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NATIONAL CANCER STRATEGY

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides the structure for VHA's National Cancer Strategy.

2. BACKGROUND

a. Cancer is a varied and complex collection of diseases having many causes and clinical characteristics. According to the American Cancer Society, it will claim more than 556,500 American lives in 2003, including a substantial fraction of the Department of Veterans Affairs (VA's) estimated 175,000 veteran cancer patients. Cancer imposes a severe and in some ways unique burden of illness. Morbidity and mortality from the disease itself are significant, and one's quality of life may be dramatically reduced by currently available treatment. Arguably, it is the most feared of diseases, and its diagnosis imposes a significant emotional burden on both patients and their families. Approximately 35,000 new cases of cancer occur in VA patients each year; and cancer is the second leading cause of death among veterans. Moreover, the course of the disease is often protracted, and the treatment is quite demanding of resources. As the veteran population ages, this encumbrance will increase. It is necessary that VA formalize its approach to this group of diseases. The purpose of this national VA cancer strategy is to ensure that users of the veterans health care system have easy access to consistently high-quality cancer prevention, detection and treatment services.

NOTE: See Attachment B for malignancies recognized as presumed service connected.

b. **Objectives.** The specific objectives of this strategy are to:

(1) Ensure that the quality of VA cancer care meets or exceeds accepted national standards of practice;

(2) Improve cancer patients' access to care;

(3) Provide appropriate cancer management expertise to each patient as promptly as possible;

(4) Provide for the continual monitoring and improvement of the outcomes of therapy;

(5) Provide clinically useful prevention, screening and early detection services;

(6) Improve the quality of life of cancer patients;

(7) Provide compassionate and humane care that clearly demonstrates respect for the patients' dignity;

(8) Ensure that the care provided derives from shared decision making between the patient and treatment personnel;

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(9) Ensure that through its clinical research activities VA continually builds upon current knowledge, contributes to the national research base, and provides for state-of-the-art preventive, diagnostic and therapeutic interventions;

(10) Facilitate patient access to promising interventions;

(11) Contribute to the common good by establishing a national model for a systematic approach to the problem of cancer; and

(12) Ensure that suitable and timely patient-centered end-of-life care is made available, when appropriate.

c. **Strategy Elements.** This strategy addresses:

(1) Prevention and education,

(2) Screening,

(3) Early detection and diagnosis,

(4) Treatment,

(5) Rehabilitation,

(6) Clinical investigation and research,

(7) Tumor registry, and

(8) Continuing and end of life care.

3. POLICY: It is VHA policy that all Veterans Integrated Service Networks (VISNs) and medical center Directors implement, as appropriate, the National Cancer Strategy.

4. ACTION

a. **Chief Patient Care Officer.** The Chief Patient Care Officer (11) is responsible for ensuring that:

(1) This strategy is reviewed and revised as appropriate by the responsible office at least every 5 years, or more often as necessitated by changing circumstances. **NOTE:** *See Attachment A for elements of the National Cancer Strategy.*

(2) Increased VA participation in clinical trials is accomplished in accordance with the Interagency Agreement (IAA) of January 1, 2000, between VA and the National Cancer Institute (NCI), and all VISN Directors, facility Directors, Clinical Managers, and Chiefs of Staff are familiar with that document.

b. **VISN Directors.** VISN Directors are responsible for ensuring that:

(1) In designated Comprehensive Cancer Centers, rehabilitation services are made available for both inpatients and outpatients.

(2) VA facilities pursue group membership in the NCI cooperative group program, or the Community Clinical Oncology Program (CCOP), or its affiliate memberships.

c. **Medical Center Director.** Each medical center Director is responsible for ensuring that:

(1) A tumor registry is established, and the data provided is reported the Central Cancer Registry in a timely manner.

(2) A formal relationship with organizations providing hospice care is established ensuring that hospice services are available to every appropriate VA cancer patient when the need so arises.

(3) If the facility provides or participates in palliative care, there is a formal, evidence-based protocol for pain management, and that documentation of adequate pain relief is recorded in the patient's medical record.

(4) If clinical research in oncology is being conducted at the facility, primacy consideration to NCI-sponsored and VA Cooperative Group research studies must be given consideration over more limited local or regional protocols.

