National Accreditation Program for Rectal Cancer
American College of Surgeons

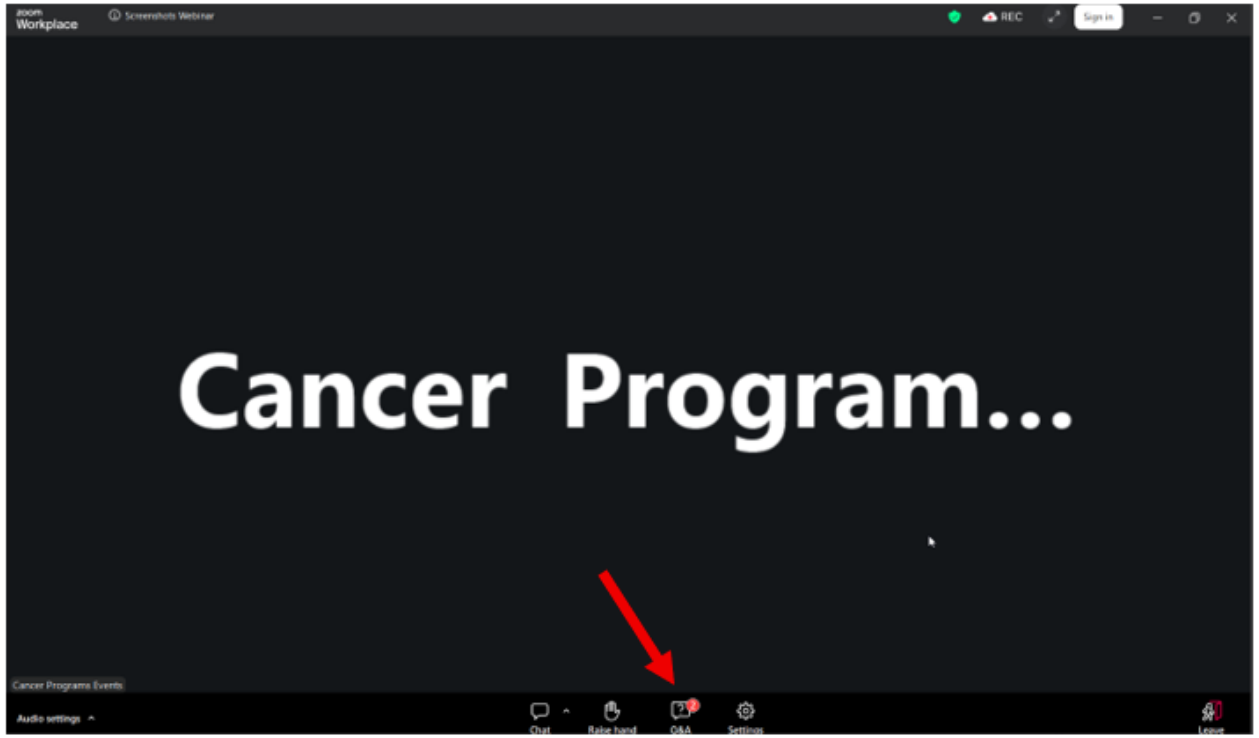
NAPRC Standards Update

April 21, 2026

4:00 PM CT

Webinar Logistics

- All participants are muted during the webinar and cannot use a webcam
- Questions – including technical issues you may be experiencing – should be submitted through the question box
- Questions will be answered as time permits
- Please complete the post-webinar evaluation you will receive via email
- Recorded content, slides, and Q & A will be posted on the Cancer Programs Events education webpage



Faculty

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Objectives

- Overview of resources available
- Review concepts new to the 2026 NAPRC Standards
- Overview of MDT templates

Standards Manual Update in December 2025

Detailed Changelog available that details changes since its original publication

Most edits were to format and/or rewording for clarity

Major changes in:

- Treatment recommendation (5.6) and outcomes (5.11) discussion and summary requirements
- QI Standards (now only one QI project per accreditation cycle instead of one/year)

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Optimal Resources for Rectal Cancer Care (2026 Standards)
NAPRC Standards Changelog

This changelog is not a substitute for reading the NAPRC standards in their entirety. Please refer to *Optimal Resources for Rectal Cancer Care (2026 Standards)* for full details.

