



A **QUALITY PROGRAM**
of the AMERICAN COLLEGE
OF SURGEONS

Optimal Resources for Cancer Care

2020 Standards | Effective January 2020

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Optimal Resources for Cancer Care

2020 Standards

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Disclaimer

These standards are intended solely as qualification criteria for Commission on Cancer (CoC) accreditation. They do not constitute a standard of care and are not intended to replace the medical judgment of the physician or health care professional in individual circumstances.

“Standard” as used in this manual is defined as a “qualification for accreditation,” not standard of care.

In order for a program to be found compliant with the CoC Standards, the program must be able to demonstrate compliance with the entire standard as outlined in the **Definition and Requirements, Documentation, and Measure of Compliance** sections under each standard. The **Documentation** and **Measure of Compliance** sections under each standard are intended to provide summary guidance on how compliance must be demonstrated but are not intended to stand alone or supersede the **Definition and Requirements**.

In addition to verifying compliance with the standards as written in this manual, the CoC may consider other factors not stated herein when reviewing a program for accreditation and reserves the right to withhold accreditation on this basis.

Confidentiality Requirements

The American College of Surgeons and the Commission on Cancer expect programs to follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

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About the Commission on Cancer

Commission on Cancer Mission

The Commission on Cancer (CoC), a program of the American College of Surgeons (ACoS), recognizes cancer care programs for their commitment to providing comprehensive, high-quality, and multidisciplinary patient-centered care. 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 Background

The CoC and its standards for cancer care originated with the ACoS. Since its foundation in 1913, the ACoS has focused on improving the care of the surgical patient through the advancement of surgical skills and physician education. Because surgery was the only available treatment for cancer at that time, the ACoS took the lead to improve cancer care by establishing the Committee on the Treatment of Malignant Diseases in 1922.

Over time, the Committee has transformed a surgical focus into one that includes all disciplines involved in cancer care. In order to recognize this transformation, the name of the Committee was changed to the Commission on Cancer in the mid-1960s.

The initial work was focused on establishing cancer clinics within hospitals where patients could expect to receive consistent diagnostic and cancer treatment services. By 1930, the first set of standards was published, and an Approvals Program (now Accreditation Program) had been established that evaluated a cancer clinic's performance against the standards.

Since then, the number of CoC-accredited programs has steadily increased to encompass approximately 1,500 hospitals, freestanding cancer centers, and cancer program networks nationwide. Every discipline involved in the care of the cancer patient is represented in the CoC, which now includes more than 100 members representing more than 50 national, professional organizations. These organizations represent members of the cancer care team and work to improve the lives of patients with cancer. The complete listing of CoC member organizations can be found on the Commission on Cancer page of the American College of Surgeons website, [facs.org](https://www.facs.org).

The multidisciplinary Commission on Cancer:

- Establishes recommended standards designed to support high-quality, multidisciplinary, and comprehensive cancer care
- Conducts site visits at cancer programs to assess compliance with those standards
- Collects standardized high-quality data from CoC-accredited organizations
- Uses data to measure cancer care quality and to monitor treatment patterns and outcomes
- Develops educational interventions to improve cancer prevention, early detection, cancer care delivery, and outcomes in health care settings

The CoC Accreditation Program

There are approximately 1,500 CoC-accredited cancer programs in the U.S. and Puerto Rico. CoC accreditation encourages hospitals, treatment centers, and other facilities to improve their quality of care through various cancer-related programs and activities. These programs are concerned with the full continuum of cancer— from prevention to survivorship and end-of-life care—while addressing both survival and quality of life.

CoC accreditation is granted to facilities that are committed to providing the best in cancer care and demonstrate compliance with the CoC standards. Each cancer program must undergo a rigorous evaluation and review of its performance and compliance with the CoC standards. To maintain accreditation, cancer programs must undergo an on-site review every three years. The standards facilitate each cancer program seeking accreditation to provide all patients with a full range of diagnostic, treatment, and supportive services either on-site at the facility or by referral to another location, including community-based resources.

Value of CoC Accreditation

CoC accreditation provides real value to cancer programs. Programs can proudly demonstrate to their communities, providers, payors, and the government that they have invested in systems aimed toward cancer patients receiving high-quality, coordinated care, and that they have made the efforts for supportive services and resources addressing the full continuum of care available in their communities.

CoC accreditation includes data reporting to, and feedback from, the National Cancer Database (NCDB) to assess hospital performance using nationally recognized quality of cancer care measures. These data systems allow hospitals to compare their quality of care, identify variations, and implement improvements to demonstrate the high quality of care that they provide and their commitment to continuous quality improvement. CoC accreditation provides your cancer program with an infrastructure and data that informs care. It also gives your team opportunities for leadership development, team building, and programmatic development.

Accreditation Process

Processes for accreditation are detailed and updated on the Commission on Cancer (CoC) website. The CoC reserves the right to revise accreditation processes as needed.

Categories of Cancer Programs

Category designations are made at the time of initial application and are retained unless there are changes to the services provided and/or the facility caseload for three consecutive years. Descriptions and definitions for the following cancer program categories can be found on the CoC website.

- Academic Comprehensive Cancer Program (ACAD)
- Community Cancer Program (CCP)
- Comprehensive Community Cancer Program (CCCP)
- Free Standing Cancer Center Program (FCCP)
- Hospital Associate Cancer Program (HACP)
- Integrated Network Cancer Program (INCP)
- NCI-Designated Comprehensive Cancer Center Program (NCIP)
- NCI-Designated Network Cancer Program (NCIN)
- Pediatric Cancer Program (PCP)
- Veterans Affairs Cancer Program (VACP)

Standards Requiring Annual Review

The following standards require a review of services at least once each calendar year. These reviews must be documented in the cancer committee minutes and must take place within the same year on which they are based or no later than the first quarter of the following calendar year. This requirement applies to the annual review required in:

- Standard 2.5: Multidisciplinary Cancer Case Conference
- Standard 4.4: Genetic Counseling and Risk Assessment
- Standard 4.5: Palliative Care Services
- Standard 4.6: Rehabilitation Care Services
- Standard 4.7: Oncology Nutrition Services
- Standard 4.8: Survivorship Program
- Standard 5.2: Psychosocial Distress Screening
- Standard 6.1: Cancer Registry Quality Control
- Standard 8.1: Addressing Barriers to Care
- Standard 8.2: Cancer Prevention Event
- Standard 8.3: Cancer Screening Event
- Standard 9.1: Clinical Research Accrual

Studies/projects/reports required in the following standards count for the year they are completed and documented in the cancer committee minutes:

- Standard 2.2: Cancer Liaison Physician
- Standard 6.4: Rapid Quality Reporting System (RQRS) Participation
- Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines
- Standard 7.3: Quality Improvement Initiative
- Standard 7.4: Cancer Program Goal

A Standard 7.3 project or Standard 7.4 goal that extends into a second year will only count for the year it is initiated.

Cancer Program Standards Rating System and Accreditation Awards

Ratings for each standard are assigned based on consensus by the cancer program’s site visit reviewer and CoC staff. When required, the applicable executive review group will also contribute to the standard rating decision as a final adjudicator.

A “Compliant,” “Noncompliant,” or “Not Applicable” rating is assigned for each standard. Any standard with a “Noncompliant” rating is a “deficiency.”

A program receives one of the following Accreditation Awards following the site visit process:

THREE-YEAR ACCREDITATION is conferred to programs that comply with all standards at the time of the site visit. This award is also applied to programs that received and resolved a deficiency for one or more standards. A certificate of accreditation is issued, and these programs are reviewed at three-year intervals.

THREE-YEAR ACCREDITATION WITH CONTINGENCY

is conferred to an established program when one to seven standards are rated noncompliant or to new programs when one or two standards are rated noncompliant. The contingency status must be resolved within 12 months from the date of the Accreditation Report. Programs follow the guidelines for deficiency resolution posted on the CoC website. “Three-Year Accreditation” status is granted following submission and approval of resolution documentation. A certificate of accreditation is issued after resolution of deficiencies, and these programs are reviewed at three-year intervals.

NON-ACCREDITATION is conferred to an established program when eight or more standards are rated non-compliant in the Accreditation Report or a new program undergoing an initial site visit is rated noncompliant in three or more standards in the Accreditation Report. CoC staff will work directly with these programs to assist with corrective action to reinstate accreditation. Programs can also choose to withdraw, improve performance, and then reapply for accreditation.

THREE-YEAR ACCREDITATION	THREE-YEAR ACCREDITATION WITH CONTINGENCY	NON-ACCREDITATION
Complies with all standards or is awarded when all deficiencies are resolved	1–7 deficiencies for established programs 1–2 deficiencies for new programs	8 or more deficiencies for established programs 3 or more deficiencies for new programs



AMERICAN COLLEGE OF SURGEONS
COMMISSION ON CANCER

1 Institutional Administrative Commitment

Rationale

Institutional commitment is essential for the development and success of an accredited Commission on Cancer program. Resource allocation (such as equipment, personnel, and administrative support), a commitment to patient safety, and an enduring focus on continuous quality improvement are the hallmarks of strong institutional administrative support that help facilitate the success.

1.1 Administrative Commitment

Definition and Requirements

Programs provide a letter of authority from facility leadership (CEO or equivalent) demonstrating the commitment to the cancer committee, which includes, but is not limited to:

- A high-level description of the cancer program
- Any initiatives involving the cancer committee during the accreditation cycle that were initiated for the purposes of ensuring quality and safety
- Facility leadership's involvement in the cancer committee
- Examples of the current and future financial investment in the cancer program

Documentation

Submitted with Pre-Review Questionnaire

- Letter of authority from facility leadership that includes all required elements

Measure of Compliance

Once each accreditation cycle, the cancer program fulfills the compliance criteria:

1. Cancer committee authority is established and documented by the facility through a letter from facility leadership that includes all required elements.

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Hoyt DB, Ko CY. *Optimal Resources for Surgical Quality and Safety*. Chicago, IL: American College of Surgeons; 2017.



AMERICAN COLLEGE OF SURGEONS
COMMISSION ON CANCER

2 Program Scope and Governance

Rationale

The cancer program and its medical staff provide the structure, process, and personnel to obtain and maintain the Commission on Cancer's standards. This includes the committee and leadership who provide cohesion in the structure of the program. The administrative, supportive care, and medical staff must commit to broad cooperation in order to improve the quality of care at the cancer program.

2.1 Cancer Committee

Definition and Requirements

The care of patients with cancer requires a multidisciplinary approach and encompasses physician and non-physician professionals. The committee responsible for program leadership is multidisciplinary and represents the full scope of cancer care and services.

Required cancer committee members include at least one physician representing each of the diagnostic and treatment services, coordinators, and representatives from administrative, clinical, and supportive services. Each program assesses the scope of services offered and determines the need for additional cancer committee members based on the major cancer sites seen by the program.

Appointments for required members must occur at the first meeting of a calendar year at least once during the accreditation cycle. The appointments are documented in the cancer committee minutes. If a required member cannot continue to serve on the cancer committee, a new member must be appointed at the next cancer committee meeting and documented in the minutes.

Required physician members:

- Cancer Committee Chair
Physician of any specialty, selected according to facility rules and/or bylaws; can also represent one of the required physician specialties
- Cancer Liaison Physician (CLP)
Can also represent one of the required physician specialties and/or the Quality Improvement Coordinator; the CLP serves as the Cancer Committee Chair's alternate
- Diagnostic radiologist
- Pathologist
- Surgeon
Can be either a general surgeon involved in cancer care or a surgical specialist involved in cancer care
- Medical oncologist
- Radiation oncologist
If all radiation oncology services are provided by referral and the facility's medical staff does not include a radiation oncologist, a radiation oncologist is recommended to be part of the committee but not required

Required non-physician members:

- Cancer Program Administrator
Responsible for the administrative oversight and has budget authority for the cancer program
- Oncology nurse
- Social worker (licensed social worker, OSW-C preferred)
- Certified Tumor Registrar (CTR)

Required coordinator members:

- Cancer Conference Coordinator
Responsible for overseeing Standard 2.5: Multidisciplinary Cancer Case Conference
- Quality Improvement Coordinator
Responsible for overseeing Standard 7.3: Quality Improvement Initiative
- Cancer Registry Quality Coordinator
Responsible for overseeing Standard 6.1: Cancer Registry Quality Control and Standard 4.3: Cancer Registry Staff Credentials
- Clinical Research Coordinator
Responsible for overseeing Standard 9.1: Clinical Research Accrual; a clinical trial principal investigator, a research data manager or associate, a clinical research nurse, an oncology nurse, or other similar role with clinical research experience is selected to fill this role
- Psychosocial Services Coordinator
Responsible for overseeing Standard 5.2: Psychosocial Distress Screening; an oncology social worker [OSW-C preferred], advanced practice nurse, clinical psychologist, or other mental health professional trained in the psychosocial aspects of cancer care is selected to fill this role
- Survivorship Program Coordinator
Responsible for overseeing Standard 4.8: Survivorship Program; a physician, physician assistant, advanced practice nurse, nurse, social worker [OSW-C preferred], nurse navigator, or therapist or other licensed health care professional is selected to fill this role

One individual may serve in a maximum of two coordinator roles and represent one of the required physician or non-physician specialties. For example, the appointed medical oncologist can serve as the Clinical Research Coordinator and Survivorship Program Coordinator.

