2016 CANCER CONTROL ANNUAL REPORT
Academic Comprehensive Cancer Program
Accredited by the American College of Surgeons Commission on Cancer
The American College of Surgeons has designated University Medical Center of Southern Nevada as an Academic Comprehensive Cancer Program and is currently the only program of its kind in the state of Nevada. This designation indicates that the hospital program has met very stringent requirements for the care of cancer patients. UMC Medical Staff Cancer Control Committee supervises the program. The UMC Academic Comprehensive Cancer Program offers a full range of diagnostic and treatment capabilities for the patients who have been found to have one of the many forms of cancer. The staff of the Academic Comprehensive Cancer Program includes physicians with special interest, training, and abilities in the care of the cancer patient. Members of the UMC medical staff with special interests in oncology include internal medicine, obstetrics/gynecology, thoracic and cardiovascular surgery, general surgery, colorectal surgery, genitourinary surgery, neurosurgery, pediatrics, plastic surgery, radiology, and pathology.

The specially trained and experienced nursing staff is of vital importance in the management of the patient. The separate oncology nursing unit assures continuity of care for our patients to include rehabilitation, home health care and hospice care.

Treatment may require surgical care, radiation and/or chemotherapy/biotherapy administration for adults and pediatric patients. Radiation treatment is provided by an affiliation with the 21st Century Oncology Radiation Center. Radioactive iodine therapy is provided for thyroid cancer patients needing inpatient services related to this type of cancer-directed therapy. The Nevada Cancer Research Foundation – one of 34 designated sites for the NCI Community Oncology Research Program (NCORP) which provides cancer patients with participation in clinical trials and supports the physicians in their care of the patient.

The Pharmacy Department plays an active role in the preparation of chemotherapy/biotherapy, pain control and assistance with research protocols. With their expertise, the pharmaceutical services ensure safe and accurate distribution of medications. Pharmacists are responsible for compliance with the American Society of Hospital Pharmacists and OSHA guidelines for chemotherapy/biotherapy preparation, handling, and dispensing of chemotherapeutic and biological agents.

Rehabilitation of patients is done with the assistance of the UMC Rehabilitation Center, the HOPE Chaplains and counseling programs at UMC and the American Cancer Society. The American Cancer Society (ACS) provides the Look Good Feel Better (LGFB) Program in the community. The LGFB program is free and teaches beauty techniques to women in active treatment to help them with appearance-related side effects of cancer treatment. A general Cancer Survivor Support Group is facilitated onsite at the UMC Healthy Living Institute. A full-time Social Worker is available to oncology patients related to psychosocial needs and patient navigation.

An enterostomal therapist is available to provide specialized care and treatment for patients with ostomies, skin problems, decubitus ulcers and draining wounds. Patients receive pre-and-post operative counseling, treatment and education.

Registered Dieticians are available to provide adequate nutritional support to patients receiving supplements, such as TPN or tube feedings, and to assist with planning special menus.

The Cancer Control Committee supervises the Academic Comprehensive Cancer Program. Professional educational programs include CME activity and the UMC Tumor Board, which reviews cases and furnishes an annual review of cancer diagnosis and therapy. The committee is responsible for supervision of the cancer registry, participation in studies of the American College of Surgeons and the publishing of the Cancer Control Annual Report.
2016 Cancer Control Committee Members

John Ellerton, M.D., C.M., Medical Oncology/Hematology
Chairperson
Quality Improvement Coordinator

Wydell Williams, M.D., Surgery
Cancer Liaison Physician
Surgical Oncologist

Ono, Jill, M.D., Pathologist
Cancer Conference Coordinator

Ronald Knoblock, M.D., Pathologist
Cancer Conference Coordinator - ALT

Diane Mazzu, M.D., Diagnostic Radiologist

Ian Haycock, M.D. Diagnostic Radiologist – ALT

Paul Treadwell, M.D., Radiation Oncologist

Scott Leader, PharmD, Hematology/Oncology

Jared Splinter, PharmD, Pharmacist – ALT

Debra Fox, RN, Chief Nursing Officer
Cancer Program Administrator

Doris Cowell, RN, BSN, OCN, Oncology Program Coordinator
Community Outreach Coordinator
Oncology Certified Nurse

