The National Accreditation Program for Rectal Cancer Standards Manual is intended as an instructive tool to assist health care providers and institutions in improving the care of rectal cancer patients. It is not intended to replace the professional judgment of the physician, health care provider, or health care administrator in individual circumstances. The American College of Surgeons and the Commission on Cancer cannot accept, and expressly disclaim, liability for claims arising from the use of this work.
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Acknowledgment of Contributors

The National Accreditation Program for Rectal Cancer (NAPRC) and the Commission on Cancer (CoC) are thankful to the representatives of the CoC member organizations, OSTRiCh Consortium (Optimizing the Surgical Treatment of Rectal Cancer) Standards Committee, and the members of the NAPRC Steering Committee for their efforts to improve the care and treatment of rectal cancer patients in the United States.

Specifically, the NAPRC acknowledges the many contributions of the following people who were vital to the creation of the National Accreditation Program for Rectal Cancer Standards Manual.

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Commission on Cancer Mission

The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and monitoring of comprehensive quality care.

NAPRC BACKGROUND AND THE VALUE OF ACCREDITATION

The National Accreditation Program for Rectal Cancer (NAPRC) was developed through collaboration between The OSTRiCh Consortium (Optimizing the Surgical Treatment of Rectal Cancer) and the Commission on Cancer (CoC), a quality program of the American College of Surgeons.

During the last 20 years, the outcomes of rectal cancer have repeatedly been shown to be tremendously variable and highly contingent upon specialization, training, and volume. Some of these very important and highly statistically significant variations relate to rates of postoperative mortality, incidence of local recurrence, incidence of construction of permanent colostomy, and five-year survival.

Recently these variations have been confirmed in the United States. Baek noted that patients in the state of California were as likely to be operated upon at a low-volume (1 to 5 cases of rectal cancer per year) as a medium-volume (6 to 10 rectal cancer surgeries per year) or high-volume (11 to 24 rectal cancer cases per year) hospital. There were highly significant differences in favor of high-volume hospitals relative to mortality and rates of sphincter preservation.

Ricciardi assessed 20,000 proctectomies undertaken between 2002 and 2004 and analyzed county data in 21 states. Fifty percent of patients underwent construction of permanent stoma and only 20 percent of the 21 counties offered colostomy rates less than 40 percent. This same problem had existed in Europe, but through numerous initiatives in Sweden, Denmark, Spain, Belgium, The Netherlands, Norway, and the United Kingdom, outcomes have been improved. Specific measureable improvements have been noted in the rates of complete total mesorectal excision, the rates of permanent stoma construction, the incidence of local recurrence, and overall survival.

Based on the significant variability in the United States and the fact that a number of European countries were able to, on a national level, improve the quality of rectal cancer care, the OSTRiCh Consortium convened in 2011. Since that time the OSTRiCh Consortium has performed several analyses, culminating in a series of publications highlighting the problem of tremendous variability of rectal cancer care on a national level in the United States.

The OSTRiCh Consortium reported these findings to the Accreditation Committee of the Commission on Cancer and the officers and regents of the American College of Surgeons. Thereafter, the NAPRC was developed.
One component of determining whether National Accreditation Program for Rectal Cancer (NAPRC) accreditation will be awarded to a Rectal Cancer Program (RCP) is the survey, which includes an on-site visit to the facility. The initial NAPRC survey occurs after the applying facility achieves Commission on Cancer (CoC) accreditation and attests that the NAPRC standards have been in place in the RCP and complied with for at least 12 months.*

At the time of application for initial survey with the NAPRC, CoC accreditation status must be Three-Year Accreditation with Contingency, Three-Year Accreditation, or Three-Year with Commendation Accreditation.

In preparation for accreditation, the RCP must:

1. Assess and demonstrate compliance with the requirements for all standards outlined in the National Accreditation Program for Rectal Cancer Standards Manual and any subsequent updates,

2. Submit payment for the annual accreditation fee,

3. Confirm the date and times of required survey elements with the assigned surveyor, and

4. Complete and provide required documentation to the NAPRC and surveyor at least 30 calendar days before the confirmed survey date.

Programs are notified of their assigned NAPRC-trained surveyors for upcoming surveys by e-mail. The selection of the survey date is coordinated between the RCP and the surveyor.

The initial NAPRC survey cannot take place at the same time as the initial CoC survey.

The CoC and the NAPRC reserve the right to modify the accreditation process as detailed in this manual as needed.

**SURVEY EXTENSIONS AND CANCELLATIONS**

When extenuating circumstances affect program activity, a survey extension may be appropriate. Extensions are granted on a case-by-case basis, with a typical extension being three months. A longer extension may be available given specific circumstances.

Valid extenuating circumstances that may warrant a survey extension include, but are not limited to:

- Natural disasters (such as hurricane, earthquake, tornado, flood) that directly affect the facility

- Anthropogenic hazards (such as fire, industrial accidents) that directly affect the facility
Examples of circumstances that do not warrant a survey extension include, but are not limited to:

- Software conversion or IT issues
- Staff absences, turnovers, or resignations
- Delayed abstracting or missing data
- Standard deficiencies

The Rectal Cancer Program Coordinator (RCP Coordinator) and/or the Rectal Cancer Program Director (RCP Director) must submit a formal request for an extension via e-mail to NAPRC@facs.org. The request must include specifics regarding the rationale for the request, a proposed plan, and a timeline to resolve the issues necessitating the extension request. Programs will be notified of the extension request decision as soon as practical following receipt of the written request.

Programs are discouraged from canceling the scheduled survey. However, if survey cancelation becomes necessary after the on-site survey date is confirmed, the RCP must submit a written notification to NAPRC@facs.org. The RCP will be invoiced for a cancelation fee and any nonrefundable travel expenses incurred by the surveyor.

THE ACCREDITATION FEE

Upon application for initial accreditation with the NAPRC, an invoice will be issued to the RCP for a one-time application fee. Initial surveys will not be scheduled until the application fee is received by the NAPRC.

Each calendar year, an invoice for the annual NAPRC accreditation fee is issued to the RCP. Payment of the accreditation fee is due within 30 days of the date of the invoice.

An RCP’s failure or delay in paying the accreditation fee may result in a suspension of NAPRC privileges and/or discontinuation of accreditation.

THE SURVEY VISIT

A member of the RC-MDT confirms with the surveyor the logistics of the agenda for the required survey components at least 14 calendar days before the on-site visit.

The surveyor’s role is to verify whether the RCP is in compliance with the NAPRC standards. On the day of survey, the surveyor will:

- Present information to key members of the program’s leadership on the NAPRC,
- Meet with the RC-MDT to discuss the activities and responsibilities of its members and to verify the accuracy of the data and documentation submitted,
- Attend an RC-MDT meeting to observe the program’s multidisciplinary patient management and discussions,
- Meet with the RCP Director and RCP Coordinator to discuss their roles and responsibilities,
- Conduct chart reviews as dictated by the standards,
• Tour the facility (optional, but encouraged), and

• Conduct a summation to provide initial impressions on the RCP’s strengths and areas in need of improvement and provide a chance for the RC-MDT members to ask any additional questions.

It is recommended that all members of the RC-MDT attend and participate in the survey. At a minimum, the surveyor must meet with the following people:

• Chief administrators and clinician leaders

• Rectal Cancer Program Director

• Rectal Cancer Program Coordinator

CHART REVIEWS

Many NAPRC standards indicate percentage requirements as part of compliance rating criteria. Compliance with these components of the rating criteria will be evaluated through the surveyor’s on-site chart review of randomly selected patient charts. The percentage of charts that meet the rating criteria during the on-site chart review will determine whether the RCP is in compliance with that aspect of the standard.

At least 14 days before survey, the RCP will provide the surveyor with a list of accession numbers that meet the definitions of eligible patients for chart review. Before the day of survey, the surveyor will inform the program of the selected, applicable charts that will be reviewed on-site.

REQUIRED DOCUMENTATION

In preparation for the on-site visit, all documentation demonstrating compliance with the NAPRC standards, excluding patient charts, must be provided to the NAPRC and surveyor through the applicable web portal at least 30 calendar days before the on-site survey.

THE POST-SURVEY EVALUATION

The Post-Survey Evaluation (PSE) is a required component of the NAPRC survey. The PSE captures feedback from the RCP, which enables the NAPRC to evaluate and improve the survey process. Feedback from the PSE also assists development of education materials and training programs for both surveyors and participating programs.

All PSE responses are confidential and do not influence the NAPRC survey results. Responses on the evaluation form must represent a consensus opinion of the RCP. The PSE must be completed within 14 calendar days after the survey.

NOTIFICATION OF SURVEY RESULTS

Performance reports detailing the results of the RCP’s survey will be available within 45 days of the on-site visit or as soon as practical thereafter. The Rectal Cancer Program Director and the Rectal Cancer Program Coordinator each receive an e-mail when the completed performance report is available.
The performance report provides the following:

- A summary of the survey outcome and accreditation award,
- The RCP's rating for each standard,
- A narrative description for noncompliant standards, and
- Suggestions to improve or enhance the RCP.

If accredited without contingency, access for ordering the Certificate of Accreditation is provided to the Rectal Cancer Program Coordinator following the performance report's release to the RCP.

**APPEALS**

Rectal Cancer Programs may appeal a finding for any eligible standard within 30 calendar days of the performance report notification.* The appeals process is outlined in the Appeal Guidelines on the NAPRC web page.

