Commission on Cancer – Round Table Discussion

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Louisiana Cancer Registrar's Association
2017 Annual Education Conference
October 13th, 2017

Presenters:

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WILLIS-KNIGHTON HEALTH SYSTEM

Standard 1.1 Physician Credentials

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Diagnostic and treatment services are provided by or referred to physicians who are currently board certified (or the equivalent) in their medical specialty or are in the process of becoming board certified.

- **Cancer Forum**

  A: Does the SAR require an upload of bylaws and roster? The CoC standards ask for one or the other and the SAR asks for both. Please clarify.

  Q: While the standard states that documentation for Standard 1.1 requires either the Bylaws or the Roster, it is recommended that both are provided. With regards to the bylaws, only provide the section having to do with the cancer committee and its authority over the cancer program. (7/17)

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Standard 1.2 Cancer Committee Membership

The membership of the cancer committee is multidisciplinary, representing physicians from diagnostic and treatment specialties and non-physicians from administrative and supportive services. Cancer committee coordinators, who are responsible for specific areas of cancer program activity, are designated each calendar year.

- Cancer Forum Question
  - Q: Can a person, not currently serving on the cancer committee (VP of nursing), be named as an alternate for more than one required member(cancer program administrator and QI Coordinator who is a nurse)?
  - A: No, as stated in the CoC Standards: Individuals cannot serve as an alternate if they are already a required member of the cancer committee and **one person cannot be an alternate for multiple roles or members.** A designated alternate can be an existing non-required member of the cancer committee if they are an appropriate choice to fulfill the alternate role of the committee. (2/2017)

Standard 1.3 Cancer Committee Attendance

Each required cancer committee member or the member's designated alternate attends at least 75 percent of the cancer committee meetings held each calendar year.

- Cancer Forum Question
  - Q: With regard to assigning alternates to required committee members, can a required member who fills multiple roles assign one alternate to cover all of his or her assigned roles? For example, we have a required member who fulfills the required roles of cancer committee chair, pathologist and cancer conference coordinator. It is very challenging for our small institution (and seems unnecessary) to have three separate alternates to fill the role of a single person in the event that person would have to miss a meeting. Could one alternate cover all three of these roles (if qualified)? I understand alternates are not required but if we don't have an alternate and a required member is unable to attend 75% of the meetings we would be deficient. This becomes quite challenging and burdensome for small hospitals/facilities.
  - A: Yes, this is the only exception to the rule that one individual cannot serve as an alternate for more than one role. Because one person is appointed as the chair, the pathologist, and the cancer conference coordinator one person can cover as the alternate. Keep in mind, however, that the alternate must be qualified to fill all three of those roles.

Standard 1.4 Cancer Committee Meetings

Each calendar year, the cancer committee meets at least once each calendar quarter.

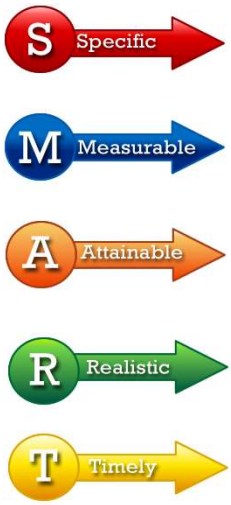
- **Cancer Forum Question**
  - **Q:** I just want to clarify how to use power point presentations in cancer committee minutes. For example, if the cancer committee coordinators are listed in the power point presentation do they have to be listed separately again in the cancer committee minutes? Is it ok to keep referring to attachments from the power point presentation rather than transfer the information into the minutes?
  - **A:** Cancer committee minutes should document all agenda items, the discussion, and outcomes. If you refer to the Power point for additional information, then you need to make sure it is uploaded with the CC minutes as supporting documentation. (3/2017)

Standard. 1.5 Cancer Program Goals

Each calendar year, the cancer committee establishes, implements, and monitors at least one clinical and one programmatic goal for endeavors related to cancer care.

- Clinical: Involves the diagnosis, treatment, services, and care of the cancer program's cancer patients
- Programmatic: Directed toward the scope, coordination, practices, and process of cancer care at the program
- Be sure to make your goals SMART goals!

What is a SMART goal?



- **Specific** = Your program's goal should be as specific as possible. What is your goal?
- **Measurable** = Measurement will give specific feedback and hold your program accountable. How will you measure your goal?
- **Attainable** = Goals should push your program to be better, but it is important that it is attainable. Is your goal attainable?
- **Realistic** = Is your program's goal realistic?
- **Timely** = A timely goal provides motivation and helps your program be accountable. What is the timeframe for your goal?

Standard. 1.5 Cancer Program Goals

- New and different clinical and programmatic goals must be established at the **beginning** of each calendar year.
- At a minimum, goal progress must be monitored and evaluated at 2 subsequent meetings – mid-year and end of same calendar year.
  - Don't forget to document the monitoring and evaluation in your minutes!
- Goals **cannot** be a restatement or an improvement of a CoC Standard or Eligibility Requirement
- A goal can come as the result of data obtained from the completion of a quality study under Standard 4.7
  - A quality study topic for Standard 4.7 **cannot** be chosen on the result (or intention of a goal used for Standard 1.5
  - A quality improvement used for Standard 4.8 **cannot** be used as a goal for Standard 1.5

Clinical Goal Examples

- Implement a lung cancer screening program using low dose CT scans
- Develop an institutional IRB to expedite review process for cancer related studies
- Refer 80% of all eligible colorectal cancer patients to a genetic counselor
- Install a Brachytherapy Suite in the Radiation Oncology Department
- Increase number of colon cases that get a pre-operative CEA
- Others?

Programmatic Goal Examples

- Pursue and participate in the Quality Oncology Program Initiative (QOPI) program
- Pursue NAPBC Accreditation
- Implementation of NurseNav
- Radiation Oncology ACR accreditation
- Develop and implement an Integrated Therapies Program for cancer patients
- Others?

NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS
NAPBC
Est. 2008

Commission on Cancer®
NATIONAL ACCREDITATION PROGRAM FOR RECTAL CANCER

Unacceptable Goals

- Establishing a virtual tumor board
  - Considered a restatement of Standard 1.7
  - Source: http://cancerbulletin.facs.org/forums/forum/-2012-cancer-program-standards/program-management-chapter-1/s1-5-cancer-program-goals/63119-programmatic-goal-establishing-a-virtual-tumor-board
- Increase clinical trial accrual
  - Considered a restatement of Standard 1.9
  - Source: http://cancerbulletin.facs.org/forums/forum/-2012-cancer-program-standards/program-management-chapter-1/s1-5-cancer-program-goals/62179-increasing-clinical-trial-accrual-as-a-goal

Unacceptable Goals (continued)

- Offer onsite Palliative Care and Hospice services
  - Considered an extension of Standard 2.4
  - Source: http://cancerbulletin.facs.org/forums/forum/-2012-cancer-program-standards/program-management-chapter-1/s1-5-cancer-program-goals/62519-programmatic-goal-on-site-palliative-care
- Start a Lay Navigation Process to assist patients through the cancer journey
  - Considered a restatement of Standard 3.1
  - Source: http://cancerbulletin.facs.org/forums/forum/-2012-cancer-program-standards/program-management-chapter-1/s1-5-cancer-program-goals/62470-programmatic-goal-establish-a-lay-navigation-process

What do I do with an incomplete goal?

- If a goal cannot be completed within the year it is established, the goal can be "rolled over" to the next year.
  - Please note:
    - In order to not receive a deficiency, the goal **must** be evaluated at least twice within the calendar year it was established and the evaluation **must** be documented in the minutes.
    - Two new goals **must** be established for the new year as well.
- Source: http://cancerbulletin.facs.org/forums/forum/-2012-cancer-program-standards/program-management-chapter-1/s1-5-cancer-program-goals/65329-goal-completion

Standard. 1.5 Cancer Program Goals

- **Cancer Forum Question**
  - **Q:** We would like to know if developing a financial advocate program (ACCC has a Cancer Patient Financial Advocate course) to offer assistance/guidance to our cancer patients would be an acceptable Programmatic Goal? We would put this goal into a SMART format and there is documentation to help support the need including recent surveys that indicate physicians are less likely to have these types of discussion with their patients due to a lack of understanding the available resources to assist their patients. The issue of financial toxicity is becoming a big issue and being able to provide this resource would increase our value to the community and enhance our services to our cancer patients.
  - **A:** This goal, in the SMART format with supporting information sounds appropriate as a programmatic goal. Keep in mind that you cannot use addressing this barrier as your compliance for 3.1 in the same year you are using it as a goal. (5/2017)

Standard. 1.5 Cancer Program Goals

- Discussion Items: Would anyone like to share great ideas for programmatic or clinical goals?

Standard 1.6 Cancer Registry Quality Control Plan

Each calendar year, the cancer committee establishes and implements a plan to annually evaluate the quality of cancer registry data and activity. The plan includes procedures to monitor and evaluate each required control plan component.

- Afternoon Presentation!

Standard 1.6 Cancer Registry Quality Control Plan

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- **Cancer Forum Question**
  - **Q:** The COC stated - 2016 Standards Manual, page 35, #3a: Physicians are to perform the QC review. However, in 3B it also states that external audits may be used to fulfill part of the requirement. If this is done then an MD does not need to perform the entire QC?
  - **A:** External audits may be used to fulfill PART of the requirements for Std 1.6. The standards do not give a number or percentage or what part. Keep this in mind, whatever part of the required criteria in Std 1.6 that the state audit does not fulfill, you are required to complete at your facility by the physician random sampling QC review. The external audit results are required to be submitted to the cancer committee and documented. This should be documented in your policy and procedure as well

Standard 1.6 Cancer Registry Quality Control Plan

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Review SAR/PAR
- Discussion Items

Standard 1.7 Monitoring Cancer Conference Activity

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, the cancer conference coordinator monitors and evaluates the cancer conference activities and reports the findings to the cancer committee.

