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Mastering the Juggling Act *of multiple program accreditations*

Multiple Cancer Program Accreditations

Mastering the Juggling Act

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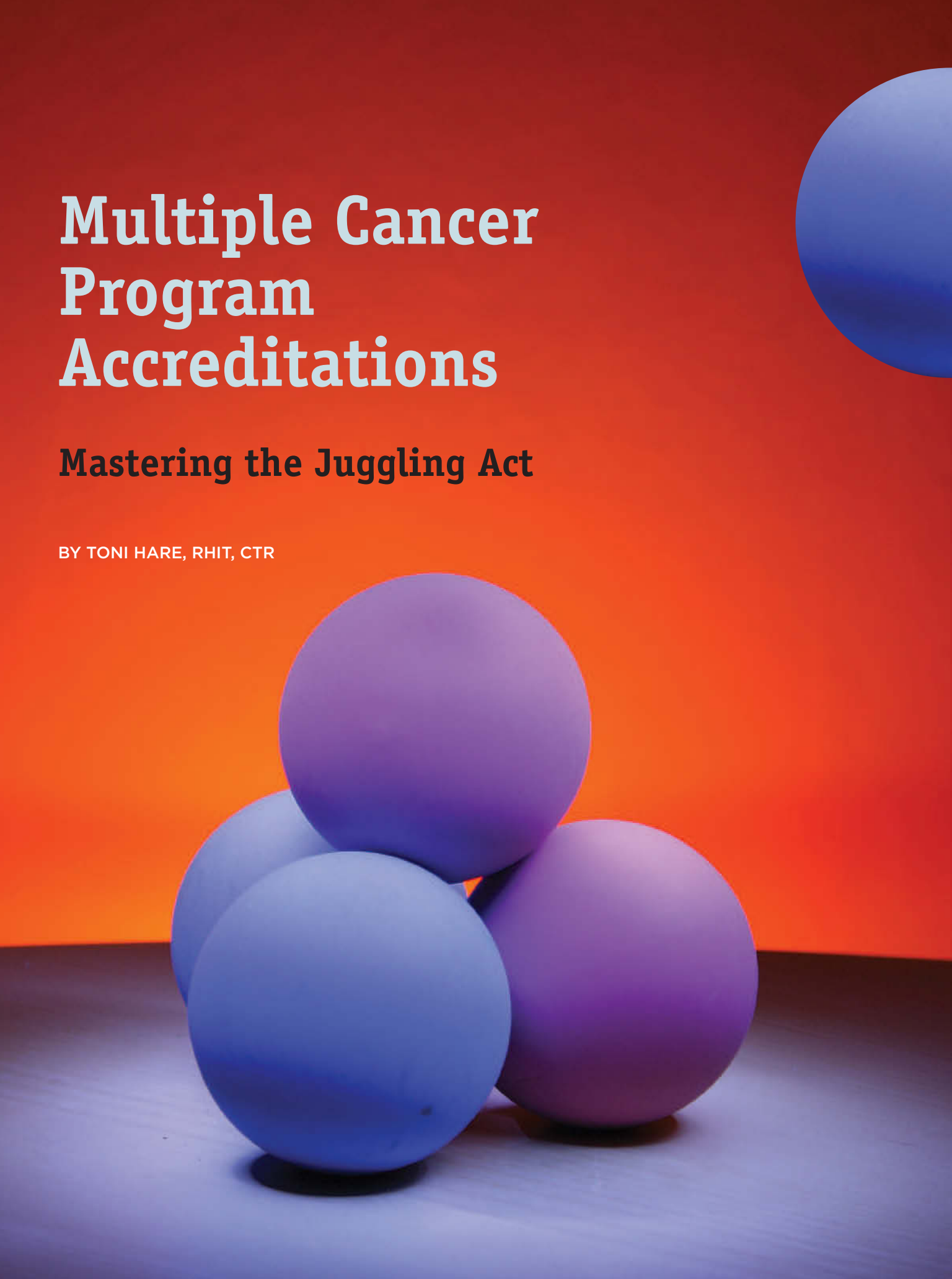


Juggling is a skill I have never mastered. In fact, it's something very few people even attempt. Yet, hospitals and healthcare systems nationwide are doing just that—juggling multiple treatment guidelines, industry standards, quality measures, and hospital-specific pathways that are the result of a transitioning healthcare system. As payers back away from transactional-based pay and towards a pay-for-performance model, hospitals are required to provide validation of the patient care and quality outcomes they provide to their communities.