**DEFICIENCY RESOLUTION**

Programs awarded “Three-Year Accreditation with Contingency” status are eligible for deficiency resolution. The deficiency resolution due date is identified on the RCP's performance report. Programs that fail to resolve deficiencies within the allotted time are at risk of having accreditation discontinued.

The deficiency resolution process is outlined in the Deficiency Resolution Guidelines on the NAPRC web page.*

**MARKETING AND VISIBILITY**

The NAPRC encourages RCPs to use the marketing tools provided by the NAPRC. These materials explain and promote the value NAPRC accreditation brings to patients, families, programs, and payers. A link to materials will be provided to the RCP after it achieves full accreditation.

**RESOURCES FOR ACCREDITED PROGRAMS**

The CAnswer Forum is an interactive, virtual bulletin board for CoC and NAPRC constituents to review questions and answers regarding standard requirements. Users can search individual chapters or standards for topics on which they may have questions. Users can also submit questions that have not already been answered. To access the forum, users must complete a one-time registration, which includes creating a user name and a password.

The Standards Resource Library (SRL) contains tools, templates, examples, and resources designed to help cancer programs meet the CoC and NAPRC standards. The SRL is located within the CAnswer Forum and can be accessed using a CAnswer Forum user name and password.

A full list of resources for NAPRC-accredited programs is located on the NAPRC web page.

**STANDARDS AND POLICIES IN DEVELOPMENT**

As of October 2017, standards and information denoted with an asterisk have components that are still in development by the NAPRC or its partners. Programs will not be held to all compliance requirements for these standards until an official announcement is made by the NAPRC. Further details, clarifications, and updates regarding these standards and NAPRC policies are provided on the NAPRC web page.
Survey Outcome Information

NAPRC STANDARDS RATING SYSTEM AND ACCREDITATION AWARDS

Ratings for each standard are assigned based on a consensus by the Rectal Cancer Program's (RCP’s) surveyor and a National Accreditation Program for Rectal Cancer (NAPRC) Technical Reviewer. When required, the applicable review subcommittee will also contribute to the standard rating decision as a final adjudicator.

Based on the rating criteria specified for each standard, a “Compliant,” “Noncompliant,” or “Not Applicable” rating is assigned for each standard. Any standard with a “Noncompliant” rating is a “deficiency.”

Accreditation awards are determined by the number of Noncompliant ratings the RCP receives. Following survey, an RCP receives one of the three available Accreditation Awards.

**Three-Year Accreditation** is conferred to a program that received a “Compliant” or “Not Applicable” rating for all standards at the time of survey. Three-Year Accreditation is also awarded to programs that received and resolved a deficiency within the allotted timeframe for one or more standards. A certificate of accreditation is issued.

**Three-Year Accreditation with Contingency** is conferred to a program when one to five* standards are rated “Noncompliant” at the time of survey. The deficiency resolution due date is indicated on the RCP’s performance report. Programs must resolve all deficiencies within the time allotted. A program that does not resolve its deficiencies within the allotted timeframe is at risk of having its accreditation status discontinued. A certificate of accreditation is only issued after resolution of all deficiencies.

**Non-Accreditation** is conferred to a program when six* or more standards are rated “Noncompliant.” When applicable, NAPRC staff will work directly with these programs to assist them with deficiency resolution so accreditation may be reinstated. A program can also choose to withdraw, improve its performance, and then reapply for accreditation as a new program. Note, new program application fees will be assessed when reapplying as a new program.

A program that receives Non-Accreditation status after its Commission on Cancer (CoC) survey, but receives Three-Year Accreditation with Contingency or Three-Year Accreditation following its NAPRC survey will remain NAPRC accredited. However, the CoC program must proceed and comply with policies relating to CoC Non-Accreditation status. If the program does not resolve its CoC deficiencies according to guidelines, NAPRC status will be discontinued.

*Policies and processes for accreditation during the initial launch of the NAPRC may differ from above. Please check the NAPRC web page for any updates.
Commission on Cancer Accreditation

The facility must be accredited by the Commission on Cancer (CoC) before earning accreditation by the National Accreditation Program for Rectal Cancer (NAPRC).

DEFINITION AND REQUIREMENTS

The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard setting, prevention, research, education, and the monitoring of comprehensive quality care. CoC accreditation is only granted to facilities that voluntarily commit to providing high-quality cancer care and comply with established CoC standards.

High-quality rectal cancer care involves the same principles that underlie CoC accreditation. Accordingly, NAPRC accreditation is only granted to facilities that currently hold CoC accreditation status of Three-Year with Commendation Accreditation, Three-Year Accreditation, or Three-Year Accreditation with Contingency.

DOCUMENTATION

The Rectal Cancer Program (RCP) must complete all required electronic data fields.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills the compliance criteria:

The facility has a Commission on Cancer accreditation status of Three-Year with Commendation Accreditation, Three-Year Accreditation, or Three-Year Accreditation with Contingency.

Noncompliance: The RCP does not fulfill the compliance criteria each calendar year.
Rectal Cancer Multidisciplinary Care

The rectal cancer program must have a defined Rectal Cancer Multidisciplinary Team with a minimum of one appointed physician member from each of the following specialties: surgery, pathology, radiology, medical oncology, and radiation oncology.

DEFINITION AND REQUIREMENTS

Cancer outcomes are better when patients are managed according to the principles of multidisciplinary team (MDT) care. There is increasing evidence that MDTs are associated with improved clinical decision making, clinical outcomes, and patient experience in several cancer types, including rectal.1-10 Implementation of an MDT approach to rectal cancer care in several European countries has resulted in lower rates of permanent stoma, reduced rates of local recurrence, greater delivery of evidence-based care, and improved overall survival.11-15

The Rectal Cancer Multidisciplinary Team (RC-MDT) must include at least one appointed physician member from each of the following specialties: surgery, pathology, radiology, medical oncology, and radiation oncology. Programs may choose to appoint more than one required member from each specialty. All surgeons, excluding fellows and residents, who perform rectal cancer surgery at the rectal cancer program must be a required member of the RC-MDT. Each surgery, pathology, radiology, medical oncology, and radiation oncology member appointed to the RC-MDT is required to meet attendance requirements as detailed in Standard 1.3.

Additional required members of the RC-MDT are the Rectal Cancer Program Director (RCP Director) (Standard 1.5) and the Rectal Cancer Program Coordinator (RCP Coordinator) (Standard 1.6).

The RC-MDT membership and identification of designated alternates must take place at the first meeting of each calendar year and must be recorded in the RC-MDT meeting minutes. It is recommended that the RC-MDT meetings are held separately from other cancer sites. However, at the discretion of the rectal cancer program, RC-MDT meetings may be held in conjunction with another cancer site(s) as long as required RC-MDT members and specialties are present and all NAPRC requirements are met.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads the RC-MDT minutes that document the appointment of all RC-MDT members and alternates and, if applicable, membership changes.

During the on-site visit, the surveyor will discuss the RC-MDT structure and process with the RCP Director and the RCP Coordinator.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. A defined Rectal Cancer Multidisciplinary Team roster is established and documented in the minutes at the first meeting of each year.
2. The membership of the Rectal Cancer Multidisciplinary Team includes at least one appointed physician member from surgery, pathology, radiology, medical oncology, and radiation oncology.

3. All surgeons, excluding fellows and residents, who perform rectal cancer surgery at the rectal cancer program are required, appointed members of the Rectal Cancer Multidisciplinary Team.

4. The Rectal Cancer Program Director and the Rectal Cancer Program Coordinator are required, appointed members of the Rectal Cancer Multidisciplinary Team.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Rectal Cancer Multidisciplinary Team Attendance

Each required Rectal Cancer Multidisciplinary Team member or the member’s designated alternate attends at least 50 percent of the Rectal Cancer Multidisciplinary Team meetings held each calendar year.

DEFINITION AND REQUIREMENTS

Each required RC-MDT member or the designated alternate must attend at least 50 percent of the RC-MDT meetings held each calendar year. Attendance at RC-MDT meetings may include participation through teleconference as long as the tele-attendee can participate in discussions and has access to necessary meeting materials, including, but not limited to, radiographic images, specimen photographs, and pathologic reports and/or slides.

One designated alternate member can be identified for each required member, excluding surgery, on the RC-MDT. Surgeons cannot have alternates because all surgeons performing rectal cancer surgery at the accredited facility must be appointed required members of the RC-MDT.

Designating alternates is optional. The designated alternate must be qualified and appropriately credentialed to serve as an alternate for the required member (in other words, the alternate for a medical oncologist must be another medical oncologist). Individuals cannot be selected to serve as an alternate if they are already a required member of the RC-MDT. An individual cannot be an alternate for multiple members.

The attendance percentage is calculated based on the attendance of the required role. If no alternate is appointed, the appointed required member must solely meet the attendance requirements. If an alternate is appointed, then the required member plus his or her designated alternate’s attendance is considered together.

The Rectal Cancer Program Director monitors attendance each year and addresses attendance outliers.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads the RC-MDT minutes that include the membership attendance for all RC-MDT meetings held during each calendar year.

RATING COMPLIANCE

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

Each required member or the designated alternate attends at least 50 percent of the Rectal Cancer Multidisciplinary Team meetings held.

Noncompliance: The RCP does not fulfill the compliance criteria each calendar year.
Rectal Cancer Multidisciplinary Team Meetings

Each calendar year, the Rectal Cancer Multidisciplinary Team meets at least twice each calendar month. At least one RC-MDT member from each of the required specialties must be in attendance at each RC-MDT meeting.

