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Commission on Cancer

Cancer Program Standards 2009

REVISED EDITION



*A multidisciplinary program of the
American College of Surgeons*

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The American College of Surgeons does not warrant or make any guarantees or assurances related to outcomes of treatment provided by institutions that have cancer programs approved by the Commission on Cancer. The examples used herein are to be used as guidelines and are not wholly inclusive of all options.

DEDICATION

This publication is dedicated to individual cancer program team members. Your participation in the Commission on Cancer Approvals Program exemplifies a steadfast commitment to providing the best care possible for your cancer patients and members of your community. Your leadership and expertise contribute to the entire scope, organization, and performance of the cancer program. Your vision is a catalyst for continued growth and improvement to ensure the delivery of high-quality cancer care.

TABLE OF CONTENTS

FOREWORD	1
Commission on Cancer Accreditations Program	1
Benefits of Being a CoC-Accredited Cancer Program	2
Member Organizations of the Commission on Cancer	2
ACKNOWLEDGMENTS	4
INTRODUCTION	5
The Accreditations Program	5
Eligibility	5
Cancer Program Category	5
The Survey Process	7
The Survey Application Record (SAR)	7
Documentation of Program Activity	8
Payment of Survey Fee	9
Guidelines for the Surveyor Meeting with the Cancer Program Leadership	9
Cancer Program Standards Rating System	10
Accreditation Awards	11
Award Notification Process	11
The CoC Outstanding Achievement Award	12
The Postsurvey Evaluation	12
Guidelines for Merged or Network Programs	12
CoC Resources and Tools for Cancer Programs	12
CHAPTER ONE—INSTITUTIONAL AND PROGRAMMATIC RESOURCES	15
Facility Accreditation	15
Standard 1.1	15
CHAPTER TWO—CANCER PROGRAM LEADERSHIP	17
Level of Responsibility and Accountability	17
Standard 2.1	17
Membership	19
Standard 2.2	19
Program Activity Coordinators	21
Standard 2.3	21
Meeting Schedule	23
Standard 2.4	23
Duties and Responsibilities	25
Standard 2.5–Standard 2.11	25
CHAPTER THREE—CANCER DATA MANAGEMENT AND CANCER REGISTRY OPERATIONS	39
Staff Qualifications	39
Standard 3.1	39

Data Collection	40
Standard 3.2–Standard 3.5	40
Data Reporting	45
Standard 3.6–Standard 3.7	45
Special Studies	47
Standard 3.8	47
CANCER REGISTRY OPERATIONS	48
CHAPTER FOUR—CLINICAL MANAGEMENT	53
Clinical Services	53
Treatment Services	53
Standard 4.1–Standard 4.2	53
Other Clinical Services	57
Standard 4.3–Standard 4.7	57
CHAPTER FIVE—RESEARCH	65
Clinical Trial Information	65
Standard 5.1	65
Clinical Trial Accrual	66
Standard 5.2	66
CHAPTER SIX—COMMUNITY OUTREACH	69
Supportive Services	69
Standard 6.1	69
Prevention and Early Detection Programs	71
Standard 6.2	71
Monitoring Community Outreach	73
Standard 6.3	73
CHAPTER SEVEN—PROFESSIONAL EDUCATION AND STAFF SUPPORT	75
Facility-Based Education	75
Standard 7.1	75
Cancer Registry Staff Education	77
Standard 7.2	77
CHAPTER EIGHT—QUALITY IMPROVEMENT	79
Studies of Quality and Outcomes	79
Standard 8.1	79
Patient Care Improvement	82
Standard 8.2	82
APPENDIX	85

FOREWORD

The Commission on Cancer 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.

Established by the American College of Surgeons (ACoS) in 1922, the multidisciplinary Commission on Cancer (CoC) establishes standards to ensure quality, multidisciplinary, and comprehensive cancer care delivery in health care settings; conducts surveys in health care settings to assess compliance with those standards; collects standardized, high-quality data from CoC-accredited health care settings to measure cancer care quality; uses data to monitor treatment patterns and outcomes, support and enhance cancer control, and monitor clinical surveillance activities; and develops effective educational interventions to improve cancer prevention, early detection, care delivery, and outcomes in health care settings.

CoC membership consists of more than 100 individuals representing the multidisciplinary professionals of the cancer care team. Members include representatives from the ACoS and 47 national, professional member organizations, and they serve on committees that work to reach the CoC's goals by doing the following:

- 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 for all cancer sites 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.

COMMISSION ON CANCER ACCREDITATIONS PROGRAM

The Accreditations 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 prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, and rehabilitation, surveillance for recurrent disease, support services, and end-of-life care. The availability of a full range of medical services, along with a multidisciplinary team approach to patient care at accredited cancer programs, has resulted in approximately 80% of all newly diagnosed cancer patients being treated in CoC-accredited cancer programs.

Obtaining care at a CoC-accredited cancer program ensures that one will receive the following:

- 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, education, and support.
- A cancer registry that collects data on cancer type, stage, and treatment results, and offers lifelong patient follow-up.
- Ongoing monitoring and improvement of care.
- Information about clinical trials and new treatment options.

Accreditation by the CoC is granted only to those 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 *CoC Cancer Program Standards 2009 Revised Edition* 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.

There are currently more than 1,400 CoC-accredited cancer programs in the United States and Puerto Rico, representing close to 25% of all hospitals. These programs are supported by a network of more than 1,600 volunteer physician representatives (cancer liaison physicians) appointed by cancer program leadership to

maintain cancer program accreditation or establish a new program, as well as to work with the local ACS on cancer-control activities for the community.

BENEFITS OF BEING A CoC-ACCREDITED CANCER PROGRAM

The CoC's Accreditations Program offers many notable benefits that will enhance a cancer program and its quality of patient care.

CoC-accredited cancer programs offer the following:

- A model for organizing and managing a cancer program to ensure multidisciplinary, integrated, and comprehensive oncology services.
- Self-assessment of cancer program performance based on recognized standards.
- Recognition by national health care organizations including The Joint Commission as having established performance measures for high-quality cancer care.
- The ability to meet demands for oncology data from clinicians and other health care professionals, third-party payers and managed care organizations, and the public because of our requirement for a cancer registry.
- Participation in a network of quality cancer programs that provide care to 80% of newly diagnosed cancer patients annually.
- Free marketing and national public exposure through partnering with the ACS in the Facility Information Profile System (FIPS)—an information-sharing program of resources, services, and cancer experience for the ACS National Call Center and Web site.
- An Accredited Cancer Program Performance Report that will enable a facility to identify quality improvement initiatives by comparing its compliance with CoC standards with other accredited programs in the state and accreditation award category.
- Participation in the National Cancer Data Base (NCDB)—a nationwide oncology outcomes database for more than 1,400 hospitals in the United States.
- Access to Hospital Comparison Benchmark Reports containing national aggregate data and individual facility data to assess patterns of care and outcomes relative to national norms.
- Participation in national studies developed to address important cancer problems.

Being a CoC-accredited cancer program demonstrates a facility's ongoing commitment to providing high-quality, multidisciplinary cancer care. The CoC wishes to acknowledge the hard work and dedication these programs put forth in meeting the CoC standards, improving the reliability of cancer data, and enabling the best possible outcomes for today's cancer patients.

MEMBER ORGANIZATIONS OF THE COMMISSION ON CANCER

American Academy of Hospice and Palliative Medicine (AAHPM)

American Academy of Pediatrics (AAP)

American Association for Cancer Education (AAE)

American Cancer Society (ACS)

American College of Obstetricians and Gynecologists (ACOG)

American College of Oncology Administrators (ACOA)

American College of Physicians (ACP)

American College of Radiology (ACR)

American College of Surgeons (ACoS)

American College of Surgeons Committee on Young Surgeons (ACOSCYS)

American College of Surgeons Oncology Group (ACOSOG)

American College of Surgeons Resident and Associate Society (ACOSRAS)

American Dietetic Association (ADA)

American Head and Neck Society (AHNS)

American Hospital Association (AHA)

American Joint Committee on Cancer (AJCC)

American Medical Association (AMA)

American Pediatric Surgical Association (APSA)

American Psychosocial Oncology Society (APOS)

American Radium Society (ARS)

American Society of Breast Surgeons (ASBS)

American Society of Clinical Oncology (ASCO)

American Society of Colon and Rectal Surgeons (ASCRS)

American Society for Radiation Oncology (ASRO)

American Urological Association (AUA)

Association of American Cancer Institutes (AACI)

Association of Cancer Executives (ACE)

Association of Community Cancer Centers (ACCC)

Association of Oncology Social Work (AOSW)

Canadian Society of Surgical Oncology (CSSO)

Centers for Disease Control and Prevention (CDC)

College of American Pathologists (CAP)

Department of Defense (DoD)

Department of Veterans Affairs (VA)

International Union Against Cancer—UICC (IUAC/UICC)

National Cancer Institute: Surveillance, Epidemiology, and End Results (SEER) Program (NCI/SEER)

National Cancer Institute: Outcomes Research

National Cancer Registrars Association (NCRA)
National Comprehensive Cancer Network (NCCN)
National Consortium of Breast Cancer, Inc. (NCBC)
National Society of Genetic Counselors (NSGC)
National Surgical Adjuvant Breast and Bowel Project
(NSABP)
North American Association of Central Cancer
Registries (NAACCR)

Oncology Nursing Society (ONS)
Society of Gynecologic Oncologists (SGO)
Society of Nuclear Medicine (SNM)
Society of Surgical Oncology (SSO)
Society of Thoracic Surgeons (STS)

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CANCER PROGRAM STANDARDS STAGING WORKGROUP MEMBERS

Diana Dickson-Witmer, MD, FACS, Chair
Aaron D. Bleznak, MD, FACS
Cynthia Boudreaux, LPN, CTR
Stephen B. Edge, MD, FACS
Frederick L. Greene, MD, FACS
Suzanna S. Hoyler, CTR
Patti Jamieson-Baker, MSSW, MBA
Roxanne C. Kelley, CCS, CTR
John S. Kennedy, MD, FACS
Robert E. McBride, CTR
Daniel P. McKellar, MD, FACS
William P. Reed, Jr., MD, FACS
Frank S. Rotolo, MD, FACS

CoC STAFF CONTRIBUTORS

David P. Winchester, MD, FACS
Connie Bura
M. Asa Carter, CTR
Vicki M. Chiappetta, RHIA, CTR
Debbie Ethridge, CTR
E. Greer Gay, RN, PhD, MPH
Lisa Landvogt, CTR
Kate Phair
Jerri Linn Phillips, MA, CTR
Karen Stachon
Andrew Steward, MA

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Cancer Program Constituents
Cancer Program Surveyors

INTRODUCTION

THE ACCREDITATIONS PROGRAM

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

The Accreditation Committee administers the activities of the Commission on Cancer (CoC) Accreditations Program, which was designed to ensure that the structures and processes necessary for quality cancer care are in place. The current CoC standards for cancer programs promote and support the 4 historic cornerstones of the Accreditations Program: a multidisciplinary cancer committee, cancer conferences, evaluation of quality outcomes and improvements, and a cancer registry.

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

ELIGIBILITY

Hospitals, freestanding treatment facilities, and health care networks are eligible to participate in the CoC Accreditations Program. Each facility 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. Services are provided on site, by referral, or are coordinated with other facilities or local agencies.

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

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

The following basic services must be provided by every CoC-accredited cancer program:

- Diagnostic
 - Clinical laboratory
 - Diagnostic imaging
- Treatment
 - Medical oncology
 - Radiation oncology
 - Surgical procedures
- Other clinical
 - American Joint Committee on Cancer (AJCC) or other appropriate staging
 - Clinical research
 - Oncology nursing
 - Pain management
 - Treatment guidelines
- Rehabilitation
- Support
 - Counseling
 - Discharge planning
 - Hospice care
 - Nutritional support
 - Pastoral care
 - Patient and family support
- Prevention and early detection

CANCER PROGRAM CATEGORY

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 Cancer Programs staff and are retained unless the facility requests a category change or there are changes to the services provided and/or facility caseload.

The Cancer Program Categories and definitions are as follows:

Network Cancer Program (NCP)

The organization owns multiple facilities providing integrated cancer care and offers comprehensive services. Generally, networks are characterized by a network-wide cancer committee/leadership body or functional equivalent, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners. The network participates in clinical research. 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 with major specialty board certification, including certification in oncology, where offered, are available. This facility participates in both basic and clinical research. Participation in the training of resident physicians is optional, and there is no minimum case-load requirement for this category.

Teaching Hospital Cancer Program (THCP)

The facility is associated with a medical school and participates in training residents in at least 4 areas, 2 of which are medicine and surgery. The facility offers the full range of diagnostic and treatment services, on site or by referral. The members of the medical staff are board certified in the major medical specialties, including oncology, where applicable. The facility is required to participate in clinical research. There is no minimum caseload requirement for this category.

Veterans Affairs Cancer Program (VACP)

The facility provides care to military veterans and offers the full range of diagnostic and treatment services, on site or by referral. The members of the medical staff are board certified in the major medical specialties, including oncology, where applicable. Participation in clinical research is required. Participation in the training of resident physicians is optional. There is no minimum caseload requirement for this category.

Pediatric Cancer Program (PCP)

The facility provides care only to children and may be associated with a medical school and participate in training pediatric residents. The facility offers the full range of diagnostic and treatment services for pediatric patients, on site or by referral. The members of the medical staff are board certified in the major medical specialties associated with pediatrics, including oncology, where applicable. The facility is required to participate in clinical research. There is no minimum caseload requirement for this category.

Pediatric Cancer Program Component (PCPC)

The pediatric component within a larger facility accessions a minimum of 50 newly diagnosed pediatric cancer cases each year and offers the full range of diagnostic and treatment services for pediatric patients, on site or by referral. The members of the medical staff are board certified in the major medical specialties associated with pediatrics, including oncology, where applicable. The facility is required to participate in clinical research. The facility may be associated with a medical school and participate in the training of pediatric residents.

Community Hospital Comprehensive Cancer Program (COMP)

The facility accessions 650 or more newly diagnosed cancer cases each year and provides a full range of diagnostic and treatment services that are available on site or by referral. The members of the medical staff are board certified in the major medical specialties, including oncology, where applicable. Participation in clinical research is required. Participation in the training of resident physicians is optional.

Community Hospital Cancer Program (CHCP)

The facility accessions between 100 and 649 newly diagnosed cancer cases each year and provides a full range of diagnostic and treatment services, but referral for a portion of treatment is common. The members of the medical staff are board certified in the major medical specialties. Facilities may participate in clinical research. Participation in the training of resident physicians is optional.

Note: A community-based facility that accessions between 300 and 649 analytic cases annually may choose either the Community Hospital or Community Hospital Comprehensive Cancer Program Category. The facility meets the requirements for the category selected.

Hospital Associate Cancer Program (HACP)

The facility accessions between 50 and 99 newly diagnosed cancer cases each year and has a limited range of diagnostic and treatment services on site. Other services are available by referral. Clinical research is not required. Participation in the training of resident physicians is optional.

Affiliate Hospital Cancer Program (AFCP)

The facility accessions fewer than 50 newly diagnosed cancer cases each year, has limited access to services on site, and forms a partnership with a CoC-accredited sponsoring hospital to provide access to the full range of diagnostic and treatment services. Clinical research is not required. Participation in the training of resident physicians is optional.

Integrated Cancer Program (ICP)

The facility offers 1 treatment modality and forms a partnership with a CoC-accredited hospital to provide access to the full range of diagnostic and treatment services. Participation by the integrated facility in clinical research is optional. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

Freestanding Cancer Center Program (FCCP)

The facility offers a minimum of 2 treatment modalities, and the full range of diagnostic and treatment services are available by referral. Referral to a CoC-accredited program is preferred. Participation in clinical research

is optional. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

The tables included in Appendix A can be used as a quick reference guide for the definition and specifications for each of the 12 Cancer Program Categories.

THE SURVEY PROCESS

CoC-accredited cancer programs are surveyed on a triennial schedule. To be considered for initial survey, the facility or cancer committee/leadership body does the following:

- Ensures that the clinical services, cancer committee/leadership body, cancer conferences, and quality management program have been in place at the facility for 1 year.
- Establishes a reference date and ensures that the cancer registry database includes 2 complete years of data and 1 year of follow-up activity.
- Meets the requirements for all standards outlined in *Cancer Program Standards 2009 Revised Edition*.
- Completes the online application for accreditation that describes the resources and services available at the facility and documents the development of the cancer program.
- Participates in a consultative evaluation of the cancer program performed by a CoC-trained independent cancer program consultant or other cancer registry professional.
- Submits a request for survey to Cancer Programs staff that documents compliance with all standards.
- Signs the American College of Surgeons Commission on Cancer Business Associate Agreement in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Submits data for all analytic cases for the last completed abstracting year to the National Cancer Data Base (NCDB).
- Completes the online Survey Application Record (SAR) in preparation for the initial survey.

Each July, an initial notification is provided to facilities due for survey in the upcoming calendar year. In preparation for survey, the cancer committee/leadership body at each CoC-accredited facility does the following:

- Assesses program compliance with the requirements for all standards outlined in *Cancer Program Standards 2009 Revised Edition*.
- Completes the online SAR in preparation for the resurvey.

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

- Database conversion
- Hospital mergers

Each request for an extension is made in writing to Cancer Programs staff by the cancer committee/leadership body chair within 45 days of the initial e-mail survey notification. Requests for extension are given individual consideration. A maximum extension of 1 year may be granted. Facilities are notified of extension decisions, and the new target date for survey is provided.

Cancer Programs staff members match a cancer program surveyor to each program due for survey. The facility is notified of the surveyor assignment and target date for survey. The surveyor's name and e-mail address are available through the password-protected CoC Datalinks Web portal. The surveyor profile, which includes a photo and brief biography, is available on the Accreditations Program page of the American College of Surgeons Web site.

The facility may decline the assigned surveyor within 14 days of notification of assignment if a conflict of interest exists. 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 new surveyor assignment will be provided to the facility within 30 days of notification of the conflict of interest.

Selection of a survey date is coordinated among the facility, surveyor, and Cancer Programs staff and must be scheduled within the quarter the survey is due. Confirmation of the survey date and time is provided to the facility administrator and other cancer program staff a minimum of 30 days prior to the on-site visit.

THE SURVEY APPLICATION RECORD (SAR)

To facilitate a thorough and accurate evaluation of the cancer program, the facility completes or updates the online Survey Application Record (SAR) 14 days before the scheduled on-site visit. The cancer registrar is notified when the SAR is available for completion. Completion of the SAR should be a team effort of members of the cancer committee/leadership body, 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. If not updated on the annual schedule, all information must be provided prior to survey.

In addition to capturing information about cancer program activity, the individual(s) responsible for completing portions of 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 shared with the American Cancer Society (ACS) as part of the Facility Information Profile System (FIPS) for posting on the ACS Web site (www.cancer.org). The data-sharing activity of the FIPS program is designed to benefit all CoC-accredited cancer programs. This facility-specific 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 facility uses the SAR to update the resource and service information for sharing with the ACS. The facility 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.

Password-protected access to FIPS and the SAR is provided to the cancer registrar, cancer committee/leadership body chair, cancer program administrator, and cancer liaison physician through an e-mail notification system. Additional users can be identified by the facility and provided access to the CoC Datalinks applications. The SAR and FIPS are accessed through CoC Datalinks located on the Cancer Programs page of the American College of Surgeons Web site at www.facs.org.

The cancer program surveyor reviews the facility's online SAR prior to the on-site visit to become familiar with the services and resources offered at the facility and the cancer program activity.

DOCUMENTATION OF PROGRAM ACTIVITY

Facilities document cancer program activity and provide the listed documentation as outlined in each standard to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

Cancer committee/leadership body minutes are a primary resource for documenting program organization and operation, as well as monitoring programmatic activity. Other facility-approved methods or sources of documentation are acceptable and are provided to the surveyor in advance of the on-site visit as specified. The cancer committee/leadership body minutes or other facility-approved documentation of cancer program activity must be provided to the surveyor in advance of the on-site visit so that the surveyor can review the information and be adequately prepared for the evaluation.

In general, depending on category, the following documentation is provided to the surveyor in advance of the on-site visit:

- A printed copy of the completed SAR.
- A copy of the certificate of accreditation or letter from the accrediting body.
- Copies of all cancer committee/leadership body minutes (including any attachments that apply to the standards) from the previous 2 complete calendar years and the current year through the survey date.
- Results of the outcomes analysis(es) and methods of dissemination for the last 2 complete calendar years, as well as the current calendar year, if the outcome analysis is completed by the time of the survey.
- A copy of the published annual report for the last 2 calendar years, if an annual report is published.
- An accession list for the last 3 complete abstracting years that identifies the major sites of cancer and surgical resections performed.

Category-specific documentation requirements are recorded with each standard. These requirements may add to or eliminate documentation from the previous list. Unless included as category-specific modifications, the surveyor will confirm cancer program activity during the on-site visit by reviewing the following:

- A copy of the written policy and procedure for documentation of physician clinical staging.
- A copy of the written policy and procedure for the plan to evaluate the quality of cancer registry data and activity, including the review of the accuracy of Collaborative Stage derived stage.
- A policy and procedure or other facility-approved documentation of the cancer conference activity that includes the cancer committee/leadership body's involvement in setting the annual frequency and format, multidisciplinary attendance requirement, annual caseload presentation, documentation of clinical/working stage, and the monitoring of conference activity.
- Bylaws, policies and procedures, or other facility-approved methods used to document the level of responsibility and accountability designated to the cancer committee/leadership body.
- Documentation of policies and procedures for providing information about cancer-related clinical trials to patients.
- Documentation of the supportive services offered to patients and their families on site or by referral. Documentation includes, but is not limited to, published brochures or flyers, meeting schedules, and Internet or Intranet postings.