The increased attention to industry standards has impacted cancer programs as well. From the cancer program administrator, to the Cancer Committee and the cancer registrar, comprehensive changes to standards are affecting data collection, utilization, and analysis. But the changes don't stop there. As healthcare consumers become more discerning, community cancer centers are feeling the pressure to meet and exceed the evolving standards of many different organizations, such as the Commission on Cancer (CoC), The Joint Commission's Disease-Specific Certification, the National Accreditation Program for Breast Centers (NAPBC), and the Quality Oncology Practice Initiative (QOPI) from the American Society of Clinical Oncology (ASCO).

In addition to managing multiple accreditations from multiple accrediting agencies, this year cancer programs also have a new set of patient-centered CoC Standards to implement. More than 1,500 hospitals, freestanding cancer centers, and cancer program networks nationwide are currently accredited by the CoC,[1] and as of January 1, 2012, all CoC-accredited programs and those programs seeking accreditation are now required to implement the new CoC 2012 standards. The new standards work to:[2]

- Coordinate and integrate care across boundaries of the healthcare system
- Provide information, communication, and education that people need and want
- Guarantee physical comfort, emotional support, and the involvement of family and friends.

As a CoC-trained Consultant, I sense the trepidation in my clients' questions, concerns, and comments regarding the new CoC standards—*Will I need to hire more staff? How can I afford to hire a nurse navigator? Will my Cancer Committee understand what we have to do? How can I do more without additional resources?*

This article highlights ways cancer programs can manage multiple and ever-changing cancer program standards. In other words, the article aims to answer the question—*how can a cancer program effectively juggle multiple accreditations, while making the most of current internal resources?*

To answer this question, cancer program leadership needs to analyze and assess the internal resources available to ensure each resource is being fully utilized. I typically ask questions that uncover the systemic and collaborative approach of the cancer program:

- Is the cancer registry acting as a strategic partner to the cancer care team?
- Is the Cancer Committee aware of the latest standards?
- Is there a shared vision within the cancer program?
- Is that shared vision supported by senior leadership?
- Are there adequate and useful communication tools to promote a successful feedback loop?

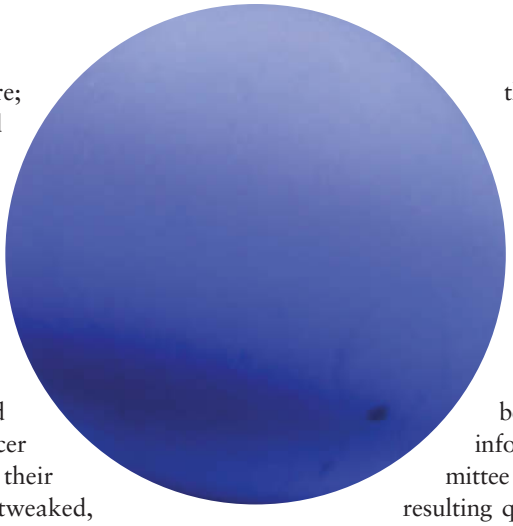
For example, I often find the cancer registry to be an underutilized resource. While many cancer programs realize the benefit of a strategic partnership with the cancer registry, others are simply not aware of the powerful potential provided by educated cancer registrars. As a cancer program and cancer registry consultant, my career has been dedicated to assisting cancer programs to become more efficient and effective. Together with my team of compliance experts, I have come up with six steps to mastering the juggling act of multiple accreditations.

step 1

Stop asking, "What does the standard say?" and start asking, "What is the right thing to do?"

Palliative care, survivorship, patient navigation, continuum of care, and psychosocial screening aren't just buzz words in today's standards, they are important components of a multidisciplinary approach to patient care that includes the family, as well as the physical and emotional aspects of care. It's not the

standard that guides us to enhance care; it's the concept that patient-centered quality care is the right thing to do.



More often than not, I find clients who focus on the large-scale changes to standards get more overwhelmed than necessary. Most clients are already performing in compliance with new standards. They understand what's right; they may just not completely understand how to incorporate it into the Cancer Committee activities. In many cases, their actions may need to be formalized, tweaked, documented, discussed, or validated to be compliant with the new standard.

