# Q&A Session for Utilizing Cancer Registry Data

# for Patient Outcomes Compliance

Thursday, July 7, 2016

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Q1: ­If you publish CP3R for Std 1.12 do you have to publish all sites or could you pick one site like breast? ­

A1: ­We would recommend you report all the measures for a cancer site, not just one site and one measure, be sure to add physician narrative so the lay public can understand and interpret what they are reviewing­.

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Q2: ­How do we show the recommended date in the abstract we can only code the treatment start date? For example a doctor may have recommended hormone on 06/05/15 but patient may not started until 07/01/16? ­

A2: Documentation is your best friend, be sure to document delays in the abstract notes, surveyors can override deficiencies. In the CP3R, you can only document one date. The start date of treatment takes priority over a recommended date. A recommended date would only be used if it is unknown if treatment is given.

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Q3: ­Why is the CoC counting patients refusing RT in the BCSRT measure against the program? ­

A3: You want to ensure there is documentation as to why the patient refused a certain treatment, if those cases cause your program to fall out of compliance, be sure the patient refusal is noted and surveyor can override deficiency¬.

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Q4: ­How often do we report to cancer committee standard 4.4 & 4.5? My understanding is that the CLP report it every quarter. Thanks! ­

A4: You want to be sure to report CP3R data 4.4 and 4.5 at least once per year. This can be use as one of the four reports from the CLP. The other three will include NCDB data but not necessarily the CP3R measures.

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Q5: But the measure says recommended...the recommended date would be within the 365 days but the start date is not.

A5: ­The CoC does allow you to use a recommended date if it is unknown if the treatment is given. Once treatment is given, the date should be updated to show the start date and treatment. Remember the intent is not to just meet the measure but to see the ­­pattern of care provided at your facility. This is information the cancer committee needs to see and evaluate.­

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Q6: ­Why is the CoC eliminating the consultant training program this year and what are the plans for replacement? ­

A6: The Commission on Cancer has eliminated the current consulting program with the intention of creating a new program. The current list of consultants will remain on the Commission on Cancer website until October. I recommend you retain a list of those individuals. If you are in need of a consultant, I would contact previous consultants and verify they have continued receiving Commission on Cancer education.

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Q8: ­How do you compare results with national benchmarks or guidelines with the study on delays in appointments, treatments, test? Thanks­

A8: We recommend you use the source of the research for what is best practice or acceptable timeliness, sometimes journal articles can also be cited, be sure to document your source¬. If you cannot locate a national benchmark, a local facility or health system may develop their own benchmark. This benchmark must be well documented within the cancer program and other related committees or task groups and be based on review of related resources.

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Q9: ­Can you do end of life as that is part of a Standard Palliative care? ­

A9: The study example reviewed the referral and length of stay for hospice patients. The facility is already compliant with Standard 2.4, Palliative care services. The study problem dug deeper into a problem with the using the hospice services available to their potential.

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Q10: ­For 4.7 - CQIP data includes number of days to treatment from dx date. Can this data be used as a quality improvement idea? ­

A10: ­You cannot utilize CQIP data for studies or improvements because that data was given to you by the CoC.­

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Q11: ­Can you do this where there is a standard for palliative care? ­

A11: The study example reviewed the referral and length of stay for hospice patients. The facility is already compliant with Standard 2.4, Palliative care services. The study problem dug deeper into a problem with the using the hospice services available to their potential.

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Q12: ­Can you use COC completeness report? ­

A12: If a problem is identified in the CoC completeness report, a further review must be done to determine if the problem is related to cancer care and includes clinical, administrative, and patient perspective. We would recommend the CoC completeness report data in general not be used for Standard 4.7, Studies of Quality. Keep in mind, if the problem is based on cancer registry processes and documentation, the study would not be compliant. The CoC completeness report data is not the data used in a quality study. The data needed for a quality study is from reviewing the root cause.

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Q13: Would you please tell us more about the RQRS requirement that will take place in 2017?

A13: RQRS participation will be required by any CoC accredited program in 2017. The RQRS submission must be completed quarterly. This needs to be reviewed by the Cancer Committee at least semi-annually and included in the Cancer Committee minutes. There will be a commendation rating for this standard. In order to be eligible for commendation, submissions to RQRS must be completed monthly. RQRS cases must be abstracted within 3 months from date of first contact.