2019 CANCER PROGRAM
REPORT OF OUTCOMES
AMITA (PRESENCE) NEW LENOX BREAST CENTER

New Lenox Breast Center
Presence Healing Arts Pavilion
410 East Lincoln Highway
New Lenox, IL (Route 30 near Cooper Road)
815.462.5545
Map and directions

The New Lenox Breast Center, a comprehensive center for all breast health needs and accredited by the National Accreditation Program for Breast Centers since 2015.

Meet Our Breast Center Care Team

Lauren Ghee, MD
Breast Surgery

Amber Rodriguez, NP
Nurse Practitioner

Karen Hucek, RN
Nurse Navigator

Ellen Gustafson, MD
Oncology

Worood Abboud, MD
Oncology
Meet Our Breast Center Care Team

Ommar Hla, MD
Radiation Oncology

Virag Dandekar, MD
Radiation Oncology

Mickey Jester, DO
Radiology

Susan Schneider, MD
Plastic and Reconstructive Surgery

Services offered:

- Diagnostic Imaging: 3D Mammography, Ultrasound, Bone Density (DEXAScan), MRI, CT scan, X-Ray, Ultrasound Guided Biopsies
- Genetic Evaluation & Management
- Physical Therapy
- Clinical Trials
- Dietician Services
- Counseling Services (coming soon)
- Breast Cancer Support Group (coming soon)
- Educational Resources
CARE CONTINUUM ROLE STATEMENT

The AMITA/Presence Saint Joseph Medical Center Cancer Program consists of a team of health care professionals who provide individualized, compassionate, quality cancer care and related services close to home. We dedicate ourselves to the treatment of people with cancer and other chronic diseases, relief of their symptoms, and promotion of comfort. We constantly strive to meet the physical, emotional, and spiritual needs of our patients and their families.

ACCREDITATION

Commission on Cancer
The cancer program at AMITA/Presence Saint Joseph Medical Center is accredited by the American College of Surgeons Commission on Cancer (CoC). CoC accreditation is a voluntary commitment by a cancer program that ensures its patients will have access to the full scope of services required to diagnose, treat, rehabilitate, and support patients with cancer and their families. A cancer program is able to continually evaluate performance and take proactive, corrective actions when necessary. This continuous evaluation reaffirms our commitment to provide high-quality cancer care. Our most current CoC survey was September 13, 2018; program awarded a three-year with commendation accreditation.

National Accreditation Program for Breast Centers
Accreditation by the National Accreditation Program for Breast Centers (NAPBC) is granted only to those centers that are voluntarily committed to providing the best possible care to patients with diseases of the breast. Each breast center must undergo a rigorous evaluation and review of its performance and compliance with NAPBC standards. To maintain accreditation, centers must monitor compliance to ensure quality care and undergo an on-site review every three years. Presence Saint Joseph Medical Center participated in its first NAPBC review on February 11, 2015 and was awarded a three-year full accreditation; our last review was January 24, 2018 with full three-year accreditation. SJMC is the first NAPBC-accredited breast cancer program in Will, Grundy, and Kankakee Counties.

CANCER COMMITTEE

Five elements are vital to the success of an accredited cancer program:

- Clinical services to provide state-of-the-art pretreatment evaluation, staging, treatment, and clinical follow-up for cancer patients
- Cancer Committee to lead the cancer program
- Cancer Conferences to provide a forum for patient consultation and contribute to physician/allied staff education
- Quality Improvement program to evaluate and improve patient outcomes
- Cancer Registry and database to monitor the quality of care

The success of the cancer program depends on the Cancer Committee to lead the program through setting goals, monitoring program activity, evaluating patient outcomes, and improving patient care. The committee membership includes multidisciplinary physician members from the diagnostic and therapeutic specialties, as well as allied health professionals involved in the care of cancer patients.

2019 Cancer/Transfusion Committee Membership

Quorum Members
Bhavin Shah, MD, Oncologic Surgery, Cancer Committee Chair
Virag Dandekar, MD, Radiation Oncology, Cancer Liaison Physician
Lauren Ghee, MD, General Surgery, Breast Program Director
Ellen Gustafson, MD, Hematology/Oncology, Cancer Committee Chair
Aamira Tahir-Malik, MD, Presence Health Palliative Care
James Urban, MD, Pathology; Co-Chair, Cancer Conference Coordinator
Raj Vasnani, MD, Radiology
Non-Quorum Members

Abigail Hornbogen, VP of Operations
Deborah Condon, Senior Physical Therapist
Alexandra Hartsell, Assistant Patient Care Manager 5 West
Susan Hawbaker, Nurse Practitioner Palliative Care
Alexandra Holdefer, LCSW, Licensed Clinical Social Worker
Maggie Hornung, Nurse Practitioner AMITA Health
Danielle Jaramillo, Manager Rad/Imaging Services
Loretta Mangers, Mammography QA Tech/Breast Navigator
Vivina Maninang, Patient Care Manager 5 West
Laura McHugh, Quality Improvement Analyst
Kim Midlock, Clinical Nurse Manager AMITA/Presence Cancer Care
Diana Page, Clinical Pharmacist
Beth Rader, Lead Cancer Registrar
Amber Rodriguez, Nurse Practitioner New Lenox Women’s Center
Lisa Ryan, Oncology Nurse Navigator AMITA/Presence Cancer Care
Jane Schwark, Breast Nurse Navigator AMITA/Presence Cancer Care
Eva Stobbe, Clinical Dietician
Danielle Villari Swets, ACS Account Representative Hospital Systems
Alida Wagner, President Sonreg Solutions, Inc.
Teffani Wellman, CTR, Sonreg Solutions, Inc.

