CONNECTICUT CANCER PARTNERSHIP

♦ NEW AMERICAN COLLEGE OF SURGEONS COMMISSION ON CANCER 2012 STANDARDS

♦ ANDREW L. SALNER, MD FACR
♦ DIRECTOR
♦ HELEN & HARRY GRAY CANCER CENTER
♦ HARTFORD HOSPITAL
♦ HARTFORD, CT
Cancer Program Standards 2012: Focusing on Patient-Centered Care and Quality
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.
New standards

• They really should help to make accreditation **meaningful** in terms of quality of cancer patient care
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
Cancer Programs in U.S. Hospitals

- Hospitals with accredited programs: 30%
- Hospitals without accredited programs: 70%

- Treated elsewhere: 29%
- Diagnosed and treated in accredited programs: 71%

General medical/surgical facilities
Including Puerto Rico: ~5000

Estimated new cancer patients in 2010: 1,529,560*

*Cancer Facts and Figures, American Cancer Society
Distribution of CoC-accredited Cancer Programs by State (1,500+)
Historical Timeline

• Current standards developed in 2004
• Revised in 2005, 2008, and 2009
• 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
Somewhere, something went terribly wrong
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
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
**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

- 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
Nursing care

• Nurses with specialized oncology knowledge and skills available
• Organizational policies and procedures to evaluate competency
• Competency evaluated annually under direction of nursing leadership
• Nursing competency reported to cancer committee annually
• Commendation-25% of chemotherapy-trained nurses hold ONC
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

NEW!
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
“I’m a Radiation Oncologist not a IT expert!”
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

NEW!
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
Navigation

- Complete community needs assessment once in 3 year survey cycle to address disparities and barriers
- Establish navigation process and identify resources (in house or referral) to address barriers
- Annual barrier assessment, navigation process evaluation and committee report
- Annual navigation modification or enhancement to address barriers from community assessment
- Phase in for 2015
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
Psychosocial distress screening

- Cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care as a standard for cancer patients
- Phase in for 2015
Survivorship care plan

• Survivorship care plan prepared by principal provider with input from other providers
• Plan given to patient upon treatment completion
• Contains record of care, disease characteristics, and follow up plan incorporating evidence based standards
• Annual monitoring, evaluation and committee presentation
• Phase in for 2015
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
Prevention

• Assess prevention needs of community
• At least 1 program annually
• Consistent with national guidelines
• Smoking cessation, sun protection, weight loss, teen smoking prevention, cancer awareness
Annual screening

- Identify screening needs of community
- Conduct at least one screening program annually
- Consistent with national guidelines
- Develop process to follow up on abnormal findings
- Breast, colorectal, cervical, prostate, skin
Cancer Liaison Physician Role

• Primary Responsibility (Standard)
  – Review and report program performance using NCDB tools to cancer committee 4 times a year
    • CP³R
    • 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

NEW!
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

CoC Survey Savvy Workshop:
INVESTING IN QUALITY PATIENT CARE
CONNECTICUT CANCER PARTNERSHIP

♦ THANK YOU!

♦ QUESTIONS