

**American College of Surgeons
Commission on Cancer
Current Activities and Future
Initiatives
November 5, 2005**

FREDERICK L. GREENE, MD
Chair, Commission on Cancer

1/05

Evolution of CoC within ACoS

- n Two plans proposed in 1912:
 - standardization of surgeons - resulted in College formation - 1913
 - standardization of hospitals - resulted in JCAH formation - 1918

Cancer Clinic Standards

- n ACoS response to the American Society for the Control of Cancer
- n First surveys conducted in 1931
- n 1937 there were 240 clinics approved
- n Approximately 78,000 patients seen in approved clinics in 1939

Stephenson GW, et al. American College of Surgeons at 75. *J Am Coll Surg* 1990

CoC Evolution . . .

- n Concept of registries introduced in 1921 - bone sarcoma
- n First standards to evaluate cancer clinics and registries published - 1930
- n Campaign Committee renamed Committee on Treatment of Malignant Disease
- n ACS support provided to survey cancer detection centers - 1947
- n Grassroots network of surgeons identified to promote cancer programs - 1947

Commission on Cancer Mission

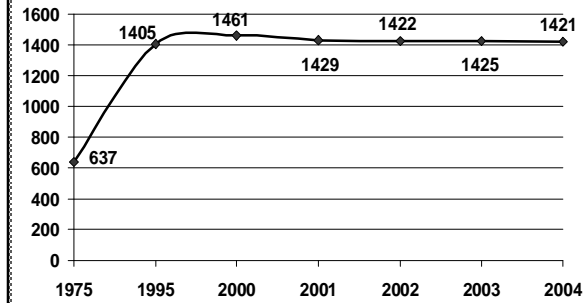
“The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.”

**Commission on Cancer
Membership**

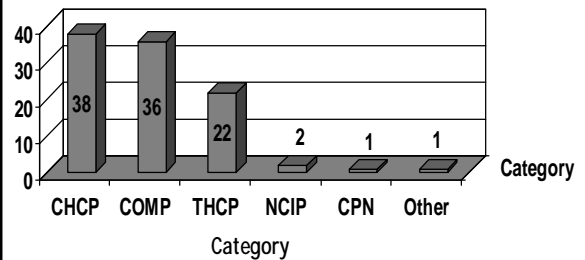
40 national professional organizations
and Fellows of ACoS

- | | |
|-------------------------|-------------------------------|
| n Surgeons | n Nurses |
| n Medical Oncologists | n Cancer Registrars |
| n Radiation Oncologists | n Nutritionists |
| n Radiologists | n Hospice and Palliative Care |
| n Pathologists | n Administrators |

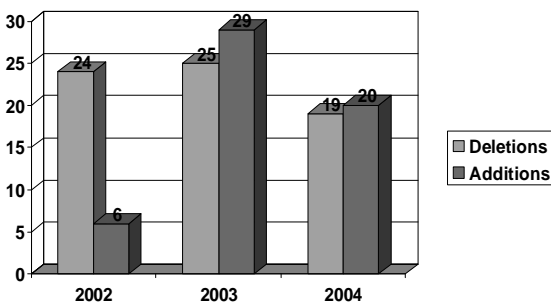
Number of Approved Programs 1975 - 2004



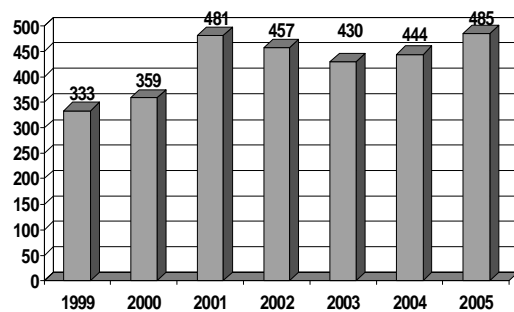
Overall Percent Distribution of Cancer Programs by Category



Annual Changes in Approved Programs



Annual Surveys Calendar Year 1999 - 2005



Facility Information Profile System - FIPS

- n Benefit for CoC-approved cancer programs
- n Data sharing activity with the American Cancer Society
- n CoC-approved cancer programs share information on resources and services and cancer caseload
- n Information shared is used by ACS National Call Center and posted on ACS Web (www.cancer.org)
- n Cancer caseload information sharing is voluntary

Cancer Liaison Program

- n Provide direction for volunteer state chairs and local cancer liaison physician network
- n Oversee appointment and reappointment process for network participants
- n Coordinate orientation and evaluation activities
- n Identify and participate in collaborative activities with ACS

Program Membership

- n 65 State chairs
 - Selected by College Chapters - surgeons
- n 1,600 physician volunteers
 - Selected by hospital cancer committees
 - 55% surgeons; 45% other specialties
- n Activities governed by Committee on Cancer Liaison
- n Program funded by American Cancer Society

State Chair Key Activities

- n Regularly communicate with liaison physicians
- n Spearhead CoC initiatives at state/regional level
 - Recruit new programs
- n Utilize NCDB data to improve quality cancer care
- n Participate in collaborative activities
 - College chapter
 - ACS
 - Comprehensive Cancer Control/State Cancer Plans

Liaison Key Activities

1. Serve as the Physician Champion within the cancer program.
2. Serve as the liaison between the CoC and the cancer program.
3. Serve as an agent of change within the community.

