



*A multidisciplinary program of the
American College of Surgeons*

Working Draft

Cancer Program Standards 2012: Ensuring Patient-Centered Care

February, 2011

TABLE OF CONTENTS

	PAGE NUMBER
INTRODUCTORY MATERIALS.....	3
Introduction	
Value of Commission on Cancer Accreditation	
Accreditation Process	
Information for New Programs	
ELIGIBILITY CRITERIA.....	4
Cancer Committee Responsibilities for Eligibility Requirements.....	5
E1 Facility Accreditation.....	5
E2 Cancer Committee Authority.....	6
E3 Cancer Conference Policy.....	6
E4 Oncology Nurse Leadership.....	6
E5 Cancer Registry Policy and Procedure.....	7
E6 Diagnostic Imaging.....	8
E7 Radiation Oncology Services.....	8
E8 Systemic Services.....	8
E9 Clinical Trial Information.....	9
E10 Psychosocial Services.....	9
E11 Rehabilitation Services.....	10
CHAPTER 1 PROGRAM MANAGEMENT.....	11
Standard 1.1 Physician Credentials.....	11
Standard 1.2 Cancer Committee Membership.....	13
Standard 1.3 Cancer Committee Attendance.....	18
Standard 1.4 Cancer Committee Meetings.....	20
Standard 1.5 Goals.....	22
Standard 1.6 Cancer Registry Quality Control Plan.....	24
Standard 1.7 Monitoring Cancer Conference Activity.....	28
Standard 1.8 Monitoring Community Outreach.....	31
Standard 1.9 Clinical Trial Screening.....	34
Standard 1.10 Clinical Trial Accrual.....	36
Standard 1.11 Annual Educational Activity.....	30
Standard 1.12 Cancer Registrar Education.....	42
CHAPTER 2 CLINICAL SERVICES.....	44
Standard 2.1 Assessment of Treatment Planning.....	44
Standard 2.2 College of American Pathologists (CAP) Protocols.....	47
Standard 2.3 Nursing Care.....	49
Standard 2.4 Risk Assessment and Genetic Testing.....	51
Standard 2.5 Palliative Care Services.....	54
CHAPTER 3 CONTINUUM OF CARE SERVICES.....	56
Standard 3.1 Patient Navigation.....	56
Standard 3.2 Psychosocial Distress Screening.....	58

Standard 3.3 Survivorship Care Plan.....	60
CHAPTER 4 OUTCOMES.....	62
Standard 4.1 Prevention Programs.....	62
Standard 4.2 Screening Programs.....	64
Standard 4.3 Cancer Liaison Physician (CLP) Responsibilities.....	66
Standard 4.4 Accountability Measures.....	68
Standard 4.5 Quality Improvement Measures.....	70
Standard 4.6 Studies of Quality.....	72
Standard 4.7 Quality Improvements.....	75
CHAPTER 5 DATA QUALITY.....	77
Standard 5.1 Cancer Registrar Credentials.....	77
Standard 5.2 Abstracting Timeliness.....	79
Standard 5.3 Follow-up of All Patients and	
Standard 5.4 Follow-up of Recent Patients.....	80
Standard 5.5 Data Submission.....	82
Standard 5.6 Accuracy of Data.....	83
Standard 5.7 Commission on Cancer Special Studies.....	85
TABLES OF CRITERIA BY CATEGORIES.....	86
GLOSSARY OF TERMS.....	119

INTRODUCTION

- Commission on Cancer background
- Accreditation Committee structure
- Acknowledgment of contributors

VALUE OF COMMISSION ON CANCER ACCREDITATION

ACCREDITATION PROCESS

- How to become accredited
- Purpose and use of the survey application record (SAR)
- Required documentation
- Survey process
- Survey agenda
- Accreditation awards
- Outstanding Achievement Award (OAA)
- Marketing and visibility
- Best Practices Repository

INFORMATION FOR NEW PROGRAMS

Note: Content for these sections is not included in the working draft.

Eligibility Requirements

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

The Commission on Cancer (CoC) Accreditation Program was designed to ensure that the structures and processes necessary for quality cancer care are in place at the program providing care to patients with cancer.

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

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

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

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

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

- The **clinical services** provide state-of-the-art pretreatment evaluation, staging, treatment, and clinical follow-up for patients with cancer seen at the program for primary, secondary, tertiary, or end-of-life care.
- The **cancer committee** leads the program through setting goals, monitoring program 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 (QI) program** is the mechanism for evaluating and improving patient outcomes.
- The **cancer registry and database** are the basis for monitoring the quality of care.

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

Structure

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

Services

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

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

Cancer Committee Responsibilities

Each year, the CoC-accredited cancer program's cancer committee is responsible for monitoring, assessing, and identifying changes that are needed to maintain the eligibility criteria. When appropriate, the cancer committee may delegate this responsibility to a specified individual, subcommittee, or department. The assessment is documented in cancer committee minutes.

Before the survey, the CoC-accredited cancer program updates information documenting adherence to the eligibility criteria in the Survey Application Record (SAR). Annually, the updated information describing the eligibility criteria is reviewed by CoC Cancer Programs staff.

Programs will be notified when one or more eligibility requirements are not met and given a specified period in which to address the failure. If adherence to eligibility requirements is not resolved, the accreditation status is suspended and any scheduled survey is canceled.

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

Structure**E1: FACILITY ACCREDITATION**

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

Accreditation ensures that care is provided in a safe environment. The boundary of the cancer program accreditation is the same as the limit of the facility established by the agency that accredits the facility.

The facility provides a copy of the accreditation certificate or accreditation letter from the accrediting agency. For an NCI-designated Comprehensive Cancer Center program (NCIP),

documentation from the NCI P30 grant substitutes for documentation of the facility accreditation. The NCIP provides a copy of the grant award letter or other documentation from the NCI.

E2: CANCER COMMITTEE AUTHORITY

Cancer committee authority is established and documented by the facility.

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

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

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

E3: CANCER CONFERENCE POLICY

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

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

The policy addresses the following:

- Cancer conference frequency and format
- Multidisciplinary composition of the conferences and attendance rate of physician participants
- Number of total case presentations (a minimum of 15% of the total case load) and the prospective presentation rate (a minimum of 80% of case presentations)
- Discussion of stage, prognostic factors, and treatment planning using evidence-based treatment guidelines
- Options for clinical trial participation
- Methods to address areas that fall below the levels established in the policy

The program provides the most recent version of the cancer conference policy.

E4: ONCOLOGY NURSE LEADERSHIP

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

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

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

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

E5: CANCER REGISTRY POLICY AND PROCEDURE

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

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

The cancer registry policy and procedure includes, but is not limited to, the following:

- History of the registry for the program or health system
- The purpose of the registry
- Operational requirements for facility-based cancer registries
- State registry reporting requirements and mechanisms
- National Cancer Data Base (NCDB) reporting requirements and mechanisms
- Cancer registry reference date
- Case eligibility
- Case finding
- Case accessions
- Abstracting
- Required coding manuals
- Follow-up
- Confidentiality and release of information
- Dates of implementation or changes in policies of registry operations
- Maintaining and using the suspense system
- Quality control of registry data
- Staging systems, including the identification of the pediatric staging systems used by the program and the fields where the pediatric staging is recorded in the cancer registry database
- Computer operations
- Retention of documents
- Disaster recovery policy
- Documentation of first course of treatment
- American Joint Committee on Cancer (AJCC) and Collaborative Stage staging policies
- Policy for CoC Survey Application Record documentation
- Job descriptions
- Request log

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

Services

E6: DIAGNOSTIC IMAGING

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

The program identifies the diagnostic imaging services available either on site or by referral.

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

The program identifies the diagnostic imaging services that are provided either on site or by referral.

E7: RADIATION ONCOLOGY SERVICES

Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility.

Radiation therapy services are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility. The treating facility is accredited either by the American College of Radiology (ACR), the American Society for Radiation Oncology (ASTRO), or the American College of Radiation Oncology (ACRO). Information about the most common referral services and locations is provided to patients seen at the CoC-accredited cancer program.

The treating program is either accredited by a recognized authority or follows minimal quality assurance (QA) practices defined in the American Association of Physicists in Medicine (AAPM) guidelines, including reporting the following items on a radiation QA form:

1. Patient identity is verified by 2 independent methods at the beginning of each encounter.
2. There is an independent check of dose calculation for every new or changed treatment before starting treatment.
3. Patient-specific QA is done before initiation of intensity-modulated radiation therapy.
4. Daily, monthly, and annual radiation treatment machine QA procedures are performed that comply with the American Association of Physicists in Medicine guidelines (machines-specific QA).

The program provides a copy of the certificate of accreditation or documentation that describes the QA practices in radiation oncology, and identifies the radiation treatment services that are available either on site or by referral.

E8: SYSTEMIC SERVICES

Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.

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

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

1. a nursing staff with the knowledge and skills to provide specialized care,
2. facilities necessary to provide the care, and
3. a distinct set of policies and procedures to guide the nursing care of patients with cancer who are receiving systemic therapy in these areas.

All of the locations within or external to the CoC-accredited program where oncology patients receive systemic therapy follow policies and procedures to guide the safe administration of systemic therapy. These areas include hospital inpatient areas, outpatient infusion centers, and the pharmacy. Standards and guidelines of the ONS, American Society of Clinical Oncology, or the National Comprehensive Cancer Network (NCCN) are used.

The program provides the policy and procedure for the safe administration of systemic therapy that is provided on site or ensures that policies and procedures for the safe administration of systemic therapy are available at referral locations.

E9: CLINICAL TRIAL INFORMATION

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

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

The program provides a copy of the policy and procedure to provide clinical trials information to patients.

E10: PSYCHOSOCIAL SERVICES

A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.

Psychosocial services are essential components of comprehensive cancer care and are provided to patients with cancer and their caregivers throughout the continuum of care. These services address physical, psychological, social, spiritual, and financial support needs that result from a cancer diagnosis and help ensure the best possible outcome.

An adequate range of services is available on site or by referral, a process is in place to make patients aware of them, and their use is monitored.

The program provides a copy of the mechanism to ensure access psychosocial services and identifies the psychosocial services provided either on site or by referral.

E11: REHABILITATION SERVICES

Rehabilitation services follow standard policies and procedures to provide access to care either on site or by referral.

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

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

Program Management

Standard 1.1: Physician Credentials

Diagnostic and treatment services are provided by or referred to physicians who are currently board certified in their general specialty or are in the process of board certification.

DEFINITION AND REQUIREMENTS

Patient management is conducted by a multidisciplinary team, including diagnosticians and pathologists, surgeons, radiation oncologists, and medical oncologists. Treatment services are provided by or referred to physicians who are currently board certified or in the process of being board certified.

