

EVALUATING QUALITY OF CARE: ACCC'S CLINICAL INDICATOR PROJECT

Part I: The Core Committee's Task: Selecting Potential Indicators



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Over the past five decades, there have been numerous attempts to measure the quality of cancer care, both from the standpoint of facilities and that of outcome. In the 1930s, the American College of Surgeons began to evaluate facilities' surgical management of malignant disease and, later, the equipment for the delivery of radiation therapy to cancer patients. With the evolution of the Joint Commission on Accreditation of Health Care Organizations, emphasis was placed on the structural elements of hospital organizations necessary to deliver quality medical care in a hospital setting. The American College of Surgeons, through the Commission on Cancer, developed the hospital cancer program—a voluntary program of hospital organizations for cancer treatment. The program emphasized the Cancer Committee, staff education programs in cancer, the tumor registry or database, and patient care evaluation studies. Because of this program, cancer care began to be evaluated through end results utilizing long-term follow up.

The American Cancer Society, in many of its localities, began to collect and publicize end results in cancer therapy based on stage of disease and diagnosis. (This is most effectively done in the state of Illinois.) The Association of Community Cancer Centers measured the quality of care through the Community Hospital Oncology Program (CHOP) and, more recently, the Community Clinic Oncology Program (CCOP), through the development of standards of treatment and utilization of survival and end results.

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The Peer Review Organization (PRO), as mandated by Congress for Medicare patients, is somewhat of an anomaly in terms of its evaluation of quality care, because its primary emphasis is on cost containment, and evaluations are done without any published or established standards. The PRO program is based on retrospective review.

The most recent search for a measure-

ment of quality of care in cancer patients is the development of clinical indicators that has been undertaken by both the ACCC and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which are attempting to look at both process and results as a measure of quality of cancer care. The Clinical Indicator Core Committee of ACCC is attempting to identify and test clinical can-

TABLE 1

ORGANIZATIONS REPRESENTED ON THE ACCC CORE COMMITTEE

American Society of Clinical Oncology
Association of American Cancer
Institutes
College of American Pathologists
Memorial Sloan-Kettering Cancer
Center
National Surgical Adjuvant Breast and
Bowel Project
National Tumor Registrars Association
North Central Cancer Treatment Group
Oncology Nursing Society
Southwest Oncology Group
Surgical Oncology Society

TABLE 2

ACCC CLINICAL INDICATOR CORE COMMITTEE

Charles Coltman, M.D., Southwest Oncology Group, San Antonio, TX
William Creasman, M.D., Medical University of South Carolina, Charleston, SC
Peter Deckers, M.D., National Surgical Adjuvant Breast & Bowel Project, Avon, CT
Herbert Derman, M.D., Riverside Methodist Hospitals, Columbus, OH
Robert E. Enck, M.D., Riverside Methodist Hospitals, Columbus, OH
Lloyd K. Everson, M.D., The Indiana Regional Cancer Center, Community Hospitals
of Indianapolis, IN
Irvin D. Fleming, M.D. (Chairman), Methodist Hospitals of Memphis, TN
Joyce M. Kane, ART, CTR, Johns Hopkins Oncology Center, Baltimore, MD
J. Gale Katterhagen, M.D., The Regional Cancer Center, Memorial Medical Center,
Springfield, IL
David P. Kelson, M.D., Memorial Sloan-Kettering Cancer Center, New York, NY
Jon Kerner, Ph.D., Memorial Sloan-Kettering Cancer Center, New York, NY
David K. King, M.D., Good Samaritan Medical Center, Phoenix, AZ
Dolores Michels, CTR, Allegheny General Hospital, Pittsburgh, PA
Larry Nathanson, M.D., Winthrop University Hospital, Mineola, NY
Ralph M. Scott, M.D., The Christ Hospital Cancer Center, Cincinnati, OH
Rodger J. Winn, M.D., University of Texas System Cancer Center, M.D. Anderson
Hospital & Tumor Institute, Houston, TX
Alan Yagoda, M.D., Memorial Sloan-Kettering Cancer Center, New York, NY
John W. Yarbro, M.D., Ph.D., University of Missouri, Columbia, MO

TABLE 3**POTENTIAL AREAS FOR DEVELOPING CANCER CLINICAL INDICATORS**

Confirmation of Diagnosis
 Elements for Proper Staging and Knowledge of Stage by Physician
 Performance Status
 Elements of Treatment

- Surgery: Procedure and Quality
- Radiation Therapy: Dosage of Ports
- Chemotherapy: Drugs, Dose and Schedule

Recurrence of Tumor

- Incidence
- Location

Patient and Family Support—Rehabilitation
 Follow-up Mechanism
 Survival by Stage

cer indicators in the community hospital oncology program setting, in an effort to determine the most practical approach to measuring quality of care.

