Commission on Cancer Cancer Liaison Physicians Meeting

September 10, 2025

Commission on Cancer
American College of Surgeons

CoC Cancer Liaison Physicians Meeting

Maria Castaldi, MD, FACS
Chair
Committee on Cancer Liaison

Quan Ly, MD, FACS
Vice-Chair
Committee on Cancer Liaison

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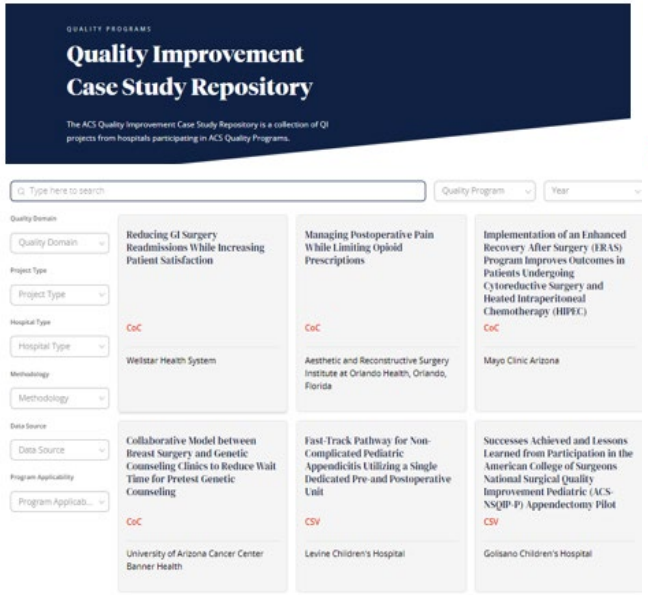
American College of Surgeons

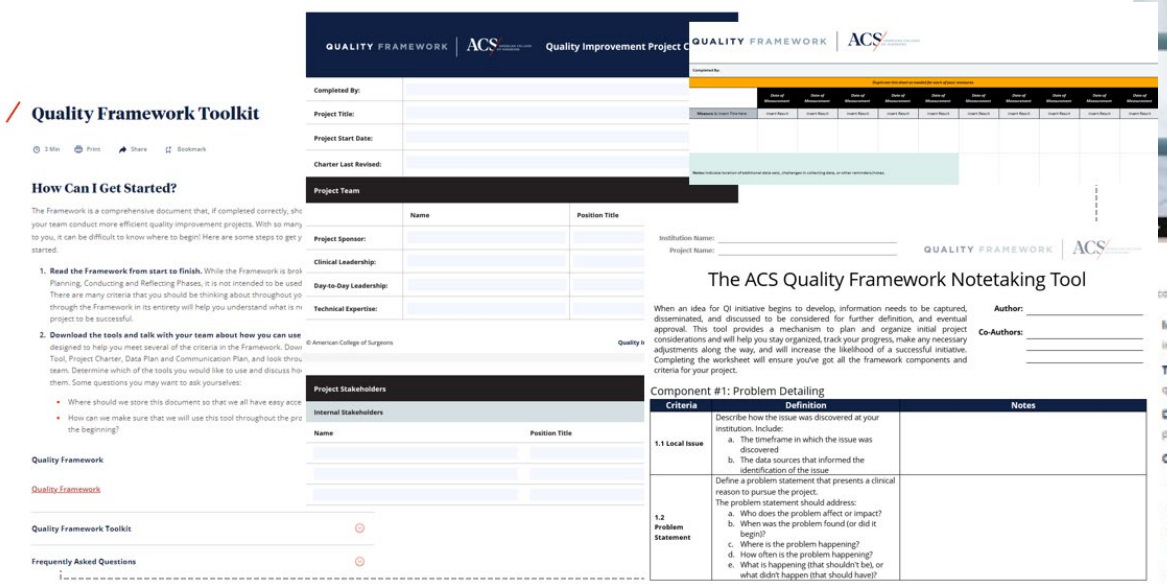
CoC Updates

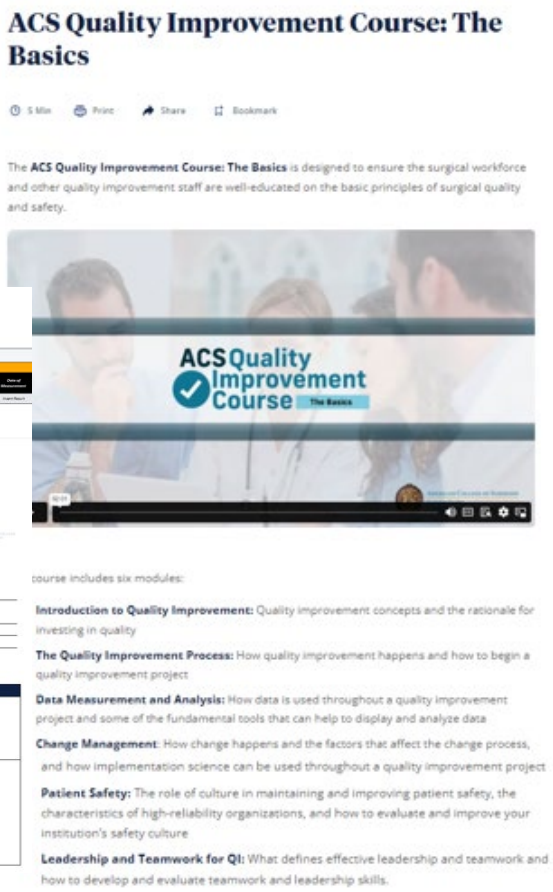
- Annual CLP Survey
- Upcoming Meetings
  - State Chair/CLP Accreditation Office Hour: September 25
    - Operative Standards with Dr. Timothy Vreeland
  - CoC Plenary Session: October 4
    - 1:30 pm, Hyatt Regency McCormick Place, Chicago

Brief QI Updates

- National QI Project on Quality Measure BLCT1 (Administration of intravesical chemotherapy after TURBT)
  - Informational webinar in November (stay tuned to Cancer Program Newsletter for more info)
- Resource Reminders:
  - NEW! Cancer Coaching QI Calls







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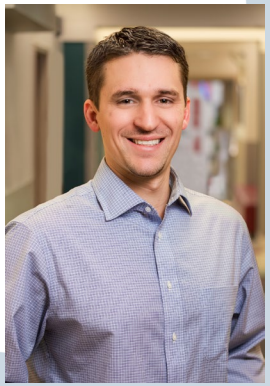
2025 CLP Outstanding Performance Award Winners

Umur Atabek, MD, FACS
Cooper University Health Care
Camden, NJ

Irina Bernescu, MD
Ascension Saint Agnes Hospital Cancer Institute
Baltimore, MD

Jessica Cohan, MD, MAS, FASCRS, FACS
University of Utah and Huntsman Cancer Institute
Salt Lake City, UT



Andrew Fintel, DO
Blue Ridge Cancer Care/LewisGale Medical Center
Salem, VA

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2025 CLP Outstanding Performance Award Winners

Christine A. Garcia, MPH, MD

Weill Cornell Medicine/New York Presbyterian

New York, NY

Paul Gordon, MD, FACS

Advocate Christ Medical Center

Oak Lawn, IL

Ihor Pidhorecky, MD, FACS

HCA Florida Westside Hospital

Plantation, FL

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2025 CLP Outstanding Performance Award Winners

Elizabeth Rinehart, MD
Waterbury Hospital
Waterbury, CT

Taylor Turner, MD
St. Luke's Cancer Institute
Boise, ID

Anthony Scholer, MD, FACS
Jersey Shore University Medical Center
Neptune, NJ

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CoC Standards Update for CLPs

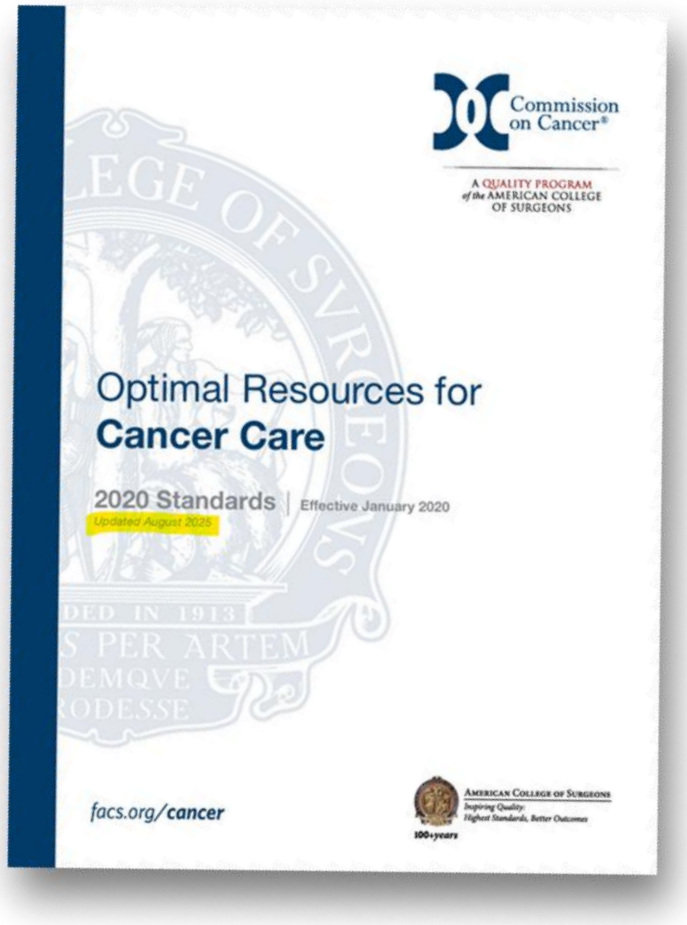
September 10, 2025

Aaron Bleznak, MD, MBA, FACS, FSSO

Chair, CoC Accreditation Committee

Standards Updates

- Restore focus on **continuous improvement**
- React to accredited programs' performance & **feedback**
- Accommodate **IT challenges** and variability
- Prepare for changes in the **healthcare mileau**

