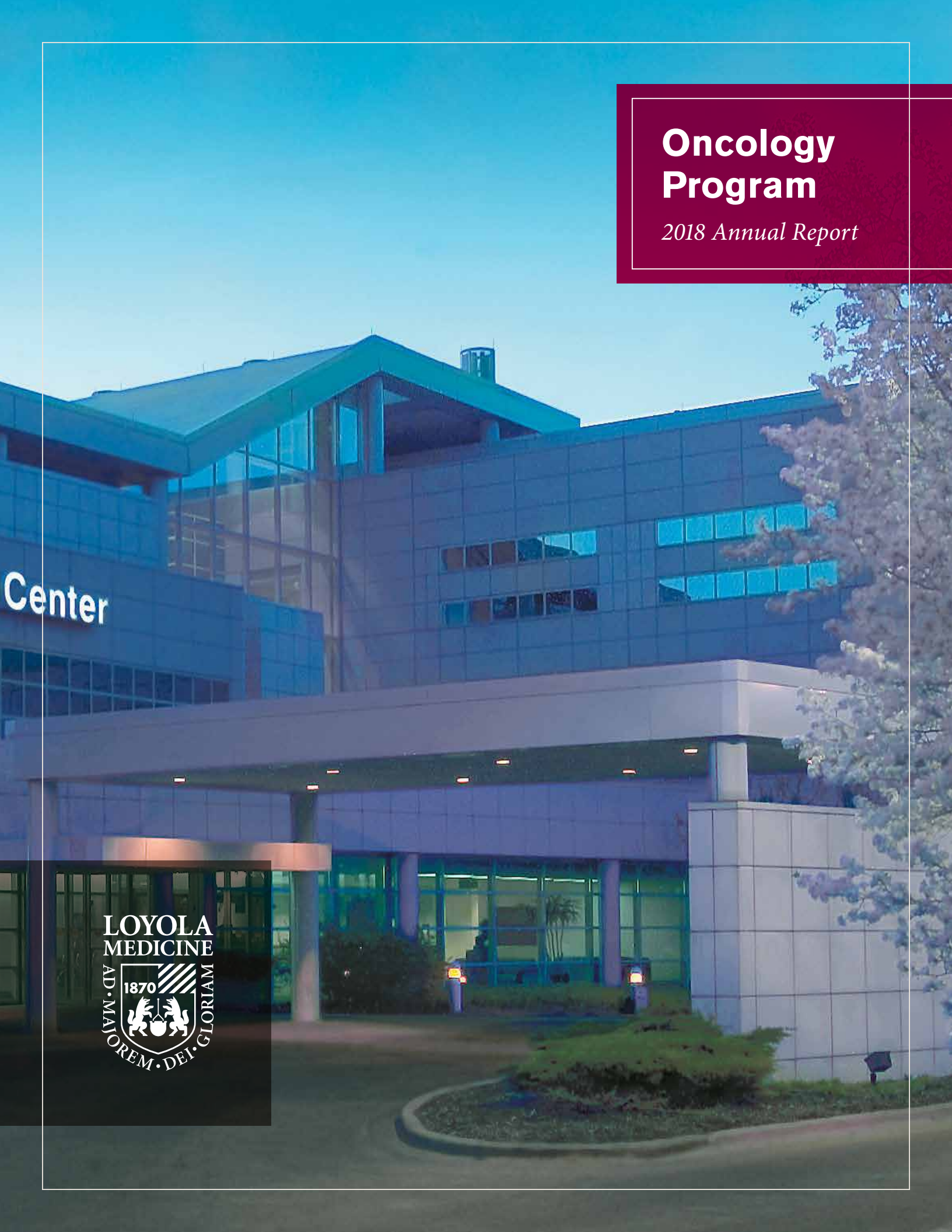
Oncology Program

2018 Annual Report



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Mission Statement

Trinity Health Mission Statement

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Loyola Medicine is committed to excellence in patient care and the education of health professionals. We believe that our Catholic heritage and Jesuit traditions of ethical behavior, academic distinction and scientific research lead to new knowledge and advance our healing mission in the communities we serve. We believe that thoughtful stewardship, learning and constant reflection on experience improve all we do as we strive to provide the highest quality health care.

We believe in God's presence in all our work. Through our care, concern, respect and cooperation, we demonstrate this belief to our patients and families, our students and each other. To fulfill our mission, we foster an environment that encourages innovations, embraces diversity, respects life and values human dignity. We are committed to going beyond the treatment of disease. We also treat the human spirit.

Brand Promise

The people of Loyola promise patients that we go beyond the illness to treat the whole person.

The Cardinal Bernardin Cancer Center is located on the east side of the campus and faces First Avenue. Parking is available in a parking lot in front of the building and valet parking is available at the entrance. A coffee bar is located just inside the building on the first floor. Named in honor of the late Archbishop of Chicago Joseph Cardinal Bernardin, the cancer center was the first free-standing facility in Illinois dedicated to cancer research, diagnosis, treatment and prevention. Loyola's cancer center contains all outpatient cancer care along with extensive research laboratories, offices and educational space. Many of the multidisciplinary clinics within the cancer center provide a one-visit, one-team approach, providing patients with a diagnosis and treatment plan in the same day. Patients can see their physician, have lab work done, undergo chemotherapy and have cancer care-related prescriptions filled, among many other services in the building.

Message from the Chairman

The year 2018 brought combined improvements to the wide array of cancer services available to patients of Loyola University Medical Center, American College of Surgeons Accredited Oncology Program. It is with great pleasure to offer my congratulations to the entire cancer team from administration to all clinical and volunteer staff in this institution for providing high quality cancer care to our patients, meeting and exceeding the standards set by our cancer program.

This report provides an overview of the program's organization of services and highlights a statistical summary in a narrative, tabular and graphic form of all cancer cases diagnosed and treated at Loyola University Medical Center.

Through our commitment and determination, the accomplishments of the oncology program are wholly dependent upon the tireless efforts of a team of caring professionals, without whom we could not strive to reach our goal in providing oncology service of highest caliber.

Celebrating the achievements of this relationship, they are working together to:

- Jointly expand access to specialty clinical services at Palos
- Improve quality of care
- Increase efficiency of services

Improved Access to Services, a one-call system, has been established for the transfer of neurosurgery patients. Since Loyola provided a telestroke neurosciences consult service for Palos physicians, the capability of both teams to treat stroke and other neurologic diseases has greatly improved. Loyola's stroke specialists use a telemedicine robot to conduct patient exams remotely, in real time.

As an academic medical center, Loyola can offer the opportunity to enroll in clinical trials of experimental new drugs that are not available at most hospitals. These new treatments potentially can reduce side effects, prolong remissions, and in some cases cure cancers.

