New accreditation program sets framework for rectal cancer care in the US

March 23 2018

For many years in the U.S., there has been tremendous variability in the treatment and outcomes for rectal cancer care. In Europe, hospital clinicians have been improving their outcomes for this disease by working in multidisciplinary teams. These teams bring together specialists with different areas of expertise to evaluate and make treatment decisions for each patient. In the last decade, there has been a movement to harness this approach in the U.S. in order to improve care, sparking the creation of a new quality improvement initiative, the National Accreditation Program for Rectal Cancer (NAPRC). The program is administered by the American College of Surgeons (ACS).

The NAPRC is based on successful international models that focus on evidence-based processes of care. Before the program is implemented, one research team looked at its proposed quality measures— the tools and processes hospitals seeking accreditation will put in place to improve care—to see how often they were completed. The researchers evaluated the proposed process measures, which are the methods put in place to improve care, and the performance measures, which assess how often the process measures were achieved.

The researchers found significant variation in how often both sets of measures were met. Process measures were completed in only about one-quarter of the cases, and performance measures were achieved in about half of the cases. Both sets of measures varied based on insurance, geographic location, operative volume, and facility type, according to new study findings published as an "article in press" on the website of

the *Journal of the American College of Surgeons* ahead of print.

In the U.S., the treatment of rectal cancer patients has been very siloed, said study coauthor Steven D. Wexner, MD, PhD(Hon), FACS, FRCS, FRCS(Ed). Dr. Wexner is a member of the ACS Board of Regents, and chair of the department of colorectal surgery at Cleveland Clinic Florida, Weston, Fla. He is also a member of the NAPRC steering committee. In Europe, it is the responsibility of more than just the surgeon to care for these patients, Dr. Wexner explained.

Many European countries have developed and are currently utilizing regional or national standardized programs to improve rectal cancer care, including the involvement of teams with specialized skills, said study coauthor David P. Winchester, MD, FACS, Medical Director of ACS Cancer Programs. A framework for these teams—composed of specialists in surgery, radiation oncology, imaging, medical oncology, and pathology—is outlined in the new NAPRC Standards Manual.

"The idea of having everybody in one room discussing each patient at different stages of their journey is, I think, the biggest difference," between rectal cancer care in the U.S. and Europe, Dr. Wexner said.

At the outset of the program, researchers wanted to analyze whether NAPRC's proposed quality measures were being met. Their study is the first to describe U.S. treatment practices in the context of the standards and performance indicators outlined in the NAPRC. It will also serve as a baseline to measure the impact of the program.

"We want definite proof that it will make a difference," Dr. Winchester said about the program.

To identify patients for analysis, the researchers used the National Cancer Database (NCDB), a nationwide database maintained by the

ACS Commission on Cancer that captures approximately 70 percent of all newly diagnosed cancer cases in the U.S. and Puerto Rico. Patients included were diagnosed with non-metastatic rectal cancer between 2011 and 2014.

NAPRC process measures captured by the NCDB included in the analysis were: clinical staging of cancer; serum carcinoembryonic antigen level measurement prior to definitive treatment; starting treatment within 60 days of diagnosis; performance of tumor regression grading; assessment of circumferential radial margin (CRM) positivity; and assessment of proximal and distal margin positivity on final pathology report. Performance measures analyzed were negative proximal and distal margin of the tumor; negative CRM; and 12 or more lymph nodes included in the surgical specimen, the researchers reported.

Among the 39,068 patients identified, 36 percent most commonly had clinical stage II and 43 percent most commonly had clinical stage III disease. Assessment of the proximal and distal margin, and treatment starting within 60 days of diagnosis were the only process measures that met the proposed completion standards. These measures were completed in 98.5 percent and 85.1 percent of cases, respectively. Completion of all process measures was completed in 26.1 percent of cases.

Among performance measures, where NAPRC goals are yet to be determined, negative proximal and distal margin was achieved in 93. 4 percent of cases, and negative CRM was achieved in 82.1 percent of cases. All performance measures were achieved in 56.3 percent of cases. In both process and performance measures, there was significant variation in completion based on geography, race, insurance, disease stage, operative volume, and facility type.

Dr. Winchester said he was not surprised at these results, "because rectal cancer has demanded increasingly complex treatment and has not been

regionalized to centers possessing teams with specialized skills." Hospitals that achieve NAPRC accreditation, however, are meeting standards that set the groundwork for creation of the multidisciplinary team.

Results from a second study published on the website of *Journal of the American College of Surgeons* as an "article in press" also support the multidisciplinary team approach to treating the disease. In this study, Cleveland Clinic (OH) researchers wanted to determine how often, and to what extent, colorectal cancer multidisciplinary conferences changed the management of rectal cancer patients at their institution.

The weekly multidisciplinary conferences have been in place at Cleveland Clinic for about 10 years, said lead study author Matthew Kalady, MD, FACS, a colorectal surgeon and co-director of the Cleveland Clinic Comprehensive Cancer Program. The conferences include the five specialists outlined in the NAPRC Standards Manual. The research team knew the conferences have been useful in patient care and education, but they wanted to collect data to prove it, Dr. Kalady said.

"Cancer care, and rectal cancer care in particular, requires a team approach as there are multiple specialties that each deliver a specific treatment modality," Dr. Kalady said. "Not every patient is the same, nor fits into a perfect category, and we need to treat each person as an individual when weighing treatment options. It's also very important that all of the physicians on the team are on the same page and deliver a consistent message to the patient about the plan."

All rectal cancer cases presented at the conferences for one year were included in the study. Physicians filled out questionnaires outlining any changes in management as a result of the team's discussion. Documented changes in clinical management occurred in 26 percent of the total cases,

which the researchers called a "significant portion." Changes were due to re-interpretation of clinical staging, a decision for further evaluation, or a discussion about appropriateness or timing of certain treatment modalities, the researchers reported. They concluded these results support the NAPRC multidisciplinary team standard.

Dr. Winchester said the first research team will likely look at the quality measures data again in two or three years. Meanwhile, patients in hospitals achieving NAPRC accreditation "should be reassured they're going to a place that's going to take optimal care of them in their evaluation, management, and follow up," he said.

Provided by American College of Surgeons