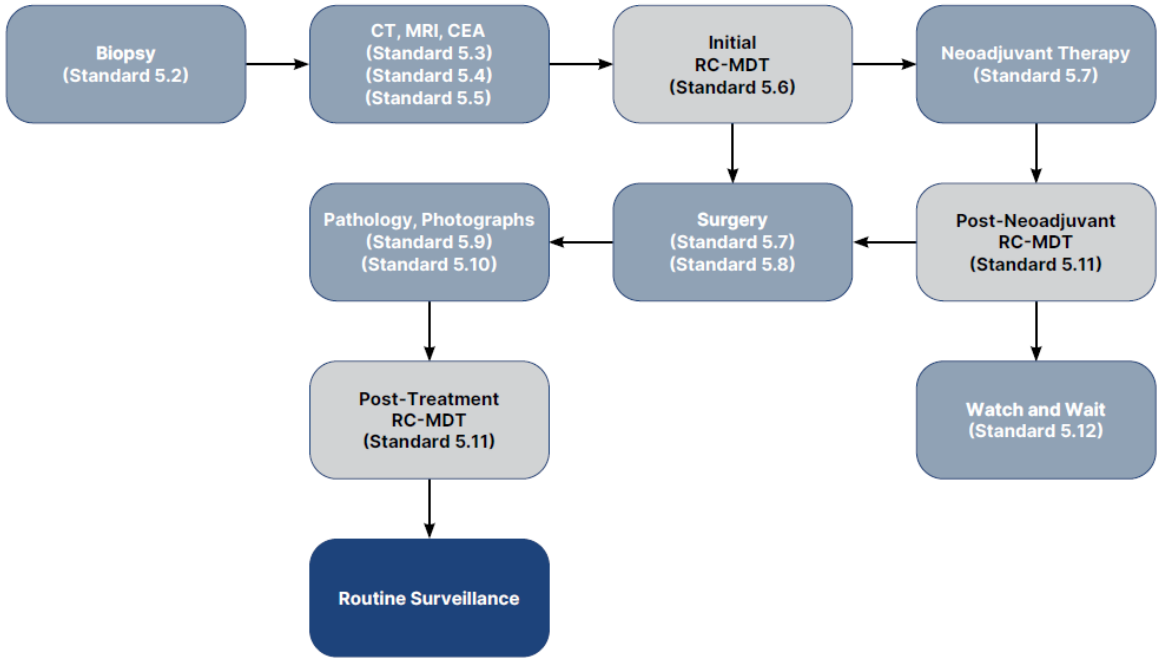
Standard	Change Date	Changes Made
Standard 1.1 Administrative Commitment	December 2025	Removed "A statement of attestation committing to healthcare equity" as a requirement.

Standard 2.2
Rectal Cancer Program Director
	December 2025	• Streamlined language throughout manual related to internal audits.
		  ○ Requirements for internal audits for Standards 5.2-5.11 are now explained in Standard 2.2.
		  ○ Descriptions in Standard 5.2-5.11 removed

Standard 2.5 Rectal Cancer Multidisciplinary Team Attendance	December 2025	• Removed duplicate words from the second bullet point under "Measure of Compliance" ○ "The RCP Director monitors attendance and addresses attendance outliers that do not ~~do not~~ meet the attendance requirements outlined in this standard"

Algorithm Examples

Surgical Resection with/without Neoadjuvant Therapy



Local Excision with/without Neoadjuvant Therapy

Treatment	Applicable NAPRC Standards										
	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	5.10	5.11	5.12
Local Excision – Incomplete Removal → Neoadjuvant Therapy	✓	✓	✓	✓	✓	✓				✓	✓
Local Excision – Incomplete Removal → Surgery or Re-Excision	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Local Excision – Complete Removal → No High-Risk Features											
Local Excision – Complete Removal → High Risk → No Further Treatment	✓	✓	✓	✓	✓					✓	
Local Excision – Complete Removal → High Risk → Neoadjuvant Therapy	✓	✓	✓	✓	✓	✓				✓	✓
Local Excision – Complete Removal → High Risk → Surgery or Re-Excision	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Available on pages ix-xi of the Standards Manual

Detailed FAQ Available

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Frequently Asked Questions

Optimal Resources for Rectal Cancer Care (2026 Standards)

FAQs Addressed

General Questions
Protocol Development
Chapter 2 Standards
Chapter 5 Standards
Chapter 7 Standards
Chapter 8 Standards
CoC Exemptions

General Questions

Are NAPRC-accredited programs required to be fully compliant with the 2026 Standards by January 1, 2026?

Beginning January 1, 2026, all NAPRC-accredited programs must implement the accreditation requirements outlined in *Optimal Resources for Rectal Cancer Care (2026 Standards)* and must begin documenting the program's compliance with the 2026 Standards. Compliance against the new standards will first be evaluated during NAPRC site visits starting in January 2027.

How do the 2026 standards apply to patients who were diagnosed or began treatment before 2026?

Patient evaluation or treatment occurring in 2026 must meet the expectations for the 2026 standards for the portion of evaluation or treatment provided in 2026. This is required even if the patient was diagnosed or began treatment in 2025 or earlier.

FYI: NAPRC Programs Exempt from CoC Standard 5.7

- Starting with 2026 CoC Site Visits, CoC Standard 5.7 (TME) will no longer be reviewed by the CoC for sites with NAPRC accreditation
  - Please enter a comment re your NAPRC status in the CoC Standard 5.7 comment box in the PRQ!

