Hawaii Society of Clinical Oncology
Annual Membership Conference
November 16, 2013

The Commission on Cancer Standards

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Vice-Chair, Accreditation Committee
Commission on Cancer

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Honolulu, Hawaii
No Disclosures
Commission on Cancer Mission

“The Commission on Cancer 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.”
Commission on Cancer

- Created by the American College of Surgeons in 1922
- “Committee on the Treatment of Malignant Diseases”
- Initial work focused on establishing Cancer Clinics
- By 1930 the first set of standards had been developed
Commission on Cancer

• Comprises more than 45 organizations
• Encompasses more than 1,500 institutions
• Accredited programs represent 30% of the general medical-surgical hospitals in the US and Puerto Rico
• Provide care to nearly 70% of patients newly diagnosed with cancer each year
Demonstrates commitment to our patients, communities, providers, payers, and policymakers to improving survival and quality of life for our patients and to evidence-based, organized, comprehensive, and quality cancer care.

Standards ensure that state-of-the-art clinical services for diagnosing, treating, rehabilitating, and supporting cancer patients and their families are available to provide quality care closer to home.

National Cancer Data Base participation by cancer registries captures more than 100 data elements for every patient and more than 70% of all new cancer patients diagnosed in the U.S. each year. Participant User File (PUF) access for research is only available to investigators at CoC-approved programs.

Measuring quality and outcomes, including overall survival, through a rapidly expanding panel of quality measures for cancers of the breast, colon, rectum, lung, esophagus, and stomach, and soon to include gynecologic and urologic malignancies, melanoma, sarcoma and pediatric tumors. Comparison with nation-wide data from all 1,500 CoC programs.

Ensures a multidisciplinary team approach including information and access to clinical trials, access to prevention and early detection programs, cancer conferences, and oversight by a Cancer Committee.
Accreditation Committee

Establishes standards for cancer care

Responsibilities

Surveys hospitals to assess compliance

Evaluates standards, surveys and review processes

Membership limited to CoC members
Standards Advisory Group for Excellence (SAGE)

Made up of CoC leadership and volunteers

Establishes dissemination strategies

Addresses:
- Common questions
- Unique challenges
- Best Practices content
Cancer Program Standards 2012 Version 1.2: Ensuring Patient-Centered Care

• The Accreditation Program ensures that each Cancer Program provides all patients with a full range of diagnostic, treatment, and supportive services

• Response to the IOM Report: Ensuring Quality Cancer Care (April 1999)

• Structure ➔ Process ➔ Outcome
Five Elements Critical for Success

• Clinical Services
• Cancer Committee
  – Governance
• Cancer Conferences
  – Forum for multidisciplinary consultation
• Quality Improvement Program
  – Mechanism for evaluating and improving patient outcomes
• Cancer Registry and Database
  – Basis for monitoring the quality of care
The Standards

- Eligibility Requirements (E1 – E12)
- Program Management (1.1 – 1.12)
- Clinical Services (2.1 – 2.4)
- Continuum of Services (3.1 – 3.3)
- Patient Outcomes (4.1 – 4.8)
- Data Quality (5.1 – 5.7)
Standard 1.1: Physician Credentials

**Intent** → All physicians are experienced and knowledgeable in cancer care

**SAGE clarifies** →
- 5 specialties listed in the standard
- **AND**
  Surgeons caring for patients from the 5 major cancer sites seen at the facility

**Rationale for change** →
Focus on key physicians providing cancer care
Standard 1.3: Cancer Committee Attendance

**Intent** → Promote member involvement

Multiple issues and frequent deficiencies (27+% → Absences or resignations in a role.

Mid-year appointments cannot meet minimum requirements.

No substitutes limits participation.

Programs meeting more than quarterly have higher requirements.
Standard 1.3:
Cancer Committee Attendance
Accreditation Committee Action
Allow a designated substitute to be identified at the beginning of the year
Attendance counted by role for sequential appointments
Eliminate the Commendation rating for this standard

Rationale for Change
Encourages planning
Removes penalty for Committees meeting more frequently than quarterly
Standard 1.9: Clinical Trial Accrual

Intent → Promote enrollment in cancer-related clinical trials.

