

Preview of Revised Standards

Optimal Resources for Cancer Care (2027 Standards)

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Implementation January 1, 2027

Changes to this standard are noted with red text

Standard 2.2: Cancer Liaison Physician

Definition and Requirements

CLP Eligibility

The Cancer Liaison Physician is a physician of any specialty who is an active member of the medical staff. The CLP is considered the physician quality leader of the cancer committee. The CLP serves as the alternate for the Cancer Committee Chair and oversees cancer committee meetings if the chair is not in attendance.

It is permissible for the CLP to also serve as the Cancer Committee Chair, but it is encouraged that the CLP role and the chair role be filled by two individuals.

CLP as Quality Champion

In the role as physician quality leader of the cancer committee, the CLP must identify, analyze, and present National Cancer Database (NCDB) data pertinent and specific to the cancer program to the cancer committee four times each calendar year. The CLP presentations to the cancer committee may occur at any time during the calendar year but must be delivered at two or more meetings.

- At least two of the reports, delivered at separate meetings during the calendar year, must utilize one of the following NCDB reporting tools: Survival Reports, NCDB Benchmark Report, or Cancer Quality Improvement Program (CQIP) Reports.
- At least two of the reports, delivered at separate meetings during the calendar year, must utilize one of the following Rapid Cancer Reporting System (RCRS) reporting tools: Quality Measures Report or Comparisons Report.

It is best practice to report on all RCRS measures applicable to the program with particular attention to areas of concern or where expected performance is not being met. The CLP reports do not substitute for and cannot duplicate reporting requirements for other standards, including Standard 7.1: Quality Measures.

Documentation of the data presented and the details of the discussion with the cancer committee must be included in the cancer committee minutes.

The CLP must attend the CoC site visit and meet with the site reviewer to discuss the cancer program, CLP responsibilities, and the NCDB quality reporting tools.

Specifications by Category

Integrated Network Cancer Program (INCP) and NCI-Designated Network Cancer Program (NCIN)

Two CLPs are appointed who represent all of the facilities within the network. Each CLP must report on NCDB data per the standard twice each calendar year (for a total of four times each year).

Pediatric Cancer Program (PCP) and CoC Pediatric Specialty Accreditation (CoC-PS)

The CLP must be a pediatric physician specialist. Programs adding a specialty pediatric accreditation to an existing CoC accreditation must have two CLPs, one for the adult cancer program, and a second CLP for the pediatric program. The pediatric CLP must meet the 75% attendance requirement per Standard 2.4.

The pediatric physician specialist CLP is not required to present NCDB data to the cancer committee.

Programs Undergoing Initial Site Visit for Accreditation

While the requirement to report NCDB data four times per year will not be rated during the initial site visit, it is encouraged that programs report data to the cancer committee relevant to the cancer program at least four times per year.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes documenting CLP reports from at least two separate meetings each calendar year on data specific to the cancer program, including actions and response

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The CLP or the CLP's alternate identifies, analyzes, and presents NCDB data specific to the cancer program to the cancer committee **four times each calendar year** at a minimum of two **separate** meetings. **The CLP reports include data from the required NCDB reports.**
2. The CLP is present during the CoC site visit and meets with the site reviewer to discuss CLP activities and responsibilities.

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New Standard

Standard 4.9: Exercise Oncology Services

Definitions and Requirements

A protocol is in place to guide referrals for patients with newly diagnosed cancer of any site to the appropriate level of exercise programming:

- Oncology rehabilitation
- Exercise oncology services
- Community-based exercise programs

Exercise oncology services are interventions led by physical therapists or nationally certified exercise professionals that guide people living with and beyond cancer toward achieving the published recommended exercise prescription to improve symptoms, side effects, and clinical outcomes. The programming could be online or in person, brief educational sessions, group exercise classes, or long-term one-on-one coaching, according to needs and resource availability.

The cancer committee must implement an assessment and referral process to be performed during the first course of treatment within the accredited program. The assessment process must discern whether the patient is most appropriate for oncology rehabilitation, exercise oncology services, or community-based exercise programs. The assessment and referral process may be provided by any member of the patient care team, including, but not limited to, medical assistants, physical therapists, occupational therapists, nurses, advanced practice providers, and physicians. For those referred to oncology rehabilitation, the referral may be made by licensed providers such as advanced practice providers and physicians.

Cancer treatments can result in a multitude of symptoms that can impair the ability of patients to complete lifesaving treatments. Many of these symptoms are addressed with exercise during and after treatment. The most appropriate setting for addressing these symptoms varies according to the overall medical condition and severity of symptoms experienced by the patient. Based on the initial assessment, referrals must be offered to the most appropriate available service for that patient. These services can include:

- Oncology rehabilitation
- Exercise oncology programs
- Community-based exercise programs

For cancer programs that do not offer exercise oncology on-site, there are a variety of programs to which patients can be referred, including programs offered online and some offered for free.

Patients already under the care of oncology rehabilitation professionals do not require assessment and referral. Similarly, patients who are already physically active may not need a referral. In such cases, it must be documented in the medical record that the patient is adequately active and was encouraged to continue the activity.

