COMMISSION ON CANCER®

Cancer Program Standards 2012: Ensuring Patient-Centered Care

V1.2.1

American College of Surgeons

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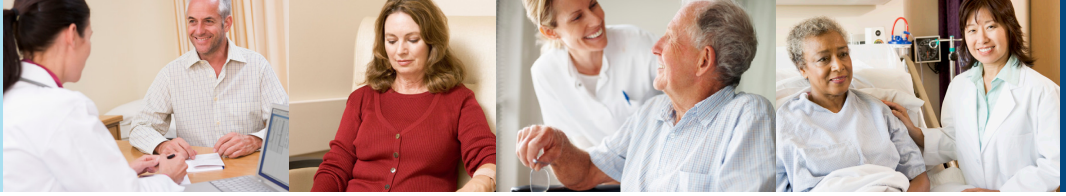

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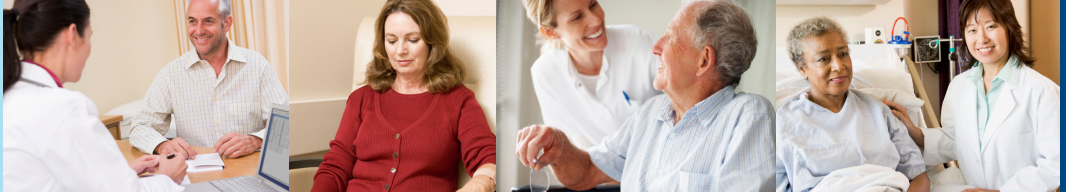

Dedication

The Commission on Cancer dedicates the new cancer program standards to those individuals who trust their care to providers at CoC-accredited facilities. We dedicate these standards to all those treated in the past, to those under treatment now, and to those who will grant us the great privilege of treating them in the years to come.

Volunteers and CoC staff worked together to develop these standards with the solitary goal of ensuring that patients with cancer will receive the highest quality care close to home.

Acknowledgment of Contributors

The Commission on Cancer acknowledges the many contributions of the following people who made the Cancer Program Standards (CPS) Project a success.

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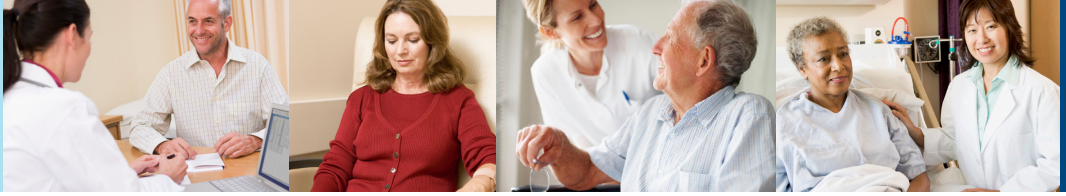
In addition, the CoC is grateful for the contributions of the representatives of the CoC member organizations who worked to improve the existing standards and to create new patient-centered standards. We would never have succeeded without you.

The CoC also thanks the members of the Cancer Program Standards Workgroups and Steering Committee for their tireless efforts on behalf of patients with cancer.

Finally, the CoC acknowledges the many cancer program constituents from CoC-accredited programs across the country who provided comments and suggestions for the standards.

Foreword



Foreword

Commission on Cancer Mission

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

Commission on Cancer Background

The history of the Commission on Cancer and standards for cancer care begins with the American College of Surgeons (ACS). From its creation in 1913, the ACoS has focused on improving the care of the surgical patient through the advancement of surgical skills and physician education. Because surgical intervention was the only available treatment for cancer at that time, it is logical that the ACoS also took the lead to improve cancer care by establishing the Committee on the Treatment of Malignant Diseases (Committee) in 1922. Over time, the Committee has transformed from its original 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 had been developed and released, and an Approvals Program (Accreditation Program) had been established that evaluated a cancer clinic's performance against the standards. By 1933, 140 clinics had gained accreditation. Since accreditation of this initial group, the number of Accredited Programs has slowly and steadily increased to encompass more than 1,500 hospitals, freestanding cancer centers, and cancer program networks nationwide. CoC-accredited programs represent 30% of the general medical-surgical hospitals in the United States and Puerto Rico and provide care to close to 70% of patients who are newly diagnosed with cancer each year.

Commission on Cancer in Today's Health Care Environment

The multidisciplinary Commission on Cancer:

- Establishes standards to ensure quality, multidisciplinary, and comprehensive cancer care delivery in health care settings.
- Conducts surveys to assess compliance with those standards.
- Collects standardized, high-quality data from CoC-accredited health care settings.
- Uses data to measure cancer care quality and to monitor treatment patterns and outcomes.
- Supports and enhances cancer control.
- Monitors clinical surveillance activities.
- Develops effective educational interventions to improve cancer prevention, early detection, care delivery, and outcomes in health care settings.

CoC membership is comprised of 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 Cancer Programs page of the American College of Surgeons website (*www.facs.org/cancer*). Each member serves on 1 or more committees that work to reach the CoC's goals by:

- Establishing standards for cancer programs and evaluating and accrediting 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. Each of these efforts supports the assessment of patterns of care and outcomes of patient management, which leads to improvements 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.
- 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 non-physician members representing professional organizations involved in cancer care, standard-setting organizations, government agencies, and physicians who represent the American College of Surgeons Fellowship.

The CoC 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. The subcommittees are:

- **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:** Recruits, trains, and oversees the CoC-trained independent consultant team members who evaluate program performance between surveys; identifies and directly recruits new programs to the CoC Accreditation Program; monitors program withdrawals; and intercedes when appropriate.

The CoC Accreditation Program

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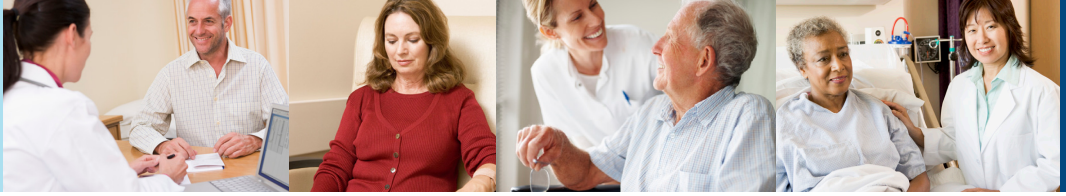


The CoC Accreditation Program

The Accreditation Program encourages hospitals, treatment centers, and other facilities to improve their quality of patient care through various cancer-related programs. These programs are concerned with the full continuum of cancer from prevention through hospice and end-of-life care or survivorship and quality of life.

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

- Quality care close to home.
- 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.
- Ongoing monitoring and improvement of care.
- 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 only to the facilities that have voluntarily committed to provide the best in cancer diagnosis and treatment and are able to comply with established CoC standards. Each cancer program must undergo a rigorous evaluation and review of its performance and compliance with the CoC standards. To maintain accreditation, facilities with accredited cancer programs must undergo an on-site review every 3 years.

The structure outlined in *Cancer Program Standards 2012: 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.

There are currently more than 1,500 CoC-accredited cancer programs in the United States and Puerto Rico, representing 30% of all hospitals that provide care to more than 70% of newly diagnosed cancer patients annually. These programs are supported by a network of more than 1,600 volunteer physician representatives (cancer liaison physicians) appointed by the cancer program leadership to serve as physician champions and to maintain cancer program accreditation or establish a new program, and to work with the local American Cancer Society on cancer-control activities that support the community.

Cancer Program Accreditation: A Central Component of Quality Cancer Care

Cancer care over the last 50 years has evolved from its primary focus on 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 afflicted with cancer as well as the impact of treatment on quality of life has improved dramatically. The application of current screening, improved local therapy, and systemic treatments has led to dramatic reductions in cancer mortality. Further contributing to this improvement in care has been the explosion in scientific research that has led to personalized understanding of prognosis and the availability of targeted treatments.

Unfortunately, there remains substantial evidence that many people with cancer do not receive the benefits of high quality care that are now possible. Variation in the quality of care affects many outcomes ranging from quality of life and organ function preservation to cancer recurrence and survival. This was specifically brought to light by the Institute of Medicine with its report in 1999 entitled, "Ensuring Quality Cancer Care." The Institute of Medicine (IOM) made a number of key recommendations to assure that all Americans receive high quality care. These include:

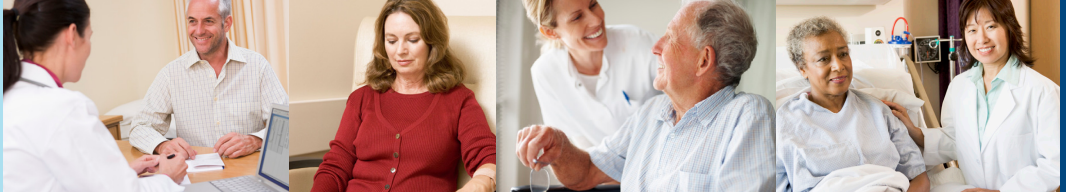
- Maintaining a system to measure and monitor the quality of care using a core set of quality measures; and to provide quality benchmarks for use by health systems
- Ensure that key elements of quality care are provided for every person with cancer
  - Treatment by experienced professionals
  - Patients are provided an agreed-upon care plan
  - Access to the full complement of resources to implement the care plan
  - Access to clinical trials
  - Policies to ensure full disclosure of information about treatment options
  - Mechanisms to coordinate services
  - Psychosocial support
- Ensure quality of care at the end of life; care for cancer-related pain; timely referral to palliative and hospice care

Responding to the IOM Report: CoC Standards and Quality Measurement

Meeting these standards is an obligation of all who provide cancer care. However, despite the passage of 12 years since this report, the Accreditation Program of the Commission on Cancer of the American College of Surgeons remains the only system in the United States that provides the standards, data system, quality metrics, and multidisciplinary program that address the recommendations of the IOM. Equally important, this program provides community-based cancer programs with systems and standards to meet these challenges, along with the oversight to ensure that these standards are met.

CoC accreditation, in evolution for over 80 years, has been continuously improved and enhanced to provide cancer programs with the structure and support to ensure high-quality care. CoC accreditation requires the involvement and leadership of experienced professionals working together to define appropriate care processes, and that the full complement of services are available to patients. The program requires access to clinical trials and mechanisms to coordinate services including psychosocial support, pain management, care plans, and palliative and hospice care. It also provides programs with the necessary systems to measure and monitor care along with benchmarks for use by the program and its affiliated health system. Further, the CoC leads the nation in developing core sets of quality measures for use by its programs to serve as the basis for quality improvement.

The most recent revision of the CoC Cancer Program Standards is set forth in this manual. These standards are built upon the successful standards of previous iterations and have been enhanced in many areas. These revisions culminate the efforts of dozens of experts from all oncology disciplines with input from hundreds of professionals from around the country. Each and every standard was carefully reviewed for relevance, value to the program and to patients, and feasibility of implementation in community settings. Many existing standards were jettisoned as outmoded and many were refined to meet current realities and high standards for quality care.



The standards provide clear guidance to the necessary professionals to support the provision of high-quality care. Providing a high level of care for most cancer types, particularly the common cancers that afflict the largest number of people, is possible in most communities however, providing 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.

Major Standard Changes: Performance Standards and Patient-Centered Programs

The most notable change in the CoC Cancer Program Standards is the shift from standards that primarily defined the structure of the cancer program to include new standards that enhance patient centered functions and define performance criteria in quality measurement and outcomes.

- 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.
- Required 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 patient-centered services are all areas where experience and research in the last decade have demonstrated that current practice is often deficient, and where implementation will enhance the patient experience with care, quality of life, and treatment outcomes. These standards set a high bar, but one that the CoC has found that most accredited programs are eager to meet and can meet. Fully defining best practices in these areas and fully implementing them nationwide will undoubtedly take a number of years, and the CoC will remain supportive throughout the survey process. However, our patients deserve nothing less that our full attention to these key areas of practice.

The quality metric standards are equally important. Applying these measures to cancer care in the community will be critical to enhance care. As recognized by the IOM, only through a program of ongoing monitoring can we assess care, define barriers to high quality, and continuously improve care. Toward this end, the CoC has worked for the last 10 years with other major oncology organizations and the National Quality Forum (NQF) to develop and implement national standards. Measures proposed by the CoC were the key quality measures approved by the NQF in 2007 for national use. The national organizations recognize that the CoC, through the National Cancer Data Base (NCDB), has the only system available to apply these measures and feed data back to programs and providers for continuous quality improvement.

CoC-accredited cancer programs are all familiar with the systems the NCDB uses to apply and report quality data. Each program receives annual updates on its practice in breast and colorectal cancer through the Cancer Program Practice Profile Reports (CP^{3}R), which allow for auditing and updating of data. Programs that have used the CP^{3}R have demonstrated the ability to collect the necessary data, and achieve high levels of performance with these measures.

Moving into the future, the CoC standard revisions accommodate two major changes. The first is the addition of new measures to the CP^{3}R. This addition will include additional breast and rectal cancer measures as well as measures in other major cancer types. The second enhancement is the Rapid Quality Reporting System—a real-time data collection program to assess hospital-level performance using NQF-endorsed quality of cancer care measures. The system tracks patients and includes alerts to ensure they receive the proper care at the appropriate time.

The revised standards require that programs meet performance criteria on each measure applied through the NCDB. Those that do not will need to provide annual review and a quality improvement program that will bring the care they provide into the acceptable level of performance.

Cost and Value: What this Means for Accredited Programs

The revised standards set forth in this manual require concerted effort from accredited programs to enhance the care they provide. Certainly there is some cost associated with this effort. Apart from the cost of maintaining the registry, these standards will require that the accredited program invest time and some resources to develop strategies to support the patient care standards. However, the majority of the cost will be in the commitment of the providers and other staff in developing the systems by which they will implement these key processes of care.

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.

Similarly, sidestepping the collection of data in a cancer outcomes database or registry will have similar negative consequences for cancer programs. Not only does use of these data promote quality improvement, it will increasingly be required by other agencies including payers and the government. A number of payers 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 public reporting, as this becomes a real necessity.

The majority of cancer care in America is community based. It is important that cancer programs demonstrate to outside parties including payers, the government, and the public, that indeed, care provided in our community-based programs is excellent. One study recently completed using the CoC data showed that more than 95% of women with breast cancer and breast conserving surgery received timely radiation, and similarly that more than 95% of those with Stage III colon cancer received appropriate chemotherapy. Many CoC programs are using such data from the CP^{3}R in negotiations with payers to receive bonuses for the quality of care they provide.

These revised standards and CoC accreditation provide real value to accredited programs. Programs can proudly demonstrate to their community of payers, providers, and the public that they have invested in systems to ensure that cancer patients receive high-quality, coordinated care, and that they have taken 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.

Accreditation Process

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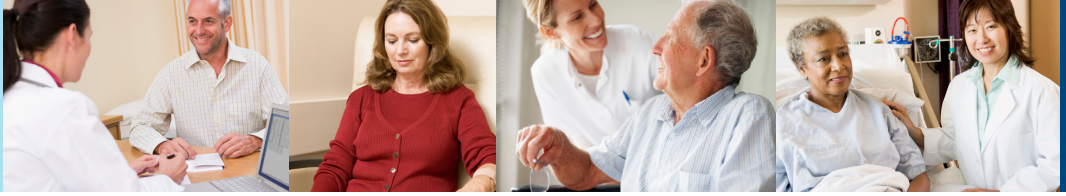


Accreditation Process

Categories of Cancer Programs

Each facility is assigned to a Cancer Program Category based on the type of facility or organization, services provided, and cases accessioned. Category assignments are made by CoC staff and are retained unless there are changes to the services provided and/or the facility caseload.

The Cancer Program Categories and definitions are as follows:

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 1 facility in the category is a hospital, and all facilities that are part of the Network are 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. This facility participates in basic and clinical research. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

ACADEMIC COMPREHENSIVE CANCER PROGRAM (ACAD)

The facility provides postgraduate medical education in at least 4 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. The facility is required to participate 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.

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). Participation in cancer-related clinical research is required 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. There is no minimum caseload required for this category.

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. Participation in cancer-related clinical research is required 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.

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. Facilities participate 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.

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.

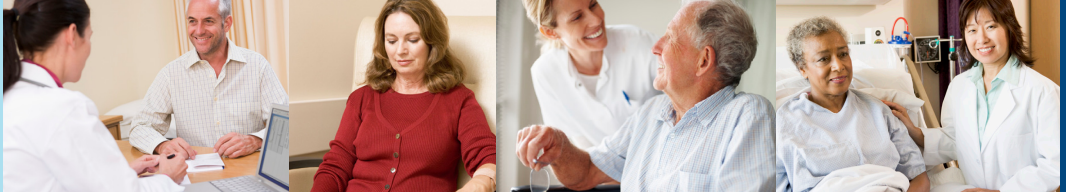
PEDIATRIC CANCER PROGRAM (PCP)

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 either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office. 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 1 cancer-related treatment modality. The full range of diagnostic and treatment services is available by referral. Referral to CoC-accredited cancer program(s) is preferred. Participation in cancer-related clinical research is encouraged but not required. Patients may be enrolled in cancer-related clinical trials either at the facility 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.

A table of eligibility and standard requirements for each CoC Cancer Program Category can be found in Appendix A.



Survey Process

CoC-accredited cancer programs are surveyed on a triennial schedule. Each July, an initial e-mail notification is provided to facilities due for survey in the upcoming calendar year. In preparation for survey, the cancer committee does the following three things:

1. Assesses program compliance with the requirements for all standards outlined in *Cancer Program Standards 2012: Ensuring Patient-Centered Care.*
2. Reviews and completes the online SAR.
3. Confirms the survey schedule and agenda with the cancer program surveyor.

CoC staff match a cancer program surveyor to each program due for survey. The program is notified of the target date for survey, the surveyor who is assigned to perform the review, and the surveyor's contact information through an e-mail notification. The profile for each surveyor, which includes a photo and brief biography, is available in the Accreditation section of the Cancer Programs page of the American College of Surgeons website (*www.facs.org/cancer*).

The program may decline the assigned surveyor if a conflict of interest exists between the surveyor and the program. A conflict of interest is defined as follows:

- Affiliation with the facility being surveyed.
- Affiliation with another facility in direct competition with the facility being surveyed.

The program must notify CoC staff of the conflict within 14 days of receipt of the surveyor notification e-mail. When a conflict is confirmed, a new surveyor assignment will be provided to the program within 30 days of notification of the conflict of interest.

A survey date must be scheduled within the calendar quarter when the survey is due. The selection of a survey date is coordinated between the facility and the surveyor. Confirmation of the survey date and time is provided to the facility administrator and other cancer program staff by e-mail a minimum of 30 days before the on-site visit.

Survey Extensions

When extenuating circumstances affect program activity, a survey extension may be appropriate. Valid extenuating circumstances reasons that warrant a survey extension include, but are not limited to, the following:

- Natural disasters (hurricane, earthquake, tornado, flood)
- Other disasters, for example, fire

Survey extension requests will be granted in these instances. The usual extension is three months. A longer extension may be available given individual circumstances.

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

- Software conversion
- Staff absence or resignation
- Delayed abstracting
- 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 request for extension by e-mail to accreditation@facs.org by the deadline specified in the initial survey notification. 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. If cancellation or postponement becomes necessary after the survey date is confirmed, the facility must contact Cancer Programs staff and submit a written notification. The facility will be assessed a cancellation fee.

The Survey Fee

An invoice for the survey fee is e-mailed to the cancer program administrator and/or the cancer registrar prior to the survey due date. Payment of the invoice is due within 30 days of receipt. Payment must be made before a survey is scheduled.

The Survey Agenda

A member of the cancer care team confirms the agenda for the on-site visit with the surveyor 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, the surveyor meets with:

- Key members of facility administration to discuss the value of CoC accreditation.
- The cancer committee to discuss the goals and responsibilities of the cancer committee in relationship to the cancer program and to verify the accuracy of the data recorded in the SAR.
- The Cancer Liaison Physician to brainstorm opportunities to use National Cancer Data Base (NCDB) data for performance improvement.
- The cancer registry staff to verify cancer registry operations.

