ACCC and JCAH Confer on Development of Clinical Indicators for Cancer Treatment in Hospitals

The Association of Community Cancer Centers (ACCC) and the Joint Commission on Accreditation of Hospitals (JCAH) have made an initial commitment to develop a working agreement and work plan on clinical indicators for oncology. The clinical indicators concept is part of the JCAH's new "Agenda for Change" and reflects the organization's growing interest in altering the accreditation process to include evaluations of the process of care and the outcomes of care.

The development of clinical indicators in oncology and the study of patterns of care is a familiar topic to ACCC member institutions, many of which have been involved in evaluations of the Community Hospital Oncology Program (CHOP), the Community Clinical Oncology Program (CCOP), the American College of Radiology's patterns of care study, and the joint ACCC/ELM Services, Inc. development of a National Clinical Data set.

"We hope to present a full action plan to the ACCC Board of Trustees for their review at the September Board meeting," says Lee E. Mortenson, the Association's Executive Director. "The plans that JCAH has laid out for other medical specialty areas are very similiar to the efforts ACCC has made over the past five years to evaluate quality cancer care. There is a great deal of common ground between the two organizations."

"A multidisciplinary group of ACCC members will be involved in the identification of potential clinical indicators, and we have secured an agreement to involve institutions contributing to ELM's CHOP-DS II national data base to validate some of the indicators," says Dr. Robert E. Enck, ACCC's President. "The ELM data base has 360 institutions in 29 states and includes data on National Clinical Data set variables. Some of this data goes back to a baseline year of 1979 when the system was first used for evaluation of CHOP programs."

Included in the work plan will be a process for identifying and selecting oncologic quality indicators, for identifying relevant risk adjustment variables, criteria of acceptable practice related to indicators, and methods of collecting storing and analyzing clinical indicator data and covariates.

"We hope to serve as a model for other professional groups that are considering assisting the Commission," says Enck. "There is a great deal that has been done by many specialty organizations in oncology that can contribute to this process. We hope to pull on expertise from those other organizations as well as our own multidisciplinary membership."

In describing the clinical indicators initiative, the Joint Commission states that it intends "to formulate a system for more effective and accurate measurement of an organization's performance through the use of clinical indicators which involve a more direct review of patient care." Commission documents note that "clinical indicators do not depict quality of clinical performance directly. Rather they are a means of predictably raising sound questions about the quality of care. Indicators are 'flags' or 'screens' which highlight the need for problem analysis and peer review, as appropriate. In that sense, indicators are intended to focus each organization's internal monitoring and evaluation process on important aspects of patient care and assist in pinpointing potential quality of care problems."

"Both the Commission and ACCC are interested in exploring a long term relationship in the development and validation of clinical indicators," says Enck. "This is only reasonable since we know that clinical cancer care is one of the major areas of rapid change. What was acceptable practice in 1971 is no longer a reasonable alternative in 1987. And, the level and pace of change are increasing every year."

Clinical Indicator Development Similar to CHOP

"The basic approach to clinical indicator development follows the framework utilized in the CHOP program evaluation and in the development of many quality assurance programs," notes Mortenson. "It involves utilizing the structure-process-outcome approach of Avedas Donebedian, with the emphasis on the implications of hospital cancer program structure and the processes of care for the outcomes of care." This same approach was used by Community Hospital Oncology Programs to evaluate whether or not they were impacting the quality of care through the development and implementation of patient management guidelines by community physicians.

"Essentially, we made the assumptions that if you knew the results of a given regimen, you had a realistic idea of the outcome," says Enck, a former CHOP and CCOP Principal Investigator, "This was much like saying that if you know the outcomes of a particular protocol and use that protocol, you can predict the results."

Several cavaets to the process are noted by Mortenson: "Early in the implementation process, it was noted by Clinical Oncology Program and CHOP participants that there needed to be categories that described impediments to the actual ability of a physician or hospital to deliver the care. For example, in some cases the patient could not tolerate the therapy. In other cases, the patient refused therapy or died before a series of tests and procedures could ever be conducted. These same items may be necessary in the development of a database for JCAH."

Another major difference is the strong emphasis on outcome measures. "NCI was wary of outcome measurements in the CHOP evaluation, and, of course, for most cancer sites there is a time lag," notes Mortenson. "JCAH staff have indicated a strong interest in developing measures that can clearly be documented to have a major impact on outcomes."

"I believe that the ACCC Board and membership will see this effort as a natural extension of Association's current efforts in this area," says Enck. ACCC members will hear more of the specifics at the upcoming September meeting. ■