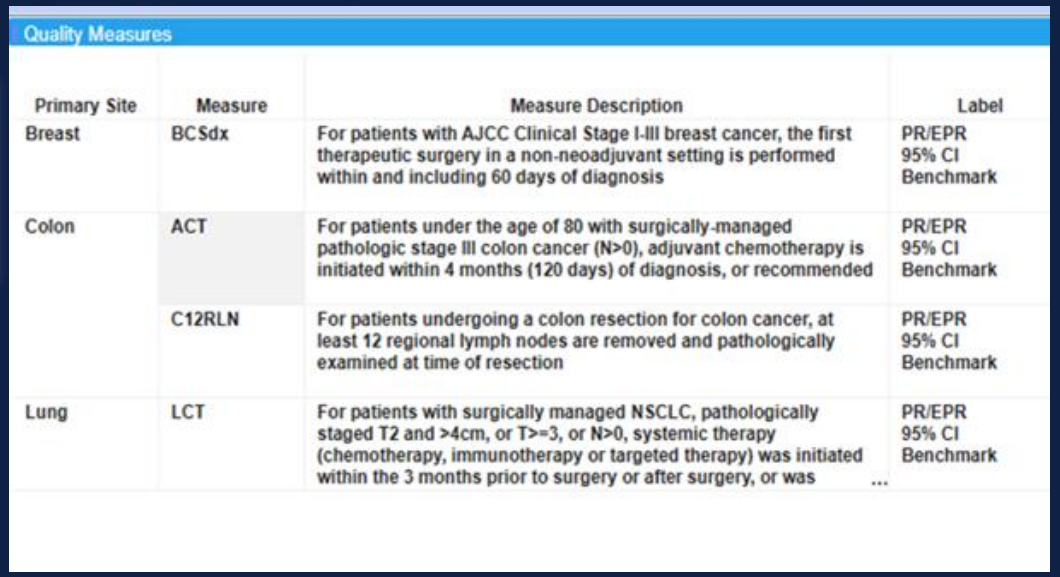


Required 7.1 Measures for Review in 2025

- **C12RLN:** For patients undergoing a colon resection for colon cancer, at least 12 regional lymph nodes are removed and pathologically examined at time of resection.
  - **95% benchmark**
- **ACT:** For patients under the age of 80 with surgically-managed pathologic stage III colon cancer (N>0), adjuvant chemotherapy is initiated within 4 months (120 days) of diagnosis, or recommended.
  - **90% benchmark**
- **LCT:** For patients with surgically managed NSCLC, pathologically staged T2 and >4cm, or T>=3, or N>0, systemic therapy (chemotherapy, immunotherapy or targeted therapy) was initiated within the 4 months prior to surgery or after surgery, or was recommended.
  - **70% benchmark**
- **BCSdx:** For patients with AJCC Clinical Stage I-III breast cancer, the first therapeutic surgery in a non-neoadjuvant setting is performed within and including 60 days of diagnosis.
  - **70% benchmark**

Standard 7.1: Quality Measures

- Actual Performance ≥ EPR
- Actual Performance < EPR but 95% CI ≥ EPR
- Actual Performance < EPR 95% CI < EPR



Quality Measures

Primary Site	Measure	Measure Description	Label
Breast	BCSdx	For patients with AJCC Clinical Stage I-III breast cancer, the first therapeutic surgery in a non-neoadjuvant setting is performed within and including 60 days of diagnosis	PR/EPR 95% CI Benchmark
Colon	ACT	For patients under the age of 80 with surgically-managed pathologic stage III colon cancer (N>0), adjuvant chemotherapy is initiated within 4 months (120 days) of diagnosis, or recommended	PR/EPR 95% CI Benchmark
	C12RLN	For patients undergoing a colon resection for colon cancer, at least 12 regional lymph nodes are removed and pathologically examined at time of resection	PR/EPR 95% CI Benchmark
Lung	LCT	For patients with surgically managed NSCLC, pathologically staged T2 and >4cm, or T>=3, or N>0, systemic therapy (chemotherapy, immunotherapy or targeted therapy) was initiated within the 3 months prior to surgery or after surgery, or was ...	PR/EPR 95% CI Benchmark

- EPRs was announced July 19, 2025
- Q3 2025: RCRS updated to show **performance vs. EPR** for these four measures only

2025 NCDB Data Reporting Summary

Standard	Data Allowed	Frequency	Reporter	Focus of Report	
2.2	1. NCDB Benchmark 2. CQIP 3. Survival Reports	Twice Yearly	CLP	Areas of Concern	
6.4	RCRS Quality Measures Comparisons	Twice Yearly	Anyone (CLP optimal)	Areas of Concern	
7.1	Selected Quality Measures (4)	≥ Twice Yearly	Anyone (CLP optimal)	Selected Quality Metrics	

When is this change happening?

2026 Program Activity: Programs must complete audits and, if applicable, action plans for Standard 5.3-5.6

2026 Site Visits: Current Site Reviewer Audit Process will apply

- 2026 completes three years of Standard 5.3-5.6 being assessed by the Site Reviewer and allows all programs to benefit from this process

Requirements during 2026

- Programs must perform an audit of 30 cases (or all applicable cases) of eligible cases. For each case, the audit must include:
  - All **required elements** are present in the operative report in **synoptic format**
  - **Responses** to the required elements are appropriate
  - All elements of the audit are **recorded in the CoC audit template**
- Audit results must be reported and discussed with the cancer committee each year AND documented in the minutes

Example of CoC Audit Template

Audit templates provided that facilitate consistent application across cancer programs

Standard 5.3: Sentinel Lymph Node Biopsy

Reminders

Standard applies to all nodal staging operations performed with curative intent for patients with breast cancers of epithelial origin. If the case does not meet these parameters, select another case.
Synoptic elements/responses must be in the operative report of record, not the brief operative note.
Cases must meet both technical and documentation requirements to be compliant.
See "Instructions for Use" tab for additional information.

Case Information			Required Elements								Compliance Summary		
	Case identifier (NO PHI)	Surgeon	Was the operation performed with curative intent?	Are all required elements and responses present and in synoptic format?	Tracer(s) used to identify sentinel nodes in the upfront surgery (non-neoadjuvant) setting	Tracer(s) used to identify sentinel nodes in the neoadjuvant setting	Were all nodes (colored or noncolored) present at the end of a dye-filled lymphatic channel removed?	Were all significantly radioactive nodes were removed?	Were all palpably suspicious nodes were removed?	Were biopsy-proven positive nodes marked with clips prior to chemotherapy identified and removed?	Overall compliant or non-compliant	If non-compliant, select whether the noncompliance was technical, documentation, or both?	If non-compliant, include any applicable comments
Column-specific instructions			If "no," the case is N/A and another must be selected for review	If "no," the case is non-compliant (documentation failure)	Non-compliant if: -"Other" is selected but no explanation is included. -N/A is selected for both column F and G. -Tracers are listed for both column F and G.	Non-compliant if: -"Other" is selected but no explanation is included. -N/A is selected for both column F and G. -Tracers are listed for both column F and G.							
1													
2													
3													
4													
5													

Requirements during 2026

- If the audit demonstrates that all requirements are met in 80% or more cases, no further action is needed

- If audit demonstrates less than 80% compliance, then a **meaningful action plan** must be developed
  - Requires a second audit within 6 months to determine impact of intervention
  - Consecutive action plans without new/additional action will result in deficiency

Benefits of this Transition

- Encourage **more focus** on the SURGERY and less on documentation
  - Current process may not recognize improvements over the accreditation cycle
- Streamlined site visit process
  - List generation and case selection is **burdensome process**
- More **timely resolution** to identified issues

Site Visits Starting in 2027

- Standard will be rated on the audit performed by the cancer program and any applicable action plans.
  - Site Reviewer will review the required audit templates and the minutes in which the audits were reported and documented
  - Site Reviewer will review the action plan(s) if any were required

- During the visit, the Site Reviewer will select two cases for each standard from those reviewed during the program's own audit.
  - Purpose is to assure that required elements are all present
  - Review will be for education purposes only; no impact on compliance rating.

Do You Wanna Be a Hero?

- Reporting Timelines
- New S5.9: Smoking Cessation
- Updated S4.2: Oncology Nursing Credentials
- S9.1: Clinical Research Accrual alternative compliance pathway
- S4.8: Survivorship Programs

Clarification on Reporting Timelines

Standards Requiring Annual Review

Work to obtain compliance in one Commission on Cancer (CoC) standard may not replace, duplicate, or augment the work required to obtain compliance with another standard. The exceptions to this rule are Standard 6.4: Rapid Cancer Reporting System: Data Submission and Standard 7.3: Quality Improvement Initiative.

The following standards must be reported at the first quarter meeting of the following year. The report must include a full calendar year of reporting data. For example, reports on 2025 activity must include data from all of 2025 and be reported at a meeting in the first quarter of 2026. Reports provided to the cancer committee with a partial calendar year of reporting data must also be included in the final report given at the first quarter meeting of the following year. The reports must be documented in the cancer committee meeting minutes and include all elements.

