Commission on Cancer
American College of Surgeons

Specifications by Category

Rural Cancer Program

NOTE: Only hospitals located within a county that has a Rural-Urban Continuum Code (RUCC) of 4 through 9 are eligible to participate in the Rural Cancer Program category.

This resource is a companion to Optimal Resources for Cancer Care (2020 Standards). If a standard is not listed below, the Rural Cancer Program meets the standard as written in Optimal Resources for Cancer Care (2020 Standards). A list of standards that must be met without modification is at the end of this document.

Standard 2.1: Cancer Committee At a minimum, the cancer committee must consist of at least the following members:

- Three physicians, representing three different medical disciplines
- Two healthcare professionals, representing different disciplines related to the management and/or care of patients with cancer
    - Examples include: nurse, genetic professional, Oncology Data Specialist, research professional, Registered Dietitian Nutritionist, navigation professionals, social worker, Licensed Professional Counselor (LPC)

The following positions must be appointed to the cancer committee:

- Cancer Program Administrator
- Cancer Committee Chair
    - The Cancer Committee Chair must be a physician.
- Cancer Liaison Physician (CLP) (see Standard 2.2)
    - One individual may serve as the Cancer Committee Chair and the Cancer Liaison Physician if desired by the program.
- Cancer Registry Quality Coordinator
- Cancer Conference Coordinator
- Survivorship Program Coordinator

Individuals filling either the physician or healthcare professional roles may also fill one of the Administrator or Coordinator roles. An individual filling one of the physician roles may also serve as the Chair and/or the CLP.

Standard 2.4: Cancer Committee Attendance For each required member/role, one designated alternate member can be identified. Designating an alternate is optional. Only one alternate can be appointed for each required member.

For the physician roles on the Cancer Committee, a Nurse Practitioner (NP) may be appointed as the alternate. However, if a NP is appointed as an alternate for a physician role, then the physician is required to attend at least 50% of meetings held each calendar year.

Standard 2.5: Multidisciplinary Cancer Case Conference Before the initial site visit as a Rural Cancer Program, it is strongly recommended, but not required, that a multidisciplinary cancer case conference be established at the applicant program. If there is not a multidisciplinary cancer conference at the applicant program, the cancer program must demonstrate that at least one oncology physician is presenting at an external multidisciplinary cancer case conference at least once each calendar quarter. The case presentation threshold requirements outlined in Standard 2.5 do not apply to physicians presenting at external cancer conferences before the initial site visit.

Before the first reaccreditation visit, there must be a multidisciplinary cancer case conference established at the accredited program that meets the requirements of Standard 2.5 for at least the last six months of the accreditation cycle. As allowed by available resources, it is strongly recommended that each case conference be attended by a surgeon, medical oncologist, pathologist, radiation oncologist, and a radiologist.

Attendance at multidisciplinary cancer case conferences may include participation through teleconference or videoconference calls if the remote attendee has access to appropriate meeting documents.

Standard 4.4: Genetic Counseling and Risk Assessment Rural Cancer Programs are not required to complete the requirements under “Monitoring Genetic Assessment for a Selected Cancer Site” and the related annual reporting requirements to the cancer committee. Instead, each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements, as needed, to genetic counseling and risk assessment services and/or referrals. The content of the review and any recommendations for improvement must be documented in the cancer committee minutes.

The protocol for genetic counseling and risk assessment is evaluated at least once each accreditation cycle.

Standard 4.5: Palliative Care Services, Standard 4.7: Oncology Nutrition Services, and Standard 5.2: Psychosocial Distress Screening Before the initial site visit, the Rural Cancer Program complies with one of the following standards: 4.5, 4.7, or 5.2.

By the reaccreditation visit and for subsequent site visits, the Rural Cancer Program must comply with at least two of the following standards: 4.5, 4.7, or 5.2. For the selected standard(s), the required annual review is limited to monitoring, evaluating, and making recommendations for improvements, as needed, to the required services and/or referrals for the selected standard. The content of the review and any recommendations for improvement must be documented in the cancer committee minutes.

The protocols for the selected standards are evaluated at least once each accreditation cycle.

Standard 4.8: Survivorship Program Only one service must be reviewed each year. It is not required that the number of participants be reported. The remainder of the standard is complied with as written.

The protocol is evaluated at least once during the accreditation cycle.

Standard 6.1: Cancer Registry Quality Control Exempt for initial site visits. The Rural Cancer Program must comply with the standard as written for its first reaccreditation visit.

Standard 6.4: Rapid Cancer Reporting System: Data Submission Exempt for initial site visits. The Rural Cancer Program must comply with the standard as written for its first reaccreditation visit.

Standard 6.5: Follow Up of Patients Exempt for initial site visits. The Rural Cancer Program must comply with the standard as written for its first reaccreditation visit.

Standard 7.1: Quality Measures Exempt for initial site visits. The Rural Cancer Program must comply with the standard as written for its first reaccreditation visit. Note: the quality measures required for review by the cancer committee may differ from those required for other CoC programs. If applicable, modifications will be identified on the CoC website.

Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines One study must be completed per standard requirements once each accreditation cycle.

Standard 7.3: Quality Improvement Initiative This standard is exempt for initial site visits. For each accreditation cycle after initial accreditation, the rural cancer program must complete a quality improvement (QI) initiative. At least two substantive status updates

must be provided to the cancer committee on the QI initiative while it is active. The status updates are documented in the minutes. It is not required that a Quality Improvement Coordinator be involved in the QI initiative.

Standard 8.1: Addressing Barriers to Care This standard is exempt for initial site visits. For each calendar year after the initial accreditation, the standard must be complied with per standard requirements.

Standard 9.1: Clinical Research Accrual A screening protocol outlining processes to identify participant eligibility for clinical research studies and how to provide clinical trial information to subjects must be in place. Rural Cancer Programs are exempt from demonstrating accruals to cancer-related clinical research studies and the Clinical Research Coordinator reporting requirements. The protocol is evaluated at least once during the accreditation cycle.

Standards that Must be Met without Modification

The following standards must be met as written in *Optimal Resources for Cancer Care (2020 Standards)*. There are no modifications for programs participating in the Rural Cancer Program category:

- 1.1: Administrative Commitment
- 2.2: Cancer Liaison Physician
- 2.3: Cancer Committee Meetings
- 3.1: Facility Accreditation
- 3.2: Evaluation and Treatment Services
- 4.1: Physician Credentials
- 4.2: Oncology Nursing Credentials
- 4.3: Cancer Registry Staff Credentials
- 4.6: Rehabilitation Care Services
- 5.1: College of American Pathologists Synoptic Reporting
- 5.3: Sentinel Node Biopsy for Breast Cancer
- 5.4: Axillary Lymph Node Dissection for Breast Cancer
- 5.5: Wide Local Excision For Primary Cutaneous Melanoma
- 5.6: Colon Resection
- 5.7: Total Mesorectal Excision
- 5.8: Pulmonary Resection
- 5.9: Smoking Cessation for Patients with Cancer
- *6.1: Cancer Registry Quality Control
- *6.4: Rapid Cancer Reporting System: Data Submission
- *6.5: Follow Up of Patients
- *7.1: Quality Measures
- *7.3: Quality Improvement Initiatives
- *7.4: Cancer Program Goal
- *8.1: Addressing Barriers to Care
- 8.2: Cancer Prevention Event
- 8.3: Cancer Screening Event
- 9.2: Commission on Cancer Special Studies

*Exempt for initial site visits