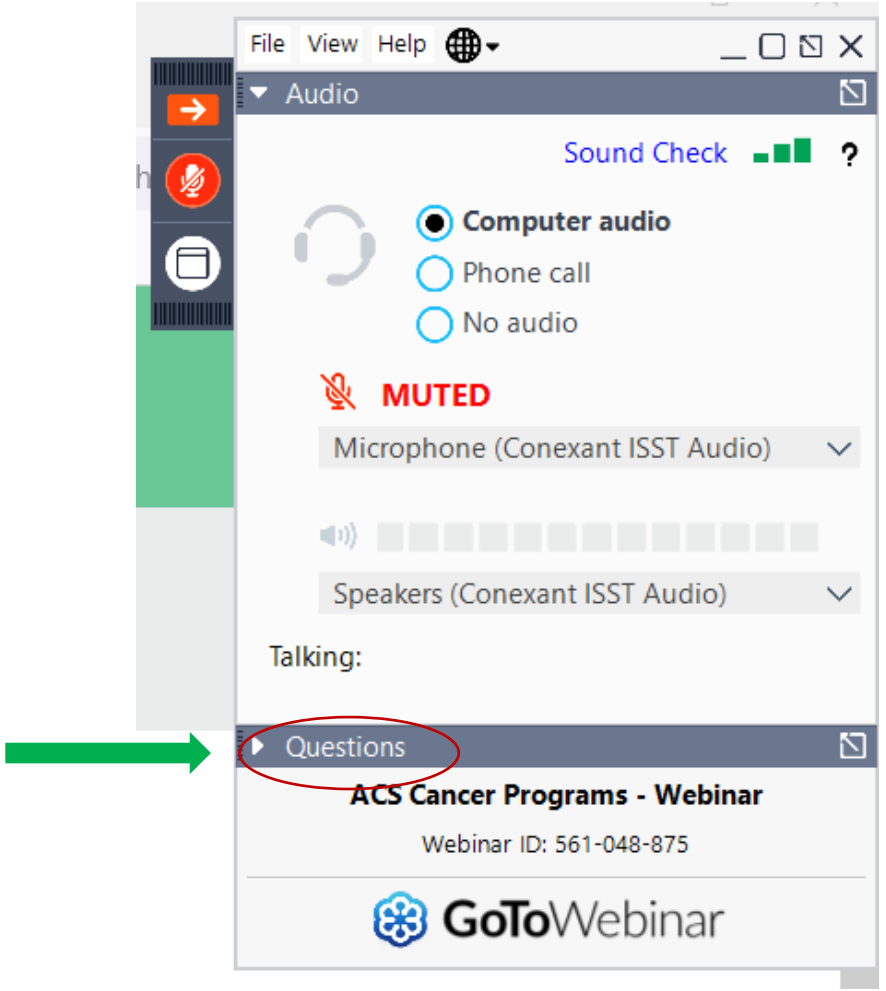
Commission on Cancer
American College of Surgeons

CoC Accreditation: What Rural Hospitals Need to Know

The webinar will start at 4:00 PM CT

Logistics

- All participants are muted during the webinar
- Questions – including technical issues you may be experiencing – should be submitted through the question pane
- Questions will be answered as time permits; additional questions and answers will be posted on the website
- Please complete the post-webinar evaluation you will receive when we end the webinar.



Commission on Cancer
American College of Surgeons

CoC Rural Cancer Program Accreditation

Erin Reuter, JD, MS

Senior Manager, Accreditation

Accreditation Tailored to Rural Programs

Eligibility: Hospital is located in a county that is designated RUCC 4-9

- RUCC: Metric that differentiates counties by their population size, degree of urbanization, and adjacency to a metro area

Eligibility is based on the **location of the hospital** not the patient population

Rural-Urban Continuum Codes

Updated: 1/7/2025 **Contact:** Austin Sanders or John Cromartie

The 2023 Rural-Urban Continuum Codes distinguish U.S. metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by their degree of urbanization and adjacency to a metro area. The division of counties as either metro or nonmetro, based on the 2023 Office of Management and Budget (OMB) delineation of metro areas, is further subdivided into three metro and six nonmetro categories. Each county and census-designated county-equivalent in the United States, including those in outlying territories, is assigned one of these nine codes. The codes allow researchers, policy makers, and others to view county-level data by finer residential groups—beyond metro and nonmetro—when analyzing trends related to population density and metro influence.

Developed in 1974, the Rural-Urban Continuum Codes have been updated each decade since (1983, 1993, 2003, 2013, 2023). Changes in the criteria used to define urban and metro areas over time has reduced the comparability of the Rural-Urban Continuum Codes over each of the past five decades. For the 2023 version, the threshold for urban area population was raised from at least 2,500 to 5,000 people, reflecting changes to urban area qualification introduced by the U.S. Census Bureau in 2020.

See the Documentation for details and a map of the codes.

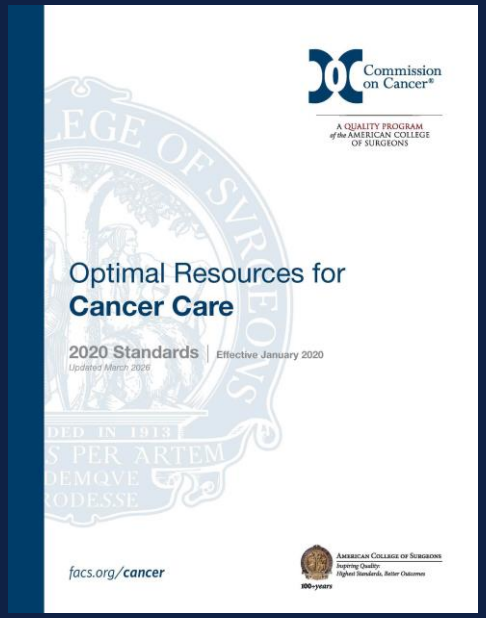
File Downloads

2023 Rural-Urban Continuum Codes
Download XLSX | Download CSV
Last Updated 1/22/2024

https://www.ers.usda.gov/data-products/rural-urban-continuum-codes

Download the CoC Rural Cancer Program Standards!

Specifications by Category section supplements the CoC Standards



RCP Specifications begin on page 100

ACS AMERICAN COLLEGE OF SURGEONS

ACS CoC Commission on Cancer
American College of Surgeons

What's Different in the Rural Cancer Program Category?

Fewer requirements to apply

Exempt at initial site visit:

- Tumor Board*
- Quality Improvement Initiative
- Barriers to Care

Only need to offer 1 of 3 supportive care services at initial site visit:

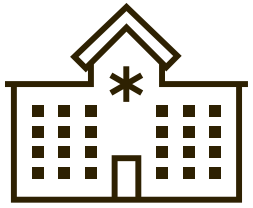
- 4.5: Palliative Care
- 4.7: Nutrition
- 5.2: Psychosocial distress screening

Decreased requirement for patient services

Standard 4.5: Palliative Care Services, Standard 4.7: Oncology Nutrition Services, and Standard 5.2: Psychosocial Distress Screening

- Before the **initial site visit**, the Rural Cancer Program complies with **one** of the following standards: 4.5, 4.7, or 5.2.

- By the **reaccreditation visit**, the Rural Cancer Program must comply with **at least two** of the following standards: 4.5, 4.7, or 5.2.



- The required annual review is limited to monitoring, evaluating, and making recommendations for improvements.