DEFINITION AND REQUIREMENTS

Each calendar year, the RC-MDT must meet at least twice each calendar month. The RC-MDT may choose to convene more frequently to ensure all patients are discussed in a timely manner and to allow for timely management decisions.

A calendar year is defined as January 1–December 31. A calendar month is defined as the first day of the month through the last day of the month (for example, March 1 to March 31).

For the RC-MDT meeting to qualify under Standard 1.4, at least one RC-MDT member from surgery, pathology, radiology, medical oncology, and radiation oncology must be in attendance.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the program uploads comprehensive minutes that document the RC-MDT’s twice-monthly meetings and standard compliance activities. All meeting minutes must contain sufficient detail to accurately reflect the activities of the RC-MDT as well as demonstrate compliance with NAPRC requirements.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. The Rectal Cancer Multidisciplinary Team meets at least twice each calendar month.

2. At least one RC-MDT member from surgery, pathology, radiology, radiation oncology, and medical oncology is present at each RC-MDT meeting.

Noncompliance: The RCP does not fulfill one or more of the compliance criteria each calendar year.
Rectal Cancer Program Director

Each calendar year, the facility appoints a Rectal Cancer Program Director who chairs the Rectal Cancer Multidisciplinary Team (RC-MDT). The RCP Director is the liaison between the RC-MDT and its facility’s Commission on Cancer committee. The RCP Director is responsible for evaluating, interpreting, and reporting the RCP’s performance through internal audits and National Cancer Database (NCDB) data. The RCP Director reports the analysis of NCDB data to the RC-MDT at least four times each calendar year.

DEFINITION AND REQUIREMENTS

The Rectal Cancer Program Director serves as the chair of the RC-MDT and as a liaison to the facility’s Commission on Cancer committee. The RCP Director must be an active physician member of the accredited RCP’s medical staff who provides care and treatment to rectal cancer patients. A co-director may be appointed at the discretion of the RCP.

The RCP Director is a required member of the RC-MDT. The identification of the RCP Director or, if applicable, the RCP co-directors must take place at the first meeting of each calendar year and must be recorded in the RC-MDT meeting minutes. If co-directors are appointed, both must individually meet the attendance requirements in Standard 1.3. If the appointed RCP Director cannot continue to serve on the RC-MDT, a new physician must be appointed at the next RC-MDT meeting.

Internal Audit Responsibilities

The RCP Director is responsible for overseeing RC-MDT activity. As dictated in the “chart review section” in each Chapter 2 standard, the RCP Director is responsible for overseeing internal audits of the RCP’s performance and the development of any necessary action plans. The RCP Director may delegate responsibility for specific audits and any necessary action plans to appropriately credentialed physician members of the RC-MDT.

CoC Committee Liaison Responsibilities

Each calendar year, the RCP Director or the designated alternate must attend one of the facility’s CoC committee meeting and present a report on the RCP’s activities. At a minimum, the RCP Director’s report must include the results of the audits required in each Chapter 2 standard.

Data Interpretation Responsibilities

The RCP Director must be authorized to access facility-specific information that is maintained in the NAPRC web portal and the NCDB. The RCP Director must evaluate the quality of rectal cancer care by monitoring, interpreting, and providing updated reports of the program’s data from the NCDB. At a minimum of four separate RC-MDT meetings each calendar year, the RCP Director or the designated alternate must report and discuss the RCP’s performance and response to the rectal cancer quality measure data. Reports must include program-specific data.

The RCP Director is responsible for overseeing that any necessary action plans are developed and implemented (see requirements under Standard 3.2). The RCP Director may delegate responsibility for specific action plans to appropriately credentialed physician members of the RC-MDT.
The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads:

- RC-MDT minutes documenting the appointment of the RCP Director,
- RC-MDT minutes that document required RCP Director reports on RCP data from NCDB, including actions and response,
- RC-MDT minutes documenting the results of all Chapter 2 audits and any necessary action plans, and
- CoC committee minutes documenting the RCP Director’s report to the CoC committee.

During the on-site visit, the surveyor will discuss the RC-MDT activity with the RCP Director.

**RATING COMPLIANCE**

**Compliance:** Each calendar year, the RCP fulfills all of the compliance criteria:

1. A Rectal Cancer Program Director is appointed. The appointment is documented in the minutes of the first yearly RC-MDT meeting.
2. The results of all Chapter 2 audits and any necessary action plans are reported and discussed at a Rectal Cancer Multidisciplinary Team meeting and documented in the minutes.
3. The Rectal Cancer Program Director or the designated alternate attends at least one of its facility’s Commission on Cancer committee meeting.
4. The Rectal Cancer Program Director reports the results of all required Chapter 2 audits to its facility’s Commission on Cancer committee at least once. The report is documented in the Commission on Cancer committee minutes.
5. At a minimum of four meetings, it is documented in the Rectal Cancer Multidisciplinary Team minutes that the Rectal Cancer Program Director or the designated alternate reports and discusses rectal cancer program data from the National Cancer Database.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Rectal Cancer Program Coordinator

A Rectal Cancer Program Coordinator is appointed each calendar year to coordinate activities of the Rectal Cancer Multidisciplinary Team. Policies and procedures are in place to define patient coordination activity, including, but not limited to: communication between departments within the facility, referring physicians, and patients; coordinating patient appointments; and oversight of data collection.

DEFINITION AND REQUIREMENTS

The RCP Coordinator provides comprehensive administrative support to RC-MDT meetings, including the management of accurate and timely information to enable clinical decision making at the RC-MDT. The RCP Coordinator is a required member of the RC-MDT. The role involves registering and monitoring of patients with suspected and confirmed rectal cancer throughout their diagnostic and treatment pathways. The RCP Coordinator ensures that patient care pathways are followed according to agreed guidelines, including time targets for relevant interventions.

The RCP Coordinator liaises with relevant departments within the facility to ensure all pertinent information is available for RC-MDT meetings. Additionally, the RCP Coordinator communicates with referring organizations or providers to capture all relevant patient details for discussion at the RC-MDT meetings. Following the RC-MDT meeting, the RCP Coordinator informs the referring organizations/providers of discussion outcomes regarding their patients.

The RCP Coordinator proactively coordinates patient pathways with health care providers/organizations ensuring that all appointments, diagnostic tests, and treatments are booked within the time targets defined by the NAPRC standards. This is not exclusively a navigation position prioritizing interacting with patients; rather it is a behind-the-scenes position coordinating patient care with health care providers. It is recognized that the RCP Coordinator may need to contact the patient to obtain information about dates, locations, and results of tests and treatments performed outside of the accredited RCP.

The RCP Coordinator is a required member of the RC-MDT. The identification of the RCP Coordinator or, if applicable, the co-coordinators, must take place at the first meeting of each calendar year and must be recorded in the RC-MDT meeting minutes. If the appointed RCP Coordinator cannot continue to serve on the RC-MDT, a new RCP Coordinator must be appointed at the next RC-MDT meeting. Whether the RCP Coordinator is dedicated to the RCP full-time is left to the discretion of the RCP/facility.
Standard 1.6 (continued)

**DOCUMENTATION**

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads:

- RC-MDT minutes documenting the appointment of the RCP Coordinator, and
- Policies and procedures for coordinating RC-MDT activity and ensuring that patients move through the RC-MDT process appropriately.

During the on-site visit, the surveyor will discuss the RC-MDT process with the RCP Coordinator.

**RATING CRITERIA**

**Compliance:** Each calendar year, the RCP fulfills all of the compliance criteria:

1. A Rectal Cancer Program Coordinator is appointed. The appointment is documented in the minutes of the first yearly RC-MDT meeting.

2. Policies and procedures are in place to define Rectal Cancer Program Coordinator patient and Rectal Cancer Multidisciplinary Team coordination activity.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Rectal Cancer Program Education

All surgeon, pathologist, and radiologist physician members of the Rectal Cancer Multidisciplinary Team complete the NAPRC-endorsed education module related to their respective specialties.

DEFINITION AND REQUIREMENTS

Current evidence supports the adoption of four main principles of rectal cancer care: (1) performing surgery that adheres to the principles of total mesorectal excision (TME); (2) pretreatment tumor assessment by specialized rectal cancer-protocol Magnetic Resonance Imaging (MRI) to identify patients at high risk for local tumor recurrence who may benefit from neoadjuvant therapies; (3) specific techniques of pathology assessment of the resected rectum that contribute to patient prognosis, need for adjuvant chemotherapy, and evaluation of the quality of surgery; and (4) a multidisciplinary team approach that identifies, coordinates, delivers, and monitors the ideal treatment for each individual patient.1

The success of a rectal cancer program may vary based on the capability of a facility’s RC-MDT to follow the above principles. The skills required to fulfill these principles, however, are not uniformly present in the United States.1 As such, a key component of an accredited rectal cancer program is the completion of education modules designed to train the facility’s RC-MDT members in these skill sets.

All required surgeon, pathologist, and radiologist physician members of the facility’s RC-MDT must complete the relevant portion of the NAPRC-endorsed education modules specific to their medical specialties within 12 calendar months of joining the RC-MDT.

Surgery

Sound surgical technique is vital to optimizing oncological outcomes and minimizing complications and morbidity in rectal cancer surgery.

Proctectomy following the principles of TME maintains the integrity of the mesorectal fascial envelope by sharp, direct vision dissection of the plane between the mesorectal fascia and the presacral and endopelvic fascia. The ability of TME to lower local recurrence rates and increase survival has been widely documented.2-4

The training of surgeons and wide implementation of TME has been shown to reduce permanent stoma rates, decrease the incidence of local recurrence, and to improve five-year survival in population-based studies.5 This NAPRC-endorsed education module is being developed by the American Society of Colon and Rectal Surgeons.