- Monitoring cancer conference activity ensures that conferences provide consultative services for patients to formulate an effective treatment plan & offer education to physicians and allied health professionals in attendance. Monitoring of cancer conference activity may also identify opportunities to improve the patient care process.
- Cancer Conference frequency – this should be stated in ER3 Cancer Conference Policy
- Multidisciplinary attendance

Standard 1.7 Monitoring Cancer Conference Activity

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Total number of case presentations – a minimum of 15% of the annual analytic case load
- Percentage of prospective case presentations – a minimum of 80% should be prospective
- Discussion of stage, including stage group when available, prognostic indicators, and treatment planning using evidence-based treatment guidelines
- Options and eligibility for clinical trial enrollment
- Adherence to cancer conference policies
- Additional areas recommended
  - Genetic testing and counseling
  - Palliative care
  - Psychosocial care
  - Rehabilitation services

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Standard 1.7 Monitoring Cancer Conference Activity

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Routine evaluation of cancer conference activity in **each of the following seven required areas** is essential to ensure compliance with the requirements set by the cancer committee:
  - Conference frequency
  - Multidisciplinary attendance
  - Total Number of Case Presentations
  - Percentage of prospective case presentations
  - Discussion of stage, prognostic indicators, and treatment guidelines
  - Options and eligibility for clinical trial enrollment
  - Adherence to cancer conference policies

Standard 1.7 Monitoring Cancer Conference Activity

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Cancer Conference Coordinator monitors each area of cancer conference activity, reports at least annually to the cancer committee, and recommends corrective action if needed
- Since final year end report will not be available at the 4th qtr. Meeting, this report will need to be reviewed at the 1st qtr. meeting the following year.
  - At the 4th qtr. Meeting an interim report still needs to be given

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Standard 1.7 Monitoring Cancer Conference Activity

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- Q: Std 1.7 now includes clinical trial options and eligibility. Do we need to document which trials they could be eligible for based on diagnosis as well as whether they were completely eligible based on all the details of the specific case?
- A: as part of the required reporting to the cancer committee, it should be tracked/monitored which cases that were presented were discussed for eligibility to clinical research trials based on information presented at cancer conference

Standard 1.7 Monitoring Cancer Conference Activity

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- Q: Do the pathologists have to show slides at the conference or is it acceptable for them to review the pathology from reports for discussion?
- A: While we don't require slides to be presented, that is the intent. It gives the conference members an opportunity to review the slides and discuss during the treatment planning for the patient

- Q: We have 2 facilities with two different CoC Accreditations, can we count all of the conferences for both facilities but only count the cases for the facility which they belong?
- A: Yes you may count your analytic cases that are presented at the other facility's cancer conference. In other words, if Facility A's analytic case is presented at Facility B's cancer conference, Facility A can count that case. But, Facility B would not be able to count Facility A's case if it is not its analytic case.

Std. 1.7 Monitoring Cancer Conference Activity

- SAR/PAR Review
- Discussion

Standard 1.8 Monitoring of Prevention, Screening, and Outreach Activities

Each calendar year, the Community Outreach Coordinator, under the direction of the cancer committee, monitors the effectiveness of prevention, screening, and outreach activities. The activities and monitoring results are documented in an annual community outreach activity summary that is presented to the cancer committee at the end of each calendar year.

Standard 1.8 Monitoring of Prevention, Screening, and Outreach Activities

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- **Step 1:** Appoint the Community Outreach Coordinator at the first cancer committee meeting
- **Step 2:** Discuss cancer prevention and screening needs of the *community*
- **Step 3:** Design prevention and screening events based on need and evidence-based guidelines
- **Step 4:** Establish mechanisms for referrals and follow-up for positive findings (screening)
- **Step 5:** Provide at least 1 prevention and 1 screening event each calendar year
- **Step 6:** Coordinator and cancer committee discuss effectiveness of 4.1 and 4.2 events
- **Step 7:** Coordinator generates a comprehensive annual summary and shares with the committee.

Standard 1.8 Monitoring of Prevention, Screening, and Outreach Activities

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- How to document **Effectiveness**
  - Was the activity useful/valuable to the community
  - Was behavior impacted?
  - Is the program able to follow-up on positive results adequately
  - Was the referral process confusing? Unhelpful?
  - Were the number of participants adequate? Could you change the process to include more participants?
  - Based on the analysis, what changes are necessary?

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Standard 1.8 Monitoring of Prevention, Screening, and Outreach Activities

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Question

- Q: **Clarification on Outreach for Community** In summary, our community needs has identified issues with healthy eating relating to obesity & cancer and higher incidence of lung cancer. This will be driving our work this year. We are designing our patient screening and prevention programs to target obesity and lung cancer.
  However, I am unclear as to what outreach activities need to occur. Our outreach activities will be done within these obesity and lung cancer programs but that targets our own patient population. If I'm reading 1.8, 4.1, 1.2 standards correctly, is there a component needed where we outreach to the general community? Meaning the non-patient population/community?
- A: Your cancer committee needs to offer the prevention and screening activities to your community, not to your cancer patients. Sometimes looking at your own data can tell you where you need to focus, such as zip code, county, ethnic population, etc. (5/2017)

Standard 1.8 Monitoring of Prevention, Screening, and Outreach Activities

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- SAR/PAR Review
- Discussion

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Standard 1.9 Clinical Research Accrual

- As appropriate to the cancer program category, the required percentages of patients are accrued to cancer-related clinical research studies each calendar year. The Clinical Research Coordinator documents and reports clinical research study enrollment information to the cancer committee annually.

Standard 1.9 Questions on Cancer Forum

- **Cancer Forum Questions**
  - **Q:** Can cases that are entered into ACR's LDCT lung cancer screening registry be counted toward our clinical research numbers similar to a few years ago when we could count the cases entered in the PET Registry?
  - **A:** Yes, this counts (July/2016)
  - **Q:** My program currently participates in the ACTR's LDCT screening. For obtaining numbers in order to help decide what our program's accrual rate is, do we only count cancer patients, or do we count all patients that consent and complete screening. Regardless of if there is a positive cancer finding or not?
  - **A:** Because you are procuring participants who meet specific criteria and then enroll them in the screening trial, you can count those who have a relationship with your hospital/facility whether they have cancer or not. (May/2017)

Standard 1.9 Clinical Research Accrual

- SAR/PAR Review
- Discussion

Standard 1.10 – Clinical Education Activity

Each calendar year, the cancer committee organizes and offers at least one cancer-related educational activity, other than cancer conferences, to physicians, nurses, and other allied health professionals. The activity is focused on the use of American Joint Committee on Cancer (AJCC) or other appropriate staging clinical practice, which includes the use of appropriate prognostic indicators and evidence-based national guidelines used in treatment planning.

- The Clinical Education Activity has to be held annually
- Educational Activity are to **exclude** cancer conference and/or tumor board of any format

Standard 1.10 – Clinical Education Activity

- The cancer committee monitors the success of and attendance at education activities each year
- The cancer committee may coordinate this activity with program's continuing education department, medical staff office or other department as appropriate
- Webinars - To fulfill the education requirement of the standard, a webinar is to be a minimum of one cumulative hour annually. The webinar is to be viewed as a group with a designated physician leader from the cancer committee to facilitate discussion following the webinar.

Standard 1.10 – Clinical Education Activity

- A published flyer/agenda, list of objectives or slides of the content presented, which demonstrates:
- Discussion of AJCC or other appropriate staging
- Appropriate prognostic indicators were presented
- Discussion of evidence-based national guidelines used in treatment planning
- Evidence that the activity was directed to physicians, nurses and allied health professionals.

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Standard 1.10 – Clinical Education Activity

Bright Idea!

- Using AJCC Webinars for physicians on the 8th edition changes and incorporating a discussion on national treatment guidelines.

Standard 1.10 – Clinical Education Activity

Cancer Forum Questions

- **Q:** Would the AJCC Disease-Site Webinars Based on AJCC 7th Edition for Melanoma, Lung, Breast, Colorectal and Prostate meet the criteria for this activity?
- **A:** Yes, as long as there is a physician leader from the cancer committee present to facilitate any discussion after the webinars & add any required information that is not part of the webinar.

- **Q:** The medical oncology director would like to provide the education activity this year, however he is only available after our last cancer committee for the year. It is required that it be documented in the meeting minutes or will completing everything in the SAR fill the requirement?
- **A:** As long as it is held within the calendar year, documented in the minutes what the activity is, who is presenting, the objectives and when, you should be ok.

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Standard 1.10 – Clinical Education Activity

- PAR/SAR Review
- Discussion

Standard 1.11 – Cancer Registry Education

Each calendar year, all members of the cancer registry staff participate in one cancer-related educational activity applicable to their role.

- All full-time and part-time registry staff for which annual education is required includes:
  - Certified Tumor Registrar (CTR) staff
  - Contract CTR staff who are contracted to work for **three of more consecutive months during the calendar year**, regardless of the number of hours worked
  - All non-credentialed registry staff, including the following:
    - Staff abstracting under the supervision of a CTR
    - Staff performing follow-up activities
    - Registry management or supervisory personnel

FOR COMMENDATION!