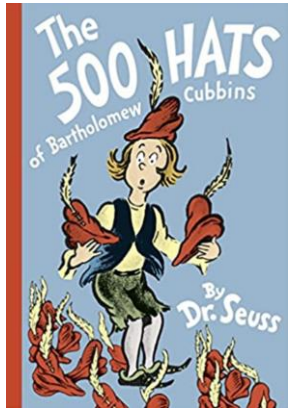
Decreased staffing requirements

Current Requirements:

- Must have a cancer committee with the following specialties: **radiology, pathology, surgery, medical oncology, radiation oncology, nursing, social work, and Oncology Data Specialist**
- Must have a CLP, Cancer Committee Chair, Cancer Program Administrator, and representatives filling **six** coordinator positions

Modified RCP Requirements:

- Must have a cancer committee with **three physicians** and **two healthcare professionals** (all from different disciplines)
- Additionally, required to have CLP, Cancer Program Administrator, and **three** coordinator positions



Decreased tracking and documentation requirements

- Reports only required once per 3-year accreditation cycle instead of annually for:
  - Monitoring Concordance with Evidence-Based Guidelines
- No requirement for tracking of number of patients referred for:
  - Genetic Counseling, Palliative Care, Nutrition, Psychosocial Distress Screening, Survivorship, Clinical Research
- Only one QI project required per accreditation cycle
- Only one survivorship program needs to be reviewed per year (vs 3)

Standard 4.4: Genetic Counseling and Risk Assessment

Current Requirements:

- Risk assessment, genetic counseling/testing provided either on-site or by referral by qualified genetics professional
- Policy in procedure in place
- Process in place to pursuant to evidence-based guidelines for specific cancer site.
  - In-depth review of a specific cancer site

Modified RCP Requirements:

- **No data review** for a specific cancer site
- **Annual review limited** to monitoring, evaluating, and making recommendations for improvement to genetics

Key standards that remain the same

- Data Submission Requirements
- Compliance with Quality Measures
- Operative Standards
- Pathology Reporting
- Smoking Cessation
- Prevention and Screening Events
- Tumor Board (after initial site visit)
- Cancer Liaison Physician

Commission on Cancer
American College of Surgeons

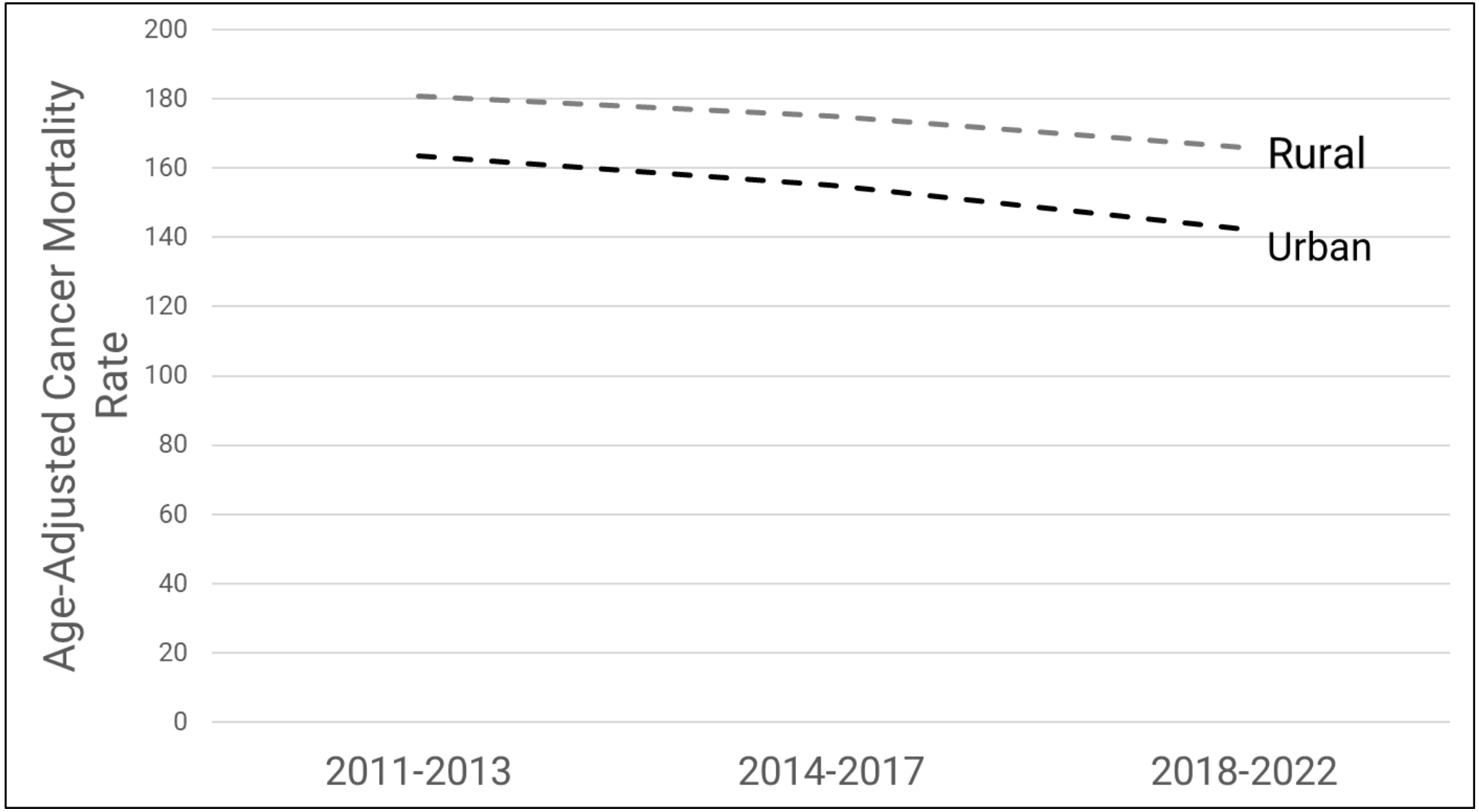
Supporting Cancer Care in the Rural Setting through Accreditation: Development of the Commission on Cancer Rural Accreditation Track

Ingrid Lizarraga MBBS, FACS

March 24, 2026

The story begins in Iowa…

US Cancer Mortality Rates by Rurality



JAMA Netw Open. 2018 Aug 3;1(4):e181235. doi: 10.1001/jamanetworkopen.2018.1235.

Geographic Distribution and Survival Outcomes for Rural Patients With Cancer Treated in Clinical Trials.

Unger JM[1,2], Moseley A[1,2], Symington B[3], Chavez-MacGregor M[4], Ramsey SD[2], Hershman DL[5].

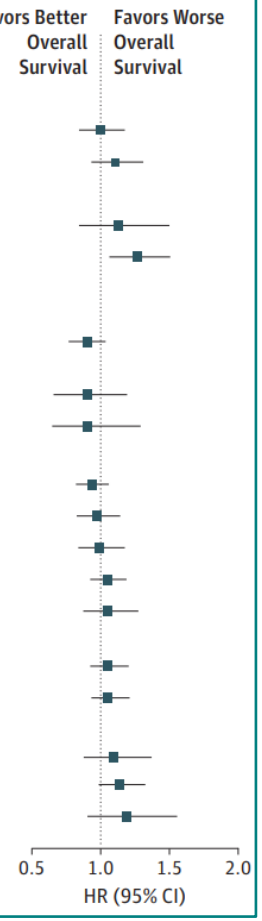
"Rural and urban patients with uniform access to cancer care through participation in a SWOG clinical trial had similar outcomes.

This finding suggests that improving access to uniform treatment strategies for patients with cancer may help resolve the disparity in cancer outcomes between rural and urban patients."

