ACS CoC
Commission on Cancer
American College of Surgeons

ACS CoC-PS
Commission on Cancer
Pediatric Specialty Accreditation
American College of Surgeons

Frequently Asked Questions for Pediatric Cancer Programs

Optimal Resources for Cancer Care (2020 Standards)

Questions and answers in this FAQ apply to both Pediatric Cancer Program (PCP) and Pediatric Specialty Accreditation (CoC-PS) unless otherwise indicated.
Additional guidance for individual standards may be found in the CoC Standards Manual section "Specifications by Category."

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General Questions

What types of programs are eligible to pursue Pediatric Cancer Program (PCP) or Pediatric Specialty Accreditation (CoC-PS)?
CoC-accredited sites are eligible if it provides care to children and adolescents under the age of 18 (a center that cares only for teens and older is excluded). Sites may either be a stand-alone pediatric hospital or program or a pediatric oncology program within an existing CoC-accredited site. Both structures must offer a full range of diagnostic and therapeutic services for pediatric patients and are required to participate in pediatric cancer-related clinical research, including the enrollment of patients in cancer-related clinical trials.

There is no minimum caseload requirement for eligibility for either PCP or CoC-PS.

The accreditation program is referred to as "Pediatric Specialty Accreditation" when it exists within an already-accredited CoC site.

To demonstrate compliance with the Pediatric Standards for accreditation within a CoC site, can some of the personnel and services come from another hospital?
Yes, as with CoC accreditation, many standards can be met if personnel and services come from another hospital, including referrals, which must be in a documented process.

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If one of the sites within an Integrated Network Cancer Program (INCP) is a children's hospital that wants to apply for Pediatric Cancer Program (PCP) accreditation, will the children's hospital need to establish a pediatric cancer committee?
If the children's hospital within the INCP meets the criteria for the PCP category, the program may choose to withdraw from the network and apply for accreditation as a standalone Pediatric Cancer Program. The site will need to demonstrate one calendar year of compliance with all of the pediatric standards, which includes the establishment of a cancer committee with required pediatric specialists. The pediatric cancer committee must include a pediatric surgical specialist, pediatric hematology/oncologist, pediatric radiologist, and pediatric pathologist.

A CoC site has both an adult and pediatric population and wants to apply for CoC-PS. Physicians in the pediatric program see patients up to 26 years of age in the pediatric hospital and up to 39 years as part of a young adult program. Can a site pursuing CoC-PS choose to include patients over 18 in its reports/analysis for the pediatric program?
Yes, the critical component is that the pediatric program provides care for young children. It is acceptable for a program to modify its definition to match the scope of its pediatric program.

What is required for standards not listed in the Specifications by Category for PCPs and CoC-PS?
If a standard is not referenced in the Specifications by Category for PCPs and CoC-PS, PCPs must meet the full standard as written. CoC-PS programs do not need to demonstrate compliance with standards not referenced in the Specifications by Category as compliance with those requirements are reviewed during the affiliated adult CoC site visit.

If the hospital is an NCI-designated cancer program, do the Specifications by Category for NCI-designated sites also apply to a CoC-PS programs?
No, NCI exemptions do not apply when adding CoC-PS to an accreditation.

Application for Accreditation

Is the application process the same as for the CoC accreditation?
For PCP site, the application process is the same. However, for a CoC-PS site, there are some differences. An online application, separate from the Quality Portal (QPort), will need to be completed. Information in this online application will be merged into QPort after the application is accepted. The CoC company ID or FIN are required to complete the CoC-PS application.

In the QPort for the CoC-PS application, no changes can be made to the existing information in the Site Information section (for example: the site's name, address, FEIN). Any information or contact changes must be reported through a "Site Information Change Request."

Programs adding the CoC-PS accreditation to its existing CoC accreditation will use the same QPort login to manage the pediatric accreditation. The primary contact for the adult program will be able to add additional users for CoC-PS.

Will a CoC-PS site have the same Company ID as the CoC site?
Yes, the same Company ID will be used for both the CoC and CoC-PS sites.

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Initial Accreditation and Reaccreditation Time Frames

When should our CoC-PS program apply for accreditation?
A CoC-PS site should consider the CoC accreditation cycle when planning for a site visit and is strongly encouraged to submit the application in late summer or early fall of the year before the CoC site visit is due. After the application has been processed, CoC staff will communicate with the CoC and CoC-PS primary contact(s) to schedule an aligned site visit.

