

## Frequently Asked Questions

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

Q: When does this standard take effect?

A: The standard is effective on January 1, 2009. The changes to standard 4.3 introduced in December 2007 directed the cancer committees in CoC-approved Cancer Programs to begin developing a process to evaluate the physician's use of staging in treatment planning. With this advance notice of the change to the standard, the cancer committee will be able to implement the process developed this year by January 1, 2009.

Q: Can we implement this process now and use it for cases diagnosed during 2008?

A: Yes. This decision can be made by the facility's cancer committee.

Q: Do we still need a staging form?

A: The cancer committee will determine the acceptable locations for the physician recording of clinical stage. These could include, but are not limited to, the physicians office records or in the operative note in the facility's medical record. The choice to use a staging form to record stage in the facility's medical record would be made by the cancer committee. This is not required by the new standard.

Q: What is the required completion rate for clinical staging by the physician?

A: The CoC has not set a completion rate for clinical staging by the physician in the new standard. The cancer committee should set the completion rate for clinical staging by the physician which will help facilitate the evaluation of the physician's use of staging in treatment planning.

Q: Are all of the elements and stage group to be recorded by the physician?

A: Complete stage (elements T, N, M and group) is preferred, however, this is not required by the new standard. The cancer committee should address this issue in the policy they develop.

Complete clinical stage is to be recorded in the cancer registry abstract. If the physician has recorded only the clinical elements or clinical group stage, then the cancer registrar should determine the rest of the staging from information recorded in the medical record and record this in the cancer registry abstract. The changes made to the AJCC staging field required by the Facility Oncology Registry Data Standards (FORDS) manual allow this.

Q: If we continue the previous physician staging practice, does this meet the requirements

for the new standard?

A: No. The physician's recording of stage in the medical record alone does not meet the requirement for the new standard 4.3. This is the first step in the cancer committee's process. The physician's clinical stage recorded in the medical record is the information that will be used by the cancer committee to evaluate the treatment choices made for the patient. When this evaluation is performed, then the new standard 4.3 is met.

Q: If clinical stage and treatment choices are recorded for the patients discussed prospectively at cancer conferences, will this meet the requirements for the new standard 4.3?

A: No. This meets the requirements for the new standard 2.8, but, recording the clinical stage and planned treatment of patients discussed at conferences alone does not meet the requirement for the new standard 4.3. First, most programs present 10% of the annual analytic caseload at cancer conferences. This percentage is too low to adequately evaluate the use of stage in treatment planning for all patients. Second, to meet requirements for standard 4.3 the cancer committee needs to evaluate the treatment choices made for the patient. The stage and treatment choices of patients presented at conferences is the first step in the cancer committee's process. The cancer committee can use this information to evaluate the physician's use of stage in treatment planning. When this evaluation is performed, then the new standard 4.3 is met.

Q: Does the cancer committee need to evaluate the stage and treatment choices for all analytic cases each year?

A: Minimally, the evaluation is to include the cases of the major sites of cancer seen at the facility each. The cancer committee can choose to add other sites based on the annual analytic caseload and the availability of nationally-recognized treatment guidelines for the other sites.

During the first year the process is implemented the committee may want to choose 1 or 2 of the major sites and 1 or 2 stages of disease within those sites to test the evaluation methodology that has been designed.

Q: What is the best method to evaluate the physician use of stage in treatment planning?

A: There is no "best" method that will work in every CoC-approved Cancer Program. The cancer committee will need to identify the method that will work the best for their physicians and facility.

The cancer committee should use the Cancer Program Practice Profile Reports (CP<sup>3</sup>R) tools to compare stage and the treatment provided. The CoC is obtaining descriptions of how programs are addressing this requirement through information gathered in the Survey Application Record (SAR) Annual Update. The best suggestions will be posted in the Best Practice Repository at <http://www.facs.org/cancer/coc/bestpractices.html>.

Q: How will this standard be evaluated during surveys performed in 2009?

A: Staging activity required by the previous standard 4.3 will not be evaluated during surveys performed in 2009 and forward. The surveyor will not review abstracts and

medical records to confirm that stage is present in the medical record.

Instead, the surveyor will discuss with the cancer committee the methods implemented to document physician use of stage, site specific prognostic indicators, and evidence-based national treatment guidelines in treatment planning.

For surveys scheduled in the first half of 2009, the surveyor will confirm with the cancer committee the implementation of the method to evaluate physician use of stage in treatment planning, the schedule for the completion of the performance monitoring, and the date that the results will be reported to the cancer committee. For surveys scheduled in the second half of 2009, the surveyor will discuss with the cancer committee the results of the performance monitoring and confirm that this has been reported to the cancer committee through the review of cancer committee minutes.

Q: How can a program receive a Commendation rating for standard 4.3 if charts are not reviewed during the survey?

A: The Commendation rating has been eliminated from the new standard 4.3. Beginning with surveys performed in 2009, no Commendation rating will be given for standard 4.3 and standard 4.3 will no longer be part of the Outstanding Achievement Award (OAA) criteria.

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