# Back to The Future: What Year Is It and What Did I Miss?

July 7, 2022

NAACCR

1

## Q&A

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails.

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

NAACCR

2

2

## Fabulous Prizes



NAACCR 3

3

## Guest Presenter

- Nancy Etzold, CTR
  - Director of Cancer Registry, Oklahoma University Health
- Lisa Landvogt, CTR
  - Director of Cancer Data and Accreditation, Henry Ford Health

NAACCR 4

4

# Back to the *Future*;

What Year Is It? What Did I Miss?

Keeping Up With The Changes

Featuring: **Nancy Etzold, CTR**

Director, Cancer Registry

OU Health (Oklahoma City, OK)

**Lisa Landvogt, BA, CTR**

Director, Cancer Data & Accreditation

Henry Ford Health (Detroit, MI)

5

## Speaker Disclosure

Nancy Etzold has nothing to disclose as a conflict of interest

Lisa Landvogt has nothing to disclose as a conflict of interest

7/15/2022

6

6

## American College of Surgeons

*The "Other" ACS*

7

## What Comes to Mind?

- **Quality Programs**
  - Accreditation & Verification
  - Standards & Staging
  - Data & Registries
  - Research & Outcomes

7/15/2022 8

8

## Accreditation & Verification Programs

- ACS Quality Verification Program™ (ACS NSQIP QVP)
- ACS Thrive
- American Joint Committee on Cancer (AJCC)
- Children's Surgery Verification (CSV)
- Commission on Cancer (CoC)
- Cancer Surgery Standards Program (CSSP)
- Geriatric Surgery Verification (GSV)
- Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- National Accreditation Program for Breast Centers (NAPBC)
- National Accreditation Program for Rectal Cancers (NAPRC)
- Verification, Review, & Consultation (VRC) for Trauma

7/15/2022 9

9

## Standards & Staging

Optimal Resources

Surgical Quality & Safety

Children's Surgical Care

Cancer Care

NAPBC (Breast)

NAPRC (Rectal)

Care of the Injured Patient

Geriatric Surgery

Metabolic & Bariatric Surgery

AJCC Cancer Staging Manual – 8th edition

7/15/2022 10

10

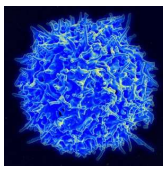
## Data & Registries


- National Trauma Data Bank
- Children's Surgical Clinical Outcomes Data
- Surgeon Specific Registry
- National Surgical Quality Improvement Program (NSQIP)
- National Cancer Database
  - Standards for Oncology Registry Entry (STORE manual)
- COVID-19 Registry

7/15/2022 11

11

## Research & Outcomes



- NCI COVID-19 in Cancer Patients Study (NCCAPS)
- American Society of Breast Surgeons Mastery of Breast Surgery Program (ASBrS)
  - American Society of Breast Surgeons COVID-19 Registry*
- American Society of Clinical Oncology (ASCO) Registry
- American Society of Hematology (ASH)
  - ASH Research Program (RP) COVID-19 Registry for Hematologic* Malignancies
- COVID-19 and Cancer Consortium*

7/15/2022 12

12

# CoC Accreditation
# Keeping Up With the Changes

July 7, 2022

Nancy Etzold, CTR

13

- Consortium of professional organizations
- American College of Surgeons 1922
- Expanded to include multidisciplinary modalities
- Standards established
- 1500 CoC-Accredited programs

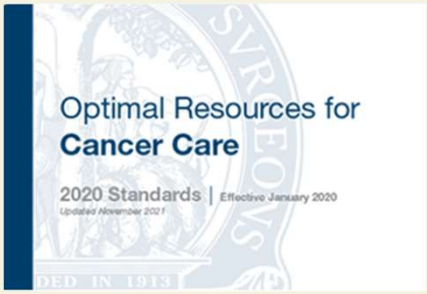
Commission on Cancer® | A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS


14

14

## Value of CoC Accreditation

- Accredited programs commitment
- NCDB data assesses performance
  - Compare quality care
  - Identify variations
  - Implement improvements
- Provides infrastructure
  - Leadership & programmatic development
  - Team building



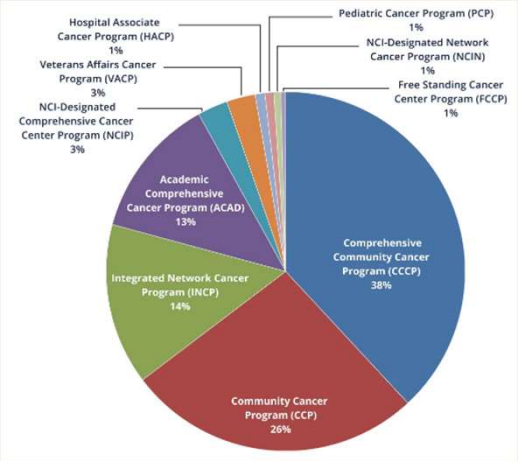


15

15

## Accreditation Process

- **Program Categories**
- **Standards requiring annual review**
- **Studies/Projects/Reports required**




16

16

## Standards Manual Changes

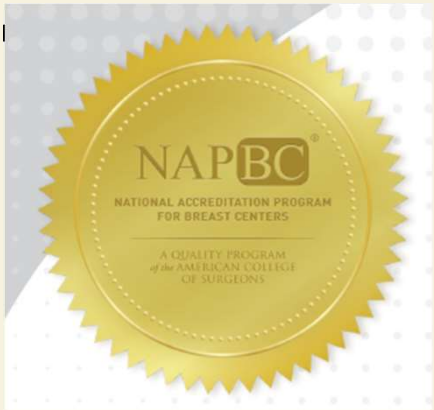
- Retired Standards
- Modifications of definitions and/or requirements


17

17

## NAPBC

- National Accreditation Program for Breast Centers
- Focus on multidisciplinary, coordinated ca
- Categories
- NABPC-Accredited centers demonstrate
- 2023 Standards Update


18

18

## NAPRC

- National Accreditation Program for Rectal Cancer
- Based on international models
- Data collection and tracking outcomes
- Verify adherence to evidence-based procedures

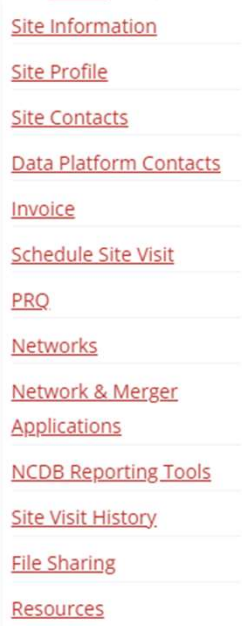
| | |
|---|---|
| 1. ASA score | I; II; III; IV; V |
| 2.Case status | Elective; urgent (obstructed; bleeding; perforated) |
| 3. Operation | LAR; APR; TPC |
| 4. Modality | Open; laparoscopic; hand-assisted laparoscopic; robotic; TES |
| 5. Location of tumor within rectum | High; middle; low |
| 6. Height of lower edge of tumor from anal verge | 0–20 cm |
| 7. Mobilization of splenic flexure | Yes; no |
| 8. Level of ligation of inferior mesenteric artery | IMA; SRA; none |
| 9. Level of ligation of inferior mesenteric vein | High; low; none |
| 10. Level of rectal transection distal to distal edge of tumor (distal margin) | 0–20 cm |

