CAnswer Forum LIVE
August 18, 2021
Webinar Logistics

- All participants are muted during the webinar
- Questions – including technical issues you may be experiencing – should be submitted through the question pane
- Questions will be answered after the webinar and will be posted with the recording.
- Please complete the post-webinar evaluation you will receive via email
- Recorded content will be posted in the ACS Learning Management System following the live presentation
Introducing Our Moderator

Frederick (Rick) Greene, MD, FACS
Panelists

Elliot A. Asare, MD, MS, CMQ
Assistant Professor, Surgical Oncology
University of Utah, Salt Lake City, UT

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Lead Tumor Registrar, Tumor Registry
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Agenda

• Introductions
• Panelist Discussion
  • Quality Improvement
  • Meeting CoC standard 7.3
  • Review QI Template

• Questions and Answers
• Marketing/Promotion Resources
• Upcoming Activities
• Adjourn
### Quality Improvement Initiative - 2020

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<th>Study title</th>
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<td>Date the quality improvement initiative was completed (mm/dd/yy)</td>
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<tr>
<td>Problem statement (including baseline and goal metrics and anticipated timeline)</td>
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<td>How problem was identified</td>
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<td>Quality improvement initiative team members</td>
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<td>Performance improvement tool</td>
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<td>Analysis of data (identifying all possible factors contributing to problem (e.g. root cause))</td>
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<td>Results</td>
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<td>Comparison to national data (if available)</td>
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<td>Intervention implemented</td>
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<td>Results of implemented intervention</td>
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<td>Planned next steps (as appropriate)</td>
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<tr>
<td>Dates of status updates reported to cancer committee (mm/dd/yy)</td>
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**Example:**

- **Study Title:**
  - Improve patient care responses to pain.

- **Date the quality improvement initiative was completed:**
  - 05/30/2020

- **Problem statement:**
  - Baseline: 50% of patients report moderate to severe pain with no reported pain management plan.
  - Goal: 80% of patients report adequate pain management by 07/30/2020.

- **How problem was identified:**
  - Through patient surveys and provider feedback.

- **Quality improvement initiative team members:**
  - Provider, nurse, pharmacist, social worker.

- **Performance improvement tool:**
  - Visual feedback dashboard.

- **Analysis of data:**
  - Pain management interventions increased by 20%.

- **Results:**
  - 85% of patients report adequate pain management by 07/30/2020.

- **Comparison to national data:**
  - National average is 70%.

- **Intervention implemented:**
  - Increased availability of pain medication.

- **Results of implemented intervention:**
  - 90% of patients report adequate pain management by 07/30/2020.

- **Planned next steps:**
  - Conduct follow-up surveys to assess long-term effects.

- **Dates of status updates reported to cancer committee:**
  - 06/10/2020, 07/15/2020, 08/15/2020.
Questions and Answers
**Standard 7.3 Quality Improvement Initiative**

We have four cancer committee meetings annually, one each quarter. At the first meeting we decide what quality improvement initiative we will be working on. Our cancer committee would like to know about updates - do we need to give two updates of QI initiatives in two meetings before the final meeting in the last quarter or is the last quarter meeting is considered as giving updates? Our committee is thinking we should give two updates before the final presentation. Can you please clarify?

**Answer:**
The meeting in the last quarter can be considered one of the updates.
**Standard 7.3 Quality Improvement Initiative**

Is the cancer committee required to vote on the quality improvement initiative?

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**Answer:**
The standard does not require that the cancer committee vote on their QI. How this is selected would be up to the discretion of the program.
Standard 7.3 Quality Improvement Initiative

The first step for Std. 7.3 is to review data to identify the problem. For 2021 we identified our problem from the annual evaluation of Standard 5.2 psychosocial distress screening. Does this satisfy the step of review data to identify the problem?

Answer:
Yes, based on what you have described this could be sufficient. Annual review of other clinical services required by CoC standards is a good place to identify a problem to study for the QI initiative. We are not able to preapprove studies/topics and the full study would need to be reviewed in order to determine compliance.
Standard 7.3 Quality Improvement Initiative

In the template for Std 7.3 in the “analysis of data” field should we include the analysis of data that was reviewed to identify the problem?

Answer:
The analysis of data reviewed to identify the problem would go in the "how problem was identified" section of the template.
**Standard 7.3 Quality Improvement Initiative**

Is it acceptable for the "Alternate" CLP to be the "Primary" Quality Improvement Coordinator? Does the Cancer QI coordinator need to be a physician?

