



CANCER PROGRAM STANDARDS: Ensuring Patient-Centered Care

2016 Edition



A QUALITY PROGRAM
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100+years

AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:
Highest Standards, Better Outcomes*



Table of Contents

Acknowledgment of Contributors

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Foreword

Commission on Cancer Mission

The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, which promotes cancer prevention, research, education, and monitoring of comprehensive quality care.

Commission on Cancer Background

The Commission on Cancer and its standards for cancer care originated with the American College of Surgeons (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 to one that involves all aspects of 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 slowly and steadily increased to encompass more than 1,500 hospitals, freestanding cancer centers, and cancer program networks nationwide.

Commission on Cancer in Today's Health Care Environment

The multidisciplinary Commission on Cancer:

- Establishes standards to ensure high-quality, multidisciplinary and comprehensive cancer care.
- Conducts surveys 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.
- Requires cancer prevention and screening at programs.
- Monitors clinical surveillance activities.
- Develops effective educational programs to achieve its goals.

Individuals and representatives of numerous cancer-related organizations comprise the CoC, including more than 100 individuals representing the multidisciplinary professionals of the cancer care team. Members include representatives from the ACoS and more than 50 national, professional member organizations. 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/quality-programs/cancer/coc/about/catlist).

Each member serves on one or more committees that work to reach the CoC's goals by:

- Establishing standards for cancer programs and evaluating programs according to those standards.
- Coordinating the annual collection, analysis, and dissemination of data from CoC-accredited cancer programs and conducting national, site-specific studies in order to support the assessment of patterns of care and outcomes of patient management. The overriding goal is to achieve improvement in the quality of cancer care.
- Coordinating the activities of a nationwide network of physician-volunteers who provide state and local support for CoC and American Cancer Society (ACS) cancer control initiatives.

Continued on next page

- Providing oversight and coordination for educational programs of the CoC that are geared toward physicians, cancer registrars, cancer program leadership, and others.
- Providing clinical oversight and expertise for CoC standard-setting activities.

The CoC Accreditation Committee

The CoC Accreditation Committee includes physician and nonphysician members representing the CoC membership. The Accreditation Committee oversees the Commission on Cancer Accreditation Program and is responsible for developing and interpreting the standards for cancer programs. Three subcommittees are integral to accomplishing this work.

- **Field Staff Subcommittee:** Recruits, trains, and oversees the surveyor team members who perform the on-site evaluations of CoC-accredited cancer programs.
- **Program Review Subcommittee:** Develops interpretations for standards, adjudicates appeal and deficiency resolution decisions, and decides on the accreditation status when deficiencies are not resolved.
- **Recruitment and Retention:** Identifies and directly recruits new programs to the CoC Accreditation Program. Ensures retention of currently accredited programs, monitors program withdrawals, and intercedes when appropriate.

The CoC Accreditation Program

There are approximately 1,500 CoC-accredited cancer programs in the United States 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.

Patients who obtain care at a CoC-accredited cancer program receive the following benefits:

- Quality cancer care
- Comprehensive care offering a range of state-of-the-art services and equipment
- A multidisciplinary, team approach to coordinate the best cancer treatment options available
- Access to cancer-related information and education
- Access to patient-centered services such as psychosocial distress screening and navigation
- Options for genetic assessment and counseling, and palliative care services
- Assessment of treatment planning based on evidence-based national treatment guidelines
- Information about clinical trials and new treatment options
- Follow-up care at the completion of treatment, including a survivorship care plan
- A cancer registry that collects data on cancer type, stage, and treatment results, and offers lifelong patient follow-up

CoC accreditation is granted to facilities that are committed to providing the best in cancer care and demonstrate compliance with the CoC Eligibility Requirements and 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 survey review every three years.

The structure outlined in *Cancer Program Standards: Ensuring Patient-Centered Care* ensures that each cancer program seeking accreditation provides 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.

Cancer Program Accreditation: Central Component of Quality Cancer Care

Cancer care over the last 50 years has evolved from being primarily focused on surgical procedures for local disease to a sophisticated, multidisciplinary approach to achieve the level of high quality care that is now available in the United States and around the world. The outlook for people with cancer and the impact of treatment on quality of life and survival have improved dramatically. The application of current screening, local therapy, and systemic treatments has led to reductions in cancer mortality. The explosion in scientific research that has led to personalized understanding of prognosis and the availability of targeted treatments has resulted in improved outcomes.

Unfortunately, there remains substantial evidence that many people with cancer do not receive the benefits of high-quality care. Variation in the quality of care affects many outcomes ranging from quality of life and organ function preservation to cancer recurrence and survival. In 1999, the Institute of Medicine (IOM) published the report *Ensuring Quality Cancer Care*, which made a number of key recommendations, including:

- Maintaining a system to measure and monitor the quality of care using a core set of quality measures and providing quality benchmarks for use by health systems
- Ensuring key elements of quality care are provided for every person with cancer
- Providing treatment by experienced professionals
- Providing patients with an agreed-upon care plan
- Ensuring access to the full complement of resources to implement the care plan
- Providing access to clinical trials
- Creating policies to ensure full disclosure of information about treatment options
- Establishing mechanisms to coordinate services
- Providing psychosocial support
- Ensuring quality of care at the end of life, including care for cancer-related pain and timely referral to palliative and hospice care.

The CoC endorses these important findings by the IOM. In response to the report, the CoC has formulated standards that enhance patient-centered functions and define performance criteria in quality measurement and outcomes.

CoC Patient-Centered Standards and Quality Measurement

The CoC standards are periodically enhanced and expanded with new, relevant requirements based on health care variability. Each standard is carefully reviewed for relevance, value to the program and to patients, and feasibility of implementation in community settings.

The standards provide clear guidance to support the provision of high-quality care. Providing a high level of quality care requires coordination of care among many medical disciplines, including physicians ranging from primary care providers to specialists in all oncology disciplines. In addition, care requires input from many other clinical and allied health professionals, including nursing, social work, genetics, nutrition, rehabilitation, and others.

Key standards require programs in patient-centered areas including the provision of treatment and survivorship plans, palliative care services, genetics services, navigation programs, and psychosocial distress screening. Key quality measurement and outcome standards require performance levels on quality metrics as defined by the data collected by the cancer program's cancer registry, along with suggested mechanisms to help the cancer committees address deficiencies in performance.

The quality metric standards are equally important. Applying these measures to cancer care is critical to enhancing care. As recognized by the IOM, only through a program of ongoing monitoring can we assess care, define and resolve barriers to high quality, and continuously improve care. Toward this end, the CoC and the National Cancer Data Base (NCDB) continue to work with major oncology organizations to develop and implement national standards and quality measures.

CoC-accredited cancer programs utilize the NCDB to collect, analyze, and report their cancer program data. Each program receives annual updates on its practices on numerous cancer sites through the Cancer Program Practice Profile Reports (CP³R), which allow for auditing and updating of data.

Another NCDB quality data tool is the Rapid Quality Reporting System (RQRS), a real-time data collection program to assess hospital-level performance using quality of cancer care measures. The system tracks patients and includes alerts to ensure they receive the proper care at the appropriate time.

Value of Accreditation

Accreditation and high-quality cancer care require concerted effort and resources by accredited programs to enhance and expand the care they provide.

Programs need to recognize that these standards merely set forth what are increasingly recognized as critical components of cancer care. Providers that do not implement these patient-centered programs will increasingly find themselves out of step with modern oncology care. Therefore, the real cost to the program in the long run is to ignore these issues.

Using and understanding NCDB data not only promotes and initiates quality improvement, it may soon be required by other agencies, including payers and the government. A number of payers and insurance companies are looking to the CoC quality metrics and programs as a core component of their Centers of Excellence programs. Government agencies including the Centers for Medicare and Medicaid Services, look to the CoC and its registry system to assist in establishing systems for reporting quality. Finally, the CoC reporting systems will help accredited programs with accurate, timely, and meaningful data for payers, providers, the government, and public reporting of quality measures as it becomes a necessity.

CoC accreditation provides real value to accredited programs. Programs can proudly demonstrate to their community of payers, providers, the government, and the public that they have invested in systems to ensure that cancer patients receive high-quality, coordinated care, and that they have made the efforts necessary to ensure that supportive services and resources addressing the full continuum of care are available in their community. Accreditation allows programs to demonstrate the high quality of care that they provide and their commitment to continuous quality improvement.

The CoC Accreditation Process

Categories of Cancer Programs

Each cancer program is designated a specific category based on the type of facility, program structure, services provided, and the number of cases accessioned each year. Category assignments are made by CoC staff at the time of initial application and are retained unless there are changes to the services provided and/or the facility caseload.

Integrated Network Cancer Program (INCP)

The organization owns, operates, leases, or is part of a joint venture with multiple facilities providing integrated cancer care and offers comprehensive services. At least one facility in the category is a hospital, and must be a CoC-accredited cancer programs. Generally, INCPs are characterized by a unified cancer committee, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners. Each entity of the INCP meets performance expectations for the quality measures under the umbrella of the integrated program. The INCP participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

NCI-Designated Comprehensive Cancer Center Program (NCIP)

The facility secures a National Cancer Institute (NCI) peer-reviewed Cancer Center Support Grant and is designated a Comprehensive Cancer Center by the NCI. A full range of diagnostic and treatment services and staff physicians are available. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement.

Academic Comprehensive Cancer Program (ACAD)

The facility participates in postgraduate medical education in at least four program areas. The facility accessions more than 500 newly diagnosed cancer cases each year. The facility offers the full range of diagnostic and treatment services either on-site or by referral.

Veterans Affairs Cancer Program (VACP)

The facility provides care to military veterans and offers the full range of diagnostic and treatment services either on-site or by referral, preferably to CoC-accredited cancer program(s). There is no minimum caseload required.

Comprehensive Community Cancer Program (CCCP)

The facility accessions 500 or more newly diagnosed cancer cases each year. The facility provides a full range of diagnostic and treatment services either on-site or by referral.

Community Cancer Program (CCP)

The facility accessions more than 100 but fewer than 500 newly diagnosed cancer cases each year and provides a full range of diagnostic and treatment services, but referral for a portion of diagnosis or treatment may occur.

Hospital Associate Cancer Program (HACP)

The facility accessions 100 or fewer newly diagnosed cancer cases each year and has a limited range of diagnostic and treatment services available on-site. Other services are available by referral. Clinical research is not required. Participation in the training of resident physicians is optional.

Pediatric Cancer Program (PCP)

The facility provides care only to children, or the pediatric oncology program is a component within a larger CoC-accredited facility. The facility may be associated with a medical school and participate in training pediatric residents. The facility or pediatric oncology program offers the full range of diagnostic and treatment services for pediatric patients either on-site or by referral. The facility is required to participate in cancer-related clinical research focused on pediatric patients. There is no minimum caseload requirement for this category.

Freestanding Cancer Center Program (FCCP)

The facility is a nonhospital-based program and offers at least one cancer-related treatment modality. The full range of diagnostic and treatment services are available by referral. Referral to CoC-accredited cancer program(s) is preferred. There is no minimum caseload requirement for this category.

Survey Process

CoC-accredited cancer programs are surveyed on a triennial basis, for which a trained CoC Surveyor(s) will visit the cancer program and review required cancer program activity documentation to ensure compliance to the standards:

1. Assess and demonstrate program compliance with the requirements for all eligibility requirements and standards outlined in *Cancer Program Standards: Ensuring Patient-Centered Care*.
2. Submit payment for the accreditation fee annually.
3. Confirm the survey date and agenda with their assigned surveyor(s).
4. Review and complete the online Survey Application Record (SAR) at least 30 calendar days prior to the confirmed survey date.

Each year, an initial e-mail notification is provided to all facilities due for survey in the upcoming calendar year. Later that year, programs are notified of their assigned CoC-trained surveyor(s) for their survey in the upcoming year. The selection of a survey date is coordinated between the program and the surveyor. Surveys are to be scheduled during the survey **due month**. Confirmation of the survey date and time is provided to the cancer program administrator via email.

The surveyor profiles, which include a photo and brief biography, are available on the Cancer Programs website (facs.org/quality-programs/cancer/accredited/info/surveyorprofiles).

Survey Extensions

When extenuating circumstances affect program activity, a survey extension may be appropriate. Survey extension requests will be granted in these instances. The usual extension is three months. A longer extension may be available given individual circumstances.

Valid extenuating circumstances that warrant a survey extension include, but are not limited to:

- Natural disasters (such as hurricane, earthquake, tornado, flood) that directly affect the facility
- Other anthropogenic hazards (such as fire, industrial accidents)

Examples of circumstances that do not warrant a survey extension include, but are not limited to:

- Software conversions or IT issues
- Staff absences, turnovers, or resignations
- Delayed abstracting or missing data
- Standard deficiencies

Survey extensions for these or similar reasons will not be accommodated.

The Cancer Committee Chair or the administrator of the facility must submit a formal request for an extension via e-mail to accreditation@facs.org. The request must include details of the rationale for the extension request, proposed plan, and timeline to resolve the issue necessitating the extension request. Facilities will be notified of the extension request decision within 14 days of receiving the written request.

Programs are discouraged from canceling or postponing the scheduled survey. However, if survey cancellation or postponement of a survey becomes necessary after the survey date is confirmed, the facility must contact CoC staff and submit a written notification. The facility will also be invoiced a cancellation fee.

The Accreditation Fee

An invoice for the annual CoC accreditation fee is e-mailed to the cancer program prior to the survey due date. Payment of the invoice is due within 30 days of receipt. No Performance Report will be provided to a cancer program that has not paid their annual accreditation fee.

The Survey Agenda

A member of the cancer committee confirms the agenda for the survey with the surveyor(s) at least 14 days before the on-site visit. The surveyor's role is to assist in accurately defining the standards and verifying that the facility's cancer program is in compliance.

To accomplish this task on the day of survey, the surveyor(s) will:

- Meet and provide education to key members of facility administrative leadership on the value of CoC accreditation and how to market this achievement.
- Meet the cancer committee to discuss the activities and responsibilities of the cancer committee in relationship to the cancer program and to verify the accuracy of the data recorded in the SAR.
- Attend a cancer conference to observe the program's multidisciplinary patient management and discussions.
- Meet with the Cancer Liaison Physician (CLP) to discuss his or her role and responsibilities, including the CLP Report and opportunities to use National Cancer Data Base (NCDB) data for performance improvement.
- Meet with the Cancer Program Administrator and cancer registry staff to discuss cancer registry and cancer committee operations.
- Review pathology reports to determine College of American Pathology protocol compliance.

Attendance is important, and it is highly encouraged that all members of the cancer committee attend and participate in the survey. At a minimum, the surveyor(s) must meet with the following staff:

- Chief Executive Officer and/or other chief leadership administrators
- Cancer Liaison Physician
- Cancer Committee Chair
- Cancer Program Administrator
- Designated cancer committee coordinators
- Hospital Registrar(s)

The Survey Application Record

The Survey Application Record (SAR) is an online reporting tool that is available and utilized during the year of the accreditation survey to demonstrate and document compliance of CoC Eligibility Requirements and Standards.

Once the survey has taken place, the SAR will close and a Program Activity Record (PAR) will then be available throughout the three-year accreditation period (non-survey years) for use as a record-keeping tool to document program activity. The SAR and PAR are essentially the same forms, but the SAR is only used during the year of survey and the PAR is used for non-survey years.

Access to the SAR/PAR is provided through *CoC Datalinks*. *CoC Datalinks* is a password-protected, web-based portal. Access to the SAR/PAR is provided to the Hospital Registrar, Cancer Committee Chair, Cancer Program Administrator, and Cancer Liaison Physician. Additional users can be identified by the program and added through the *Manage Staff Contacts* link located on the Main Activity Menu of *CoC Datalinks*.

To facilitate a thorough and accurate evaluation of the cancer program during the survey, the facility completes or updates the SAR at least 30 calendar days before the scheduled on-site visit. Completion of the SAR/PAR should be a team effort of members of the cancer committee. The SAR will close 14 calendar days before the on-site visit. The cancer program's surveyor reviews the SAR before the on-site visit to assess compliance with the standards, and to become familiar with the resources and services offered at the facility and the cancer program activity.