- For commendation, the program must upload documentation of attendance to a **regional or national** cancer-related educational meeting for <u>each current CTR staff member</u>.

Standard 1.11 – Cancer Registry Education

Cancer Forum Question

- **Q:** Is it acceptable to document in the PAR that a non-CTR staff member viewed the (named) SEER web-based training modules and/or the SEER self instruction manuals for cancer registry? No CE, but shouldn't be needed for non-CTR, correct? Thank you
- **A:** Correct. A web-based learning tool is acceptable for non-CTR staff.

Standard 1.11 – Cancer Registry Education

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Discussion: Would anyone like to share ideas for registrar education?

Standard 1.12 – Public Reporting of Outcomes

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, the cancer committee develops and disseminates a report of patient or program outcomes to the public

- The intent of this report is to demonstrate the result and/or consequence of an activity completed by the cancer program.
- Examples include demonstrating compliance with evidence-based guidelines, completed studies of quality, quality improvements, or cancer prevention/screening events

Standard 1.12 – Public Reporting of Outcomes

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

The content of the report must include outcome information on one or more of the following standards:

- Standard 4.1 – Prevention Programs
- Standard 4.2 – Screening Programs
- Standard 4.4 – Accountability Measures
- Standard 4.5 – Quality Improvement Measures
- Standard 4.6 – Monitoring Compliance with Evidence-Based Guidelines
- Standard 4.7 – Studies of Quality
- Standard 4.8 – Quality Improvements

Standard 1.12 – Public Reporting of Outcomes

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- **DO NOT** report survival rates from NCDB tools. The CoC's formal policy does not permit public reporting of survival rates from the NCDB tools**.**
- Each calendar year, the program uploads a copy or a web link to the report on patient or program outcomes.
- **NOTE** – Completion of this standard is for *Commendation only.*

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Standard 1.12 – Public Reporting of Outcomes

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- **Q:** Our hospital shares one annual report with three other hospitals in our region. At this time we are not merged with these hospitals so the CoC considers each hospital individually. Can we use this annual report for standard 1.12? Our data is listed separately in the report under our hospital - prevention & screening programs.
- **A:** Yes, a shared report can be used for 1.12 as long as individual outcomes are reported separately for each hospital.

- **Q:** The definition and requirements for Standard 1.12 "An annual report is not synonymous with reporting of outcomes". Please explain exactly what this means.
- **A:** It means that a traditional annual report that may include an overview of all your cancer program has accomplished during the year does not equal reporting of outcomes

Standard 1.12 – Public Reporting of Outcomes

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- SAR/PAR Review
- Discussion

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Standard 2.1 CAP Protocols and Synoptic Reporting

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, 95 percent of the eligible cancer pathology contain all required date elements of the College of American Pathologists (CAP) protocols and are structured using the synoptic reporting format as defined by the CAP Cancer Committee.

- If multiple responses are permitted for the same data element, the responses may be listed on a single line
- The synopsis can appear in the diagnosis section of the pathology report, at the end of the report or in a separate section, but all required data elements and responses **MUST** be listed on a single line**.**
- Additional items that are not required by CAP may be included in the synopsis
- Narrative style comments are permitted in addition to, but are NOT as a substitute for the synoptic reporting.

Examples of Synoptic Reporting

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

THYROID CARCINOMA

Procedure: Total thyroidectomy
Lymph Node Sampling: Superior mediastinal lymph nodes (level VII)

Tumor Focality: Unifocal, involves isthmus and right thyroid
Tumor Laterality: Right lobe and isthmus
Tumor Size: 2.5 cm
Histologic Type: Papillary thyroid carcinoma
Margins: Positive, right thyroid and isthmus
Angioinvasion: Not identified
Lymphatic Invasion: Not identified
Extrathyroidal Extension: Present

Pathologic Staging (pTNM):
Primary Tumor (pT): pT4a
Regional Lymph Nodes (pN): pN1
Number lymph nodes examined: 3
Number lymph nodes involved: 1
Distant metastases (pM): pMn/a

Unacceptable Synoptic Report Example

Diagnosis:

Colon, right hemicolectomy:

Invasive adenocarcinoma, 3.4 x 3.0 cm involving muscularis propria

All margins negative

No lymphatic invasion

No metastatic tumor identified

NOT ACCEPTABLE AS SYNOPTIC STYLE REPORTING:

NOT ALL ELEMENTS ARE PRESENT

Unacceptable Synoptic Report Example

Kidney, Left (Radical Nephrectomy):

Clear cell adenocarcinoma, Furhman nuclear grade 3, 8.3 cm, unifocal involving upper pole of kidney and extending into the renal vein with the renal vein margin positive. Sarcomatoid features not identified.

No lymph nodes submitted, adrenal gland uninvolved, lymphatic invasion present, no venous large vessel invasion, pT3, Nx. No significant pathologic alterations identified.

NOT ACCEPTABLE AS SYNOPTIC STYLE REPORTING:

ALTHOUGH ALL REQUIRED ELEMENTS ARE PRESENT, INSUFFICIENT SYNOPTIC STYLE REPORTING

Standard 2.1 CAP Protocols and Synoptic Reporting

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- **Q:** If a CAP protocol is revised, for example February 28, 2017 and a Pathology report from April 2017 is missing a data element would this be considered non-compliant? Is there a grace period for new revisions? or our pathology departments given enough notice that revisions are going to be released.?
- **A:** The following excerpt is taken from the CAP website under the Protocols section and clicking on the 'Frequently Asked Questions' link**: When new or revised cancer protocols are released, how soon should they be adopted?**

  Pathologists can and should begin using the updated protocols as soon as possible following their web posting. Vendors should also undertake immediate implementation of the new protocols into their products. The CAP recognizes that full implementation by some institutions and laboratory informatics software vendors may require a period of months and recognizes an 8-month period of overlap for LAP accredited laboratories in which either the previous or new version of the protocol may be used (5/2017)

Standard 2.1 CAP Protocols and Synoptic Reporting

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- SAR/PAR Review
- Discussion

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Standard. 2.2 Oncology Nursing Care

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Oncology nursing care is provided by nurses with specialized knowledge and skills. Nursing competency is evaluated each calendar year. Results are reported to the cancer committee

Cancer Forum Questions

- **Q:** Do you have to include inpatient nurses in the denominator, when the vast majority of care for oncology patients occurs in the outpatient setting?
- **A:** You should include inpatient nurses that are providing care in the designated inpatient medical/oncology unit, especially if these nurses provide any medical oncology support.

- **Q:** Does the Clinical Nurse Leader Certification count towards commendation for Std. 2.2?
- **A:** While the CNL Certification is advanced education, it does not count toward commendation for Std. 2.2 as it is not oncology specific

Standard. 2.2 Oncology Nursing Care

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- SAR/PAR Review
- Discussion

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Standard. 2.3 Genetic Counseling and Risk Assessment

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer risk assessment, genetic counseling, and genetic testing services are provided to patient either on-site or by referral to a qualified genetics professional

- The following services are provided either on-site or by referral:
  - Cancer risk assessment
  - Genetic counseling
  - Genetic testing services
  - Pretest and posttest counseling
- Purpose of this service includes:
  - Educate patients about their current risk
  - Help patients obtain meaning from genetic results
  - Empower patients to make educated, informed decisions about genetic testing needed, as well as screening/prevention in the future

Standard. 2.3 Genetic Counseling and Risk Assessment

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DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Risk Assessment (RA) and Genetic Counseling are required to be performed by:
  - Genetics professional with a background in cancer genetics and hereditary cancer syndromes
  - Professionals with extensive experience in counseling
- This allows the program to provide accurate RA results and empathetic counseling to patients and their families
- Emphasis is placed on the ongoing specialized training in cancer genetics
- Training by commercial laboratories (Ex: Myriad) about how to perform genetic testing is not considered adequate training

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Standard. 2.3 Genetic Counseling and Risk Assessment

- **If services are not available on-site:**
  - The facility must provide a *formal referral* to other facilities and/or local agencies
  - Confirm that the referral location performs pre and post testing on all patients
  - Ensure that the genetics professionals hold one of the recommended credentials
  - Identify, discuss and document the *process for referral* at Cancer Committee annually

Standard. 2.3 Genetic Counseling and Risk Assessment

Cancer Forum Question

- **Q:** 2016 Standards for 2.3 require P & P and process for monitor and evaluate the services and referrals. 2015 & 2014 were not as specific in the documentation requirements. Does this mean a 2017 Surveyor will be looking at the policies and procedures and minutes for review of process for 2016 only when the standard increased the documentation requirements?
- **A:** Yes, you are correct. For 2017 surveys, years 2014 and 2015 require documentation on the process for providing or referring genetic services. For 2016, the cancer committee must monitor, evaluate, and make recommendations for improvements, as needed, to cancer risk assessments, genetic counseling, and genetic testing and/or referrals annually and document in the cancer committee minutes.