At a minimum, the surveyor must meet with the following:

- Chief Executive Officer and/or other high-level administrator
- Cancer Liaison Physician
- Cancer Committee Chair
- Cancer Program Administrator
- The cancer program coordinators
- All members of the cancer committee

In addition to these meetings, the surveyor will attend a cancer conference to observe the multidisciplinary patient management discussion and to confirm that treatment is planned using nationally recognized, evidence-based treatment guidelines, and will review pathology reports. Other materials may also be reviewed when required by CoC Accreditation Committee initiatives.

The Survey Application Record

The Survey Application Record (SAR) is available throughout the three-year accreditation period for use as a record-keeping tool to document program activity. Access to the SAR is provided to the cancer registrar, cancer committee chair, cancer program administrator, and cancer liaison physician. Additional users can be identified by the program.

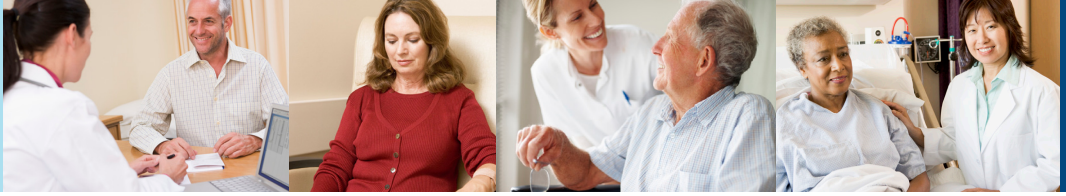
Password-protected access to the SAR is provided through CoC Datalinks. CoC Datalinks is a password-protected portal accessed via a link available on the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer.*

To facilitate a thorough and accurate evaluation of the cancer program during the survey, the facility completes or updates the SAR at least 14 days before the scheduled on-site visit. The cancer program surveyor reviews the facility's online SAR before the on-site visit to assess compliance with the standards, to become familiar with the resources and services offered at the facility and the cancer program activity.

The cancer registrar is notified by e-mail when the SAR is available for completion in preparation for the survey. Completion of the SAR should be a team effort of members of the cancer committee with 1 individual chosen to coordinate the activity and record the information in the SAR.

Each year, the facility is notified of the areas of the SAR requiring annual updates. The Eligibility Requirements must be updated on the annual schedule. If the SAR is not updated on the annual schedule, then all information must be provided before the survey.

In addition to capturing information about cancer program activity and in preparation for survey, the individual responsible for completing the SAR will perform a self-assessment and rate compliance with each standard using the Cancer Program Standards Rating System.



A portion of the information collected in the SAR describing the facility's resources and services is automatically made available to the public through the CoC Hospital Locator. This data-sharing activity is designed to benefit all CoC-accredited cancer programs. 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 SAR is used to update the resource and service information for display on the CoC Hospital Locator. The Hospital Locator is accessible from the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer*. 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, and grids; however, cancer committee minutes are the primary resource for documentation of cancer program activity. In preparation for the on-site visit, documentation is attached to the SAR. The documentation can be attached throughout the three-year accreditation period but must be attached within 14 days of the on-site visit 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 part 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. The PSE is accessed through 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 completed by the program within 2 weeks after the on-site visit.

Notification of Results

Award notification takes place within 45 days following the completed survey. The Accredited Cancer Program Performance Report (Performance Report) provides the following:

- A comprehensive summary of the survey outcome and accreditation award
- The facility's compliance rating for each standard
- An overall rating compared with other accredited facilities nationwide, facilities in the state, and category of accreditation
- A narrative description of deficiencies that require correction
- Suggestions to improve or enhance the program
- Commendations awarded

By enabling each facility to compare its ratings for the standards with other accredited programs, the Performance Report facilitates the identification of areas for program improvement. The cancer program administrator receives a letter by e-mail when the completed Performance Report is posted to CoC Datalinks. The cancer committee chair, cancer liaison physician, and cancer registrar receive a copy of this letter. The posted Performance Report is accessible to all CoC Datalinks users at the facility. A sample report appears on the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer*.

If accredited without contingency, access for ordering the Certificate of Accreditation is provided to the cancer program administrator following posting of the Performance Report to CoC Datalinks. The facility can appeal a finding for any standard or the accreditation award within 30 days of posting of the Accredited Cancer Program Performance Report. The appeals process is outlined in the appeal guidelines posted in the Accreditation section of the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer*.

Marketing and Visibility

If accredited without contingency, the program is provided access to the CoC marketing page, which includes the press release, logo, and marketing messaging that can be used by the CoC-accredited cancer program to promote its accreditation achievement.

Resource and service information for all CoC-accredited cancer programs is included on the CoC Hospital Locator where programs can also choose to share the annual caseload information. Access to the CoC Hospital Locator is available on the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer*.

Additional Accreditation Information

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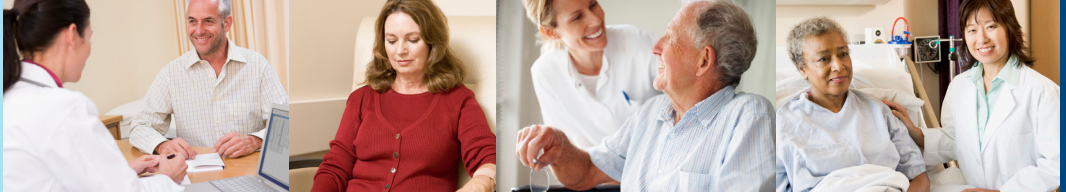


Additional Accreditation Information

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 is assigned by the program, surveyor, and CoC staff.

A deficiency is defined as any standard with a rating of 5. A deficiency in 1 or more standards will affect the accreditation award.

The Commendation rating (1+) is valid for 7 standards. The Commendation ratings are used to determine the Accreditation Award and award level (bronze, silver, gold). A Commendation rating can be earned only at the time of survey.

The following standards are eligible for Commendation. The Commendation criteria are defined within the descriptions for each of the following standards:

STANDARD 1.9: As appropriate to the cancer program category, the required percentage of patients is accrued to cancer-related clinical trials each year. The clinical trial coordinator or representative reports clinical trial participation to the cancer committee each year.

STANDARD 1.11: Each year, all members of the cancer registry staff participate in 1 cancer-related educational activity other than cancer conferences.

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

STANDARD 2.1: College of American Pathologists (CAP) protocols are followed to report the required data elements in 90% of the eligible cancer pathology reports each year.

STANDARD 2.2: Oncology nursing care is provided by nurses with specialized knowledge and skills. Competency is evaluated annually.

STANDARD 5.2: From initial enrollment and throughout the three-year accreditation period, the program participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.

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 and resubmission deadline specified in the annual Call for Data.

Accreditation Awards

Accreditation awards are based on consensus ratings by the cancer program surveyor, CoC staff, and, when required, the Program Review Subcommittee.

A program earns one of the following Accreditation Awards:

THREE-YEAR WITH COMMENDATION ACCREDITATION is given to programs, either new or established, that comply with all standards at the time of survey and receive a commendation rating for 1 or more standards. A program receiving commendation for up to 3 standards earns Three-Year with Commendation Bronze level. Commendation for 4 to 6 standards earns Three-Year with Commendation Silver level. Commendation for 7 standards earns Three-Year with Commendation Gold level. A certificate of accreditation is issued, and these programs are surveyed at three-year intervals from the date of the survey.

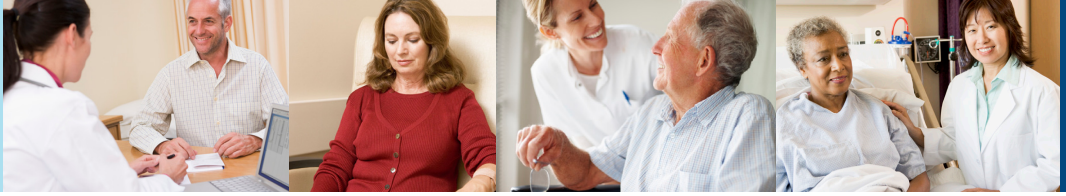
THREE-YEAR ACCREDITATION is given to programs, either new or established, that comply with all standards at the time of survey but do not receive a commendation rating for any standards. This award is also applied to programs that received and resolved a deficiency for 1 or more standards, regardless 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 from the date of the survey.

THREE-YEAR ACCREDITATION WITH CONTINGENCY is given to an established program when 1 to 7 standards are rated deficient at the time of survey. The contingency status must be resolved within 12 months. Programs follow the guidelines for deficiency resolution that are posted in the Accreditation section of the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer*. Programs submit documentation to resolve the contingency status through the SAR. Three-Year Accreditation is granted following submission and evaluation of documentation. A Certificate of Accreditation is issued after resolution of deficiencies, and these programs are surveyed at three-year intervals from the date of the survey.

PROVISIONAL ACCREDITATION is given to new programs when 1 or 2 standards are rated deficient at the time of survey. The provisional accreditation must be resolved within 12 months. Programs follow the guidelines for deficiency resolution that are posted in the Accreditation section of the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer*. Programs submit documentation to resolve the provisional status through the SAR. Three-Year Accreditation is granted following submission and evaluation of documentation. A Certificate of Accreditation is issued after resolution of deficiencies, and these programs are surveyed at three-year intervals from the date of the survey.

NON-ACCREDITATION is given when 8 or more standards are rated deficient or when a new program is deficient in more than 2 standards. Programs are encouraged to improve their performance and may reapply for accreditation when all standards are met.

THREE-YEAR WITH COMMENDATION	THREE-YEAR	THREE-YEAR WITH CONTINGENCY	PROVISIONAL	NON-ACCREDITATION
Complies with all standards at the time of survey and receives a commendation rating for 1 or more standards. **Gold:** 7 commendations **Silver:** 4–6 commendations **Bronze:** 1–3 commendations	Complies with all standards at the time of survey but does not receive a commendation rating for any standard. Or, is awarded when all deficiencies are resolved regardless of the number of commendations awarded at survey.	1–7 deficiencies at the time of survey.	**Programs undergoing initial accreditation:** 1 or 2 deficiencies in any standard.	8 or more deficiencies at the time of survey. **Programs undergoing initial accreditation:** 3 or more deficiencies.



Outstanding Achievement Award (OAA)

Programs currently accredited by the CoC are eligible to receive the CoC Outstanding Achievement Award, except for NCIP facilities and those receiving Provisional Accreditation. The OAA will be granted to a program that does both of the following at the time of re-survey:

- Receives a commendation rating in each of the Commendation standards.
- Receives a compliance rating for all other standards.

The purposes of this award are to:

- Recognize the cancer programs that strive for excellence in providing quality care to cancer patients.
- Motivate other programs to work toward improving their care.
- Foster communication between award recipients and other programs to do the following:
  - Share best practices
  - Serve as a resource to other programs
  - Act as a "champion" for CoC cancer program accreditation

Recipients are identified following the confirmation of the accreditation awards for all programs surveyed during the calendar year.

Cancer programs achieving this award will receive the following:

- A letter of recognition from the CoC chair addressed to the Chief Executive Officer/Administrator.
- A specially designed press release and marketing information.
- The Outstanding Achievement Award logo.
- The Outstanding Achievement Award trophy.
- CoC publicity via *CoC Source*, the Cancer Programs websites, and the CoC Hospital Locator.
- Acknowledgment at a public forum.

Best Practices Repository and Other Resources

The Best Practices Repository and the Resources Repository include examples of policies or procedures, job descriptions, and other tools developed by CoC staff that can be used to implement or document compliance with a standard. In addition, the Best Practices Repository and the Resources Repository include tools and examples developed and used by CoC-accredited cancer programs. Programs are encouraged to access, customize, and use all of this material when developing their own methods to meet the Cancer Program Standards.

CoC-accredited cancer programs are encouraged to use the CAnswer Forum bulletin board system to request clarification of the interpretation of a standard, search for questions and answers submitted by other users, and initiate a dialogue among users to share best practices methods for understanding and meeting the standards.

These resources are located on the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer*.

Information for Programs Seeking Initial CoC Accreditation

To be considered for initial accreditation, the cancer committee does the following:

- Ensures that the clinical services, cancer committee, cancer conferences, and quality management program have been in place at the facility for at least 1 year.
- Establishes a reference date and ensures that the cancer registry database includes complete data and follow-up activity.
- Meets all eligibility requirements outlined in *Cancer Program Standards 2012: Ensuring Patient-Centered Care.*
- Meets the requirements for all standards for the facility's category as outlined in *Cancer Program Standards 2012: Ensuring Patient-Centered Care.*
- Completes the online application for accreditation that describes the resources and services available at the facility and documents the development of the cancer program.
- Submits the new program application fee.
- Signs the American College of Surgeons Business Associate Agreement in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Completes the Eligibility Requirements and the SAR in preparation for the consultative visit and initial survey.
- Submits a request for survey to CoC staff that documents compliance with all standards.

GUIDELINES FOR MERGED OR NETWORK PROGRAMS

If the facility has merged, is merging, or plans to merge or form an integrated network, the facility must access and review either the Merged Program Guidelines or Integrated Network Program Guidelines, which outline the requirements for cancer program composition in either category These guidelines are located on the Accreditation page of the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer.*

Once the respective guidelines have been reviewed, the facility completes and submits the notification form providing general information about the merger or integrated network. This information will allow Cancer Programs staff to assign a new Facility Identification Number (FIN), Cancer Program Category, accreditation award designation, and target survey date.

GLOSSARY OF TERMS

The Glossary of Terms provides definitions and examples of terms used throughout the manual.

Eligibility Requirements

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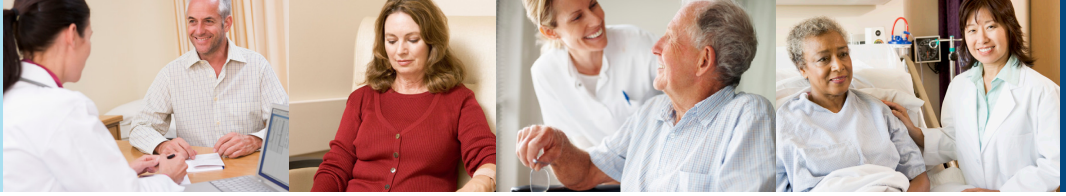


Eligibility Requirements

Standards for the evaluation of cancer clinics and registries were first published in 1930 by the American College of Surgeons Committee on the Treatment of Malignant Disease.

The CoC Accreditation Program was designed to ensure that the structures and processes necessary for high-quality cancer care are in place at the program providing care to patients with cancer.

The first surveys of cancer clinics were conducted in 1931. Since then, the standards for cancer programs have been revised and expanded to reflect the comprehensive scope of cancer programs and the continuous changes in the health care environment.

The current CoC standards for cancer programs promote and support the 4 historic cornerstones of the Accreditation Program. These are: (1) a multidisciplinary cancer committee; (2) cancer conferences; (3) evaluation of quality outcomes and improvements; and (4) and a cancer registry.

Recognizing that cancer is a complex group of diseases, the CoC's Cancer Program Standards promote pretreatment consultation among surgeons, medical and radiation oncologists, diagnostic radiologists, pathologists, and other cancer specialists. This multidisciplinary cooperation results in improved patient care.

Hospitals, freestanding treatment facilities, and integrated health care networks are eligible to participate in the CoC Accreditation Program. Each program ensures that patients have access to the full scope of services required to diagnose, treat, rehabilitate, and support patients with cancer and their families. Prevention and early-detection services are made available to the community. Community services are provided on-site or by referral or are coordinated with other facilities or local agencies.

Five elements are key to the success of a CoC-accredited cancer program:

1. The **clinical services** provide state-of-the-art pretreatment evaluation, staging, treatment, and clinical follow-up for patients with cancer seen at the program for primary, secondary, tertiary, or end-of-life care.
2. The **cancer committee** leads the program through setting goals, monitoring program activity, and evaluating patient outcomes and improving care.
3. The **cancer conferences** provide a forum for patient consultation and contribute to physician education.
4. The **quality improvement (QI) program** is the mechanism for evaluating and improving patient outcomes.
5. The **cancer registry and database** are the basis for monitoring the quality of care.

The following eligibility requirements include basic structure and services that are required of CoC-accredited cancer programs before a survey can take place:

Structure

- Facility accreditation
- Cancer committee authority
- Cancer conference policy
- Oncology nurse leadership
- Cancer registry

Services

In addition, the services listed below 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
- Radiation oncology services
- Systemic therapy services
- Clinical trial information
- Psychosocial support services
- Rehabilitation services
- Nutritional services

Cancer Committee Responsibilities

Each 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. When appropriate, the cancer committee may delegate this responsibility to a specified individual, subcommittee, or department. The assessment is documented in cancer committee minutes.

Before the survey, the CoC-accredited cancer program updates the SAR to indicate the services that are available either on-site or by referral and attaches specific information that documents adherence to the eligibility criteria. Annually, the updated information describing the eligibility criteria is reviewed by CoC staff.

Programs will be notified when 1 or more eligibility requirements are not met 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 is suspended and any scheduled survey is canceled.

As designated by the Accreditation Committee of the CoC, the surveyor will discuss 1 or more of the eligibility criteria with the cancer committee during the on-site survey.

STRUCTURE

E1: Facility Accreditation

The program 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. The scope of the cancer program is the same as the facility accreditation.

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

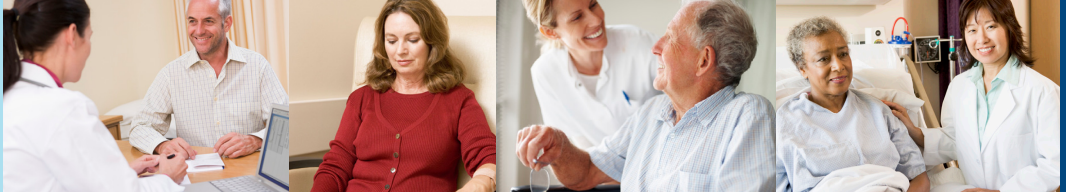
E2: Cancer Committee Authority

Cancer committee authority is established and documented by the facility.

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

The program provides the bylaws, policy or procedure, or other sources that set forth the cancer committee's authority for the cancer program.



E3: Cancer Conference Policy

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

Cancer conferences improve the care of patients with cancer by providing multidisciplinary treatment planning and contributing to physician and allied medical staff education.

The policy or procedure addresses the following:

- Cancer conference frequency and format
- Multidisciplinary composition of the conference(s) and attendance rate of physician participants
- Discussion of stage, including prognostic indicators, and treatment planning using 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% of the annual analytic case load) and the prospective presentation rate (a minimum of 80% or a maximum of 450 of the annual analytic case presentations)

  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 if management issues are discussed.

The program provides the most recent version of the cancer conference policy or procedure. An NCIP facility is exempt from this eligibility requirement.

E4: Oncology Nurse Leadership

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

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

The continuum of cancer care includes all inpatient and outpatient areas that are part of the program.

The program identifies the nurse(s) who are responsible for leadership across the continuum of care.

E5: Cancer Registry Policy and Procedure

The cancer registry policy and procedure manual is used and specifies that current CoC 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 may include, but is not limited to, the following:

- Abstracting, including RQRS participation and case submissions
- American Joint Committee on Cancer (AJCC) and Collaborative Stage staging policies
- Cancer registry reference date
- Case eligibility
- Case finding
- Case 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 SAR documentation
- Quality control of registry data
- Registry purpose
- Request log
- Required coding manuals
- Retention of documents
- State registry reporting requirements and mechanisms

The program provides the table of contents of the most recent version of the cancer registry policy and procedure manual.

SERVICES

E6: Diagnostic Imaging

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

The program identifies the diagnostic imaging services available 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.

Annually, the program provides a copy of the 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.

The program identifies in the SAR the diagnostic imaging services that are provided either on-site or by referral. An NCIP facility has the option to complete this section of the SAR to display information about available diagnostic imaging services in the CoC Hospital Locator.