Shannon Yule, CCRP, Nevada Cancer Research Foundation Program Administrator
Clinical Research Representative

Diane Segafredo, Nevada Cancer Research Foundation
Clinical Research Representative - ALT

Robyn Simon, CTR, Cancer Registrar
Cancer Registry Quality Coordinator

Sally Saban, RD, Director of Clinical Nutrition
Rehabilitation Services Representative

Maria Zenquis, LSW Oncology Social Worker
Psychosocial Services Coordinator

Pam Norcia, LCSW, Director of Social Services

Erika Gurnee, American Cancer Society Representative

Emylia Terry, American Cancer Society Representative - ALT
New and Emerging Therapies in Metastatic Melanoma
CME Program was held on May 6, 2016:

Presented by Sapna Patel, M.D.
Assistant Professor
Department of Melanoma Medical Oncology
Program Director, Melanoma Fellowship
University of Texas
MD Anderson Cancer Center Houston, TX

EDUCATIONAL OBJECTIVES
At the conclusion of this activity, participants should be able to demonstrate the ability to:
► Evaluate the efficacy and safety of approved and emerging therapies for metastatic Melanoma
► Understand the value of a multidisciplinary approach for the treatment of melanoma to improve patient outcomes
► Recognize the importance of patients actively participating in their treatment decisions and health management

TARGET AUDIENCE: This activity is intended for community-based oncologists, dermatologists, dermatologic surgeons, and other health care professionals involved in the care of patients with melanoma.
CREDIT DESIGNATION: The Potomac Center for Medical Education designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CME program entitled
Immunotherapies and Novel Agents in NSCLC
held on August 5, 2016

Presented by Vamsidhar Welcheti, M.D.
Assistant Professor, Medical Oncology
Cleveland Clinic Lerner College of Medicine
Cleveland, OH

EDUCATIONAL OBJECTIVES:
At the conclusion of this activity, participants should be able to demonstrate the ability to:
► Assess the indications and management of immunotherapeutic agents that are approved or under investigation in NSCLC.
► Evaluate the current and emerging targeted agents for NSCLC.
► Empower patients to become active participants in their treatment decisions and health management.

TARGET AUDIENCE: This activity is intended for community-based oncologists, oncology nurses, and other health care professionals involved in the care of patients with NSCLC.
CREDIT DESIGNATION: The Potomac Center for Medical Education designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CME program entitled
Current and Emerging Treatment Options for Locally Advanced and Metastatic Renal Cell Carcinoma
held on November 11, 2016
Presented by Sandy Srinivas, M.D.
Professor of Medicine (Oncology)
Stanford University Medical Center, Standford, CA.
At the conclusion of this activity, participants should be able to demonstrate the ability to:

► Discuss the tailored selection of first-line treatment options for patients with locally advanced or metastatic RCC.
► Evaluate recent clinical data on emerging agents for the treatment of RCC that has progressed.
► Review emerging data from ongoing clinical studies of novel therapies for metastatic RCC.
► Empower patients to become active participants in the management of treatment-related adverse events.

TARGET AUDIENCE: This activity is intended for community-based oncologists, urologists, surgical oncologists, radiation oncologists, and other health care professionals involved in the treatment and care of patients with advanced or metastatic RCC.

CREDIT DESIGNATION The Potomac Center for Medical Education designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

NURSING:
Greater Las Vegas Chapter Oncology Nursing Society May 14 Annual Oncology Nursing Symposium
Marwan Fakih, MD From City of Hope presented Advances in the Treatment of Metastatic Colorectal Cancer: Current Strategies and Future Directions
Donna A Enrico, MBA, BSN, RN presented Zika Virus
Matthew M. Burke, RN presented Foundational Principles and Practical Application of Immunotherapies for Oncology Nurses and Pharmacists
Kathleen Mohn, MSEd, RN, BSN presented Preventing CentralLine Associated Blood Stream Infections–Nurses–It’s Your Job!!
Jody Pelusi, PhD, FNP, AOCNP presented Beyond Care Plans: Comprehensive Survivorship Care Plan
6.0 CNE contact hours were awarded through this program.

