CAnswer Forum LIVE
September 25, 2019

Agenda

• Welcome and introductions
• Update on CoC 2020 Standards Project
• Questions and Answers
• Upcoming Events
• Wrap up
CoC Standards Revision Project Update

Standards Revision Timeline

June 2019
CoC Accreditation Committee Addressed Public Feedback

July 2019
Standards approved by CoC Accreditation and Executive Committees

Fall 2019
Publication Process

November 2019
Release to public

January 2020
Implementation
Thank you! Thank you! Thank you!

Posted draft standards on CoC website in May 2019

2,488 responses over 3 surveys*
750+ pages of responses.
*# of unique respondents unknown

Standard 2.1: Cancer Committee Membership

“The designated coordinators are sometimes needed to overlap and take on multiple responsibilities because we only have so many available members due to staff availability and finances. The rule of an individual cannot serve in more than one coordinator role during a term could be eliminated because many members are able to serve in more than one capacity to the benefit of the cancer program.”

Result: Changed standard to allow one person to serve in two coordinator roles.

Standard 2.1: Cancer Committee & Standard 4.8: Survivorship Program

“Have some concerns about the Survivorship Program having to be led by a Director who is a physician or APN. While, we are not required to hire a specific person, it will require us to pay someone a medical directorship to fill this role as a small program who only has one option in most of our oncology specialties”

Results: Changed name to “Survivorship Program Coordinator”

Expanded qualifications for role. Now includes: A physician, physician assistant, advanced practice nurse, nurse, social workers (OSW-C recommended), nurse navigator, or therapist or other licensed health care professional is selected to fill this role.

Survivorship Standard

Focus:

% of Survivorship Care Plans → Survivorship Program

Revised standard requirements:
- Designate leader of survivorship program
- Identify team & services/programs offered to address needs of cancer survivors
- Annually evaluate 3 services impacting cancer survivors

Survivorship Care Plans
- Valued and encouraged by the revised standard, but not required
- SCPs can partially meet expectations of standard
- Programs set parameters around its usage of SCPs (no required delivery percentage)
Standard 3.3: SCP Deficiency Resolution

Programs choose how to resolve Standard 3.3 deficiencies from 2019 and 2020 surveys

Programs can either develop an action plan toward compliance with:
  • The 2016 survivorship standard, *Standard 3.3: Survivorship Care Plan*, or
  • The 2020 survivorship standard, *Standard 4.8: Survivorship Program*.

Where to learn more about 2020 Standards

Communications forthcoming!
  • Blast emails to CLPs, CPAs, Chairs, CTRs from all accredited programs
  • Follow-up articles in the Brief
  • Twitter
  • facs.org/2020CoCStandards
Question NAPRC general information

How can we access the education modules, if we don't plan on applying for accreditation until next year?

Answer NAPRC general information

Pathology: Self-study of CAP protocol available on CAP’s website. Link to webinar: [https://www.youtube.com/watch?v=04Rz3h1mvTM](https://www.youtube.com/watch?v=04Rz3h1mvTM)

Radiology: Is publicly available on ACR website. **NAPRC applicants get special pricing**
Link: [https://www.acr.org/Lifelong-Learning-and-CME/Learning-Activities/Rectal-Cancer-Staging](https://www.acr.org/Lifelong-Learning-and-CME/Learning-Activities/Rectal-Cancer-Staging)

Surgery: Not yet available.

Up-to-date information: [https://www.facs.org/quality-programs/cancer/naprc/standards/resources](https://www.facs.org/quality-programs/cancer/naprc/standards/resources)
Question NAPRC Standard 1.3

As a large facility we have numerous radiology and pathology physicians that "specialize" in rectal cancer and want to be part of the Multidisciplinary Team but their role in the system has these numerous docs rotate their schedule, it is not always feasible to think (1) out of 8 physicians has to attend 50% of the meetings with an alternate who can cover the other 50%. Shouldn't the goal be to have a consistent participation list of appropriately trained radiologists or pathologists participate 100% of the time vs individual attendance or allow the facility to set the percentage (like NAPBC) so it is open to more trained physicians? The more trained subspecialists you have the harder it is to meet the 50% requirement. This seems like it works against the larger teaching or network type programs?