E7: Radiation Oncology Services

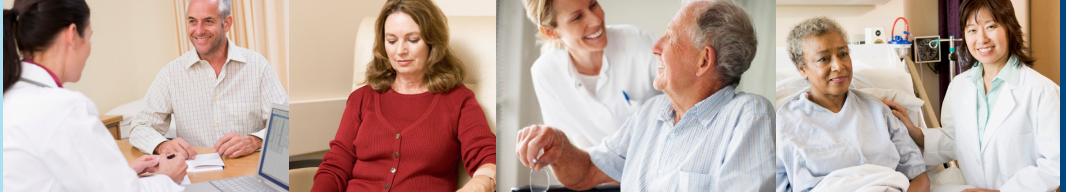
Radiation treatment service locations are currently accredited by a recognized authority or, if not accredited, follow standard quality assurance practices. Services are available either on-site, at locations that are facility owned, or by referral.

Radiation therapy services are available either on-site, at locations that are facility owned, or by referral. The treating program is either accredited by a recognized authority or follows minimal QA practices and machine-specific QA practices outlined below.

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)

CoC-accredited programs are encouraged to refer patients to accredited radiation treatment service locations.



Information about the primary referral services and location is provided to patients seen at the CoC-accredited cancer program.

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

- Patient identity is verified by 2 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 include, but are not limited to, daily, monthly, and annual radiation treatment machine QA procedures.

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

Annually, the program identifies in the SAR the radiation treatment services that are available either on-site or by referral. An NCIP facility has the option to complete this section of the SAR to display information about available radiation therapy services in the CoC Hospital Locator.

E8: Systemic Therapy Services

A policy or procedure is 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 (physician offices).

Systemic therapy encompasses the administration of chemotherapeutic, biologic, and immunotherapeutic agents that are administered for the treatment of malignant disease by an oral or a parenteral route. A standardized approach to the administration of systemic therapy creates opportunities to monitor, evaluate, and improve the safety of the administration process.

To create a safe environment, these specialized areas are characterized by 3 essential features:

1. A nursing staff with the knowledge and skills to provide specialized care;
2. Facilities necessary to provide the care; and
3. A distinct 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, follow a policy or procedure to guide the safe administration of systemic therapy. These areas include hospital inpatient areas, outpatient infusion centers, and the pharmacy. Standards and guidelines of the ONS, the American Society of Clinical Oncology (ASCO), or the National Comprehensive Cancer Network (NCCN), or other national organizations are used.

The program provides the cancer program policy or procedure 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).

Annually, the program identifies in the SAR the systemic treatment services that 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. An NCIP facility has the option to complete this section of the SAR to display information about available systemic therapy services in the CoC Hospital Locator.

E9: Clinical Trial Information

A policy or procedure is used to provide cancer-related clinical trial information to patients.

Providing information about the availability of cancer-related clinical trials offers patients the opportunity to participate in the advancement of evidence-based medicine. A policy or procedure exists to provide clinical trial information to patients.

The program provides a copy of the cancer program policies or procedures to provide clinical trial information to patients. The NCIP facilities are exempt from this eligibility requirement.

E10: Psychosocial Services

A policy or procedure is 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.

Services are available on-site or by referral, a process is in place to make patients aware of them, and their use is monitored.

The program provides a copy of the facility-wide or cancer program policy or procedure that ensures access to psychosocial services and identifies the psychosocial services provided either on-site or by referral.

Annually, the program identifies in the SAR the psychosocial services that are available either on-site or by referral. An NCIP facility has the option to complete this section of the SAR to display information about available psychosocial services in the CoC Hospital Locator.

E11: Rehabilitation Services

A policy or procedure is in place to access rehabilitation services either on-site or by referral.

Rehabilitation services help patients cope with activities of daily living affected by the cancer experience and enable them to resume normal activities. A policy or procedure is followed to access rehabilitation services.

The program provides a copy of the facility-wide or cancer program policy or procedure that ensures access to rehabilitation services and identifies the rehabilitative services that are provided either on-site or by referral.

Annually, the program identifies in the SAR the rehabilitation services that are available either on-site or by referral. An NCIP facility has the option to complete this section of the SAR to display information about available rehabilitation services in the CoC Hospital Locator.

E12: Nutrition Services

A policy or procedure is in place to access 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 procedure in place to ensure patient awareness of and access to services.

The program provides a copy of the facility-wide or cancer program policy or procedure that ensures access to nutrition services and identifies the nutrition services that are provided on-site or by referral.

Annually, the program identifies in the SAR the scope of nutrition services that are available either on-site or by referral. An NCIP facility has the option to complete this section of the SAR to display information about available nutrition services in the CoC Hospital Locator.

Program Management

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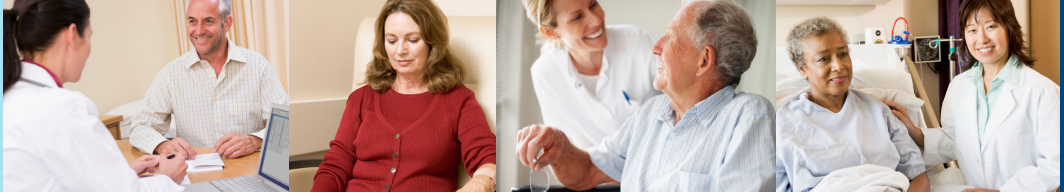


Program Management

STANDARD 1.1
Physician Credentials

Diagnostic and treatment services are provided by or referred to the leadership and cancer program evaluation and management team physicians who are currently board certified, or the equivalent, in their general specialty or are in the process of becoming board certified.

DEFINITION AND REQUIREMENTS

Patient management is conducted by a multidisciplinary team, including diagnosticians and pathologists, surgeons, radiation oncologists, and medical oncologists. As of 1/1/2012, the Cancer Program Leadership team member who serves in a required physician position on the Cancer Committee and those physicians involved in the evaluation and management of cancer patients are either:

- Board certified or in the process of becoming board certified; or
- Demonstrates ongoing cancer-related education by annually earning 12 cancer-related continuing medical education (CME) hours. (A maximum of 6 hours can be earned through educational activities within the facility; however, all 12 hours may be earned through educational activities that are external to the facility.) This option will be used for deficiency resolution.

The program provides one or more of the following:

1. A copy of the medical staff bylaws that addresses current board certification of physicians; or
2. Provides a roster of the board certification status for physicians in the Cancer Program Leadership team members who serve in a required physician position on the cancer committee and those physicians involved in the evaluation and management of cancer patients; or
3. Documentation of 12 annual cancer-related CME hours for physicians who are not board certified or in the process of becoming board certified, who are members of the Cancer Program Leadership team who serve in a required physician position on the Cancer Committee, and those physicians involved in the evaluation and management of cancer patients.

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

DOCUMENTATION

The program completes the SAR. NCIP facilities do not complete the SAR for this standard.

The program provides one or more of the following:

1. A copy of the medical staff bylaws that addresses current board certification of physicians; or
2. Provides a roster of the board certification status for physicians in the Cancer Program Leadership team members who serve in a required physician position on the cancer committee and those physicians involved in the evaluation and management of cancer patients; or
3. Documentation of 12 annual cancer-related CME hours for physicians who are not board certified or in the process of becoming board certified, who are members of the Cancer Program Leadership team who serve in a required physician position on the Cancer Committee, and those physicians involved in the evaluation and management of cancer patients.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criterion:

All physicians, who are members of the Cancer Program Leadership team and serving in a required physician position on the Cancer Committee, and those involved in the evaluation and management of cancer patients are board certified, or the equivalent, or in the process of becoming board certified, including:

1. Diagnostic radiology
2. Pathology
3. General surgery, as well as surgeons who care for patients from the five major sites of cancer seen at the facility
4. Radiation oncology
5. Medical oncology

Physicians who are not board certified or in the process of certification, demonstrate ongoing cancer-related education by annually earning 12 cancer-related continuing medical education (CME) hours. (A maximum of 6 hours can be earned through educational activities within the facility; however, all 12 hours may be earned through educational activities that are external to the facility.)

Note that programs will aggregate their top five sites over the three-year accreditation period and supply board certification or CME information for this group of physicians.

NCIP facilities: Default rating.

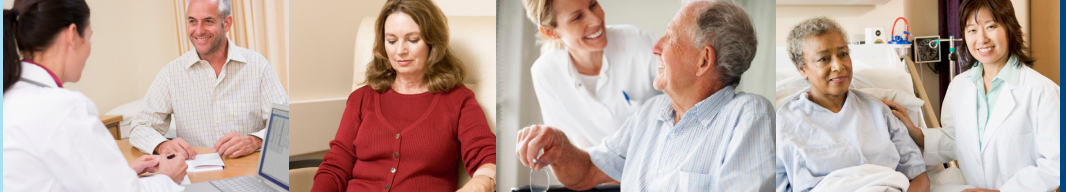
(5) Noncompliance: The program does not fulfill the following criterion:

All physicians, who are members of the Cancer Program Leadership team and serving in a required physician position on the Cancer Committee, and those involved in the evaluation and management of cancer patients are board certified, or the equivalent, or in the process of becoming board certified, including:

1. Diagnostic radiology
2. Pathology
3. General surgery, as well as surgeons who care for patients from the five major sites of cancer seen at the facility
4. Radiation oncology
5. Medical oncology

Physicians who are not board certified or in the process of certification demonstrate ongoing cancer-related education by annually earning 12 cancer-related continuing medical education (CME) hours. (A maximum of 6 hours can be earned through educational activities within the facility; however, all 12 hours may be earned through educational activities that are external to the facility.)

Note that programs will aggregate their top five sites over the three-year accreditation period and supply board certification or CME information for this group of physicians.



STANDARD 1.2
Cancer Committee Membership

The membership of the cancer committee is multidisciplinary, representing physicians from the diagnostic and treatment specialties and nonphysicians from administrative and supportive services. Coordinators who are responsible for specific areas of program activity are designated from the membership.

DEFINITION AND REQUIREMENTS

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

Required members include at least 1 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.

Required physician members for all categories are as follows:

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

The cancer committee chair is a physician who may also fulfill the role of one of the required physician specialties.

Other required members for all categories are as follows:

- Cancer program administrator who is responsible for the administrative oversight or who has budget authority for the cancer program
- Oncology nurse
- Social worker or case manager
- Certified tumor registrar (CTR)
- Performance improvement or quality management representative
- Palliative care team member, when these services are provided on site

Individual members of the committee are appointed to coordinate important aspects of the cancer program. An individual cannot fulfill more than 1 coordinator role.

The coordinators are as follows:

Cancer Conference Coordinator

The cancer conferences provide a forum for formalizing the disease stage of patients discussed; using nationally recognized, evidenced-based treatment guidelines, when appropriate; and continuing medical education. A coordinator appointed from within the membership of the cancer committee will monitor the cancer conference activity and report the findings to the cancer committee at least annually and recommend corrective action if activity falls below the annual goal or requirements. A cancer registrar who is abstracting 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 appointed from within the membership of the cancer committee will monitor the quality improvement program activity and report the findings to the cancer committee at least annually and recommend corrective action if activity falls below the annual goal or requirements. A cancer registrar who is abstracting 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 appointed from within the membership of the cancer committee will monitor the quality of 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. A cancer registrar who is abstracting **can** be selected to fulfill this coordinator role.

Community Outreach Coordinator

A coordinator for community outreach is appointed from within the membership of the cancer committee, or a member of the cancer program community outreach staff will be appointed to the committee as a member. The community outreach coordinator monitors outreach activity, reports at least annually to the cancer committee, and recommends corrective action if activity falls below the annual goal or requirements. A cancer registrar who is abstracting cannot be selected to fulfill this coordinator role.

Clinical Research Representative or Coordinator

A coordinator or representative for clinical research is appointed from within the membership of the cancer committee. This person 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, and physician office staff. A cancer registrar who is abstracting cannot be selected to fulfill this coordinator role.

Psychosocial Services Coordinator

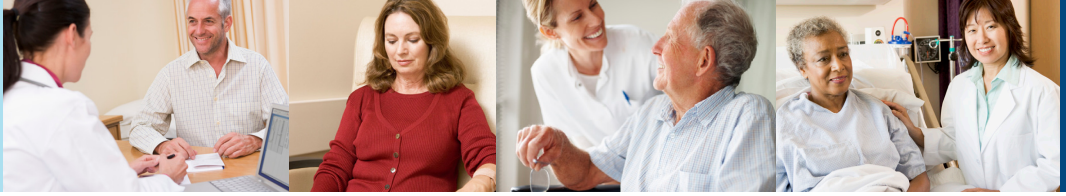
An oncology social worker (OSW-C preferred), clinical psychologist, or other mental health professional trained in the psychosocial aspects of cancer care is selected to fill this role. This representative or coordinator works collaboratively with established departments and community organizations to provide, improve, and expand the range of psychosocial services. A cancer registrar who is abstracting cannot be selected to fulfill this coordinator role.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as specified for the category.

ADDITIONAL REQUIRED CANCER COMMITTEE MEMBERS BY CATEGORY

CATEGORY	ADDITIONAL REQUIRED MEMBERS
Integrated Network Cancer Program	Corporate administrator Oncology nurse from the ambulatory care setting Clinical research representative Physician member of the palliative care team Pharmacist Registered dietician Hospice nurse or administrator Rehabilitation representative Genetics professional/counselor, if these services are provided on-site
NCI-designated Comprehensive Cancer Center Program	Program defines the structure and membership for the multidisciplinary administrative body responsible for the cancer program
Academic Comprehensive Cancer Program	Clinical research representative Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site Rehabilitation representative
Veterans Affairs Cancer Program	Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site
Comprehensive Community Cancer Program	Clinical research representative Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site



ADDITIONAL REQUIRED CANCER COMMITTEE MEMBERS BY CATEGORY	
CATEGORY	ADDITIONAL REQUIRED MEMBERS
Community Cancer Program	Clinical research representative or coordinator Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site
Hospital Associate Cancer Program	None
Pediatric Cancer Program	Child life specialist Children's Oncology Group data manager Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site
Freestanding Cancer Center Program	For freestanding cancer centers providing radiation oncology: dosimetrist or radiation physicist Palliative care team member, when these services are provided on-site

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. Additional members strongly recommended, but not required, include the following:

- Specialty physicians representing the major cancer experience(s) at the program
- Registered dietitian
- Pharmacist
- Rehabilitation representative
- Pastoral care representative
- A psychiatric or mental health professional trained in the psychosocial aspects of cancer care
- American Cancer Society staff representative

A Pediatric Cancer Program (PCP) selects additional physician or nonphysician members based on Children's Oncology Group (COG) membership requirements, the services and specialties available at the program, and the majority of the caseload. These include, but are not limited to, the following:

- 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 clinic

DOCUMENTATION

The program completes the SAR.

The program provides cancer committee minutes or other documentation that identifies the appointed cancer committee members.

MEASURING COMPLIANCE

Rating

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

1. The membership of the cancer committee includes the required physicians from the diagnostic and treatment specialties.
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 the required coordinator or representative roles.

NCIP facilities: Default rating.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. The membership of the cancer committee includes the required physicians from the diagnostic and treatment specialties.
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 the required coordinator or representative roles.

STANDARD 1.3
Cancer Committee Attendance

Each required member or the designated alternate attends at least 75% of the cancer committee meetings held during any given year.

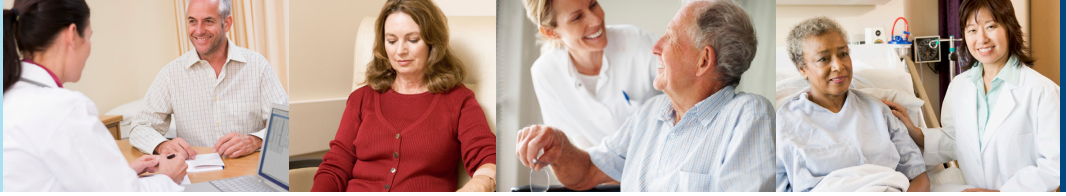
DEFINITION AND REQUIREMENTS

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, it is imperative that all appointed members (physicians and nonphysicians) regularly attend and participate in cancer committee meetings. Note: One appointed member and a designated alternate member can be identified for each required physician and nonphysician member of the cancer committee. The appointment of the member and identification of an alternate must take place at the beginning of the year when committee membership is confirmed. This information is recorded in the cancer committee minutes.

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

- Required members include physicians and nonphysicians who are specified in standard 1.2.
- Attendance to meet the standard can be calculated on the required role that is filled by the member, for example, surgeon, medical oncologist, radiation oncologist, and so on.
- Attendance at cancer committee meetings may include participation through conference or teleconference calls with appropriate meeting documents provided.
- The minutes document the attendance at each meeting.
- The cancer committee monitors the attendance of individual members to ensure participation at cancer committee meeting.

The cancer committee needs to monitor the individual attendance of all members and address attendance that does not fulfill the needs of the program or falls below the requirements set by the facility.



SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

DOCUMENTATION

The program completes the SAR. NCIP facilities do not complete the SAR for this standard.

The program provides cancer committee minutes that include the attendance for each meeting.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criterion:

Each required member or the designated alternate attends at least 75% of the cancer committee meetings held during any given year.

NCIP facilities: Default rating.

(5) Noncompliance: The program does not fulfill the following criterion:

Each required member or the designated alternate attends at least 75% of the cancer committee meetings held during any given year.

STANDARD 1.4
Cancer Committee Meetings

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

DEFINITION AND REQUIREMENTS

Regular meetings ensure that administrative responsibilities related to cancer program leadership are carried out. In all categories, the cancer committee meets each quarter, for a minimum of 4 times each year. More frequent meetings may be required to meet the overall program needs.

Calendar quarters are as follows:

- 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 larger programs, the cancer committee establishes subcommittees or workgroups to manage specific activities. Subcommittees may include, but are not limited to, the following:

- Cancer conference activity
- Clinical trial activity
- Community outreach
- Quality control of registry data
- Quality management and improvement activity
- Review of policies and procedures

The subcommittees and workgroups may call on physicians and nonphysicians outside of the cancer committee membership to accomplish their assignments. The assigned coordinator chairs the appropriate subcommittee or workgroup. Other subcommittee or workgroup chairs are chosen from the members of the cancer committee. Meetings of subcommittees and workgroups do not constitute meetings of the full cancer committee.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

The program provides cancer committee minutes that document the committee's meetings and activities.

MEASURING COMPLIANCE

Rating

(1) Compliance: Each year, the program fulfills the following criterion:

The cancer committee meets at least once each calendar quarter.

(5) Noncompliance: Each year, the program does not fulfill the following criterion:

The cancer committee meets at least once each calendar quarter.

STANDARD 1.5
Cancer Program Goals

Each year, the cancer committee establishes, implements, and monitors at least 1 clinical and at least 1 programmatic goal for the endeavors related to cancer care. Each goal is evaluated at least twice annually. The evaluation is documented in cancer committee minutes.

DEFINITION AND REQUIREMENTS

Annual goals provide direction for the strategic planning of cancer program activities and serve as the basis for cancer program evaluation. At least 1 clinical goal and at least 1 programmatic goal are established each year.

The cancer committee or appropriate subcommittee establishes goals appropriate to the program. The scope of this activity will vary, depending on the size of the program; however, it is recommended that cancer programs use the goal-setting tool known as SMART (Specific, Measurable, Achievable, Realistic, and Timely) when establishing the goals each year. Activities related to each goal must be implemented, monitored, evaluated, and documented in cancer committee minutes at least twice annually.

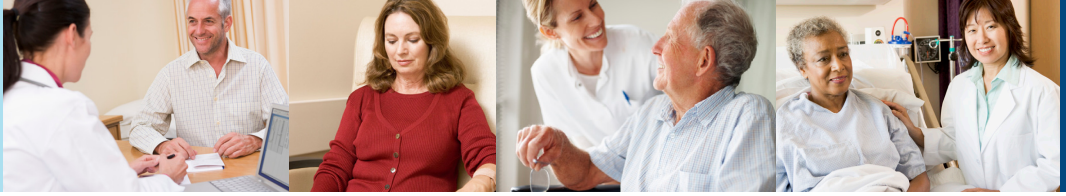
Goals do not need to be completed each year, but a different set of goals is to be established annually by the cancer committee. Goals that are not completed may be carried over into the next year; however, a new and different clinical and a new and different programmatic goal must be established each year.