Annual Nursing Chemotherapy/Biotherapy Certification Competency – May 2016
OCN Test Review Course for Oncology Nurses – October 28-29 2016
Presented by Linda Wills, RN, MN, MSN, AOCN and Brenda Keith, MN, RN, AOCNS

CNE Home Studies to include the following: Labs & Tests Pertinent to Cancer Patients; Oncology Nursing Overview; Oncologic Emergencies; Pain Management in the Cancer Patient; Oral Medications in the Treatment of Cancer and Non-Oncology Diagnoses

Acronym Glossary
ACS American Cancer Society
AJCC American Joint Commission on Cancer
NCROP NCI Community Oncology Research Program
CME Continuing Medical Education
CNE Continuing Nursing Education
ONS Oncology Nursing Society
OSHA Occupational Safety and Health Association
UMC University Medical Center
Lung cancer is the second most common cancer in both men and women, accounting for more deaths than any other cancer in both sexes. In 2016, approximately 1 in 4 cancer deaths have been attributed to lung cancer alone. By far, the most important risk factor for lung cancer is cigarette smoking; however, other risk factors such as exposure to radon gas, asbestos, certain metals, and second hand smoke have also been implicated in the development of lung cancer.

Treatment for lung cancer is based on the histologic subtype of the tumor (small cell vs. non-small cell carcinoma) as well as the stage at diagnosis. For non-small cell lung carcinomas (NSCLC), in addition to traditional therapy which could include surgery, chemotherapy, and/or radiation, select patients whose tumors harbor specific mutations in the epidermal growth factor receptor (EGFR) gene or anaplastic lymphoma kinase (ALK) genes are eligible to receive targeted therapy against these proteins. Approximately 10% of NSCLCs have an EGFR mutation and an estimated 4 to 5% of NSCLCs harbor the ALK gene rearrangement. Targeted therapy response rates for patients with EGFR mutations are in the range of 70-80% and for ALK mutations approximately 50-60%.

In late 2014, the American Society of Clinical Oncology (ASCO) issued guidelines to standardize EGFR and ALK testing practices for patients with NSCLC. Based on these guidelines, EGFR and ALK testing is recommended at the time of diagnosis for patients presenting with advanced stage (stage IV) disease and may be performed on patients with lower stage NSCLC based on the collaborative input from clinical teams and the laboratory. Molecular testing is recommended for lung adenocarcinomas or carcinomas of mixed subtype with an adenocarcinomatous component as the majority of tumors harboring mutations in EGFR and ALK show at least a component of glandular differentiation.

At the University Medical Center (UMC), there were a total of 33 new diagnoses of lung adenocarcinoma or NSCLC in 2014 and 57 initial diagnoses in 2015. The majority of these cases were biopsies or cytology specimens – 31 in 2014 and 40 in 2015, with the remainder being lung resection specimens. Of the 33 cases in 2014, EGFR/ALK testing was performed on 8 of the cases (24%). In 2015, EGFR/ALK testing was performed on 38 cases (67%). Over the 2 year period, 4 of the 90 newly diagnosed tumors were found to harbor mutations in EGFR and no ALK rearrangements were seen.

