# Standard Deficiency Resolutions: Required Documentation

**NOTE:** *For all deficiency resolutions, cancer programs are **not** to go back to amend or change any documentation or minutes from the previous years. Rather, resolution of current deficiencies requires demonstrating compliance in the survey year forward.*

**STEPS FOR SUBMITTING DOCUMENTATION:**

1) Performance Report(s) are located on the main activity menu of *CoC Datalinks*. The most recent Performance Report with the "3-Year with Contingency" accreditation status lists your deficiency resolution **due date** for the standards that must be resolved. Deficiency resolution materials **must be submitted electronically** through the "Deficiency Resolution" section **by the due date**. If documentation is not submitted prior to the due date, the program is at risk for having its Commission on Cancer accreditation status discontinued.

2) Within the "Deficiency Resolution" section of the Survey Application Record (located in the SAR drop-down menu in the top left hand corner), complete the comment fields in the "Deficiency Resolution" table and upload resolution documentation for the applicable standards. *A comment for each deficient standard must be entered for the uploaded documentation to be saved.

**Important Reminders:**

- Wait to submit all materials at one time when **all** deficient standards are resolved.
- Please allow 30 calendar days for review of the submitted documentation by the CoC staff.
- Once all standards are resolved, the cancer program will receive notification of the full accreditation status with information for your award certificate and marketing resources.

**Follow this document to resolve any deficient standard from 2016 going forward.**

| Standard | Required Documents for Resolution |
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| **CHAPTER 1: Program Management** | |

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| 1.1 – Physician Credentials | 1) Bylaws statement, roster, and/or<br>2) If required, documentation of 12 hours of **cancer-related** CME for physicians who are not board certified or those that are in the process of being board certified.<br>Reminder: This standard applies to **all** physicians who evaluate and/or treat cancer patients at the accredited program, not just those on the cancer committee. |
| 1.2 – Cancer Committee Membership | Cancer committee minutes documenting the appointment of required physicians, non-physicians, coordinators, and designated alternates (if applicable) for the most recent calendar year. |
| 1.3 – Cancer Committee Attendance | Cancer committee minutes (including attendance grid, sign-in sheet) for one complete calendar year demonstrating all required members and appropriate designated alternates attended at least 75% of the total meetings. |
| 1.4 – Cancer Committee Meetings | Cancer committee minutes for one complete calendar year demonstrating quarterly meetings took place. |
| 1.5 – Cancer Program Goals | Cancer committee minutes that clearly document the establishment and review of one clinical goal and one programmatic goal. Minutes from a minimum of three cancer committee meetings from the same calendar year must be submitted.<br>Reminder: At a minimum, goal progress must be monitored and evaluated at two subsequent meetings within the calendar year. |
| 1.6 – Cancer Registry Quality Control Plan | 1) Quality control plan including all required elements per the standard, **and**<br>2) Cancer committee minutes documenting that the results (outcomes) of the annual quality control evaluation (10% physician review) were presented and reviewed by the cancer committee.<br>Reminder: Minutes submitted must be from the same calendar year the QC review took place. |
| 1.7 – Monitoring Cancer Conference Activity | 1) The annual documentation by the Cancer Conference Coordinator that demonstrate the monitoring of the **seven** standard requirements documented under Eligibility Requirement (ER) 3,<br>2) Any corrective action taken for an area that falls below the annual goal and any quality improvement activities that may have resulted from this evaluation as defined by the cancer conference policy, **and**<br>3) Cancer committee minutes from the same calendar year as the conference activity documenting that the results of the annual report were presented and reviewed by the cancer committee. |
| 1.8 – Monitoring of Prevention, Screening, and Outreach Activities | 1) The Community Outreach Coordinator's annual community outreach activity summary that documents the methods used to monitor and evaluate the effectiveness of the prevention and screening activities (Standards 4.1 and 4.2), and<br>2) Cancer committee minutes documenting the review of the annual community outreach summary from the same calendar year as the activities. |
| 1.9 – Clinical Research Accrual | Cancer committee minutes documenting the Clinical Research Coordinator's report of the annual accruals to cancer-related clinical research studies that meet the current percentage requirement for the current cancer program category. |
| 1.10 - Clinical Education Activity | 1) A published flyer/agenda, list of objectives, and/or slides of the content presented for one annual cancer-related educational activity, other than cancer conferences, that demonstrates:<br>• Discussion of AJCC staging in clinical practice<br>• Appropriate prognostic indicators were presented<br>• Discussion of evidence-based national guidelines used in treatment planning<br>2) Evidence that the activity was directed to physicians, nurses, and allied health professionals. |

