

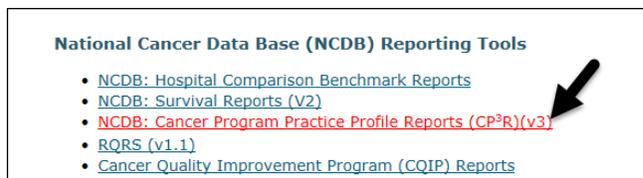
## Standards 4.4 and 4.5 Instructions Sheet

The Cancer Program Practice Profile Reports (CP3R) are important electronic tools that enable cancer programs to evaluate and improve the treatment of cancer patients and achieve better outcomes. The value of these reporting tools is fully realized if the performance rates are accurate and the tools are used to evaluate patient care. For these 2 reasons, compliance with standards 4.4 and 4.5 requires that the cancer committee evaluates the performance rates at least annually and develops an action plan to improve any performance rate that falls below the rate established by the CoC.

### Accuracy of Data Used to Calculate Performance Rates (Registry)

When reviewing the CP<sup>3</sup>R, the first consideration is to make certain that the data on which the Estimated Performance Rates (EPRs) are based is accurate. This effort is usually led by the Cancer Tumor Registrar with guidance from the Cancer Liaison Physician and should be done through the following steps.

1. Log into *CoC Datalinks* from the CoC web site, navigate to the NCDB section, and click CP<sup>3</sup>R.



2. Click through the tabs by primary site and review the EPRs for each accountability (Program Standard 4.4) and quality improvement (Program Standard 4.5) measure for each site.

Bladder Breast Cervix Colon Endometrium Gastric Lung Melanoma Ovary Rectum							
Save to Excel							
Select Measures	Measure	CoC Std / %	Estimated Performance Rates ( % )				Review
			2010	2011	2012	2013	
Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer (Accountability)	BCSRT	4.4 / 90%	98.80	100.00	98.80	97.80	
Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or stage IB-III hormone receptor positive breast cancer (Accountability)	HT	4.4 / 90%	93.20	91.80	95.80	93.20	
Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with >= 4 positive regional lymph nodes (Accountability)	MASTRT	4.4 / 90%	91.70	77.80	87.50	72.70	
Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer (Quality Improvement)	nBx	4.5 / 80%	89.30	92.40	93.00	74.30	
Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer (Surveillance)	BCS	Not Applicable	64.60	73.90	73.40	76.20	

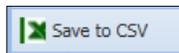
3. For those EPRs that are lower than the expected EPR established by CoC for the measure, open the case review section by clicking the measure icon in the Review column.
4. Click the number in the **Non-concordant [rRx]** row to view a detailed case listing.

Performance Rates and Reported Cases	2010	2011	2012	2013	all
<b>Estimated Performance Rates</b>	91.70 %	77.80 %	87.50 %	72.70 %	82.50 %
- Administered	75.00 %	77.78 %	87.50 %	72.73 %	77.50 %
- Considered, not administered	16.67 %	no data	no data	no data	5.00 %
<b>Performance Rate Numerator / Denominator</b>	11/12	7/9	7/8	8/11	33/40
- Administered	9/12	7/9	7/8	8/11	31/40
- Considered, not administered	2/12	0/9	0/8	0/11	2/40
<b>Cases eligible for the measure (Denominator) [Comp] + [Consid] + [rRx]</b>	12	9	8	11	40
- Concordant, treatment administered [Comp]	<u>9</u>	<u>7</u>	<u>7</u>	<u>8</u>	<u>31</u>
- Concordant, treatment considered not administered [Consid]	<u>2</u>	0	0	0	<u>2</u>
- Nonconcordant [rRx]	<u>1</u>	<u>2</u>	<u>1</u>	<u>3</u>	<u>7</u>
Cases not assessable due to incomplete tumor characteristics [I]	0	<u>1</u>	0	<u>1</u>	<u>2</u>

5. This page displays a line listing of non-concordant cases. The reason for noncompliance is in the Stat Description column. The Accession number for each case is listed to identify the patient so that the appropriate medical records can be obtained for review.