The rise in testing for EGFR and ALK at UMC is multifactorial. In mid 2015, the Medical Executive Committee at UMC approved reflex testing for EGFR and ALK on newly diagnosed lung adenocarcinoma on lung biopsy. Prior to this, oncologists or clinicians needed to specifically request these tests by contacting the Department of Pathology. Secondly, the publication of ASCO guidelines for molecular testing likely brought increased awareness of these tests. Finally, a lung tumor board at UMC was started in 2015 and decisions about whether molecular testing should be performed for patients treated at this hospital are frequently part of the discussion. Moving forward, it is anticipated that the rates of testing for EGFR and ALK will improve slightly as many of the changes from 2014 to 2015 occurred midway through the year in 2015.
The Cancer Registry at UMC is just one of the important parts of an American College of Surgeons approved Academic Cancer Program Hospital Cancer Program. The registry collects, manages, and analyzes data on patients who are diagnosed and/or treated with a malignancy or CNS Tumor at UMC. The Cancer Registry at UMC was established in 1979 and its’ reference year is 1995. There are approximately 14,500 cases in its database with 740 new cases accessioned into the registry in 2015 and approximately 6,200 patients followed annually. The registry’s primary goal is to assist the hospital in providing optimal care to the cancer patients. To ensure a credible database, the registry performs ongoing quality control checks through IOP (Improving Organizational Performance) improvement procedures on case finding for both pathology and Disease Index List sources of cases. The registry also maintains the quality of registry data with a review of ten percent of analytical cases by Cancer Control Committee Member and also assists with review of a random 10% of the Pathology Reports eligible for CAP (college of American Pathologists) protocols. These findings are reported to the Cancer Control Committee on a quarterly basis. The Registry also participates in Special Studies required by the Commission on Cancer. They work closely with the Cancer Committee Chair, Cancer Liaison Physician and the Cancer Program Coordinator to assure the hospital maintains its’ approval with the American College of Surgeons. The Registrar annually attends the yearly Education Conference.
sponsored by the National Cancer Registrars Association (NCRA) and keeps all members of the Cancer Control Committee advised of changes to the CoC Standards that will impact the facility.
Introduction
In order to identify the cancer prevention and screening needs of the community, resources such as the Nevada Cancer Coalition has developed a Nevada State Cancer Plan for 2016-2020. The Nevada Cancer Coalition is a non-profit collaboration of state and local government, health, medical, and business leaders, researchers, cancer survivors, caregivers, and advocates in Nevada. The Nevada Cancer Coalition works in partnership with the State of Nevada Comprehensive Cancer Control Program to develop, implement and manage the plan.

Nevada Demographics
With Nevada being the 7th largest state geographically, it is among the fastest growing state in the United States. The population has increased by 12.96 percent between 2006 and 2015 for a total of 2.8 million residents in 2015. There are 17 counties with only 3 of them (Clark, Washoe, and the state capital, Carson City) as urban. The other 14 counties are rural or frontier that equates to pronounced geographic disparities. The average distance between acute care facilities in rural Nevada is 115 miles.

The United States Census Bureau (2013) identifies the greatest percentage of Nevadans as white (52.2%), followed by Hispanic (27.5%), Black (9.0%), Asian (8.1%), and Pacific Islander (0.7%).

Cancer Burden in Nevada
In 2015, the number of new cancer diagnoses in Nevada was estimated at 13,640 with 4,880 estimated deaths. Lung cancer has the highest incidence of cancer for both males and females (8,559 cases) and the highest death rate at 49.9% (6,451 cases). Breast cancer in females is the second highest mortality rate (22.9%) and prostate cancer in males as the 3rd highest in cancer mortality rate (22.0%) among both sexes. And, when determining stage of disease at diagnosis, lung cancer is among the highest at late stage (79.2%) versus early stage disease (20.8%).

Cancer Profiles
Lung cancer is the leading cause of cancer death among men and women in Nevada and is the top site at University Medical Center of Southern Nevada. According to the Nevada Comprehensive Cancer Report, January 2015, smoking causes 90% of lung cancer cases, either through smoking directly or through second-hand smoke. This makes lung cancer preventable in many cases. In Nevada, 19.4% of adults have been identified as smokers, compared to 19% nationwide.

