



New!

Deficiency Resolution Process and Documentation Requirements 2012

If deficiencies in any of the standards are detected during the survey process, programs are given one year to take corrective action to resolve these issues. When documentation of corrective action has been received, and the technical staff confirms compliance (the deficiency is resolved), the contingency is lifted and the program is awarded an updated accreditation status. If the contingency status remains unresolved after one year, the Program Review Subcommittee (PRS) will review and determine the next step in the accreditation process.

The required corrective action and documentation for each standard is listed below; included is the standard number and the requirement for successful resolution. **Upload a cover letter signed by your chairman or administrator** (that includes your facility name and ID number (facility identification number)) and supporting documentation to resolve **ALL** deficiencies at one time. (Cover letter is to be addressed to Vicki Chiappetta.) The time frame for the Commission on Cancer (CoC) staff to process deficiency resolution requests is approximately 30 days.

Upload Process: A deficiency resolution link will appear on the CoC Datalinks activity menu after the survey has been reviewed. From the deficiency resolution screen, click on the “Year” the document represents and click on “Standards” to select the cover letter or a specific standard. If the document does not fall into either of these categories, select “Other” at the bottom of the drop-down box. Click in the “Browse” field and select the document to upload from your files. Then click on “Submit.” Once all documents have been uploaded, click on the “[Send to CoC](#)” button located at the bottom of the screen. All programs are required to upload documents as part of the deficiency resolution process. Hard copies or e-mailed documents will not be accepted.

**The deficiency resolution link will be disabled once the uploaded documentation has been processed by the CoC.

Following resolution of the deficiency(ies), an automated e-mail notification will be sent to the cancer program’s contact staff (chair, liaison, administrator, and registrar) informing them of the updated performance report. The updated performance report will be accessible via the CoC Datalinks activity menu.

HIPAA and Protected Health Information: In concordance with HIPAA guidelines, the Commission on Cancer cannot accept documentation that includes patient identifying information (protected health information [PHI]). Receipt of PHI violates the Business Associate Agreement between the American College of Surgeons and the CoC-accredited cancer program.

This applies to documentation submitted for survey, appeals, and/or deficiency resolutions. Documents that may include PHI, but are not limited to: accession lists, suspense reports, pathology reports, collected data for studies. Special care should be taken to ensure that all PHI is removed before documentation is uploaded to the SAR.

In compliance with the American College of Surgeons HIPAA Privacy and Security Policy, appropriate supervisory and managerial staff of the American College of Surgeons will be notified when documentation that includes PHI has been received. The American College of Surgeons Privacy Official will make a determination about a notification to the CoC-accredited cancer program and disposition of the documentation that includes PHI.

Programs will be required to remove or block the patient information and resubmit the documentation as soon as possible after receiving notification from the American College of Surgeons Privacy Official.

2012 Commendation Standards: 2.11, 3.3, 3.7, 4.6, 5.2, 6.2, 7.2, and 8.2

Commendation Criteria for 2012 OAA: 2.11, 3.3, 3.7, 4.6, 5.2, 6.2, and 8.2

NOTE: Thirty days after receiving your *initial* performance report (appeal time period), the report is *final*. There will be no requests for changes to commendation standards accepted after that time period.

IMPORTANT: RESOLUTION DOCUMENTS ARE TO REPRESENT YEAR OF SURVEY AND FORWARD. DO NOT SEND RESOLUTION DOCUMENTATION FROM THE YEARS REVIEWED DURING SURVEY as the CoC wants to see your plan of correction implemented and progress forward through documents of compliance.

****Highlight ALL resolution areas in the minutes.**

Chapter 2: Cancer Committee Leadership

- 2.1** Bylaws, policies and procedures, or other facility-approved methods used to document the level of responsibility and accountability designated to the cancer committee.
- 2.2** Documentation showing the membership of the cancer committee for the **current year**, or other appropriate leadership body, is multidisciplinary, representing required physicians from the diagnostic and treatment specialties and required nonphysicians from administrative and supportive services, as specified by category. (Ex: cancer committee minutes)
Cancer committee membership is to follow 2012 standard requirements, based on your category.
- 2.3** Cancer committee minutes, or other facility-approved sources, identifying the designated coordinators for the **current year** and their assigned areas of

responsibility, as specified by category, following 2012 standards. (Coordinators are to be different committee members.)

