Cancer Program Standards 2012: Focusing on Patient-Centered Care and Quality

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Change
“There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to manage, than to initiate a new order of things.”
—Machiavelli

Presentation Objectives
• Overview the 2012 Cancer Program Standards project
• Reinforce the importance of changes made to focus on patient needs and quality
• Outline the requirements for the Eligibility Requirements and Standards
• Describe improvements to the survey process and SAR
Commission on Cancer Mission

The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.

CoC Objectives

- Establish standards to ensure quality, multidisciplinary, and comprehensive cancer care delivery in healthcare settings.
- Conduct surveys in healthcare settings to assess compliance with those standards.
- Collect standardized, high quality data from CoC-accredited healthcare settings to measure cancer care quality.
- Use data to monitor treatment patterns and outcomes and enhance cancer control and clinical surveillance activities.
- Develop effective educational interventions to improve cancer prevention, early detection, care delivery, and outcomes in healthcare settings.

“The best way to have a good idea is to get lots of ideas.”

Linus Pauling
Commission on Cancer Membership
47 professional organization representatives and surgeons (Fellows of the ACoS)

- Surgeons
- Radiologists/Oncologists
- Medical Oncologists
- Pathologists
- Administrators
- Government
- Nurses
- Nutritionists
- Surveillance/Epidemiologists
- Cancer Registrars
- Hospice & Palliative Care
- Genetics
- Pt. Advocacy Groups

Benefits of Accreditation
- Cancer program and data standards to establish a framework for organizing cancer care
- External and internal assessment to demonstrate commitment to care
- Access to data and reporting tools to measure and improve quality of care
- National recognition and public promotion
- Access to educational tools and resources to support a comprehensive cancer program

Historical Timeline
- 1930 – Standards for cancer clinics developed
- 1931 – Pilot surveys conducted
- 1933 – Initial group of 140 facilities accredited
- 1975 – Participation increased to more than 600 facilities

![Graph showing the number of participating facilities from 1930 to 2010.](image)
Cancer Programs in U.S. Hospitals

- Hospitals with accredited programs: 40%
- Treated elsewhere: 20%
- Diagnosed and treated in hospitals without accredited programs: 70%
- Estimated new cancer patients in 2010: 1,529,560

Distribution of CoC-accredited Cancer Programs by State (1,500+)

Historical Timeline
- Current standards developed in 2004
- 36 current standards evaluate:
  - Structure (11)
    - Availability of clinical services
    - Cancer committee leadership
    - Data base
  - Process (23)
    - Access to multidisciplinary care
    - Assessment of stage in treatment planning
  - Outcomes (2)
    - National patterns of care studies
    - Local quality of care studies
    - Implemented improvements/enhancements

*Cancer Facts and Figures, American Cancer Society*
Healthcare Issues Identified by the Institute of Medicine

- Variation in quality affects outcomes
  - Quality of life
  - Organ function
  - Cancer recurrence
  - Patient survival

Healthcare Issues Identified by the Institute of Medicine

- Essential components of quality
  - Benchmarks to measure and monitor the quality of care
  - Providing key elements of quality care
    • Experienced professionals
    • Disclosure of treatment options
    • Agreed to care plan and resources to implement
    • Coordinated services
    • Psychosocial support, clinical trials, palliative and end of life care

Challenges in the Current System

- Patient-centered care is not well implemented
  - Systems can be complex and fragmented
  - Too much unwanted or unneeded care
  - Patients excluded from care team
  - Poor coordination between providers and settings
Patient-Centered Care

- Respect patients’ values, preferences and expressed needs
- Coordinate and integrate care across boundaries of the system
- Provide the information, communication, and education that people need and want
- Guarantee physical comfort, emotional support, and the involvement of family and friends

Crossing the Quality Chasm: A New Health System for the 21st Century
Institute of Medicine

