2017 Commission on Cancer Liaison Report

Frances Ross

NAACCR Liaison to the Commission on Cancer

The Commission on Cancer held its Spring Meeting for 2017 in Chicago, IL on May 11-12, 2017. The content of this two-day meeting centered on the activities of various committees. Dr. Larry Schulman, CoC Chair, welcomed everyone and gave a brief overview of his outlook on the future of cancer care. He stressed that the value of care is equal to the Benefit gained by the patient divided by the Cost and Toxicity of the care. He questioned whether the Commission should be looking at the factors of the denominator of this equation. He stated that future priorities of the CoC should be 1) exploring areas where care and outcomes are variable, 2) ensuring that actions taken truly assess and improve the quality of care, and 3) becoming a leader in driving the improvements of cancer care and outcomes in the United States.

The Accreditation Committee, headed by Dr. Danny Takanishi, reported on the activities of the Program Review Subcommittee. Their responsibilities are to implement and evaluate standards for the Approvals Program, to oversee the survey process and review the results, and to promote CoC accreditation.

There was an analysis and discussion about the Survivorship Care Plans (SCP) (Standard 3.3). There were 411 surveys conducted in 2016 on 2015 data. For the surveyed hospitals, there were 9,918 patients reported as eligible to receive SCP, and anywhere from 0 to 7572 actually received a SCP. Nationally, it was estimated that over 400,000 patients would be eligible for an SCP, and 79,120 received them (about 20%). This standard is creating the most deficiencies of the 3 new standards for cancer programs. The subcommittee recommended the following considerations:

- Retain the compliance levels to emphasize the importance of the SCP.
- Eliminate confusion on the timing of delivery of SCPs.
- Clarify compliance percent calculation language.
- Add language to allow those not in compliance to pass the standard if the Cancer Committee creates a comprehensive action plan; executes, monitors, and evaluates the plan; and demonstrates progress toward achieving compliance within a timeframe to be determined by the committee.

The Member Organizations Harmonizing Standards Workgroup proposed a structure (outline) for all Standards Manuals. If accepted, this would make the Manuals for the National Accreditation Program

for Breast Cancer (NAPBC) and the National Accreditation Program for Rectal Cancer (NAPRC) and any other specialty accreditation programs more uniform and in line with the overall CoC Accreditation Program Standards. To support this effort, Asa Carter at CoC developed a table comparing the standards of CoC with those of NAPBC.

The Oncology Medical Home Accreditation Committee is looking for surveyors for its new programs. The NAPRC has 6 pilot programs and they are reviewing their standards, following the process of the NAPBC. They will require new programs to have their standards met for 12 months before they can be surveyed.

Various Standards Workgroups addressed specific problematic standards. One group discussed standards 4.7 (Studies of Quality) and 4.8 (Quality Improvement), and recommended merging these two standards and clarifying what needs to be done to achieve compliance. They would like CoC to help institutions design studies, provide examples, provide education in data analysis, and possibly create some 'CoC suggested Quality Studies.'

Another workgroup considered standards 1.8 (Outreach), 4.1 (Prevention Programs, and 4.2 (Screening Programs). They determined that these standards do result in improvement of patient care, but they are redundant and should be merged into one standard, emphasizing all three activities. More clear, concise and straightforward measures need to be developed for this standard, and the group is considering if this category should have a commendation level as well as a compliance level.

Finally, another workgroup considered standard 1.5 (Cancer Program Goals). They questioned how it was different from standards 4.7 and 4.8 (Quality Studies) and determined that it was important to have programmatic goals clearly articulated. However, these goals do not need to be new each year; rather they should be evaluated and programs should demonstrate by progress towards the goals.

The Quality Integration Committee implemented the Site Specific Leader proposal, to provide clinical resources to NCDB staff to assist in ongoing efforts to develop quality measures. They also re-initiated measure development with the Measures Subcommittee, continued to assist NCDB with planning and prioritizing work, and reviewed proposals for collaboration for research within CoC.

Work continued on the Registry Platform Project, which seeks to unify the various databases within CoC into a new infrastructure being developed by Quintiles, a software development company. The NCDB and RQRS re-structuring is in its first phase, planned for 2018. The second phase would move registries to real time reporting and the eventual goal is to import EHR data directly into the NCDB to create various analytic files (Quality measures, Survival data, Participant User Files, CQIP, etc.).

This committee also participates in the development of the cancer care quality measures. New measures were proposed for rectal and kidney cancers, and the group was asked to vote within the week to accept or reject these new measures – 4 for rectal cancer and 3 for kidney cancer.

The FORDS Manual has been revised for 2018 and will be renamed the STORE Manual. The number of data items has risen from 250 to 375, as each site specific factor from the Collaborative Staging System, if retained, will be named as an individual data item. Other changes will be made to accommodate the implementation of AJCC staging 8th edition in 2018. And there will be additional data items for capturing radiation treatment and follow up information.

The Scientific Review Subcommittee reported impressive growth in the Participant User Files (PUF) program. In the first year (2013) the number of PUF files disseminated was 166 and that number has doubled every year since, with 872 files distributed in 2016. This group is eager to promote research collaboration with NCDB data and was soliciting ideas to expand and evaluate new research projects.

The Education Committee described various upcoming CoC sponsored workshops. There will be a Quality of Care conference in September, and plans are underway for the Clinical Congress meeting in October. The priority topic there will be approaches to asymptomatic neck cancers, innovations in pancreatic cancer treatment, and treatment options for non-small cell lung cancer in high risk patients. Nine topics are being considered and six keynote speakers have been suggested for later voting by the group during the Executive Committee meeting. The chair of this committee, Dr. Hisakazu Hoshi, outlined a framework for the foundation of any effective educational program. The framework involves first, a needs assessment, then goal setting, determining the educational methods, creating educational materials, then teaching students, and finally evaluating the effectiveness of the process.