Physician Champion within the cancer program

- n Promote CoC Approval and Compliance with CoC Standards
- n Serve on the facility cancer committee (2.5)
- n Advocate for the cancer registry (2.10)
- n Ensure accurate physician staging (4.3)
- n Support compliance with guidelines (4.6)
- n Promote participation in clinical trials (5.1,5.2)
- n Improve the quality of care delivered (8.1,8.2)

Liaison between the CoC and the cancer program

- n Regularly report to the cancer committee
- n Spearhead CoC quality studies
- n Support participation on special studies
- n Support participation in FIPS
- n Ensure quality submission of NCDB data
- n Play a role in the CoC survey

Agent of change within the community

- n Facilitate provision of support services and prevention and early detection programs
- n Facilitate the relationship with ACS
- n Invite ACS staff to cancer committee meetings
- n Become involved in the state cancer plan
- n Become engaged in the community

What Is The NCDB?

- n The NCDB was founded in 1989 as a joint project of the American Cancer Society and the Commission on Cancer (CoC) of the American College of Surgeons (ACoS).
- n The National Cancer Data Base Data (NCDB) is a nationwide oncology database for over 1,400 hospitals in 50 states.

What Is The NCDB?

- n The database has been used as a clinical surveillance mechanism, monitoring changes and variations in patterns of cancer care and patient outcomes.
- n The NCDB holds information on about 80% of all newly diagnosed cases of cancer nationwide.
- n Records include many of the demographic, clinical, and health system data elements necessary to assess the quality of care.

Data Collected

- n Patient Demographic information
- n Tumor characteristics
- n Staging information
- n First Course Therapy
 - Surgery
 - Radiation
 - Systemic
- n First Recurrence & Survival Status

Other Co-variables Of Interest

- n **Dx/Rx Hospital Characteristics**
 - Resources and services available
 - Location
 - Case volume
- n **Risk Adjustment Measures**
 - New data manual requires collection of secondary diagnoses at time of diagnosis: comorbidity index

Limitations To The Data

- n Delay between treatment and data acquisition
- n Primarily inpatient data
- n Participation is limited to approved programs
- n Need to prioritize requests, because of limited staff resources at NCDB

NCDB Database Redesign: (2000-2002)

- n Web-based data submission
- n Logging and editing submissions in real time
- n Data base quality assessment and sampling strategies

Data Quality

- n In its early years the NCDB was not tied to the COC Approvals Program and standards for data quality and consistent coding were not yet established.
- n Since the early 1990's NCDB has collaborated with software providers, state central cancer registries and SEER
 - Standardization of cancer data codes, coding rules, and data collection procedures
 - Done under the auspices of the North American Association of Central Cancer Registries (NAACCR)

Data Quality

- n Since 1996 all COC approved programs are required to submit data to the NCDB
- n The data must be submitted in standard form with uniform codes and coding rules
- n The data must pass comprehensive single-item and inter-item edit quality checks
- n Certified Tumor Registrar required

NCDB Analytic Quality

- n In addition to analytic cases diagnosed during the most recent year, COC-approved facilities submit data on cases diagnosed 5, 10 and 15 years prior, updated with follow-up information
- n The requirement that COC-approved facilities submit their historic data has had the effect of expanding and improving the data available for the early years during which NCDB participation was voluntary

NCDB Analytic Data Quality

- n Relative 5-year survival rates for endometrial carcinoma
 - African American (AA) versus non-Hispanic Caucasian (NHC)

	AA(%)	NHC(%)
NCDB	55	86
SEER	55.3	85.9

National Cancer Registration Budgets

CDC	\$34,000,000
SEER	\$22,000,000
NCDB	\$ 1,200,000

JNCT 94 (11), 2002

13 Multi-Disciplinary Disease Site Teams

- i Breast
- i Colorectal
- i Gynecologic Oncology
- i Head and Neck
- i Liver
- i Melanoma
- i Pancreas
- i Sarcoma
- i Thoracic Oncology
- i Thyroid and Parathyroid
- i Upper GI
- i Urology
- i Brain

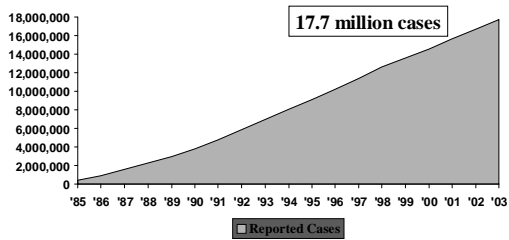
NCDB CASE COUNTS 1985-2003

n	Gastrointestinal	3,106,032
-	Colorectal	1,939,119
n	Breast	3,018,273
n	Prostate	2,230,153
n	NSCLC	1,171,958
n	Head & Neck	467,922

