CoC State Chair Town Hall
July 20, 2022
Welcome New CoC State Chairs

Daniela Ochoa, MD, FACS
Arkansas

Andrea Jester, MD, FACS
Indiana

Alissa Greenbaum, MD
New Mexico
CoC Update

CoC Research Paper Competition
• 34 abstracts submitted
• Paper Competition Advisory Group is reviewing submissions and will choose winners, who will be recognized at the fall meetings

CLP Outstanding Performance Award
• 87 nominations submitted
• CLP Education Advisory Group is reviewing nominations and will choose winners, who will be recognized at the fall meetings
October 16: CoC Fall Meetings in San Diego

- State Chair Town Hall
- CoC Plenary Session
- CoC 100th Anniversary Reception
State Comprehensive Cancer Control Coalitions

- **Nikki Hayes, MPH**
  Chief, Comprehensive Cancer Control Branch, Centers for Disease Control and Prevention

- **Gayle Bagley**
  Director, Comprehensive Cancer Control, American Cancer Society

- **State Chair Panel**
  Quan Ly, MD, FACS, Nebraska State Chair
  Jennifer McAllaster, MD, FACS, Kansas State Chair
  James McLoughlin, MD, FACS, Tennessee State Chair
National Comprehensive Cancer Control Program: Program Overview

Nikki Hayes, MPH  
Chief, Comprehensive Cancer Control Branch, Division of Cancer Prevention and Control

Commission on Cancer (CoC) State Chair  
Quarterly Town Hall  
Wednesday, July 20, 2022
National Comprehensive Cancer Control Program: Collaborating to Conquer Cancer

Supports cancer coalitions in all 50 states, the District of Columbia, 8 U.S. territories and Pacific Island Jurisdictions, and 9 tribes or tribal organizations to create and implement cancer plans that focus on:

- Risk Reduction
- Early Detection
- Better Treatment
- Improved Quality of Life for Survivors
- Advancing equity in cancer health outcomes
Strategic External Partnerships are critical.

- Local health care facilities such as community health centers, hospitals, and Indian Health Service.
- Non-traditional agencies and organizations such as Bureau of Prisons, Department of Transportation and the Housing and Urban Development.
- Federal, State and local government agencies, American Indian/Alaska Native tribal governments and/or tribally designated organizations
- Primary care associations, employers, not-for-profit organizations (e.g., the American Cancer Society), the National Association of Community Health Centers, Health Center Controlled Networks, community-based organizations, for-profit organizations, non-governmental organizations, and community advocates.
National Comprehensive Cancer Control Program Awardees Are Key Conveners

- 2,335: the number of different partners awardees reported.
- 25: the median number of partners per awardee.
- 1–157: The range in number of partners across awardees.
NCCCP Awardees Address Program Priorities

- Over 1,000 interventions were implemented in various priority areas
- Most programs reported an average of 17 interventions

- Primary Prevention: 31% of all EBPs
  - Implementing any primary prevention EBPs: 99% of recipients

- Early Detection: 28% of all EBPs
  - Implementing any early detection EBPs: 99% of recipients

- Cancer Survivorship: 22% of all EBPs
  - Implementing any cancer survivorship EBPs: 96% of recipients

- Health Equity: 19% of all EBPs
  - Implementing any health equity EBPs: 87% of recipients
Most Commonly Reported Interventions: Primary Prevention

- Reducing client out-of-pocket costs to increase tobacco use cessation
- Client reminder and recall systems to increase community demand for vaccines
- Provider education to increase tobacco use cessation
- Increase healthy food and drink availability to improve healthy behavior
- Vaccination requirements for childcare, school and college attendance to increase community demand for vaccines
- Smoking bans and restrictions to reduce secondhand smoke exposure
Most Commonly Reported Interventions: Screening

- Group education to increase community demand for cancer screening services
- One-on-one education to increase community demand for cancer screening services
- Patient navigation to facilitate timely access to screening
- Reducing structural barriers to increase community access to cancer screening services
- Small media to increase community demand for cancer screening services
- Provider assessment and feedback to increase service delivery by health care providers
- Client reminders to increase community demand for cancer screening services
- Reducing client out-of-pocket costs to increase community access to cancer screening services
Most Commonly Reported Interventions: Survivorship

- Educate health care providers about cancer survivorship issues from diagnosis through long-term treatment effects and end-of-life care.
- Develop and disseminate public education programs that empower survivors to make informed decisions.
- Educate the public that cancer is a chronic disease that people can and do survive.
- Teach survivors how to access and evaluate available information.
- Develop, test, maintain, and promote patient navigation or case management programs that facilitate optimum care.
- Develop, test, maintain, and promote patient navigation systems for people living with cancer.
- Provide information to cancer survivors, health care providers, and the public about cancer survivorship and meeting their needs.
- Establish and/or disseminate guidelines that support quality and timely service provision to cancer survivors.
- Assess and enhance provision of palliative services to cancer survivors.
# CCCNP Overview

<table>
<thead>
<tr>
<th>Vision</th>
<th>Mission</th>
<th>History</th>
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<tbody>
<tr>
<td>A national movement of states, tribes, territories, PIJ, and local communities working together to reduce the burden of cancer for all people.</td>
<td>The CCCNP facilitates CCC coalitions to develop and sustain implementation of CCC plans at the state, tribe, territory, PIJ and local levels.</td>
<td>Began informally in 1994 with 5 organizations; formalized in 1999; now 18 organizational members</td>
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Comprehensive Cancer Control Coalitions: State Chair Role

Gayle Bagley
Director, Comprehensive Cancer Control
American Cancer Society

July 20, 2022
How can CoC State Chair Involvement Benefit a Comprehensive Cancer Control Coalition?