Oncology Committee Members and Specialty

The Cancer Committee membership is multidisciplinary, representing physicians from the diagnostic and treatment specialties and non-physicians from administrative and supportive services. The following list of Committee members in 2018 reflects the multidisciplinary nature of the Cancer Committee:

Member	Specialty
Constantine Godellas, MD Oncology Program Committee Chairman	Surgical Oncology
Gerard Abood, MD Oncology Program Cancer Liaison Physician	Surgical Oncology
Carol Bier-Laning, MD	Otolaryngology
Davide Bova, MD	Diagnostic Radiology
Violeta Dimovic, CTR	Manager, Oncology Data Management
Elisa Estrada	Oncology Data Management
Debbie Fager	ACS Representative
Kathleen Fujiu, RN, BA, BSN, MBA, OCN	Nurse Manager 6 West, Coordinator
Kathy Grego, RHIT, CTR	Oncology Data Management, Coordinator
Madelyn Dupee	Rehabilitation
Elizabeth Henry, MD	Hematology/Oncology
Kate Heraty	Genetic Counselor
Edward Melian, MD	Radiation Therapy
Laura Morrell	Social Work, Cancer Center, Coordinator
Patricia Mumby, PhD	Professor, Psycho-Oncology
Gayle Payonk	Cancer Service Line, Oncology Support Executive Director
Ceil Petrowsky, RN MSN CCRC	Manager Cancer Clinical Trials Office
Maria Picken, MD, PhD	Professor of Pathology & Director of Renal Pathology
Sheryl Svoboda	Dietitian, Cancer Center
Peter Tortorice	Manager, Pharmacy Oncology
Maria Picken, MD, PhD	Professor of Pathology & Director of Renal Pathology
Mark Speyer, MD	Palliative Care
Sheryl Svoboda	Dietitian, Cancer Center
Peter Tortorice	Manager, Pharmacy Oncology

Prepared by: V. Dimovic, CTR

Oncology Services

All patients at the Cardinal Bernardin Cancer Center begin with a visit to one of the center's specialty or multidisciplinary clinics. There, the patient and family meet with the cancer specialist responsible for establishing an individual treatment plan and coordinating care. Within our unique multidisciplinary setting, a patient will meet with a team of cancer experts that may include surgeons, medical oncologists, radiation oncologists, radiologists, pathologists and plastic surgeons. These specialists work together to evaluate a patient's condition. During the same visit, patients might also meet with a nutritionist, nurse, social worker or other supportive staff.

Programs and Services

Below is a list of our programs and services for cancer care:

Art Therapy

Bone Marrow Transplantation

Breast Cancer

Breast Care

Breast Oncology Center

CAN-HELP Cancer Information Service

Cancer Genetics Evaluation Program

Cancer Risk Assessment and Prevention

Cancer-Pediatric Hematology and Oncology: Through our membership in the Children's Oncology Group, we participate in clinical trials and studies for pediatric conditions such as: leukemia, lymphoma, brain tumors, neuroblastoma, Wilm's tumor, rhabdomyosarcoma and other soft tissue sarcoma, bone malignancies)

Cancer Survivorship Program

Caregivers Class for Bone Marrow Transplant Patients

Centers for Fitness

Chaplain Services

Chemotherapy Classes

Clinical Research

Coleman Foundation Image Renewal Center

Gastroenterology Services

Gastrointestinal Oncology Center

Gynecologic Oncology Services

Head and Neck Oncology Clinic

Hematology Clinic

Hematology/Oncology Services

Home Care and Hospice

Melanoma Clinic

Neuro-Oncology Clinic

Nutrition Services

Psychology Support Services

Radiation Oncology Services

Screening and Early Detection - Cancer

Skin Cancer and Mohs Micrographic Surgery Center

Speech Therapy

Surgical Oncology

Thoracic and Lung Oncology Program

Urologic Oncology Clinic

**click on bolded programs and services to view website page.*

Primary Site Table – 2018

The following table summarizes the primary sites by gender for 2018. The top five most frequent occurring cancers at Loyola University Medical Center in 2018 were breast, lung, prostate, corpus uteri and melanoma.

TABLE: 1

Primary Site	Male	Female	Analytic	Non-analytic	Total
All Sites	**1275**	**1430**	**2417**	**288**	**2705**
ORAL CAVITY	**126**	**52**	**159**	**20**	**178**
Lip	9	1	10	0	10
Tongue	53	19	64	8	72
Oropharynx	2	0	2	0	2
Hypopharynx	3	1	4	0	4
Other	60	31	79	12	91
Digestive System	**255**	**180**	**409**	**27**	**435**
Esophagus	9	5	13	1	14
Stomach	26	19	42	3	45
Colon	39	35	66	8	74
Rectum	34	17	45	6	51
Anus/Anal Canal	7	5	11	1	12
Liver	74	33	101	6	106
Pancreas	50	38	86	2	88
Other	17	28	45	0	45
Respiratory System	**170**	**154**	**30**	**294**	**324**
Nasal/Sinus	8	4	11	1	12
Larynx	36	8	34	10	44
Lung/Bronc Small Cell	18	26	44	0	44
Lung/Bronc Non-Small Cell	99	103	186	16	202
Other	3	10	12	1	13
Blood & Bone					
Marrow	95	97	156	36	192
Leukemia	62	51	94	19	113
Multiple Myeloma	22	38	47	13	60
Other	11	8	15	4	19
Bone	**3**	**3**	**6**	**0**	**6**
Connective/Soft Tissue	**8**	**7**	**12**	**3**	**15**
Skin	**74**	**55**	**122**	**7**	**129**
Melanoma	66	52	113	5	118
Other	8	3	9	2	11

Primary Site	Male	Female	Analytic	Non-analytic	Total
Skin	**74**	**55**	**122**	**7**	**129**
Melanoma	66	52	113	5	118
Other	8	3	9	2	11
Breast	**2**	**336**	**336**	**18**	**354**
Female Genital	**0**	**236**	**193**	**43**	**236**
Cervix Uteri	0	34	27	7	34
Corpus Uteri	0	137	126	11	137
Ovary	0	55	49	6	55
Vulva	0	26	24	2	26
Other	0	9	0	9	9
Male Genital	**236**	**0**	**193**	**43**	**236**
Prostate	209	0	168	41	209
Testis	20	0	18	2	20
Other	7	0	7	0	7
Urinary System	**123**	**40**	**131**	**32**	**163**
Bladder	75	20	72	23	95
Kidney/Renal	46	17	55	8	63
Other	2	3	4	1	5
Brain & CNS	**52**	**52**	**93**	**11**	**104**
Brain (Benign)	3	1	4	0	4
Brain (Malignant)	20	14	34	0	34
Other	29	37	55	11	66
Endocrine	**44**	**95**	**119**	**20**	**139**
Thyroid	34	82	107	9	116
Other	10	13	11	12	23
Lymphatic System	**66**	**70**	**122**	**14**	**136**
Hodgkin's Disease	16	11	21	6	27
Non-Hodgkin's	50	59	101	8	109
Unknown Primary	**18**	**6**	**23**	**1**	**24**
Other/Ill-Defined	**1**	**6**	**7**	**0**	**7**

