CAnswer Forum LIVE

December 11, 2019
Agenda

Welcome

Standards
• NAPBC
• NAPRC
• NCDB
• CoC
  • 2016 Standards
  • 2020 Standards
  • Survey process - 2020 and beyond

Upcoming Activities

Adjourn
Standard 2.20 Survivorship Care Plans

Will the breast SCP delivery percentage of greater than or equal to 50% remain intact for 2020 even though the CoC SCP percentage is going away?
Standard 2.20 Survivorship Care Plans
Answer

Currently the NAPBC has not changed the Survivorship Care Plan requirement. SCPs should be provided to at least 50% of eligible patients who have completed treatment.
Standard 1.4 Rectal Cancer Multidisciplinary Team Meetings

As stated in the manual, we are required to meet twice a month. If there are no patients to present, do we have to make up the meeting?
Standard 1.4 Rectal Cancer Multidisciplinary Team Meetings

Answer

The RC-MDT must meet at least two times each month. Keep in mind that each patient must be discussed at least twice. Additionally, there are annual audits and rectal cancer program data that must be reviewed each year.
RQRS

When will the RQRS dashboards be fixed? For quite a while, our MAC dashboard does not reflect our cases correctly. I pull reports from my system using your exact criteria and find cases that meet that criteria. But the dashboard shows no cases. I have heard other registrars speak of the same issue. It is not a lone user problem.
RQRS
Answer

Please submit program specific questions to ncdb@facs.org. Include the program FIN, accession/sequence number of the measure in question.
At the Nov 22 NCDB workshop, it was mentioned in the RCRS presentation that the third phase of concurrent abstracting, surveillance, was being evaluated for the relevance of anchoring surveillance by the reference date vs a rolling surveillance window from the current date to five years back. Further, that long term surveillance information is available from other sources such as central registries. Does this mean that the current standard 6.5 may change in the near future to eliminate the 80% reference year to current follow up requirement?
RCRS
Answer

Once RCRS has been rolled out to the programs an evaluation of all applicable standards will be performed.
Reports

What is the status of the NCDB Completeness and Overuse Reports?
Communication regarding the release of the NCDB Reporting Tools, including the Completeness and Overuse Report, will appear in The Brief.
The following eligibility requirements and standards have been eliminated from the 2020 standards:

• ER5 Policy and Procedure Manual
• 1.8 Monitoring Prevention, Screening and Outreach
• 1.10 Clinical Educational Activity

Additional changes

• A community needs assessment is no longer required by the CoC standards
Standard 2.1 Cancer Committee and 2.2 Cancer Liaison Physician

Can the Cancer Committee Chair also serve as CLP?
Standard 2.1 Cancer Committee and 2.2 Cancer Liaison Physician Answer

As stated in Standard 2.2, "It is permissible for the CLP to also serve as the Cancer Committee Chair, but it is encouraged that the CLP role and the chair role be filled by two individuals."
Standard 4.1 Physician Credentials

What does 'or the equivalent' mean in this standard. Please explain further.
Standard 4.1 Physician Credentials
Answer

Equivalent typically means a foreign board certification.
Standard 4.1 Physician Credentials

Our diagnostic radiologists & pathologists rotate through all 10 of our tumor boards. Do I have to provide credentials for all of them?
Standard 4.1 Physician Credentials

Answer

Yes, you need to provide credentials for all them.
Can you please better define what is meant by nurses who provide direct oncology care means. Is this for nurses who are touching patients and caring for them clinically, or does it mean and nurse who comes in contact with patients in any fashion? For example, are nurse navigators who just help coordinate visits and who may meet with patients just to talk, but don't touch/treat the patients in any way required to submit CMEs?

When it comes to having all nurses who provide direct patient care must have an oncology certification. Would that apply to OR, pre/post op, inpatient, office based?
Standard 4.2 Oncology Nursing Credentials

Answer

This standard applies to registered nurses and advanced practice nurses who provide direct oncology care in the facility for at least one calendar year.