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| 1.11 – Cancer Registry Education | Documentation confirming education for each registry staff member (CTR and non-CTR).<br>Documentation may include confirmed registration and agenda, CE certificate, or CE summary form. |
| 1.12 – Public Reporting of Outcomes | Commendation only standard. No deficiency resolution. |
| **CHAPTER 2: Clinical Services** | |
| 2.1 – CAP Protocols and Synoptic Reporting | 1) At a minimum, a random sample of 10% or a maximum of 300 pathology reports eligible for the CAP protocols are reviewed each calendar year documenting 95% of eligible pathology reports include all required data elements per CAP protocols **and** 95% of eligible pathology reports are in synoptic format, **and**<br>2) Cancer committee minutes that include the outcomes of the review.<br>If the internal review does not meet the required percentage as listed in the standard, a corrective action plan must be developed, implemented, and documented in the minutes to ensure that at least 95% of cancer pathology reports include all required data elements per the CAP protocols and 95% of reports are in synoptic format. |
| 2.2 – Oncology Nursing Care | 1) Current oncology nursing competency policies or procedures, and<br>2) Cancer committee minutes that document the committee's review and **outcomes** of the annual oncology nursing education and **competency evaluation**. |
| 2.3 – Genetic Counseling & Risk Assessment | 1) Policies and procedures for providing cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral,<br>2) Cancer committee minutes that document the annual monitoring and evaluation of genetics services and referrals, **and**<br>3) Cancer committee minutes or other documentation that include name, credentials, and qualifications of person(s) providing testing and/or counseling and whether onsite or by referral. |
| 2.4 – Palliative Care Services | 1) Policies and procedures for providing palliative care services on-site or by referral that include definition of services, description of referral process or program, **and**<br>2) Cancer committee minutes that document the annual monitoring and evaluation of the process for referring or providing palliative care services to patients. |
| **CHAPTER 3: Continuum of Care Services** | |
| 3.1 – Patient Navigation Process | 1) A copy of the current triennial Community Needs Assessment, **and**<br>2) Cancer committee minutes that document<br>A. the identification and assessment of identified barriers to care with resources to address barriers **and**<br>B. the annual evaluation of the navigation process |
| 3.2 – Psychosocial Distress Screening | 1) The psychosocial distress screening policies and procedures that include all standard process requirements, **and**<br>2) Cancer committee minutes that document the annual evaluation of the psychosocial distress screening process **and** the Psychosocial Services Coordinator's annual psychosocial services summary. |
| 3.3 – Survivorship Care Plan | 1) Policies and procedures to generate and disseminate a comprehensive treatment summary and survivorship care plan to eligible cancer patients who have completed cancer treatment, **and**<br>2) A sample of a treatment summary and survivorship care plan that is used by the cancer program, **and**<br>3) Cancer committee minutes that document<br>a) the annual evaluation of the SCP process |

