

# Cancer staging: achieving compliance with Commission on Cancer standards

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A hospital-based initiative was established to improve compliance with the American College of Surgeons Commission on Cancer standards requiring that the stage of newly diagnosed cancer be documented in the patient's medical record. A multidisciplinary team developed a process for chart completion. Key components included receiving initiative approval by the hospital medical executive committee designating cancer staging in newly diagnosed patients as a mandatory component of the medical record as well as active involvement by cancer registrars and the medical director. Following initiation of the new program, compliance rates rose from 11% to 90%–100% and have been sustained. By initiating a program with the elements described in this report, high physician compliance with cancer staging documentation can be achieved.

**A**ccurate cancer staging, utilizing the American Joint Committee on Cancer (AJCC) system, is an indispensable aspect of quality cancer care.<sup>1</sup> Acknowledging this fact, the American College of Surgeons (ACS) Commission on Cancer (CoC) has established, as part of its approval process, standard number 4.5: "Staging appropriate to the category is assigned by the managing physician, or other approved medical professional, and is recorded in a standardized location(s) in the medical record for 90% of eligible annual analytic cases." The commendation rating for this standard, assessed at the time a hospital is undergoing cancer center accreditation, requires that at least 95% of the analytic cases for which there is established AJCC criteria have staging documented in the hospital record by the managing physician. In addition, the American Society of Clinical Oncology (ASCO) has designated that explicit statement of the patient's staging within 1 month of his/her first visit to the office be one of its core quality measures in the Quality Oncology Practice Initiative, an oncologist-led, practice-based quality-improvement program.<sup>2</sup>

For many hospitals, however, experience has shown that compliance with this standard is difficult.<sup>3</sup> A recent CoC communication has outlined plans for loosening this standard because of ongoing difficulties with its implementation.<sup>4</sup> Reasons for noncompliance are included in Table 1. Like other hospitals, our cancer program experienced

major problems in attempting to fulfill this important ACS requirement. However, despite the difficulties involved, we believe that accurate staging information on all new cancer patients, available to all physicians involved in the care of these patients, represents an important component of high-level cancer care.

The purpose of this article is to outline the program we developed to remedy these deficiencies and to demonstrate the impact of this program on compliance with staging documentation.

## Methods

The Community Hospital of the Monterey Peninsula is a 205-bed, not-for-profit community hospital on the central California coast. Accredited as a Comprehensive Community Cancer Center by the ACS since 1993, approximately 850 analytic cancer cases are seen per year.

After several years of poor compliance with the ACS requirements for documentation of cancer stage in the medical record, a working group convened to address the problem. The group consisted of the medical director, ad-

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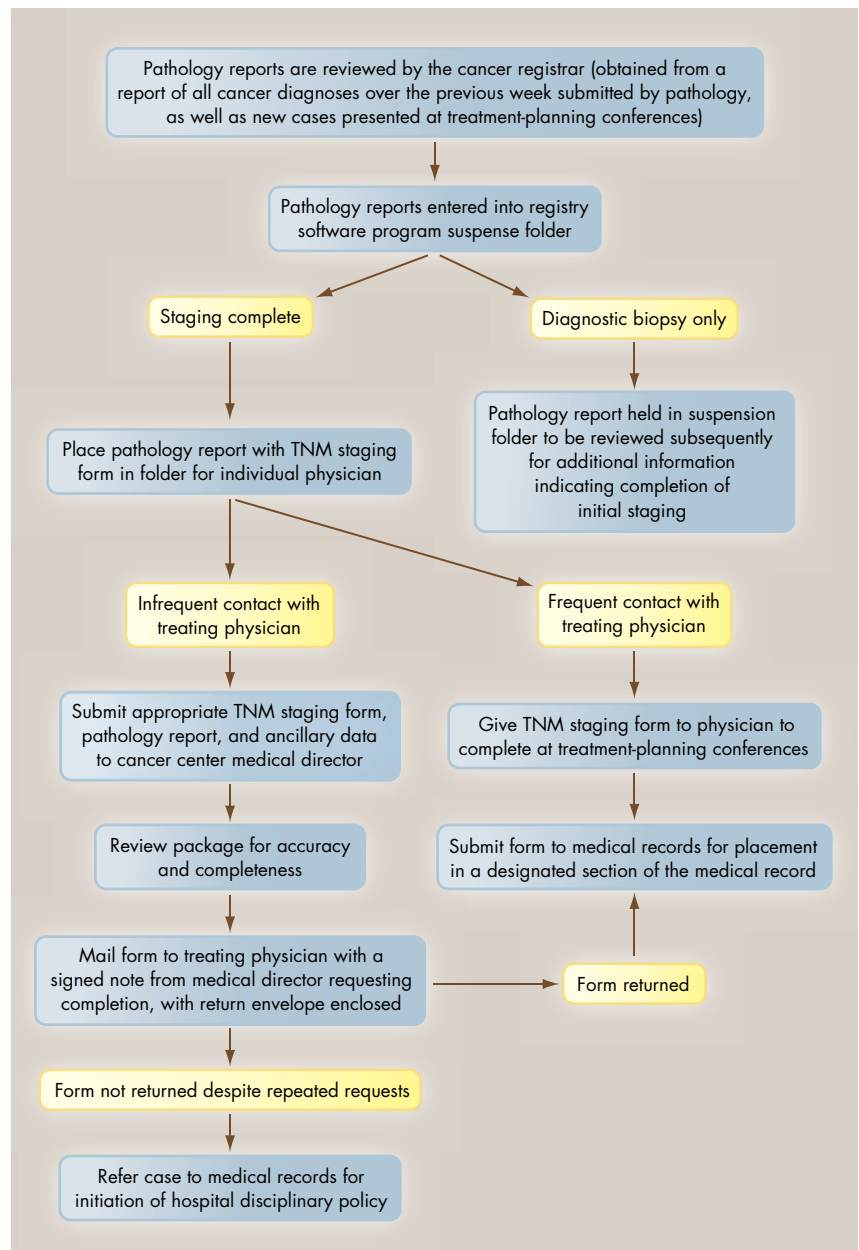
**TABLE 1**

