs (VA). Whole Health goes beyond your illnesses, injuries, or disabilities. The Whole Health concept includes conventional treatment, self-empowerment, a personalized health plan, self-healing, self-care, and non-drug complementary and integrative therapies.

In Whole Health care, the Veteran is an active partner with his/her health care team. Why is the VA changing the way health care is provided? The core mission of Veterans Health Administration is to “Honor America’s Veterans by providing exceptional health care that improves their health and well-being.” On Thursday, November 29, Dr. Tracy Gaudet, director of the Office of Patient Centered Care and Cultural Transformation – OPCC&CTC – at VA Central Office, spoke at the National Institutes of Health about the VA’s journey through this new model of health care. This innovative model of care is becoming an example to other health care systems, showing exciting potential for application to other health care systems. Dr. Gaudet’s presentation will be streamed live on the National Center for Complementary and Integrative Health Facebook page (https://bit.ly/2ArAn3c).

Join the conversation on Twitter using #Straus18 http://bit.ly/2ArAn3c

Whole Health Approach to Engage Transitioning Service Members

According to the guidance on the Executive Order signed by President Trump on January 9, 2018, the VHA Whole Health approach will be the cornerstone to engage transitioning Service members in discovering their mission, aspiration, purpose and learning activities to promote well-being.

The Whole Health Pathway component of the Whole Health approach consists of two key aspects:

1. Introduction to Whole Health sessions, that provides the context for the Whole Health approach on both the National and local levels.
2. Taking Charge of My Life & Health peer group sessions

All Veterans who participate in the Introduction to Whole Health session are prepared to join the Taking Charge of My Life and Health peer-led group sessions. These sessions provide a more in-depth immersion into self-exploration, self-care and goal-creation around what really matters to the Veteran.

Information and resources to support our facility’s Whole Health Pathway may be found https://vaww.infoshare.va.gov/sites/OPCC/2018ExecutiveOrderGuidanceTraining/Forms/AllItems.aspx.

For Whole Health education resources, visit https://vaww.infoshare.va.gov/sites/OPCC/Education/SitePages/Home.aspx

VA Puget Sound expanding Whole Health Care

As of today, every VA facility around the country is required to offer the following integrative therapies:

• Acupuncture
• Biofeedback
• Clinical Hypnosis
• Guided Imagery
• Meditation: Mindfulness, Mantram Repetition, IRest
• Massage
• Tai Chi / Qi Gong
• Yoga

Here are some examples of how Whole Health is actively being implemented at VA Puget Sound:

• Last year, VA Puget Sound held a Tai Chi training for staff where 20 health care providers completed the training, including one of our radiation oncologists, Dr. Tony Quang. Many of these providers are offering Tai Chi classes throughout the facility.
• We also continue to have an extensive Mindfulness program led by Dr. David Kearney, whose programs have reached out to Veterans and staff for many years. In addition, various staff members have recently received training in and are currently offering classes on IRest meditation.
• Within Primary Care Mental Health Integration, Dr. Kelly Caver will be offering clinical hypnosis to Veterans living with Chronic Pain.
• Both of our facilities had very active acupuncture clinics for many years, led by our two nurse acupuncturists Laurieanne Nabinger RN, L.Ac. and Mary Muth RN L.Ac. During the last year, two other staff members at American Lake (Bernard Canlas MD
and Steven Hedt PA) also received funding to attend medical acupuncture training.

- During the next 4 years, VA Puget Sound will also be one of 3 national research sites for Mission Reconnect (https://missionreconnect.com). Mission Reconnect is an evidence-based on-demand program that teaches Whole Health interventions via a mobile app. Veterans and their partners/spouses participating in this project will have free access to the mobile app where they will learn meditation techniques, relaxation exercises and instruction in simple massage techniques to promote stress reduction and interpersonal connection. To participate in this opportunity, you can email Dr. Kozak at leila.kozak@va.gov.