Community Outreach Prevention and Screening Programs
Because lung cancer accounts for more deaths than any other cancer in men and women, cancer committee decided to set a prevention goal (CoC Standard 4.1) related to smoking cessation and a screening goal (CoC Standard 4.2) to provide LD-CT scans for high-risk groups according the US Preventive Services Task Force guidelines. In 2015, the S.P.O.T.S. (Screening Pulmonary Oncologic Tumor Services) Program was developed and implemented. It is a lung cancer screening program established by University Medical Center of Southern Nevada (UMC) and University of Nevada School of Medicine (UNSOM). The program offers Low Dose CT Scans to patients at high risk for lung cancer. Patients who undergo screening are followed by a multi-disciplinary team of physicians with the benefit of expedited referrals, decreased time to therapy and coordinated treatment.

Once a patient is referred to the S.P.O.T.S. program, he or she may be scheduled for a Low Dose CT Scan at UMCSN’s Radiology Department. The goal is to look for any lung nodules or abnormalities that may suggest the presence of cancer. If the screening is positive, the patient will be evaluated in clinic by a pulmonologist and the patient may be sent for further testing. If the screening is negative, the patient will be scheduled to undergo annual Low Dose CT Scan. Patients are followed by a nurse navigator who coordinates screening/diagnostics in collaboration with UNSOM clinic staff. All appropriate patients in the S.P.O.T.S. program are also referred to a smoking cessation program.

References:
- Data Source: Preliminary data, Nevada Comprehensive Cancer Report, January 2015, Office of Public Health Informatics and Epidemiology.
- State of Nevada Comprehensive Cancer Control Plan 2016-2020 and is funded by the Division of Public Behavioral Health through grant number CDC DP12-1205 from the Centers for Disease Control and Prevention.
Review of Cancer Profiles

According to the American Cancer Society and the Nevada Cancer Coalition, lung cancer is the leading cause of cancer death among men and women in Nevada and is the top site at University Medical Center of Southern Nevada (UMCSN). According to the Nevada Comprehensive Cancer Report, January 2015, smoking causes 90% of lung cancer cases, either through smoking directly or through second-hand smoke. This makes lung cancer preventable in many cases. In Nevada, 19.4% of adults have been identified as smokers, compared to 19% nationwide.

With lung cancer accounting for more deaths than any other cancer in men and women, cancer committee at UMCSN decided to set a prevention goal (CoC Standard 4.1) related to smoking cessation and a screening goal (CoC Standard 4.2) to provide LD-CT scans for high-risk lung cancer groups according to the US Preventive Services Task Force guidelines.

Data Related to Cancer Prevention (CoC Standard 4.1) and Screening Programs (CoC Standard 4.2)

As previously mentioned in the Community Outreach Needs Assessment for 2016, the S.P.O.T.S. lung cancer screening program had been developed in collaboration with the University of Nevada School of Medicine (UNSOM). The program offers Low Dose CT Scans to patients at high risk for lung cancer. Patients who undergo screening are followed by a multi-disciplinary team of physicians with the benefit of expedited referrals, decreased time to therapy and coordinated treatment.

In 2016, the number of people who were referred to the S.P.O.T.S. program were as follows: Primary Care Referrals = 31, ED Referrals = 190, Number of Self Referrals into the S.P.O.T.S. program = 1. The NCCN guidelines for smoking cessation include a smoking history with a regular re-evaluation of smoking status, quit attempts made and interventions utilized. Therefore, a lung health/smoking history is completed for all patients in the lung cancer screening program. The number of current smokers = 59. The average smoker had a 20 pack year smoking history. All of the smokers were counseled on smoking cessation with the pulmonologist. When following the NCCN guidelines for smoking cessation, only 25% of patients who smoked, actually considered quitting. The patients who attempted to quit smoking multiple times, were not successful. Only 12% of current smokers actually quit smoking. 50% of patients who were referred to the S.P.O.T.S. program, were previous smokers and had quit on average for more than 5 years. 10% of patients were never-smokers. Two percent of patients who were non-smokers, were exposed to carcinogens to include secondhand smoke and other harmful substances through the work environment.