Surgeon members of the RC-MDT who perform rectal cancer surgery at the NAPRC-accredited program must complete the NAPRC-endorsed surgery education module at least once. At the discretion of the NAPRC, surgeons may be required to take an updated module in line with clinical advancements.

Pathology

Pathologic assessment of tumor stage and margin status is widely known as the most important prognostic factor in rectal cancer. Pathology grading of the TME specimen has also been shown as an important indicator of surgical quality and resultant oncologic outcomes.6,7
Analysis of the plane of surgery and circumferential resection margin (CRM) status in patients enrolled in a large randomized, controlled trial of preoperative radiotherapy provides evidence for the association between surgical quality and outcomes and the role of the pathologist in surgical quality assessment.8

Pathologists who are trained in specialized methods of rectal cancer specimen assessment form an important component of the direct quality assurance of rectal cancer surgery.7 The College of American Pathologists (CAP) "Cancer Protocol for the Examination of Specimens of Patients with Primary Carcinoma of the Colon and Rectum" is accessible, free of charge, from the CAP website and must be used by pathologists as a self-study. Supplemental education materials are provided by the NAPRC and must be used by pathologists as additional self-study. An attestation must be signed that the pathologist has reviewed and studied all required materials.

Pathologist members of the RC-MDT who process rectal cancer specimens and report rectal cancer findings at the NAPRC-accredited program must complete the pathology self-study portion of the NAPRC-endorsed education module at least once. At the discretion of the NAPRC, pathologists may be required to take an updated module in line with clinical advancements.

Radiology

Imaging of rectal cancer has evolved significantly in the last decade. In Europe, MRI has become the standard for the pretreatment imaging of rectal cancer based on its accuracy in predicting the CRM, tumor invasion of adjacent pelvic structures, and, to a lesser degree, tumor (T)- and nodal (N)-stage.9,10

Routine use of MRI in the context of a multidisciplinary assessment of rectal cancer has been used to plan neoadjuvant therapy and surgery and has been shown to reduce the incidence of positive circumferential margins.11,12 MRI-based treatment planning may also allow for the more efficient use of neoadjuvant therapy, an important factor in potentially reducing both the costs and morbidity of rectal cancer care.13 This NAPRC-endorsed education module is being developed by the American College of Radiology.

Radiologist members of the RC-MDT who review and report rectal cancer imaging at the NAPRC-accredited program must complete the radiology portion of the NAPRC endorsed education module at least once. At the discretion of the NAPRC, radiologists may be required to take an updated module in line with clinical advancements.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads the certificates of completion or signed attestation for the NAPRC-endorsed education module for each required surgeon, pathologist, or radiologist physician member of the RC-MDT.

RATING CRITERIA

Compliance: As required, the RCP fulfills the compliance criteria:

All surgeon, pathologist, and radiologist physician members of the facility’s Rectal Cancer Multidisciplinary Team complete the NAPRC endorsed education module related to their respective specialties and provide documentation to confirm completion.

Noncompliance: The RCP does not fulfill the compliance criteria as required.
CHAPTER 2
Clinical Services

Commission on Cancer®
NATIONAL ACCREDITATION PROGRAM FOR RECTAL CANCER
A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS
Review of Diagnostic Pathology

Each calendar year, all rectal cancer patients who are diagnosed elsewhere who have received no previous treatment have biopsy pathology slides and/or reports reviewed by an appropriate, appointed member of the Rectal Cancer Multidisciplinary Team (RC-MDT). All patients diagnosed elsewhere who received previous treatment elsewhere must have documentation of a rectal cancer diagnosis in the patient’s medical record before initiation of treatment at the accredited Rectal Cancer Program (RCP). Ninety-five percent of previously undiagnosed, previously untreated rectal cancer patients receive confirmation of diagnosis by biopsy before treatment at the accredited Rectal Cancer Program.

DEFINITION AND REQUIREMENTS

Adenocarcinomas account for the vast majority of malignant tumors of the rectum in the United States. Other histologic types are rare, accounting for an estimated 2 to 5 percent of colorectal tumors.1 Every effort must be made to document the histopathological diagnosis of invasive adenocarcinoma of the rectum before the initiation of treatment.

The RCP must confirm the diagnosis of rectal cancer before the initiation of treatment at the accredited RCP. The RCP must establish policies and procedures to obtain and review the outside biopsy pathology slides and/or biopsy pathology reports and include them in the patient’s medical record. Additionally, for patients who are previously undiagnosed and previously untreated, the RCP must establish policies and procedures for confirming rectal cancer diagnosis by biopsy prior to initiation of treatment.

For patients who are diagnosed elsewhere, pathology slides must be obtained whenever possible. RCPs must track the number of slides obtained for patients diagnosed elsewhere.

Rectal Cancer Patients Diagnosed Elsewhere with No Previous Treatment

Before the initiation of definitive treatment at the RCP:

- All rectal cancer patients who were diagnosed elsewhere and have received no previous treatment must have biopsy pathology slides obtained and reviewed by an appointed pathology member of the RC-MDT.
- If slides cannot be obtained, biopsy pathology reports must be obtained and reviewed by an appropriate, appointed member of the RC-MDT.
- If pathology slides or reports for a biopsy performed elsewhere cannot be obtained, the RCP must re-biopsy the patient.
- Review of biopsy pathology slides and/or reports is documented in the patient medical record.
Rectal Cancer Patients Diagnosed and Previously Treated Elsewhere
Before the initiation of definitive treatment at the RCP:

- All rectal cancer patients who were diagnosed elsewhere and have received any previous treatment must have biopsy slides obtained and reviewed by an appointed pathology member of the RC-MDT.

- If slides cannot be obtained, biopsy pathology reports must be obtained and reviewed by an appropriate, appointed member of the RC-MDT.

- If biopsy pathology slides or reports cannot be obtained, all rectal cancer patients diagnosed elsewhere who received any previous treatment elsewhere must have medical documentation of a confirmed rectal cancer diagnosis before the initiation of treatment at the accredited RCP.

- Confirmation of diagnosis is documented in the patient medical record.

Rectal Cancer Patients Previously Undiagnosed and Untreated
Before the initiation of definitive treatment at the RCP:

- Ninety-five percent of previously undiagnosed, previously untreated rectal cancer patients must undergo a biopsy at the RCP for confirmation of rectal cancer diagnosis.

DOCUMENTATION
The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads:

- Policies and procedures to obtain, review, and document the review of biopsy pathology slides and/or reports of patients diagnosed elsewhere who receive definitive treatment at the RCP.

- Policies and procedures for confirming rectal cancer diagnosis by biopsy in previously undiagnosed, previously untreated patients who receive definitive treatment at the RCP.

CHART REVIEW
At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director (RCP Director) each calendar year to evaluate compliance with this standard. The RCP Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.
RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills the compliance criteria:

1. Before the initiation of definitive treatment, when available, pathology slides for patients diagnosed elsewhere are obtained and reviewed by a pathology member of the Rectal Cancer Multidisciplinary Team.

2. Before the initiation of definitive treatment, all rectal cancer patients diagnosed elsewhere who received no previous treatment must have a pathology report from a biopsy completed either outside the facility or at the accredited Rectal Cancer Program reviewed by an appropriate, appointed Rectal Cancer Multidisciplinary Team member. The pathology report is included in the patient’s medical record.

3. Before initiation of treatment at the accredited facility, all patients diagnosed elsewhere who received treatment elsewhere must have documentation confirming a rectal cancer diagnosis in the patient’s medical record.

4. Before initiation of treatment at the accredited facility, 95 percent of previously undiagnosed, previously untreated rectal cancer patients undergo a biopsy at the accredited facility.

5. All required policies and procedures are in place.

Noncompliance: The RCP does not fulfill one or more of the compliance criteria each calendar year.
Staging before Definitive Treatment

Ninety-five percent of all previously untreated rectal cancer patients are staged (systemic and local tumor) before definitive treatment. Systemic staging is completed by Computerized Tomographic (CT) or Positron Emission Tomographic-Computed Tomographic (PET/CT) scanning of the chest, abdomen, and pelvis. Local tumor staging is completed by rectal cancer protocol Magnetic Resonance Imaging (MRI) of the pelvis.

DEFINITION AND REQUIREMENTS

Thorough and accurate pretreatment clinical staging of a rectal cancer patient forms the essential basis for the individualized treatment-planning discussion that occurs at RC-MDT conferences. Clinical staging of rectal cancer has two components: “systemic staging” to diagnose distant metastatic disease (for example, liver and lung metastases) and “local tumor staging” to define the extent of the primary tumor in the rectum and involvement of regional pelvic lymph nodes (for example, mesorectal and iliac).1

Systemic staging for rectal cancer is completed by CT or PET/CT scan of the chest, abdomen, and pelvis.2 Systemic staging must be completed by CT whenever possible; however, a combined PET/CT scan is an acceptable alternative. A PET scan without the CT scan does not meet this standard.

Local tumor is staged by MRI of the pelvis using a rectal cancer protocol.2 The MRI of the pelvis is designed to highlight the depth of tumor penetration into the mesorectum, status of the circumferential resection margin, involvement of adjacent organs, lymph node involvement, extramural venous invasion, and relation to the anal sphincter complex.3

STANDARD EXCEPTION

Patients with documented contraindications to CT, PET/CT, and/or MRI scanning are exempt from the standard.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads:

- Policy and procedure for systemic staging of rectal cancer using CT or PET/CT exam of the chest, abdomen, and pelvis.