Protocol

The protocol must address the following:

- Assessment tool used (for example, EXCEEDS, EXCEEDS Short Form, PERC, CORE, or CREST). If not using a validated tool, the assessment tool itself must be included in the protocol. The assessment tool must discern whether patients should be referred to oncology rehabilitation, exercise oncology services, or community-based exercise programming.
- Assessment timing
- Assessment thresholds for referral to oncology rehabilitation, exercise oncology programs, or community-based exercise programs.
- Exercise therapy, counseling, or education services offered on-site or by referral.

Sites without exercise oncology services at the facility must still assess and offer a referral to patients for appropriate services.

Evaluating Exercise Oncology Services

Each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements to on-site exercise oncology services and/or assessment and referral services.

The cancer committee must document the annual evaluation of exercise oncology services. The annual evaluation may be presented and discussed with the cancer committee at any time during the calendar year under evaluation or at a meeting during the first quarter of the following year. The annual evaluation is documented in the cancer committee meeting minutes.

If available, it is recommended but not required that a nationally certified exercise professional attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with pre-review questionnaire

- Protocol for providing exercise oncology assessment and referral services connecting patients to the appropriate services.
- Cancer committee minutes that document the required annual evaluations of the exercise oncology services.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. Exercise oncology assessment and referral services are provided on-site or by referral.
2. A protocol is in place to assess and offer a referral to patients for oncology rehabilitation, exercise oncology programs provided by nationally certified exercise professionals, or community-based options, including online options.

3. The process for referring or providing exercise oncology services to cancer patients is monitored and reviewed by the cancer committee and documented in the cancer committee meeting minutes.

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Changes to this standard are noted with red text

Standard 5.3: Sentinel Node Biopsy for Breast Cancer

Definition and Requirements

All sentinel nodes for breast cancer must be identified, removed, and subjected to pathologic analysis to ensure that lymphatic mapping and sentinel lymphadenectomy provide accurate information for breast cancer staging.

Sentinel nodes are defined as (1) node(s) having uptake of a localization substrate (radioactive tracer and/or colored dye) that has been previously injected into the affected breast, (2) node(s) to which an afferent colored lymphatic travels, or (3) dominant lymph node(s) that are palpably suspicious as identified by the operating surgeon. Nodes with radioactive counts that are at least 10% that of the most radioactive node are considered sentinel nodes and should be removed.

This standard has been satisfied if (1) a diligent search has been made for sentinel nodes, and those nodes are removed when present, and (2) documentation of those specifics is complete and in synoptic format. Specifically, operative reports must indicate that all colored, radioactive, and/or suspicious nodes were removed, in addition to any noncolored nodes at the end of a colored lymphatic.

When performing a sentinel node biopsy in patients who have received neoadjuvant chemotherapy, removing a **baseline biopsy-proven positive node (if applicable)** and/or at least two to three sentinel nodes and/or using multiple substrates for sentinel node identification reduces the false negative rate.

Removal of nodes that do not correspond to a selected identification method does not meet compliance, unless the node is documented as being palpably suspicious.

Operative Report Requirements

Operative reports for patients undergoing sentinel node biopsy for breast cancer must include the following elements in synoptic format. The required elements and responses must be in the operative report of record, clearly identified, **all in a single location**, and the response options must be the same as in the CoC standard. A uniform synoptic reporting format should be used by all surgeons at the facility. **To meet requirements for compliance, the synoptic elements/responses must be included in the operative report of record. Inclusion in a separate document (i.e. brief op note) is noncompliant.**

Element	Response Options
Operation performed with curative intent.	Yes; No.
Methods used to identify sentinel and/or biopsy-proven lymph nodes (select all that apply).	Dye; Radioactive tracer; Superparamagnetic iron oxide (SPIO); Indocyanine green dye (ICG) Clip; Other (with explanation); N/A.
Sentinel lymph nodes removed (select all that apply).	Baseline biopsy-proven positive node; Blue nodes; Radioactive nodes; Superparamagnetic iron oxide (SPIO) detected nodes; Indocyanine green dye (ICG) detected nodes; Palpably suspicious nodes; Other (with explanation).

Scope of Standard

This standard applies to all nodal staging operations performed with curative intent for patients with breast cancers of epithelial origin.

For current implementation information, visit facs.org/cocstandardsupdates

Internal Audit of Compliance

Each calendar year, the cancer program must conduct an internal audit confirming at least 80% of eligible operative reports for sentinel node biopsy for breast cancer meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements outlined in Standard 5.3.

The internal audit must evaluate a minimum of 30 total sentinel node biopsy cases. If the cancer program performs less than 30 cases meeting the scope of the standard, then all applicable cases must be reviewed. The audit must be completed using the CoC Operative Standards Audit Template for Sentinel Node Biopsy for Breast Cancer.

If the internal audit demonstrates less than 80% compliance with Standard 5.3, an action plan must be developed and implemented. An additional internal audit must be performed six months after the action plan is approved to determine the impact of the intervention(s).

The results of the internal audit and, if applicable, action plans must be presented and discussed by the cancer committee and documented in the cancer committee meeting minutes.