19

19

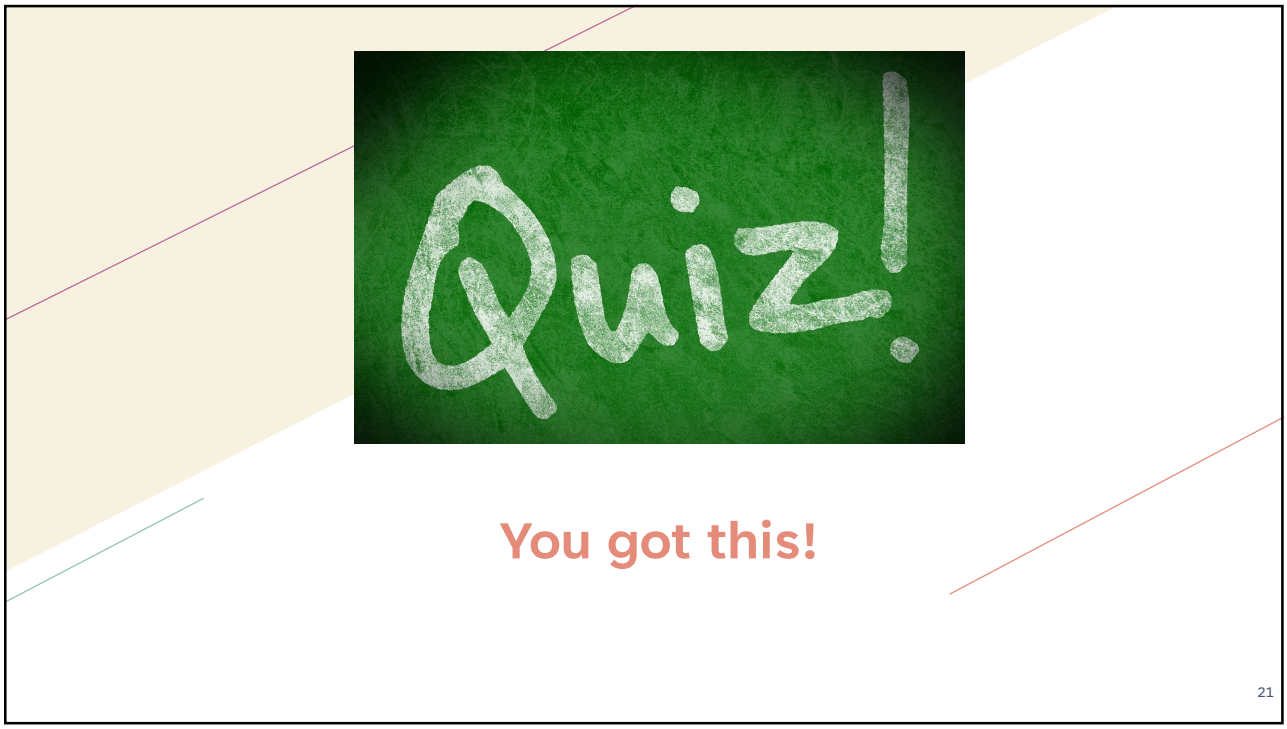
## CoC Quality Portal

- Site Details
- Contacts
- Payment
- Site Visit Resources
- Change Forms
- Templates
- Resource Library
- CAnswer Forum
- Standards Manual & Updates
- National Cancer Data Base
- General Resources
- Marketing Resources




20

20


Quiz!
You got this!
21

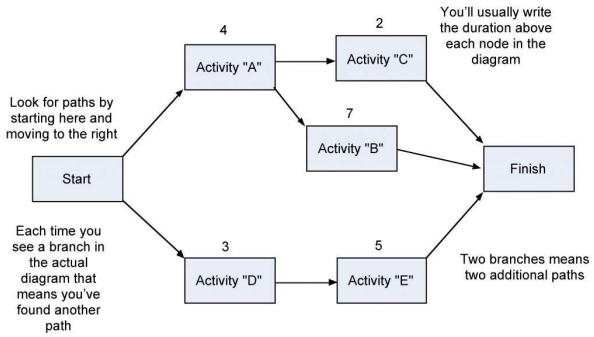
21


Optimal Resources for Cancer Care
THE Standards/THE Changes
Commission on Cancer
Optimal Resources for Cancer Care
2020 Standards
facs.org/cancer

22

## Standards/Categories: Changes & Timelines

- Original version went into effect 1/1/2020
- 2021 version went into effect 1/1/2021
- Republished in November of 2021
- Updates on current version went into effect 1/1/2022




7/15/2022 23

23

## Standard Chapters

1) Institutional Administrative Commitment (Lisa)
2) Program Scope & Governance (Lisa)
3) Facilities & Equipment Resources (Lisa)
4) Personnel & Services Resources (Lisa)
5) Patient Care: Expectations & Protocols (Nancy)
6) Data Surveillance & Systems (Nancy)
7) Quality Improvement (Lisa)
8) Education: Professional & Community Outreach (Lisa)
9) Research (Lisa)

7/15/2022 24

24

# Critical Category Changes

| Date Change Made | CoC Standard | Change Detail/Rationale |
|---|---|---|
| 11/11/2021 | Cancer Program Standards Rating System and Accreditation Awards | Cancer Program Standards Rating System and Accreditation Awards Statuses |
| 2/9/2021 | Specifications by Category-Programs Undergoing **Initial** Site Visit for Accreditation | Language added: "Standard 2.2: Cancer Liaison Physician: While the requirement to report NCDB data two times per year will not be rated during the initial site visit, it is encouraged that programs report data to the cancer committee relevant to the cancer program at least twice per year. |
| 11/11/2021 | Specifications by Category-**INCP** and **NCIN** | Specifications for Integrated Network Cancer Program and NCI-Networks updated to include requirements and clarification for how standards apply in the network setting. Updated |
| 11/11/2021 | Specifications by Category-**INCP** and **NCIN** | Standard 2.2: Co-CLPs changed to two CLP's |
| 4/6/2022 | Specifications by Category-**Pediatric Cancer Program** | Revised/added specifications by category for Pediatric Cancer Programs & those seeking an additional pediatric designation. |
| 4/21/2022 | Specifications by Category-**Pediatric Cancer Program** | Standards exempt for PCPs added to Specification by Category - Omission |

7/15/2022 25

25

# Critical Standard Changes

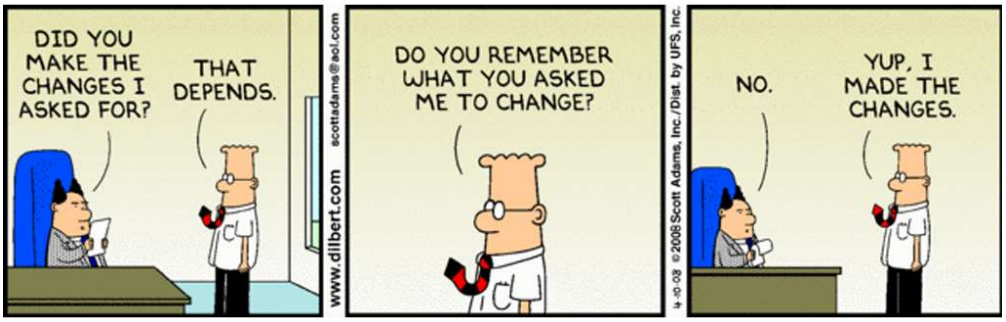
| Date Change Made | CoC Standard/Topic | Change Detail/Rationale |
|---|---|---|
| 4/6/2022 | Standard 2.1: Cancer Committee & INCP/NCIN Specifications by Category | Pastoral care representative changed to spiritual care representative |
| 2/9/2021 | Standard 4.2: Oncology Nursing Credentials | "Phase-in Standard" designation removed. Standard implemented in 2021 - Updated |
| 2/9/2021 | Standard 4.4: Genetic Counseling and Risk Assessment | Additional guidance based on program feedback. Language added: "Programs should consider conflict of interest when choosing professionals to provide cancer risk assessment and genetic counseling." |
| 4/6/2022 | Standard 4.4: Genetic Counseling and Risk Assessment | Qualification that the advanced practice oncology nurse or physician assistant must be "prepared at the graduate level (masters or doctorate)" removed |
| 2/9/2021 | Standard 4.8: Survivorship Program | "Phase-in Standard" designation removed. Standard implemented in 2021 - Updated |
| 2/12/2020 | Standard 7.3: Quality Improvement Initiative | Clarification (accountability and quality improvement measures may be used as a basis for a QI initiative (see first bullet point in the list in standard) |
| 10/25/2019 | Standard 9.1: Clinical Research Accrual | NCI programs noted as exempt in chart |

7/15/2022 26

26

# Chapter 2 Changes; Program Scope & Governance

- **For INCP/NCIN Programs**
  - **Pastoral care representative changed to spiritual care representative**




7/15/2022 27

27

# Chapter 4 Changes; Personnel & Services Resources

- **Standard 4.2 Oncology Nursing Credentials**
  - **Phase-In Status removed, implemented in 2021**

Each **accreditation cycle**, the program fulfills the compliance criteria:

All nurses providing direct oncology care hold a cancer-specific certification **or** demonstrate ongoing education by earning **36** cancer-related continuing nursing education contact hours.

Programs have in place a policy and procedure that ensures oncology nursing competency is **reviewed each year** per hospital policy.

7/15/2022 28

28

# Chapter 4 Changes; Personnel & Services Resources

- **Standard 4.4 Genetic Counseling & Risk Assessment**
  - **Language added:** "Programs should consider conflict of interest when choosing professionals to provide cancer risk assessment and genetic counseling."
  - **Removed:** Qualification that the advanced practice oncology nurse or physician assistant must be "prepared at the graduate level (masters or doctorate)"

  Each **calendar year**, the cancer program fulfills all of the compliance criteria:

  Cancer risk assessment, genetic counseling, and genetic testing services are provided to patients either on-site or by referral by a qualified genetics professional.

  A policy and procedure is in place regarding genetic counseling and risk-assessment services and includes all required elements.

  A process is in place pursuant to evidence-based national guidelines for genetic assessment for selected cancer site. The process includes all required elements.

  The process for providing and referring cancer risk assessment, genetic counseling, and genetic testing services is monitored and evaluated, contains all required elements, and is documented in the cancer committee minutes.



