



## Standard 2.5: Quality Improvement Plan Sample

**Subject:** Cancer Committee Quality Improvement Plan

**Department:** Cancer Program

**Policy #:** 13990

**Original Policy Date:**

**Effective Date:** 9/15/06

### **Purpose:**

The purpose of the Quality Management and Improvement Plan is to ensure that the Tumor Registry of XYZ Regional Medical Center demonstrates a consistent endeavor to deliver optimal care in an environment of minimal risk. The Quality Management and Improvement Plan allows for a systematic, coordinated, and continuous approach to improving performance by focusing on the processes and mechanisms that address these values.

### **Policy:**

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes, and mechanisms that comprise performance improvement activities. This program, established by XYZ Regional, with support and approval from the Medical Staff, has the responsibility for monitoring every aspect of patient care, relating to the treatment of malignant diseases, in order to identify and resolve any breakdowns that may result in suboptimal patient care and safety, while striving to continuously improve and facilitate positive patient outcomes.

### **Quality Improvement Priorities:**

1. Assure that diagnostic or therapeutic procedures are performed for clinically valid reasons.
2. Assure that health care services are accessible and available to all segments of the population who have need of them.
3. To work toward the goal of increased desirable outcomes.
4. Assure appropriate, accurate, and complete documentation of the clinical care process.
5. Focus on providing appropriate and timely consultation, diagnosis, follow-up of findings and tests, and timely referrals to assure continuity of care.
6. Provide for concise compilation of information that will be of value to other organizations, including reference databases.
7. Provide for established criteria that allow for setting of priorities for improvement activities. Such priorities will be based upon assessment of opportunities for improvement, and/or on the need to reduce or eliminate undesirable change in performance.
8. Assure that effort is made to provide care that is sufficient to assure patient cooperation and satisfaction.
9. Assure compliance with the requirements of all federal, state, and accrediting agencies in regard to quality assessment and performance improvement activities.

### **Responsibilities:**

The Tumor Registrar will be responsible for coordinating the Quality Management and Improvement Plan, and will assemble criteria, standards, professional literature, statistics from reference data banks, and whatever information is necessary to enable the Committee to evaluate their performance, to plan improvements in patient care, and to implement such improvements. The Tumor Registrar will use the following sources to identify opportunities for improvement:

- Comparative survival and outcome data
- Issues of institutional, regional, or national importance
- Patient/family satisfaction surveys
- Unacceptable or unexpected results found during routine quality monitoring by the various departments of the hospital
- Unexplained variations from established treatment guidelines

The Chairman of the Committee will be responsible for:

- Directing the evaluation of the information by the committee members
- Providing guidelines for prioritizing improvement opportunities in accordance to their impact on Improving patient care
- Final selection of the focus of studies of quality

### **Evaluation of the Plan:**

The Cancer Committee will perform an annual evaluation of the Quality Management and Improvement Plan to determine the effectiveness of the plan. The following areas will be evaluated:

- Selection of focus for studies of quality were appropriate to our specific site and practice patterns
- Indicators for monitoring were appropriate to identify the high risk, high volume, and problem prone areas of patient care
- Effectiveness of process for providing information to the community regarding issues of availability of care, and access to care
- Statistical information relating increase in desirable patient outcomes, and effectiveness of the roles of committee members to direct the quality management and improvement of the medical center



## **Standard 2.5: Quality Improvement Goals Sample Standard 8.1: Quality Improvement Sample**

### **ABC Regional Cancer Center Oncology Services Quality Improvement Plan 2006**

#### **Mission Statement:**

The Oncology Program at ABC Regional Cancer Center is committed to providing a full range of services for the prevention, diagnosis, treatment and support for the cancer patients and their families in our community. With our experienced physicians and staff, the Oncology Program provides a framework to promote improvements in the quality of care and services by ensuring that the most advanced treatment options are available to our patients and by assisting them and their families in coping with the physical and emotional impact of cancer.

#### **Scope of Cancer Program:**

To have available a full range of services, a functioning cancer committee, to publish an annual report, promote AJCC staging, conduct cancer conferences, maintain a Cancer Registry, coordinate programs and services with relevant community agencies, and to promote professional education for members of the cancer program team.