Other helpful features available in the SAR/PAR include:

- Help and FAQ icons, which contain information on each standard
- Electronic submission of appeals and deficiency resolutions
- Printing capabilities of the SAR/PAR

A portion of the information collected in the Eligibility Requirements section and SAR describing the facility's resources and services is automatically made available to the public through the American College of Surgeon's website. Facility-specific resource and service information is made available to cancer patients, caregivers, and the general public, which enables them to make more informed decisions about their options for cancer care. The Cancer Program Locator and search functions are accessible from the Cancer Programs page of the American College of Surgeons website (facs.org/search/cancer-programs/). The program is also provided the option to release annual caseload data as submitted to the CoC's NCDB, providing the public with site and stage data for cancer patients seen at the facility.

Required Documentation

CoC-accredited cancer programs document cancer program activity using multiple sources, including policies, procedures, manuals, tables and grids; however, cancer committee minutes are the **primary source** for documentation of cancer program activity. All meeting minutes should contain sufficient detail to accurately reflect the activities of the cancer committee as well as demonstrate compliance with CoC standards. Consent agendas are not permitted.

In preparation for the on-site visit, documentation must be uploaded into the SAR. The documentation can be attached throughout the three-year accreditation period but must complete within 14 calendar days of the confirmed survey date so that the documentation is available for surveyor review in preparation for the visit. The documentation required for each standard is included in the specifications for the standard.

The Post-Survey Evaluation

The Post-Survey Evaluation (PSE) is a required component of the cancer program survey. The PSE captures feedback from the facility, which enables the CoC to evaluate and improve the survey process and surveyor performance and to develop educational materials and training programs for surveyors and participating programs. Programs complete the PSE online within the SAR.

All responses are confidential and will not influence the cancer program evaluation or accreditation award. Responses on the evaluation form should represent a consensus opinion of the cancer care team. The PSE is required to be completed within 14 days of the survey.

Notification of Survey Results

Accreditation status notifications are distributed via e-mail within 45 days following the completed survey. By enabling each facility to compare its ratings for the standards with other accredited programs, the Performance Report (PR) facilitates the identification of areas for program improvement. The Cancer Program Administrator, Cancer Committee Chair, Cancer Liaison Physician, and Hospital Registrar each receive an email when the completed PR is posted electronically to *CoC Datalinks*. The posted PR is accessible to all *CoC Datalinks* users at the facility.

The accreditation survey PR provides the following:

- A comprehensive summary of the survey outcome and accreditation award
- The cancer program's compliance rating for each standard
- A narrative description of deficiencies that require correction
- Suggestions to improve or enhance the program
- Commendations awarded

If accredited without contingency, access for ordering the Certificate of Accreditation is provided to the Cancer Program Administrator following posting of the PR to *CoC Datalinks*. The program may appeal a finding for any standard or the accreditation award within 30 days of posting of the Accredited Cancer Program PR. The appeals process is outlined in the appeal guidelines on the Cancer Programs website.

Marketing and Visibility

Only accredited cancer programs have access the web-based CoC Marketing Resources Page within *CoC Datalinks*. The CoC encourages programs to use these tools to explain what CoC accreditation means patients, payers, and payees.

The materials found on the marketing web page were designed for use by public relations and/or marketing departments and include:

- "How to Market Your CoC Accreditation" PowerPoint presentation
- Access to The Award Group to order CoC Accreditation Certificates, banners, pins, and other promotional items
- CoC accreditation logo and use policy
- Sample press releases and approved marketing statements
- Patient information brochures (in English and Spanish)

Accreditation Information

Cancer Program Standards Rating System

The following rating system is used to assign a compliance rating to each standard:

1 + Commendation

1 Compliance

5 Noncompliance

8 Not Applicable

Based on the rating criteria specified for each standard, a compliance rating of “1” is assigned by the surveyor(s) and CoC staff. A deficiency is defined as any standard with a rating of “5”.

The commendation rating (1+) is currently valid for seven standards through 2017. The commendation ratings are used to determine the accreditation award level (bronze, silver, gold). A commendation rating can be earned only at the time of survey. The following standards are eligible for commendation based on the defined criteria:

STANDARD 1.9: As appropriate to the cancer program category, the required commendation percentage of patients is accrued to cancer-related clinical trials each calendar year. The program fulfills all additional compliance criteria.

STANDARD 1.11: All Certified Tumor Registrars attend a national or regional cancer-related meeting once during the three-year survey cycle. The program fulfills all additional compliance criteria.

STANDARD 1.12: Each calendar year, the cancer committee develops and disseminates a report of patient or program outcomes to the public.

***STANDARD 2.1:** 95 percent of cancer pathology reports follow the synoptic format defined by the College of American Pathologists (CAP), and 95 percent of reports include the required data elements as outlined in CAP protocols. The program fulfills all additional compliance criteria.

STANDARD 2.2: Each calendar year, 25 percent of oncology nurses employed by the facility (including full-time and part-time) hold a current, applicable oncology nursing certification. The program fulfills all additional compliance criteria.

***STANDARD 5.2:** From initial enrollment and throughout the accreditation period, the program participates in RQRS and submits all eligible cases for all valid performance measures. The program fulfills all additional compliance criteria.

STANDARD 5.6: Annually, cases submitted to the National Cancer Data Base (NCDB) that were diagnosed on January 1, 2003, or later meet the established quality criteria for the annual Call for Data on initial submission. The program fulfills all additional compliance criteria.

* These commendation standards will change as of 2017.

Accreditation Awards

Accreditation awards are based on consensus ratings by the cancer program’s surveyor, CoC staff, and, when required, the Program Review Subcommittee. A program receives one of the following Accreditation Awards following survey:

THREE -YEAR WITH COMMENDATION ACCREDITATION is conferred to programs that comply with all standards at the time of survey and receive a commendation rating for one or more standards. A program receiving commendation for one to three standards earns “Three-Year with Commendation” Bronze level. Commendation ratings for four to six standards earns “Three-Year with Commendation” Silver level. Commendation ratings for all seven standards earns “Three- Year with Commendation” Gold level. These levels are subject to change based on commendation standards. A certificate of accreditation is issued, and these programs are surveyed at three-year intervals.

THREE -YEAR ACCREDITATION is conferred to programs that comply with all standards at the time of survey but do not receive a commendation rating for any standards. This award is also applied to programs that received and resolved a deficiency for one or more standards, regardless of the number of commendations received at the time of survey. A certificate of accreditation is issued and these programs are surveyed at three-year intervals.

THREE-YEAR ACCREDITATION WITH CONTINGENCY is conferred to an established program when one to seven standards are rated deficient or to new programs when one or two standards are rated deficient at the time of survey. The contingency status must be resolved within 12 months from survey results. Programs follow the guidelines for deficiency resolution that are posted on the Cancer Programs page at (facs.org/quality-programs/cancer/accredited/info). Programs submit proper documentation to resolve the contingency status directly through the SAR. “Three-Year Accreditation” status is granted following submission and evaluation of resolution documentation. A certificate of accreditation is issued after resolution of deficiencies, and these programs are surveyed at three-year interval.

NON-ACCREDITATION is conferred to an established program when eight or more standards are rated deficient or when a new program undergoing initial survey is deficient in three or more standards. CoC staff will work directly with these programs to assist them with deficiency resolution to reinstate accreditation. Programs can also choose to withdrawal, improve their performance, and then reapply for accreditation.

Three-Year With Commendation	Three-Year Accreditation	Three-Year With Contingency	Non-Accreditation
<p>Complies with all standards at the time of survey and receives a commendation rating for one or more standards.</p> <p>Gold: 7 commendations</p> <p>Silver: 4–6 commendations</p> <p>Bronze: 1–3 commendations</p>	<p>Complies with all standards at the time of survey but does not receive a commendation rating for any standard.</p> <p>Or, is awarded when all deficiencies are resolved regardless of the number of commendations awarded at survey.</p>	<p>1–7 deficiencies at the time of survey for established programs.</p> <p>1–2 deficiencies at the time of survey for new programs.</p>	<p>8 or more deficiencies at the time of survey for established programs.</p> <p>3 or more deficiencies at the time of survey for new programs.</p>

Outstanding Achievement Award (OAA)

Established in 2004, the OAA recognizes cancer programs that demonstrate excellence by earning commendation for all applicable standards and providing quality care to patients with cancer. A program earns the OAA by completing the accreditation survey and receiving a Performance Report that indicates an accreditation award of “Three-Year with Commendation.” The OAA will be granted to a program that receives a commendation rating in each of the Commendation standards as well as compliance ratings (no deficiencies) for all other standards at the time of survey.

The purposes of the OAA are to recognize cancer programs that strive for excellence in providing quality care to cancer patients, and to motivate other programs to work toward improving their care.

Recipients are identified twice each survey year. Cancer programs achieving the OAA will receive the following:

- A letter of recognition from the CoC chair addressed to the Chief Executive Officer or Cancer Program Administrator
- A specially designed press release and marketing information
- The Outstanding Achievement Award logo
- The Outstanding Achievement Award trophy
- Publicity via the *The CoC Source*, *The Brief*, the CoC website, and the CoC-Accredited program search listing
- Resources for CoC-Accredited Programs

The *CAnswer Forum* is an interactive, virtual bulletin board for CoC constituents to ask questions, search topics, and connect with the latest CoC activities. The *CAnswer Forum* is designed as an open forum for networking, and discussion of Cancer Program Standards, American Committee on Cancer TNM Staging, Collaborative Stage, Facility Oncology Registry Data Standards (FORDS), National Cancer Data Base (NCDB), and other relevant topics. Users must complete a one-time registration where they will create a user name and password to access the forum.

The *Standard Resource Library* (SRL) contains tools, templates, examples, and resources designed to help cancer programs meet the Commission on Cancer Program Standards. The SRL is located on the home page of the *CAnswer Forum* and can be accessed using your *CAnswer Forum* user name and password.

The SRL includes role descriptions, examples of policy and procedures, goals using the SMART acronym, examples of quality studies and improvements, templates for cancer committee agendas and minutes, and much more. Programs are encouraged to access, customize, and use all of this material when developing their own methods to meet the Cancer Program Standards.

A full list of available resources is located on the CoC website at (facs.org/quality-programs/cancer/accredited/resources).

Information for Programs Pursuing Initial CoC Accreditation

To be considered for initial accreditation, the cancer committee is required to:

- Ensure that the clinical services, cancer committee, cancer conferences, and a quality management program have been in place at the facility for at least one year.
- Establish a reference date and ensure that the cancer registry database includes complete data and follow-up activity.
- Meet all eligibility requirements outlined in *Cancer Program Standards: Ensuring Patient-Centered Care* manual.
- Meet the requirements for all applicable and required standards for new programs and their designated category as outlined in *Cancer Program Standards Ensuring Patient-Centered Care*.
- Complete the online application for accreditation. Provide main contact information for the program.
- Submit the new program application fee.
- Sign the American College of Surgeons Business Associate and Data Use Agreement in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Complete the Eligibility Requirements and the SAR in preparation for the initial survey.
- Submit a request for survey to CoC staff that documents compliance with all standards (facs.org/quality-programs/cancer/accredited/benefitscoc/seekingaccred).

Guidelines for Integrated Network Cancer Programs

If the facility wishes to form an Integrated Network Cancer Program, the facility must access and review the Integrated Network Cancer Program Guidelines which outline the requirements. This document is located on the Cancer Programs website (facs.org/quality-programs/cancer/accredited/incp).

Once the guidelines have been reviewed, the facility completes and submits the network application. This step will allow CoC staff to assign a new Facility Identification Number (FIN), Integrated Network Cancer Program Category, accreditation award designation, and future survey date as a network.

Guidelines for Merged Cancer Programs

If the facility has merged, is merging, or plans to merge, the facility must access and review the Merged Cancer Program Guidelines which outline the requirements for cancer program composition. These guidelines are located on Cancer Programs website at (facs.org/quality-programs/cancer/accredited/merged).

Once the guidelines have been reviewed, the facility completes and submits the notification form providing general information about the merger. This step will allow CoC staff to assign a new Facility Identification Number (FIN), Cancer Program Category, accreditation award designation, and future survey date as a merged program.

Glossary of Terms and References

The Glossary of Terms and References section provides definitions and examples of terms used throughout the CoC Standards Manual.

Eligibility Requirements

Eligibility Requirements (ER) are considered the foundation for all CoC-accredited programs. They include the basic structure and services that are required of all cancer programs before an accreditation survey.

Cancer Program Structure

- Facility accreditation
- Cancer committee authority
- Cancer conference policy
- Oncology nursing services
- Cancer registry policy and procedure

Cancer Program Services

In addition, the services listed here can be provided either on-site or by referral to hospitals, freestanding facilities, physician offices, or local community agencies that are external to the CoC-accredited cancer program.

- Diagnostic imaging services
- Radiation oncology services
- Systemic therapy services
- Clinical research information
- Psychosocial support services
- Rehabilitation services
- Nutrition services

Cancer Committee Responsibilities

Each calendar year, the CoC-accredited cancer program's cancer committee is responsible for monitoring, assessing, and identifying changes that are needed to maintain compliance with these eligibility criteria. The annual assessment of the eligibility requirements is documented in the cancer committee minutes.

Before the survey, the CoC-accredited cancer program will update the Eligibility Requirements section within CoC *Datalinks* to indicate the services that are available either on-site or by referral and attach specific documentation to demonstrate adherence to the Eligibility Requirements. This updated information may be part of a periodic review performed by CoC staff.

Programs will be notified when one or more eligibility requirements are not completed and will be granted a specified period in which to resolve the requirement(s). If resolution of the eligibility requirement(s) is not achieved, the accreditation status and/or survey may be suspended.

ER1**Facility Accreditation**

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

Accreditation ensures that care is provided in a safe environment.

Each calendar year, the program uploads a copy of the accreditation certificate or accreditation letter from the accrediting agency.

For a National Cancer Institute (NCI)-designated Comprehensive Cancer Center Program (NCIP) facility, documentation from the NCI P30 grant substitutes for documentation of the facility accreditation. The NCIP uploads a copy of the current grant award letter or other applicable documentation from the NCI.

ER2**Cancer Committee Authority**

Cancer committee authority is established and documented by the facility.

Cancer program success depends on an effective multidisciplinary cancer committee. The cancer committee is responsible for goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the program.

The program may use any method that is consistent with program organization and operation of the facility to document the authority of the cancer committee.

Each calendar year, the program uploads the most recent version of the bylaws, policies and procedures, or other sources that set forth the cancer committee's authority for the cancer program.

ER3

Cancer Conference Policy

A cancer conference policy and procedure is used to establish the annual cancer conference activity.

Cancer conferences, or tumor boards, improve the monitoring of care of patients by providing multidisciplinary treatment planning and physician and allied medical staff collaboration.

The policies and procedures address the following criteria:

- Cancer conference frequency and format
 - » Specialty cancer site-specific conferences are optional in addition to the general cancer conference
- Multidisciplinary composition of the conference(s) and attendance rate of physician participants
- Discussion of stage, including prognostic indicators, and treatment planning using national, evidence-based treatment guidelines
- Options for clinical trial participation
- Methods to address areas that fall below the levels established in the policy
- Number of case presentations (a minimum of 15 percent of the annual analytic case load) and the prospective presentation rate (a minimum of 80 percent). Prospective cases include, but are not limited to, the following:
 - » Newly diagnosed and treatment not yet initiated
 - » Newly diagnosed and treatment initiated, but discussion of additional treatment is needed
 - » Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed
 - » Previously diagnosed, and discussion of supportive or palliative care is needed

Note that cases may be discussed more than once and counted each time as a prospective presentation as long as management issues are discussed.

Each calendar year, the program uploads the most recent version of the cancer conference policies and procedures containing the required ER3 criteria.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the ER3.

ER4**Oncology Nursing Leadership**

A designated oncology nurse provides leadership for oncology patient care across the care continuum.

To achieve optimal outcomes, a designated oncology nurse manager and/or leader uses standards and guidelines set forth by the Oncology Nursing Society (ONS) and/or other recognized national organizations to develop the nursing policies and procedures that guide patient care.

Each calendar year, the program identifies the oncology nurse(s) who are responsible for nursing leadership across the continuum of care, including all inpatient and outpatient areas that are part of the cancer program.