- The State Chair can serve as an Advocate Spokesperson for State Cancer Legislation
- The State Chair can advocate for Clinically Important Objectives (such as CoC Accreditation) in the State Cancer Plan
- The State Chair can identify Programs for Recruitment into the CoC Accreditation Program
How can CoC State Chair Involvement Benefit a Comprehensive Cancer Control Coalition? cont.

- The State Chair can **create a Link** between the CCC Coalition and Cancer Liaison Physicians and Accredited Programs.
- The State Chair can present to the CCC Coalition on behalf of the CoC.
- The State Chair can serve as a **clinical expert**, presenting information on clinically related cancer activities occurring in the state and how they could enhance the state's cancer plan.
How can State Chair Involvement in a Comprehensive Cancer Control Coalition Benefit a State Chair?

- Exposure to a larger view and understanding of the state’s cancer burden as well as cancer control efforts in the state.
- Influence the development direction of state cancer plan priorities.
- Develop new or stronger relationships with cancer control partners (individuals and organizations) throughout the state.
- Involvement on a policy level on cancer-related issues, such as pain/palliative care, tobacco and tanning bed policies.
What our organizations bring to comprehensive cancer control coalition work

CLINICAL EXPERTISE
Commission on Cancer State Chairs & Cancer Liaison Physicians

IMPLEMENTATION CAPACITY
ACS Regional Strategic Partnership staff

SKILLED ADVOCACY
ACS CAN Policy Analysts

A National reach and Local impact
State Comprehensive Cancer Control Coalitions

State Chair Panel

Quan Ly, MD, FACS, Nebraska State Chair
Jennifer McAllaster, MD, FACS, Kansas State Chair
James McLoughlin, MD, FACS, Tennessee State Chair
CoC Operative Standards Resources Update

CSSP Education Committee
Presenter, Puneet Singh MD FACS
Chair, Mediget Teshome MD MPH FACS
Vice Chair, Timothy Vreeland MD FACS

CoC State Chair Quarterly Town Hall
7.20.2022
# The CoC Operative Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Disease Site</th>
<th>Procedure</th>
<th>Documentation</th>
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<tbody>
<tr>
<td>5.3</td>
<td>Breast</td>
<td>Sentinel node biopsy</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.4</td>
<td>Breast</td>
<td>Axillary dissection</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.5</td>
<td>Melanoma</td>
<td>Wide local excision</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.6</td>
<td>Colon</td>
<td>Colectomy (any)</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.7</td>
<td>Rectum</td>
<td>Mid/low resection (TME)</td>
<td>Pathology report (CAP)</td>
</tr>
<tr>
<td>5.8</td>
<td>Lung</td>
<td>Lung resection (any)</td>
<td>Pathology report (CAP)</td>
</tr>
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Timeline for Standards 5.3-5.6

- **2020**: Introduction of operative standards
- **2021**: Plan for implementation, educate/train surgeons & registrars
- **2022**: Document final plan for implementation and conduct audits
- **2023**: Begin compliance with Standards 5.3-5.6
- **2024**: Site Visits review 2023 operative reports for 70% compliance
- **2025**: Site Visits review 2023 & 2024 operative reports for 80% compliance

**Steps to Achieve Compliance**

- **Site Reviews**
Guidelines for the Implementation Plan for Standards 5.3-5.6

• Guidelines for the implementation plan for CoC Standards 5.3-5.6 are available online.

• Site reviewers will review plans for implementation of the CoC Standards 5.3-5.6 during site visits in 2023, 2024, and 2025.
Opportunities for Improvement Identified during Site Visits

Standard 5.7 (Total Mesorectal Excision)

- TME completeness was not included in rectal cancer synoptic pathology reports
- Pathology reports did not address the intactness of mesorectum

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**Macroscopic Evaluation of Mesorectum (required for rectal cancers) (Note A)**

- Not applicable
- Complete
- Near complete
- Incomplete
- Cannot be determined: _______________
Opportunities for Improvement Identified during Site Visits

Standard 5.8 (Pulmonary Resection)

- Failure of surgeons to remove/identify required nodal stations
- Inadequate number of nodes from required stations (either no nodes removed, or fewer stations than required for mediastinal and/or hilar nodes)
- Stations not listed in pulmonary resection synoptic pathology reports
- Information included not in synoptic format
State Chair CLP Education Advisory Group Collaboration

- CSSP
- CoC State Chairs
- CLPs
Resources

• CoC Operative Standards Overview slide deck
• Comprehensive FAQ on the CoC Operative Standards
• Implementation of CoC Operative Standards Webinar – March 28, 2022
  Recording, summary document and slide deck available.
• Technical Standards for Cancer Surgery: Improving Patient Care through Synoptic Operative Reporting. Annals of Surgical Oncology
• Technical Standards for Cancer Surgery: Commission on Cancer Standards 5.3–5.8. Annals of Surgical Oncology

All resources can be found on the Operative Standards Toolkit page!
Upcoming Events

- "Next Steps for Implementing the Operative Standards" session at the virtual ACS Cancer Accreditation Programs: Continually Advancing Quality Cancer Care Conference
  - Content now available!
- Standard 5.6 Colon Resection Webinar – August 25, 2022, @ 5-6pm CT
- Registration coming soon!
Implementation Survey

• Survey on Implementation of CoC-Required Synoptic Elements in Operative Reports (Standards 5.3-5.6)
• The CSSP is seeking feedback from CoC-accredited programs that have already implemented solutions to meet CoC requirements for inclusion of the specific required synoptic elements in operative reports at their facilities.
• Due by August 1st
• Link to participate
Questions?
cssp@facs.org

Quick Links:
Operative Standards Toolkit
CoC 2020 Operative Standards
CAnswer Forum