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Standard. 2.3 Genetic Counseling and Risk Assessment

- SAR/PAR Review
- Discussion

Standard 3.1 Patient Navigation Process

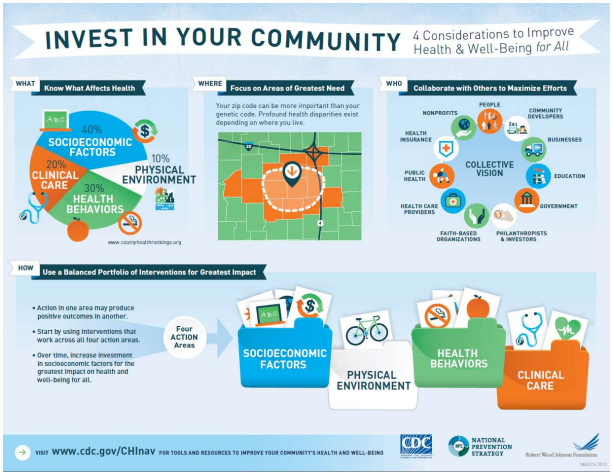
A patient navigation process, driven by a triennial Community Needs Assessment, is established to address health care disparities and barriers to cancer care. Resources to address identified barriers may be provided either on-site or by referral.

- This is a process, NOT a person. Hiring a nurse navigator does not fulfill this standard. The completion of the CNA does not fulfill the requirement.

Standard 3.1 Patient Navigation Process

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- CDC Community Health Improvement Navigator: https://www.cdc.gov/chinav/index.html



Standard 3.1 Patient Navigation Process

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

The Community Needs Assessment must define/identify:

- The cancer program's community and local patient population
- Health disparities (numerous factors can contribute to disparities in cancer incidence and death such as race, ethnicity, gender, underserved groups, and socioeconomic status)
- Barriers to health care, which may include patient centered, provider-centered, or health system-centered barriers
- Resources available to overcome barriers on site or by formal referral
- Gaps in availability of resources to overcome barriers

Standard 3.1 Patient Navigation Process

- The results from the CNA serve as the building blocks for navigation process development, implementation, and evaluation

Standard 3.1 Patient Navigation Process

The cancer committee will construct a report including, but not limited to, the following:

- Population(s) to be served identified by the CNA
- Health disparities and barriers identified by the CNA
- Description of the navigation process to overcome barriers
- Documentation of activities and outcomes of the navigation process
- Areas for improvement, enhancement, and future directions

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Standard 3.1 Patient Navigation Process

- To continually improve upon the quality of patient navigation, a new barrier is to be addressed each year.
- However, programs are allowed to address the same barrier or disparity for more than one year, as long as the cancer committee determines that addressing the barrier is the most important concern and an ongoing need for their community.

Standard 3.1 Patient Navigation Process

Cancer Forum Questions

- **Q:** Do the barriers to care that are targeted need to be in the Community Needs Assessment (CNA) that is completed in the 3 year cycle? In other words, do all results of intervention taken to address a barrier need to tie back to the issues identified in the CNA directly?
- **A:** Yes, as stated in the standard the program must use the community needs assessment to determine what barriers to address and to inform its patient navigation process.

  Q: Does the CNA format regularly done by institutions/healthcare systems need to be modified to include oncology patients served by that cancer center? Have institutions modified their CNA to match the requirements of 3.1 or is it more common for cancer centers to do their own?
- **A:** Yes, the CNA must include oncology-specific information. Programs can use the facility-wide CNA as long as there is information specific to cancer included in it and the cancer committee is involved is developing the cancer-related section. Page 54 of the 2016 Standards details what must be included as related to the cancer program's community. How the CNA is done varies from facility to facility. Facilities have done it both ways.

Standard 3.1 Patient Navigation Process

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- SAR/PAR Review
- Discussion

Standard 3.2 Psychosocial Distress Screening

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, the cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.

- Develop a process to incorporate the screening of distress into the standard procedures.
  - Process must identify: psychological, social, financial, and behavioral issues that could interfere with patients treatment or adversely affect the outcomes of treatment
  - Patients with identified distress must be provided appropriate resources and/or referrals (Close the loop)

Standard 3.2 Psychosocial Distress Screening

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Timing of Screening
  - All cancer patients must be screened at least once at a pivotal medical visit.
    - Pivotal medical visit could include 1st post surgical visit, 1st medical oncology visit to discuss chemotherapy, radiation oncology visit, or post chemotherapy follow-up visit.
    - Screening can take place at more than one pivotal visit.
- Method
  - Cancer Committee should determine the mode of administration of screening: patient questionnaire or clinician-administered questionnaire
  - If clinician-administered the clinician must be properly trained.
  - Process must address where the screening will occur.
  - Process developed must include not only the assessment, but also the treatment or referral for treatment when distress is identified. (Close the loop)

Standard 3.2 Psychosocial Distress Screening

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Tools

- Cancer committee will select and approve the screening tool with preference for standardized, validated tools or tools with established clinical cutoffs.
- Cancer committee establishes the cutoff score that will identify a patient as distressed.
- Tools that are distributed/returned by mail do not meet this standard because there is no discussion allowed. Phone interviews without discussion also do not meet this standard.
- If a program utilizes patient portal or electronic screening method the patient must complete the tool within 24 hours of the pivotal medical visit. Even when completed within 24 hours the results must be reviewed and discussed with the patient face-to-face at the visit.

Standard 3.2 Psychosocial Distress Screening

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Assessment and Referral
  - Results must be discussed with the patient at a medical visit
  - If there is clinical evidence of moderate or severe distress then a member of the oncology team must asses the patient to determine what is causing the distress (psychological, behavioral, financial and/or social problems)
  - Once the cause is determined appropriate referrals must be made.
  - Process should include psychosocial, physician, spiritual, and mental health resources either on site or by referral
- Documentation
  - Policy & Procedure should include: timing of screening, tool used and distress level that will trigger a referral
  - Patient record: screening results, referrals made and any follow-up
  - Psychosocial Services Coordinator must oversee this activity and report to the cancer committee the following: Number of patients screened, number of patients referred for distress resources or further follow-up, where the patients were referred.

Standard 3.2 Psychosocial Distress Screening

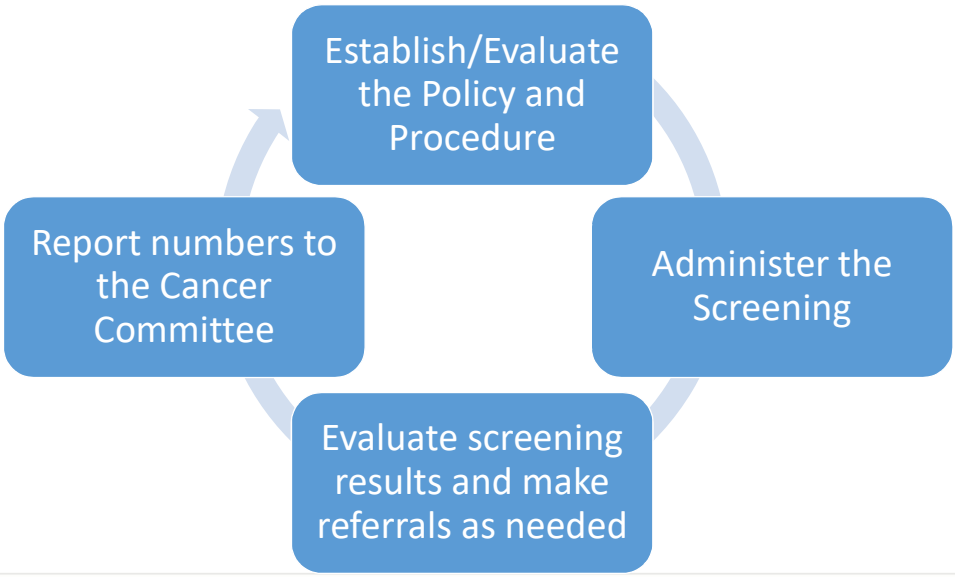
RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Commission on Cancer Questions

- Q: We had a change in personnel. The new social worker did not include documentation related: 1)number of patients screened 2) number of patients referred for follow up; and where patients were referred; in her annual summary to the cancer committee.
- A: Starting in 2016, the Psychosocial Services Coordinator is required to provide an end-of=year report that incudes (1)the number of patients screened; (2) the number of patients referred for distress resources or further follow up; and (3) where patients were referred (on-site or by referral) . For compliance this will need to be done at the end of 2016.
- Q: We have problems with social services they only work with in-patients, how can we get beyond this?
- A: This will have to be addressed by the cancer committee. Social services may need to be expanded to include outpatient and other area where cancer patients are treated.

Standard 3.2 Psychosocial Distress Screening

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING



Standard 3.2 Psychosocial Distress Screening

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- PAR/SAR Review
- Discussion

Standard 3.3 Survivorship Care Plan

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

The cancer committee develops and implements a process to disseminate a treatment summary and follow-up plan to patients who have completed cancer treatment. The process is monitored and evaluated annually by the cancer committee.

Standard 3.3 Survivorship Care Plan

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Survivorship Care Plan must include:

- Important disease characteristics
- A record of care received
- A follow-up care plan incorporating available recognized evidence-based standards of care
- Referrals for support services the patient may need going forward
- Information pertinent to the survivor's short- and long- term care.

Standard 3.3 Survivorship Care Plan

Resources:

- ASCO
- Journey Forward
- National Coalition for Cancer Survivorship
- American Cancer Society
- LIVESTRONG Foundation
- Software interfaces.

Standard 3.3 Survivorship Care Plan

Cancer Forum Questions

- **Q:** A patient completes treatment in 2016 but the SCP is delivered in 2017 within the 6 month required time frame. Calculation of numerator and denominator:

  1. Patient is counted in the 2016 denominator but 2017 numerator
  2. Denominator is adjusted based on care plan delivery date and patient counts in 2017 numerator and 2017 denominator.

  In this scenario would option #1 or option #2 be the correct way to do our calculation for this patient?