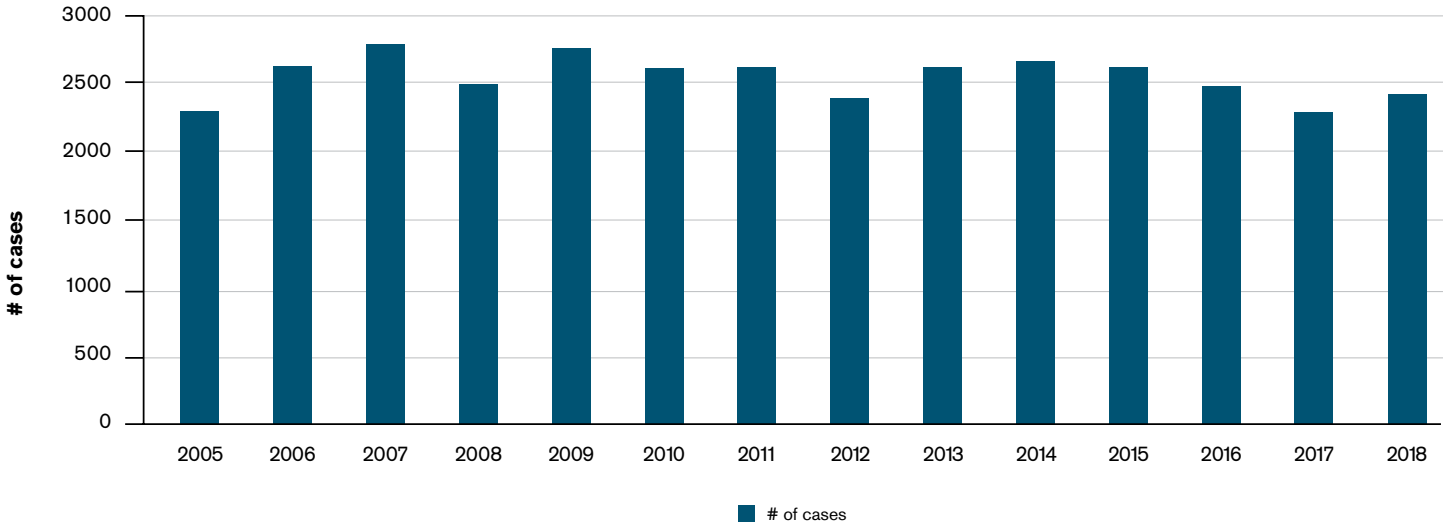
Analytic: A cases first diagnosed and/or receiving first course treatment at the facility, or diagnosed at autopsy.

Non-Analytic: Any case diagnosed at another facility and receiving all first course treatment at that facility, then seen at Loyola University Medical Center for subsequent treatment.

Data Analysis

GRAPH 1: INCIDENCE PER YEAR

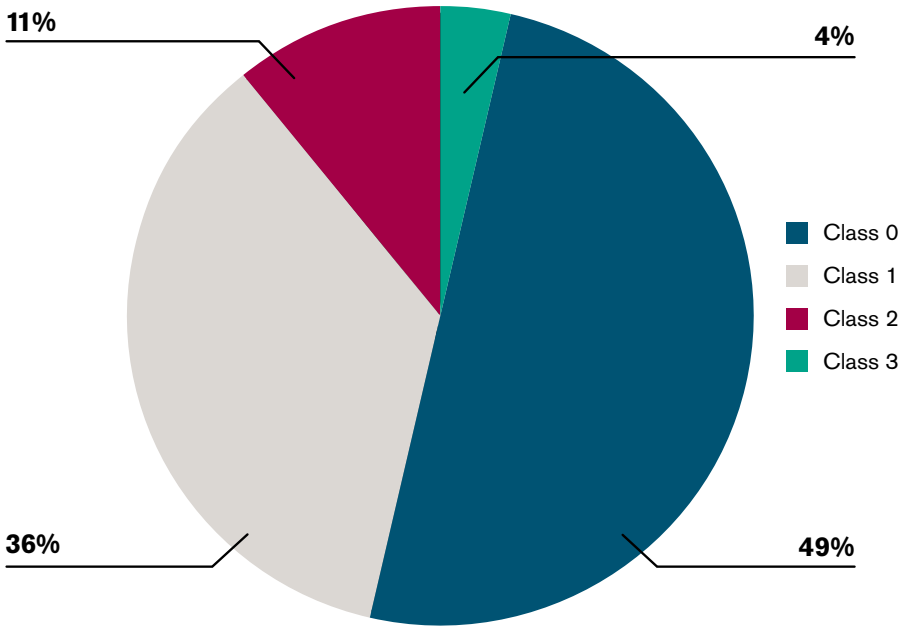
Data shows that the number of analytic cases diagnosed and treated at Loyola University Medical Center from 2005 through 2018.



In most of the 2018 cases, 49% (1,351) of patients received their initial diagnosis at LUMC, 36% (965) of patients were diagnosed elsewhere, but came in our facility to be treated; 4% (101) of patients were diagnosed at our facility and all their first course of therapy was done elsewhere; and 11% (288) of the patients came here for treatment of recurrent disease. (See Figure 1)