- In addition, Veterans at VA Puget Sound HCS have access to OPCC&CT online resources completely free of charge such as a library of guided meditations available on demand (https://www.healthjourneys.com/partneraccess/index/). Guided imagery and meditation have been shown to reduce stress, improve sleep, reduce pain, and clear the way for finding your own deep inner peace. This page streams a variety of brief meditations by leading practitioners in the mind-body field. Find your favorites, listen regularly, and enjoy the benefits. Invite your family to use the page, too. It’s available 24/7.

- Another meditation resource free of charge is the Meditation Oasis® Podcast (https://www.meditationoasis.com/podcast) that features guided meditations, instructions for meditation, and music for meditation. You can listen to it at iTunes or Google Play or by clicking on the play buttons.

- You will find other web-based and mobile tools to support your whole health journey from patient centered care at va.gov.

Recently, our facility has taken a new step by creating the Whole Health Coalition, a group that has been meeting to develop a charter and organizational plan for Whole Health at Puget Sound. This will take Whole Health to a new level of integration and implementation at both of our facilities and community clinics.

Why is Whole Health such an important addition to Cancer Care?

Integrative therapies are a big part of whole health care. Some of these therapies have been shown to decrease anxiety and pain, to improve mood and to help manage chemotherapy-induced nausea and vomiting. For example, acupuncture and aromatherapy are widely used to decrease chemotherapy-induced nausea and vomiting at cancer care services around the world. Massage, acupuncture and music are currently used to help manage pain and anxiety. Yoga, tai chi and meditation are offered within cancer care to help manage pain and anxiety and enhance quality of life.

An estimated 50% of cancer patients in the United States already use integrative therapies to deal with side effects from cancer treatment including massage, acupuncture, aromatherapy, hypnosis, guided imagery, meditation, art and music therapy, yoga and tai chi.

To learn more about Whole Health and how whole health can benefit you, visit the Office of Patient Centered Care and Cultural Transformation’s site (https://www.va.gov/patientcenteredcare/)

You can also explore a variety of Whole Health video resources, read more about VA’s Whole Health Peer to Peer program and find more information about Whole Health Peer to Peer training program from above link.
Cancer Rehabilitation/Rehabilitation Care Service
Meg Sablinsky, PT, DPT, CLT – LANA

For patients undergoing cancer treatment, quality of life matters as much—if not more—than the quantity of life. With an increasing focus on rehabilitation, patients are able to have improved quality of life during and after their cancer treatment. Patients undergoing cancer treatment may experience one or more of the following side effects: decreased muscle strength, decreased bone density, peripheral neuropathy related to chemotherapy, fatigue, decreased range of motion, pain, lymphedema, and scar adhesion. Rehabilitation Care Services can assist patients who have been diagnosed with cancer with a variety of their rehab needs on an inpatient or outpatient basis. These needs include pain control, weakness and deconditioning, mobility including assessment and provision of equipment for mobility safety, activities of daily living such as dressing/grooming/bathing, cognition, communication, swallowing, nutrition, bowel/bladder functions, skin integrity and wound management, lymphedema management, depression/adjustment/anxiety, social support, and vocational guidance. Goals for cancer rehabilitation often include effective pain control, maximal functional independence, restoration of maximal strength and mobility, prevention of further impairment, care-giver training to assist functionally-dependent patients, home management, community reintegration, and behavioral adaptation to pain and illness. In addition, a specialized service that Rehabilitation Care Services offers is Complete Decongestive Therapy (CDT), a treatment for lymphedema. Lymphedema is swelling of a body part, most commonly involving the extremities, face and neck but it may also occur in the trunk, abdomen or genital area. It is most commonly the result of damage to the lymphatic system due to surgery or radiation treatment therapy, surgical procedures performed in combination with the removal of lymph nodes such as mastectomies, lumpectomies, prostatectomies, or neck dissection procedures, trauma or infection of the lymphatic system, as well as severe venous insufficiency. There is no cure for lymphedema. However, CDT can help reduce the swelling and maintain reduction, and significantly improve a patient’s quality of life. This comprehensive treatment involves the following four steps:

• manual lymph drainage
• compression therapy (bandaging)
• decongestive exercises
• skin care

Once the treated extremity/area is back to close to normal size or is no longer reducing in size, the patient is fitted with a compression garment. Patients are also taught how to self-manage their condition after treatment has ended. At the end of 6-8 weeks of sessions, we can expect a 60% decrease in the swelling, which facilitates functional activities for these patients. In addition, the lymphedema treatment program for head and neck patients will help them recover their ability to swallow and produce saliva, voice, and ROM of the neck. These patients receive education regarding warning signs, decongestive exercises, activities of daily life, manual lymphatic drainage when indicated, and education on donning and doffing the appropriate compression garment. The overall goal is to improve a patient’s quality of life.

During this 2018 year, our Lymphedema Clinic has a total of six certified therapists: Brian Reaksecker, PT CLT, Mary Matthews-Brownell, OTR-L CLT, Maureen Mclain, PT CLT at ALVA, and in Seattle we have Meg Sablinsky, PT CLT-LANA, Melissa Smith, PTA CLT, and Jennifer Boyce, OTR-L, CLT.
Oncology Social Work  
Ana Fisher, LICSW, OSW-C, Melinda Walker, LICSW, Kimmy Van Hayes, LICSW

When patients receive a cancer diagnosis they have many concerns about what the diagnosis means, what to expect, details on medical care, concerns from loved ones, finances, and survival. Comprehending and organizing the provided information can provoke anxiety and be overwhelming while one is making important health care decisions. The role of the Oncology Social Worker (OSW) is central to helping patients, caregivers and communities with detection, prevention, navigation and survival in a rapidly-changing treatment environment. OSWs are uniquely trained in accessing resources, recognizing disparities in care, communication, stress reduction, family systems, advocacy, and community resources, allowing the OSW to affect positive change in the lives of Veterans and their families.

Specifically, OSWs strive to obtain accurate and up-to-date educational information and other resources for patients. The hope is that by contacting patients early in the process and providing them with verbal and written material, the patients will have a better understanding of what to expect during their treatment and will also be better prepared to cope. Social workers have been active in public education campaigns including workshops for veterans, conducting training for staff and community partners, and public message boards to inform Veterans about cancer prevention, detection and care; as well as Veterans’ benefits and VA resources. The OSW participated on a panel to help educate clinical social workers and hospital staff on palliative care and hospice services offered through the VA and to discuss Advance Care Planning. OSWs were involved in participated in a hospital wide event in March 2018 to help Veterans complete Advance Directives. In September 2018, OSW facilitated the Psychosocial (social workers /psychologists) breakout session at the annual Association of Veterans Affairs Oncology/Hematology conference in Chicago, Illinois and presented on Cancer Care Navigation: Addressing Psychosocial Distress at the Association of Oncology Social Workers Annual conference in Atlanta, Georgia in May 2018. OSW and OSW Intern/Patient Advocate participated in the Patient Centered Research Collaborative Group for Psychosocial Oncology from May 2017 to May 2018 and attended the PCRC/Association of Oncology Social Workers Conference, Atlanta, Georgia in May 2018. OSW was named as a Co-Chair of the Communications Committee: PCRC. Additionally, OSWs provide ongoing education to social work students through the University of Washington School of Social Work (UWSSW) practicum program, which provides hands-on experience to students and to provide the University with input regarding Social Work in health care.

Support groups and educational offerings can be beneficial at all stages of the cancer experience. At VA Puget Sound, Social Workers co-facilitate a support group for patient caregivers who receive stem cell transplants as well as a general diagnosis support group for caregivers. OSW facilitate
Oncology Social Work (Continued)

the weekly Veteran cancer support group on Fridays at noon at Seattle VA.