A Certified Tumor Registrar may only serve as the Cancer Conference Coordinator and/or the Cancer Registry Quality Coordinator.

Cancer committee members strongly recommended, but not required, include:

- Specialty physicians representing the five major cancer sites at the program
- Palliative care professional
- Genetics professional
- Registered Dietitian Nutritionist
- Rehabilitation services professional
- Pharmacist
- Pastoral care representative
- American Cancer Society representative

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes that identify the required cancer committee members

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The membership of the cancer committee includes all required specialties and coordinators.
2. Committee membership including all required roles is documented in the cancer committee minutes at the first meeting of the calendar year at least once each accreditation cycle.

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Deshields T, Kracen A, Nanna S, Kimbro L. Psychosocial staffing at National Comprehensive Cancer Network member institutions: Data from leading cancer centers. *Psychooncology*. 2016;25(2):164-169.

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2.2 Cancer Liaison Physician

Definition and Requirements

CLP Eligibility

The Cancer Liaison Physician is a physician of any specialty who is an active member of the medical staff. The CLP is considered the physician quality leader of the cancer committee. The CLP serves as the alternate for the Cancer Committee Chair and oversees cancer committee meetings if the chair is not in attendance.

It is permissible for the CLP to also serve as the Cancer Committee Chair, but it is encouraged that the CLP role and the chair role be filled by two individuals.

CLP as Quality Champion

In the role as physician quality leader of the cancer committee, the CLP must identify, analyze, and present National Cancer Database (NCDB) data pertinent and specific to the cancer program to the cancer committee at a minimum of two meetings each calendar year. CLPs are given access to NCDB reporting tools that include survival reports, benchmarking, and other cancer program performance reports. Data from the NCDB must be used as the basis of the reports. Focus is given to areas of concern or where expected performance is not being met. Reports must be given by the CLP or the CLP's alternate.

Documentation of the data presented and the details of the discussion with the cancer committee must be included in the cancer committee minutes or as an attachment to the cancer committee minutes. CLP reports do not substitute and cannot duplicate requirements from other standards, except Standard 7.1: Accountability and Quality Improvement Measures and Standard 6.4: Rapid Quality Reporting System Participation.

The CLP must attend the CoC site visit and meet with the site visit reviewer to discuss the cancer program, CLP responsibilities, and the NCDB quality reporting tools.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes documenting CLP reports from at least two separate meetings each calendar year on data specific to the cancer program, including actions and response

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The CLP or the CLP's alternate identifies, analyzes, and presents NCDB data specific to the cancer program, with preference for areas of concern and/or where benchmarks are not met, to the cancer committee at a minimum of two meetings each calendar year.
2. The CLP is present during the CoC site visit and meets with the site visit reviewer to discuss CLP activities and responsibilities.

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Hoyt DB, Ko, CY. *Optimal Resources for Surgical Quality and Safety*. Chicago, IL: American College of Surgeons; 2017.

2.3 Cancer Committee Meetings

Definition and Requirements

Regular cancer committee meetings assist with ensuring that administrative responsibilities related to cancer program functions are carried out and standard compliance is met. Each calendar year, the cancer committee meets at least once each calendar quarter. Cancer committees may choose to hold meetings more frequently in order to meet overall program needs.

Yearly calendar quarters are defined as:

- January 1–March 31
- April 1–June 30
- July 1–September 30
- October 1–December 31

It is recommended that meetings be scheduled in the first month of each quarter to allow for rescheduling if needed. It is the cancer committee's responsibility to schedule and reschedule meetings, as appropriate, for each quarter. Compliance is based on meetings held quarterly and not on the total number of meetings held each year. The triennial CoC site visit does not qualify as a meeting to comply with this standard.

Cancer committee minutes must contain sufficient details to accurately reflect the activities of the cancer committee as well as demonstrate compliance with CoC standards.

In addition to the cancer committee, programs may choose to establish optional subcommittees or workgroups to manage specific activities. If subcommittees and/or workgroups are utilized, activities and reports related to standard compliance must be presented to and approved by the cancer committee.

Examples of optional subcommittees or workgroups include:

- Clinical and translational research activity
- Screening and prevention activity
- Quality control of cancer registry data
- Quality management and improvement activity
- Review of policies and procedures

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes that document the committee's quarterly meetings and activities

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. The cancer committee meets at least once each calendar quarter.

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2.4 Cancer Committee Attendance

Definition and Requirements

To successfully complete responsibilities and guide multidisciplinary input, it is imperative that all required members regularly attend and participate in cancer committee meetings.

Each required cancer committee member or the member's designated alternate attends at least 75 percent of the cancer committee meetings held each calendar year. The cancer committee monitors the attendance of required members. It is recommended that the cancer committee also monitor attendance of non-required members.

Members subject to attendance requirements include the specialists and coordinators defined as "required members" in Standard 2.1: Cancer Committee.

Appointing Alternates

For each required member/role, one designated alternate member can be identified. Designating an alternate is optional. Only one alternate can be appointed for each required member.

The designated alternate must be qualified and appropriately credentialed to serve as an alternate for the role (for example, alternate to a medical oncologist must be another medical oncologist). An individual can only serve as an alternate for one individual.

The identification of designated alternates must take place at the first meeting of the calendar year at least once during the accreditation cycle. This information is documented in the cancer committee minutes. If a required member or alternate cannot continue to serve on the cancer committee, a new member or alternate must be appointed at the next cancer committee meeting and documented in the minutes.

The attendance percentage is calculated based on the attendance of the required role. In other words, the required member plus his or her designated alternate's attendance is considered together.

Remote Attendance

Attendance at cancer committee meetings may include participation through teleconference or videoconference calls as long as the remote attendee has access to appropriate meeting documents.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes that include the required member attendance for each cancer committee meeting held during each calendar year

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Each required member or the designated alternate attends at least 75 percent of the cancer committee meetings held.

2.5 Multidisciplinary Cancer Case Conference

Definition and Requirements

Cancer outcomes are better when patients are managed according to the principles of multidisciplinary team evaluation. This process is associated with improved clinical decision making, clinical outcomes, and patient experience.

The cancer program holds multidisciplinary cancer case conference(s) to evaluate patient management. Each calendar year, the Cancer Conference Coordinator monitors and evaluates the multidisciplinary cancer case conference activity and reports the findings to the cancer committee.

Policy and Procedure

Cancer programs have a policy and procedure to govern multidisciplinary cancer case conference activity. The policy and procedure must, at a minimum, address:

- Multidisciplinary participation
- Frequency and format of cancer case conference(s)
- Elements of discussion, including the requirement to discuss for each case: clinical and/or pathologic stage, treatment planning using evidence-based guidelines, and where applicable, options and availability for genetic testing, clinical research studies, and supportive care services
- Number of cases presented and percentage of prospective cases presented
- Methods to address areas that fall below the levels established in the policy

Format and Cases Presented

Programs evaluate the need for a general cancer case conference and any specialty- or site-specific conferences. Programs may either:

- Hold a general multidisciplinary cancer case conference
 - Specialty- or site-specific conferences may be held in addition to the general cancer case conference
- Hold specialty- or site-specific multidisciplinary cancer case conferences as long as there is a mechanism to present cases for evaluation at a multidisciplinary cancer case conference that do not fit into the defined specialty or site-specific conferences

The frequency of multidisciplinary cancer case conference is determined by the cancer program and is included in the policy and procedure.

Each year, the cancer program must present a minimum of 15 percent of the annual analytic caseload to a multidisciplinary cancer case conference. Of those presented, a minimum of 80 percent must be prospective presentations. Prospective cases include, but are not limited to:

- Newly diagnosed and treatment not yet initiated or treatment initiated and discussion of additional treatment is needed
- Previously diagnosed, initial treatment completed, and discussion of adjuvant treatment or treatment for recurrence or progression is needed
- Previously diagnosed and discussion of supportive or palliative care is needed

The same case may be discussed more than once and counted each time as a prospective presentation as long as treatment management issues are discussed.

Multidisciplinary Participation

Multidisciplinary physician attendance at a general cancer case conference must include a representative from surgery, pathology, radiology, radiation oncology, and medical oncology. Programs may define the specialties required for specialty- or site-specific cancer case conferences.

Additional physician or non-physician specialists recommended for attendance are: genetic professionals, clinical research professionals, palliative care providers, psychosocial providers, rehabilitation providers, and supportive services.

Cancer Conference Coordinator Report

The Cancer Conference Coordinator must evaluate and report annually to the cancer committee each of the following required elements:

- Cancer case conference frequency
- Multidisciplinary physician specialty attendance depending on the defined requirements in the cancer case conference policy and procedure
- Number of cases presented and percentage of prospective cases

- Elements of the discussion for each case, including, but not limited to, whether the following were discussed:
 - Clinical and/or pathologic stage
 - Treatment planning using evidence-based national guidelines
 - Options and eligibility for genetic testing (where applicable)
 - Options and eligibility for clinical research studies (where applicable)
 - Options and eligibility for supportive care services (where applicable)
- An action plan to resolve any areas that do not meet the requirements of the program's policy and procedure

The method to document multidisciplinary cancer case conference activity is left to the discretion of the cancer committee.

Documentation

Reviewed On-Site

- The site-visit reviewer will attend a multidisciplinary cancer case conference.

Submitted with Pre-Review Questionnaire

- The multidisciplinary cancer case conference policy and procedure
- The Cancer Conference Coordinator's report
- Cancer committee minutes documenting the Cancer Conference Coordinator's report

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The cancer program has a policy and procedure for multidisciplinary cancer case conference(s) that includes all required information.
2. The Cancer Conference Coordinator monitors and evaluates the multidisciplinary cancer case conference(s) and presents a report to the cancer committee that includes all required elements and any action plans to resolve issues not meeting the program's policy. The report is documented in the cancer committee minutes.

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3 Facilities and Equipment Resources

Rationale

The cancer program must maintain or provide by referral appropriate facilities and equipment for the care of cancer patients. This includes all equipment required to adequately care for the patient through the phases of care.

3.1 Facility Accreditation

Definition and Requirements

If required by state law, the facility must be licensed by the appropriate state licensing authority. If state licensure is not required, the facility is accredited or licensed by a recognized federal, state, or local authority appropriate to facility type.

Documentation

Submitted with Pre-Review Questionnaire

- Health care facility accreditation or licensure certificate or documentation

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The facility is accredited or licensed by a recognized federal, state, or local authority appropriate to the facility type.

3.2 Evaluation and Treatment Services

Definition and Requirements

The program provides diagnostic imaging services, radiation oncology services, and systemic therapy services on-site or by referral.

Quality assurance practices are in place for the required services available on-site. Quality assurance is demonstrated by accreditation and/or policies and procedures following recognized guidelines.

Accrediting organizations include, but are not limited to:

- American College of Radiology (ACR)
- American Society for Radiation Oncology (ASTRO)
- American College of Radiation Oncology (ACRO)

Applicable guidelines include, but are not limited to:

- Oncology Nursing Society (ONS)
- American Society for Clinical Oncology (ASCO)
- American Society of Health-System Pharmacists (ASHP)
- The United States Pharmacopeia (USP)
- National Comprehensive Cancer Network (NCCN)

Documentation

Submitted with Pre-Review Questionnaire

- Policies and procedures covering quality assurance practices for diagnostic imaging services, radiation oncology services, and systemic therapy services, and/or
- Certificate(s) of accreditation

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Diagnostic imaging services, radiation oncology services, and systemic therapy services are available on-site or by referral.
2. Quality assurance practices are in place for all required services available on-site.



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4 Personnel and Services Resources

Rationale

Patients with cancer have a multitude of needs. Cancer programs must oversee that patients receive appropriate care by qualified professionals. The facility must maintain optimal resources for the care of patients with cancer.

The responsibility is upon the cancer program to appropriately care for patients and develop criteria relative to the cancer program's available resources and experience.

4.1 Physician Credentials

Definition and Requirements

Cancer patient management is conducted by a multidisciplinary team, including radiologists, pathologists, surgeons, radiation oncologists, and medical oncologists. All physicians involved in the evaluation and management of cancer patients must:

- Be American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board certified (or the equivalent), or
- Demonstrate ongoing cancer-related education by earning 12 cancer-related Continuing Medical Education (CME) hours each calendar year

Scope of Standard

This standard applies to physicians who are involved in the evaluation and management of cancer patients at the accredited facility for at least one calendar year. This standard does not apply to physicians who are in fellowship or residency or physicians within the five years immediately following graduation from fellowship or residency.

Documentation

Submitted with Pre-Review Questionnaire

- A roster of the board certification status for all physicians involved in the evaluation and management of cancer patients, and
- Documentation of 12 annual cancer-related CME hours for all physicians who are not board certified and are involved in the evaluation and management of cancer patients

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. All physicians involved in the evaluation and management of cancer patients must be board certified (or the equivalent).
2. Physicians who are not board certified must demonstrate ongoing cancer-related education by earning 12 cancer-related CME hours.