Board-certified physician services are available for each of the following specialties:

- Diagnostic radiology
- Pathology
- General surgery
- Radiation oncology
- Medical oncology

The requirement for board certification is designated in the medical staff bylaws of the CoC-accredited program. A “grandfather” clause is an acceptable exemption for specific physicians.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

The program provides a copy of the medical staff bylaws that address current board certification of physicians.

MEASURING COMPLIANCE

Rating

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

The medical staff bylaws address physician current board certification and ensure that diagnostic and treatment services are provided by or referred to physicians who are board certified in their general specialty or are in the process of board certification.

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

The medical staff bylaws address physician current board certification and ensure that diagnostic and treatment services are provided by or referred to physicians who are board certified in their general specialty or are in the process of board certification.

Standard 1.2: Cancer Committee Membership

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

DEFINITION AND REQUIREMENTS

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

Required members include at least 1 physician representing each of the diagnostic and treatment services. Required nonphysician representatives from each of the administrative, clinical, and supportive services available at the program are also to be members of the committee.

Required physician members for all categories are as follows :

- Diagnostic radiologist
- Pathologist
- Surgeon (includes general surgeon and/or surgical specialist involved in cancer care of 1 of the facility's top 5 cancer sites)
- Medical oncologist
- Radiation oncologist (If all radiation oncology services are provided by referral and the program's medical staff does not include a radiation oncologist, a cancer committee member from radiation oncology is recommended, but not required.)
- Cancer Liaison Physician (A physician of any specialty is selected to be the Cancer Liaison Physician. The Cancer Liaison Physician can fulfill a leadership position within the cancer committee such as chair, vice chair, or Quality Improvement Coordinator or represent one of the required physician specialties.)

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

Required nonphysician members for all categories are as follows :

- Cancer program administrator who is responsible for the administrative oversight or who has budget authority for the cancer program
- Oncology nurse
- Social worker or case manager
- Certified tumor registrar (CTR)
- Performance improvement or quality management representative

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

The coordinators are as follows:

Cancer Conference Coordinator

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

Quality Improvement Coordinator

The quality improvement program is the mechanism for evaluating and improving patient outcomes. A coordinator appointed from within the membership of the cancer committee will monitor the quality improvement program activity and report the findings to the cancer committee at least annually and recommend corrective action if activity falls below the annual goal or requirements. The cancer registrar cannot be selected to fulfill this coordinator role.

Cancer Registry Quality Coordinator

The cancer registry database is the basis for monitoring the quality of care. A coordinator appointed from within the membership of the cancer committee will monitor the quality of registry data and report the findings to the cancer committee at least annually and recommend corrective action if activity falls below the annual goal or requirements. The cancer registrar cannot be selected to fulfill this coordinator role.

Community Outreach Coordinator

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

Clinical Research Representative or Coordinator

A coordinator or representative for clinical research is appointed from within the membership of the cancer committee. This person will be responsible for tracking patients enrolled in clinical trials from within the program and/or patients referred for enrollment in clinical trials at other facilities or physician offices. Examples include, but are not limited to, the following: clinical research coordinator, research nurse, and physician office staff. The cancer registrar cannot be selected to fulfill this coordinator role.

Psychosocial Services Coordinator

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as specified for the category.

ADDITIONAL REQUIRED CANCER COMMITTEE MEMBERS BY CATEGORY	
CATEGORY	ADDITIONAL REQUIRED MEMBERS
Integrated Network Cancer Program	Corporate administrator Oncology nurse from the ambulatory care setting Clinical research representative Pain control/palliative care physician Pharmacist Dietary/nutrition specialist Hospice nurse or administrator Rehabilitation representative Genetic professional/counselor, if these services are provided on site
NCI-designated Comprehensive Cancer Center Program	Program defines the structure and membership for the multidisciplinary administrative body responsible for the cancer program
Academic Comprehensive Cancer Program	Clinical research representative Pain control/palliative care physician or specialist Rehabilitation representative Genetic professional/counselor, if these services are provided on site
Veterans Affairs Cancer Programs	Genetic professional/counselor, if these services are provided on site
Comprehensive Community Cancer Program	Pain control/palliative care physician or specialist Clinical research representative Genetic professional/counselor, if these services are provided on site
Community Cancer Program	Clinical research representative or coordinator Genetic professional/counselor, if these services are provided on site
Hospital Associate Cancer Program	None

ADDITIONAL REQUIRED CANCER COMMITTEE MEMBERS BY CATEGORY	
CATEGORY	ADDITIONAL REQUIRED MEMBERS
Pediatric Cancer Program	Children's Oncology Group data manager Child life specialist Genetic professional/counselor, if these services are provided on site
Freestanding Cancer Center Program	For freestanding cancer centers providing radiation oncology: dosimetrist or radiation physicist

Each program assesses the scope of services offered and determines the need for additional cancer committee members based on the major cancer sites seen by the program. Additional members strongly recommended, but not required, include the following:

- Specialty physicians representing the major cancer experience(s) at the program
- Dietary/nutrition specialist
- Palliative care team members, if palliative care is offered at the program
- Pharmacist
- Rehabilitation representative
- Pastoral care representative
- Psychiatric or mental health professional
- American Cancer Society staff representative

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

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

DOCUMENTATION

The program completes the SAR.

MEASURING COMPLIANCE

Rating

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

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

2. The membership of the cancer committee includes required nonphysicians from administrative and supportive services for cancer care.
3. Cancer committee members are designated to fulfill the required coordinator or representative roles.

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

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

Phase in for 2015.

Standard 1.3: Cancer Committee Attendance

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

DEFINITION AND REQUIREMENTS

The cancer committee is responsible for leading the cancer program. This responsibility includes making important decisions about the program goals and evaluating and improving the quality of cancer care that is provided to the patients who are treated at the program. To successfully complete meet responsibilities, it is imperative that all appointed members, physicians and nonphysicians, regularly attend and participate in cancer committee meetings.

Each required member or his or her designee attends at least 75% of the cancer committee meetings held annually.

- Required members include physicians and nonphysicians who are specified in standard 1.2.
- Attendance at cancer committee meetings may include participation through conference or teleconference calls with appropriate meeting documents provided.
- An equivalent designee from the same medical specialty or with the same professional credential may represent the required committee member at meetings when needed, but this substitution is to be the exception and not the rule.
- The minutes document the attendance at each meeting.
- The cancer committee monitors the attendance of individual members to ensure individual participation at cancer committee meeting.

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 1.4: Cancer Committee Meetings

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

DEFINITION AND REQUIREMENTS

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

Calendar quarters are as follows:

January 1 – March 31

April 1 – June 30

July 1 – September 30

October 1 – December 31

It is recommended that meetings be scheduled in the first month of each quarter to allow for rescheduling needs. It is the cancer committee's responsibility to schedule meetings and reschedule meetings, as appropriate, for each quarter. Compliance is based on meetings held quarterly and not on the total number of meetings held each year.

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

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

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the Survey Application Record (SAR).

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

MEASURING COMPLIANCE

Copyright American College of Surgeons Commission on Cancer

Rating

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

The cancer committee meets at least once each quarter.

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

The cancer committee meets at least once each quarter.

Standard 1.5: Goals

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

DEFINITION AND REQUIREMENTS

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

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

Goals do not need to be completed each year, but a different set of goals is to be established annually by the cancer committee. Goals that carry over into the next year are acceptable as long as a different goal is also established for that goal type.

Goals are not to be a restatement of the CoC standards because compliance with a standard is a requirement and not a goal.

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

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

- Clinical: involving the diagnosis, treatment, and care of the program's patients
- Programmatic: directed towards the scope, coordination, and processes of care for patients in the cancer program

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 1.6: Cancer Registry Quality Control Plan

The cancer committee establishes and implements a plan to annually evaluate the quality of cancer registry data and activity. The plan includes procedures to monitor and evaluate each component.

DEFINITION AND REQUIREMENTS

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

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

The quality control plan does the following:

1. Sets the review criteria
2. Sets the quality control timetable
3. Specifies the quality control methods, sources, and individuals involved

Required activities

Random sampling of annual analytic caseload

Physician review (Reviewers may include residents and other physicians not necessarily on the cancer committee.)

Optional sources

External audits (such as, state or central cancer registry case-finding audits) may be used to fulfill part of this requirement.

4. Identifies the activities to be evaluated

Required activities

Casefinding

Abstracting timeliness

Accuracy of other abstracted data

“Class of Case”

“Primary Site”

“Histology”

“AJCC Stage”

“Collaborative Stage”

“First Course of Treatment”

Follow-up information, including “Date of First Recurrence”, “Type of First Recurrence”, and “Cancer Status”

The percentage of information coded as unknown (usually coded as 9s or a string of 9s)

NCDB data submission, correction of data errors, and resubmission of corrected data

5. Defines the scope of the evaluation

Required scope

Minimum: 15% of annual analytic caseload

Maximum: 450 cases annually

6. Establishes the minimum quality benchmarks

Required accuracy

Cancer registry data submitted to the NCDB meet the established quality criteria included in the annual NCDB Call for Data

7. Maintains documentation of the quality control activity

Required documentation

Review criteria

Cases reviewed

Identified data errors and resolutions

Reports to the cancer committee

SPECIFICATIONS BY CATEGORY

The following categories fulfill the standard as written:

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

EXCEPTIONS BY CATEGORY

NCI-designated Comprehensive Cancer Center Program (NCIP)

In an NCIP facility, the plan to ensure the quality of cancer registry data is established and implemented by the cancer registry manager or administrator. In facilities with more than 1 CTR in the cancer registry, the CTRs perform the quality control review of cancer registry data. The percentage of cases reviewed is determined by the program based on the annual analytic caseload. The results of the quality control review are shared with the administrative body, as appropriate. Physician participation in the quality control activity, particularly in resolution of conflicts, is required.

Veterans Affairs Cancer Program (VACP)

In a VACP facility, in addition to the cancer committee, review of registry quality assurance, 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

The program completes the SAR.

At the on-site visit, the program provides the quality control plan and cancer committee minutes or other documentation that includes the results of the annual quality control evaluation. This documentation includes the process for resolving conflicts identified during the quality control review and any audit reports from the state or central registry that were used in the evaluation of the cancer registry data. This information may be recorded in cancer committee minutes or other program-approved sources.

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

MEASURING COMPLIANCE

Rating

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

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

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

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

NCIP Rating

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

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

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

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

Standard 1.7: Monitoring Conference Activity

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

DEFINITION AND REQUIREMENTS

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

Routine evaluation of cancer conference activity in each of 5 areas is essential to assure compliance with the requirements set by the cancer committee. These 5 areas are defined as follows:

- Conference frequency
- Multidisciplinary attendance
- Total case presentation
- Prospective case presentation
- Treatment planning discussion, including notation of clinical, pathologic, or other appropriate stage; the first course of treatment; site-specific prognostic indicators; and nationally recognized treatment guidelines
- Adherence to conference policy

The methods used to monitor the cancer conference activity are set by the cancer committee and documented in the cancer committee minutes. The assigned coordinator monitors each area of cancer conference activity, reports regularly to the cancer committee, and recommends corrective action if any area falls below the annual goal or requirement. In addition, the report will make reference to any recommendation for a QI activity that results from an evaluation of the cancer conference activity. These results are documented in the cancer committee minutes or other program-approved source.