Forest Plot Showing the Association of Rural Residence and Survival Outcomes from Cox Regression Analyses

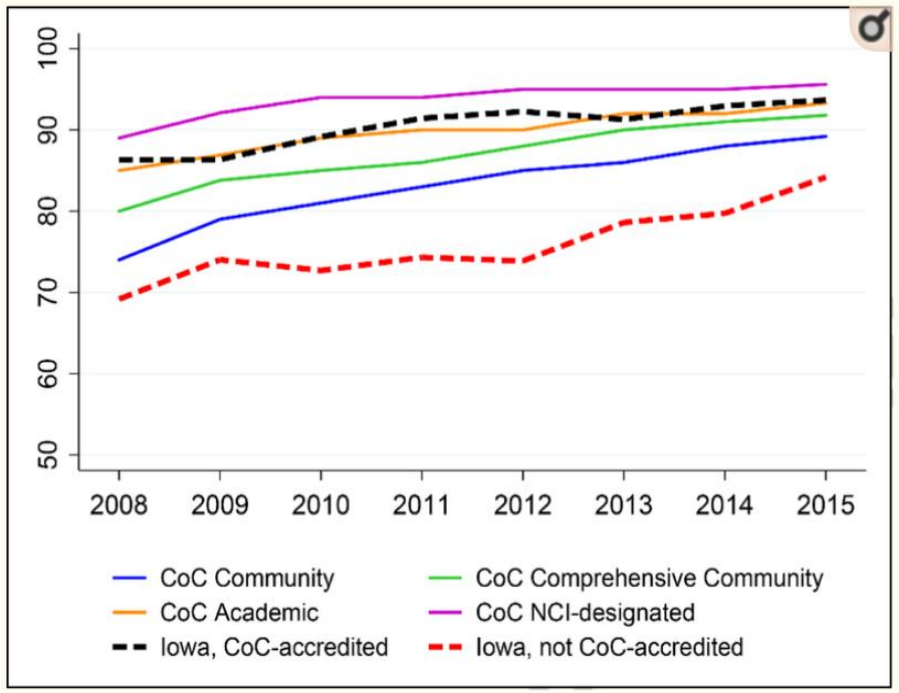
A Overall survival

Cancer Cohort	Patients, No.	HR (95% CI)
Adjuvant		
Adjuvant colorectal	2593	0.99 (0.84-1.17)
Adjuvant breast, ER-positive and/or PR-positive	11413	1.10 (0.93-1.30)
Adjuvant gastric	488	1.12 (0.84-1.50)
Adjuvant breast, ER-negative and PR-negative	5026	1.27 (1.06-1.51)
Advanced		
Advanced prostate, hormone refractory	1658	0.90 (0.79-1.03)
Brain	323	0.90 (0.68-1.19)
Advanced indolent non-Hodgkin lymphoma	1035	0.91 (0.64-1.29)
Acute myeloid leukemia	1748	0.94 (0.83-1.06)
Advanced prostate 2	2055	0.97 (0.83-1.14)
Advanced breast	1247	0.99 (0.83-1.18)
Multiple myeloma	2493	1.05 (0.93-1.18)
Advanced aggressive non-Hodgkin lymphoma	1155	1.05 (0.87-1.27)
Advanced colorectal	1431	1.05 (0.92-1.20)
Advanced non-small cell lung cancer	1461	1.06 (0.93-1.20)
Advanced ovarian	903	1.10 (0.88-1.37)
Advanced prostate 1	1333	1.14 (0.98-1.32)
Advanced gastrointestinal stromal tumor	633	1.19 (0.90-1.56)



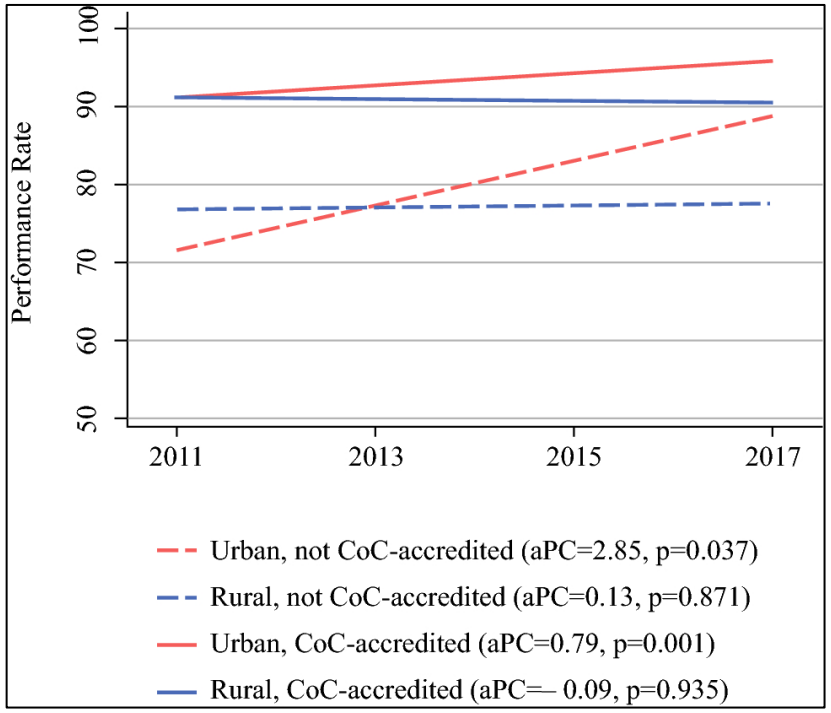
Compliance with Quality Measures is Worse in Non-CoC Hospitals

Percent of colon cases compliant with lymph node measure by CoC accreditation category



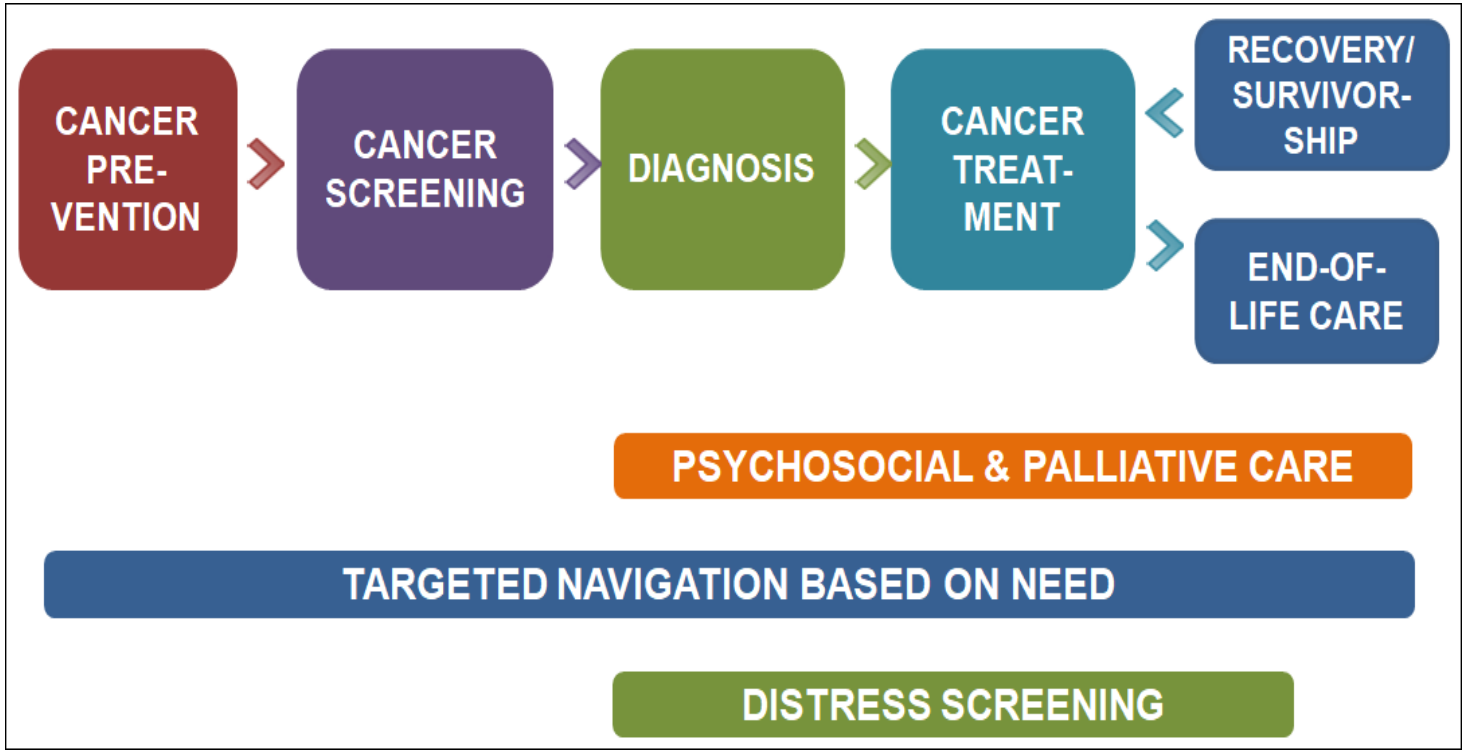
Shulman et al. 2019. Compliance with Cancer Quality Measures Over Time and Their Association with Survival Outcomes: The CoC's Experience with the Quality Measure Requiring >12 Regional Lymph Nodes to be Removed and Analyzed with Colon Cancer Resections.

