Background

The Institute of Medicine (IOM) noted in a 1999 report that the quality of cancer care varies in the United States. In order to assess and address these variations, the IOM report recommended establishing and monitoring quality cancer care measures, creating benchmarks for quality improvement and developing reporting mechanisms or report cards to foster improvement of care at the local level. In 2005, the American College of Surgeons’ Commission on Cancer (CoC) launched the Cancer Program Practice Profile Reports (CP3R) with the objective of responding to the IOM recommendations by providing a nationwide reporting mechanism to its accredited cancer programs for select evidence-based consensus measures assessing the quality of care for breast and colorectal cancer.2

The CP3R provides CoC-accredited programs with report-card style summaries of program-specific performance rates for 6 process measures: 3 for breast, 2 for colon and 1 for rectal cancer. These reports also allow comparisons to other CoC-accredited programs by state, regional, national, and structural characteristics. These performance rates are based on retrospective data, and are at best reported to cancer programs some 18 to 24 months following patient diagnosis and treatment. Beginning in 2009, the CP3R reports were integrated into the CoC program standards, making them a fixture of cancer registry operations and program cancer committee review. In spite of the broad implementation of these reports, they are frequently critiqued as being out of date (due in part to the lengthy period of time required to collect, report, and aggregate data through cancer registries) and for under-reporting actual performance, related to the difficulty faced by hospital-based registries to ascertain the status of treatment provided in ambulatory settings.

What is the RQRS?

The Rapid Quality Reporting System (RQRS) represents a significant extension of the CP3R reporting tool. The RQRS: 1) allows expedited data entry of a critical subset of items specifically relevant to anticipated standard of care treatments; 2) enables accredited cancer programs to report data on patients concurrently; 3) provides programs with up-to-date concordance rates relative to the state, other similar programs, and all CoC-accredited programs across the country; and 4) provides the hospitals timely notification of treatment expectations. The RQRS takes advantage of the extensive and well established cancer surveillance infrastructure and standardized cancer registry operations that exist across the US. The goal of this application is to promote evidenced-based cancer care at the local level by making performance information available sooner, ie, in “real clinical time.” The RQRS provides support through an alert system intended to ensure timely and coordinated care by prompting programs to review treatment plans and assure that processes are in place to foster this care, and to help identify demographic variables that may have an impact on the successful delivery of this care.

The RQRS uses Web-based data-collection and reporting technologies. All case information reported to the RQRS is collected by cancer registries at participating hospitals and entered into their registry database. On a locally determined schedule, breast and colorectal cases are extracted from the cancer registry database, transmitted to the RQRS, and housed within the National Cancer Data Base (NCDB) using the same nationally standardized data transmission specifications used when making annual data submissions to the NCDB.

Reports available through the RQRS are based exclusively on the case records reported from each participating program’s cancer registry. Case records in the RQRS can be modified or updated via a resubmission of cases from the local cancer registry. Participating programs are responsible for monitoring and updating case records and may use the alerts and case listing features of the RQRS to manage and facilitate any necessary updates. These actions promote and ensure accurate and complete reporting of ambulatory treatment data.

The RQRS provides users with 6 separate reports:

• Year-to-date performance dashboards show the performance rate for cases which, according to each measure specification, the treatment window is within the previous 365 days or, in the case of the 12 regional lymph node (RLN) measure, the case was diagnosed in the previous 365 days. The rates are updated daily, based on the most recent data submission.

• Alerts highlight the timeliness of patient-specific expected adjuvant therapy using color coded lists. Displayed colors range from white to dark red, depending on how much time remains for each eligible patient to receive adjuvant therapy in accordance with the performance measure. These lists or individual patient profiles can be printed and used when working with physicians or nurse...
navigators to follow up on patient treatment status. An aggregated report of cases with orange, red and dark red alerts for each performance measure are e-mailed to your cancer program on the first Monday of each month.

- **Case lists** provide a comprehensive account of all cases ever reported to the RQRS. Cases are classified as concordant, non-concordant, in suspense, or ineligible for assessment for each performance measure by year of diagnosis.

- **Comparison reports** are provided in the form of figures and tables allowing participating programs to compare annual and quarterly performance rates by state, region or type of cancer program. Reports are designed to be aggregated, or stratified by patient characteristics such as age, insurance, race, education, or income.

- **Frequently asked questions and best practices** are supported through RQRS, allowing participants to post general questions for NCDB staff to consider and share with all other programs using RQRS. Additionally, programs are encouraged to share best practices for the benefit of the broader community of users. At any time, users can post comments and share observations with the aim of building an informed community of users.

- **Program account information** is maintained and available for review at any time. This information itemizes case reporting history, registrants and their subscription status to a variety of communication and informational services provided through RQRS.

