Each year the Cancer Committee at CHRISTUS St. Patrick Hospital develops and disseminates a report or program outcomes to the public as required by the American College of Surgeons (ACOS) Commission on Cancer (CoC) standards. The content of the report includes outcome information on one or more of the Patient Outcomes standards:

**Colon Cancer Prevention Community Activity (Standard 4.1)**

**Date of event:** April 12-14, 2016

**Community Screening Needs Assessment:** Per the National Cancer Institute Colorectal cancer is the third most common non-skin cancer in both men and women. It is the second leading cause of cancer-related mortality in the United States. Over the past decade, colorectal cancer incidence and mortality rates have decreased in all racial/ethnic populations except American Indians/Alaska Natives. Men and women have similar incidence rates through age 39; at and above age 40, rates are higher in men.

Differences exist between racial/ethnic groups in both incidence and mortality. African Americans have higher mortality rates than all other racial/ethnic groups and higher incidence rates than all except American Indians/Alaska Natives. Incidence and mortality rates are lowest among Hispanics and Asians/Pacific Islanders. Overall colorectal cancer incidence and mortality rates have been declining over the past two decades; these declines have been attributed largely to increased use of screening tests.

Risk factors for colorectal cancer include increasing age, colorectal polyps, a family history of colorectal cancer, certain genetic mutations, excessive alcohol use, obesity, being physically inactive, cigarette smoking, and a history of inflammatory bowel disease. Effective colorectal cancer screening tests include the fecal occult blood test, sigmoidoscopy, and colonoscopy. Standard treatments for colorectal cancer include surgery, chemotherapy, radiation therapy, cryosurgery, radiofrequency ablation, and targeted therapy.

**Evidence Based National Guidelines:** Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 years and continuing until age 75 years.

People at higher risk of developing colorectal cancer should begin screening at a younger age, and may need to be tested more frequently. The decision to be screened after age 75 should be made on an individual basis. If you are older than 75, ask your doctor if you should be screened. For more information, read the current colorectal cancer screening guidelines from the USPSTF.
**Process:** The purpose of the event was to promote early detection of colon cancer through preventative education and screening techniques.

**Target Audience:** 50+ Males and Females

**Event Promotion and Messaging**

At the 3 day event education will be handed on by staff of the Regional Cancer Center and the ACS representative. Participants will be asked their age and if they have had a screening colonoscopy or taken an at home colon test.

**Action Plan**

The City’s employee health nurse will follow-up with age 50+ participants and encourage those who have not taken the home colon test to do so. Participants will be given instructions for collection along with risk factors and warning signs of colorectal cancer.

**Evaluation:** Each person attending was asked to complete a survey. The rating structure was scale of Strongly Agree to Strongly Disagree. The survey results are in the table below:

### COLORECTAL (COLON) CANCER HOME KIT: How effective has our prevention education been?

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel more informed about the risk factors and warning signs of colorectal (colon) cancer?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you more incline to change your dietary and smoking habits after knowing how your risk factors developing colorectal (colon) cancer?</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you more incline to begin or continue exercising more now to lower your risk?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you more concerned about colorectal (colon) cancer knowing how family history and ethnic background play a part in determining risk?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After being educated about the risk of developing colorectal (colon) cancer are you going to use this colorectal (colon) cancer FIT TEST and/or schedule a colonoscopy?</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Outcome:

117 participants were interviewed and asked their age and if they had had a colonoscopy screening or take home colon test kit.

71 indicated they had and will continue this screening in the future.

46 made a commitment to further evaluation thorough a FIT test and/or through a colonoscopy

3 participants completed survey – majority strongly agreed to prevention education.

Monitoring Compliance with Evidence-Based Guidelines (Standard 4.6)

Each year, a physician member of the cancer committee performs a study to examine the evaluation and treatment of patients and ensure that it is compliant with evidence-based national guidelines. The study must determine that the diagnostic evaluation is adequate and the treatment plan is concordant with a recognized guideline. Any problems identified with the diagnostic evaluation or treatment planning process could serve as a source for a performance improvement.

Physician Leading the Study: Mohammad Khan, MD

Method: Random Chart Audit

Study: Compliance with American Society of Colon and Rectal Surgeons evaluating the timeliness of Surgery following neoadjuvant therapy in locally advanced or high-risk rectal cancer patients.

Outcome/Improvements Suggested: The average time from completing neoadjuvant treatment to surgery for the 5 patients that were candidates was 10.8 weeks. Only 1 of the 5 patients fell outside of the 8-12 week recommended window, therefore, compliance with the guideline was 80%.

- The cancer committee supported the improvement recommendation of the Oncology Nurse Navigator to follow patients throughout treatment to ensure that patient gets referred for surgical evaluation once treatment is complete to prevent delay in surgery when appropriate.
Quality Improvement (Standard 4.7 & 4.8)

The Chemotherapy department took an opportunity to evaluate how patients undergoing chemotherapy were educated on what to expect when they are under treatment and measure its effectiveness.

The ACCC recommends that patients understand their therapy plan and their therapy. Current practice is that the patient receives initial chemo education with informed consent in the Medical Oncologists office. This is followed by one-to-one teaching with documentation of written materials given to patient placed in the chemotherapy chart and on-going education during each visit for chemotherapy administration.

A baseline review of the MD office process revealed limited time, staff and appropriate materials, plus the high level of anxiety the patient as causal factors which impacted effectiveness of education. A baseline review of the one-on-one education with the nurse revealed that because the education was happening the day prior to treatment, the patient did not have as much time to prepare for what to expect with treatment and ask the appropriate questions. A random sample of eight patients going through this process were given an evaluation form to rate effectiveness of their chemotherapy education resulting in 0% of these patients feeling the process was beneficial.

The chemotherapy nurses had researched the impact to providing the patient an option of group education to go along with the office education and first day treatment education. They want to implement this option and measure the impact. So the nurses gathered information they felt relevant to the patient’s treatment including handouts, important contact information, available resources and supplemental video. The MD’s office was given a schedule of classes to notify their new chemotherapy patients. The office and first day education was kept in place and this option was implemented. A random measure of six patients who went through the new program answered the same questionaries’ and 67% of those responding said they benefited from the group education. The committee felt this was a great demonstration of improving an important process.

Leah Marcantel, RN introduced an improvement to the chemotherapy education process.

**Improvement:** Patients are now notified of available group chemotherapy classes provided weekly for new chemotherapy patients as well as any patients that want further education. They can also receive this information at any time, even if unable to attend weekly sessions. Folders with information will now be given to all patients beginning chemotherapy in addition to drug specific information. This improvement resulted from a Study of Quality.