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of the AMERICAN COLLEGE
OF SURGEONS

Optimal Resources for **Cancer Care**

2020 Standards | Effective January 2020

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Optimal Resources for **Cancer Care**

2020 Standards

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Important Information

These standards are intended solely as qualification criteria for Commission on Cancer (CoC) accreditation. They do not constitute a standard of care and are not intended to replace the medical judgment of the physician or health care professional in individual or general circumstances.

"Standard" as used in *Optimal Resources for Cancer Care (2020 Standards)* is defined as a "qualification for accreditation," not standard of care.

In order for a program to be found compliant with the CoC Standards, the program must be able to demonstrate compliance with the entire standard as outlined in the **Definition and Requirements**, **Documentation**, and **Measure of Compliance** sections under each standard. The **Documentation** and **Measure of Compliance** sections under each standard are intended to provide summary guidance on how compliance must be demonstrated but are not intended to stand alone or supersede the **Definition and Requirements**.

In addition to verifying compliance with the standards as written and outlined in *Optimal Resources for Cancer Care (2020 Standards)*, the CoC may also consider additional administrative factors when reviewing a program for accreditation. The CoC reserves the right to withhold accreditation based on such factors. Examples include, but are not limited to: non-payment of accreditation invoices and outstanding fees, failure to schedule or complete an accreditation site visit in a timely manner, failure to properly remit any or all contracts and contractual obligations related to CoC accreditation.

Confidentiality Requirements

The American College of Surgeons and the Commission on Cancer expect programs to 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.

Acknowledgments

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About the Commission on Cancer

Commission on Cancer Mission

The Commission on Cancer (CoC), a program of the American College of Surgeons (ACoS), recognizes cancer care programs for their commitment to providing comprehensive, high-quality, and multidisciplinary patient-centered care. The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.

Commission on Cancer Background

The CoC and its standards for cancer care originated with the ACoS. Since its foundation in 1913, the ACoS has focused on improving the care of the surgical patient through the advancement of surgical skills and physician education. Because surgery was the only available treatment for cancer at that time, the ACoS took the lead to improve cancer care by establishing the Committee on the Treatment of Malignant Diseases in 1922.

Over time, the Committee has transformed a surgical focus into one that includes all disciplines involved in cancer care. In order to recognize this transformation, the name of the Committee was changed to the Commission on Cancer in the mid-1960s.

The initial work was focused on establishing cancer clinics within hospitals where patients could expect to receive consistent diagnostic and cancer treatment services. By 1930, the first set of standards was published, and an Approvals Program (now Accreditation Program) had been established that evaluated a cancer clinic's performance against the standards.

Since then, the number of CoC-accredited programs has steadily increased to encompass approximately 1,500 hospitals, freestanding cancer centers, and cancer program networks nationwide. Every discipline involved in the care of the cancer patient is represented in the CoC, which now includes more than 100 members representing more than 50 national, professional organizations. These organizations represent members of the cancer care team and work to improve the lives of patients with cancer. The complete listing of CoC member organizations can be found on the Commission on Cancer page of the American College of Surgeons website, *facs.org*.

The multidisciplinary Commission on Cancer:

- Establishes recommended standards designed to support high-quality, multidisciplinary, and comprehensive cancer care
- Conducts site visits at cancer programs to assess compliance with those standards
- Collects standardized high-quality data from CoC-accredited organizations
- Uses data to measure cancer care quality and to monitor treatment patterns and outcomes
- Develops educational interventions to improve cancer prevention, early detection, cancer care delivery, and outcomes in health care settings

The CoC Accreditation Program

There are approximately 1,500 CoC-accredited cancer programs in the U.S. and Puerto Rico. CoC accreditation encourages hospitals, treatment centers, and other facilities to improve their quality of care through various cancer-related programs and activities. These programs are concerned with the full continuum of cancer— from prevention to survivorship and end-of-life care—while addressing both survival and quality of life.

CoC accreditation is granted to facilities that are committed to providing the best in cancer care and demonstrate compliance with the CoC standards. Each cancer program must undergo a rigorous evaluation and review of its performance and compliance with the CoC standards. To maintain accreditation, cancer programs must undergo an on-site review every three years. The standards facilitate each cancer program seeking accreditation to provide all patients with a full range of diagnostic, treatment, and supportive services either on-site at the facility or by referral to another location, including community-based resources.