So, my first step is to help clients realize the standards aren't groundbreaking. Instead, these new standards help community cancer centers solidify and validate that appropriate care is being provided. Of course, corrections, changes, and new processes may be added here and there, but, in my experience, it is easier to first identify what a client is doing right, and build from there.

By shifting your perspective from semantics to ethics, the standards for each accreditation will start to become interwoven, and identifying similar logic, overlapping requirements, and where gained efficiencies can be realized will become easier. For example, cancer registrars at CoC-accredited cancer programs already collect stage, prognostic indicators, and treatment information for the assessment of treatment planning standards. That information then can be used for both CoC and NAPBC quality outcome studies. Another example is the overlap in the NAPBC and the CoC standards to develop a process to monitor physician use of the American Joint Committee on Cancer (AJCC) or other appropriate staging in treatment planning. Both accrediting agencies require that this process be developed, so communication between the two oversight committees is essential to reduce redundant activities.

step 2

Illustrate the changes to standards, the overlapping requirements, and the overarching objectives.

As a consultant, I find it easiest to explain how to manage multiple accreditations efficiently by creating a matrix that illustrates this information. A scorecard or dashboard can serve the same purpose. Basically, the matrix needs to outline each CoC standard, and map it to a correlating NAPBC standard or disease-specific measure and then provide detail of what information needs to be captured and by whom. In most instances, the cancer registry plays an important role.

A matrix or diagram that connects the dots for everyone in the cancer program is very helpful in explaining *what* you are doing, *why* you are doing it, and *how* you are doing it. For example, The Joint Commission disease-specific certification for breast, colorectal, lung, pancreatic, prostate, or renal cancer does not come with a clear set of quality indicators; it is up to the cancer center to determine what those indicators are and how they will be collected and measured. By having an informed and educated taskforce or subcommittee in charge of this certification process, the resulting quality indicators should be aligned with the overarching goals and objectives of the cancer program and the hospital. The matrix can then start to pinpoint exactly what information needs to be collected, in what time period, and where the information can be found.

It's true that someone needs to have an intimate understanding of each of the accreditations or certifications in order to put this kind of matrix together. As a result, it seems to work best if one person from the Cancer Committee is charged with this task and that person can request assistance as needed.

However, more work and change can be hard to swallow. Applying for additional accreditations needs to be an objective or goal that is shared not only within the cancer center, but also with the hospital senior leadership. So, prior to moving forward with additional accreditations, make sure they fit with the goals of the hospital and that your senior leadership understands the who, what, where, when, why, and how.

step 3

Realize the connection between CP³R and NAPBC.

It's important to realize the universal nature of these standards. For example, both the Commission on Cancer's National Quality Forum (NQF)-endorsed, evidence-based quality care measures, which are reported through the Cancer Program Practice Profile Report (CP³R), and certain NAPBC standards require the utilization of quality measures endorsed by the NQF. So by design, meeting the requirements of CP³R also positions a cancer center to be on the right track to comply with certain NAPBC standards.

However, before applying for the NAPBC accreditation, your cancer center must exhibit an extreme focus on breast health; it must have a multidisciplinary approach, with oncologists, radiologists, surgeons, pathologists, nurses, and other healthcare professionals all working in concert to efficiently guide patients through a cohesive system of comprehensive breast care.[3]

Applying for additional accreditations needs to be an objective or goal that is shared not only within the cancer center, but also with the hospital senior leadership.

A common misstep is when a community cancer center wants to be NAPBC accredited, but has not taken any of the necessary steps to plan and prepare for this survey process. While commonalities exist between the CP³R and NAPBC, and while you can most definitely realize time savings from accurate, timely, and complete cancer data collected in the registry, your breast program needs to be multidisciplinary in structure and focused on the diagnosis and treatment of patients with diseases of the breast.

step 4

Get the Cancer Committee aware, educated, and involved.