- Standard 2.5: Multidisciplinary Cancer Case Conference
- Standard 4.4: Genetic Counseling and Risk Assessment
- Standard 4.5: Palliative Care Services
- Standard 4.8: Survivorship Program
- Standard 5.2: Psychosocial Distress Screening
- Standard 9.1: Clinical Research Accrual

The following standards require an annual evaluation, but do not necessarily require data review. These standards may be presented and discussed with the cancer committee at any time during the calendar year under evaluation or at a meeting during the first quarter of the following year.

- Standard 4.2: Oncology Nursing Credentials
- Standard 4.6: Rehabilitative Care Services
- Standard 4.7: Oncology Nutrition Services
- Standard 8.1: Addressing Barriers to Care

The following standards require annual activities such as audits, projects, reports, or events. They must be conducted and presented to the cancer committee within the calendar year per the frequency required in the standard. The presentation to the cancer committee may be provided at any time during the calendar year after the activity has been completed. These standards cannot be presented in the first quarter of the following calendar year.**

- Standard 2.2: Cancer Liaison Physician*
- Standard 5.1: College of American Pathologists Synoptic Reporting
- Standard 5.9: Smoking Cessation for Patients with Cancer
- Standard 6.1: Cancer Registry Quality Control
- Standard 6.4: Rapid Cancer Reporting System: Data Submission*
- Standard 7.1: Quality Measures
- Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines
- Standard 7.3: Quality Improvement Initiative*
- Standard 7.4: Cancer Program Goal*
- Standard 8.2: Cancer Prevention Event
- Standard 8.3: Cancer Screening Event

*Standard requires multiple status updates per calendar year. Both updates must be provided within the calendar year or per standard requirements.

**Standards 7.3 and 7.4 activities can be extended into a second year. To be compliant, the intent to do so must be stated during the calendar year the quality improvement or goal was initiated and a final report must be given in the subsequent year after the QI or goal is completed.

Standard	Data Required	Reporting Timeframe
Standard 2.2: Cancer Liaison Physician*	Activity Completed	During the year of activity
Standard 2.5: Multidisciplinary Cancer Conference	Full Calendar Year of data	Q1 of the following year
Standard 4.4: Genetic Counseling	Full Calendar Year of data	Q1 of the following year
Standard 4.5: Palliative Care Services	Full Calendar Year of data	Q1 of the following year
Standard 4.6: Rehabilitative Care Services	12 months of Observations	During the year of activity or Q1 following year
Standard 4.7: Oncology Nutrition Services	12 months of Observations	During the year of activity or Q1 following year
Standard 4.8: Survivorship Program	Full Calendar Year of data	Q1 of the following year
Standard 5.1: CAP Synoptic Reporting	Activity Completed	During the year of activity
Standard 5.2: Psychosocial Distress Screening	Full Calendar Year of data	Q1 of the following year
Standard 6.1: Cancer Registry Quality Control	Activity Completed	During the year of activity
Standard 6.4: RCRS: Data Submission*	Activity Completed	During the year of activity
Standard 7.1: Quality Measures	Activity Completed	During the year of activity
Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines	Activity Completed	During the year of activity
Standard 7.3: Quality Improvement Initiative*	Activity Completed	During the year of activity
Standard 7.4: Cancer Program Goal*	Activity Completed	During the year of activity
Standard 8.2: Cancer Prevention Event	Activity Completed	During the year of activity
Standard 8.3: Cancer Screening Event	Activity Completed	During the year of activity
Standard 8.1: Addressing Barriers to Care	12 months of Observations	During the reporting year or Q1 following year
Standard 9.1: Clinical Research Accrual	Full Calendar Year of data	Q1 of the following year

Clarification on Reporting Timelines

Standards that must be reported at the **First Quarter Meeting of the Following Year**

Must include a **full calendar year's** worth of data

- **Standard 2.5:** Multidisciplinary Cancer Case Conference
- **Standard 4.4:** Genetic Counseling
- **Standard 4.5:** Palliative Care Services
- **Standard 4.8:** Survivorship Program
- **Standard 5.2:** Psychosocial Distress Screening
- **Standard 9.1:** Clinical Research Accrual

Clarification on Reporting Timelines

Standards that can be **reported at any time during the year of activity**

Data review not required

- **Standard 4.6:** Rehabilitative Care Services
- **Standard 4.7:** Oncology Nutrition Services
- **Standard 8.1:** Addressing Barriers to Care

Clarification on Reporting Timelines

Standards that require **audits/projects/reports/events**

Report to cancer committee **within year of activity**

- **Standard 2.2:** CLP (2x/year)
- **Standard 5.1:** CAP Reporting
- **Standard 6.1:** Cancer Registry Quality Control
- **Standard 6.4:** RCRS: Data Submission
- **Standard 7.1:** Quality Measures
- **Standard 7.2:** Monitoring Concordance w/ Evidence-Based Guidelines
- **Standard 7.3:** QI Initiative (2x/year)
- **Standard 7.4:** Cancer Program Goal (2x/year)
- **Standard 8.2 & 8.3:** Cancer Prevention & Screening Event

Standard 5.9: Smoking Cessation for Patients with Cancer

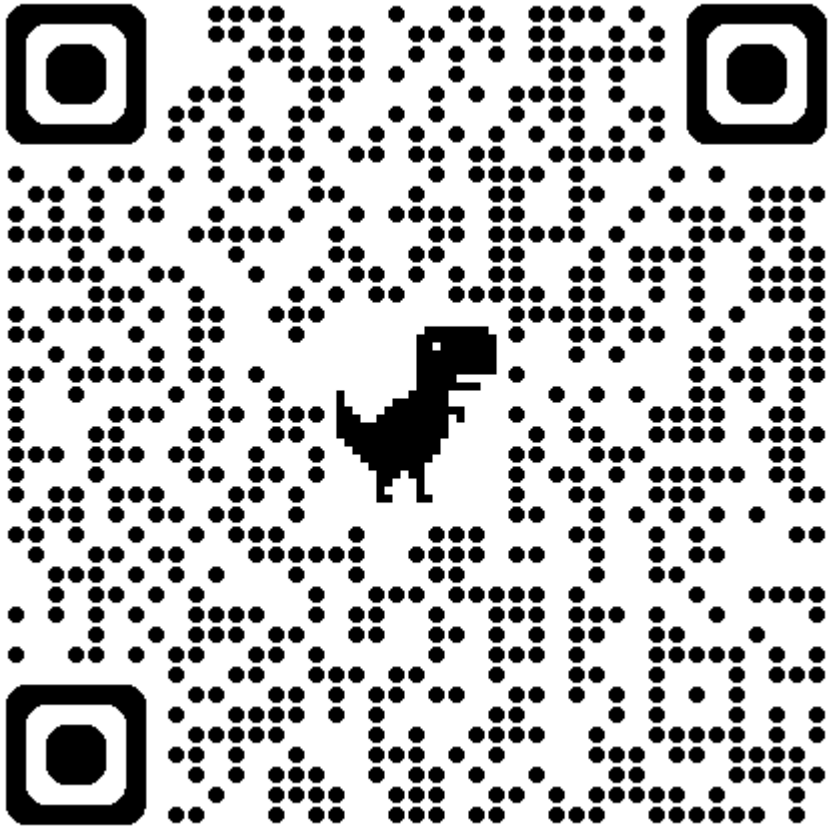
Process Requirements

- Must implement process to screen for smoking status in patients with newly diagnosed cancer at initial consultation at accredited program for cancer treatment
- Referrals must receive or be referred for smoking cessation treatment consistent with evidence-based guidelines.
- Services must be available on-site or by referral