Value of CoC Accreditation

CoC accreditation provides real value to cancer programs. Programs can proudly demonstrate to their communities, providers, payors, and the government that they have invested in systems aimed toward cancer patients receiving high-quality, coordinated care, and that they have made the efforts for supportive services and resources addressing the full continuum of care are available in their communities.

CoC accreditation includes data reporting to, and feedback from, the National Cancer Database (NCDB) to assess hospital performance using nationally recognized quality of cancer care measures. These data systems allow hospitals to compare their quality of care, identify variations, and implement improvements to demonstrate the high quality of care that they provide and their commitment to continuous quality improvement. CoC accreditation provides your cancer program with an infrastructure and data that informs care. It also gives your team opportunities for leadership development, team building, and programmatic development.

Accreditation Process

Processes for accreditation are detailed and updated on the Commission on Cancer (CoC) website. The CoC reserves the right to revise accreditation processes as needed.

Categories of Cancer Programs

Category designations are made at the time of initial application and are retained unless there are changes to the services provided and/or the facility caseload for three consecutive years. Descriptions and definitions for the following cancer program categories can be found on the CoC website.

- Academic Comprehensive Cancer Program (ACAD)
- Community Cancer Program (CCP)
- Comprehensive Community Cancer Program (CCCP)
- Free Standing Cancer Center Program (FCCP)
- Hospital Associate Cancer Program (HACP)
- Integrated Network Cancer Program (INCP)
- NCI-Designated Comprehensive Cancer Center Program (NCIP)
- NCI-Designated Network Cancer Program (NCIN)
- Pediatric Cancer Program (PCP)
- Veterans Affairs Cancer Program (VACP)

Cancer Program Standards Rating System and Accreditation Awards

Ratings for each standard are assigned based on consensus by the cancer program's site reviewer and CoC staff.

When required, the applicable executive review group will also contribute to the standard rating decision as a final adjudicator.

Accreditation Awards

A "Compliant," "Noncompliant," or "Not Applicable" rating is assigned for each standard. Any standard with a "Noncompliant" rating is a "deficiency."

Accreditation Status	Definition
Accredited	Awarded when the program has completed a site visit and demonstrated full compliance with all applicable standards and has provided all required documentation to support compliance: • Program appears on Find an Accredited Program website • Certificate of accreditation awarded
Accredited-Corrective Action Required ***Renewal Programs Only***	Awarded when a renewal program receives a noncompliant rating on at least one standard but less than 20% of standards rated during the site visit process: • Program appears on Find an Accredited Program website • Program has one year to resolve noncompliant standards • Program receives a certificate once all standards have been resolved and "Accredited" status has been achieved
Not Accredited-Corrective Action Required ***Initial Applicants Only***	Awarded when a new program, including new Integrated Network Cancer Programs or NCI Networks consisting of currently accredited programs, receives a noncompliant rating on four or fewer standards during the site visit process: • Program does not appear on Find an Accredited Program website • Program has one year to resolve noncompliant standards • Program does not have access to the National Cancer Database (NCDB) until accreditation is achieved
Not Accredited	Awarded when a renewal program receives a noncompliant rating on more than 20% of standards rated during the site visit process, when an initial applicant receives five or more noncompliant standards, or a program does not resolve non-compliant standards within established timeframe: • Program does not have access to the Quality Portal or National Cancer Database tools • Program does not appear on Find an Accredited Program website • Program may re-apply as an initial applicant program after one calendar year of compliance with all applicable standards

Standards Requiring Annual Review

Work to obtain compliance in one Commission on Cancer (CoC) standard may not replace, duplicate, or augment the work required to obtain compliance with another standard. The exceptions to this rule are Standard 6.4: Rapid Cancer Reporting System: Data Submission and Standard 7.3: Quality Improvement Initiative.

The following standards must be reported at the first quarter meeting of the following year. The report must include a full calendar year of reporting data. For example, reports on 2025 activity must include data from all of 2025 and be reported at a meeting in the first quarter of 2026. Reports provided to the cancer committee without a full calendar year of reporting data do not meet the measure of compliance for these standards. The reports must be documented in the cancer committee meeting minutes and include all required elements.