Analysis of the numbers and types of cancer diagnoses through the lung cancer screening program are as follows:

► NSCLC = 22
► SCLC= 3
► Other = 2 NHL, 1 metastatic prostate, 1 giant cell, 1 angiosarcoma, 1 sarcoma, 1 squamous cell tongue, 1 papillary
► Unknown primary = 4

All patients had follow up care with the oncologist and radiation oncologist through the lung cancer screening program. Challenges: Since the lung cancer screening clinic is located at the UNSOM building, it poses challenges regarding patient records and coordination of follow up care. Multiple emails and calls have been placed for updating of patient records and coordination of follow up LD-CT Scans and other diagnostics. There is a short lag time (1 month) in timeliness of repeat scans and annual LD-CT scans for high risk groups due to communication with the UNSOM office staff, the UMC program coordinator and the patients.
Community Outreach Summary
CoC Standard 1.8 Community Outreach
Doris Cowell, BSN, RN, OCN
Community Outreach Coordinator

Effectiveness of Prevention and Screening Programs:
When analyzing the effectiveness of the smoking cessation program for current smokers, the number of people who have been counseled on smoking cessation and quit smoking is a very low percentage (12%). Cancer committee and the Community Outreach Coordinator can further analyze the tools used to help people quit smoking such as pharmacological and behavioral methods of smoking cessation.

When analyzing the effectiveness of the lung cancer screening program, we have found more patients with late stage disease. However, 30% of those screened for a lung cancer primary, were shown to have metastatic disease to the lung. Of those patients with a lung cancer primary, 8% were considered to have an earlier Stage of disease (Stage I).

Recommendations from cancer committee:
► Form a community outreach subcommittee to further evaluate the tools/methods of smoking cessation and determine how to increase the number of current smokers to participate in the smoking cessation program and ways to capture lung cancer at an earlier stage of disease.
► Improve smoking cessation program by first identifying gaps in assessment of smoking history and methods of smoking cessation to include pharmacological and behavioral methods.
► Develop an algorithm of the communication process between UMC and UNSOM clinic staff.
► The addition of a dedicated Oncology Nurse Navigator will help with a more focused approach to the lung cancer screening program with duties that will include coordination of care with the multidisciplinary team, promoting timely follow-up for diagnostics, treatment and supportive care.

Actions: Under the direction of cancer committee, the Community Outreach Coordinator will coordinate a subcommittee for cancer prevention and screening in an effort to provide community outreach programs that are multidisciplinary and outreaching in the community for 2017.
Based on a Study of Quality, decrease CLABSI (Central Line Blood Stream Infection) Rates. A Quality Improvement Study (Standard 4.8)
Doris Cowell, BSN, RN, OCN

Introduction
In December 2013, the UMC Infection Prevention department had identified 9 central line associated blood stream infections on the inpatient oncology unit. There were a total of 14 CLABSI in 2013, and 12 CLABSI in 2014. Cancer committee and the Quality Improvement Coordinator had identified a need to review the CLABSI data and identify ways to decrease infections in oncology patients. When taking a closer look at the data, there were central line infections related to mucosal barrier injury (MBI). With mucosal barrier issues during cancer treatment, the gut becomes leaky and poses an issue with bacteria traveling throughout the blood stream that can cause central line infections. The National Healthcare Safety Network (CDC) is a federal report with Benchmarks for Device Utilization and Rates of Infection. The Standard Infection Ratio or SIR (O/E Goal <1.000) represents the Observed infections or total number of infections over the Expected rate of infection per clinical department and type of facility. In 2015, there were a total of 9 CLABSI for the first 3 quarters. However, 5 of the 9 CLABSI were related to mucosal barrier injury (MBI). Unfortunately at this time, the NHSN groups all CLABSI together. Therefore, all CLABSI are reported to NHSN to include the MBIs. The Expected SIR is <1.000. When reviewing UMC data for the oncology unit, the SIR for 2014 averaged 5.934. In 2015 for the first 3 quarters, the SIR averaged 5.276. Both years represent 5 times that of the NHSN Benchmark.