29

# Chapter 4 Changes; Personnel & Services Resources

- **Standard 4.7 Survivorship Program**
  - **Phase-In Status removed, implemented in 2021**

  **Each calendar year**, the program fulfills the compliance criteria:

  Cancer risk assessment, genetic counseling, and genetic testing services are provided to patients either on-site or by referral by a qualified genetics professional.

  A policy and procedure is in place regarding genetic counseling and risk-assessment services and includes all required elements.

  A process is in place pursuant to evidence-based national guidelines for genetic assessment for a selected cancer site. The process includes all required elements.

  The process for providing and referring cancer risk assessment, genetic counseling, and genetic testing services is monitored and evaluated, contains all required elements, and is documented in the cancer committee minutes.



30

# Break

31

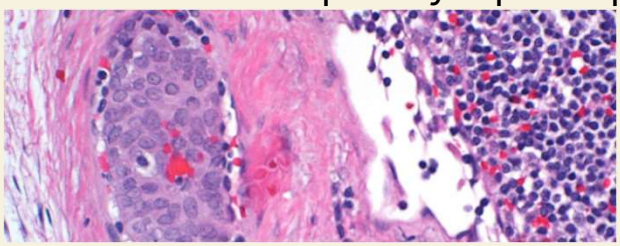
## CHAPTER 5: PATIENT CARE EXPECTATIONS & PROTOCOLS

Commission on Cancer®
A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

32

## 5.1 College of American Pathologists (CAP) Synoptic Reporting

- Synoptic Format
- Eligible Records
- Procedures that do not require synoptic reporting



https://www.cap.org/protocols-and-guidelines/cancer-reporting-tools/cancer-protocol-templates

33

## 5.1 College of American Pathologists (CAP) Synoptic Reporting

- Reviewed on Site
- Documentation uploaded prior to site visit
- 90% Of 20 Patients selected

+ **RESULTS**

+ ***BRAF* Mutational Analysis (Note B)**
+ ___ No mutation detected
+ ___ Mutation identified
  + ___ p.V600E, c.1799T>A
  + ___ p.K601E, c.1801A>G
  + ___ Other *BRAF* mutation (specify): _____
    + Indicate mutant allele frequency: _____%
+ ___ Cannot be determined (explain): _____

+ ***TERT* Mutational Analysis (Note B)**
+ ___ No mutation detected
+ ___ Mutation identified
  + ___ c.1-124 (C228T)
  + ___ c.1-146 (C250T)
  + ___ Other *TERT* mutation (specify): _____
+ ___ Cannot be determined (explain): _____

https://accreditation.facs.org/AccreditationDocuments/CoC/Resources/PathologyReportReviewTemplateStds5.1_5.7and5.8.xlsx

34

34

## 5.2 Psychosocial Distress Screening

- Psychosocial Services Policy & Procedures
- Screening Criteria


**Process**

1. Timing of Screening
   The screening will take place at each inpatient admission, and at initial evaluation for new radiation therapy cancer patients that have not been admitted to inpatient unit in the last year.
2. Method of Screening
   The admitting nurse queries the patient and records responses as part of the admission assessment.
3. Tools
   A distress screening tool has been built into Meditech in the nursing admission assessment. The screening tool assesses stress level using a 4-point system: none, mild, moderate, and severe. A list of problems causing the patient distress is also created. The problems are divided into the following categories: practical, emotional, family, physical, spiritual/religious.
4. Assessment and Referral
   If a patient indicates moderate or severe stress, appropriate referrals must be made based on the patient's problem list. When referrals to the navigator and/or psych nurse are made in the assessment, a consult is automatically sent to the appropriate department/person. When referrals to social services and/or chaplain are made in the assessment, the nurse is prompted to order a consultation to the appropriate department.
5. Documentation
   The distress screening, referrals and departmental consults become a part of the patient's permanent medical record in Meditech. The cancer committee will monitor screenings, referrals and consults through a Meditech-generated report on a quarterly basis. The results of the monitor will be documented in the cancer committee minutes.

35

35

## 5.2 Psychosocial Distress Screening

- Screening criteria
- Tools
- Assessment and Referral
- Documentation

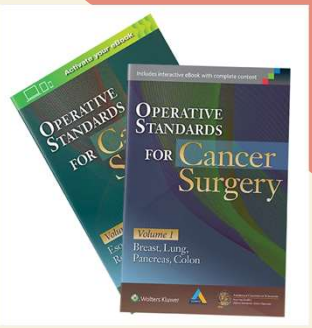
| | | Currently Receiving Cancer Treatment | | | Subjective Stress Level | | | | Consults/Referrals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # Patients | Admit Location Name | No | Yes | Unknown | Mild | Moderate | Severe | None | ACS Pt Navigator | Psych Nurse | Soc Svcs | Chaplain |
| 925 | 2 East | 813 | 73 | 39 | 31 | 3 | 1 | 890 | 3 | 3 | 3 | 4 |
| 186 | 3 East | 168 | 9 | 9 | 2 | 0 | 0 | 184 | 0 | 1 | 1 | 1 |
| 548 | 3 West | 503 | 22 | 23 | 8 | 2 | 0 | 538 | 2 | 3 | 1 | 3 |
| 1086 | 4 East | 960 | 68 | 58 | 24 | 6 | 0 | 1056 | 5 | 8 | 8 | 9 |
| 682 | 4 West | 574 | 65 | 43 | 28 | 6 | 2 | 646 | 6 | 10 | 5 | 10 |
| 462 | East | 428 | 12 | 22 | 3 | 0 | 0 | 459 | 0 | 2 | 2 | 2 |
| 472 | 5 West | 431 | 15 | 26 | 6 | 1 | 1 | 464 | 2 | 3 | 3 | 3 |
| 695 | 6 East | 612 | 52 | 31 | 14 | 7 | 1 | 673 | 7 | 9 | 8 | 8 |
| 640 | 6 West | 543 | 59 | 38 | 20 | 5 | 0 | 615 | 4 | 7 | 8 | 7 |
| 552 | 7 East | 305 | 232 | 15 | 93 | 37 | 7 | 415 | 45 | 35 | 35 | 37 |
| 325 | 7 West | 114 | 197 | 14 | 73 | 13 | 2 | 237 | 13 | 22 | 26 | 25 |
| 36 | Bone Marrow Unit | 7 | 28 | 1 | 15 | 1 | 1 | 19 | 2 | 7 | 1 | 9 |
| 440 | CV Surg ICU 2NE | 345 | 42 | 53 | 15 | 8 | 1 | 416 | 9 | 11 | 8 | 10 |

36

36

## CoC Operative Standards

| | | |
|---|---|---|
| **2021** | Programs begin developing plans for how they will meet the requirements of Standards 5.3–5.6. | Standards 5.7 and 5.8 take effect starting January 1. Programs must achieve at least 70 percent compliance in 2021. |
| **2022** | Programs document their final plans and work on getting up to compliance. | Programs must achieve at least 80 percent compliance in 2022. Site visits assess pathology reports from 2021 for 70 percent compliance. |




https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/standards-and-resources/2020/

37

37

## Visit Process for Operative Standards

| | | |
|---|---|---|
| **2023** | Standards 5.3, 5.4, 5.5, and 5.6 take effect starting January 1. Programs must achieve at least 70 percent compliance in 2023. | Programs must achieve at least 80 percent compliance in 2023. Site visits assess pathology reports from 2021-2022 for 80 percent compliance. |
| **2024** | Programs must achieve at least 80 percent compliance in 2024. Site visits assess operative reports from 2023 for 70 percent compliance. | Programs must achieve at least 80 percent compliance in 2024. Site visits assess pathology reports from 2021-2023 for 80 percent compliance. |
| **2025** | Programs must achieve at least 80 percent compliance in 2025. Site visits assess operative reports from 2023-2024 for 80 percent compliance. | Programs must achieve at least 80 percent compliance in 2025. Site visits assess pathology reports from 2021-2024 for 80 percent compliance. |