- NAPRC sites may exclude rectal cancer patients from the patient list provided to the CoC Site Reviewer
  - Networks: Just provide rectal cancer cases that occurred at your non-NAPRC sites

RC-MDT Updates: Specialty Attendance

- At least one RC-MDT member must be present from each specialty at any meeting held (even if more than 2/month)
  - **Required specialties:** surgery, pathology, radiology, medical oncology, radiation oncology

- If one of more RC-MDT members from each specialty missing:
  - Meeting does not count for Standard 2.4
  - Meeting cannot be counted for individual attendance for Standard 2.5 for those who were present

RC-MDT Appointments at Multiple Hospitals

Physicians practicing at multiple NAPRC programs only have to meet attendance requirements at one

- Must provide a letter of attestation documenting attendance to other NAPRC accredited programs so they can upload it in the PRQ

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Local Excision

Standards 5.1: Local Excision of Rectal Cancer

- NAPRC program must develop a protocol for management of high-risk malignant rectal lesions and advanced transanal procedures.
- Protocol must include:
  - How to identify cases for presentation to the RC-MDT
  - Criteria for high-risk malignant lesions to present to RC-MDT

Standard 5.1 – Local Excision of Rectal Cancer

New Standard

All Chapter 5 standards now include **Requirements for Local Excision**

- Local excision as **definitive treatment**
  - Requirements for Local Excision apply
- Local excision is **diagnostic**, further treatment recommended
  - Requirements for Local Excision **do not apply**
    - Follow the traditional standard as written

Outside Scope of NAPRC

- Local excision with complete endoscopic removal; no high-risk features
- Local excision without referral to NAPRC program

Standard 5.3 – Systemic Staging with Computerized Tomography

Invasive rectal cancer determined during local excision

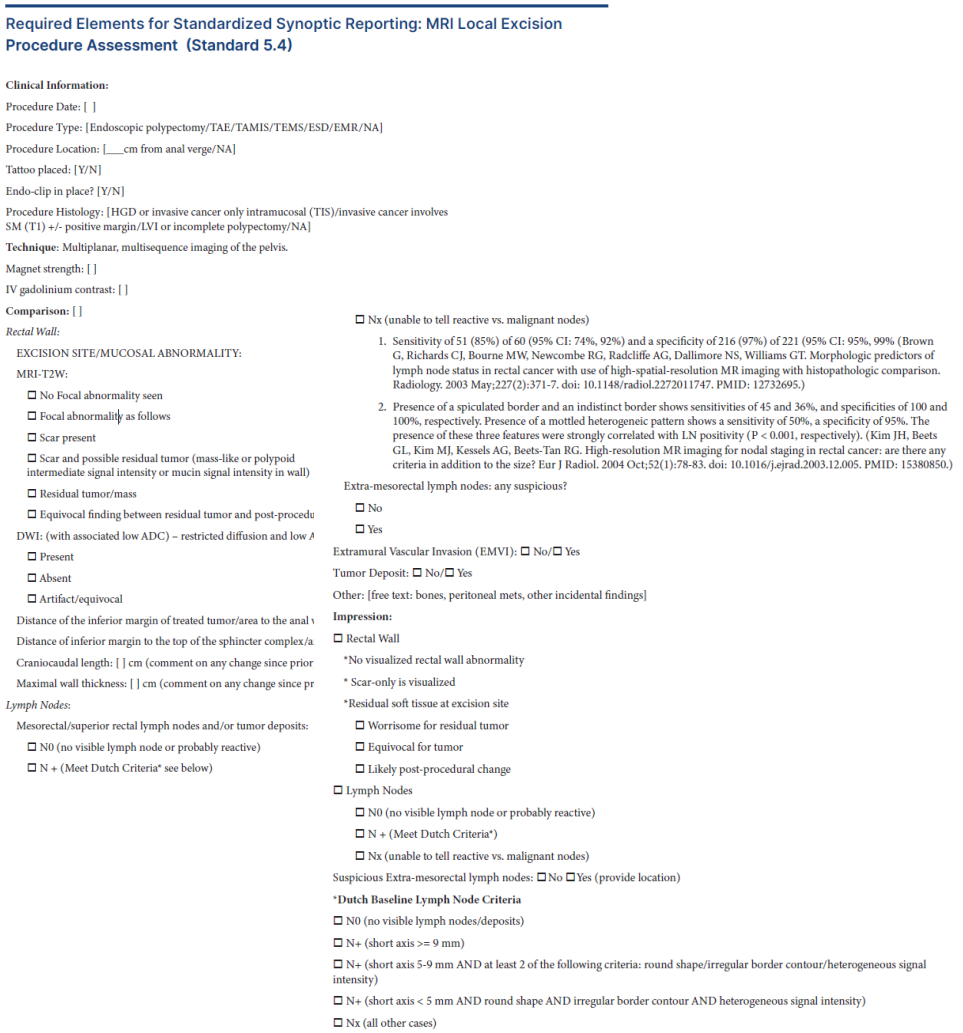
CT must be done **within <u>90</u> days** of signed path report diagnosing rectal cancer

