Cancer Program's Seal of Approval

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by Susan M. Koering, MEd, RHIA, CTR

Like hospitals and other healthcare organizations, cancer programs are also eligible for accreditation. Here's an overview of how the process works, and how HIM professionals can contribute.

Like everyone else, cancer patients want to be treated in facilities that are recognized for quality care. One way for a program to distinguish itself is through accreditation—a process already well known in hospitals and other healthcare programs. How does the cancer program accreditation process work, and how does the HIM professional play a role? This article answers these questions.

Why Accreditation?

Cancer is the second leading cause of death in the United States, which means one of every four deaths is from cancer. The American Cancer Society estimated that in 2001 about 1,268,000 new cases of cancer were expected to be diagnosed and about 553,400 people were expected to die of cancer—1,500 per day.[1] Clinicians and researchers constantly seek effective treatments to sustain and improve the quality of life. Receiving healthcare help from qualified healthcare facilities is important to all cancer patients.

When a patient or a family seeks cancer care, they look for new as well as proven effective treatment methods, qualified staff, and favorable outcomes. When an employer seeks healthcare plans for employees, it also seeks quality treatment, qualified staff, and successful treatment outcomes at reasonable costs.

In the 1930s, the Commission on Cancer (COC) of the American College of Surgeons (ACS) established standards and a program of review and approvals for hospitals, clinics, and other healthcare centers involved in the diagnosis, treatment, and follow-up of cancer. The goal of the commission is to decrease the morbidity and mortality caused by cancer through prevention, monitoring and reporting of care, standard setting, and education.[2]

Accreditation status lets the public know that a program has met the standards of high-quality, multidisciplinary care. This is particularly important when a patient has cancer. As one *Journal of AHIMA* author puts it, "Healthcare accreditation has become a vital function in the evaluation of healthcare delivery in the United States and many other countries. Accreditation processes of all kinds will shape and redefine our healthcare system—not only now, but in the years to come."[3]

Today more than 1,400 cancer programs are accredited by the COC in the United States—the equivalent of 1 in 4 hospitals that treat patients diagnosed with cancer. Currently, 82 percent of newly diagnosed patients with cancer are treated in programs accredited by the COC.[4]

The Joint Commission on Accreditation of Healthcare Organizations has also formally recognized the COC's review process, which assists a cancer program in becoming more visible to healthcare professionals, the public, and other interested groups.

How Does a Cancer Program Become Accredited?

When a cancer program seeks to obtain an approval status, it needs to contact the COC for three publications:

- Volume I: Cancer Program Standards
- Volume II: Registry Operations and Data Standards (ROADS)
- Volume III: ROADS Edits

These publications help programs build the foundation of their accreditation.

Volume I includes 10 areas of review, ranging from research to public education to management of cancer data, each with a set of required standards. These standards promote and support a multidisciplinary approach to the management of cancer. The best approach to review the standards for initial approval or re-approval is to assign staff to teams representing each of the 10 sections of Volume I. The team members should be staff with responsibility in each specified area.

Volume II contains the required data set and detailed instructions for registry operations and coding of malignancies. Volume III is a quality control resource for the collection of data items.

Hospitals seeking approval will need to determine a category of approval (see "A NCIP Worth 1,000 words").5 Categories are based on type of facility, annual cancer case load, and resources available. They must establish a cancer committee, cancer conferences, a cancer registry with cancer data management software, and a program to review quality management and improvement.

A cancer liaison physician is appointed by the cancer committee and will routinely report activities of the COC to the facility.

One year from when the program was initiated, a consultative visit can be requested from the COC to evaluate its progress. A program can apply for its first formal approval when the cancer registry has two years of accrued data and one year of patient follow-up. A three-year approval is awarded to programs meeting the standards.

The COC is presently revamping the accreditation process with incorporation of patient data from the ACS National Cancer Data Base (NCDB), including quality of care measures important to assessing cancer care patterns and outcomes. Changes to the NCDB patient data set include collection of more contemporary treatment ascertainment and data to allow risk, as well as disease-specific stage-adjustments of outcomes.6

How Is the Cancer Registry Involved?

A cancer registry (or tumor registry) is a key component of a cancer program. The registry is a data management system designed to collect, manage, and analyze data on persons diagnosed with cancer and certain benign (non-cancer) conditions.

The patient is identified by the registry at the time of diagnosis, tracked through treatments such as surgery, chemotherapy, or radiation therapy, and followed for a lifetime. Data collected in the registry includes patient demographics, medical history, diagnostic tests and results, specific cancer information such as tumor site and histology and extent of disease, therapy, and last contact status.

The registry is involved in the accreditation process by its functions in potentially four of the 10 sections set by the COC in Volume I. In many facilities, registries coordinate tumor boards or conferences according to predefined standards, such as these enumerated in Section 3:

- 3.3.1 Cancer conference is multidisciplinary
- 3.3.4 The number of cases discussed is proportional (10 percent) to annual newly diagnosed case load
- 3.3.5 Frequency of meetings is appropriate to the category of approval

The registry is represented on the facility's cancer committee and is responsible for agenda items referencing cancer data. Staff may be involved in maintaining the minutes of the committee for ongoing follow-up of committee actions. The cancer committee must also publish a report annually reporting on the cancer program activities. This includes registry activity, statistical summary of registry data, and a detailed statistical analysis of at least one cancer site. Registrars often coordinate this process, as noted in Section 2.

The cancer care team is responsible for at least two quality management and improvement initiatives annually. The registry helps in identifying cancer program quality issues and improvements through the data it captures and displays. The COC offers two patient care evaluation studies annually for voluntary participation. These are site-specific, detailed studies that compare a facility's data with national data to identify potential quality of care issues; for example, the 2001 studies focus on gastric cancer and lung cancer, as noted in Section 7.