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCIP

The specific criteria for this category have not yet been finalized.

DOCUMENTATION

The program completes the SAR.

The program provides the cancer committee minutes or other documentation that demonstrates the monitoring of cancer conference frequency, multidisciplinary attendance, total case presentation and prospective case presentation, and any corrective action taken for an area that falls below the annual goal and mentions any QI activities that may have resulted from this evaluation as defined by the cancer conference policy.

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

NCIP facilities

The NCIP facility completes the SAR.

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

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

MEASURING COMPLIANCE

Rating

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

1. The cancer conference coordinator monitors and evaluates the cancer conference activities, including *all* of the following areas:

- Conference frequency
- Multidisciplinary attendance
- Total case presentation
- Prospective case presentation
- Treatment planning discussion, including notation of clinical, pathologic, or other appropriate stage; the first course of treatment; site-specific prognostic indicators; and nationally recognized treatment guidelines
- Adherence to conference policy

2. The cancer conference coordinator reports the findings of the cancer conference evaluation to the cancer committee.

3. The report is documented in cancer committee minutes.

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

1. The cancer conference coordinator monitors and evaluates the cancer conference activities including *all* of the following areas:

- Conference frequency
- Multidisciplinary attendance
- Total case presentation
- Prospective case presentation

- Treatment planning discussion, including notation of clinical, pathologic, or other appropriate stage; the first course of treatment; site-specific prognostic indicators; and nationally recognized treatment guidelines
 - Adherence to conference policy
2. The cancer conference coordinator reports the findings of the cancer conference evaluation to the cancer committee .
 3. The report is documented in cancer committee minutes.

Standard 1.8: Monitoring Community Outreach

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

DEFINITION AND REQUIREMENTS

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

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

The Community Outreach Coordinator Job Description

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

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

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

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

The community outreach coordinator works in collaboration with the applicable program departments and external organizations to develop, implement, and monitor community outreach activities. If the program has an established outreach department, the coordinator has the authority and responsibility to contribute to the community outreach plan and to coordinate and monitor activities ensuring that the appropriate number of support, prevention, and screening programs are in place.

Minimally, the community outreach coordinator is required to:

- Contribute to the development of community outreach activities
- Work with community outreach organizations such as the local American Cancer Society representative on strategies to accomplish community outreach activities.
- Ensure that the provided prevention and early detection/screening programs reflect the cancer experience at the program and the community-defined needs.
- Ensure that the prevention and early detection/screening activities follow nationally accepted evidence-based guidelines and evidence-based interventions.
- Ensure that a mechanism is in place to assure follow-up of all positive findings identified

through early detection/screening activities.

- Evaluate the effectiveness of access and referral processes.
- Use the NCDB comparison benchmark reports and cancer registry data to study patterns of care at the program and QI initiatives to target improving any identified gaps in care.
- Create a community outreach activity summary report that outlines the activities provided, the results of outreach programs, and follow-up. The report must contain the following information: identified areas of community need, specific community outreach activities performed, and summary of effectiveness of each activity.

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

The VACP facilities follow the US Preventive Services Task Force recommendations for prevention or early-detection programs provided by the VACP facilities. Community outreach activities focus on veteran-related issues such as smoking and alcohol cessation. Prevention services are offered at the VACP to more effectively reach the veteran population through ongoing programs or clinics. The VACP may participate in community-based activities (such as health fairs), but this participation is not required to meet the standard.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the program provides copies of cancer committee minutes and the community outreach activity summary report 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 members during the on-site visit and review the community outreach activity summary report.

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 1.9: Clinical Trial Screening

The cancer committee develops and implements a process to screen patients to determine eligibility for available cancer-related clinical trials. Each year, the screening process for cancer-related clinical trial enrollment is evaluated, assessed, and documented in the minutes of the cancer committee.

DEFINITION AND REQUIREMENTS

By screening patients for participation in cancer-related clinical trials, the cancer program offers patients the opportunity to participate in the advancement of evidence-based medicine.

The evaluation and assessment of the screening process enables the cancer committee to identify and address barriers to patient participation. Identified areas of improvement are addressed and include a follow-up action plan.

Evaluation and assessment are the responsibilities of the cancer committee and are to be completed under the direction of a clinical staff member who may fill the role of the clinical research representative or coordinator member of the cancer committee. Professionals who can fill the role of the clinical research representative or coordinator include, but are not limited to, the following:

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

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

NCI Physician Data Query
American Cancer Society clinical trials matching service

The documentation of the evaluation and assessment includes, but is not limited to, the following:

- The methods used to assess and screen patients for possible cancer-related clinical trials (review of pathology reports, cancer conferences, clinics, staff physician offices)
- Types of cancer-related clinical trials available (cancer sites, cooperative groups, pharmaceutical companies, NCI)
- Identification of any barriers related to patient refusal to participate in cancer-related clinical trials

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for Hospital Associate Cancer Programs (HACP).

HACP

An HACP facility is not required to accrue patients to clinical trials. However, an HACP that participates in clinical trials will meet the standard as written.

DOCUMENTATION

The program completes the Survey Application Record (SAR).

The program provides the process to screen patients, and the cancer committee minutes or other documentation demonstrates the annual evaluation and assessment of the cancer-related clinical trials process.

During the on-site visit, the surveyor discusses with the cancer committee the process to screen patients to determine eligibility for clinical trials, identified barriers in the process, and how barriers were addressed.

MEASURING COMPLIANCE

Ratings

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

1. The cancer committee has developed a process to screen patients to determine eligibility for available cancer-related clinical trials.
2. The cancer committee has implemented a process to screen patients to determine eligibility for available cancer-related clinical trials.
3. Each year, the screening process for cancer-related clinical trial enrollment is evaluated and assessed.
4. The assessment of the clinical trial screening process is documented in the cancer committee minutes.

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

1. The cancer committee has developed a process to screen patients to determine eligibility for available cancer-related clinical trials.
2. The cancer committee has implemented a process to screen patients to determine eligibility for available cancer-related clinical trials.
3. Each year, the screening process for cancer-related clinical trial enrollment is evaluated and assessed.
4. The assessment of the clinical trial screening process is documented in the cancer committee minutes.

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

Phase in for 2015.

Standard 1.10: Clinical Trial Accrual

As appropriate to the cancer program category, the required percentage of patients is accrued to cancer-related clinical trials each year. Clinical trial participation is reported to the cancer committee each year.

DEFINITION AND REQUIREMENTS

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

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

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

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

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

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

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

- Cooperative cancer clinical trial groups such as American College of Surgeons Oncology Group (ACOSOG), and Eastern Cooperative Oncology Group (ECOG), and university-related research
- NCI-sponsored programs such as the Community Clinical Oncology Program (CCOP) or Cooperative Group Outreach Program (CGOP)
- Pharmaceutical company research
- Locally developed, peer-reviewed research

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

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

A research coordinator, data manager, or other clinical research professional is available to assist with enrolling patients, monitoring patient accrual, and identifying and providing information and education about new cancer-related clinical trials in all categories of accreditation.

Researchers and clinical trial investigators who accept patients from other programs for the purpose of participation in a cancer-related clinical trial must fully cooperate with the data management team of the cancer program from which the patient was referred. This cooperation ensures that the information about patients enrolled into a cancer-related clinical trial is shared with the program that referred the patient.

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

Patient accrual must be monitored and reported to the cancer committee each year. The report includes the number of patients accrued to cancer-related clinical trials each year. The report is documented in cancer committee minutes.

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

SPECIFICATIONS BY CATEGORY

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

MINIMUM REQUIRED AND COMMENDATION CLINICAL TRIAL ACCRUAL PERCENTAGES FOR EACH CATEGORY		
CATEGORY	MINIMUM REQUIRED PERCENTAGE* ACCRUAL TO CLINICAL TRIALS	COMMENDATION PERCENTAGE* ACCRUAL TO CLINICAL TRIALS
Integrated Network Cancer Program	6%	8%
NCI-designated Comprehensive Cancer Center Program	20%	Not applicable
Academic Comprehensive Cancer Program	6%	8%
Veterans Affairs Cancer Program	2%	4%

MINIMUM REQUIRED AND COMMENDATION CLINICAL TRIAL ACCRUAL PERCENTAGES FOR EACH CATEGORY		
CATEGORY	MINIMUM REQUIRED PERCENTAGE* ACCRUAL TO CLINICAL TRIALS	COMMENDATION PERCENTAGE* ACCRUAL TO CLINICAL TRIALS
Comprehensive Community Cancer Program	4%	6%
Community Cancer Program	2% Note: Until 2015, new programs in this category are exempt from the accrual percentage at the initial survey.	4%
Hospital Associate Cancer Program	Exempt	2%
Pediatric Cancer Program	30%	40%
Freestanding Cancer Program	2%	4%

*Of the number of annual analytic cases.

DOCUMENTATION

The program completes the SAR.

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

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

MEASURING COMPLIANCE

Rating

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

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

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

1. As appropriate to the cancer program category, the minimum required percentage of patients is accrued to cancer-related clinical trials.
2. The annual patient accruals to cancer-related clinical trials are monitored.

3. The annual number of patient accruals to cancer-related clinical trials is reported to the cancer committee.
4. The report is documented in cancer committee minutes.

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

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

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

Standard 1.11: Annual Educational Activity

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

DEFINITION AND REQUIREMENTS

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

Each year, the cancer committee offers at least 1 cancer-related educational activity to physicians, nurses, and allied health professionals. The 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.

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

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

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

- An educational symposium
- A lecture on a cancer-related topic
- A video conference (excludes patient management cancer conferences)
- A "Webinar"

Educational activities exclude patient management cancer conferences (tumor board) in any format.

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

In *PCPs*, at least 1 pediatric-focused cancer-related educational activity is offered to all pediatric medical staff members and pediatric allied health professionals each year. The educational activity relates to pediatric staging and treatment protocols used by the program.

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCIP

The specific criteria for this category have not yet been finalized.

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the program provides the documentation of 1 annual cancer-related educational activity, other than cancer conferences, including an overview or objectives of the content presented and a published notice or agenda for each year.

NCIP facilities

The program provides a sample listing of cancer-related educational program offerings.

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 1.12: Cancer Registrar Education

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

DEFINITION AND REQUIREMENTS

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

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

Contract CTR staff who are contracted to work for 3 or more consecutive months during the calendar year, regardless of the number of hours worked

All noncredentialed staff, including the following:
staff abstracting under the supervision of a CTR
staff performing follow-up activities
administrative staff

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

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

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

- A cancer-related lecture offered by the program (local activity)
- A face-to-face meeting or workshop
 - Local – involves 1 program or facilities located in 1 city (local activity)
 - State – involves 1 state (state activity)
 - Regional – involves a region of the country and/or multiple states (regional activity)
 - National – is sponsored by a national organization and targeted to a national audience (national meeting)
- A video conference (local activity)
- A Webinar (local activity)
- A Web-based training module (local activity)
- Journal-based articles that offer continuing education credits (local activity)

Educational activities exclude patient management cancer conferences in any format.

