Commission on Cancer® | A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

CoC Standards 4.4 and 4.5 and Implementation for Surveys in 2017

The updates for the 2014 CP^{3}R data became available on October 26, 2016. Accredited cancer programs are required to review the data during each calendar year with the cancer committee for compliance to Standards 4.4 and 4.5.

We have received several questions regarding the availability of the updated CP^{3}R data for the fourth quarter meeting of 2016. Cancer programs whose last cancer committee meeting of 2016 took place in October will be required to review its 2014 CP^{3}R data in the first quarter (January, February, or March) of **2017** to remain compliant. This does not replace the CP^{3}R measures review for Standards 4.4 and 4.5 for compliance in 2017. Cancer programs with fourth quarter cancer committee meetings that take place in November or December **2016** must review the 2014 CP^{3}R data during the last quarter meeting to be in compliance for 2016.

Meeting dates and minutes will be reflected in program's SAR/PAR and verified by the surveyor at the time of survey.

The expected Estimated Performance Rates (EPR) for accountability and quality improvement measures assessed for the Commission on Cancer (CoC) Standards 4.4 and 4.5 for programs being surveyed in 2017 are below. These standards require performance levels be met annually according to the specified accountability and quality improvement measures defined by the CoC.

Evaluation Criteria of Measures

To be compliant with Standards 4.4 and 4.5, cancer programs must:

1) Meet the above performance rates either with their EPR in CP^{3}R or the upper bound of the 95% confidence interval; or

2) If the performance rates are below the EPR, cancer programs must establish and implement an action plan that reviews and addresses improving performance.

Expected Performance Rates

Expected EPRs have been established based on a review of current performance by CoC accredited cancer centers for these measures. Each of the following measures listed below will be assessed and rated for 2016 surveys. To rate this standard programs must assess their attainment of the expected estimated performance rates for each of the years listed below. EPRs remain the same as previously released for cases diagnosed in 2012-2013.

Table 1 2017 CoC Survey's Assessed Quality Measures and Expected EPRs

Measures	Expected EPR		
	2012	2013	2014
Standard 4.5 Accountability Measures			
BCSRT - Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer	90%		
HT - Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or stage II or stage III hormone receptor positive breast cancer.	90%		
MASTRT - Radiation therapy is considered or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with >= 4 positive regional lymph nodes.	90%		
Standard 4.5 Quality Improvement			
nBx - Image or palpation-guided needle biopsy (core or FNA) is performed to establish diagnosis of breast cancer.	80%		
G15RLN -At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer.	NA	80%	80%
12RLN - At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	85%	85%	85%
LCT - Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is considered for surgically resected cases with pathologic, lymph node-positive (pN1) and (pN2) NSCLC.	NA	85%	85%
LNoSurg - Surgery is not the first course of treatment for cN2, M0 lung cases	NA	85%	85%
RECRTCT - Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or Postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is considered; for patients under the age of 80 receiving resection for rectal cancer	NA	85%	85%

Note: Expected EPRs include the EPR and the upper limit of the confidence interval for the EPR.

How to Interpret Confidence Intervals

The following tables provide examples on how to interpret the 95% Confidence Intervals for compliance with Standards 4.4 and 4.5.

Example 1 – Compliance with Standard 4.4 based on the upper limit of the confidence interval

Survey Year	CP3R Diagnosis Year	Measure	EPR	Calculated Performance Rate (95% CI)	Rating
2017	2013	**BCS/RT**	90%	94.6 (90-99.2)	**1**
		HT	90%	86.4 (72.1-100)	
		MASTRT	90%	85.7 (59.8-100)	

In the table above, the program's actual performance rate for the HT measure is 86.4%, and the upper bound of the 95% CI is 100%, which is above the 90% expected EPR. The program will be assessed as meeting the performance criteria for the HT measure as the CI indicates that the rate is not significantly different from the EPR. In Example 1, all of the accountability measures meet the evaluation criteria.

Example 2 – Non-compliance with expected EPR based on the upper limit of the confidence interval

Survey Year	CP3R Diagnosis Year	Measure	EPR	Calculated Performance Rate (95% CI)	Rating
2017	2012	**BCS/RT**	90%	80.2 (75-85)	**5* (if no action plan in place)**
		HT	90%	86.4 (72.1-100)	
		MASTRT	90%	79.6 (73.3-85.9)	

In the table above the program's calculated performance rate for BCS/RT is 80.2% and the MASTRT is 79.6%. These performance rates do not meet the 90% EPR; neither do the upper bound of the CI (85% and 85.9% respectively) meet or exceed the 90% EPR. In order to be compliant with Standard 4.4 this program would need to develop an action plan for these measures.

Programs should apply this assessment for each diagnosis year and quality measure being assessed.