CAAnswer Forum LIVE

June 26, 2019
Agenda

1:00 pm Central  Welcome and General Information
1:05 pm  Update on the 2020 CoC Standard Revisions
1:10 pm  NAPBC Clarifications, Reminders, and FAQ
1:15 pm  Submitted Questions and Answers
1:55 pm  Wrap-up
THANK YOU for your feedback!

Next steps:

• CoC Accreditation Committee currently reviewing issues raised
• Anticipated release: Fall 2019
• Educational resources (webinars/templates) will accompany release
• Keep your eye on *The Brief* for updates!
When the revised standards go into effect, when will the SAR reflect the changes? For the year the changes take effect or the following calendar year?
A new SAR will be developed to reflect the changes in the revised standards. Updates will be provided as they develop.
Our program category changed to INCP on Jan 1, 2019. Our initial survey will be sometime in 2020. Are we able to achieve OAA or does that designation apply only to established programs being surveyed?
The Outstanding Achievement Award is being retired as of December 31, 2019.

2019 is the last year the CoC will be awarding the OAA.
CoC 2020 Standard Revision Update

Will NAPBC revise standard 2.20 (Breast Cancer Survivorship Care) in 2019 to reflect the CoC revisions to standard 3.3 (Survivorship Care Plan)?
The NAPBC leadership will begin a project to review the current standards soon.

At this time, no changes to Standard 2.20.
NAPBC Clarifications, Reminders, and FAQs

- Published May, 2019
- Clarifies survey process and standards
- Available for download at https://www.facs.org/quality-programs/napbc/standards
Pay close attention to the ★

Deficiency Resolution Time Frame
  • 12 months to resolve all deficiencies from date of performance report

Standard 2.7 Pathology
  • Does not apply to fine needle aspirations or core biopsies
NAPBC Clarifications, Reminders, and FAQs

• Pay close attention to the ⭐

• Standard 2.11 Stereotactic Core Needle Biopsy
  • American College of Surgeons (ACS) and American College of Radiology (ACR) Stereotactic Breast Biopsy Accreditation Program has been retired.
NAPBC Clarifications, Reminders, and FAQs

- Pay close attention to the ★

- Standard 2.19 Evaluation and Management of Non-Malignant Breast Disease
  - Surveyor reviews special group of patient records
    - 5 patients with benign breast disease (fibroadenoma, mastitis, etc.)
    - 5 patients with high-risk lesions (atypical ductal hyperplasia, lobular carcinoma in situ, etc.)

- Standard 3.2 Clinical Trial Accrual
  - Denominator to calculate clinical trial accrual is the number of the accredited center’s breast cancer patients
Can the radiologist alternate also read the MRIs and if both are unavailable can another rad read and then the rad that is a member of the Rectal Cancer Multidisciplinary Team (RC-MDT) read when available?

Can the pathologist alternate also read and do the path report and if both are unavailable can another pathologist read and then the pathologist that is a member of the Rectal Cancer Multidisciplinary Team (RC-MDT) read when available.
Alternates are considered RC-MDT members

It is preferred that only the RC-MDT pathologists/radiologists do the review/sign off. However, a non-MDT member can do the first review as long as a MDT member is involved before the report is signed out. The report should note that the RC-MDT member was involved in the read/review.
I have tuned in to the orientation webinars that are posted on the Datalinks website. I heard “enter one date for each ER,” so I just want to confirm that date could be 2019, if it is an ER that we have reviewed and updated in our quarter one or quarter two of our Cancer Committee Meetings.
You would need to enter the year that the Eligibility Requirements were reviewed. If the policy did not change, then a new copy isn’t needed.
CoC Standard 1.1 Physician Credentials

Are internal medicine doctors, psychiatrists, cardiologists excluded from this standard at cancer hospitals since they do not diagnose/manage cancer?
If these individuals do not diagnose or treat cancer patients or sit as members of the Cancer Committee then they do not need to submit documentation for standard 1.1.
The standard states the physician must be board certified or "the equivalent." If the "equivalent" is not delineated in the Medical Staff Bylaws but instead in a policy that is linked and referenced to within the Bylaws, will this be allowed for compliance?
The equivalent statement primarily applies to physicians with foreign board certification.

