



CANCER PROGRAM STANDARDS 2004 Revised 2006

Standard 2.3 Program Activity Coordinators

One coordinator is designated for each of the four area of cancer committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach.

Definition and Requirements

To promote team involvement and shared responsibilities, one member of the cancer committee is designated to coordinate one of the four major areas of program activity. Members cannot serve as more than one coordinator. It is not recommended to have the certified tumor registrar serve as the coordinator of the quality control of cancer registry data. The Cancer Liaison Physician is assigned to coordinate the community outreach activities. The other coordinators are chosen on the basis of their specialty, knowledge, and skills. Both physicians and nonphysician members of the committee may be selected as coordinators.

Coordinator roles and responsibilities are defined by the cancer committee. These include, but are not limited to:

- 1) Contributing to the development of the annual goals and objectives of the cancer committee;
- 2) Monitoring the activity of the assigned area of responsibility;
- 3) Reporting regularly to the cancer committee;
- 4) Recommending corrective action if activity falls below the annual goal or requirements.

Annually, Cancer Committee minutes identify the designated coordinators, their assigned area of activity, and the defined duties and responsibilities. The minutes also document the reported results of activities and recommendations for corrective action.

CANCER CONFERENCE/TUMOR BOARD

Designated Coordinator: Kenneth Blankstein, M.D.

Defined Duties and Responsibilities:

1. Cancer Conference Frequency – Tumor Boards are held every other Friday at 7:30 a.m., with a minimum of 22 per year.
2. Conferences that include case presentations are available to the entire medical staff.
3. Departmental or site-focused conferences or lectures may be included in the cancer conference program.
4. Consultative services are optimal when representatives from diagnostic radiology, pathology, surgery, medical oncology, and radiation oncology participate in conferences. These specialists must attend 80% of conferences.
5. A cancer conference grid showing multidisciplinary attendance is presented annually to the cancer committee.
6. At least 10 percent of the analytic cases seen each year are presented annually at cancer conference.
7. To provide a consultative service for patients and physicians, 75 percent of the cases presented must be discussed prospectively, that is, addressing patient management issues. Prospective cases include, but are not limited to:
 - Newly diagnosed and treatment not yet initiated.
 - Newly diagnosed and treatment initiated, but discussion of additional treatment is needed.
 - Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed.
 - Previously diagnosed, and discussion of supportive or palliative care is needed.
8. Cases selected for discussion include the five major sites seen at Hunterdon Medical Center (breast, lung, colorectal, prostate, melanoma) as well as cases with unusual sites and/or histologies and challenging management issues.
9. The number of cases presented at each conference is monitored to ensure adequate time for thorough discussion.
10. A cancer conference tracking tool that shows the annual conference schedule and format is presented to cancer committee on an annual basis.
11. The assigned coordinator monitors each area of cancer conference activity (frequency, attendance, total case presentation and prospective case presentation) and recommends corrective action if any area falls below the annual goal or requirements, and reports quarterly to the cancer committee.

QUALITY CONTROL OF CANCER REGISTRY DATA

Designated Coordinator: Steven Diamond, D.O.

Defined Duties and Responsibilities:

1. Ten percent of analytic cases are reviewed annually by physicians for accuracy and completeness. CoC data standards and coding instructions are used to describe all reportable cases. Accuracy of abstracted data reviewed include the following data items:
 - Class of case
 - Primary site
 - Histology
 - First Course of Treatment
2. A formal case finding audit is completed on a quarterly basis to ensure all cases are being reported.
3. Ongoing timely abstracting is essential for accurate data collection, evaluation and reporting of outcomes. More than 90 percent of cases are abstracted within six months of the first date of contact.
4. An 80 percent follow-up rate is maintained for all analytic patients from the cancer registry reference date (1991).
5. A 90 percent follow-up rate is maintained for all analytic patients diagnosed within the last five years, or from the cancer registry reference date, whichever is shorter. All reportable cases are followed except:
 - Residents of foreign countries.
 - Cases that are reportable-by-agreement.
 - Patients whose age exceeds 100 years and who are without contact for more than 12 months.
6. Complete data for all analytic cases are submitted to the National Cancer Data Base (NCDB) in accordance with the annual Call for Data.
7. Cases submitted to the NCDB for the most recent accession year requested meet the established criteria included in the Annual Call for Data.
8. The Cancer Registry participates in special studies as requested by the Commission on Cancer. Complete data are submitted for each special study in which HMC is requested to participate.
9. AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on 90 percent of eligible annual analytic cases.
10. The assigned coordinator monitors each area of cancer registry activity, reports quarterly to the Cancer Care Committee, and recommends corrective action if any area falls below the annual goal. The results and recommendations are documented in the Cancer Care Committee minutes.

QUALITY IMPROVEMENT

Designated Coordinator: Myron Bednar, M.D.

Defined Duties and Responsibilities:

1. Each year, the Cancer Care Committee completes and documents two studies that measure quality and outcomes. One study must be based on registry data. The Committee should focus on quality-related issues relevant to HMC and local patient population and any area of cancer program activity. Studies of quality should include patient outcomes, if appropriate. Survival analysis is the preferred method; however, other outcome measures may be selected at the discretion of the Cancer Care Committee.
2. For each quality study, the Cancer Care Committee is responsible for:
 - Establishing the study topic.
 - Defining quality measures to evaluate the topic.
 - Evaluating the data related to the quality measures.
 - Designing and initiating actions based on the evaluation of the data.
 - Monitoring the effectiveness of action plans and all cancer-related quality improvement activities at HMC.
3. The assigned coordinator monitors activity related to the studies of quality, reports regularly to the cancer committee, and recommends corrective action if any area falls below the annual goal or requirements by reporting to the cancer committee.
4. Annually, the Cancer Care Committee implements two or more improvements that directly affect cancer patient care. Sources for improvement include, but are not limited to:
 - Actions based on analysis of a study
 - Actions to address undesirable performance
 - Changes to improve acceptable performance
 - Additional programs or services addressing patients needs or staff concerns
5. The methods used to monitor the quality improvement program are set by the Cancer Care Committee and documented in the Cancer Care Committee minutes.

COMMUNITY OUTREACH – CANCER LIAISON

Designated Coordinator: Douglas Worden, M.D.

Defined Duties and Responsibilities:

1. Supportive services are provided on-site or coordinated with local agencies and facilities. Supported services include, but are not limited to:
 - Genetic testing and counseling
 - Grief counseling
 - Home care and/or hospice
 - Nutritional counseling
 - Pastoral services
 - Reference library
 - Support groups
2. Patient assessment, discharge planning, and referral should begin on the day of admission and is documented in the patient chart and/or team minutes.
3. Procedures are followed to ensure that patient needs are anticipated and managed. The process includes the mechanism to:
 - Evaluate patient needs
 - Facilitate direct access or referral
 - Monitor quality
 - Evaluate the effectiveness of the access and referral
4. Each year, three or more prevention or early detection programs are provided on-site or coordinated with other facilities or local agencies. Prevention programs use strategies to monitor attitudes and behaviors to reduce the risk of developing a malignancy.
5. Early detection discovers cancers at an early stage when the application of prompt treatment can increase survival and decrease morbidity.
6. Prevention programs include, but are not limited to:
 - Chemoprevention programs (ie, Study of Tamoxifen and Raloxifen (STAR))
 - Skin Cancer Prevention
 - Smoking Cessation
 - Smoking prevention in adolescents
7. Early detection programs include, but are not limited to:
 - Breast Care education
 - Colonoscopy, flexible sigmoidoscopy, or Hemoccult stool testing.
 - PAP testing
 - Prostate exams with or without PSA testing
 - Screening mammography and clinical exams
 - Skin surveys
 - Surveillance of high-risk groups