Specifically, the standard applies to nurses in medical oncology who give chemotherapy, nurses in radiation oncology nurse navigators, and nurses in the cancer center or cancer clinic within the facility.

It does not apply to nurses in the hospital who might have occasional contact with cancer patients, and it does not apply to operating room or recovery room nurses.
Standard 4.2 Oncology Nursing Credentials

Can the 36 hours of cancer-related continuing education be pro-rated for nurses who are part time (a 0.5 FTE RN complete 18 hours or is 36 hours still required)?

If employed for only a portion of the three-year accreditation cycle (can a nurse working only 12 months complete 12 hours)?
Standard 4.2 Oncology Nursing Credentials

Answer

The required number of CNEs cannot be prorated for nurses that are part-time.

It will be taken into consideration if a nurse is only there for a portion of the accreditation cycle.
Standard 4.3 Cancer Registry Staff Credentials

Do tumor boards satisfy the education requirement for non-certified registrars and supervisors?
Standard 4.3 Cancer Registry Staff Credentials
Answer

Yes, attendance at the tumor board (facility cancer conference) can count toward education requirements for non-CTRs and supervisors as long as it is applicable to their roles.
Standard 4.5 Palliative Care Services

After tracking the number of patients referred to Palliative Care, we need to also track the number of patients that receive each service?

For example:
___ received pain management
___ received education about illness
___ received attention to spiritual needs etc.
Standard 4.5 Palliative Care Services
Answer

Yes. This information is important in order for the Cancer Committee to assess the effectiveness and the availability of the services to patients and their families or caregivers.
Standard 4.8 Survivorship Program

Do the "three services" need to be documented at a patient-level or system level?

How long would a patient remain in a Survivorship Program after completing treatment?

Can you provide us with a recommended framework for a survivorship program that meets the new standard?
Standard 4.8 Survivorship Program

Answers

The survivorship team at each program would identify and document the services that are offered to the patients.

This is left to the Cancer Committee and the Survivorship Program team to define.

The Survivorship Program is unique to each facility so we are unable to provide a recommended framework.
Standard 4.8 Survivorship Program

What measures can be taken to assure understandable and actionable documentation gets to our patients and their non-oncology care teams for evidence-based lifelong risk awareness and screening?
Standard 4.8 Survivorship Program

Answer

Survivorship care plans and treatment summaries are still very much a part of Standard 4.8: Survivorship Program. A cancer program may utilize SCPs/treatment summaries as services to meet partial requirements of Standard 4.8. If utilized, the program will be required to evaluate the SCP and treatment summary process and identify resources needed to improve the services if barriers were encountered.
Standard 4.8 Survivorship Program

A sample of an annual report for this program would be helpful. Is a sample available?
Standard 4.8 Survivorship Program

Answer

The CoC is working on developing resources for all standards and will roll out resources as they are finalized.
Standard 5.2 Psychosocial Distress Screening

Can a Distress Screening Assessment be administered electronically? Sent to a patient email or via an App?
Standard 5.2 Psychosocial Distress Screening

Answer

Yes, the screening assessment can be done electronically as long as there is a process for follow up for those that score above the cut-off score.

The method for conducting a distress screening assessment is determined by the cancer committee.
Standards 5.3 – 5.8 Operative Standards

Does the synoptic portion of this standard need to be in the Operative Report (summary) or can it be a separate document, but still a part of the operative documents?
Standards 5.3 – 5.8 Operative Standards

Answer

No, it cannot be separate. The required minimum elements must be included in its own section in the operative report in synoptic format.
Standards 5.3 – 5.8 Operative Standards

Will the operative synoptic format be supplied through the CoC or is this something each reporting facility will do on their own?
Standards 5.3 – 5.8 Operative Standards
Answer

Resources are being created to help assist with the adoption with these standards, including operative report templates. Resources will be added to a dedicated website in early 2020.
Standards 5.3 – 5.8 Operative Standards