If a site is planning for the CoC-PS site visit to occur in the middle of the CoC accreditation cycle, the CoC-PS site may submit an application at any time. For a site visit in the same calendar year, the application must be submitted no later than June 30.

If our CoC program had a site visit last year, do we need to wait until the triennial reaccreditation before our CoC-PS program can have a site visit?
No, although programs are encouraged to coordinate their initial site visit with the CoC site visit, they can submit for a site visit at any time. However, once accredited, the CoC-PS accreditation end date will match the CoC accreditation end date, which will result in a CoC-PS accreditation term of less than three years.

If our CoC-PS site had a site visit during our CoC's accreditation term, when will our reaccreditation site visit occur?
Since the accreditation end date for the CoC-PS program will be the same as the CoC program, the reaccreditation site visits will be aligned to occur at the same time. As a result, the activity reviewed during the accreditation site visit might be reviewed for less than three years. For example, if the initial CoC-PS site is in 2027 and the reaccreditation site visit is in 2029, the reaccreditation site visit will review only two years of activity (2027 and 2028) since the first year's activity (2026) was reviewed during the initial site visit. The CoC-PS and CoC programs must coordinate to identify the preferred reaccreditation site visit dates within the required scheduling window.

Site Visit Process

Will the visit be in person?
All initial site visits are in-person. After that, your site may choose to have the site visit virtual or in-person.

Does the site visit for CoC-PS need to coordinate with the adult program?
Yes, the CoC-PS site visit will occur immediately following the CoC site visit. The application for CoC-PS must be submitted in the fall prior to the calendar year of the site visit for the accredited CoC site so opening the PRQs for the site visits can be coordinated.

Will my site reviewer be a pediatric specialist?
Yes. For a CoC-PS site visit, the pediatric specialist site reviewer will conduct the site visit for the pediatric visit. In most cases, the same site reviewer will also conduct the adult site visit.

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Standard 1.1: Administrative Commitment

If a CoC-accredited site is seeking CoC-PS, is a separate letter required for administrative commitment? Or can one letter address both?
Either option is fine. Both options must address how pediatric cancer care is administered relative to the adult program.

Standard 2.1: Cancer Committee

If a CoC site applies for CoC-PS, does the site need to add pediatric subspecialties to the current cancer committee or does the site need to create a separate pediatric cancer committee?
This decision would be left to the discretion of the program. For example, the requirements may be met through the cancer committee for the CoC site or a separate committee for CoC-PS accreditation.

Is a radiation oncologist required to be on the pediatric cancer committee/subcommittee?
Although preferred, a radiation oncologist is not required to be on the pediatric cancer committee or the pediatric subcommittee. However, if a pediatric radiation oncologist is appointed then they must meet attendance requirements for Standard 2.4.

Standard 2.2: Cancer Liaison Physician

If a CoC site is applying for CoC-PS, is it required to appoint a pediatric CLP?
A pediatric-specific CLP must be appointed.

What is the process to add a pediatric-specific CLP in QPort?
To add a pediatric-specific CLP, the primary contact will need to log into QPort and click on the Site Contacts section. At the bottom of the page, there is a link to add contacts. The primary contact will click on that area and add the individual with the role of CLP.

Under the Specifications by Category for Pediatric Cancer Programs, the standard states that the CLP does not need to present NCDB data two times a year. What is the role of the pediatric-specific CLP?
The Pediatric CLP serves as a leader of the pediatric program. It is encouraged that the Pediatric CLP present relevant pediatric-specific data to the cancer committee. The Pediatric CLP is also expected to meet with the site reviewer during the tri-annual site review.

Is the pediatric CLP required to meet attendance requirements per Standard 2.4?
Yes.

Standard 2.3: Cancer Committee Meetings

If a pediatric subcommittee is developed to meet Standard 2.1 for a CoC-PS, how often should this committee meet?
The pediatric subcommittee must meet at least quarterly to meet the standard.

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Standard 2.4: Cancer Committee Attendance

For a CoC-PS, if the required pediatric specialties are added to our cancer committee, are these members required to attend at least 75% of the meetings?
Yes, the required members will need to attend at least 75% of the cancer committee meetings.

Can alternates be appointed for each of the required members of the cancer committee or pediatric subcommittee for each of the pediatric specialties to meet the 75% attendance requirements?
Yes, a program can appoint an alternate for each required position on the cancer committee or pediatric subcommittee as long as the alternate meets the requirements of that role.