	RECORD#	MSR STAT	STAT DSCRPT
1	7532218	rRx	RT status unknown, assumed not administered, more than 365 days following diagnosis
2	200271262	rRx	Date RT started unknown, assumed started more than 365 days of diagnosis

6. A list should be created of each non-concordant case with the stated reason and the accession number. You can click Save to CSV to save the list as an Excel spreadsheet.



7. A review of the clinical records for each of these cases is performed to determine if the stated reason for non-concordance is accurate for the case, or if the non-concordance is due to missing, incomplete, or inaccurate data.
8. Records to review to verify the case data:
- Inpatient or outpatient hospital charts
  - Pathology reports
  - Cancer Conference minutes
  - Consultation reports
  - Office records from physicians to whom cancer patients were referred for treatment physicians
9. For cases in which data is missing or incorrectly entered into the abstract, the Tumor Registrar can edit the CP<sup>3</sup>R. Hover over the column header of the data item you would like to edit to see a description of available valid values for the data item.

REG LN POS	REG LN EXM	cT	cN	cM	cSTG GR	pT	pN
05						2	2A
13	20	2	3A	0	3C	2	3A

00 = All reg LN examined were negative  
 01-89 = Exact # of reg LN positive  
 90 = 90 or more reg LN were positive  
 95 = Positive aspiration or core biopsy of lymph node(s)  
 97 = Positive nodes - number unspecified  
 98 = No reg LN were examined  
 99 = It is unknown whether nodes were positive

- Click the pull-down menu to select the appropriate updated value, and click Update to save your changes.

REG LN POS	REG LN EXM	cT	cN	cM	cSTG GR	pT	pN
00	05	X	0		99	X	0
		Update		Cancel			
00	02	X	X	0	99	X	0
00	05	X	X	0	99	X	0

- Once additional information is entered and saved by the registrar, the case status will be re-categorized as either eligible ([Comp]+[rRx] or non-eligible [NE]. To view the updated cases status the browser must be refreshed.
  - Displayed EPRs and confidence intervals are updated in the CP<sup>3</sup>R application within 24 hours after case edits are completed by the Tumor Registrar.
- Any case edits made within the CP<sup>3</sup>R should also be made in the hospital registry database. Updated cases will automatically be included in the next NCDB Call for Data submission to the NCDB.
  - Return to the Performance Rates and Reported Cases page.

Performance Rates and Reported Cases	2010	2011	2012	2013	all
<b>Estimated Performance Rates</b>	91.70 %	77.80 %	87.50 %	72.70 %	82.50 %
- Administered	75.00 %	77.78 %	87.50 %	72.73 %	77.50 %
- Considered, not administered	16.67 %	no data	no data	no data	5.00 %
<b>Performance Rate Numerator / Denominator</b>	11/12	7/9	7/8	8/11	33/40
- Administered	9/12	7/9	7/8	8/11	31/40
- Considered, not administered	2/12	0/9	0/8	0/11	2/40
<b>Cases eligible for the measure (Denominator) [Comp] + [Consid] + [rRx]</b>	12	9	8	11	40
- Concordant, treatment administered [Comp]	9	7	7	8	31
- Concordant, treatment considered not administered [Consid]	2	0	0	0	2
- Nonconcordant [rRx]	1	2	1	3	7
Cases not assessable due to incomplete tumor characteristics [I]	0	1	0	1	2

- Click the number in the **Cases not assessable due to incomplete tumor characteristics [I]** row to view a detailed case listing.
- Repeat steps 4-11 for **Cases not assessable due to incomplete tumor characteristics [I]**.
  - [I] cases are cases that cannot be evaluated by the measure logic due to missing information in one or more data items assessed by the measure.
  - If known information can be located for an incomplete data item, the Tumor Registrar should enter this information and update the case.

### Standard 4.3 Cancer Liaison Physician Responsibilities

The next consideration is to use the accurate performance rates to evaluate the patient care process and make improvements if needed. This is the step in which the Cancer Liaison Physician plays a very active role. The CP<sup>3</sup>Rs are one of the reporting tools that the CLP can use to meet the requirements of standard 4.3.