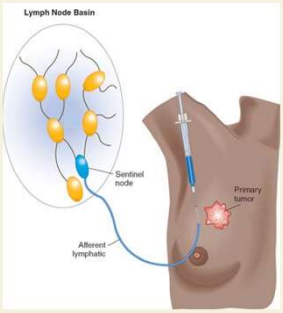
| Visit Year | Standard | Materials Assessed | Requirement |
|---|---|---|---|
| **2022** | 5.3-5.6 | No requirements for this site visit year. | N/A |
| | 5.7 | 7 rectal pathology reports from 2021 | 70% compliance |
| | 5.8 | 7 lung pathology reports from 2021 | 70% compliance |
| **2023** | 5.3-5.6 | Implementation plan for Standards 5.3-5.6 | Plan documented in 2022 |
| | 5.7 | 7 rectal pathology reports from 2021-2022 | 80% compliance |
| | 5.8 | 7 lung pathology reports from 2021-2022 | 80% compliance |
| **2024** | 5.3-5.6 | Implementation plan for Standards 5.3-5.6 | Plan documented in 2022 |
| | 5.3 | 7 breast SLNB operative reports from 2023 | 70% compliance |
| | 5.4 | 7 breast ALND operative reports from 2023 | 70% compliance |
| | 5.5 | 7 melanoma operative reports from 2023 | 70% compliance |
| | 5.6 | 7 colon operative reports from 2023 | 70% compliance |
| | 5.7 | 7 rectal pathology reports from 2021-2023 | 80% compliance |
| | 5.8 | 7 lung pathology reports from 2021-2023 | 80% compliance |
| **2025** | 5.3-5.6 | Implementation plan for Standards 5.3-5.6 | Plan documented in 2022 |
| | 5.3 | 7 breast SLNB operative reports from 2023-2024 | 80% compliance |
| | 5.4 | 7 breast ALND operative reports from 2023-2024 | 80% compliance |
| | 5.5 | 7 melanoma operative reports from 2023-2024 | 80% compliance |
| | 5.6 | 7 colon operative reports from 2023-2024 | 80% compliance |
| | 5.7 | 7 rectal pathology reports from 2022-2024 | 80% compliance |
| | 5.8 | 7 lung pathology reports from 2022-2024 | 80% compliance |

| Number | Standard Name | Documentation Assessed | Date Implemented |
|---|---|---|---|
| 5.3 | Sentinel Node Biopsy for Breast Cancer | Operative reports | January 1, 2023 |
| 5.4 | Axillary Lymph Node Dissection for Breast Cancer | Operative reports | January 1, 2023 |
| 5.5 | Wide Local Excision for Primary Cutaneous Melanoma | Operative reports | January 1, 2023 |
| 5.6 | Colon Resection | Operative reports | January 1, 2023 |
| 5.7 | Total Mesorectal Excision | Pathology reports | January 1, 2021 |
| 5.8 | Pulmonary Resection | Pathology reports | January 1, 2021 |

38

## 5.3 Sentinel Node Biopsy for Breast Cancer

- Phase in
- Sentinel lymph node mapping and analysis
- Standard compliance
- Synoptic Operative Report




**CRITICAL ELEMENTS**

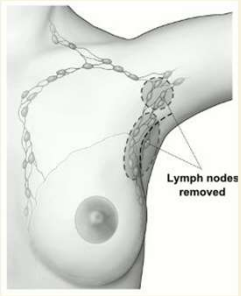
- Identification of All Sentinel Nodes
- Technique for Injecting Localizing Tracer or Dye
- Preincision Evaluation of Drainage Pattern
- Node Removal Technique to Limit Seroma Formation

| Element | Response Options |
|---|---|
| Operation performed with curative intent. | Yes;<br>No. |
| Tracer(s) used to identify sentinel nodes in the upfront surgery (non-neoadjuvant) setting *(select all that apply)*. | Dye;<br>Radioactive tracer;<br>Superparamagnetic iron oxide;<br>Other *(with explanation)*;<br>N/A. |
| Tracer(s) used to identify sentinel nodes in the neoadjuvant setting *(select all that apply)*. | Dye;<br>Radioactive tracer;<br>Superparamagnetic iron oxide;<br>Other *(with explanation)*;<br>N/A. |
| All nodes (colored or non-colored) present at the end of a dye-filled lymphatic channel were removed. | Yes;<br>No *(with explanation)*;<br>N/A. |
| All significantly radioactive nodes were removed. | Yes;<br>No *(with explanation)*;<br>N/A. |
| All palpably suspicious nodes were removed. | Yes;<br>No *(with explanation)*;<br>N/A. |
| Biopsy-proven positive nodes marked with clips prior to chemotherapy were identified and removed. | Yes;<br>No *(with explanation)*;<br>N/A. |

39

## 5.4 Axillary Lymph Node Dissection for Breast Cancer

- Procedure
- Standard Compliance
- Synoptic Operative Reports
- Compliance



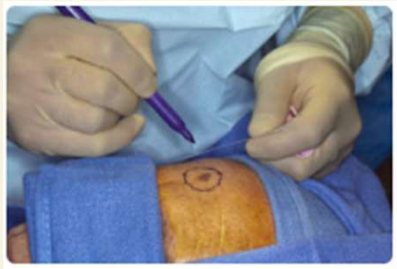

| Element | Response Options |
|---|---|
| Operation performed with curative intent. | Yes;<br>No. |
| Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi. | Yes;<br>No *(with explanation)*. |
| Nerves identified and preserved during dissection *(select all that apply)*. | Long thoracic nerve;<br>Thoracodorsal nerve;<br>Branches of the intercostobrachial nerves;<br>Other *(with explanation)*. |
| Level III nodes were removed. | Yes *(with explanation)*;<br>No. |

40

40

## 5.5 Wide Local Excision for Primary Cutaneous Melanoma

- Phase In
- Required Clinical Margin Widths
- Synoptic Operative Report Requirements
- Compliance



| Element | Response Options |
|---|---|
| Operation performed with curative intent | Yes;<br>No. |
| Original Breslow thickness of the lesion | Melanoma in situ (MIS);<br>_._ mm *(to the tenth of a millimeter).* |
| Clinical margin width *(measured from the edge of the lesion or the prior excision scar)* | 0.5 cm;<br>1 cm;<br>2 cm;<br>Other: __ cm due to cosmetic/anatomic concerns;<br>Other *(with explanation).* |
| Depth of excision | Full-thickness skin/ subcutaneous tissue down to fascia (melanoma);<br>Only skin and superficial subcutaneous fat (melanoma in situ);<br>Other *(with explanation).* |

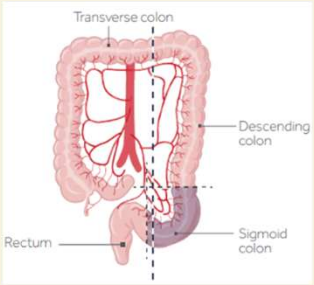
Operative Standards for Cancer Surgery, Volume 2, page 392

41

41

## 5.6 Colon Resection

- Phase-In
- Surgical Requirement
- Extent of Colon & Vascular Resection




- Right hemicolectomy - ileocolic and right colic (if present).
- Extended right hemicolectomy - ileocolic, right colic (if present), and middle colic.
- Transverse colectomy - middle colic.
- Splenic flexure – middle colic and ascending left colic.
- Left hemicolectomy - inferior mesenteric.
- Sigmoid resection - inferior mesenteric.
- Total abdominal colectomy - ileocolic, right colic (if present), middle colic, and inferior mesenteric.
  - If performed with proctectomy - superior and middle rectal.
- Other – Describe segments and vasculature resected anomalous to standard practice and explain the reason(s).

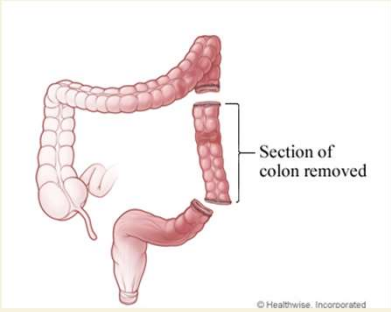
Operative Standards for Cancer Surgery, Volume 1, page 288

42

42

## 5.6 Colon Resection

- Synoptic Operative Report Requirements
- Site Visit
- Compliance



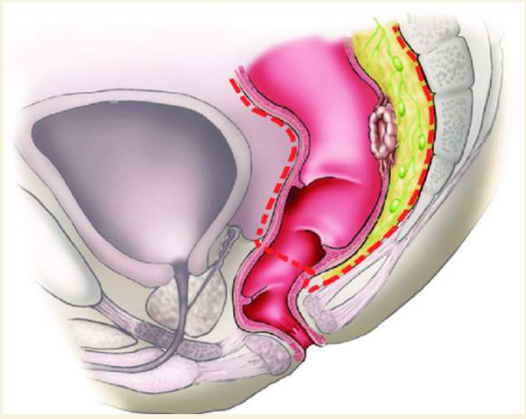

| Element | Response Options |
|---|---|
| Operation performed with curative intent | Yes;<br>No. |
| Tumor location | Cecum;<br>Ascending colon;<br>Hepatic flexure;<br>Transverse colon;<br>Splenic flexure;<br>Descending colon;<br>Sigmoid colon;<br>Rectosigmoid junction;<br>Rectum, NOS;<br>Colon, NOS. |
| Extent of colon and vascular resection | Right hemicolectomy – ileocolic, right colic (if present);<br>Extended right hemicolectomy – ileocolic, right colic (if present), middle colic;<br>Transverse colectomy – middle colic;<br>Splenic flexure resection – middle and ascending left colic;<br>Left hemicolectomy – inferior mesenteric;<br>Sigmoid resection – inferior mesenteric;<br>Total abdominal colectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric;<br>Total abdominal colectomy, with proctectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric, superior and middle rectal;<br>Other *(with explanation)*. |