CANCER CONFERENCES (TUMOR BOARDS)

Cancer conferences improve the care of patients with cancer by providing multidisciplinary treatment planning and contributing to physician and allied medical staff education. PSJMC Cancer and Breast conferences are held on the second and fourth Wednesday at 12:00 p.m. All conferences are now held jointly with the staff at Presence Mercy Medical Center in Aurora. The team reviews each patient’s history and physical examination, diagnostic procedures performed, radiology images, pathology slides, and treatment given. Physicians from Pathology, Radiology, Medical Oncology, Radiation Oncology and Surgery attend as well as other physician and allied health specialties. All physicians attending cancer conferences at SJMC receive one hour of Category I Continuing Medical Education (CME) credit for each hour of tumor board/specialty cancer conference that they attend. Information about upcoming Cancer Conferences is posted in the Medical Staff lounge and the CME bulletin board.

In July 2014, we instituted Breast Cancer Conferences twice a month as a supplement to our bi-monthly Tumor Boards. For 2019, we held 22 Tumor Boards and 22 Breast Cancer Conferences and presented a grand total of 150 cases.

CANCER REGISTRY

The Cancer Registry staff monitor all types of reportable neoplasms diagnosed and/or treated at AMITA/Presence Saint Joseph Medical Center (SJMC). This is a critical element in the evaluation of oncology care. Registry data collected include patient demographics, diagnosis, staging, treatment, and disease outcome. Data management contributes to each patient’s treatment planning, staging, and continuity of care. Complete and accurate cancer registry data enables the facility cancer program and administration to plan and allocate hospital resources and is a valuable resource for research activities. The Cancer Registry reports to the Vice President of Operations.
ACCOUNTABILITY/QUALITY IMPROVEMENT

CANCER PROGRAM PRACTICE PROFILE REPORT (CP³R) 2013-2016 (released 11/27/18)

CoC Standard 4.4 Accountability Measures: Each calendar year, the expected Estimated Performance Rate (EPR) is met for each accountability measure as defined by the Commission on Cancer.

CoC Standard 4.5 Quality Improvement Measures: Each calendar year, the expected Estimated Performance Rate (EPR) is met for each quality improvement measure as defined by the Commission on Cancer.

<table>
<thead>
<tr>
<th>Measure</th>
<th>CoC Std / Benchmark</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCSRT</td>
<td>Radiation administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conservation surgery (Accountability measure)</td>
<td>4.4 / 90%</td>
<td>96.00</td>
<td>93.10</td>
<td>100</td>
<td>94.40</td>
</tr>
<tr>
<td>HT</td>
<td>Tamoxifen or third generation aromatase inhibitor considered or administered within 1 year (365 days) of dx for women with AJCC T1c or Stage IB-III hormone receptor positive breast cancer (Accountability)</td>
<td>4.4 / 90%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>MASTRT</td>
<td>Radiation therapy considered or administered after mastectomy within 1 year (365 days) of dx of breast cancer for women with &gt;=4 positive regional lymph nodes (Accountability)</td>
<td>4.4 / 90%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>nBX</td>
<td>Image or palpation-guided needle biopsy to the primary site performed to establish diagnosis of breast cancer (Quality Improvement)</td>
<td>4.5 / 80%</td>
<td>88.30</td>
<td>97.60</td>
<td>98.70</td>
<td>100</td>
</tr>
<tr>
<td>BCS</td>
<td>Breast conservation surgery rate for women with AJCC clinical stage 0, I or II breast cancer (Surveillance)</td>
<td>Not applicable</td>
<td>65.70</td>
<td>67.10</td>
<td>56.60</td>
<td>73.70</td>
</tr>
<tr>
<td>MAC</td>
<td>Combination chemotherapy recommended or administered within 4 mos (120 days) of dx for women under 70 with AJCC T1cN0 or Stage IB-III hormone receptor negative breast cancer (Accountability)</td>
<td>Not applicable</td>
<td>91.70</td>
<td>90.0</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

The AMITA/Presence Saint Joseph Medical Center expected estimated performance rates exceed the CoC benchmarks. Currently, all analytic breast cancer cases are reviewed for compliance with evidence-based national treatment guidelines.
CANCER SCREENING PROGRAM

Breast Cancer Screening - 2019

CoC Standard 4.2: Each calendar year, the cancer committee organizes and offers at least one cancer screening program that is designed to decrease the number of patients with late-stage disease and is targeted to meet the screening needs of the community. Each screening program is consistent with evidence-based national guidelines and interventions and must have a formal process developed to follow up on all positive findings.

NAPBC Standard 4.1: Each year, two or more breast disease education, prevention, and/or early detection programs are provided or coordinated with other facilities or local agencies targeted to the community. For early detection programs, follow-up is provided to patients with positive findings.