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

- American Health Information Management Association (cancer-related educational activities)
- Association of Community Cancer Centers

- Commission on Cancer
- National Cancer Registrar Association
- National Comprehensive Cancer Network
- North American Association of Central Cancer Registries

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

- Cancer registry software providers
- Cancer Registrars Association of New England
- Cancer Registrars Association of the Dakotas
- Oncology Registrars of New York and New Jersey

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

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

1. All cancer registry staff participate in a cancer-related educational activity each year.
2. All CTR staff attend a national or regional cancer-related meeting once during the 3 year survey cycle.

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

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

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

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

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

Clinical Services

Standard 2.1: Assessment of Treatment Planning

Each year, a physician member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer.

DEFINITION AND REQUIREMENTS

The role of this standard is to ensure that treatment plans for patients newly diagnosed with cancer include consideration of stage, site-specific prognostic indicators, and nationally recognized treatment guidelines.

The intent of this standard is to evaluate treatment planning beyond patients whose cases are presented at cancer conferences. When all patients diagnosed with cancer of a specific site or cancer with specific histology are prospectively presented at a cancer conference, then cancer conference discussion fulfill the requirements of this standard.

The stage of newly diagnosed cancer cases may be described by a variety of methods.

- The AJCC clinical (this is the preferred stage) or pathologic stage.
- Other descriptive options could include the following:
 - nationally recognized site specific clinical staging methods or
 - a disease assessment that is sufficient enough to permit appropriate treatment planning by methods such as imaging, physical examination, or laboratory studies.
- Site-specific prognostic indicators should be incorporated into treatment planning when available and appropriate.
- Nationally recognized treatment guidelines should be used to determine appropriate treatment.

A standardized approach to diagnosis and treatment planning will generate reliable data that can be used by the facility to

- monitor the initial treatment plan,
- evaluate outcomes,
- perform comparative analysis with national data, and
- plan effective performance improvements.

To comply with this standard, the study must confirm that the diagnostic evaluation accurately determined the extent of disease before treatment and that the treatment plan was concordant with a recognized guideline.

The annual study includes all of the following components:

1. Sources for the study that include one of the following:

- * 10% random review of the annual analytic case load; maximum review of 300 cases for any facility
 - * 10% random review of the 5 most common cancer sites
 - * A site-specific review:
 - * involves all cases from that site, to a maximum of 100;
 - * is based on an identified need, concern, or problem; or
 - * is based on uncommon cases such as cases not generally presented at cancer conferences
2. Accuracy of the physician-determined stage recorded in the medical record or in another source
 3. A determination that the first course of therapy is concordant with a nationally recognized treatment guideline and/or prognostic indicators when available and appropriate
 4. Comparison of the results of the study with national data
 5. Reporting format that permits analysis and provides an opportunity to recommend performance improvements

The results of the annual study are presented to the cancer committee and documented in the cancer committee minutes. The completion of this study does not fulfill the requirement for S 4.6.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

The program provides copies of the annual study results and cancer committee minutes in which the results were reported.

RATING

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

1. The cancer committee conducts a study to assure that formulation of the first course of treatment for patients newly diagnosed with cancer includes consideration of the following:
 - a) An accurate assessment of the stage
 - b) Nationally recognized treatment guidelines
 - c) Prognostic indicators when available and appropriate
2. The study results are reported to the cancer committee.
3. The study results are documented in cancer committee minutes.

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

1. The cancer committee conducts a study to assure that formulation of the first course of treatment for patients newly diagnosed with cancer includes consideration of:
 - a) An accurate assessment of the stage
 - b) Nationally recognized treatment guidelines

- c) Prognostic indicators when available and appropriate
- 2. The study results are reported to the cancer committee.
- 3. The study results are documented in cancer committee minutes.

Standard 2.2: College of American Pathologists Protocols

College of American Pathologists (CAP) protocols are followed to report the required data elements in 95% of the eligible cancer pathology reports each year.

DEFINITION AND REQUIREMENTS

The CoC requires that 95% of eligible pathology reports that include a cancer diagnosis will contain the required data elements outlined on the currently applicable surgical case summary checklist of the CAP publication, *Reporting on Cancer Specimens*.

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

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

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

The cancer committee should consider adoption of the synoptic format defined by the CAP cancer committee for use in cancer-related pathology reports. This definition is posted in the CoC Best Practices repository located on the Cancer Programs page of the American College of Surgeons Web site at <http://www.facs.org/cancer/index.html>.

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

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCIP facilities

The specific criteria for this category have not yet been finalized.

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

DOCUMENTATION

The program completes the SAR.

During the on-site visit, the surveyor will evaluate the pathology reports for a random sample of eligible analytic cases for the 3 most recently completed years of abstracting to confirm that 95% of the reports include all of the required data items defined by the protocols. A maximum of 30 pathology reports will be reviewed.

NCIP facilities

The specific documentation criteria for this category have not yet been finalized.

.

MEASURING COMPLIANCE

Rating

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

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

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

95% of cancer pathology reports include the required data elements as outlined in the CAP protocols.

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

95% of cancer pathology reports include the required data elements as outlined in the CAP protocols.

Standard 2.3: Nursing Care

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

DEFINITION AND REQUIREMENTS

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

Nursing Education

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

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

The nursing education focuses on the knowledge base needed to administer cancer treatments in a safe and consistent manner and to care for patients with cancer across the continuum of care. Organizational support for oncology nursing continuing education is strongly encouraged.

Nursing Competency

Nursing education and competency evaluation in oncology are implemented in all areas of the health care program where cancer care is provided. Annual nursing competency evaluation of oncology knowledge and skills is completed and documented according to organizational policy. Oncology nursing certification for all nurses providing oncology care is strongly encouraged. The oncology nursing certifications include, but are not limited to, the following:

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

The credentials of nursing personnel will be verified by nursing service and confirmation reported at least annually to the cancer committee.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 2.4: Risk Assessment and Genetic Testing

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

DEFINITION AND REQUIREMENTS

Cancer risk assessment and genetic counseling are the processes to identify and counsel people at risk for familial or hereditary cancer syndromes. The purposes of genetic counseling are to educate patients about their chance of developing cancers, help them obtain personal meaning from cancer genetic information, and empower them to make educated, informed decisions about genetic testing, cancer screening, and cancer prevention. Identifying patients at increased risk of developing cancer due to a family history of cancer or a known hereditary cancer syndrome can have dramatic effects on early detection and cancer outcome. For this reason, cancer risk assessment and genetic counseling are rapidly becoming standards of care for patients with personal and/or family history of cancer who are at high risk of having a hereditary syndrome.

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

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

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

Genetics professionals include people with the following:

- An American Board of Genetic Counseling or (ABGC) or American Board of Medical Genetics (ABMG) board-certified/board-eligible or (in some states) a licensed genetic counselor
- An American College of Medical Genetics physician board certified in medical genetics
- A Genetics Clinical Nurse (GCN), credentialed through the Genetics Nursing Credentialing Commission (GNCC). Credentialing is obtained through successful completion of a professional portfolio review process.
- An advanced practice oncology nurse who is prepared at the graduate level (master or doctorate) with specialized education in cancer genetics and hereditary cancer predisposition syndromes*; certification by the Oncology Nursing Certification Corporation is preferred.
- A board-certified physician with experience in cancer genetics (defined as providing cancer risk assessment on a regular basis).

The Cancer Committee defines the appropriate individuals who will provide risk assessment and counseling for major cancer disease sites (breast, colorectal, etc). In addition, those programs not

having immediate access to formal genetic counseling services should identify resources for referral.

*Please note, specialized training in cancer genetics should be ongoing; educational seminars offered by commercial laboratories about how to perform genetic testing are not considered adequate training for cancer risk assessment and genetic counseling.

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

Pretest Counseling

- Collecting relevant information needed to assess a patient's personal and family medical history

A 3- to 4-generation pedigree, including detailed medical information about the patient's first-, second-, and third-degree relatives should be obtained. Gathering information about paternal and maternal family history, ancestry/ethnicity, and consanguinity as available is necessary.

- Evaluating the patient's risk

One aspect of risk assessment is discussing the absolute risk that the patient will develop a specific type of cancer or cancers based on the family history. The second aspect is the risk that the patient carries a heritable or germ line mutation in a cancer susceptibility gene.

- Performing a psychosocial assessment
- Educating the patient about the suspected hereditary cancer syndrome, if appropriate

The provider reviews cancer risks associated with gene mutations, including basic concepts such as genes and inheritance patterns and more advanced concepts of penetrance and variable expressivity and the possibility of genetic heterogeneity.

- Obtaining informed consent for genetic testing (if genetic testing is recommended).

Posttest Counseling

- Disclosure of the results and posttest counseling include a discussion of the results, significance and impact of the test results, medical management options, informing other relatives, future contact, and available resources.

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 2.5: Palliative Care Services

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

DEFINITION AND REQUIREMENTS

Palliative care refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering (National Quality Forum [NQF]). The availability of palliative care services is an essential criterion of cancer care, beginning at the time of diagnosis and being “continuously available” throughout treatment, surveillance, and, when applicable, during bereavement.

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

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

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

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

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

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

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

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

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

Continuum of Care Services

Phase in for 2015.

Standard 3.1: Patient Navigation

The cancer committee conducts an assessment of barriers to care for patients with cancer. A patient navigation process is established to address barriers to care for patients with cancer and health care disparities either on site or by referral. The cancer committee evaluates and reports on the process annually.

DEFINITION AND REQUIREMENTS

Patient navigation is individualized assistance offered to patients, their families, and caregivers to help overcome barriers to care, whether through the health care system or the environment, and facilitate timely access to quality medical and psychosocial care from before the final diagnosis is determined through all phases of the cancer experience.

Patient navigation is made available to address barriers to timely diagnosis, treatment, and optimal quality of life. The program can provide services either on site or by referral. Because the providers in each program or health system understand the cancer patient population and the community served, the cancer committee can best create a navigation process that suits its needs and determine appropriate staffing.

All cancer patient populations are included in the needs assessment, and the needs assessment guides the initiatives planned to comply with the community outreach standards and/or the psychosocial services eligibility criteria. The completion of this needs assessment does not fulfill the requirement for S 4.6.

The cancer committee evaluates and reports on the navigation process annually. The evaluation and report includes, but is not limited to, the following:

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

The program provides a copy of the evaluation and report of the navigation process. During the on-site visit, the surveyor discusses the navigation process with the cancer committee.