Yes, a program’s definition of “equivalent” can be in either the medical staff bylaws or a policy that is linked to and/or referenced in the bylaws.
Can a goal be established that is already stated as a requirement under an NCCN guideline? For instance, Increase the percentage of CEA or CAP CT before CRC surgery? These are already required by NCCN guidelines for colon cancer.
This could be an appropriate goal, especially if the gap in CEA or CAP CT before CRC surgery is identified during the evaluation that is part of standard 4.6 (Monitoring Compliance with Evidence-Based Guidelines). Improving clinical care is an important aspect of all CoC-accredited programs.
What documentation is recommended for research patients who are referred to other institutions?
When patients are referred to another facility or to a physician’s office for accrual to a clinical trial, your program needs confirmation that the patient was accrued to a cancer-related trial and when that accrual took place.
LDCT is exempt at the ACR level. Is this then considered an "external" IRB exemption for Std 1.9?
There are two issues here:

1st
Under the federal policy for the protection of human subjects, the IRB may approve an informed consent process that
• Waives the requirement to obtain informed consent, or
• Alters some or all of the elements of informed consent, or
• Waives the requirement to document informed consent (i.e., to obtain a signature)
The IRB can give an exemption to informed consent if the research presents a low risk to patients.

2nd
Lung Cancer Screening Registry

The ACR Lung Cancer Screening Registry™ (LCSR) is approved by CMS to enable providers to meet quality reporting requirements for receiving Medicare CT lung cancer screening payment. Participants receive quarterly reports for their facility, with peer comparisons, as well as data for individual physicians to help refine and improve lung cancer screening for everyone.

The LCSR also offers additional quality measures to fulfill reporting requirements for the Merit-based Incentive Payment System (MIPS).

In light of this change, participation in this registry may no longer qualify as clinical research. We are working with our ACR representative on a clarification and will share additional information through The Brief and the CAnswer Forum.
What do you consider an eligible clinical trial? What is the difference between a registry and a registry trial? I consider a trial requirement of a protocol, informed consent and IRB approval looking at a research question.
Clinical Research – NIH defines clinical research as: **Patient-oriented research.** Research conducted with human subjects (or on material of human origin such as tissues, specimens and cognitive phenomena) for which an investigator directly interacts with human subjects.

Both the CoC and NAPBC take a broad view on what qualifies as clinical research and counting patients. Options include, but are not limited to:
- Interventions (medical products, drugs, procedures)
- Quality of life studies
- Cancer-specific biorepositories or tissue banks

Key factors that apply to both accreditation programs are:
- Cancer focus
- IRB approval
- Informed patient consent unless waived by the IRB
Our cancer center works with contracted medical oncology. The medical oncology group feels that they can cover the psychosocial distress screening through their software program used for patient visits. Their software does not address spiritual/religious concerns. The radiation oncology group uses the NCCN Distress Thermometer that was voted in by the cancer committee. My question is would it be acceptable to use two different forms for screening for distress?
According to the standard, the Cancer Committee selects and approves the tools that a program uses to conduct psychosocial distress screening. Keep in mind that the policy needs to address both tools.
Is it acceptable to select a random sample of individuals who attended a smoking cessation program to determine the number who quit for monitoring effectiveness of program?
No. In order to determine the effectiveness of your smoking cessation activity, you would need to monitor the effectiveness in all of the individuals who attended the program.
Please confirm, if the program's EPR falls within the range of the CI, the standard is met; and is an action plan not required?
There are 2 factors that must be met.
1. The upper limit of the Confidence Interval must meet or exceed the required EPR.
2. The EPR must fall within the Confidence Interval
If both conditions are met, then an action plan is not required.
### Examples