Purpose: To decrease the numbers of patients with late-stage breast cancers.

Identified Need: In 2019, approximately 268,600 new cases of invasive breast cancer will be diagnosed among women in the US with 42,260 deaths. Approximately 62% of cases are diagnosed at a localized stage and the five-year survival rate for these patients is 99%. Female breast cancer death rates have been declining since 1989 in the US, in part due to early detection by mammography screening and treatment. (American Cancer Society Cancer Facts & Figures 2019)

SJMC Cancer Registry Statistics (by date of first contact):

At SJMC in 2013 - 2018, breast cancer was the most common cancer site in women and accounted for one-third of all of the cancer cases diagnosed in women.

Incidence of breast cancer at SJMC:

<table>
<thead>
<tr>
<th>Accession year</th>
<th>Number of breast cases</th>
<th>Annual analytic caseload female cases</th>
<th>Percentage of annual caseload female cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>147</td>
<td>426</td>
<td>35%</td>
</tr>
<tr>
<td>2014</td>
<td>151</td>
<td>435</td>
<td>35%</td>
</tr>
<tr>
<td>2015</td>
<td>149</td>
<td>469</td>
<td>32%</td>
</tr>
<tr>
<td>2016</td>
<td>187</td>
<td>515</td>
<td>36%</td>
</tr>
<tr>
<td>2017</td>
<td>145</td>
<td>426</td>
<td>34%</td>
</tr>
<tr>
<td>2018</td>
<td>174</td>
<td>423</td>
<td>41%</td>
</tr>
</tbody>
</table>

Stage of disease at diagnosis at SJMC (*Percentage of cases by accession year):

<table>
<thead>
<tr>
<th>AJCC STAGE</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>19%</td>
<td>18%</td>
<td>13%</td>
<td>14%</td>
<td>24%</td>
<td>17%</td>
</tr>
<tr>
<td>Stage I</td>
<td>45%</td>
<td>49%</td>
<td>44%</td>
<td>41%</td>
<td>42%</td>
<td>57%</td>
</tr>
<tr>
<td>Stage II</td>
<td>26%</td>
<td>18%</td>
<td>20%</td>
<td>25%</td>
<td>23%</td>
<td>14%</td>
</tr>
<tr>
<td>Stage III</td>
<td>8%</td>
<td>9%</td>
<td>16%</td>
<td>14%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Stage IV</td>
<td>2%</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Unknown/NA stage</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Number of cases</td>
<td>147</td>
<td>153</td>
<td>149</td>
<td>189</td>
<td>145</td>
<td>175</td>
</tr>
</tbody>
</table>

[*Percentages may not equal 100 due to rounding]

The percentage of cases with Stage III disease decreased from 2016 to 2017.
Comparisons of breast cancer data from SJMC and the National Cancer Data Base (NCDB) by date of diagnosis (not accession year).

SJMC data compared to 34 Comprehensive Cancer Programs in Illinois

AJCC Stage comparison:

<table>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>19%</td>
<td>22%</td>
<td>18%</td>
<td>21%</td>
<td>13%</td>
<td>21%</td>
<td>16%</td>
<td>21%</td>
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<tr>
<td>Stage I</td>
<td>47%</td>
<td>41%</td>
<td>48%</td>
<td>43%</td>
<td>47%</td>
<td>42%</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>Stage II</td>
<td>27%</td>
<td>24%</td>
<td>19%</td>
<td>24%</td>
<td>20%</td>
<td>23%</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Stage III</td>
<td>5%</td>
<td>8%</td>
<td>9%</td>
<td>7%</td>
<td>15%</td>
<td>7%</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Stage IV</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The percentage of Stage III cases at SJMC increased from 9% in 2014 to 15% in 2015 then dropped back to 10% in 2016 but remains significantly higher than the NCDB data.

Will County Community Health Needs Assessment and Will County Community Health Implementation Plan 2017-2020

Executive Committee:

AMITA Adventist Medical Center Bolingbrook
Aunt Martha’s Youth Services
Catholic Charities Diocese of Joliet
Chestnut Health Systems
Easter Seals Joliet Region, Inc.
Edward-Elmhurst Hospital
Governors State University
New Life Church
Presence Saint Joseph Medical Center
Senior Services of Will County
Silver Cross Hospital
Stepping Stones, Inc.
Three Rivers Manufacturers’ Association
United Way of Will County
Will County Community Health Center
Will County Executive’s Office
Will County Health Department
Will-Grundy Medical Clinic

The Community Health Status Assessment (CHSA) is one of four assessments performed as part of the Mobilizing for Action through Planning and Partnerships (MAPP) strategic framework. During the assessment, information about demographics, health status, health behaviors and social determinants is gathered and analyzed. Data is collected from a variety of resources and analyzed comparing local, state and national benchmarks when available. This assessment is performed to meet the hospital partners' IRS requirement every three years and the Will County Health Department’s Illinois Department of Public Health IPLAN (Illinois Plan for Local Assessment of Needs) requirement every five years.

The CHSA provides a picture of our community by answering three questions:
1. Who are we and what do we bring to the table?
2. What are the strengths and risks in our community that contribute to health?
3. What is our health status?