Goals are not to be a restatement of a CoC standard because compliance with a standard is required.

Goals are to be established at the beginning of each year and evaluated at mid-year and at the end of the same year.

Examples of the topics to be addressed in the 2 types of goals include, but are not limited to, the following:

- **Clinical:** Involving the diagnosis, treatment, and care of the program's patients



- **Programmatic:** Directed toward the scope, coordination, and processes of care for patients in the cancer program

The cancer committee chair or an appropriate subcommittee chair is responsible for guiding the committee through the development and evaluation of the annual goals. The cancer committee establishes a time frame for achieving each goal. Monitoring and evaluation are necessary and are to be documented in the cancer committee minutes at least twice annually.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

The program provides the cancer committee minutes or other sources that document the annual goals, time frame for evaluation and completion, assigned coordinator, and responsibilities of other committee members.

MEASURING COMPLIANCE

Rating

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

1. At least 1 clinical goal is established, monitored, evaluated, and documented twice annually and documented by the cancer committee.
2. At least 1 programmatic goal is established, monitored, evaluated, and documented twice annually and documented by the cancer committee.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. At least 1 clinical goal is established, monitored, evaluated, and documented twice annually and documented by the cancer committee.
2. At least 1 programmatic goal is established, monitored, evaluated, and documented twice annually and documented by the cancer committee.

STANDARD 1.6 Cancer Registry Quality Control Plan

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 component.

DEFINITION AND REQUIREMENTS

High-quality cancer registry data are 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 assigned coordinator works cooperatively with registry staff or other departments to implement the quality control plan. The assigned coordinator monitors each area of cancer registry activity, reports at least annually to the cancer committee, and recommends corrective action if any area falls below the measures specified in the plan. The results, recommendations, and outcomes of recommendations are documented in the cancer committee minutes or other program-approved sources.

The quality control plan does the following:

1. Sets the review criteria
2. Sets the quality control timetable
3. Specifies the quality control methods, sources, and individuals involved
   - » Required activities
     - Random sampling of annual analytic caseload
     - Physician review (Reviewers may include residents and other physicians not necessarily on the cancer committee)
   - » Optional sources

- 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
   - » Casefinding
   - » Abstracting timeliness
   - » Accuracy of abstracted data
     - Class of Case
     - Primary Site
     - Histology
     - AJCC Stage
     - Collaborative Stage
     - First Course of Treatment
     - Follow-up information, including Date of First Recurrence, Type of First Recurrence, and Cancer Status
   - » The percentage of information coded as unknown (usually coded as 9 or a string of 9s)
   - » NCDB data submission, correction of data errors, and resubmission of corrected data

5. Defines the scope of the evaluation
Required scope
   - » Minimum: 10% of annual analytic caseload
   - » Maximum: 300 cases annually

6. Establishes the minimum quality benchmarks
Required accuracy
   - » Cancer registry data submitted to the NCDB meet the established quality criteria included in the annual NCDB Call for Data

7. Maintains documentation of the quality control activity
   - » Required documentation
   - » Review criteria
   - » Cases reviewed
   - » Identified data errors and resolutions
   - » Reports to the cancer committee

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Integrated Network Cancer Program
- Academic Comprehensive Cancer Program
- Comprehensive Community Cancer Program
- Community Cancer Program
- Hospital Associate Cancer Program
- Pediatric Cancer Program
- Freestanding Cancer Center Program

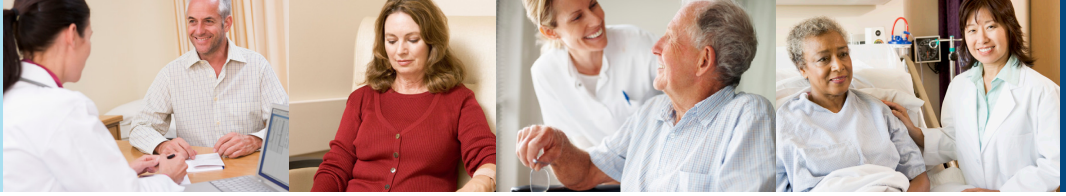
EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

In an 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 1 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, as appropriate. Physician participation in the quality control activity, particularly in resolution of conflicts, is required.

Veterans Affairs Cancer Program (VACP)

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 the SAR.

At the on-site visit, the program provides the quality control plan and cancer committee minutes or other documentation that includes the results of the annual quality control evaluation. 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. This information may be recorded in cancer committee minutes or other program-approved sources.

The surveyor discusses the cancer registry quality control activities and results with the quality control coordinator or with the NCIP facility's cancer registry manager or administrator, and other members of the cancer committee during the on-site visit.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criteria:

1. The cancer committee establishes and implements a plan to evaluate the required areas.
2. Each year, the cancer committee performs the required quality control review as outlined in the plan.
3. Each year, the findings of the review are reported to the cancer committee.
4. Each year, the review findings are documented in cancer committee minutes.

(5) Noncompliance: The program does not fulfill 1 or more of the following criteria:

1. The cancer committee establishes and implements a plan to evaluate the required areas.
2. Each year, the cancer committee performs the required quality control review as outlined in the plan.
3. Each year, the findings of the review are reported to the cancer committee.
4. Each year, the review findings are documented in cancer committee minutes.

NCIP Rating

(1) Compliance: The program fulfills all of the following criteria:

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

(5) Noncompliance: The program does not fulfill 1 or more of the following criteria:

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

STANDARD 1.7
Monitoring Conference Activity

The cancer conference coordinator monitors and evaluates the cancer conference activities and reports findings to the cancer committee at least annually.

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. The cancer committee monitors the cancer conference activity through the work of the cancer conference coordinator.

Routine evaluation of cancer conference activity in each of 7 areas is essential to ensure compliance with the requirements set by the cancer committee. These 7 areas are defined as follows:

- Conference frequency
- Multidisciplinary attendance
- Total case presentation
- Prospective case presentation
- Discussion of stage, including prognostic indicators, and treatment planning using evidence-based treatment guidelines
- Options for clinical trials
- Adherence to conference policy

Additional areas for discussion 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 are set by the cancer committee and documented in the cancer committee minutes. The assigned 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. In addition, the report will make reference to any recommendation for a QI activity that results from an evaluation of the cancer conference activity. These results are documented in the cancer committee minutes or other program-approved source.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCI-designated Comprehensive Cancer Center Program (NCIP) facilities.

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

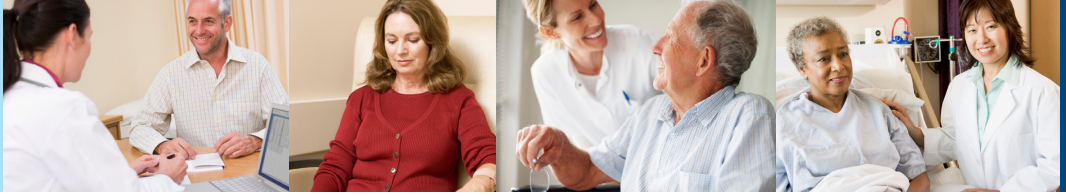
DOCUMENTATION

The program completes the SAR.

The program provides the cancer committee minutes or other documentation that demonstrates the monitoring of cancer conference frequency, multidisciplinary attendance, total case presentation and prospective case presentation, and any corrective action taken for an area that falls below the annual goal and mentions any QI 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.

An NCIP facility provides a monthly or yearly calendar of the cancer conference schedule to the surveyor during the on-site visit.



During the NCIP on-site visit, the program representatives will discuss and describe the cancer conference program activities with the surveyor. The surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

MEASURING COMPLIANCE

Rating

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

1. The cancer conference coordinator monitors and evaluates the cancer conference activities, including *all* of the following areas:
   - Conference frequency
   - Multidisciplinary attendance
   - Total case presentation
   - Prospective case presentation
   - Discussion of stage, including prognostic indicators, and treatment planning using evidence-based treatment guidelines
   - Options for clinical trials
   - Adherence to conference policy
2. The cancer conference coordinator reports the findings of the cancer conference evaluation to the cancer committee.
3. The report is documented in cancer committee minutes.

NCIP facilities: Default rating.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. The cancer conference coordinator monitors and evaluates the cancer conference activities including *all* of the following areas:
   - Conference frequency
   - Multidisciplinary attendance
   - Total case presentation
   - Prospective case presentation
   - Discussion of stage, including prognostic indicators, and treatment planning using evidence-based treatment guidelines
   - Options for clinical trials
   - Adherence to conference policy
2. The cancer conference coordinator reports the findings of the cancer conference evaluation to the cancer committee.
3. The report is documented in cancer committee minutes.

STANDARD 1.8
Monitoring Community Outreach

The community outreach coordinator monitors the effectiveness of community outreach activities on an annual basis. The activities and findings are documented in a community outreach activity summary that is presented to the cancer committee annually.

DEFINITION AND REQUIREMENTS

Based on the identified needs of the community, the prevention and early-detection/screening programs offered each year are monitored to ensure that appropriate services are provided to patients and the community.

The scope of services and the methods to access services and programs are evaluated annually. A coordinator who is a cancer committee member is designated to oversee this activity and report to the cancer committee annually. The methods used to monitor outreach activity are set by the cancer committee and are documented in cancer committee minutes.

The Community Outreach Coordinator Job Description

The cancer committee monitors community outreach activity through the work of the community outreach coordinator. The coordinator is chosen on the basis of his or her specialty, knowledge, skills, and interest. The community outreach coordinator may be:

- The director of the program's outreach department or
- A staff member of the program's outreach department.

In the absence of a program-designated outreach coordinator, a member of the cancer committee is selected to fulfill this role.

- The community outreach coordinator may be a physician or a nonphysician.
- The community outreach coordinator must be affiliated with or employed by the program.

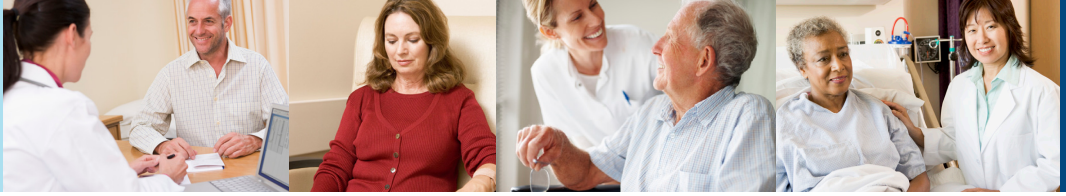
The community outreach coordinator works in collaboration with the applicable program departments and external organizations to develop, implement, and monitor community outreach activities. If the program has an established outreach department, the coordinator has the authority and responsibility to 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.

Minimally, the community outreach coordinator is required to:

- Contribute to the development of community outreach activities
- Work with community outreach organizations such as the local American Cancer Society representative on strategies to accomplish community outreach activities.
- Ensure that the provided prevention and early-detection/screening programs reflect the cancer experience at the program and the community-defined needs.
- Ensure that the prevention and early-detection/screening activities follow nationally accepted, evidence-based guidelines and evidence-based interventions.
- Ensure that a mechanism is in place to ensure follow-up of all positive findings identified through early-detection/screening activities.
- Evaluate the effectiveness of access and referral processes.
- Create a community outreach activity summary report that outlines the activities provided, the results of outreach programs, and follow-up. The report must contain the following information: identified areas of community need, specific community outreach activities performed, and summary of effectiveness of each activity.

The community outreach activity summary is shared with the cancer committee to facilitate discussion and decision making based on the activities of the year and assist in the establishment of goals and cancer registry data analysis. This discussion is documented in the cancer committee minutes on an annual basis. This report will also allow for follow-up recommendations and any necessary corrective actions.

The VACP facilities follow the U.S. Preventive Services Task Force recommendations for prevention or early-detection programs provided by the VACP facilities. Community outreach activities 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. The VACP may participate in community-based activities (such as health fairs) but this participation is not required to meet the standard.

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the program provides copies of cancer committee minutes and the community outreach activity summary that document the methods used to monitor and evaluate the community outreach activities. NCIP facilities provide the community outreach activity summary report to emphasize best practices for other facilities.

The surveyor will discuss the community outreach program with the designated coordinator and cancer committee members during the on-site visit and review the community outreach activity summary.

MEASURING COMPLIANCE

Rating

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

1. The cancer committee monitors the effectiveness of community outreach activities on an annual basis.
2. The activities and findings are documented in a community outreach activity summary.
3. The summary is shared with the cancer committee.
4. The summary is documented in cancer committee minutes.

NCIP facilities: Default rating.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. The cancer committee monitors the effectiveness of community outreach activities on an annual basis.
2. The activities and findings are documented in a community outreach activity summary.
3. The summary is shared with the cancer committee.
4. The summary is documented in cancer committee minutes.

Phase in for 2015.

STANDARD 1.9
Clinical Trial Accrual

As appropriate to the cancer program category, the required percentage of patients is accrued to cancer-related clinical trials each year. The clinical trial coordinator or representative reports clinical trial participation to the cancer committee each year.

DEFINITION AND REQUIREMENTS

Clinical research advances science and ensures that patient care approaches the highest possible level of quality. Patients who participate in clinical trials have the opportunity to advance evidence-based medicine.

A screening process is in place to identify patient eligibility. Through the clinical research coordinator or representative, the cancer committee evaluates and assesses the clinical trial screening process to identify and address barriers to patient participation. Identified areas in need of improvement are addressed, and a follow-up action plan is developed.

Professionals who can fill the role of the clinical research representative or coordinator include, but are not limited to, the following:

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

Resources for clinical trials include, but are not limited to, the following:

- NCI Physician Data Query
- American Cancer Society clinical trials matching service

Programs participating in cancer-related clinical research demonstrate that an independent peer-review mechanism consistent with national standards is in place and used. Research projects involving participation with human subjects must be approved by an internal or external institutional review board (IRB). Patients participating in clinical trials must give their informed written consent, unless verbal consent has been specified by the IRB.

The program accrues patients to cancer-related clinical research and enters at least the minimum number of patients (percentage) based on the category and the number of annual analytic accessions.

Patients eligible to meet this standard are seen at the program for:

- Diagnosis and/or treatment and placed in a cancer-related clinical trial through the program;
- Diagnosis and/or treatment and placed in a cancer-related clinical trial through the office of a staff physician;
- Diagnosis and/or treatment and placed in a cancer-related clinical trial through another program (referral); or
- Any reason and placed in a cancer prevention or cancer control clinical trial.

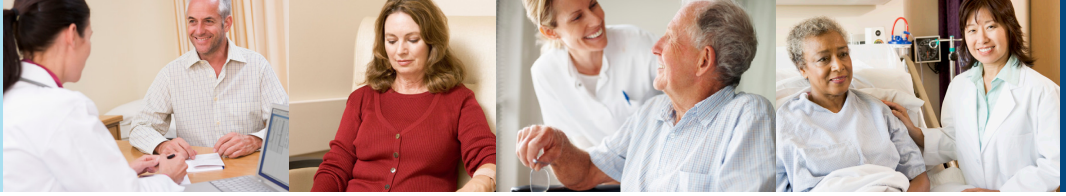
Basic science, clinical, and prevention and control research studies are generally conducted in cancer centers supported by grants from the NCI or in academic health centers. Research in community-based facilities involves therapeutic and nontherapeutic clinical trials.

Treatment-related clinical trial groups include, but not limited to, the following:

- NCI-sponsored cooperative cancer clinical trial groups
- Pharmaceutical company sponsored research
- Locally developed, investigator-initiated, peer-reviewed research

Cancer prevention and cancer control research includes, but is not limited to, the following:

- Primary prevention of cancer
- Early detection of cancer
- Quality of life related to cancer (supportive care trials)
- Economics of care related to cancer



Other eligible cancer-related research activities include the following:

- Bio repositories
- Patient registries with an underlying research focus (for example, the National Oncologic PET Registry)

A research coordinator, data manager, or other clinical research professional is available to assist with enrolling patients, monitoring patient accrual, and identifying and providing information and education about new cancer-related clinical trials in all categories of accreditation. Patient accrual must be monitored and reported to the cancer committee each year by the clinical research representative or coordinator. The report includes the number of patients accrued to cancer-related clinical trials each year. The report is documented in cancer committee minutes.

Researchers and clinical trial investigators who accept patients from other programs for the purpose of participation in a cancer-related clinical trial 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.

It is expected that all CoC-accredited programs will provide enrollment data and assistance to the cancer programs that refer patients for enrollment in cancer-related clinical trial.

Until 2015, cancer programs are expected to achieve the minimum and commendation accrual percentages set forth in standard 5.2 as published in *Cancer Program Standards 2009, Revised Edition* and based on the facility category as of 2011.

SPECIFICATIONS BY CATEGORY

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

MINIMUM REQUIRED AND COMMENDATION CLINICAL TRIAL ACCRUAL PERCENTAGES FOR EACH CATEGORY

Category	Minimum Required Percentage* Accrual to Clinical Trials	Commendation Percentage* Accrual to Clinical Trials
Integrated Network Cancer Program	6	8
NCI-designated Comprehensive Cancer Center Program	20	30
Academic Comprehensive Cancer Program	6	8
Veterans Affairs Cancer Program	2	4
Comprehensive Community Cancer Program	4	6
Community Cancer Program	2 Note: Until 2015, programs seeking initial accreditation in this category are exempt from the accrual percentage at the first survey.	4
Hospital Associate Cancer Program	Exempt	2
Pediatric Cancer Program	30	40
Freestanding Cancer Program	2	4

**Of the number of annual analytic cases.*

DOCUMENTATION

The program completes the SAR.

The program provides the cancer committee minutes that include the reports of the annual accruals to cancer-related clinical trials each year.

During the on-site visit, the surveyor will discuss the cancer-related clinical trials program activity with the cancer committee.

MEASURING COMPLIANCE

Rating

(1+) Commendation: Each year, the program fulfills the following criteria:

1. As appropriate to the cancer program category, the required Commendation percentage of patients is accrued to cancer-related clinical trials.
2. The annual number of patient accruals to cancer-related clinical trials are monitored.
3. The annual number of patient accruals to cancer-related clinical trials is reported to the cancer committee.
4. The report is documented in cancer committee minutes.

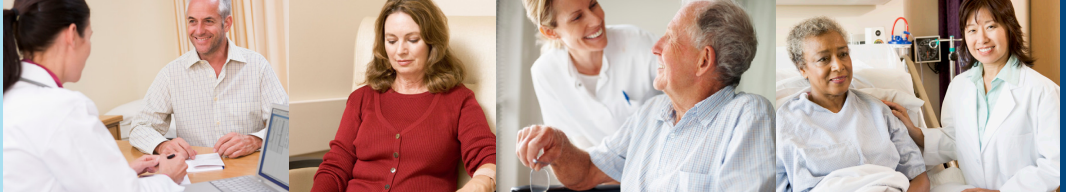
(1) Compliance: Each year, the program fulfills the following criteria:

1. As appropriate to the cancer program category, the minimum required percentage of patients is accrued to cancer-related clinical trials.
2. The annual patient accruals to cancer-related clinical trials are monitored.
3. The annual number of patient accruals to cancer-related clinical trials is reported to the cancer committee.
4. The report is documented in cancer committee minutes.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. As appropriate to the cancer program category, the minimum required percentage of patients is accrued to cancer-related clinical trials.
2. The annual number of patient accruals to cancer-related clinical trials are monitored.
3. The annual number of patient accruals to cancer-related clinical trials is reported to the cancer committee.
4. The report is documented in cancer committee minutes.

(8) Exempt: For use by HACP facilities that do not accrue patients to clinical trials.



STANDARD 1.10
Clinical Educational Activity

Each year, the cancer committee offers at least 1 cancer-related educational activity, other than cancer conferences, to physicians, nurses, and other allied health professionals. The activity is focused on 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.

