Quality of Patient Care: New CoC Standards

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Program Planning Committee Disclosure

The following members of the Program Planning Committee have nothing to disclose:

• Connie Bura
• M. Asa Carter
• Greer Gay
• Jerri Linn Phillips

Topics Covered in This Presentation

• Quality – Background & Concepts
• Quality Measurement Systems from the CoC
• Define the new QOPC Standards (S4.4 & S4.5)
• Assessing compliance
• How the CoC will rate these new standards

Ernest A. Codnam, MD, FACS
Three ways to measure components of quality:

Structure
Process
Outcomes

Avedis Donabedian, MD, MPH

“...the relatively stable characteristics of the providers of care...tools and resources...physical and organizational settings...increases or decreases the probability of good performance...”

Examples:
Number/credentials of cancer program staff
Medical oncology reporting system
Relationship with chemo treatment facilities/offices
Registry workload
Formalized support programs
Transportation
Support groups

“...a set of activities that go on within and between practitioners and patients...elements of the process of care do not signify quality until their relationship to desirable health status has been established.”

Examples:
Use of cancer committee for treatment protocol discussion
Surgeon-oncologist communication, documentation
Administration of adjuvant chemotherapeutic agent
Physician-patient communication
Appropriate registry abstraction
Outcomes

“...a change in a patient’s current and future health status that can be attributed to antecedent health care.”

Example:
Proportion of patients being treated with standard of care.
- e.g., Patients receiving adjuvant chemotherapy for node positive (Stage III) colon cancer

Structure, Process & Outcomes: Interconnected

Outcomes can indirectly give information on process
Measuring adherence to established standards of care
Outcomes can guide monitoring activities
- Surgeon referrals
- Medical oncologist
- Registrar activity

Donabedian, MD, 1980.

Continuous Quality Improvement (CQI)

“...is a structured organizational process for involving personnel in planning and executing a continuous flow of improvements to provide quality health care that meets or exceeds expectations.”

McLaughlin and Kaluzny
A Word About Systems...

“Systems thinking is a discipline for seeing wholes. It is a framework for seeing interrelationships, rather than things, for seeing patterns of change rather than static snapshots”

Senge, 1990

QIC in Complex Organizations

Data Intensive
Information Intensive

DYNAMIC
Over time gain new “customers”
Involves change in staff at various times
New questions to be answered
Thus, More time—More action

McLaughlin and Kaluzny

Modeling Quality Improvement

Baseline
Worse Better

After
Worse Better

Horn, 1996 ISIS
• Noted that the quality of cancer care varies in the United States.
• Recommended that:
  – Quality care measures be established.
  – These measures be monitored through repeated studies.
  – That benchmarks be established for quality improvement.
  – Reporting mechanisms or report cards be developed to promote improvement of care at the local level.

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Institute of Medicine Report - 1999

Process Measures Most Widely Used

The most common measures used in oncology are Process Measures

– Assess care as it is provided
– Allow for real-time tracking of care
– Provide assessment of care that is not dependent on other factors affecting outcomes

– Outcome of recurrence and survival affected by many factors such as biology of cancer and status of patient
– Applying best processes of care provide each patient the best chances of achieving good outcome

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Criteria for Selecting a Measure

• Must be based on high-level evidence.
• Must be common across the spectrum of CoC approved programs.
• Must be logical to providers and programs.
• Must address aspects of care that can be modified by providers and/or programs.
• Must be derived from existing data sources.
Quality Improvement in CoC Programs

- CoC provides quality measurement based on the cancer registry
- Measures allow retrospective assessment of care
- New program to provide real-time monitoring of care through registry – based patient tracking
  - Rapid Quality Reporting System
  - To be implemented 2011 for voluntary use
  - Not directly required in new standards, but will be a key resource for programs in the future

Cancer Program Practice Profile Reports provide CoC-Accredited cancer programs:

- Report cards to promote improvement of care at the local level.
- Measures that can be monitored through repeated studies.
- Comparative benchmarks for quality improvement.

Breast Measures Endorsed by NQF*

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

Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer. MAC

Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or Stage II or III hormone receptor positive breast cancer. HT

* Measures, as stated, harmonized with ASCO/NCCN
Colon Measure Endorsed by NQF*

Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. AGT

At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. 12RLN

Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer. AdjRT

* Measures, as stated, harmonized with ASCO/NCCN

CoC Measures Under Consideration

Breast

Needle Core or FNA biopsy is performed prior to surgical treatment of breast cancer.

Breast Conservation Surgery Rate for women with AJCC Stage 0, I or II breast cancer.

Radiation therapy is considered or administered within 1 year (365 days) of diagnosis for women undergoing mastectomy for breast cancer with >=4 positive regional lymph nodes.

Chemotherapy (Trastuzumab) is considered or administered within 4 months (120 days) of diagnosis for women with AJCC Stage II or III Her-2-neu + breast cancer.

CoC Measures Under Consideration

GI

Chemo-radiation therapy is considered or administered within 4 months (120 days) of diagnosis for patients with AJCC stage II or III rectal cancer.

At least 16 regional lymph nodes are removed and pathologically examined for resected gastric cancer.

Adjuvant chemotherapy for resected node positive (pN1 or pN2) gastric cancer.