Cancer treatment moves patients into a new awareness and self-image. Patients and their loved ones may feel incapable of managing independently at home. OSWs are highly skilled at assessing patients’ and families’ resources and referring patients to the level of care appropriate for their current situation and needs, including community outpatient programs, home health care, skilled nursing or assisted living facilities, or hospice/palliative care. OSW assisted in the implementation of the NCCN Distress Thermometer for Patients and is addressing the psychosocial needs of the Veterans at their initial radiation oncology and cancer care clinic visits.

OSWs participate as members of the inpatient consultation team in the palliative and hospice care program. Social workers, along with other staff members, focus on the patient’s quality of life by assisting with end-of-life planning, care resources and emotional support. Additionally, OSWs provide the patient and loved ones with grief and bereavement support and referral to resources during this transition. Social workers participate in end-of-life education for staff members and education for community partners about the VA hospice and palliative care program, survivor benefits, and burial benefits.

OSWs are essential in Advance Care Directive (ACD) planning, education and completion. The Cancer Care Navigation Team OSW is participating in educating hospital nurses, social workers, psychologists and chaplains on how to improve goals of care conversations and documentation regarding life sustaining treatment initiative. Social workers participate in a hospital-wide initiative to improve Veterans’ and staff members’ understanding of living wills, durable power of attorney, and the role of surrogate decision makers. Veterans are encouraged to complete health care directives to ensure their ongoing participation in their own health care and to relieve stress for loved ones who are named as surrogate decision makers.

During the next year, OSWs at VA Puget Sound will continue to advocate for Veterans in our care, reducing barriers to care and increasing access to treatment whether through locating appropriate transportation resources or finding financial resources to allow them to keep their appointments.

Social workers conduct quality training for veterans, caregivers, staff, and community members and will continue to train student interns at VA Puget Sound. Social Work will continue to hold trainings at community hospitals and institutions of higher education to increase awareness of Veterans’ benefits, programs and unique health care needs. With renewed emphasis on survivorship, there are is now a cancer survivorship clinic at VA Puget Sound. OSWs will continue to work on the committee to improve the cancer survivorship resources and pass that information to Veterans and medical professionals at the hospital. We will continue to provide caregiver and Veteran education and support groups. These efforts support the overall goal to help patients maintain their quality of life while they cope with various issues that arise during cancer care.
The Chaplain Service of the VA Puget Sound Health Care System has been given the overall spiritual care of all VA patients. Among our Veterans are those that experience the diagnosis and treatment of cancer. At the time of a patient’s diagnosis and treatment projection, Chaplaincy endeavors to support the patient and their family as they progress through the various treatments, whether it is surgery, chemotherapy, radiation, or a stem cell transplant. Spiritual support covers both the negative and positive aspects of cancer care such as times of wellness and times of palliative intervention.

Chaplains are available with the treatment teams as various spiritual needs surface in the treatment process. Often, along with the concerns of treatment symptoms, comes uncertainty, anxiety, fear of treatment outcomes, guilt, and spiritual distress. Through consults and various patient contacts, chaplains give spiritual support affecting patient and family morale. Chaplains have also been involved in the Tele-health program which brings care to patients in their home. Chaplains are trained to work with patients of any faith, or none, without prejudice; chaplains never proselytize.

One aspect of care involves times when treatment options become limited. Palliative Care chaplaincy affords opportunity to bring meaning and purpose to these times to help patients and their families transition to a different perspective on their treatment goals. Chaplains have given consistent and positive support through this process. When the limitations of science lead a patient toward another destiny, Chaplains are prepared to give spiritual support through these un-charted experiences to both the patient and the families surrounding them.

Finally, Chaplains bring bereavement care to patients and families in the journey of finishing their time of life. Memorial services are held annually for all patients who have been in the hospital at their end of life. Their families are invited to attend as a way of celebrating their memory. Each family is invited to attend and to bring pictures and memorabilia that helps share their memory with others. The Hospital Director and various staff members are invited to share the experience. Family members are invited to share their loved ones experience. Many of the stories of support by the VA Hospital give overwhelming credibility to the Cancer program.
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