National Accreditation Program for Rectal Cancer

RegistryPartners
DATA ABSTRACTION / REGISTRY MANAGEMENT / CONSULTING

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ONCOLOGY
DIVISION

Objectives

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1. Understand NAPRC Standards and Requirements for Compliance
2. Understand the Cancer Registrar's role in NAPRC Standard Compliance
3. Review strategies for ensuring your program's survey readiness

Presentation Content

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Content for this presentation is from the NAPRC 2017 Edition Manual as well as the 2019 Commission on Cancer Cluster Conference

Ensures the program and multidisciplinary team is overseen by a qualified Rectal Cancer Program Director

Std 1.1: Commission on Cancer Accreditation

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Facility must be accredited by the Commission on Cancer before earning accreditation by the National Accreditation Program for Rectal Cancer.

Std 1.2: Rectal Cancer Multidisciplinary Care

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Multidisciplinary Rectal Cancer Conference Required Members:

- One appointed physician member from following specialties:
  - Surgery
    - All surgeons (excluding fellows and residents) who perform rectal cancer surgery at the rectal cancer program **must** be a required member
  - Pathology
  - Radiology
  - Medical Oncology
  - Radiation Oncology
- Rectal Cancer Program Director
- Rectal Cancer Program Coordinator - pivotal to ensure everything is done properly

Std 1.3: Rectal Cancer Multidisciplinary Team Attendance

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- Alternates can be appointed for required members with the exception of surgery
  - Surgery has no alternates – all surgeons performing rectal cancer surgery must be appointed required members
- **50%** attendance requirement
- Document attendance rate

Common Problem

- No attendance sheet

Std 1.4: Rectal Cancer Multidisciplinary Team Meetings

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- Must meet at least twice each calendar month
- At least one RC-MDT member from each required specialty must attend

Recommendations:

- Be complete but brief
- Don’t bring standards to the group until all needed information is available
- Have a leadership group that meets outside of MDT meetings to discuss standards not related to cancer conference

Std 1.5: Rectal Cancer Program Director

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- Rectal Cancer Program Director is a required member of the RC-MDT
  - Suggest this is a surgeon given their involvement
  - Needs to be someone well respected
- Responsible for evaluating, interpreting, and reporting the RCP's performance through internal audits and NCDB data
- Reports the analysis of NCDB data to the RC-MDT at least **4** times a year
- Reports results of all required Chapter 2 audits to Cancer Committee at least once annually

Update from NAPRC:

- RCP Director reports on hold due to NCDB infrastructure upgrade
- NAPRC recommends reporting on rectal data from other sources in the interim.

Std 1.6: Rectal Cancer Program Coordinator

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- Provides comprehensive administrative support to RC-MDT
- Ensures pathways are followed according to guidelines set by MDT, including timeliness
- Liaises with relevant departments to ensure all pertinent information is available for RC-MDT meetings
- This is not exclusively a navigation position but a behind-the-scenes position coordinating patient care with health care providers

Std 1.7 Rectal Cancer Program Education

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- All surgeon, pathologist, and radiologist physician members of MDT must complete NAPRC-endorsed education module related to their respective specialties
  - Educational modules on-line
    - Radiology Module is available through the American College of Radiology (ACR)
    - College of American Pathologists' (CAP) – found on CAP's Cancer Protocol Templates website

- **Update from NAPRC:**
  - Currently not rated, surgery modules not yet available

Confirms rectal cancer patients receive appropriate care based on diagnosis and within specified time targets

Std 2.1: Review of Diagnostic Pathology

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- Rectal Program must confirm diagnosis of rectal cancer before initiation of treatment
  - If reviewed by a non-MDT member initially it can be reviewed by MDT and an addendum added.
  - If diagnosed elsewhere, pathology slides must be obtained whenever possible and reviewed by a pathology member of the RC-MDT
    - Must track number of slides obtained for patients diagnosed elsewhere

- **95%** of previously undiagnosed, previously untreated rectal cancer patients receive confirmation of diagnosis by biopsy before treatment

Std 2.2: Staging Before Definitive Treatment

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- **95%** of all previously untreated rectal cancer patients are staged (systemic and local tumor) before definitive treatment.
- Systemic staging is completed by CT or PET/CT of chest, abdomen, pelvis
- Local tumor staging is completed by MRI of pelvis