SAGE clarifies →
Count patient specimens accrued to bio-repositories and subjects enrolled in registries that have a cancer-related focus.

Both must be IRB approved and patients must provide informed consent.

Rationale for change →
Recognizes the effort for non-traditional accrual
Standard 1.9: Clinical Trials

**SAR Changes**
- Added both types of studies to SAR table to indicate accrual numbers for tracking

**Effect on Surveys**
- Inform about new requirements
- Include biorepository and registry accruals in rating of compliance
Standard 1.11: Registrar Education

**Intent →** Promote ongoing education
Recognize **regional and national** meeting attendance with commendation

**SAGE clarifies →**
Regional meeting = Two state associations working collaboratively to develop agenda and offer one workshop.

National designation limited to not-for-profit organizations

**Rationale for change →**
Standardize commendation definitions
Standard 1.11: Registrar Education

SAR Changes
Improved table design

Effect on Surveys
Include 2011 national attendance in rating
Ready, Set, Go . . .
Implementation January 1, 2015

Patient-Centered Standards

- Psychosocial Distress Screening
- Patient Navigation
- Survivorship Care Plan
Standard 4.1: An Effective Prevention Program Will...

- Improve the health of a community reducing incidence

- Identify community need
  - Study top 5 cancer sites
  - State cancer registry - incidence data
  - NCI State Cancer Profiles
  - Factors and behaviors that could be altered reduce risk
Standard 4.2: Effective Screening Programs

- Uses guidelines and deals with results
- Supports quality care
- Identify area of need
Standard 4.3: Cancer Liaison Physician Responsibilities

A Cancer Liaison Physician serves in a leadership role within the cancer program and is responsible for evaluating, interpreting, and reporting the program’s performance using the National Cancer Data Base data. The CLP reports the results of this analysis to the cancer committee at least four times a year.
Data Tools and Resources

National Cancer Data Base (NCDB) Reporting Tools

- NCDB: Public Benchmark Reports
- NCDB: Hospital Comparison Benchmark Reports
- NCDB: Survival Reports
- NCDB: Cancer Program Practice Profile Reports (CP3R) (v2)
- RQRS (v1.1)
- CQIP [Available soon!]

National Cancer Data Base (NCDB) Data Transmission

- NCDB: Data Submission History and Edits
- NCDB Completeness Reports for 2011 Diagnoses Submitted in 2013
<table>
<thead>
<tr>
<th>Select Breast &amp; Colorectal Measures</th>
<th>Estimated Performance Rates (click rate for comparisons)</th>
<th>Case Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2004</td>
<td>2005</td>
</tr>
<tr>
<td>Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. [BCS/RT]</td>
<td>94.9%</td>
<td>100%</td>
</tr>
<tr>
<td>Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c N0 M0, or Stage II or III ERA and PRA negative breast cancer. [MAC]</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c N0 M0, or Stage II or III ERA and/or PRA positive breast cancer. [HT]</td>
<td>94.9%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. [ACT]</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. [12RLN]</td>
<td>88.9%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer. [AdjRT]</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Utilizing CP$^3$R Data

<table>
<thead>
<tr>
<th>FACILITY SELECTION</th>
<th>ALL MEASURES SUMMARY</th>
<th>THIS MEASURE SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage II or III hormone receptor negative breast cancer. [MAC]</td>
<td>Diagnosis Year: 2010 (Last Update: Feb 16, 2013 11:02:12 PM CST)</td>
<td>Perf. Rate</td>
</tr>
<tr>
<td>My Cancer Program</td>
<td></td>
<td>85.7 %</td>
</tr>
<tr>
<td>My State</td>
<td></td>
<td>92.4 %</td>
</tr>
<tr>
<td>My ACS Division</td>
<td></td>
<td>94.2 %</td>
</tr>
<tr>
<td>My Census Region</td>
<td></td>
<td>96 %</td>
</tr>
<tr>
<td>My CoC Program Type</td>
<td></td>
<td>91.5 %</td>
</tr>
<tr>
<td>All CoC Approved Programs</td>
<td></td>
<td>91.5 %</td>
</tr>
</tbody>
</table>
SURVIVAL REPORT

Observed Survival For Colon
Cases Diagnosed in 2003 - 2005
Data from 1480 Programs [National]
WARNING: The information within this graphic is not to be used for clinical decision making.