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 year, the cancer committee offers at least 1 cancer-related educational activity, other than cancer conferences, to physicians, nurses, and allied health professionals. The educational activity focuses 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 (tumor board) in 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, but are not limited to, the following:

- An educational symposium
- 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 physician leader from the cancer committee designated to facilitate discussion.)

In NCIP facilities, cancer-related educational activities are offered, documented, and monitored centrally, departmentally, or by disease site teams each year as directed by the cancer center.

In PCP facilities at least 1 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

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

DOCUMENTATION

The program completes the SAR. NCIP facilities do not complete the SAR for this standard.

During the on-site visit, the program provides the documentation of 1 annual cancer-related educational activity, other than cancer conferences, including:

- An overview or objectives of the content presented, which includes AJCC or other appropriate staging in clinical practice;
- The use of appropriate prognostic indicators;

- Evidence-based national guidelines used in treatment planning; and
- Published notice or agenda for each year.

MEASURING COMPLIANCE

Rating

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

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

NCIP facilities: Default rating.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria.

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

STANDARD 1.11
Cancer Registrar Education

Each year, all members of the cancer registry staff participate in 1 cancer-related educational activity other than cancer conferences.

DEFINITION AND REQUIREMENTS

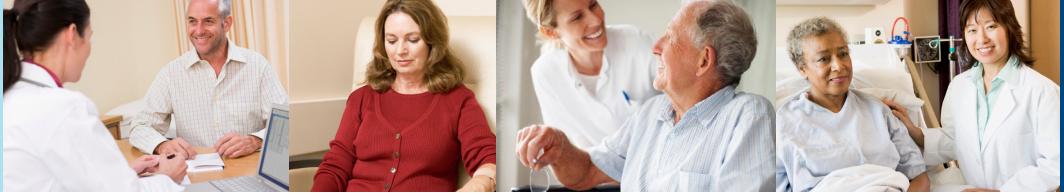
Ongoing cancer-related education enhances knowledge and skills. To facilitate accurate data collection and to gain or maintain their credentials, all members of the cancer registry staff participate in ongoing cancer-related education at the local, state, regional, or national level.

Full-time and part-time registry staff for whom annual education is required are:

- CTR staff
- Contract CTR staff who are contracted to work for 3 or more consecutive months during the calendar year, regardless of the number of hours worked
- All noncredentialed staff, including the following:
  - Staff abstracting under the supervision of a CTR
  - Staff performing follow-up activities
  - Management or supervisory personnel

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

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



Educational activities that can be used to fulfill the standard include, but are not limited to, the following:

- A cancer-related lecture offered by the program (local activity)
- A face-to-face meeting or workshop
  - Local—involves 1 program or facilities located in 1 city (local activity)
  - State—involves 1 state (state activity)
  - Regional—involves more than one state organization working collaboratively to develop the workshop. Agendas and meeting notices indicate the collaborative effort (regional activity)
  - National—is sponsored by a national organization and targeted to a national audience (national meeting)
- A video conference (local activity)
- A webinar (local activity)
- A Web-based training module (local activity)
- Journal-based articles that offer continuing education credits (local activity)

Educational activities exclude patient management cancer conferences in any format.

National organizations that sponsor national meetings include, but are not limited to the following:

- American Health Information Management Association (cancer-related educational activities)
- Association of Community Cancer Centers
- Commission on Cancer
- National Cancer Registrars Association
- National Comprehensive Cancer Network
- North American Association of Central Cancer Registries

Organizations that sponsor regional meetings include, but are not limited to:

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the program provides the documentation of the annual cancer-related educational activity for each member of the cancer registry staff.

MEASURING COMPLIANCE

Rating

(1+) Commendation: The program fulfills the following criteria:

1. All cancer registry staff participate in a cancer-related educational activity each year.
2. All CTR staff attend a national or regional cancer-related meeting once during the three-year survey cycle.

- NCIP facilities are exempt from the Commendation rating for this standard.

(1) Compliance: The program fulfills the following criterion:

- All cancer registry staff participate in a cancer-related educational activity each year.

(5) Noncompliance: The program does not fulfill the following criterion:

- All cancer registry staff participate in a cancer-related educational activity each year.

STANDARD 1.12
Public Reporting of Outcomes

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

DEFINITION AND REQUIREMENTS

Each year, the cancer committee develops and disseminates a report of patient or program outcomes to the public. The content of the report includes outcome information on 1 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

The report may be published in electronic or printed format and must be distributed to an audience external to the facility and medical staff.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written for commendation.

DOCUMENTATION

The program completes the SAR.

The program provides electronic copies of the report on patient or program outcomes for each year.

MEASURING COMPLIANCE

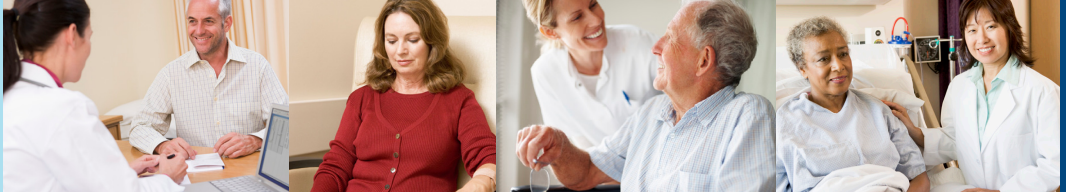
Rating

(1+) Commendation: The program fulfills the following criterion:

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

Clinical Services

NOTES



Clinical Services

STANDARD 2.1
College of American Pathologists Protocols

College of American Pathologists (CAP) protocols are followed to report the required data elements in 90% of the eligible cancer pathology reports each year.

DEFINITION AND REQUIREMENTS

The CoC requires that 90% of eligible pathology reports that include a cancer diagnosis will contain the required data elements outlined on the currently applicable surgical case summary checklist of the CAP publication, *Reporting on Cancer Specimens.*

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

- Pathology reports created by the program from resected specimens with an invasive histologic diagnosis
- Pathology reports created by the program from resected specimens with ductal carcinoma in situ (DCIS) histologic features

Diagnostic biopsy specimens, cytology specimens, special studies, and reports of in situ tumors (except for ductal carcinoma in situ) are excluded.

The cancer committee should encourage its pathology departments to adopt the synoptic format defined by the CAP cancer committee for use in cancer-related pathology reports. This definition is posted in the CoC Best Practices Repository located on the Cancer Programs page of the American College of Surgeons website at *www.facs.org/cancer/coc/bestpractices.html.*

At a minimum, a random sample of 10% of the 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.

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

Pediatric Cancer Program (PCP)

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

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the surveyor will evaluate the pathology reports for a random sample of eligible analytic cases for the 3 most recent complete years of abstracting to confirm that 90% of the reports include all of the required data items defined by the protocols. A maximum of 30 pathology reports will be reviewed.

MEASURING COMPLIANCE

Rating

(1+) Commendation: Each year, the program fulfills the following criteria:

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

(1) Compliance: The program fulfills the following criterion:

90% of cancer pathology reports include the required data elements as outlined in the CAP protocols.

(5) Noncompliance: The program does not fulfill the following criterion:

90% of cancer pathology reports include the required data elements as outlined in the CAP protocols.

STANDARD 2.2
Nursing Care

Oncology nursing care is provided by nurses with specialized knowledge and skills. Competency is evaluated annually.

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

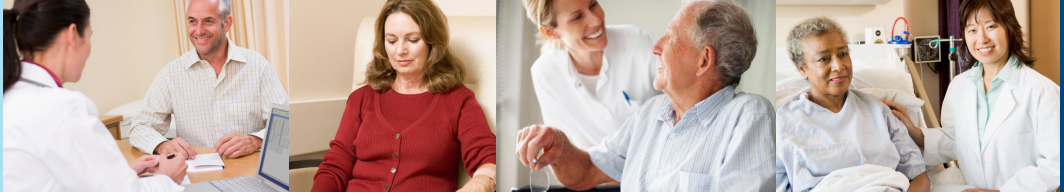
Nursing education is based on resources available from the ONS including, but not limited to, the following:

- ONS Cancer Basics Course
- ONS Chemotherapy and Biotherapy Course
- ONS Radiation Therapy Course
- Core Curriculum for Oncology Nursing

The 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. Organizational support for oncology nursing continuing education is strongly encouraged.

Nursing Competency

Nursing education and competency evaluation in oncology are implemented in all areas of the health care program where cancer care is provided. Annual nursing competency evaluation of oncology knowledge and skills is completed and documented according to organizational policy. Oncology nursing certification for all nurses providing oncology care is strongly encouraged.



The oncology nursing certifications include, but are not limited to, the following:

- 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™)

The credentials of nursing personnel will be verified by nursing service and confirmation reported at least annually to the cancer committee and documented in cancer committee minutes. All nurses caring for patients with cancer are encouraged to be certified. For commendation for this standard, 25% of the nurses who are employed by the facility (full time, part time, PRN) and who are chemotherapy trained currently hold one of the OCN certifications.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the surveyor will discuss with the cancer committee and oncology nurse managers and leaders the availability of oncology nursing education curricula and review the organizational policies for evaluating nursing competency. Nursing competencies specific to oncology nursing care are evident in the documentation provided.

MEASURING COMPLIANCE

Rating

(1+) Commendation: The program fulfills the following criteria:

1. 25% of chemotherapy-trained nurses employed by the facility (full-time, part-time, or PRN) hold a current oncology nursing certification (see list included in Definition and Requirements).
2. Nurses with specialized oncology knowledge and skills are available at the program.
3. Organizational policies and procedures are in place to evaluate oncology nursing competency.
4. Nursing competency is evaluated each year under the direction of the program's nursing department leadership.
5. Nursing competency is reported to the cancer committee and documented in minutes.

(1) Compliance: The program fulfills the following criteria:

1. Nurses with specialized oncology knowledge and skills are available at the program.
2. Organizational policies and procedures are in place to evaluate oncology nursing competency.
3. Nursing competency is evaluated each year under the direction of the program's nursing department leadership.
4. Nursing competency is reported to the cancer committee and documented in minutes.

(5) Noncompliance: The program does not fulfill 1 or more of the following criteria:

1. Nurses with specialized oncology knowledge and skills are available at the program.
2. Organizational policies and procedures are in place to evaluate oncology nursing competency.
3. Nursing competency is evaluated each year under the direction of the program's nursing department leadership.
4. Nursing competency is reported to the cancer committee and documented in minutes.

STANDARD 2.3
Risk Assessment and Genetic Counseling

Cancer risk assessment, genetic counseling, and testing services are provided to patients either on-site or by referral, by 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. Identifying patients at increased risk of developing cancer because of a family history of cancer or a known hereditary cancer syndrome can have dramatic effects on early detection and cancer outcome. For this reason, cancer risk assessment and genetic counseling are rapidly becoming standards of care for patients with personal and/or family history of cancer who are at high risk of having a hereditary syndrome.

The program provides cancer risk assessment and genetic counseling on-site or by referral to another facility or community-based organization.

Cancer risk assessment and genetic counseling are performed by a cancer genetics professional who has extensive experience and educational background in genetics, cancer genetics, counseling, and hereditary cancer syndromes to provide accurate risk assessment and empathetic genetic counseling to patients with cancer and their families.

Cancer risk assessment and the potential for referral may be discussed as part of the multidisciplinary cancer conference.

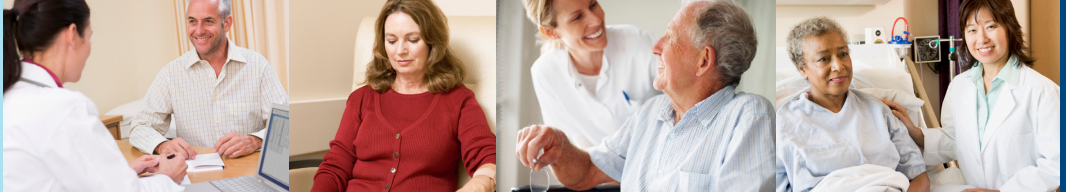
Genetics professionals include people with the following:

- 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 physician board certified in medical genetics
- A Genetics Clinical Nurse (GCN) or an Advanced Practice Nurse in Genetics (APNG), credentialed through the Genetics Nursing Credentialing Commission (GNCC). Credentialing is obtained through successful completion of a professional portfolio review process
- An advanced practice oncology nurse 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 physician with experience in cancer genetics (defined as providing cancer risk assessment on a regular basis)

**Please note, 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 risk assessment and genetic counseling.*

The Cancer Committee defines the appropriate individuals who will provide risk assessment and counseling for major cancer disease sites (such as breast and colorectal). In addition, the programs not having immediate access to formal genetic counseling services should identify resources for referral.

Cancer risk assessment and genetic counseling involve pretest and posttest counseling. At a minimum, this counseling includes the following:



Pretest Counseling

- Collecting relevant information needed to assess a patient's personal and family medical history
  - » A three- to four-generation pedigree, including detailed medical information about the patient's first-, second-, and third-degree relatives should be obtained. Gathering information about paternal and maternal family history, ancestry/ethnicity, and consanguinity, as available, is necessary.
- Evaluating the patient's risk
  - » One aspect of risk assessment is discussing the absolute risk that the patient will develop a specific type of cancer or cancers based on the family history. The second aspect is the risk that the patient carries a heritable or germ line mutation in a cancer susceptibility gene.
- Performing a psychosocial assessment
- Educating the patient about the suspected hereditary cancer syndrome, if appropriate
  - » The provider reviews and discusses with the patient the cancer risks associated with gene mutations, including basic concepts such as genes and inheritance patterns and more advanced concepts of penetrance and variable expressivity and the possibility of genetic heterogeneity.
- Obtaining informed consent for genetic testing (if genetic testing is recommended).

Posttest Counseling

- Disclosure of the results and posttest counseling include a discussion of the results, significance and impact of the test results, medical management options, informing other relatives, future contact, and available resources. The test results and interpretation will be communicated to the provider.

Guidelines and recommendations for cancer risk assessment and genetic counseling for hereditary cancer syndromes are available from the Agency for Healthcare Research and Quality (AHRQ) and the NCCN.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criterion:

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

(5) Noncompliance: The program does not fulfill the following criterion.

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

STANDARD 2.4
Palliative Care Services

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

DEFINITION AND REQUIREMENTS

Palliative care refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering (National Quality Forum [NQF]). 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.

An interdisciplinary team of medical and mental health professionals, social workers, and spiritual counselors provides palliative care services. Palliative care services on-site will vary depending on the scope of the program, local staff expertise, and patient population. The cancer committee will define on-site and off-site services. This definition will be reviewed by the cancer committee annually. A member of the palliative care team is a required member of the cancer committee when these services are provided at the facility.

Palliative care services not provided on-site are provided through referral to other facilities and/or local agencies. It is suggested that a team consist of *at least* 1 physician and 1 nonphysician member and may include the following:

- Physician: Board certification in hospice and palliative medicine is strongly encouraged
- Nurse: Specialized training or certification in hospice and palliative nursing is strongly encouraged
- Pharmacist
- Social worker
- Mental health clinician
- Chaplain or spiritual care counselor
- Trained volunteer

Palliative care services include, but are not limited to, the following:

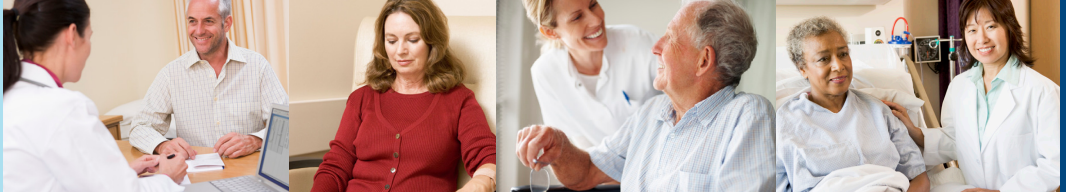
- Team-based care planning that involves the patient and family
- Pain and nonpain symptom management
- Communication among patients, families, and provider team
- Continuity of care across a range of clinical settings and services
- Attention to spiritual comfort
- Psychosocial support for patients and families
- Bereavement support for families of patients who die and team members who provided care to the person who died
- Hospice care: Hospice care is one aspect of palliative care and is a service delivery system that provides palliative care for patients who have a limited life expectancy. Hospice is presented as an option to patients and families when the prognosis is limited and death would not be surprising

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

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.



DOCUMENTATION

The program completes the SAR. NCIP facilities are not required to complete the SAR for this standard but are encouraged to participate so that data can be displayed in the CoC Hospital Locator.

During the on-site visit, the surveyor will discuss the palliative care services offered on-site or by referral.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criterion:

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

NCIP facilities: Default rating.

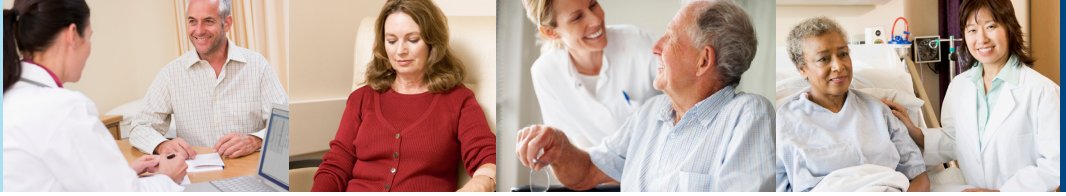
(5) Noncompliance: The program does not fulfill the following criterion:

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

NOTES

Continuum of Care Services

NOTES



Continuum of Care Services

Phase in for 2015.

STANDARD 3.1
Patient Navigation Process

A patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients. Resources to address identified barriers may be provided either on-site or by referral to community-based or national organizations. The navigation process is evaluated, documented, and reported to the cancer committee annually. The patient navigation process is modified or enhanced each year to address additional barriers identified by the community needs assessment.

DEFINITION AND REQUIREMENTS

Patient navigation in cancer care refers to individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care and can occur from prior to a cancer diagnosis 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 conducts a community needs assessment at least once during the three year survey cycle to identify: the needs of the population served, potential to improve cancer health disparities, and gaps in resources. The results from this community needs assessment can serve as the building blocks for program development, implementation, and evaluation. The cancer committee may delegate the responsibility for the community needs assessment and program implementation to a specified individual, subcommittee, or department. The community needs assessment results are documented in the cancer committee minutes.

The community needs assessment can be used to guide the initiatives planned to comply with the community outreach standards and/or the psychosocial services eligibility criteria. The completion of the community needs assessment does not fulfill the requirement for S 4.7 Studies of Quality.

The cancer committee, or responsible designee, selects appropriate tools to perform the community needs assessment. The cancer committee evaluates and reports on the navigation process annually. The evaluation and report includes, but is not limited to, the following:

- Health disparities identified
- Description of the navigation process
- Population(s) served and barriers identified by the community needs assessment
- Documentation of activities and metrics (outcomes/outputs)
- Areas for QI, enhancement, and future directions

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

The program provides a copy of the findings of the community needs assessment, evaluation, and report of the navigation process.

During the on-site visit, the surveyor discusses the navigation process with the cancer committee.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criteria:

1. Conduct a community needs assessment at least once during the three-year survey cycle to address health care disparities and barriers to care for patients.
2. Establish a patient 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 year, barriers to care are assessed and the navigation process is evaluated, documented, and the findings are reported to the cancer committee.
4. Each year, the patient navigation process is modified or enhanced to address additional barriers identified by the community needs assessment.

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

1. Conduct a community needs assessment at least once during the three-year survey cycle to address health care disparities and barriers to care for patients.
2. Establish a patient 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 year, barriers to care are assessed and the navigation process is evaluated, documented, and the findings are reported to the cancer committee.
4. Each year, the patient navigation process is modified or enhanced to address additional barriers identified by the community needs assessment.

Phase in for 2015.