Recommended Solutions

- System focused on patient needs. Sensitive to:
  - Cultural traditions
  - Personal preferences
  - Personal values
  - Family and lifestyle situations
- Patients collaborate with healthcare team to make decisions
- Increase patient role in self care and monitoring
  - Provide tools and support
- Seamless transition between providers and healthcare settings

Accomplishments in the New Standards

- Address needs by developing new patient-centered standards
  - Patient navigation
  - Psychosocial distress screening
  - Survivorship care plan
  - Genetic assessment and counseling
  - Palliative care services
Accomplishments in the New Standards

- Increased focus on the quality of care through performance metrics and quality improvement activities
  - Accountability measures
  - Quality improvement measures
  - Assessment of treatment planning
  - Increase clinical trial accruals
  - Prevention and early detection activities
  - Studies of quality and improvements
  - Public reporting of outcomes

Accomplishments in the New Standards

- Establish minimum thresholds through eligibility criteria
- Redefined program categories
- Additional focus on cancer committee leadership through expanded coordinator and CLP role

Accomplishments in the New Standards

- Address the full continuum of care
- Improve coordination of care
- Increase participation in care decisions by patients and family members
- Increase patient satisfaction
- Decrease costs
## Redefined Categories

- Identified issues with the current categories
  - Category selected by program
    - Perceived increased value or importance at “higher” level
      - Community vs Comprehensive Community
    - Some requirements/categories outdated
      - Affiliate Hospital Cancer Program
      - Integrated Cancer Program
      - Pediatric Cancer Program Component
  - Outcomes of category revisions
    - Combine categories with limited use
    - Assign category based on facility type, services, and caseload
      - Similar facilities grouped together
        - Allows for meaningful comparison
          - Data
          - Services
          - Resources

## Revised Categories

- Integrated Network Cancer Program
  - Multiple facilities provide comprehensive care across continuum
- NCI-designated Comprehensive Cancer Center Program
  - Key involvement in basic and clinical research
- Academic Comprehensive Cancer Program
  - Provide post-graduate education
  - At least 500 cases annually
    - Patients enrolled in clinical research
- Veterans Affairs Cancer Program
  - Specific to VA facilities
    - Patients enrolled in clinical research on-site or referred

## Revised Categories

- Comprehensive Community Cancer Program
  - At least 500 cases annually
    - Patients enrolled in clinical research on-site or by referral
- Community Cancer Program
  - 101 – 499 cases annually
    - Patients enrolled in clinical research on-site or by referral
- Hospital Associate Cancer Program
  - Up to 100 cases annually
    - Patients enrolled in clinical research optional
- Pediatric Cancer Program
  - Pediatric hospital or component
    - Patients enrolled in clinical research
- Freestanding Cancer Center Program
  - Any non hospital facility
    - Patients enrolled on clinical research on-site or by referral
Establish Eligibility Requirements

- Identified services and resources common to all programs, including:
  - Committee authority
  - Cancer conference program and cancer registry policies and procedures
  - Diagnostic and treatment services (diagnostic and therapeutic radiology, systemic services)
  - Essential supportive care (psychosocial and nutritional services, clinical trial information)
- Essential for comprehensive care, but allows for provision by referral
- Information displayed in CoC Hospital Locator

Eligibility Requirements

- Required of all programs
- Cancer committee evaluates eligibility requirements annually
- Confirmed through completion of SAR prior to survey scheduling
- Resolution timeframe will apply
- Failure to resolve results in suspension of accreditation

Eligibility Requirements

- E1: Facility is accredited
- E2: Cancer committee authority and responsibility established (bylaws)
- E3: Establish cancer conference policy
- E4: A nurse provides leadership for oncology care
- E5: Cancer registry policy and procedure manual addresses use of current CoC data definitions and codes
- E6: Diagnostic imaging is provided on-site or by referral
Eligibility Requirements