In an effort to decrease the number of CLABSI in oncology, the Infection Prevention Department at UMCSN is first looking at the Device Utilization. The primary care nurse needs to ask if the central line is needed or if it can be removed. The less central lines seen in the department, the less CLABSI. In oncology, we see that most patients need a central line for cancer-related treatments particularly when receiving vesicants and irritants. Symptom management after chemotherapy warrants a central line as well. Cancer committee suggested using this Study of Quality to make quality improvements in 2016.

Quality Improvement Related to CLABSI Rates
In 2015, the CLABSI Ad Hoc Committee had developed a way to capture information related to CLABSI with an RCA (Root Cause Analysis) tool. This tool was able to identify specific health care practices that lead to possible reasons why CLABSI rates were sustained in 2014 and 2015. In addition, the CLABSI Root Cause Analysis led to areas of focus for improvement and a targeted action plan in early 2016 with anticipated completion dates. Identified areas of improvement with an action plan were as follows:

1. Availability of PPE (personal protective equipment): Plant Operations at UMC worked in collaboration with nursing to install glove dispensers on the wall (inside patient rooms) next to the hand sanitizer immediately upon entering the patient’s room.

2. Raise awareness of the Importance of Measures to decrease infections in immunocompromised patients: a. Unit staff education was completed during unit staff meetings regarding current CLABSI and re-enforce strict hand hygiene and aseptic technique with central line dressing changes per hospital policy. b. Development of a 5-minute Charge RN Huddle to inform RN staff of CLABSI in patients. c. Additional nursing staff education and hands-on competency with accessing and de-assessing implanted ports at the annual chemotherapy skills/competency lab. Education included central line “Do’s and Don’ts.” d. Stress the importance of hand hygiene through unit staff meetings and throughout the day to all members of the health care team when entering and exiting patient rooms. e. Continued Hand Hygiene surveillance. f. Education of patients and family members regarding hand hygiene and to refrain from touching medical equipment. Family members to use public restrooms and not patient restrooms. g. Ensure patients and families receive a short handout on chemotherapy and neutropenia/ways to decrease infection (CDC handout). h. Create large poster to place strategically on the unit to raise awareness to health care providers, patients and public of entering a “Hand Hygiene Zone.”
3. Focused cleaning of rooms for patients with a compromised immune system (e.g. neutropenic patients and leukemia/lymphoma patients): a. Ensure patient rooms are kept clean on a daily basis – particularly for neutropenic patients – proper ways to clean dust – with a damp cloth as to decrease dust in the environment.

4. Increase Hand Hygiene compliance: a. Continued constant reminders to wash in and wash out every time with all members of the health care team through the use of wall mounted flyers of staff and hand hygiene champions.

5. Change current practice of clinical staff to decrease potential sites of infection related to medical equipment. a. After strict hand hygiene, use of gloves when touching all invasive lines and to wipe medical equipment down such as IV pumps, for example, at least once a shift. Education of practice change was completed through staff meetings, emails, and a staff Education Board.

After implementation of the CLABSI Plan of Action in early 2016, the UMC Infection Prevention department reported the number of CLABSIs for the 1st quarter of 2016 as 5 (2 CLABSI in January, 2 CLABSI in February, and 1 CLABSI in March). The device utilization total for the 1st quarter was 0.39 with Device Utilization Benchmark at 0.25. The total central line days for 1st quarter was 949. However, the patients who had a central line needed them for chemotherapy treatment/symptom management. The 2nd quarter showed 651 central line days and the 3rd quarter with 772 central line days. Device Utilization was 0.27 for the 2nd quarter and 0.32 for the 3rd quarter. The 2nd and 3rd quarters of 2016 revealed 0 (zero) CLABSIs for the inpatient oncology unit. Therefore, the action plan for decreasing CLABSI rates has shown thus far that the measures taken to educate and make small, but significant changes in practice, has made a difference in achieving this quality improvement goal.
The mission of the NCI-supported NCORP Network is to develop and conduct state-of-the-art cancer prevention, control, and treatment clinical trials with significant involvement of community oncologists and populations they serve. The NCORP Network mission includes: (1) accelerating development of interventions to prevent and treat cancer and its symptoms by increasing accrual to trials; (2) fostering quality care in the community through adoption of results from clinical trials; and (3) increasing the involvement of minority and underserved patient/participant populations in cancer clinical trials.