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Standard 5.2: Abstracting timeliness

Intent → On time abstracting throughout the 3 year cycle.

Accreditation Committee Action

Effective 7/1/2013, eliminated abstracting timeliness.

Replaced with RQRS participation

Only for commendation; required for OAA.

Rationale for change → On time submission to NCDB is primary concern.
New RQRS Standard

“From initial enrollment and throughout the three-year accreditation period, the program participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.”

1. Participation required for all eligible measures.

2. Quarterly case submissions required.

3. Some programs or categories exempt (e.g. pediatric facilities and new programs undergoing initial survey).

4. For exempt programs, standard is excluded from OAA criteria.
585 RQRS Participating Programs

Legend / Toggles
- Commission on Cancer
- NAPBC

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<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Measure Type</th>
<th>Measure in RQRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Accountability</td>
<td>Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. (BCS/RT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer. (MAC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or Stage II or III hormone receptor positive breast cancer. (HT)</td>
</tr>
<tr>
<td>Colon</td>
<td>Accountability</td>
<td>Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. (ACT)</td>
</tr>
<tr>
<td></td>
<td>Quality Improvement</td>
<td>At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. (12RLN)</td>
</tr>
<tr>
<td>Rectum</td>
<td>Accountability</td>
<td>Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer.</td>
</tr>
</tbody>
</table>
Monthly Alert Report

Aggregated list of all cases with orange, red or dark red alerts in RQRS.

No accession numbers are reported on this e-mail distribution. Users may access this information through the RQRSRS application.
Program Currency of Cases in RQRS

>45% of programs

<table>
<thead>
<tr>
<th>Month</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 13</td>
<td>15</td>
</tr>
<tr>
<td>Aug 13</td>
<td>40</td>
</tr>
<tr>
<td>July 13</td>
<td>45</td>
</tr>
<tr>
<td>June 13</td>
<td>35</td>
</tr>
<tr>
<td>May 13</td>
<td>20</td>
</tr>
<tr>
<td>April 13</td>
<td>40</td>
</tr>
<tr>
<td>March 13</td>
<td>40</td>
</tr>
<tr>
<td>Feb 13+</td>
<td>65</td>
</tr>
</tbody>
</table>
Standard 5.2: RQRS Participation

**SAR Changes**
- New pages added
- NCDB staff rate based on RQRS registrations and submissions

**Effect on Surveys**
- Inform about new requirements
- Surveyor can assign commendation if RQRS registration and data submission prior to survey can be confirmed
CQIP
Cancer Quality Improvement Program

1 of 1500 CoC Hospitals
[FIN]
City, State

Annual Report 2013
ACoS: 100 Years of Quality Improvement
CQIP Principles and Assumptions  
(February 8, 2013)

Only data under CoC and NCDB
Version 1 is a “static” report (future may be interactive)
PPT will be **individualized** for all 1500 programs
PDF will accompany the PPT

**Includes:** Quality measure performance, complex surgical procedures, mortality of surgical procedures, survival data, administrative data (insurance, out-migration, distance travelled), stage, treatment, etc.