- Standard 2.5: Multidisciplinary Cancer Case Conference
- Standard 4.4: Genetic Counseling and Risk Assessment
- Standard 4.5: Palliative Care Services
- Standard 4.8: Survivorship Program
- Standard 5.2: Psychosocial Distress Screening
- Standard 9.1: Clinical Research Accrual

The following standards require an annual evaluation, but do not necessarily require data review. These standards 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.

- Standard 4.2: Oncology Nursing Credentials
- Standard 4.6: Rehabilitation Care Services
- Standard 4.7: Oncology Nutrition Services
- Standard 8.1: Addressing Barriers to Care

The following standards require annual activities such as audits, projects, reports, or events. They must be conducted and presented to the cancer committee within the calendar year per the frequency required in the standard. The presentation to the cancer committee may be provided at any time during the calendar year after the activity has been completed. These standards cannot be presented in the first quarter of the following calendar year.**

- Standard 2.2: Cancer Liaison Physician*
- Standard 5.1: College of American Pathologists Synoptic Reporting
- Standard 5.3: Sentinel Node Biopsy for Breast Cancer
- Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer
- Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma
- Standard 5.6: Colon Resection
- Standard 5.9: Smoking Cessation for Patients with Cancer
- Standard 6.1: Cancer Registry Quality Control
- Standard 6.4: Rapid Cancer Reporting System: Data Submission*
- Standard 7.1: Quality Measures
- Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines
- Standard 7.3: Quality Improvement Initiative*
- Standard 7.4: Cancer Program Goal*
- Standard 8.2: Cancer Prevention Event
- Standard 8.3: Cancer Screening Event

*Standard requires multiple status updates each calendar year. All updates must be provided within the calendar year or per standard requirements.

**Standards 7.3 and 7.4 activities can be extended into a second year. To be compliant, the intent to do so must be stated during the calendar year the quality improvement or goal was initiated and a final report must be given in the subsequent year after the QI or goal is completed.

The annual review requirements are summarized below:

Standard	Data Required	Review Timeframe
Standard 2.2: Cancer Liaison Physician*	Activity Completed	During the year of activity
Standard 2.5: Multidisciplinary Cancer Case Conference	Full Calendar Year	Q1 of the following year
Standard 4.2: Oncology Nursing Credentials	12 months of Observations	During the year of activity or Q1 following year
Standard 4.4: Genetic Counseling and Risk Assessment	Full Calendar Year	Q1 of the following year
Standard 4.5: Palliative Care Services	Full Calendar Year	Q1 of the following year
Standard 4.6: Rehabilitation Care Services	12 months of Observations	During the year of activity or Q1 following year
Standard 4.7: Oncology Nutrition Services	12 months of Observations	During the year of activity or Q1 following year
Standard 4.8: Survivorship Program	Full Calendar Year	Q1 of the following year
Standard 5.1: CAP Synoptic Reporting	Activity Completed	During the year of activity
Standard 5.2: Psychosocial Distress Screening	Full Calendar Year	Q1 of the following year
Standard 5.3: Sentinel Node Biopsy for Breast Cancer	Activity Completed	During the year of activity
Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer	Activity Completed	During the year of activity
Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma	Activity Completed	During the year of activity
Standard 5.6: Colon Resection	Activity Completed	During the year of activity
Standard 5.9: Smoking Cessation for Patients with Cancer	Activity Completed	During the year of activity
Standard 6.1: Cancer Registry Quality Control	Activity Completed	During the year of activity
Standard 6.4: RCRS: Data Submission*	Activity Completed	During the year of activity
Standard 7.1: Quality Measures	Activity Completed	During the year of activity
Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines	Activity Completed	During the year of activity
Standard 7.3: Quality Improvement Initiative*	Activity Completed	During the year of activity
Standard 7.4: Cancer Program Goal*	Activity Completed	During the year of activity
Standard 8.1: Addressing Barriers to Care	12 months of Observations	During the reporting year or Q1 following year
Standard 8.2: Cancer Prevention Event	Activity Completed	During the year of activity
Standard 8.3: Cancer Screening Event	Activity Completed	During the year of activity
Standard 9.1: Clinical Research Accrual	Full Calendar Year	Q1 of the following year

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1 Institutional Administrative Commitment

Rationale

Institutional commitment is essential for the development and success of an accredited Commission on Cancer program. Resource allocation (such as equipment, personnel, and administrative support), a commitment to patient safety, and an enduring focus on continuous quality improvement are the hallmarks of strong institutional administrative support that help facilitate the success.

