Frequently Asked Questions on the 2020 Optimal Resources for Cancer Care Standards
Chapter 2: Program Scope and Governance

Standard 2.1: Cancer committee

The standard states there can only be an alternate for one person. What if a required member on the cancer committee holds two required positions? Ex: Cancer Liaison Physician (CLP) & Medical Oncology. Can one person be the alternate for both if they qualify?

Yes, the alternate can be appointed for two roles if it is for the same required member and if they qualify.
Ex: Yes –CLP & Medical Oncology
No – Survivorship Program Coordinator and Certified Tumor Registrar (CTR)

Does the CLP HAVE to be the alternate for the chair?

Yes, the CLP is the Cancer Committee Chair’s alternate.

If our Cancer Committee Chair is a surgeon, can he also fulfill the surgeon membership role?

Yes.

Is a three-year appointment required to serve on the cancer committee? Can changes to committee membership take place during the accreditation cycle?

Programs may choose to appoint more often than once every three years. Appointments need to occur during the first meeting of a calendar year at least one time during the three-year accreditation cycle. If any changes to committee membership are made during the cycle, you will need to document it in the minutes. This includes member replacement, interim members, and change in alternates.

Our current CLP wants to step down. Is there a best practice to do this? Our next site visit is eight months later.

An interim CLP must be appointed. It is recommended that your cancer committee review the CLP guidelines on our web site; Cancer Liaison Program. The site also includes the steps for changing the CLP information in the ACS Portal.

Can the CLP and Cancer Committee Chair positions be held by the same person?

Yes, Standard 2.2 states; “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.”
What is the best course of action if both the cancer committee member and alternate leave the facility during the year?

First you need to document the departure for the two positions in the minutes. If you do not have an immediate replacement to appoint, then you should name an ‘interim’ member (naming an interim alternate is up to your committee). Once you have found a replacement, then document the appointment for the required role as well as the alternate. Keep in mind that alternates are optional. When tracking attendance for Standard 2.4, you would add the attendance of the former appointee and alternate with the interim member and the newly appointed member (and alternate) for the year.

What if you refer out for radiation oncology?

The standard states that “if all radiation oncology services are provided by referral and the facility’s medical staff does not include a radiation oncologist, a radiation oncologist is recommended but not required.”

Does the Cancer Conference Coordinator have to be a CTR?

No, there is no requirement that the Cancer Conference Coordinator must be a CTR.

What are the requirements to serve as the Survivorship Program Coordinator?

As stated in the standard, page 7, the Survivorship Program Coordinator can be a physician, physician assistant, advanced practice nurse, nurse, social worker (OSW-C preferred), nurse navigator, or therapist or other licensed health care professional.

Standard 2.2: Cancer Liaison Physician

Does the CoC provide basic guidelines for the time expectations that can be expected by committee members?

No, time commitments vary by facility.

Does the CLP no longer have an application process and three-year commitment? Is the CLP simply appointed each year?

The CLP will be appointed to their role like all other required members of the cancer committee.
Since the CLP only needs to present two times a year, can this just be on the quality measures in the Rapid Cancer Reporting System (RCRS)? What if both are compliant and aren’t areas of concern, would this still be compliant?

Technically, if the CLP reports on RCRS at cancer committee twice per year it will comply for Standard 2.2. However, for Standard 2.2, the CLP is the quality leader and should be using all the NCDB tools to identify, analyze and present the data to the cancer committee. Standard 2.2 is intended to focus on areas of concern or where expected performance is not being met.

Can you give examples of who qualifies as a CLP alternate for Standard 2.2?

An alternate would be another physician who meets criteria of the CLP role.

**Standard 2.3: Cancer Committee Meetings**

Do we have to document subcommittee meetings in the Pre-Review Questionnaire?

As stated in the standard on page 10, “if subcommittees and/or workgroups are utilized, activities and reports related to standard compliance must be presented to and approved by the cancer committee.”

**Standard 2.4: Cancer Committee Attendance**

Does CoC want to see attendance for non-required members?

The CoC requires that all required members’ attendance be documented, and it is recommended that guest attendance be documented. However, non-required member attendance is not required to be tracked for compliance.

**Standard 2.5: Multidisciplinary Cancer Case Conference**

What do you consider to be supportive services?

These services should be determined by your cancer committee, but may include psychosocial care, rehabilitation services, nutrition, nursing and rehab services (outside of physician specialties).

With site-specific conferences, where it states committee determines who will need to attend – can a radiologist be in attendance as needed?

This is not recommended, but it would depend on the cancer site. A physician specialty involved in the treatment of a specific cancer type should be given a required attendance percentage to attend that site-specific cancer conference.
Does pre-review of clinical trial eligibility count for discussion at the cancer conference?

No. it is required that clinical research trial eligibility be discussed at cancer conferences for appropriate patients to qualify for Standard 2.5.

Do programs have to report/record total numbers or percent of cases in which genetic testing, research, and support services is applicable and discussed?

Reporting on the number of cases discussed for these areas is required to be part of the coordinator report.

How do you measure genetics and support services involvement in cancer conference now that it is a requirement?

Supportive services (outside of physician specialties) reporting should be determined by your cancer committee, but may include psychosocial care, rehabilitation services, nutrition and rehab services. Genetic testing and counseling should be discussed at conferences as appropriate. Your program may determine what is appropriate based on the services you offer.

Can CoC provide best practice on tumor board documentation? We have encountered some challenges in implementing standardization since the standard is not explicit.

The cancer program should consult with its legal and/or risk management department to conform to local policy and requirements for documenting cancer conferences. A template is also available that must be completed with the PRQ before the site visit.

Who must be present at specialty tumor boards?

Programs may define the specialties required for specialty or site-specific cancer case conferences.

The addition of genetics testing to cancer conference; does this include both on-specimen and testing the patient (genetic counseling)? i.e., FISH on AML patients or BRCA on breast patients.

Genetic testing and counseling should be discussed at conferences as appropriate. Your program may determine what is appropriate based on the services you offer.

Integrated Network Cancer Program (INCP): Is the 15% calculated per facility or as a network?

15% is required at the network level, but all facilities must be represented and included.
Is the attendance requirement for surgery, medical oncology, radiation oncology, etc. at general cancer conference to be 100%? Or can we have a committee decide the rate? Ex: 80%

The cancer program is to set the policy and procedure to govern multidisciplinary cancer case conference activity, which includes multidisciplinary participation. This is to be submitted and reviewed by the cancer committee and documented in the cancer committee meeting minutes. The CoC Standards does not specify an attendance requirement. Keep in mind that each general cancer case conference must have a representative from the five required disciplines in attendance.

If a cancer program has seven specialty case conferences and allows general cases to be presented as needed, is that acceptable?

This is acceptable as long as there is a mechanism to present cases for evaluation at a multidisciplinary cancer case conference that do not fit into the defined specialty or site-specific conferences. This should be included in the policy and procedure.

Do the tumor boards need to have accreditation approval that awards CME for them to count towards the education standard?

Not for purposes of Standard 2.5. However, if physicians or nurses wish to use the cancer conference to meet continuing education requirements in Standard 4.1 or 4.2, then CME or CNE would be required.

Is the multidisciplinary cancer case conference the same as tumor board?

Yes.