Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Memorial Mission Medical Center Mountain Area Cancer Center

Oncology Clinical Indicators

To cite this article: (1994) Memorial Mission Medical Center Mountain Area Cancer Center, Oncology Issues, 9:2, 14-15, DOI: 10.1080/10463356.1994.11904458

To link to this article: https://doi.org/10.1080/10463356.1994.11904458

Published online: 18 Oct 2017.

Memorial Mission Medical Center Mountain Area Cancer Center

Oncology Clinical Indicators

"What stands out about our cancer program is the fact that we are pursuing quality improvement very aggressively," said Debra Cobb, Director of Cancer Services at the Mountain Area Cancer Center, Memorial Mission Medical Center in Asheville, N.C.

Cobb and the staff at Mission are serious about pursuing excellence through quality care initiatives and reviews. Mission is pilot testing Joint Commission on Accreditation of Healthcare Organizations (JCAHO) oncology clinical indicators, which one day will be part of a databased performance-monitoring system. These clinical indicators are proving to be a valuable vehicle in helping Mission's Cancer Committee assure the highest quality cancer care.

Mission is doing more than just documenting and analyzing data about clinical oncology indicators. Staff are also improving procedures by applying information they have learned, according to Cobb. A year end review of the data identified three specific areas needing improvement: pathology report contents, documentation of stage by managing physician, and pre-op work-up for colorectal patients. "Physicians see these indicators as something they can buy into and have become more interested in quality improvement," said Cobb.

Memorial Mission Medical Center is one of 400 hospitals selected to participate in the beta-testing phase of JCAHO's monitoring system. Mission's Cancer Registry has collected one year's data on 10 of the 11 JCAHO Oncology Clinical Indicators. Data on clinical indicator #3, which includes survival information, are not being collected.

THE CANCER REGISTRY

"The most logical department to gather these indicators was the registry," said Cancer Registrar Linda Mulvihill, C.T.R. "After all, registry personnel were already gathering data from every cancer patient's chart. Cancer data is our area of expertise."

Mission's registry, approved by the American College of Surgeons

Memorial Mission Medical Center is a tertiary care referral center serving western North Carolina. The Mountain Area Cancer Center offers a wide spectrum of cancer services, including diagnostic, treatment, education, and support services. Specific components include inpatient and outpatient oncology, radiation oncology, and a stem cell transplant program.

VITAL STATISTICS

- Total institution bed size: 410
- Dedicated cancer unit beds: 20
- New cancer patients seen each year: 1,279
- Annual number of patients on NCI-approved protocols: 75
- Managed care penetration in the state: 9.2 percent

SOCIAL SUPPORT SERVICES

- Community outreach programs, including the Learning Together program and the Cancer Center's Colorectal Cancer Awareness Project, provide cancer prevention and early detection to civic, community church groups, and professional nursing groups.
- A bereavement program provides follow-up for families.
- The Breast Rehabilitation Program provides patients with emotional support and education.
- An American Cancer Society community education program is aimed at teaching young people about the risks of smoking and smokeless tobacco. More than 700 children were reached in 1992.
- Patient and family support include social work and chaplaincy services.

since 1985, has two full-time and one part-time certified cancer registrars. They have a case load of 1,200 to 1,300 patients each year. Of these patients, about 85 percent represent newly diagnosed cancer cases. The database consists of more than 12,000 patients diagnosed since January 1, 1983.

"Our main obstacle to gathering JCAHO clinical indicators was time," said Mulvihill. Although registrars typically work four to six months post-discharge, the JCAHO wanted the oncology indicator information within six weeks of discharge.

The registry devised a process to overcome this time limitation. As weekly pathology reports came in, the Cancer Registry went through its usual procedures, but then sorted out those sites (i.e., colon, rectum, breast, and lung) that would help define the clinical indicator patients. These pathology reports were put into a separate folder. Once a month, these reports were abstracted first, and the data sent to JCAHO.

Since setting up the process, Mulvihill has had few problems meeting the six week deadline. Although a few charts were outliers—and there was no way to capture all the data within the six week deadline—she has found these to be a remarkably small number.

Mission now has a complete year's worth of data. "We had 1992 data available in February 1993, rather than in summer or early fall," said Mulvihill. "Physicians really liked having the data available so much earlier than is usually the case with registry data. By the very fact that data were available to them sooner, physicians could take actions to remedy flagged areas."

WHAT MISSION FOUND

Analysis of the clinical indicators showed three areas needing improvement.

1) The pathology department was not always including full documentation on its reports (i.e., lymph node documentation, tumor size, status of margins). During discussions, the department agreed that the information is valuable and should be included within the pathology report.

2) A second problem area involved documentation of stage by the managing physician. Staging by the managing physician was documented only 46 percent of the time.

Analysis showed that the presence of a staging sheet on the hospital chart had a favorable effect on whether American Joint Committee on Cancer (AJCC) staging was used. The presence of a staging sheet on the hospital chart appeared to promote continuity of patient care on subsequent admissions and served both as a guide and a reminder to physicians to use AJCC staging on all patients diagnosed as having malignant disease. Thus, it was decided that as of January 1, 1994, a staging form must be filled out and signed by every managing physician.

3) The third area involved incomplete colorectal diagnostic work-ups. The problem was a lack of documentation of tests performed *outside* the hospital. The surgeons agreed to include diagnostic work-up information in their dictation when the patient is admitted.

The focused review of indicators is helping Mission to improve internal processes and communication, which in turn improve quality of patient care. "For instance, when we thought about how important the staging sheets are," said Mulvihill, "we decided they should become a permanent part of the patient's medical record. That decision involved the registry, physicians, and the medical records committee and department. It was not just a process taking place in the Cancer Registry. It was a process involving different areas of the hospital working together to improve patient care."

The Cancer Registry will continue to monitor oncology clinical indicators, and a follow-up of the three areas needing improvement will be presented to the Cancer Committee. Although beta testing will end with December 1993 discharges, Mission has already signed up with JCAHO to be part of its transition stage for 1994, which will involve continuing to collect indicators through 1994.

QUALITY SERVICE CLOSE TO HOME

Because western North Carolina is somewhat geographically removed from the heart of the state, the Mountain Area Cancer Center at Memorial Mission Medical Center strives to assure its patients and their families access to quality care close to home. Over the last few years, the Cancer Center has been expanding its physician services and administrative leadership into rural communities in neighboring counties.

Accrual to cancer treatment clinical trials also helps to keep patients in the community. As a CCOP affiliated with the Southeast Cancer Control Consortium, the Cancer Center offers clinical trials for a wide variety of cancer sites and stages. A total of 65 patients were entered on clinical trials in 1992, helping to make Asheville a leader in the Southeast in offering state-of-the-art cancer treatment.

"We have been very community-focused," said Director of Cancer Services Debra Cobb. "Here in western North Carolina, we are seen as cut off from the mainstream of university-type cancer programs. Yet, on quality and service levels we are equal to any university setting. We are proud of that."