1.1 Administrative Commitment

Definition and Requirements

Programs provide a letter of authority from facility leadership (CEO or equivalent) demonstrating the commitment to the cancer committee, which includes, but is not limited to:

- A high-level description of the cancer program
- Any initiatives involving the cancer committee during the accreditation cycle that were initiated for the purposes of ensuring quality and safety
- Facility leadership's involvement in the cancer committee
- Examples of current and future initiatives promoting equitable and inclusive healthcare practices and a culture of safety for providers and patients
- Examples of current and future financial investment in the cancer program

Documentation

Submitted with Pre-Review Questionnaire

- Letter of authority from facility leadership that includes all required elements

Measure of Compliance

Once each accreditation cycle, the cancer program fulfills the compliance criteria:

1. Cancer committee authority is established and documented by the facility through a letter from facility leadership that includes all required elements.

Bibliography

Hoyt DB, Ko CY. *Optimal Resources for Surgical Quality and Safety.* Chicago, IL: American College of Surgeons; 2017.

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2 Program Scope and Governance

Rationale

The cancer program and its medical staff provide the structure, process, and personnel to obtain and maintain the Commission on Cancer's standards. This includes the committee and leadership who provide cohesion in the structure of the program. The administrative, supportive care, and medical staff must commit to broad cooperation in order to improve the quality of care at the cancer program.

2.1 Cancer Committee

Definition and Requirements

The care of patients with cancer requires a multidisciplinary approach and encompasses physician and non-physician professionals. The committee responsible for program leadership is multidisciplinary and represents the full scope of cancer care and services.

Required cancer committee members include at least one physician representing each of the diagnostic and treatment services, coordinators, and representatives from administrative, clinical, and supportive services. Each program assesses the scope of services offered and determines the need for additional cancer committee members based on the major cancer sites seen by the program.

Appointments for required members must occur at the first meeting of a calendar year at least once during the accreditation cycle. The appointments are documented in the cancer committee minutes. If a required member cannot continue to serve on the cancer committee, a new member must be appointed at the next cancer committee meeting and documented in the minutes.

Required physician members:

- Cancer Committee Chair
  Physician of any specialty, selected according to facility rules and/or bylaws; can also represent one of the required physician specialties
- Cancer Liaison Physician (CLP)
  Can also represent one of the required physician specialties and/or the Quality Improvement Coordinator; the CLP serves as the Cancer Committee Chair's alternate
- Diagnostic radiologist
- Pathologist
- Surgeon
  Can be either a general surgeon involved in cancer care or a surgical specialist involved in cancer care
- Medical oncologist
- Radiation oncologist
  If all radiation oncology services are provided by referral and the facility's medical staff does not include a radiation oncologist, a radiation oncologist is recommended to be part of the committee but not required

Required non-physician members:

- Cancer Program Administrator
  Responsible for the administrative oversight and has budget authority for the cancer program
- Oncology nurse
- Social worker (licensed social worker, OSW-C preferred)
- Oncology Data Specialist (ODS)

Required coordinator members:

- Cancer Conference Coordinator
  Responsible for overseeing Standard 2.5: Multidisciplinary Cancer Case Conference
- Quality Improvement Coordinator
  Responsible for overseeing Standard 7.3: Quality Improvement Initiative
- Cancer Registry Quality Coordinator
  Responsible for overseeing Standard 6.1: Cancer Registry Quality Control and Standard 4.3: Cancer Registry Staff Credentials
- Clinical Research Coordinator
  Responsible for overseeing Standard 9.1: Clinical Research Accrual; a clinical trial principal investigator, a research data manager or associate, a clinical research nurse, an oncology nurse, or other similar role with clinical research experience is selected to fill this role
- Psychosocial Services Coordinator
  Responsible for overseeing Standard 5.2: Psychosocial Distress Screening; an oncology social worker [OSW-C preferred], advanced practice nurse, clinical psychologist, or other mental health professional trained in the psychosocial aspects of cancer care is selected to fill this role
- Survivorship Program Coordinator
  Responsible for overseeing Standard 4.8: Survivorship Program; a physician, physician assistant, advanced practice nurse, nurse, social worker [OSW-C preferred], nurse navigator, or therapist or other licensed health care professional is selected to fill this role