Specifications by Category

Integrated Network Cancer Program (INCP) and NCI-Designated Network Cancer Program (NCIN)

The network cancer program must conduct an internal audit of sentinel node biopsy operative reports that includes a minimum of 30 eligible operative reports from each facility within the network. Compliance with this standard is evaluated separately for each facility in the network. Each facility must achieve at least 80% compliance. If a facility falls below the 80% threshold, an action plan is required for that facility. Facilities that meet or exceed 80% compliance are not required to develop an action plan. The audit(s) must comply with the standard as written.

Pediatric Cancer Program (PCP) and

Standalone PCPs are exempt from this standard.

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Documentation

Reviewed On-Site

- The site reviewer will review synoptic operative reports from applicable sentinel node biopsies for breast cancer.

Submitted with Pre-Review Questionnaire

- CoC Operative Standards Audit Template for Sentinel Node Biopsy for Breast Cancer
- Cancer committee meeting minutes documenting the required audit of operative reports each calendar year, including any required action plans

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. All sentinel nodes for breast cancer are identified using one or more of the following methods: tracer(s), clips, and/or palpation.
2. All nodes identified as being sentinel nodes are removed at the time of surgery.
3. All removed sentinel nodes are subjected to pathologic analysis.

4. Compliance with sentinel node removal is achieved if at least one of the following conditions is met:
 - a. Removal of the baseline biopsy-proven positive node or at least one palpably suspicious node, regardless of the method of detection selected.
 - b. Removal of nodes that correspond to the identification method(s) selected, as follows:
 - i. Blue-stained nodes and/or nodes at the end of a blue lymphatic channel are compliant only if dye is selected as an identification method.
 - ii. Radioactive nodes are compliant only if radioactive tracer is selected.
 - iii. Superparamagnetic iron oxide (SPIO) detected nodes are compliant only if SPIO is selected.
 - iv. Indocyanine green dye (ICG) detected nodes are compliant only if ICG is selected.
5. Operative reports for sentinel node biopsies for breast cancer document the required elements in synoptic format.
6. Each calendar year, the cancer program conducts an internal audit confirming at least 80% of eligible operative reports for sentinel node biopsy for breast cancer meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements.
7. The results of the internal audit and any action plans are presented to the cancer committee and documented in the cancer committee meeting minutes. The cancer committee report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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Changes to this standard are noted with red text

Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer

Definition and Requirements

Axillary lymph node dissection (ALND) for breast cancer **involves** removal of level I and II lymph nodes within an anatomic triangle defined by the axillary vein, chest wall, and latissimus dorsi, with preservation of key neurovascular structures.

For appropriately selected patients, ALND serves two purposes: (1) to provide important staging and prognostic information that can inform treatment decisions, and (2) to improve locoregional disease control.

When ALND is performed, the standard has been satisfied if (1) dissection to established axillary anatomic boundaries is complete, and (2) documentation of operative specifics is complete and in synoptic format. The contents of an ALND for breast cancer should include the level I and II axillary lymph node basins. Complete removal of the nodes within these basins constitutes complete dissection within the following boundaries: the axillary vein, the latissimus dorsi muscle, and the chest wall (serratus anterior muscle). In the course of the dissection, the long thoracic nerve and the thoracodorsal nerve should be preserved unless visibly involved with cancer. The intercostobrachial nerves should be spared when possible. Although the numbers of lymph nodes retrieved in an ALND performed after neoadjuvant chemotherapy is often lower than when ALND is performed in the upfront surgery setting, the surgical techniques that guide ALND are identical in these two settings.

Axillary dissection of levels I and II should be complete, with resection of all soft tissue within the boundaries specified above. Level III nodes also may be removed if clinically involved or suspicious at surgery, although the benefit of their removal is isolated to improvement of local-regional control, and limited data support their removal.

Operative Report Requirements

Operative reports for patients undergoing axillary lymph node dissection must include the following elements in synoptic format. The required elements and responses must be in the operative report of record, clearly identified, **all in a single location**, and the response options must be the same as in the CoC standard. A uniform synoptic reporting format should be used by all surgeons at the facility. **To meet requirements for compliance, the synoptic elements/responses must be included in the operative report of record. Inclusion in a separate document (i.e. brief op note) is noncompliant.**

Element	Response Options
Operation performed with curative intent.	Yes; No.
Axillary nodal tissue within the boundaries of the axillary vein, chest wall and latissimus dorsi muscle was resected.	Yes; No (<i>with explanation</i>).
Nerves identified and preserved during dissection (<i>select all that apply</i>).	Long thoracic nerve; Thoracodorsal nerve; Branches of the intercostobrachial nerves; Other (<i>with explanation</i>).
Level III nodes removed.	No. Yes (<i>with explanation</i>)

Scope of Standard

This standard applies to all axillary lymph node dissections performed with curative intent for patients with breast cancers of epithelial origin.

For current implementation information, visit facs.org/cocstandardsupdates

Internal Audit of Compliance

Each calendar year, the cancer program must conduct an internal audit confirming at least 80% of eligible operative reports for axillary lymph node dissection for breast cancer meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements outlined in Standard 5.4.

