2017

EVANGELICAL COMMUNITY HOSPITAL

ONCOLOGY OUTCOMES REPORT

EVANGELICAL™
COMMUNITY HOSPITAL

One Hospital Drive, Lewisburg, PA 17837
570-522-2000 | evanhospital.com

Cancer Screening

The Commission on Cancer requires annual dissemination of a Public Outcomes Report. This year Evangelical Community Hospital is highlighting the outcomes of its screening program (Commission on Cancer standard 4.1).

The goal was to pilot a program that provides individualized cancer screening recommendations to patients and providers allowing informed, shared decision making. This helps patients determine which cancer screenings to have each year. While the tool addresses individual screenings for six of the most common cancers, this year's goal was to track the effectiveness in improving compliance to breast cancer screening recommendations.

Women attending the Annual Women's Health Screen were asked to participate in a pilot program for assessment and appropriate implementation of screening. The program is known as the Guideline, Awareness, and Prevention (GAP) Tool.

The committee tracked how many women took advantage of the tool during the Women's Health Screen and how many recommendations were made.

What Was Introduced

Patients were asked to complete a personal intake form including individual, social, and family histories (see page 7).

A nurse reviewed the histories and showed patients how the individual results drive decision making for each cancer screening offered (see attached GAP chart on page 4).

Recommendations were made at the event but patients were encouraged to take a copy of the chart to their primary care provider for shared decision making. The breast portion of the GAP chart utilizes the American Cancer Society guidelines (American Cancer Society screening recommendations for women at average breast cancer risk- www.Cancer.org). The patients were shown the guideline and the rationale for the screening was explained.

Cancer

Guidelines. Awareness. Prevention.

G.A.P. Chart

EVANGELICAL COMMUNITY HOSPITAL

	CANCER	SCREENING TEST	AGE	FREQUENCY	NOTES	RECOMMENDATIONS/COMMENTS
WOMEN	Breast	Mammogram	45-54	Annual	Option to screen at 40 if desired	
			55+	Every 2 years	Option to continue annual screening	
		Mammogram and MRI	All ages - higher than average risk	Annual	As determined by Doctor	
	Cervical	Pap Smear	21-29	Every 3 years	HPV screening may be used as follow up for an abnormal pap smear.	
			30-65	Every 3 years	Option 1	
		Pap Smear with HPV Testing	30-65	Every 5 years	Option 2	
		None	65+	___	None required if no pre-cancers have been detected in the previous 20 years and are not otherwise high risk	
		None	Any	None required for women who have had a hysterectomy	Unless hysterectomy was done as treatment for cervical cancer/pre-cancer, or cervix was not removed, adhere to the above.	
	Skin	None	Adult, Senior	Monthly	Regular exams by doctor and self-check can aid in early detection.	
	Thyroid	None	Higher risk for women 40+	Twice per year	Self-check your neck for growths or lumps and discuss any changes with doctor.	
	Colorectal	Guaiac- Based Fecal Occult Blood Test	50+	Yearly	If positive, a colonoscopy is recommended.	
		Fecal Immunochemical Test (FIT)		Yearly		
		Stool DNA Test		Every 3 Years*	If positive, a colonoscopy is recommended. Determine if insurance considers colonoscopy a screening and not diagnostic testing.	
		Flexible Sigmoidoscopy		Every 5 Years*	If positive, a colonoscopy is recommended.	
		CT Colonography (Virtual Colonoscopy)		Every 5 Years*		
		Double Contrast Barium Enema		Every 5 Years*		
		Colonoscopy		Every 10 Years*	___	
				*Frequency may be increased if patient is considered high risk.		
	Lung	Annual Low-Dose CT Scan (LDCT) of chest	55-74	___	Recommended for people who smoke 30 packs or more a year or people who have quit within the last 15 years.	

Disclaimer: This information is offered and available to users who are 18 years of age or older. The chart is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Never disregard professional medical advice or delay in seeking it because of something you have read. Reliance on any information provided herein is solely at your own risk. Recommendations are based on the most conservative suggestions, and are compiled from American Cancer Society (ACS) and US Preventive Services Task Force (USPSTF). 2017

Cancer

Guidelines. Awareness. Prevention.