<table>
<thead>
<tr>
<th>Measure</th>
<th>EPR</th>
<th>Calculated Performance Rate (95% CI)</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCSRT</td>
<td>90%</td>
<td>94.6 (90-99.2)</td>
<td>1</td>
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<tr>
<td>HT</td>
<td>90%</td>
<td>86.4 (72.1-100)</td>
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</tr>
<tr>
<td>MASTRT</td>
<td>90%</td>
<td>85.7 (59.8-100)</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>BCSRT</td>
<td>90%</td>
<td>80.2 (75-85)</td>
<td>5* (if no action plan in place)</td>
</tr>
<tr>
<td>MASTRT</td>
<td>90%</td>
<td>79.6 (73.3-85.9)</td>
<td></td>
</tr>
</tbody>
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Examples copied from NCDB documentation posted to the ACS website https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/coc_standards_2019.ashx?la=en&hash=71B3CB4BCB137B032F7DEA076B4F790B01E0F63E
This standard allows for the calendar year to implement an improvement yet requires 'results' to be reported to meet the standard. Can you comment or how to approach this for an improvement that went into effect later in the calendar year? There is not much time to collect data and then also report it.
The term “results” can be broadly interpreted.
• Initial steps taken to implement the improvement, e.g., developing a policy, completing a training program for staff
• Short-term results following implementation
• Long-term results after full implementation

Document the available results in committee minutes for the current year and follow up to report long-term results during the next calendar year.
We have received the upgrade to our software, and we have completed (including AJCC Stage) a good number of edit-free cases, and the case list is still showing the Missing cStage and pStage Group AJCC8. The cases have been reviewed and they do contain the Stage Groups for the 8th edition.
Please be careful when submitting questions for both CAnswer Forum and CAnswer Forum LIVE.

We are unsure of your question and suggest that you work with your software vendor to clarify and resolve.
I know there was an exception made for 2018, changing the required percentage to 50% of RQRS data. Will there be any exception for 2019?
No, at this point no exception is planned.
For plastic surgery attendance, can we have a nurse practitioner that works with our plastic surgeons attend BPL meetings or does it have to be the surgeon?
The standard requires that the plastic surgery physician attend the BPL meeting.
Can you please confirm the class of case used for this standard? The manual states 10-22 but we were told that it should have been 10-14 at the Annual Cancer Programs conference.
The NAPBC Board has discussed this question and agrees that the information in the manual is correct.

Please note that the center is not accountable for surgery that took place outside of the center. We apologize for any confusion.
If a RN does not have OCN certification, how do you demonstrate "documented knowledge and skills."
Examples include, but are not limited to:

• Name, date, and location of education programs that the person attended
• Information on special training
• Results of tests or other measures
• Previous work experience.
At the Annual Cancer Programs Conference in September, Dr. Kurtzman stated that there was an error in the new manual and that the standard should apply to all breast biopsies, not just for breast cancer patients. There are conflicting comments on this forum. Attendees at the conference were told that a clarification/correction would be sent out. Would it be possible for all NAPBC centers to receive an email with the clarifications to this standard? Also, does anyone have a good method of tracking open surgical biopsies?
Information on this standard is provided in the NAPBC Clarifications, Reminders and Frequently asked Questions document that is available on the NAPBC website. This was released in May and all centers were notified of the release.

“Needle biopsy is the preferred method for all patients including nonmalignant cases. However, for purposes of filling out the Standard 2.9 section of the Survey Application Record (SAR), numbers should be provided for just breast cancer patients. The reason only cancer patients are requested is that the NAPBC recognizes the difficulty in ascertaining the total number of non-malignant breast biopsies since they are not in the cancer registry.”

I would suggest that your post your request for a good method of tracking open surgical biopsies on CAncer Forum.
We have both Radiologists & Surgeons who perform Stereotactic Breast Biopsies at our facility. At this time, only one of our surgeons is certified through ASBrS. Our Imaging Center, where these biopsies are performed, is not a BICOE. Until our Imaging Center becomes a BICOE, can the surgeons that are not certified through ACoS or ASBrS perform biopsies? Or will this cause us to miss this standard when we go through survey next year?
The American College of Surgeons program on stereotactic breast biopsy has been retired.