The internal audit must evaluate a minimum of 30 total axillary lymph node dissection cases. If the cancer program performs less than 30 cases meeting the scope of the standard, then all applicable cases must be reviewed. The audit must be completed using the CoC Operative Standards Audit Template for Axillary Lymph Node Dissection for Breast Cancer.

If the internal audit demonstrates less than 80% compliance with Standard 5.4, an action plan must be developed and implemented. An additional internal audit must be performed six months after the action plan is approved to determine the impact of the intervention(s).

The results of the internal audit and, if applicable, action plans must be presented and discussed by the cancer committee and documented in the cancer committee meeting minutes.

Specifications by Category

Integrated Network Cancer Program (INCP) and NCI-Designated Network Cancer Program (NCIN)

The network cancer program must conduct an internal audit of ALND operative reports that includes a minimum of 30 eligible operative reports from each facility within the network. Compliance with this standard is evaluated separately for each facility in the network. Each facility must achieve at least 80% compliance. If a facility falls below the 80% threshold, an action plan is required for that facility. Facilities that meet or exceed 80% compliance are not required to develop an action plan. The audit(s) must comply with the standard as written.

Pediatric Cancer Program (PCP) and

Standalone PCPs are exempt from this standard.

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Documentation

Reviewed On-Site

- The site reviewer will review synoptic operative reports from applicable axillary lymph node dissections for breast cancer.

Submitted with Pre-Review Questionnaire

- CoC Operative Standards Audit Template for Axillary Lymph Node Dissection for Breast Cancer
- Cancer committee meeting minutes documenting the required audit of operative reports each calendar year, including any required action plans

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Axillary lymph node dissections for breast cancer include removal of level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall (serratus anterior), and latissimus dorsi, with preservation of the main nerves in the axilla.
2. Operative reports for axillary lymph node dissections for breast cancer document the required elements in synoptic format.

3. Each calendar year, the cancer program conducts an internal audit confirming at least 80% of eligible operative reports for axillary lymph node dissection for breast cancer meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements.
4. The results of the internal audit and any action plans must be presented to the cancer committee and documented in the cancer committee meeting minutes. The cancer committee report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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Changes to this standard are noted with red text

Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma

Definition and Requirements

Clinical margin width for wide local excision of a melanoma is based on the original Breslow thickness of the primary tumor, as indicated on the initial biopsy pathology report. The clinical margin width for wide local excision of invasive melanoma should be 1 cm for melanomas <1 mm thick, 1 to 2 cm for invasive melanomas 1 to 2 mm thick, and 2 cm for invasive melanomas >2 mm thick. The clinical margin width for wide local excision of a melanoma in situ should be at least 5 mm. Cosmetic concerns or anatomic limitations, particularly on the hands, feet, or face, may dictate narrower margins. If this is the case, the operative report must document the reason for this deviation.

“The appropriate [wide local excision] margins are measured from the periphery of any gross residual tumor or the edges of the entire previous biopsy scar (shave or excisional).” *Operative Standards for Cancer Surgery*, Volume 2, page 392. The depth of resection should include the skin and all underlying subcutaneous tissue to the level of the underlying fascial plane. For in situ disease, the wide local excision need only include the skin and the superficial subcutaneous fat.

Operative Report Requirements

Operative reports for patients undergoing wide local excision of primary cutaneous melanomas must include the following elements in synoptic format. The required elements and responses must be in the operative report of record, clearly identified, **all in a single location**, and the response options must be the same as in the CoC standard. A uniform synoptic reporting format should be used by all surgeons at the facility. **To meet requirements for compliance, the synoptic elements/responses must be included in the operative report of record. Inclusion in a separate document (i.e. brief op note) is noncompliant.**

Element	Response Options
Operation performed with curative intent	Yes; No.
Original Breslow thickness of the lesion	Melanoma in situ (MIS); __. __ mm (<i>to the tenth of a millimeter</i>).
Clinical margin width (<i>measured from the edge of the lesion or the prior excision scar</i>)	0.5 cm; 1 cm; 2 cm; Other: __ cm due to cosmetic/anatomic concerns; Other (with explanation).
Depth of excision	Full-thickness skin/subcutaneous tissue down to fascia (melanoma); Only skin and superficial subcutaneous fat (melanoma in situ); Other (<i>with explanation</i>).

Scope of Standard

This standard applies to all curative-intent wide local excisions of primary cutaneous melanoma lesions. Mucosal, ocular, and subungual melanomas are excluded.

For current implementation information, visit facs.org/cocstandardsupdates

Internal Audit of Compliance

Each calendar year, the cancer program must conduct an internal audit confirming at least 80% of eligible operative reports for wide local excision for primary cutaneous melanoma meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements outlined in Standard 5.5.

The internal audit must evaluate a minimum of 30 total wide local excision for primary cutaneous melanoma cases. If the cancer program performs less than 30 cases meeting the scope of standard, then all applicable cases must be reviewed. The audit must be completed using the CoC Operative Standards Audit Template for Wide Local Excision for Primary Cutaneous Melanoma.

If the internal audit demonstrates less than 80% compliance with Standard 5.5, an action plan must be developed and implemented. An additional internal audit must be performed six months after the action plan is approved to determine the impact of the intervention(s).