One individual may serve in a maximum of two coordinator roles and represent one of the required physician or non-physician specialties. For example, the appointed medical oncologist can serve as the Clinical Research Coordinator and Survivorship Program Coordinator.

An Oncology Data Specialist (ODS) may only serve as the Cancer Conference Coordinator and/or the Cancer Registry Quality Coordinator.

Cancer committee members strongly recommended, but not required, include:

- Specialty physicians representing the five major cancer sites at the program
- Palliative care professional
- Genetics professional
- Registered Dietitian Nutritionist
- Rehabilitation services professional
- Pharmacist
- Spiritual care representative
- American Cancer Society representative

Documentation

Submitted with Pre-Review Questionnaire

- Cancer Committee Template
- Cancer committee minutes that identify the required cancer committee members

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The membership of the cancer committee includes all required specialties and coordinators.
2. Committee membership including all required roles is documented in the cancer committee minutes at the first meeting of the calendar year at least once each accreditation cycle.

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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 at a minimum of two meetings each calendar year. The CLP presentations to the cancer committee may occur at any time during the calendar year. CLPs are given access to NCDB reporting tools that include survival reports, benchmarking, and other cancer program performance reports. Data from the NCDB must be used as the basis of the reports. Focus is given to areas of concern or where expected performance is not being met. Reports must be given by the CLP or the CLP's alternate.

Documentation of the data presented and the details of the discussion with the cancer committee must be included in the cancer committee minutes or as an attachment to the cancer committee minutes. CLP reports do not substitute for and cannot duplicate requirements from other standards. For example, the CLP reports required by this standard cannot also satisfy the requirements for Standard 6.4: Rapid Cancer Reporting System: Data Submission.

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.

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, with preference for areas of concern and/or where benchmarks are not met, to the cancer committee at a minimum of two meetings each calendar year.
2. The CLP is present during the CoC site visit and meets with the site reviewer to discuss CLP activities and responsibilities.

Bibliography

Hoyt DB, Ko, CY. *Optimal Resources for Surgical Quality and Safety.* Chicago, IL: American College of Surgeons; 2017.

2.3 Cancer Committee Meetings

Definition and Requirements

Regular cancer committee meetings assist with ensuring that administrative responsibilities related to cancer program functions are carried out and standard compliance is met. Each calendar year, the cancer committee meets at least once each calendar quarter. Cancer committees may choose to hold meetings more frequently in order to meet overall program needs.

Yearly calendar quarters are defined as:
- January 1–March 31
- April 1–June 30
- July 1–September 30
- October 1–December 31

It is recommended that meetings be scheduled in the first month of each quarter to allow for rescheduling if needed. It is the cancer committee's responsibility to schedule and reschedule meetings, as appropriate, for each quarter. Compliance is based on meetings held quarterly and not on the total number of meetings held each year. The triennial CoC site visit does not qualify as a meeting to comply with this standard.

Cancer committee minutes must contain sufficient details to accurately reflect the activities of the cancer committee as well as demonstrate compliance with CoC standards.

In addition to the cancer committee, programs may choose to establish optional subcommittees or workgroups to manage specific activities. If subcommittees and/or workgroups are utilized, activities and reports related to standard compliance must be presented to and approved by the cancer committee.

Examples of optional subcommittees or workgroups include:
- Clinical and translational research activity
- Screening and prevention activity
- Quality control of cancer registry data
- Quality management and improvement activity
- Health equity activity
- Review of protocols

Documentation

Submitted with Pre-Review Questionnaire
- Cancer Committee Template
- Cancer committee minutes that document the committee's quarterly meetings and activities

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. The cancer committee meets at least once each calendar quarter.