MAPP identifies health indicators in the following categories for conducting the CHSA:
- Demographics
- Socioeconomics
- Health resource availability
- Quality of life
- Behavioral risk factors
- Environmental health
- Social and mental health
- Maternal and child health
- Death, illness and injury
- Communicable diseases
- Sentinel events
Demographic Profile of Will County

According to the U.S. Census Bureau, Will County has grown rapidly over the past decade. Although the total population for Will County was projected to reach 810,000 by 2015, it only reached 687,263. However, Will County’s population has and is expected to continue outpacing the growth rate for Illinois.

Will County has a total of 849 square miles (12 of which are water), 31 zip codes, 23 cities, and five area codes. Of 12,859,995 Illinois residents, 5% (687,263) resided in Will County in 2015. A majority of these Will County residents reside in Joliet, Plainfield, Bolingbrook, and Romeoville. Will County is predominantly urban, with 96.07% of the total population living in urban areas. Geographically, southern Will County is largely rural.

The median age of Will County is 36.2 years, and the County’s population is slightly younger than Illinois’ population. According to the 2014 U.S. Census Bureau, 63% of Will County’s population is below the age of 45, compared to 60% statewide.

In 2014, the majority of Will County’s population was White (77.6%), followed by Black/African American (12.2%), Asian (5.6%), and American Indian/Alaska Native (0.7%). The population for all races increased since 2010, however the White population has decreased overall since 2000. The Hispanic/Latino ethnicity has increased since 2000 and 2010 (8.7% in 2000 to 15.6% in 2010 to 16.1% in 2014).

The population of foreign-born residents in Will County increased slightly between 2011 and 2014 (an increase of 3,057 residents). Currently, the foreign-born population constitutes 11.8% of the Will County population. As of 2014, a little over half of the foreign-born population had become U.S. citizens. Almost 80% of Will County’s foreign-born population originated from Latin America (48.9%) and Asia (30.4%) in 2014. A higher concentration of Will County’s foreign-born population resided in northern Will County and in the Joliet area.

As of 2014, there are 94,393 families with children (under age 18) which accounts for 42.3% of total households in Will County. This percentage is 10% higher than in Illinois (32.3%).

In Will County, 8.32% of the population, or 56,202 people has a disability. This percentage is slightly lower than Illinois (10.62%). Large concentrations of this population resided in certain areas in northern, eastern, and southern Will County, as well as Joliet.

In Will County, 6.6% of the total population, or 32,514 people, are veterans, who mostly reside in southern and eastern Will County.

Key findings of 2017 Will County Community Health Needs Assessment (CHNA)
Top identified health needs:
  - Access to dental and primary care
  - Improving behavioral health
  - Preventing and reducing chronic disease

Preventing and reducing chronic disease key assessment findings:
  - Cancer incidence and mortality issue
    - Cancer second cause of death; lung cancer top cancer death
    - Men slightly more likely to develop cancer
    - Only 58% of women had breast cancer screening in 2017, which is down 15% from 2009
    - Target populations: Males, Adults 50-75 years, Women 21+ years
  - Chronic disease mortality issue
    - Whites highest percent with heart disease; heart disease mortality highest in African-Americans
    - High percentage of Medicare beneficiaries with diabetes
    - Target populations: African-Americans, Medicare beneficiaries
• Food access issue
  • Over 450,000 residents live in designated food desert census tract
  • Target populations: 60417, 60432, 60433, 60436, 60440, 60441, and 60484 zip codes

• Obesity issue
  • One-fourth of adults obese; more males than females
  • One-third of adults overweight; mostly non-Hispanic White
  • 20% of adults not physically active; 80% not consuming recommended servings of vegetables and fruits
  • Two-thirds of youth not meeting recommended physical activity guidelines; 50% not consuming recommended servings of vegetables and fruits
  • Target populations: White Males, Middle & High School Youth

• Tobacco use issue
  • Adult use higher than HP2020 target of 12%
  • 12% of 12th graders smoking cigarettes; 10% using smokeless tobacco
  • Target populations: Adults, High School Youth

After completing the CHNA, partners met to develop goals, strategies, and objectives to be addressed over the next three years. Many of the strategies were determined to be cross-cutting across the selected health priorities and are labeled Overarching Goals.

Overarching Goals:

1. Advocate for a “Health in All Policies” approach to improve Will County’s built environment and transportation system.
2. Collect, analyze, and disseminate high quality public health data.
3. Explore becoming a trauma-informed county.
4. Increase business and philanthropy partnerships in community engagement.
5. Raise awareness of health inequities and expand understanding of health equity.
6. Reduce prevalence and inequities of obesity and obesity-related disease.

In 2014, there were 4,223 deaths in Will County. Cancer was the leading cause of death in Will County until 2014, when it was surpassed by diseases of the heart. Cancer is now the second leading cause of death. Of the total cancer deaths, lung cancer is the top cause in Will County.