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| | b) the outcomes of the evaluation demonstrating **50%** of eligible cases compliance, including the number of eligible patients **and** the completed SCPs delivered<br>c) **and** a written action plan if the required delivery of completed SCPs is not met. Action Plan is to set in motion a plan to be in compliance with the standard within one calendar year. |
| **CHAPTER 4: Patient Outcomes** | |
| 4.1 – Cancer Prevention Programs | Cancer committee minutes documenting the planning and provision of at least one cancer prevention activity or event organized by the cancer committee based on the identified prevention needs of its community. Minutes must document the:<br>a) identification of the prevention needs of the community (from database, CNA, etc.)<br>b) the national guideline used<br>c) discussion of the activity after it took place |
| 4.2 – Cancer Screening Programs | Cancer committee minutes documenting the planning and provision of at least one cancer screening activity organized and offered by the cancer committee based on the identified screening needs of its community. The documentation includes:<br>a) references to the national guidelines<br>b) stated community need<br>c) interventions used<br>d) the process in place to follow up on positive findings<br>e) **and** discussion of the activity after it took place, including analysis of effectiveness of the screening program |
| 4.3 – Cancer Liaison Physician Responsibilities | 1) Cancer committee minutes that document at least **four** CLP reports on NCDB data, including actions and response, from four separate meetings within a calendar year, **and**<br>2) Copy of each CLP report, which includes which tool was used, presented to the cancer committee. |
| 4.4 – Accountability Measures | 1) Cancer committee minutes that demonstrate the monitoring of the quality of patient care by the cancer committee using the $CP^3R$ accountability measures, **and**<br>2) If required, the action plan that was developed and executed if the program's performance rates were below the expected EPRs established by the CoC. |
| 4.5 – Quality Improvement Measures | 1) Cancer committee minutes that demonstrate the monitoring of the quality of patient care by the cancer committee using the $CP^3R$ quality improvement measures, **and**<br>2) If required, the action plan that was developed and executed if the program's performance rates were below the expected EPRs established by the CoC. |
| 4.6 – Monitoring Compliance with Evidence-Based Guidelines | 1) Documentation of the in-depth analysis by a physician, including the methodology, summaries, analysis, national treatment guideline, recommendations, and follow-up, **and**<br>2) Cancer committee minutes documenting that the evaluation's results were reported and discussed. |
| 4.7 – Studies of Quality | 1) Documentation for the required number of quality studies (based on category), including the problem statement, methodology, summaries, analysis, national benchmark, recommendations, and follow-up, **and**<br>2) Cancer committee minutes documenting that the study's results were reported and discussed.<br>Reminder: This standard is about identifying a problematic quality-related issue and conducting a study to understand |

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| | what is causing the program (i.e. a root cause analysis). |
| 4.8 – Quality Improvements | 1) Documentation demonstrating the implementation of two quality improvements, one of which is based on a compliant Standard 4.7 study, **and**<br>2) Cancer committee minutes in which the results of the improvements were reported. |
| **CHAPTER 5: Data Quality** | |
| 5.1 – Cancer Registrar Credentials | 1) Current CTR validation (NCRA CE Cycle Validation Certificate) for abstractors and staff providing supervision to non-CTRs, **and**<br>2) Non-credentialed staff supervision plan that includes the education component. |
| 5.2 – RQRS Participation | Note: RQRS participation and data submission is required by all cancer programs as of 2018.<br><br>1) If Deficiency is due to non-enrollment in RQRS: Enroll in RQRS within one calendar quarter from receipt of performance report, and upload the RQRS enrollment email as the deficiency resolution documentation. (Programs accredited before January 2017 are required to enroll and submit prior to April 30, 2017. New Program must enroll in RQRS within 90 days of accreditation.)<br>2) If Deficiency is due to non-submission of data: Upload RQRS data submission receipt email that documents submission to RQRS within one calendar quarter from receipt of performance report.<br>3) If Deficiency is due to absence of cancer committee discussion of RQRS data: Submit cancer committee minutes that document one of the required semiannual reviews of RQRS data by the cancer committee that occurred post-survey. |
| 5.3 – Follow-Up of all Patients | Upload the most recent copy of the registry follow-up report. |
| 5.4 – Follow-Up of Recent Patients | For 2019 surveys, this standard will be rated as not applicable. |
| 5.5 – Data Submission | In order to resolve a deficiency for Standard 5.5:<br><br>Upload the NCDB email notification that shows the full analytic caseload for the deficient years of data were submitted without errors and/or the screenshot of the information in "View Detail" on the NCDB Submission History, which includes the submission date, receipt ID and records rejected/data quality problems for each file submitted to NCDB if deficiency is due to:<br>1) diagnosis year/s that were not submitted,<br>2) diagnosis year/s with far below the expected number of new and updated cases, and/or<br>3) diagnosis year/s submitted after the due date.<br><br>**Your resolution is not considered received until you upload the documents to the deficiency resolution link within your survey SAR.**<br><br>There is no need to schedule data resubmission.<br><br>*If you received a deficiency for Standard 5.6 solely because of a deficiency on Standard 5.5, both deficiencies will be* |

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| | *resolved by this resubmission.* |
| 5.6 – Accuracy of Data | See Standard 5.5. |
| 5.7 – CoC Special Studies | Deficiency will time out in one year post-survey if not asked to participate in next study or no study is released by the CoC. |

Updated 5/9/19