Standard 5.4 – Local Staging with Magnetic Resonance Imaging

90% of all newly diagnosed patients with rectal cancer must have completed local staging by MRI before definitive treatment

When invasive rectal cancer determined during local excision

- **MRI must be done within 90 days** of the signed path report diagnosing rectal cancer
- MRI report must include elements outlined on page 76 in Appendix (different template!)



Required Elements for Standardized Synoptic Reporting: MRI Local Excision Procedure Assessment (Standard 5.4)

Clinical Information:

Procedure Date: [ ]

Procedure Type: [Endoscopic polypectomy/TAE/TAMIS/TEMS/ESD/EMR/NA]

Procedure Location: [___cm from anal verge/NA]

Tattoo placed: [Y/N]

Endo-clip in place? [Y/N]

Procedure Histology: [HGD or invasive cancer only intramucosal (TIS)/invasive cancer involves SM (T1) +/- positive margin/LVI or incomplete polypectomy/NA]

Technique: Multiplanar, multisequence imaging of the pelvis.

Magnet strength: [ ]

IV gadolinium contrast: [ ]

Comparison: [ ]

Rectal Wall:

EXCISION SITE/MUCOSAL ABNORMALITY:

MRI-T2W:

☐ No Focal abnormality seen

☐ Focal abnormality as follows

☐ Scar present

☐ Scar and possible residual tumor (mass-like or polypoid intermediate signal intensity or mucin signal intensity in wall)

☐ Residual tumor/mass

☐ Equivocal finding between residual tumor and post-procedu

DWI: (with associated low ADC) – restricted diffusion and low A

☐ Present

☐ Absent

☐ Artifact/equivocal

Distance of the inferior margin of treated tumor/area to the anal v

Distance of inferior margin to the top of the sphincter complex/a

Craniocaudal length: [ ] cm (comment on any change since prior

Maximal wall thickness: [ ] cm (comment on any change since pr

Lymph Nodes:

Mesorectal/superior rectal lymph nodes and/or tumor deposits:

☐ N0 (no visible lymph node or probably reactive)

☐ N + (Meet Dutch Criteria* see below)

☐ Nx (unable to tell reactive vs. malignant nodes)

1. Sensitivity of 51 (85%) of 60 (95% CI: 74%, 92%) and a specificity of 216 (97%) of 221 (95% CI: 95%, 99% (Brown G, Richards CJ, Bourne MW, Newcombe RG, Radcliffe AG, Dallimore NS, Williams GT. Morphologic predictors of lymph node status in rectal cancer with use of high-spatial-resolution MR imaging with histopathologic comparison. Radiology. 2003 May;227(2):371-7. doi: 10.1148/radiol.2272011747. PMID: 12732695.)
2. Presence of a spiculated border and an indistinct border shows sensitivities of 45 and 36%, and specificities of 100 and 100%, respectively. Presence of a mottled heterogeneic pattern shows a sensitivity of 50%, a specificity of 95%. The presence of these three features were strongly correlated with LN positivity (P < 0.001, respectively). (Kim JH, Beets GL, Kim MJ, Kessels AG, Beets-Tan RG. High-resolution MR imaging for nodal staging in rectal cancer: are there any criteria in addition to the size? Eur J Radiol. 2004 Oct;52(1):78-83. doi: 10.1016/j.ejrad.2003.12.005. PMID: 15380850.)

Extra-mesorectal lymph nodes: any suspicious?

☐ No

☐ Yes

Extramural Vascular Invasion (EMVI): ☐ No/☐ Yes

Tumor Deposit: ☐ No/☐ Yes

Other: [free text: bones, peritoneal mets, other incidental findings]

Impression:

☐ Rectal Wall

*No visualized rectal wall abnormality

* Scar-only is visualized

*Residual soft tissue at excision site

☐ Worrisome for residual tumor

☐ Equivocal for tumor

☐ Likely post-procedural change

☐ Lymph Nodes

☐ N0 (no visible lymph node or probably reactive)

☐ N + (Meet Dutch Criteria*)

☐ Nx (unable to tell reactive vs. malignant nodes)

Suspicious Extra-mesorectal lymph nodes: ☐ No ☐ Yes (provide location)

***Dutch Baseline Lymph Node Criteria**

☐ N0 (no visible lymph nodes/deposits)

☐ N+ (short axis >= 9 mm)

☐ N+ (short axis 5-9 mm AND at least 2 of the following criteria: round shape/irregular border contour/heterogeneous signal intensity)