**Barriers to documenting AJCC staging in the hospital record**

- Resistance by physicians to additional paperwork
- Identifying the primary specialist responsible for an individual patient's management
- Physicians' uncertainty regarding details of the current staging system
- Lack of tumor (T) and nodal (N) staging on pathology reports
- Multiple surgical and radiologic steps in staging a newly diagnosed cancer patient
- Mixture of inpatient and outpatient staging studies, ordered by different physicians involved in a patient's care
- Lack of a mechanism for enforcement of this standard

AJCC = American Joint Committee on Cancer

ministrator, and two cancer registrars. A staging algorithm was generated (Figure 1). The primary aspects of this process include 1) identification of all new cancer cases by collaboration between cancer registrars and the pathology department; 2) individual presentation of the tumor nodal metastases (TNM) staging forms, pathology reports, and other relevant test results to treating physicians for completion at weekly cancer conferences; and 3) submission of a personal request for form completion from the medical director to those physicians who must be contacted by mail. Clinician staging is facilitated by the fact that pathology reports include the TNM elements assessed by the pathologist (as mandated by the CoC/College of American Pathologists Cancer Checklist requirement, initiated in January 2004). Our pathologists classify the T and N aspects of the tumor on the basis of the pathologic specimen. In the pathology report, M is always categorized as MX (unknown) because the pathologist does not have access to all staging studies. The M aspect of tumor characterization is



**FIGURE 1** Comprehensive cancer center TNM (tumor, nodal, metastases) staging procedure/algorithm.

entered on the staging form by the treating physician.

Completion of the TNM staging form is monitored every month by the cancer registry. Forms not completed by the next monthly audit precipitate a second letter (again with copies of all relevant materials) from the medical director. TNM forms not submitted within 1 additional month

prompt a third note from the medical director stating that if the form is not completed within 7 days, the physician will be held as delinquent and subject to fines and restriction of medical privileges as per the medical staff policy for all incomplete medical records. Prior to implementation of this policy, formal approval of the disciplinary aspects of this policy was

obtained from the medical staff executive committee.

For physicians to be designated as compliant in this study, the TNM form had to be present in the medical record, had to be completed in its entirety, and both the TNM and the AJCC stage groupings had to be correct. The completed form must be consistent with the pathology report and clinical staging studies. Data were collected and analyzed by retrospective chart review by the medical director and the cancer registrars.

## Results

Compliance with cancer staging documentation in our hospital is shown in Figure 2. The current policy was initiated in the spring of 2003. At chart review, records from the previous 3 to 6 months were randomly selected for evaluation; they represented 10% of all new cancer cases, showing an increase in compliance with the staging standard from 11% to 90%–100%. Compliance is defined as having the TNM form in the hospital chart and both the TNM and the AJCC stage groupings correct. Accuracy of TNM and stage groupings was assessed by review of accompanying pathology reports. Of note is the rapid improvement in compliance following the introduction of the new policy.

## Discussion

Through implementation of a systematic program involving treating physicians, pathologists, and cancer registrars, it is possible to achieve a high rate of documentation of cancer

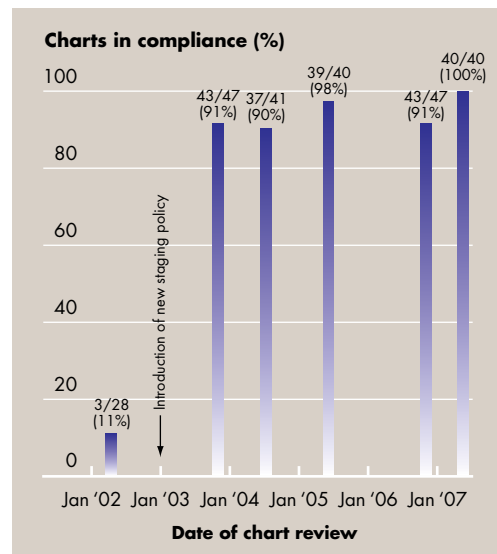
stage in the hospital medical record. There are several aspects of this program that are crucial to its success.

Of primary importance, completion and submission of the cancer staging form must be designated by the medical staff executive committee as a mandatory component of the medical record. Without this mechanism of enforcing the standard, there is no recourse for simple refusal to comply. At our institution, medical records that remain incomplete after repeated requests to the physician result in monetary fines and suspension of clinical privileges.

Next, the valuable role of the cancer registrars cannot be overemphasized. They must identify new cases, determine when initial staging is complete (in conjunction with the medical director when necessary), and have a rapport with the treating physicians so that most forms can be completed in person, at cancer conferences.

Finally, active involvement by the medical director is necessary to “personalize” the requests sent via mail to treating physicians and to serve as a resource for complicated or confusing staging cases. Also, it is ultimately the medical director’s responsibility to decide when a physician is delinquent, requiring formal notification of the medical records/medical staff office with initiation of disciplinary procedures.

We believe that the system developed here is applicable to all hospital settings. With it, this important information regarding all newly diagnosed cancer patients can be readily available to all involved in their care.



**FIGURE 2** Percentage of charts in compliance with staging standard (charts in compliance/charts reviewed  $\times$  100%). Compliance is defined as having the TNM (tumor, nodal, metastases) form found in the hospital chart and both the TNM and the AJCC (American Joint Committee on Cancer) stage groupings correct.

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*Conflicts of interest:* None to disclose.