#### Annual Evaluation of Accountability and Quality Improvement Measures (CLP)

After the update of any errant or incomplete data has been completed, the CLP should evaluate the performance rates for the measures using the following criteria. For a particular measure to be compliant one of the following conditions must be met:

- The program's EPR must meet or exceed the CoC Performance Rate for the measure, or

- The upper limit of the 95% Confidence Interval for the program's EPR must equal or exceed the CoC Performance Rate for the measure.

The CLP report should be produced utilizing the following steps:

before our evening engagements Log into *CoC Datalinks* from the CoC web site, navigate to the NCDB section, and click CP<sup>3</sup>R.

**National Cancer Data Base (NCDB) Reporting Tools**

- [NCDB: Hospital Comparison Benchmark Reports](#)
- [NCDB: Survival Reports \(V2\)](#)
- [NCDB: Cancer Program Practice Profile Reports \(CP<sup>3</sup>R\)\(v3\)](#)
- [RQRS \(v1.1\)](#)
- [Cancer Quality Improvement Program \(CQIP\) Reports](#)

1. Click through the tabs by primary site and review the EPRs for each accountability (Program Standard 4.4) and quality improvement (Program Standard 4.5) measure for each site. Make a table of the performance rates for each measure being evaluated.

Facility Measures		Measures Comparison		Estimated Performance Rates ( % )				Review
Select Measures	Measure	CoC Std / % ^	2010	2011	2012	2013		
Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer (Accountability)	BCSRT	4.4 / 90%	98.80	100.00	98.80	97.80		
Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or stage IB-III hormone receptor positive breast cancer (Accountability)	HT	4.4 / 90%	93.20	91.80	95.80	93.20		
Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with >= 4 positive regional lymph nodes (Accountability)	MASTRT	4.4 / 90%	91.70	77.80	87.50	72.70		
Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer (Quality Improvement)	nBx	4.5 / 80%	89.30	92.40	93.00	74.30		
Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer (Surveillance)	BCS	Not Applicable	64.60	73.90	73.40	76.20		

2. If any performance rate is low, then open the Measures Comparison tab to obtain the upper limit of the 95% Confidence Interval and record that rate in the table also.

Facility Measures		Measures Comparison		Facility minus National EPR Difference				Review
Select Measures	Measure	2010	2011	2012	2013			
Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer (Accountability)	BCSRT	6.70	6.70	6.20	5.40			
Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or stage IB-III hormone receptor positive breast cancer (Accountability)	HT	3.60	-1.20	3.70	0.70			
Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with >= 4 positive regional lymph nodes (Accountability)	MASTRT	8.90	-9.20	-2.40	-17.30			
Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer (Quality Improvement)	nBx	7.20	5.40	2.80	-16.70			
Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer (Surveillance)	BCS	2.00	10.60	10.80	13.50			
Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0, or stage IB - III hormone receptor negative breast cancer (Accountability)	MAC	-1.20	-2.10	-9.90	-10.40			

3. The main Measures Comparison window displays the difference between your cancer program's reported EPR and the reported EPR for all CoC accredited cancer programs. Highlighted differences are shown for quality improvement and accountability measures only.
  - a. A positive number highlighted green indicates that your EPR is higher than the national average (lower 95% confidence interval above the mean).
  - b. A negative number highlighted red indicates your EPR is lower than that in all CoC accredited cancer programs (upper 95% confidence interval below the mean).
  - c. Non highlighted cells indicate no difference or surveillance measures.
4. For those EPRs that are lower than the expected EPR established by CoC for the measure, note the diagnosis year(s) that are problematic, and open the EPR Comparison window by clicking the measure icon in the Review column.