- Documentation of 2 annual prevention or early detection programs through cancer committee/leadership body minutes or other sources.
- Documentation of the methods to monitor and evaluate the community outreach activities.
- Documentation of 2 annual educational activities, other than cancer conferences, one of which addresses stage, clinical guidelines, and prognostic factors, including a published notice or agenda.
- Summaries of each year's studies of quality and outcomes, including the study topic, analyses, recommendations, and follow-up.
- Summaries of each year's patient care improvements.
- Verification of current credentialing from the National Cancer Registrars Association (NCRA) for all certified tumor registrars (CTRs) on staff at the facility or for contract CTRs.
- Written policy or plan outlining the system of referral.
- Policy and procedure manual for the following: nursing, social services, rehabilitation, hospice, discharge planning team.
- Institutional review board (if applicable).
- Policy and procedure for peer review of clinical trial studies (if applicable).

The surveyor will review a minimum of 30 abstracts to confirm abstracting timeliness and a minimum of 25 pathology reports to confirm the presence of the scientifically validated data items. As part of the evaluation of the quality of care through the CoC quality reporting tools, the surveyor will review up to 25 medical records and abstracts for cases identified by the NCDB. The selected cases will be identified by accession number and the information will appear in pages for standard 4.6 that appear in the SAR.

NCI-designated Comprehensive Cancer Center Program (NCIP) facilities document cancer program activity and provide the listed documentation as outlined in each standard to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit. The following documentation is provided to the surveyor in advance of the on-site visit:

- A printed copy of the completed SAR.
- A copy of the certificate of accreditation or letter from the accrediting body.
- A copy of the facility organizational chart or oncology service line organizational chart that identifies the staff names, roles, and responsibilities.
- A copy of the overall description of the cancer center from the NCI grant.

- A list of names, credentials, titles, roles, and responsibilities of the program/facility leaders. This list may be included in the facility organizational chart or oncology service line organizational chart.
- A list of all published journal articles or abstracts from the last calendar year that include an analysis(es) of outcomes. If the list of journal articles is published in an annual report, then the annual report substitutes for a separate list.
- A copy of the annual report for the last 2 calendar years, if an annual report is published.

As part of the evaluation of the quality of care through the CoC quality reporting tools, the surveyor will review up to 25 medical records and abstracts for cases identified by the NCDB. The selected cases will be identified by accession number and the information will appear in pages for standard 4.6 that appear in the SAR. The program may choose to be evaluated for commendation for standard 4.6. If this option is selected, the surveyor will review a minimum of 25 pathology reports from the 5 major sites of cancer to confirm the presence of the scientifically validated data items in synoptic format.

PAYMENT OF SURVEY FEE

An invoice for the survey fee will be mailed to the cancer registrar within 30 days prior to the date of the scheduled survey. Payment of the invoice is due within 30 days of receipt.

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.

GUIDELINES FOR THE SURVEYOR MEETING WITH THE CANCER PROGRAM LEADERSHIP

A member of the cancer care team confirms the agenda for the on-site visit with the surveyor at least 2 weeks (14 days) prior to the on-site visit. The surveyor meets with key members of the program to discuss the facility and the program and to verify data on the SAR. The surveyor's role is to assist in accurately defining the standards and verifying that the facility's cancer program is in compliance with the standards. The surveyor also discusses the goals and responsibilities of the cancer committee/leadership body in relationship to the cancer program.

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

- Member of administration
- Cancer committee/leadership body chair

- Cancer liaison physician
- Cancer registrar
- Each of the appointed cancer program coordinators required for the category
- Cancer committee/leadership body representatives from the following services or departments:
 - Clinical research
 - Oncology nursing
 - Oncology social services
 - Quality improvement
 - Diagnostic radiology
 - Radiation oncology
 - Hospice services
 - Discharge planning team
 - Public education

Following a review of documentation and discussion with the members of the cancer care team, a wrap-up session will be held with all available members of the cancer care team. The cancer program surveyor will delineate the program's strengths and weaknesses and offer suggestions to correct any noted deficiencies. The cancer program surveyor will respond to questions from the facility's cancer program leadership regarding the standards, SAR, and rating system.

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 facility, surveyor, and Cancer Programs 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 8 (22%) of the standards, as follows:

- Standard 2.11 Each year, the cancer committee, or other appropriate leadership body, analyzes patient outcomes and disseminates the results of the analysis.
- Standard 3.3 For each year between survey, 90% of cases are abstracted within 6 months of the date of first contact.
- Standard 3.7 Annually, cases submitted to the National Cancer Data Base (NCDB) that were diagnosed in 2003 or more recently meet the established quality criteria and resubmission deadline specified in the annual Call for Data.
- Standard 4.6 The guidelines for patient management and treatment currently required by the CoC are followed.
- Standard 5.2 As appropriate to category, the required percentage of cases is accrued to cancer-related clinical trials on an annual basis.
- Standard 6.2 Each year, 2 prevention or early detection programs are provided on site or are coordinated with other facilities or local agencies.
- Standard 7.2 Other than cancer conferences, all members of the cancer registry staff participate in a local, state, regional, or national cancer-related educational activity each year.
- Standard 8.2 Annually, the cancer committee, or other appropriate leadership body, implements 2 improvements that directly affect cancer patient care. The improvements are documented.

ACCREDITATION AWARDS

Accreditation awards are based on consensus ratings by the cancer program surveyor, Cancer Programs staff, and when required, the Program Review Subcommittee for the 36 standards.

ACCREDITATION AWARD MATRIX					
	THREE-YEAR WITH COMMENDATION	THREE-YEAR ACCREDITATION	THREE-YEAR WITH CONTINGENCY	NONACCREDITATION	ACCREDITATION DEFERRED (VALID ONLY FOR NEW PROGRAMS)
36 Standards	No deficiencies and 1 or more commendation ratings for the eligible standards	No deficiencies but without a commendation rating for any of the eligible standards	One to 7 deficiency(ies) (up to 19% of standards)	Eight or more deficiencies (22% or more of standards); requires recommendation by the Program Review Subcommittee and confirmation by the Committee on Accreditations	One deficiency (2% of standards)

Three-Year with Commendation is given to programs, either new or established, that comply with all standards and receive a commendation rating for 1 or more standards. A certificate of accreditation is issued and these programs are surveyed at a 3-year interval from the date of the survey.

Three-Year Accreditation is given to programs, either new or established, that comply with all standards but do not receive a commendation rating for any standards. A certificate of accreditation is issued, and these programs are surveyed at a 3-year interval from the date of the survey.

Three-Year Accreditation with Contingency is given when 1–7 standards are rated deficient. The contingency status is resolved by the submission of documentation of compliance within 12 months. Documentation required to resolve the deficiency for each standard is available on the Cancer Programs page of the American College of Surgeons Web site. Three-Year with Commendation or Three-Year Accreditation is granted following submission of documentation. A certificate of accreditation is issued after resolution of deficiencies, and these programs are surveyed at a 3-year interval from the date of the survey.

Nonaccreditation is given when 8 or more standards are rated deficient. Programs are encouraged to improve their performance and may reapply.

Accreditation Deferred is given when a new program is rated deficient in 1 standard. The deferred status is resolved by the submission of documentation of compliance within 12 months. Documentation required to resolve the deficiency for each standard is available on

the Cancer Programs page of the American College of Surgeons Web site. Three-Year with Commendation or Three-Year Accreditation is granted following submission of documentation without resurvey. A certificate of accreditation is issued after resolution of deficiencies, and these programs are surveyed at a 3-year interval from the date of the submission of documentation. Programs that do not resolve this status at the end of the 12-month period must reapply for survey.

AWARD NOTIFICATION PROCESS

Award notification takes place 6–8 weeks following survey. The Accredited Cancer Program Performance Report (Performance Report) provides a comprehensive summary of the survey outcome and accreditation award. It provides the facility's compliance rating for each standard; an overall rating compared with other accredited facilities nationwide, as well as other accredited facilities in the state and category of accreditation; a narrative description of deficiencies that require correction; and any commendations awarded.

By enabling each facility to compare its ratings for the standards with other accredited programs, the Performance Report will facilitate the identification of areas for program improvement. Facility staff identified as CoC Datalinks users receive an e-mail notification when the completed Performance Report is posted to CoC Datalinks. The e-mail notification includes a cover letter explaining the information provided in the report and explains how to interpret the comparison information. The posted Performance Report is accessible to all CoC Datalinks users at the facility.

The certificate of accreditation, press release, and marketing materials are provided to the cancer registrar following posting of the Performance Report to CoC Datalinks. A sample report appears on the Cancer Programs page of the American College of Surgeons Web site.

The facility can appeal the deficiency finding for any standard or the accreditation award within 45 days of receipt of the Accredited Cancer Program Performance Report. The appeals process is outlined in the cover letter that accompanies the Performance Report and also appears on the Cancer Programs page of the American College of Surgeons Web site.

A listing of all CoC-accredited cancer programs appears on the Cancer Programs page of the American College of Surgeons Web site.

THE CoC OUTSTANDING ACHIEVEMENT AWARD

The CoC Outstanding Achievement Award (OAA) will be granted to any cancer program that does both of the following:

- At the time of survey, receives a commendation rating in each of the areas defined annually by the Accreditation Committee.
- At the time of survey, receives a compliance rating for all other standards.

The purpose of this award is to

- Recognize those cancer programs that strive for excellence in providing quality care to the cancer patient.
- 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
 - 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 receiving this award will receive the following:

- A letter of recognition from the CoC chair addressed to the CEO/administrator.
- A specially designed press release, marketing information, and the Three-Year with Commendation award certificate.
- The Outstanding Achievement Award trophy.

- CoC publicity via *CoC Flash* and the CoC Web site.
- Acknowledgment at a public forum.

THE POSTSURVEY EVALUATION

The postsurvey evaluation is a required part of the cancer program evaluation and is accessed through the SAR. This evaluation captures feedback from the facility, which enables the CoC to evaluate and improve the survey process and surveyor performance, as well as to develop educational materials and training programs for surveyors and participating programs.

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 postsurvey evaluation is completed within 3 weeks following the survey date.

GUIDELINES FOR MERGED OR NETWORK PROGRAMS

If the facility has merged, is merging, or plans to merge or form a network, the facility must access and review either the Merged Program Guidelines or Network Program Guidelines located on the Cancer Program Accreditation, Resources for Cancer Programs page of the American College of Surgeons Web site. Guidelines outline the requirements for cancer program composition as a merged or network program.

Once the respective guidelines have been reviewed, the facility completes and submits the notification form providing general information about the merger or 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.

CoC RESOURCES AND TOOLS FOR CANCER PROGRAMS

Survey-related resources and tools are available on the Cancer Programs pages of the American College of Surgeons Web site. These include, but are not limited to, the following.

SURVEY-RELATED RESOURCES

- Appeals Process
- CoC-trained Independent Cancer Consultant List
- Deficiency Resolution Documentation
- Merged Program Guidelines
- Network Program Guidelines
- Information for CoC Special Studies
- Job descriptions for the cancer committee/leadership body chair and coordinators

- NCDB Case Submission, Transmission File Specifications/Format
- NCDB Hospital Edit Report Documentation
- Sample Accredited Cancer Program Performance Report

CANCER PROGRAM TRACKING TOOLS

- Cancer Conference Grid
- Cancer Registry Abstracting Quality Control Tool
- Pathology Report Quality Control Tool

OTHER CANCER PROGRAM RESOURCES

- ACoS Publications and Services Catalog
- Benefits of Being an Accredited Cancer Program
- Benefits of Being an Accredited Cancer Program Network
- Cancer Liaison Physician Membership Criteria and Membership Application
- CoC Cancer Program Data Standards
- Facility Information Profile System (FIPS)
- Find an Accredited Cancer Program Near You
- How Are Cancer Programs Accredited?
- How to Start an Accredited Cancer Program
- Inquiry and Response (I&R) System
- NCDB Benchmark Reports
- Quality Improvement Best Practices in CoC-Accredited Cancer Programs
- What Is an Accredited Cancer Program?

Institutional and Programmatic Resources

Purpose: The standard confirms the accreditation standing for the facility or facilities.

FACILITY ACCREDITATION

Standard 1.1 The facility is accredited by a recognized authority appropriate to the facility type.

DEFINITION AND REQUIREMENTS

Accreditation ensures that care is provided in a safe environment. The boundary of the cancer program accreditation is established by the facility(ies) and/or locations included in the accreditation.

The accrediting organizations recognized by the Commission on Cancer (CoC) follow:

- Accreditation Association of Ambulatory Healthcare (AAAHC)
- American Osteopathic Association (AOA)
- Health facility licensure agency (usually located within the state department of health)

- The Joint Commission
- American College of Radiology (ACR)
- American College of Radiation Oncology (ACRO)

The ACR and ACRO practice accreditation program fulfills the eligibility requirements for freestanding cancer center programs and integrated cancer programs offering radiation oncology services.

No survey will be performed if the facility is not accredited by a recognized authority.

SPECIFICATIONS BY CATEGORY

ACCEPTED ACCREDITING BODIES BY CATEGORY	
CATEGORY	REQUIRED ACCREDITATION (one of the following)
Network Cancer Program (NCP)	The Joint Commission AOA Health facility licensure agency
NCI-designated Comprehensive Cancer Center Program (NCIP)	The Joint Commission AOA Health facility licensure agency
Teaching Hospital Cancer Program (THCP)	The Joint Commission AOA Health facility licensure agency
Veterans Affairs Cancer Program (VACP)	The Joint Commission AOA Health facility licensure agency
Pediatric Cancer Program (PCP)	The Joint Commission AOA Health facility licensure agency
Pediatric Cancer Program Component (PCPC)	The Joint Commission AOA Health facility licensure agency

ACCEPTED ACCREDITING BODIES BY CATEGORY (continued)

CATEGORY	REQUIRED ACCREDITATION (one of the following)
Community Hospital Comprehensive Cancer Program (COMP)	The Joint Commission AOA Health facility licensure agency
Community Hospital Cancer Program (CHCP)	The Joint Commission AOA Health facility licensure agency
Hospital Associate Cancer Program (HACP)	The Joint Commission AOA Health facility licensure agency
Affiliate Hospital Cancer Program (AFCP)	The Joint Commission AOA Health facility licensure agency
Integrated Cancer Program (ICP)	The Joint Commission AAAHC ACR ACRO
Freestanding Cancer Center Program (FCCP)	The Joint Commission AAAHC ACR ACRO

DOCUMENTATION

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with a copy of the certificate of accreditation or letter from the accrediting body.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

The facility provides the surveyor with a copy of the certificate of accreditation or letter from the accrediting body.

RATING

(1) **Compliance:** The facility is accredited by a recognized accrediting authority.

(5) **Noncompliance:** The facility is not accredited, or is accredited by an authority not recognized by the CoC. No survey will take place.

NCIP facilities:

(1) **Compliance:** The facility is accredited by a recognized accrediting authority.

(5) **Noncompliance:** The facility is not accredited, or is accredited by an authority not recognized by the CoC. No survey will take place.

Cancer Program Leadership

Purpose: The standards establish the cancer program's leadership responsibility and accountability for cancer program activities at the facility.

LEVEL OF RESPONSIBILITY AND ACCOUNTABILITY

Standard 2.1 The organizational structure of the facility or medical staff gives the cancer committee, or other appropriate leadership body, responsibility and accountability for the cancer program activities.

DEFINITION AND REQUIREMENTS

Leadership is the key element in an effective cancer program, and program success depends on an effective cancer committee or other appropriate leadership body. The cancer committee/leadership body is responsible for goal setting for, as well as planning, initiating, implementing, evaluating, and improving, all cancer-related activities in the facility.

The facility or medical staff formally establishes the responsibility, accountability, and multidisciplinary membership required for the cancer committee/leadership body to fulfill its role. The facility documents the cancer committee/leadership body's responsibility and accountability using a method appropriate to the facility's organizational structure. Examples include, but are not limited to, the following:

- The facility bylaws designate the cancer committee/leadership body to be a standing committee with authority defined.
- The medical staff bylaws designate the cancer committee/leadership body to be a standing committee with authority defined.
- Policies and procedures for the facility define authority of the cancer committee/leadership body.
- Policies and procedures for the medical staff define the authority of the cancer committee/leadership body.

Other methods that are consistent with the facility organization and operation are acceptable.

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Network Cancer Program (NCP)
- Teaching Hospital Cancer Program (THCP)
- Veterans Affairs Cancer Program (VACP)
- Pediatric Cancer Program (PCP)

- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)
- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

An NCIP facility defines the structure for the multidisciplinary administrative body responsible for the cancer program. Examples include, but are not limited to, the following:

- Cancer center board
- Executive committee
- Quality council
- Disease site (departmental) teams
- Cancer committee/leadership body

The NCIP facility maintains documentation of structure and organization in facility-defined sources not limited to bylaws statements.

Pediatric Cancer Program Component (PCPC)

A PCPC should establish a pediatric subcommittee of the facility's cancer committee/leadership body that will be responsible for the pediatric cancer program component. The PCPC may also choose to manage the activities of the pediatric cancer program component through the facility's cancer committee/leadership body. If the facility's cancer committee/leadership body is responsible for the pediatric component, then the pediatric members specified in Standard 2.2 are members of the facility's cancer committee/leadership body. Otherwise, the

pediatric physician and nonphysician members outlined in Standard 2.2 are members of the pediatric subcommittee.

The structure and organization of the pediatric subcommittee and the relationship to the facility's cancer com-

mittee/leadership body are defined in the bylaws or other facility-approved sources and specify the cancer committee/leadership body's oversight of the pediatric component through the regular reporting of pediatric activities.

DOCUMENTATION

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

Facilities provide the surveyor with a copy of the bylaws, policies and procedures, or other facility-approved methods used to document the level of responsibility and accountability designated to the cancer committee/leadership body.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

The NCIP facility provides the surveyor with a copy of the facility's organizational chart or oncology service line organizational chart that identifies the staff names, roles, and responsibilities.

The facility provides the overall description of the cancer center from the NCI grant.

RATING

(1) **Compliance:** The cancer committee/leadership body's responsibility and accountability are documented in bylaws, policies and procedures, or other facility-approved methods.

(5) **Noncompliance:** The cancer committee/leadership body's responsibility and accountability are not documented.

NCIP facilities:

(1) **Compliance:** The structure of the multidisciplinary administrative body is documented in facility-defined sources.

(5) **Noncompliance:** The structure of the multidisciplinary administrative body is not documented.

MEMBERSHIP

Standard 2.2 The membership of the cancer committee, or other appropriate leadership body, is multidisciplinary, representing physicians from the diagnostic and treatment specialties and nonphysicians from administrative and supportive services.

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DEFINITION AND REQUIREMENTS

Cancer patient care 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. Required nonphysician representatives from each of the administrative, clinical, and supportive services available at the facility are also to be members of the committee. The committee fulfills the attendance and quorum requirements set by the facility.

Required physician members are as follows:

- Diagnostic radiologist
- Pathologist
- General surgeon
- Medical oncologist
- Radiation oncologist (If all radiation oncology services are provided by referral, and the facility's medical staff does not include a radiation oncologist, then a cancer committee/leadership body member from radiation oncology is recommended, but not required.)

The cancer liaison physician must be a member of the cancer committee/leadership body. The cancer liaison physician may also fulfill the role of one of the required physician specialties.

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

A Pediatric Cancer Program (PCP) and a Pediatric Cancer Program Component (PCPC) within a larger facility select physician members specializing in the care of pediatric cancer patients.

Required nonphysician members 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 professional

A PCP and a PCPC select nonphysician members specializing in the care of pediatric cancer patients, including a certified pediatric oncology nurse (CPON).

Additional physician or nonphysician cancer committee/leadership body members are required for specific categories. (See specifications by category.) These include, but are not limited to, the following:

- Hospice/home care nurse or administrator
- Pain control/palliative care physician or specialist
- Clinical research data manager or nurse

Each facility should assess the scope of services offered and determine the need for additional cancer committee/leadership body members based on the major cancer sites seen by the facility. Additional members may include, but are not limited to, the following:

- Specialty physicians representing the major cancer experience(s) at the facility
- Dietary/nutrition specialist
- Pharmacist
- Pastoral care representative
- Psychiatric or mental health professional
- American Cancer Society Cancer Control representative
- A public member of the community served

A PCP and a PCPC select additional physician or nonphysician members based on Children's Oncology Group membership requirements, the services and specialties available at the facility, 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 oncology surgeon
- Pediatric subspecialists in anesthesiology, intensive care, infectious diseases, cardiology, nephrology, and neurology
- Pediatric psychologist
- A representative from the late effects clinic

SPECIFICATIONS BY CATEGORY

ADDITIONAL REQUIRED CANCER COMMITTEE/LEADERSHIP BODY MEMBERS BY CATEGORY	
CATEGORY	ADDITIONAL REQUIRED CANCER COMMITTEE/LEADERSHIP BODY MEMBERS
Network Cancer Program (NCP)	Network administrator Oncology nurse from the ambulatory care setting Clinical research data manager or nurse Pain control/palliative care physician Pharmacist Dietary/nutrition specialist Hospice nurse or administrator
Teaching Hospital Cancer Program (THCP)	Clinical research data manager or nurse Pain control/palliative care physician or specialist
Veterans Affairs Cancer Programs (VACP)	None
Pediatric Cancer Program (PCP)	Children's Oncology Group (COG) data manager Child Life specialist
Pediatric Cancer Program Component (PCPC)	COG data manager Child Life specialist
Community Hospital Comprehensive Cancer Program (COMP)	Pain control/palliative care physician or specialist
Community Hospital Cancer Program (CHCP)	None
Hospital Associate Cancer Program (HACP)	None
Affiliate Hospital Cancer Program (AFCP)	Representative from hospital partner
Integrated Cancer Program (ICP)	None
Freestanding Cancer Center Program (FCCP)	For freestanding cancer centers providing radiation oncology: dosimetrist or radiation physicist

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

An NCIP facility defines the physician and nonphysician participation in the administrative body responsible

for the cancer program based on the structure, organization and needs of the facility.