- 2.4** Cancer committee minutes documenting the required frequency of cancer committee meetings for the **last complete calendar year or last consecutive 12 months to present.**

Meets quarterly in a calendar year (January–March, April–June, July–September, October–December)

- 2.5** Cancer committee minutes or other facility-approved sources documenting that annual goals for the required goal types (clinical and programmatic) for the current year were set, monitored, and evaluated twice within one year.

- 2.6** Develop and submit cancer conference policy that addresses all areas outlined in E3.

- 2.7** Develop and submit cancer conference policy that addresses all areas outlined in E3.

- 2.8** Develop and submit cancer conference policy that addresses all areas outlined in E3.

- 2.9** Cancer committee minutes or other facility-approved documentation showing the monitoring of the following:

- cancer conference frequency
- multidisciplinary attendance
- total case presentation
- prospective case presentation
- discussion of stage, including prognostic indicators, and treatment planning using evidence-based treatment guidelines
- options for clinical trials
- adherence to conference policy

- 2.10** Quality Control Plan and cancer committee minutes or other facility-approved documentation, showing the following:

- results of quality control (QC) activities of the cancer registry data for current year
- reporting of activities to include the seven (7) measures of the QC Plan
- documentation of corrective action taken for areas that fall below the measures identified in QC Plan.

- 2.11** This standard no longer exists in the 2012 Standards. Deficiency will be considered resolved.

Note new standard: **Public Reporting of Outcomes (S1.12)**; Each year, the cancer committee develops and disseminates a report of patient or program

outcomes to the public. This is a commendation only standard.

Chapter 3: Cancer Data Management and Cancer Registry Operations

3.1 Verification of current credentialing from the National Cancer Registrars Association (NCRA) for all certified tumor registrar (CTR) staff at the facility.

Verification that abstracting is performed or supervised by a CTR either through contracted data collection or the use of a registry service agency, company, or independent contractor. (job description, NCRA credentials certificate, NCRA CE Hour document, etc.)

Plan for CTR supervision of non-credentialed staff that performs case abstracting in the cancer registry

Verification of the date of hire in the cancer registry for non-credentialed staff that perform case abstracting.

Educational and training activities for staff that are not credentialed.

Note: The CoC does not establish a staffing guideline. The CoC supports the information in the textbook *Cancer Registry Management: Principles*, First Edition, 1997 and the article, *NCRA Workload and Staffing Study: Guidelines for Hospital Cancer Registry Programs* published in 2011.

3.2 Cancer registry policy and procedure or registry software documentation requiring the use of current CoC data standards. (FORDS, CS, AJCC staging, etc.)

3.3 Current abstracting status information that includes

- Cancer registry software report for cases abstracted the **last three completed and consecutive months**. This report is to include the accession number, date of first contact with facility, and the date abstracted. The report is also to include the calculation of time to completion for each case (number of days and/or months). **Do NOT send reports with patient identifying information.**
- Registry Suspense Report from the last complete year and the current year (2011 and 2012). If there are no cases on the suspense list, print out the page that documents there are zero cases. **Do NOT send reports with patient identifying information.**
- The most recent cancer committee minutes documenting cases that are currently being abstracted within six months of the date of first contact (month and year). Abstracting status is to be reported by month and year (not days).
- Later in 2012, the CoC will be providing vendors with report specs in relation to this standard to help assist cancer registrars provide the correct reports.

Note: If you currently have or receive a deficiency for Standard 3.3, your cancer program is required to resolve the deficiency even though the 2010 and first quarter of 2011 abstracting time frame has been rescinded.

- 3.4 Follow-up report status
- a recent copy of the registry software report
 - **current** cancer committee minutes documenting the overall follow-up to be within the required 80 percent rate

- 3.5 Follow-up report status
- a recent copy of the registry software report
 - **current** cancer committee minutes documenting the follow-up for analytic cases diagnosed within the last five years to be within the required 90 percent rate

Note: To resolve deficiency for Stds 3.6 and/or 3.7, you will need to contact Vicki Chiappetta at vchiappetta@facs.org to schedule a special date for resolution submission.

Web link to NCDB Submission Dates and Deadlines:

<http://www.facs.org/cancer/ncdb/schedule-NCDB-data-submission.pdf>

- 3.6 E-mail notifications the facility received from the NCDB stating the appropriate data (years from the annual Call for Data not submitted by due date) was submitted and received.