#### **Cancer Committee Roles/Responsibilities:**

The Cancer Committee is a multidisciplinary committee composed of board certified physicians, members from administration, nursing, social services, radiology, quality assurance, health promotions and the cancer registry.

1. To develop and evaluate annual goals and objectives for the cancer program
2. To organize, publicize, conduct, and evaluate regular educational and consultative cancer conferences that are multidisciplinary, hospital-wide, and patient-oriented
3. To make certain that consultative services from all major disciplines are available to all patients
4. To plan and conduct the required number of studies of quality annually, one to include survival data and, if available, comparison data
5. To monitor and evaluate patient care, either directly or by interaction with and review of audit data from other committees
6. To supervise the cancer registry (data system) for quality control, abstracting, staging, and follow-up
7. To make certain that a supportive care system is available for all patients with cancer, their families and staff
8. To ensure that physicians and patients have access to information on clinical trials

#### **Role of Chairman:**

The Chairman serves as the medical director for the cancer program by coordinating activities and providing guidance and evaluation of all program activities through the Cancer Committee. Performs quality case review for accurate and consistent physician staging and directs the cancer registry activities. Monitors and participates in the development of the annual report. Supports cancer program members to fulfill each of their individual duties and objectives in order to meet the program objectives.

#### **Role of Cancer Liaison Physician:**

The Cancer Liaison Physician serves on the Cancer Committee providing guidance and evaluation of program activities. Ensures that registry data, including studies and national statistics are reported to Cancer Committee. Approves registry data for the Facility Information Profile System (FIPS). Assists with quality case reviews. Coordinates activities with the hospital and the local ACS control staff.

### **Oncology Task Force Roles/Responsibilities:**

This multi-disciplinary team consists of hospital associates that are members of the Cancer Committee.  
This team:

1. Performs clinical management for the program by ensuring appropriate policies and procedures are in place within each department of the oncology service line
2. Implements quality improvement activities within each department
3. Focuses on the provision of supportive services for patients and their families
4. Assists and works in public education activities and screenings
5. Seeks and coordinates professional development for departmental staff

### **Objectives:**

Organizational dimensions of performance measures are used to determine Cancer Program objectives, these are: Operations/Financial, Clinical/Quality, Service/Satisfaction and Safety.I.

#### **I. Program**

- A. Ensure the provision of safe and quality oncology patient care by providing appropriate services and staff in accordance with our organizational quality improvement plan
- B. Achieve accreditation with American College of Surgeons Approvals Program
- C. Ensure the timely publication of the 2003 Cancer Program Annual Report, utilizing a time line.

#### **II. Quality**

- A. Complete an in-depth site analysis study for the 2003 Annual Report
- B. Implement quality improvement initiatives on any suggested topic that demonstrates the need for improvement
- C. Establish improvement priorities for the cancer program:
  - Breast Health
  - Pain Management
- D. Continue to offer community screening for prostate, skin and breast cancers

#### **III. Education**

- A. Continue to host the support groups sponsored by the American Cancer Society; continue to promote the Friend for Life program
- B. Develop an ABC Regional Cancer Center educational brochure
- C. Assist the American Cancer Society with the Fall Cancer Institute
- D. Plan to host two CME activities for staff physicians based on data generated from, but not limited to, registry data and physician reviews

**Improvement Priorities for 2003:** Breast Health and Pain Management

**Assessment of Objective Achievement:** Objectives for 2002 were met.

**Assessment of Improvement Priorities:** Improvement priorities for 2002 were met, but remain as the priorities for 2003 due to further developments in both Breast Health and Pain Management.



### **PDQ MEDICAL CENTER CANCER PROGRAM QUALITY MANAGEMENT PLAN**

The Quality Management Plan of the Cancer Program is an organization-wide, multidisciplinary effort involving various departments and disciplines.

The objectives of the cancer program are in accordance with the mission of PDQ Medical Center to provide high quality, cost-effective care to promote the health and well-being of those living in our community. These objectives include promotion of cancer prevention and screening for early detection, provision for up-to-date diagnostic, treatment and support services, and the evaluation of the effectiveness of various treatments and monitoring clinical outcomes including site-specific survival rates.