Documentation of membership and/or participation is specified in facility-defined sources such as the facility oncology service line organizational chart.

DOCUMENTATION

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The surveyor will evaluate cancer committee/leadership body membership by reviewing cancer committee/leadership body minutes.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR) or provides a list of names, credentials, titles, roles, and responsibilities of the program/facility leaders.

This information may be included in the facility organizational chart or oncology service line organizational chart.

RATING

(1) **Compliance:** All required cancer committee/leadership body members are appointed.

(5) **Noncompliance:** One or more of the required cancer committee/leadership body members are not appointed.

NCIP facilities:

(1) **Compliance:** A multidisciplinary group of physicians and nonphysicians is appointed to the administrative body responsible for the cancer program/facility.

(5) **Noncompliance:** Multidisciplinary physician and nonphysician members are not appointed to the administrative body responsible for the cancer program/facility.

PROGRAM ACTIVITY COORDINATORS

Standard 2.3 Based on category requirements, 1 coordinator is designated for each of the specified areas of cancer program activity.

DEFINITION AND REQUIREMENTS

To promote team involvement and shared responsibilities, 1 member of the cancer committee, or appropriate leadership body, is designated to coordinate 1 of the specified major areas of program activity.

The coordinators are chosen on the basis of their specialty, knowledge, and skills. Both physician and nonphysician members of the committee may be selected as coordinators. The coordinators are appointed or reappointed annually. The coordinator appointments are documented in committee minutes or other facility-approved sources.

Coordinator roles and responsibilities are defined by the cancer committee/leadership body. These include, but are not limited to, the following:

- Contributing to the development of the annual goals and objectives of the cancer committee/leadership body.
- Monitoring the activity of the assigned area of responsibility.
- Reporting regularly to the cancer committee/leadership body.
- Recommending corrective action if activity falls below the annual goal or requirements.

Cancer committee/leadership body minutes identify the designated coordinators, their assigned areas of activity, and their annual appointment or reappointment. The coordinators' defined duties and responsibilities are documented in cancer committee/leadership body minutes or other facility-approved sources. The minutes also document the reported results of activities and recommendations for corrective action.

In some facilities, the coordinator(s) works cooperatively with established departments or staff leadership to facilitate, monitor, and recommend improvements to the assigned areas or programs. In this instance, the coordinator(s) acts as the cancer committee/leadership body liaison to the established departments or staff leadership.

In Veterans Affairs Cancer Program (VACP) facilities accessioning fewer than 175 cases annually, ad hoc (for this purpose only) coordinators may be designated on an as-needed basis, or facilities may fulfill this standard through the Veterans Integrated Service Network (VISN)-assigned coordinators, who may serve more than 1 facility.

The process for ad hoc coordinator appointments or for using VISN-assigned coordinators in VACP facilities is documented in a facility-approved source, as are the names of the ad hoc or VISN coordinators and their area of responsibility.

In Pediatric Cancer Program Component (PCPC) facilities, the pediatric cancer conference coordinator works cooperatively with the facility's cancer conference coordinator to ensure that pediatric cancer cases are appropriately presented and discussed at cancer conference.

In NCI-designated Comprehensive Cancer Center Program (NCIP) facilities, the cancer liaison physician (or the designee) oversees CoC quality initiatives, such as participation in CoC special studies, and acts as the lead for interpreting the facility's Cancer Program Practice Profile Reports (CP³R).

SPECIFICATIONS BY CATEGORY

CATEGORY	REQUIRED COORDINATORS
Network Cancer Program (NCP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach
NCI-designated Comprehensive Cancer Center Program (NCIP)	None
Teaching Hospital Cancer Program (THCP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Veterans Affairs Cancer Program (VACP)	Cancer conference Quality of cancer registry data Quality improvement For facilities that qualify, ad hoc or VISN-assigned coordinators are appointed

SPECIFICATIONS BY CATEGORY (continued)

CATEGORY	REQUIRED COORDINATORS
Pediatric Cancer Program (PCP)	Cancer conference Quality of cancer registry data Quality improvement Child Life or long-term follow-up
Pediatric Component Cancer Program (PCPC)	Facility coordinators responsible for activities of the pediatric cancer program Pediatric cancer conference Child Life or long-term follow-up
Community Hospital Comprehensive Cancer Program (COMP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Community Hospital Cancer Program (CHCP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Hospital Associate Cancer Program (HACP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Affiliate Hospital Cancer Program (AFCP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Integrated Cancer Program (ICP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Freestanding Cancer Center Program (FCCP)	Cancer conference Quality of cancer registry data Quality improvement Community outreach

DOCUMENTATION

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

Coordinator appointments and/or reappointments are confirmed by the surveyor through review of cancer committee/leadership body minutes.

NCIP facilities:

No documentation is required from the NCIP facility.

The surveyor discusses the cancer liaison physician's involvement in CoC special studies and how the CP³R reports have been used by the facility to affect care.

RATING

(1) **Compliance:** A coordinator is designated for each of the required areas of activity.

(5) **Noncompliance:** A designated coordinator is not appointed for 1 or more of the required areas of activity.

NCIP facilities:

(8) **Not Applicable:** NCIP facility only.

MEETING SCHEDULE

Standard 2.4 The meeting schedule and structure of the cancer committee, or other appropriate leadership body, fulfill the requirements for the category.

DEFINITION AND REQUIREMENTS

Regular meetings ensure that administrative responsibilities related to cancer program leadership are carried out. In Network Cancer Programs, the cancer committee/leadership body meets every other month to complete the administrative responsibilities related to cancer program leadership. In all other categories, the cancer committee/leadership body meets at least quarterly. More frequent meetings may be required to meet the overall program needs.

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

- Cancer conference 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/leadership body 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/leadership body. Meetings of subcommittees and workgroups do not constitute meetings of the full cancer committee/leadership body.

SPECIFICATIONS BY CATEGORY

CANCER COMMITTEE/LEADERSHIP BODY MEETING SCHEDULE AND STRUCTURE RECOMMENDATIONS BY CATEGORY		
CATEGORY	REQUIRED SCHEDULE	SUBCOMMITTEE WORKGROUPS
Network Cancer Program (NCP)	Every other month	Recommended
NCI-designated Comprehensive Cancer Center Program (NCIP)	Established by the program/exempt	Established by the program/exempt
Teaching Hospital Cancer Program (THCP)	Quarterly	Recommended
Veterans Affairs Cancer Program (VACP)	Quarterly	Optional
Pediatric Cancer Program (PCP)	Quarterly	Optional
Pediatric Cancer Program Component (PCPC)	The pediatric subcommittee meets quarterly	Not applicable
Community Hospital Comprehensive Cancer Program (COMP)	Quarterly	Optional
Community Hospital Cancer Program (CHCP)	Quarterly	Optional
Hospital Associate Cancer Program (HACP)	Quarterly	Optional
Affiliate Hospital Cancer Program (AFCP)	Quarterly	Optional
Integrated Cancer Program (ICP)	Quarterly	Optional
Freestanding Cancer Center Program (FCCP)	Quarterly	Optional

EXCEPTIONS BY CATEGORY

An NCI-designated Comprehensive Cancer Center Program (NCIP) facility is exempt from this standard but is requested to provide general information in the

Survey Application Record (SAR) for this standard that describes the facility's meeting schedule and structure. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with copies of all cancer committee/leadership body minutes for the last 2 complete calendar years and the current year through the survey date.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

The surveyor will discuss the committee structure and meeting frequency during the on-site visit.

RATING

(1) **Compliance:** The cancer committee/leadership body fulfills meeting requirements specified for the category.

(5) **Noncompliance:** The cancer committee/leadership body does not fulfill meeting requirements specified for the category.

NCIP facilities:

(1) **Compliance:** Default rating.

DUTIES AND RESPONSIBILITIES

Standards 2.5 through 2.11 are the minimum activities required for program leadership and operation. The cancer committee/leadership body duties and responsibilities must specify the activities described in each of these standards. Additional duties and responsibilities are defined by each cancer program based on the size of the facility and scope of services provided.

Standard 2.5 As required by the category, the cancer committee, or other appropriate leadership body, develops and evaluates the annual goals and objectives for the endeavors related to cancer care.

DEFINITION AND REQUIREMENTS

Annual goals provide direction for cancer program activities and serve as the basis for cancer program evaluation.

The cancer committee/leadership body or appropriate subcommittee establishes goals appropriate to the facility as required for the category of accreditation. The scope of this activity and method of documentation will vary, depending on the size of the facility; however, goals and activities related to goals must be documented in cancer committee/leadership body minutes or other facility-approved sources.

Examples of goals include, but are not limited to:

- Clinical: Improve turnaround time for chemotherapy administration in the outpatient infusion center.
- Community outreach: Improve follow-up of positive findings from the prostate screening program.
- Quality improvement: Implement synoptic reporting in the pathology reports.
- Programmatic: Improve overall performance to earn the CoC Outstanding Achievement Award.

The cancer committee/leadership body chair, or appropriate subcommittee chair, is responsible for guiding the committee through the development and evaluation of the annual goals. The cancer committee/leadership body establishes a time frame for achieving each goal. Frequent monitoring and evaluation are necessary.

SPECIFICATIONS BY CATEGORY

REQUIRED GOALS BY CATEGORY	
CATEGORY	REQUIRED GOALS
Network Cancer Program (NCP)	Clinical Community outreach Programmatic endeavors Quality improvement
NCI-designated Comprehensive Cancer Center Program (NCIP)	Cancer conference Clinical Quality improvement
Teaching Hospital Cancer Program (THCP)	Clinical Community outreach Programmatic endeavors Quality improvement
Veterans Affairs Cancer Program (VACP)	Clinical Programmatic endeavors Quality improvement
Pediatric Cancer Program (PCP)	Clinical Clinical research Programmatic endeavors Quality improvement
Pediatric Cancer Program Component (PCPC)	Clinical Clinical research Programmatic endeavors Quality improvement
Community Hospital Comprehensive Cancer Program (COMP)	Clinical Community outreach Programmatic endeavors Quality improvement

REQUIRED GOALS BY CATEGORY (continued)

CATEGORY	REQUIRED GOALS
Community Hospital Cancer Program (CHCP)	Clinical Community outreach Programmatic endeavors Quality improvement
Hospital Associate Cancer Program (HACP)	Clinical Community outreach Programmatic endeavors Quality improvement
Affiliate Cancer Program (ACP)	Clinical Community outreach Programmatic endeavors Quality improvement
Integrated Cancer Program (ICP)	Clinical Community outreach Programmatic endeavors Quality improvement
Freestanding Cancer Center Program (FCCP)	Clinical Community outreach Programmatic endeavors Quality improvement

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

In an NCIP facility, goals are set, documented, and monitored centrally, departmentally, or by disease site teams, as directed by the cancer center.

The documentation source for the goals and the schedule for the review of goals are based on the facility structure and organization.

Veterans Affairs Cancer Program (VACP)

A VACP facility accessioning fewer than 175 cases annually may substitute 1 or more Veterans Integrated Service Network (VISN) regional goals for 1 or more facility-based goals. The selection of VISN regional goals is documented in cancer committee/leadership body minutes or other facility-approved sources.

Pediatric Cancer Program Component (PCPC)

Pediatric goals in a PCPC facility are set by the cancer committee/leadership body or the pediatric cancer subcommittee as appropriate to the organization of the program.

DOCUMENTATION

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with copies of cancer committee/leadership body minutes or other sources that document the annual goals, time frame for evaluation and completion, assigned coordinator, and responsibilities of other committee members.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR) or provides facility-approved documentation of the annual goals from the last calendar year to the surveyor during the on-site visit.

During the on-site visit, the surveyor will discuss how goals are identified, established, and evaluated.

RATING

(1) **Compliance:** Annual cancer program goals required for the category are documented and evaluated.

(5) **Noncompliance:** Annual cancer program goals required for the category are not developed and/or documented.

NCIP facilities:

(1) **Compliance:** Annual cancer program goals required for the category are documented and evaluated.

(5) **Noncompliance:** Annual cancer program goals required for the category are not developed and/or documented.

Standard 2.6 The cancer committee, or other appropriate leadership body, establishes the cancer conference frequency and format on an annual basis.

DEFINITION AND REQUIREMENTS

Setting the cancer conference frequency and format allows for prospective review of cancer cases and encourages multidisciplinary involvement in the care process. Cancer conferences are integral to improving the care of cancer patients by contributing to the patient management process and outcomes and providing education to physicians and other staff in attendance.

The annual cancer conference frequency and format are documented in cancer committee/leadership body minutes, a cancer conference policy and procedure, or other facility-approved sources. The cancer committee/leadership body considers the minimum percentage of cases to be presented at cancer conferences (Standard 2.8) when determining the cancer conference frequency.

Frequency and format should be based on the following:

- Category
- Number of annual analytic accessions
- Types of cases seen by the facility
- Need for consultative services
- Need for educational activities

Conferences that include case presentation should be available to the entire medical staff and are the preferred format for community-based facilities. Network Cancer Programs use current technology to offer network-wide conferences to multiple locations. Departmental and site-focused conferences or grand rounds are appropriate for larger community-based facilities, teaching hospitals, and Network Cancer Programs. Departmental or site-focused conferences or lectures may be included in the cancer conference program by any facility at the discretion of the cancer committee/leadership body.

In Pediatric Cancer Program Component (PCPC) facilities, a separate pediatric cancer conference program should be established and documented by the pediatric cancer subcommittee or the facility's cancer committee/leadership body, as appropriate. The frequency and format for the pediatric cancer conferences are documented in cancer committee/leadership body minutes, a cancer conference policy and procedure, or other facility-approved sources.

CATEGORY-SPECIFIC REQUIREMENTS

CANCER CONFERENCE FREQUENCY AND RECOMMENDED FORMAT BY CATEGORY		
CATEGORY	RECOMMENDED MINIMUM FREQUENCY	RECOMMENDED FORMAT
Network Cancer Program (NCP)	Weekly	Network-wide Site-focused
NCI-designated Comprehensive Cancer Center Program (NCIP)	Established by the program/exempt	Established by the program/exempt
Teaching Hospital Cancer Program (THCP)	Weekly	Departmental Site-focused Facility-wide
Veterans Affairs Cancer Program (VACP)	Weekly	Departmental Site-focused Facility-wide
Pediatric Cancer Program (PCP)	Weekly	Departmental Site-focused Histology-specific Facility-wide
Pediatric Cancer Program Component (PCPC)	Monthly	Departmental Site-focused Histology-specific
Community Hospital Comprehensive Cancer Program (COMP)	Weekly	Departmental Site-focused Facility-wide

CANCER CONFERENCE FREQUENCY AND RECOMMENDED FORMAT BY CATEGORY (continued)

CATEGORY	RECOMMENDED MINIMUM FREQUENCY	RECOMMENDED FORMAT
Community Hospital Cancer Program (CHCP)	Monthly	Facility-wide
Hospital Associate Cancer Program (HACP)	Monthly	Facility-wide
Affiliate Hospital Cancer Program (AFCP)	Monthly with hospital partner	Facility-wide
Integrated Cancer Program (ICP)	Monthly with hospital partner	Facility-wide
Freestanding Cancer Center Program (FCCP)	Monthly	Facility-wide

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

In an NCIP facility, cancer conference activities are set, documented, and monitored centrally, departmentally, or by disease site teams as directed by the cancer center. Departmental, site- or histology-focused conferences, or

grand rounds are appropriate formats in NCIP facilities. An NCIP facility is exempt from this standard but is requested to provide general information in the Survey Application Record (SAR) that describes the facility’s cancer conference program. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The cancer committee/leadership body determines the method for documenting cancer conference activity based on facility requirements and the needs of the program. A cancer conference grid, calendar, or tracking tool that shows the annual conference frequency and format may be used, and a sample is included in the online Best Practices Repository.

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with copies of cancer committee/leadership body minutes or other documentation showing that the cancer committee/leadership body established or reestablished the annual frequency and format of cancer conferences of the cancer program.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

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

During the on-site visit, the facility will discuss and describe the cancer conference program activities with the surveyor.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

RATING

(1) **Compliance:** The annual conference frequency and format are established and documented by the cancer committee/leadership body on an annual basis.

(5) **Noncompliance:** The annual conference frequency and/or format are not established and/or documented by the cancer committee/leadership body.

NCIP facilities:

(1) **Compliance:** Default rating.

Standard 2.7 The cancer committee, or other appropriate leadership body, establishes the multidisciplinary attendance requirements and attendance rate for cancer conferences on an annual basis.

DEFINITION AND REQUIREMENTS

Setting the multidisciplinary attendance requirement and attendance rate for cancer conferences encourages multidisciplinary involvement in prospective discussion of cancer cases. Cancer conferences are integral to improving the care of cancer patients by contributing to the patient management process and outcomes, as well as by providing education to physicians and other staff in attendance. Consultative services are optimal when physician representatives from diagnostic radiology, pathology, surgery, medical oncology, and radiation oncology participate in facility-wide or network-wide cancer conferences.

Representatives from surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology are present at the facility-wide or network-wide cancer conferences. The cancer committee/leadership body sets the annual attendance rate for each of these specialties that are required to attend the facility-wide or network-wide cancer conferences. The annual percentage of attendance is documented in cancer committee/leadership body minutes, the cancer conference policy and procedure, or other facility-approved documentation.

The minimum multidisciplinary attendance rate should be based on the following:

- Types of cases seen by the facility
- Format of conferences (facility-wide or network-wide, departmental, site-focused, grand rounds)

Multidisciplinary physician attendance at departmental or site-focused conferences or grand rounds will depend on the diagnostic and treatment needs of the sites presented. On an annual basis, the cancer committee/leadership body defines the multidisciplinary specialties required for each departmental or site-focused conference held at the facility.

The cancer committee/leadership body also determines how often each specialty must attend cancer conferences by setting the annual attendance rate for each specialty required to attend the departmental or site-focused conferences or grand rounds. The annual attendance rate is documented in cancer committee/leadership body minutes, the cancer conference policy and procedure, or other facility-approved documentation.

Network-wide cancer conferences involve physicians from all sites within the network who provide diagnostic and treatment services. All members of the medical staff of the Cancer Program Network are actively involved in network-wide cancer conferences.

In Pediatric Cancer Program Component (PCPC) facilities, a separate pediatric cancer conference program should be established and documented by the pediatric cancer subcommittee or the facility's cancer committee/leadership body, as appropriate. The multidisciplinary attendance and the annual percentage of attendance for the pediatric cancer conferences are documented in cancer committee/leadership minutes, a cancer conference policy and procedure, or other facility-approved sources.

EXAMPLES OF MODIFICATIONS FOR MULTIDISCIPLINARY ATTENDANCE AT SITE-FOCUSED CONFERENCES					
Conference Type	RECOMMENDED MULTIDISCIPLINARY ATTENDANCE				
	Diagnostic Radiology	Pathology	Surgery	Medical Oncology	Radiation Oncology
Leukemia		X 100% annual attendance		X 100% annual attendance	
Brain/Central Nervous System	X 80% annual attendance	X 80% annual attendance	X 100% annual attendance		X 100% annual attendance

SPECIFICATIONS BY CATEGORY

All programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The cancer committee/leadership body determines the method for documenting cancer conference activity based on facility requirements and the needs of the program. A cancer conference grid, calendar, or tracking tool that shows the annual conference attendance may be used, and a sample is included in the online CoC Best Practices Repository for cancer programs.

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with copies of cancer committee/leadership body minutes or other documentation showing that the cancer committee/leadership body established or reestablished the multidisciplinary attendance requirements for cancer conferences of the cancer program.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

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

During the on-site visit, the facility will discuss and describe the cancer conference program activities with the surveyor.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

RATING

(1) **Compliance:** The multidisciplinary conference attendance requirement and the attendance rate are established and documented by the cancer committee/leadership body on an annual basis.

(5) **Noncompliance:** The cancer committee/leadership body does not establish and document either the multidisciplinary conference attendance or the attendance rate on an annual basis.

NCIP facilities:

(1) **Compliance:** Default rating.

Standard 2.8 The cancer committee, or other appropriate leadership body, ensures that the required number of cases are discussed at the cancer conference on an annual basis, that at least 75% of the cases discussed are presented prospectively and that AJCC or other appropriate stage of the cases is discussed and documented for the 5 major sites seen at the facility.

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DEFINITION AND REQUIREMENTS

Cancer conferences are an essential forum to provide multidisciplinary consultative services for patients, as well as to offer education to physicians and allied health professionals.