PHASE-IN STANDARD

4.2 Oncology Nursing Credentials

Definition and Requirements

Oncology nursing care is provided by nurses with specialized knowledge and skills demonstrated by a cancer-specific certification or continuing education in oncology nursing. Oncology nursing competency is reviewed each year per hospital policy.

All registered nurses and advanced practice nurses providing direct oncology care must demonstrate one of the following:

- Current cancer-specific certification in the nurse's specialty by an accredited certification program, or
- Ongoing education by earning 36 cancer-related continuing education nursing contact hours each accreditation cycle

Nurses who are in the process of obtaining a cancer-specific certification do not need to submit documentation of cancer-related continuing education but must provide documentation of progress toward certification.

Oncology Nursing Certifications

Oncology nursing certifications that qualify for this standard include, but are not limited to:

- Advanced Oncology Certified Nurse Practitioner (AOCNP®)
- Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
- Advanced Oncology Certified Nurse (AOCN®)
- Blood & Marrow Transplant Certified Nurse (BMTCN®)
- Certified Pediatric Hematology Oncology Nurse (CPHON®)
- Certified Pediatric Oncology Nurse (CPON®)
- Certified Breast Care Nurse (CBCN®)
- Oncology Certified Nurse (OCN®)

A certification qualifies under this standard as long as it includes cancer-specific criteria. For example, a palliative care certification meets the certification expectations under this standard as long as it contains cancer-specific criteria.

Continuing Education

Oncology nursing certification is strongly preferred. If a nurse providing direct oncology care is not certified, then the nurse must complete 36 cancer-related continuing nursing education contact hours each accreditation cycle.

Scope of Standard

This standard applies to registered nurses and advanced practice nurses who provide direct oncology care in the accredited facility for at least one calendar year. Specifically, the standard applies to nurses in medical oncology who give chemotherapy, nurses in radiation oncology, nurse navigators, and nurses in the cancer center or cancer clinic within the accredited facility. It does not apply to nurses in the hospital who might have occasional contact with cancer patients, and it does not apply to operating room or recovery room nurses.

Documentation

Submitted with Pre-Review Questionnaire

- A roster of nursing certification status for all nurses providing direct oncology care and documentation of 36 cancer-related continuing education nursing contact hours for each nurse providing direct oncology care who does not hold a cancer-specific certification
- A policy and procedure that states that oncology nursing competency will be evaluated each year per hospital or facility policy

Measure of Compliance

Each accreditation cycle, the program fulfills the compliance criteria:

1. All nurses providing direct oncology care hold a cancer-specific certification or demonstrate ongoing education by earning 36 cancer-related continuing nursing education contact hours.
2. Programs have in place a policy and procedure that ensures oncology nursing competency is reviewed each year per hospital policy.

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4.3 Cancer Registry Staff Credentials

Definition and Requirements

Case abstracting is performed by a Certified Tumor Registrar (CTR). Each calendar year, non-CTR members of the cancer registry staff demonstrate completion of cancer-related continuing education applicable to their roles.

CTRs apply knowledge obtained from formal education and work experience to correctly interpret and code cancer diagnosis, stage, treatment, and outcomes information for each case that is seen at the Commission on Cancer (CoC)-accredited program that meets CoC reporting requirements. The CTR credential is granted and overseen by the National Cancer Registrars Association.

All cancer registry staff who abstract cases at a CoC-accredited program must either:

- Hold a current Certified Tumor Registrar (CTR) credential, or
- Perform case abstracting under the supervision of a CTR

These requirements apply to those employed by the program, working on a contract basis, and/or working through a registry service company.

It is encouraged that CTRs attend in-person education at a state, regional, or national level.

Non-Credentialed Registry Staff

A plan for CTR supervision of non-credentialed staff performing abstracting must be established and include the scope of supervision, quality control, education, and training activities for non-credentialed staff.

Any non-CTR hired to perform abstracting under the supervision of a CTR in a CoC-accredited program must pass the CTR examination within three years of the date hired to perform abstracting. If the CTR credential is not successfully obtained within the three-year grace period, then the person may not perform case abstracting at any CoC-accredited program until the credential is obtained.

Non-credentialed cancer registry staff may perform case finding and follow-up, but cannot perform any abstracting on analytic cases unless they are performed under the supervision of a CTR per the documented plan.

Continuing Education Requirements

Each calendar year, members of the cancer registry staff who do not hold a CTR credential must demonstrate completion of three hours of cancer-related continuing education applicable to their roles.

This continuing education requirement applies to all non-credentialed registry staff, including staff abstracting under the supervision of a CTR, staff performing follow-up activities, and registry management or supervisory personnel.

This education includes, but is not limited to, topics in the following areas:

- Advances in cancer diagnosis and treatment
- Changes in cancer program standards
- Changes in data collection requirements

Scope of Standard

The requirement to provide documentation of a CTR's credential and continuing education requirements for a non-CTR apply to those who work in the accredited facility for at least one calendar year.

Documentation

Reviewed On-Site

- When applicable, verification of the date of hire for staff to perform case abstracting in the cancer registry

Submitted with Pre-Review Questionnaire

- Current CTR credentials for all certified cancer-registry staff
- Plan for CTR supervision of non-credentialed staff who perform case abstracting in the cancer registry
- Documentation of cancer-related continuing education for non-credentialed members of the cancer registry staff

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Case abstracting is performed by a Certified Tumor Registrar.
2. Non-credentialed cancer registry staff in the three-year grace period who abstract cases are supervised by a Certified Tumor Registrar.
3. All non-credentialed cancer registry staff demonstrate completion of three hours of cancer-related continuing education applicable to their roles.

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4.4 Genetic Counseling and Risk Assessment

Definition and Requirements

Cancer risk assessment and genetic counseling are the processes to identify and counsel people at risk for familial or hereditary cancer syndromes. Purposes of cancer genetic counseling are to: educate patients about their chance of developing cancer, help patients obtain personal meaning from genetic information, and empower patients to make educated, informed decisions about genetic testing, cancer screening, and cancer prevention.

Policy and Procedure for Genetic Counseling and Risk Assessment Services

Cancer programs must develop a policy and procedure for providing cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral. Genetic services not provided on-site at the facility must be provided through a referral relationship to other facilities and/or local agencies. The policy and procedure must include information/processes for the following:

- Criteria for referral for a genetics evaluation
- Identification of the genetics professionals available on-site and/or by referral
- Identification of the genetics professionals qualified to perform post-test counseling either on-site and/or by referral

Cancer risk assessment and genetic counseling are performed by a genetics professional with an educational background in cancer genetics and hereditary cancer syndromes. Specialized training in cancer genetics is required. Educational seminars offered by commercial laboratories about how to perform genetic testing are not considered adequate training.

Genetics professionals may include:

- An individual board-certified/board-eligible by American Board of Genetic Counseling (ABGC) or American Board of Medical Genetics and Genomics (ABMGG)
- An Advanced Practice Nurse in Genetics (APNG), or an Advanced Genetics Nursing Certification (AGN-BC) credentialed through the American Nurses Credentialing Center (ANCC), or a Genetics Clinical Nurse (GCN)
- An advanced practice oncology nurse or physician assistant who is prepared at the graduate level (masters or doctorate) with specialized education in cancer genetics and hereditary cancer predisposition syndromes
 - The Advanced Oncology Certified Nurse Practitioner (AOCNP) or equivalent certification from the Oncology Nursing Certification Corporation (ONCC) is preferred.

- A registered nurse with specialized education in cancer genetics and hereditary cancer predisposition syndromes (defined as education resulting in a certification and undergoing ongoing continuing medical education in cancer genetics and hereditary cancer predisposition syndromes)
- A board-certified/board-eligible physician with experience in cancer genetics (defined as providing cancer risk assessment on a regular basis and undergoing ongoing continuing medical education in cancer genetics and hereditary cancer predisposition syndromes)

Monitoring Genetic Assessment for a Selected Cancer Site

While it is expected that programs provide genetics assessment for all relevant cancers on an on-going basis, each calendar year programs must identify a process pursuant to evidence-based national guidelines for genetic assessment for a specific cancer site. Some examples include, but are not limited to: colon, breast, ovarian, endometrial, pancreatic, and prostate. The process must address identifying individuals for whom further genetic risk evaluation for the selected cancer site is indicated and making appropriate referrals for genetic evaluation/counseling to see if genetic testing is indicated.

Programs may repeat the same site year to year, but it is encouraged that the program evaluate different sites over time.

Evaluating Genetic Counseling and Risk Assessment Services

Each calendar year, the cancer committee must review the policy and procedure for genetic assessment and referral for genetic evaluation/counseling.

The cancer committee must review and document in the minutes:

- The number of patients identified as needing referrals for the selected cancer site each year, and
- How many patients identified as needing referrals for the selected cancer site received a referral for genetic counseling
 - It is encouraged, but not required, that programs track whether patients who received referrals ultimately had genetic counseling

If available, it is recommended that a genetics professional attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Policy and procedure for providing cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral that includes all required elements
- Cancer committee minutes that document the required yearly evaluations of the genetic counseling and risk assessment services.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Cancer risk assessment, genetic counseling, and genetic testing services are provided to patients either on-site or by referral by a qualified genetics professional.
2. A policy and procedure is in place regarding genetic counseling and risk-assessment services and includes all required elements.
3. A process is in place pursuant to evidence-based national guidelines for genetic assessment for a selected cancer site. The process includes all required elements.
4. The process for providing and referring cancer risk assessment, genetic counseling, and genetic testing services is monitored and evaluated, contains all required elements, and is documented in the cancer committee minutes.

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4.5 Palliative Care Services

Definition and Requirements

Palliative care services are available to cancer patients and their family members or caregivers either on-site or by referral and are evaluated at least once each calendar year.

Palliative care refers to patient- and family-centered care that optimizes quality of life. The availability of palliative care services is an essential component of cancer care, beginning at the time of diagnosis and being continuously available throughout treatment and surveillance and, when applicable, during bereavement.

Palliative care is provided per evidence-based national treatment guidelines and includes palliative care provided by oncology teams and, as needed, consultation with palliative care specialists. It is recommended that the following specialties participate in providing palliative care services: physicians, advanced practice providers, nurses, mental health professionals, social workers, and spiritual counselors.

Palliative care is integrated in the continuum of cancer care. Types of palliative care services include, but are not limited to:

- Team-based care planning that involves the patient and family
- Pain and non-pain symptom management
- Communication among patients, families, and provider team members
- Education about illness and prognosis
- Assistance with medical decision making
- Continuity of care across a range of clinical settings and services
- Attention to spiritual needs
- Psychosocial support for patients and families
- Bereavement support for families and care team members

Palliative care services on-site will vary depending on the scope of the program, local staff expertise, and patient population. The cancer committee will define and identify in a policy and procedure the following:

- On-site and off-site palliative care services
- The palliative care team available on-site
- Criteria for referral to a palliative care specialist

Palliative care services not provided on-site at the facility must be provided through a referral relationship to other facilities and/or local agencies.

Evaluating Palliative Care Services

Each calendar year, the cancer committee monitors, evaluates, and makes recommendations for improvements to palliative care services. The evaluation is documented in the cancer committee minutes.

During this evaluation, the cancer committee must:

- Assess the approximate number of cancer patients referred for palliative care services and for what services or resources
- Discuss the criteria utilized to trigger referrals to palliative care services
- Discuss areas of improvement
 - Examples include, but are not limited to, barriers to access of palliative care services, addition of palliative care services, decreasing emergency department usage, or improving the timeliness of referrals

If available, it is recommended that a palliative care professional attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Policy and procedure for providing palliative care services on-site or by referral
- Cancer committee minutes that document the required yearly evaluations of the palliative care services.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Palliative care services are available to cancer patients either on-site or by referral.
2. A policy and procedure is in place regarding palliative care services that includes all required elements.
3. The process for providing and referring palliative care services to cancer patients is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes.

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4.6 Rehabilitation Care Services

Definition and Requirements

Policies and procedures are in place to guide referral to appropriate rehabilitation care services on-site or by referral. Rehabilitation care is patient-centered care that optimizes patient functional status and quality of life through preventive, restorative, supportive, and palliative interventions. The availability of rehabilitation care services is an essential component of comprehensive cancer care, beginning at the time of diagnosis and being continuously available throughout treatment, surveillance, and, when applicable, through end of life.

Rehabilitation professionals associated with cancer rehabilitation typically include, but are not limited to:

- Psychiatrists
- Physical therapists
- Occupational therapists
- Speech language pathologists

Types of rehabilitative care services may include, but are not limited to:

- Screening, diagnosis, and management of physical dysfunction, impairments, and disabilities
- Interventions to manage identified functional impairments and disabilities
- Screening, diagnosis, and management of pain and non-pain symptoms
- Screening, diagnosis, and management of cognitive function
- Lymphedema management
- Physical activity recommendations during and after treatment
- Vocational rehabilitation

The cancer program defines and identifies in a policy and procedure the rehabilitation care services provided on-site and by referral. Rehabilitation services not available at the facility must be provided through a referral relationship to other facilities and/or agencies. The cancer committee will define and identify in a policy and procedure the following:

- On-site and off-site rehabilitation care services
- The rehabilitation care team available on-site
- Criteria for performing functional assessments
- Criteria for referral to a rehabilitation care specialist

Evaluating Rehabilitation Care Services

Each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements, as needed, to rehabilitation care services and/or referrals. The content of the review and any recommendations for improvement are documented in the cancer committee minutes.