Percent of colon cases compliant with lymph node measure by hospital rurality and CoC accreditation status



Schroeder, M.C., Gao, X., Lizarraga, I. *et al.* The Impact of Commission on Cancer Accreditation Status, Hospital Rurality and Hospital Size on Quality Measure Performance Rates. *Ann Surg Oncol* **29**, 2527–2536 (2022). https://doi.org/10.1245/s10434-021-11304-3

Commission on Cancer (CoC)



CoC is an accreditation program designed to promote **comprehensive, evidence-based cancer care** through **measurement and quality improvement**

CoC standards address the full continuum of cancer— from prevention to survivorship and end-of-life care—while addressing both survival and quality of life

National Cancer Database

ACS NCDB National Cancer Database
American College of Surgeons

- National, clinical cancer registry system
- Over **36 million** cancer cases diagnosed beginning in 1985
- NCDB captures over 250 data points
  - All cancer types
  - Includes patient characteristics, cancer staging and tumor histological characteristics, type of first course treatment administered and outcomes information
- **Continuous quality improvement** for the evaluation, management, and surveillance of cancer patients

“If you can’t measure it, you can’t improve it.”

Data on performance

Quality of Care Measure:

- A high priority, disease specific evidence-based best practice in cancer care
- Performance tracked by the Commission on Cancer and reported to member hospitals

Cancer sites with quality measures:

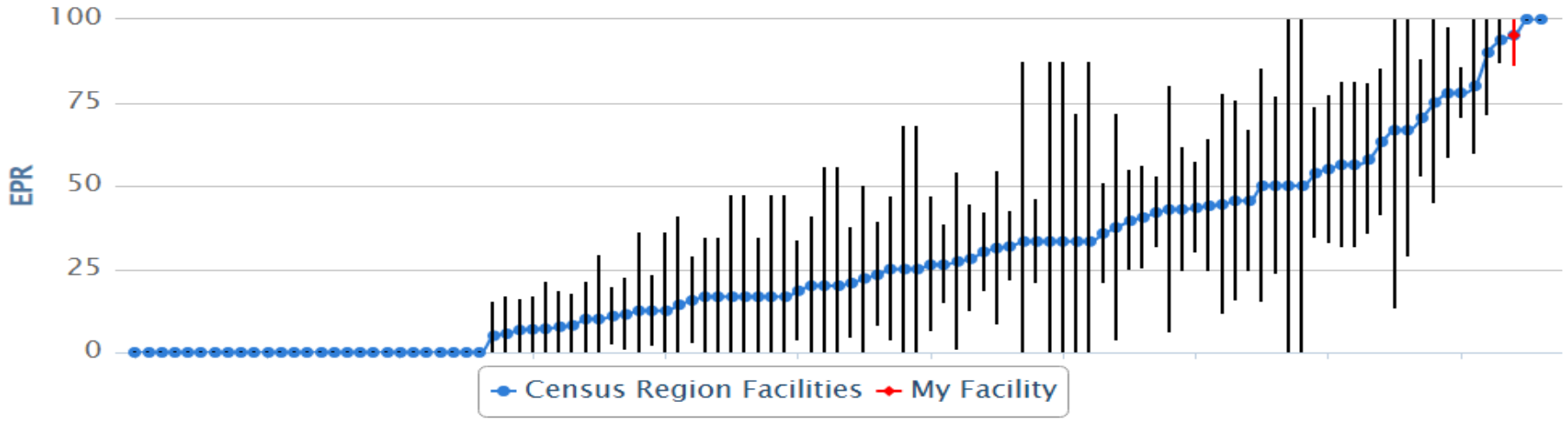
Breast, colon/rectum, lung, head and neck, melanoma, prostate, cervix, bladder, kidney

CoC Quality Measures

Note: report displays data available for the current year - 2, as well as 2 years of subsequent data.

Primary Site	Measure	2023 PR	2022 PR	2021 PR
Cervical	CBRRT	57.14%	56.25%	47.06%
Colon	ACT	71.43%	73.33%	100.00%
	C12RLN	96.88%	98.00%	97.78%
Gastric	G16RLN	75.00%	100.00%	100.00%
	GCTRT	83.33%	71.43%	84.62%
HeadNeck	HadjRT	18.52%	20.00%	34.15%
Kidney	KPN	100.00%	86.11%	85.71%
Lung	LCT	100.00%	78.57%	73.91%
Melanoma	MadjRx	100.00%	100.00%	85.71%
Prostate	PTSRV	100.00%	85.19%	73.08%
Rectum	RCRM	100.00%	100.00%	96.15%
	RneoRT	75.00%	66.67%	93.75%