The NCORF NCORP is fortunate that the University Medical Center of Southern Nevada (UMCSN) has been affiliated with the NCRF since 1983. To assist the NCRF, UMCSN provides a regulatory umbrella for studies that are conducted at UMCSN. In addition, the UMCSN Institutional Review Board reviews Non - NCI CIRB approved studies so that these studies are available for patients being treated in local oncologists’ and radiation oncologists’ offices.

These clinical trials are available to the patients because UMCSN is a member of NCI Clinical Trials Networks through its affiliation with the NCRF NCORP. These networks serve as ‘research bases’ for the NCRF NCORP and provide a portfolio of clinical trials from which the NCRF NCORP and UMCSN are able to choose studies that best fit the patient population. The national Networks which UMCSN is affiliated with via the NCRF NCORP include: Alliance, COG, ECOG-ACRIN, NRG, SWOG, the University of Rochester Cancer Center and Wake Forest. There are approximately 40 studies that are active currently and many more studies that are closed to new patient enrollment but the NCRF NCORP and UMCSN continue to collect data on these patients. This collaboration will continue for many years as each study has a unique period of time where the patient is followed after active treatment. This may range from a few months to the lifetime of the patient.

In 2008, UMCSN became a member of the Children’s Oncology Group (COG). The UMCSN now has 4 pediatric oncology studies available for children with leukemia which include correlative science and quality of life studies.

UMCSN has been instrumental in the success of the NCRF NCORP program due to the support and commitment of the UMC administration, as well as the medical and nursing staff of the Pediatric and Oncology Units.

For more information on the Nevada Cancer Research Foundation NCI Community Oncology Research Program, telephone 702-384-0013.
UMC Cancer Survivor Celebration 2016
Celebrating National Cancer Survivor Day
Tuesday, May 3rd
5:30 p.m. - 7:30 p.m.
Michelle McGrorey, BSN, RN, OCN, HTCP, CA
and Debbie McKinney, BSN, RN, OCN
UMC Oncology Certified Nurses
Presenting: Essential Oils and Your Health
Relaxing hand massages will be provided
Refreshments will be served
Family Resource Center at Delta Point
901 Rancho Lane, Las Vegas, Nevada 89106
(Across the street from CVS Pharmacy)
Please RSVP by April 29 to Doris Cowell, RN at 702-383-2713

CANCER SURVIVOR HOLIDAY PARTY
CANCER SURVIVORS, FAMILIES AND FRIENDS WELCOMED
Tuesday, December 6
Registration and Holiday Entertainment begin at 5:30 p.m.
Activities will include:
Wellness Through Meditation & Arts
Amy Runge, BSN, RN, M.Ed
Healthy Living Institute at UMC
901 Rancho Lane Suite 180, Las Vegas, NV 89106
Enter on the Tonopah Rd side of the building - to the right of the entrance
Light refreshments and door prizes.
RSVP with Doris Cowell at 702-383-2713
no later than December 2, 2016

2016 CANCER SURVIVOR SUPPORT GROUP
FIRST TUESDAY EVERY MONTH
6PM TO 7PM
FEBRUARY 2ND
MARCH 1ST
APRIL 5TH
MAY 3RD
CANCER SURVIVOR CELEBRATION
5:30 P.M. – 7:30 P.M.
JUNE 7TH
AUGUST 2ND
OCTOBER 4TH
LUNG CANCER AWARENESS
NOVEMBER 1ST
BREAST CANCER AWARENESS
DECEMBER 6TH
CANCER SURVIVOR HOLIDAY PARTY
5:30 P.M. – 7:30 P.M.

FAMILY RESOURCE CENTER
DELTA POINTE BUILDING
901 RANCHO LANE SUITE #180
LAS VEGAS NV 89106
RSVP: DORIS COWELL, RN AT 702-383-2713