☐ N+ (short axis < 5 mm AND round shape AND irregular border contour AND heterogeneous signal intensity)

☐ Nx (all other cases)

Standard 5.6: Local Excision Determined as Definitive Treatment During Meeting

RC-MDT decides local excision was definitive treatment during MDT discussion

The treatment recommendation summary + outcome summary can be completed at same RC-MDT meeting

Standard 5.7 – Definitive Treatment Timing

Minimum of 80% of previously untreated patients must begin definitive treatment within sixty (60) days

Local Excision

- No further treatment
  - **Standard 5.7 is not applicable**
- Diagnosis before local excision
  - **60 days from initial clinical evaluation**
- Local excision and further treatment recommended
  - **60 days from RC-MDT treatment planning discussion**

Special Templates Required for Local Excision

- **Radiology (5.4):** MRI template for use post-local excision (in Standards Manual Appendix OR on SAR website)

- **Surgery (5.8):** Local Excision Operative Report in Standards Manual Appendix

- **Pathology (5.9):** CAP Protocol for the Examination of Excisional Biopsy or Polypectomy Specimens from Patients with Primary Carcinoma of the Colon and Rectum

Standard 5.10 – Specimen Photographs

65% of rectal cancer specimens must be photographed to document the quality of the local excision

Surgical Resection

- 4 views (anterior, posterior, right lateral, left lateral)

Local Excision

- 1 full-on view photograph

Non-Operative Management

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Post-Neoadjuvant MRI

Must meet the requirements of Standard 5.4

- Read by a RC-MDT radiologist
- Use the Society of Abdominal Radiology (SAR) restaging template

Standardized MRI rectum *restaging* template by the Society of Abdominal Radiology (SAR) Colorectal and Anal Cancer Disease-Focused Panel (DFP).

Rectal Cancer Restaging MRI

CLINICAL INFORMATION: Rectal Cancer Restaging
Prior treatment: ☐ post CRT ☐ post TNT ☐ post induction chemotherapy ☐ post immunotherapy ☐ other [free text; include date of radiotherapy completion, if relevant]

TECHNIQUE:
Multiplanar, multisequence imaging of the pelvis.
Magnet strength: ☐ 1.5T ☐ 3.0T
Microenema: ☐ yes ☐ no
Glucagon: ☐ no ☐ SQ ☐ IV ☐ IM
IV gadolinium contrast: ☐ yes ☐ no

COMPARISON:
Date of most recent comparison exam: [date]
Date of baseline staging exam: [date]

Standard 5.11 –Treatment Outcome Discussion and Outcome Summary

- Compliance with this standard is evaluated based on the completion of the required RC-MDT treatment outcome discussion **AND** the treatment outcome summary

- 90% post-treatment presentation requirement for 5.11 includes:
  - TNT
  - Neoadjuvant therapy only
  - Surgical resections
  - Local excision
  - Patients under consideration for W&W

Treatment outcome discussion for any type of neoadjuvant therapy must occur **within 150 days** of completion of treatment

Neoadjuvant therapy stopped or aborted before completion

If neoadjuvant therapy is stopped or aborted before completion:

- RC-MDT presentation IS required
- If patient being considered for watch and wait, restaging MRI or post-treatment endoscopy must be completed
  - For other instances, up to RC-MDT

Standard 5.12: Watch and Wait Protocol

- Programs develops protocol for the clinical management of patients approved for watch and wait surveillance
- RC-MDT determines eligibility criteria to identify candidates for watch and wait

The standard does not have specific requirements regarding clinical management under watch and wait

Standard 5.12: Watch and Wait Protocol

- Watch and Wait candidates must be presented to the RC-MDT and approved for surveillance. Must include review of:
  - Complete local re-staging
    - Post-treatment MRI (all elements of Standard 5.4 apply)
  - Post-treatment endoscopy
  - PET scans, if available

Approval for W&W can be during the RC-MDT treatment outcome discussion following neoadjuvant therapy

- Does not have to be separate presentation for W&W approval

Standard 5.12: Watch and Wait Protocol

RC-MDT has discretion to establish all the specifics of the required elements

Watch and Wait protocol must include:

- Eligibility criteria, including contraindications
- Documentation of clinical processes
- Frequency of follow-up
- Considerations for follow-up imaging (MRI/CT/endoscopy)
- The providers responsible for reviewing follow-up imaging, endoscopy, and patient clinical assessment
- Specific mechanisms for patient follow-up and patient tracking
  - Intended to minimize # lost to follow-up while under W&W

Standard 5.12: Watch and Wait Protocol

Patients under Watch and Wait Surveillance are only required to be re-presented to the RC-MDT **in the event of a significant clinical finding from any follow-up assessment or imaging study**