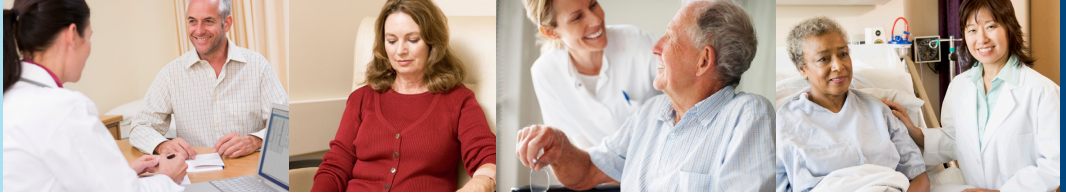
STANDARD 3.2
Psychosocial Distress Screening

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

Cancer is a complex disease process that affects patients in a variety of ways. Patients experience psychological, social, financial, and behavioral issues that can interfere with their treatment plan and adversely affect their outcome. 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.* According to the NCCN, *distress should be recognized, monitored, and documented and treated promptly at all stages of the disease.* In addition, this report emphasizes that all patients with cancer need to be referred for the appropriate provision of care and that high-quality psychosocial cancer care includes systematic follow-up and reevaluation. The purpose of this standard is to develop a process to incorporate the screening of distress into the standard care of oncology patients and provide patients identified with distress with resources and/or referral for psychosocial needs.

The psychosocial representative 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.



PROCESS REQUIREMENTS

(a) Timing of Screening: Patients with cancer are offered screening for distress a minimum of 1 time per patient at a pivotal medical visit to be determined by the program. Some examples of a "pivotal medical visit" include time of diagnosis, presurgical and postsurgical visits, first visit with a medical oncologist to discuss chemotherapy, routine visit with a radiation oncologist, or a postchemotherapy follow-up visit. Preference is 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), and transitions off treatment.

(b) Method: The mode of administration (such as patient questionnaire, clinician-administered questionnaire) is to be determined by the program.

(c) Tools: Facilities select the tool to be administered to screen for current distress. Preference is given to standardized, validated instruments with established clinical cutoffs; however, facilities may use a measure of their choice. Facilities are encouraged to use established clinical cutoffs when possible; however, facilities may determine the cutoff score used to identify distressed patients.

(d) Assessment and Referral: As recommended in the 2007 IOM report, if there is clinical evidence of moderate or severe distress, the patient's oncology team (oncologist, nurse, social worker, and/or psychologist) is to "identify and examine the psychological, behavioral and social problems of patients that interfere with their ability to participate fully in their health care and manage their illness and its consequences." This evaluation will confirm the presence of physical, psychological, social, spiritual, and financial support needs and indicate the need to link patients with psychosocial services offered on-site or by referral.

(e) Documentation: Screening, referral or provision of care, and follow-up are documented in the patient medical record to facilitate integrated, high-quality care.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

The program provides cancer committee minutes along with other sources that document the methods implemented to monitor and evaluate psychosocial distress screening.

During the on-site visit, the surveyor will discuss with the designated psychosocial representative and the cancer committee the psychosocial distress screening activities and the methods implemented to offer screening, referral or provision of care, and follow-up for psychosocial distress to patients with cancer.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criterion:

> 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.

(5) Noncompliance: The program does not fulfill the following criterion:

> 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.

Phase in for 2015.

STANDARD 3.3
Survivorship Care Plan

The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the cancer committee and documented in minutes.

DEFINITION AND REQUIREMENTS

The IOM and National Research Council 2005 report, *From Cancer Patient to Cancer Survivor: Lost in Transition,* recommends that patients with cancer who are completing the first of course treatment be "provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained." The recommendation suggested that these plans would help cancer survivors who may otherwise get "lost" in the transitions from the care they received during treatment through the phases of their life or stages of their disease course. The purpose of this standard is to have cancer programs develop and implement a process to monitor the dissemination of a survivorship care plan as a part of the standard care of patients with cancer. The process is implemented, monitored, evaluated, and presented annually to the cancer committee. The presentation is documented in minutes.

PROCESS REQUIREMENTS

(a) A survivorship care plan is prepared by the principal provider(s) who coordinated the oncology treatment for the patient with input from the patient's other care providers.

(b) The survivorship care plan is given to the patient on completion of treatment.

(c) The written or electronic survivorship care plan contains a record of care received, important disease characteristics, and a follow-up care plan incorporating available and recognized evidence-based standards of care, when available. The minimum care plan standards are included in the Fact Sheet: Cancer Survivorship Care Planning, from the IOM.

Additional resources are available to assist programs with the development of these tools, including care planning templates. Care planning templates are available from, for example, the American Society of Clinical Oncology, National Coalition for Cancer Survivorship, and the Lance Armstrong Foundation.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the surveyor will discuss with the cancer committee the methods implemented to create and disseminate a survivorship care plan.

MONITORING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criteria:

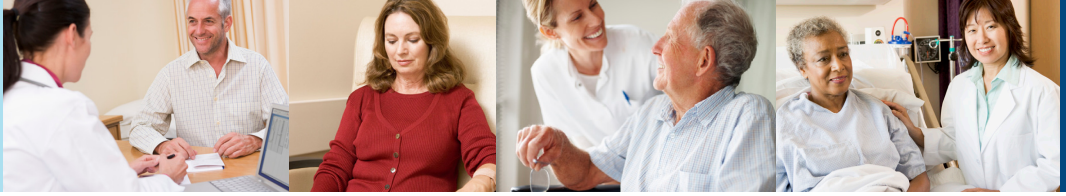
1. The cancer committee has developed a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment.
2. Each year, the process is implemented, monitored, evaluated, and presented to the cancer committee.

(5) Noncompliance: The program does not fulfill 1 or more of the following criteria:

1. The cancer committee has developed a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment.
2. Each year, the process is implemented, monitored, evaluated, and presented to the cancer committee.

Patient Outcomes

NOTES



Patient Outcomes

STANDARD 4.1
Prevention Programs

Each year, the cancer committee provides at least 1 cancer prevention program that is targeted to meet the needs of the community and should be designed to reduce the incidence of a specific cancer type. The prevention program is consistent with evidence-based national guidelines for cancer prevention.

DEFINITION AND REQUIREMENTS

Cancer prevention programs identify risk factors and use strategies to modify attitudes and behaviors to reduce the chance of developing cancer.

Annually, the cancer committee identifies the cancer prevention needs of the community and provides at least 1 cancer prevention program that is focused on decreasing the number of patients with a specific type of cancer. The prevention program is consistent with evidence-based national guidelines for cancer prevention.

Resources for evidence-based national guidelines related to cancer prevention include, but are not limited to, the following:

- Agency for Healthcare Research and Quality
  www.ahrq.gov
- American Cancer Society
  www.cancer.org/professional
- Cancer Control P.L.A.N.E.T.
  www.cancercontrolplanet.cancer.gov
- Centers for Disease Control and Prevention
  www.cdc.gov
- National Cancer Institute
  www.cancer.gov

Cancer prevention programs are provided on-site or are coordinated with other facilities and/or local agencies.

Cancer prevention programs include, but are not limited to, the following:

- Chemoprevention programs
- Education/cancer awareness
- Skin cancer prevention
- Smoking cessation
- Smoking prevention in adolescents
- Nutrition, physical activity, and weight loss programs

The VACP facilities follow the U.S. Preventive Services Task Force recommendations for prevention or early-detection 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. The VACP may participate in community-based activities (such as health fairs), but this participation is not required to meet the standard.

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

DOCUMENTATION

The program completes the SAR. NCIP facilities are not required to complete the SAR for this standard but are encouraged to participate so that data can be displayed in the CoC Hospital Locator.

The program provides documentation of the planning and provision of at least 1 annual cancer prevention program provided by the cancer committee and documented in minutes or other sources.

The surveyor discusses the prevention program with the designated coordinator and cancer committee members during the on-site visit.

MEASURING COMPLIANCE

Rating

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

1. The cancer committee assesses the prevention needs of the community.
2. The cancer committee provides at least 1 cancer prevention program.
3. The cancer prevention program is consistent with evidence-based national guidelines and evidence-based interventions.

NCIP facilities: Default rating.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. The cancer committee assesses the prevention needs of the community.
2. The cancer committee provides at least 1 cancer prevention program.
3. The cancer prevention program is consistent with evidence-based national guidelines and evidence-based interventions.

STANDARD 4.2
Screening Programs

Each year, the cancer committee provides at least 1 cancer screening program that is targeted to decreasing the number of patients with late-stage disease. The screening program is based on community needs and is consistent with evidence-based national guidelines and evidence-based interventions. A process is developed to follow up on all positive findings.

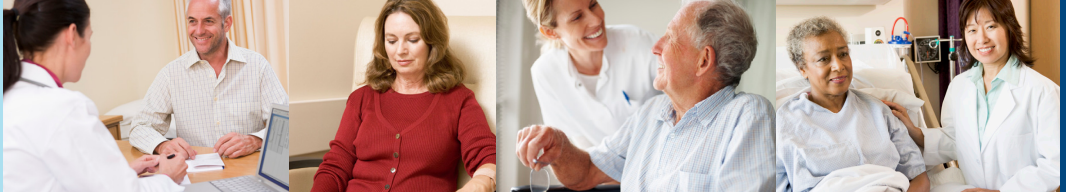
DEFINITION AND REQUIREMENTS

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

Annually, the cancer committee provides at least 1 cancer screening program that is focused on an identified community need. Cancer screening activities are provided according to recognized evidence-based national guidelines. 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.

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

- Agency for Healthcare Research and Quality
  www.ahrq.gov
- American Cancer Society
  www.cancer.org/professional
- American Society of Clinical Oncology
  www.asco.org
- National Cancer Center Network
  www.nccn.org
- National Cancer Institute
  www.cancer.gov



Cancer screening programs are provided on-site or are coordinated with other facilities and/or local agencies such as the American Cancer Society.

Cancer screening programs include, but are not limited to, the following:

- Breast (radiographic and physical examination)
- Colonoscopy, flexible sigmoidoscopy, or fecal occult blood testing (such as Hemoccult, Beckman Coulter, Brea, CA)
- Papanicolaou testing with or without human papillomavirus (HPV) testing
- Prostate Screening Programs (Note: The American Cancer Society and The U.S. Preventive Services Task Force do not recommend PSA-based screening for prostate cancer in asymptomatic men in the general U.S. population, regardless of age. Both organizations recommend that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer.)
- Skin surveys

In PCP facilities, cancer screening programs include, but are not limited to, the following:

- Testicular screening
- Breast cancer screening for survivors of Hodgkin's disease
- Skin

The VACP facilities follow the U.S. Preventive Services Task Force recommendations for screening.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for NCIP facilities and Veterans Affairs Cancer Program (VACP) facilities.

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

VACP

In VACP facilities, screening services are offered at the VACP to more effectively reach the veteran population through ongoing programs or clinics. The VACP may participate in community-based activities (such as health fairs), but this participation is not required to meet the standard. The rating for this standard defaults to 1, Compliance.

DOCUMENTATION

The program completes the SAR. NCIP facilities do not complete the SAR for this standard but are encouraged to participate so that data can be displayed in the CoC Hospital Locator.

The program provides documentation of at least 1 annual cancer screening program provided by the cancer committee and recorded in minutes or other documents. The documentation includes a reference to the guidelines and interventions used and the process in place to follow up on positive findings.

During the on-site visit, the surveyor discusses the screening program with the designated coordinator and cancer committee members.

During the NCIP on-site visit, the program provides the surveyor with copies of the appropriate section of the NCI grant that describes the prevention activities at the program.

MEASURING COMPLIANCE

Rating

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

1. The cancer committee identifies the screening needs of the community.
2. The cancer committee provides at least 1 cancer screening program.
3. The cancer screening program is consistent with evidence-based national guidelines and evidence-based interventions.
4. A process is developed to follow up on all positive findings.

NCIP facilities: Default rating.

VACP facilities: Default rating.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. The cancer committee identifies the screening needs of the community.
2. The cancer committee provides at least 1 cancer screening program.
3. The cancer screening program is consistent with evidence-based national guidelines and evidence-based interventions.
4. A process is developed to follow up on all positive findings.

STANDARD 4.3
Cancer Liaison Physician Responsibilities

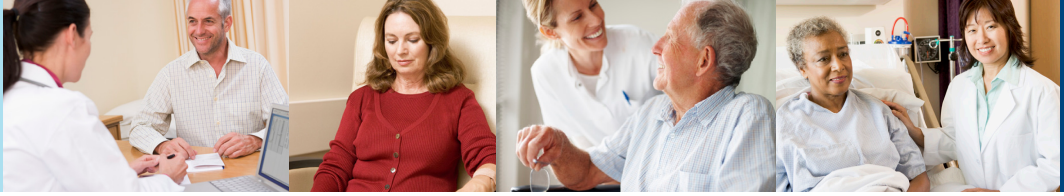
A Cancer Liaison Physician serves in a leadership role within the cancer program and is responsible for evaluating, interpreting, and reporting the program's performance using the National Cancer Data Base (NCDB) data. The CLP, or an equivalent designee, reports the results of this analysis to the cancer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

DEFINITION AND REQUIREMENTS

A CLP is a volunteer physician responsible for providing the leadership and direction to monitor, maintain, and improve quality at the cancer program.

Recommended Selection Criteria

- The CLP position is a required component of 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 required member of the cancer committee.
- The CLP is a member of the medical staff. The cancer committee must ensure that the physician is authorized to access facility-specific information that is maintained by the CoC.
- The CLP serves as the liaison among the cancer program, the CoC, and the American Cancer Society.
- The CLP can fulfill a leadership position within the cancer committee such as chair, vice chair, or quality improvement coordinator.



Primary Responsibilities

The primary responsibilities of the CLP are to monitor, interpret, and report the program's performance using NCDB data to evaluate and improve the quality of care. The CLP reports and discusses the facility's performance and response related to the accountability and quality improvement measures or other NCDB facility data (such as the NCDB Hospital Comparison Benchmark Reports and NCDB Survival Reports) with the cancer committee 4 times each year. 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.

Secondary Responsibilities

- The CLP reports on CoC activities, initiatives, and priorities to the cancer committee.
- The CLP serves as liaison for the cancer program with the American Cancer Society.
- The CLP is present during the CoC survey and meets with the surveyor.

Educational Requirements

- The CLP is required to complete CLP orientation within three months of initial appointment and on reappointment every three years.
- It is suggested that the CLP view all Web-based CLP education programs provided by the CoC each year. These programs are intended to facilitate the CLP's role in quality assessment and improvement using the NCDB tools. These programs are specific to continuously informing and enhancing the role of the CLP.

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.

DOCUMENTATION

The CLP completes the CLP Activity Report of the SAR annually.

A newly appointed CLP and a CLP who is reappointed for a three-year term complete Web-based orientation and training.

The program provides cancer committee minutes that document the CLP reports on NCDB data, including actions and response.

During the on-site visit, the CLP discusses CLP activities with the surveyor.

MEASURING COMPLIANCE

Rating

(1) Compliance: The CLP fulfills the following criteria:

1. Each year, the CLP evaluates and interprets the program's performance using the NCDB data.
2. Each year, the CLP, or an equivalent designee, reports this information to the cancer committee at least four times each year.
3. The CLP is present during the CoC survey and meets with the surveyor.

(5) Noncompliance: The CLP does not fulfill 1 or more of the following criteria:

1. The program has not appointed a CLP for a period of six consecutive months.
2. Each year, the CLP evaluates and interprets the program's performance using the NCDB data.
3. Each year, the CLP, or an equivalent designee, reports this information to the cancer committee at least four times each year.
4. The CLP is present during the CoC survey and meets with the surveyor

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

STANDARD 4.4
Accountability Measures

Annually, performance levels are met for each of the specified accountability measures as defined by the Commission on Cancer.

DEFINITION AND REQUIREMENTS

The cancer committee ensures that patients with cancer are treated according to nationally accepted measures as measured by compliance with the current CoC quality reporting tools (such as the Cancer Program Practice Profile Reports [CP^{3}R]). An accountability measure is the standard of care based on clinical trial evidence.

The CoC requires the cancer committee to review the quality of patient care using CoC quality reporting tools appropriate to the patients who are treated by the program each year. 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 evidenced-based practice.

The cancer committee addresses performance rates that fall below levels established by the CoC. Evidence of this monitoring activity will be documented in the cancer committee minutes and reflected in the CoC quality reporting tools. The action(s) taken and any required follow-up, if relevant, are included in the documentation. Specifics about the performance rates can be found on the CoC website.

Multidisciplinary effort will be required under the guidance of the cancer committee or other appropriate leadership body.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written except for Integrated Network Cancer Programs (INCP).

EXCEPTIONS BY CATEGORY

INCP

Performance levels for facilities that are part of an Integrated Network Cancer Program are evaluated individually and as an INCP overall. Each facility that is part of an INCP is expected to individually meet the performance levels set by the CoC. The INCP as a whole is expected to meet the performance levels set by the CoC.

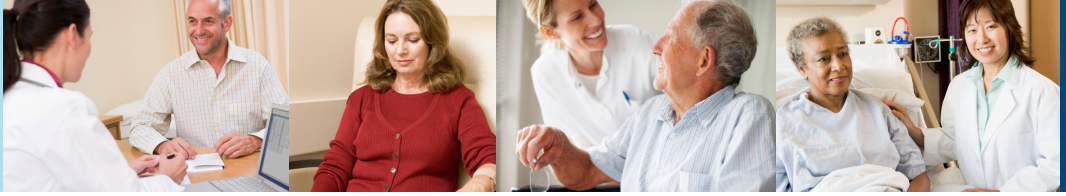
Programs in all categories undergoing initial survey for accreditation are exempt from this standard. The rating defaults to 8 Not Applicable.

DOCUMENTATION

The program completes the SAR.

The CoC issues a provisional rating, based on current data in the quality reporting tools.

Through cancer committee minutes, the surveyor will be provided documentation that demonstrates the monitoring of the quality of patient care by the cancer committee using the CoC quality reporting tools as evidenced at least annually and verify that an action plan was developed and executed if the program's performance rates were observed to be below levels established by the CoC.



MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criteria:

1. Each year, the cancer committee reviews the program's performance using the CoC quality reporting tools.
2. Each year, the review activity is reported in cancer committee minutes.
3. For every measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC in each year since the program's last survey, or the program has implemented an action plan that reviews and addresses program performance.

(5) Noncompliance: The program does not fulfill 1 or more of the following criteria:

1. Each year, the cancer committee reviews the program's performance using the CoC quality reporting tools.
2. Each year, the review activity is reported in cancer committee minutes.
3. For every measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC in each year since the program's last survey, or the program has implemented an action plan that reviews and addresses program performance.

(8) Not Applicable: Cancer programs with no cases eligible for assessment in all of the selected measures.

Programs in all categories undergoing initial survey for accreditation.

STANDARD 4.5
Quality Improvement Measures

Annually, performance levels are met for each of the specified quality improvement measures as defined by the Commission on Cancer.

DEFINITION AND REQUIREMENTS

The cancer committee ensures that patients with cancer are treated according to nationally accepted QI measures as measured by compliance with the current CoC quality reporting tools (such as the Cancer Program Practice Profile Reports [CP^{3}R]). A QI measure is one that demonstrates good practice but is not based on clinical trial evidence.

The CoC requires the cancer committee to review the quality of patient care using CoC quality reporting tools appropriate to the patients who are treated by the program annually. 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 high-quality care.

The cancer committee addresses performance rates that fall below levels established by the CoC. Evidence of this monitoring activity will be documented in the cancer committee minutes and reflected in the CoC quality reporting tools. The action(s) taken and any required follow-up, if relevant, are included in the documentation. Specifics about the performance rates can be found on the CoC website.

Multidisciplinary effort will be required under the guidance of the cancer committee or other appropriate leadership body.

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. The rating defaults to 8 Not Applicable.

DOCUMENTATION

The program completes the SAR.

The CoC issues a provisional rating, based on current data in the quality reporting tools.

Through cancer committee minutes, the surveyor will be provided documentation that demonstrates the monitoring of the quality of patient care by the cancer committee using the CoC quality reporting tools as evidenced at least annually and verify that an action plan was developed and executed if the program's performance rates were observed to be below levels established by the CoC.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criteria:

1. Each year, the cancer committee monitors the program's performance using the CoC quality reporting tools.
2. Each year, the monitoring activity is reported in cancer committee minutes.
3. For the measure(s) selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC, or the program has implemented an action plan that reviews and addresses program performance.