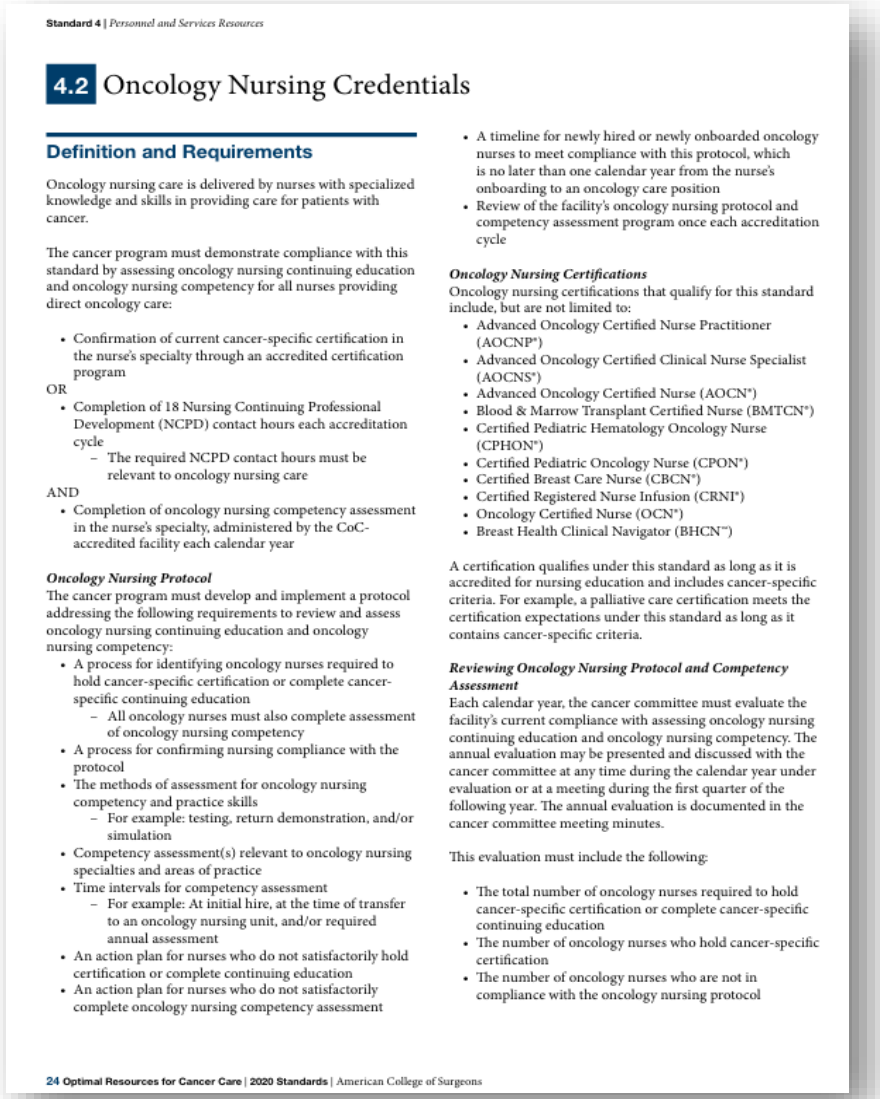
Audit Requirements

- Each year, cancer committee must conduct an internal audit of a **minimum of 20 patients** with newly diagnosed cancer to determine:
  - # screened
  - # who reported current smoking
  - # who reported smoking and received/were referred for smoking cessation treatment
- Action plan required if audit shows:
  - Less than 90% of patients were screened for smoking status
  - Less than 80% of current smokers were referred for treatment

Link to full Standard 5.9 Text



S4.2: Oncology Nursing Credentials



Standard 4 | *Personnel and Services Resources*

4.2 Oncology Nursing Credentials

Definition and Requirements

Oncology nursing care is delivered by nurses with specialized knowledge and skills in providing care for patients with cancer.

The cancer program must demonstrate compliance with this standard by assessing oncology nursing continuing education and oncology nursing competency for all nurses providing direct oncology care:

- Confirmation of current cancer-specific certification in the nurse's specialty through an accredited certification program

OR

- Completion of 18 Nursing Continuing Professional Development (NCPD) contact hours each accreditation cycle
  - The required NCPD contact hours must be relevant to oncology nursing care

AND

- Completion of oncology nursing competency assessment in the nurse's specialty, administered by the CoC-accredited facility each calendar year

Oncology Nursing Protocol

The cancer program must develop and implement a protocol addressing the following requirements to review and assess oncology nursing continuing education and oncology nursing competency:

- A process for identifying oncology nurses required to hold cancer-specific certification or complete cancer-specific continuing education
  - All oncology nurses must also complete assessment of oncology nursing competency
- A process for confirming nursing compliance with the protocol
- The methods of assessment for oncology nursing competency and practice skills
  - For example: testing, return demonstration, and/or simulation
- Competency assessment(s) relevant to oncology nursing specialties and areas of practice
- Time intervals for competency assessment
  - For example: At initial hire, at the time of transfer to an oncology nursing unit, and/or required annual assessment
- An action plan for nurses who do not satisfactorily hold certification or complete continuing education
- An action plan for nurses who do not satisfactorily complete oncology nursing competency assessment
- A timeline for newly hired or newly onboarded oncology nurses to meet compliance with this protocol, which is no later than one calendar year from the nurse's onboarding to an oncology care position
- Review of the facility's oncology nursing protocol and competency assessment program once each accreditation cycle

Oncology Nursing Certifications

Oncology nursing certifications that qualify for this standard include, but are not limited to:

- Advanced Oncology Certified Nurse Practitioner (AOCNP®)
- Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
- Advanced Oncology Certified Nurse (AOCN®)
- Blood & Marrow Transplant Certified Nurse (BMTCN®)
- Certified Pediatric Hematology Oncology Nurse (CPHON®)
- Certified Pediatric Oncology Nurse (CPON®)
- Certified Breast Care Nurse (CBCN®)
- Certified Registered Nurse Infusion (CRNI®)
- Oncology Certified Nurse (OCN®)
- Breast Health Clinical Navigator (BHCN™)

A certification qualifies under this standard as long as it is accredited for nursing education and includes cancer-specific criteria. For example, a palliative care certification meets the certification expectations under this standard as long as it contains cancer-specific criteria.

Reviewing Oncology Nursing Protocol and Competency Assessment

Each calendar year, the cancer committee must evaluate the facility's current compliance with assessing oncology nursing continuing education and oncology nursing competency. The annual evaluation may be presented and discussed with the cancer committee at any time during the calendar year under evaluation or at a meeting during the first quarter of the following year. The annual evaluation is documented in the cancer committee meeting minutes.

This evaluation must include the following:

- The total number of oncology nurses required to hold cancer-specific certification or complete cancer-specific continuing education
- The number of oncology nurses who hold cancer-specific certification
- The number of oncology nurses who are not in compliance with the oncology nursing protocol

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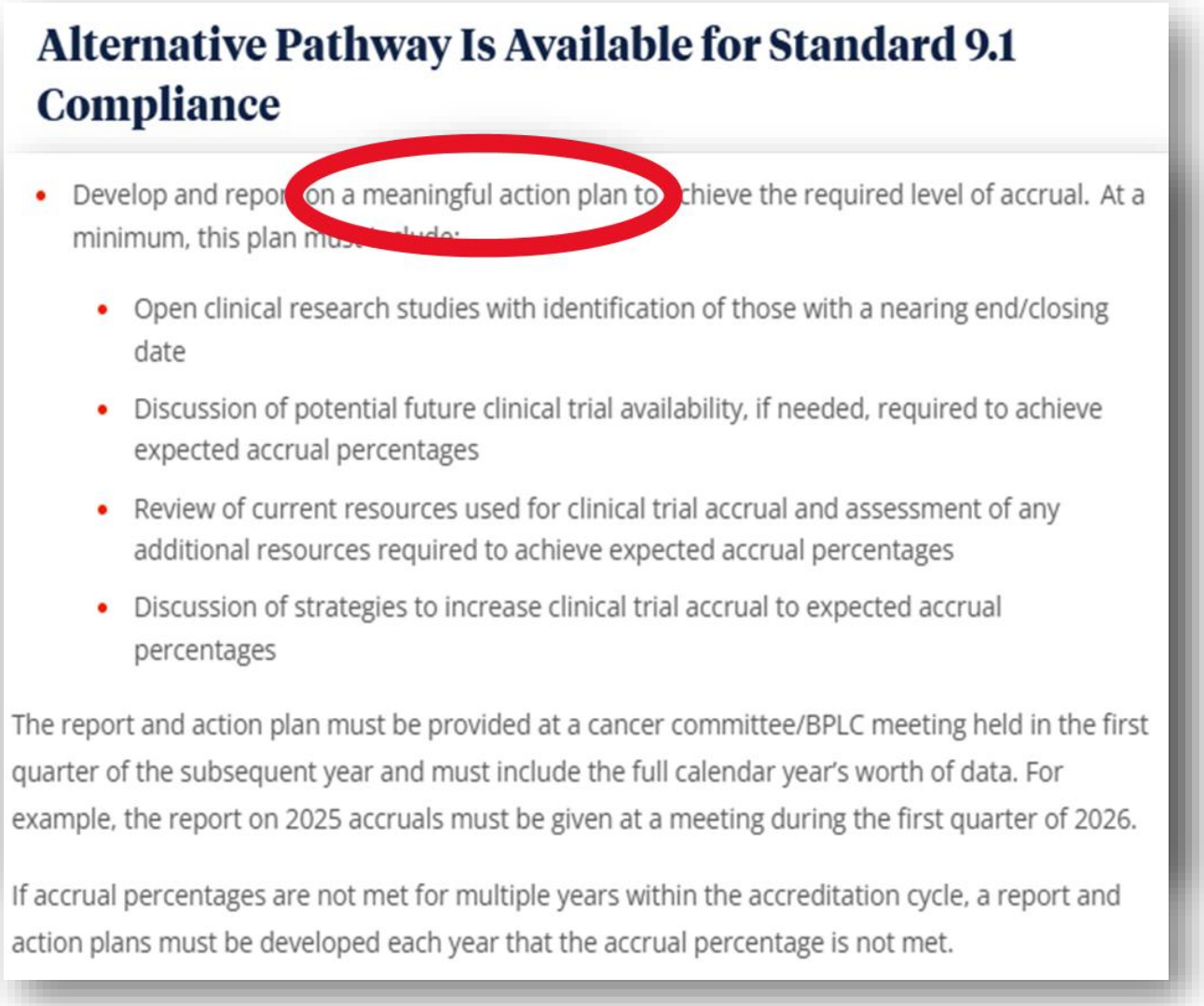
- **Education:**
  - Oncology nursing certification or
  - Completion of 18 oncology nursing education credits
  - Internally tracked vs. external review
- **Annual Competency:**
  - Increased specifics outlined for annual oncology competency assessments
  - ROBUST
- **Action plan for compliance if not meeting requirements**

S9.1: Clinical Research Accrual

- More specifics provided on the annual report requirements and time frame.
- The clinical research activity annual report must contain the following elements:
  - The specific clinical research studies where subjects were accrued, including the trial/study name and, when applicable, the clinicaltrials.gov trial number
  - Number of subjects accrued to each individual clinical research study
  - Open clinical research studies with identification of those with a nearing end date
  - New trials that will be added



Alternative Pathway Is Available for Standard 9.1 Compliance

- Develop and report on a meaningful action plan to achieve the required level of accrual. At a minimum, this plan must include:
  - Open clinical research studies with identification of those with a nearing end/closing date
  - Discussion of potential future clinical trial availability, if needed, required to achieve expected accrual percentages
  - Review of current resources used for clinical trial accrual and assessment of any additional resources required to achieve expected accrual percentages
  - Discussion of strategies to increase clinical trial accrual to expected accrual percentages

The report and action plan must be provided at a cancer committee/BPLC meeting held in the first quarter of the subsequent year and must include the full calendar year's worth of data. For example, the report on 2025 accruals must be given at a meeting during the first quarter of 2026.