NCDB CASE COUNTS 1985-2003

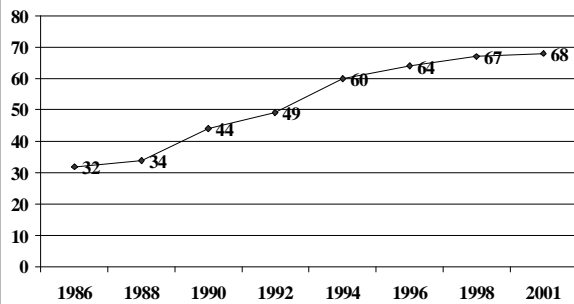
n	Cervix	590,412
n	Non-Hodgkin's Lymphoma	599,915
n	Melanoma	444,732
n	Ovary	310,085
n	Thyroid	226,746
Total		17,723,963

Cumulative Cases Captured by NCDB
by Diagnosis Year

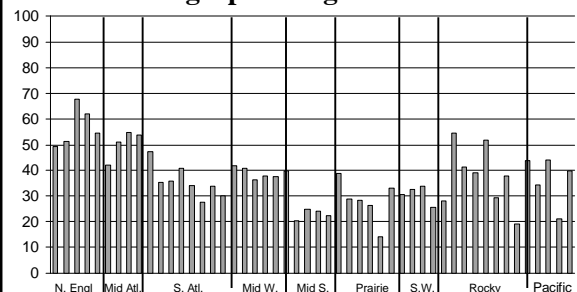


Breast Cancer A Benchmarking Example

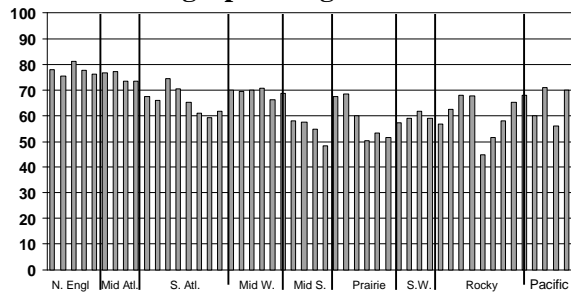
% Partial Mastectomies (Stage 0 & I)



% of Stage 0 and I Breast Cancer Patients
Receiving Partial Mastectomy by State and
Geographic Region: 1990



% of Stage 0 and I Breast Cancer Patients Receiving Partial Mastectomy by State and Geographic Region: 2000

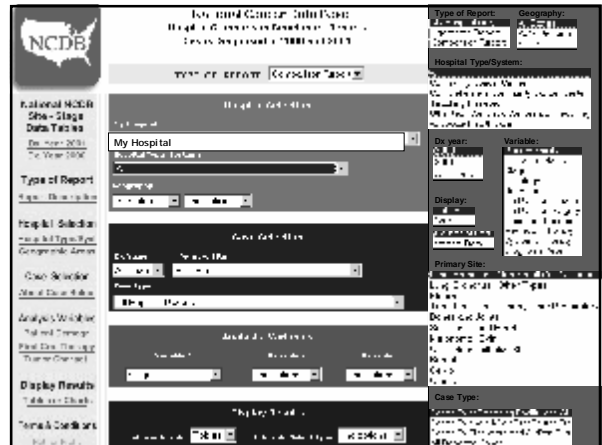


Breast Cancer at Your Hospital Comparisons with NCDB Norms

- n AJCC Stage
- n Mastectomy Surgery Patterns
- n Stage/Treatment-Specific Survival

Facility-Specific Benchmark Reports

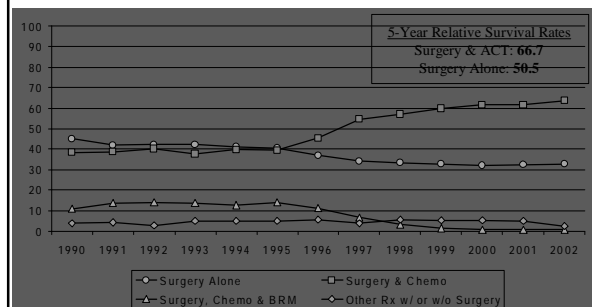
- n Released on web in April, 2003
- n Application password-protected to CoC approved programs
- n Generates reports
 - Data for your own program
 - Aggregate data
 - Data from your own program compared to aggregate
- n Data now available for 60 cancer sites
- n 950,000 cases submitted to NCDB for 2002



Colon Cancer

A Benchmarking Example

Treatment Modality Reported for Stage III Colon Cancers: 1990 - 2002



National Quality Forum

CoC proposed measures for:

Breast

Needle biopsy precedes excision/resection.
Post-operative radiation for early stage BCS recipients.
Post-operative chemotherapy administered to patients with tumors greater than 1 cm in greatest diameter.
Tamoxifen or Anastrozole administered to patients with HRP+ Stage I or Stage II disease.

Colon

Pre-operative colonoscopy.
Extent of lymph node examination for patients undergoing resection.
Post-operative administration of chemotherapy for Stage III disease.



Commission on Cancer Mission

“The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.”