The results of the internal audit and, if applicable, action plans must be presented and discussed by the cancer committee and documented in the cancer committee meeting minutes.

Specifications by Category

Integrated Network Cancer Program (INCP) and NCI-Designated Network Cancer Program (NCIN)

The network cancer program must conduct an internal audit of wide local excision for primary cutaneous melanoma operative reports that includes a minimum of 30 eligible operative reports from each facility within the network. Compliance with this standard is evaluated separately for each facility in the network. Each facility must achieve at least 80% compliance. If a facility falls below the 80% threshold, an action plan is required for that facility. Facilities that meet or exceed 80% compliance are not required to develop an action plan. The audit(s) must comply with the standard as written.

Pediatric Cancer Program (PCP) and

Standalone PCPs are exempt from this standard.

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Documentation

Reviewed On-Site

- The site reviewer will review synoptic operative reports from applicable wide local excisions for melanoma.

Submitted with Pre-Review Questionnaire

- CoC Operative Standards Audit Template for Wide Local Excision for Primary Cutaneous Melanoma
- Cancer committee meeting minutes documenting the required audit of operative reports each calendar year, including any required action plans

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Wide local excisions for melanoma include the skin and all underlying subcutaneous tissue down to the fascia (for invasive melanoma) or the skin and the superficial subcutaneous fat (for in situ disease). Clinical margin width is selected based on original Breslow thickness:
 - a. Clinical margin width for wide local excision is 1 cm for invasive melanomas less than 1 mm thick.
 - b. Clinical margin width for wide local excision is 1 to 2 cm for invasive melanomas 1 to 2 mm thick.

- c. Clinical margin width for wide local excision is 2 cm for invasive melanomas greater than 2 mm thick.
 - d. Clinical margin width for wide local excision is at least 5 mm for melanoma in situ.
- 2. Operative reports for wide local excisions of primary cutaneous melanomas document the required elements in synoptic format.
 - 3. Each calendar year, the cancer program conducts an internal audit confirming at least 80% of eligible operative reports for wide local excision for primary cutaneous melanoma meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements.
 - 4. The results of the internal audit and any action plans must be presented to the cancer committee and documented in the cancer committee meeting minutes. The cancer committee report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

Bibliography

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Changes to this standard are noted with red text

Standard 5.6: Colon Resection

Definition and Requirements

Tumor Location

Preoperative and intraoperative tumor location of colon cancer may both be recorded, but in cases of discrepancy, the intraoperative tumor location should be considered the definitive tumor location. **In some cases, tumor location may be determined intraoperatively to be different from preoperative assessment.** Colon and Rectum, NOS can be used sparingly for rare tumors where more than one segment of colon is involved, and origin cannot be determined.

Extent of Colon and Vascular Resection

For patients with colon cancer, resection of the tumor-bearing bowel segment and complete lymphadenectomy must be performed en bloc with proximal vascular ligation at the origin of the primary feeding arteries and veins* as follows:

- Right hemicolectomy - ileocolic and right colic (if present).
- Extended right hemicolectomy - ileocolic, right colic (if present), and middle colic.
- Transverse colectomy - middle colic.∞
- Splenic flexure – middle colic and ascending left colic.∞
- Left hemicolectomy - inferior mesenteric.
- Sigmoid resection - inferior mesenteric.
- Total abdominal colectomy - ileocolic, right colic (if present), middle colic, and inferior mesenteric.
 - If performed with proctectomy - superior and middle rectal.
- Other – Describe segments and vasculature resected anomalous to standard practice and explain the reason(s).

**Operative Standards for Cancer Surgery*, Volume 1, page 288.

∞ **In the event that the middle colic artery and vein is absent or dangerously short, then ligation at the origin of the left or right branch of the middle colic artery and vein is acceptable.**

Operative Report Requirements

Operative reports for patients undergoing resection for colon cancer must include the following elements in synoptic format. The required elements and responses must be in the operative report of record, clearly identified, **all in a single location**, and the response options must be the same as in the CoC

standard. If the operation involves more than one primary tumor/resection, a distinct synoptic section is required for each tumor/resection. A uniform synoptic reporting format should be used by all surgeons at the facility. To meet requirements for compliance, the synoptic elements/responses must be included in the operative report of record. Inclusion in a separate document (i.e. brief op note) is noncompliant.

Element	Response Options
Operation performed with curative intent	Yes; No.
Tumor location (select all that apply)	Cecum; Ascending colon; Hepatic flexure; Transverse colon; Splenic flexure; Descending colon; Sigmoid colon; Rectosigmoid junction; Rectum NOS; Colon, NOS.
Procedure (select all that apply)	Right hemicolectomy; Extended right hemicolectomy; Transverse colectomy; Splenic flexure resection; Left hemicolectomy; Sigmoid colon resection; Total abdominal colectomy; Total abdominal colectomy, with proctectomy; Other (with explanation).
En bloc lymphadenectomy with proximal vascular ligation was performed (select all that apply)	Ileocolic artery and vein; Right colic artery and vein (if present); Middle colic artery and vein or left or right branches at their origin; Ascending left colic artery and vein; Inferior mesenteric artery and vein; Superior and middle rectal artery and vein; Other (with explanation).

