



OVERVIEW

Cancer Program Practice Profile Report (CP³R), version 3

Introduction

The success of the Commission on Cancer's (CoC) Cancer Program Practice Profile Reports (CP³R) have demonstrated that improvements in data quality and patient care are possible when the entire cancer committee supports system level enhancements to ensure complete and precise documentation.

Measure Development

The Commission on Cancer (CoC) of the American College of Surgeons (ACoS) submitted quality of care measures for breast and colorectal cancer to the National Quality Forum (NQF) in response to its call for proposed breast measures in late 2004 and colorectal measures in early 2005. More information on this process can be found at <https://www.facs.org/quality-programs/cancer/ncdb/qualitymeasurescocweb>.

The Quality Integration Committee (QIC) of the CoC partners with internal and external clinical experts to develop quality measures. The development and approval of quality measures encompassing multiple primary sites relies on the specialized expertise of members of the QIC and CoC Member Organizations. The currently reported gynecologic measures were developed in the conjunction with the Society of Gynecologic Oncology (SGO). Additionally, the QIC is collaborating with experts from the Society of Surgical Oncology (SSO) and the Society of Urologic Oncology (SUO)/ American Urologic Association (AUA) on quality measures.

Current Measures

CP³R, reports estimated performance rates with 23 quality measures, from 10 primary sites including breast, colon, rectum, lung, cervix, gastric, ovary, endometrium, bladder, and kidney.

Detailed measure specification documents are found on the CoC Quality of Care Measures Page at <https://www.facs.org/quality-programs/cancer/ncdb/qualitymeasurescocweb>

CoC Quality of Patient Care Reports

The CP³R(v3) provides feedback to our programs to:

- Improve the quality of data across several disease sites;
- Foster pre-emptive awareness to the importance of charting and coding accuracy;
- Improve clinical management and coordination of patient care in the multidisciplinary setting.

In addition, the CP³R has been specifically incorporated into the CoC 2020 Program Standard 7.1 where each year cancer committees are required to review the quality of patient care using the CP³R to evaluate care within and across disciplines, to discuss successful processes, and to evaluate how processes can be improved to promote evidenced-based practice. The cancer committee is expected to address performance rates that fall below specific thresholds established by the CoC. Evidence of this monitoring activity should be documented in the cancer committee minutes and reflected in the CoC quality reporting tools.

The CP³R is accessed via CoC Datalinks, and provides individual-level case summary reports for cancer cases, as transmitted to the NCDB by each CoC accredited cancer program.

The CP³R(v3) for the ten cancer sites is directed toward assuring the completeness of data for the cancer patients recorded in each cancer program's registry as a central means to facilitate accurate comparisons of clinical performance among CoC accredited cancer programs. The CP³R(v3) provides a case-by-case review of cancer cases reported to the NCDB and identifies cases that lend themselves to the evaluation of concordance for each of the measures.

Supporting documentation

A [user guide](#) of CP³R describes the information found in the system and how to interpret the CP³R.

Relating Data to Quality Measurement and Improvement

Every year, following call for data term, NCDB uploads the most recently submitted data into CP³R. In addition, the registrars have an option to update the data items within CP³R manually at the same time when they update the same items in their database; the manual update immediately impacts the eligibility criteria and case status, and provides the description on the current case status against the compliance with standard treatment. Following the updates, the Estimation Performance Rate (EPR) reflects the change immediately, and the comparative EPR as well as Confidence Interval (CI) reflect the change within 24 hrs.

The following table provides an overview of the types of issues frequently observed in breast and colorectal cancer cases, and identifies the implications of incomplete data and the potential impact this has on measuring and reporting quality of patient care.

Table 1 Relating CP3R Data to Quality Measurement and Improvement

Complete vs. Incomplete Data		Implication	Action
Complete Data – complete tumor identification and treatment data available.		Patients treated according to standard of care guidelines.	Programs may wish to examine the processes that guide administration of quality care for this disease, and determine if similar methods can be employed in other areas of cancer care requiring improvement.
		Eligible patients failed to receive standard of care therapies, or documentation regarding treatment indicates unjustified, suboptimal therapies administered.	Programs should investigate reasons for variations from standard of care.
Incomplete Data – complete tumor identification data but treatment data are questionable or incomplete	Incomplete tumor size, regional lymph node status, or hormone receptor (ER / PR) status.	Cases cannot be assessed for measurement if these data are missing or incomplete. Determination of appropriate treatment cannot be made without complete tumor identification.	Develop QI processes and tools to uncover root causes of incomplete or missing data. Example: form letter from surgeon or registrar to pathologist or lab to ensure accurate tumor characteristics/ HR status are documented and abstracted into the cancer registry.
	Incomplete treatment information.	Determination of adherence to standards of care cannot be made in the absence of accurate and complete treatment information.	Provide QI tool to uncover root causes of missing data. Example: form letter from program cancer committee physicians to ensure accurate and complete treatment information is documented and abstracted into the cancer registry.

Patient Confidentiality and HIPAA Compliance

The Cancer Program Practice Profile Reports (CP³R) has been implemented for the purpose of fostering quality improvement at cancer programs awarded Commission on Cancer (CoC) Accreditation. This activity falls within the scope of the American College of Surgeons (ACoS) Business Associate Agreement and the HIPAA, Administrative Simplification Act (CFR §164.501 and is consistent with the applicable requirements of CFR §164.514).

No patient identifiers (e.g. name, social security number, address) were collected in order to generate this CP³R. This CP³R merely uses an existing data collection scheme, analyzes the performance of the individual cancer program relative the standard of care for selected cancers, provides aggregate feedback for comparison with similar CoC accredited cancer programs, uses the survey process as an active form of intervention, to provide suggestions as to ways to assist each cancer program with implementing mechanisms to foster ongoing quality improvement cancer patients.

A data use agreement is in place between the American College of Surgeons and each of the hospitals whose cancer program registry data were used to create and develop this CP³R. This agreement exists in

order for the CoC to meet the business associate obligations rendered to participating programs (45 C.F.R. § 164.514(e)(4)). The evaluations and analyses of the data become the foundation of the quality improvement process for these cancer programs, a requisite for maintaining CoC Accreditation. Both of these functions fall under the rubric of health care operations as defined by the HIPAA regulations (CFR §164.501) and are within the scope of the CoC Business Associate Agreement signed by these hospitals.

Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment (CFR §164.501).