If W&W patients require surgical intervention, the patient's evaluation and treatment must meet compliance with all applicable NAPRC standards

- Standard 5.12 does not address classifications of regrowth or recurrence

Recurrence

- After resection or excision

Regrowth

- After watch and wait

Treatment Recommendation & Outcome Summaries

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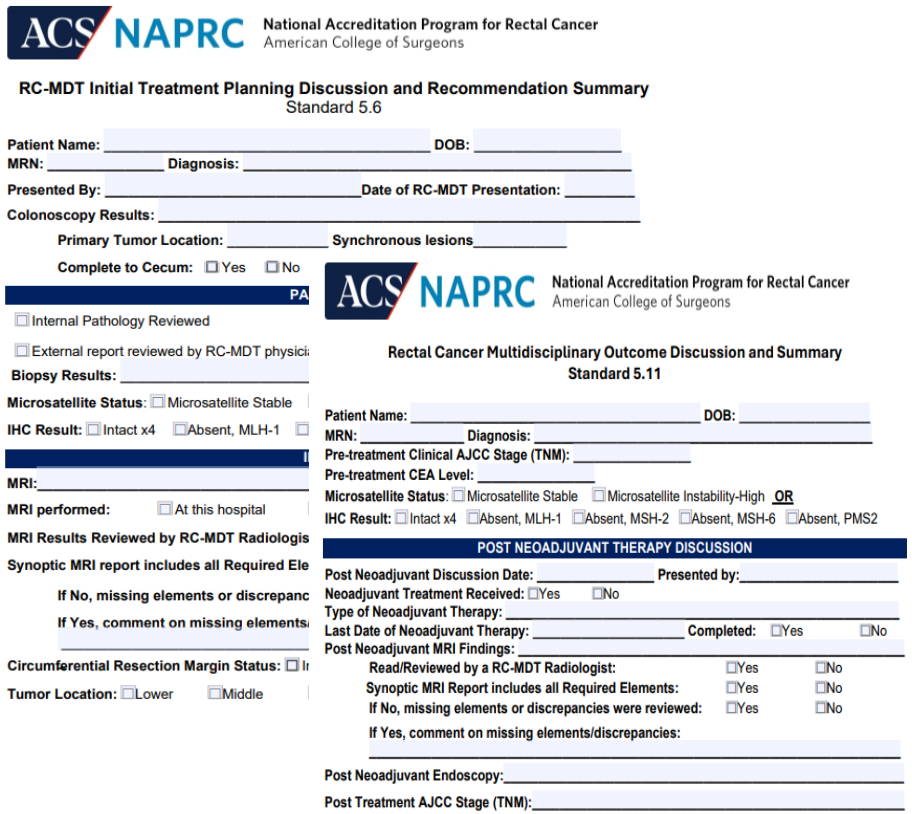
- Templates available in Quality Portal Resources section:
  - Initial Treatment Recommendation Summary
    - Includes section for diagnostic transanal excision, if applicable
  - Post-Treatment Outcome Discussion and Summary
    - Includes sections on post-neoadjuvant therapy, post-surgical TME, post local excision, if applicable



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RC-MDT Initial Treatment Planning Discussion and Recommendation Summary
Standard 5.6

Patient Name: _____ DOB: _____
MRN: _____ Diagnosis: _____
Presented By: _____ Date of RC-MDT Presentation: _____
Colonoscopy Results: _____
Primary Tumor Location: _____ Synchronous lesions_____
Complete to Cecum: ☐Yes ☐No

PA
☐Internal Pathology Reviewed
☐External report reviewed by RC-MDT physici
Biopsy Results: _____
Microsatellite Status: ☐Microsatellite Stable
IHC Result: ☐Intact x4 ☐Absent, MLH-1 ☐
I
MRI:_____
MRI performed: ☐At this hospital
MRI Results Reviewed by RC-MDT Radiologis
Synoptic MRI report includes all Required Ele
If No, missing elements or discrepanc
If Yes, comment on missing elements
Circumferential Resection Margin Status: ☐ I
Tumor Location: ☐Lower ☐Middle

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Rectal Cancer Multidisciplinary Outcome Discussion and Summary
Standard 5.11

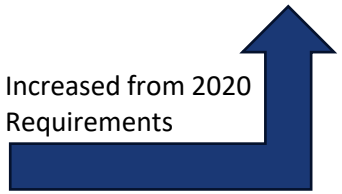
Patient Name: _____ DOB: _____
MRN: _____ Diagnosis: _____
Pre-treatment Clinical AJCC Stage (TNM): _____
Pre-treatment CEA Level: _____
Microsatellite Status: ☐Microsatellite Stable ☐Microsatellite Instability-High OR
IHC Result: ☐Intact x4 ☐Absent, MLH-1 ☐Absent, MSH-2 ☐Absent, MSH-6 ☐Absent, PMS2