5. REFERENCES

a. Interagency Agreement (IAA) of January 1, 2000, between VA and NCI.

b. 1997 VHA-NCI IIA.

c. Physicians Data Query (PDQ) Database, NCI, available through the National Library of Medicine.

6. FOLLOW-UP RESPONSIBILITY: Patient Care Services (11) is responsible for the contents of this Directive. Questions may be directed to 202-273-8490.

7. RESCISSION: None. This VHA Directive expires on June 30, 2008.

S/ Louise Van Diepen for
Robert H. Roswell, M.D.
Under Secretary for Health

Attachments

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ATTACHMENT A**ELEMENTS OF THE NATIONAL CANCER STRATEGY**

1. Prevention. Prevention and education are central to a comprehensive approach to the management of any neoplastic disease. All medical facilities must provide and promote programs to encourage lifestyle changes such as smoking cessation and dietary counseling, as well as evidence-based disease prevention services which include, but are not limited to, those contained in the United States (U.S.) Preventive Services Task Force Guide and those recommended by the Department of Veterans Affairs (VA) National Center for Disease Prevention and Health Promotion.

2. Screening

a. Many screening issues are controversial, and objective data does not always support some opinions about the value of implementation of a number of screening practices. The value of any cancer screening practice is demonstrated by the extent to which it has been confirmed to reduce morbidity and mortality. Prolongation of survival is insufficient evidence to support screening, since earlier diagnosis results in longer survival whether or not early treatment, or any treatment, is effective.

b. VA shall utilize screening practices, which have been shown to be evidence-based. Those endorsed by the U.S. Preventive Services Task Force are considered appropriate for standardization in VA. Recommendations by other groups or professional associations such as the American College of Physicians, the American Cancer Society, et al., needs to be carefully considered by clinicians; utilization of those recommendations should be based upon the physician's best judgment combined with the wishes of the individual patient subsequent to careful counseling by treatment personnel about the risks and benefits of screening.

3. Clinical Practice Recommendations

a. VA recognizes the utility of evidence-based standards in providing best practices to our patients, as well as the complexity and difficulty inherent in developing them. Recommendations can only be as valid and reliable as the evidence upon which they are based. Moreover, they require frequent review and revision as new information becomes available. In addition, appropriate recommendations must be promulgated and disseminated widely and in a timely fashion, and be easily accessible to clinicians. For all of those reasons, the recommendations contained in the Physicians Data Query (PDQ) database provided by the National Cancer Institute (NCI) and made available through the National Library of Medicine represent the standard of care to be provided in VA, and are designated as the VA national cancer care guideline.

b. PDQ recommendations are the result of a comprehensive review by national cancer experts, and are based upon objective data carefully evaluated according to the strength of evidence. These statements are reviewed by the respective editorial boards at frequent intervals, thus assuring contemporaneous information. The database is electronically available through the National Library of Medicine 24 hours a day, at every VA medical facility. As part of the 1997 VHA-NCI Interagency Agreement, the NCI has agreed to provide PDQ for any VA facility or

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clinic lacking such access. *NOTE: The Under Secretary for Health strongly encourages that cancer patients be provided the "patient version" PDQ related to their disease so as to improve joint decision making.*

4. Rehabilitation. Rehabilitation is an integral component of cancer care. In designated Comprehensive Cancer Centers, rehabilitation services must be made available for both inpatients and outpatients. This treatment must be provided through the use of physical, occupational, recreational, and speech therapy services, at a minimum. Every facility caring for cancer patients has an obligation to provide rehabilitation directly or by appropriate referral.

5. Clinical Investigation and Research

a. Clinical trials provide an avenue for VA to make available to veteran patients new preventive, diagnostic, or treatment options, which may become the standard of future care. Further, they represent the only reliable process to acquire objective data suitable for the provision of efficacious and cost-effective patient care. Increased VA participation in clinical trials will be accomplished in accordance with the Interagency Agreement (IAA) of January 1, 2000, between VA and NCI, and all Veterans Integrated Service Networks (VISN) and facility directors and clinical managers and chiefs of staff are expected to be familiar with that document.

b. The basic intent of this new partnership is to increase the access of eligible veterans to NCI-sponsored trials of new preventive, diagnostic, and treatment interventions, and to provide VA clinical investigators with expanded opportunities to participate in clinical research. VA facilities are to pursue group membership in the NCI cooperative group program, or the Community Clinical Oncology Program (CCOP) or its affiliate memberships. VA facilities conducting clinical research in oncology must give primacy consideration to NCI-sponsored and VA Cooperative Group research studies over more limited local or regional protocols. In addition, particular attention needs to be paid to the enrollment of patients of ethnic or racial backgrounds, which predispose to the incidence of cancer or to poorer outcomes (e.g., prostate cancer in Afro-Americans).