MEASURING COMPLIANCE

Rating

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

1. The cancer committee conducts a needs assessment of barriers to health care access.
2. Patient navigation services addressing health care disparities are provided on site or by referral.
3. The cancer committee evaluates and reports on the navigation process.

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

1. The cancer committee conducts a needs assessment of barriers to health care access.
2. Patient navigation services addressing health care disparities are provided on site or by referral.
3. The cancer committee evaluates and reports on the navigation process.

Standard 3.2: Psychosocial Distress Screening

The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care as the standard for patients with cancer.

DEFINITION AND REQUIREMENTS

Cancer is a complex disease process that affects patients in a variety of ways. Patients experience psychological, social, financial, and behavioral issues that can interfere with their treatment plan and adversely affect their outcome. To address the psychosocial issues experienced by patients with cancer, the 2007 report of the Institute of Medicine (IOM), *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, emphasizes the importance of screening patients for distress and psychosocial health needs as a critical first step to providing *quality cancer care*. According to the NCCN, *distress should be recognized, monitored, and documented and treated promptly at all stages of the disease*. In addition, this report emphasizes that all patients with cancer need to be referred for the appropriate provision of care and that quality psychosocial cancer care includes systematic follow-up and reevaluation. The purpose of this standard is to develop a process to incorporate the screening of distress into the standard care of oncology patients and provide patients identified with distress with resources and/or referral for psychosocial needs.

The cancer committee defines the patient population that is to be screened for psychosocial distress.

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

Process requirements

(a) Timing of Screening: Patients with cancer are offered screening for distress a minimum of 1 time per patient at a pivotal medical visit to be determined by the program. Some examples of a “pivotal medical visit” include time of diagnosis, pre-surgical and postsurgical visits, first visit with a medical oncologist to discuss chemotherapy, routine visit with a radiation oncologist, or a post-chemotherapy follow-up visit. Preference is given to pivotal medical visits at times of greatest risk for distress, such as at time of diagnosis, transitions during treatment (such as from chemotherapy to radiation therapy), and transitions off treatment.

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

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

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

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

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

MEASURING COMPLIANCE

Rating

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

The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care as the standard for patients with cancer.

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

The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care as the standard for patients with cancer.

Phase in for 2015.

Standard 3.3: Survivorship Care Plan

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

DEFINITION AND REQUIREMENTS

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

Process requirements

- (a) A survivorship care plan is prepared by the principal provider(s) who coordinated the oncology treatment for the patient.
- (b) The survivorship care plan is given to the patient on completion of treatment.
- (c) The survivorship care plan contains a record of care received, important disease characteristics, and a written follow-up care plan incorporating available and recognized evidence-based standards of care, when available. The minimum care plan standards are included in the Fact Sheet: Cancer Survivorship Care Planning, from the IOM.

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

MONITORING COMPLIANCE

Rating

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

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

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

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

Outcomes

Standard 4.1: Prevention Programs

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

DEFINITION AND REQUIREMENTS

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

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

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

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

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

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

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

The VACP facilities follow the US Preventive Services Task Force recommendations for prevention or early-detection programs provided by the VACP facilities. Prevention programs focus on veteran-related issues such as smoking and alcohol cessation. Prevention services are offered at the VACP to more effectively reach the veteran population through ongoing programs or clinics. The VACP may participate in community-based activities (such as health fairs), but this participation is not required to meet the standard.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

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

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 4.2: Screening Programs

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

DEFINITION AND REQUIREMENTS

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

Annually, the cancer committee provides at least 1 cancer screening program that is focused on an identified community need. Cancer screening activities are provided according to recognized evidence-based national guidelines. The cancer committee and designated community outreach coordinator will have a mechanism in place to assure that all positive findings identified as a result of these cancer screening programs are addressed.

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

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

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

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

- Breast (radiographic and physical examination)
- Colonoscopy, flexible sigmoidoscopy, or fecal occult blood testing (such as Hemoccult, Beckman Coulter, Brea, CA)
- Papanicolaou testing
- Prostate examinations with or without prostate-specific antigen testing
- Skin surveys

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

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

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

SPECIFICATIONS BY CATEGORY

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

EXCEPTIONS BY CATEGORY

NCIP

The specific criteria for this category have not yet been finalized.

VACP

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

DOCUMENTATION

The program completes the SAR.

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

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

NCIP facilities

The NCIP facility completes the SAR.

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

MEASURING COMPLIANCE

Rating

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

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

Note: This is the default rating for VACP facilities.

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

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

Standard 4.3: Cancer Liaison Physician Responsibilities

A Cancer Liaison Physician serves in a leadership role within the cancer program and is responsible for evaluating, interpreting, and reporting the program's performance using the National Cancer Data Base data to the cancer committee quarterly.

DEFINITION AND REQUIREMENTS

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

Recommended Selection Criteria

The CLP position is a required component of CoC-accredited cancer programs and is a member of the cancer committee.

The CLP is either a member of the active medical staff or an alumnus who is dedicated to improving the quality of care provided to patients with cancer.

The CLP serves as the liaison among the cancer program, the CoC, and the American Cancer Society.

The CLP serves a 3-year term with eligibility to serve an unlimited number of terms based on performance as assessed by the CoC and the cancer committee.

The CLP can fulfill a leadership position within the cancer committee such as chair, vice chair, or quality improvement coordinator.

Primary Responsibilities

The primary responsibilities of the CLP are to monitor and interpret the program's performance using NCDB data and use the information to evaluate and improve the quality of care.

The CLP reports and discusses the facility's performance and response related to the accountability measures and QI standards with the cancer committee at least quarterly. A quality-related audit is initiated for any metric(s) that fall below required levels of compliance. Additional resources for quarterly reports include NCDB Hospital Comparison Benchmark reports and NCDB Survival reports.

Discussions are documented in the cancer committee minutes and subsequently shared with the medical staff and administration.

Secondary Responsibilities

- The CLP reports on CoC activities, initiatives, and priorities to the cancer committee.
- The CLP serves as liaison for the cancer program with the American Cancer Society.
- The CLP (or his or her designee) is present during the CoC survey and meets with the surveyor. The CLP designee, if applicable, must be a member of the active medical staff.

Educational Requirements

The CLP is required to complete CLP orientation within 6 months of initial appointment and, on reappointments, every 3 years.

The CLP is required to view all Web-based CLP education programs provided by the CoC each year. These programs are intended to facilitate the CLP's role in quality assessment and improvement using the NCDB tools. These programs are specific to continuously informing and enhancing the role of the CLP.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

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

A newly appointed CLP and a CLP who is reappointed for a 3-year term complete Web-based orientation and training.

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

During the on-site visit, the CLP, or his or her designee, discusses CLP activities with the surveyor.

MEASURING COMPLIANCE

Rating

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

1. Each year, the CLP evaluates and interprets the program's performance using the NCDB data.
2. Each year, the CLP (or designee) reports this information to the cancer committee quarterly.
3. The CLP (or designee) is present during the CoC survey and meets with the surveyor.

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

1. Each year, the CLP evaluates and interprets the program's performance using the NCDB data.
2. Each year, the CLP (or designee) reports this information to the cancer committee quarterly.
3. The CLP (or designee) is present during the CoC survey and meets with the surveyor.

Standard 4.4: Accountability Measures

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

DEFINITION AND REQUIREMENTS

The cancer committee assures that patients with cancer are treated according to nationally accepted measures as measured by compliance with the current CoC quality reporting tools. An accountability measure is the standard of care based on clinical trial evidence. These accountability measures may affect reimbursement.

The CoC requires the cancer committee to review the quality of patient care using CoC quality reporting tools appropriate to the patients who are treated by the program each year. The cancer committee is a multidisciplinary forum that provides a platform to evaluate care within and across disciplines to discuss processes that work and to evaluate how processes can be improved to promote evidenced-based practice.

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

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

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

(2) Data are validated by onsite review.

The surveyor will confirm compliance with a standard of care measure selected to be evaluated by the CoC through cancer registry abstract and medical record review. The cases for review will be identified by the CoC through the NCDB submissions. Not more than 25 analytic cases related to the measurement under review will be selected.

MEASURING COMPLIANCE

Rating

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

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

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

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

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

Standard 4.5: Quality Improvement Measures

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

DEFINITION AND REQUIREMENTS

The cancer committee assures that patients with cancer are treated according to nationally accepted QI measures as measured by compliance with the current CoC quality reporting tools. A QI measure is one that demonstrates good practice but is not based on clinical trial evidence.

The CoC requires the cancer committee to review the quality of patient care using CoC quality reporting tools appropriate to the patients who are treated by the program annually. The cancer committee is a multidisciplinary forum that provides a platform to evaluate care within and across disciplines to discuss processes that work and to evaluate how processes can be improved to promote high quality care.

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

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

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

MEASURING COMPLIANCE

Rating

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

1. Each year, the cancer committee monitors the program's performance using the CoC quality reporting tools.

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

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

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

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

Standard 4.6: Studies of Quality

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

DEFINITION AND REQUIREMENTS

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

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

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

- Structure
- Process
- Outcomes

Studies are designed to involve physicians and allied health professionals.

Tools to help address these issues include, but are not limited to, the following:

- Fishbone diagram
- Pareto charts
- Run charts
- Flowcharts
- Checklists

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

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

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

- Monitoring the effectiveness of the study action plans and all cancer-related QI activities at the program

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

Note the following:

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

SPECIFICATIONS BY CATEGORY

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

DOCUMENTATION

The program completes the SAR.

The program provides summaries of studies, analyses, recommendations, and follow-up for each year.

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 4.7: Quality Improvements

Annually, the quality improvement coordinator, under the direction of the cancer committee, implements 2 patient care improvements. One improvement is based on the results of a completed study that measures cancer patient quality of care and outcomes. One improvement can be identified from another source or from a completed study that measures cancer patient quality of care and outcomes. Improvements are documented in the cancer committee minutes and shared with medical staff and administration.

DEFINITION AND REQUIREMENTS

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

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

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

In NCIP facilities, at least 2 quality improvements affecting patient care are implemented centrally, departmentally, through disease site teams, or through other program-appropriate methods as directed by the cancer center.

The QI coordinator monitors, reports, and recommends activity related to the QI program, reports regularly to the cancer committee, and recommends corrective action if any area falls below acceptable norms or when undesirable performance is identified. The results and recommendations are documented in cancer committee minutes that are shared with the medical staff and administration.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

MEASURING COMPLIANCE

Rating

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

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

4. The improvements are shared with medical staff and administration.

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

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

Data Quality

Standard 5.1: Cancer Registrar Credentials

Case abstracting is performed by a Certified Tumor Registrar.