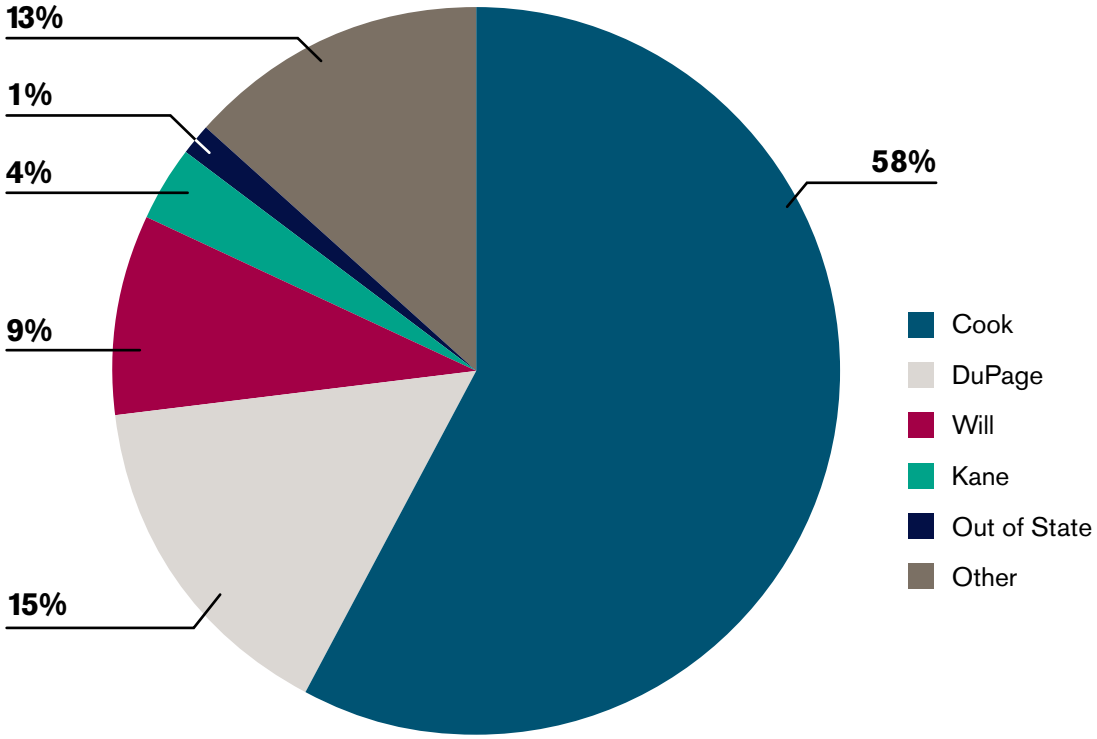
Total 2,705

FIGURE 1: CLASS OF CASE



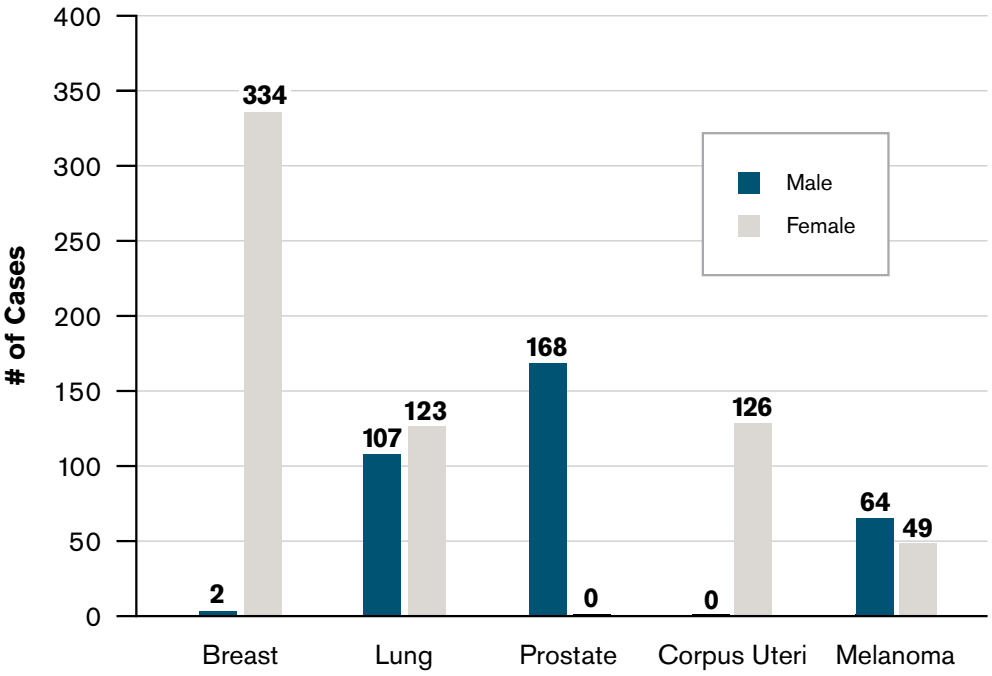
Most of the 2018 cases, 58% (1,564) of the patients were seen from Cook county, followed by 15% (417) from DuPage, 9% (237) from Will, and 4% (96) from Kane. Out-of-state cases accounted for 1% (31) and the remaining others accounted for 13% (360).

FIGURE 2: CASES BY DIAGNOSIS COUNTY



For all analytical cases, the most frequent site is Breast 35% (336). Next in frequency is Lung with 24% (230), Prostate 17% (168), Corpus Uteri with 13% (126) and finally Melanoma with 11% (113) (See Graph 2)

GRAPH 2: FIVE MAJOR SITES



For new analytic cases, 54% (1304) were female and 46% (1113) male. Graph 3 below shows that the diagnosis of cancer was most found in the 60-69 year range for males and females.