#### **Assignment of Responsibility**

Several individuals and/or groups are assigned various responsibilities to effectively manage the quality activities of the cancer program.

The *Cancer Committee* is defined as a multidisciplinary committee of the Medical Staff with ex-officio members from administration and hospital departments and services involved in the Cancer Program. Functions of the Committee are outlined in the Medical-Dental Staff Bylaws.

The *Chairman of the Cancer Committee* provides medical leadership for the Cancer Program:

- Serves as moderator for the multidisciplinary cancer conferences
- Recommends sites to be studied annually based on volume of cases, previous recommendations for follow-up studies, and identified opportunities for improvement
- Serves as physician advisor to the cancer registry
- Encourages medical staff participation of appropriate disciplines to participate in conferences and committee meetings

The *Cancer Physician Liaison* serves as an active member of the Cancer Committee and supports the Cancer Program by participating in the review and evaluation of the annual report, acts as a liaison to the Commission on Cancer, and participates in the survey process.

The *Cancer Registrar* is responsible for case-finding, accurate retrieval and data entry, and follow-up of all cancer cases in accordance with the data standards of the Commission on Cancer. Responsibilities also include providing aggregate data for the annual report and studies of quality, and also provides support for the multidisciplinary cancer conferences.

The *Performance Improvement Coordinator* supports the Cancer Program by reviewing aggregate data of the annual report and all quality studies. Data is then compiled and presented in an appropriate display format (i.e. graphs, tables) to facilitate study evaluation by the Cancer Committee. Other duties may include participating in data retrieval and summary of focused studies as requested by the Cancer Committee and/or a Medical Staff Department.

Other individuals and/or groups may be identified and assigned responsibility as appropriate to participate in quality improvement activities of the Cancer Program.

#### **Performance Improvement Process**

All aspects of the Cancer Program are continuously evaluated for opportunities for improvement. Once

an improvement opportunity is identified, the improvement process is carried out as outlined in the Organization-wide Performance Improvement Plan.



## Standard 2.5: Quality Improvement Sample

### GHI Cancer Committee Quality Management Plan

#### Purpose:

The purpose of the *Quality Management Plan* is to provide a mechanism for the continuous, prospective and retrospective monitoring of the quality of cancer care at GHI Cancer Center in order to determine current performance levels, assess the need for interventions that are aimed at reducing or eliminating undesirable outcomes and/or identify opportunities for refining existing processes.

#### Objectives:

1. To ensure objective identification, measurement and evaluation of the appropriateness, timeliness, efficiency and effectiveness of patient care, treatment and outcomes.
2. To ensure that patients are respected and care/treatment is based on individual needs.
3. To identify opportunities for continuous improvement in patient care and to ensure that actions are implemented to improve care.
4. To ensure coordination and communication of quality improvement activities with departments that treat cancer patients.
5. To ensure a continuing level of professional performance by patient care providers.
6. To ensure hospital compliance with standards set by external review agencies.
7. To guarantee compliance with regulatory bodies, including the Commission on Cancer (CoC) of the American College of Surgeons (ACoS), Joint Commission on Accreditation of Health Care Organizations (JCAHO), American College of Radiation Oncology (ACRO) and other regulatory agencies.

#### Scope of Cancer Program

The Cancer Program Quality Management Plan will be coordinated with the Continuous Quality Improvement Plan of the Medical Center. The Cancer Program Quality Management Plan will include, but is not limited to:

1. At least two (2) evaluation priorities are defined and documented annually by the Cancer Committee. A minimum of one (1) improvement priority must include improving tumor-specific patient care, treatment, and/or survival rates. Data from the National Cancer Data Base (NCDB) and other published data are used to compare medical center tumor specific survival rates.
2. At least two (2) cancer patient enhancements or improvements are documented in a twelve-month period. One or more measures of quality are defined for each enhancement/improvement. Measures relative to each improvement topic are reviewed and evaluated by the Cancer Committee at least annually. One (1) or more measures of quality are defined for evaluating practitioners compliance with treatment guidelines.