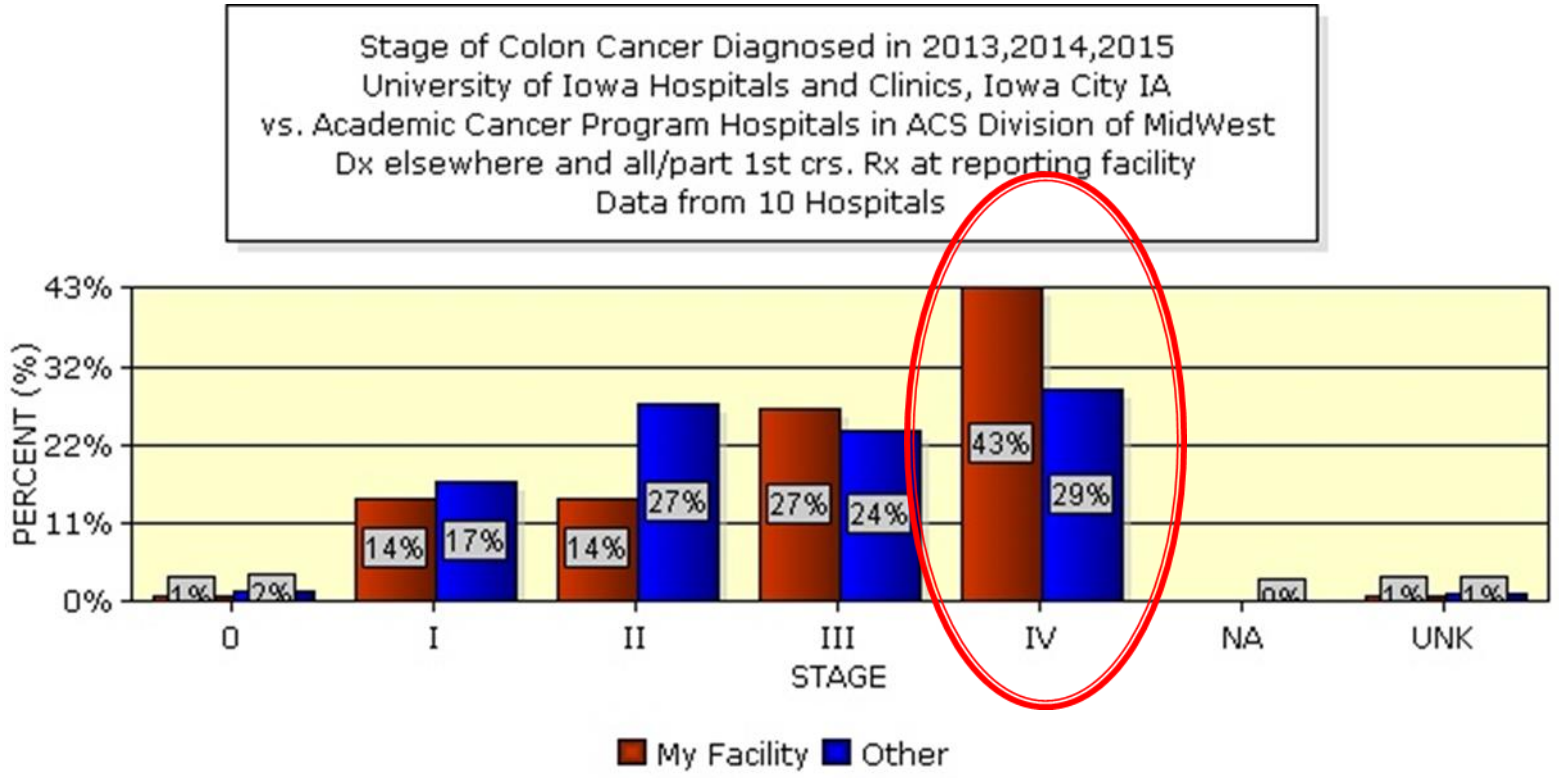
Breast, 2023, BnoLN: Age >= 70, grade 1-2, HR+ and HER2- invasive breast carcinoma <=2cm and AJCC cN0, who underwent BCS, a SNBx or ALND was not performed



	My Program	My State (IA)	My Census Region (West North Central)	My ACS Region (North)	My CoC Program Type (ACAD)	All CoC Programs
Performance Rate	95.2 %	32.9 %	33.5 %	46.3 %	55.5 %	45.5 %
Denominator	21	149	1452	4701	4465	18067
95 % CI	(86.1,100.0)	(25.3,40.4)	(31.0,35.9)	(44.9,47.8)	(54.1,57.0)	(44.7,46.2)

For patients age >= 70, grade 1-2, hormone receptor positive and HER2 negative invasive breast carcinoma with tumor size <=2cm and AJCC cN0, who underwent breast conserving surgery, sentinel lymph node biopsy or axillary lymph node dissection was not performed (RCRS data as of 11/3/2025)