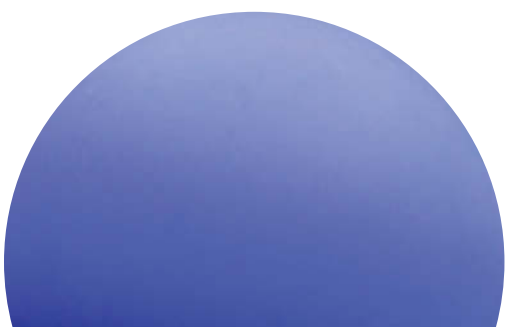
The Cancer Committee is the governing body that directly affects and validates patient care. It has the responsibility and accountability for cancer program activities. In some situations, a cancer center may decide to apply for NAPBC or a Joint Commission disease-specific certification and form a leadership team without the involvement of the Cancer Committee. This decision can result in duplicative action, competing objectives, and inefficiencies when preparing for multiple surveys. Prevent these types of challenges by creating a collaborative effort with the Cancer Committee in support of all cancer care quality initiatives. Therefore, the Cancer Committee is one of the first places to start when considering applying for an accreditation. By leveraging the involvement of dedicated and knowledgeable Cancer Committee members, cancer centers can efficiently and effectively juggle multiple accreditations.

For example, the HERS Breast Center at Mayo Clinic Health System in Eau Claire, Wisconsin, created a Breast Program Leadership Committee of key leadership and care providers dedicated to breast cancer in order to achieve two significant accreditations:

- The Breast Imaging Center of Excellence by the Commission on Quality and Safety
- The Commission on Breast Imaging of the American College of Radiology.

"After achieving these accreditations for our Breast Center, the NAPBC accreditation was a logical next step," said Barb Eidahl, RN, director of oncology at Mayo Clinic Health System in Eau Claire. "A committee of Breast Program Leadership already existed and the knowledge and resources required to apply for NAPBC had already been pulled together. We were also able to streamline our meetings by scheduling the Breast Program Leadership meeting to occur directly after the quarterly Cancer Committee meetings. That way the members of the Cancer Committee who were also on the Breast Program Leadership committee were already in the right place," Eidahl said.

Bottom line, the cancer registry is your data mine.



step 5

Invest in the cancer registry.

Bottom line, the cancer registry is your data mine. It's up to you to mine the data and turn it into information that can be used to set objectives related to accreditation, cancer care, patient outcomes, reimbursement, and business decisions. Specifically, cancer registry information can be used to:

- Establish population trends and stage of disease
- Identify physician referral patterns
- Determine hospital outmigration patterns
- Enhance and monitor existing cancer program services
- Assist in resource and equipment allocation
- Populate oncology scorecards.

By setting accreditation objectives, the team of registrars can identify upfront the data to be collected, and can determine an efficient process for collecting any necessary additional data items outside of the Facility Oncology Registry Data Standards (FORDS). By working collaboratively with your team of registrars, you can streamline the process to prepare for and achieve accreditation with multiple guidelines, and get more from your current resources.

For example, suspecting an issue with physician and patient referrals, Denise Clark, director of oncology at the

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A CASE STUDY

Ohio Health's Riverside Methodist Hospital is an organization that is successfully managing multiple accreditations. An ACCC Cancer Program member, Riverside has been CoC accredited for 28 years. In 2005 the hospital achieved The Joint Commission's disease-specific certification for lung cancer and, in 2009 achieved NAPBC accreditation for breast cancer. Riverside's cancer program exemplifies the comprehensive, collaborative approach necessary to enhance quality of care and achieve additional accreditations, while maximizing the internal resources available. The cancer registry at Riverside is a well-used, reliable data source, and the Cancer Committee, originally developed to assist the hospital achieve CoC accreditation, plays an important role in the oversight of the entire cancer program. A look at Riverside's operations reveals that mastering the art of juggling multiple accreditations is not so difficult after all.

The Cancer Committee

For Riverside Methodist Hospital the first step in effectively managing multiple accreditations was to make the process the responsibility of subcommittees of the larger Cancer Committee. Upon agreement, smaller subcommittees with a disease-specific focus were established to support the additional accreditations (i.e., The Joint Commission's disease-specific certification for lung cancer and NAPBC's accreditation for breast cancer). The Cancer Committee was familiar with the CoC Standards and understood the importance of accreditation—from both the hospital and patient perspectives. Because of this understanding, the subcommittees were able to benefit from what had been done for the CoC accreditation, and then work to drill down to more specific quality measures and data elements for lung and breast cancer.