ER5

Cancer Registry Policy and Procedure

The cancer registry policy and procedure manual is implemented and specifies that current Commission on Cancer data definitions and coding instructions are used to describe all reportable cases.

All CoC-accredited cancer programs use the data standards defined by the CoC appropriate for the year of diagnosis for any specific case. Cancer registries may be required to comply with additional mandates pertaining to case and data reporting established by the federal or state government or by the facilities' cancer committee.

The cancer registry policy and procedure manual must include, but is not limited to:

- Abstracting, including RQRS participation and case submissions
- American Joint Committee on Cancer (AJCC) and Collaborative Stage staging policies
- Cancer registry reference date
- Case eligibility, finding, and accessions
- Confidentiality and release of information
- Computer operations
- Dates of implementation or changes in policies for registry operations
- Disaster recovery policy
- Documentation of first course of treatment
- Follow-up
- History of the registry for the program or health system (which may include facility mergers, network formation, facility name changes, vendor information, or identification of previous staff)
- Job descriptions
- Maintaining and using the suspense system
- NCDB reporting requirements and mechanisms
- Operational requirements for facility- based cancer registries
- Policy for CoC accreditation documentation
- Quality control of registry data
- Registry purpose
- Request log
- Required coding manuals
- Retention of documents
- State registry reporting requirements and mechanisms

Each calendar year, the program will review the cancer registry policies and procedures manual and upload the table of contents of the most recent version that outlines the inclusion of the required ER5 criteria.

ER6**Diagnostic Imaging Services**

Diagnostic imaging services are provided either on-site or by referral.

All of the locations within the CoC-accredited program where oncology patients receive diagnostic imaging services follow policies and procedures to guide the safe performance of diagnostic examinations.

Each calendar year, the program uploads a copy of the most recent certificate of accreditation, attestation letter, or documentation that describes the patient-specific and machine-specific quality assurance (QA) practices for diagnostic imaging services for the most common referral locations.

Annually, the program indicates in the ER section of *CoC Datalinks* which diagnostic imaging services are available either on-site or by referral for public posting on the CoC website.

ER7

Radiation Oncology Services

Radiation treatment services are currently accredited by a recognized authority or, if not accredited, follow standard quality assurance practices. Services are available either on-site, at locations that are facility owned, or by referral.

The radiation treatment facility is either accredited by a recognized authority or follows minimum QA practices and machine-specific QA practices as outlined below. Information about the primary referral services and location is provided to patients seen at the CoC-accredited cancer program.

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)

Patient-specific QA practices include, but are not limited to:

- Patient identity is verified by two independent methods at the beginning of each encounter.
- Patient-specific QA is done before initiation of intensity-modulated radiation therapy.
- Independent check of dose calculation is done for every new or changed treatment before treatment is started.

Machine-specific QA practices:

- Machine-specific QA practices are defined in the American Association of Physicists in Medicine (AAPM) guidelines. These practices must include, but are not limited to, daily, monthly, and annual radiation treatment machine QA procedures.

Each calendar year, the program uploads a copy of the most recent certificate of accreditation, attestation letter, or documentation that describes the patient-specific and machine-specific QA practices in radiation oncology for the program or most common referral locations.

Annually, the program indicates in the ER section of *CoC Datalinks* which radiation treatment services are available either on-site or by referral for public posting on the CoC website.

ER8

Systemic Therapy Services

Policies and procedures are in place to guide the safe administration of systemic therapy provided either on-site, at locations that are facility owned, or at locations that are contracted by the facility or are supervised by members of the facility's medical staff, including physician offices.

Systemic therapy encompasses the administration of chemotherapeutic, biologic, and immunotherapeutic agents that are administered for the treatment of malignant disease by routes that may include, but are not limited to, oral, parenteral, intravesical or intrathecal. A standardized approach to the administration of systemic therapy creates opportunities to monitor, evaluate, and improve the safety of the administration process.

A policy or procedure is in place to guide the safe handling and administration of systemic therapy provided in specialized areas either on-site, at locations that are facility owned, or at locations that are contracted by the facility or are supervised by members of the facility's medical staff (e.g., in physician offices or clinics).

To create a safe environment, these specialized areas are characterized by four essential features:

1. A nursing staff with the knowledge and skills to provide specialized care.
2. Facilities or specialized areas necessary to provide the care.
3. A specific set of policies or procedures to guide the pharmacy and ensure compliance with regulations for the safe handling and preparation of systemic therapy.
4. A specific set of policies or procedures to guide the nursing care of patients with cancer who are receiving systemic therapy in these areas.

On-site or facility-owned locations, locations contracted by the facility, or locations supervised by members of the facility's medical staff, which includes physician offices or clinics, follow a policy or procedure to guide the safe handling and administration of systemic therapy. These areas include hospital inpatient areas, outpatient infusion centers, and the pharmacy. Standards, regulations, and guidelines of the Oncology Nursing Society, The American Society of Clinical Oncology (ASCO), the American Society of Health-System Pharmacists (ASHP), the United State Pharmacopeia (USP), or the National Comprehensive Cancer Network (NCCN), or other national organizations are used.

Each calendar year, the program uploads a copy of the most recent policies and procedures for the safe administration of systemic therapy that is provided on-site, at facility-owned locations, or at locations that are contracted by the facility or are supervised by members of the facility's medical staff (physician offices or clinics).

Annually, the program indicates in the ER section of *CoC Datalinks* which systemic treatment services are available either on-site, at locations that are facility owned, or at locations that are contracted by the facility or are supervised by members of the facility's medical staff.

ER9**Clinical Research Information**

Policies and procedures are in place to provide cancer-related clinical research information to patients.

Providing information about the availability of cancer-related clinical research studies offers patients the opportunity to enroll in treatment or observational research studies and trials. Policies and procedures outline the process of providing clinical research information and consent to patients.

Each calendar year, the program uploads a copy of the most recent policies and procedures regarding availability of cancer-related research information for patients for on-site studies or studies by referral.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the ER9.

ER10**Psychosocial Services**

Policies and procedures are in place to ensure patient access to psychosocial services either on-site or by referral.

Psychosocial services are essential components of comprehensive cancer care and are provided to patients with cancer and their caregivers throughout the continuum of care. These services address physical, psychological, social, spiritual, and financial support needs that result from a cancer diagnosis and help ensure the best possible outcome. Resources and services are available on-site or by referral with an established process in place to inform patients how to access them.

Each calendar year, the program uploads a copy of the most recent facility-wide or cancer program policies and procedures that ensures access to psychosocial services either on-site or by referral, and includes annual monitoring of the referral process.

Annually, the program indicates in the ER section of *CoC Datalinks* the psychosocial services that are available either on-site or by referral for public posting on the CoC website.

ER11

Rehabilitation Services

Policies and procedures are in place to ensure patient access to rehabilitation services either on-site or by referral.

Cancer rehabilitation services and treatments help patients cope with activities of daily living affected by the cancer experience and enable them to resume normal activities. Rehabilitation assists cancer patients and survivors to improve functional status and quality of life.

Rehabilitation services include, but are not limited to:

- Lymphedema program
- Pain management
- Physical impairments and disabilities
- Lifestyle and weight management programs
- Physical and exercise therapy
- Reflexology, Massage Therapy, Chiropractic Care
- Occupational therapy

Each calendar year, the program uploads a copy of the most recent facility-wide or cancer program policies and procedures that ensures access to rehabilitation services either on-site or by referral, and includes annual monitoring of the referral process.

Annually, the program indicates in the ER section of *CoC Datalinks* which rehabilitation services are available either on-site or by referral for public posting on the CoC website.

ER12

Nutrition Services

Policies and procedures are in place to ensure patient access to nutrition services either on-site or by referral.

Nutrition services are essential components of comprehensive cancer care and patient rehabilitation. These services provide safe and effective nutrition care across the cancer continuum (prevention, treatment, and survivorship) and are essential to promoting quality of life. An adequate spectrum of services is available (screening and referral for nutrition-related problems, comprehensive nutrition assessment, nutrition counseling, and education) either on-site or by referral, with a policy or procedure in place to ensure patient awareness of and access to services.

Each calendar year, the program uploads a copy of the most recent facility-wide or cancer program policies and procedures that ensure patient access to a Registered Dietitian Nutritionist (RDN) and nutrition services is available either on-site or by referral, and includes annual monitoring of the referral process.

Annually, the program indicates in the ER section of *CoC Datalinks* which nutrition services are available either on-site or by referral for public posting on the CoC website.



Chapter 1: Program Management

STANDARD 1.1

Physician Credentials

Diagnostic and treatment services are provided by or referred to physicians who are currently board certified (or the equivalent) in their medical specialty or are in the process of becoming board certified.

DEFINITIONS AND REQUIREMENTS

Cancer patient management is conducted by a multidisciplinary team, including diagnosticians, pathologists, surgeons, radiation oncologists, and medical oncologists. All physicians involved in the evaluation and management of cancer patients and serving in a required physician position on the cancer committee **must be one** of the following:

- Board certified; or
- In the process of becoming board certified, and
- Demonstrate ongoing cancer-related education by earning 12 cancer-related continuing medical education (CME) hours each calendar year. A **maximum** of six of the 12 hours can be earned through educational activities offered by the facility; however, all 12 hours can be earned through educational activities that are external to the facility.

SPECIFICATIONS BY CATEGORY

All cancer programs fulfill the standard as written, except for NCIP facilities.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the standard.

DOCUMENTATION

The program must complete all required fields in the Survey Application Record (SAR).

Each calendar year, the program uploads:

- A copy of the medical staff bylaws that address the requirements of current board certification of physicians; or
- A roster of the board certification status for all physicians involved in the evaluation and management of cancer patients and serving in a required physician position on the cancer committee; and
- Documentation of 12 annual cancer-related CME hours for all physicians who are not board certified or those in the process of becoming board certified who are involved in the evaluation and management of cancer patients and serving in a required physician position on the cancer committee.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. All physicians involved in the evaluation and management of cancer patients and serving in a required physician position on the cancer committee must be board certified, or the equivalent, or in the process of becoming board certified.
2. Physicians who are not board certified or are in the process of certification must demonstrate ongoing cancer-related education by earning 12 cancer-related CME hours annually.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: NCIP facilities.

STANDARD 1.2

Cancer Committee Membership

The membership of the cancer committee is multidisciplinary, representing physicians from diagnostic and treatment specialties and non-physicians from administrative and supportive services. Cancer committee coordinators, who are responsible for specific areas of cancer program activity, are designated each calendar year.

DEFINITIONS AND REQUIREMENTS

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

The cancer committee must be chaired by a physician (of any specialty). The Cancer Committee Chair is selected according to each institutions rules and/or bylaws. The Cancer Committee Chair is responsible for overseeing compliance of Eligibility Requirement (ER) 2 and Standards 1.1–1.4.

Required cancer committee members must include at least one physician representing each of the diagnostic and treatment services. Other required members include representatives from each of the administrative, clinical, and supportive services available at the program. 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.

Required physician members for all program categories are:

- Diagnostic radiologist
- Pathologist
- Surgeon (includes general surgeon and surgical specialist(s) involved in cancer care)
- Medical oncologist
- Radiation oncologist (if all radiation oncology services are provided by referral and program's medical staff does not include a radiation oncologist, a radiation oncologist is recommended to be part of the committee but not required.)
- Cancer Liaison Physician (a physician of any specialty, the Cancer Liaison Physician can fulfill one additional leadership position within the cancer committee such as chair or a designated coordinator and represent one of the required physician specialties)

Required non-physician members are:

- Cancer Program Administrator (responsible for the administrative oversight and has budget authority for the cancer program)
- Oncology nurse
- Social worker or case manager
- Certified Tumor Registrar (CTR)
- Palliative care professional, if services are provided on-site
- Genetics professional, if services are provided on-site

Additional members strongly recommended, but not required, include:

- Specialty physicians representing the five major cancer sites at the program
- Registered Dietitian Nutritionist or nutrition services representative
- Pharmacist
- Rehabilitation services representative
- Pastoral care representative
- A psychiatric or mental health professional trained in the psychosocial aspects of oncology
- American Cancer Society representative

Each calendar year, all required coordinators are appointed for one calendar-year term at a time by the cancer committee at the first quarter meeting and are responsible for specific areas of cancer program activity and compliance. An individual **cannot** serve in **more than one** coordinator role during a term.

Cancer Conference Coordinator

Cancer conferences provide a forum to formalize the disease stage of patients discussed using nationally recognized, evidenced-based treatment guidelines, when appropriate, and continuing medical education. A coordinator is appointed each calendar year and is a required member of the cancer committee. This coordinator is responsible for monitoring the cancer conference activity. He or she will report the findings to the cancer committee at least annually and recommend corrective action if activity falls below the annual goal or requirements. The cancer conference coordinator will be responsible for overseeing compliance for **ER3** and **Standard 1.7**. A cancer registrar can be selected to fulfill this coordinator role.

Quality Improvement Coordinator

The quality improvement program is the mechanism for evaluating and improving patient outcomes. A coordinator is appointed each calendar year and is a required member of the cancer committee. This coordinator is responsible for monitoring the quality improvement program activity and reports the findings to the cancer committee at least annually. He or she recommends corrective action if activity falls below the annual goal or requirements. The quality improvement coordinator will be responsible for overseeing compliance for **Standards 4.7** and **4.8**. A cancer registrar **cannot** be selected to fulfill this coordinator role.

Cancer Registry Quality Coordinator

The cancer registry database is the basis for monitoring the quality of care. A coordinator is appointed each calendar year and is a required member of the cancer committee. This coordinator will monitor the quality of the cancer registry data and report the findings to the cancer committee at least annually and recommend corrective action if activity falls below the annual goal or requirements. The cancer registry quality coordinator will be responsible for overseeing compliance for **ER 5** and **Standard 1.6**. A cancer registrar can be selected to fulfill this coordinator role.

Community Outreach Coordinator

A community outreach coordinator is appointed each calendar year and is a required member of the cancer committee. This coordinator monitors the prevention and screening activities, reports at least annually to the cancer committee, and recommends corrective action if activity falls below the annual goal or requirements. The coordinator is not a marketing position and eligibility for the role is outlined in **Standard 1.8**. The community outreach coordinator will be responsible for overseeing compliance for **Standards 1.8, 4.1, and 4.2**. A cancer registrar **cannot** be selected to fulfill this coordinator role.

Clinical Research Coordinator

A clinical research coordinator is appointed each calendar year and is a required member of the cancer committee. This coordinator will be responsible for tracking patients enrolled in clinical trials from within the program and/or patients referred for enrollment in clinical trials at other facilities or physician offices. Examples include, but are not limited to, the following: clinical research coordinator, research nurse, or research data manager. This coordinator will be responsible for overseeing **ER9** and **Standard 1.9**. A cancer registrar **cannot** be selected to fulfill this coordinator role.

Psychosocial Services Coordinator

A psychosocial services coordinator is appointed each calendar year and is a required member of the cancer committee. An oncology social worker (OSW-C preferred), clinical psychologist, or other mental health professional trained in the psychosocial aspects of cancer care is selected to fill this role. This coordinator works collaboratively with established departments and community organizations to provide, improve, and expand the range of psychosocial services. This coordinator will be responsible for overseeing **ER10** and **Standard 3.2**. A cancer registrar **cannot** be selected to fulfill this coordinator role.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the standard.

SPECIFICATIONS BY CATEGORY

Pediatric Cancer Programs (PCP) select additional physician or nonphysician members based on the Children's Oncology Group (COG) membership requirements, the services and specialties available at the program, and the program's caseload majority.

Members should include, but are not limited to:

- Surgeons with pediatric expertise in neurosurgery, urology, and orthopedic surgery
- Pediatric surgical oncologist
- Pediatric subspecialists in anesthesiology, intensive care, infectious diseases, cardiology, nephrology, and neurology
- Pediatric psychologist
- A representative from the late-effects or survivorship clinic

All other cancer programs fulfill the standard as specified by the category except NCIP.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads the cancer committee minutes that identifies the required cancer committee members and appointed designated coordinators.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. The membership of the cancer committee includes the required physicians from the diagnostic and treatment specialties for cancer care.
2. The membership of the cancer committee includes required nonphysicians from administrative and supportive services for cancer care.
3. Cancer committee members are designated to fulfill all required coordinator roles.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: NCIP facilities.