Standard 2.11 requires that stereotactic core needle biopsy is performed:
• At an ACR accredited facility OR
• By an ASBrS breast procedure program-certified surgeon
Do you have a list or inventory of breast CME events for provider? If not, where can I find breast CME events to distribute to my breast clinic providers?
It would be impossible to maintain an inventory of all available breast related CME events. Your best resource for this is the providers themselves.

The following organizations offering CME easily come to mind:
- American College of Surgeons Clinical Congress
- American Society of Breast Surgeons
- American Society of Clinical Oncology
- National Consortium of Breast Centers
Can NAPBC mirror CoC survey application record which will allow programs to monitor compliance yearly?
No, the two systems are independent and we are not able to offer this option.
Is the requirement of 50% or greater for SCP's going to apply for facilities with deficiencies?

If a program with a deficiency on survivorship cannot hit their target percentage what would the course of action be?
If a program has not be able to meet the 50% to demonstrate compliance to resolve their deficiency, the program will need to provide an action plan that would outline how the program plans to meet the standard moving forward.
Being that we were not able to collect data due to lack of software, we were unable to perform a direct download of patient treatment information to Journey Forward to distribute the Survivorship Care Plans. Is the CoC going to be lenient with the 50% guideline for providing SCPs during this time frame of 2019?
As of this date, all programs will need to provide 50% of their patients with a survivorship care plan. This applies to programs with a deficiency as well as those with software issues.
Due to the severe shortage of genetic counselors in our area, if we utilize online counseling services as needed, is that acceptable to meet the standard? Our physicians would order the genetic testing and refer patients to online counseling if needed.
Telemedicine is a great option. This could be allowed if your program demonstrates that this method is available to provide your patients with genetic counseling. You need to make sure that there is a policy and procedure for this. Make sure the annual review of the program is included your Cancer Committee minutes.
Please provide a final answer regarding the group stage for post therapy. Donna Gress's responses in forum direct us to STORE.

STORE states to code 99. Some posts state to code to 88, others state blank.
Code 99
- Staging system exists for that site
- If case doesn’t meet criteria for clinical or pathological staging and TNM are blank
- No valid stage group for the TNM combination

Code 88
- No staging system for that disease site
- Staging system exists, but stage group not defined
- Using 88 instead of 99 indicates you can never assign a stage group, not a data/combination problem
Our facility owns an off-site medical oncology infusion center in another city. This is a hospital outpatient department of our hospital and is covered under our facility's Joint Commission Accreditation. Their cases are captured by our facility's cancer registry and are considered part of our facility for CoC accreditation. The patients at the off-site facility are not included in tumor board of our main hospital. The community of the off-site medical oncology department has their own hospital and most patients receive all their care at this other hospital and are referred to our off-site medical oncology office. Our medical oncologists participates in tumor boards at the other hospital. The hospital that hosts the tumor boards is not CoC accredited. Would our off-site medical oncology department be included with our facility for our NAPBC Accreditation? If so, would that physician need to be listed as part of the Breast Cancer Team?
Answer

This is a complex issue affecting both the CoC and NAPBC Accreditation for this program.

The key line is this:
This is a hospital outpatient department of our hospital and is covered under our facility's Joint Commission Accreditation

For CoC – Because the medical oncology department is part of the Joint Commission accreditation, then physicians and patients in that department are included in the CoC Accreditation. Physicians should be participating in the program, including cancer committee and cancer conferences.

The same may not be true for the NAPBC Accreditation. The NAPBC Board will be making decisions related to the definition of a satellite at its July meeting.

We will be contacting the person who submitted this question following that meeting to clarify requirements.
A Look Toward the Future

Future CAnswer Forum LIVE Sessions

• September 25, 2019: Noon – 1:00 pm Central
• December 11, 2019: Noon – 1:00 pm Central
Upcoming Educational Conferences

Pursuing Excellence Through NAPBC Accreditation Workshop
September 20, 2019
Denver, CO

Commission on Cancer Educational Summit 2020: A Glimpse Into the Future
November 21–22, 2019
Chicago, IL
Thank you!

Please complete the online evaluation.