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Standard 3.3 Survivorship Care Plan

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions (continued)

- **A:** The tricky part about calculating the percentage is accepting the fact that your patients in your numerator will often times be different form the patients in your denominator, The numerator is your total number of SCPs delivered in 2017. Your denominator is the number of patients that finished treatment in 2017. The patient that finished treatment in November 2016 and was delivered a SCP in 2017 will not be included in your 2017 denominator. BUT they will be in your numerator. Once your process starts and is running smoothly, as long as you try to deliver SCPs to as many patients as you can within 6 months of them finishing treatment the numerator and denominator will work themselves out year after year. (July 2017)

Standard 3.3 Survivorship Care Plan

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions (continued)

- **Q:** Curative treatment for prostate cancer includes: prostatectomy, cryotherapy, green light photo-vaporization, and radiation. The question we have is, the patient that received radiation therapy with hormones. In our experience each patient and physician is different when it comes to hormone therapy timeframes. Is it acceptable to do the SCP after a curative radiation therapy, regardless of hormones. We are having difficulty tracking when and if the hormones are completed.
- **2nd Response:** To keep the algorithm simple for our large network, we disregard the hormones and aim to provide the SCP within 6 months of completing "active therapy," which is surgery, radiation and chemo. This is our goal for all cancer types. Hope this helps!

Standard 3.3 Survivorship Care Plan

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions (continued)

- **A:** Agree with Second response. Just make sure the hormone therapy is included in the SCP. (June 2017)
- **Q:** 1) Dr. Danny Takanishi did a presentation on SCP delivery in November 2016 in which he said we can exclude patients who decline survivorship or are no shows to their survivorship appointments. Is this correct?
  2) The standard excludes stage IV patients. Is this meant to exclude M1 patients only, or are non-metastatic stage IV patients excluded as well?
- **A:** 1): If a patient cancels or is a no show, they can be removed from your denominator for care plan delivery. The inability to deliver the plan should be noted in the patient's medical record and documented in the Cancer Committee minutes. Please see the table in the SAR, where it shows these areas are subtracted from the denominator.
  2): You can exclude all Stage IV patients. (July 2017)

Standard 3.3 Survivorship Care Plan

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- PAR/SAR Review
- Discussion

Standard 4.1 Cancer Prevention Programs

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, the cancer committee organizes and offers at least one cancer prevention program designed to reduce the incidence of a specific cancer type and targeted to meet the prevention needs of the community. Each prevention program is consistent with evidence-based national guidelines for cancer prevention.

- Education and cancer risk awareness for specific type of cancer
- Skin cancer prevention (UV rays, tanning beds)
- Tobacco cessation
- Smoking prevention in adolescents
- Radon education and testing
- Nutrition, physical activity and weight loss programs (specifically related to weight loss programs)Vaccine (HPV)

Standard 4.1 Cancer Prevention Programs

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- Q: Our local paper is wanting to do an interview with our medical oncologist over skin cancer prevention, if this is published in our local paper would this count as a prevention "program"? If so what would I upload into the SAR for number of participants?
- A: No. Prevention education provided via newspaper article, television interview, or social media etc. without any actual interaction with the participants is not a compliant prevention activity for 4.1. (4/2017)

- Q: Our Genetics Counselor, who heads up our Cancer Risk Prevention Program is conducting a study in which she is evaluating the outcomes of her patients who have tested positive for a hereditary cancer syndrome. She wants to determine if the patients are following up with her recommendations for prophylactic surgery that will greatly decrease the chance of the hereditary cancer from occurring. She wants to see if her intervention/counseling is helping her patients decrease their chance of developing the hereditary cancer. Can we use her study as part of a prevention program? If not, can we use it as a Quality Improvement study?

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Standard 4.1 Cancer Prevention Programs

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions (continued)

- A: This would not qualify as a prevention program according to the requirements detailed in the 2016 Cancer Program Standards. Prevention events must be focused on prevention needs of your community. It must identify risk factors within your community and patient population and use strategies/education to modify attitudes/behaviors to prevent the cancer from ever developing in the first place. Following up on whether a patient has received a treatment is not considered a prevention activity.

  Quality studies for 4.7 must be based on an identified-quality related problem. You must already know that something is not occurring or is not occurring properly before the root-cause study takes place. Doing a check to see whether a procedure is taking place does not meet that requirement. (4/2017)

Standard 4.2 Screening Programs

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Discussion: Would anyone like to share a great ideas for screening programs?

Standard 4.2 Screening Programs

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, the cancer committee organizes and offers at least one cancer screening program that is designated to decrease the number of patients with late-stage disease and is targeted to meet the screening needs of the community. Each screening program is consistent with evidence-based national guidelines and interventions and must have a formal process developed to follow up on all positive findings.

- Breast (radiographic or physical examination
- Colon (colonoscopy, FOBT< flexible sigmoidoscopy)
- Cervical (Papanicolaou testing with / without HPV DNA testing)
- Skin (physician-directed total-body skin exams)

Standard 4.2 Screening Programs

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- **Q:** Our program offers the Low Dose CT Lung Screenings throughout the year and walk-in same-day digital screening mammograms throughout the year. These are not free screenings, For the mammograms we partner with A Silver Lining Foundation to offer free mammograms to women and men who cannot afford one. The patients who have positive results are followed by our Breast and Lung Nurse Navigators. Would these two programs qualify for compliance of Standard 4.2?
- **A:** If these activities are based on an identified community need and organized by the cancer committee, they would qualify for compliance. (6/2017)

- **Q:** We implemented a LDCT lung screening program in 2016 as one of our standard 4.7 studies of quality. Now, it is ongoing, and we have data of how many patients have been screened and how many new cancers have been detected so far - can this be used for standard 4.2 as a screening program for 2017?
- **A:** Yes, as long as it is not being used as your QI based on a study to comply with Standard 4.8. To qualify for 4.2, be sure you are reviewing and documenting the community screening need and documenting this in your minutes.

Standard 4.2 Screening Programs

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Discussion: Would anyone like to share a great ideas for prevention programs?

Standard 4.3 Cancer Liaison Physician Responsibilities

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

A Cancer Liaison Physician (CLP) serves in a leadership role within the cancer program and is responsible for evaluating, interpreting, and reporting the cancer program's performance using National Cancer Data Base data. The CLP, or an equivalent designee, reports the results of this analysis to the cancer committee at least four times each calendar year.

Standard 4.3 Cancer Liaison Physician Responsibilities

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- CLP's serve 3-year terms with an unlimited number of terms
- CLP must be a physician and an active member of the medical staff
- CLP must have access to CoC Datalinks (and use it!)
- CoC Required Education:
  - Complete the CLP Orientation within 3 months of initial appointment and on re-appointment
  - View all Web-based CLP education programs provided by the CoC each year

Standard 4.3 Cancer Liaison Physician Responsibilities

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Reports can include:

- Cancer Program Practice Profile Reports (CP^3R)
- Additional NCDB Tools, such as:
  - Cancer Quality Improvement Program (CQIP)
  - Rapid Quality Reporting System (RQRS)
    - An in-depth report, not just the dashboard with current rates
  - Hospital Comparison Benchmark Reports
  - Survival Reports

*CLP reports do not count towards 4.6 or 4.7 studies

Standard 4.3 Cancer Liaison Physician Responsibilities

- CLP may appoint a designee to deliver the report at Cancer Committee, however, the designee must be eligible to be a CLP
  - CLP must also prepare the report themselves
- Standards Resource Library includes the CLP Program Webpage link
  - CoC CLP page includes State Chair Contact List
- MANY other great PDF's on the website that may be beneficial for your CLP's
  - https://www.facs.org/quality-programs/cancer/clp/ncdbtools
    - Time to Treatment PDF
    - Stage at Diagnosis PDF
    - NCDB Tip Card

Standard 4.3 Cancer Liaison Physician Responsibilities

Cancer Forum Questions

- **Q:** Could you please provide clarification regarding the role of Clinical Liaison Physician on the Cancer committee? I am aware that one person cannot fulfill more than one coordinator position on the Cancer Committee; can the CLP also be a coordinator, ie Cancer Committee Chairperson?
- **A:** Wording from the 2016 standards manual, page 29: The CLP can fulfill one additional leadership position within the cancer committee such as chair or a designated coordinator and represent one of the required physician specialties. (3/2017)

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Standard 4.3 Cancer Liaison Physician Responsibilities

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- **Q:** Standard 4.3 states the CLP can report and discuss the Rapid Quality Reporting System. However Standard 5.2 is worded differently and states CLPs may report RQRS data and performance in partial fulfillment of the requirement for Standard 4.3. What does partial fulfillment mean?

- **A:** Standard 4.3 requires that the CLP report and discuss the program's performance using NCDB data at least four times per calendar year. RQRS is listed as one of the data sources that can be used in the CLP's required reports. If the CLP reports on RQRS data twice during the calendar year, these reports would satisfy two of the required four Standard 4.3 reports. It would also fully satisfy the reporting requirement in Standard 5.2. (July 2017)

Standard 4.3 Cancer Liaison Physician Responsibilities

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Discussion: How do you keep your CLP engaged?

Standard 4.6 Monitor Compliance with Evidence-Based Guidelines

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, the cancer committee designates a physician member to complete an in-depth analysis to assess and verify that cancer program patients are evaluated and treated according to evidence-based national treatment guidelines. Results are presented to the cancer committee and documented in cancer committee minutes.