- Policy and procedure for local tumor staging of rectal cancer using MRI of the pelvis.
**Chart Review**

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

**Rating Criteria**

**Compliance:** Each calendar year, the RCP fulfills all of the compliance criteria:

1. Ninety-five percent of previously untreated rectal cancer patients are staged (systemic and local tumor) before definitive treatment.

2. All required policies and procedures are in place.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Standardized Staging Reporting for Magnetic Resonance Imaging Results

Each calendar year, 90 percent of pretreatment MRI exams for previously untreated rectal cancer patients are read by a radiologist who is an appointed member of the Rectal Cancer Multidisciplinary Team. Staging results for 95 percent of previously untreated rectal cancer patients who complete MRI exams are recorded in a standardized report containing the minimum required elements.

DEFINITION AND REQUIREMENTS

MRI has replaced endorectal ultrasound (EUS) as the primary imaging modality used for the local staging of rectal cancer. MRI’s significant advantages over EUS include: the ability to have independent review, improved accuracy of extramural depth of invasion and extramural vascular invasion, detection of the anticipated circumferential margin clearance, and the ability to compare pre- and post-treatment studies.1-4

The protocol for MRI staging of rectal cancer has been refined and standardized by European experts.5 For MRI staging to be effective, the technique of acquiring and interpreting the images must be uniform and the results must be reported in a standardized report.6,7 Without standardized reporting, less than 40 percent of MRI reports contain all of the necessary information to make treatment decisions.8

Each calendar year, 90 percent of pretreatment MRI exams for previously untreated rectal cancer patients are read by a radiologist who is a member of the RC-MDT.

Each calendar year, MRI staging results for 95 percent of all previously untreated rectal cancer patients who complete MRI exams are recorded in a standardized report containing the minimum required elements. These elements are defined in the Cancer Care Ontario template, which is available on the Cancer Care Ontario website. The standardized report is included in the patient’s medical record.

DOCUMENTATION

The RCP must complete all required electronic data fields.

CHART REVIEW

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.
RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. Ninety percent of pretreatment Magnetic Resonance Imaging exams for rectal cancer patients are read by a radiologist who is a member of the Rectal Cancer Multidisciplinary Team.

2. Ninety-five percent of Magnetic Resonance Imaging staging results for rectal cancer patients are reported in standardized format containing all required elements. The report is included in the patient's medical record.

Noncompliance: The RCP does not fulfill one or more of the compliance criteria each calendar year.
Carcinoembryonic Antigen Level

For 75 percent of previously untreated rectal cancer patients, a carcinoembryonic antigen (CEA) level is obtained before definitive treatment and the pretreatment CEA level is recorded in the patient’s medical record.

DEFINITION AND REQUIREMENTS

Testing for CEA, a glycoprotein that is released from tumor cells into patient serum, is recommended by the National Comprehensive Cancer Network (NCCN) guidelines for both colon and rectal cancer. Testing is recommended before initiation of treatment in patients with rectal cancer as the result can be used as a baseline for surveillance after treatment.

Each calendar year, a CEA level is obtained before definitive treatment for 75 percent of all previously untreated rectal cancer patients and the pretreatment CEA level is recorded in the patient’s medical record. Policies and procedures are in place for obtaining and tracking pretreatment CEA levels for all previously untreated rectal cancer patients.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads policies and procedures for obtaining and tracking pretreatment CEA levels for all previously untreated rectal cancer patients.

CHART REVIEW

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. A carcinoembryonic antigen level is obtained before definitive treatment and is recorded in the patient’s medical record for 75 percent of previously untreated rectal cancer patients.

2. All required policies and procedures are in place.

Noncompliance: The RCP does not fulfill the compliance criteria each calendar year.
Rectal Cancer Multidisciplinary Team Treatment Planning Discussion

Before the initiation of definitive treatment, all rectal cancer patients must have an individualized treatment planning discussion conducted at a Rectal Cancer Multidisciplinary Team meeting.

DEFINITION AND REQUIREMENTS

All rectal cancer patients who undergo treatment at an NAPRC-accredited program, excluding emergency patients, must be discussed at a Rectal Cancer Multidisciplinary Team meeting before beginning definitive treatment. Definitive treatment is defined as neoadjuvant therapy, surgical resection, or initiation of palliative care.

Emergency patients who do not require a treatment planning discussion are those that present with tumor-related complications that require immediate or urgent treatment. Examples of emergent conditions include, but are not limited to: rectal tumor perforation, life-threatening tumor hemorrhage, and acute large bowel obstruction.

The RC-MDT treatment planning discussion must include, but is not limited to:

Review of diagnostic and staging studies

- Colonoscopy report (location of primary tumor and synchronous lesions) if present/available
- Biopsies of primary rectal cancer and metastases if present/available (Standard 2.1)
- CT scan or PET/CT of chest, abdomen, and pelvis (Standard 2.2)
- Rectal Cancer MRI (Standard 2.2)
- Pretreatment CEA level (Standard 2.4)

Assignment of clinical stage

- Clinical stage according to the American Joint Committee on Cancer

Creation of individualized treatment plan

- Neoadjuvant therapy regimen, when indicated
- Anticipated surgical procedure
- Referral to radiation oncology, when indicated
- Referral to medical oncology, when indicated
- Palliative care, when indicated

The RCP Coordinator must document in the patient’s medical record the date the patient was discussed at the RC-MDT meeting and which physician presented the case.
In rectal cancer programs with 100 or more cases, the RCP Director may develop criteria to determine which patients must be presented at the RC-MDT for a treatment planning discussion. These criteria must be documented in a policy and procedure. Regardless of criteria put in place, at least 100 cases must be presented for treatment planning discussion in accordance with this standard each year. The patients who are not presented at RC-MDT must still meet the requirements of all other standards.

**DOCUMENTATION**

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads the policy and procedure for ensuring pretreatment discussion of all rectal cancer patients at a RC-MDT meeting.

During the on-site visit, the surveyor will discuss with the RCP Director and the RCP Coordinator the process for ensuring appropriate content and documentation of patient discussions at RC-MDT meetings.

**CHART REVIEW**

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the RCP Director each calendar year to evaluate compliance with this standard. The RCP Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

**RATING CRITERIA**

**Compliance:** Each calendar year, the RCP fulfills the compliance criteria:

1. Excluding emergency patients, an individualized treatment planning discussion is conducted at a Rectal Cancer Multidisciplinary Team meeting for all rectal cancer patients before initiation of definitive treatment.

2. The Rectal Cancer Program Coordinator documents in the patient’s medical record the date the patient was discussed at a Rectal Cancer Multidisciplinary Team meeting and which physician presented the case.

3. All required policies and procedures are in place.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Treatment Evaluation and Recommendation Summary

Before the initiation of definitive treatment, a standardized treatment evaluation and recommendation summary is completed and provided to the primary care and/or referring physician for at least 50 percent of rectal cancer patients.

DEFINITION AND REQUIREMENTS

A lack of substantial information in treatment summaries has been recognized to negatively affect rectal cancer patient outcomes.1 The standardized evaluation and treatment recommendation summary provides documentation of all information pertinent to the treatment of the patient’s rectal cancer and communicates this information to the patient’s primary care and/or referring physician in order to improve coordination and delivery of care. A treatment evaluation and recommendation summary must be provided to the primary care and/or referring physician for at least 50 percent of rectal cancer patients. It is anticipated that many RCPs will exceed the minimum 50 percent required by this standard.

The physician who presents the patient to the RC-MDT is responsible for ensuring communication and presentation of the evaluation and treatment recommendation summary to the patient.

The standardized evaluation and treatment recommendation summary includes, but is not limited to:

- Tumor location in the rectum (lower, middle, or upper third)
- Indication of sphincter involvement
- Pretreatment (clinical) American Joint Committee on Cancer stage
- Pretreatment circumferential resection margin status (involved, threatened, or not threatened)
- Carcinoembryonic antigen level
- Neoadjuvant therapy recommendation
- Type and duration of neoadjuvant therapy recommended
- Anticipated date and type of surgical procedure
- Clinical research study eligibility and/or enrollment

The treatment recommendation summary is recorded in the patient’s medical record.
**DOCUMENTATION**

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads:

- Policies and procedures for completing the evaluation and treatment recommendation summary and providing it to the primary care and/or referring physician
- Sample of a standardized evaluation and treatment recommendation summary

During the on-site visit, the surveyor will discuss with the RCP the process for completing the evaluation and treatment recommendation summary, recording the summary in the patient’s medical record, and disseminating this information to the patient’s primary care and/or referring physician.

**CHART REVIEW**

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

**RATING CRITERIA**

**Compliance:** Each calendar year, the RCP fulfills all of the compliance criteria:

1. Before the initiation of definitive treatment, a standardized evaluation and treatment recommendation summary is completed and provided to the patient’s primary care and/or referring physicians and included in the patient’s medical record for at least 50 percent of rectal cancer patients.

2. All required policies and procedures are in place.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Definitive Treatment Timing

Eighty percent of all previously untreated rectal cancer patients begin definitive treatment within 60 days of initial clinical evaluation at the accredited Rectal Cancer Program.

DEFINITION AND REQUIREMENTS

Once a diagnosis of rectal cancer has been made, the rectal cancer program is responsible for ensuring that patients receive a thorough and efficient evaluation for prompt initiation of therapy. A patient-centered approach dictates minimal delay between diagnosis and treatment to avoid undue patient anxiety.