The ACCC Clinical Indicator Core Committee is made up of representatives from a variety of cancer organizations and treatment centers (see table 1, page 13). The committee is also representative of the wide range of treatment and support modalities necessary for cancer management (see table 2, page 13).

The Core Committee has defined clinical indicators as items of clinical data which are:

- Clearly defined
- Available in the clinical record
- Easily documented
- Impact cancer care and outcomes
- Discriminate between good and poor clinical cancer programs

The first question that must be asked is: "Is such data available in the existing records of care for cancer patients in the current community hospital setting?" As one looks for clinical indicators in the management of cancer, there are obvious areas that should be included: confirmation of diagnosis, the elements of staging, patient performance status, appropriate consultation based

on diagnosis and stage, the elements of treatment, the incidence and location of recurrence, appropriate rehabilitation, and survival by stage (see table 3, above left).

As the Core Committee considered the above items, it became apparent that unless clinical indicators were limited to the diagnosis, staging, and acute treatment of cancer patients, some mechanism for long-term follow up would be essential for the evaluation of treatment results. Any meaningful clinical indicators relevant to cancer control must be associated with a long-term, follow-up program. This makes it essential that data bases, similar to existing tumor registries, be established in hospitals for the confirmation of diagnosis, stage, treatment, and end results. This data base also needs to contain certain core data information on all cancer sites being considered as cancer clinical indicators (see table 4, above right).

The Core Committee then reviewed the 1988 national clinical data set for a variety of sites, including core data. This data set is made up of material from the individual registries of hospitals that send data to the centralized registry program at ELM Service's CHOP-DS data system. This national data system encompasses more than 600 hospitals of varying size, which treat from 200 to more than 1,000 new cancer patients per year. The cancer sites included in the Core Committee's data review were:

- Female breast
- Colon
- Hodgkin's disease
- Acute leukemia
- Small cell lung cancer
- Ovarian cancer
- Rectal cancer
- Testicular tumors
- Bladder cancer
- Soft tissue sarcomas

(The Core Committee is currently considering broadening the scope of the clinical indicator project through the inclusion of

TABLE 4**CLINICAL INDICATORS (MINUS) SITE-SPECIFIC DATA = REGISTRY**

Demographics	Site
Histology and Grade	Stage
Performance Status	Treatment
Residual Tumor	Recurrence
Biologic Markers	Metastasis
Subsequent Treatment	Survival

additional disease sites, including head and neck cancers, malignant melanoma, pancreatic carcinoma, gastric carcinoma, and carcinoma of the cervix and endometrium.)

For each of the above disease sites, the Core Committee selected between 7 and 10 items that it considered to be potential indicators of quality care for review. Examples of these potential indicators for both ovarian and colorectal carcinomas are shown in tables 5 and 6 below. Similar clinical indicators have been developed in each of the other disease sites under consideration.

The next step that the Core Committee will be taking is to refine these potential indicators to ensure that the questions asked elicit the information needed to evaluate quality of care. These refined clinical indicators will then be field tested, using the CHOP-DS national data system, to see how they meet the criteria for potential clinical indicators in cancer care. After field testing is completed, the potential indicators will be further refined to ensure that appropriate questions are being asked, and to determine whether clinical indicators can be evolved from traditional data sets (tumor registries) and from the information that currently exists in the more than 1,500 U.S. hospitals that have cancer programs. ■

TABLE 5**POTENTIAL CLINICAL INDICATORS FOR OVARIAN CANCER**

Biopsy Procedure and Stage

- Omentectomy
- Evaluation of Diaphragm
- Abdominal Washing or Fluid
- Periaortic Node Biopsy

Gynecologic/Surgical Consultation
 Medical Oncology Consultation
 Chemotherapy

- Drug
- Dose

TABLE 6**POTENTIAL CLINICAL INDICATORS FOR COLON/RECTAL CANCER**

Family History
 Biochemical Profile
 Colonoscopy or Barium Enema
 Before Surgery
 Surgical Consultation
 Operative Mortality
 Radiation Oncology Consultation for Stage II and III Disease