POST NEOADJUVANT THERAPY DISCUSSION
Post Neoadjuvant Discussion Date: _____ Presented by:_____
Neoadjuvant Treatment Received: ☐Yes ☐No
Type of Neoadjuvant Therapy: _____
Last Date of Neoadjuvant Therapy: _____ Completed: ☐Yes ☐No
Post Neoadjuvant MRI Findings: _____
Read/Reviewed by a RC-MDT Radiologist: ☐Yes ☐No
Synoptic MRI Report includes all Required Elements: ☐Yes ☐No
If No, missing elements or discrepancies were reviewed: ☐Yes ☐No
If Yes, comment on missing elements/discrepancies:
_____
Post Neoadjuvant Endoscopy:_____
Post Treatment AJCC Stage (TNM):_____

Use one initial summary & one post-treatment summary per patient
- Complete whichever sections applicable

Treatment Recommendation & Outcome Discussion Summaries: Delivery Requirements

A treatment recommendation summary must be provided to the treating physician for a minimum of **90%** of patients with rectal cancer



If the treating physician is in attendance for the RC-MDT discussion → treatment recommendation summary **does not** need to be provided to them

Quality Improvement for NAPRC Programs (Standard 7.2)

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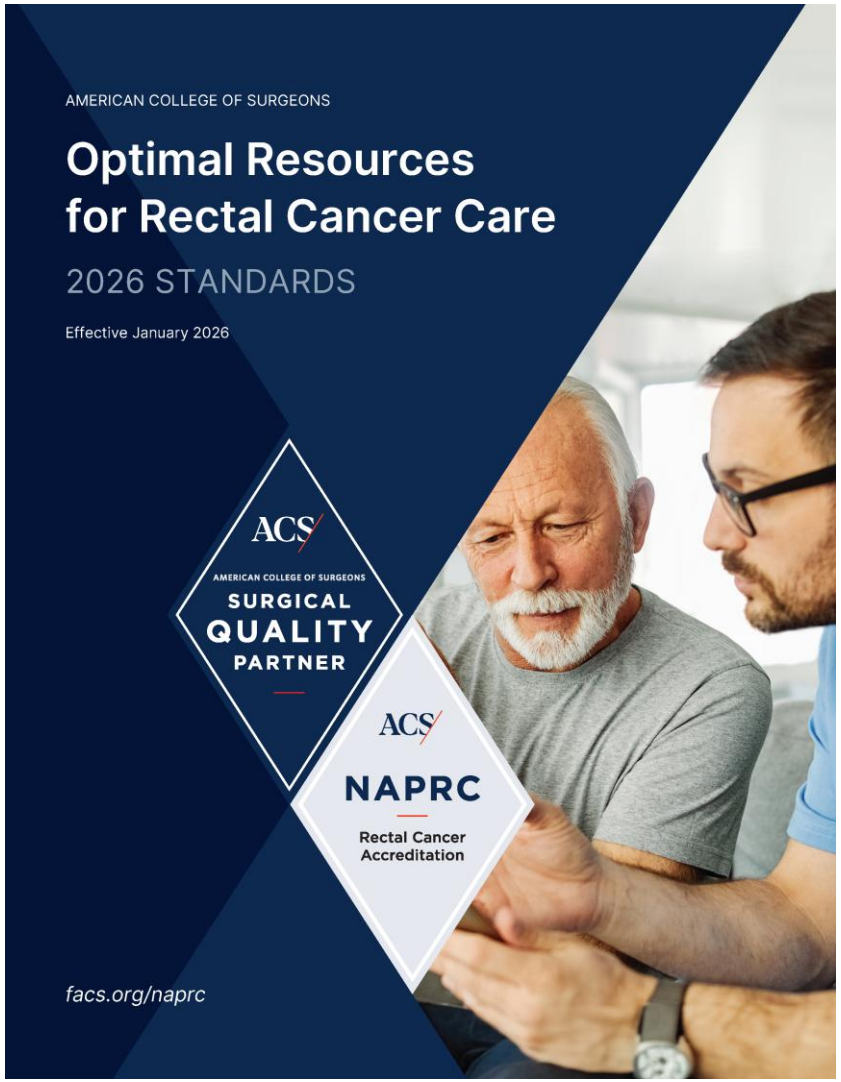
Standard 7.2: Quality Improvement Initiative

- New standard for NAPRC Programs starting in 2026
- Aligned with CoC and NAPBC QI standards

Programs must implement at least **one** rectal cancer-specific quality improvement (QI) initiative **each accreditation cycle**

- **More time, higher quality projects**

Utilize a consistent quality improvement methodology (DMAIC, PDSA)



Components of the Standard

1. Review Data to Identify the Problem
2. Write the Problem Statement
3. Choose QI Methodology and Metrics
4. Implement Intervention and Monitor Data
5. Present Quality Improvement Initiative Summary

Measure of Compliance:

- Document in meeting minutes 2x/year while project is active
- Complete the 7.2 template

7.2 Quality Improvement Initiative

Definition and Requirements

Under the guidance of the Rectal Cancer Program (RCP) Director, the NAPRC-accredited program must measure, evaluate, and improve its performance through at least one rectal cancer-specific quality improvement initiative each calendar year. The NAPRC quality improvement initiative must be separate and distinct from the quality improvement initiative implemented to demonstrate compliance with CoC Standard 7.3: Quality Improvement Initiative.

