It’s a Partnership –
Inspiring Quality:
Highest Standards, Better Outcomes

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Thomas L. Eisenhauer, MD, FACS

- Previous CLP for six years
- Current Chair of the Cancer Committee
- Surveyor for six years
- Elected to represent the ACoS to the Commission on Cancer
- Survived 9 out of 10 surveys personally
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Commission on Cancer: Our 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.

Carried out with the active involvement of 49 national professional organizations
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
Value of CoC Accreditation

• Highlights program’s commitment to patients, community, and payers
• Demonstrates commitment to enhance cancer care and demonstrate healthcare outcomes
• Demonstrates dedicated resources by the cancer program to best treat and support cancer patients
• Patients recognize that your facility has a system of care focused on the patient experience that ensures optimal treatment outcomes
• Demonstrates to payers and the public that your facility is focused on quality —— accredited programs are ready, accreditation makes a difference!
Rapid Quality Reporting System (RQRS)

• Provides “real clinical time” assessment of adherence to National Quality Forum (NQF) endorsed quality of care measures for breast and colorectal cancers

• Most recent addition to the NCDB tool-set
  – Available to all CoC-accredited cancer programs as of September, 2011

• RQRS is free and OPTIONAL for use by all accredited programs
RQRS Dashboard

**BREAST MEASURES**

- **BCS**
  - Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.
  - 91.4% n=104

- **MAC**
  - 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.
  - 60.6% n=17

- **HT**
  - Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or Stage II or III hormone receptor positive breast cancer.
  - 92.0% n=136

**COLON MEASURES**

- **12RLN**
  - At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.
  - 84.3% n=18

- **ACT**
  - Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 60 with AJCC Stage III (lymph node positive) colon cancer.
  - 90.0% n=10

**RECTAL MEASURE**

- **AdjRT**
  - Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 or with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer.
  - 0.0% n=1
RQRS Benefits

• Improve patient care with access to “real clinical time” performance rates
• Evaluate performance over time
• Use RQRS to implement interventions to enhance the quality of care in your cancer program
• Prevent patients from experiencing a delay in treatment
• Identify patients who are at risk of “slipping through the cracks”
RQRS Benefits

- Compare performance rates in your cancer program with other participating cancer programs
- Encourage timely and accurate collection of adjuvant treatment information
- Negotiate favorable reimbursement rates with payers by demonstrating current practices
RQRS Alerts

**Breast**

Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.

8 Patients were diagnosed over 365 days ago. RQRS has no record of receipt of radiation therapy. According to this measure treatment is now past due.

12 Patients were diagnosed over 275 days ago. To remain concordant with this measure, patients must receive radiation therapy in less than 90 days.

10 Patients were diagnosed over 185 days ago. To remain concordant with this measure, patients must receive radiation therapy in less than 180 days.

Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1NO0, or Stage II or III hormone receptor positive breast cancer.

6 Patients were diagnosed over 365 days ago. RQRS has no record of hormone therapy consideration or administration for these patients. According to this measure treatment for these patients is now past due.

24 Patients were diagnosed over 290 days ago. To remain concordant with this measure there are less than 75 days remaining for these patients to consider or be administered hormone therapy.

20 Patients were diagnosed over 215 days ago. To remain concordant with this measure there are less than 150 days remaining for these patients to consider or be administered hormone therapy.
Current CoC Accreditation Standards

- Current standards developed in 2004
- 36 standards evaluate:
  - Structure (11)
    - Availability of clinical services
    - Cancer committee leadership
    - Cancer registry
  - 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
CoC Response to Needs

• Address needs by developing new patient-focused standards
  – Patient navigation
  – Psychosocial distress screening
  – Survivorship care plan
  – Genetic assessment and counseling
  – Palliative care services
  – Increased clinical trial accrual
• Address the full continuum of care
• Improve coordination of care
• Increase participation in care decisions by patients and family members
• Increase patient satisfaction
New 2012 Standards: Other Significant Changes

• Ensuring multidisciplinary cancer committee focus – attendance requirements (50% for compliance)
• Specific monitoring of community outreach identified needs and activities
• Encourage public reporting of outcomes for commendation only
• Establish a threshold for the percentage of OCN certified nurses
• Improve data collection by requiring CTR abstracting
Cancer Program Eligibility Requirements

• Eligibility Requirements Summary:
  – Common to all programs
  – Essential for comprehensive treatment
  – Provide physical comfort and emotional support to patients
  – Integrate care across boundaries
Navigating the System

- E-1: Facility Accreditation - Incomplete
- E-2: Cancer Committee Authority - Complete
- E-3: Cancer Conference Policy - Incomplete
- E-4: Oncology Nurse Leadership - Incomplete
- E-5: Cancer Registry Policy and Procedure - Incomplete
- E-6: Diagnostic Imaging - Complete
- E-7: Radiation Oncology Services - Complete
- E-8: Systemic Therapy Services - Complete
- E-9: Clinical Trial Information - Complete
- E-10: Psychosocial Services - Complete
- E-11: Rehabilitation Services - Complete
- E-12: Nutrition Services - Complete
- Surgical Procedures - Complete
Risk Assessment and Genetic Testing

• S 2.3: “Cancer risk assessment, genetic counseling, and testing services are provided to patients either on-site or by referral, by a qualified genetics professional.”
Your Implementation Plan For 2012

• How do you educate your patients about genetic risks?
• Do you have an identified genetics professional on-site? Or, is this person available by referral?
• How will the cancer committee follow the evolution of this new standard?
Palliative Care Services

• S 2.4: “Palliative care services are available to patients either on-site or by referral.”
Your Implementation Plan For 2012

• How are palliative care services made available (on-site or by referral)?
• Who are the members of the palliative care team?
• How do you ensure continuity across the range of clinical settings and services?
Patient Navigation (Phase-In)

- S 3.1: “A patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients. Resources to address identified barriers may be provided either on-site or by referral to community-based or national organizations. The navigation process is evaluated, documented, and reported to the cancer committee annually. The patient navigation process is modified or enhanced each year to address additional barriers identified by the community needs assessment.”
Your Implementation Plan 2012 - 2015

• What are your thoughts about how you will conduct your community needs assessment to identify health care disparities and barriers to care for patients?
• What methods are available to you to address the health care disparities and barriers?
• What is your plan for the navigation process and what resources will be required?
Psychosocial Distress Screening (Phase-In)

- S 3.2: “The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for provision of psychosocial care.”
Your Implementation Plan 2012 - 2015

• What methods have been discussed to incorporate screening of distress?
• How will resources to address psychosocial needs be identified and provided?
• What options have been discussed to define the timing of screening, screening methods and tools, assessment and documentation for this activity?
Survivorship Care Plan (Phase-In)

• S 3.3: “The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the cancer committee and documented in the minutes.”
Your Implementation Plan 2012 - 2015

- What is the process the cancer committee is considering to disseminate a comprehensive care summary for patients completing cancer treatment?
- How will you monitor and evaluate the process?
- Who are the principle providers who will be involved in creating and/or disseminating this plan?
Resources Related to All the Standards

- Review the new standards manual
- Webinars
- Video vignettes
- Best Practice Repository
- Live workshops
- CAAnswer Forum
Good luck and keep up the hard work!