Accredited rectal cancer programs must ensure that 80 percent of previously untreated patients begin definitive treatment within 60 days of the patient’s initial clinical evaluation for rectal cancer at the accredited RCP. The treatment plan is documented in the patient’s medical record.

STANDARD EXCEPTIONS

Delays due to documented patient noncompliance or failure of payers to authorize recommended treatment in a timely fashion shall not be considered a failure to meet this standard.

DOCUMENTATION

The RCP must complete all required electronic data fields.

CHART REVIEW

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

Eighty percent of previously untreated rectal cancer patients begin definitive treatment within 60 days of the patient’s initial clinical evaluation for rectal cancer at the accredited rectal cancer program.

Noncompliance: The RCP does not fulfill the compliance criteria each calendar year.
Surgical Resection and Standardized Operative Reporting

Each calendar year, 80 percent of surgical resections for rectal cancer patients are performed by a surgeon who is an appointed member of the Rectal Cancer Multidisciplinary Team. Operative reports for 95 percent of all rectal cancer patients who undergo surgical resection for rectal cancer are recorded in a standardized synoptic report format containing the minimum required elements.

DEFINITION AND REQUIREMENTS

Surgery Standardization

Surgeon specialization has been shown to improve rectal cancer outcomes. Proper surgical technique is vital to optimizing oncological outcome and minimizing morbidity in rectal cancer surgery. The operative technique of total mesorectal excision (TME) is technically demanding and a clear correlation exists between surgeon experience and knowledge and patient outcomes, which may partially explain observed discrepancies between high- and low-volume surgeons. To encourage standardization and adherence to standards, rectal cancer surgery must be performed by a member of the Rectal Cancer Multidisciplinary Team.

Each calendar year, 80 percent of all surgical resections for rectal cancer patients are performed by a surgeon who is an appointed member of the RC-MDT.

Standardized Synoptic Reporting

The use of checklists for complex processes is widely advocated in many fields, including medicine, where particular attention has been paid toward procedural-based specialties like surgery. Checklist implementation is credited with significant reductions in rates of inpatient complications and perioperative mortality in both developing and mature health care systems. Checklists help eliminate omission of crucial steps, particularly during uncommon procedures or at times when information complexity may reduce situational awareness. The management of rectal cancer fulfills these criteria as the majority of patients with rectal cancer in North America are treated by surgeons who perform 10 or fewer cases annually, and the disease requires a high level of coordination between multiple specialists.

Recognizing the value of checklists in improving patient safety and outcomes, the Quality and Safety Assessment Committee of the American Society of Colon and Rectal Surgeons (ASCRS) has developed a comprehensive rectal cancer surgery checklist as a guide to enhance safety and quality of care for patients with rectal cancer undergoing surgery, to incorporate best practices in treating these patients, to raise general awareness of the importance of each individual checklist item, and to serve as a potential foundation for building centers of excellence in rectal cancer treatment.

Additionally, the use of synoptic operative reporting in rectal cancer has been shown to increase the completeness and reliability of documentation of critical elements when compared to narrative reporting.
The OSTRiCh Standardized Synoptic Operative Report Committee subsequently utilized the ASCRS rectal cancer checklist as a guide in the development of its standardized synoptic operative report. The required elements are defined in Table 1 in the Appendix of this manual.

Each calendar year, operative reports for 95 percent of all rectal cancer patients who undergo surgical resection are recorded in a standardized synoptic report containing the minimum required elements.

**DOCUMENTATION**

The RCP must complete all required electronic data fields.

**CHART REVIEW**

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

**RATING CRITERIA**

**Compliance:** Each calendar year, the RCP fulfills all of the compliance criteria:

1. Rectal cancer surgery is performed by a surgeon member of the Rectal Cancer Multidisciplinary Team for 80 percent of patients undergoing surgical resections for rectal cancer.

2. Operative reports for 95 percent of surgical resections for rectal cancer are reported in standardized synoptic format containing all required elements and are included in the patient’s medical record.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Pathology Reports after Surgical Resection

Each calendar year, 90 percent of definitive rectal cancer surgical resection specimens of the primary tumor performed at the accredited rectal cancer program are read and the pathology report completed by an appointed Rectal Cancer Multidisciplinary Team pathologist. Pathology reports for 95 percent of rectal cancer patients undergoing a definitive surgical resection of the primary tumor at the accredited rectal cancer program are completed within two weeks of the definitive surgical resection, contain all required College of American Pathologists (CAP) data elements, and use a standardized synoptic format.

DEFINITION AND REQUIREMENTS

Beyond the important staging characteristics of tumor depth of invasion (T-category) and nodal status (N-category), important diagnostic and prognostic information can be gained from an evaluation of the completeness of the mesorectal excision, the status of the circumferential margin, and the response of the tumor to neoadjuvant therapy (Tumor Regression Grade).1-5

Pathologic assessment of the resected rectal cancer specimen provides critical information for prognosis, forms the basis for decisions on adjuvant therapy, serves as an important indicator of quality of surgery, and can validate the soundness of the RC-MDT discussion process.

Pathology results for 95 percent of rectal cancer patients undergoing a definitive surgical resection performed at the accredited rectal cancer program must:

- Include all required data elements as outlined in the College of American Pathologists (CAP) rectal cancer protocols,
- Use a standardized synoptic format, and
- Be completed within two weeks of the definitive surgical resection.

Ninety percent of definitive rectal cancer surgical resection specimens of the primary tumor are read and the pathology report completed by a pathologist who is an appointed member of the RC-MDT.

DOCUMENTATION

The RCP must complete all required electronic data fields.
Standard 2.9 (continued)

CHART REVIEW

At a minimum, a random sample of 20 percent of eligible patient pathology reports or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. Ninety percent of definitive rectal cancer surgical resection specimens of the primary tumor performed at the accredited rectal cancer program are read and the pathology report completed by a pathologist who is an appointed member of the Rectal Cancer Multidisciplinary Team.

2. Pathology reports for 95 percent of rectal cancer patients undergoing a definitive surgical resection of the primary tumor at the accredited rectal cancer program are completed within two weeks of the definitive surgical resection, contain all required College of American Pathologists data items, and are in standardized synoptic format.

Noncompliance: The RCP does not fulfill one or more of the compliance criteria each calendar year.
Photographs of Surgical Specimens

Each calendar year, a minimum of 65 percent of all eligible surgical specimens are photographed to include anterior, posterior, and lateral views. Photographs of the fresh or formalin fixed ex-vivo specimen may be obtained using any standard digital camera in either the operating room or in the pathology laboratory. These images are subsequently presented to and discussed by the Rectal Cancer Multidisciplinary Team and are electronically stored with patient identifier.

DEFINITION AND REQUIREMENTS

The integrity of the mesorectum correlates with oncologic outcomes. The plane in which the surgeon performs the dissection of the rectum will influence the completeness of the mesorectum and therefore reflects the quality of the surgery. The presence of mesorectal tears or defects predisposes to both local and distant recurrence. Photographs of the surgical specimens displaying the integrity of the mesorectum provide useful feedback to the surgeon.

A minimum of 65 percent of rectal cancer specimens are photographed to document the quality of the mesorectum and include anterior, posterior, and lateral views. These images are shown and discussed at RC-MDT meetings and are electronically stored with a patient identifier. If the specimen is photographed but not presented and discussed at an RC-MDT meeting, then it does not qualify for the 65 percent required for compliance with this standard.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads the policy and procedure for obtaining, displaying, and storing photographs of rectal cancer specimens.

CHART REVIEW

At a minimum, a random sample of 20 percent of eligible cases or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. A minimum of 65 percent of all eligible surgical specimens are photographed to include anterior, posterior, and lateral views and are presented to and discussed by the Rectal Cancer Multidisciplinary Team and electronically stored with the patient identifier.

2. All required policies and procedures are in place.

Noncompliance: The RCP does not fulfill one or more of the compliance criteria each calendar year.
Multidisciplinary Team Treatment Outcome Discussion

Within four weeks of definitive surgical treatment completion, an individualized treatment outcome discussion occurs for all rectal cancer patients at a Rectal Cancer Multidisciplinary Team meeting.

DEFINITION AND REQUIREMENTS

After completion of definitive surgical treatment, all rectal cancer patients treated at an NAPRC-accredited program must be discussed at an RC-MDT meeting. The treatment outcome discussion must occur within four weeks of the patient’s definitive surgical treatment. The discussion is documented in the patient’s medical record.

The four primary steps of the treatment outcome discussion for rectal cancer patients are:

1. Presurgical Evaluation and Treatment
   - Clinical stage according to American Joint Committee on Cancer (AJCC)
   - Neoadjuvant therapy

2. Review of the outcome of the surgery
   - Proctectomy or local excision
   - Approach (open, laparoscopic, robotic)
   - Presence or absence of stoma and type of stoma
   - Postoperative complications that may impact further treatment
   - Unexpected findings (for example, metastatic disease, adjacent organ involvement, grossly involved margins after resection)
   - Specimen photographs

3. Review of the final pathology report and stage
   - CRM and distal margin status
   - Tumor regression grade
   - Mesorectal grade
   - Pathological stage according to the AJCC

4. Recommendation for adjuvant treatment
   - Adjuvant therapy regimen, when indicated
   - Referral to medical oncology, when indicated
   - Referral to radiation oncology, when indicated
   - Palliative care, when indicated
In rectal cancer programs with 100 or more cases, the RCP Director may develop criteria to determine which patients must be presented at the RC-MDT for a treatment outcome discussion. These criteria must be documented in a policy and procedure. Regardless of criteria put in place, at least 100 cases must be presented for treatment outcome discussion in accordance with this standard each year. The patients who are not presented at RC-MDT must still meet the requirements of all other standards.