GRAPH 3: AGE BY SEX

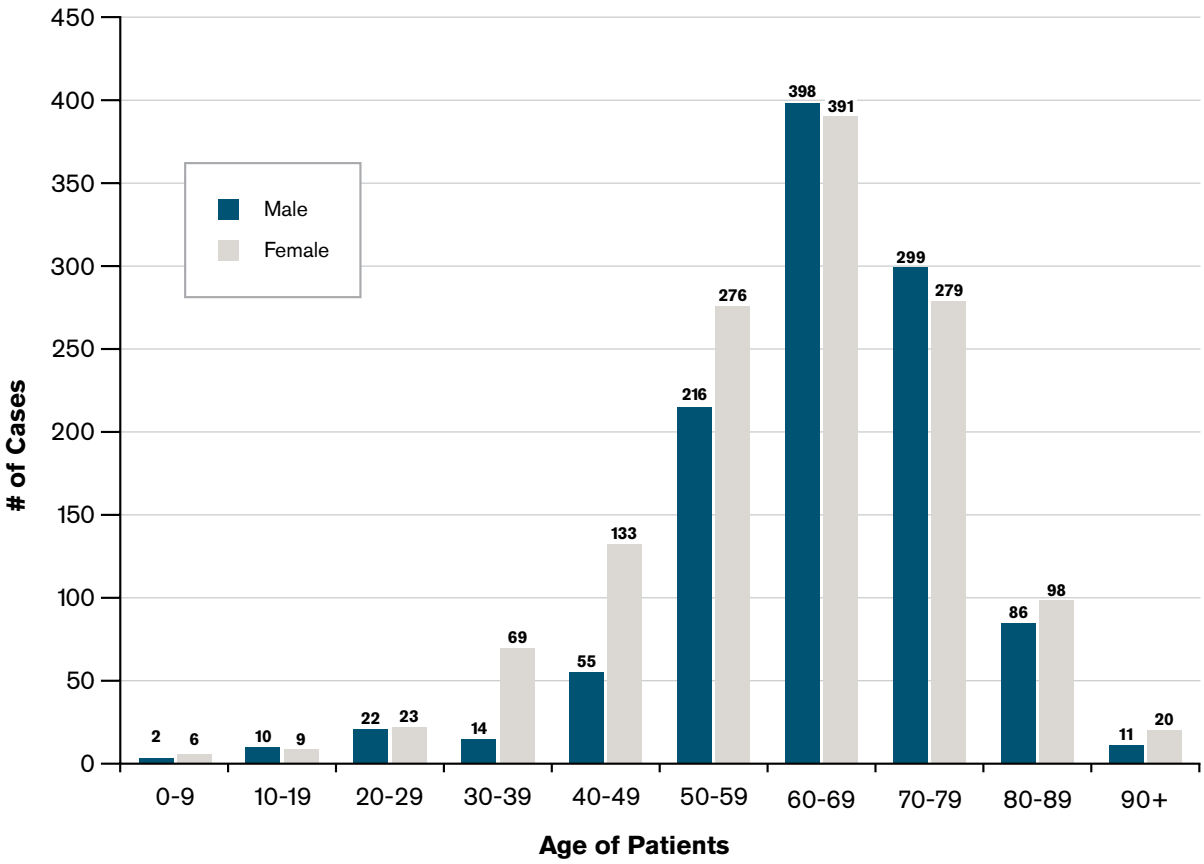
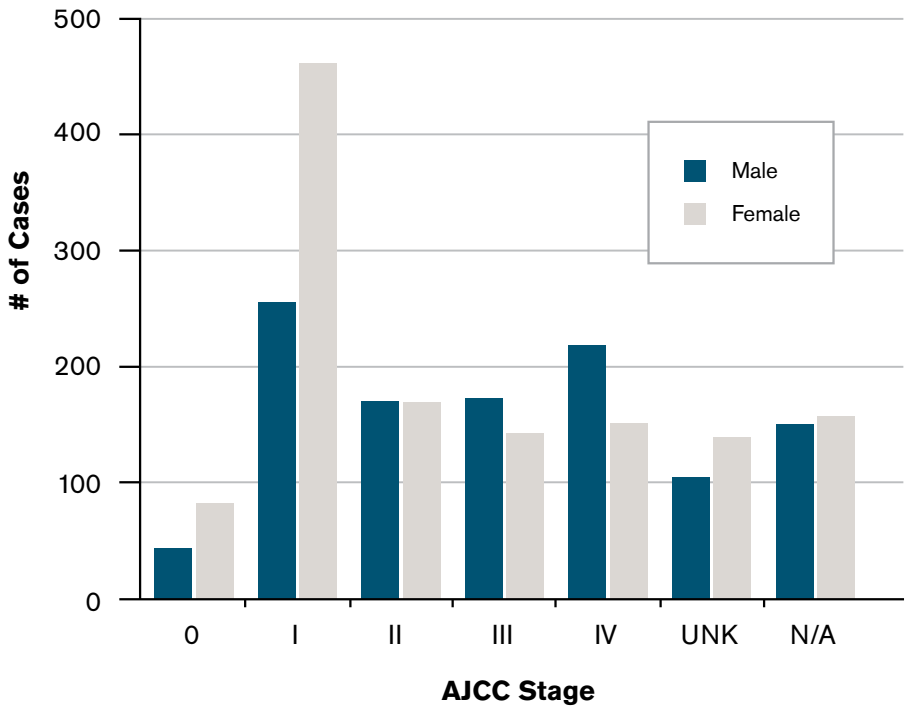


TABLE 2: AGE BY SEX

Age Range	Male	Female
0-9	2	6
10-19	10	9
20-29	22	23
30-39	14	69
40-49	55	133
50-59	216	276
60-69	398	391
70-79	299	279
80-89	86	98
90+	11	20
Total (2,548)	**1113**	**1304**

For all analytic combined staged cases: (126) were stage 0; (715) Stage I; (341) Stage II; (315) Stage III; (372) Stage IV, (242) Unknown Stage and Non-applicable (306).

GRAPH 4: AJCC STAGE BY SEX



Cancer Incidence by Sex and Site with the State and National

The American Cancer Society National estimates for site and sex distribution for all races were used to compare the estimates with Loyola University Medical Center data and the State of Illinois Cancer Statistics. The numbers reported are percentages of the total cases by sex. For the male population as compared to both the state and the nation, we observed quite a high incidence of kidney, liver, leukemia and pancreas but a lower level of prostate, lung and colorectal.

For the female population as compared to the state and nation, we observed quite a high incidence of corpus uteri, thyroid, and ovary, but a lower level of breast, lung and colorectal.

TABLE 3: MALES

SITE	LUMC %(1,076)Year-2018	ILLINOIS % (33,712) Year-2016	NATIONAL % (856,370)
Prostate	15.6	23.0	19.2
Lung	10.1	13.9	14.2
Liver	5.8	2.1	3.6
Melanoma	5.5	5.3	6.4
Colorectal	4.9	9.8	8.8
Leukemia	4.0	3.1	4.1
Non-Hodgkin's	3.9	4.4	4.9
Pancreas	3.7	3.0	3.4
Thyroid	3.4	1.6	1.5
Bladder	3.3	6.8	7.3

**Estimated New Cancer Cases Year-2018*

TABLE 4: FEMALES

SITE	LUMC %(n=1,304)	ILLINOIS % (n=35,242)	NATIONAL% (n=878,980)
Breast	25.6	29.4	30.3
Corpus Uteri	9.6	7.0	7.2
Lung	9.4	13.2	12.8
Thyroid	5.6	4.2	4.7
Non-Hodgkin's	4.1	3.8	3.7
Melanoma	3.8	4.0	4.1
Ovary	3.8	2.4	2.5
Colon	3.6	8.8	7.4
Multiple Myeloma	2.5	1.3	1.6
Cervix Uteri	2.0	1.6	1.5

Loyola University Medical Center

Patient Care Evaluation Study

Constantine Godellas, MD
Cancer Liaison Physician
Cancer Program

Violeta Dimovic, CTR
Manager, Oncology Data
Cancer Program

Treatment of Multiple Myeloma

Standard 4.6

PLAN

1. **Opportunity/Aim Statement:** What are you trying to accomplish?
   - To assess the percentage of patients, aged 18 years and older, with a diagnosis of multiple myeloma (MM), not in remission who are receiving medications that follow treatment plan recommended at an encounter during a reporting period.
   - Increase patient safety
   - Ensure appropriate use of medications
   - Reduce painful bony complications
   - Patient benefits; reducing the number and activity of osteoclasts
   - Improve clinical management and coordination of patients with multiple myeloma in the multidisciplinary setting
2. **Measurable Goal:** How will you know that a change has resulted in an improvement? What are you measuring?