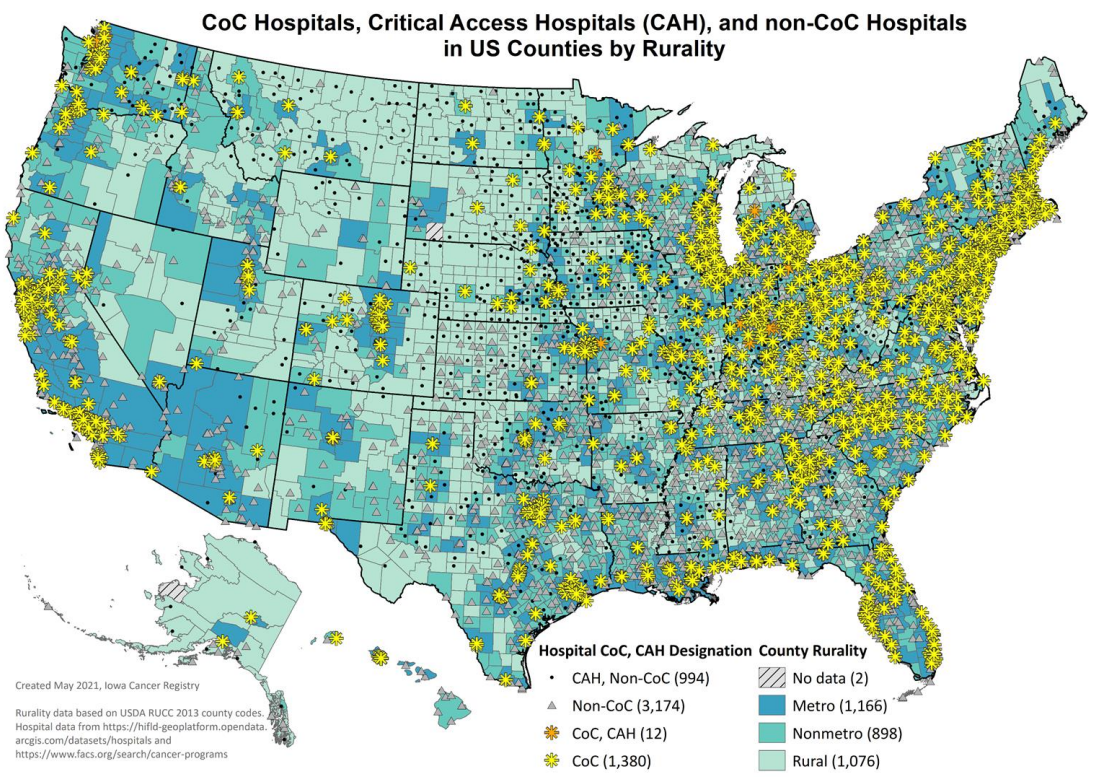
Data on areas of opportunity



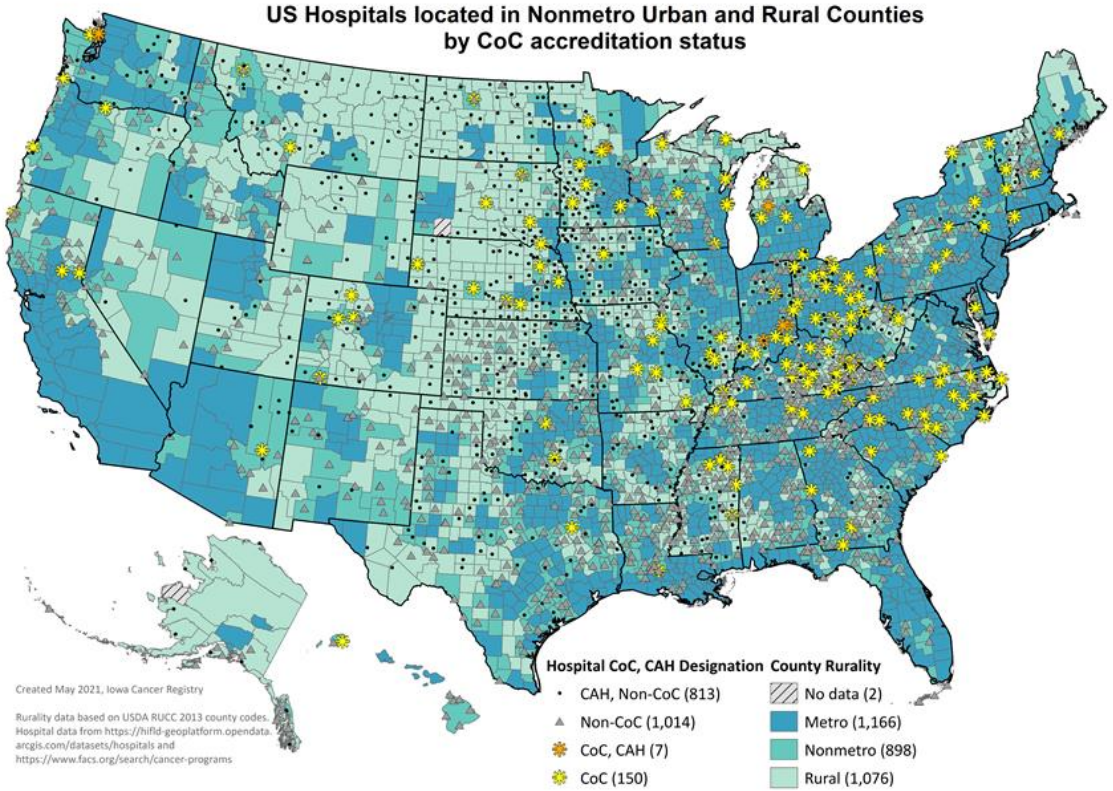
	0	I	II	III	IV	NA	UNK
My Facility	1%	14%	14%	27%	43%		1%
Other	2%	17%	27%	24%	29%	0%	1%

Rural urban differences in Commission on Cancer (CoC) accreditation

All CoC Hospitals

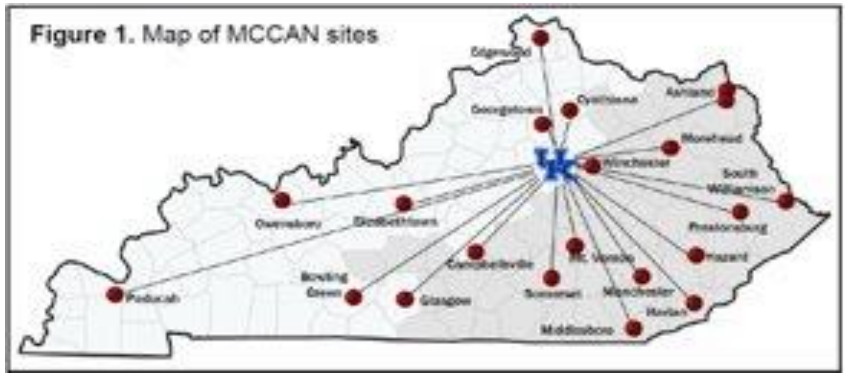


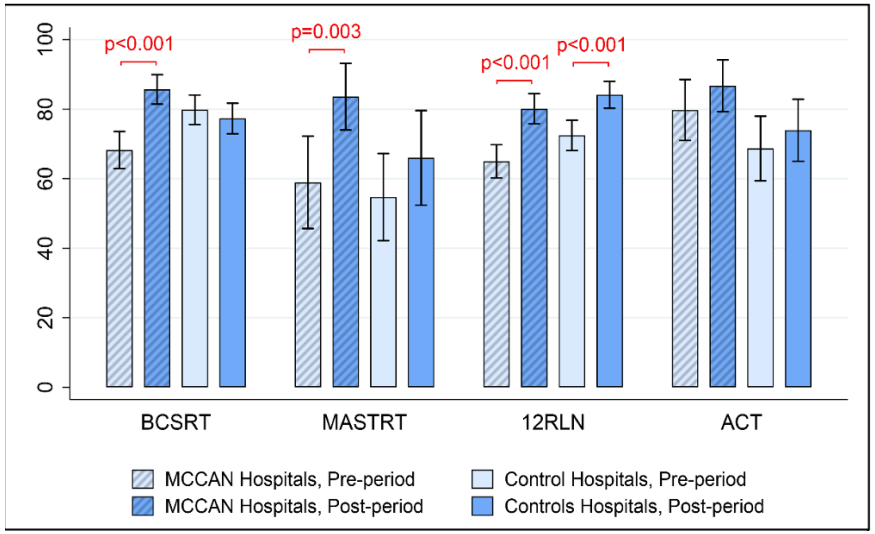
Rural CoC Hospitals



Improving Rural Cancer Care: Network Model

- Since 2006, Markey has extended their resources across Kentucky through a **collaborative network of hospitals**
- MCCAN assists hospitals in achieving the CoC standards through:
  - Tailored programs and resources
  - Supporting data collection
  - Consultative expertise
  - Guidance and templates
  - QI assistance
  - Maintaining accreditation





Effectiveness and implementation of a health system intervention to improve quality of cancer care for rural, underserved patients