### Testing

Beginning in 2007, the CoC initiated an alpha test of the RQRS at 7 CoC-accredited cancer programs in Georgia. The objective of the alpha test was to test the basic functionality of the system and ensure the successful exchange of data and information between participating test sites and the RQRS. Testing was expanded in the summer of 2009 to include 61 beta test sites. Beta test sites included 25 CoC-accredited programs in Georgia, each of the 16 National Cancer Institute Community Comprehensive Cancer Centers pilot sites, 13 of the Cancer Institute of New Jersey affiliated hospitals in New Jersey, and 7 CoC-accredited programs that had individually volunteered to participate in the beta test phase. The beta test phase has had 3 aims: 1) to demonstrate the ability to utilize existing cancer registry operations to collect a minimum necessary quantity of data elements for breast and colorectal cancers in order to support ongoing quality assurance programs through the RQRS; 2) to identify the impact a Web-based data collection and reporting system has on promoting quality of care for breast and colorectal cancer cases through assessing the change in performance rate for each of the measures at participating hospitals; and 3) to assess the acceptability of the RQRS to providers through an assessment of a range of institutional and operational factors.

### Results

The response by the RQRS beta test sites has been overwhelmingly positive. When asked, 80% of all respondents, including cancer registry staff, program administrators and clinical leaders, indicated they would recommend the use of RQRS to their colleagues at other facilities. A majority of all respondents, including 75% of cancer registrars, 83% of cancer committee chairs and cancer liaison physicians, and 88% of cancer program administrators stated that RQRS was a “somewhat” or “very positive” addition to their facility.

Beta test sites using RQRS reported that using the system helps to prevent patients from “falling through the cracks” and provides an extra layer of assurance that the continuity of care is successfully coordinated and managed at their program. Additionally, a number of registry staff have indicated that the system helps to ensure that data are correct and useful. Of particular interest is the fact that participation in RQRS highlights the importance and skills of cancer registrars. One registry reported that their “registry, which is a non-revenue department, is being looked at in a different light since we can now present quality measures in a more current time frame.”

There are some operational costs to consider, particularly with respect to registry workload. More than half of the beta test sites made RQRS a priority task of their registries. Seventy-one percent of beta sites reported that RQRS changed their workload. On average, about 6 hours a week were being dedicated to monitoring and interacting with the RQRS. Generally speaking, it took about 5 months for registries and their cancer committees to work through a learning curve before RQRS became a routine part of their operations. A number of programs reported that this uptake period was due in part to their efforts to shift to concurrent case abstracting, as this maximized their ability to take advantage of the prospective alerts feature of RQRS. While cancer programs with electronic medical records (EMRs) found it easier and quicker to adapt to incorporating RQRS into their work flow, other programs noted that staffing limitations made it difficult to utilize RQRS to its fullest potential. Nonetheless, over a third of the registries attributed the increased workload to time spent actively following up on treatment information as the RQRS performance dials and alerts brought specific cases to their attention.

As cancer programs consider enrolling in RQRS, they are encouraged to weigh the opportunities and potential challenges of committing to using this reporting system. One important finding from the beta test sites has been that programs with committed interest and involvement from registry staff, program administrators, and clinical leadership (either cancer committee chair or cancer liaison physician) were able to incorporate RQRS into standing operational procedures more quickly and with a higher level of satisfaction than programs where this interdisciplinary support was not as strong. One of the enrollment criteria, when RQRS is made generally available, is that the 4 individuals in recognized CoC roles (the cancer registrar, program administrator, the cancer liaison physician and the chair of the cancer committee) each have to complete the initial registration process. At a minimum, this will provide a baseline assurance that there is consensus and programmatic support for using RQRS.
Conclusion

Cancer registration in the United States has a deep and well developed infrastructure, providing an exceptional platform from which to launch national quality improvement and monitoring systems for cancer care. With the introduction of anything new, it is critically important to keep cost, feasibility and implementation issues in focus. While it is clear that beta test site registry staff were initially nervous about participating in RQRS, once they had the opportunity to realize its usefulness, they became advocates for the program. The beta test of the RQRS has demonstrated 2 key benefits: 1) the high value of having access to real-time data illustrating hospital and comparative performance rates; and 2) the prospective alerts feature has been key in helping to coordinate care for patients with breast and colorectal cancer. Approximately one third of the beta test sites in Georgia reported having stopped at least 1 patient from “falling through the cracks” at their cancer program within the first 9 months of adopting RQRS.

While the CP3R has proven to be an effective tool to broadly disseminate retrospective information describing program specific adherence to standards of care, the RQRS is prospective and concurrent and thus significantly increases opportunities to improve local coordination of care, which has a direct impact on the quality of patient care. The CoC is taking all necessary steps to enhance RQRS and make this novel reporting tool available on a volunteer basis to all CoC-accredited cancer programs across the United States.

For additional information regarding the Rapid Quality Reporting System, please visit the NCDB Quality Tools Web page at: http://www.facs.org/cancer/ncdb/qualitytools.html.

References


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