**DOCUMENTATION**

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads policies and procedures used to monitor treatment completion status for each rectal cancer patient and ensure that the patient is scheduled for presentation at an RC-MDT meeting following completion of definitive surgery.

During the on-site visit, the surveyor and the Rectal Cancer Program Coordinator will discuss the process for ensuring that after completion of definitive surgical treatment an individualized treatment outcome discussion is held at an RC-MDT meeting for all rectal cancer patients.

**CHART REVIEW**

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

**RATING CRITERIA**

**Compliance:** Each calendar year, the RCP fulfills the compliance criteria:

1. Within four weeks of definitive surgical treatment completion, an individualized treatment outcome discussion occurs for all rectal cancer patients at a Rectal Cancer Multidisciplinary meeting and the discussion is documented in the patient’s medical record.

2. All required policies and procedures are in place.

**Noncompliance:** The RCP does not fulfill the compliance criteria each calendar year.
Treatment Outcome Discussion Summary

Each calendar year, a standardized treatment summary is provided to at least 50 percent of all rectal cancer patients within four weeks of the Multidisciplinary Team Treatment Outcome Discussion. A copy is provided to the primary care and/or referring physician.

DEFINITION AND REQUIREMENTS

High-quality rectal cancer treatment involves a series of interventions occurring over three to 12 months. Rectal cancer patients who have completed treatment require surveillance for recurrent or metastatic disease. Treatment and follow-up care information must be provided to assist patients’ and their primary care and/or referring physicians’ understanding of the treatment course that transpired. A lack of substantial information in treatment summaries has been recognized to negatively affect outcomes for rectal cancer patients.1

The standardized treatment summary provides documentation of the treatment provided for the patient’s rectal cancer and prognostic information based on tumor staging and other pathology factors. The treatment summary must be provided to at least 50 percent of patients with a copy to the primary care and/or referring physician within four weeks of the Standard 2.11 treatment outcome discussion. It is anticipated that many RCPs will exceed the minimum 50 percent required by this standard.

The treatment summary must include, but is not limited to, the following information:

- Pretreatment (clinical) stage according to American Joint Committee on Cancer (AJCC)
- Pretreatment CEA level
- Neoadjuvant therapy before surgery
- Type of neoadjuvant therapy
- Neoadjuvant therapy date of completion
- Surgical procedure
- Date of surgery
- Final pathological stage according to AJCC
- Tumor Regression Grade
- Microsatellite instability status
- Circumferential Resection Margin
- Distal Resection Margin
- Mesorectal Grade
- Recommendation for adjuvant therapy (if applicable)
- Recommendation for adjuvant therapy regimen (if applicable)
Note: This treatment summary is not a survivorship care plan as defined by Commission on Cancer Standard 3.3. Satisfaction of this standard does not necessarily qualify as completion of a survivorship care plan for Commission on Cancer Standard 3.3.

**DOCUMENTATION**

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads:

- A template for the standardized content of the treatment summary.
- Policies and procedures to generate and disseminate treatment summaries to patients and their applicable primary care and/or referring physician(s).

During the on-site visit, the surveyor will discuss the process for preparing the treatment summaries and disseminating this information to the patient and the patient's primary care and/or referring physician with the Rectal Cancer Program Coordinator.

**CHART REVIEW**

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

**RATING CRITERIA**

**Compliance:** Each calendar year, the RCP fulfills the compliance criteria:

1. A standardized treatment completion summary is provided to 50 percent of all rectal cancer patients within four weeks of the Standard 2.11 Multidisciplinary Team Treatment Outcome Discussion.

2. The treatment summary is included in the patient’s medical record and is provided to the patient’s primary care and/or referring physician within four weeks of the Standard 2.11 Rectal Cancer Multidisciplinary Team Treatment Outcome Discussion.

3. All required policies and procedures are in place.

**Noncompliance:** The RCP does not fulfill one or more of the compliance criteria each calendar year.
Adjuvant Therapy after Surgical Resection

Each calendar year, 50 percent of all eligible rectal cancer patients who elect to initiate recommended adjuvant treatment regimen begin within eight weeks of definitive surgical resection of the primary tumor. Referrals for adjuvant treatment are evaluated and monitored by the Rectal Cancer Program Coordinator and reported to the Rectal Cancer Multidisciplinary Team.

DEFINITION AND REQUIREMENTS

National Comprehensive Cancer Network guidelines recommend that patients with clinical or pathologic Stage II and III rectal cancer undergo adjuvant chemotherapy after curative surgical resection of the primary tumor.¹ Both overall and disease-free survival are improved with 5-fluorouracil-based systemic therapy.²

Reviews of randomized, controlled trial data suggest that adjuvant chemotherapy should be initiated four to eight weeks after surgery.³ ⁴ Delay in the initiation of adjuvant chemotherapy beyond this time leads to a progressive decrease in the efficacy of chemotherapy to improve both overall and disease-free survival.³ ⁴

If recommended by the RC-MDT and elected by the patient, adjuvant chemotherapy must be initiated within eight weeks of definitive surgical resection in eligible patients without surgical complications. Policies and procedures are in place to track the timely initiation of adjuvant chemotherapy.

Referrals for adjuvant treatment are evaluated and monitored each calendar year by the RCP Coordinator who reports results to the RC-MDT. The review is documented in the RC-MDT meeting minutes.

STANDARD EXCEPTIONS

Delays due to documented patient noncompliance or failure of payers to authorize recommended treatment in a timely fashion shall not be considered a failure to meet this standard.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads:

- Policies and procedures to track and monitor eligible patients electing to receive adjuvant treatment and when the adjuvant treatment was initiated.
- RC-MDT meeting minutes that document the annual evaluation and monitoring of the referral process for adjuvant therapy.
CHART REVIEW

At a minimum, a random sample of 20 percent of eligible patient medical records or a maximum of 100 cases are reviewed by the Rectal Cancer Program Director each calendar year to evaluate compliance with this standard. The Rectal Cancer Program Director may delegate this review to an appropriately credentialed physician member of the RC-MDT. For any result that does not meet the required percentages as listed in the rating criteria section, an action plan must be developed and implemented.

During the on-site visit, the surveyor will evaluate the randomly, preselected medical records of eligible patients to confirm compliance with the rating criteria.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. Fifty percent of eligible rectal cancer patients who elect to initiate recommended adjuvant treatment regimen begin treatment within eight weeks of definitive surgical resection of the primary tumor.

2. Referrals for adjuvant treatment are evaluated and monitored by the Rectal Cancer Program Coordinator, reported to the Rectal Cancer Multidisciplinary Team, and documented in the Rectal Cancer Multidisciplinary Team meeting minutes.

3. All required policies and procedures are in place.

Noncompliance: The RCP does not fulfill one or more of the compliance criteria each calendar year.
CHAPTER 3
Quality Improvement
Rapid Quality Reporting System

The Rectal Cancer Program actively participates in the Rapid Quality Reporting System (RQRS), submits all eligible rectal cancer cases for all valid performance measures, and adheres to the RQRS terms and conditions.

DEFINITION AND REQUIREMENTS

The Rapid Quality Reporting System was developed by the National Cancer Database (NCDB) to allow concurrent reporting of cancer treatment data, to facilitate quality improvement projects at the program level, to offer alerts to remind the program of anticipated treatments that have not yet been provided or documented, and to provide the program with year-to-date concordance rates relative to other programs.1,2

The NCDB will accommodate collection of data for rectal cancer performance measures for rectal cancer patients. Data for the rectal cancer performance measures must be submitted to RQRS within three months of the patient’s first contact with the facility.

Data submission timeline requirements for rectal cancer patients under this standard are the same as the Commission on Cancer Standard 5.2 commendation requirements.

Each calendar year, the rate of compliance with each rectal cancer performance measures based on rectal data collected through RQRS are reviewed and monitored by the Rectal Cancer Program Director (RCP Director). Specific reporting requirements are described and rated under Standard 1.5.

DOCUMENTATION

The RCP must complete all required electronic data fields.

RATING CRITERIA

Compliance: Each calendar year, the RCP fulfills all of the compliance criteria:

1. Submits all new and updated cancer cases at least once each calendar month.

2. Rapid Quality Reporting System rectal cancer cases are submitted within three months of date of first contact.

3. All cancer cases submitted to Rapid Quality Reporting System with edit errors are corrected and resubmitted.

Noncompliance: The RCP does not fulfill the compliance criteria each calendar year.

Not Applicable: Rectal cancer programs undergoing initial survey for accreditation.
Accountability and Quality Improvement Measures

Each calendar year, the expected Estimated Performance Rate (EPR) is met for each accountability and quality improvement measure as defined by the National Accreditation Program for Rectal Cancer (NAPRC).

DEFINITION AND REQUIREMENTS

The NAPRC requires that accredited rectal cancer programs treat rectal cancer patients according to nationally accepted accountability and quality improvement measures indicated by the National Cancer Database quality reporting tool, the Rapid Quality Reporting System.