STANDARD 1.3

Cancer Committee Attendance

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.

DEFINITION AND REQUIREMENTS

The cancer committee is responsible for leading the cancer program. This responsibility includes making important decisions about the program goals and evaluating and improving the quality of cancer care that is provided to the patients who are treated at the program. To successfully complete responsibilities and ensure multidisciplinary input, it is imperative that all appointed members (physicians and non-physicians) regularly attend and participate in cancer committee meetings. The cancer committee monitors the attendance of individual members to ensure participation at cancer committee meeting.

Each required member or the designated alternate must attend at least 75 percent of the cancer committee meetings held each calendar year. Attendance at cancer committee meetings may include participation through face-to-face conference or teleconference calls with appropriate meeting documents provided. One appointed member and one designated alternate member (optional) can be identified for each required physician and non-physician role on the cancer committee. The attendance percentage is calculated based on the attendance of required role (either the required member or his or her designated alternate in attendance).

The cancer committee membership and identification of designated alternates must take place at the first meeting of the year when committee membership is confirmed. This information is recorded 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.

The designated alternate must be qualified and appropriately credentialed to serve as an alternate for a member (i.e. alternate to a medical oncologist must be another medical oncologist). Individuals cannot be selected to serve as an alternate if they are already a required member of the cancer committee and cannot be an alternate for multiple roles or members. A designated alternate can be an existing non-required member of the cancer committee if they are an appropriate choice to fulfill the alternate role of the committee.

Required members include physicians and non-physicians who are specified in Standard 1.2. If the Cancer Liaison Physician appoints an alternate, his or her alternate must be a physician who can fulfill the CLP requirements as outlined in Standard 4.3. However, the CLP alternate is not required to submit a formal CLP application.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP facilities.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads the cancer committee minutes that include the membership attendance for every cancer committee meeting held during each calendar year.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

Each required member or the designated alternate attends at least 75 percent of the cancer committee meetings held during each calendar year.

(5) Noncompliance: The program does not fulfill the compliance criteria.

(8) Not Applicable: NCIP facilities.

STANDARD 1.4

Cancer Committee Meetings

Each calendar year, the cancer committee meets at least once each calendar quarter.

DEFINITION AND REQUIREMENTS

Regular cancer committee meetings ensure that administrative responsibilities related to cancer program functions are carried out and standard compliance is met. In all program categories, the cancer committee assembles **each quarter**, with a minimum of four meetings each calendar year. Cancer committees may choose to establish more frequent meetings in order to meet the 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 needs. It is the cancer committee's responsibility to schedule meetings 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.

In addition to the cancer committee, programs may choose to establish subcommittees or workgroups to manage specific activities, noting that activities and reports must be presented and approved by the cancer committee. Example of subcommittees may include:

- Cancer conference activity
- 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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes that document the committee's quarterly meetings and activities. In addition, all meeting minutes must contain sufficient detail to accurately reflect the activities of the cancer committee as well as demonstrate compliance with CoC standards.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria.

The cancer committee meets at least once each calendar quarter.

(5) Noncompliance: The program does not fulfill the compliance criteria each calendar year.

STANDARD 1.5

Cancer Program Goals

Each calendar year, the cancer committee establishes, implements, and monitors at least one clinical and one programmatic goal for endeavors related to cancer care.

DEFINITION AND REQUIREMENTS

Annual goal setting provides direction for the strategic planning of cancer program activities and serve as the basis for cancer program evaluation and accomplishing improvements. At least **one** clinical goal and at least **one** programmatic goal are established each calendar year.

The cancer committee establishes goals **appropriate and relevant** to the cancer program and its patient population. The scope of this activity will vary, depending on the size of the program; however, cancer programs are to use the goal-setting tool known as **SMART** (Specific, Measurable, Achievable, Realistic, and Timely) when establishing the goals each year.

Establish goals based on the two defined goal types:

1. **Clinical:** Involving the diagnosis, treatment, services, and care of the cancer program's cancer patients.
2. **Programmatic:** Directed toward the scope, coordination, practices, and processes of cancer care at the program.

New and different clinical and programmatic goals must be established at the beginning of each calendar year. At a minimum, goal progress must be monitored and evaluated at two subsequent meetings, mid-year and at the end of the same calendar year.

Goals cannot be a restatement or an improvement of a CoC Standard or Eligibility Requirement because compliance with a standard/ER is required for accreditation. A goal can come as the result of data obtained from the completion of a quality study under Standard 4.7. However, a quality study topic for Standard 4.7 cannot be chosen based on the result (or intention) of a goal used for Standard 1.5. A quality improvement used for Standard 4.8 cannot be used as a goal for Standard 1.5.

SPECIFICATIONS BY CATEGORY

In a PCP facility, the program may choose to select only one goal (clinical or programmatic) each calendar year to meet compliance.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes that clearly define the annual goals, the time frame for evaluation and completion, and the responsibilities of applicable coordinator and/or other committee members to monitor and complete the goals.

RATING COMPLIANCE

(1) **Compliance:** Each calendar year, the program fulfills all of the compliance criteria:

1. At least **one clinical goal** is established by the cancer committee. The goal must be evaluated during at least two subsequent cancer committee meetings. The establishment of the goal and subsequent monitoring must be documented in the cancer committee minutes.
2. At least **one programmatic goal** is established by the cancer committee. The goal must be evaluated during at least two subsequent cancer committee meetings. The establishment of the goal and subsequent monitoring must be documented in the cancer committee minutes.

(5) **Noncompliance:** The program does not fulfill one or more of the compliance criteria each calendar year.

STANDARD 1.6

Cancer Registry Quality Control Plan

Each calendar year, the cancer committee establishes and implements a plan to annually evaluate the quality of cancer registry data and activity. The plan includes procedures to monitor and evaluate each required control plan component.

DEFINITION AND REQUIREMENTS

High-quality cancer registry data is essential to accurately assess treatment outcomes and patient survival. The cancer committee ensures the quality of cancer registry data by establishing and implementing a quality control plan to monitor and evaluate multiple areas of cancer registry activity and the accuracy and completeness of abstracted data.

The Cancer Registry Quality Coordinator works cooperatively with registry staff and other applicable departments to implement the quality control plan. The coordinator is required to 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 meeting minutes.

The quality control plan, at a minimum:

1. Sets the review criteria
2. Sets the quality control timetable
3. Specifies the quality control methods, sources, and individuals involved
 - a. Required activities:
 - » Random sampling of annual analytic caseload
 - » Physician review (reviewers may include residents and other physicians not necessarily on the cancer committee)
 - b. External audits (such as state or central cancer registry case-finding audits) may be used to fulfill part of this requirement.
4. Identifies the activities to be evaluated. Required activities:
 - a. Casefinding
 - b. Abstracting timeliness
 - c. Accuracy of abstracted data
 - » Class of case
 - » Primary site
 - » Histology
 - » American Joint Committee on Cancer (AJCC) Stage or other appropriate staging system
 - » First course of treatment
 - » Follow-up information, including Date of First Recurrence, Type of First Recurrence, and Cancer Status
 - d. The percentage of information coded as unknown (usually coded as 9 or a string of 9s)
 - e. National Cancer Data Base (NCDB) data submission, correction of data errors, and resubmission of corrected data
5. Defines the scope of the evaluation. Required scope:
 - a. Minimum: 10 percent of annual analytic caseload
 - b. Maximum: 300 cases annually
6. 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.

7. Maintains documentation of the quality control activity:

- a. Required documentation
- b. Review criteria
- c. Cases reviewed
- d. Identified data errors and resolutions
- e. Reports findings to the cancer committee annually

Patient data reviewed under the quality control plan for Standard 1.6 cannot be used as an in-depth analysis review for compliance to Standard 4.6.

SPECIFICATIONS BY CATEGORY

In a NCIP facility, the plan to ensure the quality of cancer registry data is established and implemented by the cancer registry manager or administrator. In facilities with more than one CTR in the cancer registry, the CTRs perform the quality control review of cancer registry data. The percentage of cases reviewed is determined by the program based on the annual analytic caseload. The results of the quality control review are shared with the administrative body. Physician participation in the quality control activity, particularly in resolution of conflicts, is required.

In a VACP facility, in addition to the cancer committee, the lead Veterans Integrated Service Network (VISN) CTR may assist with development of the quality control plan or coordinate the quality control review of cancer registry data. The participation and role of the lead VISN CTR is documented in the quality control plan. The coordinator for cancer registry quality or the lead VISN CTR reports quality control activity and quality control outcomes regularly to the cancer committee.

DOCUMENTATION

The program completes all required fields in the SAR.

Each calendar year, the program uploads:

- An up-to-date quality control plan. This documentation includes the process for resolving conflicts identified during the quality control review and 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.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. The cancer committee establishes and implements a quality control plan to evaluate the required areas of the cancer registry.
2. The Cancer Registry Control Coordinator, under the direction of the cancer committee, performs the required quality control review as outlined in the plan.
3. The findings and recommendations from the annual review are reported to the cancer committee.
4. The annual review findings are documented in cancer committee minutes.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

NCIP-Specific Rating

(1) Compliance: Each calendar year, the NCIP fulfills all of the compliance criteria:

1. The cancer registry manager or administrator establishes and implements a plan to evaluate the required areas.
2. The cancer registry manager or staff performs the required quality control review as outlined in the plan.
3. The findings and recommendations from the annual review are reported to the cancer committee.
4. The annual review findings are documented in cancer committee minutes.

(5) Noncompliance: The NCIP does not fulfill the one or more of the compliance criteria each calendar year.

STANDARD 1.7

Monitoring Cancer Conference Activity

Each calendar year, the cancer conference coordinator monitors and evaluates the cancer conference activities and reports the findings to the cancer committee.

DEFINITION AND REQUIREMENTS

Monitoring cancer conference activity ensures that conferences provide consultative services for patients to formulate an effective treatment plan and offer education to physicians and allied health professionals in attendance. Monitoring of cancer conference activity may also identify opportunities to improve the patient care process.

*Routine evaluation of cancer conference activity in each of the following **seven required areas** is essential to ensure compliance with the requirements set by the cancer committee:*

- Cancer conference frequency
 - » Specialty cancer site-specific conferences are optional in addition to the general cancer conference
- Multidisciplinary attendance
- Total number of case presentations
- Percentage of prospective case presentations
- Discussion of stage, including stage group when available, prognostic indicators, and treatment planning using evidence-based treatment guidelines
- Options and eligibility for clinical trial enrollment
- Adherence to cancer conference policies

Additional areas recommended to attended cancer conferences include, but are not limited to:

- Genetic testing and counseling
- Palliative care
- Psychosocial care
- Rehabilitation services

The methods used to monitor the cancer conference activity (for example, a grid or spreadsheet) are set by the cancer committee and discuss of the review is documented in the cancer committee minutes. The designated Cancer Conference Coordinator monitors each area of cancer conference activity, reports regularly to the cancer committee, and recommends corrective action if any area falls below the annual goal or requirement. These results are documented in the cancer committee minutes.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP facilities.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes to demonstrate the monitoring of the seven standard requirements, and any corrective action taken for an area that falls below the annual goal and mentions any quality improvement activities that may have resulted from this evaluation as defined by the cancer conference policy.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions and will discuss the cancer conference activity with the cancer committee members.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer conference coordinator monitors and evaluates all of the seven required cancer conference criteria.
2. The cancer conference coordinator reports the findings of the cancer conference evaluation to the cancer committee annually.
3. The review of the annual report is documented in cancer committee minutes.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: NCIP facilities.

STANDARD 1.8

Monitoring of Prevention, Screening, and Outreach Activities

Each calendar year, the Community Outreach Coordinator, under the direction of the cancer committee, monitors the effectiveness of prevention, screening, and outreach activities. The activities and monitoring results are documented in an annual community outreach activity summary that is presented to the cancer committee at the end of each calendar year.

DEFINITION AND REQUIREMENTS

Based on the identified screening and prevention needs of the program's served community, the prevention and screening programs (Standards 4.1 and 4.2) offered each calendar year are discussed and monitored for effectiveness. In order to monitor "effectiveness," the cancer committee will discuss if the activities are or are not producing the intended results of the prevention and screening program. The scope of outreach and the methods to organize and offer prevention and screening programs are evaluated annually.

COMMUNITY OUTREACH COORDINATOR RESPONSIBILITIES

The cancer committee monitors prevention, screening, and outreach activities through the work of the Community Outreach Coordinator. The coordinator is chosen on the basis of their specialty, knowledge, skills, and interest. The Community Outreach Coordinator must be affiliated with or employed by the program and cannot an American Cancer Society representative.

Professionals who can fill the Community Outreach Coordinator role may include:

- The director or staff member of the program's outreach department
- A physician or a nonphysician with screening and prevention program knowledge/experience

The Community Outreach Coordinator works in collaboration with the cancer committee, applicable program departments and may also work with external organizations such as the American Cancer Society to develop, implement, and monitor community outreach activities. If the program has an established outreach department, the coordinator has the authority and responsibility to contribute to the community outreach plan and to coordinate and monitor activities ensuring that the appropriate number of support, prevention, and screening programs are in place.

At a minimum, the Community Outreach Coordinator is required to:

- Contribute to the development of community outreach activities.
- Ensure that the provided prevention and screening programs reflect the cancer experience at the program and the community-defined needs.
- Ensure that the prevention and screening activities follow nationally accepted, evidence-based guidelines and interventions.
- Establish mechanisms to ensure follow-up of all positive findings identified through screening activities.
- Evaluate the effectiveness of access and referral processes of screening and early detection activities to ensure appropriate referrals are made.
- Create a community outreach activity summary report that outlines the activities provided, the results of outreach programs, and follow-up. The report should specifically focus on prevention and screening activities and must contain, at a minimum, the following information: identified areas of community need, specific community outreach activities performed, and summary of effectiveness of each activity.

At the end of each calendar year, the community outreach activity summary is presented to the cancer committee to facilitate discussion and decision-making based on the activities throughout the year. This report will also allow for follow-up recommendations and any necessary corrective actions or enhancements for the prevention, screening and outreach programs. This discussion is documented in the cancer committee minutes on an annual basis.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP facilities.

The VACP facilities follow the U.S. Preventive Services Task Force recommendations for prevention or screening programs provided by the VACP facilities. Community outreach activities focus on veteran-related issues such as smoking and alcohol cessation.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- The annual community outreach activity summary that documents the methods used to monitor and evaluate the effectiveness of the prevention and screening activities
- Cancer committee minutes documenting the review of the annual community outreach summary

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee monitors the effectiveness of the prevention, screening, and outreach activities on an annual basis.
2. The activities and monitoring results are documented in an annual community outreach activity summary.
3. The annual community outreach activity summary is shared with the cancer committee.
4. The review of the annual community outreach activity summary is documented in the cancer committee minutes.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: NCIP facilities.

STANDARD 1.9

Clinical Research Accrual

As appropriate to the cancer program category, the required percentages of patients are accrued to cancer-related clinical research studies each calendar year. The Clinical Research Coordinator documents and reports clinical research study enrollment information to the cancer committee annually.

DEFINITION AND REQUIREMENTS

Clinical research advances science and ensures that patient care approaches the highest possible level of quality. All cancer programs are required to accrue or refer participants to eligible, cancer-related clinical research studies each calendar year.

There are two main types of clinical research studies: clinical trials and observational studies. In a clinical trial, participants receive specific interventions according to the research plan or protocol. These interventions may be medical products, such as drugs or devices; procedures; or changes to participants' behavior, such as diet. In an observational study (for example, quality of life or bio-repository), investigators assess health outcomes, but participants are not assigned to specific interventions (as in a clinical trial).

The cancer program must establish a screening process to identify participant eligibility. 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.

Professionals who can fill the Clinical Research Coordinator role include:

- A clinical trial principal investigator
- A research data manager or associate
- A clinical research nurse or oncology nurse

All eligible, **cancer-related** clinical research studies involving human subjects must be approved by an internal or external Institutional Review Board (IRB) that is responsible for the oversight and review of the research study. Subjects participating in clinical research studies must give their informed, written consent unless the requirement for written consent has been waived by the overseeing IRB. The program is responsible for documenting enrollment and accrual of subjects to cancer-related clinical research studies within their program or once a patient is referred and enrolled onto an external research study.