Answer NAPRC Standard 1.3

Intent of MDT and attendance requirements:
- Same people evaluating specimens and imaging as the people discussing treatment recommendations at the MDT.

Recommend review of “RC-MDT Membership and Attendance Guide”
Question NAPRC Standard 1.3

Can you please clarify the attendance requirement for members of the RCMT? Do all surgeons have to be at 100% of the meetings or only when their cases are presented?

Answer NAPRC Standard 1.3

Each surgeon must be attend at least 50% of RC-MDT meetings each year (Standard 1.3). An RC-MDT surgeon must be at each RC-MDT meeting (Standard 1.4).

If only one surgeon at the program, then that surgeon must attend 100%.

Recommend review of “RC-MDT Membership and Attendance Guide”

**Different requirements for pathology, radiology, radiation oncology, and medical oncology**
Question NAPRC Standard 1.4

Why can't the standard be flexible to allow for holidays that fall on the date of RC meetings? 
You can't just move it to another day/time and location in most cases.

Answer NAPRC Standard 1.4

We recommend that all meetings be set at the beginning of the calendar year and scheduled around holidays and large events (such as ACS Clinical Congress or ASCRS annual meeting).

At least twice-monthly meetings are needed so that treatment decisions can be made for patients in a timely manner.
Question NAPRC Standards 2.3 and 2.8

Do our physicians need to use specific synoptic report templates for MRI/surgical resection/pathology reports or can we use our own standardized reports?

Answer NAPRC Standards 2.3 and 2.8

Radiology: Must use the elements listed in the Cancer Care Ontario template.

Pathology: Follow CAP protocols.

Surgery: Still in development. But will need to use standardized elements once the standard is activated.

Links available on NAPRC website
Question NAPBC general information

Does your hospital have to have a CoC accredited cancer program to apply for the NAPBC Breast Center Program?

Answer NAPBC general information

CoC accreditation is not required to apply for NAPBC accreditation.
Question NAPBC Standard 1.1

Please, could you distinguish the Breast Care Team (BCT) from the Breast Care Leadership Team (BCLT)? It is not clear to me who needs to be on the BCT.

Breast Program Leadership Committee (BPLC) – is the governing board of the breast center and oversees its work.
• BPLC chaired by the Breast Program Director
• BPLC meets at least four times per year
• Membership includes, but is not limited to;
  • at least one physician from pathology, radiology, surgery, medical oncology, radiation oncology, reconstruction surgeon (not required if referred out)
  • Representatives from research, nursing, social work, hospital administration, and other members deemed necessary.

Breast Care Team (BCT) – (formerly called The Roster) are the professionals that provide treatment or care for the breast cancer patient
• Membership includes
  • all physicians involved in breast care including; pathologists, radiologists, surgeons, medical oncologists, and radiation oncologists.
  • Attendance for designated specialties is outlined on page 18 of the standards manual.
Question NAPBC Standard 2.14

On P. 47 of the 2018 NAPBC standards for Standard 2.14 it is NOT clear what you mean by "documented qualifications of specialized knowledge and skills"?

Answer NAPBC Standard 2.14

“Documented qualifications of specialized knowledge and skills in diseases of the breast” is meant to cover nurses who have evolved into a seasoned nurse treating patients with breast disease, but have not sought to formalize their experience with a certification.

The standard applies to nurses in medical oncology who give chemotherapy, nurses in radiation oncology, nurse navigators, and nurses who are full-time in the breast center. It does not apply to nurses in the hospital with occasional contact with cancer patients, including Operating Room or Recovery Room nurses.
Question NAPBC Standard 2.2

What documented training is acceptable for nurse or APN serving as a navigator?