Does the pediatric CLP have to comply with the attendance requirements?
Yes.

An institution provides a pediatric medical oncology service and includes a physician hematology/oncology specialist from that department as a member of the cancer committee, but neither that provider nor their alternate was able to attend the first two meetings of the year. If their status is changed to ad hoc member, does the 75% attendance requirement still apply?
All required members as identified in the Pediatric Cancer Program Specifications by Category for Standard 2.1 must attend a minimum of 75% of the meetings; a specialist in pediatric hematology/oncology is required. A required member cannot be considered an ad-hoc member.

Standard 2.5: Multidisciplinary Cancer Case Conference

Are there recommendations for a staging system that a pediatric program should use when discussing pediatric patients?
There are standard staging methods for pediatric malignancies, which are commonly used in North America and Europe. Contact your pediatric specialist(s) to learn more about applicable staging methods.

What disciplines are required to attend pediatric cancer conferences?
For pediatric cancer conferences or discussions of pediatric cancer patients, the following specialties must be in attendance:

- Pediatric surgical specialist
- Pediatric hematology/oncology
- Pediatric radiology
- Pediatric pathology
- Radiation oncology with experience treating a pediatric patient

Does the attendance requirement for each of the required disciplines need to be 100%?
It is expected that a representative from each of the required pediatric specialties (surgical specialist, hematology/oncology, radiology, and pathology) will attend each case conference where pediatric patients are discussed. The site determines the individual attendance rate.

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A program is required to present 15% of its annual analytic caseload, and 80% of the caseload needs to be prospective. Can the annual analytic caseload be determined by reviewing NCDB data?
Yes. The program can use NCDB data to determine its analytic caseload. If predicting the caseload for the upcoming year, it is recommended 10% be added to account for any growth in caseload.

Does a program need to provide documentation for each case that is discussed during the multidisciplinary case conference?
No. It is not required that the minutes for multidisciplinary cancer case conferences be submitted to the CoC.

Standard 3.2: Evaluation and Treatment Services

Please clarify what the term "available" means with reference to "the radiologist is available to address radiation exposure"?
This statement means that a radiologist can be referred to as needed. This individual does not need to be "on call."

Is a CoC-PS program required to have a policy and procedure that covers quality assurance for the evaluation and treatment services they provide?
Yes, the program is required to have policies and procedures that address pediatric care. This can be included in the general policy and procedures, but the program may need to ask pediatric and medical oncologists to review the information. The ACR requirements do include pediatric requirements, so the standard ACR accreditation does meet the expectation.

What are some examples of guidelines for pediatric quality assurance?
Examples of quality assurance guidelines for pediatrics include but are not limited to the American College of Radiology, the American Society of Pediatric Hematology/Oncology (ASPHO), and the Association of Pediatric Hematology/Oncology Nurses (APHON).

Standard 4.1: Physician Credentials

Are physicians required to have a certain board certification to treat pediatric patients?
No, but the physicians need to have pediatric training in surgery, hematology/oncology, radiology, and radiation oncology.

What does the program need to provide to document that the physicians have board certification or that the non-Board-Certified physicians have the appropriate pediatric training?
The program will need to complete the Standard 4.1 Physician Certification Credential Template. The template has a tab to provide information on the Board-Certified physicians and another tab to include CME information for non-Board-Certified physicians. Only physicians who regularly evaluate and treat pediatric patients need to be included on the template.

If the pediatric cancer conferences offer CMEs, can the CMEs count toward the 12 annual pediatric cancer-related CMEs?

Yes, these CMEs would be accepted. Programs must first submit an application to an appropriate

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CME provider before the educational activity can be approved to award CME credit. The activity must award NCPD or CME credit.

Standard 4.4: Genetic Counseling and Risk Assessment

Does a CoC-PS program need to provide a separate report that addresses pediatric malignancies?
Yes, the program will need to provide a report separate from the adult program that addresses pediatric malignancies.

What outside source is available to help programs develop policies and procedures?
It is recommended that the program work with the genetics professionals within their CoC-accredited program to assist with the development of the policies and procedures. In addition, when developing the policies and procedures, programs can reference Druker H, Zelley K, McGee RB, Scollon SR, Kohlmann WK, Schneider KA, Wolfe Schneider K. Genetic Counselor Recommendations for Cancer Predisposition Evaluation and Surveillance in the Pediatric Oncology Patient. Clin Cancer Res. 2017 Jul 1;23(13):e91-e97. doi 10.1158/1078-0432.CCR-17-0834. PMID: 28674117.