This quality improvement (QI) initiative requires the NAPRC-accredited program to identify a problem, understand the root cause of the identified problem through the use of a recognized performance improvement methodology, and implement a planned intervention to the problem. Reports on the status of the QI initiative must be given to the RC-MDT at least twice each calendar year and documented in the RC-MDT meeting minutes.

Required Components for Quality Improvement Initiatives

1. **Review Data to Identify the Problem**
   The QI initiative must be focused on an already identified, quality-related problem specific to the NAPRC-accredited program.

   The following may be used to identify the focus of the QI initiative:
   - Problems identified in a National Cancer Database (NCDB) quality measure
   - Problems identified through review of NCDB data, including Cancer Quality Improvement Program (CQIP)
   - Data-focused quality problems identified through a chart review of a specific cohort of patients in order to assess an area of specific concern or to assess an area of care specified in nationally recognized guidelines
   - Data-focused quality problems identified through an internal institution-specific or health-system-specific database, which may include the entire cancer registry or a smaller established clinical database
   - Problems identified through review of data related to cultural competency, individualized shared decision making, and the implementation of health equity interventions in the cancer program
   - Any other rectal cancer-specific, quality-related problem identified by the RC-MDT

2. **Write the Problem Statement**
   The QI initiative must have a problem statement. The problem statement must outline:
   - A specific, already identified, quality-related problem that is specific to the NAPRC-accredited program to solve through the QI initiative
   - The baseline and goal metrics (must be numerical)
   - The anticipated timeline for completing the QI initiative, and achieving the expected outcome

   The problem statement for the QI initiative cannot state that a study is being done to see if a problem exists. The problem must already be known to exist.

3. **Choose and Implement Performance Improvement Methodology and Metrics**
   The RCP Director and RC-MDT must identify the subject matter experts needed to execute the QI initiative.
   A recognized, standardized performance improvement methodology must be selected and implemented to conduct the QI initiative (for example, Lean, DMAIC, or PDCA/PDSA).

   In line with the performance improvement methodology selected, the team must conduct analysis to identify all possible factors contributing to the problem. This may involve literature review and/or root-cause analyses. Based on the results of this analysis, an intervention must be developed that aims to fix the cause of the problem being studied.

   It is recommended to establish a project calendar, which includes the launch date of the QI initiative, when status updates will be given at RC-MDT meetings, and a project end date.

   QI initiatives are expected to last approximately one calendar year. If additional time is required, the initiative may be extended for a second year (for a total of two years). However, a new QI initiative must be started at the beginning of each calendar year, even if a previous QI initiative is still in progress. The last RC-MDT meeting of the calendar year must include a status update for any ongoing QI initiative that will be extended into a second calendar year.

Standard 7.2: Only One QI Project Required Each Accreditation Cycle

Initial Site Visits

- Must "plan" the QI and demonstrate the following:
  - QI Initiative Title
  - Performance Improvement Approach
  - Problem Statement
  - Data source used to identify the problem
  - QI initiative team members

Does the project have to be completed during the accreditation cycle? Yes.

Reporting requirements to the RC-MDT

- While the project is active, at least 2 status updates/year must be provided.
- No status updates required after completion of the project

If the program completes a project in Year 1 or Year 2, do we have to start another one? No

NEW: NAPBC/NAPRC project can count for CoC credit

During each accreditation cycle, one NAPBC project and one NAPRC project can be submitted for CoC credit

Example

2026 (Year 1)	2027 (Year 2)	2028 (Year 3)
• CoC start QI project • Counts for 2026 credit	• NAPRC project completed • Counts for 2027 credit	• NAPBC project completed • Counts for 2028 credit

NOTE: This is OPTIONAL. CoC programs must complete a QI Project each year. If not utilizing NAPBC/NAPRC projects, must start a new project each year.

QI for NAPRC Webinar Available!

Q&A

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2025-2026 Cancer Programs On-Demand Webinars
Now Available

- NAPRC Site Visit Process: Success Using the New Standards
- NAPRC Standard 5.10 Photographs of Surgical Specimens
- AJCC Protocol on Version 9 Staging System for Lung
- NAPRC Tools and Resources
- New Smoking Cessation Standard
- QI for NAPRC Programs
- Standards Updates
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