The number of cases presented each year at cancer conferences is a percentage of the number of annual analytic cases added to the cancer registry database. The minimum required percentage is 10% of the annual analytic caseload. The cancer committee/leadership body should consider a higher benchmark, depending on the annual caseload. Programs accessioning 3,000 or more cases annually present 300 cases each year at cancer conferences. In Network Cancer Programs, the cases selected ensure equal representation of each network site.

To provide a consultative service for patients and physicians, 75% of the cases presented must be discussed prospectively, that is, addressing patient management issues. Discussion of cases presented prospectively includes the AJCC stage (either clinical stage or working stage), or other appropriate stage and should include the treatment options for each case. AJCC working stage is defined as all staging information (clinical and pathologic) that is available at the time of discussion.

The stage of the prospective cases discussed is to be documented, either on the cancer conference agenda or using another method determined by the cancer committee/leadership body. In facilities with multiple site focused conferences, the stage discussed at conferences for the 5 major sites of cancer seen at the facility is documented.

National Comprehensive Cancer Center Network (NCCN) treatment guidelines or other treatment guidelines developed by nationally recognized organizations, such as the American Society of Clinical Oncology (ASCO), should be considered when discussing treatment options.

Cases selected for discussion include the 5 major sites seen at the institution, as well as cases with unusual sites and/or histologies and challenging management issues. The number of cases presented at each conference is monitored to ensure adequate time for thorough discussion.

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.

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

In Pediatric Cancer Program Component (PCPC) facilities, a separate pediatric cancer conference program should be established and documented by the pediatric cancer subcommittee or the facility's cancer committee/leadership body, as appropriate.

The percentage of prospective presentations at the pediatric cancer conferences is documented in cancer committee/leadership body minutes, a cancer conference policy and procedure, or other facility-approved sources.

SPECIFICATIONS BY CATEGORY

All programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The cancer committee/leadership body determines the method for documenting cancer conference activity based on facility requirements and the needs of the program. A cancer conference grid, calendar, or tracking tool that shows the annual case presentation, AJCC stage (clinical stage or working stage), or other appropriate stage, may be used. It is acceptable to include the clinical or working stage on the cancer conference agenda. Samples of documentation are included in the online Best Practices Repository for cancer programs.

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit. The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with copies of cancer committee/leadership body minutes or other documentation showing the case presentation at cancer conferences and AJCC stage (clinical or working stage), or other appropriate stage, used by the cancer program. During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

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

During the on-site visit, the facility will discuss and describe the cancer conference program activities with the surveyor, including the use of clinical or working stage in treatment planning.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

RATING

(1) **Compliance:** Presentation of 10% of the annual analytic caseload or 300 cases annually and 75% of the cases presented are discussed prospectively and AJCC clinical or working stage, or other appropriate stage, of the cases is discussed.

(5) **Noncompliance:** Presentation of less than 10% of the annual analytic caseload or 300 cases annually and or 75% of the cases are not discussed prospectively and/or the AJCC clinical or working stage, or other appropriate stage, of the cases is not discussed.

NCIP facilities:

(1) **Compliance:** Default rating.

Standard 2.9 The cancer committee, or other appropriate leadership body, monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.

DEFINITION AND REQUIREMENTS

Monitoring of cancer conference activity ensures that conferences provide consultative services for patients, as well as offer education to physicians and allied health professionals. Monitoring cancer conference activity also ensures that the educational and consultative goals of the cancer program are fulfilled. The cancer committee/leadership body monitors cancer conference activity through the work of the cancer conference coordinator.

Routine evaluation of cancer conference activity in each of 4 areas is essential to ensure compliance with the requirements set by the cancer committee/leadership body:

- Conference frequency
- Multidisciplinary attendance
- Total case presentation
- Prospective case presentation, including the clinical or working stage

The methods used to monitor cancer conference activity are set by the cancer committee/leadership body and documented in cancer committee/leadership body minutes. The assigned coordinator monitors each area of

cancer conference activity, reports regularly to the cancer committee/leadership body, and recommends corrective action if any area falls below the annual goal or requirements. The results and recommendations are documented in cancer committee/leadership body minutes or other facility-approved sources.

The pediatric cancer conference coordinator in the Pediatric Cancer Program Component (PCPC) monitors cancer conference activity and reports regularly on the pediatric cancer conference activity to the pediatric subcommittee or the facility cancer committee/leadership body, as appropriate.

SPECIFICATIONS BY CATEGORY

All programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The cancer committee/leadership body determines the method for documenting cancer conference activity based on facility requirements and the needs of the program. A cancer conference grid, calendar, or tracking tool that shows the frequency, format, multidisciplinary attendance, and annual case presentation may be used, and a sample is included in the online Best Practices Repository.

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with copies of cancer committee/leadership body minutes or other documentation showing the monitoring of cancer conference frequency, multidisciplinary attendance, total case presentation, and corrective action taken for any area that falls below the annual goal.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

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

During the on-site visit the facility will discuss and describe the cancer conference program activities with the surveyor.

During the on-site visit, the surveyor attends a cancer conference to observe the multidisciplinary involvement in case discussions.

RATING

(1) **Compliance:** The 4 areas of the cancer conference activity are monitored and evaluated annually by the cancer committee/leadership body.

(5) **Noncompliance:** The cancer committee/leadership body does not monitor and evaluate the 4 areas of the cancer conference activity on an annual basis.

NCIP facilities:

(1) **Compliance:** Default rating.

Standard 2.10 The cancer committee, or other appropriate leadership body, establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis. The plan includes procedures to monitor casefinding, accuracy of data collection (especially the accuracy of Collaborative Stage), abstracting timeliness, follow-up, and data reporting.

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DEFINITION AND REQUIREMENTS

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

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 (residents and other physicians may be included)

Optional sources

External audits (e.g., state/central cancer registry casefinding audits) may be used to fulfill part of this requirement

4. Identifies the activities to be evaluated

Required activities

Casefinding
Abstracting timeliness
Accuracy of the Collaborative Stage (CS) derived stage recorded on the cancer registry abstract
Correcting the information recorded in the CS data items to obtain a correct derived stage.
Accuracy of other abstracted data
Class of Case
Primary Site
Histology
First Course of Treatment
Follow-up information
National Cancer Data Base (NCDB) data submission, correction of data errors, and resubmission of corrected data

Recommended activities

Accuracy of AJCC clinical or working stage assigned by the managing physician

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 Call for Data

Accuracy rate of CS derived stage as set by the cancer committee

Recommended accuracy

90% of AJCC staging assigned by the managing physician is accurate

7. Maintains documentation of the quality control activity

Required documentation

Review criteria
Cases reviewed
Identified errors and resolutions
Reports to the cancer committee

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 regularly to the cancer committee/leadership body, and recommends corrective action if any area falls below the annual goal. The results and recommendations are documented in the cancer committee/leadership body minutes or other facility-approved sources.

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Network Cancer Program (NCP)
- Teaching Hospital Cancer Program (THCP)
- Pediatric Cancer Program (PCP)

- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)
- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)

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 certified tumor registrar (CTR) in the cancer registry, the CTR staff performs the quality control review of cancer registry data. The percentage of cases reviewed is determined by the facility 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 is encouraged, but not required.

Pediatric Cancer Program Component (PCPC)

In a PCPC, a separate plan to monitor and evaluate the quality of pediatric data and activity is established and implemented by the pediatric cancer subcommittee or facility cancer committee/leadership body, as appropriate. Physicians specializing in the care of pediatric cancer patients participate in this quality control review.

Veterans Affairs Cancer Program (VACP)

In a VACP facility, 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 are 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 or other appropriate leadership body.

DOCUMENTATION

At the on-site visit, the facility provides the surveyor with the results of the annual quality control evaluation, including the process for resolving conflicts identified during the quality control process and any audit reports from the state/central registry that were used in the evaluation of the cancer registry data. This information may be recorded in cancer committee/leadership body minutes or other facility-approved sources. The surveyor discusses the cancer registry quality control activities and results with the quality control coordinator and other members of the cancer committee during the on-site visit.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

During the on-site visit, the NCIP facility provides the surveyor with the quality control plan, the quality control initiatives, or the annual quality control study results. The quality control plan includes the process for resolving conflicts identified during the quality control process and any audit reports from the state/central registry that were used in the evaluation of the cancer registry data.

The NCIP facility provides a copy of the most recent quality control initiatives to the surveyor during the on-site visit.

RATING

(1) **Compliance:** The cancer committee/leadership body establishes and implements a plan to evaluate the required areas of cancer registry activity on an annual basis.

(5) **Noncompliance:** The cancer committee/leadership body does not establish and implement a plan to evaluate the required areas of cancer registry activity on an annual basis.

NCIP facilities:

(1) **Compliance:** The cancer registry staff members establish and implement a quality control plan to evaluate the required areas of cancer registry activity on an annual basis.

(5) **Noncompliance:** The cancer registry staff members do not establish and implement a quality control plan to evaluate the required areas of cancer registry activity on an annual basis.

Standard 2.11 Each year, the cancer committee, or other appropriate leadership body, analyzes patient outcomes and disseminates the results of the analysis.

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DEFINITION AND REQUIREMENTS

Clinically meaningful analyses of patient diagnosis, treatment, and outcomes are necessary to ensure that quality care is administered to cancer patients. A survival analysis of 1 cancer site is the preferred method; however, other outcome measures may be selected at the discretion of the cancer committee/leadership body.

This analysis includes the facility's experience with cancer. Use of cancer registry data as the basis of this analysis is recommended. The analysis should compare the hospital's experience with National Cancer Data Base (NCDB) data through benchmark reports and is the primary source for comparison data. If comparison data are not available through the NCDB, then other comparative data may be used.

The analysis includes the program's experience with the following:

- Diagnostic evaluation
- Treatment modalities
- Prognostic factors
- Survival data by American Joint Committee on Cancer (AJCC) stage of disease
- Comparison with NCDB benchmarks

The results of the cancer committee/leadership body's analysis are shared with the medical staff and administration annually. Acceptable methods for disseminating results include, but are not limited to, the following:

- Written reports

DOCUMENTATION

Documentation is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

The facility completes the Survey Application Record (SAR).

The facility provides the surveyor with copies of cancer committee/leadership body minutes or other sources that show the results of the outcomes analysis and method of dissemination.

If an annual report is published, a copy of the annual report for the last 2 calendar years is provided to the surveyor prior to the on-site visit.

- Presentation at cancer committee/leadership body meetings followed by presentation at cancer conferences or other activities
- Presentations at lectures or workshops
- Electronic postings on internal or external Web sites

Dissemination of results is documented in cancer committee/leadership body minutes.

An annual report may be published at the discretion of the cancer committee/leadership body. If an annual report is published, the cancer committee/leadership body is responsible for determining the report content. The publication schedule is at the discretion of the cancer committee, but publication must take place by December 31 each year. The cancer committee/leadership body's analysis of patient outcomes must be included if not disseminated using other methods.

SPECIFICATIONS BY CATEGORY

All programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

In an NCIP facility, outcomes analysis(es) performed and published by staff physicians and/or researchers fulfills this requirement.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

The NCIP facility provides the surveyor with a list of all published journal articles or abstracts, or an annual report, from the last calendar year that includes an analysis(es) of outcomes.

During the on-site visit, the surveyor will request copies of 2 journal articles from the list provided.

If an annual report is published, the NCIP facility provides the surveyor with a copy of the annual report for the last 2 calendar years.

RATING

(1+) **Commendation:** Documentation and dissemination of more than 1 outcomes analysis annually by the cancer committee/leadership body to the medical and administrative staff, or an annual report of cancer program activity published by the cancer committee/leadership body that includes an outcomes analysis.

(1) **Compliance:** The cancer committee/leadership body documents and disseminates results of 1 patient outcomes analysis to the medical staff and administration annually.

(5) **Noncompliance:** The cancer committee/leadership body does not document and disseminate results of 1 patient outcomes analysis to the medical staff and administration annually.

NCIP facilities:

(1+) **Commendation:** Documentation and dissemination of more than 1 outcomes analysis annually through articles published by staff physicians and/or researchers or in an annual report.

(1) **Compliance:** Documentation and dissemination of 1 outcomes analysis annually through articles published by staff physicians and/or researchers or in an annual report.

(5) **Noncompliance:** No documentation of the annual dissemination of an outcomes analysis.

Cancer Data Management and Cancer Registry Operations

Purpose: The standards ensure accurate and timely collection of cancer patient data, which allows for the evaluation of patient outcomes and identification of opportunities for improvement.

STAFF QUALIFICATIONS

Standard 3.1 Case abstracting is performed or supervised by a certified tumor registrar (CTR).

DEFINITION AND REQUIREMENTS

To positively affect cancer patient care, the facility must ensure that case abstracting is performed or supervised by a CTR. Successful operation of the cancer registry requires credentialed staff who are trained and knowledgeable in all aspects of oncology data collection and case abstracting. The recognized credential for a cancer registry professional is CTR, which is granted through the National Cancer Registrars Association (NCRA). Details on eligibility, testing, and recertification are available from the NCRA. In all instances, case abstracting must be performed or supervised by a CTR. The case abstracting or data supervision responsibilities of the CTR are documented and include the scope of

supervision, quality control rate, and educational activities for staff who are not credentialed.

Methods to ensure case abstracting or supervision by a CTR include, but are not limited to, the following:

- Facility-employed CTR
- Contracted data collection, using a registry service agency or company or an independent contractor
- Enabling current staff to earn the CTR credential
- Veterans Integrated Service Network (VISN) lead CTR, in Veterans Affairs Cancer Program (VACP) facilities without a CTR

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard.

DOCUMENTATION

All facilities complete the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with verification of current credentialing from NCRA for all CTRs on staff at the facility.

During the on-site visit, the facility also provides the surveyor with documentation showing that the case abstracting or data supervision is performed by the CTR.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with verification of current credentialing from NCRA for all CTRs on staff at the facility.

During the on-site visit, the facility also provides the surveyor with documentation showing that the case abstracting or data supervision is performed by the CTR.

RATING

(1) **Compliance:** Case abstracting is performed or supervised by a CTR.

(5) **Noncompliance:** Case abstracting is not performed or supervised by a CTR.

NCIP facilities:

(1) **Compliance:** Case abstracting is performed or supervised by a CTR.

(5) **Noncompliance:** Case abstracting is not performed or supervised by a CTR.

DATA COLLECTION

Standard 3.2 CoC data standards and coding instructions are used to describe all reportable cases.

DEFINITION AND REQUIREMENTS

CoC data standards ensure consistent and accurate hospital cancer registry data that support the meaningful evaluation of patient diagnosis and treatment. All CoC-accredited cancer programs use the data standards defined by the CoC appropriate for the year of diagnosis for that 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 facility's cancer committee/leadership body.

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Network Cancer Program (NCP)
- Teaching Hospital Cancer Program (THCP)
- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)
- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

In an NCIP facility, in addition to recording the Collaborative Staging data elements, the American Joint Committee on Cancer (AJCC) staging elements (T, N, M) and Stage Group that are assigned or supervised by a certified tumor registrar (CTR) may be recorded in the cancer registry database for all analytic cases that are eligible for AJCC staging. Pathologic AJCC staging elements and Stage Group that are assigned or supervised by

a certified tumor registrar (CTR) may also be recorded in the cancer registry data base for all analytic cases eligible for AJCC staging.

Veterans Affairs Cancer Program (VACP)

In a VACP facility, in addition to recording the Collaborative Staging data elements, the clinical AJCC staging elements (T, N, M) and Stage Group that are assigned or supervised by a certified tumor registrar (CTR) may be recorded in the cancer registry database for all analytic cases that are eligible for AJCC stage. Pathologic AJCC staging elements and Stage Group that are assigned or supervised by a certified tumor registrar (CTR) may also be recorded in the cancer registry data base for all analytic cases eligible for AJCC staging.

Pediatric Cancer Program (PCP)

In a PCP facility, the recording of the *Facility Oncology Registry Data Standards (FORDS)* data elements for AJCC staging (T, N, M), Stage Group, and Staged By in the cancer registry database is excluded. The recording of *FORDS* data elements for Collaborative Staging is included.

Pediatric staging, including but not limited to Children's Oncology Group (COG) and National Wilms Tumor Study (NWTS) staging, is recorded in text or in user-defined data fields in the cancer registry database.

Pediatric Cancer Program Component (PCPC)

In a PCPC facility, the recording of the *FORDS* data elements for AJCC staging elements (T, N, M), Stage Group, and Staged By in the cancer registry database is excluded. The recording of *FORDS* data elements for Collaborative Staging is included.

Pediatric staging, including but not limited to COG and NWTS staging, is recorded in text or in user-defined data fields in the cancer registry database.

DOCUMENTATION

All facilities complete the Survey Application Record (SAR).

During the on-site visit, the facility provides documentation that the cancer registry policy and procedure manual or the registry software manual requires the use of the CoC data standards.

NCIP facilities:

No information is recorded in the Survey Application Record (SAR).

RATING

(1) **Compliance:** Appropriate CoC data standards and coding instructions are used to describe all reportable cases.

(5) **Noncompliance:** The cancer registry does not use appropriate CoC data standards and coding instructions to describe all reportable cases.

NCIP facilities:

(1) **Compliance:** Appropriate CoC data standards and coding instructions are used to describe all reportable cases.

(5) **Noncompliance:** The cancer registry does not use appropriate CoC data standards and coding instructions to describe all reportable cases.

Standard 3.3 For each year between survey, 90% of cases are abstracted within 6 months of the date of first contact.

DEFINITION AND REQUIREMENTS

Ongoing timely abstracting is essential for accurate data collection, evaluation, and reporting of outcomes. Abstracting timeliness is calculated from the “Date of First Contact” (see definition in the current version of CoC data standards) to the date the case is abstracted. Abstracting timeliness is maintained throughout the survey cycle. Abstracting timeliness can be estimated by using the following formula:

- Total cases for last completed accession year = 1,200.
- Monthly case average: $1,200 \div 12 = 100$.
- If the date is January 1, then approximately 600 cases ($100 \times 6 = 600$) from the previous year should be abstracted.

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

The surveyor will verify the abstracting currency during the on-site visit through a review of a random sample of cancer registry abstracts.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

During the on-site visit, the NCIP facility provides the surveyor with reports of abstracting status made to the appropriate department, subcommittee, or workgroup.

RATING

(1+) Commendation: More than 90% of cases are abstracted within 6 months of the date of first contact for each year between survey.

(1) Compliance: For each year between survey, 90% of cases are abstracted within 6 months of the date of first contact.

(5) Noncompliance: For each year between survey, fewer than 90% of cases are abstracted within 6 months of the date of first contact.

NCIP facilities:

(1+) Commendation: More than 90% of cases are abstracted within 6 months of the date of first contact for each year between survey.

(1) Compliance: For each year between survey, 90% of cases are abstracted within 6 months of the date of first contact.

(5) Noncompliance: For each year between survey, fewer than 90% of cases are abstracted within 6 months of the date of first contact.

TARGETED ABSTRACTING TIME LINE FOR THE MONTH OF SURVEY

MONTH OF SURVEY	TARGETED ABSTRACTING TIME LINE
January	July 1 of previous year
February	August 1 of previous year
March	September 1 of previous year
April	October 1 of previous year
May	November 1 of previous year
June	December 1 of previous year
July	January 1 of current year
August	February 1 of current year
September	March 1 of current year
October	April 1 of current year
November	May 1 of current year
December	June 1 of current year

Standard 3.4 An 80% follow-up rate is maintained for all eligible analytic patients from the cancer registry reference date.

.....

Standard 3.5 A 90% follow-up rate is maintained for all eligible analytic patients 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 facility to compare outcomes with regional, state, or national statistics. Follow-up information is obtained at least annually for all living analytic patients included in the cancer registry database.

All reportable cases are followed, 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 0.

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

- Letters or phone calls to the physician(s)
- Letters or phone calls to the patient or the patient's next of kin
- Admission or readmission to the facility
- Pathology reports
- Clinic and outpatient visits
- Internet sources
- Death certificate matches
- Review of newspaper obituary columns

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Network Cancer Program (NCP)
- Teaching Hospital Cancer Program (THCP)
- Veterans Affairs Cancer Program (VACP)
- Pediatric Cancer Program (PCP)
- Pediatric Cancer Program Component (PCPC)
- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)

- Hospital Associate Cancer Program (HACP)
- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

With permission from the CoC, NCIP facilities may establish special follow-up definitions for specific patient groups. Examples include, but are not limited to, the following:

- Breast cancer patients are followed for a maximum of 15 years after diagnosis.
- Patients participating in a specific protocol are followed for the duration the protocol-required follow-up period.
- Special populations (e.g., the homeless) are not followed.

Follow-up attempts should continue for patients with special follow-up definitions, but these patients are excluded from the follow-up calculations.

The NCIP identifies the specified and patient groups and the special follow-up definitions in the SAR at the time of survey. The groups and definitions are reviewed by the CoC.

Pediatric Cancer Program (PCP)

In a PCP facility, annual follow-up information is obtained for eligible analytic patients until they reach the age of 26. Once patients reach the age of 27, follow-up attempts should continue, but these patients are excluded from the follow-up calculations.