• E7: Radiation Oncology services available on site or by referral and follow standard QA practices
• E8: Policies and procedures guide administration of systemic therapy, either on-site or by referral
• E9: A policy and procedure is used to provide clinical trial information
• E10: A mechanism ensures patient access to psychosocial support services either on-site or by referral
• E11: Rehabilitation services follow standard policies and procedures; access provided either on-site or by referral
• E12: A policy and procedure to access nutrition services

New Compound Requirements for Ratings

• Multiple activities demonstrate cancer committee involvement in improving patient care
  – Assess needs
  – Develop plan
  – Implement plan
  – Evaluate activity
  – Report results
• Rating format changed to clearly state components
• Brings depth to standards

Program Management

• 12 standards focus on role of cancer committee and oversight of program
• Physicians are board certified or in the process of certification (NEW)
  – Applies to all specialties
• Cancer committee membership
  – Revised to reflect new members
  – Additional coordinator/representative positions established
• Cancer committee attendance (NEW)
  – Each member attends 50% of meetings
  – Commendation for 75% attendance
Program Management

• Committee meeting frequency
  – Clarification of meeting options to once each calendar quarter
• Goals
  – Limited to clinical and programmatic
  – Reduced from 4 to 2
• Cancer registry quality control plan
  – Includes review of data items that are coded unknown
• Monitoring conference activity
  – Includes all areas addressed in conference policy
  – Similar to current standard
• Monitoring community outreach
  – Coordinator prepares and presents summary of Community Outreach Activity

Clinical Services

• 4 standards focused on clinical services
• Pathology reports follow CAP protocols
  – 95% of reports follow synoptic format for commendation
  – Similar to current standard
• Oncology nurses have specialized knowledge and skills
  – Competency evaluated annually
  – Commendation for 25% of chemo trained nurses hold oncology nursing certification

Program Management

• Clinical trial accrual
  – New required and commendation levels implemented in 2015
• One annual educational activity
  – Focused on select cancer site
  – Includes discussion of stage, prognostic factors & guidelines
  – Similar to current standard
• Cancer registrar education
  – Regional or national meeting attendance meets commendation rating
  – Similar to current standard
• Public reporting (NEW)
  – Report of program outcomes for one or more of 7 standards
  – Includes prevention, screening, quality measures, studies, & improvements, assessment of treatment planning
  – Commendation is only rating
Clinical Services

- Risk assessment and genetic counseling
  - Services provided either on-site or by referral by qualified professionals
- Palliative care services
  - Services provided on-site or by referral
  - Includes specifications for palliative care team members

Data Quality

- 7 standards focusing on registry operations
- Abstracting performed by a CTR
  - Phase-in period established
  - Existing registry staff and new hires have 3 years to obtain credential
- Abstracting timeliness
  - 95% abstracted within timeframe each year for commendation
  - Similar to current standard
- Follow-up of patients
  - 80% follow-up rate from reference date & 90% rate within last 5 years
  - Similar to current standards

Data Quality

- Data submission to NCDB
  - Similar to current standard
- Quality of data submitted
  - Similar to current standard
  - Commendation standard
- CoC special studies
  - Similar to current standard
Clinical Services

- Risk assessment and genetic counseling
  - Services provided either on-site or by referral by qualified professionals
  - Includes both pre-test and post-test counseling
- Palliative care services
  - Services provided on-site or by referral
  - Includes specifications for team members
    - Physician (suggested)
    - At least one other member
      - Nurse
      - Pharmacist
      - Social Worker
      - Other

Continuum of Care

- 3 standards supporting patient-centered focus with implementation required beginning 2015
  - Patient Navigation
    - Assess community
    - Identify disparities, barriers, or gaps in care
    - Develop and implement a navigation process to address issues
    - Work with community-based or national organizations to provide resources

Continuum of Care

- Psychosocial distress screening
  - Process monitors for distress
  - Time period and method defined by cancer committee
  - Services are provided on-site or by referral
    - May include community or national organizations
- Survivorship care plan
  - Survivorship care plan is prepared and provided to the patient upon completion of treatment
  - Principal provider is key to process
Patient Outcomes