Accountability measures promote improvements in care delivery and are the highest standard for measurement. These measures demonstrate provider accountability, influence payment for services, and promote transparency. An accountability measure is the standard of care derived from evidence-based data, including multiple randomized control trials.¹

The function of a quality improvement measure is to monitor the need for quality improvement or remediation of treatment provided. Evidence from experimental studies, not randomized control trials, support these measures. Quality improvement measures are intended for internal monitoring of performance within a cancer program.¹

If an RCP is not meeting the expected Estimated Performance Rate (EPR) of an accountability or quality improvement measure(s), then a corrective action plan must be developed and executed to improve performance. The corrective action plan must document how the program will investigate the issue for each measure, as needed, with the intent of resolving the problem and improving compliance.

The RCP reviews EPRs, and monitoring activity is documented in the Rectal Cancer Multidisciplinary Team (RC-MDT) minutes. A quality-related audit is initiated for any accountability or quality improvement measure that falls below required levels of compliance. The corrective action taken and any required follow-up needed to meet EPRs are included in the documentation. The RCP Director is responsible for overseeing that any necessary action plans are developed and implemented. The RCP Director may delegate responsibility for specific action plans to appropriately credentialed physician members of the RC-MDT.

DOCUMENTATION

The RCP must complete all required electronic data fields.

Each calendar year, the RCP uploads RC-MDT minutes that demonstrate the monitoring of the accountability and quality improvement measures located in RQRS and, if necessary, the corrective action plan that was developed and executed if the program’s performance rates were observed below the expected EPRs established by the NAPRC.
RATING CRITERIA

Compliance: Each calendar year, the program fulfills the following criteria:

1. The Rectal Cancer Multidisciplinary Team monitors performance rates for all quality measures using the Rapid Quality Reporting System.

2. For each measure, the rectal cancer program’s performance rate must be equal to or greater than the expected Estimated Performance Rates specified by the National Accreditation Program for Rectal Cancer each year of the survey cycle or the program has implemented an action plan that reviews and addresses program performance below the expected Estimated Performance Rates.

3. The monitoring activity, outcomes, and any required action plans are reported in Rectal Cancer Multidisciplinary Team minutes.

Noncompliance: The RCP does not fulfill one or more of the compliance criteria each calendar year.

Not Applicable: Rectal cancer programs undergoing initial survey for accreditation.
Accession number: A unique patient identifier assigned when the patient is abstracted in the cancer registry. The accession number consists of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.

Analytic cases: Cases for which the hospital provided the initial diagnosis of cancer and/or for which the hospital contributed to first course of treatment, if those cancers were diagnosed on or after the hospital’s reference date and are diseases the Commission on Cancer requires to be abstracted.

Annually: Once each calendar year.

Appropriately-credentialed physician: The Rectal Cancer Program Director has the discretion to delegate certain responsibilities to other physicians on the RC-MDT. Any delegated obligation must be given to a physician whose specialty relates to the subject matter of the audit or other responsibility. For example, a pathologist should be chosen to perform the Standard 2.9 Pathology Reports after Surgical Resection required audit.

Calendar year: January 1–December 31.

Calendar month: The first of the month through the last day of the month. For example, March 1 to March 31 or April 1 to April 30.

CAnswer Forum: An interactive, virtual bulletin board for CoC and NAPRC constituents to review questions and answers regarding standard requirements. Users can search individual chapters or standards for topics on which they may have questions. If the question has not already been answered, users can post a question. Within a reasonable time, questions posted to the forum are answered by a CoC staff member. Users must complete a one-time registration that includes creating a user name and a password.

Chart review: The review of randomly selected patient medical records to determine compliance with specific standard requirements.

CoC: Commission on Cancer.

Definitive treatment: Neoadjuvant therapy, surgical resection, or initiation of palliative care.

Elsewhere: A hospital, facility, or health care organization that is not owned, co-owned, or part of the hospital licensure of the accredited facility. A network clinic or outpatient center owned by the facility is part of the facility.

NAPRC: National Accreditation Program for Rectal Cancer.

Monitor: Closely and consistently observe and evaluate a function or process.

On-site: The Rectal Cancer Program’s facility or off-campus location(s) that are either owned by its facility or part of the same hospital licensure.
Performance report: Document released to Rectal Cancer Programs at the conclusion of the initial or reaccreditation survey. The performance report includes rating compliance for each applicable standard and may include specific comments regarding the rectal cancer program’s performance. The performance report also states the assigned accreditation award and, if applicable, the deficiency resolution due date.

Previously undiagnosed: Rectal cancer patients who receive the first diagnosis of rectal cancer at the accredited rectal cancer program.

Previously untreated: Rectal cancer patients who have received no treatment for rectal cancer.

Rating criteria: The required elements for each standard that must be demonstrated to receive a “Compliant” rating at the time of survey.

RCP: Rectal Cancer Program.

RCP Director: Rectal Cancer Program Director. See definition and requirements in Standard 1.5.

Referred services: Components of evaluation and management not under the control or accountability of the Rectal Cancer Program and/or its facility.

RC-MDT: Rectal Cancer Multidisciplinary Team. See required members in Standard 1.2.

RCP Coordinator: Rectal Cancer Program Coordinator. See definition and requirements in Standard 1.6.

Standards Resource Library (SRL): A repository that contains tools, templates, examples, and resources designed to help cancer programs meet the CoC and NAPRC standards. The SRL is located on the home page of the CAnswer Forum and can be accessed using a CAnswer Forum user name and password.

Survey: The review of rectal cancer program data to determine compliance with NAPRC standards and the respective accreditation award. The survey includes an on-site visit to the facility by an NAPRC surveyor. After initial accreditation, the survey process occurs once every three years.

Surveyor: NAPRC-trained physician who conducts on-site visits and reviews rectal cancer program activity documentation, including reviewing randomly selected patient charts. The surveyor assists in verifying whether the RCP is in compliance with the NAPRC standards.
Table 1.* Required elements and response options for standardized synoptic operative report (Standard 2.8).

<table>
<thead>
<tr>
<th>Elements</th>
<th>Response options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ASA score</td>
<td>I; II; III; IV; V</td>
</tr>
<tr>
<td>2. Case status</td>
<td>Elective; urgent (obstructed; bleeding; perforated)</td>
</tr>
<tr>
<td>3. Operation</td>
<td>LAR; APR; TPC; local excision</td>
</tr>
<tr>
<td>4. Modality</td>
<td>Open; laparoscopic; hand-assisted laparoscopic; robotic; TES</td>
</tr>
<tr>
<td>5. Location of tumor within rectum</td>
<td>High; middle; low</td>
</tr>
<tr>
<td>6. Height of lower edge of tumor from anal verge</td>
<td>0–20 cm</td>
</tr>
<tr>
<td>7. Mobilization of splenic flexure</td>
<td>Yes; no</td>
</tr>
<tr>
<td>8. Level of ligation of inferior mesenteric artery</td>
<td>IMA; SRA; none</td>
</tr>
<tr>
<td>9. Level of ligation of inferior mesenteric vein</td>
<td>High; low; none</td>
</tr>
<tr>
<td>10. Level of rectal transection distal to distal edge of tumor (distal margin)</td>
<td>0–20 cm</td>
</tr>
<tr>
<td>11. Type of reconstruction</td>
<td>Stapled end-end; stapled end-side; handsewn end-end; handsewn end-side; colon J-pouch; ileal pouch-anal anastomosis; coloplasty; none</td>
</tr>
<tr>
<td>12. Anastomotic testing method(s)</td>
<td>Rectal air infusion under pelvic fluid; rectal instillation of betadine, indigo, or other fluid; palpation; observation of circular stapler rings only; none</td>
</tr>
<tr>
<td>13. Creation of stoma</td>
<td>Yes (ileostomy; colostomy); no</td>
</tr>
<tr>
<td>14. En bloc resection</td>
<td>Yes (bladder; vagina; prostate; ureter; small intestine; sacrum; other); no</td>
</tr>
<tr>
<td>15. Metastectomy</td>
<td>Yes (liver; peritoneum; other); no</td>
</tr>
<tr>
<td>16. Completeness of tumor resection</td>
<td>R0; R1; R2</td>
</tr>
<tr>
<td>17. Intraoperative complications</td>
<td>Yes (ureter injury; rectal perforation; enterotomy; vascular injury; other); no</td>
</tr>
<tr>
<td>18. Blood transfusion</td>
<td>Yes; no</td>
</tr>
<tr>
<td>19. TME photographed</td>
<td>Yes—in pathology report; yes—in operative report; no</td>
</tr>
<tr>
<td>20. Short narrative</td>
<td>***</td>
</tr>
</tbody>
</table>

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References

Introduction: NAPRC Background and the Value of Accreditation


References (continued)

Standard 1.2–Standard 1.4 (RC-MDT Care; RC-MDT Team Attendance; RC-MDT Team Meetings)


Standard 1.7 (Rectal Cancer Program Education)


Standard 2.1 (Review of Diagnostic Pathology)


Standard 2.2 (Staging before Definitive Treatment)


Standard 2.3 (Standardized Staging Reporting for MRI Results)


Standard 2.4 (CEA Level)


Standard 2.6 (Treatment Evaluation and Recommendation Summary)

Standard 2.7 (Definitive Treatment Timing)


Standard 2.8 (Surgical Resection and Standardized Operative Reporting)


Standard 2.9 (Pathology Reports after Surgical Resection)


Standard 2.10 (Photographs of Surgical Specimens)


Standard 2.12 (Treatment Outcome Discussion Summary)


Standard 2.13 (Adjuvant Therapy after Surgical Resection)


Standard 3.1 (Rapid Quality Reporting System)


Standard 3.2 (Accountability and Quality Improvement Measures)