Preventing and Reducing Chronic Disease

Chronic diseases are the most common, costly, and preventable of all health problems. Heart disease is the second leading cause of hospitalizations in Will County and cancer is the fifth. Heart disease, cancer, and diabetes account for approximately 58% of all deaths in Will County. Many chronic diseases are linked to lifestyle choices, or health risk behaviors, which can be changed. Four of these health risk behaviors—lack of physical activity, poor nutrition, tobacco use, and excess alcohol consumption—cause much of the illness, suffering, and early death related to chronic diseases and conditions. Findings from the assessments detail access issues to chronic disease resources. Specific priority needs and populations identified in the assessment process include:

• Better data to define and prioritize chronic disease problems, identify populations most affected, and monitor progress
• Healthcare services to prevent or enable early detection of disease, reduce risk factors, and manage conditions
• Strategies that link community and clinical services to ensure that people with or at high risk of chronic diseases have access to the resources they need to prevent or manage these diseases
• Access to affordable, healthy foods
Breast Cancer

In Will County, 58.4% of women met breast cancer screening guidelines, which is approximately a 15% decrease from 2009 and well below the Healthy People 2020 goal. The Will County breast cancer mortality rate is 16.6 deaths, which is lower than the state and Healthy People 2020 target. However, female breast cancer incidence increased 5% between 2000 and 2013.

According to the 2010-2014 Behavioral Risk Factor Surveillance System (BRFSS), in Illinois approximately 58.4% of women ages 40 and older have reported having a mammogram in the past year. This is a significant decrease from 2007-2009 in which 68.1% of this population reported the same. The Will County Breast Cancer mortality rate was 16.6 deaths per 100,000 females in 2013. This is lower than Illinois’ Breast Cancer mortality rate of 22.2 deaths per 100,000 females and also lower than Healthy People 2020's target of 20.6 deaths per 100,000 females. While the breast cancer mortality rate in Will County is lower than the state and national rate, the percentage of women who have had a mammogram in the past year is significantly below the Healthy People 2020 target. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Barriers to breast cancer screening addressed in 2019:

- Lack of health insurance. Women who are uninsured or are underinsured are much less likely to get mammograms and are more likely to be diagnosed at an advanced stage.
- Low income
- Only 58% of women had breast cancer screening in 2017, which is down 15% from 2009
- HP 2020 Target: 76.8% of women having mammograms per year
  Will County (2014): 58.4% of women having mammograms per year

National Guideline:

American College of Radiology (ACR) Position Statement on Screening Mammography
October 6, 2016

The American College of Radiology recommends annual screening mammography for women starting at age 40. This affords the maximum benefits of reduced breast cancer deaths, less extensive treatments for cancers that are found, decreased chance of advanced disease at diagnosis, and discovery and treatment of high risk lesions. Breast cancer incidence increases substantially around age 40 and even earlier for high risk women and women of color.

All health insurers, including the Centers for Medicare & Medicaid (CMS), should cover women ages 40 and older for annual mammograms as a preventive service, without additional cost sharing or copayments. Extensive scientific research shows a 40 percent reduction of breast cancer deaths with regular mammographic screening. The greatest mortality reduction, the most lives saved and the most life years gained occur with yearly mammography starting at age 40. There is no established age for women to stop screening. Women should continue breast cancer mammography screening as long as they are healthy and desire to remain so. Therefore, health care coverage for screening should not have an upper age limit.

Team members: Ellen Gustafson, MD
Nancy Gerum, NP
Susan Hatfield, NP
Kim Midlock Clinical Nurse Manager PCC/JOHA
Lori Mangers, Mammo QA Tech/Breast Health Navigator
Lori Plese, Executive Assistant PCC/JOHA
Karen Sceniak, CCRC, Clinical Trials Manager PCC/JOHA
Jane Schwark, RN, Oncology Nurse Navigator PCC/JOHA
Activity:

The JOHA Foundation hosted the Breast Cancer Awareness Fair at Presence Cancer Care on Friday, October 4, 2019 from 2:00 p.m. to 4:00 p.m. Breast exams were performed by Ellen Gustafson, MD; Nancy Gerum, NP and Sue Hatfield, NP. Event participation: 20 women enrolled; one called in sick; 3 were no show; 16 received free breast exam, free mammogram and breast educational material. All participants received a voucher for a free mammogram at SJMC. The vouchers were paid for by the JOHA Foundation. Volunteers included Kim Midlock, Lori Plese, Karen Sceniak and Jane Schwark from PCC and Lori Mangers from SJMC. Wellness information was also provided.

Findings:

SJMC, PCC and the JOHA Foundation partnered to provide a free breast cancer screening to uninsured and underinsured women and/or low income women in our community.

Screening Process/Duties:

1. A process is in place to ensure that patients with abnormal screening results are referred for appropriate follow-up.
2. The breast exam is performed by one of the JOHA physicians who counsel the patient on any abnormal findings. The mammography results are sent to the patient’s Primary Care Physician for follow-up unless the patient does not have one in which case Dr. Nafisa Burhani receives the results for further recommendation.
3. Lori Mangers, SJMC QC Tech/Breast Health Navigator also follows all patients with abnormal mammography or ultrasound testing performed at SJMC.
   a. The patient comes in for diagnostic mammogram and/or ultrasound of the breast and the Radiologist suggests a biopsy. Lori Mangers speaks with the patient regarding the results and biopsy procedures. She gives the patient an information packet regarding the testing needed.
   b. Lori Mangers makes sure that Birads 4 and 5 patients are followed by a physician and contacts the patient or physician if we do not get an order for a biopsy within a month. She sends the physician and the patient letters regarding the biopsy and the need for one.
4. The Presence Health INFO Line will provide assistance to patients in need of a physician.