If available, it is recommended that a rehabilitation professional attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Policy and procedure defining rehabilitation services that are provided on-site and by referral
- Cancer committee minutes that document the required yearly evaluations of the rehabilitation care services

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The cancer committee develops policies and procedures to guide referral to appropriate rehabilitation care services on-site or by referral.
2. The process for referring or providing rehabilitation care services to cancer patients is monitored and reviewed by the cancer committee and documented in the cancer committee minutes.

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4.7 Oncology Nutrition Services

Definition and Requirements

Oncology nutrition services are provided, on-site or by referral, by Registered Dietitian Nutritionists (RDN) with knowledge and skills to address nutrition and hydration requirements and recommendations throughout the continuum of cancer care, including prevention, diagnosis, treatment, survivorship, and palliative care.

Multi-modality cancer treatments can impair a cancer patient's ability to consume, digest, and absorb essential nutrition and hydration. RDNs—also known as Registered Dietitians (RDs)—are uniquely trained to address treatment-related symptom management, nutrition support, and quality-of-life concerns through medical nutrition therapy and education. In addition, RDNs are qualified to discuss diet, nutrition, and lifestyle recommendations for survivorship, health promotion, and disease prevention.

The cancer program defines and identifies the nutrition services provided on-site and by referral. Components of oncology nutrition services include, but are not limited to:

- Screening and nutrition assessment for risk and diagnosis of malnutrition, nutrition-related problems, and overweight and obesity
- Medical nutrition therapy
- Nutrition counseling
- Nutrition education
- Management and coordination of enteral and parenteral nutrition

Nutrition services not available at the facility must be provided through a referral relationship to other facilities and/or agencies.

Evaluating Oncology Nutrition Services

Each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements to on-site oncology nutrition and hydration services and/or referral services. The content of the review and any recommendations for improvement are documented in the cancer committee minutes.

If available, it is recommended that a RDN attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Policies and procedures for providing oncology nutrition services, on-site or by referral, by a Registered Dietitian Nutritionist
- Cancer committee minutes that document the required yearly evaluations of the oncology nutrition services

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Oncology nutrition services are provided, on-site or by referral, by a Registered Dietitian Nutritionist.
2. The process for referring or providing oncology nutrition services to cancer patients is monitored and reviewed by the cancer committee and documented in the cancer minutes.

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PHASE-IN STANDARD

4.8 Survivorship Program

Definition and Requirements

The cancer committee oversees the development and implementation of a survivorship program directed at meeting the needs of cancer patients treated with curative intent.

Survivorship Program Team

The cancer committee appoints a coordinator of the survivorship program per the requirements in Standard 2.1: Cancer Committee.

The Survivorship Program Coordinator develops a survivorship program team. Suggested specialties include physicians, advanced practice providers, nurses, social workers, nutritionists, physical therapists, and other allied health professionals.

The survivorship program team determines a list of services and programs, offered on-site or by referral, that address the needs of cancer survivors. The team formally documents a minimum of three services offered each year. Services may be continued year to year, but it is expected that cancer programs will strive to enhance existing services over time and develop new services.

Each year, the survivorship program coordinator gives a report, and the cancer committee reviews the activities of the survivorship program. The report includes:

- An estimate of the number of cancer patients who participated in the three identified services
- Identification of the resources needed to improve the services if barriers were encountered

Survivorship Program Services

Services utilized by the survivorship program may include, but are not limited to:

- Treatment summaries
- Survivorship care plans
- Screening programs for cancer recurrence
- Screening for new cancers
- Seminars for survivors
- Rehabilitation services
- Nutritional services
- Psychological support & psychiatric services
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling
- Financial support services
- Physical activity programs

Survivorship Care Plans (SCP)

The CoC recommends and encourages that patients receive a survivorship care plan (SCP), but delivery of such plans is not a required component of this standard. Delivery of SCPs may be utilized as one of the services offered to survivors to meet the requirements of this standard. If so, then the program defines the population to receive care plans.

Documentation

Submitted with Pre-Review Questionnaire

- Policy and procedure defining the survivorship program requirements
- Cancer committee minutes that document the required yearly evaluations of the survivorship program

Measure of Compliance

Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee identifies a survivorship program team, including its designated coordinator and members.
2. The survivorship program is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes.

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AMERICAN COLLEGE OF SURGEONS
COMMISSION ON CANCER

5 Patient Care: Expectations and Protocols

Rationale

Patient care expectations are the backbone of the accreditation program, ranging from the patient's psychosocial well-being, the quality of the cancer surgery, and to the completeness of operative and pathologic reports.

Standards 5.3 through 5.8 were developed from guidelines described in Operative Standards for Cancer Surgery (OSCS), a surgical manual that provides recommendations regarding the effective technical conduct of surgical operations and review of the quality of evidence upon which those recommendations are based. Commission on Cancer (CoC) accreditation reaches approximately 70 percent of patients with newly diagnosed cancer each year. Incorporation of the OSCS recommendations as CoC accreditation standards is a step toward improving oncologic outcomes by reducing the variation in the way cancer operations are performed across the United States.

These standards are intended solely as qualification criteria for CoC accreditation. They do not constitute a standard of care and are not intended to replace the medical judgment of the physician or health care professional in individual circumstances.

5.1 College of American Pathologists Synoptic Reporting

Definition and Requirements

Ninety percent of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologists (CAP) cancer protocols, including containing all core data elements within the synoptic format.

The synoptic format is defined as a structured format that includes all of the following:

- All core elements must be reported whether applicable or not, except for those that are defined as “conditional.” Elements identified in the Cancer Protocols as “conditional” only need to be reported if applicable.
- All core elements must be reported in a “diagnostic parameter pair” format, in other words, data element followed by its response (answer).
- Each diagnostic parameter pair must be listed on a separate line or in a tabular format to achieve visual separation (refer to CAP Cancer Protocols for exceptions to this rule).
- All core elements must be listed together in synoptic format in one location in the pathology report.

Note: Please refer to the CAP Cancer Protocols for specific guidance and examples.

For CoC-accredited programs, “eligible cancer pathology reports” are defined as:

- Definitive surgical resection of primary invasive malignancies and ductal carcinoma in situ (DCIS), and
- Definitive surgical resection in patients who have received neoadjuvant therapy AND who have residual tumor

*The following do **not** need to be reported using the CAP Cancer Protocols:*

- Definitive surgical resection in which no residual tumor is present
- Additional surgical procedure performed after definitive resection (for example, resection of positive margins or node biopsy/resection)
- Diagnostic biopsy, cytology specimens, or other diagnostic procedures done before definitive surgical therapy
- Surgical resection for recurrent tumor
- In situ carcinomas (except for DCIS)
- Special studies (for example, biomarker or prognostic testing)

Documentation

Reviewed On-Site

- The site visit reviewer reviews the standardized synoptic pathology reports for eligible patients.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

During the accreditation cycle, the cancer program fulfills the compliance criteria:

1. Ninety percent of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologist (CAP) cancer protocols, including containing all core data elements within the synoptic format.

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5.2 Psychosocial Distress Screening

Definition and Requirements

Psychosocial services are available on-site or by referral. Each calendar year, the cancer committee implements a policy and procedure for providing and monitoring psychosocial distress screening and referral for psychosocial care. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator.

Psychosocial Services Policy and Procedure

Services that address physical, psychological, social, spiritual, and financial needs that result from a cancer diagnosis must be available on-site or by referral with an established policy and procedure in place to inform patients how to access them.

Psychosocial Distress Screening

Cancer programs must implement a policy and procedure for psychosocial distress screening for cancer patients. The process identifies psychological, social, financial, and behavioral issues that may interfere with a patient's treatment plan and adversely affect treatment outcomes. The process also provides patients identified with distress the appropriate resources and/or referral for psychosocial needs.

Timing of Screening

Cancer patients must be screened for distress at least one time during the patient's first course of treatment. Additional screenings may be provided per cancer program or health care provider discretion, but are not required by this standard.

The following patients are not included in compliance for this standard:

- Biopsy only or class of case "00" patients
- Patients who are admitted to the hospital with a history of cancer, but for non-cancer related issues
- Inpatients with a current diagnosis of cancer who are treated for a non-cancer issue and do not receive cancer treatment

Method

The mode of administration (patient questionnaire or clinician-administered questionnaire) is determined by the cancer committee and may be tailored to the workflow of the practice. Medical staff, including medical assistants, nurses, social workers, and physicians who administer or interpret the screening tool must be properly trained.

The policy and procedure must address the sites of service where screenings occur, including at the CoC-accredited facility and/or with designated providers (for example, offices of medical oncologists and/or radiation oncologists affiliated with the CoC program). The policy and procedure must include processes for assessment and treatment (on-site or by referral) appropriate for the source of distress identified by the screening, including the psychosocial, physician, spiritual, and mental health resources available to patients on-site or by referral.

Tools

The cancer committee selects and approves the psychosocial distress screening tool to be administered. Preference is given to standardized, validated instruments or tools with established clinical cutoffs. The cancer committee determines the cutoff score used to identify distressed patients.

Assessment and Referral

If there is clinical evidence of moderate or severe distress based on the results of the distress screening, a member of the patient's oncology team (physician, nurse, social worker, psychologist, and/or contracted mental health professional) must assess the patient (through direct contact) to identify the problems initiating the distress. Direct contact means discussion of the results with the patient face-to-face, by telephone, or by telemedicine. This assessment will confirm the distress screening results and identify the appropriate referrals as needed.

Documentation

The screening process, timing of screening, identified tool, and distress level triggering a referral to services are documented in the policy and procedure.

The distress screening(s) results, referral for provision of care, and any follow-up are documented in the patient medical record to facilitate integrated, high-quality care.

The Psychosocial Services Coordinator is required to oversee this activity and report to the cancer committee each year. Reports must include one year's worth of data.

The annual psychosocial services summary must include, but is not limited to:

- Number of patients screened
- Number of patients referred for distress resources or further follow-up
- Where patients were referred (on-site or by referral)

Documentation

Submitted with Pre-Review Questionnaire

- Policies and procedures that provide patient access to psychosocial services either on-site or by referral
- The psychosocial distress screening policy and procedure
- The annual psychosocial services summary that documents all required elements and cancer committee minutes documenting the report

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Policies and procedures are in place to provide patient access to psychosocial services either on-site or by referral.
2. The cancer committee implements a policy and procedure that includes all requirements for providing and monitoring psychosocial distress screening and referral for psychosocial care.
3. Cancer patients are screened for psychosocial distress at least once during the first course of treatment.
4. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator. The coordinator's report includes all required elements and is documented in the cancer committee minutes.

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PHASE-IN STANDARD

5.3 Breast Sentinel Node Biopsy

Definition and Requirements

All sentinel nodes for breast cancer must be identified, removed, and subjected to pathologic analysis to ensure that sentinel lymph node mapping and sentinel lymphadenectomy provide accurate information for breast cancer staging.

Sentinel nodes are defined as nodes having uptake of a localization substrate (radioactive tracer and/or colored dye) that has been previously injected into the affected breast, a node to which an afferent colored lymphatic travels, or dominant lymph nodes that are suspicious as identified by the operating surgeon.

This standard is satisfied if a diligent search has been made for sentinel nodes, with those nodes removed when present, and documentation of those specifics. Operative reports must indicate that colored, radioactive, and/or suspicious nodes were removed, in addition to any non-colored nodes at the end of a colored lymphatic.

When performing a sentinel node biopsy in patients who have undergone neoadjuvant chemotherapy, removing a clipped node and/or at least two to three sentinel nodes and/or using multiple substrates for sentinel node identification improves the false negative rate.

Synoptic Operative Report Requirements

Operative reports for patients undergoing breast sentinel node biopsy must include the following minimum elements in synoptic format (see Table at right):

Element	Response
Substrate(s) used for sentinel node biopsy in the non-neoadjuvant setting	Dye; Radiotracer; Clips; Dye and Radiotracer; Dye and Clips; Radiotracer and Clips; Dye, Radiotracer, and Clips; None; N/A.
Substrate(s) used for sentinel node biopsy in the neoadjuvant setting	Dye; Radiotracer; Clips; Dye and Radiotracer; Dye and Clips; Radiotracer and Clips; Dye, Radiotracer, and Clips; None; N/A.
All colored nodes or non-colored nodes present at the end of a dye filled lymphatic channel were removed, if dye was used as the substrate for localization.	Yes; No; N/A.
All significantly radioactive nodes were removed, if radionuclide was used as the substrate for localization.	Yes; No; N/A.
All palpably suspicious nodes were removed, if present.	Yes; No; N/A. If no, why.
If clips were placed in pathologically-involved nodes, those nodes were identified and removed.	Yes; No; N/A.

Patient Criteria

This standard applies to patients undergoing nodal staging in a curative setting for patients having breast cancers of epithelial origin.