When will the synoptic operative reports be phased in? These standards are listed as "phase in" but do not give a phase in period. Is this also by 2021?
Standards 5.3 – 5.8 Operative Standards
Answer

The timeline for implementation of the operative standards will be determined based on focus group and cancer program feedback. We will provide a timeline as soon as it is available.
Standards 5.3 – 5.8 Operative Standards

How will these operative standards work for pediatric-only centers? Many of the sites are not applicable; all would be rare in our pediatric population.
Standard 5.3 – 5.8 Operative Standards

Answer

If the program does not have any cases that fit into the operative standards denominator, then the program is exempt from the standard.
Standard 7.3 Quality Improvement Initiative

Am I understanding correctly, that a sub-team of the cancer committee has to be formed to execute the QI initiative? The team must take minutes of their meetings including all work product and submit for review during survey?
Standard 7.3 Quality Improvement Initiative

Answer

The CLP and the quality improvement coordinator (QIC) are the members of the Cancer Committee that take the lead on conducting at least one cancer-specific quality improvement initiative. The QIC and the CLP must identify content experts necessary for success of the project. These content experts do not necessarily need to be members of the cancer committee.

If the QI project team has meetings where minutes are taken, then they can be reviewed by the site visit reviewer at the site visit. The standard does requires that the CLP and quality improvement coordinator report on the progress of the activity at least twice a year. The progress reported should be included in the cancer committee minutes which need to be uploaded.
Standard 7.3 Quality Improvement Initiative

For the review of the data to identify a problem statement, please explain in detail the list that is provided that may be used to identify the focus of the problem and more specifically how to apply the notation "in order of preference."

Is it okay to use something like QOPI data abstraction results compared to benchmark reference to identify a problem of focus?

Many quality improvements, particularly those that focus on process improvements, do not have evidence based guidelines ... can you please give us examples of what literature is acceptable for these types of projects?
Standard 7.3 Quality Improvement Initiative
Answers

The list that is provided encourages the program to study an issue based on the NCDB data and tools. However, it is acknowledged that there may be a more pressing or more appropriate issue that warrants a quality improvement initiative. The standard allows the program to choose for itself the source that is most relevant to its needs.

Yes QOPI is a good source of data to identify a problem to focus on for a quality improvement initiative. The last bullet under "Review Data to Identify the Problem" gives the program an option to study any cancer-specific quality related problem.

A national benchmark comparison is only required if it's available. The standard specifically states that national data comparison is only required "if possible."
Standard 7.3 Quality Improvement Initiative

Since we are now implementing a more robust Quality Improvement Initiative, can we use the lack of experience in conducting a complete quality improvement (Understanding, Planning, Doing, Studying, Implementing, Evaluating and Sustaining) training in this area as a quality improvement?
Standard 7.3 Quality Improvement Initiative

Answer

No, this would not qualify as a 7.3 quality improvement initiative.
Standard 8.1 Addressing Barriers to Care

Is the patient navigator responsible for this standard? In the 2016 Standards it stated that the navigator assisted with identifying barriers.
Standard 8.2 Addressing Barriers to Care

Answer

The Cancer Committee is responsible for this standard. The program will be responsible for identifying the staff who should take the lead in identifying and meeting barriers. A navigator is a great leader for this standard.
Standard 9.1 Clinical Research Accrual

Will low dose CT scans for lung cancer screening count towards standard 9.1 if they are included in the American College of Radiology (ACR) Registry?
Standard 9.1 Clinical Research Accrual

Answer

If you are just submitting patients to this database, then it does not count for accrual.