According to Anna Hensley, MBA, RT(T), director of Cancer Services at Riverside Methodist Hospital, the collaboration between the Cancer Committee and subcommittees for the lung certification and breast accreditation increased efficiencies and allowed for goals and objectives to be overarching and consistent throughout the cancer program.

"The key is to not reinvent the wheel for each quality measure or initiative in the cancer program," Hensley said. "By having clarity on the goals and objectives of the hospital and of the cancer program, committees can be clear with one another and work in harmony to meet multiple accreditations, while streamlining processes and avoiding duplicative work."

Annually, Riverside's Cancer Committee agrees on goals that are aligned with the overall goals of the organization. Each subcommittee can then develop goals that will work to support and advance the overarching goals of the oncology program. The subcommittees report to the Cancer Committee on a regular basis, providing updates on goal status and requesting support for any barriers that may have come up.

The Riverside Cancer Services Cancer Management Team.

The Cancer Registrar

Another important component, Hensley explained, was involving the cancer registrar very early in the process. "By adding a cancer registrar to the multidisciplinary subcommittees, you can be assured that not only is the quality measure *meaningful* to cancer patients, but also that it is *realistic* to measure."

For example, for the NAPBC accreditation, the cancer registrar worked very closely with the physicians; she had a good understanding of how the data was captured and the steps required to capture additional and concurrent data. In some situations, the information necessary to measure a specific quality metric was simply too time intensive for what the outcome may have meant to the cancer program. And the cancer registrar helped Riverside's subcommittee make this determination.

The Joint Commission Disease-Specific Certification

At the point Riverside applied for The Joint Commission's disease-specific certification for lung cancer, the cancer program had already been working to achieve improved processes and outcomes for lung cancer. Given that there are no nationally recognized quality indicators for lung cancer, the cancer center formed a lung subcommittee that developed very specific criteria to measure using Riverside's lung cancer dashboard. After applying for The Joint Commission's certification, this subcommittee of specialists worked in conjunction with a Joint Commission surveyor to refine the final metrics that would be used for The Joint Commission's lung-specific certification process.

NAPBC Accreditation

At the same time the lung subcommittee was managing The Joint Commission survey process, a breast cancer subcommittee was managing the process for NAPBC.

The decision to move forward with additional certifications and accreditations needs to be thoroughly evaluated. While there can be a benefit to the quality of care, the actual accreditation can be expensive in terms of application costs *and* resource costs. A hospital needs to be prepared to dedicate a variety of resources and there has to be physician and staff buy-in. Riverside's decision to move forward with NAPBC accreditation was

discussed and agreed on easily because the cancer program was already submitting to the CoC's CP³R and had already implemented a breast navigation program.

"We were on the right track, so the next step was forming a team dedicated to breast cancer care," Hensley said. Riverside's NAPBC subcommittee consisted of a breast surgeon, radiation oncologist, medical oncologist, pathologist, radiologist, breast navigators, administrative staff, and more.

Planning & Goal Setting

To increase awareness of all quality measures being tracked at Riverside, Hensley, in collaboration with her team, implemented a Quality Scorecard that serves as the measurement tool for clinical indicators for all accreditations. As the director of the cancer program, Hensley made herself accountable for updating and posting this scorecard in a centralized location. "The scorecard is very helpful. It's easy to read, and is used to keep all stakeholders across the board involved and aware of the quality initiatives happening at Riverside," Hensley said.

The scorecard is a highly utilized communication tool at Riverside. Metrics on the scorecard serve as agenda items for the Cancer Committee, are frequently discussed in the subcommittees for disease-specific certifications, and are presented by Hensley to hospital senior leadership quarterly.

"Because the clinical indicators on the scorecard actually roll up into the hospital's Process Improvement Committee's scorecard, the hospital leadership at Riverside understands the importance and relevance of these accreditations," Hensley explained. "Also, the cancer program leadership, including the Cancer Committee, understands how these accreditations fit into the bigger picture goals and objectives of the hospital," Hensley said.

The scorecard (Figure 1, below) identifies several clinical indicators tracked by Riverside. It is organized by accreditation and tracks each data set by a year-to-date comparison, target, current status, and monthly progress of each clinical indicator.

Additionally, having a point person to manage the multiple timelines, dashboards, and goal deployment documents helps keep all of the teams on the right path. Riverside maintains a shared calendar of studies being performed, unique data being collected, and important survey dates so that the entire team can quickly see a snapshot of what's going on in their cancer program.