SJMC PATIENT NAVIGATOR RESPONSIBILITIES

1. Check the schedule daily for patients that are scheduled for diagnostic and/or ultrasound exams so that I know what patient I may be speaking with later with the Radiologist.
2. Assemble patient education folders to give patients who need biopsies.
3. Order all the patient education materials.
4. Accompany the Radiologist when results are given to the patient and explain in lay terms what the results mean to the patient and what the next step will be.
5. Contact and fax the results to the ordering physician’s office next day and request biopsy order from physician’s office.
6. Schedule patient for biopsy and obtain orders from physician’s office for biopsies if needed.
7. Collaborate schedules between Radiologist, Technologists, and Ultrasound to assure there is adequate staff available to do procedure.
8. Make sure U/S obtains orders they need for the biopsies. Work with U/S staff to get patients scheduled.
9. Obtain pathology report and input into Penrad for tracking purposes.
10. Patient will call regarding their cancer treatment and I listen and support any way that I can.
11. Follow up with patient through the treatment until they are past their 6 months f/u mammogram or further if need be.
12. Document everything in binder including reports and physician correspondence.
13. Ensure that every Birads 4 and 5 sees a physician and gets the appropriate treatment prescribed by their physician.
14. After the patient has their surgical procedure, give patient binder information to Jane Schwark at JOHA to continue patients’ treatment...
15. Attend tumor board for further information regarding breast cancer patients.
16. Send patient reminder letters every 6 months for the next 3 years to follow up with mammograms and/or ultrasound after cancer treatment.

**Screening Results:**

<table>
<thead>
<tr>
<th>Date</th>
<th>10/2/15</th>
<th>10/28/16</th>
<th>10/27/17</th>
<th>10/19/18</th>
<th>10/4/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td># registered</td>
<td>25</td>
<td>20</td>
<td>17</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td># of participants</td>
<td>11</td>
<td>20</td>
<td>17</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td># free mammo vouchers</td>
<td>11</td>
<td>17</td>
<td>17</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td># mammograms performed</td>
<td>11</td>
<td>8</td>
<td>8</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td># with abnormal results</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

10/4/19
Breast physical exam:
16 breast exams – all normal, no abnormalities detected
Mammo results as of 11/19/19:
- Mammo scheduled: 7
- Mammo performed: 7
- # Benign: 7
- # Abnormal: 0

**Effectiveness/Recommendations:**
Continue breast cancer awareness program. Improve marketing/public relations process to increase community awareness and participation.

**Additional SJMC/PCC education, prevention and early detection programs:**
Morning Star Treasure Chest included our Mammogram screen event on their Facebook page.
Church members of two different African American churches promoted Breath Health and the free mammogram program at their Sunday Morning Worship Service.
Plainfield Junior women’s Club promoted Breast Awareness in October
10/10/19 Reflections Boutique: Free Consultation and Fitting Event October 10th
10/4/19 Maggie Hornung spoke on BRCA testing at the Sonreg Solutions annual meeting.
10/25/19 Informal community outreach in the field house at Joliet Junior College. Dan Brown, JJC Building Operations Coordinator/Head volleyball coach reached out to us and asked if we would attend for Breast Cancer Awareness month. There was a women's basketball and volleyball game that night. Pink Heels also attended. Moving forward, this is an event Dan would like to promote on an annual basis. We had breast cancer awareness information/pamphlets including dense breast pamphlets and breast screening information. We also were available to answer any questions. The event was attended by Amber Rodriguez, FNP, Lori Mangers from Mammography and Karen Hucek, RN, CNBN. We were present from 4:30pm-7:30pm.
10/28/19 Lori Mangers spoke at a luncheon at Child Care Resource & Referral in Joliet. She gave Power Point presentation on Breast Health Awareness and answered questions. There were approximately 30 women and 1 gentlemen at this event.

Page on SJMC internet site on breast health:

Presence Health internet
Breast cancer:
Early detection:
Cancer diagnosis:
Survivorship and rehab:
PATIENT/FAMILY RESOURCES AND SUPPORT

AMERICAN CANCER SOCIETY
The American Cancer Society is a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy and service.

SJMC WEBSITE
The PSJMC website at http://www.presencehealth.org/body.cfm?id=1657 provides information about the Sister Theresa Cancer Care Center and radiation oncology services; infusional therapy; inpatient oncology unit; clinical trials; support services and counseling; rehabilitation services; surgical services; support groups; facility accreditations and affiliations; and specific information about breast, prostate, and colorectal cancers.

POSITIVE PEOPLE
For cancer patients and their families. Meets the first and third Wednesday of each month, 3:30 - 5 p.m. in the Sister Theresa Cancer Center. Free. For more information call 877-737 INFO (4636).

BOSOM BUDDIES
Bosom Buddies support group for breast cancer meets the 1st and 3rd Tuesday of each month at Presence Cancer Care/JOHA, 2614 West Jefferson Street, Joliet. Call 815-725-1355 for information.