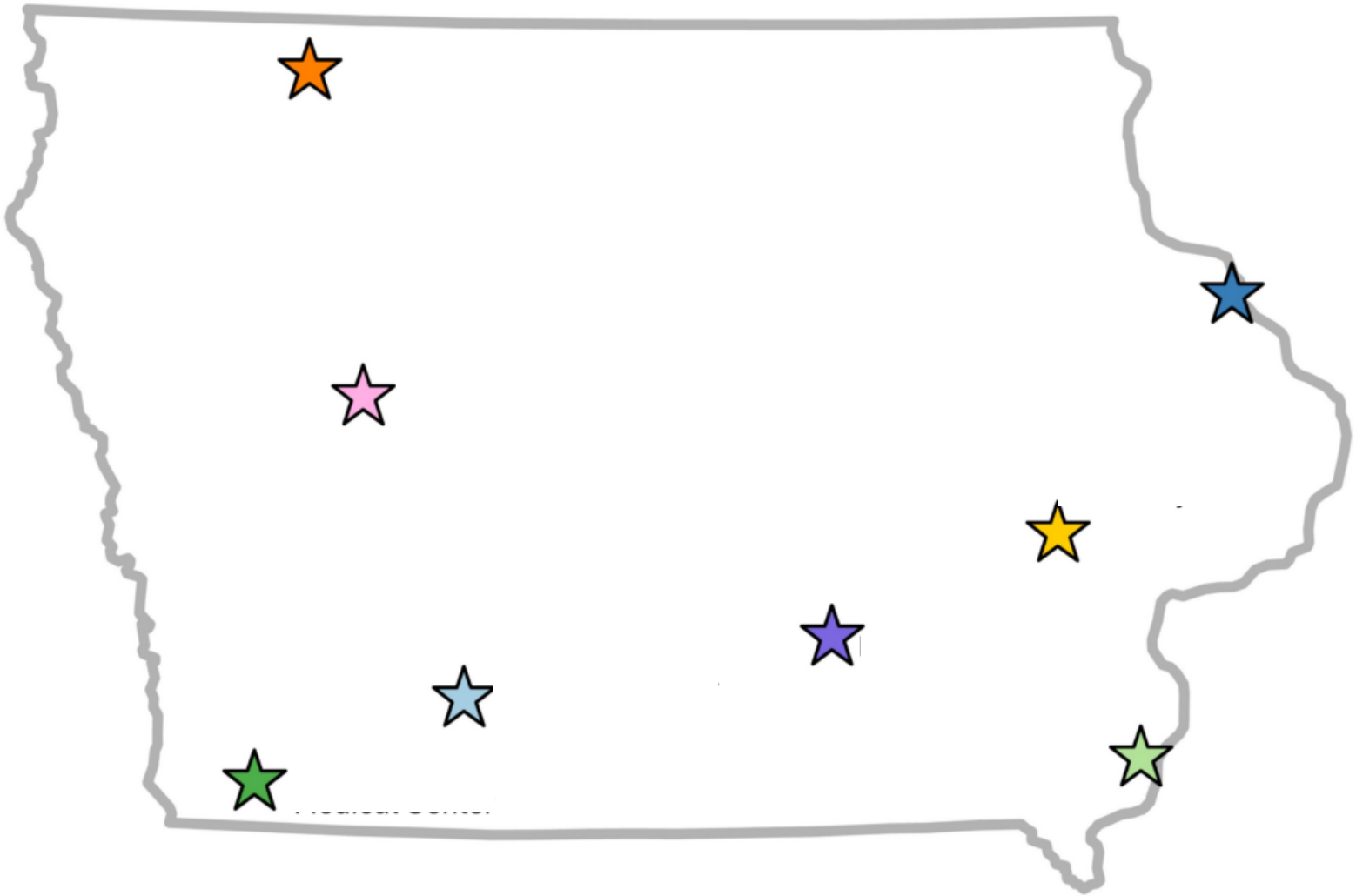
I·CAN
IOWA CANCER AFFILIATE NETWORK

Objectives:

1. Determine the core functions (what makes the intervention effective) of the MCCAN model, and document the specific strategies or activities that may be customized to Iowa and are needed to carry out the core functions
2. Implement a collaborative network adapted for Iowa to make achievement of the CoC standards more feasible for rural community hospitals
3. Measure progress towards achievement of CoC standards and impact on quality measures of cancer care

Mary Charlton PhD
Professor of Epidemiology
College of Public Health
University of Iowa

Iowa Cancer Affiliate Network (I-CAN) Hospitals



Iowa-Cancer Affiliate Network (I-CAN): Hospital characteristics

Hospital	Annual number of new cancer cases*	Bed size	# of medical oncologists	# of radiation oncologists	# of general surgeons
1	499	307	1	1	4
2	191	107	1	1	2
3	205	90	2	1	3
4	314	99	1	1	5
5	100	25	1	0	3



* Average of annual analytic cases 2015-2019

IOWA Cancer Affiliate Network

What we've learned

- **Strengths** – provide rural patients the ability to receive care close to home, strong community ties, dedicated staff, engaged patient population, focus on barriers to care

- **Challenges** – workforce shortages, physician retention, payor mix, less access to services, less favorable patient population

- Size does not predict success, and senior leadership and physician buy-in are essential

What we've learned

- Using the CoC accreditation standards has improved ability to deliver comprehensive cancer care
  - Tumor board
  - Cancer committee
  - Supportive services
- Accessing their own cancer data for program assessment and quality improvement very challenging for hospitals without support
- Some standards can be prohibitively challenging for rural hospitals
  - Access to clinical trials
  - Genetic counseling
  - Palliative care
  - Attendance based standards

Feedback from I-CAN sites: why pursue CoC accreditation?

Yes, there are more meetings, but….

- Increases collaboration and collegiality across specialties
- Builds medical staff cohesion/communication
- Build data infrastructure
  - Measure, benchmark, continuous data driven improvement
- Comprehensive care
  - Tumor board
  - Non-medical care
  - Survivorship & Palliative care

- Improves cancer outcomes
- Increases ancillary volumes
- Spins off into other service lines
- Helps with recruitment and retention
- Builds community awareness
- Improves hospital reputation and market
- Cost of accreditation offset by
  - Improve guideline adherence
  - Patient retention
  - Reduced treatment variation

I·CAN
IOWA CANCER AFFILIATE NETWORK

CoC Rural Accreditation Track

- Informed by findings of study
- Tailored to needs and resources of rural hospitals
- Focused on the standards shown to have maximum impact on quality of care

CoC Rural Taskforce

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Mary Charlton, PhD	Researcher	Iowa City, IA
Charles Shelton, MD	Radiation Oncologist	Nags Head, NC
Michael Sarap, MD, FACS	Surgeon	Cambridge, OH
David Mullins, MD, FACS	Surgeon	Princeton, WV
Cliff Connery, MD, FACS	Surgeon	Westport, NY
Liz Marshall, RHIA, ODS-C, CCS	Oncology Data Specialist	Cheyenne, WY
John Montville	Administrator	Paducah, KY
Ron Weigel, MD, FACS	Surgeon	Iowa City, IA

Acknowledgments

I·CAN
IOWA CANCER AFFILIATE NETWORK

St Anthony Medical Center
Carroll, IA

Southeast Iowa Regional Medical Center
Burlington, IA

Spencer Hospital
Spencer, IA

Mahaska Health,
Oskaloosa, Iowa

Shenandoah Medical Center
Shenandoah, IA

UK HealthCare
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Available Resources and FAQs

New Resources Available!

ACS CoC Commission on Cancer
American College of Surgeons

Commission on Cancer
Rural Cancer Program Requirements Crosswalk

This is a high-level overview of the compliance measures found in *Optimal Resources for Cancer Care (2020 Standards)*. This is not a comprehensive guide, and it is not a substitute for reading the CoC standards in their entirety. Please refer to *Optimal Resources for Cancer Care (2020 Standards)* for full details.

Standard		Standard Requirements for Compliance with Original Track	Standard Modifications for Compliance Rural Track
1.1	Administrative	Programs provide a letter of authority from facility	No change

Crosswalk

FAQs

ACS CoC Commission on Cancer
American College of Surgeons

Frequently Asked Questions on the Commission on Cancer's (CoC) Rural Cancer Program

How is eligibility determined?
The hospital must be located in a county with a Rural Urban Continuum Code (RUCC) designation of 4-9.

My hospital is not in a RUCC 4-9 county, but it primarily serves patients living in rural counties. Can my hospital participate as a RCP?
No. The hospital's location determines eligibility, not it's patient population.

Connect with us!

CoC Accreditation: A Proven Path to Stronger Cancer Care in Rural Communities

To better address the needs of hospitals providing cancer care in rural communities, the Commission on Cancer (CoC) has developed a category for participation that includes standards tailored for hospitals in rural counties. A CoC Rural Cancer Program focuses on tailored standards that are proven to have maximum impact on patient quality of care while meeting the needs unique to a hospital in a rural area.

Learn more about the development of the CoC Rural Accreditation offering.

Determine Your Eligibility

To determine which RUCC level your facility resides in:

1. Visit the USDA website.
2. Download the most recent "Rural-Urban Continuum Codes" file.
3. Search the county your program is located in.
4. Confirm your facility is located in a RUCC Category 4–9.

Apply for CoC Rural Cancer Program Accreditation

If you are a **new program**, go to our Apply for Accreditation page to get started.

Is your program a **CoC-accredited program**? Programs who meet the eligibility criteria and wish to request a designation change should email CoC@facs.org for more information.

Visit the CoC Accreditation page for more information on the accreditation process.

Accreditation status—not hospital size or rurality—has been shown as the strongest predictor of cancer care quality performance.†

Connect with CoC

Want to discuss how CoC accreditation fits in your rural hospital? Fill out our form and we will reach out.