The registry is responsible for Section 8, Cancer Data Management, with nine standards (see "Data Management Spotlight"). Investment in a cancer data software program meeting the COC standards is necessary for accuracy, completeness, and ease of reporting of data.

Volume II addresses the data items required on each cancer case abstracted, along with definitions. Software programs must also meet the requirement of data submission to state or central registries, as required by law.

Standard 8.7.0 states that the registry must submit data to the NCDB. The NCDB provides a benchmark for patient care and quality improvements of each cancer program. The data evaluates therapies and outcomes and compares each program to national data.

What Role Do Cancer Registrars Play?

Cancer registrars are data experts and serve as a valuable resource for cancer information. They must respond to requests for data from national organizations, regulatory agencies, administration, physicians, nurses, rehabilitation teams, and other registries. They are responsible for ensuring accuracy, completeness, and timely reporting as well as maintaining privacy of patient information.

The COC encourages registry staff to attain a certified tumor registrar (CTR) credential as awarded by the National Board for Certification of Registrars. Certification demonstrates that a registrar has met or exceeded the standard level of experience and technical knowledge required for effective cancer data management.

Membership is voluntary with the National Cancer Registrars Association (NCRA), whose purpose is to:

- provide educational opportunities for continuous learning
- advance knowledge of all new technologies that influence cancer data
- establish standards of education
- promote the value of a certified registry professional
- support professional standards and ethics[7]

NCRA presently has approximately 4,000 members, including those who also have an RHIT or RHIA.

Registrar positions are rewarding in that the registrars can feel they are a vital part of a team helping to conquer cancer. Registrars are irreplaceable, essential links between cancer care and rational cancer control.[8] Each registrar has a challenging position, whether it is abstracting a new cancer case or obtaining lifetime follow-up on a 10-year survivor. Every cancer case identifies a person with his or her own set of data.

The HIM Role

All patient care programs have patients, data, and a set of guidelines to follow to assure quality of care. Training in data management can support multiple areas, including cancer care.

A cancer program accreditation relies on the skills of the healthcare team including the cancer registry and their skills in HIM. We strive to give the best of care to our cancer patients and continue to find new treatments, new technologies, and educational processes to conquer cancer. Cancer patients want the best care possible. They will know they are getting the best care when a cancer program achieves and maintains a COC accreditation status.

Notes

1. *Cancer Facts & Figures-2001*. Atlanta, GA: American Cancer Society, 2000.
2. *Standards of the Commission on Cancer*, Volume I: Cancer Program Standards. Chicago, IL: American College of Surgeons, 1996.
3. Baldwin-Stried, Kimberly A. and Constantine V. Godellas. "Accreditation 2000: The Journey Continues," *Journal of AHIMA* 71, no. 2 (2000): 32-39.
4. "How to Start an Approved Cancer Program." Available at the Commission on Cancer Web site, www.facs.org/dept/cancer/coc/approval.html.

5. "What is an Approved Cancer Program?" Available at the Commission on Cancer Web site, www.facs.org/dept/cancer/coc/whatis.html.
6. "Hospital Cancer Programs Approved by the COC Up by 10 Percent." Available at the Commission on Cancer Web site, www.facs.org/dept/cancer/coc/coc10per.html.
7. NCRA Web site, available at www.ncra-usa.org/_purpose.html.
8. Hutchinson, Carol. L., Steven D. Roffers, and April G. Fritz. *Cancer Registry Management: Principles and Practice*. Lenexa, KS: National Cancer Registrars Association, 1997, p. 7.

For more information on cancer registries and the cancer accreditation process, visit the COC's Web site at www.facs.org/dept/cancer/index.html.

A NCIP Worth 1,000 Words

Following are some of the regularly used abbreviations for approved cancer programs:

- Comprehensive Cancer Program (NCI*-designated program)(NCIP)
- Teaching Hospital Cancer Program (THCP)
- Community Hospital Comprehensive Cancer Program (COMP)—greater than 300 new cancer cases/year
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)—100 or fewer new cancer cases/year
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)
- Affiliate Hospital Cancer Program (AFCP)—fewer than 50 new cancer cases/year
- Managed Care Organization (MCO)
- Special Hospital Cancer Program (SHCP)
- Network Cancer Program (NCP)

*National Cancer Institute

Data Management Spotlight

Standards in Volume I, Section 8: Cancer Data Management (4) include:

8.1.0—A cancer registry that meets the standards as defined in Volume II: ROADS is maintained to collect and analyze data on all reportable diagnoses.
8.2.0—The registry is staffed by knowledgeable personnel.
8.3.0—The maximum abstracting delay is six months and is calculated from the date of initial diagnosis to the time the data are available for analysis.
8.4.0—The registry maintains patient confidentiality.
8.5.0—The registry collects the required data set and utilizes the data definitions and codes in Volume II of ROADS.
8.6.0—Follow-up information is systematically obtained for patients in the registry database, and the required follow-up rates are met.

8.7.0—Registry submits data to the NCDB.
8.8.0—Data are used for special studies and reported to the medical and administrative staff.
8.9.0—A quality control plan is in place with documentation of procedures to monitor case finding, data collection, accuracy, and timeliness.

Program Standards to Know

Sections in Volume I of the COC's Cancer Program Standards are:

1. Institutional and Programmatic Resources
2. Program Management and Administration
3. Clinical Management
4. Inpatient and Outpatient Care
5. Supportive and Continuing Care Services
6. Research
7. Quality Management and Improvement
8. Cancer Data Management
9. Public Education, Prevention, and Detection
10. Professional Education and Staff Support

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