Us TOO Prostate Cancer Support Group
The Us TOO Prostate Cancer Support Group usually meets the fourth Monday of every month at 5:30 p.m. at Advanced Urology Associates, 1541 Riverboat Center Drive, Joliet, IL 60431. Call 814-469-4930.

Reflections Boutique at Presence Cancer Care/Joliet Oncology Hematology Associates
Located at: 2614 W Jefferson Street
Joliet, IL 60435
Phone: 815-730-3033 Ext. 1300
Fax: 815-725-9857

Services offered:
- Hair & breast prostheses
- Shapers after having lumpectomy or reconstruction
- Fashion wigs
- Synthetics
- Human hair
- Post-surgical garments to take to hospital
- Chemotherapy/Radiation/Alopecia
- Certified breast consultants
- Licensed cosmetologist
- Medicare and most insurance accepted
- Complimentary consultation
<table>
<thead>
<tr>
<th>Study Title</th>
<th>Radiation consultation for breast cancer patients prior to surgical resection.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problematic Concern:</strong></td>
<td>The problematic concern is that breast cancer patients are not receiving a radiation therapy consult prior to definitive cancer-directed surgery. Patients should be offered a radiation therapy consult prior to making final surgical plan/decisions. This problematic concern was brought forward by the radiation therapy department.</td>
</tr>
<tr>
<td><strong>Root Cause:</strong></td>
<td>Concern that patients are not receiving a radiation therapy consult prior to surgery. Dr. Ghee can advise patients if she thinks they may need radiation but feels that medical and radiation treatment discussions and recommendations are best left up to those specialists. Surgeons and medical oncologists are not aware of the recommendations for and benefits of referring breast cancer patients for radiation consultation prior to making surgical recommendation/plan.</td>
</tr>
<tr>
<td><strong>Source of information:</strong></td>
<td>SJMC-J Cancer Registry database, SJMC-J and JOHA/CIJ electronic medical records</td>
</tr>
<tr>
<td><strong>Assessment data:</strong></td>
<td>Identify and review analytic breast cancer cases accessioned at SJMC in 2018. Primary sites: C50.0 – C50.9 Radiation administered at AMITA SJMC Joliet or AMITA Cancer Institute Joliet</td>
</tr>
<tr>
<td><strong>Analysis of the information:</strong></td>
<td>(UpToDate® “Overview of the treatment of newly diagnosed, non-metastatic breast cancer”) Globally, breast cancer is the most frequently diagnosed and the leading cause of cancer death in women. For women with newly diagnosed, non-metastatic breast cancer, treatment consists of a multidisciplinary approach that involves input from surgery, radiation oncology, and medical oncology. The objective of adjuvant radiation therapy is to eradicate any tumor deposits remaining following surgery for patients treated by either breast-conserving surgery or mastectomy. Doing so reduces the risk of locoregional recurrence and improves breast cancer-specific and overall survivals. Whole breast radiation therapy (WBRT) following breast conservation therapy reduces the locoregional recurrence rate and risk of breast cancer death. These benefits of WBRT are demonstrated by the 2011 meta-analysis performed by the Early Breast Cancer Trialists’ Collaborative Group (EBCTCG), which included over 10,000 women (known to be either pathologically node-negative or positive) in 17 trials. The main results of the meta-analysis were that WBRT resulted in: ● A nearly 50 percent reduction in the 10-year risk of any first recurrence compared with breast-conserving surgery alone (19 versus 35 percent, respectively, relative risk [RR] 0.52, 95% CI 0.48-0.56). The reduction in recurrence rate associated with RT was due to a decrease in locoregional rather than distant recurrences. ● A reduction in the 15-year risk of breast cancer death (21 versus 25 percent, RR 0.82, 95% CI 0.75-0.90).</td>
</tr>
</tbody>
</table>
• Analysis of the information (continued):

Risks and toxicities — WBRT is associated with acute toxicities that involve the area treated (eg, skin, muscle, and internal organs), although these complications are relatively uncommon. WBRT can also result in long-term complications, including cardiotoxicity, lung injury, and second malignancies, which can occur many years after treatment has been completed. However, improvements in radiation techniques over time have likely reduced long-term toxicities. Management of these issues may require ongoing care beyond the completion of radiation. Physical therapy may assist in management of decreased range of motion associated with scarring and fibrosis.

Postmastectomy radiation therapy (PMRT) has two potential benefits: a decrease in the rate of locoregional recurrence, and an increase in long-term breast cancer-specific and overall survivals for certain patient populations. These benefits have been consistently reported in multiple studies. Decisions on who should receive PMRT depend on the baseline risk for recurrence.

Trials have demonstrated reductions in risk of recurrence at local and distant sites in patients receiving both systemic therapy and radiation therapy (RT) compared with RT alone. Therefore, in patients who are candidates for adjuvant systemic therapy, strategies are needed to sequence systemic therapy and RT.

The purpose of adjuvant radiation therapy (RT) is to eradicate any tumor deposits remaining following surgery. Doing so reduces risk of locoregional recurrence and improves breast cancer-specific and overall survivals. Recommendations on adjuvant RT depend on the type of surgery received, extent of disease, and other patient factors. There are considerations for specific patient populations.