- 8 standards supporting quality improvement
- Annual prevention programs provided
  - Focus on meeting community needs
  - Goal to reduce cancer incidence
- Annual screening program provided
  - Focus on meeting community needs
  - Goal to decrease the number of patients with late stage disease

Cancer Liaison Physician Role

- Primary Responsibility (Standard)
  - Review and report program performance using NCDB tools to cancer committee 4 times a year
    - CPQR
    - Benchmark reports
    - Other
- Secondary responsibilities
  - Report on CoC activities to cancer committee
  - Serve as liaison with the American Cancer Society with an annual assessment of the program’s collaborative agreement for support services
  - Serve in a leadership position as Chair or Vice-Chair of cancer program

Patient Outcomes

- Accountability measures
  - Considered the standard of care based on clinical trial evidence
  - Currently applied to specific breast and colon cases
  - CoC sets expected performance rates annually
  - Review of performance is key role for CLP
- Quality improvement measures
  - Demonstrates good clinical practice
  - Currently applies to specific colon and rectal cases
  - CoC sets expected performance rates annually
  - New measures under development
  - Review of performance is key role for CLP
**Patient Outcomes**

- Assessment of Evaluation and Treatment Planning
  - Revision of current standard 4.3 staging and treatment planning
  - Reinforces importance of treatment planning using national treatment guidelines
  - Cancer committee performs annual study of quality; implements improvements when needed
- Studies of quality
  - Measure quality of care and outcomes
  - Similar to current standard
- Quality improvements
  - Implement 2 improvements to patient care
  - 1 improvement is based on the results of a study of quality
  - Similar to current standard

**Commendations**

- 8 areas of Commendation
  - Cancer committee attendance (NEW)
  - Clinical trial accrual
  - Registrar education
  - Public reporting (NEW)
  - College of American Pathology (CAP) protocols
  - Oncology nursing certification for oncology nurses (NEW)
  - Abstracting timeframe
  - NCDB data quality
- All are used to determine Outstanding Achievement Award recipients

**Benefits of the Proposed Standards**

- Establish minimum thresholds for all programs through eligibility criteria
- Increased depth through addition of continuum of care standards
- Additional focus on cancer committee leadership through expanded coordinator and CLP role
- Increased focus on the quality of care through performance metrics and quality improvement activities
2012 Survey Process

- 2012 Transitions
  - For programs
    - Ratings based on current standards
  - For Surveyors
    - Review and discuss development of 2012 standards with the program leadership
    - Strategies for implementation
    - Resources for cancer programs

2012 Survey Agenda

- No significant changes introduced
- Time allotments adjusted to allow for education and discussion
  - 2012 standards
  - Best practices
- Optional activities identified
  - Facility presentation of key program activities
  - Facility tour
  - Surveyor private time prior to summation

2012 Surveys

- Enhance presentation to Cancer Program Leadership
  - Focus on importance of the new standards for patients and facilities
  - Describe the value of the standards and CoC Accreditation
  - Address added resources that will be required of the program
  - Identify quality improvement and marketing opportunities
2012 and Beyond

- New and improved SAR
  - Pre-populate information from Cancer Programs database
  - Attach supporting documents to standards page
  - Re-designed tables
- Automated review of abstracting timeliness by NCDB
  - Timeliness calculated from data submissions
  - Surveyor reviews a limited number of abstracts

Timeline

- **August 31, 2011** – Manual released
- **January 1, 2012** – New standards implemented

Education and Resources

- Comprehensive standards manual
- Redesigned CoC website
- Redesigned Best Practices Repository
- Webinar Series
  - Video vignettes
  - CoC Flash newsletter articles begins this month
  - Face to Face Workshops
    - Survey Savvy-Sept. 15-16, Los Angeles, CA
    - 2012 workshops planned
“All organizations need to know that virtually no program or activity will perform effectively for a long time without modification and redesign. Eventually every activity becomes obsolete.”  
—Peter Drucker

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Thank you!

Questions?