Numerator

Patients who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period

Bisphosphonate therapy includes the following medications: pamidronate and zoledronate

Denominator

Denominator: All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period.

Denominator Exceptions

The medical reasons for denominator exceptions are:

1) Documentation of medical reasons for not prescribing bisphosphonates (e.g., patients who do not have bone disease, patients with dental disease, patients with renal insufficiency)

2) Documentation of patients reasons for not prescribing bisphosphonates

The patient reasons for denominator exclusions are:

1) Patient declines treatment

2) Economic, social or religious reasons

3) Other documented patient reasons

Goal or Target

Ensuring acceptable NCCN recommendations are applied as defined by the guideline once per reporting period to the treatment of multiple myeloma and reduce vertebral fracture and probably pain.

Rationale

Multiple myeloma is a disease characterized by bone destruction, in the form of diffuse osteopenia and/or osteolytic lesions, which develop in a significant number of patients.

Bony manifestations of myeloma, according to NCCN guidelines, develop in 85% of patients. Related complications are the major cause of limitations in quality of life and performance status in patients with multiple myeloma. Bisphosphonates can inhibit bone resorption.

According to the American Cancer Society, MM accounts for 1% of all cancers and is the second most common hematologic malignancy after lymphoma with an estimated 24,280 to 30,330 new cases and 12,650 deaths that occurred in 2016.

Source of Goal or Target

NCCN, Outpatient Quality Reporting (OQR), National Quality Forum (NQF), ASCO

DO

- Ensure use of the agents in reducing painful bony complications
- Ensure that the care provided is to inhibit bone resorption by reducing the number and activity of osteoclasts
- Follow evidence-based guidelines to improve practice variation patterns in multiple myeloma patients and prevent bone destruction

STUDY

Results: Report to the Cancer Committee in June 2018 meeting.

Analysis: From 2013 to 2016 LUMC analytic, Multiple Myeloma case total is 158 patients (96 Males, 62 Females). The majority of the patients are aged 60-69 years at diagnosis, which is 33% of the 158 cases.

GRAPH 1: AGE BY GENDER

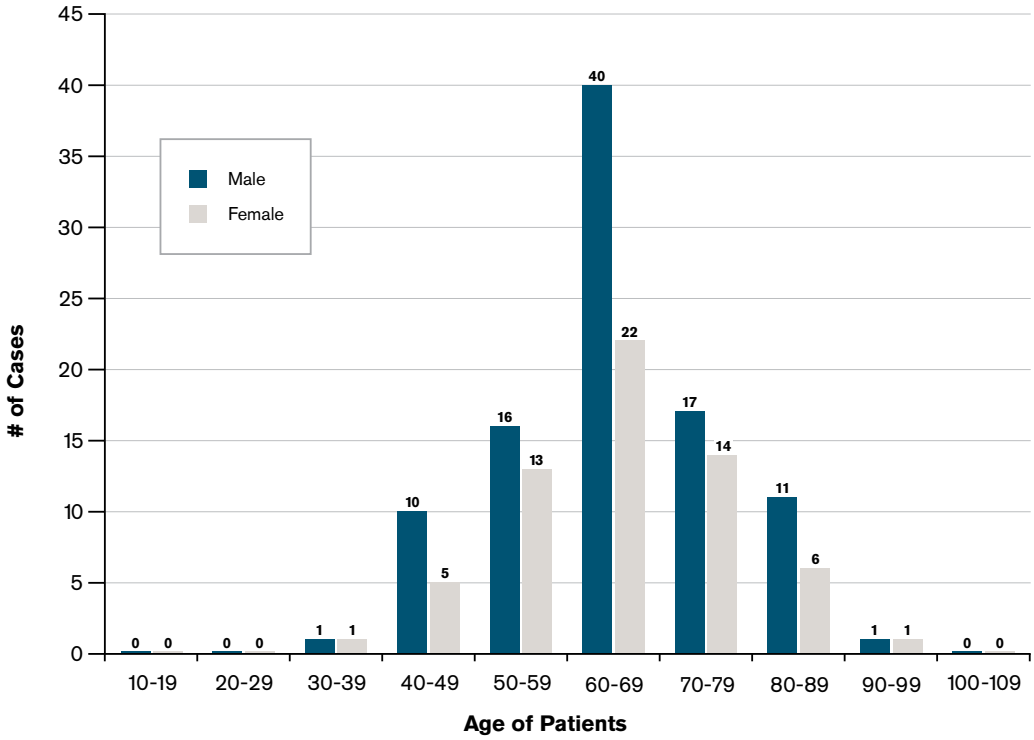


TABLE 1: AGE

Age Range	Male	Female
10-19	0	0
20-29	0	0
30-39	1	1
40-49	10	5
50-59	16	13
60-69	40	22
70-79	17	14
80-89	11	6
90-99	1	1
100-109	0	0
Total	**96**	**62**

Diagnosis:

The diagnosis of multiple myeloma is determined by a number of different diagnostic tests, because myeloma is difficult to diagnose on the basis of any single laboratory test result. Accurate diagnosis generally results from consideration of several factors, including physical evaluation, patient history, symptoms and diagnostic testing results. The initial evaluation to help confirm a diagnosis of myeloma includes blood and urine tests as well as a bone marrow biopsy. Other tests include X-rays. MRIs, CT scans and PET scans.

Results of the tests assist physicians to better determine treatment options and a prognosis. Many of these tests are also used to assess the extent of the disease and to plan and monitor treatment.

Patients in some categories do not have to receive treatment immediately, but may receive bisphosphonates of osteoporosis if present.