However, if one of your providers is conducting a clinical research study that utilizes data from the database, then this may count for accrual if it meets all other requirements (IRB approval, patient consent, cancer-related).
General Topic

Accreditation Process - standards requiring annual review. “...reviews must take place within the same year on which they are based or no later than the first quarter of the following calendar year." So, no full year of activity would be reported; only Jan. 1 to whatever date the last Cancer Committee meeting is held?
General Topic

Answer

Reviews would be based on activity for the calendar year (January 1 – December 31). That is the reason that the Cancer Committee is allowed to review the previous year's activity at the first meeting of the following year.
General topic

"Accreditation cycle" is stated multiple times throughout the manual. Does this refer to 1 time per 3 year survey period or each annual calendar year?
The accreditation cycle is the three year period of time for which the program needs to demonstrate compliance for each year.
Survey Process - 2020

SAR for the new standards

When will the SAR for the new standards be released?

How will the SAR be changing? Will the existing information documented in the SAR be retained for the next survey visit?
SAR for the new standards

Answer

The Cancer Accreditation programs will soon be part of the new Accreditation platform. In the new platform, the SAR will be called the Pre-Review Questionnaire (PRQ) and it will be released in the third quarter of 2020.

The information in your current SAR will not transfer to the PRQ.

Note: The 2021 date provided in the webinar is incorrect. The correct date is 2020 as shown here.
Could you clarify if we are responsible for the 2019 requirement for survivorship care plans if our survey is not until 2020?

Needing clarity on what to tell our facility about meeting this year’s 50%.
Answer

Yes, you are responsible for meeting this requirement.

Programs being surveyed in 2020 are responsible for demonstrating compliance with the 2016 standards for the activities during the years 2017, 2018, and 2019.
If a facility is surveyed in 2021, will we be surveyed for 2018 and 2019 under the 2016 standards and 2020 under the 2020 standards?

In the webinar on 11/18/19 overview of 2020 standards it almost seemed like we would be only surveyed for the year 2020.
Answer

Programs that have a site visit in 2021 will be surveyed only on the standards detailed in *Optimal Resources for Cancer Care* (2020 Standards) and for 2020 activity. 2019 and 2018 activity will not be reviewed.

You do not need to continue providing 2018 and 2019 data in the PAR.
Will the 2020 Standards Manual be phased in for use in all accreditations?
Survey Process

Answer

No, *Optimal Resources for Cancer Care (2020 Standards)* will be used for all Commission on Cancer accredited programs beginning January 1, 2020.

Except where a standard is noted as a phase-in standard, programs are expected to implement the *Optimal Resources for Cancer Care (2020 Standards)* beginning January 1, 2020.
VA programs

I notice that there are no VA specific rules listed as there were in previous standards. Is there a reason for this?

Are VA Facilities still exempt from Standard 8.3 CoC 2020
VA facilities

The standards that had VACP specifications are either not included in the 2020 standards or the need for the specification was no longer applicable due to the revision of the standard. Thus, VA facilities fulfill all of the standards in Optimal Resources for Cancer Care (2020 Standards) including standard 8.3.

Note that VACPs do have their own delineated clinical research accrual requirement in Standard 9.1.
Upcoming Activities

Workshops
April 22–24, 2020—Rosemont, IL (CoC/NAPBC joint workshop) also includes NCDB

August 27–29, 2020—Denver, CO (CoC and NCDB)

Online Education
Webinar series with tips for each standard—To be released early 2020
Upcoming Activities

- Six webinar series answering questions about standards and survey process
  - CoC
  - NAPBC
  - NAPRC
- Also including questions on
  - AJCC
  - CRP
  - NCDB
- Live webinar with recording posted online
- Moderator
  - Frederick Greene, MD, FACS
- Applying for CE credits from NCRA
Upcoming Activities

Mark your calendar and plan to join us on the following dates:

• February 12, 2020
• May 6, 2020
• June 10, 2020
• August 5, 2020
• October 14, 2020
• December 9, 2020

• All webinars begin at 12:00 Noon, Central Time
• Watch the CAnswer Forum and CAnswer Forum LIVE web page for additional information
Thank you for joining us today

The webinar recording and slide PDF will be posted on the CAnswer Forum LIVE web page within 1 week.

Please help us improve the webinar by completing the evaluation.