Optimal Resources for Cancer Care

2020 Standards Webinars

General Information

Cancer PROGRAMS
AMERICAN COLLEGE OF SURGEONS

Effective January 1, 2020

Review all information in the manual

- Address changes to Accreditation process
- New terms defined in glossary
- Specifications by category

Access the 2020 Standards and Resources page for more information on the standards and upcoming activities

https://www.facs.org/quality-programs/cancer/coc/standards/2020

6

Data Surveillance and Systems

Rationale

- **High-quality data** from accredited programs critical to
  - Inform quality improvement
  - Measure the performance

- All required cases must be submitted to the **National Cancer Database (NCDB)** using nationally standardized data item and coding definitions

- Data are validated through multiple mechanisms that are continuously updated to optimize the quality of the data collected

6.1 – Cancer Registry Quality Control

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Scope of the Standard

- High-quality cancer registry data are essential to accurately assess treatment outcomes and patient survival
- Cancer committee
    - Evaluates the quality of cancer registry data and activity, including each required control component

- **Cancer Registry Quality Coordinator** works with registry staff and other applicable departments to implement the quality control policy and procedure
- Coordinator responsibilities:
    - Monitors each area of cancer registry activity
    - Recommends corrective action if any area falls below the measures specified in the plan
    - Reports results, recommendations and outcomes to the cancer committee **at least annually**

6.1 – Cancer Registry Quality Control

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Scope of the Standard

- The quality control policy and procedure includes the following, at a minimum:
    A. Sets the review criteria
    B. Sets the quality control timetable
    C. Specifies the quality control methods, sources, and individuals involved. Specifications include:
        - Random sampling of annual analytic caseload
        - Review by designated person(s)
            - Reviewer(s) may be CTR(s), Advanced Practice Registered Nurse(s), Physician Assistant(s), physician(s), fellow(s), or resident(s)
            - CTRs cannot review their own cases
        - External audits may be used to fulfill part of this requirement

6.1 – Cancer Registry Quality Control

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Scope of the Standard

D. Identifies the activities to be evaluated for all cases each year:
   - Case finding
   - Abstracting timeliness
   - The percentage of information coded as unknown

E. Identifies the activities to be evaluated each year for accuracy
   - A review of **a minimum of 10 percent** of the annual analytic caseload (up to **200** cases annually) is required each year for the accuracy of the following:
     1. Class of case
     2. Primary site
     3. Histology
     4. Grade
     5. AJCC Stage or other appropriate staging system as appropriate for cancer site
     6. First course of treatment
     7. Follow-up information, specifically:
        - Date of first recurrence
        - Type of first recurrence
        - Cancer status
        - Date of last cancer status

6.1 – Cancer Registry Quality Control

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Scope of the Standard

F. Establishes the minimum quality benchmarks and required accuracy. Cancer registry data submitted to the NCDB meet the established quality and timeliness criteria included in the annual NCDB Call for Data.

G. Maintains documentation of the quality control activity:
   - Review criteria
   - Cases reviewed
   - Identified data errors and resolutions
   - Reports the percentage of accuracy to the cancer committee annually of the review of elements listed in sections D and E.
   - Documented in the cancer committee minutes.

6.1 – Cancer Registry Quality Control

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- Quality Control **Exceptions:**
  - Patient data reviewed under the cancer registry quality control plan for Standard 6.1 cannot be used as an in-depth analysis review for compliance to Standard 7.2: Monitoring Compliance with Evidence-Based Guidelines.

6.1 – Cancer Registry Quality Control

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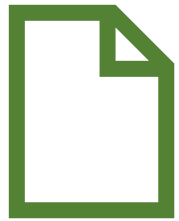
- **Pre-Review Questionnaire (PRQ)** documentation
  - Quality control **policy and procedure** including
    - Process for resolving conflicts identified during the quality control review
  - **External audit reports**
  - **Cancer committee minutes**



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6.1 – Cancer Registry Quality Control

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Compliance:

1. The cancer committee implements a quality control **policy and procedure** to evaluate the required areas of the cancer registry.
2. The Cancer Registry Quality Control Coordinator, under the direction of the cancer committee, performs or oversees the required **quality control review** as outlined in the policy and procedure.
3. The results, recommendations, and outcomes of recommendations are reported to the cancer committee and documented in the **cancer committee meeting minutes**.

6.2 – Data Submission

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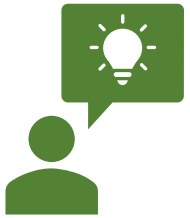
- Data submitted to the NCDB **provide feedback** to assess the quality of patient care



Scope of the Standard

- **Each calendar year**, complete data for all requested analytic cases are submitted to the NCDB in accordance with the annual Call for Data
  - Data submission to the NCDB must be performed by using the Commission on Cancer's secure online data submission application in accordance with the annual Call for Data specifications.