6. Tumor Registry

a. A formal means of tracking patient care and outcomes is a critical element in any cancer program. This function is normally achieved through a cancer registry.

b. Registries provide important epidemiological, staging, demographic, survival, and other clinical data. A VA national tumor registry is established; this facilitates compilation of accurate incidence statistics, comparison of system wide outcomes with national standards, analysis of specific therapies and outcomes, evaluation of prevention practices, and planning for resource allocation. It also assists in providing analytic reports and contributes to nationwide cancer information. Each medical treatment facility must establish a tumor registry reporting to the central registry, or provide data that may be so reported.

7. Continuing Care and Terminal Care

a. The professional and ethical obligations of VA providers does not end when it is clear that further therapeutic interventions do not hold the hope of cure. Indeed, it is then that the greater challenges to medical care begin. It is not appropriate to believe, and never to state, that there is no more that can be done for the patient. While cure may not be possible, care is always needed to provide a dignified and comfortable end to life which should be as free as possible from anxiety, pain, and suffering.

b. VA is actively engaged in the national effort to develop precepts, guidelines, and research-based outcome measures for palliative care. The Under Secretary for Health endorses the "Elements of Quality Care for Patients in the Last Phase of Life" established by the Institute for Ethics at the American Medical Association. VA also supports the recommendations of the Institute of Medicine on Care at the End of Life. The National Hospice Organization has published "A Pathway for Patients and Families Facing Terminal Illness" that is organized around the outcome areas of self-determination, safe, and comfortable dying, and effective grieving. VA clinicians are strongly encouraged to use this systematic approach to care of terminally ill patients and their families.

c. Every VA medical treatment facility shall provide or have a formal relationship with organizations providing hospice care; those relationships must ensure that hospice services are made available to every appropriate VA cancer patient when the need so arises. Pain management is of critical importance in these circumstances, and current evidence demonstrates that pain relief is virtually always possible, though frequently not achieved. VA facilities providing or participating in palliative care must have a formal, evidence-based protocol for pain management. Documentation of adequate pain relief in the patient's medical record is essential.

d. The foundation of continuing and terminal care needs to afford dignity, comfort, communication, and the company of loved ones during a patient's final days. This is provided through services, which reduce discomfort while attending to the unique clinical, ethical, and spiritual care that is needed.

ATTACHMENT B

**MALIGNANCIES RECOGNIZED BY VA AS PRESUMED TO BE SERVICE
CONNECTED BASED ON HAZARDOUS EXPOSURES****1. EXPOSURE TO MUSTARD GAS. NOTE: Must be full-body exposures.**

a. **Full-body Exposure to Nitrogen or Sulfur Mustard.** Cancers of the nasopharynx, larynx, lung (except mesothelioma) and squamous cell carcinoma of the skin.

b. **Full body Exposure to Nitrogen Mustard.** Acute nonlymphocytic leukemia.

2. EXPOSURE TO IONIZING RADIATION. NOTE: Limited to atmospheric nuclear weapons test participants, occupation forces in Hiroshima and Nagasaki, plus others listed in Title 38 Code of Federal Regulations (CFR) 3.309(d) (3) (ii) (C) and (D). All forms of leukemia except chronic lymphocytic leukemia, cancer of the thyroid, bone, brain, breast, colon, lung, ovary, pharynx, esophagus, stomach, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary tract (kidneys, renal pelvis, ureter, urinary bladder and urethra), lymphomas (except Hodgkin's disease), multiple myeloma, primary liver cancer, and bronchioloalveolar carcinoma (a rare lung cancer).

3. EXPOSURE TO CERTAIN HERBICIDE AGENTS. NOTE: Service in Vietnam establishes exposure; exposure to herbicides in other locations must be confirmed by official records. Non-Hodgkin's lymphoma, soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma), Hodgkin's disease, multiple myeloma, respiratory cancers (lung, larynx, trachea and bronchus), prostate cancer; in process of being added - chronic lymphocytic leukemia.