Std 2.3: Standardized Staging Reporting for MRI Results

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- MRI has replaced EUS as primary imaging modality used for local staging of rectal cancer
- Pelvic MRI Requirements
  - **90%** should be read by member of team
  - **95%** have to have staging in reports via synoptic format
  - Suggestion – order for all patients undergoing transanal excision of rectal polyps if suspicious for malignancy
- Recommend re-imaging after therapy
- Must do standardized reporting at each image, even after neoadjuvant treatment

Common Problem:

- Radiology report not signed by MDT
  - If report gets read by non-MDT and then reviewed by MDT at meeting, they can document an addendum

Std 2.4: CEA Level

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- CEA Requirements
  - 75% CEA before definitive treatment
    - Difficult to comply with as often gets missed

Recommendations:

- Before initial visit to surgery, obtain all reports to verify done; if not, surgeon orders
- Order CEA in patients getting transanal excision of rectal polyps
- Have office checklist that coordinator checks

Std 2.5: RC-MDT Treatment Planning Discussion

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- All rectal cancer patients must have an individualized treatment planning discussion, before initiation of definitive treatment, at a RC-MDT meeting and must include but not limited to:
  - Review of diagnostic and stating studies
  - Assignment of clinical stage
  - Creation of individualized treatment plan
- Emergency patients who do not require a treatment planning discussion:
  - Patients who present with tumor-related complications that require immediate or urgent treatment. Examples include:
    - Rectal tumor perforation
    - Life-threatening tumor hemorrhage
    - Acute large bowel obstruction

Common Problem

- Tumor board notes but no Treatment Planning Summary

Std 2.6: Treatment Evaluation and Recommendation Summary

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- **50%** of rectal cancer patients must have a standardized treatment evaluation and recommendation summary completed and provided to PCP or referring physician before initiation of definitive treatment. This includes but not limited to:
  - Tumor location in rectum (lower, middle, or upper third)
  - Indication of sphincter involvement
  - Pretreatment (clinical) AJCC stage
  - Pretreatment CRM status (involved, threatened, or not threatened)
  - CEA level
  - Neoadjuvant therapy recommendation
  - Type and duration of neoadjuvant therapy recommended
  - Anticipated date and type of surgical procedure
  - Clinical research study eligibility and/or enrollment

Common Problem:

- No treatment evaluation and recommendation summary placed in EMR or made available to patient or referring doctor

Std 2.7: Definitive Treatment Timing

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- **80%** of all previously untreated rectal cancer patients begin definitive treatment within 60 days of diagnosis.
- Standard exceptions:
  - Delays due to documented patient noncompliance or failure of payers to authorize recommended treatment in a timely fashion
- Site should be defined prior to surgery
  - 15 cm from dentate line
  - 17 cm from anal verge

Std 2.8: Surgical Resection and Standardized Operating Reporting

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- **80%** of surgical resections are performed by an appointed surgeon member of the RC-MDT.
- **95%** of operative reports for all patients undergoing surgical resection are recorded in a standardized synoptic format
  - Ostrich website and Rectal Registry are available for everyone to be a part of

Update:

- Synoptic report portion currently not rated
  - Pilot programs ongoing at several hospitals

Std 2.9: Pathology Reports after Surgical Resection

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- **90%** of definitive rectal cancer surgical specimens of primary tumor are read and pathology report completed by an appointed pathologist of the RC-MDT
- **95%** of definitive rectal cancer surgical pathology reports are completed within 2 weeks

Common Problem:

- Resection specimen not signed by MDT
  - If report gets read by non-MDT and then reviewed by MDT at meeting, they can document an addendum

Std 2.10: Photographs of Surgical Specimens

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- Minimum of **65%** of all eligible surgical specimens are photographed to include anterior, posterior, and lateral views and are presented to and discussed by the RC-MDT

Std 2.11: MDT Treatment Outcome Discussion

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- Within 4 weeks of definitive surgical treatment completion, an individualized treatment outcome discussion occurs for all rectal cancer patients at a RC-MDT meeting
- Four primary steps discussion are:
  - Pre-surgical evaluation and treatment
  - Review of outcome of surgery
  - Review of final pathology report and stage
  - Recommendation for adjuvant treatment

Common Problem:

- Tumor board notes but no Treatment Outcome Summary created

Std 2.12: Treatment Outcome Discussion Summary

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- A standardized treatment summary is provided to at least 50% of all patients within 4 weeks of the MDT Treatment Outcome Discussion.
- A copy is provided to the PCP or referring physician
- This is not a Survivorship Care Plan as defined by std 3.3 for CoC

Common Problem:

- No treatment outcome summary placed in EMR or made available to patient

Std 2.13: Adjuvant Therapy after Surgical Resection

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- **50%** of all eligible patients who elect to initiate recommended adjuvant therapy regimen begin within 8 weeks of definitive surgical resection

Utilizes data to improve efficiency, standardize care, and improve outcomes

Std 3.1 / Std 3.2

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- Std 3.1: RQRS
  - Submit all eligible cases to RQRS

- Std 3.2 Accountability and Quality Improvement Measures
  - Meet expected performance rates

Update:

- Data submission and quality measures on hold due to NCDB infrastructure upgrade
- Will be rewritten to accommodate new structure

Becoming NAPRC Ready

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- Identify team (different than MDT)
  - Cancer registry staff
  - Tumor board coordinator
  - Executive director/hospital administrator
  - Administrative assistant
  - Nurse navigator
  - Physician assistant
- Standard Preparation
  - Meet weekly for 3 months to work on/report Standard preparation initially

Becoming NAPRC Ready

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- Letters of appointment to get approval from medical specialist
  - Keep for documentation
- Policies:
  - Cover all roles and responsibilities: Leadership, RC-MDT, Pre-treatment, Treatment & Quality Improvement
  - Keep as simple as possible
  - Get approval by Cancer Committee
  - Roll out to institution

  Policies Should Include:
    - Policy – Rules and Standards
    - Process – What, Who, and When
    - Procedure – How and Where

Compliance Tools

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- Standards Grid
  - Compliance/what is necessary
  - Action Items
  - Responsible Person
  - Meet weekly for 3 months to report on where things are on the grid
- Attendance with date members joined and left team
  - If both member and alternate come to meeting, this only counts once
- Tumor Conference Grid
- Have an excel spreadsheet with all clinical standards to track compliance
  - Year of evaluation, name, date of birth, date of diagnosis, date pathology returned, etc

Are you ready to be surveyed?

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- Compliant with standards for 12 consecutive months
- Be sure you have strong compliance with commitment to continue
- NAPRC is more flexible, if delays occur due to patient preferences be sure to document these and this will not count against you.
- Contact the CoC to let them know you are ready and request potential dates
- Start preparing (4-6 weeks prior)
  - Make a paper chart for chart review
  - Patient report card (screenshot)
  - Site visit binder

Survey Preparation

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- Start preparing patient charts (4-6 weeks prior)
  - 20 pre-selected adenocarcinoma of rectum
    - If <20, they will review all of your cases
    - 5 cases with adjuvant chemo; these could be part of the 20 cases
    - Categorize charts by diagnosis and treatment at RCP
      - Diagnosed elsewhere and received treatment at RCP
      - Diagnosed and treated elsewhere and surgery at RCP
  - Make a paper chart for chart review for easy navigation/review
    - Mark documents with the respective standard number
    - Include a patient report card at the beginning of each chart including all chapter 2 standards. Sample:

Standards	Compliant	Non-Compliant	Comments
2.1 Review of Diagnostic Pathology			
2.2 Staging before Definitive Treatment			
2.3 Standardized Staging Reporting For MRI Results			
2.4 CEA Level			

Day of Survey

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- Surveyor Presentation – Value of NAPRC, updates to NCDB, brief overview of pre-site visit evaluation
- Quality Improvement Presentation & Facility Tour – Optional, but encouraged
- Medical Record Review – 3-5 Hours
- Director Meeting –One on One with Surveyor
  - Discussion Points
    - Administrative support
    - Program strength and weaknesses
    - Challenging part of NAPRC launch
    - Special resistance for compliance with standard(s)
- Coordinator Meeting – One on One with Surveyor
  - Discussion Points
    - Most challenging part of complying with requirements?
    - Program strengths and weaknesses
    - What resources you have that are helpful? Resources you need to help achieve requirements?
- Open Discussion – Time to address any questions you have with the surveyor
- Summation