Name *

Email: *

Hospital Name: *

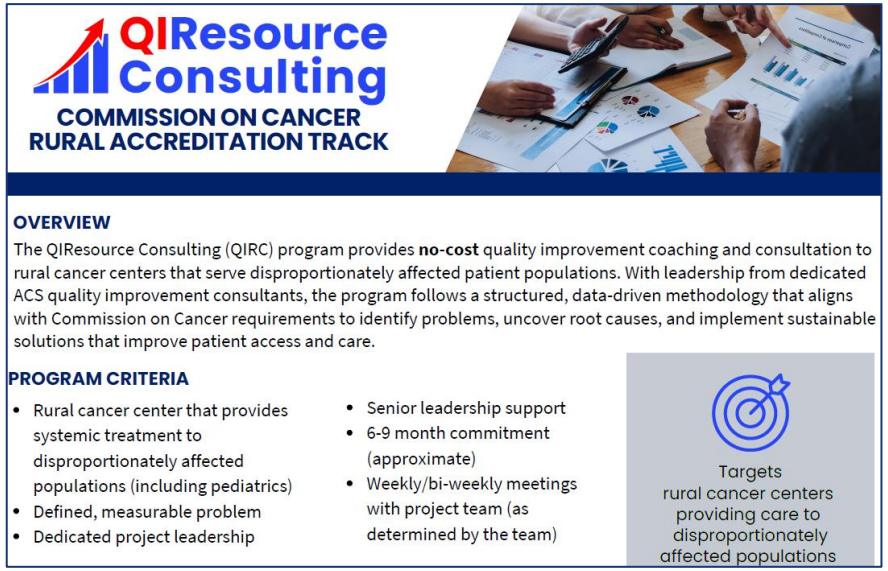
City: *

State: *

Role: *

- Dedicated website for interested rural hospitals
- Learn about the Application Process
- Request more info
- Set up a call to discuss how this can work with you program

Apply for QI Help from the American Cancer Society



- ACS is prioritizing applications from NEW hospitals applying for the rural cancer program

- **IMPORTANT:** Focused on projects to “fix something” not “do something”

PROCESS STEPS

Selected centers will be assigned an ACS QI coach to facilitate the following project milestones:

1. Team Charter
2. Problem/Aim Statement
3. Measurement Plan
4. Process Map
5. Cause & Effect
6. Solution Prioritization
7. Pilot & Evaluation
8. Implement
9. Monitor & Measure
10. Sustain & Share

IMPORTANT DATES

- Application opens: **March 25, 2026**
- Application closes: **June 30, 2026 at 8:00 pm ET**

Application Process & Fees

Initial Applicants

1

Begin complying with the CoC Rural Cancer Program standards on January 1 of compliance year

2

Demonstrate compliance with the Rural Cancer Program Standards January 1–December 31

3

Submit an application for a Site Visit for the year following the compliance year

NCRA Resources to Help Determine Registry Needs

NCRA Executive Summary

Cancer Registrar Workload and Staffing Worksheet

UCSF Research Report: Cancer Registrar Workload and Staffing Study: Guidelines for Hospital Cancer Registry Programs

Workload & Staffing Worksheet

Row Headers	Description
Registry Type	(Multi-Institution, Single Institution) - PickList
Total Accessioned Cases	Actual number of cases handled by the registry
Allocated FTEs	Actual number of Full-Time Equivalents (FTEs) allocated
Recommended FTEs	Calculated number of FTEs needed based on the guidelines
Fully Staffed (Yes/No)	Formula to indicate if the registry is fully staffed. If number is greater than or equal to **Allocated FTEs** then "Yes" otherwise "No". If "No," consider whether additional hiring is needed or if workload management strategies should be evaluated.

Staffing Analysis	
Registry Type	***Single Institution***
Total Accessioned Cases	***100***
Allocated FTEs	***Enter Number Here***
Recommended FTEs	0.20
Fully Staffed (Yes/No)	Yes

Existing CoC Programs Switching to RCP

- Processed like a category change
- Category change requests will be accepted Fall 2026
- Fee will change with 2027 annual invoices

Let us know your intention!

Complete the interest survey

Important!!

"Initial" Site Visit Exemptions Do Not Apply to Existing Programs Switching Categories

Example

Standard 4.5: Palliative Care Services
Standard 4.7: Oncology Nutrition Services
Standard 5.2: Psychosocial Distress Screening

Before the initial site visit, the Rural Cancer Program complies with one of the following standards: 4.5, 4.7, or 5.2.

By the reaccreditation visit and for subsequent site visits, the Rural Cancer Program must comply with at least two of the following standards: 4.5, 4.7, or 5.2

Existing Programs Timeline Example

No Change to Site Visit Schedule

Site visit will evaluate whatever category you were at the time of activity.

2028 Site Visit		
Year of Activity included in Site Visit	**Category at the Time of Activity**	**Standards Applied**
2027	RCP	RCP
2026	RCP	RCP
2025	CCP	CCP

CoC Participation Questions

RCP modifications cannot be applied in the Integrated Network Cancer Program structure

- Program in an existing network wanting to pursue RCP must withdraw from network and pursue accreditation as an individual program

RCP participation meets the CoC accreditation requirement for other cancer accreditation offerings:

- National Accreditation Program for **Rectal Cancer** (NAPRC)
- National Accreditation Program for **Breast Centers** (NAPBC)
- CoC **Pediatric** Specialty Accreditation (CoC-PS)

Network v RCP Category: Things to Consider

Network: Facilities belonging to an organization that owns a group of facilities that offer integrated and comprehensive cancer care services. These facilities are overseen by a centralized governance structure/board and CEO.

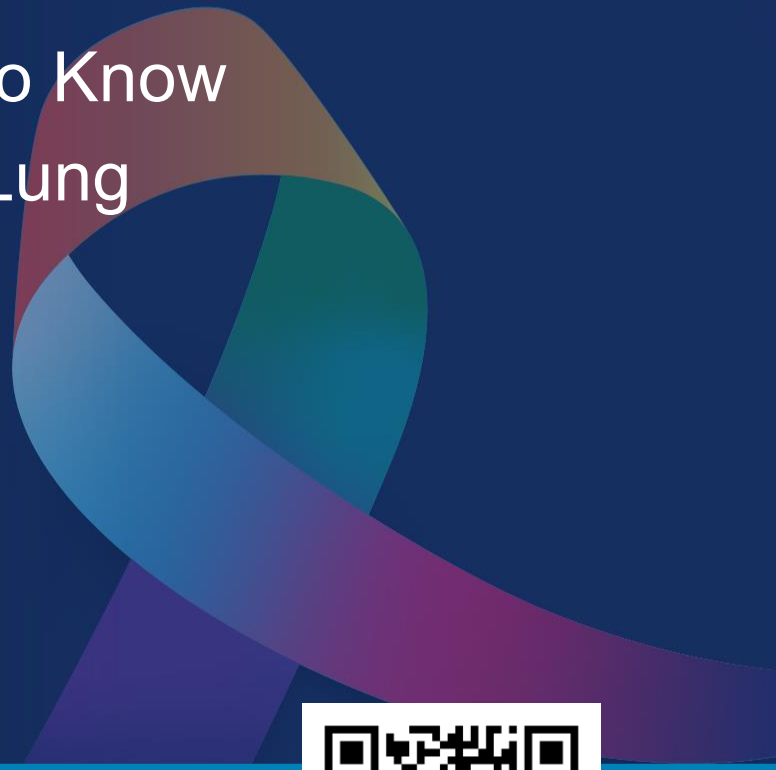
Rural Cancer Program: Individual hospital located in a rural county

- How easily would the rural program integrate into other facilities?
- Are the physicians the same at both facilities?
- Is there a shared cancer registry?
- Could the network include the rural program in the additional network requirements?

Questions?

2025-2026 Cancer Programs On-Demand Webinars
Now Available

- Breast Screening: What Every Physician Needs to Know
- AJCC Protocol on Version 9 Staging System for Lung
- Technical Standards for Sarcoma Surgery
- New Smoking Cessation Standard
- QI for NAPRC Programs
- Standards Updates
- And More!



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Thank you for attending today.

This concludes the What Rural Hospitals Need to Know webinar.

You may now disconnect.