**Answer:**
The Quality Improvement Coordinator can be the CLP or another member of the Cancer Committee. The Quality Improvement Coordinator is not required to be a physician.
Standard 7.3 Quality Improvement Initiative

In 2020 we did not complete our QI project, which was establishing a department wide chemotherapy consent form. Are we noncompliant if we didn't end up getting the consent approved? Does it make a difference if it came down to hospital risk management not allowing it?

Answer:
According to Standard 7.3, your QI project can be extended for a second year, but you will need to select a new initiative for the following year. You will need to provide a detailed status update to the cancer committee at the last meeting of the first calendar year. Please make sure that your studies are based on an identified quality related problem.
Standard 7.3 Quality Improvement Initiative

Our research staff has asked if we can do a study on staging of patients who have surgery only. The patients who have surgical treatment only and are not seen by medical and/or radiation oncology are not always staged. Would this count as a study for 2021?

Answer:
You need to make sure that the Quality Improvement Initiative is based on a problem within your program. An analysis must be conducted to see if there is a problem that warrants a quality improvement initiative. If you have a problem statement around surgical treatment only and problems with missing staging, this could be a reasonable topic. Of course, all the elements would need to be met for the QI Initiative.
Standard 7.3 Quality Improvement Initiative

Similar questions

Q1. Our institution conducted an in-depth data analysis on the use of our distress flowsheet (psychosocial distress screening tool) over a five-year period. The results showed a sub-optimal usage percentage, so we decided to use this as our S7.3 QI for 2021. The standard notes "problems identified through annual review of clinical services in other CoC standards." qualifies. So, we are wondering if it would be acceptable to use the psychosocial distress screening improvement for S7.3 (keeping in mind that in and of itself psychosocial distress screening is a standard)?

Q2. Under Standard 7.3 section it reads that another standard can be used for the QI initiative, correct? Can we use the Standard 9.1 as the basis for our QI initiative.

Answer:
Yes, the problem you discovered can be used as the basis for Standard 7.3. Problems identified through review of other standards can be used for this standard.
**Standard 7.3 Quality Improvement Initiative**

Our Cancer Program is looking at excessive inpatient days for our oncology patients. We have been gathering data to see expected inpatient days vs. actual in-patient days and re-admission rates as well. We are then doing a chart review to determine root-causes of excessive inpatient days and re-admissions. Would this qualify as a good QI for standard 7.3?

**Answer:**
From the limited information you have shared this could comply with the 7.3 requirements. Please make sure you use the required 7.3 template and provide all the documentation that is requested. No since we do not preapprove study topics these make me uncomfortable
Standard 7.3 Quality Improvement Initiative

With approval from our cancer committee, a sub-committee has been reviewing data on the delay in treatment times for patients receiving concurrent chemoradiation therapy.

We believe some of the delays could be avoided by shifting the current Radiation Oncology simulation planning times to better align with Medical Oncology, thus avoiding cancellations and rescheduling.

Answer:
Your first statement could be considered a problem statement that needs to be studied. However, if you have determined your improvement without completing the study using one of the PI tools and root cause analysis, it would not meet the standard. Make sure that all the components of the Standard 7.3 template are addressed.
Standard 7.3 Quality Improvement Initiative

Do we need to provide a QI report in addition to completing the template? We will still report in the minutes as well.

Answer:
The quality improvement initiative is to be recorded on the CoC template for each year and submitted for survey and documented in the minutes. Additionally, the required components of the reporting to the committee are included in the standard. The CLP or the QI Coordinator must provide updates to the cancer committee on the QI initiative at least twice each year. The second report can be the summary report required by the standard. The reports must be documented in the minutes.


**Standard 7.3 Quality Improvement Initiative**

The standard states the CLP or the Quality Coordinator must report out to the committee at least two times during the calendar year. Does it have to be either the CLP or Quality Coordinator? If the Program Administrator and Survivorship Coordinator are taking the lead on the project. Can they then present the report?

**Answer:**
To meet the intent of the standard the Quality Coordinator or CLP should introduce the topic to the Cancer Committee and then turn over the presentation to the others to present the work.
Standard 6.1 Quality and Outcomes

Can a study for Standard 6.1 relate to another NAPBC standard?

Answer:
A study cannot be conducted solely for purposes of meeting a NAPBC standard. For example, a study cannot be done to make sure that required multidisciplinary attendance is met for the Multidisciplinary Breast Care Conference. But a study could aim to enhance upon how a program meets the requirements of a standard.
Standard 6.1 Quality and Outcomes

Does a study need to be completed within one year?