DEFINITION AND REQUIREMENTS

Beginning January 1, 2012, all cancer registry staff who perform case abstracting at a CoC-accredited program must either:

1. Hold a current Certified Tumor Registrar (CTR) credential. This applies to staff who are employed by the program and to staff who work on a contract basis or through a registry service company.
2. A noncredentialed abstractor currently working in a CoC-accredited program must pass the CTR examination by January, 2015. During this time frame, a noncredentialed abstractor may perform case abstracting at a CoC-accredited program under the supervision of a CTR. The plan for CTR supervision of noncredentialed staff includes the scope of supervision, quality control rate, and educational and training activities for staff who are not credentialed.

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

If the person does not successfully obtain the CTR credential within the 3-year grace period, he or she may not perform case abstracting at *any* CoC-accredited program until the credential is obtained.

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

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

Certified Tumor Registrars apply knowledge obtained from formal education and work experience to correctly interpret and code cancer diagnosis, stage, treatment, and outcomes information for each case that is seen at the CoC-accredited program that meets CoC reporting requirements.

The case abstracting responsibilities of the CTR are documented.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

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

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

The CoC tracks the status of noncredentialed staff.

MEASURING COMPLIANCE

Rating

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

1. Case abstracting is performed by a CTR.
2. Noncredentialed staff who are abstracting and who are in the 3-year grace period are supervised by a CTR.

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

1. Case abstracting is performed by a CTR.
2. Noncredentialed staff who are abstracting and who are in the 3-year grace period are supervised by a CTR.

Standard 5.2: Abstracting Timeliness

Each year, 90% of cases are abstracted within 6 months of the date of first contact with the program.

DEFINITION AND REQUIREMENTS

Ongoing timely abstracting is essential for accurate data collection, evaluation, and reporting of outcomes. Abstracting timeliness is calculated from the month and year recorded in the field “Date of First Contact” (see definition in the current version of CoC data standards) to the date the case is completed. Beginning with cases diagnosed and treated in 2010, the abstracting timeliness is based on the information recorded in the “Date Case Completed – CoC” field (see definition). Abstracting timeliness is maintained throughout the survey cycle.

It is expected that all CoC-accredited programs, including the NCIP facilities, will provide treatment information and assistance to the cancer programs that refer patients to their program for diagnosis and/or treatment.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

The program completes the SAR.

Abstracting currency is verified by the NCDB through the submitted data and by surveyor review of cancer registry abstracts during the on-site visit.

MEASURING COMPLIANCE

Rating

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

95% or more of cases are abstracted within 6 months of the date of first contact with the program.

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

90% of cases are abstracted within 6 months of the date of first contact with the program.

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

90% of cases are abstracted within 6 months of the date of first contact with the program.

Standard 5.3: Follow-up of All Patients

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

Standard 5.4: Follow-up of Recent Patients

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

All reportable cases are followed up, except the following:

- Residents of foreign countries
- Cases that are reportable by agreement
- Patients whose age exceeds 100 years and who are without contact for more than 12 months
- Patients diagnosed on or after January 1, 2006, and classified as “Class of Case” 00.

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

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

The cancer committee monitors the use of unknown values to ensure complete data reporting. This monitoring is particularly important for information describing “Date of First Recurrence”, “Type of First Recurrence”, and “Cancer Status.”

It is expected that all CoC-accredited programs, including the NCIP facilities, will provide follow-up information and assistance to the cancer programs that refer patients to their program for treatment or follow-up care.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written, except for PCPs.

EXCEPTIONS BY CATEGORY

PCP

In a PCP, annual follow-up information is obtained for eligible analytic cases until the patients reach the age of 26 years. Once patients reach the age of 27 years, follow-up attempts are to continue, but the data for the patients are excluded from the follow-up calculations.

DOCUMENTATION

The program completes the SAR.

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

MEASURING COMPLIANCE

Rating

Standard 5.3: Follow-up of All Patients

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

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

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

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

Standard 5.4: Follow-up of Recent Patients

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

Excluding patients with age-specific exclusions, a follow-up rate 90% to 94% is maintained for all analytic patients diagnosed within the last 5 years or from the cancer registry reference date, whichever is shorter.

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

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

Standard 5.5: Data Submission

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

DEFINITION AND REQUIREMENTS

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

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

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

After the request for the initial survey of a new program is accepted by the CoC, the program submits data for the most recent abstracting year completed to the NCDB. Data are submitted, and errors/rejected records are corrected (Standard 5.6) before scheduling the initial survey.

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

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

MEASURING COMPLIANCE

Rating

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

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

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

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

Standard 5.6: Accuracy of Data

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

DEFINITION AND REQUIREMENTS

Accurate data are necessary for meaningful comparison of treatment and patient outcomes. These data are the basis for the feedback provided to cancer programs. As part of its annual Call for Data, the NCDB will document the conditions that will cause the cases submitted to the NCDB to be rejected. Rejected cases do not meet specified data quality criteria.

Standardized, nationally accepted data edits are applied to all analytic cases submitted. The reporting registry is notified of the problematic cases through an edit report. The reporting registry must correct outstanding data quality errors and resolve errors resulting in rejected records.

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

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

SPECIFICATIONS BY CATEGORY

All programs fulfill the standard as written.

DOCUMENTATION

Resubmission history is confirmed by the CoC and displayed in the SAR.

MEASURING COMPLIANCE

Rating

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

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

NCIP facilities are not eligible for commendation for this standard.

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

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

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

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

2. Corrected cases are resubmitted to the NCDB by the due date specified in the Call for Data.

Standard 5.7: Commission on Cancer Special Studies

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

DEFINITION AND REQUIREMENTS

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

The CoC will periodically design and conduct special studies. Based on study criteria, select accredited programs will participate in each study.

The cases included in the study and due date are specified in the study documentation provided by the CoC. To fulfill the standard, the selected program submits all requested information for the cases identified by the specified deadline.

Based on study criteria, the CoC will determine if CoC-designed special studies will fulfill the requirements for Standard 5.7. This information will be documented in CoC communications and provided to programs that are selected to participate.

SPECIFICATIONS BY CATEGORY

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

DOCUMENTATION

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

MEASURING COMPLIANCE

Rating

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

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

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

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

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

TABLES OF CRITERIA BY CATEGORY

Integrated Network Cancer Program (INCP)	
The organization owns, operates, leases, or is part of joint ventures with multiple facilities providing integrated cancer care and offers comprehensive services. At least 1 facility in the category is a hospital. Generally, Integrated Network Cancer Programs (INCPs) are characterized by a unified cancer committee leadership body or functional equivalent, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners. Each entity of the INCP meets performance expectations for the quality measures under the umbrella of the integrated program. The INCP participates in cancer-related clinical research. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.	
Definition	Specification
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic

	therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E9 Clinical Trial Information	A formal mechanism is used to inform patients about clinical trials.
E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
Standard 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Corporate administrator Oncology nurse from the ambulatory care setting Clinical research representative Pain control/palliative care physician Pharmacist Dietary/nutrition specialist Hospice nurse or administrator Rehabilitation representative Genetic professional/counselor, if these services are provided on site
Standard 1.3 Cancer Committee Attendance	2015 phase in Each required cancer committee member attends 75% of meetings annually; occasional attendance by an equivalent designee is acceptable
Standard 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter
Standard 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year
Standard 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
Standard 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
Standard 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach

	activity report, and shares the report with the cancer committee each year.
Standard 1.9 Clinical Trial Screening	The cancer committee develops and implements a process to determine patient eligibility for clinical trials; the process is evaluated and assessed annually and documented in cancer committee minutes.
Standard 1.10 Clinical Trials Accrual	2015 phase in 6% of the number of annual analytic cases; 8% of the number of annual analytic cases for commendation
Standard 1.11 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
Standard 1.12 Cancer Registrar Education	All registry staff participate in an annual educational activity.
Standard 2.1 Assessment of Treatment Planning	A member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
Standard 2.2 CAP Protocols	95% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
Standard 2.3 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
Standard 2.4 Risk Assessment and Genetic Testing	Risk assessment and genetic testing are provided either on site or by referral, by a qualified genetic professional.
Standard 2.5 Palliative Care Services	Palliative care services are provided either on site or by referral.
Standard 3.1 Patient Navigation	2015 phase in The cancer committee assesses barriers to care once during the survey cycle, provides navigation services either on site or by referral, and assesses and reports on the process annually.
Standard 3.2 Psychosocial Distress Screening	The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with

	cancer.
Standard 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
Standard 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
Standard 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
Standard 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least quarterly.
Standard 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
Standard 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
Standard 4.6 Studies of Quality	Each year, 3 studies of cancer patient care quality and outcomes are conducted.
Standard 4.7 Quality Improvements	Each year, 2 improvements in patient care are implemented.
Standard 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
Standard 5.2 Abstracting Timeliness	Each year, 90% of cases are abstracted within 6 months of the date of first contact.
Standard 5.3 Follow-up of All Patients	80% follow-up from reference date
Standard 5.4 Follow-up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
Standard 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
Standard 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
Standard 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

NCI-designated Comprehensive Cancer Center Program (NCIP)	
The facility secures an 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 basic and clinical research. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.	
Definition	Specification
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E9 Clinical Trial Information	A formal mechanism is used to inform

	patients about clinical trials.
E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	**
Standard 1.2 Cancer Committee Membership	
Standard 1.3 Cancer Committee Attendance	
Standard 1.4 Cancer Committee Meetings	
Standard 1.5 Goals	
Standard 1.6 Cancer Registry Quality Control Plan	
Standard 1.7 Monitoring Cancer Conference Activity	
Standard 1.8 Monitoring Community Outreach	
Standard 1.9 Clinical Trial Screening	
Standard 1.10 Clinical Trials Accrual	
Standard 1.11 Annual Educational Activity	
Standard 1.12 Cancer Registrar Education	
Standard 2.1 Assessment of Treatment Planning	
Standard 2.2 CAP Protocols	
Standard 2.3 Nursing Care	
Standard 2.4 Risk Assessment and Genetic Testing	
Standard 2.5 Palliative Care Services	
Standard 3.1 Patient Navigation	
Standard 3.2 Psychosocial Distress Screening	
Standard 3.3 Survivorship Care Plan	
Standard 4.1 Prevention Program	
Standard 4.2 Screening Program	
Standard 4.3 CLP Responsibilities	
Standard 4.4 Accountability Measures	
Standard 4.5 Quality Improvement Measures	
Standard 4.6 Studies of Quality	
Standard 4.7 Quality Improvements	
Standard 5.1 Cancer Registrar Credentials	
Standard 5.2 Abstracting Timeliness	

Standard 5.3 Follow-up of All Patients	
Standard 5.4 Follow-up of Recent Patients	
Standard 5.5 Data Submission	
Standard 5.6 Accuracy of Data	
Standard 5.7 Commission on Cancer Special Studies	