The minimum percentage of patients (subjects) required to meet Standard 1.9 is based on the program's category and the number of annual analytic accessions. Patients eligible to meet this standard are:

- Diagnosed and/or treated, and enrolled in a cancer-related clinical research study within the program or facility
- Diagnosed and/or treated, and placed in a cancer-related clinical research study within a staff physician's office of the program or facility
- Diagnosed and/or treated at the program or facility, then referred by your facility for enrollment onto a cancer-related clinical research study through another program or facility
- Referred to your 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 clinical study must fully cooperate with the data management team of the cancer program from which the patient was referred. This cooperation ensures that the information about patients enrolled into a cancer-related clinical trial is shared with the program that referred the patient.

Cancer-related research studies eligible for accrual under Standard 1.9 include:

- Cancer-specific biorepositories or tissue banks
- Prevention trials (testing new approaches that are aimed to lower the risk of developing a certain type of cancer)

- Screening trials (examining new approaches to detect cancer)
- Diagnostic trials (examining tests or procedures used to identify or diagnosis cancer)
- Treatment trials
- Economics of care related to cancer care
- Quality-of-life or supportive care trials
- Genetic studies
- Patient registries with an underlying cancer research focus (such as the National Oncologic PET Registry)

Humanitarian Use Devices studies are not eligible for accrual under Standard 1.9.

Subject accrual must be monitored and reported to the cancer committee each year by the Clinical Research Coordinator. The review of the report is documented in cancer committee minutes.

Resources for clinical research studies and trials:

- National Cancer Institute
- U.S. National Institutes of Health's *ClinicalTrials.gov*
- American Cancer Society (clinical trials matching service)

SPECIFICATIONS BY CATEGORY

Programs meet the clinical trial accrual percentage that is specified for their current accreditation cancer program category.

INCP's clinical research accrual percentages are calculated based on cumulative accrual percentage met collectively across the network campuses.

EXCEPTIONS BY CATEGORY

HACP facilities are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes that include the reports of the annual accrual percentages to cancer-related clinical research studies each calendar year.

RATING COMPLIANCE

(1+) Commendation: Each calendar year, the program fulfills all of the commendation criteria:

1. Based on the Commission on Cancer designated cancer program category, the required commendation percentages of patients are accrued to cancer-related clinical research studies each year.
2. The number of accruals to cancer-related clinical research studies is monitored annually.
3. The annual number of accruals to cancer-related clinical research studies is reported to the cancer committee.
4. The review of the report is documented in cancer committee minutes.

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. Based on the Commission on Cancer designated cancer program category, the minimum required percentage of patients is accrued to cancer-related clinical research studies each year.
2. The number of accruals to cancer-related clinical research studies is monitored annually.
3. The annual number of accruals to cancer-related clinical research studies is reported to the cancer committee.
4. The review of the report is documented in cancer committee minutes.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: HACP facilities.

Minimum Required and Commendation Accrual Percentages to Clinical Research Studies Each Calendar Year		
Category	Minimum Required Percentage*	Commendation Percentage*
INCP	6	8
NCIP	20	30
ACAD	6	8
VACP	2	4
CCCP	4	6
CCP	2	4
HACP	Exempt	2
PCP	30	40
FCCP	2	4

*Determined by the number of annual analytic cases.

STANDARD 1.10

Clinical Educational Activity

Each calendar year, the cancer committee organizes and offers at least one cancer-related educational activity, other than cancer conferences, to physicians, nurses, and other allied health professionals. The activity is focused on the use of American Joint Committee on Cancer (AJCC) or other appropriate staging in clinical practice, which includes the use of appropriate prognostic indicators and evidence-based national guidelines used in treatment planning.

DEFINITION AND REQUIREMENTS

Educational activities ensure that members of the cancer care team have current knowledge of cancer prevention, early detection, diagnosis, stage of disease, treatment guidelines and prognostic factors, treatment, and follow-up care.

Each calendar year, the cancer committee offers at least one cancer-related educational activity, other than cancer conferences, to physicians, nurses, and allied health professionals. The educational activity **must focus** on a selected cancer treatment and the use of AJCC or other appropriate staging in clinical practice, which includes the use of appropriate prognostic indicators and evidence-based national guidelines used in treatment planning. Educational activities **exclude** patient management cancer conferences and/or tumor boards of any format.

The cancer committee is encouraged to use the AJCC-developed materials and to obtain continuing medical education or other appropriate credits for cancer conferences and other clinically focused educational activities.

The cancer committee may coordinate this activity with the program's continuing education department, medical staff office, or other department as appropriate.

The cancer committee monitors the success of and attendance at educational activities each year.

Educational formats that can be used to fulfill this standard include:

- An educational symposium or grand round
- A lecture or panel discussion
- A video conference
- A webinar (To fulfill the educational requirement of the standard, a webinar is to be a minimum of one cumulative hour annually. The webinar is to be viewed as a group with a designated physician leader from the cancer committee to facilitate discussion following the webinar.)

In PCP facilities, at least one pediatric-focused, cancer-related educational activity, other than cancer conferences, is offered to all pediatric medical staff members and pediatric allied health professionals each year. The educational activity relates to pediatric staging and treatment protocols used by the program.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP facilities.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads documentation of one annual cancer-related educational activity, other than cancer conferences:

- A published flyer/agenda, list of objectives, or slides of the content presented, which demonstrates:
 - » Discussion of AJCC or other appropriate staging in clinical practice
 - » Appropriate prognostic indicators were presented

» Discussion of evidence-based national guidelines used in treatment planning

- Evidence that the activity was directed to physicians, nurses, and allied health professionals

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. The cancer committee organizes and offers at least one cancer-related educational activity, other than cancer conferences, to physicians, nurses, and other allied health professionals.
2. The educational activity must include discussion of AJCC staging or other appropriate staging, which includes appropriate prognostic indicators and evidence-based national treatment guidelines in planning treatment for patients with cancer.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: NCIP facilities.

STANDARD 1.11

Cancer Registry Education

Each calendar year, all members of the cancer registry staff participate in one cancer-related educational activity applicable to their role.

DEFINITION AND REQUIREMENTS

Ongoing cancer-related education enhances knowledge and skills of the cancer registry staff. To facilitate accurate data collection and to gain or maintain their credentials, all members of the cancer registry staff must participate in ongoing **cancer-related education** applicable to their role at the local, state, regional, or national level annually.

All full-time and part-time registry staff for which annual education is required includes:

- Certified Tumor Registrar (CTR) staff
- Contract CTR staff who are contracted to work for three or more consecutive months during the calendar year, regardless of the number of hours worked
- All non-credentialed registry staff, including the following:
 - » Staff abstracting under the supervision of a CTR
 - » Staff performing follow-up activities
 - » 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 requirement

Educational activities that can be used to fulfill the standard (excluding all formats of patient management cancer conferences and/or tumor boards) include:

- For face-to-face meetings, workshops, or conferences:
 - A “Local” educational activity—involves only one program, organization, or facility (local educational activity)
 - A “State” educational activity—involves one state-level program or organization
 - A “Regional” educational activity—involves more than one state-level program or organization working collaboratively to develop the workshop. Agendas and meeting notices must indicate the collaborative effort by each state.
 - A “National” educational activity—is sponsored by a national association or organization and targeted to a national audience.
- A video conference (local educational activity [local educational activity, including those sponsored by regional or national organizations])
- A webinar (local educational activity, including those sponsored by regional or national organizations)
- A cancer-related lecture offered by the program (local educational activity)
- A Web-based training module (local educational activity including those sponsored by regional or national organizations)
- Journal-based articles that offer continuing education credits (local educational activity)

Examples of organizations that sponsor regional meetings include, but are not limited to:

- Cancer Registrars Association of New England
- Cancer Registrars Association of the Dakotas

Examples of national organizations that sponsor national meetings include, but are not limited to:

- American Health Information Management
- Association (cancer-related educational activities)
- Association of Community Cancer Centers
- American College of Surgeons (including Commission on Cancer and National Accreditation Program of Breast Centers)
- National Cancer Registrars Association
- National Comprehensive Cancer Network
- North American Association of Central Cancer Registries

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

For commendation, the program uploads documentation of attendance to a regional or national cancer-related educational meeting for each current CTR staff member.

RATING COMPLIANCE

(1+) Commendation: Each calendar year, the program fulfills all of the commendation criteria:

1. All cancer registry staff participates in at least one cancer-related educational activity.
2. All Certified Tumor Registrar staff attends a national or regional cancer-related educational meeting at least once during the three-year survey cycle.

NCIP facilities are exempt from the commendation rating for this standard.

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

All cancer registry staff participates in at least one cancer-related educational activity.

(5) Noncompliance: The program does not fulfill the compliance criteria each calendar year.

STANDARD 1.12

Public Reporting of Outcomes

Each calendar year, the cancer committee develops and disseminates a report of patient or program outcomes to the public.

DEFINITION AND REQUIREMENTS

Each calendar year, the cancer committee develops and disseminates a report of patient or program **outcomes** to the public. An annual report is not synonymous with reporting of outcomes, and the public reporting must include outcomes related to applicable Chapter 4 standards.

The content of the report **must include outcome information on one or more** of the following standards:

- Standard 4.1 Prevention Programs
- Standard 4.2 Screening Programs
- Standard 4.4 Accountability Measures
- Standard 4.5 Quality Improvement Measures
- Standard 4.6 Monitoring Compliance with Evidence-Based Guidelines
- Standard 4.7 Studies of Quality
- Standard 4.8 Quality Improvements

Reporting of survival rates from NCDB tools **does not** meet the commendation requirements. The CoC's formal policy does not permit public reporting of survival rates from the NCDB tools. The report may be published in electronic or printed format but must be distributed to an audience external to the facility and medical staff. The intent of this report is to demonstrate the result and/or consequence of an activity completed by the cancer program. Examples include demonstrating compliance with evidence-based guidelines, completed studies of quality, quality improvements, or cancer prevention/screening events.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written for commendation.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads a copy of web link to the report on patient or program outcomes.

RATING COMPLIANCE

(1+) Commendation: Each calendar year, the program fulfills the commendation criteria.

The cancer committee develops and disseminates a report of patient or program outcomes to the public.



Chapter 2: Clinical Services

Phase-in for 2017

STANDARD 2.1

College of American Pathologists Protocols and Synoptic Reporting

Each calendar year, 95 percent of the eligible cancer pathology contain all required data elements of the College of American Pathologists (CAP) protocols and are structured using the synoptic reporting format as defined by the CAP Cancer Committee.

DEFINITION AND REQUIREMENTS

The CoC requires that 95 percent of eligible pathology reports that include a cancer diagnosis are formatted using synoptic reporting and incorporate the required data elements outlined in the current applicable surgical case protocols and summary checklists of the College of American Pathologists (CAP) publication, *Reporting on Cancer Specimens*. Synoptic pathology reporting uses discrete data field format (i.e., each required data element has a specific place and format in the report).

For CoC-accredited programs, the CAP protocols apply to the following:

- Pathology reports created by the program from resected specimens with a diagnosis of invasive cancer.
- Pathology reports created by the program from resected specimens with a diagnosis of ductal carcinoma in situ (DCIS). Diagnostic biopsy specimens, cytology specimens, special studies, and reports of carcinoma in situ (except for ductal carcinoma in situ) are excluded.

At a minimum, a random sample of 10 percent of pathology reports eligible for the CAP protocols or a maximum of 300 cases are reviewed each year to document compliance with this standard. The cancer committee may delegate this quality control activity to the pathologists who report the quality control activity and a summary of findings regularly to the cancer committee or to other physicians on the cancer committee.

SPECIFICATIONS BY CATEGORY

All facilities fulfill the standard as written, except for PCP facilities.

EXCEPTIONS BY CATEGORY

PCP facilities are exempt from the standard. In a PCP, the CAP protocols are followed when they are applicable to pediatric sites and/or histologic diagnoses.

DOCUMENTATION

The program must complete all required fields in the SAR.

During the on-site visit, the surveyor will evaluate the pre-selected pathology reports of eligible analytic cases for the three most recent complete years of abstracting to confirm that 95 percent of the reports include all of the required data items defined by the CAP protocols and follow the synoptic format defined by the CAP Cancer Committee.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. 95 percent of cancer pathology reports follow the synoptic format defined by the CAP cancer committee.
2. 95 percent of cancer pathology reports include all required data elements as outlined in the CAP protocols.

(5) Noncompliance: The program does not fulfill the one or more of the compliance criteria.

(8) Not Applicable: PCP facilities.

STANDARD 2.2

Oncology Nursing Care

Oncology nursing care is provided by nurses with specialized knowledge and skills. Nursing competency is evaluated each calendar year. Results are reported to the cancer committee and documented in the cancer committee minutes.

DEFINITION AND REQUIREMENTS

The treatment of cancer is a dynamic patient care process characterized by the continuous introduction of new cancer treatments, treatment protocols, and delivery methods. The evolving body of knowledge and inherent risks associated with cancer treatments require ongoing education and an evaluation process for oncology nurses.

Nursing Education

Oncology nursing education focuses on the knowledge base needed to administer cancer treatments in a safe and consistent manner and to care for patients with cancer across the continuum of care. Nursing education is through the Oncology Nursing Society (ONS) or Oncology Nursing Certification Corporation (ONCC). Educational courses provided by these organizations may include:

- ONS Cancer Basics Course
- ONS Chemotherapy Basics Course
- ONS/ONCC Chemotherapy Biotherapy Certificate Course
- ONS/ONCC Radiation Therapy Certificate Course

Nursing Competency

Oncology nursing education and competency evaluations are required for all areas of the program where cancer care is provided. Annual nursing competency evaluation of oncology knowledge and skills is completed and documented according to organizational policy, is approved by the cancer committee, and is documented in the cancer committee minutes. Oncology nursing certification for all nurses providing oncology care is strongly encouraged. All nurses who administer chemotherapy to patients need documented certification of chemotherapy training for both in-patient and out-patient units.

Oncology nursing certifications include, but are not limited to:

- Oncology Certified Nurse (OCN®)
- Advanced Oncology Certified Nurse (AOCN®)
- Certified Pediatric Oncology Nurse (CPON®)
- Certified Pediatric Hematology Oncology Nurse (CPHON™)
- Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
- Advanced Oncology Certified Nurse Practitioner (AOCNP®)
- Certified Breast Care Nurse (CBCN™)

Each calendar year, the credentials of oncology nursing personnel will be verified by nursing leadership, reported to the cancer committee, and documented in cancer committee minutes. For commendation, each calendar year 25 percent of oncology nurses employed and/or contracted with the facility (including full-time and part-time) hold an applicable oncology nursing certification.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program must complete all required fields in the SAR.

Each calendar year, the program uploads:

- The oncology nursing competency policies or procedures
- Cancer committee minutes that document the committee's review of the competency training results

RATING COMPLIANCE

(1+) Commendation: Each calendar year, the program fulfills all of the commendation criteria:

1. 25 percent of oncology nurses employed and/or contracted with the facility (including full-time and part-time) hold a current, applicable oncology nursing certification.
2. Nurses with specialized oncology knowledge and skills are available at the cancer program.
3. Organizational policies and procedures are in place to evaluate oncology nursing competency.
4. Nursing competency for all oncology nurses employed and/or contracted with the facility (including full-time and part-time) is evaluated each year under the direction of the cancer program's nursing department leadership.
5. Oncology nursing competency results are reported to the cancer committee and documented in the minutes.

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. Nurses with specialized oncology knowledge and skills are available at the cancer program.
2. Organizational policies and procedures are in place to evaluate oncology nursing competency.
3. Nursing competency for all oncology nurses employed and/or contracted with the facility (including full-time and part-time) is evaluated each year under the direction of the cancer program's nursing department leadership.
4. Oncology nursing competency results are reported to the cancer committee and documented in the minutes.

(5) Noncompliance: The program does not fulfill the one or more of the compliance criteria.

STANDARD 2.3

Genetic Counseling and Risk Assessment

Cancer risk assessment, genetic counseling, and genetic testing services are provided to patients either on-site or by referral to a qualified genetics professional.