(5) Noncompliance: The program does not fulfill 1 or more of the following criteria:

1. Each year, the cancer committee monitors the program's performance using the CoC quality reporting tools.
2. Each year, the monitoring activity is reported in cancer committee minutes.
3. For the measure(s) selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC, or the program has implemented an action plan that reviews and addresses program performance.

(8) Not Applicable: Cancer programs with no cases eligible for assessment in all of the selected measure(s).

Programs in all categories undergoing initial survey for accreditation.

STANDARD 4.6
Monitoring Compliance with Evidence-Based Guidelines

Each year, a physician member of the cancer committee performs a study to assess whether patients within the program are evaluated and treated according to evidence-based national treatment guidelines. Study results are presented to the cancer committee and documented in cancer committee minutes.

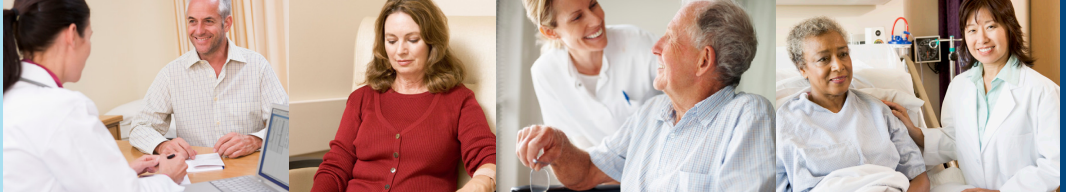
DEFINITION AND REQUIREMENTS

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 year, a physician member of the cancer committee performs a study to examine the evaluation and treatment of patients and ensure that it is compliant with evidence-based national guidelines. The study must determine that 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 could serve as a source for a performance improvement.

The annual study includes all of the following components:

1. Sources for the study include 1 of the following:
   - » A site-specific sample:
     - Involves all cases from that site, to a maximum of 300 cases;
     - Is based on an identified need, concern, or problem; or
     - Is based on uncommon cases such as cases not generally presented at cancer conferences.
   - » 10% random review of the annual analytic case load; maximum review of 300 cases for any facility
   - » Review of a single treatment for a specific cancer site (such as neoadjuvant therapy for breast cancer, radiation therapy for breast conservation)



2. A determination that the first course of therapy is concordant with an evidence-based national treatment guideline and/or prognostic indicators, when available

3. Reporting format that permits analysis and provides an opportunity to recommend performance improvements

The results of the annual study are presented to the cancer committee and documented in the cancer committee minutes. The cancer committee should use the findings to make improvements in patient care. The completion of this study does 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

NCI-designated Comprehensive Cancer Center Programs (NCIP)

NCIP facilities are exempt from the standard. The rating defaults to 1, Compliance.

DOCUMENTATION

The program completes the SAR. NCIP facilities do not complete the SAR for this standard.

The program provides copies of the annual study results and cancer committee minutes in which the results were reported. When applicable, the program provides a list of performance improvements that have been implemented as a result of the study.

RATING

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

1. A physician member of the cancer committee conducts a study 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 study results are reported to the cancer committee.

3. The study results are documented in cancer committee minutes.

NCIP facilities: Default rating.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. A physician member of the cancer committee conducts a study 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 study results are reported to the cancer committee.

3. The study results are documented in cancer committee minutes.

STANDARD 4.7
Studies of Quality

Each year, based on category, the quality improvement coordinator, under the direction of the cancer committee, develops, analyzes, and documents the required studies that measure the quality of care and outcomes for patients with cancer.

DEFINITION AND REQUIREMENTS

The annual evaluation of the care of patients with cancer provides a baseline to measure quality and an opportunity to correct or enhance care and quality outcomes. Quality improvement is a multidisciplinary effort and must include support and representation from all clinical, administrative, and patient perspectives.

The QI coordinator, under the direction of the cancer committee, focuses on evaluating areas of cancer care. Study topics are selected by the cancer committee and the QI coordinator.

The study focuses on areas with *problematic* quality-related issues relevant to the program and local cancer patient population. When possible, studies are designed to evaluate the entire spectrum of cancer care, including diagnosis and treatment and the psychosocial and supportive care of patients. The spectrum of cancer includes issues related to the following:

- Structure
- Process
- Outcomes

Studies are designed to involve physicians and allied health professionals.

Quality improvement tools to help address these issues include, but are not limited to, the following:

- Checklist
- Fishbone diagram
- Flowchart
- Pareto chart
- Run chart

Completing a study of quality is the first step in the QI process. Standard 4.7 provides information for the second step in the QI process. The second step focuses on implementation of a correction or improvement in performance that is based on the findings from a study of quality.

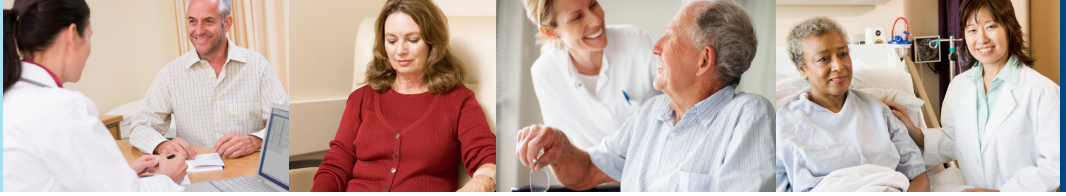
For each quality study, the QI coordinator and the cancer committee are responsible for the following:

- Setting the study topic that identifies problematic quality-related issues
- Defining criteria for evaluation, including data needed to evaluate the study topic or answer the quality-related question
- Conducting the QI study according to the identified measures
- Preparing a summary of the findings
- Comparing data results with national benchmarks
- Designing and initiating action plans based on the evaluation of the data
- Establishing follow-up steps to monitor the actions implemented
- Monitoring the effectiveness of the study action plans and all cancer-related QI activities at the program

The methods used to monitor studies of quality are set by the QI coordinator and the cancer committee and documented in cancer committee minutes and are shared with the medical staff and administration.

Note the following:

- Data monitoring may be used once to examine (study) a quality topic but not continued annually.
- Activities that duplicate study topics and criteria without analysis of the findings do not fulfill this standard.
- Ongoing monitoring activities do not fulfill this standard.
- A study required by outside organizations related to oncology is acceptable if it follows the study criteria that are outlined in this standard.
- Review of data presented in the CoC quality reporting tools does not fulfill the requirement for this standard.



SPECIFICATIONS BY CATEGORY

CATEGORY	REQUIRED NUMBER OF STUDIES OF THE QUALITY OF CANCER CARE AND OUTCOMES
Integrated Network Cancer Program	3
NCI-designated Comprehensive Cancer Center Program	3 (published studies of quality are acceptable)
Academic Comprehensive Cancer Program	2
Veterans Affairs Cancer Program	1 study of the quality of cancer care and outcomes; 1 additional program-defined study or study of quality defined at the VISN or regional level
Comprehensive Community Cancer Program	2
Community Cancer Program	2
Hospital Associate Cancer Program	2
Pediatric Cancer Program	2
Freestanding Cancer Center Program	2

DOCUMENTATION

The program completes the SAR.

The program provides summaries of studies, analyses, recommendations, and follow-up for each year. The NCIP facilities submit a list of published studies.

MEASURING COMPLIANCE

Rating

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

1. Based on category, the QI coordinator, under the direction of the cancer committee, develops the required number of cancer patient care studies.
2. The results of the required number of studies are analyzed by the QI coordinator, under the direction of the cancer committee.
3. The results of the required number of studies are documented by the QI coordinator in cancer committee minutes.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. Based on category, the QI coordinator, under the direction of the cancer committee, develops the required number of cancer patient care studies.
2. The results of the required number of studies are analyzed by the QI coordinator, under the direction of the cancer committee.
3. The results of the required number of studies are documented by the QI coordinator in cancer committee minutes.

STANDARD 4.8
Quality Improvements

Annually, the quality improvement coordinator, under the direction of the cancer committee, implements 2 patient care improvements. One improvement is based on the results of a completed study that measures cancer patient quality of care and outcomes. One improvement can be identified from another source or from a completed study. 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 patient care. Implementation of improvements demonstrates a program's continuous commitment to providing high-quality cancer care. The results of a study of cancer patient care provide a baseline to measure and improve quality.

Sources for improvements include, but are not limited to, the following:

- Actions based on analysis of a study of quality
- Actions to address undesirable performance
- Changes to improve acceptable performance

In NCIP facilities, at least 2 quality improvements affecting patient care are implemented centrally, departmentally, through disease site teams, or through other program-appropriate methods as directed by the cancer center. One improvement is linked to a completed study of quality.

The QI coordinator monitors, reports, and recommends activity related to the QI 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 results and recommendations are documented in cancer committee minutes that are shared with the medical staff and administration.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

MEASURING COMPLIANCE

Rating

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

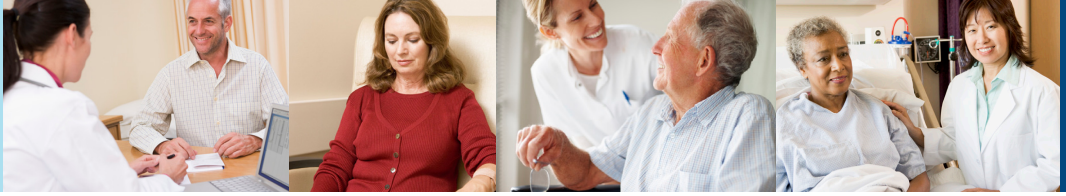
1. The QI coordinator, under the direction of the cancer committee, implements 1 patient care improvement based on the results of a completed study.
2. The QI coordinator, under the direction of the cancer committee, implements 1 patient care improvement based on any source.
3. The improvements are documented in the cancer committee minutes.
4. The improvements are shared with medical staff and administration.

(5) Noncompliance: Each year, the program does not fulfill 1 or more of the following criteria:

1. The QI coordinator, under the direction of the cancer committee, implements 1 patient care improvement based on the results of a completed study.
2. The QI coordinator, under the direction of the cancer committee, implements 1 patient care improvement based on any source.
3. The improvements are documented in the cancer committee minutes.
4. The improvements are shared with medical staff and administration.

Data Quality

NOTES



Data Quality

STANDARD 5.1
Cancer Registrar Credentials

Case abstracting is performed by a Certified Tumor Registrar.

DEFINITION AND REQUIREMENTS

Beginning January 1, 2012, all cancer registry staff who perform case abstracting 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. The plan for CTR supervision of noncredentialed staff includes the scope of supervision, quality control rate, and educational and training activities for staff who are not credentialed. A noncredentialed abstractor currently working in a CoC-accredited program must pass the CTR examination by January 2015.

Anyone hired after January 1, 2012, to perform abstracting in a CoC-accredited program must pass the CTR examination within 3 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.

The CTR credential is granted through the National Cancer Registrars Association, which provides details on eligibility, testing, and recredentialing.

High-quality cancer registry data are essential to accurately access treatment outcomes and patient survival. Successful operation of the cancer registry requires credentialed staff who are trained and knowledgeable in all aspects of oncology data collection and case abstracting. Abstracting is defined as coding and entering patient- and disease-specific information into the cancer registry data base.

Certified Tumor Registrars 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 case abstracting responsibilities of the CTR are documented.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the program provides the following:

- Confirmation of a valid CTR credential for all certified staff
- Verification of the date of hire to perform case abstracting in the cancer registry
- The plan for CTR supervision of noncredentialed staff who perform case abstracting in the cancer registry

The CoC tracks the status of noncredentialed staff.

MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills either or both of the following criteria:

1. Case abstracting is performed by a CTR.
2. Noncredentialed staff who are abstracting and who are in the three-year grace period are supervised by a CTR.

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

1. Case abstracting is performed by a CTR.
2. Noncredentialed staff who are abstracting and who are in the three-year grace period are supervised by a CTR.

STANDARD 5.2
Rapid Quality Reporting System (RQRS) Participation

From initial enrollment and throughout the three-year accreditation period, the program participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to 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.

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, receive notifications of treatment expectations, and presents year-to-date concordance rates for each measure as compared to the state, other hospital groups, and hospitals at the national level.

The details for RQRS participation are provided in the RQRS terms and conditions available in the National Cancer Data Base (NCDB) section of the Cancer Program page of the American College of Surgeons website (*www.facs.org/cancer*).

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

SPECIFICATIONS BY CATEGORY

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

Programs that are not eligible for RQRS, including new programs undergoing initial survey for accreditation, are exempt from the standard. The rating defaults to 8 Not Applicable.

This standard is excluded from the OAA criteria for programs that are not eligible for RQRS participation.

DOCUMENTATION

The program completes the SAR.

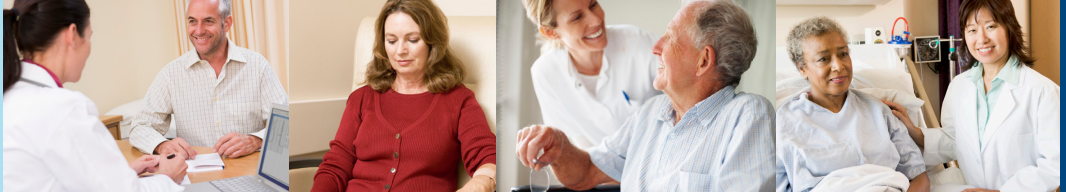
The NCDB confirms submission of cases as outlined in the RQRS terms and conditions.

MEASURING COMPLIANCE

Rating

(1+) Commendation: The program fulfills the following criterion:

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



STANDARD 5.3
Follow-Up of All Patients

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

STANDARD 5.4
Follow-Up of Recent Patients

A 90% follow-up rate is maintained for all eligible analytic cases diagnosed within the last 5 years or from the cancer registry reference date, whichever is shorter.

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 that are 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 monitorings particularly 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.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for pediatric cancer program (PCP) facilities.

EXCEPTIONS BY CATEGORY

Pediatric Cancer Program (PCP)

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 27 years, follow-up attempts are to continue, but the data for the patients are excluded from the follow-up calculations.

Programs in all categories undergoing initial survey for accreditation are exempt from this standard. The rating defaults to 8 Not Applicable.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the program provides a copy of the cancer committee's policies for obtaining follow-up information and a current follow-up report.

MEASURING COMPLIANCE

Rating

Standard 5.3: Follow-Up of All Patients

(1) Compliance: The program fulfills the following criterion:

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

(5) Noncompliance: The program does not fulfill the following criterion:

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

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

Standard 5.4: Follow-Up of Recent Patients

(1) Compliance: The program fulfills the following criterion:

> Excluding patients with age-specific exclusions, a 90% follow-up rate is maintained for all analytic cases diagnosed within the last 5 years or from the cancer registry reference date, whichever is shorter.

(5) Noncompliance: The program does not fulfill the following criterion:

> Excluding patients with age-specific exclusions, a 90% follow-up rate is maintained for all analytic cases diagnosed within the last 5 years or from the cancer registry reference date, whichever is shorter.

(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.

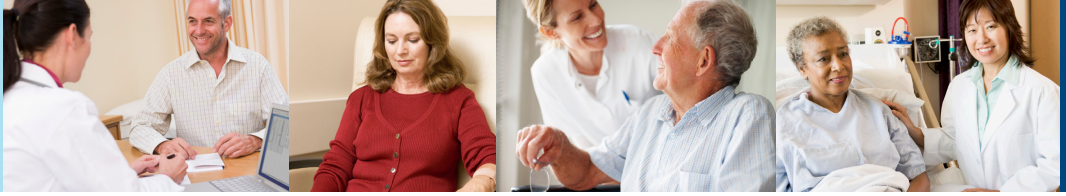
DEFINITION AND REQUIREMENTS

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. The NCDB data are useful benchmarks for patient care and continuous QI 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 request for the initial survey of a new program is accepted by the CoC, the program submits data to the NCDB for the most recent complete abstracting year currently accepted by the NCDB. Data are submitted, and errors and rejected records are corrected (Standard 5.6) 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. The rating defaults to 8 Not Applicable.

DOCUMENTATION

Data submission history is confirmed by the CoC and displayed in the SAR.

MEASURING COMPLIANCE

Rating

(1) Compliance: Each year, the program fulfills the following criterion:

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

(5) Noncompliance: Each year, the program does not fulfill the following criterion:

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

(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

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

DOCUMENTATION

Programs in all categories undergoing initial survey for accreditation are exempt from this standard. The rating defaults to 8 Not Applicable.

MEASURING COMPLIANCE

Rating

(1+) Commendation: Each year, the program fulfills the following criterion:

> 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 year, the program fulfills the following 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: Each year, the program does not fulfill 1 or more of the following 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.

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

STANDARD 5.7 Commission on Cancer Special Studies

The 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, select accredited programs will participate in each study.

The cases included in the study and due date are specified in the study documentation provided by the CoC. To fulfill the standard, the selected program submits 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

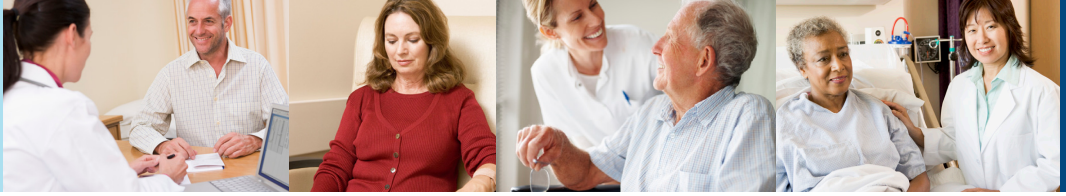
Upon request, all cancer programs fulfill the standard as written except for programs in all categories undergoing initial survey for accreditation.

EXCEPTIONS BY CATEGORY

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

DOCUMENTATION

Participation in CoC special studies is confirmed by the CoC and displayed in the SAR.



MEASURING COMPLIANCE

Rating

(1) Compliance: The program fulfills the following criteria:

1. The program participates in each study, as requested.
2. Complete data are submitted by the established deadline for each special study.

(5) Noncompliance: The program does not fulfill 1 or more of the following criteria:

1. The program participates in each study, as requested.
2. Complete data are submitted by the established deadline for each special study.

(8) Not Applicable: The program was not selected to participate in a special study.

Programs in all categories undergoing initial survey for accreditation.

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Glossary of Terms

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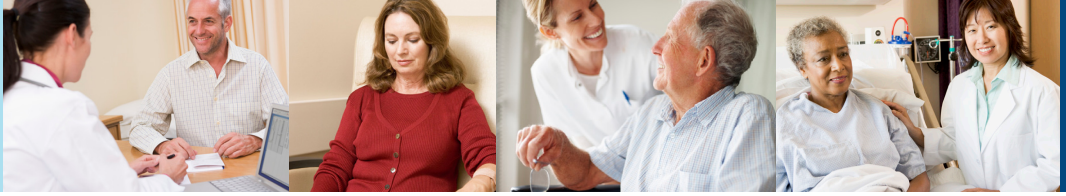


Glossary of Terms

Annually: Activity performed every year.

Cancer committee: The group responsible for leading the cancer program; also known as the leadership body, quality council, etc.

Clinical trial: A type of research study that tests how well new medical approaches work in people. These studies test new methods of screening, prevention, diagnosis, or treatment of a disease. Also called a clinical study.

CoC quality reporting tools: Cancer Program Practice Profile Reports (CP^{3}R)

Evaluate: To examine and judge carefully.

High-quality care: Care that meets or exceeds accepted standards.

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.

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

On-site: Services provided to the patient at facilities or locations that are part of the cancer program.

Pareto chart: A series of bars whose heights reflect the frequency or impact of problems. The bars are arranged in descending order of height from left to right, which means the categories represented by the tall bars on the left are relatively more significant than categories represented on the right. This bar chart is used to separate the "vital few" from the "trivial many." These charts are based on the Pareto Principle, which states that 80% of the problems come from 20% of the causes. Pareto charts are extremely useful because they can be used to identify factors that have the greatest cumulative effect on the system and, thus, screen out the less significant factors in an analysis. Ideally, this approach allows a user to focus attention on a few important factors in a process.