Answer NAPBC Standard 2.2

Please review the information in the NAPBC Clarifications, Reminders, and Frequently asked Questions (https://www.facs.org/quality-programs/napbc/standards)

This answer applies to both nurses and lay navigators. There must be documented training in patient navigation which results in a certificate. Examples include but are not limited to:

- Academy of Oncology Nurse and Patient Navigators (AONN+) Certification
- National Consortium of Breast Centers (NCBC) Breast Patient Navigator Certification Program
- Oncology Nursing Society (ONS) Oncology Nurse Navigator Core Competencies
- EduCare (Note that this course is now self study)
- Harold P. Freeman Patient Navigation Institute
- George Washington University Cancer Institute

Your internal navigation orientation and competency may comply but your program should review and compare for equivalency.
Can you provide further clarification regarding Cancer Status, Type of First Recurrence, Recurrent Date 1st Flag and the new Date last Cancer Status. More examples other than what was in The Brief on 8/16/19 would be appreciated. What about a scenario where a patient is diagnosed with prostate ca, goes on active surveillance, but then 2 years later decides to have a prostatectomy? How would all those items be coded?

Example: Patient diagnosed with prostate CA, chose active surveillance which is treatment. Two years later the patient has a prostatectomy.

Why did they have a prostatectomy? For Recurrence? For the prostate cancer under active surveillance? The cancer status is 2-active disease. Date of cancer status only changes when a physician states there is a change to cancer status.

Based on this scenario, there is not enough information to determine the other data items.
August 22 issue of The Brief, it is mentioned that • A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed. Also, a Modified Radical Mastectomy is: "Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of skin in continuity with the axilla." My question is: If the surgery is stated to be a simple or total or for even that matter, not stated, but the surgery qualifies as a MRM, but there is a sentinel Lymph node dissection followed by an Axillary lymph node dissection, are we to presume that any otherwise Simple or Total mastectomy is to be coded as a MRM if there is an Axillary Lymph Node Dissection?

STORE rules were developed to capture standard coding across CoC accredited programs. Registrars have the knowledge to determine if surgery is a Simple, Total, or MRM, based on the body of the operative report. Read the body of the procedure report and assign the surgical code from STORE Surgery for Breast. Discussion with the managing physician and or surgeon may be required to assign the appropriate code.
Question STORE Multiple Data Elements

Given that the CoC does not require us to collect second course/subsequent treatment, please explain the usefulness of the date of last cancer (tumor) status field beyond the date of first recurrence. How do the dates recorded in this field for changes that happen after first recurrence facilitate research on cancer recurrence without the context of the treatment that prompted the changes?

Answer STORE Multiple Data Elements

The date of last cancer (tumor) status field identifies the time from the date the patient is considered NED to date of first recurrence/active disease. If a patient is never disease free the date never changes and that will indicate to the researcher that the patient had active disease.
In recent years, we received the NCDB Practice Profile reports in November. What month can we expect the 2017 data to be released?

We expect that the CP3R will be updated in 4th quarter 2019.
Question CoC Standard 1.7

Please specify what is to be presented for the area of monitoring "Options and eligibility for clinical trial enrollment." Most cases are not fully staged when we discuss them at Cancer Conference therefore specific trial options cannot be presented. Is it acceptable to say clinical trial options and eligibility to be determined?

Answer CoC Standard 1.7

No. The clinical research coordinator or other individual should provide information on the available trials that may apply to the patient.

Clinical trial options may change as the workup progresses and more information is available.

Don’t forget to discuss clinical trials options for patients with recurrent or metastatic disease that are discussed at the conference.
Question CoC Standard 4.7

If your committee wants to investigate a decline in a surveillance measure EPR and a problem is identified can you use as a quality study?

Answer CoC Standard 4.7

Yes, a program is able conduct a quality study if there a problem with meeting a surveillance measure.

A program cannot do a study to determine the reasons an accountability or quality improvement measure is not being met as it is part of Standard 4.4 and Standard 4.5 to determine the problem and to correct it through an action plan.
Special Activities

Centers solely accredited by the NAPBC
Login to the NAPBC Portal.
Open the Resources Tab.
Click on the NAPBC Marketing Resources Link.

Programs that are accredited by the CoC solely and/or by both the CoC and NAPBC
Login in to CoC Datalinks.
Click on the CoC-Accredited Cancer Program Marketing Materials link.
Download and print the Breast Cancer Awareness Month Poster.

Upcoming Events

Commission on Cancer Educational Summit: 2020:
A Glimpse Into the Future
November 21–22, 2019 | Rosemont, IL

CAanswer Forum LIVE
December 11, 2019
Addressing questions on the current and 2020 standards
Thank you for attending the webinar.