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. The purposes of genetic counseling are to educate patients about their chance of developing cancers, help them obtain personal meaning from cancer genetic information, and empower them to make educated, informed decisions about genetic testing, cancer screening, and cancer prevention. Cancer risk assessment and genetic counseling involve pretest and posttest counseling.

Cancer risk assessment and genetic counseling are performed by a genetics professional with an educational background in cancer genetics and hereditary cancer syndromes and extensive experience in counseling, to provide accurate risk assessment and empathetic genetic counseling to patients with cancer and their families. Specialized training in cancer genetics should be ongoing; educational seminars offered by commercial laboratories about how to perform genetic testing are not considered adequate training for cancer.

Genetics professionals may include:

- An American Board of Genetic Counseling (ABGC) or American Board of Medical Genetics (ABMG) board-certified/board-eligible or (in some states) a licensed genetic counselor
- An American College of Medical Genetics (ACMG) physician/PhD board-certified/board-eligible in clinical or medical genetics
- A Genetics Clinical Nurse (GCN), an Advanced Practice Nurse in Genetics (APNG), or an Advanced Genetics Nursing-Board Certified (AGN-BC) credentialed through the American Nurses Credential Center (ANCC).
- An advanced practice oncology nurse or Physician Assistant who is prepared at the graduate level (master or doctorate) with specialized education in cancer genetics and hereditary cancer predisposition syndromes; certification by the Oncology Nursing Certification Corporation is preferred
- A board-certified/board-eligible physician with experience in cancer genetics (defined as providing cancer risk assessment on a regular basis)

The program provides 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 formal referral to other facilities and/or local agencies. The cancer committee will monitor, evaluate, and make recommendations for improvements, as needed, cancer risk assessment, genetic counseling, and genetic testing and/or referrals annually and document in the cancer committee minutes.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program must complete all required fields in the SAR..

Each calendar year, the program uploads:

- Policies or procedures for providing cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral
- Cancer committee minutes that document the processes implemented to monitor and evaluate the services and referrals

During the on-site visit, the surveyor will discuss the process for providing cancer risk assessment and genetic counseling services either on-site or the referral process.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills 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. The process for referring or providing cancer risk assessment, genetic counseling, and genetic testing services to patients is monitored and reviewed by the cancer committee and documented in the minutes.

(5) Noncompliance: The program does not fulfill the compliance criteria each calendar year.

STANDARD 2.4

Palliative Care Services

Palliative care services are available to patients either on-site or by referral.

DEFINITION AND REQUIREMENTS

Palliative care is not simply hospice care. Palliative care refers to patient- and family-centered care that optimizes quality of life and end-of-life care. 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, surveillance, and, when applicable, during bereavement.

A multidisciplinary team of physicians, nurses, mental health professionals, social workers, and spiritual counselors provide palliative care services. A member of the palliative care team is a required member of the cancer committee when these services are provided at the facility.

Types of palliative care services include:

- Team-based care planning that involves the patient and family
- Pain and non-pain symptom management
- Communication among patients, families, and provider team members
- Continuity of care across a range of clinical settings and services
- Attention to spiritual comfort
- Psychosocial support for patients and families
- Bereavement support for families and care team members
- Hospice care

The cancer committee will define and identify the on-site and off-site services. Palliative care services on-site will vary depending on the scope of the program, local staff expertise, and patient population. Palliative care services not provided on-site at the facility must be provided through a formal referral to other facilities and/or local agencies. The cancer committee will monitor, evaluate, and make recommendations for improvements, as needed, to palliative care services and/or referrals annually and document in the cancer committee minutes.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- Policies or procedures for providing palliative care on-site or by referral
- Cancer committee minutes that document the processes implemented to monitor and evaluate the palliative care services and referrals

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

1. Palliative care services are available to patients either on-site or by referral.
2. The process for referring or providing palliative care services to patients is monitored and reviewed by the cancer committee and documented in the minutes.

(5) Noncompliance: The program does not fulfill the compliance criteria each calendar year.



Chapter 3: Continuum of Care Services

STANDARD 3.1

Patient Navigation Process

A patient navigation process, driven by a triennial Community Needs Assessment, is established to address health care disparities and barriers to cancer care. Resources to address identified barriers may be provided either on-site or by referral.

DEFINITION AND REQUIREMENTS

Patient navigation in cancer care refers to specialized assistance for the community, patients, families, and caregivers to assist in overcoming barriers to receiving care and facilitating timely access to clinical services and resources. Navigation processes encompass prediagnosis through all phases of the cancer experience. The navigation services implemented will depend upon the particular type, severity, and/or complexity of the identified barriers.

Prior to establishing the navigation process, the cancer committee must conduct a Community Needs Assessment (CNA) at least once every three years during the three-year accreditation cycle. The cancer committee defines the scope, selects appropriate tools to perform the CNA, and is involved in the assessment and evaluation of results. Local, county, or state cancer-related information may be utilized in obtaining data. Further, the cancer committee may work with outreach and/or marketing departments, as well as community-based organizations outside of the facility to accomplish a robust CNA.

The CNA must define/identify:

- The cancer program's community and local patient population
- Health disparities (numerous factors can contribute to disparities in cancer incidence and death such as race, ethnicity, gender, underserved groups, and socioeconomic status)
- Barriers to care, which may include patient-centered, provider-centered, or health system-centered barriers
- Resources available to overcome barriers on-site or by formal referral
- Gaps in the availability of resources to overcome barriers

The results from the CNA serve as the building blocks for navigation process development, implementation, and evaluation. Data and results of the CNA are presented to the cancer committee and documented in the cancer committee minutes. As part of establishing the appropriate patient navigation to address the results of the CNA, the cancer committee will construct a report including, but not limited to, the following:

- Population(s) to be served identified by the CNA
- Health disparities and barriers identified by the CNA
- Description of the navigation process to overcome barriers
- Documentation of activities and outcomes of the navigation process
- Areas for improvement, enhancement, and future directions

To continually improve upon the quality of patient navigation, a new barrier should be addressed each calendar year. However, programs are allowed to address the same barrier or disparity for more than one year, as long as the cancer committee determines that addressing the barrier is the most important concern and an ongoing need for their community. Documentation should demonstrate the efforts put forth over the year and that there is an ongoing need to continue addressing the barrier in an attempt to make more significant progress to address the barrier.

The completion of the CNA does not fulfill the requirement for Standard 4.7 Studies of Quality. This standard **does not require** the hiring of a patient navigator, but rather focuses on the processes to understand health disparity populations and rectify barriers to care.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR

Each calendar year, the program uploads:

- A copy of the results and findings of the triennial Community Needs Assessment
- Documentation of the monitoring, evaluation, and findings of the patient navigation process including the health disparity populations served and the barrier(s) that are addressed

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. Conduct a Community Needs Assessment at least once during the three-year accreditation cycle to address health care disparities and barriers to cancer care.
2. Establish a navigation process and identify resources to address barriers that are provided either on-site or by referral to community-based or national organizations.
3. Each calendar year, barriers to care are identified and assessed, the navigation process is evaluated and documented, and the findings are reported to the cancer committee.
4. Each calendar year, the patient navigation process is modified or enhanced to address the barrier or additional barriers identified by the Community Needs Assessment.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

STANDARD 3.2

Psychosocial Distress Screening

Each calendar year, the cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.

DEFINITION AND REQUIREMENTS

To address the psychosocial issues experienced by patients with cancer, the 2007 report of the IOM, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, emphasizes the importance of screening patients for distress and psychosocial health needs as a critical first step to providing high-quality cancer care. In addition, this report emphasizes that all patients with distress need to be referred for the appropriate provision of care and that high-quality psychosocial cancer care includes systematic follow-up and reevaluation.

Cancer programs must develop a process to incorporate the screening of distress into the standard care of oncology patients. The process will identify psychological, social, financial, and behavioral issues that may interfere with a patient's treatment plan and adversely affect treatment outcomes, and provide patients identified with distress the appropriate resources and/or referral for psychosocial needs.

PROCESS REQUIREMENTS

(a) Timing of Screening: All cancer patients must be screened for distress a **minimum of one time** at a pivotal medical visit as determined by the program. The cancer committee defines one or more medical visits that are part of a pivotal time for the distress screening process. Examples of a "pivotal medical visit" may include postsurgical visits, first visit with a medical oncologist to discuss chemotherapy, routine visit with a radiation oncologist, or a post chemotherapy follow-up visit. Preference could be given to pivotal medical visits at times of greatest risk for distress, such as at time of diagnosis, transitions during treatment (such as from chemotherapy to radiation therapy), or transitions off treatment.

(b) Method: The mode of administration (patient questionnaire or clinician-administered questionnaire) is to be 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 method process must address the sites of service where screenings occur, including at the CoC-accredited facility and/or with the designated provider (such as offices of physicians) that are part of the program (medical oncologists and/or radiation oncologists). The process developed by the cancer committee must include assessment and treatment, or referral for treatment for the source of distress identified by the screening.

(c) Tools: The cancer committee selects and approves the screening tool to be administered to screen for current distress. Preference should be given to standardized, validated instruments or tools with established clinical cutoffs. The cancer committee determines the cutoff score used to identify distressed patients.

Questionnaires or forms that are distributed or returned by mail and/or phone interviews without discussion at a medical visit do not meet the standard because this method does not allow for immediate attention for severe distress or suicidal ideation, if patient reported, and does not allow for active dialogue with the patient. For those programs utilizing a patient portal or electronic screening method, patients may complete the distress screening tool within 24 hours of the pivotal medical visit; however, screening results must be reviewed and discussed with patients face-to-face at the visit.

(d) Assessment and Referral: The distress screening results must be discussed with the patient at the medical visit. 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, and/or psychologist) must assess the patient to identify the psychological, behavioral, financial and/or social problems initiating the distress. This assessment will confirm the presence of physical, psychological, social, spiritual, and financial support needs and identify the appropriate referrals as needed. The process developed by the cancer committee includes the psychosocial, physician, spiritual, and mental health, resources available to patients on-site or by referral.

(e) Documentation: The screening process, timing of screening, identified tool, and distress level triggering a referral to services are documented in the policies and procedures.

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 on the cancer committee (oncology social worker, clinical psychologist, or other mental health professional trained in the psychosocial aspects of cancer care) is required to oversee this activity and report to the cancer committee annually. 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)

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- The annual psychosocial services summary that documents the methods used to monitor and evaluate the psychosocial distress screening activities
- Cancer committee minutes that document discussion of the process and tools implemented to provide, monitor, and evaluate the psychosocial distress screening.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

1. The cancer committee develops and implements a process to integrate, provide, and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care that includes all of the standard process requirements.
2. All cancer patients must be screened for psychosocial distress a minimum of one time during a pivotal medical visit as determined by the cancer program.
3. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator.

(5) Noncompliance: The program does not fulfill of the compliance criteria each calendar year.

STANDARD 3.3

Survivorship Care Plan

The cancer committee develops and implements a process to disseminate a treatment summary and follow-up plan to patients who have completed cancer treatment. The process is monitored and evaluated annually by the cancer committee.

DEFINITION AND REQUIREMENTS

The Institute of Medicine report *From Cancer Patient to Cancer Survivor* outlines the importance of providing cancer survivors with a comprehensive treatment summary and follow-up plan (i.e. survivorship care plan) that reflects the treatment they received, and addresses post-treatment needs and follow-up care to improve health and quality of life.

The Survivorship Care Plan (SCP) is a record that summarizes and communicates what transpired during active cancer treatment, recommendations for follow-up care and surveillance testing/examinations, referrals for support services the patient may need going forward and other information pertinent to the survivor's short- and long-term survivorship care.

The American Society of Clinical Oncology (ASCO) has defined the minimum data elements to be included in a treatment summary and SCP. This core set of data elements and templates are available on the ASCO website. At a minimum, all SCPs must include ASCO's recommended elements describing treatment summary and a follow-up care plan to meet compliance for this standard. Additional resources to assist with the development of SCPs are available through the National Coalition for Cancer Survivorship, Journey Forward, American Cancer Society, and LIVESTRONG Foundation.

PROCESS REQUIREMENTS

Cancer programs must develop and implement processes to monitor the formation and dissemination of a SCP for analytic cases with Stage I, II, or III cancers that are treated with curative intent for initial cancer occurrence and who have completed active therapy.

Within the SCP processes are policies and procedures identifying the appropriate healthcare provider(s) from patients' oncology care team who will be responsible for approving and discussing the SCP. Providers who are part of the patient's care team that are appropriate under the standard to deliver the SCP include:

- Physicians
- Registered Nurses
- Advanced Practice Nurses
- Nurse Practitioners
- Physician Assistants
- Credentialed clinical navigators (does not include lay navigator)

The printed or electronic survivorship care plan must contain input from the principal physician and oncology care team who coordinated the oncology treatment for the patient, as well as input from the patient's other care providers (outside treatment information), if applicable. If two separate facilities are providing treatment, both facilities collaborate to complete and provide the SCP. In all cases, programs, hospitals, and physician offices should work together to provide the information necessary for completion of a SCP that contains all required elements.

The survivorship care plan is given and discussed with the patient upon completion of active, curative treatment and recorded in the patient medical record. The timing of delivery of the SCP is within one year of the diagnosis of cancer and no later than six months after completion of adjuvant therapy (other than long-term hormonal therapy). The 'one-year from diagnosis' requirement to have a SCP delivered is extended to 18-months for patients receiving long-term hormonal therapy. Providing the SCP by mail, electronically, or through a patient portal without discussion with the patient does not meet the standard.

Patients excluded (ineligible) from Standard 3.3 requirement include:

- Patients with Stage 0 or IV or metastatic disease, though survivors by varying definitions are not required to receive a SCP under Standard 3.3. However, programs may choose to provide SCPs to metastatic patients.
- Patients who are pathologically diagnosed but never treated or seen for follow-up by the accredited program are not required to receive a SCP from the facility providing diagnosis.

Implementation of the standard and required percentage of SCPs provided must follow the schedule as outlined:

- January 1, 2015–December 31, 2015: Implement process to provide SCPs to ≥ 10 percent of eligible patients who have completed treatment.
- End of 2016: Provide SCPs to ≥ 25 percent of eligible patients who have completed treatment.
- End of 2017: Provide SCPs to ≥ 50 percent of eligible patients who have completed treatment.
- End of 2018 and on: Provide SCPs to ≥ 75 percent of eligible patients who have completed treatment.

During the implementation periods, cancer programs may choose to initially concentrate on their most common cancer sites while demonstrating progress on expanding SCP to eligible patients for all disease sites. To calculate the percentage of eligible patients, it is recommended that you begin with your number of analytic cases as the denominator and then subtract ineligible patients.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- Policies and procedures to generate and disseminate a comprehensive treatment summary and survivorship care plan to eligible cancer patients who have completed cancer treatment. The documented processes must include, at a minimum:
 - » Defined patient eligibility
 - » Identify appropriate mechanisms for generating the survivorship care plan
 - » Identify the appropriate individual(s) for delivering the survivorship care plan
 - » The method and timing of delivery of the survivorship care plan
 - » Tracking and reporting the number of SCP's provided to patients
- A sample of a treatment summary and survivorship care plan that is used by the cancer program Cancer committee minutes that document the annual number of eligible patients that were provided a SCP
- Cancer committee minutes that document the annual evaluation of the SCP processes and the outcomes of the evaluation

During the on-site visit, the surveyor will discuss with the cancer committee the process implemented to create and disseminate SCPs for eligible patients.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee develops a process to generate and disseminate a comprehensive treatment summary and survivorship care plan to eligible cancer patients who have completed cancer treatment.
2. The process is monitored, evaluated, and presented to the cancer committee annually, and documented in the minutes.
3. The number of eligible patients who received a survivorship care plan meets the implementation criteria.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.



Chapter 4: Patient Outcomes

STANDARD 4.1

Cancer Prevention Programs

Each calendar year, the cancer committee organizes and offers at least one cancer prevention program designed to reduce the incidence of a specific cancer type and targeted to meet the prevention needs of the community. Each prevention program is consistent with evidence-based national guidelines for cancer prevention.

DEFINITION AND REQUIREMENTS

Cancer prevention requires cancer programs to identify risk factors within their community and patient population, and use strategies to modify attitudes and behaviors to reduce the chance of developing cancer.