Comparison To:	Diagnosis			
	EPR (%)	95% CI	# Cases	# Facilities
My Cancer Program	74.3	[65.9 - 74.9]	134	1
My ACS Division ( Eastern )	87.4	[86.8 - 88]	11414	113
My Census Region ( Middle Atlantic )	89.6	[89.2 - 90]	18847	186
My CoC program Type (VACP)	91.5	[91.2 - 91.8]	34788	239
My State ( XX )	87.2	[86.4 - 88]	6437	68
All CoC Approved Programs	91	[90.8 - 91.2]	125904	1432

5. When the EPR for a measure appears to be non-compliant, review of the 95% confidence intervals (CI) for your cancer program's EPR is necessary.
  - a. If the upper bound of your cancer programs' CI is higher than CoC Standard's EPR your program's EPR would be deemed compliant.
    - i. Although you may have non-concordant cases, and your EPR is below CoC Standard's EPR, if the upper bound of your program's CI is higher than the CoC Standard's EPR the measure your program's EPR would still be considered compliant with the standard.
    - ii. Another item to note when reviewing the EPRs is that the larger the CI the less robust the data are, and small numbers result in a large CI.
  - b. If the upper bound of your cancer programs' CI is lower than the CoC Standard's EPR your program's EPR would be deemed non-compliant.
    - i. In the example shown, the program's EPR is 74.3% (lower than the CoC Standard's EPR of 80% for the measure). The upper bound of the CI is 74.9%. As a result, this program would be considered non-compliant with the standard.
6. Generate a table consisting of each measure that must be reviewed for compliance. The data to include would be the CoC Standard's EPR for the measure, your program's EPR, the 95% CI, and whether or not your program is compliant with the Standard for the measure.

**An example table of compliance rates:**

Measure	CoC Standard's EPR	Program's EPR	Program's EPR 95% CI	Compliant
BCSRT	90%	96.8%		Yes
12RLN	85%	72.5%	66.7 – 100 %	Yes
HT	90%	66.7%	44.5% - 78.9%	No

7. This table is part of the data portion in the CLP report on the CP<sup>3</sup>R results.

8. If there are measures on the list for which the performance rate is below the CoC Standard's EPR, and the upper bound of your cancer programs' CI is lower than the CoC Standard's EPR an individual case study would be required to determine the cause of non-compliance.
9. To perform the individual case study, return to the Facility Measures tab and open the case review section by clicking the measure icon in the Review column.
10. Click the number in the **Non-concordant [rRx]** row to view a detailed case listing.

Performance Rates and Reported Cases	2010	2011	2012	2013	all
<b>Estimated Performance Rates</b>	89.30 %	92.40 %	93.00 %	74.30 %	86.43 %
<b>Performance Rate Numerator / Denominator</b>	50/56	85/92	80/86	78/105	293/339
<b>Cases eligible for the measure (Denominator) [Comp] +[rRx]</b>	56	92	86	105	339
- Concordant, treatment administered [Comp]	<a href="#">50</a>	<a href="#">85</a>	<a href="#">80</a>	<a href="#">78</a>	<a href="#">293</a>
- Nonconcordant [rRx]	<a href="#">6</a>	<a href="#">7</a>	<a href="#">6</a>	<a href="#">27</a>	<a href="#">46</a>

11. This page displays a line listing of non-concordant cases. The reason for noncompliance is in the Status Description column (STAT DSCRPT). The Accession number for each case is listed to identify the patient so that the appropriate medical records can be obtained for review.

MSR STAT	STAT DSCRPT
rRx	No evidence of a biopsy (incisional, needle, aspiration) to the primary
rRx	No evidence of a biopsy (incisional, needle, aspiration) to the primary

12. From the individual case studies of non-concordant cases, a table should be created which lists the reason for noncompliance for each measure. This table is also part of the data portion in the CLP report on the CP<sup>3</sup>R results.

**An example table of results from individual case studies for non-concordant cases:**

Measure	Total number	Standard of care treatment not administered	Standard of care treatment administered later than treatment expectation timeframe	No evidence of needle biopsy
HT	21	3 cases	4 cases	
nBx	20			5 cases

## CLP Study Report

The CLP should generate a report from the measure review processes described above. The report should consist of 6 sections: Title, Topic of study, Purpose of study, Data, Conclusion, and Recommendation.

### Compliance on all measures:

If all of the measures are found to be compliant with the required performance rates then no problem exists. The report would contain the table of the measures and performance rates with a concluding statement that each measure is compliant and there is not a need for further study.