Pediatric Cancer Program Component (PCPC)

In a PCPC facility, annual follow-up information is obtained for eligible analytic patients until they reach the age of 26. Once patients reach the age of 27, follow-up attempts should continue, but these patients are excluded from the follow-up calculations.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with a copy of the cancer committee/leadership body's policies for obtaining follow-up information. The facility also provides a current follow-up report to the surveyor on the day of the on-site visit.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

The NCIP facility provides a copy of the cancer registry follow-up report and the Special Follow-up Definitions accredited by the CoC to the surveyor during the on-site visit.

The surveyor discusses the follow-up process and activities with the cancer program leadership during the on-site visit.

RATING

Standard 3.4

(1) **Compliance:** Excluding patients with special follow-up definitions or age-specific exclusions, an 80% follow-up rate is maintained for all analytic patients from the cancer registry reference date.

(5) **Noncompliance:** Excluding patients with special follow-up definitions or age-specific exclusions, a follow-up rate of less than 80% is maintained for all eligible analytic patients from the cancer registry reference date.

NCIP facilities:

(1) **Compliance:** Excluding patients with special follow-up definitions or age-specific exclusions, an 80% follow-up rate is maintained for all analytic patients from the cancer registry reference date.

(5) **Noncompliance:** Excluding patients with special follow-up definitions or age-specific exclusions, a follow-up rate of less than 80% is maintained for all eligible analytic patients from the cancer registry reference date.

Standard 3.5

(1) **Compliance:** Excluding patients with special follow-up definitions or age-specific exclusions, a 90% follow-up rate is maintained for all analytic patients diagnosed within the last 5 years, or from the cancer registry reference date, whichever is shorter.

(5) **Noncompliance:** Excluding patients with special follow-up definitions or age-specific exclusions, a follow-up rate of less than 90% is maintained for all eligible analytic patients diagnosed within the last 5 years, or from the cancer registry reference date, whichever is shorter.

NCIP facilities:

(1+) **Commendation:** Excluding patients with special follow-up definitions or age-specific exclusions, a follow-up rate of 95% or more is maintained for all eligible analytic patients diagnosed within the last 5 years, or from the cancer registry reference date, whichever is shorter. Note that this Commendation rating applies *only* to NCIP facilities.

(1) **Compliance:** Excluding patients with special follow-up definitions or age-specific exclusions, a 90% follow-up rate is maintained for all eligible analytic patients diagnosed within the last 5 years, or from the cancer registry reference date, whichever is shorter.

(5) **Noncompliance:** Excluding patients with special follow-up definitions or age-specific exclusions, a follow-up rate of less than 90% is maintained for all eligible analytic patients diagnosed within the last 5 years, or from the cancer registry reference date, whichever is shorter.

DATA REPORTING

Standard 3.6 Complete data for all analytic cases are submitted to the National Cancer Data Base (NCDB) in accordance with the annual Call for Data.

DEFINITION AND REQUIREMENTS

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

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

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

After the request for initial survey of a new program is accepted by the CoC, the program submits data for the most recent abstracting year completed to the NCDB. Data are submitted and errors/rejected records corrected (Standard 3.7) prior to scheduling the initial survey.

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard.

DOCUMENTATION

Data submission history is confirmed by the CoC and displayed in the Survey Application Record (SAR).

NCIP facilities:

Data submission history is confirmed by the CoC and displayed in the Survey Application Record (SAR).

RATING

(1) **Compliance:** Complete data for all requested analytic cases are submitted to the NCDB for each call year between survey in accordance with the annual Call for Data.

(5) **Noncompliance:** Incomplete data for all requested analytic cases are submitted or no data are submitted for 1 or more years between survey in accordance with the annual Call for Data.

NCIP facilities:

(1) **Compliance:** Complete data for all requested analytic cases are submitted to the NCDB for each call year between survey in accordance with the annual Call for Data.

(5) **Noncompliance:** Incomplete data for all requested analytic cases are submitted or no data are submitted for 1 or more years between survey in accordance with the annual Call for Data.

Standard 3.7 Annually, cases submitted to the National Cancer Data Base (NCDB) that were diagnosed in 2003 or more recently 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 in 2003 or more recently are corrected and resubmitted by the deadline specified in the Call for Data. The cancer committee/ leadership body monitors the resolution and resubmission of problematic cases (Standard 2.10).

For each year between survey, the cases diagnosed in 2003 or more recently satisfy the established quality criteria by the deadline date specified in each Call for Data. New programs correct and resubmit cases prior to scheduling the initial survey.

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard.

DOCUMENTATION

Resubmission history is confirmed by the CoC and displayed in the Survey Application Record (SAR).

NCIP facilities:

Resubmission history is confirmed by the CoC and displayed in the Survey Application Record (SAR).

RATING

(1+) **Commendation:** For every year between survey, the cases diagnosed in 2003 or more recently meet the quality criteria for the annual Call for Data on initial submission.

(1) **Compliance:** For every year between survey, cases diagnosed in 2003 or more recently meet the established quality criteria by the deadline specified in the Call for Data.

(5) **Noncompliance:** Cases diagnosed in 2003 or more recently do not meet the established quality criteria by the deadline specified in the Call for Data for 1 or more years between survey.

NCIP facilities:

(1+) **Commendation:** For every year between survey, the cases diagnosed in 2003 or more recently meet the quality criteria for the annual Call for Data on initial submission.

(1) **Compliance:** For every year between survey, cases diagnosed in 2003 or more recently meet the established quality criteria by the deadline specified in the Call for Data.

(5) **Noncompliance:** Cases diagnosed in 2003 or more recently do not meet the established quality criteria by the deadline specified in the Call for Data for 1 or more years between survey.

SPECIAL STUDIES

Standard 3.8 The facility participates in special studies as requested by the CoC.

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. Facilities keep a record of all communication(s) and information/data provided to the CoC for these special studies.

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 facility 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 fulfill the requirements for Standard 8.1. This information will be documented in CoC communications and provided to programs that are selected to participate.

SPECIFICATIONS BY CATEGORY

Upon request, cancer programs in all categories must fulfill this standard.

DOCUMENTATION

Participation in CoC special studies is confirmed by the CoC and displayed in the Survey Application Record (SAR).

NCIP facilities:

Participation in CoC special studies is confirmed by the CoC and displayed in the Survey Application Record (SAR).

RATING

(1) **Compliance:** Complete data are submitted by the established deadline for each special study in which the facility is requested to participate.

(5) **Noncompliance:** Incomplete or no data are submitted for each special study in which the facility is requested to participate **or** complete or incomplete data are submitted after the established deadline for 1 or more of the studies in which the program is requested to participate.

(8) **Not Applicable:** The facility was not requested to participate in special studies.

NCIP facilities:

(1) **Compliance:** Complete data are submitted by the established deadline for each special study in which the facility is requested to participate.

(5) **Noncompliance:** Incomplete or no data are submitted for each special study in which the facility is requested to participate **or** complete or incomplete data are submitted after the established deadline for 1 or more of the studies in which the program is requested to participate.

(8) **Not Applicable:** The facility was not requested to participate in special studies.

CANCER REGISTRY OPERATIONS

The Commission on Cancer has established these operational requirements for hospital-based cancer registries.

CANCER REGISTRY

The cancer registry is a component of the cancer program designed to accession, abstract, and conduct follow-up for patients with reportable primaries diagnosed and/or initially treated at the facility since the registry reference date. The cancer registry database is a vital tool for programmatic and administrative planning and research and for monitoring patient outcomes.

Data are collected according to the current CoC data standards and coding instructions. These data include patient identification, cancer identification, stage of disease at diagnosis, first course of treatment, outcomes, and administrative information. Facility-defined data items and/or benign or borderline histologies, other than central nervous system tumors, are also included, as requested by the cancer committee/leadership body.

Network Cancer Programs establish a uniform data repository with the means to enter data from each of the network service locations. A system is in place to provide for unduplicated data.

CoC-accredited cancer programs routinely communicate with the cancer registry software provider to ensure that changes in data and cancer program requirements are appropriately reflected in the cancer registry software.

PROCEDURE MANUAL

A procedure manual is necessary to document policies and procedures for the daily operations of the cancer registry and may also include policies and procedures for the cancer program. The cancer committee/leadership body reviews and updates the procedure manual annually. Changes to policies and procedures are approved by the cancer committee/leadership body and documented in the cancer committee/leadership body minutes. The cancer registry procedure manual includes, but is not limited to, the following:

- Abstracting
- Case accessions
- Case eligibility
- Casefinding
- Coding references
- Confidentiality and release of information
- Dates of implementation or changes in policies or registry operations
- Follow-up
- Job descriptions
- Maintaining and using the suspense system

- Quality control of registry data
- Reference date
- Reporting requirements and mechanisms
- Retention of documents
- Staging systems, including the identification of the pediatric staging systems used by the facility and the field(s) where the pediatric staging is recorded in the cancer registry database

Areas of program activity include, but are not limited to, the following:

- Cancer committee/leadership body meetings
- Cancer conference activities
- Cancer program objectives
- Policy for American Joint Committee on Cancer (AJCC) clinical staging by the physician or other applicable staging (e.g., Children's Oncology Group, staging nomograms, etc)
- Studies of quality and quality improvement system

REFERENCE DATE

The reference date is the date after which all eligible cases must be included in the registry. A reference date is established by the cancer committee/leadership body prior to the initial survey. The reference date is January 1 of the specified year.

Once accredited, programs cannot change the reference date unless circumstances cause a need to petition the CoC for a change. Each request is given individual consideration based on changes in the patient population or hospital census, flaws or lapses in data collection, changes in data acquisition methods, or a high lost-to-follow-up rate due to the longevity of the registry. A reference date change can be requested one every five years. The CoC-accredited program must retain 5 complete years of data in the cancer registry data base.

One disadvantage of changing the reference date is that cases accessioned prior to the new reference date are deleted or become nonanalytic (Class of Case 4) and are not included in outcomes analysis.

The reference date is documented in the cancer registry policy and procedure manual.

CASE ELIGIBILITY

The CoC requires registries in accredited cancer programs to accession and abstract reportable primaries diagnosed and/or initially treated at the facility. The tumors must meet the criteria for analytic cases (Class of Case 0, 1, or 2). Both pathologically and clinically diagnosed cases are included. Follow-up information is to be obtained annually for analytic cases excluding cases classified as Class of Case 0 and diagnosed on or after January 1, 2006.

Please refer to the current CoC data standards and coding instructions for specific requirements describing the following:

- Ambiguous terminology
- Cases reportable-by-agreement
- Case eligibility
- Class of Case
- Tumors accessioned, abstracted, and followed

The case eligibility criteria are documented in the cancer registry policy and procedure manual.

CASEFINDING

Casefinding is a systematic method of identifying all eligible cases that are included in the cancer registry database. All points of service in the health care delivery system must be included in the casefinding process.

Casefinding will identify both new cases and cases already in the cancer registry database. Information about cases that are already included in the registry can be used for follow-up.

Multiple sources are used to identify eligible cases. Primary sources include, but are not limited to, the following:

- Disease index
- Medical oncology log
- Operative reports
- Pathology reports
- Radiation oncology log

Secondary sources include, but are not limited to, the following:

- Cytology reports
- Diagnostic/medical imaging
- Discharge log
- Other outpatient logs

The casefinding procedures are documented in the cancer registry policy and procedure manual.

SUSPENSE SYSTEM

A suspense system provides temporary storage for potential cases and those cases that have not been completely abstracted. A case is entered into the suspense system during the casefinding process and remains there until case abstracting is completed. A suspense system typically includes the following:

- Patient name
- Patient identifier
- Date of diagnosis or date of first contact
- Primary site

Most cancer registry software includes an automated suspense system. If the cancer registry software does not include a suspense system, a spreadsheet can be used to track cases held in suspense.

Cases are listed by the date of diagnosis or date of first contact, and cases are abstracted in date order to ensure that abstracting timeliness is maintained.

The policies and procedures for the suspense system are documented in the cancer registry policy and procedure manual.

ACCESSION REGISTER

The accession register is an annual, sequential listing of all eligible cases included in the registry database. The accession register includes, but is not limited to, the following:

- Accession and sequence number
- Date of initial diagnosis
- Patient name
- Primary site

The accession register is used to do the following:

- Assess the registry workload
- Audit other registry files
- Monitor casefinding
- Plan cancer conferences
- Select cases for quality control review

If a registry serves multiple facilities, the accession register includes facility identifiers.

The policies and procedures for the accession register are documented in the cancer registry policy and procedure manual.

PATIENT INDEX

The patient index is an alphabetical list of each patient entered into the registry since the reference date. The typical index includes, but is not limited to, the following:

- Date of birth
- Date of diagnosis
- Date of last contact or death
- Histology
- Laterality
- Medical record number
- Patient name
- Primary site(s)
- Sequence number
- Sex

For patients with multiple reportable primaries, the patient index also includes, but is not limited to, the following for each primary:

- Date of diagnosis
- Histology
- Laterality
- Primary site
- Sequence number

If a registry serves multiple facilities, the patient index includes facility identifiers.

The policies and procedures for the patient index are documented in the cancer registry policy and procedure manual.

ABSTRACT

The abstract is a summary of pertinent information about the patient, cancer diagnosis and treatment, and patient follow-up. Accurate and complete registry data allow for optimal cancer program and administrative planning to allocate hospital resources. The cancer registry database is also a valuable resource for research investigations, studies of quality, and outcome evaluation.

An abstract must be completed for all reportable primaries diagnosed and/or initially treated at the facility since the registry reference date. If a patient has multiple cancers, an abstract must be prepared for each reportable primary diagnosed or treated at the reporting institution after the reference date.

The components of an abstract are outlined in the current CoC data standards and include the following:

- Patient identification
- Cancer identification
- Stage of disease at diagnosis
- First course of treatment
- Outcomes
- Case administration descriptors

Refer to Standard 3.3 for specific requirements regarding abstracting timeliness.

The policies and procedures for abstracting are documented in the cancer registry policy and procedure manual.

RETENTION OF DOCUMENTS

Abstracted data for cases diagnosed and/or treated at the facility after the cancer registry reference date are retained in perpetuity. If the reference date is changed, abstracted data for cases diagnosed and/or treated at the facility prior to the new reference date are deleted or archived.

All other documentation of cancer program and cancer registry activity meets the facility standard for retention of documents or 5 years, whichever is longer. This documentation includes, but is not limited to, the following:

- Cancer conference documentation or grids

- Minutes of cancer committee/leadership body meetings
- Outcome analysis and reports
- Results of quality control of cancer registry data
- Results of studies of quality

The policy for retention of documents is documented in the cancer registry policy and procedure manual.

QUALITY CONTROL OF CANCER REGISTRY DATA

The cancer committee/leadership body is responsible for supervising the cancer registry and quality control of cancer registry data. The quality control plan and cancer committee/leadership body involvement in quality control activities are outlined in Standard 2.10.

The cancer registry staff are responsible for visual review of abstracts and the accession register and periodic reabstracting of cases. The cancer registry staff is also responsible for reviewing edit reports from central registries, state registries, and the National Cancer Data Base, and for correcting and resubmitting cases to these agencies.

The policies and procedures for quality control of cancer registry data are documented in the cancer registry policy and procedure manual.

FOLLOW-UP

Follow-up collects information about the cancer and patient status. Follow-up data include the following:

- Cancer status
- Date of first recurrence
- Date of last contact or death
- Following registry
- Follow-up source
- Type of first recurrence
- Vital status

Refer to Standards 3.4 and 3.5 for specific requirements regarding follow-up rates and special exceptions for follow-up that are available for facilities in selected categories.

The policies and procedures for follow-up are documented in the cancer registry policy and procedure manual.

CONFIDENTIALITY, RELEASE OF INFORMATION, AND REQUEST LOG

The cancer registry activities and database meet the patient confidentiality standards defined by the facility, as well as state and federal regulations. These policies and procedures address the following:

- Data release criteria
- Informed consent and authorization
- Patient rights

Data requests are documented in a data request log that includes, but is not limited to, the following:

- Copy of data provided
- Data requested
- Date request was fulfilled
- Intended use of data
- Request date
- Requester's name or organization

The policies and procedures for confidentiality, release of information, and the request log are documented in the cancer registry policy and procedure manual.

Clinical Management

Purpose: The standards identify the minimum scope of clinical services needed to provide high-quality cancer care to patients. The managing physician is essential to coordinating a multidisciplinary team approach to patient care, including the accurate and complete staging of each patient.

CLINICAL SERVICES

Cancer patients require specialized diagnostic and therapeutic services. Care often continues for weeks or months following diagnosis. Depending on the facility, some services may be provided by referral, including the administration of chemotherapy and radiation therapy.

The minimum scope of clinical services are available to patients diagnosed and treated at the cancer program. Referral services and sources are documented for internal use, and the information is available to patients.

Diagnostic services

- Clinical laboratory
- Diagnostic imaging

Treatment services

- Surgical procedures
- Radiation treatment
- Systemic therapy

Other clinical services

- Cancer staging
- Oncology nursing
- Treatment guidelines
- Rehabilitation

TREATMENT SERVICES

Standard 4.1 Radiation treatment services are available on site or by referral.

DEFINITION AND REQUIREMENTS

Radiation therapy is a primary component of multi-modality treatment. Radiation therapy services are available on site or by referral to 1 or more locations.

Information about referral services and locations is provided to patients seen at the facility.

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Network Cancer Program (NCP)
- Teaching Hospital Cancer Program (THCP)
- Veterans Affairs Cancer Program (VACP)
- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)

- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard but are requested to complete the Survey Application Record (SAR) for this standard as part of the data-sharing agreement with the American Cancer Society. The rating for this standard defaults to (1) Compliance.

Pediatric Cancer Program (PCP)

A PCP facility that is a Children's Oncology Group (COG) member complies with the COG requirements for the accessibility of pediatric radiation oncology services and physicians who are familiar with pediatric

radiation oncology. Information about radiation oncology services is provided through the SAR.

PCP facilities that are not COG members fulfill the standard as written.

Pediatric Cancer Program Component (PCPC)

A PCPC facility that is a COG member complies with the COG requirements for the accessibility of pediatric

radiation oncology services and physicians who are familiar with pediatric radiation oncology. Information about radiation oncology services is provided through the SAR. The rating for this standard defaults to (1) Compliance.

PCPC facilities that are not COG members fulfill the standard as written.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

The surveyor discusses the availability of radiation therapy services, either at the facility or through referral, with members of the cancer program team during the on-site visit. The surveyor discusses the methods for distributing information to patients with the members of the cancer program team.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

RATING

(1) **Compliance:** Radiation therapy services are available on site or by referral.

(5) **Noncompliance:** Radiation therapy services are not available on site or by referral.

NCIP facilities:

(1) **Compliance:** Default rating.

Standard 4.2 Based on the category, a designated inpatient medical oncology unit or a functional equivalent is available on site or by referral to provide specialized care to patients.

DEFINITION AND REQUIREMENTS

Medical oncology (systemic therapy) is a primary component of multimodality treatment. Patients needing hospitalization for chemotherapy or as a result of treatment are assured of receiving comprehensive and specialized cancer-related care in a safe environment.

Based on the category, the facility will designate 1 or more inpatient areas as a medical oncology unit. Smaller facilities may set aside certain beds or an area of an inpatient unit as a functional equivalent of a medical oncology unit. In this instance, specialized care is provided to the patient regardless of the location.

Facilities in any category that accession fewer than 175 cases annually may choose to refer patients needing inpatient medical oncology services to a facility with a designated inpatient medical oncology unit rather than providing these services on site. In the case of patient referral for medical oncology services, the facility documents a policy and procedure describing the access to the off-site designated medical oncology unit and ensuring patient safety during the transfer process.

A Pediatric Cancer Program (PCP) or Pediatric Cancer Program Component (PCPC) that is a member of the Children’s Oncology Group (COG) ensures the on-site availability of specialized staff for the designated pediatric inpatient medical oncology unit or functional equivalent that is part of an adult unit. This staffing includes the provision of nurses with additional training in the management of children and adolescents with cancer and blood disorders, as well as documented in-house training in chemotherapy administration.

Policies and procedures address the special needs of the patients cared for on the medical oncology unit or functional equivalent. These policies and procedures include, but are not limited to, the following:

- Adequate nursing coverage
- Criteria for patient admission
- Management of immunocompromised patients
- Nursing staff orientation and training
- Safe handling and disposal of chemotherapy agents

SPECIFICATIONS BY CATEGORY

INPATIENT MEDICAL ONCOLOGY SERVICE REQUIREMENT BY CATEGORY	
CATEGORY	MEDICAL ONCOLOGY SERVICES
Network Cancer Program (NCP)	One or more designated inpatient medical oncology unit(s)
NCI-designated Comprehensive Cancer Center Program (NCIP)	Designated inpatient medical oncology unit/exempt
Teaching Hospital Cancer Program (THCP)	Designated inpatient medical oncology unit Functional equivalent Referral to a facility with an inpatient medical oncology unit if the THCP accessions fewer than 175 cases annually
Veterans Affairs Cancer Program (VACP)	Designated inpatient medical oncology unit Functional equivalent Referral to a facility with an inpatient medical oncology unit if the VACP accessions fewer than 175 cases annually
Pediatric Cancer Program (PCP)	Designated pediatric inpatient medical oncology unit Functional equivalent
Pediatric Cancer Program Component (PCPC)	Functional equivalent Referral to a facility with an inpatient medical oncology unit if the PCPC accessions fewer than 50 cases annually
Community Hospital Comprehensive Cancer Program (COMP)	Designated inpatient medical oncology unit Functional equivalent
Community Hospital Cancer Program (CHCP)	Functional equivalent Referral to a facility with an inpatient medical oncology unit if the CHCP accessions fewer than 175 cases annually

INPATIENT MEDICAL ONCOLOGY SERVICE REQUIREMENT BY CATEGORY (continued)

CATEGORY	MEDICAL ONCOLOGY SERVICES
Hospital Associate Cancer Program (HACP)	Functional equivalent Referral to a facility with an inpatient medical oncology unit
Affiliate Hospital Cancer Program (AFCP)	Exempt
Integrated Cancer Program (ICP)	Functional equivalent at hospital partner Referral to a facility with an inpatient medical oncology unit if the hospital partner accessions fewer than 175 cases annually
Freestanding Cancer Center Program (FCCP)	Exempt

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

The surveyor discusses how inpatient medical oncology services are provided to patients with the cancer program leadership team during the on-site visit.