Expandable, annual

**Audience:** Cancer Comm., CLP, oncology community, C-suite, staff

Parallel to NSQIP (3x hospital participation from the start)
Insurance Status, 2009 - 2011 (My Facility vs. all CoC)

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>All CoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Insured</td>
<td>0.84 %</td>
<td>0.67 %</td>
<td>1.28 %</td>
<td>3.33 %</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.17 %</td>
<td>0.28 %</td>
<td>2.15 %</td>
<td>2.17 %</td>
</tr>
<tr>
<td>Other Government</td>
<td>0.11 %</td>
<td>0.17 %</td>
<td>0.47 %</td>
<td>3.09 %</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1.18 %</td>
<td>1.45 %</td>
<td>1.22 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Medicare</td>
<td>49.41 %</td>
<td>50.72 %</td>
<td>43.8 %</td>
<td>45.23 %</td>
</tr>
<tr>
<td>Private/Managed</td>
<td>48.29 %</td>
<td>46.71 %</td>
<td>51.08 %</td>
<td>40.18 %</td>
</tr>
</tbody>
</table>
Total In/Out Migration, 2007-2011 (My Facility)

- **Diagnosed and Treated Here**:
  - 2006: 73.85%
  - 2007: 73.36%
  - 2008: 71.82%
  - 2009: 70.35%
  - 2010: 70.39%

- **Diagnosed Here and Treated Elsewhere**:
  - 2006: 5.81%
  - 2007: 7.46%
  - 2008: 8.4%
  - 2009: 9.2%
  - 2010: 12.45%

- **Diagnosed Elsewhere and Treated Here**:
  - 2006: 20.34%
  - 2007: 19.17%
  - 2008: 19.78%
  - 2009: 20.46%
  - 2010: 17.16%
Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.

Current compliance threshold set by the CoC.
Stage Distribution - Breast Cancer Diagnosed in 2011 (My Hospital vs. All CoC)

<table>
<thead>
<tr>
<th>Stage</th>
<th>My Facility</th>
<th>All CoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>23.1%</td>
<td>20.57%</td>
</tr>
<tr>
<td>I</td>
<td>44.3%</td>
<td>40.58%</td>
</tr>
<tr>
<td>II</td>
<td>17.41%</td>
<td>23.7%</td>
</tr>
<tr>
<td>III</td>
<td>9.18%</td>
<td>8.53%</td>
</tr>
<tr>
<td>IV</td>
<td>5.06%</td>
<td>3.86%</td>
</tr>
<tr>
<td>NA</td>
<td>0.32%</td>
<td>0.09%</td>
</tr>
<tr>
<td>UNK</td>
<td>0.63%</td>
<td>2.67%</td>
</tr>
</tbody>
</table>

National Cancer Data Base 2013
Breast Conserving Surgery Rate Surveillance Measure
(Includes only patients with Stage 0, I, II)

Breast Conserving Surgery Rate

<table>
<thead>
<tr>
<th>BCS Rate</th>
<th>2009 My Facility</th>
<th>2010 My Facility</th>
<th>2010 All CoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009 My Facility</td>
<td>79.84 %</td>
<td>72.92 %</td>
<td>59.96 %</td>
</tr>
</tbody>
</table>
CQI - Objective

Baseline

Worse

Better

After

Worse

Better

Horn, 1996 ISIS
Pathologic Examination of >= 12 RLN in a Resected Colon Cancer: Changing Hospital Performance 2004-2010

Shifting the Curve: Changing Practice
Positive Changes for New Cancer Programs

Exempt from specific standards when undergoing initial accreditation

S4.3 – CLP Responsibilities
S4.4 – Accountability Measures
S4.5 – Quality Improvement Measures
S5.2 – Participation in RQRS (ineligible)
S5.3 – Follow up of all patients
S5.4 – Follow up of recent patients
S5.5 – Data Submission
S5.6 – Accuracy of Data
S5.7 – CoC Special Studies.

Submit data to NCDB after receiving initial accreditation.

Consultant release for survey not required.
More Great News

2009 Standards will be retired on 12/31/2013

Exception: Std 1.11 National meeting attendance in 2011 for commendation

2014 surveys will use only 2012 standards
Surveyor evaluates only 2012 & 2013 activity and data.

30 pathology reports from 2012 & 2013 reviewed.

NO ABSTRACT REVIEW
Dedicated resources to provide the best treatment and support to cancer patients.

- Focus on the patient experience that ensures optimal treatment outcomes.

- Availability and use of data to measure and report outcomes.

- Improved patient outcomes across all domains of cancer care.

- Commitment to patients, providers, payers and policymakers.