Each calendar year, the cancer committee identifies the cancer prevention needs of the community and offers at least one cancer prevention program that is focused on **decreasing the number of diagnoses** of a specific type of cancer. The prevention program must be consistent with evidence-based national guidelines for cancer prevention. Cancer prevention programs are provided on-site or may be coordinated with other facilities and/or local agencies as long as it is under the direction of the cancer committee.

Examples of cancer prevention programs include, but are not limited to:

- Education and cancer risk awareness for a specific cancer type
- Skin cancer prevention (UV rays, tanning bed use)
- Smoking/chewing tobacco cessation
- Smoking prevention in adolescents
- Radon education and testing (related to lung cancer prevention)
- Nutrition, physical activity, and weight loss programs (specifically related to cancer prevention)
- Vaccine/Human papillomavirus (HPV)

Resources for evidence-based national guidelines related to cancer prevention include:

- Agency for Healthcare Research and Quality
- American Cancer Society
- Cancer Control P.L.A.N.E.T.
- Centers for Disease Control and Prevention
- National Cancer Institute
- The Community Guide

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP and PCP facilities.

VACP facilities adhere to the U.S. Preventive Services Task Force recommendations for prevention programs provided by the VACP facilities. Prevention programs focus on veteran-related issues such as smoking and alcohol cessation. Prevention services are offered at the VACP to more effectively reach the veteran population through ongoing programs or clinics.

PCP facilities are only required to do at least one prevention program once over the three-year accreditation cycle. Prevention programs must focus on pediatric or adolescent-related cancer prevention issues, such as sun exposure, smoking, and alcohol cessation.

EXCEPTIONS BY CATEGORY

NCIP facilities are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes documenting the planning and provision of at least one annual cancer prevention program organized by the cancer committee. The documentation includes references to the national guidelines used.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee assesses the cancer prevention needs of their community and patient population.
2. The cancer committee organizes and offers at least one cancer prevention program.
3. The cancer prevention program is consistent with evidence-based national guidelines and evidence-based interventions.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria.

(8) Not Applicable: NCIP facilities.

STANDARD 4.2

Screening Programs

Each calendar year, the cancer committee organizes and offers at least one cancer screening program that is designed to decrease the number of patients with late-stage disease and is targeted to meet the screening needs of the community. Each screening program is consistent with evidence-based national guidelines and interventions and must have a formal process developed to follow up on all positive findings.

DEFINITION AND REQUIREMENTS

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

Each calendar year, the cancer committee organizes and offers at least one cancer screening program that is focused on an identified **cancer screening need** within the community and designed to **decrease** the number of patients with **late-stage disease**. The screening activities must be consistent with evidence-based national guidelines and interventions for cancer screening.

The cancer committee and designated community outreach coordinator will have a mechanism in place to ensure that all positive findings identified as a result of these cancer screening programs are addressed with participants. Cancer screening programs are provided on-site or may be coordinated with other facilities and/or local agencies as long as it is under the direction of the cancer committee.

Examples of cancer screening programs include, but are not limited to:

- Breast (radiographic and physical examination)
- Colon (colonoscopy, flexible sigmoidoscopy, or fecal occult blood testing)
- Cervical (Papanicolaou testing with or without human papillomavirus [HPV DNA] testing)
- Skin (physician-directed total-body skin exams)
- Lung (low-dose computed tomography)

Resources for evidence-based national guidelines and evidence-based interventions include:

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP, PCP, and VACP facilities.

PCP facilities are only required to do at least one screening program once over the three-year accreditation cycle.

EXCEPTIONS BY CATEGORY

NCIP and VACP facilities are exempt from the standard.

All VACP facilities must follow the U.S. Preventive Services Task Force recommendations for screening to more effectively reach the veteran population and are exempt from the standard due to the mandated screening services offered at the VACP.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes documenting the planning and provision of at least one annual cancer screening program organized and offered by the cancer committee. The documentation includes references to the national guidelines and interventions used and the process in place to follow up on positive findings.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. The cancer committee identifies the cancer screening needs of their community and patient population.
2. The cancer committee organizes and offers at least one cancer screening program.
3. The cancer screening program is consistent with evidence-based national guidelines and evidence-based interventions.
4. Each screening program has a process developed to follow up on all positive findings of participants.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: NCIP and VACP facilities.

STANDARD 4.3

Cancer Liaison Physician Responsibilities

A Cancer Liaison Physician (CLP) serves in a leadership role within the cancer program and is responsible for evaluating, interpreting, and reporting the cancer program's performance using National Cancer Data Base data. The CLP, or an equivalent designee, reports the results of this analysis to the cancer committee at least four times each calendar year.

DEFINITION AND REQUIREMENTS

A CLP is a physician responsible for providing leadership and direction to monitor and improve quality within the cancer program.

CLP Selection Criteria

The CLP position is a required role in CoC-accredited cancer programs. The CLP serves a three-year term with eligibility to serve an unlimited number of terms based on performance as assessed by the CoC and the cancer committee.

The CLP is a physician and active member of the medical staff. The cancer committee must ensure that the physician is authorized to access facility-specific information that is maintained in *CoC Datalinks*. The CLP may also fulfill a leadership position on the cancer committee such as chair, vice-chair, or quality improvement coordinator.

CLP Educational Requirements

The CLP is required to complete CLP orientation within three months of initial appointment and on reappointment every three years. The CLP will view all Web-based CLP education programs provided by the CoC each year. These programs are specific to continuously informing and enhancing the role of the CLP. All CLP education is located in the Cancer Liaison Program section of the CoC website.

Primary CLP Responsibilities

The primary responsibility of the CLP is to monitor, interpret, and provide updated reports of the program's performance using NCDB data to evaluate and improve the quality of care. At least four times each calendar year, the CLP reports and discusses the facility's performance and response related to the accountability and quality improvement measures in the Cancer Program Practice Profile Reports, and on data from additional NCDB reporting tools such as the Cancer Quality Improvement Program, the Rapid Quality Reporting System, Hospital Comparison Benchmark Reports, or Survival Reports. A quality-related audit is initiated for any of the accountability and quality improvement measures that fall below required levels of compliance.

Discussions related to facility performance are documented in the cancer committee minutes and subsequently shared with the medical staff and administration. CLP reports **do not** fulfill the requirements for Standards 4.6 or 4.7.

Secondary Responsibilities

- The CLP reports on CoC activities, initiatives, and priorities to the cancer committee.
- The CLP serves as liaison between the cancer program, the CoC, and the American Cancer Society.
- The CLP attends the CoC accreditation on-site survey and meets with the surveyor to discuss the NCDB Quality Reporting Tools and CLP responsibilities.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written except for programs in all categories undergoing initial survey for accreditation.

EXCEPTIONS BY CATEGORY

Programs in all categories undergoing initial survey for accreditation are exempt from this standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the CLP completes the CLP Activity Report and uploads a copy of each CLP report presented to the cancer committee into the SAR.

Each calendar year, the program uploads cancer committee minutes that document at least four CLP reports on NCDB data, including actions and response.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The CLP generates reports that evaluate and interpret the cancer program's performance using NCDB data.
2. The CLP, or an equivalent designee, reports this information to the cancer committee at least four times each calendar year.
3. The CLP is present during the CoC accreditation survey and meets with the surveyor to discuss CLP activities and responsibilities.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: Programs undergoing initial survey for accreditation.

STANDARD 4.4

Accountability Measures

Each calendar year, the expected Estimated Performance Rates (EPR) is met for each accountability measure as defined by the Commission on Cancer.

DEFINITION AND REQUIREMENTS

The cancer committee is a multidisciplinary forum that provides a platform to evaluate care within and across disciplines to discuss processes that work and to evaluate how processes can be improved to promote evidence-based practice. The CoC requires accredited cancer programs to treat cancer patients according to nationally accepted accountability measures indicated by the CoC quality reporting tool, Cancer Program Practice Profile Reports (CP³R).

Accountability measures promote improvements in care delivery and are the highest standard for measurement. These measures demonstrate provider accountability, influence payment for services, and promote transparency. An accountability measure is the standard of care derived from evidence-based data, including multiple randomized control trials.

If a cancer program is not meeting the EPR of a measure(s), then a corrective action plan is required to 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, as needed, with intent of resolving the deficiency and improving compliance.

The cancer committee addresses EPRs and monitoring activity is documented in the cancer committee minutes. The corrective action taken and any required follow-up needed to meet EPRs are included in the documentation.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written except for programs in all categories undergoing initial survey for accreditation and PCP facilities.

Expected EPRs for facilities that are part of an Integrated Network Cancer Program (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 set by the CoC.

EXCEPTIONS BY CATEGORY

Programs in all categories undergoing initial survey for accreditation and PCP facilities are exempt from this standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes that demonstrate the monitoring of the quality of patient care by the cancer committee using the CP³R accountability measures and, if necessary, the action plan that was developed and executed if the program's performance rates were observed to be below the expected EPRs established by the CoC.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee monitors the program's expected Estimated Performance Rates for all accountability measures using the CP³R.
2. The monitoring activity is reported in cancer committee minutes.
3. For each accountability measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the expected Estimated Performance Rates specified by the CoC each year since the program's last survey, or the program has implemented an action plan that reviews and addresses program performance below the expected Estimated Performance Rates.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: Cancer programs in all categories undergoing initial survey for accreditation, PCP facilities, and programs with no cases eligible for assessment in all of the selected measure(s).

STANDARD 4.5

Quality Improvement Measures

Each calendar year, the expected Estimated Performance Rates (EPR) is met for each quality improvement measure as defined by the Commission on Cancer.

DEFINITION AND REQUIREMENTS

The CoC requires accredited cancer programs to treat cancer patients according to nationally accepted quality improvement measures indicated by the CoC quality reporting tool, Cancer Program Practice Profile Reports (CP³R). The function of a quality improvement measure is to monitor the need for quality improvement or remediation of treatment provided. Evidence from experimental studies, not randomized control trials, supports these measures. Quality improvement measures are intended for internal monitoring of performance within a cancer program.

If a cancer program is not meeting the EPR of a measure(s), then a corrective action plan is required to 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, as needed, with intent of resolving the deficiency and improving compliance.

The cancer committee addresses EPRs and monitoring activity is documented in the cancer committee minutes. The corrective action taken and any required follow-up needed to meet EPRs are included in the documentation.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written except for programs in all categories undergoing initial survey for accreditation and PCP facilities.

Expected EPRs for facilities that are part of an Integrated Network Cancer Program (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 set by the CoC.

EXCEPTIONS BY CATEGORY

Programs in all categories undergoing initial survey for accreditation and PCP facilities are exempt from this standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads cancer committee minutes that demonstrate the monitoring of the quality of patient care by the cancer committee using the CP³R quality improvement measures and, if necessary, the action plan that was developed and executed if the program's performance rates were observed to be below the expected EPRs established by the CoC.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee monitors the program's expected Estimated Performance Rates for all quality measures using the CP³R.
2. The monitoring activity is reported in cancer committee minutes.
3. For each quality measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the expected Estimated Performance Rates specified by the CoC each year since the program's last survey, or the program has implemented an action plan that reviews and addresses program performance below the expected Estimated Performance Rates.

(5) Noncompliance: The program does not fulfill one or more of compliance criteria each calendar year.

(8) Not Applicable: Cancer programs in all categories undergoing initial survey for accreditation, PCP facilities, and programs with no cases eligible for assessment in all of the selected measure(s).

STANDARD 4.6

Monitoring Compliance with Evidence-Based Guidelines

Each calendar year, the cancer committee designates a physician member to complete an in-depth analysis to assess and verify that cancer program patients are evaluated and treated according to evidence-based national treatment guidelines. Results are presented to the cancer committee and documented in cancer committee minutes.

DEFINITION AND REQUIREMENTS

The role of this standard is to ensure that evaluation and treatment conforms to evidence-based national treatment guidelines using AJCC stage or other appropriate staging, including appropriate prognostic indicators.

Each calendar year, a **physician member** of the cancer committee performs an in-depth review to examine the evaluation and treatment of patients and ensure that it is compliant with evidence-based national guidelines and is appropriate for AJCC stage or other appropriate staging system, including prognostic indicators. The analysis must aim to determine if the diagnostic evaluation is adequate and the treatment plan is concordant with a recognized guideline. Any problems identified with the diagnostic evaluation or treatment planning process may serve as a source for performance improvement.

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

1. Sources for the assessment must include one of the following:
 - a. A cancer site-specific sample:
 - » Involving all cases from that cancer site, to a maximum of 300 cases; or
 - » Based on an identified need, concern, or problem with a specific cancer site; or
 - » Based on uncommon cancer cases (i.e. cases not generally presented at cancer conferences)
 - b. Review of a single treatment regimen for a specific cancer site.
 - » Involving all cases who received that treatment regimen, to a maximum of 300 cases; or
 - » Based on an identified need, concern, or problem with a specific treatment regimen
2. A determination that the first course of therapy is concordant with evidence based national treatment guidelines and/or prognostic indicators.
3. A reporting format that permits analysis and provides an opportunity to recommend performance improvements based on data from the analysis.

The formal report with the analysis results is presented to the cancer committee and documented in the cancer committee minutes. The completion of this analysis and treatment discussions of patients at cancer conferences **do not** fulfill the requirement for Standard 4.7.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP facilities.

EXCEPTIONS BY CATEGORY

NCIP and PCP facilities are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- Completed documentation of the in-depth analysis, including the methodology, summaries, analyses, recommendations, and follow-up
- Cancer committee minutes in which the results of the analysis were reported.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. A physician member of the cancer committee is selected to conduct an in-depth analysis to ensure that evaluation and treatment provided to patients is compliant with evidence-based national treatment guidelines and is appropriate for AJCC stage or other appropriate staging system, including prognostic indicators.
2. The analysis results are reported to the cancer committee.
3. The analysis results are documented in cancer committee minutes.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year

(8) Not Applicable: NCIP and PCP facilities.

STANDARD 4.7

Studies of Quality

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, develops, analyzes, and documents the required number of studies (based on the program category) that measure the quality of care and outcomes for cancer patients.

DEFINITION AND REQUIREMENTS

The annual evaluation of the care of cancer patients provides a baseline to measure quality and an opportunity to correct or enhance care and quality outcomes. Quality improvement efforts focus on evaluating areas of cancer care and must include multidisciplinary representation from clinical, administrative, and patient perspectives.

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, develops, analyzes, and documents the required number of studies (based on the program category) that measure the quality of care and outcomes for cancer patients.

Study topics must be selected based on a **problematic quality-related** issue relevant to the cancer program and local cancer patient population, and used as a means to identify a potential issue or understand why a problem is occurring. Quality studies can evaluate various spectrums of cancer care, including diagnosis, treatment, and supportive care of patients; within that spectrum can be issues related to structure, process, and outcomes.

Each quality study is required to have the following components, at a minimum:

- Must indicate the study topic that identifies a problematic quality-related issue within the cancer program
- Define study methodology and the criteria for evaluation, including data needed to evaluate the study topic or answer the quality-related question
- Conduct the study according to the identified measures and methodology
- Prepare a summary of the study findings
- **Compare data results with national benchmarks or guidelines**
- Design a corrective action plan based on evaluation of the data
- Establish follow-up steps to monitor the actions implemented

The methods used to monitor the quality studies and action plans are set by the Quality Improvement Coordinator and the cancer committee. Completion of a study of quality must provide data results that serve as the first step in the quality improvement process. The second step focuses on the implementation of a correction or performance improvement that comes as a result from a quality study. The findings of the studies are documented in the minutes and shared with the medical staff and administration.