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients with breast cancer of epithelial origin who underwent nodal staging in a curative setting.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. All sentinel nodes for breast cancer are identified, removed, and subjected to pathologic analysis.
2. Operative reports for patients undergoing breast sentinel node biopsy includes required minimum elements in synoptic format.

Bibliography

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Nelson H, Hunt KK, Veeramachaneni N, et al. *Operative Standards for Cancer Surgery, Volume I*. Chicago, IL. Wolters Kluwer; 2015.

PHASE-IN STANDARD

5.4 Breast Axillary Dissection

Definition and Requirements

Axillary dissection for breast cancer constitutes removing level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and latissimus dorsi, while preserving key neurovascular structures.

Axillary lymph node dissection (ALND) is a staging and therapeutic procedure that serves two purposes: (1) to provide important staging and prognostic information that can affect treatment decisions and determine prognosis, and (2) provides local control in certain settings where sentinel node biopsy, systemic and endocrine therapies, and radiotherapy, alone or combined, have not yet demonstrated adequate local control within the axilla.

The standard has been satisfied if dissection to established axillary boundaries is complete and documented. The boundaries of an ALND for breast cancer include the level I and II axillary lymph nodes. Their complete removal constitutes dissection within the following boundaries: the axillary vein, the latissimus dorsi muscle, and the serratus anterior muscle and chest wall. The long thoracic nerve and the thoracodorsal nerve shall be preserved unless visibly involved with cancer. The intercostobrachial nerves should be spared when possible. Although the numbers of lymph nodes retrieved in an ALND after neoadjuvant chemotherapy tends to be fewer, the surgical techniques that guide ALND are the same.

Axillary dissection of levels I and II should be complete, with resection of all tissue within the boundaries specified above. Level III nodes may be removed if clinically involved or suspicious at operation, although the benefit of their removal is isolated to local control, with limited data to support their removal.

Programs are encouraged to review the number of lymph nodes retrieved in patients who did not receive neoadjuvant therapy.

Synoptic Operative Report Requirements

Operative reports for patients undergoing axillary dissection must include the following minimum elements in synoptic format:

Element	Response
Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi.	Yes; No.
The long thoracic and thoracodorsal nerves were spared during dissection.	Yes; No; Not identified.
Attempts were made to spare the intercostobrachial nerves during dissection if possible.	Yes; No.
If one or more level III nodes is/are removed, then document why.	Yes; No. If yes, then why.

Patient Criteria

This standard applies to patients undergoing axillary dissection with diagnostic or therapeutic intent for patients having breast cancers of epithelial origin.

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients with breast cancer of epithelial origin who underwent axillary dissection with diagnostic or therapeutic intent.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Axillary dissections for breast cancer remove level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and latissimus dorsi, while preserving key neurovascular structures.
2. Operative reports for patients undergoing axillary dissection include the required minimum elements in synoptic format.

Bibliography

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Olson JA, McCall LM, Beitsch P, et al. Impact of immediate versus delayed axillary node dissection on surgical outcomes in breast cancer patients with positive sentinel nodes: Results from American College of Surgeons Oncology Group Trials Z0010 and Z0011. *J Clin Onc.* 2008;26(21):3530-3535.

Nelson H, Hunt KK, Veeramachaneni N, et al. *Operative Standards for Cancer Surgery, Volume I.* Chicago, IL: Wolters Kluwer; 2015.

PHASE-IN STANDARD

5.5 Primary Cutaneous Melanoma

Definition and Requirements

Clinical margin width for wide local excision of invasive melanoma is 1 cm for melanomas <1 mm thick, 1 to 2 cm for invasive melanomas 1 to 2 mm thick, and 2 cm for invasive melanomas > 2 mm thick. The clinical margin width for wide local excision of a melanoma in situ is at least 5 mm.

“The margin width for wide local excision of melanoma is based on the Breslow thickness of the primary tumor.... The margin is measured circumferentially at the level of the skin from either residual gross tumor and/or the previous biopsy scar.” *Operative Standards for Cancer Surgery, Volume II*, page 390.

The depth of resection should include the skin and all underlying subcutaneous tissue to the level of the underlying fascial plane. For in situ disease, the wide local excision need only include the skin and the superficial subcutaneous fat.

Synoptic Operative Report Requirements

Operative reports for patients undergoing a wide local excision of a primary cutaneous melanoma must include the following minimum elements in synoptic format:

Element	Response
Original Breslow thickness of the lesion	Melanoma in situ (MIS); Invasive (to the tenth of a millimeter).
Clinical margin from the edge of the lesion or the prior excision scar	0.5 cm; 1 cm; 2 cm; Other; ___ cm due to cosmetic/anatomic concerns; Mohs micrographic surgery with ___ cm initial margin
Depth down to the fascia; if not down to the fascia, then document why	Yes; No; If no, why.

Patient Criteria

This standard applies to patients undergoing curative-intent wide local excision of a primary cutaneous melanoma lesion. Mucosal, ocular, and subungual melanomas are excluded. Cosmetic concerns or anatomical limitations particularly on the hands, feet, or face may dictate smaller margins. If so, operative report must include documentation why.

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients who underwent a curative-intent wide local excision for primary cutaneous melanoma.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

- Clinical margin width for wide local excision of invasive melanoma is 1 cm for melanomas less than 1 mm thick.
- Clinical margin width for wide local excision of invasive melanoma is 1 to 2 cm for melanomas 1 to 2 mm thick.
- Clinical margin width for wide local excision of invasive melanoma is 2 cm for melanomas greater than 2 mm thick.
- The clinical margin width for wide local excision of a melanoma in situ is at least 5 mm.
- Operative reports for patients undergoing a wide local excision of a primary cutaneous melanoma include the required minimum elements in synoptic format.

Bibliography

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PHASE-IN STANDARD

5.6 Colon Resection

Definition and Requirements

Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s).

“Proximal vascular ligation with en bloc lymphadenectomy ensures complete resection of the associated lymph nodes for pathologic evaluation. The number of lymph nodes resected surgically and evaluated pathologically reflects the completeness of the lymphadenectomy and is an indicator of surgical quality and oncologic outcomes.” *Operative Standards for Cancer Surgery Volume I*, page 288.

Synoptic Operative Report Requirements

Operative reports for patients undergoing resection for colon cancer must include the following minimum elements in synoptic format:

Element	Response	
Tumor location	Right colon; hepatic flexure; transverse colon; splenic flexure; descending colon; sigmoid colon	
Extent of lymphovascular resection	<i>Tumor location</i>	<i>Proximal vascular ligation</i>
	Right colon (cecum and ascending colon)	Ileocolic artery and vein and, if present, right colic artery and vein
	Hepatic flexure	Ileocolic artery and vein and, if present, right colic artery and vein and middle colic artery and vein
	Transverse colon	Middle colic artery and vein
	Splenic flexure	Middle colic artery and vein and ascending left colic artery and vein
	Descending colon	Inferior mesenteric artery and vein to include ascending left colic artery and vein
	Sigmoid colon	Inferior mesenteric artery and vein
If anatomic guidance other than listed above, document why	If yes, why.	
If patient is excluded, then document why	If yes, why.	

Patient Criteria

This standard applies to all curative resections for colon cancer and applies to all operative approaches.

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic operative reports for patients who underwent resection for colon cancer.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

- Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s).
- Operative reports for patients undergoing resection for colon cancer include the required minimum elements in synoptic format.

Bibliography

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PHASE-IN STANDARD

5.7 Total Mesorectal Excision**Definition and Requirements**

Total mesorectal excision (TME) is performed for all patients undergoing radical surgical resection of mid and low rectal cancers. Limited, tumor-specific mesorectal excision with a distal mesorectal margin of 4 to 5 cm of mesorectum may be performed for proximal rectal cancers.

“Total mesorectal excision (TME) of rectal cancer leverages existing tissue planes to perform a complete resection of the tumor and the associated draining lymph nodes. By maintaining the intact fascia propria of the rectum and operating in the space between the mesorectum and the presacral fascia, the surgeon can achieve a resection with a negative margin, while simultaneously preserving neurovascular structures.” *Operative Standards for Cancer Surgery Volume II*, page 194.

Per College of American Pathologists (CAP) cancer protocol template for rectal cancer resections, the quality of TME resection (complete, near complete, or incomplete) must be documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format.

Although the surgeon should always strive to perform a complete TME, near complete TME offers similar oncologic outcomes relative to local recurrence and survival and is considered to meet the expectations of this standard. Conversely incomplete TME is associated with a significantly higher risk of local recurrence and cancer related death.

Patient Criteria

This standard applies to operations for curative intent radical resections of rectal adenocarcinoma and excludes local excision approaches.

Documentation**Reviewed On-Site**

- The site visit reviewer will review the standardized synoptic pathology reports for rectal cancer patients with middle and low rectal cancers.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Total mesorectal excision is performed for all patients undergoing radical surgical resection of mid and low rectal cancers and results in a complete or near complete mesorectal excision.
2. The quality of TME resection (complete, near complete, or incomplete) is documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format.

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PHASE-IN STANDARD

5.8 Pulmonary Resection

Definition and Requirements

The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.

“The hilum and mediastinum should be thoroughly staged at the time of the lung resection, even in patients who are undergoing nonanatomic parenchyma-sparing resections such as... [a] wedge resection.” *Operative Standards for Cancer Surgery Volume I*, page 93.

For reference, single digit stations are mediastinal (1-9) and double digit stations are hilar (10 or higher).

Per the College of American Pathologists (CAP) cancer protocol template for pulmonary resections, the nodal stations examined by the pathologist must be documented in curative pulmonary resection pathology reports in synoptic format. Surgeons are expected to identify on the histology requisition form the station from which each group of nodes has been taken.

Patient Criteria

This standard applies to the primary surgical procedure for curative intent pulmonary resections for non-small cell lung cancer (NSCLC), small cell lung cancer (SCLC), and carcinoid tumors of the lung. This standard applies to all operative approaches.

Documentation

Reviewed On-Site

- The site visit reviewer will review the standardized synoptic pathology reports for curative intent pulmonary resections.

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

- The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.
- The nodal stations examined by the pathologist must be documented in curative pulmonary resection pathology reports in synoptic format.

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6 Data Surveillance and Systems

Rationale

High-quality data are critical to inform quality improvement and measure the performance of programs. All required cases must be submitted to the National Cancer Database (NCDB) using nationally standardized data item and coding definitions.

Data are validated through multiple mechanisms that are continuously updated to optimize the quality of the data collected.

6.1 Cancer Registry Quality Control

Definition and Requirements

High-quality cancer registry data are essential to accurately assess treatment outcomes and patient survival. Each calendar year, the cancer committee implements a policy and procedure to annually evaluate the quality of cancer registry data and activity, including procedures to monitor and evaluate each required control component.

The Cancer Registry Quality Coordinator works cooperatively with registry staff and other applicable departments to implement the quality control policy and procedure. The coordinator must monitor each area of cancer registry activity and recommends corrective action if any area falls below the measures specified in the plan. The results, recommendations, and outcomes of recommendations must be reported to the cancer committee at least annually and documented in the cancer committee minutes.

The quality control policy and procedure includes the following, at a minimum:

- A. Sets the review criteria
- B. Sets the quality control timetable
- C. Specifies the quality control methods, sources, and individuals involved. Specifications include:
 - Random sampling of annual analytic caseload
 - Review by designated person(s)
 - Reviewer(s) may be CTR(s), Advanced Practice Registered Nurse(s), Physician Assistant(s), physician(s), fellow(s), or resident(s)
 - CTRs cannot review their own cases
 - External audits (such as state or central cancer registry case-finding audits) may be used to fulfill part of this requirement
- D. Identifies the activities to be evaluated for all cases each year:
 1. Case finding
 2. Abstracting timeliness
 3. The percentage of information coded as unknown (usually coded as 9 or a string of 9s)
- E. Identifies the activities to be evaluated each year for the accuracy of abstracted data. A review of a minimum of 10 percent of the annual analytic caseload (up to 200 cases annually) is required each year for the accuracy of the following:
 1. Class of case
 2. Primary site
 3. Histology
 4. Grade
 5. American Joint Committee on Cancer (AJCC) Stage or other appropriate staging system as appropriate for cancer site
6. First course of treatment
7. Follow-up information, specifically:
 - Date of first recurrence
 - Type of first recurrence
 - Cancer status
 - Date of last cancer status
- F. Establishes the minimum quality benchmarks and required accuracy. Cancer registry data submitted to the NCDB meet the established quality and timeliness criteria included in the annual NCDB Call for Data.
- G. Maintains documentation of the quality control activity:
 - Review criteria
 - Cases reviewed
 - Identified data errors and resolutions
 - Reports the percentage of accuracy to the cancer committee annually of the review of elements listed in sections D and E above. The report must be documented in the cancer committee minutes.

Patient data reviewed under the cancer registry quality control plan for Standard 6.1 cannot be used as an in-depth analysis review for compliance to Standard 7.2: Monitoring Compliance with Evidence-Based Guidelines.