If accrual percentages are not met for multiple years within the accreditation cycle, a report and action plans must be developed each year that the accrual percentage is not met.

Standard 4.8 Survivorship Program

CHANGE YOUR PERSPECTIVE

- NOT about your survivorship services
- NOT about how you define survivorship

- This standard is about EVALUATING the survivorship services you offer to patients who have completed first course of treatment

ACS CoC Commission on Cancer
American College of Surgeons

Thanks for everything you do!

American Cancer Society®

ACTS

ACS ACTS™

Access to Clinical Trials & Support

American Cancer Society®

Vision: End cancer as we know it, for everyone.

Mission: Improve the lives of people with cancer and their families through advocacy, research, and patient support, to ensure everyone has an opportunity to prevent, detect, treat, and survive cancer.

The Problem: Barriers to Clinical Trials

- **Only 7% of cancer patients participate in clinical trials, with participation from historically underrepresented communities at just 4%**
- **20% of cancer trials fail due to insufficient enrollment**

Administrative Burden

- Medical Records
- Travel

Trial Match Challenges

- Lack of onsite trials
- Complex eligibility criteria

Financial Burden

- Transportation & lodging
- Lost wages

Limited Awareness

- Provider lacks time to discuss/research trials
- Unconscious biases

Health-Related Social Needs

- Food insecurity
- Affordable housing & transportation

The Solution: ACS ACTS

Strategic Goal:
Improve equitable access to cancer clinical trials by reducing the barriers to enrollment and participation

Key Constituents:
Patients, healthcare providers, and caregivers

Program Offerings:

Program Eligibility

Age

All ages

Cancer Types

All cancer types

Location

- Feb 2025: Regional launch[1] for patients living in or willing to travel to Northeast US[2]

- Oct 2025: National launch expected; no location restriction

Interest

Interested in exploring eligible clinical trials:

- All interventional cancer clinical trials listed on clinicaltrials.gov
- Agnostic to sponsor

[1] The Northeast region contains the largest concentration of clinical trial sites in the US and includes regions where ACS can more easily provide transportation and lodging for clinical trial participation.

[2] Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Virginia, Vermont, West Virginia, or Washington, D.C.

Program Costs

ACS ACTS is **FREE!**

ACS is a non-profit, with programming supported by donations and sponsorships

Some ACS programs for health-related social needs involve a small cost, which the patient is informed of (e.g., prosthetics)

The Patient Journey

Contacts the American Cancer Society's 24/7 National Cancer Information Center via phone or live chat

Fills out form on cancer.org and receives a callback from a cancer information specialist

Receives clinical trials education

Completes health-related social needs assessment and receives support

- Lodging
- Financial resources
- Transportation to clinical trials
- Prostheses & survivor care supplies
- Social support
- Local & national resources

Consents to medical record collection for matching purposes

Receives AI-powered clinical trials matching report and follow-up call from oncology nurse

Provides consent to share report with treating provider, if desired

Reviews matching report with treating provider (preferred) and/or Massive Bio clinical team to select trial

Re-assessed for health-related social needs if interested in enrolling in a trial

Receives health-related social needs support, including specific to trial enrollment

Referred to clinical trial site with coordination of pre-enrollment logistics

Successfully enrolls and participates in a clinical trial

Service Facilitator

- American Cancer Society
- Massive Bio

CoC Accreditation: Standard 9.1

Accredited cancer programs are required to enroll a specified percentage of eligible patients into cancer-related clinical trials.

ACS ACTS can help fulfill compliance with CoC Standard 9.1 by increasing enrollment rates

1) If a patient or caregiver initiates contact with ACS ACTS, how is the provider informed?

- Patient will be asked to consent to send the trial matching report to the provider.
- Patient is encouraged to discuss trial matches with their provider so the provider can make and document the referral to a qualifying trial prior to enrollment.

2) If a provider initiates contact with ACS ACTS, how is this process different?

- Providers may designate themselves or the patient as the point of contact.
- If the provider is the contact, the dedicated provider team delivers matches directly to the provider.

3) Does documentation for CoC Standard 9.1 differ if the ACS ACTS service was utilized?

- No, the organization's internal procedures for compliance with this Standard should be followed.
- The clinical trials matching report can be used as part of the required documentation.

4) Can ACS track my organization's referrals to the program or trial enrollments of our patients?

- ACS is not a clinical entity and does not maintain patient-specific information. Tracking is the responsibility of the organization.

ACS ACTS | Successes

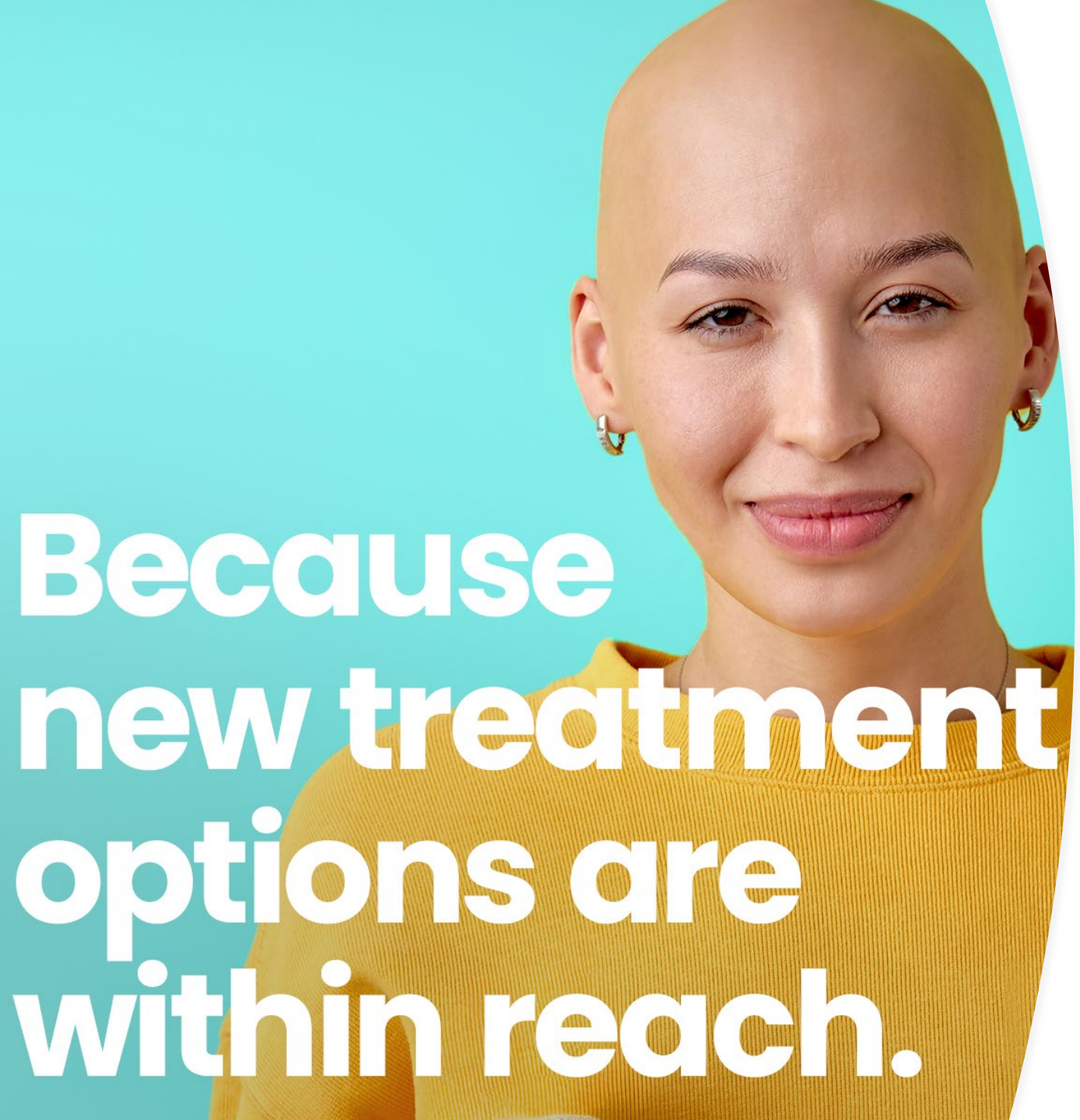
ACTS allows trials to be more accessible and equitable.

Program Participants	Patients Receiving Match Report	Trial Matches Offered	Health-Related Social Needs Identified
736	162	752	1,307

What's Next?

This fall, the ACS ACTS program is launching nationwide, unlocking new opportunities to expand access to clinical trials and support services -- and moving us closer to a truly equitable cancer care system for all.