43

43

## 5.7 Total Mesorectal Excision

- Surgical Requirement
- Complete or Near-Complete
- Site Review
- Compliance



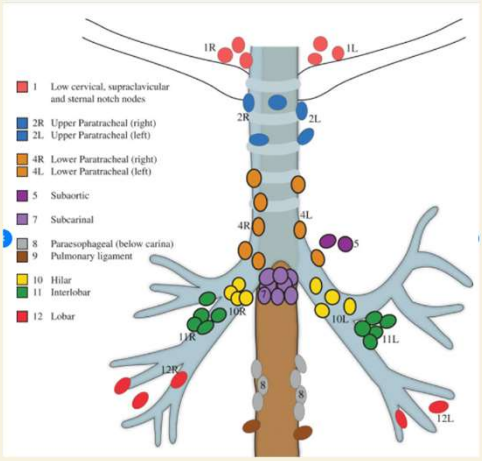
Operative Standards for Cancer Surgery, Volume 2, page 194

44

44

## 5.8 Pulmonary Resection

- Surgical Requirement
- Site Visit
- Compliance




Operative Standards for Cancer Surgery, Volume 1, page 93

45

45

## CHAPTER 6: DATA SURVEILLANCE & SYSTEMS

46

## 6.1 Cancer Registry Quality Control

- Policy & Procedure includes:

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 (such as state or central cancer registry case-finding audits) may be used to fulfill part of this requirement
D. Identifies the activities to be evaluated for all cases each year:
   1. Case finding
   2. Abstracting timeliness
   3. The percentage of information coded as unknown (usually coded as 9 or a string of 9s)

E. Identifies the activities to be evaluated each year for the accuracy of abstracted data. 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. American Joint Committee on Cancer (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

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 above. The report must be documented in the cancer committee minutes.

47

47

## 6.4 Rapid Cancer Reporting System

- Retired Standards
  - 6.2 Data Submission
  - 6.3 Data Accuracy
- Requirement
- Compliance
- Data Submission
- Edits
- Alert/Quality Reports
- Cancer Committee Presentations

https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/rapid-cancer-reporting-system/

48

48

## 6.5 Follow-up Of Patients

- Requirements
  - Reference Date
  - Five Years
- Methods
- Site Visit
- Compliance


49

49

## Tag, Lisa! You're IT!

50

50

# Critical Changes; Chapter 7

- Not **THAT** Chapter **7**



7/15/2022 51

51

# Chapter 7: Quality Improvement

## Problem Statement


"My team has created a very innovative solution, but we're still looking for a problem to go with it."

7/15/2022 52

52

## Standard 7. 1: Accountability & Quality Improvement Measures

- **Each calendar year**, the cancer program fulfills all of the compliance criteria:
- The cancer committee monitors the program's expected Estimated Performance Rates for accountability and quality improvement measures selected by the CoC.
- The monitoring activity is documented in the cancer committee minutes.
- For each accountability and quality improvement measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the expected EPR specified by the CoC. If the expected EPR is not met, the program has implemented an action plan that reviews and addresses program performance below the expected EPR.

7/15/2022 53

53

## NCDB Resources – A CTR "MUST READ"

Cancer PROGRAMS | QUALITY PROGRAMS of the AMERICAN COLLEGE OF SURGEONS | NATIONAL CANCER DATABASE

Rapid Cancer Reporting System (RCRS)

User's Guide Updated June 2022

A quality data platform brought to you by the National Cancer Database (NCDB)

This document is designed to provide the basic of the different reports/pages of RCRS and what function it provides. For questions regarding the data contact NCDB Staff at NCDB@facs.org including program FIN and relevant accession numbers and for questions regarding the system such as logging in contact IQVIA at ACSTechsupport@iqvia.com.

0


7/15/2022 54

54

## Hot Off the Presses...Changes

Effective January **2023**, four quality measures will be removed and no longer supported.

- **MASTRT** (Breast – RT following any mastectomy with >4 positive regional lymph nodes)
- **HT** (Tamoxifin or third generation aromatase inhibitor T1cN0M0 or stage IB-III hormone receptor positive breast cancer)
- **nBx** (Breast – image orpalpation-guided needle biopsy to the primary site before resection)
- **LNoSurg** (Lung – Surgery is not the first course of treatment for Stage III lung cancer)

These measures will continue to populate data and update nightly for cases submitted between **2017-2019**.

Data from **2020 forward** will no longer be available as of **June 27, 2022**.

Starting with **2023 site visits**, these four measures will not be evaluated to determine compliance with Standard 7.1.



55

## Standard 7. 1: Accountability & Quality Improvement Measures

To locate cases included in your program's EPRs, first open the Quality Measures Report and select the filters under the Summary Panel.

The Quality Measure Report will default opening the tab at left bottom of screen labeled Quality Measures.

To view Rolling Year Estimated Performance Rates (EPR), click on the tab at left bottom of screen labeled Rolling Year EPR, circled in blue.


By design all cancer reports will load with blank data, including the Rolling EPR tab. Filters must be selected under the Summary Panel for data to populate.



Screenshot courtesy of NCDB/RCRS User Guide

56

## Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines

**Each calendar year**, the cancer program fulfills all of the compliance criteria:

A physician conducts an in-depth analysis to determine whether initial diagnostic evaluation and first course of treatment provided to patients is concordant with evidence-based national treatment guidelines.

The report detailing all required elements of the study, including the results of the analysis and any recommendations for improvement, are reported to the cancer committee and documented in the cancer committee minutes.


7/15/2022 57

57

## Standard 7.2: Required Elements/Components

- Specific cancer site or stage (within specific site), **maximum** of **100** cases **OR** an identified need or concern within specific cancer site or stage (within specific site)
- Medical record review; pathology, diagnostic imaging, lab tests, and consultations recommended within the specific guideline being reviewed.
- Medical record review; first course of treatment is appropriate for the stage of disease or prognostic indicators and is concordant with evidence-based national treatment guidelines for each patient being reviewed.
- A reporting format that permits analysis and provides an opportunity to recommend performance improvements based on data from the analysis.
- A presentation of a report detailing all required elements of the study, including the results of the analysis, to the cancer committee. The report is documented in the cancer committee minutes. The documentation includes any recommendations for improvement.

*Analysis and treatment discussions for patients at multidisciplinary cancer case conferences do not fulfill the requirements for Standard 7.2. Any problems identified with the diagnostic evaluation or treatment planning process may serve as a source for a quality project under Standard 7.3: Quality Improvement Initiative.*

7/15/2022 58

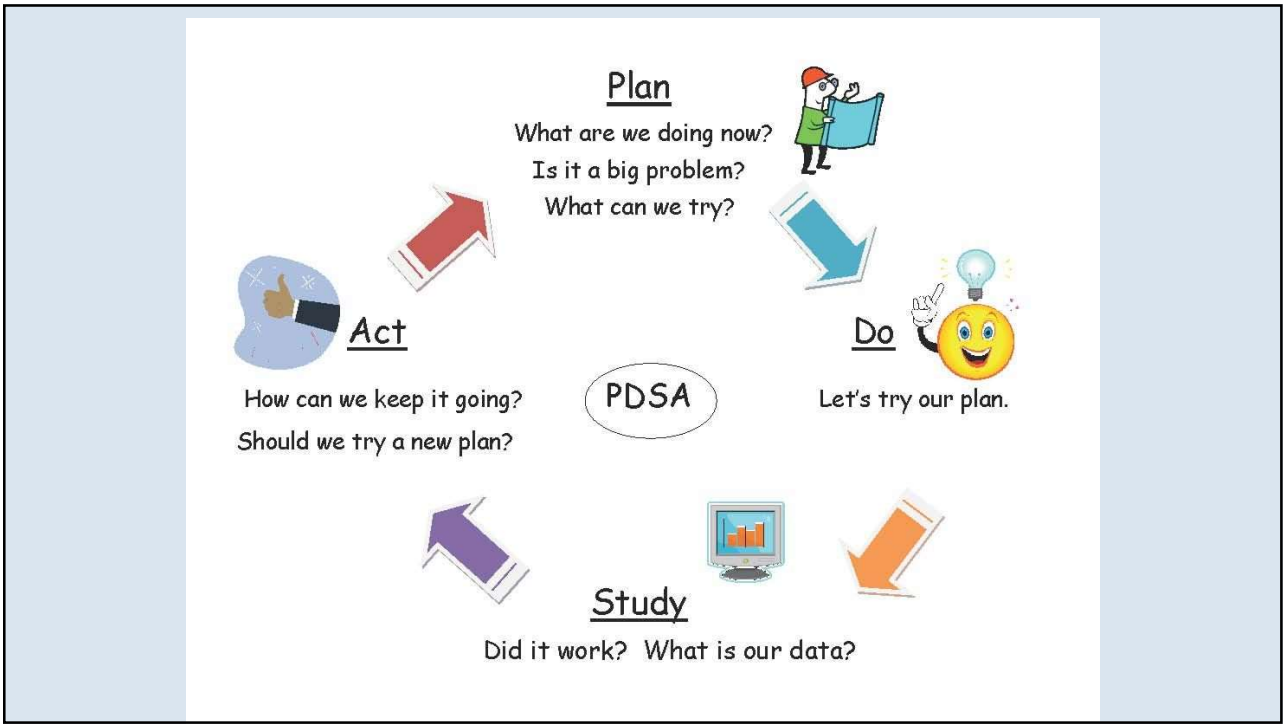
58

## Standard 7.3: Quality Improvement Initiative

- Under the guidance of the Cancer Liaison Physician (CLP), the Quality Improvement Coordinator, and the cancer committee, the cancer program must measure, evaluate, and improve its performance through at least **one** cancer-specific quality improvement initiative each year.
- This quality improvement (QI) initiative requires the program to identify a problem, understand what is causing the identified problem through use of a recognized performance improvement methodology, and implement a planned solution to the problem. Reports on the status of the QI initiative must be given to the cancer committee at least **twice** each calendar year and **documented** in the cancer committee minutes.