Note the following standard specifications:

- Quality studies that duplicate topics or studies from year-to-year do not fulfill this standard.
- Ongoing monitoring activities following a completed quality study does not fulfill this standard.
- Survival studies and the in-depth analysis used in Standard 4.6 do not fulfill this standard.
- A study that is required by an outside, recognized organization related to oncology is acceptable if it follows the required study criteria outlined in this standard.
- Review of data presented in the NCDB data reports or tools (including measure compliance) do not fulfill the requirement for this standard.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- Completed documentation for the required number of quality studies, including the methodology, summaries, analyses, recommendations, and follow-up
- Cancer committee minutes in which the results of the studies were reported.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. Based on category, the Quality Improvement Coordinator, under the direction of the cancer committee, develops and conducts the required number of quality studies.
2. The results of the required number of quality studies are analyzed.
3. The results of the required number of quality studies are reviewed by the cancer committee and documented in the meeting minutes.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

Cancer Program Category	Required Number of Quality Studies Each Calendar Year
INCP	3
NCIP	3 (peer-reviewed, published manuscripts on quality studies are acceptable if authored by cancer program staff)
ACAD	2
VACP	1 study of the quality of cancer care and outcomes; 1 program-defined study or study of quality defined at the VISN or regional level
CCCP	2
CCP	2
HACP	2
PCP	2 studies per three-year accreditation cycle
FCCP	2

STANDARD 4.8

Quality Improvements

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, implements two cancer care improvements. One improvement is based on the results of a quality study completed by the cancer program that measures the quality of cancer care and outcomes. One improvement can be based on a completed study from another source. Quality improvements are documented in the cancer committee minutes and shared with medical staff and administration.

DEFINITION AND REQUIREMENTS

Quality or performance improvements are the actions taken, processes implemented, or services created to improve cancer care. Implementation of improvements demonstrates a program's continuous commitment to providing high-quality patient care. The results of a cancer-related quality study provide a baseline to measure and improve quality.

Each calendar year, at least two quality improvements affecting cancer patient care are implemented centrally, departmentally, through disease site teams, or through other program-appropriate methods as directed by the cancer committee. One quality improvement is implemented as a result of data collected from a quality study conducted by the cancer committee. The second improvement can be based on any study or relevant data source.

Sources for quality improvements may include:

- Actions based on analysis and findings of a quality study under Standard 4.7
- Actions to address substandard patient care or process performance
- Changes to improve upon acceptable patient care or process performance

The Quality Improvement Coordinator monitors, reports, and recommends activity related to the quality improvement program; reports regularly to the cancer committee; and recommends corrective action if any area falls below acceptable norms or when undesirable performance is identified. The recommendations and improvements are reported to the cancer committee. The reports are documented in the minutes and shared with the medical staff and administration.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- Completed documentation for the implementation of the quality improvements
- Cancer committee minutes in which the results of the improvements were reported

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. The cancer committee, under the guidance of the Quality Improvement Coordinator, implements one cancer care improvement based on the results of a completed quality study.
2. The cancer committee, under the guidance of the Quality Improvement Coordinator implements one cancer care improvement based on any study or data source.
3. The quality improvements are reviewed by the cancer committee and documented in the minutes.
4. The quality improvements are shared with medical staff and administration.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.



Chapter 5: Data Quality

STANDARD 5.1

Cancer Registrar Credentials

Case abstracting is performed by a Certified Tumor Registrar.

DEFINITION AND REQUIREMENTS

High-quality cancer registry data is essential to accurately assessing treatment outcomes and patient survival. Successful operation of the cancer registry requires trained, credentialed staff who are knowledgeable in all aspects of oncology data collection and case abstracting.

Certified Tumor Registrars (CTR) 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 CoC-accredited program that meets CoC reporting requirements. The CTR credential is granted through the National Cancer Registrars Association, which provides details on eligibility, testing, and re-credentialing.

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

- Hold a current Certified Tumor Registrar (CTR) credential. This requirement applies to staff who are employed by the program and to staff who work on a contract basis or through a registry service company; OR
- Perform case abstracting at a CoC-accredited program under the supervision of a CTR. A plan for CTR supervision of non-credentialed staff 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. If the person does not successfully obtain the CTR credential within the three-year grace period, then he or she may not perform case abstracting at *any* CoC-accredited program until the credential is obtained.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program uploads:

- CTR credentials for all certified staff
- Verification of the date of hire to perform case abstracting in the cancer registry
- The plan for CTR supervision of non-credentialed staff who perform case abstracting in the cancer registry

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills one or both of the compliance criteria:

1. Case abstracting is performed by a Certified Tumor Registrar.
2. Non-credentialed staff that abstract cases and who are in the three-year grace period are supervised by a Certified Tumor Registrar.

(5) Noncompliance: The program does not fulfill one of the compliance criteria.

STANDARD 5.2

Rapid Quality Reporting System (RQRS) Participation

From initial enrollment and throughout the accreditation period, the cancer program actively participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to the RQRS terms and conditions.

DEFINITION AND REQUIREMENTS

Promoting evidence-based cancer care is of key importance to improving the quality of care and patient outcomes. Therefore, the 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.

For compliance, programs must actively participate in RQRS submissions and adhere to the RQRS requirements from initial enrollment (or from beginning of the accreditation period) up until survey. The full details for RQRS participation are provided in the RQRS terms and conditions available on the National Cancer Data Base (NCDB) website (facs.org/quality-programs/cancer/ncdb/qualitytools/rqrs).

RQRS data and performance must be reported to the cancer committee semi-annually. The Cancer Liaison Physicians may report RQRS data and performance in partial fulfillment of the requirement for Standard 4.3.

SPECIFICATIONS BY CATEGORY

All programs that are eligible for RQRS participation fulfill the standard as written.

EXCEPTIONS BY CATEGORY

Programs undergoing initial survey for accreditation and pediatric programs are exempt from the standard.

DOCUMENTATION

The program completes all required standard fields in the SAR.

Each calendar year, the program completes submission of cases as outlined in the RQRS requirements

RATING COMPLIANCE

Rating

(1+) Commendation: Each calendar year, the program fulfills all of the commendation criteria:

1. Submits all new and updated cancer cases at least once each calendar month.
2. RQRS cancer cases are submitted within three months of date of first contact.
3. All cancer cases submitted to RQRS with edit errors are corrected and resubmitted.
4. RQRS data and performance reports are reviewed by cancer committee at least quarterly and documented in the cancer committee minutes.

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. Submits all new and updated cancer cases at least once each calendar quarter.
2. RQRS data and performance reports are reviewed by cancer committee at least semi-annually and documented in the cancer committee minutes.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: PCP facilities and programs undergoing initial survey for accreditation.

STANDARD 5.3

Follow-Up of All Patients

For all eligible analytic cases, an 80 percent follow-up rate is maintained from the cancer registry reference date.

DEFINITION AND REQUIREMENTS

Long-term follow-up is essential to evaluate outcomes of cancer care. Accurate follow-up data enable 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.

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
- Patients diagnosed on or after January 1, 2006, and classified as Class of Case 00

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 follow-up information and assistance to the referring cancer programs of treatment or follow-up care.

EXCEPTIONS BY CATEGORY

All programs fulfill the standard as written except programs undergoing initial survey for accreditation, which are exempt from this standard.

SPECIFICATIONS BY CATEGORY

In a PCP facility, for all eligible analytic cases, a 60 percent follow-up rate is maintained from the cancer registry reference date.

DOCUMENTATION

The program completes all required standard fields in the SAR.

During the on-site visit, the surveyor reviews the current follow-up report.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

Excluding patients with age-specific exclusions, an 80 percent follow-up rate is maintained for all eligible analytic cases from the cancer registry reference date.

For PCP facilities, a 60 percent follow-up rate is maintained for all eligible analytic cases from the cancer registry reference date.

(5) Noncompliance: The program does not fulfill the compliance criteria each calendar year.

(8) Not Applicable: Programs undergoing initial survey for accreditation.

STANDARD 5.4

Follow-Up of Recent Patients

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.

EXCEPTIONS BY CATEGORY

All programs fulfill the standard as written except programs undergoing initial survey for accreditation, which are exempt from this standard.

SPECIFICATIONS BY CATEGORY

In a PCP, 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.

DOCUMENTATION

The program completes all required standard fields in the SAR.

During the on-site visit, the surveyor reviews the current follow-up report.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

Excluding patients with age-specific exclusions, 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.

(5) Noncompliance: The program does not fulfill the compliance criteria each calendar year.

(8) Not Applicable: Programs undergoing initial survey for accreditation.

STANDARD 5.5

Data Submission

Each year, complete data for all requested analytic cases are submitted to the National Cancer Data Base (NCDB) in accordance with the annual Call for Data.

DEFINITION AND REQUIREMENTS

Data submitted to the 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.

Data submission to the NCDB must be performed by using the CoC's secure online data submission application in accordance with the annual Call for Data specifications.

After the initial survey 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 your Reference Date. Data are submitted, and errors and rejected records are corrected (Standard 5.6).

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written except for programs in all categories undergoing initial survey for accreditation.

EXCEPTIONS BY CATEGORY

Programs in all categories undergoing initial survey for accreditation are exempt from this standard. A new program's initial data submission to the NCDB will occur during the first Call for Data after the new program is accredited.

DOCUMENTATION

The program submits data as required for compliance by NCDB.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

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

(5) Noncompliance: The program does not fulfill the compliance criteria each calendar year.

(8) Not Applicable: Programs undergoing initial survey for accreditation.

STANDARD 5.6

Accuracy of Data

Annually, cases submitted to the National Cancer Data Base (NCDB) that were diagnosed on January 1, 2003, or later meet the established quality criteria and resubmission deadline specified in the annual Call for Data.

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 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.

Problematic cases diagnosed on January 1, 2003, or later are corrected and resubmitted by the deadline specified in the Call for Data. The cancer committee monitors the resolution and resubmission of problematic cases (Standard 1.6).

Annually, the cases diagnosed on January 1, 2003, or later satisfy the established quality criteria by the deadline date specified in each Call for Data. New programs correct and resubmit cases before scheduling the initial survey.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written except for programs in all categories undergoing initial survey for accreditation.

EXCEPTIONS BY CATEGORY

Programs in all categories undergoing initial survey for accreditation are exempt from this standard. A new program's initial data submission to the NCDB will occur during the first Call for Data after the new program is accredited.

DOCUMENTATION

The program submits data as required for compliance by NCDB.

RATING COMPLIANCE

(1+) Commendation: Each calendar year, the program fulfills all of the commendation criteria:

The cases diagnosed on January 1, 2003, or later meet the quality criteria for the annual Call for Data on initial submission.

(1) Compliance: Each calendar year, the program fulfills all of the compliance criteria:

1. Identified errors in submitted cases and rejected records are corrected by the due date specified in the Call for Data.
2. Corrected cases are resubmitted to the NCDB by the due date specified in the Call for Data.

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year:

(8) Not Applicable: Programs undergoing initial survey for accreditation.

STANDARD 5.7

Commission on Cancer Special Studies

The cancer program participates in special studies as selected by the Commission on Cancer.

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 CoC will periodically design and conduct special studies. Based on study criteria, selected accredited programs will be required 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.

Based on study criteria, the CoC will determine if CoC-designed special studies will meet the requirements for this Standard. This information will be documented in CoC communications and provided to programs that are selected to participate.

SPECIFICATIONS BY CATEGORY

Upon request, all cancer programs fulfill the standard as written.

EXCEPTIONS BY CATEGORY

All programs fulfill the standard as written except for programs in all categories undergoing initial survey for accreditation.

DOCUMENTATION

The program completes all required standard fields in the SAR.

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

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

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

(5) Noncompliance: The program does not fulfill one or more of the compliance criteria each calendar year.

(8) Not Applicable: Programs in all categories undergoing initial survey for accreditation or if the program was not selected to participate in a special study.

Glossary of Terms

Accountability Measure: Evidence-based measures or accountability measures promote improvements in care delivery and are the highest standard for measurement. These measures demonstrate provider accountability, influence payment for services, and promote transparency. An accountability measure is the standard of care derived from evidence-based data, including multiple randomized control trials. The CoC requires accredited cancer programs to treat cancer patients according to nationally accepted accountability measures indicated by the Cancer Program Practice Profile Reports (CP³R).

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.

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

Benchmark: Point of reference by which quality study results can be measured as established by a nationally recognized health care organization.

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

Clinical trial: A prospective, biomedical, or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (drugs, biologics, treatments, devices, or new ways of using known drugs, biologics, treatments, or devices).

Community Needs Assessment: A Community Needs Assessment (under Standard 3.1) is a systematic process to define and identify health disparity populations in the community and to determine and address gaps in care or health care system barriers.

CoC Datalinks: A password-protected, Web-based portal that houses the SAR, PAR, Staff Contacts, NCDB Tools, and additional accreditation information.

CoC Quality Reporting Tools: Includes NCDB data tools and reports such as Cancer Program Practice Profile Reports (CP³R), the Rapid Quality Reporting System (RQRS), Hospital Benchmark Reports, and Survival Reports.

Psychosocial Distress: Distress extends along a continuum, ranging from common normal feelings of vulnerability and sadness to problems that can be disabling, such as depression, anxiety, panic, social isolation and spiritual crisis. There are a number of sources of distress that can all have negative effects from unmet psychosocial needs including poor coping skills, inadequate control of co-morbidities and financial concerns.

Effectiveness: In the context of monitoring effectiveness of community outreach activities, effectiveness for a screening activity might be the rate of diagnosis made in the group screened, or perhaps it is an increase in screening participation because of a new tool or new communication strategy. Effectiveness in a prevention activity could include the number of participants who stopped smoking or who began to change their lifestyle.

Facility Oncology Registry Data Standards (FORDS): FORDS is a manual that contains all of the data items with rules and coding options for cancer registrars to collect data in their hospital registries. These data are then submitted to the National Cancer Data Base (NCDB). The data available in the NCDB come from FORDS, Collaborative Stage, and the American Joint Committee on Cancer's AJCC Cancer Staging Manual (facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals)

Informed Consent: A process in which a person is given important facts about a medical procedure or treatment, a clinical trial, or genetic testing before deciding whether to participate. It also includes informing the patient when there is new information that may affect his or her decision to continue. Informed consent includes information about the possible risks, benefits, and limits of the procedure, treatment, trial, or genetic testing.

Integrated Network Cancer Program (INCP): INCP category is defined as “an organization that owns, operates, leases, or is part of a joint venture with multiple facilities providing integrated cancer care and comprehensive services.” At least one facility in the category is a hospital, and all facilities that are part of the INCP are CoC-accredited cancer programs. INCPs are characterized by a unified cancer committee, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners.

Monitor: Closely and consistently observe and evaluate a function or process.

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

Quality Improvement Measure: The function of a quality improvement measure is to monitor the need for quality improvement or remediation of treatment provided. Evidence from experimental studies, not randomized control trials supports these measures. Quality improvement measures are intended for internal monitoring of performance within a cancer program. CoC requires accredited cancer programs to treat cancer patients according to nationally accepted quality improvement measures indicated by the CP³R.

Patient population: Patients or potential patients being served in the community by the cancer program.

Phase-In Period: When a standard is defined as “Phase-In”, this definition means that beginning January 1 of the year that the phase-in of the standards goes into effect; programs must be in compliance with the standard criteria. Cancer program will be rated on the standard compliance criteria that were in place for the activity years prior to the initial of the phase-in date. For example, for Standard 2.1, all programs must meet the new compliance criteria beginning January 1, 2017. At the time of survey, activity years prior to 2017 will be rated at survey based on the previous manual version (V1.2.1).

Program Activity Record (PAR): The PAR is an online reporting tool located in *CoC Datalinks* that is open for editing throughout the three-year accreditation period during the non-survey years for use as a record-keeping tool to document program activity. The SAR and PAR are essentially the same forms, but the SAR is only used during the year of survey, and the PAR is used for non-survey years.

Prospective cases: Include, but are not limited to, the following:

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

Note that cases may be discussed more than once and counted as a prospective presentation if management issues are discussed.

Quarterly: Occurring at three-month intervals during a calendar year.

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

Surveillance Measure: Surveillance measures are used to identify the status quo, generate information for decision-making, and/or to monitor patterns and trends of care.

Survey Application Record (SAR): The SAR is an online reporting tool located in *CoC Datalinks* that is open for editing and utilized during the year **due** for accreditation survey to demonstrate compliance of CoC Eligibility Requirements and Standards.

References and Citations

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CoC Mission

The Commission on Cancer is a consortium of professional organizations dedicated to improving survival and quality of life of cancer patients through standards setting, prevention, research, education, and the monitoring of comprehensive quality care.



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*Inspiring Quality:
Highest Standards, Better Outcomes*

100+years