The surveyor visits the medical oncology unit or functional equivalent during the on-site visit.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

RATING

(1) **Compliance:** Depending on the category, an inpatient medical oncology unit or a functional equivalent is on site or available by referral to a facility that provides inpatient medical oncology services.

(5) **Noncompliance:** Depending on the category, an inpatient medical oncology unit or a functional equivalent is not available at the facility, or patients are not referred to a facility that provides inpatient medical oncology services.

(8) **Not Applicable:** Facility is exempt from this standard.

NCIP facilities:

(1) **Compliance:** Default rating.

OTHER CLINICAL SERVICES

Standard 4.3 The cancer committee, or other appropriate leadership body, develops a process to monitor physician use of AJCC or other appropriate staging, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning for cancer patients. The findings of the monitoring are presented at least annually to the cancer committee, or other appropriate leadership body, and are documented in minutes.

DEFINITION AND REQUIREMENTS

Proper pre-operative clinical staging of cancer allows the physician to determine appropriate treatment. Staging enables the reliable evaluation of treatment results and outcomes reported from various institutions on a local, regional, and national basis.

When developing the method to document this activity, the cancer committee should consider the following:

Where staging should be recorded

Options include, but are not limited to:

- In the hospital medical record
- As part of the treatment plan
- In the pre-surgical physical examination
- In clinic or consultation notes
- In the records in the physician office

What rate will be set for the completion and accuracy of the clinical or working stage. Working stage is defined as all staging information (clinical and pathologic) that is available at the time of discussion.

What mechanism will be used for performing a quality audit to compare the stage with the appropriate treatment as set forth in site specific national

guidelines, e.g. National Comprehensive Cancer Center Network (NCCN), American Society of Clinical Oncology (ASCO).

How appropriate changes will be implemented to address performance issues.

When, and how, findings of the quality audit will be presented to the cancer committee each year.

American Joint Committee on Cancer (AJCC) staging is the primary system used in CoC-accredited programs. Facilities in specified categories are allowed to use other staging systems.

When using the AJCC system, clinical or working stage is assigned to each case designated Class of Case 1 and 2 using the criteria in the current edition of the *AJCC Cancer Staging Manual*.

Clinical or working stage is not required for cases diagnosed on or after January 1, 2006, and designated as Class of Case 0.

Programs are encouraged to continue successful physician staging practices.

SPECIFICATIONS BY CATEGORY

All programs must fulfill this standard as written.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the surveyor will discuss with the cancer committee the methods implemented to document physician use of AJCC or other appropriate stage, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning. The surveyor will also discuss with the cancer committee the results of monitoring and improvements in performance.

NCIP facilities:

The facility completes the Survey Application Record (SAR).

During the on-site visit, the surveyor will discuss with the cancer committee the methods implemented to document physician use of AJCC or other appropriate stage, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning. The surveyor will also discuss with the cancer committee the results of monitoring and improvements in performance.

RATING

(1) **Compliance:** The cancer committee, or other appropriate leadership body, has developed a process to monitor physician use of AJCC or other appropriate stage, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning. The process has been implemented, compliance evaluated, and results reported to the cancer committee, or other appropriate leadership body, at least annually.

(5) **Noncompliance:** The cancer committee, or other appropriate leadership body, has either not developed a process to monitor physician use of AJCC or other appropriate stage, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning, OR the process has not been implemented, compliance not evaluated, and/or results not reported to the cancer committee, or other appropriate leadership body, at least annually.

NCIP facilities:

(1) **Compliance:** The cancer committee, or other appropriate leadership body, has developed a process to monitor physician use of AJCC or other appropriate stage, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning. The process has been implemented, compliance evaluated, and results reported to the cancer committee, or other appropriate leadership body, at least annually.

(5) **Noncompliance:** The cancer committee, or other appropriate leadership body, has either not developed a process to monitor physician use of AJCC or other appropriate stage, site specific prognostic indicators, and evidence based national treatment guidelines in treatment planning, OR the process has not been implemented, compliance not evaluated, and/or results not reported to the cancer committee, or other appropriate leadership body, at least annually.

Standard 4.4 Nursing care is provided by nurses with specialized knowledge and skills in oncology. Competency is evaluated annually.

Standard 4.5 An oncology nurse manager or a registered nurse (RN) provides direction to the inpatient medical oncology unit or the functional equivalent as appropriate to the category.

DEFINITION AND REQUIREMENTS

The complex needs of cancer patients and their families require specialized oncology nursing knowledge and skills to achieve optimal patient care outcomes. The oncology nurse is an integral member of the multidisciplinary team. Oncology nursing services are managed by a registered nurse who has appropriate experience and educational background to provide effective leadership and direction to the nurses providing care to cancer patients and their families.

A clinical expert in oncology nursing can be

- An oncology certified clinical nurse specialist (AOCNS)
- An oncology certified nurse practitioner (AOCNP)
- An advanced practice oncology nurse (AOCN)
- An oncology certified nurse (OCN)
- A certified pediatric oncology nurse (CPON) in pediatric facilities or a pediatric component within a larger facility

As appropriate to the category, an oncology nurse manager provides day-to-day direction to staff of the medical oncology unit. An oncology nurse manager is a registered nurse (RN) with 3 years’ clinical experience and at least 1 year in oncology nursing. An OCN or advanced credential is preferred. An RN provides day-to-day direction to staff of a functional equivalent.

In Pediatric Cancer Program (PCP) facilities, an oncology nurse manager provides day-to-day directions to staff of the pediatric medical oncology unit. A CPON is preferred.

In Pediatric Cancer Program Component (PCPC) facilities, a CPON or an RN with specialized training in

pediatrics provides day-to-day directions to staff caring for pediatric patients receiving care in an adult medical oncology unit or the functional equivalent of a pediatric oncology unit.

Orientation and annual competency of oncology knowledge and skills are documented for nurses providing care to oncology patients. Adequate staffing by oncology nurses is provided to meet the needs of cancer patients and families. Staffing needs are evaluated by the nursing administration at least annually.

Oncology Nursing Society (ONS) standards and guidelines for all aspects of patient care, professional practice, research, education, and administrative topics should be used when developing the facility standards and guidelines. Oncology nursing policies and procedures are documented and approved by the nursing administration in consultation with the cancer committee/leadership body. Standards are reviewed and revised on an annual basis by the nursing administration in consultation with the cancer committee/leadership body, as needed.

Policies and procedures include, but are not limited to, the following:

- Administration and safe handling of cytotoxic agents
- Blood product administration
- Care of immunocompromised patients
- Management of oncologic emergencies
- Management of vascular access devices
- Radiation safety
- Symptom management

SPECIFICATIONS BY CATEGORY

ONCOLOGY NURSING SERVICE REQUIREMENTS BY CATEGORY		
CATEGORY	STANDARD 4.4	STANDARD 4.5
Network Cancer Program (NCP)	Required	Oncology nurse manager
NCI-designated Comprehensive Cancer Center Program (NCIP)	Required	Oncology nurse manager
Teaching Hospital Cancer Program (THCP)	Required	Oncology nurse manager (designated unit) Registered nurse (functional equivalent)

ONCOLOGY NURSING SERVICE REQUIREMENTS BY CATEGORY (continued)

CATEGORY	STANDARD 4.4	STANDARD 4.5
Veterans Affairs Cancer Program (VACP)	Required	Oncology nurse manager (designated unit) Registered nurse (functional equivalent)
Pediatric Cancer Program (PCP)	CPON preferred	Oncology nurse manager (designated unit) Registered nurse (functional equivalent)
Pediatric Cancer Program Component (PCPC)	CPON preferred	Oncology nurse manager (designated unit) Registered nurse (functional equivalent)
Community Hospital Comprehensive Cancer Program (COMP)	Required	Oncology nurse manager (designated unit) Registered nurse (functional equivalent)
Community Hospital Cancer Program (CHCP)	Required	Registered nurse
Hospital Associate Cancer Program (HACP)	Required	Registered nurse
Affiliate Hospital Cancer Program (AFCP)	Required	Exempt
Integrated Cancer Program (ICP)	Required	Exempt
Freestanding Cancer Center Program (FCCP)	Required	Exempt

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the surveyor will discuss with the cancer committee/leadership body the availability of oncology-trained and OCN nurses and nursing management of the inpatient medical oncology unit or functional equivalent.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

RATING

Standard 4.4

(1) **Compliance:** Nurses with specialized oncology knowledge and skills in oncology are available at the facility. Documentation is available to verify annual competency.

(5) **Noncompliance:** Nurses with specialized oncology knowledge and skills in oncology are not available at the facility and/or documentation is not available to verify annual competency.

Standard 4.5

(1) **Compliance:** Based on the category, an oncology nurse manager provides day-to-day direction for the inpatient medical oncology unit, or an RN provides day-to-day direction to the functional equivalent.

(5) **Noncompliance:** Based on the category, an oncology nurse manager does not provide day-to-day direction for the inpatient medical oncology unit, or an RN does not provide day-to-day direction to the functional equivalent.

(8) **Not Applicable:** The facility is exempt from this standard.

NCIP facilities:

(1) **Compliance:** Nurses with specialized oncology knowledge and skills in oncology are available at the facility. Documentation is available to verify annual competency.

(5) **Noncompliance:** Nurses with specialized oncology knowledge and skills in oncology are not available at the facility and/or documentation is not available to verify annual competency.

NCIP facilities:

(1) **Compliance:** Based on the category, an oncology nurse manager provides day-to-day direction for the inpatient medical oncology unit, or an RN provides day-to-day direction to the functional equivalent.

(5) **Noncompliance:** Based on the category, an oncology nurse manager does not provide day-to-day direction for the inpatient medical oncology unit, or an RN does not provide day-to-day direction to the functional equivalent.

Standard 4.6 The guidelines for patient management and treatment currently required by the CoC are followed.

.....

DEFINITION AND REQUIREMENTS

Patient management and treatment guidelines promote an organized approach to providing quality care. This standard has two components.

CAP Protocols

The CoC requires that 90% of eligible pathology reports that include a cancer diagnosis will contain the scientifically validated data elements outlined on the surgical case summary checklist of the College of American Pathologists (CAP) publication *Reporting on Cancer Specimens*.

The CAP protocols apply to pathology reports created by the facility from resected specimens with an invasive histology. Diagnostic biopsies, cytology specimens, special studies, and reports of in situ tumors are excluded.

At a minimum, the pathology reports for a random sample of 10% of the annual analytic cases or a maximum of 300 cases are reviewed each year to document compliance with this standard. The cancer committee, or other appropriate leadership body, may delegate this quality control activity to the pathologist(s) who reports the quality control activity and a summary of findings regularly to the cancer committee/leadership body.

In Pediatric Cancer Program (PCP) and Pediatric Cancer Program Component (PCPC) facilities, the CAP protocols are followed when they are applicable to pediatric sites and/or histologies.

Quality of Patient Care

The CoC requires the cancer committee, or other appropriate leadership body, to regularly review the quality of patient care using CoC quality reporting tools appropriate to the patients that are treated by the facility. The cancer committee/leadership body is a multi-disciplinary forum that provides a platform to evaluate care within and across disciplines, discuss processes that work, and evaluate how processes could be improved to promote evidenced-based practices locally.

The cancer committee/leadership body monitors the program's quality of patient care using each of the CoC quality reporting tools. The monitoring activity is reported to and discussed at the cancer committee/leadership body meeting at least annually. The committee addresses performance rates that fall below the established levels. Evidence of this monitoring activity will be documented in the minutes and reflect a report of the CoC quality reporting tools discussed, the actions taken, and follow-up, if relevant.

SPECIFICATIONS BY CATEGORY

CAP Protocols

All cancer programs must fulfill the CAP protocol component of this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

Quality of Patient Care

The following categories fulfill this component of the standard as written.

- Network Cancer Program (NCP)
- NCI-designated Comprehensive Cancer Center Program (NCIP)
- Teaching Hospital Cancer Program (THCP)
- Veterans Affairs Cancer Program (VACP)
- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)
- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Program (FCCP)

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from the CAP protocol component of this standard but are requested to provide general information in the Survey Application Record (SAR) for this standard that describes how CAP guidelines are used and reported by the facility.

The rating for this portion of the standard defaults to (1) Compliance unless the facility chooses to be evaluated for the (1+) Commendation rating (see Documentation section).

Pediatric Cancer Program (PCP)

The current CoC Quality of Patient Care measures do not apply to Pediatric Cancer Program facilities. For Pediatric Cancer Program facilities, compliance with this standard is based on the presence in the pathology reports of all of the scientifically validated data elements specified by the CAP protocols.

Pediatric Cancer Program Component (PCPC)

The current CoC Quality of Patient Care measures do not apply to Pediatric Cancer Program Component (PCPC) facilities. For Pediatric Cancer Program Component facilities, compliance with this standard is based

on the presence in the pathology reports of all of the scientifically validated data elements specified by the CAP protocols.

Programs undergoing initial survey

The CoC Quality of Patient Care measures do not apply to facilities undergoing initial survey. For new programs

in all categories, except the Network Cancer Programs, compliance with this standard is based on the presence in the pathology reports of all of the scientifically validated data elements specified by the CAP protocols.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

CAP Protocols

For compliance, the surveyor will evaluate the pathology reports for a random sample of eligible analytic cases for the last complete year, and the current year, of abstracting to confirm that 90% of the reports include all of the scientifically validated data items defined by the protocols. A maximum of 25 pathology reports will be reviewed.

For commendation the surveyor will confirm that 90% of the pathology reports include all of the scientifically validated data items defined by the protocols **and** 90% of the reports use a synoptic format.

Quality of Patient Care

The surveyor will evaluate compliance with the quality of patient care portion of this standard in two ways:

First, the surveyor will be provided with documentation demonstrating the monitoring of the quality of patient care by the cancer committee/leadership body using the CoC quality reporting tools.

Second, the surveyor will confirm compliance with the standard of care measure selected to be evaluated by the CoC by reviewing abstracts and medical records identified by the CoC for not more than 25 analytic cases related to the measure under review. As part of the educational component of the survey, the surveyor discusses the findings of this review with the cancer committee.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

CAP Protocols

The surveyor discusses the process for recording the scientifically validated data elements outlined in the CAP protocols with the appropriate facility leadership during the on-site visit.

Facilities choosing to be evaluated for the (1+) commendation rating for recording the scientifically validated data elements outlined in the CAP protocols, provide pathology reports for a random sample of analytic cases from the last complete year, and the current year, of abstracting. The surveyor will confirm that 90% of the pathology reports include all of the scientifically validated data items defined by the protocols **and** 90% of the reports use a synoptic format. A maximum of 25 pathology reports will be reviewed.

Quality of Patient Care

The surveyor will evaluate compliance with the quality of patient care portion of this standard in two ways:

First, the surveyor will be provided with documentation demonstrating the monitoring of the quality of patient care by the cancer committee/leadership body using the CoC quality reporting tools.

Second, the surveyor will confirm compliance with the standard of care measure selected to be evaluated by the CoC by reviewing abstracts and medical records identified by the CoC for not more than 25 analytic cases related to the measure under review. As part of the educational component of the survey, the surveyor discusses the findings of this review with the cancer committee.

RATING

(1+) **Commendation:** Ninety percent of cancer pathology reports include all of the scientifically validated data times defined by the CAP protocol and use a *synoptic* format, **and** the quality of patient care is actively monitored by the cancer committee/leadership body using the CoC quality reporting tools.

(1) **Compliance:** Ninety percent of cancer pathology reports include the scientifically validated data elements as outlined in the CAP protocols, **and** the quality of patient care is actively monitored by the cancer committee/leadership body using the CoC quality reporting tools.

(5) **Noncompliance:** Ninety percent of cancer pathology reports do not include the scientifically validated data elements as outlined in the CAP protocols, **and/or** the quality of patient care is not actively monitored by the cancer committee/leadership body using the CoC quality reporting tools.

NCIP facilities:

(1+) **Commendation:** Ninety percent of cancer pathology reports include all of the scientifically validated data times defined by the CAP protocol and use a *synoptic* format, **and** the quality of patient care is actively monitored by the cancer committee/leadership body using the CoC quality reporting tools.

(1) **Compliance:** CAP compliance defaults to 1 **and** quality of patient care is actively monitored by the cancer committee/leadership body using the CoC quality reporting tools.

(5) **Noncompliance:** The quality of patient care is not actively monitored by the cancer committee/leadership body using the CoC quality reporting tools.

**Standard 4.7 Rehabilitation services are provided on site or by referral.
Compliance is evaluated on an annual basis.**

DEFINITION AND REQUIREMENTS

Rehabilitation services help patients cope with activities of daily living affected by the cancer experience and enable them to resume normal activities. The cancer committee/leadership body documents policies and procedures to access rehabilitation services. Rehabilitation services include, but are not limited to, the following:

- Physical therapy
- Speech therapy
- Stomal therapy

In Pediatric Cancer Program (PCP) and Pediatric Cancer Program Component (PCPC) facilities, rehabilitation services appropriate to children are required. These include, but are not limited to, the following:

- Physical therapy
- Speech therapy

The cancer committee/leadership body evaluates the needs of its patients on an annual basis and offers ser-

vices that can be used by a majority of patients, as well as those services targeting special populations. Results of the annual evaluation are documented in cancer committee/leadership body minutes.

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard but are requested to provide general information in the Survey Application Record (SAR) for this standard as part of the data-sharing agreement with the American Cancer Society. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the surveyor discusses the scope of rehabilitation services and the annual evaluation of rehabilitation services with the cancer committee/leadership body.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

RATING

(1) **Compliance:** Rehabilitation services are provided on site or by referral, and documentation of the annual evaluation of these services is available.

(5) **Noncompliance:** Rehabilitation services are not provided on site or by referral, and/or documentation of the annual evaluation of these services is not available.

NCIP facilities:

(1) **Compliance:** Default rating.

Research

Purpose: The standards promote advancement in cancer treatment through the provision of clinical trial information and patient accrual to cancer-related clinical trials.

CLINICAL TRIAL INFORMATION

Standard 5.1 Information about the availability of cancer-related clinical trials is provided to patients through a formal mechanism.

DEFINITION AND REQUIREMENTS

By providing information about the availability of cancer-related clinical trials, the facility offers patients the opportunity to participate in the advancement of evidence-based medicine.

A formal mechanism is established to provide information about cancer-related clinical trials to patients seen at the facility. Methods to provide information include, but are not limited to, the following:

- Access to the Internet or Intranet search services through the patient library
- Articles in facility newsletters
- Pamphlets or brochures in patient waiting rooms or patient information packets

In Pediatric Cancer Program (PCP) facilities, information about pediatric cancer-related clinical trials is provided to families and/or guardians of pediatric patients.

In Pediatric Cancer Program Component (PCPC) facilities, information about pediatric cancer-related clinical trials is provided to families and/or guardians of pediatric patients as part of the overall clinical trial information program of the larger facility.

The cancer committee/leadership body documents and monitors the effectiveness of the formal mechanism annually, making revisions as needed. The review is documented in cancer committee/leadership body minutes.

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with documentation of policies and procedures for providing information about cancer-related clinical trials to patients or with samples of written/printed information provided to patients.

NCIP facilities:

No information is recorded in the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with copies of the appropriate sections of NCI Summary Report.

RATING

(1) **Compliance:** A formal mechanism is used to provide information to patients about cancer-related clinical trials.

(5) **Noncompliance:** A formal mechanism is not used to provide information to patients about cancer-related clinical trials.

NCIP facilities:

(1) **Compliance:** Default rating.

CLINICAL TRIAL ACCRUAL

Standard 5.2 As appropriate to the category, the required percentage of cases is accrued to cancer-related clinical trials on an annual basis.

DEFINITION AND REQUIREMENTS

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

Facilities that accrue patients to cancer-related clinical research enter at least the minimum percentage based on the category and number of annual analytic accessions. Patients eligible to meet this standard are those patients

- Seen at the facility for diagnosis and/or treatment and placed on a trial through the facility.
- Seen at the facility for diagnosis and/or treatment and placed on a trial through the office of a staff physician.
- Seen at the facility for diagnosis and/or treatment and placed on a trial through another facility.
- Seen at the facility for any reason and placed on a prevention or cancer control trial.

Basic science, clinical, and prevention and control research is generally conducted in cancer centers supported by grants from the National Cancer Institute (NCI) or in academic health centers. Research in community hospitals typically involves therapeutic and nontherapeutic trials.