Scope of Standard

This standard applies to all resections performed with curative intent for patients with colon adenocarcinoma, **including emergent cancer operations when the cancer is biopsy-proven or suspected**, and applies to all operative approaches.

If cancer is identified or suspected intraoperatively and a cancer-directed operation is performed, the applicable synoptic elements and responses must be included.

In urgent or emergent circumstances when a metastatic workup cannot be completed prior to surgery, designate the surgical intent as curative if, notwithstanding the incomplete metastatic workup, the operation is intended to leave the patient with no evidence of disease.

If cancer is identified unexpectedly only on final pathology and malignancy was not known or suspected at the time of surgery, the original operative report does not need to be retrospectively amended or added to include the required elements and responses.

For current implementation information, visit facs.org/cocstandardsupdates

Internal Audit of Compliance

Each calendar year, the cancer program must conduct an internal audit confirming at least 80% of eligible operative reports for colon resection meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements outlined in Standard 5.6.

The internal audit must evaluate a minimum of 30 total colon resection cases. If the cancer program performs less than 30 cases meeting the scope of standard, then all applicable cases must be reviewed. The audit must be completed using the CoC Operative Standards Audit Template for Colon Resection.

If the internal audit demonstrates less than 80% compliance with Standard 5.6, an action plan must be developed and implemented. An additional internal audit must be performed six months after the action plan is approved to determine the impact of the intervention(s).

The results of the internal audit and, if applicable, action plans must be presented and discussed by the cancer committee and documented in the cancer committee meeting minutes.

Specifications by Category

Integrated Network Cancer Program (INCP) and NCI-Designated Network Cancer Program (NCIN)

The network cancer program must conduct an internal audit of colon resection operative reports that includes a minimum of 30 eligible operative reports from each facility within the network. Compliance with this standard is evaluated separately for each facility in the network. Each facility must achieve at least 80% compliance. If a facility falls below the 80% threshold, an action plan is required for that facility. Facilities that meet or exceed 80% compliance are not required to develop an action plan. The audit(s) must comply with the standard as written.

Pediatric Cancer Program (PCP) and

Standalone PCPs are exempt from this standard.

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Documentation

Reviewed On-Site

- The site reviewer will review synoptic operative reports from applicable resections for colon cancer.

Submitted with Pre-Review Questionnaire

- CoC Operative Standards Audit Template for Colon Resection
- Cancer committee meeting minutes documenting the required audit of operative reports each calendar year, including any required action plans

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s). **The resection is compliant if the corresponding vessels below are ligated or if an explanation is included with "other":**
 - a. Right hemicolectomy – ileocolic, right colic artery and vein (if present)
 - b. Extended right hemicolectomy –ileocolic, right colic (if present), middle colic artery and vein
 - c. Transverse colectomy – middle colic artery and vein or left and right branches at their origins if middle colic artery and vein absent or dangerously short
 - d. Splenic flexure resection – middle and ascending left colic artery and vein or left branch of middle colic artery and vein at its origin if middle colic artery and vein absent or dangerously short
 - e. Left hemicolectomy – inferior mesenteric artery and vein
 - f. Sigmoid resection – inferior mesenteric artery and vein
 - g. Total abdominal colectomy –ileocolic, right colic (if present), middle colic, inferior mesenteric artery and vein
 - h. Total abdominal colectomy, with proctectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric, superior and middle rectal artery and vein
2. Operative reports for resections for colon cancer document the required elements in synoptic format.

3. Each calendar year, the cancer program conducts an internal audit confirming at least 80% of eligible operative reports for colon resection meet the technical requirements of the standard, are structured using synoptic format, and include all required data elements.
4. The results of the internal audit and any action plans must be presented to the cancer committee and documented in the cancer committee meeting minutes. The cancer committee report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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Changes to this standard are noted with red text

Standard 5.7: Total Mesorectal Excision

Definition and Requirements

Total mesorectal excision (TME) is performed for patients undergoing radical surgical resection of mid and low rectal cancers.

“Total mesorectal excision (TME) of rectal cancer leverages existing tissue planes to perform a complete resection of the tumor and the associated draining lymph nodes. ... As shown in several studies, a complete mesorectum resulting from performing a TME in the proper tissue plane results in lower rates of local and distant recurrence than resection with an incomplete mesorectum.” *Operative Standards for Cancer Surgery*, Volume 2, page 194.

By maintaining the intact fascia propria of the rectum and operating in the space between the mesorectum and the endopelvic fascia, the surgeon can achieve a resection with a negative margin, while simultaneously preserving neurovascular structures.

Per the College of American Pathologists (CAP) cancer protocol template for rectal cancer resections, the quality of TME resection (complete, near complete, or incomplete) must be documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format.

Although the surgeon should always strive to perform a complete TME, near-complete TME yields similar rates of local recurrence and survival and is considered to meet the expectations of this standard. Conversely, incomplete TME is associated with a significantly higher risk of local recurrence and cancer related death than either complete or nearcomplete TME.