- The role of this standard is to ensure that evaluation and treatment conforms to evidence-based national treatment guidelines using AJCC stage or other appropriate staging, including appropriate prognostic indicators

Standard 4.6 Monitor Compliance with Evidence-Based Guidelines

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Cancer committee select relevant cancer site, year(s) and stage selection
- Cancer committee select physician volunteer based on site and treatment
- Cancer committee select national treatment guide for comparison
- CTR provide data report which pre-quality review
- Physician lead in-depth review, interpretation and outcome analysis
- Physician present to the cancer committee in the same year the study was performed

Standard 4.6 Monitor Compliance with Evidence-Based Guidelines

- Any physician member can complete the analysis
- Cancer committee cannot use QOPI (Quality Oncology Practice Initiative) results for this review
- Quality measures used for Standard 4.4 and 4.5 cannot be used for Standard 4.6
- The completion and analysis of this review does not fulfill the requirement for Standard 4.7

Standard 4.6 Monitor Compliance with Evidence-Based Guidelines

5 Rights:

- *Are the right patients receiving the right treatment in the right way at the right time for the right reasons.*

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Standard 4.6 Monitor Compliance with Evidence-Based Guidelines

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions

- **Q:** Can an alternate on the Cancer Committee perform the NCCN Guideline review?
- **A:** The review is to be conducted by a physician member of the Cancer Committee. If the alternate has been appointed, he/she may perform the review (7/2017)

Standard 4.6 Monitor Compliance with Evidence-Based Guidelines

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Questions (continued)

- **Q:** Would reviewing and ensuring that our ovarian CA patients are offered genetic counseling per NCCN guidelines be a 4.5 topic? We do diagnose and surgically treat ovarian CA at our community hospital, but refer out to two, nearby, and not officially affiliated, independent medical oncology practices for genetic counseling. It would be good to ensure that counseling is occurring with patients, and affected family, and if not, how to correct/communicate need.
- **A:** This may be a study topic for Standard 4.6. Is the genetic counseling referral part of first course of treatment? If so, review the requirements for S4.6 to determine is your topic meets all of the requirements for monitoring compliance with evidence-based guidelines.
  Even if this is part of your 4.6 study, you must review all aspects of evaluation and treatment to determine whether the patient received treatment per evidence-based guidelines. (4/2017)
-

Standard 4.6 Monitor Compliance with Evidence-Based Guidelines

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

- Discussion: Would anyone like to share their ideas for 4.6 studies?

Standard 4.7 Studies of Quality

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator (QIC), develops, analyzes, and documents the required number of studies (based on program category) that measure the quality of care and outcomes for cancer patients.

- Step 1a: Appoint Quality Improvement Coordinator
- Step 1b: Determine required number of studies and

Standard 4.7 Studies of Quality

- Step 2: Study topics must be selected based on a **problematic quality-related issue** specific to the cancer program
  - The quality study is conducted to understand **why** a problem is occurring (**NOT** if there is a problem and **NOT** if an improvement is successful)
  - Studies can be designed to evaluate the entire spectrum of cancer care or cancer program operations in which a problem or error is occurring
    - Gaps in resources or care services?
    - Gaps in healthcare technology?
    - Issues from patient satisfaction survey results?
    - Safety and cleanliness problems?
    - Educational gaps/needs for staff or patients?
    - Delays in appointments, treatments, tests, etc.?
    - Concerns from data in National Cancer Data Base (NCDB) Hospital Benchmark reports?

Standard 4.7 Studies of Quality

- Step 2 Continued: Topics that are **not applicable** to meet compliance include:
  - Quality studies that duplicate topics or studies from year-to-year
  - Ongoing monitoring activities following a completed study
  - Quality studies cannot be an examination, restatement, or an improvement of a CoC Standard or Eligibility Requirement
  - Survival studies and the in-depth analysis used in Standard 4.6
  - Simple review of data presented in NCDB reports or tools

  (including measure compliance)

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Standard 4.7 Studies of Quality

- Step 3: The criteria for evaluation (study methodology) must identify what type of data you will need to effectively evaluate the study topic or answer the quality-related question
- Set up a framework for the study
  - Specify the data set or population (i.e., patients, cancer types, etc.) that you are going to analyze
  - Define what type of data you will obtain that will help you understand the cause of the problem
  - Identify who will conduct the study and compile the results
  - Determine whether your study design is suitable for the questions you need to answer

Standard 4.7 Studies of Quality

- Step 4: Conduct the study according to the identified methodology and measures, and organize the data collection.
  - The presentation data proves the cause of the problem. Data showing the improvement does not qualify for compliance with this standard.
- Step 5: Analyze the data and prepare a summary of findings
  - The study should not be submitted without guidance on how the data and findings were obtained and calculated
  - Determine the best tools to use to display the study results in an organized and readable manner
  - Microsoft Excel, Tables, Charts, or Graphs

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Standard 4.7 Studies of Quality

- Step 6: Compare data results with national benchmark / guidelines
  - Without a benchmark, performance rate, or guideline there is no way to know whether the program is meeting expectations, if an improvement of the problem is warranted, and/or how much of an improvement is needed
  - National benchmark or guideline sources
    - Centers for Disease Control and Prevention
    - National medical or professional healthcare organizations (i.e., NCCN, ONS, ASCO, NHPCO, NCI/NIH, ACS)
    - Other Federal or State organizations including state cancer registries
    - Private organizations that provide consulting services to healthcare facilities
    - Manuscripts from peer-reviewed, professionally-recognized healthcare journals

Standard 4.7 Studies of Quality

- Step 7: Design an action plan (quality improvement) based on study findings and follow up to monitor implementation
  - Completion of a quality study provides data to serve as the next step in the quality improvement process – correcting and improving the problem that initiated the quality study
- Step 8: Presentation of study results with documentation of results, discussion, and decisions in the cancer committee minutes.

Standard 4.7 Studies of Quality

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

CHECKLIST

- Indicate the study topic that identifies a problematic quality-related issue with the cancer program
- Define the study methodology and criteria for evaluation, including data needed to evaluate the study topic or answer the quality-related question
- Conduct the study according to the identified measures and methodology
- Prepare a summary of findings
- Compare data results with national benchmarks or guidelines
- Design a corrective action plan based on evaluation of the data
- Establish follow-up steps to monitor the actions implemented

Standard 4.7 Studies of Quality

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

DO	DON'T
IDENTIFY A RELEVANT CANCER PROBLEMATIC ISSUE	DUPLICATE A TOPIC OR STUDY ALREADY PERFORMED FROM A PREVIOUS YEAR
DEFINE THE STUDY METHODOLOGY	UTILIZE ANOTHER STANDARD TO COMPLY WITH THIS STANDARD (EXAMPLE 4.6)
USE QUALITY TOOLS AND RESOURCES	UTILIZING ALREADY CREATED NCDB DATA THAT IS PROVIDED TO YOUR FACILITY
COMPARE DATA RESULTS WITH NATIONAL BENCHMARKS OR GUIDELINES	FORGET TO ENTER ALL REQUIRED INFORMATION IN THE SAR OR PAR EACH YEAR
PREPARE A SUMMARY OF FINDINGS	ALLOW A SINGLE INDIVIDUAL TO COMPLETE THE STUDIES – SHOULD BE MULTIDISCIPLINARY
DOCUMENT RESULTS IN CANCER COMMITTEE MINUTES	FORGET TO IDENTIFY ANY CORRECTIVE ACTION PLAN BASED ON THE STUDY EVALUATION
PERFORM THE CORRECT NUMBER OF STUDIES EACH CALENDAR YEAR BASED ON YOUR COC CATEGORY	FORGET TO ESTABLISH ANY FOLLOW-UP SEPS TO MONITOR THE ACTIONS IMPLEMENTED
CREATE A MEANINGFUL QUALITY STUDY IDENTIFY WAYS TO IMPROVE CANCER CARE	FORGET TO IDENTIFY AN IMPROVEMENT THAT CAN BE IMPLEMENTED FOR COMPLIANCE WITH 4.8

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Standard 4.7 Studies of Quality

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Cancer Forum Question

- Q: Our program developed and conducted a study of Physician communication using data that is required to be collected by CMS. This study looks only at oncology patients interaction with physicians in the in-patient setting. There is a concern that because the data is require to be collected for Medicare/Medical that the report will not be accepted. I am requesting confirmation that data required to be collected by CMS or other agencies falls under the standard specification, "A study that is required by an outside, recognized organization related to oncology is acceptable if it follows the required study criteria outlined in this standard."

- A: Based on the information provided it will not meet the standard. There is no problematic issue noted, but rather monitoring the interaction with physicians. Additionally, this is not aimed at the cancer patient, but all inpatients. Please review the Steps for Standard 4.7 Compliance, which can be found in the Standards Resource Library. (6/2017)

Standard 4.7 Studies of Quality

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- Discussion: Would anyone like to share great study topics?

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Standard 4.8 Quality Improvements

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, implements two cancer care improvements. One improvement is based on the results of a quality study completed by the cancer program that measures the quality of cancer and outcomes. One improvement can be based on a completed study from another source. Quality improvements are documented in the cancer committee minutes and shared with medical staff and administration.