7/15/2022 59

59




60

- **Review Data to Identify the Problem**

  **EXAMPLES**
  - Problem may be identified by NCDB quality measures
  - Problem may be identified by Standard 7.2
  - Problem may be identified by annual review of clinical services
  - Problem may be identified by NAPBC or NAPRC accreditation initiative
  - Problem may be identified by NCDB CQIP
- **Write the Problem Statement**
  - The QI initiative must have a problem statement that is specific to the cancer program to solve through the QI initiative
  - Baseline and goal metrics must be numerical
  - Anticipated timeline and estimate outcomes
  - The problem statement cannot state that a study is being done to see if a problem exists, rather it must already be known that a problem exists.

7/15/2022 61

61

- **Choose and Implement Performance Improvement Methodology and Metrics**
  - A recognized, standardized performance improvement tool must be chosen and used to conduct the QI initiative (for example, Lean, DMAIC, or PDCA/PDSA).
- **Implement Intervention and Monitor the Data**
  - The intervention chosen in step three must be implemented. If oversight of the implementation suggests the intervention is not working, then it must be modified.
- **Present Quality Improvement Initiative Summary**
  - Once the initiative has been completed, a document summarizing the initiative and the results must be presented and discussed with the cancer committee and documented in the cancer committee minutes. If possible, results are compared with national data.

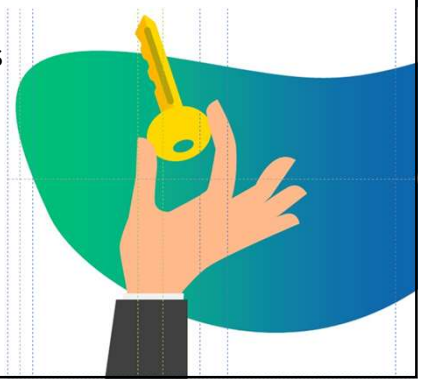
7/15/2022 62

62

## Standard 7.3: Quality Improvement Initiative

**Key Takeaways:**

- **Each** Calendar Year
- **One** Quality Improvement Initiative
- Presented at least **TWICE** per calendar year
- **Documentation** in Cancer Committee Minutes



7/15/2022

63

## Standard 7.4: Cancer Program Goal

Annual goal setting provides direction for the strategic planning of cancer program activities.

It is recommended the goal-setting tool known as SMART (Specific, Measurable, Achievable, Realistic, and Timely) be used when establishing the goal. Goals must be directed toward the scope, coordination, practices, processes, and provision of services for cancer care at the program.


7/15/2022

64

64

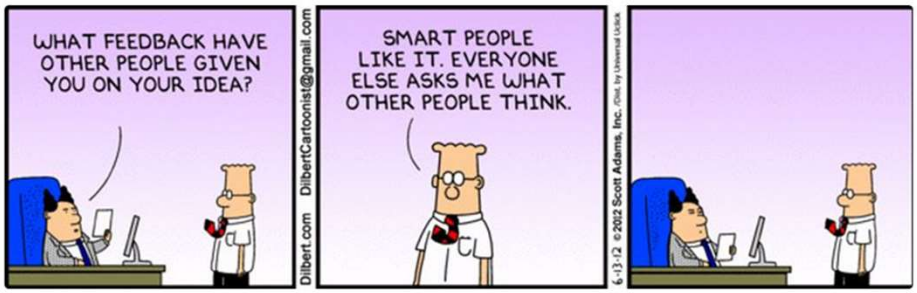
## Standard 7.4: Cancer Program Goal

**Each calendar year**, the cancer program fulfills all of the compliance criteria:

**One** cancer program goal is established and documented in the cancer committee minutes.

At least **two** substantive status updates on goal progress are documented in the cancer committee minutes in the same calendar year as its establishment.

For any goal extended into a second year, at least one status update is documented in the minutes during the second year to indicate whether the goal was completed.




7/15/2022

65

65


You got this!

66

66

# National Cancer Data Base Tools

Commission on Cancer®
A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

67

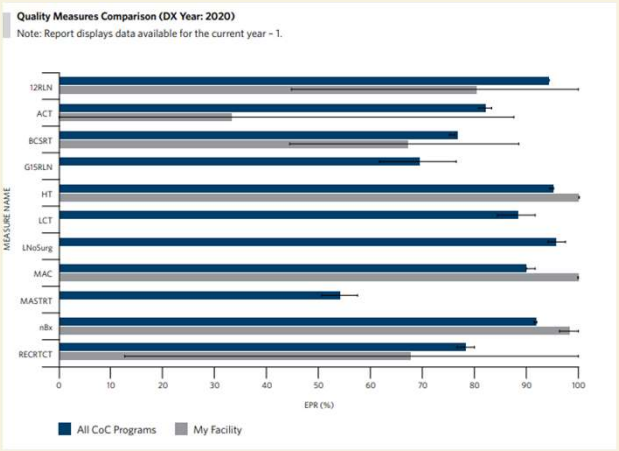
## National Cancer Data Base

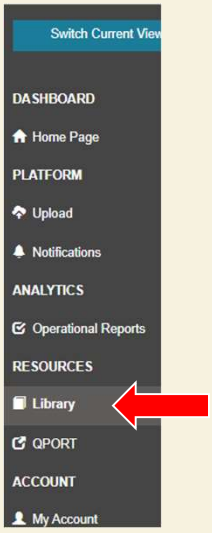
- Track and Analyze
- Community Assessment
- Quality Improvement
- Cancer Facility Administration


68

68

# RCRS Reports

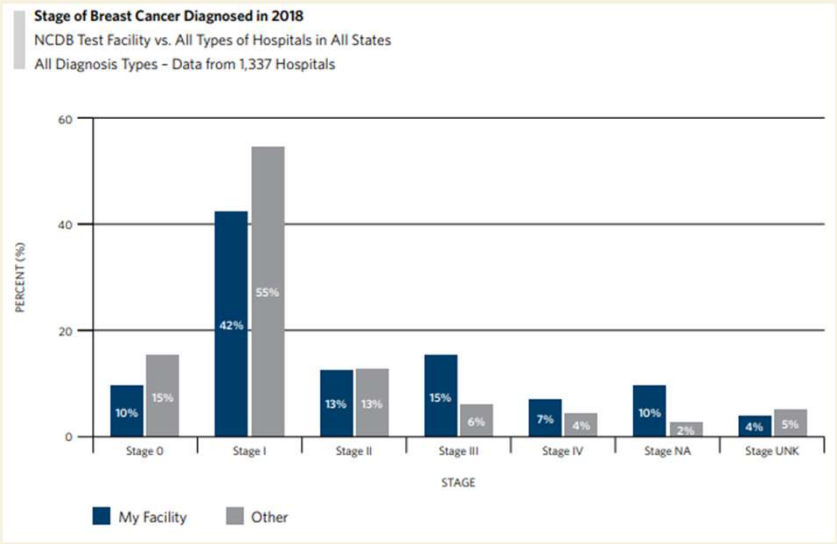



69

69

# Hospital Comparison Benchmark Reports




70

70

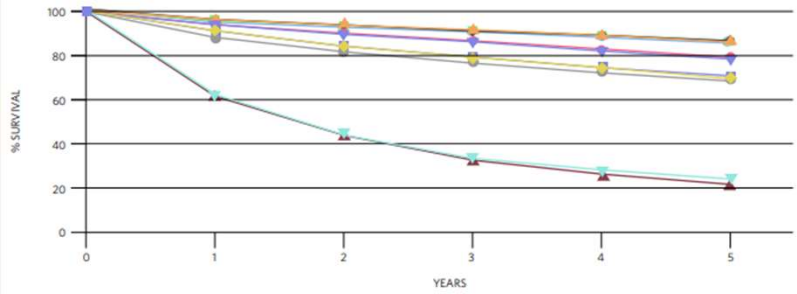
## Survival Reports

**Observed Survival for Colon**

Cases Diagnosed in 2010–2013 | Data from 1,268 Programs

Aggregate Report for all CoC Hospitals

WARNING: The information within this graphic is not to be used for clinical decision making.