Scope of Standard

This standard applies to all radical, anatomic operations for rectal adenocarcinoma performed with curative intent and excludes in-situ lesions ~~and primary resection specimens with no residual cancer (e.g. following neoadjuvant therapy)~~. CoC programs accredited by the National Accreditation Program for Rectal Cancer (NAPRC) are exempt from demonstrating compliance with CoC Standard 5.7.

For current implementation information, visit facs.org/cocstandardsupdates

Tumor Location

The table below provides guidance on tumor location.

NAPRC Synoptic Report		CAP Pathology Report
Data Element Name	Location of tumor within rectum	Rectal tumor location
"High" rectal tumor response	High	Entirely above anterior peritoneal reflection
"Mid" rectal tumor response	Middle	Straddles anterior peritoneal reflection
"Low" rectal tumor response	Low	Entirely below anterior peritoneal reflection

Specifications by Category

Pediatric Cancer Program (PCP)

Standalone PCPs are exempt from this standard.

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Documentation

Reviewed On-Site

- The site reviewer will review synoptic pathology reports from applicable radical resections for middle and low rectal cancers.

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

- Total mesorectal excision is performed for patients undergoing radical surgical resections of mid and low rectal cancers, resulting in complete or near-complete total mesorectal excision.

2. Pathology reports for resections of rectal adenocarcinoma document the quality of TME resection (complete, near complete, or incomplete) in synoptic format.

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Changes to this standard are noted with red text

Standard 5.8: Pulmonary Resection

Definition and Requirements

The surgical pathology report associated with any curative intent pulmonary resection for primary lung malignancy must report the oncologic status of lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.

“The hilum and mediastinum should be thoroughly staged at the time of lung resection, even in patients who are undergoing nonanatomic parenchymal-sparing resections such as... [a] wedge resection.”
Operative Standards for Cancer Surgery, Volume 1, page 93.

For reference, single digit stations are mediastinal (2-9) and double digit stations are hilar (10 or higher).

Per the College of American Pathologists (CAP) cancer protocol template for pulmonary resections, the nodal stations examined by the pathologist must be documented in curative pulmonary resection pathology reports in synoptic format. Surgeons are expected to designate the lymph node station from which each node/group of nodes was/were taken on the histology requisition form.

Scope of Standard

This standard applies to all primary pulmonary resections performed with curative intent for non-small cell lung cancer (NSCLC), small cell lung cancer (SCLC), and carcinoid tumors of the lung, ~~and excludes primary resection specimens with no residual cancer (e.g. following neoadjuvant therapy).~~ This standard applies to all operative approaches. This standard applies to all lung cancer subtypes regardless of their propensity for nodal metastasis. At present, the AJCC Version 9 Lung does not distinguish radiographic ground glass opacities from other lung tumors.

Mediastinoscopy specimens are surgical and therefore may be included in the final pathology synoptic report to count towards the Standard 5.8 nodal requirements. While transbronchial FNA/EBUS sampling is a critical component of the pre-operative clinical staging process, it is not considered completely equivalent to surgical lymph node sampling when a curative operation is performed. Transbronchial FNA nodal samples, therefore, do not count towards the Standard 5.8 surgical nodal requirements.

This standard applies to all operative approaches for curative lung cancer resection and outlines a minimum systematic sampling paradigm for early-stage lung cancer treatment. Further, patients with more advanced disease may benefit from a more thorough nodal dissection.

For current implementation information, visit facs.org/cocstandardsupdates

Specifications by Category

Pediatric Cancer Program (PCP) and

Standalone PCPs are exempt from this standard.

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Documentation

Reviewed On-Site

- The site reviewer will review synoptic pathology reports from applicable pulmonary resections for NSCLC, SCLC, or carcinoid tumors of the lung.

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Pulmonary resections for primary lung malignancy include lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.
2. Pathology reports for curative pulmonary resection document the nodal stations examined by the pathologist documented in synoptic format.

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Currently Effective

Significant portions of standard revised. Changes not marked.

Standard 6.2: Rapid Cancer Reporting System: Data Submission

Definition and Requirements

The Rapid Cancer Reporting System (RCRS) enables accredited cancer programs to report data on patients concurrently and receive notifications of treatment expectations. This tool presents facility submission practices as well as performance rates for CoC quality measures for individual programs as well as comparison with the state, other hospital groups, and hospitals at the national level.

The cancer program actively participates in the RCRS, submits all required cases, and adheres to the RCRS terms and conditions. Compliance with Standard 6.2 is assessed through two components: annual submission compliance and monthly submission compliance.

1. Annual Submissions

At least 90% of a program's analytic case load diagnosed during the previous calendar year is submitted to RCRS on or before December 31 of each year free of edits or errors. For example, 90% of cases diagnosed in 2026 must be submitted as complete by December 31, 2027.

The remaining eligible cases are submitted within the first quarter of the next year. For example, the remaining 10% of cases from 2026 should be submitted by March 31, 2028.