- Quality or performance improvements are the actions taken, process implemented, or services created to improve cancer care
- Implementation of improvements demonstrates a program's continuous commitment to providing high-quality patient care

Quality Improvement Examples

- Improve turnaround time of lab results for outpatients receiving chemotherapy
- Assemble and provide education folders to newly diagnosed breast cancer patients
- Observe and shorten the time to antibiotic treatment to improve morbidity of inpatients with neutropenia
- Develop and implement a chemotherapy follow-up assessment for patients receiving chemotherapy in the Infusion Center
- Improve scheduling process for cancer patients who need PET scans and MRI's
- Improve hospice referral timeliness

Quality Improvement Examples

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- **Cancer Forum Question**
  - **Q:** Please clarify as I am seeing conflicting responses in the forum. We looked at our Cancer Registry data and found opportunity for a Standard 4.8 QI in our H & N cancer population. We are not using this data to conduct a Standard 4.7 study, but want to use the data for a Standard 4.8 QI in 2017. Can we use a data source for Standard 4.8 QI that was not used as a Standard 4.7 study?
  - **A:** I am assuming this is regarding the 2nd QI, the one NOT resulting from a quality study? Yes, as long as you are implementing an improvement. (5/2017)

Quality Improvement Examples

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- Discussion: Would anyone like to share improvements they have made to their cancer programs?

Standard 5.1 Cancer Registry Credentials

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Case abstracting is performed by a Certified Tumor Registrar

- Any non-CTR hired to perform abstracting under the supervision of a CTR in a CoC-accredited program must pass the CTR examination within 3 years of the date hired. If the person does not successfully obtain the CTR credential with the three-year grace period, then he or she may not perform case abstracting at any CoC-accredited program until the credential is obtained.

Std. 5.1 Cancer Registry Education

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- Cancer Forum Question
  Q: Can Non-CTR staff enter information into the type of 1st recurrence field or does a CTR have to enter this information?
  A: Needs to be the CTR.
- SAR/PAR Review
- Discussion

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Std. 5.2 Rapid Quality Reporting System (RQRS) Participation

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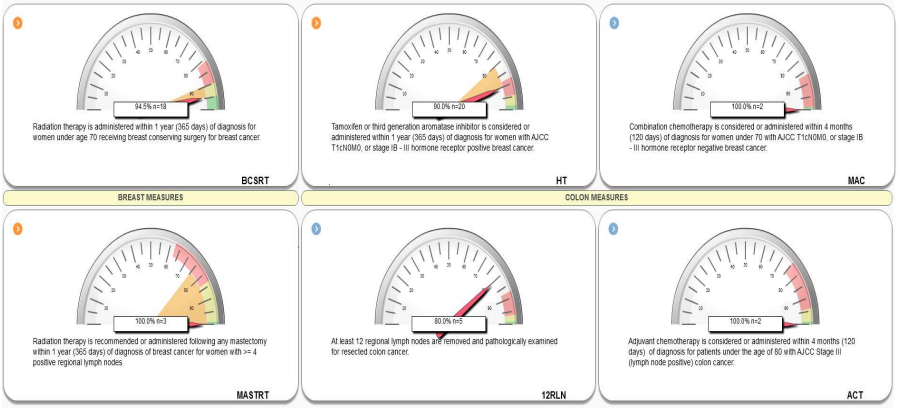
- From initial enrollment and throughout the accreditation period, the cancer program actively participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to the RQRS terms and conditions.



RQRS Dashboard Timeframes

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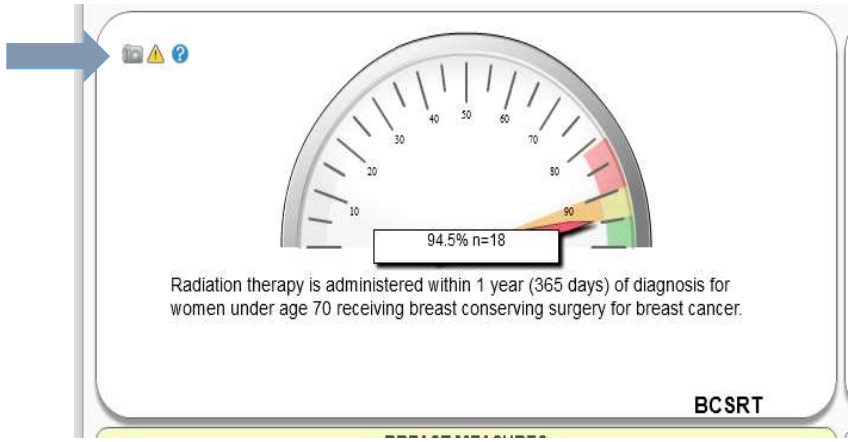
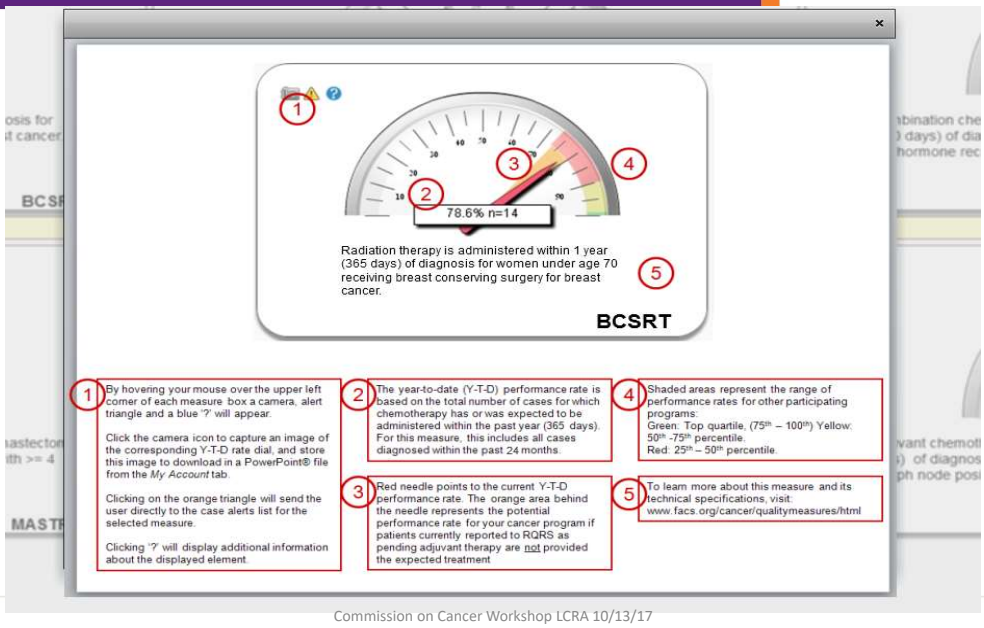
	# of months to receive therapy	# of months cases found in RQRS dashboards
Breast • Hormone Therapy (HT) • Radiation following BCS (BCSRT) • Radiation following mastectomy (MASTRT)	12 months	24 months
Breast and Colon • Adjuvant Chemotherapy (ACT & MAC)	4 months	16 months
Colon • Removal of 12 regional lymph nodes (12RLN)	0 months	12 months

RQRS Dashboard - Dial

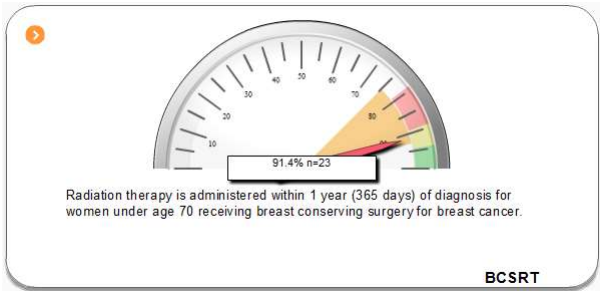


RQRS Dashboard – "?"



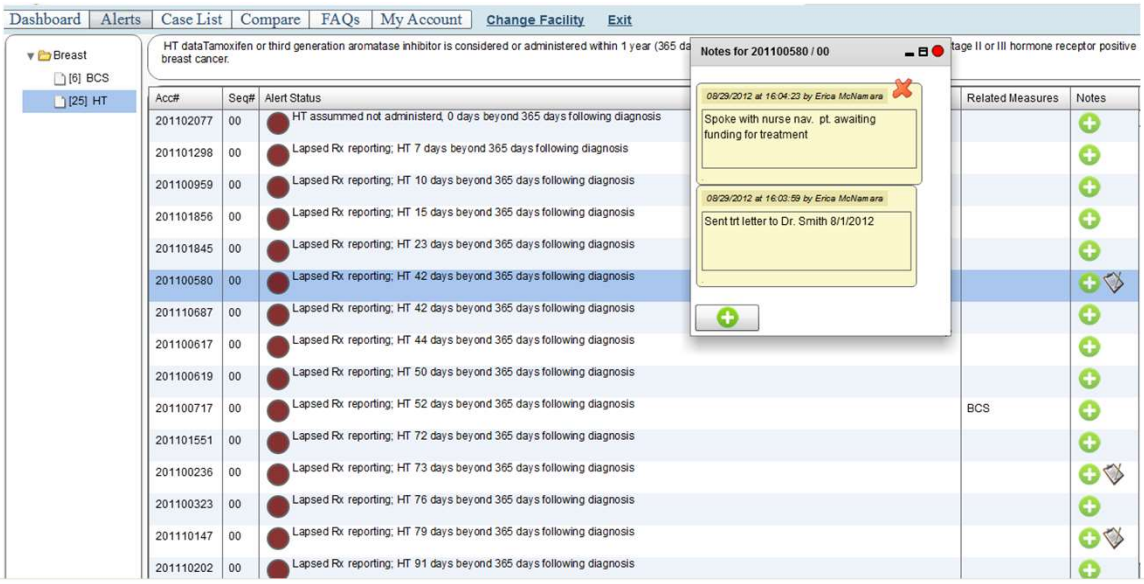
RQRS Functionality

- **Dashboard**
  - Data is updated nightly
  - N value = total number of cases included in the denominator of the calculation
  - Orange shaded area represents the potential performance rate for your program if none of the patients reported to RQRS as *pending therapy* are provided the expected treatment
  - Shaded areas represent the range of performance rates for other participating programs: Green = Top quartile (75th-100th); Yellow = 50th-75th percentile; Red = 25th-50th percentile