**** The specific criteria for this category have not yet been finalized.**

Academic Comprehensive Cancer Program (THCP)	
The facility provides postgraduate medical education in at least 4 programs. The minimum caseload requirement for this category is more than 500 newly diagnosed cancer patients each year. 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 cancer-related clinical research.	
Definition	Specification
Residencies	Surgery and internal medicine and any 2 of the following residency programs: diagnostic radiology family practice gynecology pathology radiation oncology urology or a recognized fellowship related to cancer care
Annual Caseload	More than 500
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements.
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations

	that are facility owned, or at locations that contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E9 Clinical Trial Information	A formal mechanism is used to inform patients about clinical trials.
E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
Standard 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Clinical research representative Pain control/palliative care physician or specialist Rehabilitation representative Genetic professional/counselor, if these services are provided on site
Standard 1.3 Cancer Committee Attendance	2015 phase in Each required cancer committee member attends 75% of meetings annually; occasional attendance by an equivalent designee is acceptable.
Standard 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
Standard 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year.
Standard 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
Standard 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
Standard 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity report, and shares the report with

	the cancer committee each year.
Standard 1.9 Clinical Trial Screening	The cancer committee develops and implements a process to determine patient eligibility for clinical trials; the process is evaluated and assessed annually and documented in cancer committee minutes.
Standard 1.10 Clinical Trials Accrual	2015 phase in 6% of the number of annual analytic cases; 8% of the number of annual analytic cases for commendation
Standard 1.11 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
Standard 1.12 Cancer Registrar Education	All registry staff participate in an annual educational activity.
Standard 2.1 Assessment of Treatment Planning	A member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
Standard 2.2 CAP Protocols	95% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
Standard 2.3 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
Standard 2.4 Risk Assessment and Genetic Testing	Risk assessment and genetic testing are provided either on site or by referral, by a qualified genetic professional.
Standard 2.5 Palliative Care Services	Palliative care services are provided either on site or by referral.
Standard 3.1 Patient Navigation	2015 phase in The cancer committee assesses barriers to care once during the survey cycle, provides navigation services on site or by referral, and assesses and reports on the process annually.
Standard 3.2 Psychosocial Distress Screening	The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.

Standard 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
Standard 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
Standard 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
Standard 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least quarterly.
Standard 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
Standard 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
Standard 4.6 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
Standard 4.7 Quality Improvements	Each year, 2 improvements in patient care are implemented
Standard 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
Standard 5.2 Abstracting Timeliness	Each year, 90% of cases are abstracted within 6 months of the date of first contact.
Standard 5.3 Follow-up of All Patients	80% follow-up from reference date
Standard 5.4 Follow-up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
Standard 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
Standard 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
Standard 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

Veterans Affairs Cancer Program (VACP)	
The facility provides care to military veterans and offers the full range of diagnostic and treatment services, on site or by referral to CoC-accredited program(s). The members of the medical staff are board certified in the major medical specialties, including oncology, where applicable. Participation in cancer-related clinical research is required. Participation in the training of resident physicians is optional. There is no minimum caseload required for this category.	
Definition	Specification
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E9 Clinical Trial Information	A formal mechanism is used to inform patients about clinical trials.

E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
Standard 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Genetic professional/counselor, if these services are provided on site
Standard 1.3 Cancer Committee Attendance	2015 phase in Each required cancer committee member attends 75% of meetings annually; occasional attendance by an equivalent designee is acceptable.
Standard 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
Standard 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year.
Standard 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
Standard 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
Standard 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity report, and shares the report with the cancer committee each year.
Standard 1.9 Clinical Trial Screening	The cancer committee develops and implements a process to determine patient eligibility for clinical trials; the process is evaluated and assessed annually and documented in cancer committee minutes.
Standard 1.10 Clinical Trials Accrual	2015 phase in 2% of the number of annual analytic cases; 4% of the number of annual analytic cases for commendation
Standard 1.11 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the

	use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
Standard 1.12 Cancer Registrar Education	All registry staff participate in an annual educational activity.
Standard 2.1 Assessment of Treatment Planning	A member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
Standard 2.2 CAP Protocols	95% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
Standard 2.3 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
Standard 2.4 Risk Assessment and Genetic Testing	Risk assessment and genetic testing are provided either on site or by referral, by a qualified genetic professional.
Standard 2.5 Palliative Care Services	Palliative care services are provided either on site or by referral.
Standard 3.1 Patient Navigation	2015 phase in The cancer committee assesses barriers to care once during the survey cycle, provides navigation services either on site or by referral, and assesses and reports on the process annually.
Standard 3.2 Psychosocial Distress Screening	The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
Standard 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
Standard 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
Standard 4.2 Screening Program	VACP facilities follow the US Preventive

	Services Task Force recommendations for screening; screening services reach the veteran population through ongoing programs or clinics; the rating for this standard defaults to (1) Compliance. Patients with positive findings are followed.
Standard 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least quarterly.
Standard 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
Standard 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
Standard 4.6 Studies of Quality	1 study of cancer patient care quality and outcomes; 1 additional program-defined study or study of quality defined at the VISN or regional level
Standard 4.7 Quality Improvements	Each year, 2 improvements in patient care are implemented
Standard 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
Standard 5.2 Abstracting Timeliness	Each year, 90% of cases are abstracted within 6 months of the date of first contact.
Standard 5.3 Follow-up of All Patients	80% follow-up from reference date
Standard 5.4 Follow-up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
Standard 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
Standard 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
Standard 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

Comprehensive Community Cancer Program (COMP)	
The facility accesses more than 500 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 available. Participation in cancer-related clinical research is required. Participation in the training of resident physicians is optional.	
Definition	Specification
Residencies	Optional
Annual Caseload	More than 500
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E9 Clinical Trial Information	A formal mechanism is used to inform patients about clinical trials.

E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
Standard 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Pain control/palliative care physician or specialist Clinical research representative Genetic professional/counselor, if these services are provided on site
Standard 1.3 Cancer Committee Attendance	2015 phase in Each required cancer committee member attends 75% of meetings annually; occasional attendance by an equivalent designee is acceptable.
Standard 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
Standard 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year
Standard 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
Standard 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
Standard 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity report, and shares the report with the cancer committee each year.
Standard 1.9 Clinical Trial Screening	The cancer committee develops and implements a process to determine patient eligibility for clinical trials; the process is evaluated and assessed annually and documented in cancer committee minutes.
Standard 1.10 Clinical Trials Accrual	2015 phase in 4% of the number of annual analytic cases; 6% of the number of annual analytic cases for commendation

Standard 1.11 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
Standard 1.12 Cancer Registrar Education	All registry staff participate in an annual educational activity.
Standard 2.1 Assessment of Treatment Planning	A member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
Standard 2.2 CAP Protocols	95% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
Standard 2.3 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
Standard 2.4 Risk Assessment and Genetic Testing	Risk assessment and genetic testing are provided either on site or by referral by a qualified genetic professional.
Standard 2.5 Palliative Care Services	Palliative care services are provided either on site or by referral.
Standard 3.1 Patient Navigation	2015 phase in The cancer committee assesses barriers to care once during the survey cycle, provides navigation services either on site or by referral, and assesses and reports on the process annually.
Standard 3.2 Psychosocial Distress Screening	The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
Standard 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
Standard 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and

	reduce the incidence of a specified cancer type.
Standard 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
Standard 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least quarterly.
Standard 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
Standard 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
Standard 4.6 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
Standard 4.7 Quality Improvements	Each year, 2 improvements in patient care are implemented
Standard 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
Standard 5.2 Abstracting Timeliness	Each year, 90% of cases are abstracted within 6 months of the date of first contact.
Standard 5.3 Follow-up of All Patients	80% follow-up from reference date
Standard 5.4 Follow-up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
Standard 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data.
Standard 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
Standard 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

Community Cancer Program (CCP)	
The facility accedes more than 100 but fewer than 500 newly diagnosed cancer cases each year and provides a full range of diagnostic and treatment services, but referral for a portion of diagnosis or treatment may occur. The members of the medical staff are board certified in the major medical specialties. Facilities participate in cancer-related clinical research by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office. Participation in the training of resident physicians is optional.	
Definition	Specification
Residencies	Optional
Annual Caseload	101-499
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.

E9 Clinical Trial Information	A formal mechanism is used to inform patients about clinical trials.
E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
Standard 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Clinical research representative or coordinator Genetic professional/counselor, if these services are provided on site
Standard 1.3 Cancer Committee Attendance	2015 phase in Each required cancer committee member attends 75% of meetings annually; occasional attendance by an equivalent designee is acceptable.
Standard 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
Standard 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year.
Standard 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
Standard 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
Standard 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity report, and shares the report with the cancer committee each year.
Standard 1.9 Clinical Trial Screening	The cancer committee develops and implements a process to determine patient eligibility for clinical trials; the process is evaluated and assessed annually and documented in cancer committee minutes.
Standard 1.10 Clinical Trials Accrual	2015 phase in 2% of the number of annual analytic cases Note: Until 2015, new programs in this

	category are exempt from the accrual percentage at the initial survey; 4% of the number of annual analytic cases for commendation
Standard 1.11 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
Standard 1.12 Cancer Registrar Education	All registry staff participate in an annual educational activity.
Standard 2.1 Assessment of Treatment Planning	A member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
Standard 2.2 CAP Protocols	95% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
Standard 2.3 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
Standard 2.4 Risk Assessment and Genetic Testing	Risk assessment and genetic testing are provided either on site or by referral, by a qualified genetic professional.
Standard 2.5 Palliative Care Services	Palliative care services are provided either on site or by referral.
Standard 3.1 Patient Navigation	2015 phase in The cancer committee assesses barriers to care once during the survey cycle, provides navigation services on site or by referral, and assesses and reports on the process annually.
Standard 3.2 Psychosocial Distress Screening	The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
Standard 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is

	monitored, evaluated, and reported to the cancer committee each year.
Standard 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
Standard 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
Standard 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least quarterly.
Standard 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
Standard 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
Standard 4.6 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
Standard 4.7 Quality Improvements	Each year, 2 improvements in patient care are implemented
Standard 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
Standard 5.2 Abstracting Timeliness	Each year, 90% of cases are abstracted within 6 months of the date of first contact.
Standard 5.3 Follow-up of All Patients	80% follow-up from reference date
Standard 5.4 Follow-up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
Standard 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
Standard 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
Standard 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

Hospital Associate Cancer Program (HACP)	
The facility accessions 100 or fewer newly diagnosed cancer cases each year and has a limited range of diagnostic and treatment services available on site. Other services are available by referral. Clinical research is not required. Participation in the training of resident physicians is optional.	
Definition	Specification
Residencies	Optional
Annual Caseload	100 or fewer
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	**
E1 Facility Accreditation	
E2 Cancer Committee Authority	
E3 Cancer Conference Policy	
E4 Oncology Nurse Leadership	
E5 Cancer Registry Policy and Procedure	
E6 Diagnostic Imaging	
E7 Radiation Oncology Services	
E8 Systemic Services	
E9 Clinical Trial Information	
E10 Psychosocial Services	
E11 Rehabilitation Services	
Standards	
Standard 1.1 Physician Credentials	
Standard 1.2 Cancer Committee Membership	
Standard 1.3 Cancer Committee Attendance	
Standard 1.4 Cancer Committee Meetings	
Standard 1.5 Goals	
Standard 1.6 Cancer Registry Quality Control Plan	
Standard 1.7 Monitoring Cancer Conference Activity	
Standard 1.8 Monitoring Community Outreach	
Standard 1.9 Clinical Trial Screening	
Standard 1.10 Clinical Trials Accrual	
Standard 1.11 Annual Educational Activity	
Standard 1.12 Cancer Registrar Education	
Standard 2.1 Assessment of Treatment Planning	
Standard 2.2 CAP Protocols	