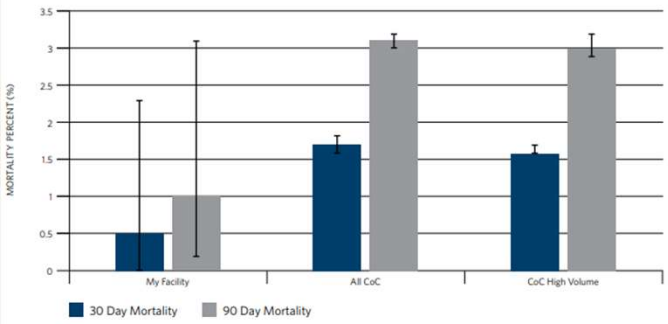

71

71

## Cancer Quality Improvement Program (CQIP)

**NSCLS Resections, Unadjusted 30, 90 Day Mortality, 95% CI, 2016-2018**

My Facility vs. All CoC and CoC High Volume



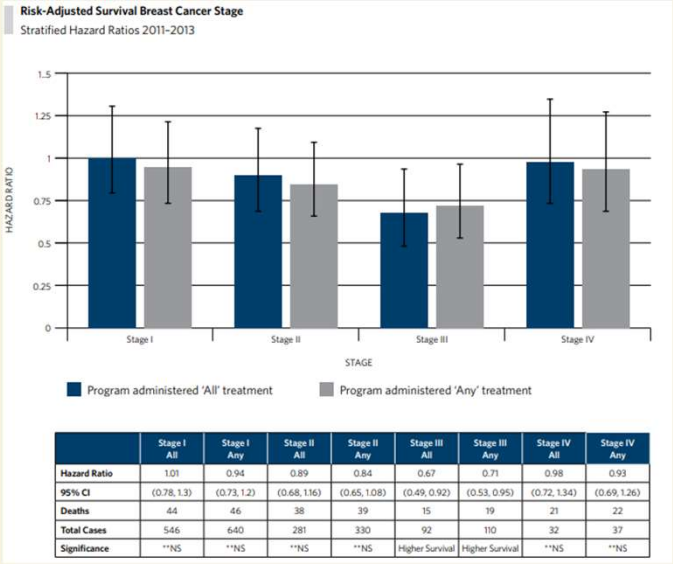

| | My Facility | | All CoC | | CoC High Volume | |
|---|---|---|---|---|---|---|
| | 30 Day | 90 Day | 30 Day | 90 Day | 30 Day | 90 Day |
| Mortality Percent | 0.5% | 1.0% | 1.7% | 3.1% | 1.6% | 3.0% |
| 95% CI | (0.0,2.3) | (0.2,3.1) | (1.6,1.8) | (3.0,3.2) | (1.6,1.7) | (2.9,3.2) |
| Deaths | 1 | 2 | 1,369 | 2,474 | 1,244 | 2,266 |
| Resections | 208 | 203 | 80,293 | 78,830 | 75,754 | 74,374 |

*NA No resections, or < 30 or < 90 days of follow-up for alive patients

72

72

# Survival Reports




| | Stage I All | Stage I Any | Stage II All | Stage II Any | Stage III All | Stage III Any | Stage IV All | Stage IV Any |
|---|---|---|---|---|---|---|---|---|
| Hazard Ratio | 1.01 | 0.94 | 0.89 | 0.84 | 0.67 | 0.71 | 0.98 | 0.93 |
| 95% CI | (0.78, 1.3) | (0.73, 1.2) | (0.68, 1.16) | (0.65, 1.08) | (0.49, 0.92) | (0.53, 0.95) | (0.72, 1.34) | (0.69, 1.26) |
| Deaths | 44 | 46 | 38 | 39 | 15 | 19 | 21 | 22 |
| Total Cases | 546 | 640 | 281 | 330 | 92 | 110 | 32 | 37 |
| Significance | **NS | **NS | **NS | **NS | Higher Survival | Higher Survival | **NS | **NS |

73

73

# Completeness Reports

| Registry Item | Subset (denominator is in range described below) | Subset Description | NAACCR # | Code Evaluated | Benchmark (highlighted if % above this value | Hospital Percent | Number (Num/ Denom) | Message |
|---|---|---|---|---|---|---|---|---|
| 1. Date of First Course of Treatment | Class of Case (#610) = 10-22 | At least some treatment was provided at the facility | 1270 | blank day | 5% | 5.13% | 71732 / 1397425 | Full date of first treatment or decision not to treat not consistently recorded |
| 2. Rx Summ - Treatment Status | Class of Case (#610) = 0-22 | All analytic diagnoses | 1285 | 9 | 1% | 0.4% | 5527 / 1397425 | High portion of cases with unknown treatment status |
| 3. Chemotherapy at This Facility | Chemotherapy at This Facility (#700) NOT = 00 | Patient was given chemotherapy at the facility or it was unknown | 700 | 86, 88, 99 | 8% | 6.11% | 24336 / 398263 | High unknown for chemotherapy given at this facility (allows that some 88s may not be given yet) |

74

74

## Site by Stage Distribution

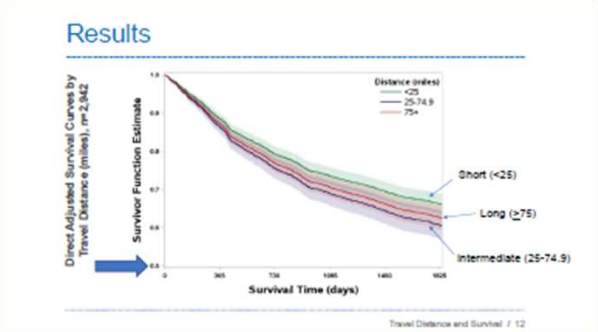
| Head and Neck: 172 | Stg 0 | Stg I | Stg II | Stg III | Stg IV | Unk. | N.A. | All |
|---|---|---|---|---|---|---|---|---|
| Lip | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Tongue | 0 | 14 | 13 | 11 | 13 | 1 | 5 | 57 |
| Salivary Gland | 0 | 4 | 3 | 5 | 4 | 0 | 0 | 16 |
| Floor of Mouth | 1 | 4 | 2 | 0 | 4 | 1 | 1 | 13 |
| Gum and Other Mouth | 0 | 9 | 7 | 1 | 21 | 0 | 2 | 40 |
| Nasopharynx | 0 | 0 | 1 | 1 | 2 | 0 | 0 | 4 |
| Tonsil | 0 | 6 | 7 | 3 | 6 | 2 | 5 | 29 |
| Oropharynx | 0 | 1 | 1 | 2 | 1 | 2 | 0 | 7 |
| Hypopharynx | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 4 |
| Other Oral Cavity and Pharynx | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| TOTAL | 1 | 39 | 34 | 24 | 52 | 7 | 15 | 172 |

NCDB Primary Site-Histology Groupings • View, save or print an "All Sites Report" as HTML PDF Excel