Data from 2/24/25 - 9/1/25



American Cancer Society® ACTS

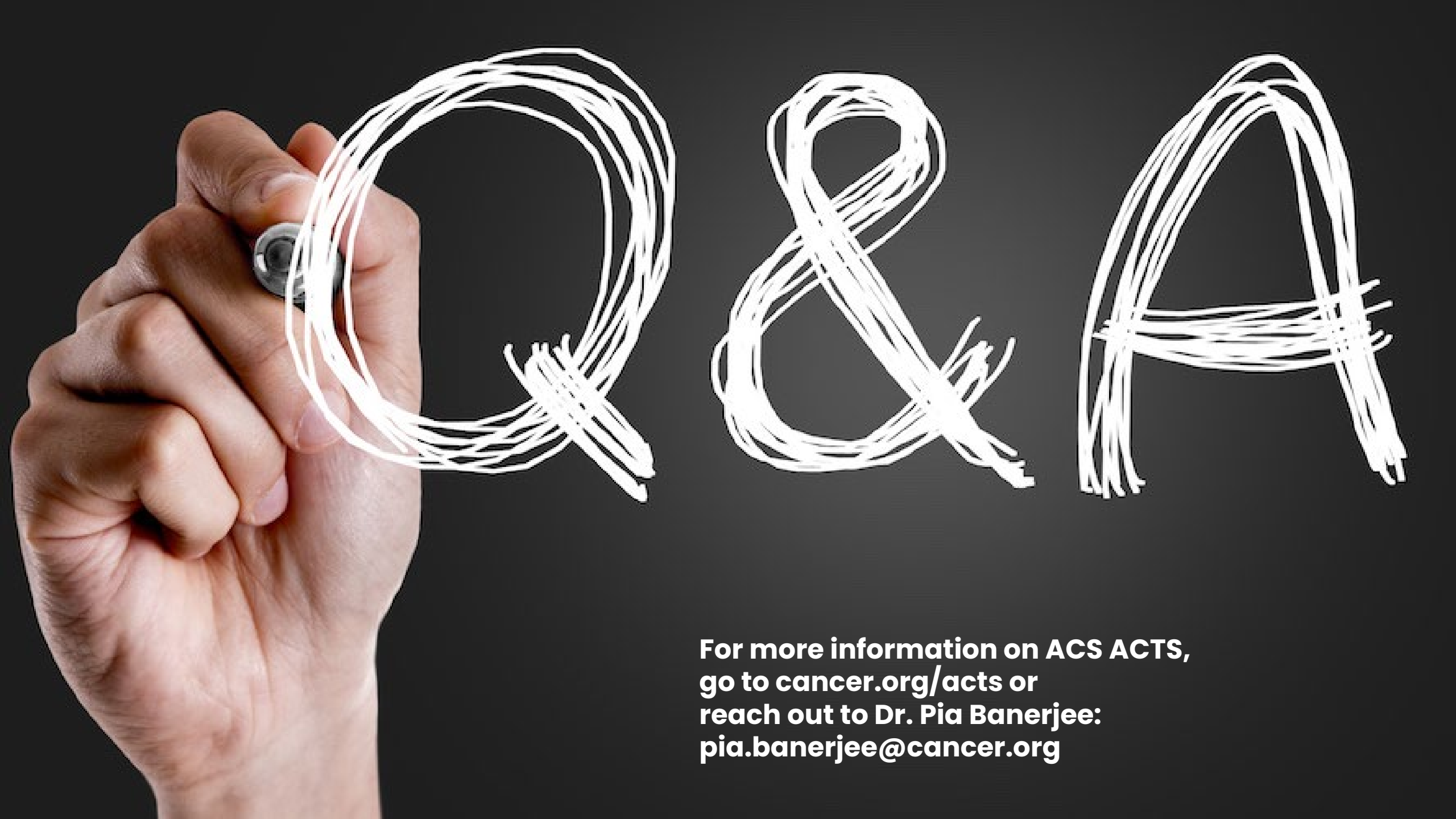
Sign up for ACS ACTS today!

- Scan the QR code to go to **cancer.org/acts**

or

- Call our 24/7 National Cancer Information Center line at 1-800-227-2345

Questions? Contact Dr. Pia Banerjee at pia.banerjee@cancer.org



For more information on ACS ACTS, go to cancer.org/acts or reach out to Dr. Pia Banerjee: pia.banerjee@cancer.org

ACS CRP Cancer Research Program
American College of Surgeons

Assessing the Effectiveness and Significance of the Operative Standards Program (AESOP)

September 10, 2025

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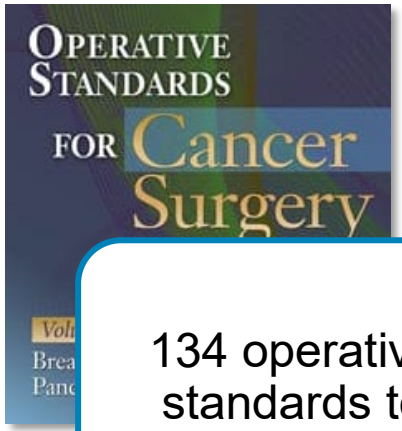
Postdoctoral Research Fellows
General Surgery Residents

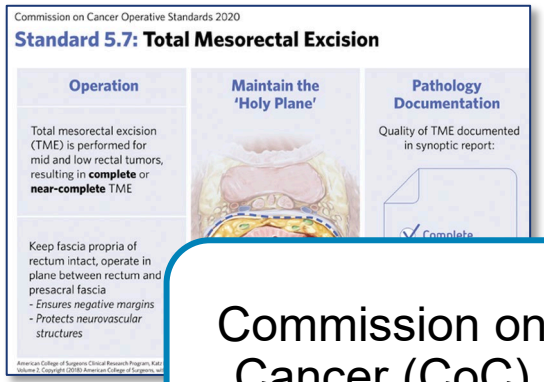
Lesly A. Dossett, MD, MPH
Daniel J. Boffa, MD, MBA
MPIs of AESOP Study (NCI R01 Grant)

High-quality surgery is a cornerstone of cancer care, yet variation in technical quality exists

2 million patients diagnosed with cancer in 2024; 60% had surgery



134 operative standards to improve surgical technical quality and outcomes

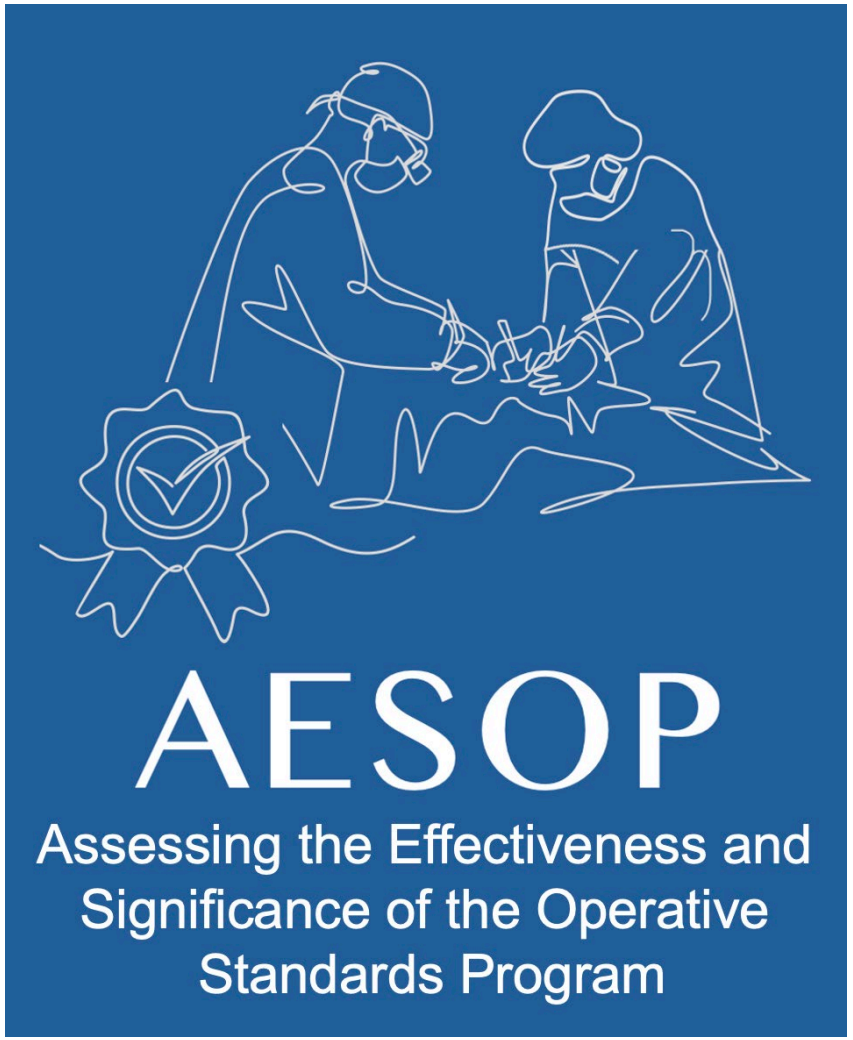


Commission on Cancer (CoC) implemented 6 Operative Standards in 2020

With CoC caring for >70% of cancer patients, the Standards have potentially broad impact

AESOP Grant Aims

- Evaluate the implementation of the CoC Operative Standards across cancer and hospital types
- Evaluate the impact of the CoC Operative Standards on cancer outcomes through an NCDB Special Study
- Assess barriers and facilitators of implementation with **Cancer Liaison Physicians**