Standard 2.3 Nursing Care	
Standard 2.4 Risk Assessment and Genetic Testing	
Standard 2.5 Palliative Care Services	
Standard 3.1 Patient Navigation	
Standard 3.2 Psychosocial Distress Screening	
Standard 3.3 Survivorship Care Plan	
Standard 4.1 Prevention Program	
Standard 4.2 Screening Program	
Standard 4.3 CLP Responsibilities	
Standard 4.4 Accountability Measures	
Standard 4.5 Quality Improvement Measures	
Standard 4.6 Studies of Quality	
Standard 4.7 Quality Improvements	
Standard 5.1 Cancer Registrar Credentials	
Standard 5.2 Abstracting Timeliness	
Standard 5.3 Follow-up of All Patients	
Standard 5.4 Follow-up of Recent Patients	
Standard 5.5 Data Submission	
Standard 5.6 Accuracy of Data	
Standard 5.7 Commission on Cancer Special Studies	

**** The specific criteria for this category have not yet been finalized.**

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, or the pediatric oncology program is a component within a larger CoC-accredited facility. The facility or pediatric oncology program 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 cancer-related clinical research focused on pediatric patients. There is no minimum caseload requirement for this category.	
Definition	Specification
Residencies	If associated with a medical school, pediatric medicine and pediatric surgery and any 2 of the following: pediatric diagnostic radiology pediatric pathology pediatric radiation oncology or a pediatric oncologic fellowship
Annual Caseload	None
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that

	contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E9 Clinical Trial Information	A formal mechanism is used to inform patients about clinical trials.
E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
Standard 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary. Category-specific members are: Children's Oncology Group data manager Child life specialist Genetic professional/counselor, if these services are provided on site
Standard 1.3 Cancer Committee Attendance	2015 phase in Each required cancer committee member attends 75% of meetings annually; occasional attendance by an equivalent designee is acceptable.
Standard 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
Standard 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year.
Standard 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
Standard 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
Standard 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity report, and shares the report with the cancer committee each year.
Standard 1.9 Clinical Trial Screening	The cancer committee develops and

	implements a process to determine patient eligibility for clinical trials; the process is evaluated and assessed annually and documented in cancer committee minutes.
Standard 1.10 Clinical Trials Accrual	2015 phase in 30% of the number of annual analytic cases; 40% of the number of annual analytic cases for commendation
Standard 1.11 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
Standard 1.12 Cancer Registrar Education	All registry staff participate in an annual educational activity.
Standard 2.1 Assessment of Treatment Planning	A member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
Standard 2.2 CAP Protocols	95% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
Standard 2.3 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
Standard 2.4 Risk Assessment and Genetic Testing	Risk assessment and genetic testing are provided either on site or by referral, by a qualified genetic professional.
Standard 2.5 Palliative Care Services	Palliative care services are provided either on site or by referral.
Standard 3.1 Patient Navigation	2015 phase in The cancer committee assesses barriers to care once during the survey cycle, provides navigation services either on site or by referral, and assesses and reports on the process annually.
Standard 3.2 Psychosocial Distress Screening	The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
Standard 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and

	implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
Standard 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.
Standard 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
Standard 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least quarterly.
Standard 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
Standard 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
Standard 4.6 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
Standard 4.7 Quality Improvements	Each year, 2 improvements in patient care are implemented.
Standard 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
Standard 5.2 Abstracting Timeliness	Each year, 90% of cases are abstracted within 6 months of the date of first contact.
Standard 5.3 Follow-up of All Patients	80% follow-up from reference date for patients 26 years and younger
Standard 5.4 Follow-up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years for patients 26 years and younger
Standard 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
Standard 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
Standard 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

Freestanding Cancer Center Program (FCCP)	
The facility is a non-hospital-based program and offers at least 1 cancer-related treatment modality. The full range of diagnostic and treatment services are available by referral. Referral to CoC-accredited program(s) is preferred. Participation in cancer-related clinical research is encouraged but not required. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.	
Definition	Specification
Residencies	Optional
Annual Caseload	None
Eligibility Requirements	Specification
Cancer committee responsibilities for eligibility requirements	Annual monitoring, assessing, and identifying changes that are needed in each of the eligibility requirements
E1 Facility Accreditation	The facility is accredited by a recognized federal, state, or local authority.
E2 Cancer Committee Authority	Bylaws or policy and procedure define the cancer committee's authority and responsibility for the program.
E3 Cancer Conference Policy	Policy establishes the cancer conference program and addresses the frequency, format, multidisciplinary attendance, attendance rate, prospective case presentations, discussion of stage and treatment planning, and clinical trial options.
E4 Oncology Nurse Leadership	A nurse provides leadership within the program.
E5 Cancer Registry Policy and Procedure	The policy and procedure address the use of CoC data elements and codes along with all other cancer registry activities.
E6 Diagnostic Imaging	Services are provided either on site or by referral.
E7 Radiation Oncology Services	Radiation treatment services follow standard quality assurance practices and are available either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E8 Systemic Services	Policies and procedures are in place to guide the safe administration of systemic therapy provided either on site, and/or at locations that are facility owned, or at locations that contract with the facility.
E9 Clinical Trial Information	A formal mechanism is used to inform patients about clinical trials.

E10 Psychosocial Services	A mechanism is in place to ensure patient access to psychosocial services either on site or by referral.
E11 Rehabilitation Services	Rehabilitative services are provided either on site or by referral.
Standards	Specification
Standard 1.1 Physician Credentials	Physicians are currently board certified or in the process of certification.
Standard 1.2 Cancer Committee Membership	The cancer committee is multidisciplinary; Category-specific members are: For freestanding cancer centers providing radiation oncology, a dosimetrist or radiation physicist
Standard 1.3 Cancer Committee Attendance	2015 phase in Each required cancer committee member attends 75% of meetings annually; occasional attendance by an equivalent designee is acceptable.
Standard 1.4 Cancer Committee Meetings	The cancer committee meets at least once each calendar quarter.
Standard 1.5 Goals	The cancer committee sets at least 1 programmatic and 1 clinical goal each year.
Standard 1.6 Cancer Registry Quality Control Plan	The cancer committee establishes and implements a registry quality control plan each year. The plan addresses all required criteria.
Standard 1.7 Monitoring Cancer Conference Activity	The cancer conference coordinator monitors the cancer conference program annually and reports conference activity to the cancer committee each year.
Standard 1.8 Monitoring Community Outreach	The community outreach coordinator monitors the community outreach program annually, prepares the community outreach activity report, and shares the report with the cancer committee each year.
Standard 1.9 Clinical Trial Screening	The cancer committee develops and implements a process to determine patient eligibility for clinical trials; the process is evaluated and assessed annually and documented in cancer committee minutes.
Standard 1.10 Clinical Trials Accrual	2015 phase in 2% of the number of annual analytic cases; 4% of the number of annual analytic cases for commendation
Standard 1.11 Annual Educational Activity	Each year, 1 educational activity is offered to physicians, nurses, and allied health

	professionals; the activity focuses on the use of stage, prognostic factors, and evidence-based treatment guidelines in treatment planning.
Standard 1.12 Cancer Registrar Education	All registry staff participate in an annual educational activity.
Standard 2.1 Assessment of Treatment Planning	A member of the cancer committee performs a study to assess the use of staging, site-specific prognostic indicators, and nationally recognized treatment guidelines in the formulation of the first course of treatment for patients newly diagnosed with cancer each year.
Standard 2.2 CAP Protocols	95% of eligible pathology reports include the required data items as specified in the site-specific CAP protocols.
Standard 2.3 Nursing Care	Care is provided by nurses with specialized knowledge and skills; competency is evaluated annually.
Standard 2.4 Risk Assessment and Genetic Testing	Risk assessment and genetic testing are provided either on site or by referral, by a qualified genetic professional.
Standard 2.5 Palliative Care Services	Palliative care services are provided either on site or by referral.
Standard 3.1 Patient Navigation	2015 phase in The cancer committee assesses barriers to care once during the survey cycle, provides navigation services either on site or by referral, and assesses and reports on the process annually.
Standard 3.2 Psychosocial Distress Screening	The cancer committee develops and implements a process to assess and address the psychosocial distress of patients with cancer.
Standard 3.3 Survivorship Care Plan	2015 phase in The cancer committee develops and implements a process to provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment; the process is monitored, evaluated, and reported to the cancer committee each year.
Standard 4.1 Prevention Program	Each year, 1 prevention program is offered to address the needs of the community and reduce the incidence of a specified cancer type.

Standard 4.2 Screening Program	Each year, 1 screening program is offered to decrease the number of patients with late-stage disease. Patients with positive findings are followed.
Standard 4.3 CLP Responsibilities	The CLP uses NCDB data to evaluate and interpret program performance; program performance is reported to the cancer committee at least quarterly.
Standard 4.4 Accountability Measures	Each year, performance levels defined by the CoC are met for each accountability measure.
Standard 4.5 Quality Improvement Measures	Each year, performance levels defined by the CoC are met for each QI measure.
Standard 4.6 Studies of Quality	Each year, 2 studies of cancer patient care quality and outcomes are conducted.
Standard 4.7 Quality Improvements	Each year, 2 improvements in patient care are implemented.
Standard 5.1 Cancer Registrar Credentials	Case abstracting is performed by a CTR.
Standard 5.2 Abstracting Timeliness	Each year, 90% of cases are abstracted within 6 months of the date of first contact.
Standard 5.3 Follow-up of All Patients	80% follow-up from reference date
Standard 5.4 Follow-up of Recent Patients	90% follow-up rate for patients diagnosed in the last 5 years
Standard 5.5 Data Submission	Complete data for all cases submitted each year as specified in the Call for Data
Standard 5.6 Accuracy of Data	Each year, the cases submitted meet the quality criteria specified in the Call for Data; cases with errors or rejected cases are corrected and resubmitted by the deadline specified in the Call for Data.
Standard 5.7 Commission on Cancer Special Studies	The program participates as specified by the CoC.

Glossary of Terms

Annually: Activity performed every year.

CoC Cancer Programs Staff: Commission on Cancer staff.

Evaluate: To examine and judge carefully.

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

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

NCDB tools:

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

Patient population: Patients being served by the cancer program

Quarterly: Occurring at 3-month intervals during a calendar year.

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