Overall, Riverside Methodist Hospital has been successful at managing ever-changing and multiple accreditations because of their ability to communicate, identify meaningful and realistic clinical indicators, and plan and leverage existing internal resources. Their commitment to quality cancer registry data and their ability to utilize a very involved Cancer Committee has been valuable in the process of successfully applying for additional certifications and accreditations. OI

Figure 1. Riverside Methodist Hospital, Cancer Services, Quality Scorecard FY12: Sample Clinical Indicators

QUALITY MEASURES	FY12 YTD	TARGET	STATUS	JUL-11
CoC Accreditation Performance Measures				
Chemotherapy administration				
Pain satisfaction (Press Ganey quarterly percentile, any unit, ICD-9 cancer diagnosis code)				
Chemo extravasations				
Planned vs. given dose (Radiation Oncology)				
Patients accrued to clinical trials				
Percent of patients seen by navigator				
The Joint Commission Disease-Specific Certification Performance Measures				
Social work evaluation for Radiation Oncology patients (Outpatient)				
Documentation of patient education (Outpatient)				
Nutrition consult for inpatients (Inpatient)				
Multimodal therapy—Stage III cancer evaluated for chemotherapy/radiation therapy (Inpatient)				
Lung cancer lymph node dissection rate				
NAPBC Accreditation Performance Measures				
Breast—days detection to diagnosis				
Breast—days abnormal mammography to final pathology				

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Indiana University West, used the registry to evaluate where and why patients were being referred. "By using the new 2010 class of case coding structure, our cancer registrars created a special study of the top three primary sites by type of treatment and location of treatment," explained Clark. "This [study] allowed us to perform a needs assessment for radiation oncology patients."

The needs assessment at Indiana University West will also be used to help evaluate equipment allocation, physician, and patient referral patterns; ensure appropriate services are provided to their patients; and serve as a benchmark for an awareness campaign targeting patients within a specific zip code and informing them of options at Indiana University West.

step 6

Don't re-invent the wheel; instead look to hospitals that juggle multiple accreditations well for tips, tools, and techniques.

One tip I know many hospitals would share is their partnership with the American Cancer Society (ACS). Specifically, community cancer centers can benefit from two ACS programs: the Patient Navigator Program and the Collaborative Action Plan. The ACS Patient Navigator Program, initiated in 2001, partners with hospitals and treatment centers to provide trained patient navigators to help patients, families, and caregivers navigate the many systems needed during the cancer journey. These patient navigators can provide information on the following:

- Information on clinical trials
- Questions to ask the doctor
- Day-to-day help
- Emotional support
- Prescription and medical supply assistance
- Travel assistance
- Lodging through *Hope Lodge*.

The long-standing relationship between ACS and CoC (since the 1930s) has led the CoC to develop standards regarding information about the availability of clinical trials, support services, and prevention and early detection programs. Today, ACS supports CoC hospitals by providing a dedicated Collaborative Action Plan and an ACS staff partner to the hospital. This staff member is in frequent communication with the Cancer Liaison Physician (CLP), present at Cancer Committee, and can provide the Collaborative Action Plan.

On the Association of Community Cancer Centers' *MyNetwork* members-only online community, the *ACCCExchange* Listserv, is also a good source for ACCC members to have open dialogue on various topics, including how to implement tools, such as a scorecard or matrix, to help all members of the cancer program stay on the same page.

Just as the act of juggling requires an intense and unrelenting focus on each and every ball in the air simultaneously, a cancer program's ability to manage multiple accreditations also requires an intensity and a never-ending focus on multiple facets of patient care at one time.

Why Even Attempt the Juggling Act?

Consistent communication, an involved Cancer Committee, educated cancer registrars, overarching goals, a scorecard, and planning allow cancer programs to effectively and efficiently juggle multiple accreditations. But what's most significant about organizations that are successfully juggling multiple accreditations isn't the stamp of approval from the accrediting agency every two or three years, it's the outcome. Facilities that strive to achieve multiple accreditations are in essence striving for continuous enhancements to quality of care and improved patient outcomes. These cancer programs know what it means to set and closely monitor quality clinical data that is relevant and meaningful to patient-centered cancer care.

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