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

- NCI-sponsored programs such as the Community Clinical Oncology Program (CCOP) or Cooperative Group Outreach Program (CGOP)
- Cooperative trial groups such as the American College of Surgeons Oncology Group (ACOSOG)
- University-related research

- Pharmaceutical company research
- Locally developed, peer-reviewed studies

Cancer control research studies include, but are not limited to, the following:

- Primary prevention
- Early detection
- Quality of life
- Economics of care

Facilities participating in clinical research show that an independent peer review mechanism consistent with national standards is in place and used. Research projects involving participation by human subjects must be approved by an internal or external institutional review board (IRB). Patients participating in clinical trials must give their informed consent.

A study coordinator, data manager, or other clinical research professional is available to assist with enrolling patients, monitoring patient accrual, and identifying and providing information/education about new trials in Network Cancer Programs, NCI-designated Comprehensive Cancer Center Programs, Teaching Hospital Cancer Programs, and Veterans Affairs Cancer Programs. A study coordinator, data manager, or other clinical research professional may also be available at facilities in other categories accruing a large number of patients to cancer-related clinical trials. Examples include pediatric hospitals and pediatric components within larger facilities.

Patient accrual is monitored, and the results are documented in cancer committee/leadership body minutes.

SPECIFICATIONS BY CATEGORY

MINIMUM REQUIRED AND COMMENDATION CLINICAL TRIAL ACCRUAL PERCENTAGE FOR EACH CATEGORY

CATEGORY	MINIMUM REQUIRED PERCENTAGE ACCRUAL TO CLINICAL TRIALS	COMMENDATION PERCENTAGE ACCRUAL TO CLINICAL TRIALS
Network Cancer Program (NCP)	6% of the number of annual analytic cases	8% of the number of annual analytic cases
NCI-designated Comprehensive Cancer Center Program (NCIP)	Evaluated by NCI—exempt	15% of the number of annual analytic cases
Teaching Hospital Cancer Program (THCP)	4% of the number of annual analytic cases	6% of the number of annual analytic cases
Veterans Affairs Cancer Program (VACP)	2% of the number of annual analytic cases	4% of the number of annual analytic cases

MINIMUM REQUIRED AND COMMENDATION CLINICAL TRIAL ACCRUAL PERCENTAGE (continued)

CATEGORY	MINIMUM REQUIRED PERCENTAGE ACCRUAL TO CLINICAL TRIALS	COMMENDATION PERCENTAGE ACCRUAL TO CLINICAL TRIALS
Pediatric Cancer Program (PCP)	4% of the number of annual analytic cases	6% of the number of annual analytic cases
Pediatric Cancer Program Component (PCPC)	4% of the number of annual analytic pediatric cases	6% of the number of annual analytic pediatric cases
Community Hospital Comprehensive Cancer Program (COMP)	2% of the number of annual analytic cases	4% of the number of annual analytic cases
Community Hospital Cancer Program (CHCP)	Exempt	2% of the number of annual analytic cases
Hospital Associate Cancer Program (HACP)	Exempt	2% of the number of annual analytic cases
Affiliate Hospital Cancer Program (AFCP)	Exempt	2% of the number of annual analytic cases
Integrated Cancer Program (ICP)	Exempt	2% of the number of annual analytic cases
Freestanding Cancer Center Program (FCCP)	Exempt	2% of the number of annual analytic cases

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

The surveyor discusses the clinical trials program with the cancer program team during the on-site visit.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR) to indicate the clinical trials groups in which they participate.

During the on-site visit, the facility provides the surveyor with copies of the appropriate sections of NCI Summary Report.

Facilities choosing to be evaluated for the (1+) Commendation rating for the accrual of patients to cancer-related clinical trials record the number of patients accrued annually to clinical trials in the SAR.

RATING

(1+) **Commendation:** The commendation percentage of cases for the category is accrued to cancer-related clinical trials each year.

(1) **Compliance:** The required percentage of cases for the category is accrued to cancer-related clinical trials each year.

(5) **Noncompliance:** Less than the required percentage of cases for the category is accrued to cancer-related clinical trials each year.

(8) **Not Applicable:** The facility is exempt from this standard.

NCIP facilities:

(1+) **Commendation:** The commendation percentage of cases for the category is accrued to cancer-related clinical trials each year.

(1) **Compliance:** Default rating.

Community Outreach

Purpose: The standards ensure that supportive services and prevention and early detection opportunities are provided to cancer patients and their families.

SUPPORTIVE SERVICES

Standard 6.1 Supportive services are provided on site or coordinated with local agencies and facilities.

DEFINITION AND REQUIREMENTS

Comprehensive cancer care is multidisciplinary and includes medical and mental health professionals addressing patient needs identified along the cancer continuum from diagnosis through survivorship. Supportive services help patients and their families cope with the day-to-day details of a cancer diagnosis. These resources address emotional, physical, financial, and other needs of the cancer patients.

Supportive services address the needs of the majority of patients, as well as provide for special populations or needs. The supportive services offered on site will vary depending on the scope of the facility, local staff expertise, and patient mix. Supportive services not provided on site are provided through referral to other facilities and/or local agencies such as the American Cancer Society.

Supportive services include, but are not limited to, the following:

- Career counseling
- Genetic testing and counseling
- Grief counseling
- Home care program
- Mental health counseling
- Nutritional counseling
- Palliative care
- Support and educational groups
- Transportation services

In Pediatric Cancer Program (PCP) and Pediatric Cancer Program Component (PCPC) facilities, supportive services include, but are not limited to, the following:

- Candlelighters

- Childhood cancer camps
- Child Life program
- Parent support groups
- School reentry programs
- Sibling support groups

Patient assessment, discharge planning, and referral should begin on the day of admission and are documented in the patient chart and/or in discharge planning team minutes.

Procedures are followed to ensure that patient needs are anticipated and managed. The process includes the mechanism to do the following:

- Evaluate patient needs
- Facilitate direct access or referral
- Monitor quality
- Evaluate the effectiveness of the access and referral process

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard but are requested to complete the Survey Application Record (SAR) for this standard as part of the data-sharing agreement with the American Cancer Society. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with documentation of the supportive services offered to patients and their families available on site or by referral. Documentation includes, but is not limited to, the following:

- Published brochures or flyers
- Meeting schedules
- Electronic media such as Internet or Intranet postings

The surveyor will discuss the community outreach program with the designated coordinator and cancer committee/leadership body members during the on-site visit.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

RATING

(1) **Compliance:** Supportive services are available on site or are coordinated with other facilities or local agencies.

(5) **Noncompliance:** Supportive services are either not available on site or are not coordinated with other facilities or local agencies.

NCIP facilities:

(1) **Compliance:** Default rating.

PREVENTION AND EARLY DETECTION PROGRAMS

Standard 6.2 Each year, 2 prevention or early detection programs are provided on site or are coordinated with other facilities or local agencies.

DEFINITION AND REQUIREMENTS

Prevention programs identify risk factors and use strategies to modify attitudes and behaviors to reduce the chance of developing cancer. Early detection programs apply screening guidelines to detect cancers at an early stage, which improves the likelihood of increased survival and decreased morbidity.

Prevention and early detection programs are offered at scheduled intervals as defined by the cancer committee/leadership body and the designated community outreach coordinator. Prevention and early detection programs are provided on site or are coordinated with other facilities and/or local agencies such as the American Cancer Society.

Prevention programs include, but are not limited to, the following:

- Chemoprevention programs
- Education/cancer awareness
- Skin cancer prevention
- Smoking cessation
- Smoking prevention in adolescents
- Weight loss programs

Early detection programs include, but are not limited to, the following:

- Breast care education
- Colonoscopy, flexible sigmoidoscopy, or hemoccult stool testing
- PAP testing
- Prostate examinations with or without prostate-specific antigen (PSA) testing
- Screening mammography and clinical examinations
- Skin surveys

In Pediatric Cancer Program (PCP) and Pediatric Cancer Program Component (PCPC) facilities, prevention and

early detection programs include, but are not limited to, the following:

- Long-term follow-up
- Testicular
- Breast screening for Hodgkin's disease
- Skin

Veterans Affairs Cancer Program (VACP) facilities follow the U.S. Preventive Services Task Force recommendations for screening for cervical and colorectal cancer and tobacco use counseling. In VACP facilities, prevention or early detection programs focus on veteran-related issues such as smoking and alcohol cessation, prostate and colon screening, chemical or other exposure during military service, and breast and cervical cancer in female veterans.

Screening and 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 (e.g, health fairs), but this participation is not required to meet the standard.

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard but are requested to complete the Survey Application Record (SAR) for this standard as part of the data-sharing agreement with the American Cancer Society. The rating for this standard defaults to (1+) Commendation.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with documentation of 2 annual prevention or early detection programs through cancer committee/leadership body minutes or other sources. The surveyor will discuss the community outreach program with the designated coordinator and cancer committee/leadership body members during the on-site visit.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with copies of the appropriate section of the NCI grant.

RATING

(1+) **Commendation:** Three or more prevention or early detection programs are offered each year, either on site or coordinated with other facilities or local agencies.

(1) **Compliance:** Two prevention or early detection programs are offered each year, either on site or coordinated with other facilities or local agencies.

(5) **Noncompliance:** Two prevention or early detection programs are not offered each year, either on site or coordinated with other facilities or local agencies.

NCIP facilities:

(1+) **Commendation:** Default rating.

MONITORING COMMUNITY OUTREACH

Standard 6.3 The cancer committee, or other appropriate leadership body, monitors the community outreach activities on an annual basis. The findings are documented.

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DEFINITION AND REQUIREMENTS

Supportive services, prevention, and early detection programs are monitored to ensure that appropriate services are provided to patients and the community.

Both the scope of services and the methods to access services and programs are evaluated annually. The methods used to monitor outreach activity are set by the cancer committee/leadership body and are documented in cancer committee/leadership body minutes.

The assigned coordinator or facility community outreach staff member monitors outreach activity, reports regularly to the cancer committee/leadership body, and recommends corrective action if activity falls below the annual goal or requirements. The results and recommendations are documented in cancer committee/leadership body minutes.

In some facilities, the community outreach coordinator works cooperatively with established departments or staff leadership to coordinate, monitor, and recommend improvements to community outreach programs.

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Network Cancer Program (NCP)
- Teaching Hospital Cancer Program (THCP)
- Pediatric Cancer Program (PCP)
- Pediatric Cancer Program Component (PCPC)
- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)
- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard. The rating for this standard defaults to (1) Compliance.

Veterans Affairs Cancer Program (VACP)

VACP facilities are exempt from this standard. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with copies of cancer committee/leadership body minutes or other sources that document the methods used to monitor and evaluate the community outreach activities. The surveyor will discuss the community outreach program with the designated coordinator and cancer committee/leadership body members during the on-site visit.

NCIP facilities:

No information is recorded in the Survey Application Record (SAR).

RATING

(1) **Compliance:** Community outreach activities are monitored each year. The findings are documented. Default rating for VACP.

(5) **Noncompliance:** Community outreach activities are not monitored each year and/or the findings are not documented.

NCIP facilities:

(1) **Compliance:** Default rating.

Professional Education and Staff Support

Purpose: The standards promote increased knowledge through annual educational programs and registry staff participation in local, regional, or national educational activities.

FACILITY-BASED EDUCATION

Standard 7.1 Other than cancer conferences, the cancer committee, or other appropriate leadership body, offers 2 cancer-related educational activities each year to physicians, nurses, and other allied health professionals. One of these activities relates to the use of AJCC stage, or other appropriate staging, other site specific prognostic indicators and evidence-based national treatment guidelines in planning treatment for cancer patients.

DEFINITION AND REQUIREMENTS

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

The cancer committee/leadership body offers 2 cancer-related educational activity annually to physicians, nurses, and allied health professionals. One educational activity focuses on the use of AJCC or other appropriate staging, in clinical practice and also includes the use of site specific prognostic factors, and evidence-based national guidelines used in treatment planning. One educational activity focuses on a cancer-related topic which may or may not address stage or treatment planning issues.

The cancer committee/leadership body is encouraged to use the AJCC-developed Staging Moments slide sets and to obtain CME credits for both cancer conferences and other clinically-focused educational activities.

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

Educational activities include, but are not limited to, the following:

- An educational symposium
- A lecture on a cancer-related topic
- A video conference
- A Webinar

In NCI-designated Comprehensive Cancer Center Program (NCIP) facilities, cancer-related educational activities are offered, documented, and monitored centrally, departmentally, or by disease site teams as directed by the cancer center.

In Pediatric Cancer Program (PCP) facilities, 2 pediatric-focused educational activities are offered to all members of the pediatric medical staff and pediatric allied health professionals. One educational activity relates to pediatric staging and treatment protocols used by the facility.

In Pediatric Cancer Program Component (PCPC) facilities, the pediatric subcommittee or facility cancer committee/leadership body, as appropriate, offers 2 pediatric-focused educational activities to all members of the pediatric medical staff and the pediatric allied health professionals. One educational activity relates to pediatric staging and treatment protocols used by the pediatric component.

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard except for NCI-designated Comprehensive Cancer Center Programs (NCIP).

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

NCIP facilities are exempt from this standard. The rating for this standard defaults to (1) Compliance.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with documentation of 2 annual educational activities other than cancer conferences, including an overview of the content presented and a published notice or agenda.

NCIP facilities:

No information is recorded in the Survey Application Record (SAR).

The facility provides the surveyor with a sample listing of cancer-related educational program offerings.

RATING

(1) **Compliance:** Other than cancer conferences, the cancer committee offers 2 educational activities to physicians, nurses, and other allied health professionals each year. One of these activities includes AJCC stage, or other appropriate staging, site specific prognostic indicators, and evidence based national treatment guidelines in planning treatment for cancer patients.

(5) **Noncompliance:** Other than cancer conferences, the cancer committee either does not offer 2 educational activities, 1 including AJCC stage, or other appropriate staging, site specific prognostic indicators, and evidence-based national treatment guidelines in planning treatment for cancer patients OR the 2 educational activities do not involve physicians, nurses, and other allied health professionals.

NCIP facilities:

(1) **Compliance:** Default rating.

CANCER REGISTRY STAFF EDUCATION

Standard 7.2 Other than cancer conferences, all members of the cancer registry staff participate in a local, state, regional, or national cancer-related educational activity each year.

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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. This education includes, but is not limited to, topics such as the following:

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

Educational activities include, but are not limited to, the following:

- A cancer-related lecture
- A local, state, regional, or national meeting or workshop
- A video conference
- A Web-based training module

A national meeting or workshop is one sponsored by a national organization with attendance targeted to a national audience.

SPECIFICATIONS BY CATEGORY

All programs must fulfill this standard.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with documentation of the continuing education activity for each member of the cancer registry staff.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

RATING

(1+) Commendation: The cancer registry staff members who are certified tumor registrars (CTRs) attend a national cancer-related educational activity once every 3 years, **and** all other registry staff members participate in a local, state, regional, or national cancer-related educational activity annually.

(1) Compliance: Other than cancer conferences, all members of the cancer registry staff participate in a local, state, regional, or national cancer-related educational activity annually.

(5) Noncompliance: Other than cancer conferences, all members of the cancer registry staff do not participate in a local, state, regional, or national cancer-related educational activity annually.

NCIP facilities:

(1+) Commendation: The cancer registry staff members who are certified tumor registrars (CTRs) attend a national cancer-related educational activity once every 3 years, **and** all other registry staff members participate in a local, state, regional, or national cancer-related educational activity annually.

(1) Compliance: Other than cancer conferences, all members of the cancer registry staff participate in a local, state, regional, or national cancer-related educational activity annually.

(5) Noncompliance: Other than cancer conferences, all members of the cancer registry staff do not participate in a local, state, regional, or national cancer-related educational activity annually.

Quality Improvement

Purpose: The standards ensure that cancer services, care, and patient outcomes are evaluated and improved so that patients receive care that meets or exceeds patient expectations and standards distributed by local, state, regional, and national standard-setting organizations.

STUDIES OF QUALITY AND OUTCOMES

Standard 8.1 Each year, based on category, the cancer committee, or other appropriate leadership body, completes and documents the required studies that measure quality and outcomes.

DEFINITION AND REQUIREMENTS

The annual evaluation of services and care provides a baseline to measure quality and an opportunity to correct or enhance patient outcomes. Quality improvement is a multidisciplinary effort and must include support and representation from all clinical, administrative, and patient perspectives. These standards are closely related, and fulfillment of Standard 8.1 may serve as the basis for meeting Standard 8.2.

The cancer committee/leadership body focuses on quality-related issues relevant to the facility and local patient population and any area of cancer program activity. Studies of quality may include structure, process, and outcome variables, and are selected at the discretion of the cancer committee/leadership body. Examples include, but are not limited to, the following domains:

Structure: Studies of tangible issues affecting the delivery of treatment to ensure a positive patient experience. An example is the evaluation of chemotherapy clinic wait times due to understaffing or overscheduling or the examination of the delay of time for ERA/PRA results for breast cancer patients. Perhaps the location or the labor understaffing is contributing to these delays.

Process: Evaluation of appropriate care for Stage III colon cancer patients. According to current treatment guidelines, Stage III colon cancer patients should be treated with surgery and adjuvant chemotherapy. Measurement of nonconcordance with this standard may uncover issues related to data quality and registry coding, physician-patient interaction, and surgical oncology and medical oncology interaction. Another recommendation is to examine final American Joint Committee on Cancer (AJCC) stage in the determination of treatment options.

Outcome: Patient outcomes are measured by recurrence or survival rates, 7-day readmission rates, or iatrogenic events (ie, adverse medical events inadvertently caused by clinical staff). Another example is to measure the success of pain management protocols.

Studies relating to patient safety, satisfaction, and disparities may affect any or all of the above 3 domains.

When appropriate, National Cancer Data Base (NCDB) Web tools such as the NCDB Benchmark Reports, NCDB Hospital Comparison Reports, Cancer Program Practice Profile Reports (CP³R), and NCDB Survival Reports may be utilized for process and outcome studies.

In NCI-designated Comprehensive Cancer Center Program (NCIP) facilities, studies of quality are developed departmentally or by disease/organ site teams. At least 1 completed study includes comparison with national benchmarks.

For each quality study, the cancer committee/leadership body is responsible for the following:

- Establishing the study topic
- Defining quality measures to evaluate the topic
- Evaluating the data related to the quality measures
- Designing and initiating actions based on the evaluation of the data
- Monitoring the effectiveness of action plans and all cancer-related quality improvement activities at the facility

Consideration of the following Plan-Do-Study-Act (PDSA) cycle (see also Standard 8.2) may help to design, conduct, implement, and evaluate a study:

Plan: Study the process. What is the scope of the issue? Why is this issue one that needs to be addressed? Who is

affected? What data are available to define the issue, opportunity, or area requiring investigation or improvement? What factors contribute to the issue? What initiatives/interventions are needed?

Tools to help answer these questions include the use of a fishbone diagram, a Pareto chart, run charts, flowcharts, and checklists. This action is the first step in quality improvement. Standard 8.2 follows with implementation analysis and evaluation (ie, Do-Study-Act, the remainder of the approach).

A summary of the analysis of data, findings, and recommendations for each study, as well as the process to implement changes in program activity, is documented in cancer committee/leadership body minutes. The documentation includes the following:

- The study topic
- Criteria for evaluation
- A summary of the findings
- The actions recommended (note that if the action is the basis for Standard 8.2, then the action recommended should be to use these findings to support Standard 8.2)

- Follow-up steps to monitor the actions implemented

The methods used to monitor studies of quality are set by the cancer committee/leadership body and documented in cancer committee/leadership body minutes.

The assigned coordinator monitors activity related to studies of quality improvement; reports regularly to the cancer committee/leadership body the impact of actions taken, processes implemented, or services created to improve patient care; and recommends corrective action if any area falls below the annual goal or requirements.

The results and recommendations are documented in cancer committee/leadership body minutes.

Note that activities that duplicate study topics and criteria without analysis of the findings and/or ongoing monitoring activities do not fulfill this standard, because the study is without a conclusion.

Based on study criteria, the CoC will determine if CoC-designed special studies will fulfill this standard. This information will be documented in CoC communications to programs selected to participate.

SPECIFICATIONS BY CATEGORY

THE NUMBER AND TYPE OF STUDIES TO BE COMPLETED EACH YEAR FOR EACH CATEGORY	
CATEGORY	NUMBER AND TYPE OF STUDIES
Network Cancer Program (NCP)	1 study based on registry data 2 additional studies
NCI-designated Comprehensive Cancer Center Program (NCIP)	1 study based on registry data 2 additional studies
Teaching Hospital Cancer Program (THCP)	1 study based on registry data 1 additional study
Veterans Affairs Cancer Program (VACP)	1 study based on registry data 1 additional facility-defined study or study of quality defined at the Veterans Integrated Service Network (VISN) or regional level
Pediatric Cancer Program (PCP)	1 study based on registry data or Children's Oncology Group (COG) protocol data 1 additional study
Pediatric Cancer Program Component (PCPC)	1 study focusing on the pediatric cancer program (this study is in addition to the studies of quality required for the adult program)
Community Hospital Comprehensive Cancer Program (COMP)	1 study based on registry data 1 additional study
Community Hospital Cancer Program (CHCP)	1 study based on registry data 1 additional study
Hospital Associate Cancer Program (HACP)	1 study based on registry data 1 additional study
Affiliate Hospital Cancer Program (AFCP)	1 study of any topic in cooperation with hospital partner
Integrated Cancer Program (ICP)	1 study based on registry data 1 additional study
Freestanding Cancer Center Program (FCCP)	1 study based on registry data 1 additional study

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with summaries of each year's studies, analyses, recommendations, and follow-up.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

During the on-site visit, the NCIP facility provides the surveyor with facility-determined documentation of at least 3 studies completed annually.