Continuous Quality Improvement studies may include:

- a. Patient satisfaction
- b. Blood and blood component administration and utilization
- c. Performance evaluations based on age appropriate care and competencies
- d. Medical Records documentation intra-disciplinary team
- e. Medical administration and utilization evaluation including adverse drug reactions
- f. Surgery case review
- g. Risk management activities
- h. Utilization management
- i. Morbidity and mortality review (Cancer Conference)
- j. CQI team results as appropriate

## Authority and Responsibilities

The **Cancer Committee** will be a multidisciplinary committee comprised of, but not limited to, representatives from surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, administration, nursing, social services, cancer registry, and quality assurance. The Committee will meet at least quarterly. Additional meetings may be scheduled as needed.

The Cancer Committee will be responsible for establishing the quality improvement priorities of the cancer program. The Committee shall define quality measures and guidelines based on current national standards as well as published literature for the treatment of cancer. The Committee will monitor compliance with treatment guidelines and report findings and recommended actions to the Quality Improvement Committee of the Medical Center. At least two studies of quality will be defined by the Committee each year. The Committee will annually assess whether improvement priorities have been achieved.

1. The multi-disciplinary cancer committee is responsible for both the governance and operations of the Cancer Program.
2. The Cancer Committee is accountable for the quality of programs and services for cancer patient care. The Cancer Committee is responsible for the integrity, integration, development, maintenance, and monitoring of the Cancer program interdisciplinary quality management plan. The Cancer Committee complies with the Medical Center's continuous quality improvement plan.
3. The Medical Director, the Program Manager of the Oncology Program, and administrative representatives provide consistent and ongoing leadership in the Cancer Program to ensure the highest quality teaching, research, and clinical care for the Cancer Program. Reports are provided to the Cancer Committee as appropriate at the scheduled meetings.
4. The Cancer Committee Chairperson and Oncology Program Manager facilitate, enable and coordinate cancer program activities with allied health care professionals, department directors and hospital administration. Reports are submitted to the Cancer Committee at scheduled meetings.
5. The Cancer Committee must be a standing committee of the medical staff. The Cancer Committee membership will include multidisciplinary physician members from diagnostic and therapeutic specialties as well as allied health professionals involved in the care of cancer patients.

The required cancer care committee responsibilities and membership composition are defined in *CoC Cancer Program Standards 2004 Revised Edition*.

The **Chairperson of the Cancer Committee** shall ensure the committee's involvement in defining, evaluating, and monitoring quality management activities. The Chairperson will be responsible for reporting the committee activities and findings.

The **Cancer Liaison Physician** of the American College of Surgeons, Commission on Cancer will assure that the quality assurance activities of the cancer program meet the standards of the Commission on Cancer.

The **Cancer Registrar** will be responsible for documenting all quality management activities of cancer committee. The Registrar will perform studies of quality designed by the ACoS Commission on Cancer with the approval and guidance of the Cancer Committee. The summarized results of national care evaluations will be reported to the Cancer Committee by the Cancer Registrar.

### **The Cancer Committee will:**

1. Ensure that the Medical Staffs *Organization and Functions Manual* provide for the information and delineation of duties and responsibilities for programmatic leadership for the cancer program.
2. Annually define key quality processes for improvement in concert with the medical center's Quality Improvement Department.
3. Ensure that all quality improvements activities are documented and reported to the Quality

Improvement Committee of the medical center on an at least quarterly basis.

4. Coordinate educational programs based on data analysis (i.e., two cancer patient enhancements).

### **Continuous Quality Monitors of the Cancer Committee**

**Goal #1            To assure timely diagnosis, to promote appropriate diagnostic procedures and to preserve appropriate referrals for treatment of cancers.**

Every new cancer case presenting to GHI Cancer Center will be discussed at the cancer conference. Each case will be evaluated for appropriate diagnosis, work-up, and treatment. If there is a question in the management of a case, a peer review form will be generated which outlines the concerns and recommendations of the cancer conference members. The peer review form is then forwarded to the Quality Improvement Department for action by the appropriate department. The outcome of each action is reported back to the committee.