- Notes for new programs
  - Data submitted to NCDB after the initial site visit and accreditation is awarded
  - Submit data for all applicable years currently accepted by the NCDB
  - Submit all analytic cases for any diagnosis years beginning with its Reference Date
  - Data are submitted, and errors and rejected records are corrected (Standard 6.3)

6.2 – Data Submission

- Documentation
  - The facility submits data as required for compliance by the NCDB

6.2 – Data Submission

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Compliance

1. Complete data for all required analytic cases are submitted to the NCDB in accordance with the annual call for data specifications.

6.3 – Data Accuracy

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- Accurate data are necessary for meaningful comparison of treatment and patient outcomes. These data are the basis for the feedback provided to cancer programs.

Scope of the Standard

- The reporting registry must
  - Correct outstanding data quality errors
  - Resolve errors resulting in rejected records

- **Each year**
  - Cases satisfy the established quality criteria by the deadline specified in each Call for Data specification
  - Problematic cases are corrected and resubmitted according to the Call for Data specifications
  - Cancer committee monitors the resolution and resubmission of problematic cases (Standard 6.1)

6.3 – Data Accuracy

- Documentation
  - The facility submits data as required for compliance by the NCDB

6.3 – Data Accuracy

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Compliance

1. The cases meet the quality criteria as defined in the annual Call for Data specifications on the initial submission

2. If cases submitted do not meet the quality criteria, on initial submission then the identified errors in submitted cases and rejected records are corrected and resubmitted by the due date specified

6.4 – RQRS Participation

- **Promoting evidence-based cancer care** is of key importance to improving the quality of care and patient outcomes
- Therefore, the CoC has developed the **Rapid Quality Reporting System (RQRS)** to facilitate quality improvement by encouraging evidence-based care in CoC-accredited programs for select quality measures
- Accredited cancer programs use RQRS to
  - **Report data on patients** concurrently
  - **Receive notifications of treatment expectations**
- This tool presents year-to-date concordance rates for each measure as compared with the state, other hospital groups, and hospitals at the national level

6.4 – RQRS Participation

- The cancer program actively participates in RQRS
  - Submits all cases for all measures
  - Adheres to the RQRS terms and conditions
  - Reports data and performance to the cancer committee **at least twice each calendar year**

- Programs must actively participate in RQRS submissions and adhere to the RQRS requirements through the entire accreditation cycle

6.4 – RQRS Participation

- Documentation
  - The program submits data as required for compliance by the NCDB

6.4 – RQRS Participation

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Compliance

1. All new and updated cancer cases are submitted at least once each calendar quarter according to the RQRS terms and conditions
2. RQRS data and performance reports are reviewed by the cancer committee at least twice each calendar year and documented in the cancer committee minutes

6.5 – Follow-Up of Patients

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- **Long-term follow-up** is essential to evaluate outcomes of cancer care
- Accurate follow-up data enables the program to compare outcomes
  - **Regional**
  - **State**
  - **National**

Scope of the Standard

- **80 percent** follow-up rate for all eligible cases from the cancer registry reference date

80%

- **90 percent** follow-up rate for all eligible analytic cases diagnosed within the last five years or from the cancer registry reference date, whichever is shorter

90%

6.5 – Follow-Up of Patients

- **Follow-up Exceptions:**
  - Residents of foreign countries
  - Cases reportable by agreement
  - Patients whose age exceeds **100 years** and who are without contact for **more than 12 months**
  - Patients diagnosed on or after **January 1, 2006**, and classified as Class of Case 00

6.5 – Follow-Up of Patients

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Scope of the Standard

- Methods to obtain follow-up information include, but are not limited to, the following:

Following or managing physician(s)

Program inpatient or outpatient services

Pathology reports or death certificates

Patient or patient's family

Internet sources (such as death index, patient locator software, obituary listings)

Communication with other facilities

- The cancer committee monitors the use of unknown values to ensure complete data reporting

6.5 – Follow-Up of Patients

- On-site documentation reviewed by site visit reviewer
  - Current **follow-up report**

6.5 – Follow-Up of Patients

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Compliance

1. **80 percent follow-up rate** for all eligible analytic cases from the cancer registry reference date — **80%**
2. **60 percent follow-up rate** for all eligible analytic cases in **PCP facilities** from the cancer registry reference date — **60%**
3. **90 percent follow-up rate** for all analytic cases diagnosed within the last five years or from the cancer registry reference date, whichever is shorter — **90%**