The Advocacy Committee has been focused on several important and topical issues: access to care and the health care reform act (ACHA), cancer research funding, graduate medical education requirements, drug use, particularly opioid use, and the importance of immigrants in health care delivery. At the Committee's February in person meeting at the Capitol, members made 36 visits to congressional representatives, three visits to leaders in childhood cancers, and they spoke in support of several bills in Congress. Specifically, they sent letters of support for One Voice Against Cancer (OVAC) research programs, removing barriers to colorectal cancer screening, cancer care payment reform, cancer drug coverage, and active treatment planning.

In addition to the issue of health care reform, the committee made recommendations for legislation to support effective use of sunscreen in schools. Several organizations have developed position statements (AMA, ACS, and the American Dermatological Society) and recommend uniting with CoC to introduce a bill to allow the application of sunscreen in schools. Currently, most states prohibit the possession and application of sunscreen in public schools, and only 5 states allow it.

Distress screening was another area of focus for the Advocacy Committee. They mentioned specifically the screening of clinical trials participants for aspects of distress – disruption to work life, home life and family. A bill has been introduced in the House called the Patient Experiences in Research Act, which, included with the Drug Use Act, seeks to get patient experience metrics from different clinical trial arms to measure these disruptions.

At the state level, they reported that 5 states have bills pending to ban tanning beds for minors (2 states have banned them); 3 states have active bills to allow sunscreen in schools; 2 states have palliative care councils (1 has enacted this law); and 20 states have active bills prohibiting tobacco use in public places, (2 states have passed a tobacco ban). On another topic, the Massachusetts Board of Registration has proposed a change requiring doctors to have specific conversations with patients discussing all forms of treatment and documenting compliance with the law in the patient's medical record. The patient must sign a written consent or refusal of treatment form, acknowledging the discussion of treatment possibilities. There were strong opinions both for and against this proposal. Some physicians said, 'Of course, this is how we practice anyway.' Other said it would set a bad precedent for legislators to mandate specific conversations between doctors and patients, and it would just invite lawsuits, with its ambiguous language.

There was a brief tutorial on physician payment systems, the latest of which is a merit-based fee for service system, based on performance measures. Finally, the committee reported on a survey they had conducted regarding advocacy efforts by the CoC Member Organizations. Nearly 80% of the member organizations participate in advocacy activities, mostly in regard to federal legislation and regulatory requirements.

The Member Organization Representative Committee continued discussion on 4 'hot topics' from this committee's meeting last spring: Advocacy, Harmonizing Standards Requirements, Survivorship Care Plans, and Distress Screening. Advocacy recommendations were presented by the Advocacy Committee, and the report of the Harmonizing Standards Workgroup was addressed by the Accreditation

Committee. For distress screening (Standard 3.2), the committee recommended having the necessary measurement data incorporated into the Electronic Health Record. These would be: name of the person providing the screening, the interval for follow up, any non-English resources, and any best practices. Currently, EPIC, Cerner, and Meditech can capture distress screening information in their systems; it was felt that Varian and Elekta could develop this as well. Recent accreditation surveys found that, out of 469 facilities, 443 were compliant with this standard, 2 were deficient but the deficiencies were resolved, and 21 were deficient. The group will monitor the results of 2017 surveys and make any recommendations to the Accreditation Committee.

The purpose of the Survivorship Care Plans is to provide a list of treatments received, enhance communication about continued care, and inform the patient about the possibility of late effects. Of 464 surveys, 16% had a deficiency for this standard. There was concern among the attendees that there is not currently enough evidence from outcomes to confirm the value of having this standard. There were numerous challenges to meeting this standard cited: lack of technology to create the care plans, limited staff to create and deliver the plans, lack of support from hospital leaders, and difficulty in identifying 'eligible' patients. The group recommended clarification of the standard, the development of an SCP education and dissemination plan, and an assessment of the outcomes showing the benefit of providing these plans. There was concern that the SCPs were really not being used by either the patient or by their primary care providers. They recommended revisiting this standard, focusing not on the percentage of patients receiving them, but rather on the resources needed to produce these documents, and on the impact of these plans to empower patients to regain their lives and take charge of their continued care.

The Cancer Liaison Committee recommended keeping cancer liaison physicians (CLP) who are State award winners, but no longer CLPs, involved in the CoC by inviting them to become part of the Advisory Group. Next, the American Cancer Society provided an update of their new Regional Model map, reducing 11 divisions down to 6 regions. They are taking a market center approach with 46 markets led by volunteer boards who will focus on delivering their services to the customers in their communities. Their strategic plan is to define the future of cancer control in the U. S. and to develop new tools for fighting cancer through investment in research.

Brainstorming Sessions – Friday's meeting started with 3 separate brainstorming sessions focused on 1) CoC accreditation standards, 2) specialty accreditations, and 3) patient centered care. The conclusion of the discussions was that each standard needs to emphasize its purpose to improve a particular problem and to let individual programs demonstrate efforts to address the problem and develop measures of

progress. They also concluded that the survey process needs to be more uniform across programs and suggested better training for surveyors, more objective measures of compliance, and more pre-survey preparation. The surveyor can then spend his or her on-site time on verification, education, and CoC promotion. The patient centered standards need to emphasize their focus on processes, outcomes, and documentation.