**Goal #2            In accordance with guidelines established by the College of American Pathologists (CAP); and to assure complete, consistent documentation of pathologic findings for "Breast" and "Prostate" cancer are being reviewed and audited.**

The pathology reports are reviewed for completeness. A checklist has been established by the Department of Pathology in accordance with CAP guidelines; which lists criteria that should be documented within the pathology report. These findings are summarized quarterly and forwarded to the Department of Pathology for corrective action, if required

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**Goal #3            To continuously strive for early diagnosis, and improved cancer care and survival.**

Quality improvement studies will continue to be performed. Site-specific studies are requested to support our current patient care or to identify problem areas that may need to be enhanced. The results of these studies are discussed among committee members, and recommendations are made for further dissemination of results or actions to be taken.

**Goal #4            To improve the continuum of care for cancer patients which should ultimately improve patient survival.**

The Cancer Committee has agreed to follow the National Comprehensive Cancer Network (NCCN) Oncology Practice Guidelines, for the management of cancer patient that have been diagnosed and/or treatment at GHI Cancer Center. Quality measures will be defined for evaluating practitioner's compliance with these treatment guidelines.

**Goal #5            To measure long-term survival of patients with malignant tumors who are diagnosed and/or received first course of treatment at GHI Cancer Center.**

The Cancer Committee will annually designate a site-specific malignancy. Cancer Registry data will be utilized to measure treatment and survival rates. Comparison will be made to regional and/or national published data.

These studies will be published in the Cancer Program's Annual Report. Findings from this report will be used to establish future goals for patient care improvement.



## **Standard 2.5: Quality Assurance Sample**

### **JKL Health System Quality Assurance Plan - Hospital Cancer Programs**

#### **Objectives:**

The quality assurance program of the Hospital Cancer Program will serve to delineate the quality of cancer patient care

#### **Goals:**

##### **Patient Management**

1. To assure that all patients have access to consultative services in all disciplines wherever possible.
2. To assure that pre-treatment work-up and staging are accomplished in a timely, cost-effective manner in accordance with national and community standards.
3. To assure that cancer patient treatment and ultimate survival reflect a high standard of practice and are comparative to state and national outcomes.

##### **Patient Satisfaction**

The Cancer Committee will make every effort to address the needs of the patients to improve patient satisfaction and comfort. It is believed that patients with positive attitudes toward their care have increased probability outcomes.

##### **Tumor Registry**

The Cancer Committee will strive to assure that all data collected within the Tumor Registry is of the highest quality achievable in order to provide a meaningful database. This database is the essential component of all quality care reviews.

##### **Rehabilitation and Social Services**

The Cancer Committee will evaluate and assess the total care of the cancer patient, including the patient's quality of life. The availability and utilization of all rehabilitative services and social support systems will be evaluated on a regular basis to assure that resources are appropriate.

##### **Education**

The Cancer Committee shall regularly review and evaluate the needs of the professional staff. Educational topics shall be coordinated with the findings of the formal evaluations, attempting to problem focus the educational efforts. All educational offerings shall be multidisciplinary and cover the entire scope of cancer care.

Patient and community education plays an important role in the prevention and treatment of cancer. Every effort will be made to define the needs of the community and focus on prevention, screening, and rehabilitation activities.

##### **Methods**

The Cancer Committee shall be responsible for ensuring compliance with the American College of Surgeon's cancer program standards. All quality assurance functions shall be coordinated with the total hospital quality assurance program.

All evaluations shall be problem-focused, monitoring only those areas which are known or suspected to have problems.

Problems shall be prioritized according to their potential impact on patient care and outcome, their impact on efficacy of care, their frequency of occurrence, and their impact on cost-effectiveness.

Problem assessment shall be accomplished by whatever method best yields the desired results. These may include: formal audit with the pre-established criteria, process reviews, evaluations.

The Cancer Committee shall be responsible for the identification and analysis of problems. Outcome assessments and action implementation shall be referred to the appropriate medical staff committee or administrative department.

Periodic evaluation of the results of corrective actions shall be the responsibility of the Cancer Committee.

At least annually, the Cancer Committee shall evaluate and assess the effectiveness of the quality assurance program to assure that it meets the needs of the committee and the hospital. A summary of the results will be presented to the Cancer Committee and staff.