AESOP Study Team

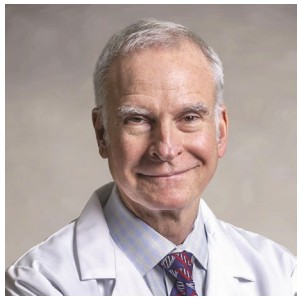
NIH
NATIONAL CANCER INSTITUTE

Study MPIs

Lesly Dossett

Dan Boffa

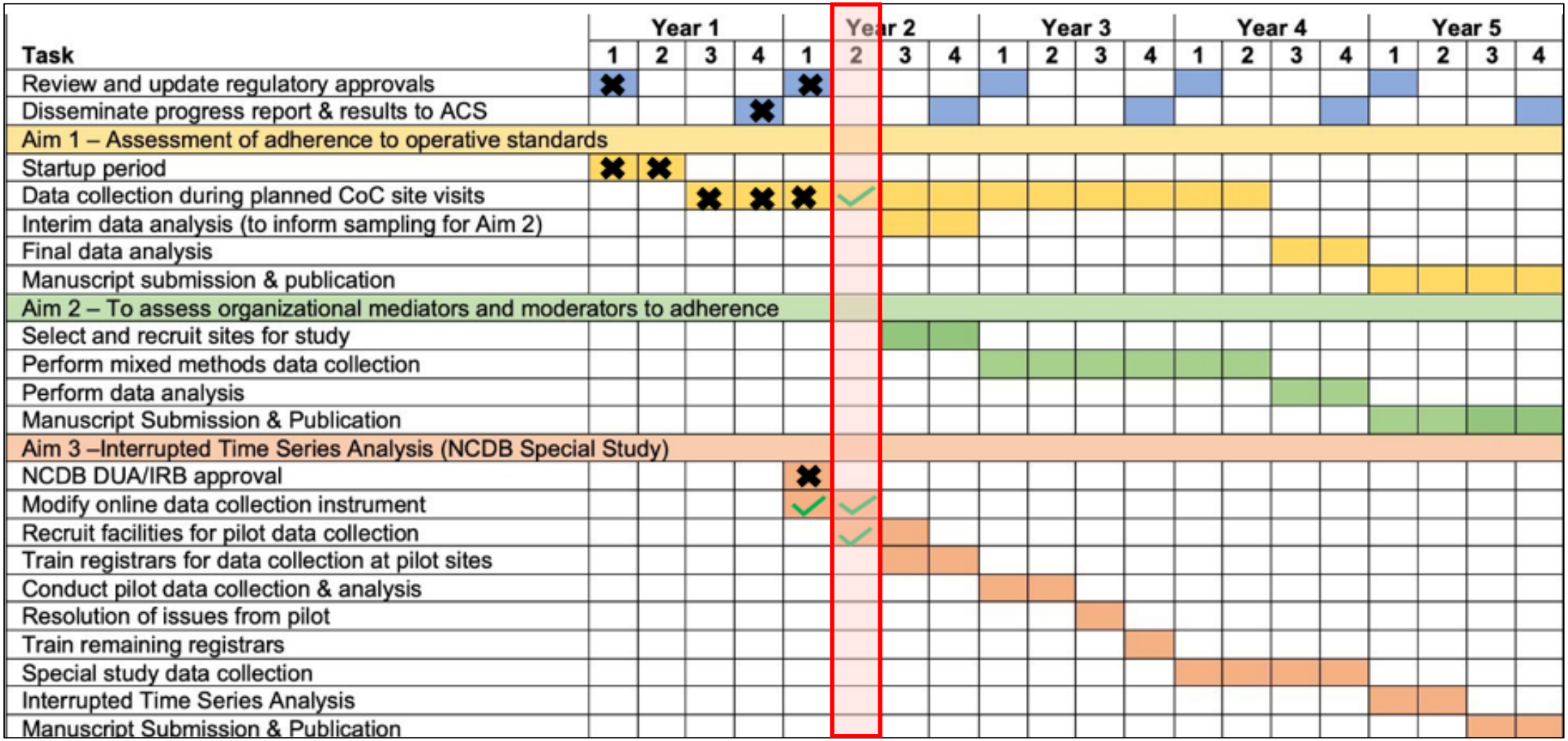
Cancer Programs Leadership



Statistical Expertise

Other Key AESOP Members

AESOP Study Timeline



AESOP Grant Aims

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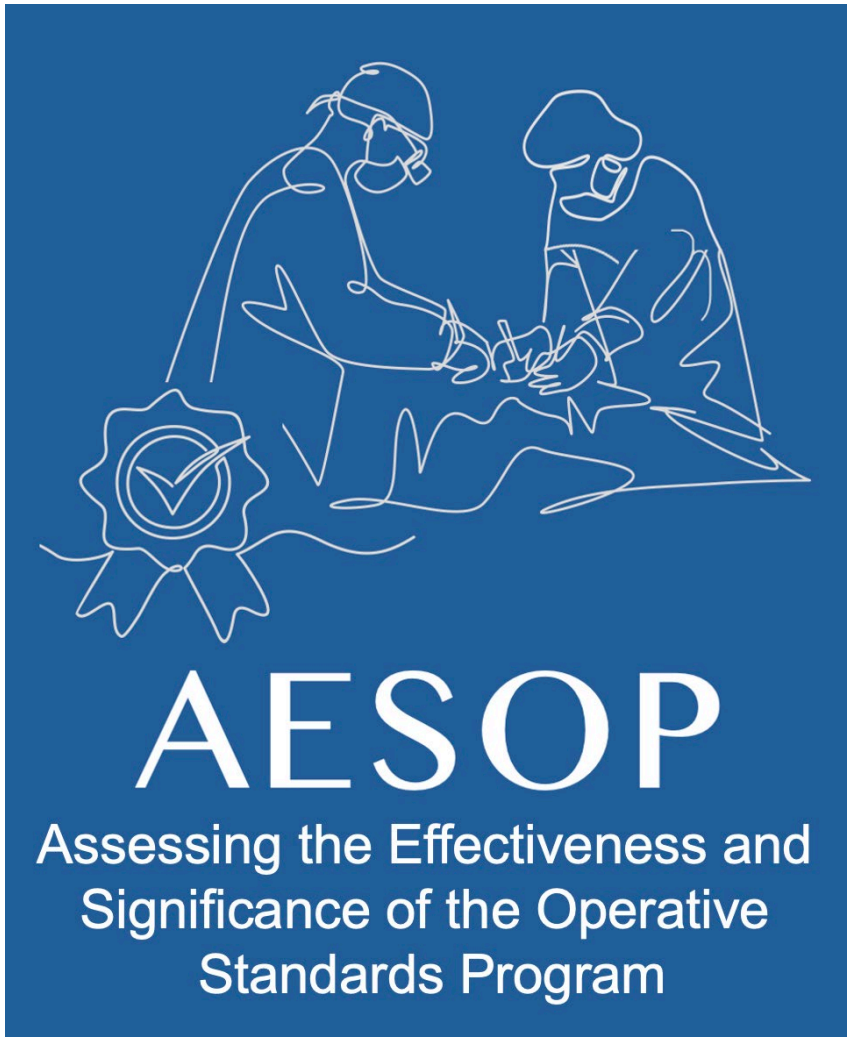


Evaluating Implementation of the CoC Operative Standards

Standards with Synoptic Pathology Reports
(5.7) Rectal Cancer TME*
(5.8) Pulmonary Resection

CoC communicates requirements

Site visits review pathology reports for compliance

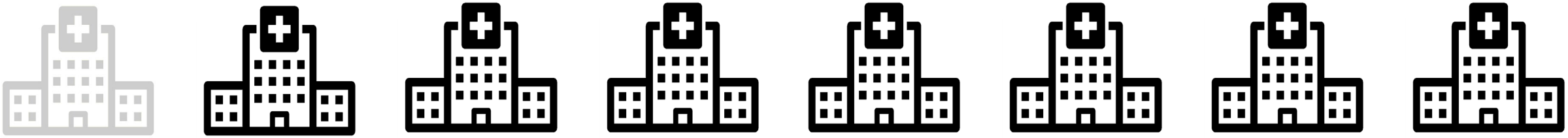
Standards with Synoptic Operative Reports
(5.3) Breast SLNB*
(5.4) Breast ALND*
(5.5) Cutaneous Melanoma
(5.6) Colon Resection

CoC communicates requirements

Site visits review synoptic operative reports for compliance

*TME: Total Mesorectal Excision; SLNB: Sentinel Lymph Node Biopsy; ALND: Axillary Lymph Node Dissection

Early Trends in Compliance with Standard 5.7 on Total Mesorectal Excision for Rectal Cancer



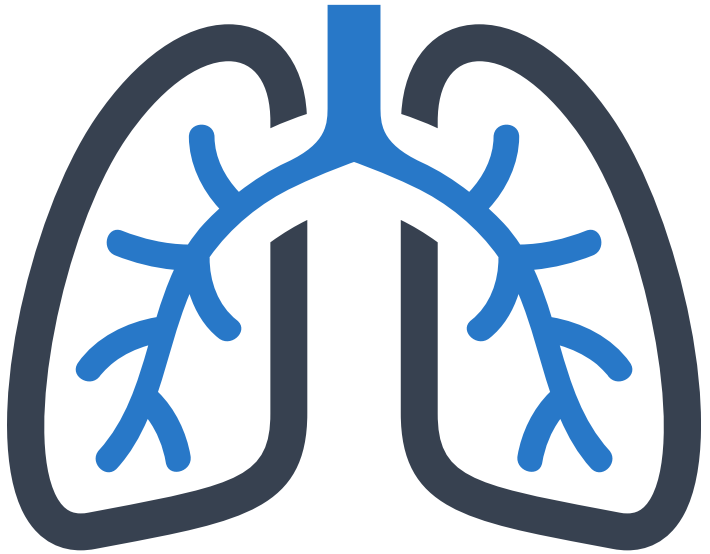
- **7 of 8** sites were compliant
- No change in compliance from 2022 to 2023
- No difference in compliance by CoC site type
- Most non-compliant hospitals were **close to achieving compliance** (often needing just 1-2 additional compliant cases)