Answer

No. As necessary, a study may extend into a second year. However, the center still needs to start at least one new center-specific quality study and one physician, specialty-specific quality improvement program OR two center-specific quality studies each year even if the study from the previous year is still ongoing.
Standard 6.1 Quality and Outcomes

Can studies be almost the same topics for consecutive years?

Answer:
No, studies need to be on different topics.
Standard 6.1 Quality and Outcomes
Questions on a similar theme

Q1. Does participation in the CMS's Oncology Care Management Program count as a physician specialty specific quality improvement program?

Q2. Can the Breast Module QOPI be used for a study?

Answer:
See the next slide
Answer:
Yes, QOPI can be used as physician participation in a specialty-specific quality improvement program, but CMS's Oncology Care Management Program cannot be used for this purpose.

Please note that: "For specialty-specific quality improvement program to qualify, a summary of the data over the past year or time of study must be presented to the BPLC and the data must be breast specific."

Specialty-Specific QI programs
• The American Society of Breast Surgeons Mastery of Breast Surgery℠ Program
• ASCO's Quality Oncology Practice Initiative (QOPI®)
• ASPS Tracking Operations and Outcomes for Plastic Surgeons (TOPS)
• The American College of Surgeons Surgeon Specific Registry (SSR)
• ASTRO Radiation Oncology Incident Learning System (RO-ILS)

Answer:
Yes, QOPI can be used as physician participation in a specialty-specific quality improvement program but CMS's Oncology Care Management Program cannot be used for this purpose.

Please review the other information on the slide.
Resources to Publicize your Accreditation

- Dedicated websites for the CoC, NAPBC, and NAPRC with the resources you need
  - CoC – access via CoC Datalinks
  - NAPBC and NAPBC – access via the respective portal

**CoC Resources**
- 2021 Accreditation Fee Chart
- 2022 Accreditation Fee Chart
- Accreditation Fee FAQ (updated 8/2021)
- CoC COVID-19 Accreditation Tracker 2021
- CoC COVID-19 Accreditation Tracker (Example)
- CoC COVID-19 Accreditation Tracker 2020
- Regulated Documents for the Pre-Review Questionnaire (PRQ) (updated 11/25/20)
- Accountability and Quality Improvement Measures for 2022
- Site Reviews
  - 2020 Surveys: Important Changes to CoC Standards for Accreditation
  - Resources to Market CoC Accreditation
  - NCCN/ACR/DCC Joint Public Webinar Series
  - Site Reviewer Profiles
  - Cancer Programs Categories
  - Find a CoC-Accredited Cancer Program

**Marketing Resources**

**NAPBC**
- Site Visit Resources
  - Preparing for the Site Visit
  - Sample Site Visit Agenda
  - Virtual Site Visit Webinar Recording (September 2020)
  - Site Visit Review Timeline
    - Pre-Radio Questionnaire (PRQ) PDF
    - Required PRQ documents for initial site visit
    - Internal Audit Template
    - Site Reviewer Profiles
    - Site Visit Experience Survey (to be completed within 14 days of a site visit)
    - Site Visit Evaluation
    - Site Visit Review Timeline
    - Site Visit Action Plan Template
    - Appeal

  - Marketing Resources (for programs with "Accredited" status only)

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Resources to Publicize your Accreditation

- Resources include:
  - Press release
  - Accredited program logos
  - Artwork for poster and banners
  - Patient brochures on the value of accreditation
  - Posters for recognition month
  - Social media artwork
  - E-mail signature

Answer

We recommend reviewing the required elements in the Standards manual. A good start is writing it out using the required CoC template, to determine if it meets the SMART criteria.
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<th>Upcoming Webinars</th>
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| **Pelvic MRI for Rectal Cancer: Tips on Interpretation**  
Tuesday, September 14, 2021, at 5 pm CDT |
| **Assisting Centers with Meeting the Special Needs of Patients with Metastatic Breast Cancer**  
Wednesday, October 6, 2021, at 12 pm CDT |
| **CAnswer Forum LIVE – October 2021**  
**Topic:** *RCRS 1 year later: What we have learned and where we are going*  
Wednesday, October 13, 2021, at 12 pm CDT |
| **CAnswer Forum LIVE – December 2021**  
**Topic:** STORE changes for 2022  
Wednesday, December 15, 2021, at 12 pm CDT |

Webinar information and registration is located:
https://www.facs.org/quality‐programs/cancer/events

Cancer Programs Newsletter - Register
https://www.facs.org/quality‐programs/cancer/news

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