## Flow of Information in Hospital Cancer Program Patient Care Evaluation Plan

### Cancer Committee

Problem identification through profile analysis, evaluation,  
patient questionnaire, etc

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Problem analysis to identify source of problem

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Formulate action plans to correct problem

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+

+

Recommend implementation

+

+

+

Executive Committee / Administration

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+

+

Approve or modify action plan

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+

+

Implement action plan

+

+

+

Follow-up through Cancer Committee quality monitoring program



## Cancer Registry Quality Assurance Program

**Goal:** In accordance with the JKL Health System Quality Assurance Plan, the goals of the Quality Assurance Plan for the Cancer Registry are as follows:

1. To objectively and systematically monitor and evaluate the quality and appropriateness of the services performed by the Cancer Registry
2. To address any areas where the services may be improved
3. To demonstrate efforts toward resolution of identified problems

**Responsibility:** A Quality Assurance team composed of the Cancer Program Manager, a representative from the Cancer Registry Staff, and a physician consultant appointed by the hospital cancer committee will regularly plan and conduct Quality Assurance reviews. The Cancer Program Manager has the responsibility of assuring the plan is implemented and regularly reported to hospital administration and to the Cancer Committee if appropriate.

**Scope of Care:** The Cancer Registry is responsible for identifying all patients diagnosed and/or treated for cancer or Central Nervous System neoplasia at JKL Health System. The records of these patients are abstracted with pertinent data including demographics, cancer identification, treatment, and subsequent follow-up entered into the database.

**Important Aspects of Care:** The data collected by the Cancer Registry is used to monitor the care of the patients seen at JKL Health System as compared to national, regional and local statistics. The data may also be used to monitor need for increase in cancer services and administrative decisions regarding the increase of services.

The data is also used by the medical staff as a basis for research projects and development of materials for publication.

**Implementation of System:** The committee will select the indicator to be evaluated and collect data to assess any problems. Data collected may result from but not be limited to are view of the medical record, edit checks produced by the CansurFacs software, diagnostic disease listings from the Medical Record Department, checklists, logs, and reports produced by other departments.

**Action:** When problems are identified, the Quality Assurance Committee will take steps to address the problem including assessment of who or what needs to be changed and to initiate the change.

**Follow-up Action:** After an appropriate length of time to allow for change of the problem, data collection will again be initiated to assess the effectiveness of the changes instituted. If changes are not made the problem will be reassessed.

## Overview: Flow of Data

**Pathology**  
**Radiation Oncology**  
**Diagnostic Disease Listing**  
+  
+  
**Suspense**  
+  
+  
**Abstracting**  
+  
+  
**Database**  
+  
+  
**Follow-up**  
+  
**Physician**  
**Patient Contact**  
**Studies of Quality**  
+  
**Reporting**  
+  
**Physician**  
**Administration**  
**Marketing**  
**State Registry**  
**National Cancer Data Base**

**I. The Cancer Committee Responsibilities:**

- Develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer
- Promotes a coordinated, multidisciplinary approach to patient management
- Ensures that educational and consultative cancer conferences cover all major sites and related issues
- Ensures that an active supportive care system is in place for patients, families, and staff
- Monitors quality management and improvement through completion of quality Management studies that focus on quality, access to care, and outcomes
- Promotes clinical research
- Supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting
- Performs quality control of registry data
- Encourages data usage and regular reporting
- Ensures content of the annual report meets requirements
- Publishes the annual report by November 1 of the following year
- Upholds medical ethical standards

**II. Cancer Committee Chair/Physician Liaison Responsibilities:**

- Coordinates cancer program activities through the Cancer Committee
- Oversees the Cancer Registry in order to assure maintenance of the Commission on Cancer accreditation
- Relays information from the Commission on Cancer and the National Cancer Data Base to the Cancer Committee
- Compares Cancer Registry statistics to the National Cancer Data Base for discrepancies and make appropriate changes in Casefinding procedures such as adding staff physician's office cases to the registry
- Coordinates with the Cancer Registrar the preparation and publication of the Cancer Program Annual Report
- Ensures compliance of the Commission on Cancer Standards through the Cancer Committee