Documentation

Submitted with Pre-Review Questionnaire

- A quality control policy and procedure, which includes the process for resolving conflicts identified during the quality control review.
- If utilized, any audit reports from the state or central registry that were used in the evaluation of the cancer registry data
- Cancer committee minutes documenting that the results of the annual quality control evaluation were presented and reviewed by the cancer committee

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The cancer committee implements a quality control policy and procedure to evaluate the required areas of the cancer registry.
2. The Cancer Registry Quality Control Coordinator, under the direction of the cancer committee, performs or oversees the required quality control review as outlined in the policy and procedure.
3. The results, recommendations, and outcomes of recommendations are reported to the cancer committee and documented in the cancer committee meeting minutes.

Bibliography

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6.2 Data Submission

Definition and Requirements

Data submitted to the National Cancer Database (NCDB) are used to provide feedback to assess the quality of patient care. This feedback enables cancer programs to compare treatment and outcomes with regional, state, and national patterns of care.

The NCDB is a nationwide oncology outcomes database used as a clinical surveillance mechanism to monitor changes and variations in patterns of cancer care and patient outcomes. NCDB data serves as useful benchmarks for patient care and continuous quality improvement for cancer programs.

Each calendar year, complete data for all requested analytic cases are submitted to the NCDB in accordance with the annual Call for Data. Data submission to the NCDB must be performed by using the Commission on Cancer's secure online data submission application in accordance with the annual Call for Data specifications.

After the initial site visit of a new program is completed and accreditation is awarded, the program submits data to the NCDB for all applicable years currently accepted by the NCDB. New programs will submit all analytic cases for any diagnosis years beginning with its Reference Date. Data are submitted, and errors and rejected records are corrected (Standard 6.3).

Documentation

The facility submits data as required for compliance by the NCDB.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. Complete data for all requested analytic cases are submitted to the NCDB in accordance with the annual Call for Data specifications.

6.3 Data Accuracy

Definition and Requirements

Accurate data are necessary for meaningful comparison of treatment and patient outcomes. These data are the basis for the feedback provided to cancer programs.

As part of its annual Call for Data, the National Cancer Database (NCDB) will document the conditions that will cause the cases submitted to the NCDB to be rejected. Rejected cases do not meet specified data quality criteria. Standardized, nationally accepted data edits are applied to all analytic cases submitted. The reporting registry is notified of the problematic cases through an edit report. The reporting registry must correct outstanding data quality errors and resolve errors resulting in rejected records.

Each year, the cases satisfy the established quality criteria by the deadline specified in each Call for Data specification. Problematic cases are corrected and resubmitted according to the Call for Data specifications. The cancer committee monitors the resolution and resubmission of problematic cases (Standard 6.1).

Documentation

The facility submits data as required for compliance by the NCDB.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The cases meet the quality criteria as defined in the annual Call for Data specifications on the initial submission.
2. If cases submitted do not meet the quality criteria on initial submission then identified errors in submitted cases and rejected records are corrected and resubmitted by the due date specified.

6.4 Rapid Quality Reporting System (RQRS) Participation

Definition and Requirements

Promoting evidence-based cancer care is of key importance to improving the quality of care and patient outcomes. Therefore, the Commission on Cancer (CoC) has developed the RQRS to facilitate quality improvement by encouraging evidence-based care in CoC-accredited programs for select quality measures. RQRS enables accredited cancer programs to report data on patients concurrently and receive notifications of treatment expectations. This tool presents year-to-date concordance rates for each measure as compared with the state, other hospital groups, and hospitals at the national level.

The cancer program actively participates in RQRS, submits all cases for all measures, and adheres to the RQRS terms and conditions. Programs must actively participate in RQRS submissions and adhere to the RQRS requirements through the entire accreditation cycle. The full details for RQRS participation are provided in the RQRS terms and conditions available on the National Cancer Database website.

RQRS data and performance must be reported to the cancer committee at least twice each calendar year. The Cancer Liaison Physician may report RQRS data and performance in partial fulfillment of the requirement for Standard 2.2.

Documentation

The program submits data as required for compliance by the NCDB.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. All new and updated cancer cases are submitted at least once each calendar quarter according to the RQRS terms and conditions.
2. RQRS data and performance reports are reviewed by the cancer committee at least twice each calendar year and documented in the cancer committee minutes.

6.5 Follow-Up of Patients

Definition and Requirements

Long-term follow-up is essential to evaluate outcomes of cancer care. Accurate follow-up data enables the program to compare outcomes with regional, state, or national statistics. Follow-up information is obtained at least annually for all analytic cases of living patients included in the cancer registry database.

For all eligible cases, an 80 percent follow-up rate is maintained from the cancer registry reference date. A 90 percent follow-up rate is maintained for all eligible analytic cases diagnosed within the last five years or from the cancer registry reference date, whichever is shorter.

All reportable cases are followed up, except the following:

- Residents of foreign countries
- Cases reportable by agreement
- Patients whose age exceeds 100 years and who are without contact for more than 12 months
- Analytic cases *Class of Case* OO

Methods to obtain follow-up information include, but are not limited to, the following:

- Following or managing physician(s)
- Program inpatient or outpatient services
- Pathology reports or death certificates
- Patient or patient's family
- Internet sources (such as death index, patient locator software, obituary listings)
- Communication with other facilities

The cancer committee monitors the use of unknown values to ensure complete data reporting. This monitoring is extremely important for information describing the date of first recurrence, type of first recurrence, and cancer status.

It is expected that all CoC-accredited programs will provide treatment or follow-up information and assistance to the referring cancer programs.

Documentation

Reviewed On-Site

- The site visit reviewer reviews the current follow-up report.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. An 80 percent follow-up rate is maintained for all eligible analytic cases from the cancer registry reference date.
2. For PCP facilities, a 60 percent follow-up rate is maintained for all eligible analytic cases from the cancer registry reference date.
3. A 90 percent follow-up rate is maintained for all analytic cases diagnosed within the last five years or from the cancer registry reference date, whichever is shorter.



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7 Quality Improvement

Rationale

Problem resolution, outcomes improvement, and assurances of patient safety must be readily identifiable through structured quality improvement initiatives. In support of these efforts, the cancer program must develop a culture of collaboration in order to analyze and implement strategies based on data to drive improvement in the quality of care. Continuous quality improvement must be reflected in the results of such efforts.

7.1 Accountability and Quality Improvement Measures

Definition and Requirements

The Commission on Cancer (CoC) requires accredited cancer programs to treat cancer patients according to nationally accepted accountability and quality improvement measures indicated by the CoC quality reporting tool.

The cancer committee monitors the program's expected Estimated Performance Rates for accountability and quality improvement measures selected annually by the CoC. Details on the quality measures for this standard may be referenced on the National Cancer Database (NCDB) website which includes measure specifications, years for performance evaluation, and quality measure performance thresholds for this standard. Facility performance rates for these quality measures will be extracted from the NCDB reporting tools.

If the cancer program is not meeting the expected EPR of a measure(s), then a corrective action plan must be developed and executed in order to improve performance. The corrective action plan must document how the program will investigate the issue for each measure with the goal of resolving the deficiency and improving compliance.

The cancer committee's review of compliance with required accountability and quality improvement measures and monitoring activity is documented in the cancer committee minutes. The action plan and any corrective action taken are included in the documentation.

Programs with no cases eligible for assessment in a selected measure are exempt from requirements for that individual measure.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes documenting the presentation and review of required accountability and quality improvement measures; documentation includes any required action plans

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The cancer committee monitors the program's expected Estimated Performance Rates for accountability and quality improvement measures selected by the CoC.
2. The monitoring activity is documented in the cancer committee minutes.
3. For each accountability and quality improvement measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the expected EPR specified by the CoC. If the expected EPR is not met, the program has implemented an action plan that reviews and addresses program performance below the expected EPR.

7.2 Monitoring Concordance with Evidence-Based Guidelines

Definition and Requirements

Each calendar year, a physician performs an in-depth analysis of the diagnostic evaluation and treatment of individual patients to determine whether it is concordant with recognized evidence-based national guidelines. The study must be a retrospective review of individual patient evaluation and treatment information, which includes a patient medical record review. The study and results are presented to the cancer committee and documented in cancer committee minutes.

The annual in-depth analysis must include all of the following components:

1. The choice of a patient population to review. Sources for the assessment must include one of the following study topics:
 - All cases from a specific cancer site (or stage within that site), to a maximum of 100 cases OR
 - An identified need or concern within a specific cancer site or stage of cancer
2. Through a review of each patient, which includes review of the medical record, a determination whether the pre-treatment initial diagnostic evaluation process is concordant with evidence-based national treatment guidelines for each patient being reviewed. Initial evaluation indicated will differ by cancer site. However, review of the initial evaluation should include pathology, diagnostic imaging, laboratory tests, and consultations recommended within the specific guideline(s) being reviewed.
3. Through a review of each patient, which includes review of the medical record, a determination whether the first course of treatment is appropriate for the stage of disease or prognostic indicators and is concordant with evidence-based national treatment guidelines for each patient being reviewed.
4. A reporting format that permits analysis and provides an opportunity to recommend performance improvements based on data from the analysis.
5. A presentation of a report detailing all required elements of the study, including the results of the analysis, to the cancer committee. The report is documented in the cancer committee minutes. The documentation includes any recommendations for improvement.

Analysis and treatment discussions for patients at multidisciplinary cancer case conferences do not fulfill the requirements for Standard 7.2. Any problems identified with the diagnostic evaluation or treatment planning process may serve as a source for a quality project under Standard 7.3: Quality Improvement Initiative.

Documentation

Submitted with Pre-Review Questionnaire

- A report of the in-depth analysis which documents the completed analysis, including identification of the patient population reviewed, methodology, and results
- Cancer committee minutes that document that the conclusions and the results of the analysis were reported and any recommendations for improvement

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. A physician conducts an in-depth analysis to determine whether initial diagnostic evaluation and first course of treatment provided to patients is concordant with evidence-based national treatment guidelines.
2. The report detailing all required elements of the study, including the results of the analysis and any recommendations for improvement, are reported to the cancer committee and documented in the cancer committee minutes.

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7.3 Quality Improvement Initiative

Definition and Requirements

Under the guidance of the Cancer Liaison Physician (CLP), the Quality Improvement Coordinator, and the cancer committee, the cancer program must measure, evaluate, and improve its performance through at least one cancer-specific quality improvement initiative each year.

This quality improvement (QI) initiative requires the program to identify a problem, understand what is causing the identified problem through use of a recognized performance improvement methodology, and implement a planned solution to the problem. Reports on the status of the QI initiative must be given to the cancer committee at least twice each calendar year and documented in the cancer committee minutes.

Quality Improvement Initiative Required Components

1. Review Data to Identify the Problem

The QI initiative must be focused on an already identified, quality-related problem specific to the cancer program.

The following (in order of preference) may be used to identify the focus of the QI initiative:

- Problems identified in a National Cancer Database (NCDB) accountability or quality improvement measure
- Problems identified in a Standard 7.2: Monitoring Compliance with Evidence Based Guidelines study
- Problems identified through annual review of clinical services in other CoC standards (for example, palliative care services, genetics services, operative standards)
- Problems identified through National Accreditation Program for Rectal Cancer or National Accreditation Program for Breast Centers accreditation initiatives
- Problems identified through review of NCDB data other than accountability or quality improvement measures, including Cancer Quality Improvement Program (CQIP)
- Any other cancer-specific, quality-related problem determined by the cancer committee

2. Write the Problem Statement

The QI initiative must have a problem statement. The problem statement must identify:

- A specific, already identified, quality-related problem specific to the cancer program to solve through the QI initiative
- The baseline and goal metrics (must be numerical)
- Anticipated timeline for completing the QI initiative and achieving the expected outcome

The problem statement cannot state that a study is being done to see if a problem exists, rather it must already be known that a problem exists.

3. Choose and Implement Performance Improvement Methodology and Metrics

The Quality Improvement Coordinator and the CLP must identify the content experts needed to execute the QI initiative. For example, if the QI initiative is on the BCSRT accountability measure, then at least one breast surgeon and one radiation oncologist are included on the initiative team.

A recognized, standardized performance improvement tool must be chosen and used to conduct the QI initiative (for example, Lean, DMAIC, or PDCA/PDSA).

In line with the performance improvement tool selected, the team conducts analysis to identify all possible factors contributing to the problem. This may involve a literature review and/or a root-cause analysis. Based on the results, an intervention is developed that aims to fix the cause of the problem being studied.

It is recommended that a project calendar is identified, which includes the initiative's launch date, when status updates will be given at cancer committee meetings, and a goal wrap-up date.

QI initiatives should last approximately one year. But if additional time is needed, it may be extended for a second year (for a total of two years). However, a new initiative must be started at the beginning of each calendar year even if a previous QI initiative is still in progress. If the QI initiative will extend into the second year, then a status update to the cancer committee must be given at the last meeting of the first calendar year.

4. Implement Intervention and Monitor Data

The intervention chosen in step three must be implemented. If oversight of the implementation suggests the intervention is not working, then it must be modified.

5. Present Quality Improvement Initiative Summary

Once the initiative has been completed, a document summarizing the initiative and the results must be presented and discussed with the cancer committee and documented in the cancer committee minutes. If possible, results are compared with national data.