National Institute of Health
“Coordination of Breast Cancer Care between Radiation Oncologists and Surgeons: A Survey Study”  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4373416/

Purpose: To assess whether radiation oncologists and surgeons differ in their attitudes regarding the local management of breast cancer, and to examine coordination of care between these specialists.

Methods and Materials: Survey of attending surgeons and radiation oncologists who treated a population-based sample of patients diagnosed with breast cancer in metropolitan Detroit and Los Angeles. Assessed were demographic, professional, and practice characteristics; challenges to coordinated care; and attitudes toward management.

Results: 92.1% of surgeons and 94.8% of radiation oncologists indicated access to a multidisciplinary tumor board. Nevertheless, the most commonly identified challenge to radiation oncologists, cited by 27.9%, was failure of other providers to include them in the treatment decision process early enough. Nearly half the surgeons (49.7%) stated that few or almost none of the breast cancer patients they saw in the past 12 months had consulted with a radiation oncologist before undergoing definitive surgery. Surgeons and radiation oncologists differed in their recommendations in management scenarios. Radiation oncologists were more likely to favor radiation than were surgeons for a patient with 3/20 lymph nodes undergoing mastectomy; surgeons were more likely to favor more widely clear margins after breast conservation than were radiation oncologists.

Conclusions
Despite the widespread availability of tumor boards, a substantial minority of radiation oncologists indicated other providers failed to include them in the breast cancer treatment decision-making process early enough. Earlier inclusion of radiation oncologists may influence patient decisions, and interventions to facilitate this should be considered.
**Evidence-based guidelines utilized:**

UpToDate®

*Overview of the treatment of newly diagnosed, non-metastatic breast cancer*


**Method of program evaluation: outcomes to be assessed**

Dr. Virag Dandekar, Dr. Lauren Ghee and Beth Rader identified analytic cases accessioned in 208; data compiled from Metriq cancer registry database included patient name, SJMC medical record number, year first seen this primary, date of first contact, age, class of case, primary site, histology, AJCC stage, date of surgical procedure, radiation oncologist, medical oncologist, and surgeon.

We reviewed each case for the following:
- Surgical procedure performed
- Was radiation therapy recommended?
- Did the patient have preoperative consult with radiation oncologist?

**Program report: Outcomes**

<table>
<thead>
<tr>
<th>SJMC data:</th>
<th>2018 (complete)</th>
<th>2019 (Jan - Aug)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 No</td>
<td>116</td>
<td>51</td>
<td>167</td>
</tr>
<tr>
<td>1 Yes</td>
<td>21</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>3 On neoadjuvant tx</td>
<td>0</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>7 Pt refused</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused XRT</td>
<td>3</td>
<td>0</td>
<td>3</td>
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<tr>
<td>Refused surgery</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8 Not applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No surgery</td>
<td>10</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>LCIS</td>
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<td>1</td>
<td>4</td>
</tr>
<tr>
<td>9 Unknown</td>
<td>21</td>
<td>12</td>
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<td>Total # cases</td>
<td>175</td>
<td>101</td>
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<table>
<thead>
<tr>
<th>2018</th>
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<th>Trend</th>
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<tbody>
<tr>
<td>No</td>
<td>66%</td>
<td>50%</td>
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<tr>
<td>Yes</td>
<td>12%</td>
<td>21%</td>
</tr>
<tr>
<td>Unknown</td>
<td>12%</td>
<td>12%</td>
</tr>
</tbody>
</table>

**References**

UpToDate®

*“Overview of the treatment of newly diagnosed, non-metastatic breast cancer”*

Interdisciplinary Breast Cancer Care: Declaring and Improving the Standard  
Rebecca Garcia, PhD  
“Decision-Making in the Surgical Treatment of Breast Cancer: Factors Influencing Women’s Choices for Mastectomy and Breast Conserving Surgery”  
Emily Catherine Bellavance and Susan Beth Kesmodel  
| Date reported to Cancer Committee | 11/19/19 |
| Opportunity for QI | The study objective is to determine if breast cancer patients are SJMC and CIJ were offered a preoperative referral to radiation therapy prior to definitive cancer-directed surgery. Patients should be offered a radiation therapy consult prior to making final surgical plan/decisions. If our data shows a need for improvement, we can develop a best practice process to recommend that breast cancer patients be offered a referral to radiation oncology prior to making final surgical plan/decisions. |
| Root Cause: | Root cause: Concern that patients are not receiving a radiation therapy consult prior to surgery. Dr. Ghee can advise patients of recommendations for radiation but feels that medical and radiation treatment discussions and recommendations are best left up to those specialists. Surgeons and medical oncologists are not aware of the recommendations for and benefits of referring breast cancer patients for radiation consultation prior to making surgical recommendation/plan. |
| QI Plan: | QI Plan: Our data shows a need for improvement. Develop a best practice process to recommend that breast cancer patients be offered a referral to radiation oncology prior to making final surgical plan/decisions. We can share study information with other physicians with recommendation to consider radiation oncology consult prior to making the final surgical plan for breast cancer patients. |
|  | May 2019: Dr. Ghee refers all surgical breast cancer patients for a preoperative radiation oncology consult prior to making a final surgical plan. For patients being referred to AMITA Cancer Institute of Joliet, the preoperative radiation oncology consults are coordinated with Dr. Dandekar. |