G.A.P. Chart

EVANGELICAL COMMUNITY HOSPITAL

	CANCER	SCREENING TEST	AGE	FREQUENCY	NOTES	RECOMMENDATIONS/COMMENTS
MEN	Prostate	Prostate-Specific Antigen (PSA) Blood Test	Higher risk age 40+		Higher risk = more than one first-degree relative diagnosed with prostate cancer at an early age	
			High risk age 45+		High risk = African American and/or a father, son, brother (first-degree relative) diagnosed with prostate cancer before 65	
			Average risk age 50+	Every 1-2 years	• Results less than 2.5 ng/mL to be retested every 2 years • Results greater than 2.5 ng/mL to be retested yearly	
	Testicular	Self-examination	15+	monthly	Discuss lumps, tenderness, or changes with doctor.	
	Skin	None	Adult, Senior	Monthly	Regular exams by doctor and self-check can aid in early detection.	
	Thyroid	None	Higher risk for women 40+	Twice per year	Self-check your neck for growths or lumps and discuss any changes with doctor.	
	Colorectal	Guaiac- Based Fecal Occult Blood Test	50+	Yearly	If positive, a colonoscopy is recommended.	
		Fecal Immunochemical Test (FIT)		Yearly		
		Stool DNA Test		Every 3 Years*	If positive, a colonoscopy is recommended. Determine if insurance considers colonoscopy a screening and not diagnostic testing.	
		Flexible Sigmoidoscopy		Every 5 Years*	If positive, a colonoscopy is recommended.	
		CT Colonography (Virtual Colonoscopy)		Every 5 Years*		
		Double Contrast Barium Enema		Every 5 Years*		
		Colonoscopy		Every 10 Years*	___	
				*Frequency may be increased if patient is considered high risk.		
	Lung	Annual Low-Dose CT Scan (LDCT) of chest	55-74	___	Recommended for people who smoke 30 packs or more a year or people who have quit within the last 15 years.	

Disclaimer: This information is offered and available to users who are 18 years of age or older. The chart is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Never disregard professional medical advice or delay in seeking it because of something you have read. Reliance on any information provided herein is solely at your own risk. Recommendations are based on the most conservative suggestions, and are compiled from American Cancer Society (ACS) and US Preventive Services Task Force (USPSTF). 2017

Outcomes

There were 47 women in attendance at the Women's Health Screen on September 20, 2017. A total of 45 women participated in the completion of a GAP chart.

Two women already had mammograms in 2017 and six were not eligible because they did not fit the guidelines or were being followed in the High Risk Breast Clinic. That left 37 women who were eligible for screening mammograms in 2017 and not compliant at the time of the event. Of these, 18 had mammograms the day of the event, 14 agreed to schedule on their own, and five declined screening. Therefore, 49% of noncompliant patients had mammograms on the day of the event, 38% agreed to schedule on their own, and only 14% declined screening. Those who agreed to schedule on their own were called in December if they had not yet scheduled.

Future Plans

This pilot program was a success and we learned that when women are shown the ACS guideline and have an opportunity to discuss the rationale for the screening recommendations, almost 90% will agree to screening.

The committee will pursue introducing the GAP tool to the primary care offices for daily use and it will continue to be used at community events for women and men.

EVANGELICAL COMMUNITY HOSPITAL

PATIENT INFORMATION:

Date: _____

Name: _____
Last *Middle* *First* *Suffix*

Social Security #: _____ **Gender:** ___ Male ___ Female

Date of Birth: _____ **Email:** _____

Home Address: _____

_____

Home phone: _____ **Cell phone:** _____

Emergency Contact Name: _____ **Phone:** _____

Patient's Employer: _____ **Employer Phone:** _____

Race: ___ Am. Indian or Alaska Native ___ Asian ___ Black or African Am. ___ Native Hawaiian

___ Pacific Islander ___ White ___ Other ___ Declined **Language:** _____

Primary Care Physician: _____

How were you referred to our office? _____

May we speak to/leave a voicemail regarding your health with anyone other than you? ___YES ___ NO

If YES, name(s) of individual(s): _____

LEGAL REPRESENTATIVE/RESPONSIBLE PAYOR: ___ Self/Patient ___ OTHER (or if Patient is a MINOR):

_____

If OTHER: *Name* *Date of Birth* *Social Sec #* *Address* *City/ST/Zip*

SIGNATURE ON FILE

- I authorize use of my personal information above on insurance submissions
- I authorize release of health information to my other physicians and/or health care professionals
- I understand that I am responsible for knowing if ECH is a provider of my insurance company(ies)
- I understand that I am financially responsible for any payment due or not covered by insurance
- I authorize ECH to help me to obtain payment from insurance companies
- I authorize payment to be made directly to ECH or my physician
- I permit a copy of this authorization to be used in place of the original
- I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose to) and understand the Notice
- My signature below indicates the information provided on this form is true and complete.

_____

***SIGNATURE** of Patient/Legal Representative* *Date*

FAMILY HISTORY: Check all that apply

	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling
Breast Cancer								
Cervical Cancer								
Skin Cancer								
Thyroid Cancer								
Colorectal Cancer								
Lung Cancer								
Prostate Cancer								
Testicular Cancer								

SOCIAL HISTORY: Check all that apply

Do you use tobacco products? ___ Daily ___ Weekly ___ Monthly ___Never

Do you regularly drink alcoholic beverages? ___Daily ___Weekly ___Monthly ___Never

Have you ever used recreational drugs? ___ Yes ___ No

If yes, what?_____ How regular?_____

Are you now, or have you ever been treated for an addiction? ___Yes ___ No

It yes, what substance?_____

MEDICATIONS:

Name	Dosage	Frequency	Reason

___ List of medications provided on separate sheet