The report would be prepared in the following format as a word document or power point presentation:

- **Title:** Standard 4.3 CLP Report for the annual review of performance rates of the accountability and quality improvement measures.
- **Topic of study:** Name of the measures
- **Purpose of study:** To evaluate compliance with required performance rates.
- **Data:** The table listing the measures and the performance rates
- **Conclusion:** Each measure is in compliance.
- **Recommendation:** No action is required.

**Non-compliance on one or more measures:**

If there any measures are identified as non-compliant, the Data section of the report will consist of 2 parts:

- The entire table of performance rates for all measures and
- The table of non-compliant measures with the reason for noncompliance for each measure

For each non-compliant measure that is studied, a report should be made in the following format:

- **Title:** Standard 4.3 CLP Report for the annual review of performance rates of the accountability and quality improvement measures.
- **Topic of study:** Name of the non-compliant measure studied.
- **Purpose of study:** To identify reasons for low performance rate.
- **Data:** the table containing the number of cases reviewed and list of reasons for non-compliance
- **Conclusion:** The performance rate is non-compliant for the following reasons and needs to be improved.
- **Recommendation:** Further study to determine factors that caused the treatment to be omitted or delayed beyond the critical time, inadequate pathologic examination of lymph nodes or reason needle biopsy was not done.

The compliant and non-compliant measures can be combined into 1 report.

Although it is not required, it is highly recommended to include a measures comparison study for the accountability and quality improvement measures in the data section of the report. It would be very important especially with non-compliant measures to demonstrate the need to improve the performance rates. The comparison data could be incorporated into the Action Plan.

To obtain the comparison data follow these steps:

- Click on the Measures Comparison tab.
- Click through the site tabs to select a particular measure.
- To obtain comparison data click on the review file for a specific measure.
- Then select the year for which comparison data is wanted.
- Note the comparison rates between your facility and each of the categories.

**Action Plan for Accountability and Quality Improvement Measures with Unacceptable Performance Rates**

The Cancer Committee minutes would document:

1. The findings of the study including the measure comparison data.
2. The study plan to determine factors that contributed to the low performance rates. Sources of information would include:
  - a. A list of each non-concordant case with the stated reason and the accession number
  - b. Records for each case

- Inpatient or outpatient hospital charts
  - Pathology reports
  - Cancer Conference minutes
  - Consultation reports
  - Office records from physicians to whom cancer patients were referred for treatment physicians
  - Individual patient interviews
3. Formulation of the action plan to correct the low performance rate would be attached to the minutes and uploaded into the PAR in standard 4.4 and 4.5.
  4. A plan to restudy the measure to verify effectiveness of the action plan.

## **Conclusion**

There are a variety of ways that the CP<sup>3</sup>Rs can be used by a program to study, evaluate patient process, and plan for process improvements.

1. Evaluating the accuracy of the performance rates can identify problems related to the data collection process. By identifying this as the cause for the low performance rate, the cancer committee can initiate a collaborative effort to improve data gathering from both inside and outside the organization. Under the direction of the cancer committee, this collaborative effort often involves the CTR, CLP, and a program administrator.
2. Reviewing the cases listed as incomplete tumor characteristics can have several benefits depending upon whether it is a data collection issue, a misinterpretation of the data, an oversight, or the data item is missing from the pathology report. A review of these cases will ultimately lead to more timely and accurate data entry, more complete pathology reports, and more accurate performance rates, and more patients being considered for optimal care.
3. An established process for evaluating the performance rates will have the positive effect of demonstrating high quality care in a number of sites and provide positive feedback to medical and nursing staffs. The review can also identify areas for improvement and stimulate the formulation of an action plan to improve performance rates when it is needed.
4. The Veteran Affairs Cancer Programs also have the ability to compare their performance rates with the aggregate rates for the other VACPs. This can be very valuable information for the program and the hospital administration. It will demonstrate areas of excellence and also provide the cancer committee and the hospital administration with identified areas for patient care improvement. It is recommended to the CLPs to include measures comparison studies in their reports.