Chemo-radiation is administered for AJCC Stage II or III cancer of the esophagus prior to esophagectomy.
CoC Measures Under Consideration

**Lung**
Chemotherapy is considered or administered within 4 months of surgical resection for pathologic, lymph node-positive (N1 or N2) NSCL cancer.
Regional lymph nodes are pathologically examined following resection of Stage IA or IB NSCL cancer.
Pre-operative chemotherapy is administered to AJCC clinical Stage III NSCL cancer.
AJCC T1-T2, N0-N1 NSCL cancers undergoing surgery with positive margins receive adjuvant radiation therapy.
Un-resectable T1-2 N2 NSCL cancer patients receive chemotherapy or radiation therapy.

CoC Quality of Patient Care Standards

S 4.4 – Accountability Measures
S 4.5 - Quality Improvement Measures
• Hold programs accountable for demonstrating compliance with NQF endorsed evidence-based measures of patient care
• Accountability measures can be used for such purposes as:
  – Public reporting
  – Payment incentive programs
  – Selection of providers by consumers, health plans, or purchasers

QOPC – Quality Improvement Measures

• Assess program compliance with a variety of quality improvement measures
• Quality Improvement Measures are intended to:
  – Promote local internal monitoring of performance
  – Be actionable

QOPC – Accountability Measures

<table>
<thead>
<tr>
<th>Select Breast &amp; Colorectal Measures</th>
<th>Evidence-Based Practice (Rate of Use for Performance)</th>
<th>Care Quality</th>
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<tbody>
<tr>
<td></td>
<td>2004</td>
<td>2005</td>
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<tr>
<td></td>
<td>23.6%</td>
<td>25.0%</td>
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<td>100%</td>
<td>100%</td>
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**QOPC – Quality Improvement Measures**

### S 4.4 Compliance
The facility fulfills all the following criteria:
1. Quarterly, the cancer committee/leadership body monitors the facility's performance using the CoC quality reporting tools
2. The monitoring activity is reported in cancer committee/leadership body minutes
3. For every measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC in each year since the program's last survey

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**QOPC – Accountability Measures**

### S 4.5 Compliance
The facility fulfills all the following criteria:
1. Quarterly, the cancer committee/leadership body monitors the facility's performance using the CoC quality reporting tools
2. The monitoring activity is reported in cancer committee/leadership body minutes
3. For the measure(s) selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC
How To “eye-ball” Compliance (4.4, 4.5)

How To “eye-ball” Compliance

- Rating = 1: Performance Rate >= Threshold
  OR
  95% CI UL >= Threshold
- Rating = 5: Otherwise
### How To "eye-ball" Compliance

**Rating = 1:** Performance Rate \(>=\) Threshold  
**OR**  
95% CI UL \(>=\) Threshold  

**Rating = 5:** Otherwise

**Hypothetical Threshold = 90%**

<table>
<thead>
<tr>
<th>Year</th>
<th>Performance Rate</th>
<th>95% CI UL</th>
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<tbody>
<tr>
<td>2006</td>
<td>92% (88%, 95%)</td>
<td>(90%, 93%)</td>
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<tr>
<td>2006</td>
<td>93% (90%, 97%)</td>
<td>(92%, 94%)</td>
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</table>

**Rating: 5**

**Hypothetical Threshold = 90%**

<table>
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<th>Performance Rate</th>
<th>95% CI UL</th>
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**Rating: 1**

**Hypothetical Threshold = 90%**

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**Rating: 1**

**Hypothetical Threshold = 90%**

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**Rating: 1**
How To “eye-ball” Compliance

• Rating = 1: Performance Rate >= 90%
  OR
  95% CI UL >= 90%
• Rating = 5: Otherwise

<table>
<thead>
<tr>
<th>Hypothetical Threshold = 90%</th>
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<tbody>
<tr>
<td>My Cancer Program</td>
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<td></td>
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<tr>
<td>Profile Rate: 90% CI</td>
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<tr>
<td>Cases</td>
</tr>
<tr>
<td>95% CI UL</td>
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<tr>
<td>90%</td>
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Implementation Plan

Joint Working Group of the Accreditation and Quality Improvement Committees will:

• Review the four accountability measures to determine the performance rate threshold against which all programs will be assessed

• Select one or more quality improvement measure(s) and determine the performance rate threshold against which all programs surveyed in the next calendar year will be assessed.

Implementation Plan

Modify the Chart Review Application:

• Continue to issue case lists for targeted chart review
  – Adjust focus of reviews away from general qualitative review toward measure compliance
• Issue a “provisional” rating
  – Automated algorithm
  – Rating will be annotated
Surveyor Action:
• Review the CoC provisional rating
• Review the cancer committee’s monitoring activities
• Surveyor may override the provisional rating based on findings from review and discussion with program

Roll-out:
• 2011
  – Field testing
  – Chart review modifications in place
  – Formally identify measures and publish thresholds

Roll-out:
• 2012
  – Begin incremental application of the QOPC standards

<table>
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<tr>
<th>Survey Year</th>
<th>Diagnosis Year Cohort Subject to Standard</th>
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<tbody>
<tr>
<td>2012</td>
<td>2009</td>
</tr>
<tr>
<td>2013</td>
<td>2009, 2010</td>
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Questions?

Please visit the CoC’s CAnswer Forum to post questions on this Webinar.

The URL and log in instructions can be found in an attachment posted along with the presentation handouts.