One study uses cancer registry data, and 1 study includes comparison with national benchmarks.

RATING

(1) **Compliance:** Each year, the cancer committee/ leadership body completes and documents the required studies that measure quality and outcomes as appropriate to the category.

(5) **Noncompliance:** Each year, the cancer committee/ leadership body does not complete and/or document the required studies that measure quality and outcomes as appropriate to the category.

NCIP facilities:

(1) **Compliance:** Each year, the cancer committee/ leadership body completes and documents the required studies that measure quality and outcomes as appropriate to the category.

(5) **Noncompliance:** Each year, the cancer committee/ leadership body does not complete and/or document the required studies that measure quality and outcomes as appropriate to the category.

PATIENT CARE IMPROVEMENT

Standard 8.2 Annually, the cancer committee, or other appropriate leadership body, implements 2 improvements that directly affect cancer patient care. The improvements are documented.

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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 quality 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
- Actions to address undesirable performance
- Changes to improve acceptable performance
- Additional programs or services addressing patient needs or staff concerns

Whether or not findings from Standard 8.1 are used as the basis of the approach to Standard 8.2 is the decision of the cancer committee/leadership body. Nonetheless, the same Plan-Do-Study-Act (PDSA) cycle can be used to approach this standard. The definition of *Plan* remains as described in Standard 8.1.

Do: Make the change on a small scale. Implement interventions as determined in the Plan phase. Document the results.

Study: Observe and analyze the effects. If a process exhibits variation, then the cause of that variation has to be discovered and analyzed to determine what action or improvement, if any, is necessary.

Act: Identify what was learned, continue improvement, and return to the Plan phase to modify as necessary.

This PDSA cycle is ongoing and continuous.

In NCI-designated Comprehensive Cancer Center Program (NCIP) facilities, at least 2 quality improvements affecting patient care are implemented centrally, departmentally, through disease site teams, or through other facility-appropriate methods as directed by the cancer center.

The methods used to monitor the quality improvement program are set by the cancer committee/leadership body and documented in cancer committee/leadership body minutes.

The assigned coordinator monitors activity related to the quality improvement program, reports regularly to the cancer committee/leadership body, and recommends corrective action if any area falls below the annual goal or requirements. The results and recommendations are documented in cancer committee/leadership body minutes.

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

- Network Cancer Program (NCP)
- NCI-designated Comprehensive Cancer Center Programs (NCIP)
- Teaching Hospital Cancer Program (THCP)
- Veterans Affairs Cancer Program (VACP)
- Pediatric Cancer Program (PCP)
- Community Hospital Comprehensive Cancer Program (COMP)
- Community Hospital Cancer Program (CHCP)
- Hospital Associate Cancer Program (HACP)
- Affiliate Hospital Cancer Program (AFCP)
- Integrated Cancer Program (ICP)
- Freestanding Cancer Center Program (FCCP)

EXCEPTIONS BY CATEGORY

Pediatric Cancer Program Component (PCPC)

In a PCPC facility, the pediatric subcommittee or the facility cancer committee/leadership body, as appropriate, initiates 1 pediatric cancer patient care improvement annually in addition to the patient care improvements required for the adult component.

DOCUMENTATION

The facility completes the Survey Application Record (SAR).

During the on-site visit, the facility provides the surveyor with summaries of each year's patient care improvements.

NCIP facilities:

The NCIP facility completes the Survey Application Record (SAR).

During the on-site visit, the NCIP facility provides the surveyor with facility-determined documentation of at least 2 annual patient care improvements.

RATING

(1+) **Commendation:** More than 2 improvements that directly affect patient care are implemented and documented each year.

(1) **Compliance:** Two improvements that directly affect patient care are implemented and documented each year.

(5) **Noncompliance:** Two improvements that directly affect patient care are not implemented and/or documented each year.

NCIP facilities:

(1+) **Commendation:** More than 2 improvements that directly affect patient care are implemented and documented each year.

(1) **Compliance:** Two improvements that directly affect patient care are implemented and documented each year.

(5) **Noncompliance:** Two improvements that directly affect patient care are not implemented and/or documented each year.

Cancer Program Category Definitions and Requirements

NETWORK CANCER PROGRAM (NCP)	
The organization owns multiple facilities providing integrated cancer care and offers comprehensive services. Generally, networks are characterized by a network-wide cancer committee/leadership body or functional equivalent, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners. The network participates in clinical research. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.	
Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	None
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership responsibility and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	Network administrator Ambulatory oncology nurse Clinical research data manager or nurse Pain control/palliative care physician Pharmacist Dietary/nutrition specialist Hospice nurse or administrator
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Every other month required Recommend subcommittee or workgroups
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Weekly Network-wide and site-focused
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	Indicate specialties at site-focused conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload or a maximum of 300 cases Documentation of clinical stage of cases from 5 major sites seen at the facility

NETWORK CANCER PROGRAM (NCP) (continued)

Definition	Specifications
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other sources
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	10% of annual analytic caseload or a maximum of 300 cases
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	Designated inpatient medical oncology unit
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Nursing management of the designated inpatient medical oncology unit or functional equivalent	Oncology nurse manager
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	6% of the number of annual analytic cases for the network
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Completed studies of quality	1 study based on registry data 2 additional studies
Standard 8.2 Implement quality improvements	2 quality improvements annually

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 with major specialty board certification, including certification in oncology, where offered, are available. This facility participates in both basic and clinical research. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	None
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Structure and organization documented in facility-defined sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	Facility defines physician and nonphysician membership based on program organization, structure, and needs
Standard 2.3 Cancer program coordinators required for the category	None
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Established by the program
Standard 2.5 Annual cancer program goals required for the category	Cancer conference Clinical Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Established by the program
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	Established by the program
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	Exempt
Standard 2.9 Annual evaluation of cancer conference program	Exempt
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	Established and implemented by cancer registry manager or administrator 10% of annual analytic caseload or a maximum of 300 cases
Standard 2.11 Evaluation of patient outcomes	Analysis performed and published by staff physicians and/or researchers
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i> CTR-assigned or -supervised clinical and pathologic AJCC stage is recorded in the cancer registry database.
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Special follow-up definitions allowed for specific patient groups Required percentage met for patients without special definitions

NCI-DESIGNATED COMPREHENSIVE CANCER CENTER PROGRAM (NCIP) (continued)

Definition	Specifications
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Special follow-up definitions allowed for specific patient groups Required percentage met for patients without special definitions
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	Exempt
Standard 4.2 Inpatient medical oncology unit or functional equivalent	Designated inpatient oncology unit/exempt
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Oncology nurse manager
Standard 4.6 Required patient guidelines are followed	Exempt from CAP unless evaluated for Commendation when scientifically validated data elements are present in synoptic format in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	Exempt
Standard 5.1 Clinical trial information provided	Exempt
Standard 5.2 Percentage accrual to clinical trials	Exempt unless evaluated for Commendation rating
Standard 6.1 Supportive services available	Exempt
Standard 6.2 Screening and early detection services available	Exempt
Standard 6.3 Annual evaluation of community outreach activities	Exempt
Standard 7.1 Educational opportunities for staff	Exempt
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 2 additional studies
Standard 8.2 Quality improvements	2 quality improvements annually

TEACHING HOSPITAL CANCER PROGRAM (THCP)

The facility is associated with a medical school and participates in training residents in at least 4 areas, 2 of which are medicine and surgery. The facility offers the full range of diagnostic and treatment services, on site or by referral. The members of the medical staff are board certified in the major medical specialties, including oncology, where applicable. The facility is required to participate in clinical research. There is no minimum caseload requirement for this category.

Definition	Specifications
Residencies	Surgery and medicine and any 2 of the following diagnostic radiology, family practice, gynecology, pathology, radiation oncology, urology, or an oncologic fellowship
Annual caseload requirement based on analytic cases	None
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	Clinical research data manager or nurse Pain control/palliative care physician or specialist
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups recommended
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Weekly Departmental, site-focused, facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Specialties defined for site-focused and departmental conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	10% of annual analytic caseload to a maximum of 300 cases
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required

TEACHING HOSPITAL CANCER PROGRAM (THCP) (continued)

Definition	Specifications
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	One of the following: Designated inpatient medical oncology unit Functional equivalent If accessioning fewer than 175 cases, then referral to an inpatient medical oncology unit
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Oncology nurse manager (inpatient unit) Registered nurse (functional equivalent)
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	4% of the number of annual analytic cases
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 1 additional study
Standard 8.2 Quality improvements	2 quality improvements annually

VETERANS AFFAIRS CANCER PROGRAM (VACP)

The facility provides care to military veterans and offers the full range of diagnostic and treatment services, on site or by referral. The members of the medical staff are board certified in the major medical specialties, including oncology, where applicable. Participation in clinical research is required. Participation in the training of resident physicians is optional. There is no minimum caseload requirement for this category.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	None
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	None
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Ad hoc or Veteran Integrated Service Network (VISN)-assigned coordinators may be applicable
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Weekly Departmental, site-focused, facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Specialties defined for site-focused and departmental conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed, contract staff, or VISN lead CTR
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i> CTR-assigned or -supervised clinical and pathologic AJCC stage is recorded in the cancer registry database.
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required

VETERANS AFFAIRS CANCER PROGRAM (VACP) (continued)

Definition	Specifications
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	One of the following: Designated inpatient medical oncology unit Functional equivalent If accessioning fewer than 175 cases, then referral to an inpatient medical oncology unit
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Oncology nurse manager (inpatient unit) Registered nurse (functional equivalent)
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	2% of the number of annual analytic cases
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	U.S. Preventive Services Task Force recommendations followed for selected sites Services focus on veterans-related issues Services provided through ongoing activities or clinics
Standard 6.3 Annual evaluation of community outreach activities	Exempt
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 1 additional facility-defined or VISN-defined or regional study
Standard 8.2 Quality improvements	2 quality improvements annually

PEDIATRIC CANCER PROGRAM (PCP)

The facility provides care only to children and may be associated with a medical school and participate in training pediatric residents. The facility offers the full range of diagnostic and treatment services for pediatric patients, on site or by referral. The members of the medical staff are board certified in the major medical specialties associated with pediatrics, including oncology, where applicable. The facility is required to participate in clinical research. There is no minimum caseload requirement for this category.

Definition	Specifications
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 requirement based on analytic cases	None
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	Children's Oncology Group (COG) data manager Child Life specialist
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Child Life and/or long-term follow-up
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Clinical research Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Weekly Departmental, site-focused, histology-specific, facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Specialties defined for site-focused, histology-specific, and departmental conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff

PEDIATRIC CANCER PROGRAM (PCP) (continued)	
Definition	Specifications
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i> AJCC staging elements (T, N, M), Stage Group, and Staged By are excluded Pediatric staging is recorded in text or user-defined fields
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required percentage met for patients younger than age 27
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required percentage met for patients younger than age 27
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	One of the following: Designated pediatric inpatient oncology unit Functional equivalent
Standard 4.3 Monitoring physician use of staging in treatment planning	Children's Oncology Group (COG) substitutes for AJCC staging Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified in pediatrics or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Oncology Nurse Manager (designated unit) Registered nurse (functional equivalent)
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Exempt from quality of care component of standard
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	4% of the number of annual analytic cases
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry or COG protocol data and 1 additional study
Standard 8.2 Quality improvements	2 quality improvements annually

PEDIATRIC CANCER PROGRAM COMPONENT (PCPC)

The pediatric component within a larger facility accesses a minimum of 50 newly diagnosed pediatric cancer cases each year and offers the full range of diagnostic and treatment services for pediatric patients, on site or by referral. The members of the medical staff are board certified in the major medical specialties associated with pediatrics, including oncology, where applicable. The facility is required to participate in clinical research. The facility may be associated with a medical school and participate in the training of pediatric residents.

Definition	Specifications
Residencies	If associated with a medical school
Annual caseload requirement based on analytic cases	At least 50
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Pediatric committee or pediatric subcommittee of the facility cancer committee/leadership body Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	Children's Oncology Group (COG) data manager Child Life specialist
Standard 2.3 Cancer program coordinators required for the category	Facility coordinators are responsible for activities of the pediatric cancer program Pediatric cancer conference Child Life or long-term follow-up
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Pediatric committee or subcommittee meets quarterly required Subcommittees and workgroups not applicable
Standard 2.5 Annual cancer program goals required for the category	Clinical Clinical research Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Monthly Departmental, site-focused, histology-specific, facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Specialties defined for site-focused, histology-specific, and departmental conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i> AJCC staging elements (T, N, M), Stage Group, and Staged By are excluded Pediatric staging is recorded in text or user-defined fields

PEDIATRIC CANCER PROGRAM COMPONENT (PCPC) (continued)

Definition	Specifications
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required percentage met for patients younger than age 27
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required percentage met for patients younger than age 27
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	One of the following: Functional equivalent If accessioning fewer than 50 cases, then referral to an inpatient medical oncology unit
Standard 4.3 Monitoring physician use of staging in treatment planning	Children's Oncology Group (COG) substitutes for AJCC staging Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified in pediatrics or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Oncology Nurse Manager (designated unit) Registered nurse (functional equivalent)
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Exempt from quality of care component of standard
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	4% of the number of annual analytic cases
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study focusing on the pediatric program in addition to the requirements for the adult facility
Standard 8.2 Quality improvements	2 quality improvements annually

COMMUNITY HOSPITAL COMPREHENSIVE CANCER PROGRAM (COMP)

The facility accesses 650 or more newly diagnosed cancer cases each year and provides a full range of diagnostic and treatment services that are available on site or by referral. The members of the medical staff are board certified in the major medical specialties, including oncology, where applicable. Participation in clinical research is required. Participation in the training of resident physicians is optional.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	650 or more
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	Pain control/palliative care physician or specialist
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Weekly Departmental, site focused, facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Specialties defined for site-focused and departmental conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required

COMMUNITY HOSPITAL COMPREHENSIVE CANCER PROGRAM (COMP) (continued)

Definition	Specifications
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	One of the following: Designated inpatient oncology unit Functional equivalent
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Oncology nurse manager (inpatient unit) Registered nurse (functional equivalent)
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	2% of the number of annual analytic cases
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 1 additional study
Standard 8.2 Quality improvements	2 quality improvements annually

COMMUNITY HOSPITAL CANCER PROGRAM (CHCP)

The facility accesses between 100 and 649 newly diagnosed cancer cases each year and provides a full range of diagnostic and treatment services, but referral for a portion of treatment is common. The members of the medical staff are board certified in the major medical specialties. Facilities may participate in clinical research. Participation in the training of resident physicians is optional.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	100 to 649
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	None
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Monthly Facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Define annual attendance rate for all specialties
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan, including the accuracy of Collaborative Stage	10% of annual caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required

COMMUNITY HOSPITAL CANCER PROGRAM (CHCP) (continued)

Definition	Specifications
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	Functional equivalent If accessioning fewer than 175 cases, then referral to an inpatient medical oncology unit
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Registered nurse
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	Exempt
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 1 additional study
Standard 8.2 Quality improvements	2 quality improvements annually

HOSPITAL ASSOCIATE CANCER PROGRAM (HACP)

The facility accesses between 50 and 99 newly diagnosed cancer cases each year and has a limited range of diagnostic and treatment services on site. Other services are available by referral. Clinical research is not required. Participation in the training of resident physicians is optional.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	50–99
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	None
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Monthly Facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data

HOSPITAL ASSOCIATE CANCER PROGRAM (HACP) (continued)

Definition	Specifications
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	Functional equivalent Referral to an inpatient oncology unit
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Registered nurse
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	Exempt
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 1 additional study
Standard 8.2 Quality improvements	2 quality improvements annually

AFFILIATE HOSPITAL CANCER PROGRAM (AFCP)

The facility accessions fewer than 50 newly diagnosed cancer cases each year, has limited access to services on site, and forms a partnership with a CoC-accredited sponsoring hospital to provide access to the full range of diagnostic and treatment services. Clinical research is not required. Participation in the training of resident physicians is optional.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	Less than 50
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AOA State level of accreditation for hospitals
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	Representative from hospital partner
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Monthly with hospital partner Facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Define annual attendance rate for all specialties
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data

AFFILIATE HOSPITAL CANCER PROGRAM (AFCP) (continued)

Definition	Specifications
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	Exempt
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Exempt
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	Exempt
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Completed studies of quality	1 study in cooperation with hospital partner
Standard 8.2 Implement quality improvements	2 quality improvements annually

INTEGRATED CANCER PROGRAM (ICP)

The facility offers 1 treatment modality and forms a partnership with a CoC-accredited hospital to provide access to the full range of diagnostic and treatment services. Participation by the integrated facility in clinical research is optional. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	None
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AAAHC ACR, if applicable ACRO, if applicable
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	None
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees or workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Monthly with hospital partner Facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Define annual attendance rate for all specialties and conferences
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data

INTEGRATED CANCER PROGRAM (ICP) (continued)

Definition	Specifications
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	Functional equivalent at hospital partner If hospital partner accessions fewer than 175 cases, then referral to an inpatient medical oncology unit
Standard 4.3 Monitoring physician use of staging in treatment planning	Analysis of physician clinical stage in treatment planning and compliance with National treatment guidelines
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Exempt
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	Exempt
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 1 additional study
Standard 8.2 Quality improvements	2 quality improvements annually

FREESTANDING CANCER CENTER PROGRAM (FCCP)

The facility offers a minimum of 2 treatment modalities, and the full range of diagnostic and treatment services are available by referral. Referral to a CoC-accredited program is preferred. Participation in clinical research is optional. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

Definition	Specifications
Residencies	Optional
Annual caseload requirement based on analytic cases	None
Standard 1.1 Facility accreditation	One of the following: The Joint Commission AAAHC ACR, if applicable ACRO, if applicable
Standard 2.1 Cancer program leadership and accountability	Documented in bylaws or other facility-approved sources
Standard 2.2 Cancer committee/leadership body membership (additional required members)	If providing radiation therapy, dosimetrist or radiation physicist
Standard 2.3 Cancer program coordinators required for the category	Cancer conference Quality of cancer registry data Quality improvement Community outreach
Standard 2.4 Cancer committee/leadership body meeting schedule and structure	Quarterly required Subcommittees and workgroups optional
Standard 2.5 Annual cancer program goals required for the category	Clinical Community outreach Programmatic endeavors Quality improvement
Standard 2.6 Cancer conference recommended frequency and format	Monthly Facility-wide
Standard 2.7 Multidisciplinary (surgery, medical and radiation oncology, diagnostic radiology, pathology) participation and attendance at cancer conference	All specialties required at facility-wide conferences Define annual attendance rate for all specialties
Standard 2.8 Annual prospective case presentations at cancer conference and documentation of clinical stage	10% of annual analytic caseload Documentation of clinical stage of cases from 5 major sites seen at the facility
Standard 2.9 Annual evaluation of cancer conference program	Documented in cancer committee/leadership body minutes or other facility-approved sources
Standard 2.10 Establish and implement cancer registry quality control plan	10% of annual analytic caseload
Standard 2.11 Evaluation of patient outcomes	Analyze and disseminate annually
Standard 3.1 Abstracting performed or supervised by CTR	Facility-employed or contract staff
Standard 3.2 CoC data standards are followed	Current edition of <i>Facility Oncology Registry Data Standards (FORDS)</i>
Standard 3.3 Timely completion of abstracting	Within 6 months of the date of first contact
Standard 3.4 80% follow-up of all patients	Required
Standard 3.5 90% follow-up of patients diagnosed in the last 5 years	Required
Standard 3.6 Timely submission of data to the NCDB	As specified in the NCDB Call for Data

FREESTANDING CANCER CENTER PROGRAM (FCCP) (continued)

Definition	Specifications
Standard 3.7 Data submission meets quality standards	Errors and rejected records corrected and resubmitted by the deadline in the NCDB Call for Data
Standard 3.8 Participation in CoC special studies	Required if selected
Standard 4.1 Radiation oncology services are available	A full range of services, either on-site or by referral
Standard 4.2 Inpatient medical oncology unit or functional equivalent	Exempt
Standard 4.3 Staging in the medical record by the managing physician or other appropriate professional	Present in the medical record on 90% of eligible cases
Standard 4.4 Specialized knowledge and skills in oncology nursing	ONS-certified or oncology-trained nurses
Standard 4.5 Management of the designated inpatient medical oncology unit or functional equivalent	Exempt
Standard 4.6 Required patient guidelines are followed	Scientifically validated data elements present in 90% of eligible pathology reports Quality of care monitored and reported annually using CoC tools
Standard 4.7 Rehabilitative services are provided	A full range of services, either on site or by referral
Standard 5.1 Clinical trial information provided	Information provided to patients
Standard 5.2 Percentage accrual to clinical trials	Exempt
Standard 6.1 Supportive services available	A full range of services, either on site or by referral
Standard 6.2 Screening and early detection services available	A full range of services, either on site or by referral
Standard 6.3 Annual evaluation of community outreach activities	Documented in cancer committee/leadership body minutes or other sources
Standard 7.1 Educational opportunities for staff	1 cancer-related educational opportunity focuses on AJCC stage, prognostic factors, and treatment guidelines 1 additional educational activity annually
Standard 7.2 Annual cancer registry staff education	Local, state, regional, or national education for all registry staff annually
Standard 8.1 Studies of quality	1 study based on registry data and 1 additional study
Standard 8.2 Quality improvements	2 quality improvements annually