75

75

## Participant User Files (PUF)

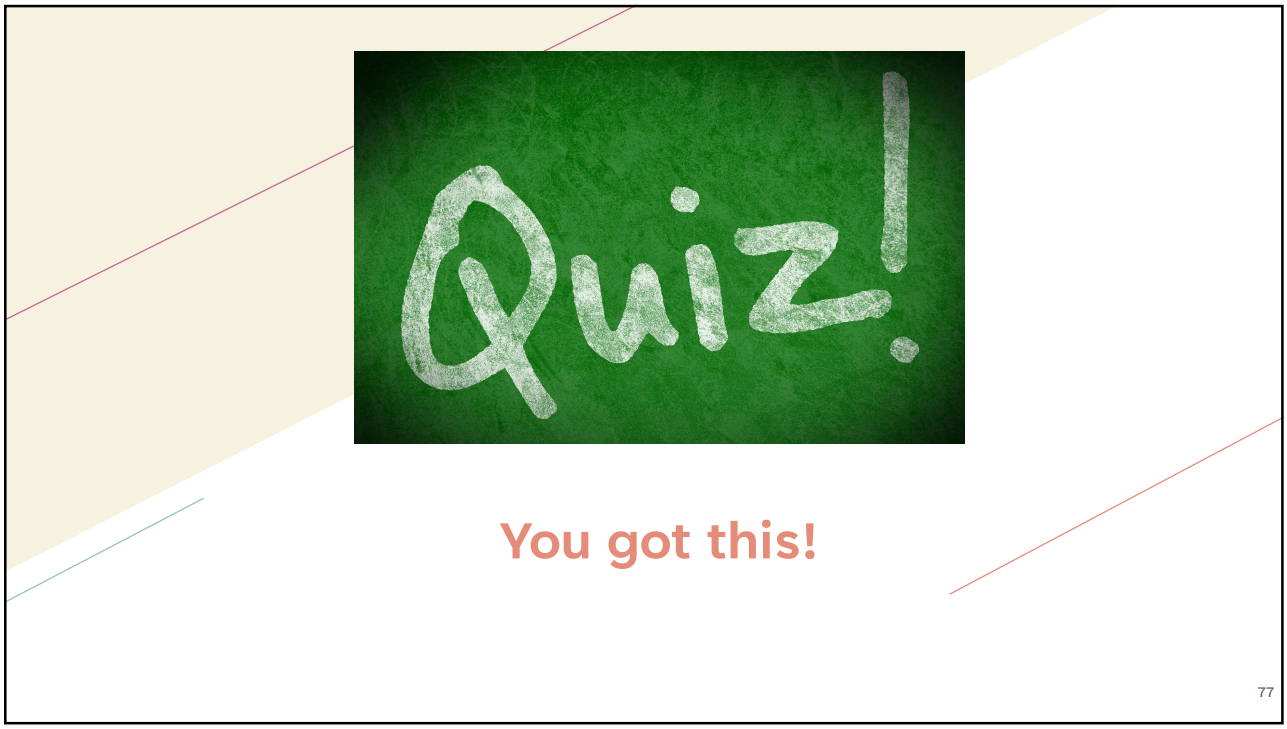



| Site Role | Status |
|---|---|
| Cancer Committee Chair, NCDB PUF Applicant | Active |
| Cancer Liaison Physician, NCDB PUF Applicant, NCDB Tools User | Active |
| Cancer Program Administrator, CoC Contact | Active |
| Cancer Registry Quality Coordinator, Hospital Registrar | Active |
| Clinical Research Representative | Active |
| CoC Contact | Active |
| CoC Contact, NCDB Tools User | Active |
| Community Outreach Coordinator | Active |
| Hospital Co-Registrar | Active |
| NCDB PUF Applicant | Active |

https://qualityportal.facs.org/Qport/Facility#

76

76




77


78

# Evolution Revolution

## The Cancer Registrar's Role


79

## Cancer Registrars: Certified Tumor Registrars (CTR's)

**"We Go WAY Back, But We Never Go AWAY!"**

**1926:** First hospital registry at Yale-New Haven Hospital

**1935:** First central cancer registry established in Connecticut.

**1956:** American College of Surgeons requires a cancer registry for approved cancer programs.

7/15/2022

80

80

# Cancer Registrars: Certified Tumor Registrars (CTR's)

**"We Go WAY Back, But We Never Go AWAY!"**

- **1971:** National Cancer Act budgets monies to the National Cancer Institute for research, detection and treatment of cancer.
- **1973:** Surveillance, Epidemiology and End Results (SEER) Program of NCI establishes the first national Cancer Registry.
- **1983:** NCRA's Council of Certification establishes the Certified Tumor Registrar (CTR®) credential.
- **1992:** Congress establishes a National Program of Cancer Registries (Public Law 102-515).
- **1993:** State laws make cancer a reportable disease.


7/15/2022

81

81

# Cancer Registrars: Certified Tumor Registrars (CTR's)

**Highly trained** data management **experts** who collect and process cancer data.

The primary responsibilities of the cancer registrar are to collect and consolidate accurate data on cancers diagnosed and/or treated within an institution or other defined population while making important decisions related to those activities.

Cancer registrars' work goes **far beyond** simply collecting cancer data.

They also work closely with physicians and other healthcare professionals, administrators, researchers, and healthcare planners to **provide support** for:

Cancer Program Development

Ensure compliance with reporting standard

Serve as a valuable resource for cancer information.

7/15/2022

Definition Compliments of SEER

82

# $how Me the Money!

As of 6/27/2022 the **average** annual pay for a CTR in the U.S. is $58,732 a year.

That works out to be **approximately** $28.24 an hour. $1,129 per week, or $4,894 per month

ZipRecruiter is seeing annual salaries as high as $85,500 and as low as $36,000,

The majority of CTR salaries currently range between $50,500 (25th percentile) to $67,500 (75th percentile) with top earners (90th percentile) making $75,500 annually across the U.S.

**The average pay range for a CTR varies greatly (by as much as $17,000), which suggests there may be many opportunities for advancement and increased pay based on skill level, location and years of experience.**

ZipRecruiter

7/15/2022 83

83

# $how Me the Money!

We found jobs related to the CTR job category that pay more per year than a typical CTR salary. Examples of these roles include: Brain Tumor Research, Manager, Cancer Registry and Cancer Registry Manager.

Importantly, all of these jobs are paid between $22,143 (37.7%) and $50,876 (86.6%) more than the average CTR salary of $58,732.

Must be qualified, educated, experienced and motivated. What are you waiting for?


ZipRecruiter

7/15/2022

84

## The Good Days


7/15/2022

85

85

## The Not So Good Days


7/15/2022

86

86

## Your Future Belongs to You!


7/15/2022
87

87

## From Inspiration to Implementation

88

## Commission on Cancer

- Research
- Quality Improvement
- Staging
- Accreditation

89

## Cancer Registry

- Demand for Cancer Registrars
- Expanding roles and responsibilities
- Technology
- Pay it forward


90

90

## Thank You


7/15/2022
91

91

## Fabulous Prizes

NAACCR
92

92

## Coming UP…

- Solid Tumor Rules 2022
  - Guest Host:  Denise Harrison, CTR; Louanne Currence, RHIT, CTR
  - 08/04/2022
- Coding Pitfalls 2022
  - Co Host: Janel Vogel CTR
  - 09/01/2022

93

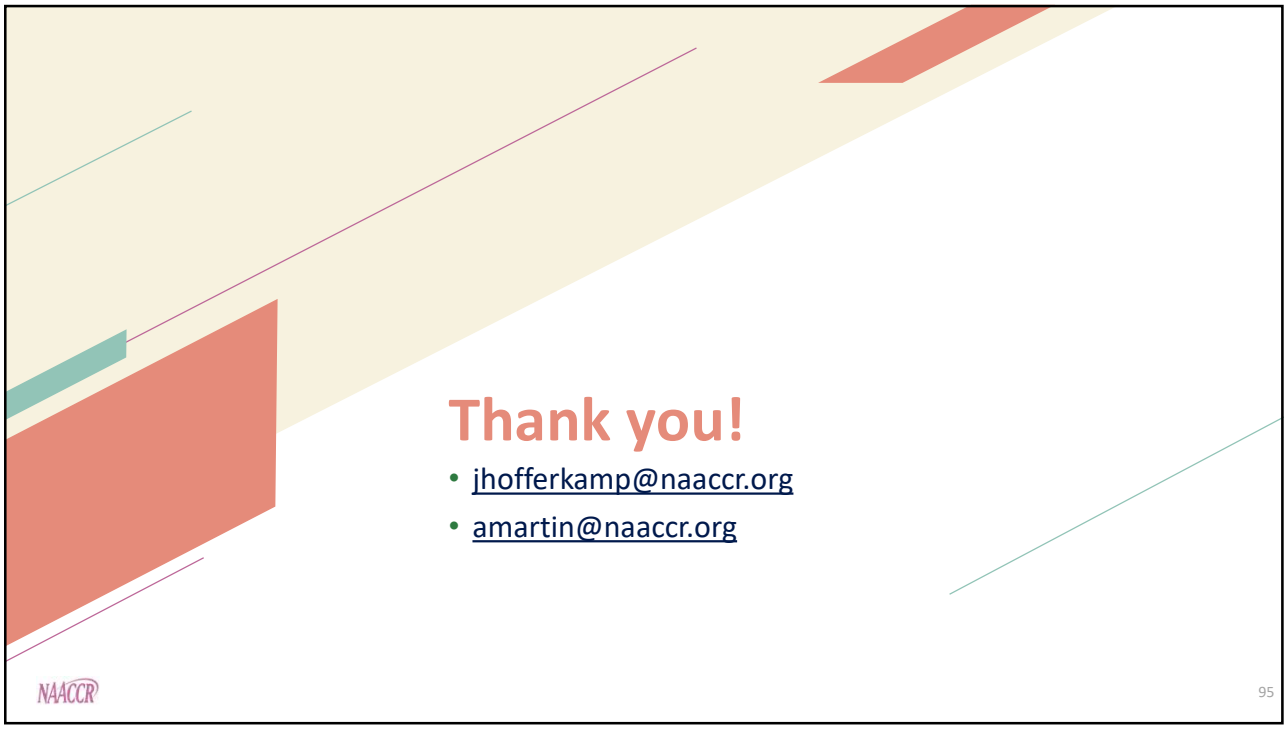
## CE Certificate Quiz/Survey

CE Phrase

Link

https://survey.alchemer.com/s3/6563886/Back-to-The-Future-What-year-is-it-and-What-did-I-Miss

94


Thank you!
jhofferkamp@naaccr.org
amartin@naaccr.org
NAACCR
95

95