Standard 4.6: Rehabilitation Care Services

Does the CoC-PS program need to provide a separate report specifically on pediatric services?
Yes, the program needs to include a report separate from the adult program that specifically addresses pediatric services that are being offered.

Standard 4.7: Oncology Nutrition Services

Does the CoC-PS program need to provide a separate report specifically on oncology nutrition pediatric services?
Yes, the program needs to include a report separate from the adult program that specifically addresses the pediatric oncology nutrition services that are being offered.

Standard 4.8: Survivorship Program

Can the same survivorship program team be used for both adult and pediatric programs for a CoC-PS?
No, the program needs to meet the standard separately for pediatrics. The program needs to have one separate pediatric-specific service that is reviewed and evaluated each year.

Does the CoC-PS program need to provide a separate report specifically on pediatric survivorship services?
Yes, the program needs to include a report that specifically addresses the pediatric survivorship services that are being offered. However, the survivorship program report for the CoC-PS only needs to evaluate one survivorship program service each calendar year.

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How many services must standalone PCPs evaluate each year?
Standalone PCPs must evaluate three survivorship program services each calendar year, as outlined in Standard 4.8.

Standard 5.1: College of American Pathologists Synoptic Reporting

What are the requirements to demonstrate compliance with this standard?
Starting in January 2024, the site will be required to audit pathology reports for compliance with CAP protocols. In general, Standard 5.1 applies to all pediatric cancer patients that are 18 years of age (or according to the site's definition of its pediatric program) and under in the annual analytic caseload. See the Definitions and Requirements in Standard 5.1.

Programs seeking CoC-PS must complete two internal audits that comply with the written standard. One audit for eligible adult surgical resection pathology reports, and a second audit for eligible pediatric surgical resection pathology reports.

Which protocols are required for pediatric programs?
The protocols would be any resections that a pediatric patient might have. The following is a current list of templates that the College of American Pathologists (CAP) has that are dedicated to pediatric cancer surgical resections:

- Extragonadal Germ Cell Tumor: Resection
- Kidney, Pediatric Renal Tumors: Resection
- Hepatoblastoma: Resection
- Neuroblastoma: Resection
- Ewing Sarcoma: Resection
- Rhabdomyosarcoma and Related Neoplasms: Resection

The CAP templates are subject to change. For the most current information and language, please refer to the information on the CAP website.

Standard 6.5: Follow Up of Patients

Will CoC-PS programs be required to demonstrate compliance with the required follow up percentages during the CoC-PS visit?
No. Standard 6.5 will be reviewed during the affiliated adult CoC site visit only.

Are there any modifications to the Standard 6.5 requirements for programs in the PCP category?
No, PCPs must meet the standard as written.

Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines

How many studies per year are required?
The site must conduct one study per accreditation cycle (in other words, one study every three years). For a program undergoing an initial site visit, one study is required during the initial year of compliance.

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Are programs undergoing an initial site visit required to submit a study for Standard 7.2?
Yes.

Standard 8.1: Addressing Barriers to Care

Can the same barriers to care be used for both the adult and the CoC-PS program?
Yes, if the barriers are appropriate for both the adult and the pediatric program then the same barriers can be used.

Standard 8.2: Cancer Prevention Event

Can the same prevention event be used for both the adult and the CoC-PS program?
Starting in 2026, a prevention event will need to be offered for children and/or young adults that addresses topics such as HPV vaccination, obesity, smoking, sunscreen use, etc. If the prevention event offered by the adult CoC site applies to children and/or young adults, it can be used to support compliance for both adult and pediatric compliance.

Standard 9.1: Clinical Research Accrual

Can the denominator to calculate compliance be any patients the program chooses to include in their pediatric program?
It is acceptable to use the program's pediatric definition for the denominator. However, the patient is either in the numerator/denominator for pediatrics or for adult, but they cannot be included in both.

What is the percentage of accruals to cancer-related clinical research studies needed to meet the standard?
The required number of accruals for cancer-related clinical research studies is required to meet or exceed 50%. This could include non-Children's Oncology Group (COG) studies.

If biorepository and specimens are waiting to be used for studies, can these patients be counted towards accrual?
Yes, patients who have their pathological specimens sent to a biorepository with the intent of using that tissue to do cancer research may be counted towards accrual. IRB approval and patient consent are required. There needs to be a definite, planned study to be part of it.

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