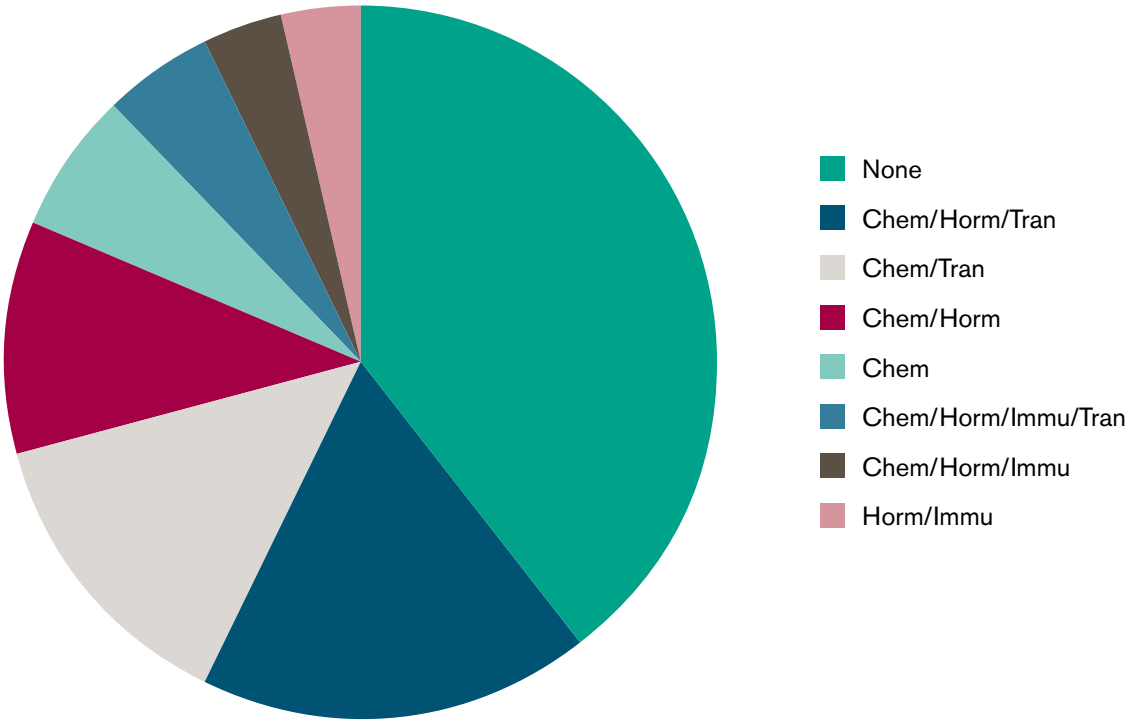
Variation within a recommended time frame is expected when each patient presents a unique set of comorbidities, performance status, reactions to treatment and life circumstances.

TABLE 2: RX COMBINATION

Myeloma

Rx Type	Number of Cases	Percent
None	56	35.44%
Chem/Horm/Tran	25	15.82%
Chem/Tran	19	12.03%
Chem/Horm	15	9.49%
Chem	9	5.70%
Chem/Horm/Immu/Tran	7	4.43%
Chem/Horm/Immu	5	3.16%
Horm/Immu	5	3.16%
Chem/Rad/Horm	4	2.53%
Chem/Immu	3	1.90%
Chem/Immu/Tran	3	1.90%
Chem/Rad/Horm/Immu	2	1.27%
Horm	2	1.27%
Immu/Tran	1	0.63%
Rad/Horm	1	0.63%
Chem/Rad/Immu	1	0.63%
Total Cases	**158**	**100.00%**

GRAPH 2: TREATMENT COMBINATION



A total of 56 patients (35%) cases were identified to have no treatment administered.

Since the cancer registry database does not capture or report ancillary medications (bisphosphonates), all cases were retrospectively reviewed and information on stage and/or IV bisphosphonate therapy administration was extracted from Epic and documented in the diagnosis data field text box.

Concordance with treatment guidelines:

According to NCCN guidelines, all patients receiving primary myeloma therapy should be given bisphosphonates.

Patients experiencing some form of bone problems received bisphosphonate injections on a monthly basis.

Data showed that 58 patients were administered IV bisphosphonate.

Reporting rate=Performance met (58 patients) + Exclusions (40) + Performance not met (3) = 101 = 85.5%

Eligible population (118 patients) = 118

Total patients documented with the type of stage:

Type of Stage	Number of Patients
Unknown	100
1A	6
1NOS	2
2NOS	7
2A	5
3NOS	10
3A	20
3B	8
Total	**158**

Sixty-three percent were not staged and the remaining cases (37%) were accurately staged using the Durie-Salmon system.

Staging is the process of finding out how much the cancer has advanced. It is very important for treatment options and prognosis. Multiple myeloma may be staged using the Durie-Salmon system. Recently, a new staging system called the International Staging System for MM has been developed.

DURIE-SALMON SYSTEM

The Durie-Salmon system has been traditionally been used for the staging of myeloma. This staging system is good for assessing the extent of the disease and/or size of the tumor. According to this system, there are three stages, called stages I, II, or III (1, 2, or 3). Stage was further classified as A or B, depending on whether kidney function has been affected. The B classification means that there is significant kidney damage.

Stage I – A relatively small number of myeloma cells are found.

All of the following features must be present:

- Hemoglobin level is only slightly below normal (still above 10 g/dL)
- Bone X-rays appear normal or show only one area of bone damage
- Calcium levels in the blood are normal (less than 12 mg/dL)
- Only a relatively small amount of monoclonal immunoglobulin is in blood or urine

Stage II – A moderate number of myeloma cells are present. Features are between stage I and stage III

Stage III – A large number of myeloma cells are found. One or more of the following features must be present:

- Low hemoglobin level (below 8.5 g/dL)
- High blood calcium level (above 12 mg/dL)
- Three or more areas of bone destroyed by the cancer
- Large amount of monoclonal immunoglobulin in blood or urine

The International Staging System

This system divides myeloma into three stages based only on the serum beta-2 microglobulin and serum albumin levels.

Stage I – Serum beta-2 microglobulin is less than 3.5 (mg/L) and the albumin level is above 3.5(g/L)

Stage II – Neither stage I or III, meaning that either:

- The beta-2 microglobulin level is between 3.5 and 5.5 (with any albumin level)

OR

- The albumin is below 3.5 while the beta-2 microglobulin is less than 3.5

Stage III – Serum beta-2 microglobulin is greater than 5.5 (American Cancer Society)

ACT

Next Steps:

- Continue to track complete diagnostic and treatment information
- Promote pre-emptive awareness to the importance of charting
- To demonstrate adherence to the best evidence-based practices
- Enhance capturing and documenting pertinent laboratory tests, imaging and treatment
- For purposes of improving future quality for this disease population, propose a user-defined field be added in the registry database to capture the bisphosphonates therapy. Collecting ancillary drug information is not one of the data standards for inclusion, but will maximize an added reporting and characterize the process in measurable terms as guided by evidence-based entities.
- To educate the oncology registry staff the importance of the needed information to be collected for multiple myeloma patients in the registry database and documenting the information in concise terms for future sharing and aggregating health data across specialties and sites of care.
- Continue to conduct retrospective chart review for patients diagnosed with MM

Loyola University Medical Center

Quality Study 2018

D. Bova, MD

Breast Imaging: Effective Retrieval of Outside Priors

BACKGROUND

- Interpretation of mammograms is facilitated by available priors
- When priors <5 yrs, increase in specificity >> sensitivity
- Indeterminate and benign appearing lesions do not need call backs for additional views if stability over time (better if > 2 yrs) can be documented
- Occasionally, a developing density (over time) can be the only sign of malignancy (i.e., infiltrating lobular carcinoma)

PROBLEM

Obtaining prior studies from outside facilities is a labor intensive process. It requires:

- Written and signed release by the patient
- Contacting the outside facilities to request priors
- Facilities not always correctly identified by patients
- Facilities not always responsive at first or even second attempt
- Acknowledging receipt
- Manually loading priors in PACS and Hologic
- "Chasing" the original reader to "addend" the report with comparison

ADVERSE EVENTS

- Although the overwhelming majority of priors requested for comparison are for generally benign appearing lesions, there may be malignancies within benign appearing masses or calcifications.
- Due to cuts in staffing, list of "awaiting priors" left unattended
- Database did not issue reminders for "0"s – awaiting priors
- Malignancies may be left undiagnosed

INTERVENTION

- Creation of a weekly automated report of cases pending comparisons
- Appointment of dedicated staff to review and monitor reports

MEASUREMENTS

Cases pending comparison identified prior to intervention:

- Aug. – Dec. 2016 = 5
- Jan. – Apr. 2017 = 12
- May – Aug. 2017 = 5

Cases pending comparison identified after intervention:

- Jan. – Apr. 2018 = 23

Cases pending comparison identified AFTER 6 MOS post intervention:

- Sep. 10, 2018 = 14 (Aug. 21)
- Sep. 4, 2018 = 7 (Aug. 21)
- Aug. 27, 2018 = 12 (Aug. 15)
- Aug. 6, 2018 = 13 (Jul. 23)
- Jul. 23, 2018 = 5 (Jul. 9)
- Jul. 16, 2018 = 6 (Jun. 19)

Cases pending comparison identified after intervention:

- Apr. 30, 2018 = 23

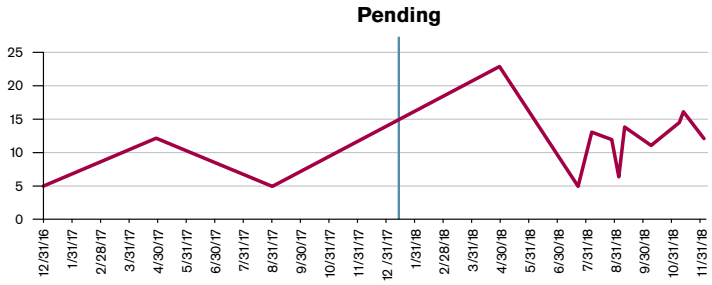
Cases pending comparison identified AFTER 9 MOS post intervention:

- Oct. 8, 2018 = 11 (Sep. 26)
- Nov. 5, 2018 = 14 (Oct. 15)
- Nov. 12, 2018 = 16 (Oct. 15)
- Dec. 3, 2018 = 12 (Nov. 23)

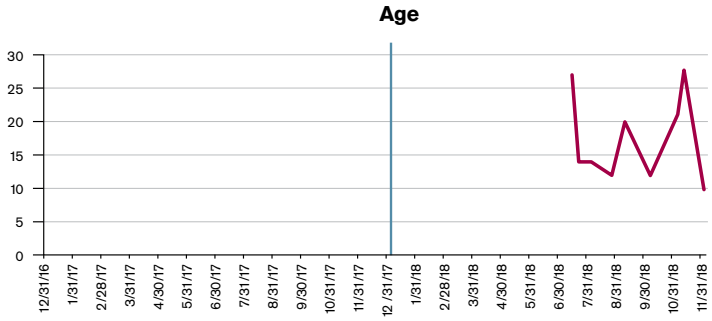
Cases pending comparison identified after intervention:

- Apr. 30, 2018 = 23

PENDING PRIORS:



DAYS PENDING:



CONCLUSION

Through an automated weekly report by RIS, we obtained:

- CONFIDENT AUTOMATED IDENTIFICATION OF CASES PENDING
- Decreased number of pending cases after intervention
- Decreased time lag for resolving pending cases
- We built REDUNDANCY in managing pending cases

Lead tech AND Service Rep. (Manager back-up)

Glossary of Terms

Accession: The addition of new cancer cases to the Oncology Registry.

Accession: The addition of new cancer cases to the Oncology Registry. Each patient is assigned a separate and permanent number.

ACOS: American College of Surgeons

ACS: American Cancer Society

Class of Case: The class of case divides cases recorded in the database of the facility into categories of analytic and non-analytic. Analytic data includes cases diagnosed at the accessioning facility and/or administration of any of the first course of treatment after the *registry's reference date. Non-analytic cases are first diagnosed and receive all of first course of therapy at another institution, or are diagnosed at autopsy or by death certificate only. Non-analytic cases are not usually included in routine treatment or survival statistics. Based on category, the cancer program selects cases to be used by their facility or to be reported to the central registry, as well as, the National Cancer Data Base (NCDB).

- Analytic: A case first diagnosed and/or receiving first course treatment at that facility, or diagnosed at autopsy.
- Non-analytic: Any case diagnosed at another facility and receiving all of first course treatment at that facility, then seen at Loyola University Medical Center for subsequent treatment.

Class 0	Diagnosis at accessioning facility and the entire first course of treatment was performed elsewhere or the decision not to treat was made at another facility. ▪ Patients who elect to be treated elsewhere. ▪ Patients who are referred elsewhere for treatment for any reason. For example, lack of special equipment; proximity of a patient's residence; financial, social or rehabilitative considerations.
Class 1	Diagnosis at the accessioning facility, and all or part of the first course of treatment was performed at the accessioning facility. Patients diagnosed at the accessioning facility whose treatment plan is either not to treat or watchful waiting. Patients diagnosed at the accessioning facility who refuse treatment. Patients diagnosed at the accessioning facility who are not treatable or who were given palliative care only due to age, advanced disease, or other medical conditions. Patients diagnosed at the accessioning facility for whom it is unknown whether treatment was recommended or administered. Patients diagnosed at the accessioning facility for whom treatment was recommended, but it is unknown whether it was administered. Patients diagnosed at a staff physician's office who receive their first course of treatment at the accessioning facility. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility. Patients diagnosed at the accessioning facility who received all or part of their first course of treatment in a staff physician's office.
Class 2	Diagnosis elsewhere, and all or part of the first course of treatment was performed at the accessioning facility. Patient provided palliative care in lieu of first course treatment, or as part of the first course of treatment, at the accessioning facility.
Class 3	Diagnosis and all of first course treatment done elsewhere. Patient treated or managed at the accessioning facility, but first course of treatment information is unknown. Patient for whom the accessioning facility developed a treatment plan or provided "second opinion" services, but the diagnosis and treatment was provided elsewhere. Patient treated for a recurrence or progression for a previously diagnosed malignancy.

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Surveillance, Epidemiology, and End Results

www.seer.cancer.gov National Cancer Institute, Surveillance, Epidemiology and End Results Program

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