If all years were submitted, but were past the due date, submit a copy of the e-mail notification for the **latest** Call for Data from the NCDB (year of survey or after) showing it was submitted by the required due date. Data submission will be confirmed by the CoC.

- 3.7 E-mail the notification the facility received from the NCDB stating the resubmitted corrected data was received for the year(s) in question and the submission was **error free – for years 2003 and forward**. (This information is included at the end of the e-mail.)

If the corrected data was resubmitted after the due date, provide a copy of the e-mail from the NCDB that shows the next Call for Data was **submitted on time (with no errors) OR** that errors were corrected and resubmitted to the NCDB by the **due date**. Data quality will be confirmed by the CoC.

- 3.8 Please contact the CoC regarding the resolution of this standard. If you are not asked to participate in the next study or there is no special study the next year, the deficiency will be considered resolved.

Chapter 4: Clinical Management

4.1 Documentation of the radiation oncology services available either on-site or by referral. (Referral policy and procedure or minutes)

4.2 Documentation showing an inpatient medical oncology unit or a functional equivalent exists, as appropriate to the category. (Admitting or referral policy and procedure that includes oncology patients.)

4.3 Results of a study evaluating the use of national guidelines and other criteria to plan treatment.

Committee minutes documenting presentation of results to cancer committee.

4.4 Cancer committee minutes documenting that annual competency evaluations of oncology skills for oncology nurses were performed for the **last complete year** (year of survey or after).

4.5 Deficient, but resolved. Program will provide nurse leader as part of eligibility requirement 4 (E4).

4.6 Cancer committee minutes documenting post-survey review results of pathology reports for compliance to the College of American Pathologists (CAP)

4.7 Policy and procedure documenting the evaluation of the rehabilitation services that are available on-site or by referral.

Chapter 5: Research

5.1 Develop and submit policy or procedure that addresses clinical trial information outlined in E9.

5.2 Documentation of the appropriate number of patients accrued to cancer-related clinical trials during the **last complete calendar year** (year of survey or after) that include year, trial name or group, and number of cases accrued.

NCP (ICP)	6%
THCP (ACAD)	4%
COMP (CCCP)	2%
VACP	2%
PCP	2%

Chapter 6: Community Outreach

6.1 Deficient, but resolved.

- 6.2 Deficient, but resolved.
- 6.3 Cancer committee minutes or other facility-approved sources that document the monitoring and evaluation of the community outreach activities from the **last complete year** (year of survey or after).

Community outreach activities summary.

Chapter 7: Professional Education and Staff Support

- 7.1 Documentation of **one** annual educational activity, OTHER THAN CANCER CONFERENCES, provided to physicians, nursing, AND allied health staff for the **last complete year (survey year) or current year**. Documentation is to include the date, agenda, objectives, announcement/posting, and attendance sheet.
- Cancer-related educational activity
 - Educational activity documenting the use of AJCC stage, site specific prognostic indicators, and national treatment guidelines
- 7.2 Documentation of annual education activity for **each** member of the cancer registry staff (CTR, non-CTR, follow-up clerk, management or supervisory personnel, and contract staff: full and part-time), including the agenda and attendance sheet, certificate, or confirmed registration form, from the **last complete year (year of survey) or current year**.

Chapter 8: Quality Improvement

- 8.1 Completed quality studies
- The two (three for networks and NCI) studies of quality **completed** during the **current year**
 - Cancer committee minutes document the QI coordinator's involvement to analyze the results and make recommendations for improvement.

Study criteria that should be documented in the minutes include the following:

- setting the study topic that identifies problematic quality-related issues
- defining criteria for evaluation
- conducting the QI study according to the identified measures
- preparing a summary of the findings
- comparing data results with national benchmarks
- designing and initiating action plans based on the evaluation of the data
- establishing follow-up steps to monitor the actions implemented
- monitoring the effectiveness of the study action plans and all cancer-related QI activities at the program

8.2 Cancer committee minutes from the current year documenting the QI coordinator's involvement in the improvement, recommendation, and implementation process for two quality improvements per year.

- One improvement is to be based on results of a completed study
- Second improvement is to be based on any source.

Note: Do not send a list of goals. These are to be activities that have been implemented.

1/18/2012