The summary presentation must include:

- Summary of the data reviewed to identify the problem to study
- The problem statement
- The QI initiative team members
- Performance improvement tool utilized
- The intervention implemented
- If applicable, any adjustments made to the intervention
- Results of the implemented intervention

Cancer Committee Reports

The CLP or the Quality Improvement Coordinator must provide updates to the cancer committee on the QI initiative's status at least twice each calendar year. Status updates, at a minimum, indicate the current status of the QI initiative and any planned next steps. The final summary and results report may qualify as one of the required reports.

3. A final presentation of a summary of the quality improvement initiative is presented after the QI initiative is complete. The summary presentation includes all required elements.

Bibliography

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Hoyt DB, Ko CY. *Optimal Resources for Surgical Quality and Safety*. Chicago, IL: American College of Surgeons; 2017.

Documentation

Reviewed On-Site

- Documentation of QI initiative team's work from throughout the initiative (for example, minutes, literature used).

Submitted with Pre-Review Questionnaire

- Document summarizing at least one QI initiative each calendar year, which includes all required elements
- Cancer committee minutes documenting required status updates and presentation of the QI initiative summary

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. One quality improvement initiative based on an identified quality-related problem is initiated each year. The QI initiative documentation includes how it measured, evaluated, and improved performance through implementation of a recognized, standardized performance improvement tool.
2. Status updates are provided to the cancer committee two times. Reports are documented in the cancer committee minutes.

7.4 Cancer Program Goal

Definition and Requirements

Annual goal setting provides direction for the strategic planning of cancer program activities. Each calendar year, the cancer program establishes, and documents in the cancer committee minutes, one cancer program goal appropriate and relevant to the cancer program and its patient population.

It is recommended the goal-setting tool known as SMART (Specific, Measurable, Achievable, Realistic, and Timely) be used when establishing the goal. Goals must be directed toward the scope, coordination, practices, processes, and provision of services for cancer care at the program.

The cancer committee must document substantive status updates on goal progress at two subsequent meetings after the goal's establishment in the same calendar year. For example, the status update may include any progress made, road blocks encountered, or a description of any necessary next steps.

Goals should last approximately one year. If additional time is needed, a goal may be extended for a second year (for a total of two years). However, a new goal must be established at the beginning of each calendar year even if a previous goal is still in progress. If the goal will extend into the second year, then a status update must be provided at the last meeting of the first calendar year. Additionally, there must be at least one additional status update documented in the cancer committee minutes during the second year. By the end of the second year, the cancer program must document in the cancer committee minutes that the goal is either completed or retired.

A goal established under this standard cannot duplicate requirements or be an improvement on requirements from another standard or be a program or initiative submitted to meet requirements of another standard.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes documenting the establishment and status updates of the cancer program goal

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. One cancer program goal is established and documented in the cancer committee minutes.
2. At least two substantive status updates on goal progress are documented in the cancer committee minutes in the same calendar year as its establishment.
3. For any goal extended into a second year, at least one status update is documented in the minutes during the second year to indicate whether the goal was completed or retired.

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8 Education: Professional and Community Outreach

Rationale

Part of being a quality cancer program is not only addressing the program's current patients, but also those in the community who may develop cancer or have difficulty receiving cancer treatment.

Outreach to the community through screening and prevention events aids in reducing the risk of developing cancer and in diagnosing cancer at an earlier stage than it might be otherwise.

8.1 Addressing Barriers to Care

Definition and Requirements

Each calendar year, the cancer committee identifies at least one patient-, system-, or provider-based barrier to accessing health and/or psychosocial care that its patients with cancer are facing and develops and implements a plan to address the barrier.

Cancer Barriers Analysis

The cancer committee reviews and analyzes the strengths and barriers of the cancer program. Resources for identifying strengths and barriers may include, but are not limited to:

- Cancer Quality Improvement Program (CQIP) reports
- Cancer patient satisfaction surveys
- Patient focus groups
- Use of state cancer registry data compared to cancer program data
 - Is the cancer program treating the main cancers that occur in its area?
 - Are vulnerable populations being reached?
- Population health resources from public health work done locally and regionally
- Community Needs Assessment
- Analysis of unique features of the cancer program and/or state (for example, affordable or adequate lodging for patients receiving care at a rural facility)

Identification of Barriers

Each calendar year, the cancer committee identifies barriers that are specific to the cancer program and chooses one to focus on for the upcoming year. Examples include, but are not limited to:

- Gaps in community resources
- Identified populations in need
- Uninsured or underinsured
- Health care provider shortages

Each calendar year, the cancer committee minutes document a report that includes all required elements:

- What barrier was chosen
- What resources/processes were utilized to identify and address this barrier
- Metrics related to outcomes of reducing the chosen barrier

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes documenting the required report to the cancer committee

Measure of Compliance

Each calendar year, the program fulfills the compliance criteria:

1. The cancer committee identifies at least one barrier to focus on for the year and identifies resources and processes to address the barrier.
2. At the end of the year, the cancer committee evaluates the resources and processes adopted to address the barrier to care and identifies strengths and areas for improvement.
3. The cancer committee minutes include all required elements.

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8.2 Cancer Prevention Event

Definition and Requirements

According to the National Cancer Institute, cancer prevention is “action taken to decrease the chance of getting a disease or condition. For example, cancer prevention includes avoiding risk factors (such as smoking, obesity, lack of exercise, and radiation exposure) and increasing protective factors (such as getting regular physical activity, vaccination, staying at a healthy weight, and having a healthy diet).”

The cancer committee holds at least one event each year focused on decreasing the number of diagnoses of cancer. It is recommended, but not required, that the cancer committee partner with a community organization to hold the event. Examples of community organizations include, but are not limited to, a church, a school, the American Cancer Society, or a health district.

Prevention events focus on at least one of two intended results: (1) a change in behavior that reduces the risk a cancer will develop, and/or (2) an increase in the participant’s knowledge and awareness of cancer risks.

Examples of behavioral risk reduction events include, but are not limited to:

- Smoking/tobacco/vaping cessation
- Alcohol avoidance
- Nutrition, physical activity, and weight loss programs
- HPV vaccinations
- Radon exposure reduction
- Avoidance of sun exposure
- Chemoprevention

Cancer education and risk awareness lectures or events are considered a prevention activity when they address one of the above behavioral risk reduction areas.

The planned event must be consistent with evidence-based national guidelines and interventions, where applicable. Potential sources for evidence-based national guidelines and interventions include, but are not limited to:

- Agency for Healthcare Research and Quality
- American Cancer Society
- Cancer Control P.L.A.N.E.T.
- National Cancer Institute
- Centers for Disease Control and Prevention
- American Institute for Cancer Research/World Cancer Research Fund
- U.S. Preventive Services Task Force Recommendations

Examples of non-compliant events include, but are not limited to:

- Programs held only on the Internet, through social media, or through a mail campaign without real-time interaction with participants
- Prevention education given in the regular course of business
- Events or programs that educate about cancer screening or reduction of late-stage at diagnosis

Cancer Committee Report

A summary of the event must be presented to and discussed by the cancer committee that includes the following:

- The cancer site(s) on which the event focused
- The partnering community organization (where applicable)
- Target audience
- Guideline(s) used in planning the prevention event (where applicable)
- The type of prevention event held (behavioral risk reduction or cancer education/risk awareness lecture)

While it is encouraged that cancer programs hold as many cancer prevention events as appropriate for their needs, only one event is submitted for purposes of this standard.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes that document all required elements of the cancer prevention event

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The cancer committee offers at least one cancer prevention event.
2. Where applicable, the cancer prevention event is consistent with evidence-based national guidelines and interventions.
3. A summary of the cancer prevention event is presented to the cancer committee and documented in the cancer committee minutes.

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8.3 Cancer Screening Event

Definition and Requirements

Cancer screening events apply screening guidelines to detect cancers at an early stage, which improves the likelihood of increased survival and decreased morbidity.

The cancer committee holds at least one event each year focused on decreasing the number of individuals who present with late-stage cancer. It is recommended, but not required, that the cancer committee partner with a community organization to hold the event. Examples of community organizations include, but are not limited to, a church, a school, the American Cancer Society, or a health district.

Examples of screening events include, but are not limited to:

- Breast (imaging and physical examination)
- Colon (colonoscopy, flexible sigmoidoscopy, fecal immunochemical testing, or fecal occult blood testing)
- Cervical (Papanicolaou testing with or without HPV DNA testing)
- Skin (clinician-directed total body skin exams)
- Lung (low-dose computed tomography)
- Head and neck (oral examination)

The planned event must be based on evidence-based national guidelines and interventions, where applicable, and have a formal process for follow up on all positive findings.

Resources for evidence-based national guidelines and interventions include, but are not limited to:

- Agency for Healthcare Research and Quality
- American Cancer Society
- American Society of Clinical Oncology
- National Comprehensive Cancer Network
- National Cancer Institute
- National Colorectal Cancer Roundtable

Examples of non-compliant programs/events include, but are not limited to:

- Screening programs performed in the regular course of business
- Events or programs that educate about cancer screening or reduction of stage at diagnosis that do not provide an actual screening

Cancer Committee Report

A summary of the event must be presented to and discussed by the cancer committee that includes the following:

- The cancer site on which the event focused
- The partnering community organization (where applicable)

- Target audience
- Guideline(s) used in planning the screening event (where applicable)
- The process for follow up for all positive findings

While it is encouraged that cancer programs hold as many cancer screening events as appropriate for their needs, only one event is submitted for purposes of this standard.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes that document all required elements of the cancer screening event

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The cancer committee offers at least one cancer screening event.
2. Where applicable, the cancer screening event is consistent with evidence-based national guidelines and interventions.
3. The cancer screening event has a process for follow up on all positive findings.
4. A summary of the cancer screening event is presented to the cancer committee and documented in the cancer committee minutes.

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AMERICAN COLLEGE OF SURGEONS
COMMISSION ON CANCER

9 Research

Rationale

Clinical research advances science and assists with ensuring that patient care approaches the highest possible level of quality.

9.1 Clinical Research Accrual

Definition and Requirements

As prescribed for cancer program category, the required percentage of subjects is accrued to eligible cancer-related clinical research studies each calendar year. The Clinical Research Coordinator documents and reports clinical research information and the annual enrollment in clinical research studies to the cancer committee each calendar year.

Clinical Research Information and Screening Processes

The cancer program must establish a screening policy and procedure to identify participant eligibility for clinical research studies and how to provide clinical research information to subjects. Through the Clinical Research Coordinator, the cancer committee evaluates and assesses the eligibility and screening processes to identify and address barriers to enrollment and participation.

Cancer-Related Research Studies Eligible for Accrual

Research studies eligible to count as accruals must: (1) be cancer-related, (2) be approved by an internal or external Institutional Review Board (IRB) that is responsible for the review and oversight of the research study, and (3) have informed, written patient/subject consent (unless consent is waived by the IRB).

Categories of cancer-related clinical research studies eligible for accrual:

- Basic Science
- Device Feasibility
- Diagnostic
- Health Services Research
- Prevention
- Screening
- Supportive Care
- Treatment

Definitions for these categories may be found on the National Cancer Institute Clinical Trial Reporting Program User Guide (see Primary Purpose Value Definitions).

Additional categories of cancer-related clinical research studies for accrual are:

- Cancer-specific biorepositories or tissue banks
Cancer specific-biobanks that collect cancer tissue or blood samples specifically for cancer research purposes
- Economics of care related to cancer care
Assesses the costs and effectiveness of cancer interventions and/or analyzes the financial impact of oncology care on patients

- Genetic studies
Studies that examine contributing genes or how different exposures could modify the effect of a gene mutation that may be at risk for cancer development OR genetic assessments that examine genetic polymorphisms and mutations for early risk assessment
- Patient registries with an underlying cancer research focus
Epidemiological studies. Must have underlying cancer research focus

Humanitarian Use Devices studies cannot be counted as an accrual under this standard.

Calculating Compliance

The denominator used to calculate compliance with this standard is the number of annual analytic cases. The numerator is the number of subjects enrolled in eligible research studies who were:

- Diagnosed and/or treated at your program or facility and enrolled in a cancer-related clinical research study within your program or facility,
- Diagnosed and/or treated at your program or facility and enrolled in a cancer-related clinical research study within a staff physician's office of your program or facility,
- Diagnosed and/or treated at the program or facility, then referred by your program or facility for enrollment onto a cancer-related clinical research study through another program or facility, or
- Referred to your program or facility for enrollment onto a cancer-related clinical research study through another program or facility

Researchers and clinical trial investigators who accept referral of subjects from other programs for the purpose of participation in a cancer-related research study must cooperate with the data management team of the cancer program from which the patient was referred.

If a subject is enrolled in two different trials/studies, then the subject may be counted in the numerator twice. However, it qualifies as one accrual if one subject is enrolled into two arms of one protocol or one subject is enrolled into a sub-study of one protocol.