Compliance is evaluated using the Submission Compliance Report in RCRS. Annual submission compliance is based on the display in the **Total Complete Cases Submitted by Diagnosis Year** panel:

- Complete cases submitted to RCRS on or before December 31 are represented in the diagnosis year column in green. Complete cases means they are edit and error free.
- Complete cases submitted after December 31 are represented in the diagnosis year column in blue.
- The yellow line in the report is the projected 90% analytic case volume expected to be submitted on or before December 31. The yellow line is based on the average of the program's previous three years.
- A program is compliant when, at minimum, 90% of the analytic case load was submitted to RCRS on or before December 31, which is indicated when the green column exceeds the yellow line for the diagnosis year.

If a program was non-compliant in either of the first two calendar years within the accreditation cycle, they may receive a "Deficiency Resolved" rating if the following conditions are met:

- The program has since submitted at least 90% of its annual caseload free of errors/edits for the non-compliant year(s) (represented in the report by the green or blue bar meeting or exceeding the yellow line for the relevant year).

- The final year of the accreditation cycle is compliant (represented by the green bar meeting or exceeding the yellow line for that year).

If a program experiences a decrease in case volume, the rating may be adjusted to compliant if the program documents the following in the cancer committee minutes:

- All analytic cases were submitted to RCRS without errors/edits
- At least 90% of the actual analytic case volume was submitted by December 31
- Any known reasons for a decrease in case volume to confirm the change reflects actual case volume and not incomplete case submission.

2. Monthly Submissions

Programs must successfully submit all new and updated analytic cases to RCRS every month.

Compliance is evaluated using the Submission Compliance Report in RCRS. Monthly submission compliance is based on the display in the **Case Data for Months by Year** panel:

- A green tile indicates cases were successfully submitted or resubmitted to RCRS that month.
- A red tile indicates no cases were successfully submitted to RCRS in that month.
- If any calendar year has three or more months of no submissions to RCRS, this will result in a “non-compliant” rating.
 - If the program is non-compliant in year 1 or 2 of the accreditation cycle but demonstrates at least 12 months of successful monthly submissions in the year before their site visit, they will be rated as “Deficiency Resolved.”

Specifications by Category

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Programs Undergoing Initial Site Visit for Accreditation

Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

Documentation

Reviewed on Site

- The site reviewer will review the Submission Compliance Report in RCRS.

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. A minimum of 90% of the program's analytic case load diagnosed in the previous calendar year is submitted to RCRS as complete (without edits/errors) on or before December 31 as demonstrated in the Submission Compliance Report, Total Complete Cases Submitted by Diagnosis Year panel.
2. All new and updated cancer cases are submitted to RCRS at least once a month as demonstrated in the Submission Compliance Report, Case Data for Months by Year panel.

Changes to this standard are noted with red text

Standard 6.3: Follow-Up of Patients

Definition and Requirements

Long-term follow-up is essential to evaluate outcomes of cancer care. Accurate follow-up data enables the program to compare outcomes with regional, state, or national statistics. Follow-up information is obtained at least annually for all analytic cases of living patients included in the cancer registry database.

For all eligible cases:

- An **80% follow-up rate** is maintained **from the current year** through 15 previous years or the program's first accreditation date, whichever is shorter.
- A **90% follow-up rate** is maintained **from the current year** through five previous years or the program's first accreditation date, whichever is shorter.

The following table provides examples of follow-up windows based on current calendar year:

Current Calendar Year	15-year Follow-up window (80%)	5-year Follow-up window (90%)
2026	2026 through 2011	2026 through 2021
2027	2027 through 2012	2027 through 2022
2028	2028 through 2013	2028 through 2023

The follow-up calculation is based on the "Date of Last Contact or Death" data item. If this date is within 15 months of today's date, the case is considered followed up.

All reportable cases are followed up, except the following:

- Residents of foreign countries
- Cases reportable by agreement (non-analytic)
- Patients whose age exceeds 100 years and who are without contact for more than 12 months
- Analytic cases Class of Case 00

~~"Most current year of completed cases" is defined as cases diagnosed three years before the current calendar year. For example, in calendar year 2022, the window for long-term follow up would be cases diagnosed 2005–2019 (80 percent required). The window for short-term follow up is 2015–2019 (90 percent required).~~

Methods to obtain follow-up information include, but are not limited to, the following:

- Following or managing physician(s)
- Program inpatient or outpatient services
- Pathology reports or death certificates
- Internet sources (such as death index, patient locator software, obituary listings)
- Communication with other facilities
- Patient communication (e.g. Letters, text, message apps, phone calls)

The cancer committee monitors the use of unknown values to ensure complete data reporting. This monitoring is extremely important for information describing the date of first recurrence, type of first recurrence, and cancer status.

It is expected that all CoC-accredited programs will provide treatment or follow-up information and assistance to the referring cancer programs.

Specifications by Category

CoC Pediatric Specialty Accreditation (CoC-PS)

CoC-PS programs do not need to demonstrate compliance with this standard.

Programs Undergoing Initial Site Visit for Accreditation

Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

Documentation

Reviewed On-Site

- The site reviewer will review the current follow-up report.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. An **80% follow-up rate** is maintained for all eligible analytic cases **from the current year** through the previous 15 years or the program's first accreditation date, whichever is shorter.
2. A **90% follow-up rate** is maintained for all analytic cases diagnosed **from the current year** through the previous five years or the program's first accreditation date, whichever is shorter.