Baskin et al., SSO Annual Meeting, March 2025

Katz MHG, et al. *Ann Surg*. 2025;282(3):371-381. 10.1097/SLA.0000000000006785

Early Trends in Compliance with Standard 5.8 on Lymph Node Sampling in Lung Cancer

- Most (77%) of CoC hospitals are performing curative-intent lung cancer surgery
- Only **about half** of sites were compliant
- No significant differences by site visit year (2002 vs 2023)
- NCI-designated centers and Academic programs had the highest compliance rates



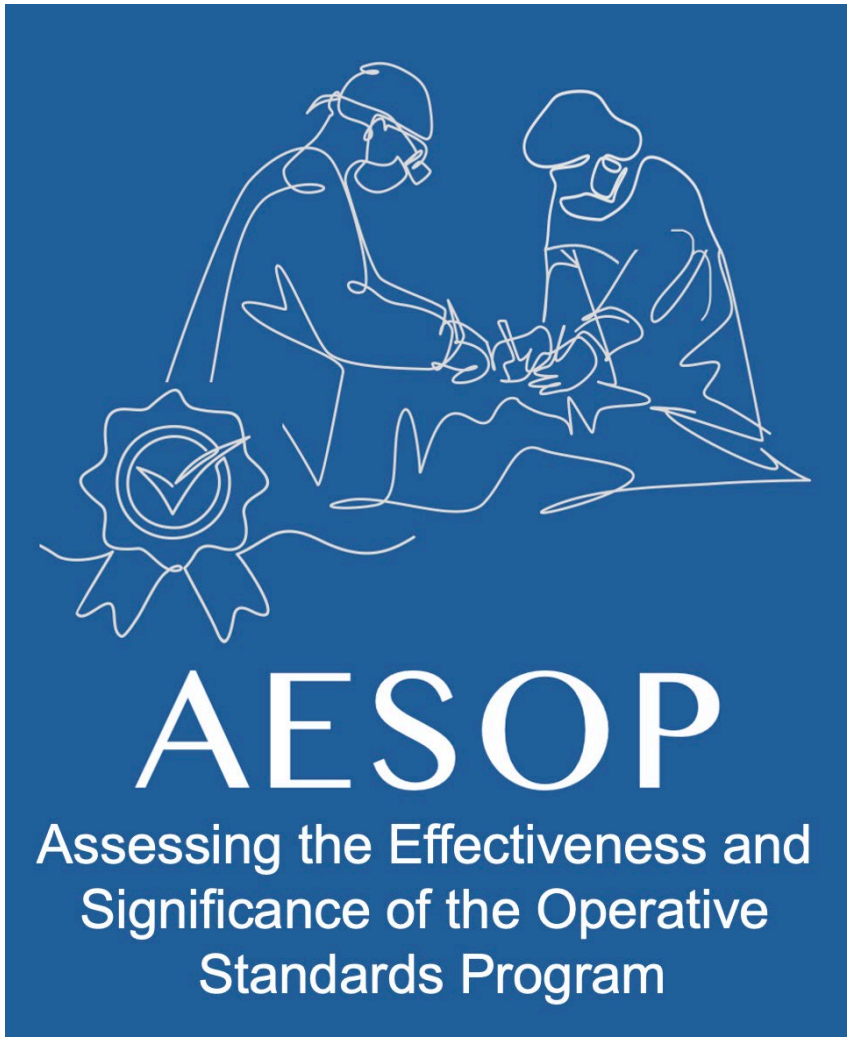
Baskin AS, et al. *J Thorac Cardiovasc Surg*. 10.1016/j.jtcvs.2025.04.041

AESOP Grant Aims

Evaluate the implementation of the CoC Operative Standards across cancer and hospital types

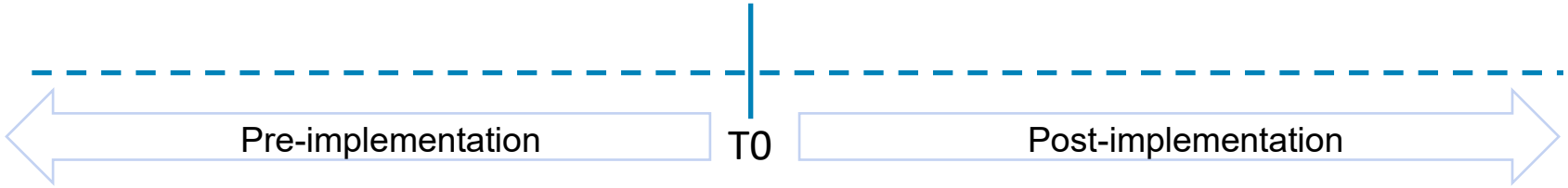
Evaluate the impact of the CoC Operative Standards on cancer outcomes through an NCDB Special Study

Assess barriers and facilitators of implementation with **Cancer Liaison Physicians**



Evaluate the impact of the CoC Operative Standards on short-term cancer outcomes

NCDB special study: data collection on 2-year oncologic outcomes



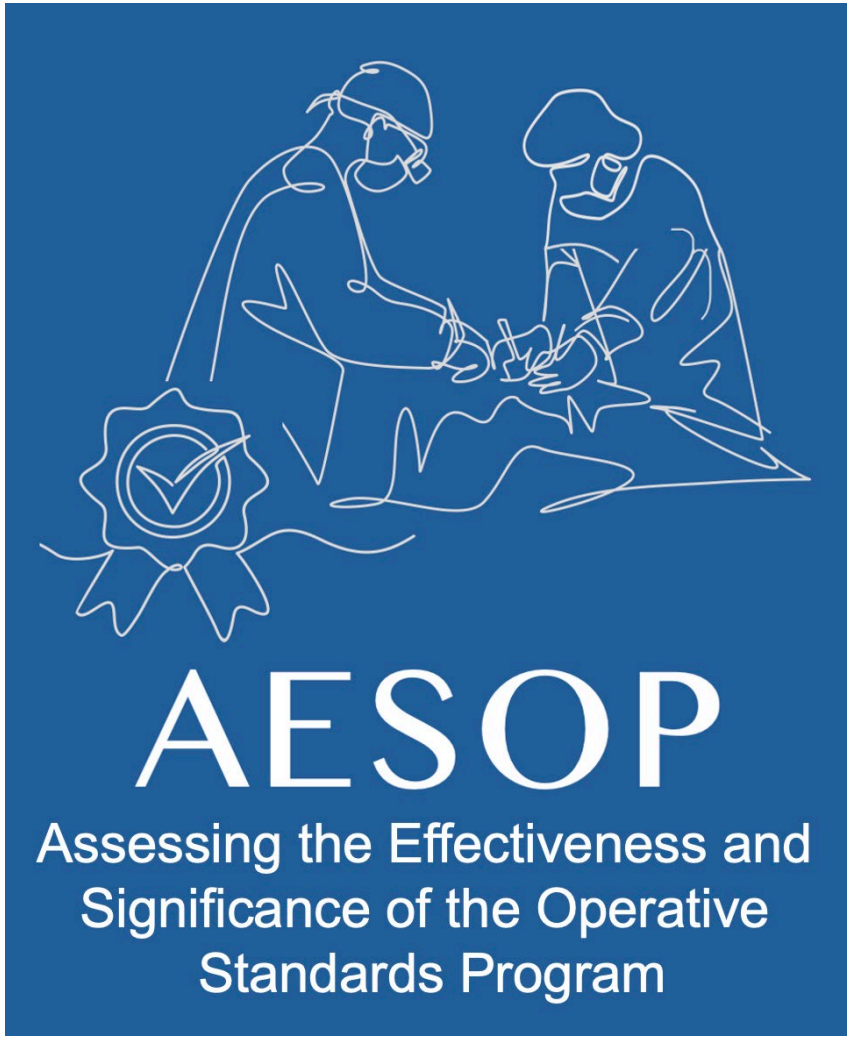
- Registrars will be asked to abstract specific data elements not currently collected by NCDB to assess for key 2-year cancer outcomes (e.g., progression)
- We will conduct an interrupted time-series analysis to evaluate the impact of implementing the CoC Operative Standards
- Pilot study will begin April 2026 (25 volunteering facilities)

AESOP Grant Aims

Evaluate the implementation of the operative standards across cancer and hospital types

Evaluate the impact of the operative standards on cancer outcomes through an NCDB Special Study

Assess barriers and facilitators of implementation with **Cancer Liaison Physicians**



Assess guideline and facility-level barriers and facilitators of implementation

Recognizing the Cancer Liaison Physicians (CLP) as key voices to convey unique institutional experience

Survey all CLPs at sites who undergo a site visit in 2026 (n~400)

Interview a select CLPs from high and low performing institutions to further understand experience (n=30)

Inform data analysis and future care practices

Look out for us in your inbox in 2026!

Thank you! Questions?

Further questions can be directed to AESOP@facs.org

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Questions?

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Thank you!

Questions?

Melissa Leeb: mleeb@facs.org

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