Minimum required accrual percentages each calendar year:

Category	Percentage Requirement
ACAD	6
CCCP	4
CCP	2
FCCP	2
HACP	Exempt
INCP	6
NCIP	Exempt
PCP	30
VACP	2

Clinical Research Coordinator

The Clinical Research Coordinator must track and report to the cancer committee:

- The specific clinical research studies where subjects were accrued, including the trial/study name and, when applicable, the clinicaltrials.gov trial number
- Number of subjects accrued to each individual clinical research study
- Open clinical research studies with identification of those with a nearing end date
- New trials that will be added
- If the required accrual percentage is not met, the report identifies contributing factors and identifies an action plan to address those factors

The report and analysis must be documented in the cancer committee minutes.

Documentation

Reviewed On-Site

- Tracking documents that detail the number of subjects accrued to specific clinical research studies

Submitted with Pre-Review Questionnaire

- Cancer committee minutes documenting the Clinical Research Coordinator's report that includes all required elements
- Policy and procedure for screening patients for clinical research studies and for providing subjects with information on clinical research studies

Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The program has a screening policy and procedure to identify participant eligibility for clinical research studies and how to provide clinical trial information to subjects. These processes are assessed to identify and address barriers to enrollment and participation.
2. The number of accruals to cancer-related clinical research studies meets or exceeds the required percentage.
3. The Clinical Research Coordinator reports all required information to the cancer committee and the report is documented in the cancer committee minutes.

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9.2 Commission on Cancer Special Studies

Definition and Requirements

Hypothesis-based special studies are designed to evaluate patient care, set benchmarks, and provide feedback to improve patient care in cancer programs.

The Commission on Cancer (CoC) will periodically design and conduct special studies. Based on study criteria, selected accredited programs will be required to participate in each study for standard compliance.

The cases included in the study and due date will be specified in the study documentation provided by the CoC.

To fulfill the standard, all selected programs must submit all requested information for the cases identified by the specified deadline.

Documentation

The program uploads all required documentation or data as required for the special study.

Measure of Compliance

As requested, the cancer program fulfills all of the compliance criteria:

1. The program participates in each special study.
2. Complete data and documentation are submitted by the established deadline for each special study.

Specifications by Category

Integrated Network Cancer Program (INCP)

STANDARD 1.1: Administrative Commitment The letter also addresses the organizational structure and processes that facilitate integration among the programs in the network.

STANDARD 6.1: Cancer Registry Quality Control Policy The minimum requirement of a 10 percent review (up to 200 cases annually) applies to each facility within a network.

STANDARD 7.1: Accountability and Quality Improvement Measures Expected EPRs for facilities that are part of an INCP are evaluated individually and as an INCP overall. Each facility that is part of an INCP is required to individually meet all expected EPRs, and the INCP as an entire program is also required to meet all expected EPRs.

STANDARD 9.1: Cancer Research Accrual Clinical research accrual percentages are calculated based on cumulative accrual percentage met collectively across the network facilities.

National Cancer Institute (NCI)-Designated Comprehensive Cancer Center Program (NCIP)

STANDARD 2.1: Cancer Committee NCIP facilities are exempt from this standard of accreditation.

STANDARD 2.4: Cancer Committee Attendance NCIP facilities are exempt from this standard of accreditation.

STANDARD 2.5: Multidisciplinary Cancer Case Conference NCIP facilities are exempt from this standard of accreditation.

STANDARD 3.1: Facility Accreditation Documentation from the National Cancer Institute P30 grant substitutes for documentation of facility accreditation. The NCIP uploads a copy of the current grant award letter or other applicable documentation from the NCI.

STANDARD 4.1: Physician Credentials NCIP facilities are exempt from this standard of accreditation.

STANDARD 7.2: Monitoring Compliance with Evidence-Based Guidelines NCIP facilities are exempt from this standard of accreditation.

STANDARD 8.2: Cancer Prevention Event NCIP programs are exempt from this standard of accreditation.

STANDARD 8.3: Cancer Screening Event NCIP programs are exempt from this standard of accreditation.

STANDARD 9.1: Clinical Research Accrual NCIP programs are exempt from this standard of accreditation.

NCI-Designated Network Cancer Program (NCIN)

STANDARD 1.1: Administrative Commitment The letter also addresses the organizational structure and processes that facilitate integration among the programs in the network.

STANDARD 2.1: Cancer Committee NCIN facilities are exempt from this standard of accreditation.

STANDARD 2.4: Cancer Committee Attendance NCIN facilities are exempt from this standard of accreditation.

STANDARD 2.5: Multidisciplinary Cancer Case Conference NCIN facilities are exempt from this standard of accreditation.

STANDARD 3.1: Facility Accreditation Documentation from the National Cancer Institute P30 grant substitutes for documentation of facility accreditation. The NCIP uploads a copy of the current grant award letter or other applicable documentation from the NCI. Grant must include all facilities included in the NCIN.

STANDARD 4.1: Physician Credentials NCIN facilities are exempt from this standard of accreditation.

Specifications by Category

STANDARD 6.1: Cancer Registry Quality Control Policy The minimum requirement of a 10 percent review (up to 200 cases annually) applies to each facility within a network.

STANDARD 7.1: Accountability and Quality Improvement Measures Expected EPRs for facilities that are part of an NCIN are evaluated individually and as an NCIN overall. Each facility that is part of an NCIN is required to individually meet all expected EPRs, and the NCIN as an entire program is also required to meet all expected EPRs.

STANDARD 7.2: Monitoring Compliance with Evidence-Based Guidelines NCIN facilities are exempt from this standard of accreditation.

STANDARD 8.2: Cancer Prevention Event NCIN programs are exempt from this standard of accreditation.

STANDARD 8.3: Cancer Screening Event NCIN programs are exempt from this standard of accreditation.

STANDARD 9.1: Clinical Research Accrual NCIN programs are exempt from this standard of accreditation.

Hospital Associate Cancer Program (HACP)

STANDARD 9.1: Clinical Research Accrual HACP facilities are exempt from this standard of accreditation.

Pediatric Cancer Program (PCP)

STANDARD 2.2: Cancer Liaison Physician PCP's CLP presentations utilize data relevant to the pediatric program with comparison to a national guideline.

STANDARD 5.1: CAP Synoptic Reporting PCPs are exempt from this standard of accreditation.

STANDARD 6.2: Follow-Up of Patients Annual follow-up information is obtained for eligible analytic cases until the patients reach the age of 26 years. Once patients reach the age of 26 years, follow-up attempts are to continue, but the data for the patients are excluded from the follow-up calculations. For PCP, a 60 percent follow-up rate is maintained for all eligible analytic cases from the cancer registry reference date.

STANDARD 7.1: Accountability and Quality Improvement Measures PCPs are exempt from this standard of accreditation.

STANDARD 7.2: Monitoring Compliance with Evidence-Based Guidelines PCPs are exempt from this standard of accreditation.

Programs Undergoing Initial Site Visit for Accreditation

STANDARD 6.2: Data Submission Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 6.3: Data Accuracy Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 6.4: Rapid Quality Reporting System (RQRS) Participation Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 6.5: Follow-Up of Patients Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 7.1: Accountability and Quality Improvement Measures Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 9.2: Commission on Cancer Special Studies Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

Glossary

ABCG: American Board of Genetic Counseling

ABMGG: American Board of Medical Genetics and Genomics

ABMS: American Board of Medical Specialties

ACAD: Academic Comprehensive Cancer Program

Accreditation report: Document released to cancer programs at the conclusion of the initial or reaccreditation site visit. The accreditation report includes rating compliance for each applicable standard and may include specific comments regarding the cancer program's performance. The accreditation report also states the assigned accreditation award and, if applicable, the corrective action due date.

ACR: American College of Radiology

ACRO: American College of Radiation Oncology

AGN-BC: Advanced Genetics Nursing Certification

AJCC: American Joint Committee on Cancer

Analytic case: Cases for which the hospital provided the initial diagnosis of cancer and/or for which the hospital contributed to first course treatment, if those cancers were diagnosed on or after the hospital's Reference Date and are diseases the CoC requires to be abstracted

ANCC: American Nurses Credentialing Center

Annually: Activity performed or monitored at least once every calendar year

AOA: American Osteopathic Association

AOCN[®]: Advanced Oncology Certified Nurse

AOCNP[®]: Advanced Oncology Certified Nurse Practitioner

AOCNS[®]: Advanced Oncology Certified Clinical Nurse Specialist

APRN: Advanced Practice Registered Nurse

APNG: Advanced Practice Nurse in Genetics

ASCO: American Society for Clinical Oncology

ASHP: American Society of Health-System Pharmacists

ASTRO: American Society for Radiation Oncology

ALND: Axillary lymph node dissection

Barriers to care: Challenges to health care service delivery. May include patient-, system-, or provider-based barriers to accessing health and/or psychosocial care.

BMTCN[®]: Blood & Marrow Transplant Certified Nurse

Calendar year: January 1–December 31

Cancer Committee: The multidisciplinary group responsible for leading the cancer program and ensuring the compliance with CoC Standards

ACoS Cancer Programs: American College of Surgeons' programs focused on improving care and treatment for patients with cancer, including Commission on Cancer, National Accreditation Program for Breast Centers, National Accreditation Program for Rectal Cancer, the National Cancer Database, American Joint Committee on Cancer, and the Clinical Research Program

CAP: College of American Pathologists

CBCN[®]: Certified Breast Care Nurse

CCCP: Comprehensive Community Cancer Program

CCP: Community Cancer Program

CLP: Cancer Liaison Physician

CoC: Commission on Cancer

Corrective action: The process by which a cancer program shows they have met a standard(s) that was noncompliant at the time of the site visit

CME: Continuing Medical Education

CP³R: Cancer Program Practice Profile Reports

CPA: Cancer Program Administrator

CPHON[®]: Certified Pediatric Hematology Oncology Nurse

CPON[®]: Certified Pediatric Oncology Nurse

Glossary

CQIP: Cancer Quality Improvement Program, a report provided to accredited programs by the National Cancer Database that includes short-term quality and outcome data and long-term data, including five-year survival rates for commonly-treated malignancies

CTR: Certified Tumor Registrar

DMAIC: Acronym for Define, Measure, Analyze, Improve, and Control; DMAIC is a quality improvement method

DCIS: Ductal carcinoma in situ

Expected Estimated Performance Rate (EPR): A performance rate that a cancer program is expected to meet for an NCDB accountability or quality improvement measure

FCCP: Freestanding Cancer Center Program

GCN: Genetics Clinical Nurse

HACP: Hospital Associate Cancer Program

HPV: Human papillomavirus infection

INCP: Integrated Network Cancer Program

IRB: Institutional Review Board

NAPBC: National Accreditation Program for Breast Centers

NAPRC: National Accreditation Program for Rectal Cancer

NCCN: National Comprehensive Cancer Network

NCDB: National Cancer Database

NCI: National Cancer Institute

NCIN: NCI-Designated Network Cancer Program

NCIP: NCI-Designated Comprehensive Cancer Center Program

NSCLC: Non-small cell lung cancer

OCN: Oncology Certified Nurse

ONS: Oncology Nursing Society

OSW-C: Oncology Social Worker certified by the Board of Oncology Social Work.

ONCC: Oncology Nursing Certification Corporation

On-site: The accredited facility or off-campus locations that are owned or part of the hospital licensure

OSCS: *Operative Standards for Cancer Surgery*; a surgical manual published by the American College of Surgeons that provides recommendations regarding the effective technical conduct of surgical operations and review of the quality of evidence upon which those recommendations are based

PA: Physician Assistant

PCP: Pediatric Cancer Program

PDCA: Acronym for Plan, Do, Check, Act or Plan, Do, Check, Adjust; PDCA is a quality improvement method

PDSA: Acronym for Plan, Do, Study, Act; PDSA is a quality improvement method

Phase-in standard: Standard that is not expected to be complied with in 2020

Pre-Review Questionnaire (PRQ): An online reporting tool that is utilized to demonstrate compliance with CoC standards; formally known as the “Survey Application Record (SAR)”

QI: Quality improvement

Reference date: Start date established for CoC accredited registries

RD: Registered Dietitian

RDN: Registered Dietitian Nutritionist

Referral: Services provided to the patient at a facility or physician office external to the cancer program

RQRS: Rapid Quality Reporting System

SCLC: Small-cell lung cancer

SCP: Survivorship Care Plan

Site visit: An on-site visit by a CoC site visit reviewer to review cancer program data to aid in determining compliance with CoC standards and the respective accreditation award. After initial accreditation, the on-site visit occurs once every three years. Formally known as the “survey.”

Glossary

Site Visit Reviewer: CoC-trained professional who conducts on-site visits and reviews cancer program activity documentation. The site visit reviewer assists in verifying whether the cancer program is in compliance with the CoC standards. Formally known as the “surveyor.”

SMART: Acronym for “Specific, Measurable, Achievable, Realistic, and Timely”; SMART format is a goal-setting method

Standard: Qualification criteria for CoC accreditation (not standard of care)

Synoptic format: A structured format that includes all of the following:

- All core elements must be reported (whether applicable or not),
- All core elements must be reported in a “diagnostic parameter pair” format, in other words, data element followed by its response (answer),
- Each diagnostic parameter pair must be listed on a separate line or in a tabular format to achieve visual separation, and
- All core elements must be listed together in one location in the pathology or operative report

TME: Total mesorectal excision

USP: United States Pharmacopeia

VACP: Veteran Affairs Cancer Program



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