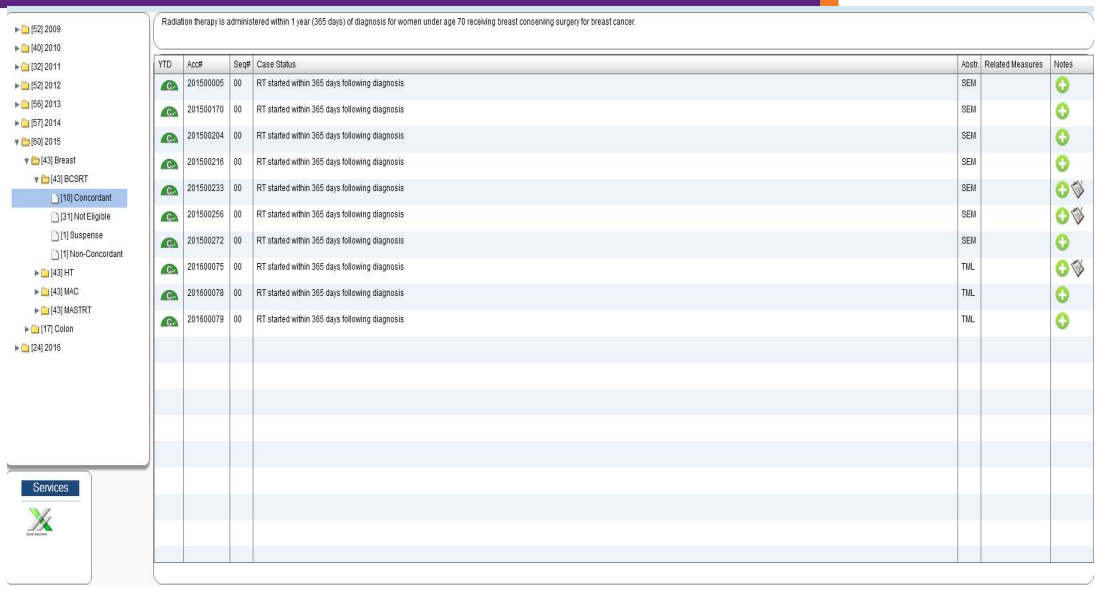


**Please reference the RQRS User Guide (page 14) for specific details on YTD dashboard calculations: O:\15. OSD CoC Accredited Program Documents\Commission on Cancer\Standard 5.2 RQRS\Resources\"rqrs_userguide_2016"*

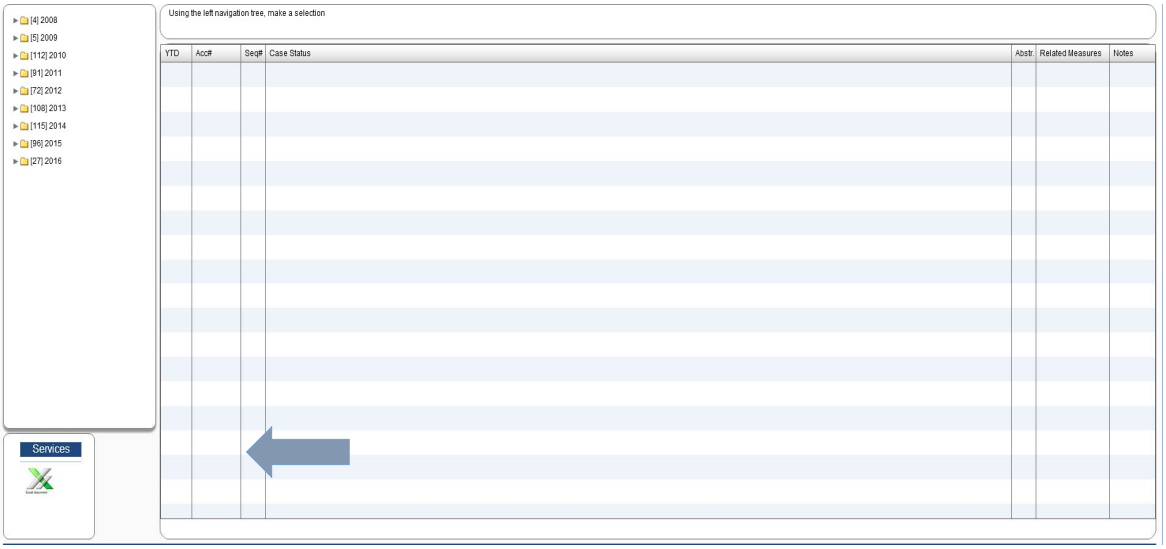
RQRS Alerts



RQRS Case Lists



Export to Excel



RQRS Minimum Required Fields

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Demographic:

- ☐ Facility Identification Number
- ☐ Accession Number
- ☐ Class of Case
- ☐ Sex
- ☐ Age
- ☐ Birth Date
- ☐ Race
- ☐ Spanish origin
- ☐ Primary Payor
- ☐ Zip Code at Dx
- ☐ Vital Status

Diagnostic:

- ☐ Sequence Number
- ☐ Date of Diagnosis
- ☐ Primary Site
- ☐ Last Contact Date

Staging:

- ☐ Clinical T
- ☐ Clinical N
- ☐ Clinical M
- ☐ Clinical Stage Group
- ☐ Pathologic T
- ☐ Pathologic N
- ☐ Pathologic M
- ☐ Pathologic Stage Group

Characteristics:

- ☐ Tumor Behavior
- ☐ Tumor Histology
- ☐ Tumor Size
- ☐ ERA
- ☐ PRA

Treatment:

- ☐ Primary Site Surgery – Summary
- ☐ Primary Site Surgery - Facility
- ☐ Regional LN Examined
- ☐ Regional LN Positive
- ☐ Cancer Directed Surgery Date
- ☐ Chemotherapy
- ☐ Chemotherapy Date
- ☐ Hormone Therapy
- ☐ Hormone Therapy Date
- ☐ Radiation Regional Rx Modality
- ☐ Radiation Date
- ☐ Reason for No Radiation

Comparison Reports

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Current 2017 Requirements

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Compliance

- Adhere to RQRS requirements from initial enrollment (or beginning of accreditation period) up until survey
- Submits all new and updated cancer cases at least once each calendar quarter
- RQRS data and performance reports are reviewed by cancer committee at least semi-annually (twice per year) and documented in the minutes

Commendation

- All cancer cases submitted to RQRS with edit errors are corrected and resubmitted
- Submits all new and updated cancer cases at least once each calendar month
- RQRS cancer cases are submitted within 3 months of date of first contact
- RQRS data and performance reports are reviewed by cancer committee at least quarterly and documented in the minutes

Standard 5.3 and 5.4 Follow-Up of All and Recent Patients

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For all eligible analytic cases, an 80 percent follow up rate is maintained from the cancer registry reference date. A 90 percent follow up rate is maintained for all eligible analytic cases diagnosed within the last five years or from the cancer registry reference date, whichever is shorter.

Cancer Forum Question

- Q: Using CDC/NDI as a resource for follow-up This was presented at NCRA with the hospital using only this tool as a means of follow up. If the patient had not expired at the date the file was sent then the patient was assumed alive. This center was able to pass their CoC Accreditation but am wondering if this could be bias based on the surveyor. Could you confirm that this process is acceptable as a means of follow-up
- A: According to FORDS, page 329, 'failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive.' We do not comment on other program surveys or surveyors. (4/2017)

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Standard. 5.3 and 5.4 Follow-Up of All and Recent Patients

- Review SAR/PAR
- Discussion Items

Standard. 5.5 – 5.6 Data Submission and Accuracy of Data

Each year, complete data for all requested analytic cases are submitted to the National Cancer Data Base in accordance with the annual Call for Data. Annually, cases submitted to the National Cancer Data Base.

Cancer Forum

- Q: For these 2 standards 5.5 and 5.6, do we need to report this to our cancer committee or is it sufficient that we send the data on time and error free.
- A: No official report to the CC is required. However, noting that the submission was made on time and that the data submission had no errors is usually part of the registry report. (5/2017)

Std. 5.5 – 5.6 Data Submission and Accuracy of Data

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- Review SAR/PAR
- Discussion Items

Std. 5.7 Commission on Cancer Special Studies

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The cancer program participates in special studies as selected by the Commission on Cancer.

- Review SAR/PAR
- Discussion Items

Eligibility Requirements

- Ensure documents uploaded are the most recent and are still accurate.
- SAR/PAR Review
- Discussion

SAR / PAR Maintenance

- Discussion: Are you the “Lone Ranger”, or have you found ways to engage others in SAR/PAR activities?

Cancer Committee Documentation

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- Discussion: Are you including the “meat and potatoes” in your minutes or adding attachments?

Commission on Cancer Survey

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- Discussion: Would anyone like to share recent survey experiences?

Deficiency Resolution

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- Discussion: Does anyone have tips to share for deficiency resolution?

New Programs – Initial Accreditation

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- Discussion

Commission on Cancer – Round Table Discussion

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Thank you

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