Patient population: Patients being served by the cancer program.

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.

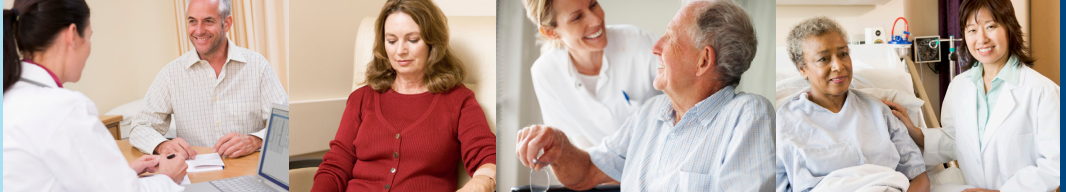
Quarterly: Occurring at three-month intervals during a calendar year.

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

Run chart: Also known as a run-sequence plot; a graph that displays observed data in a time sequence. Often, the data displayed represent some aspect of the output or performance of a manufacturing or other business process. Run-sequence plots are an easy way to graphically summarize a univariate data set. With run-sequence plots, shifts in location and scale are typically evident. Also, outliers can easily be detected. Time is generally represented on the horizontal (x) axis and the property under observation on the vertical (y) axis. Often, some measure of central tendency (mean or median) of the data is indicated by a horizontal reference line. Run charts are analyzed to find anomalies in data that suggest shifts in a process over time or special factors that may be influencing the variability of a process.

Appendix A: Tables of Criteria by Category

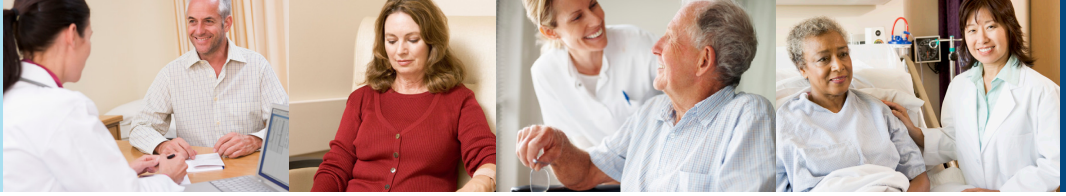
NOTES



Appendix A: Tables of Criteria by Category

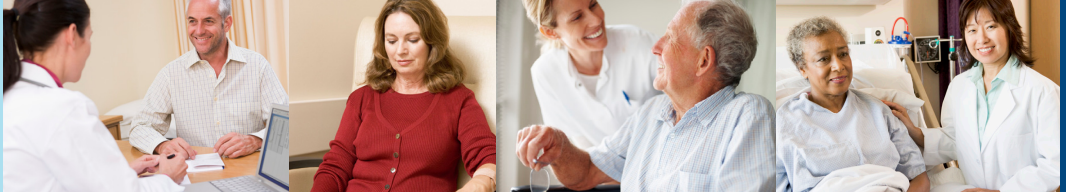
INTEGRATED NETWORK CANCER PROGRAM (INCP)	
The organization owns, operates, leases, or is part of a joint venture with multiple facilities providing integrated cancer care and offers comprehensive services. At least 1 facility in the category is a hospital, and all facilities that are part of the network are 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.	
Definition	**Specification**
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.

Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Corporate administrator Oncology nurse from the ambulatory care setting Clinical research representative Physician member of the palliative care team Pharmacist Registered dietician Hospice nurse or administrator Rehabilitation representative Genetics professional/counselor, if these services are provided on-site
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 6% of the number of annual analytic cases; 8% of the number of annual analytic cases for commendation Coordinator/representative reports on activity yearly.
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.



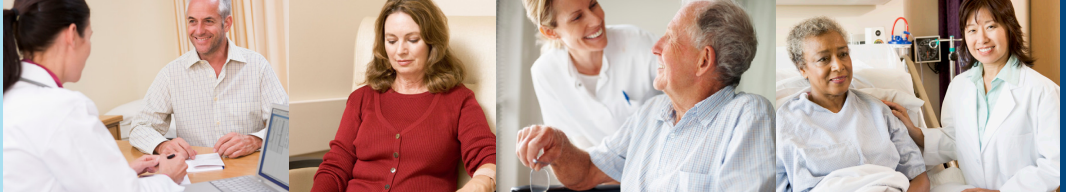
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.
STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure. Performance levels are met by each facility in the network and by the network overall.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	Each year, 3 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

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. This facility participates in basic and clinical research. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.	
Definition	**Specification**
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Exempt
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Optional to complete the SAR
E7 Radiation Oncology Services	Optional to complete the SAR
E8 Systemic Services	Optional to complete the SAR
E9 Clinical Trial Information	Exempt
E10 Psychosocial Services	Optional to complete the SAR
E11 Rehabilitation Services	Optional to complete the SAR
E12 Nutrition Services	Optional to complete the SAR
Standards	**Specification**
STANDARD 1.1 Physician Credentials	Exempt. Defaults to compliance.
STANDARD 1.2 Cancer Committee Membership	Program defines structure and membership for administrative body responsible for the program.
STANDARD 1.3 Cancer Committee Attendance	Exempt. Defaults to compliance.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer registry manager establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	Exempt. Defaults to compliance.
STANDARD 1.8 Monitoring Community Outreach	Exempt. Defaults to compliance.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 20% of the number of annual analytic cases; 30% of the number of annual analytic cases for commendation Coordinator/representative reports on activity yearly.



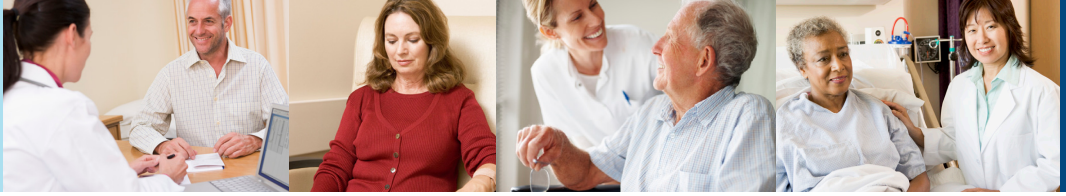
STANDARD 1.10 Annual Educational Activity	Exempt. Defaults to compliance.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Exempt. Defaults to compliance.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.
STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Exempt. Defaults to compliance.
STANDARD 4.2 Screening Program	Exempt. Defaults to compliance.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	Exempt. Defaults to compliance.
STANDARD 4.7 Studies of Quality	Each year, 3 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.

STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.



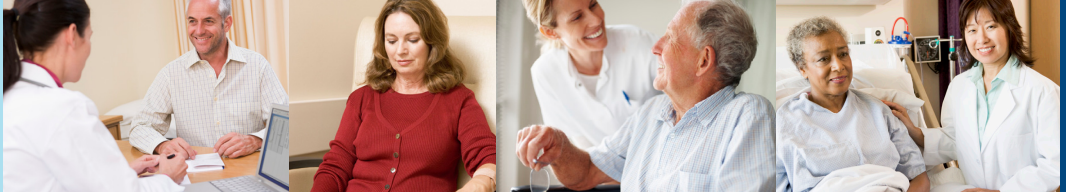
ACADEMIC COMPREHENSIVE CANCER PROGRAM (ACAD)	
The facility provides postgraduate medical education in at least 4 program areas. The facility accessions more than 500 newly diagnosed cancer cases each year. The facility offers the full range of diagnostic and treatment services either on-site or by referral. The facility is required to participate 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.	
Definition	**Specification**
Residencies	Surgery and internal medicine and any 2 of the following residency programs: diagnostic radiology family practice gynecology pathology radiation oncology urology or a recognized fellowship related to cancer care
Annual Caseload	More than 500
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.

Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Clinical research representative Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site Rehabilitation representative
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 6% of the number of annual analytic cases; 8% of the number of annual analytic cases for commendation Coordinator/representative reports on activity yearly.
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.



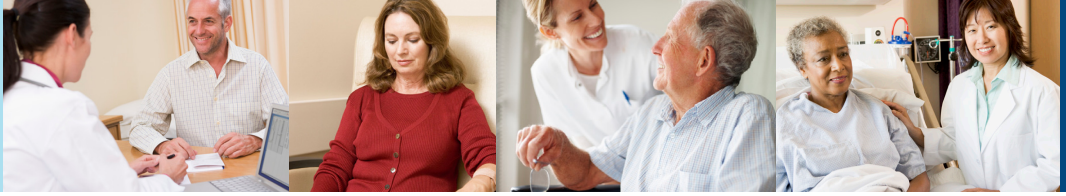
STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years.
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

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). Participation in cancer-related clinical research is required 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. There is no minimum caseload required for this category.	
Definition	**Specification**
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements.
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.



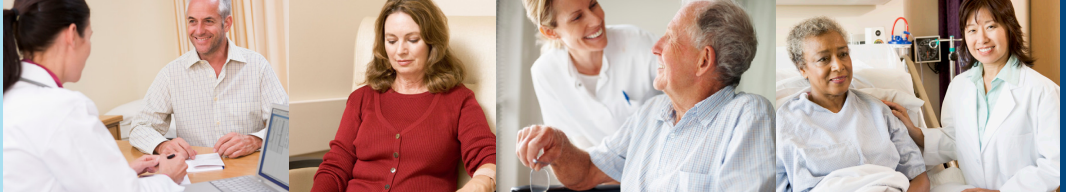
Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Genetics professional/counselor, if these services are provided on-site Palliative care team member, if these services are provided on-site
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 2% of the number of annual analytic cases; 4% of the number of annual analytic cases for commendation Coordinator/representative reports on activity yearly
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 NURSING CARE	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.
STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.

STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community of veterans through ongoing programs or clinics and to reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	VACP facilities follow the US Preventive Services Task Force recommendations for screening; screening services reach the veteran population through ongoing programs or clinics; the rating for this standard defaults to 1, Compliance. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	1 study of cancer patient care quality and outcomes; 1 additional program-defined study or study of quality defined at the VISN or regional level.
STANDARD 4.8 QUALITY Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 CANCER Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date.
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years.
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.



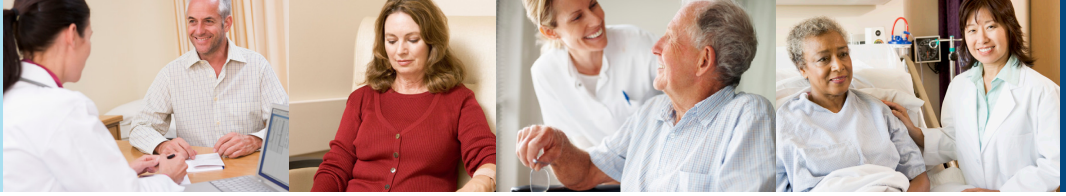
COMPREHENSIVE COMMUNITY CANCER PROGRAM (CCCP)	
The facility accessions 500 or more newly diagnosed cancer cases each year. The facility provides a full range of diagnostic and treatment services either on-site or by referral. Participation in cancer-related clinical research is required either by enrolling 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.	
Definition	**Specification**
Residencies	Optional
Annual Caseload	More than 500
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements.
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.

Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Clinical research representative Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 4% of the number of annual analytic cases; 6% of the number of annual analytic cases for commendation Coordinator/representative reports on activity yearly.
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.
STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.



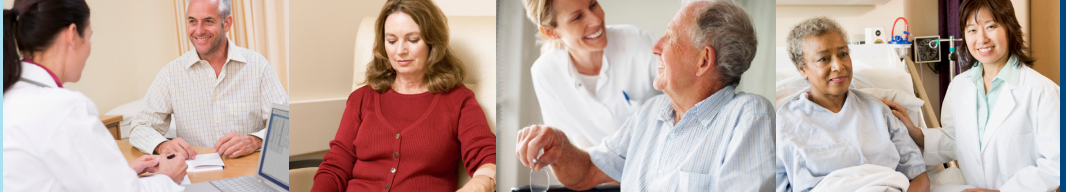
STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date.
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years.
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

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. Facilities participate 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.	
Definition	**Specification**
Residencies	Optional
Annual Caseload	101–499
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements.
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.



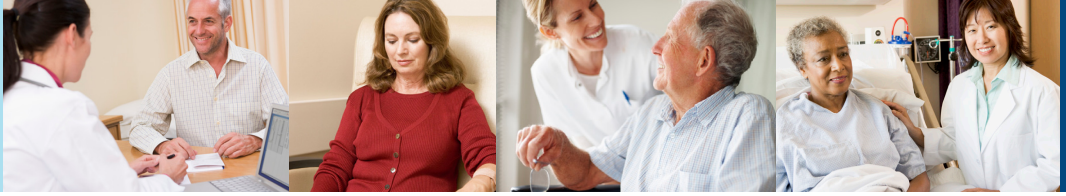
Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Clinical research representative or coordinator Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on-site
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 2% of the number of annual analytic cases Note: Until 2015, new programs in this category are exempt from the accrual percentage at the initial survey 4% of the number of annual analytic cases for Commendation Coordinator/representative reports on activity yearly
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.

STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date.
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years.
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.



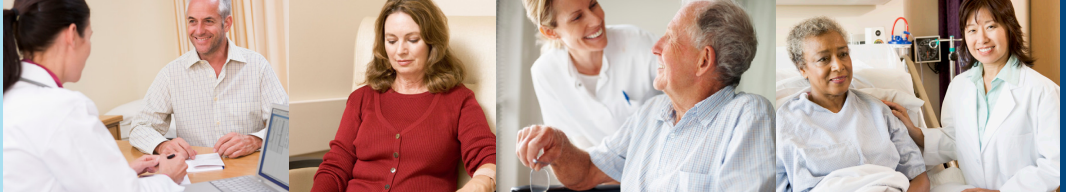
HOSPITAL ASSOCIATE CANCER PROGRAM (HACP)	
The facility accessions 100 or fewer newly diagnosed cancer cases each year and has a limited range of diagnostic and treatment services available on-site. Other services are available by referral. Clinical research is not required. Participation in the training of resident physicians is optional.	
Definition	**Specification**
Residencies	Optional
Annual Caseload	100 or fewer
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements.
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.

Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. No additional category-specific members are required.
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in Exempt from annual accrual requirement; 2% of the number of annual analytic cases for Commendation Coordinator/representative reports on activity yearly
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.
STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.



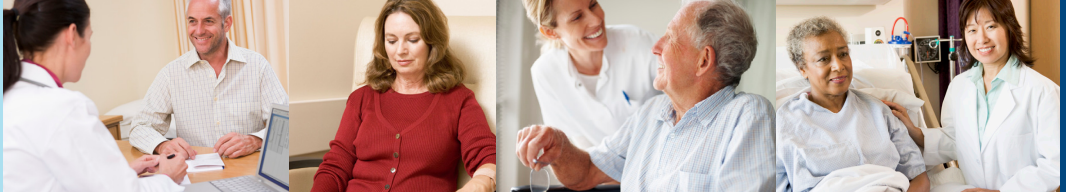
STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date.
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years.
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

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 either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office. There is no minimum caseload requirement for this category.	
Definition	**Specification**
Residencies	If associated with a medical school, pediatric medicine and pediatric surgery and any 2 of the following: pediatric diagnostic radiology pediatric pathology pediatric radiation oncology or a pediatric oncologic fellowship
Annual Caseload	None
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements.
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.



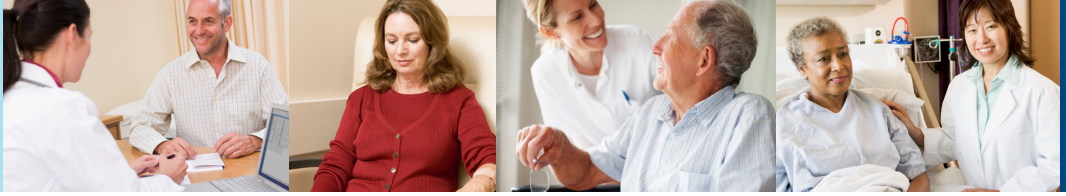
Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Child life specialist Children's Oncology Group data manager Genetics professional/counselor, if these services are provided on-site Palliative care team member, when these services are provided on site
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 30% of the number of annual analytic cases; 40% of the number of annual analytic cases for Commendation Coordinator/representative reports on activity yearly
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.

STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date for patients 26 years and younger.
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years for patients 26 years and younger.
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.



FREESTANDING CANCER CENTER PROGRAM (FCCP)	
The facility is a non–hospital-based program and offers at least 1 cancer-related treatment modality. The full range of diagnostic and treatment services is available by referral. Referral to CoC-accredited cancer program(s) is preferred. Participation in cancer-related clinical research is encouraged but not required. Patients may be enrolled in cancer-related clinical trials either at the facility 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.	
Definition	**Specification**
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	**Specification**
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements.
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations and total case presentations, discussion of stage and treatment planning, clinical trial options, and methods to address activities that fall below expected levels.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure addresses the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on-site or by referral.
E7 Radiation Oncology Services	Radiation treatment service locations 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.
E8 Systemic Services	Policies or procedures are in place to guide the safe administration of systemic therapy provided either on-site and/or at locations that are facility owned or supervised by members of the facility's medical staff (physician offices).
E9 Clinical Trial Information	A policy or procedure is used to inform patients about clinical trials.
E10 Psychosocial Services	A policy or procedure is in place to ensure patient access to psychosocial services either on-site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on-site or by referral.
E12 Nutrition Services	Nutrition services are provided either on-site or by referral.

Standards	Specification
STANDARD 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
STANDARD 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary; Category-specific members are: For freestanding cancer centers providing radiation oncology, a dosimetrist or radiation physicist Palliative care team member, when these services are provided on site
STANDARD 1.3 Cancer Committee Attendance	Each required cancer committee member or the designated alternate attends 75% of meetings annually.
STANDARD 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
STANDARD 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year. Each goal is evaluated twice annually, and the evaluation is documented.
STANDARD 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
STANDARD 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
STANDARD 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity summary, and shares the report with the cancer committee each year.
STANDARD 1.9 Clinical Trials Accrual	2015 phase in 2% of the number of annual analytic cases; 4% of the number of annual analytic cases for Commendation Coordinator/representative reports on activity yearly
STANDARD 1.10 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
STANDARD 1.11 Cancer Registrar Education	All registry staff participate in an annual educational activity.
STANDARD 1.12 Public Reporting of Outcomes	Cancer committee develops and disseminates a report of patient outcomes to the public each year. This standard is for Commendation only.
STANDARD 2.1 CAP Protocols	90% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
STANDARD 2.2 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
STANDARD 2.3 Risk Assessment and Genetic Testing and Counseling	Risk assessment and genetic testing and counseling are provided either on-site or by referral, by a qualified genetics professional.
STANDARD 2.4 Palliative Care Services	Palliative care services are provided either on-site or by referral.
STANDARD 3.1 Patient Navigation	2015 phase in The cancer committee assesses the community to identify barriers to care, provides navigation services either on-site or by referral or in partnership with local or national organizations, and assesses and reports on the process annually. The assessment is documented.
STANDARD 3.2 Psychosocial Distress Screening	2015 phase in The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.



STANDARD 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
STANDARD 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
STANDARD 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
STANDARD 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least 4 times annually.
STANDARD 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
STANDARD 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
STANDARD 4.6 Monitoring Compliance with Evidence-Based Guidelines	A physician member of the cancer committee performs a study to assess that nationally recognized treatment guidelines are used in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
STANDARD 4.7 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
STANDARD 4.8 Quality Improvements	Each year, 2 improvements in patient care are implemented.
STANDARD 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
STANDARD 5.2 RQRS Participation	Participates in RQRS, submits all eligible cases for all valid performance measures, and adheres to RQRS terms and conditions.
STANDARD 5.3 Follow-Up of All Patients	80% follow-up from reference date.
STANDARD 5.4 Follow-Up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years.
STANDARD 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
STANDARD 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
STANDARD 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

NOTES

www.facs.org/cancer

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.

American College of Surgeons

Inspiring Quality:
Highest Standards, Better Outcomes

100+years

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