Bibliography

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2.4 Cancer Committee Attendance

Definition and Requirements

To successfully complete responsibilities and guide multidisciplinary input, it is imperative that all required members regularly attend and participate in cancer committee meetings.

Each required cancer committee member or the member's designated alternate attends at least 75 percent of the cancer committee meetings held each calendar year. The cancer committee monitors the attendance of required members. It is recommended that the cancer committee also monitor attendance of non-required members.

Members subject to attendance requirements include the specialists and coordinators defined as "required members" in Standard 2.1: Cancer Committee.

Appointing Alternates
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.

The designated alternate must be qualified and appropriately credentialed to serve as an alternate for the role (for example, alternate to a medical oncologist must be another medical oncologist). An individual can only serve as an alternate for one individual.

The identification of designated alternates must take place at the first meeting of the calendar year at least once during the accreditation cycle. This information is documented in the cancer committee minutes. If a required member or alternate cannot continue to serve on the cancer committee, a new member or alternate must be appointed at the next cancer committee meeting and documented in the minutes.

The attendance percentage is calculated based on the attendance of the required role. In other words, the required member plus his or her designated alternate's attendance is considered together.

Remote Attendance
Attendance at cancer committee meetings may include participation through teleconference or videoconference calls as long as the remote attendee has access to appropriate meeting documents.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer Committee Template
- Cancer committee minutes that include the required member attendance for each cancer committee meeting held during each calendar year

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. Each required member or the designated alternate attends at least 75 percent of the cancer committee meetings held.

2.5 Multidisciplinary Cancer Case Conference

Definition and Requirements

Cancer outcomes are better when patients are managed according to the principles of multidisciplinary team evaluation. This process is associated with improved clinical decision making, clinical outcomes, and patient experience.

The cancer program holds multidisciplinary cancer case conference(s) to evaluate patient management. Each calendar year, the Cancer Conference Coordinator monitors and evaluates the multidisciplinary cancer case conference activity and reports the findings to the cancer committee.

Cancer Case Conference Protocol
Cancer programs have a protocol to govern multidisciplinary cancer case conference activity. The protocol must, at a minimum, address:

- Multidisciplinary participation
- Frequency and format of cancer case conference(s)
- Elements of discussion, including the requirement to discuss for each case: clinical and/or pathological stage, treatment planning using evidence-based guidelines, and where applicable, options and availability for genetic testing, clinical research studies, and supportive care services
- Number of cases presented and percentage of prospective cases presented
- Methods to address areas that fall below the levels established in the protocol

Format and Cases Presented
Programs evaluate the need for a general cancer case conference and any specialty- or site-specific conferences. Programs may either:

- Hold a general multidisciplinary cancer case conference
  - Specialty- or site-specific conferences may be held in addition to the general cancer case conference
- Hold specialty- or site-specific multidisciplinary cancer case conferences as long as there is a mechanism to present cases for evaluation at a multidisciplinary cancer case conference that do not fit into the defined specialty or site-specific conferences

The frequency of multidisciplinary cancer case conference is determined by the cancer program and is included in the protocol.

Each year, the cancer program must present a minimum of 15 percent of the annual analytic caseload to a multidisciplinary cancer case conference. Of those presented, a minimum of 80 percent must be prospective presentations. Prospective cases include, but are not limited to:

- Newly diagnosed and treatment not yet initiated or treatment initiated and discussion of additional treatment is needed
- Previously diagnosed, initial treatment completed, and discussion of adjuvant treatment or treatment for recurrence or progression is needed
- Previously diagnosed and discussion of supportive or palliative care is needed

The same case may be discussed more than once and counted each time as a prospective presentation as long as treatment management issues are discussed.

Multidisciplinary Participation
Multidisciplinary physician attendance at a general cancer case conference must include a representative from surgery, pathology, radiology, radiation oncology, and medical oncology. Programs may define the specialties required for specialty- or site-specific cancer case conferences.

Additional physician or non-physician specialists recommended for attendance are: genetic professionals, clinical research professionals, palliative care providers, psychosocial providers, rehabilitation providers, and supportive services.

Cancer Conference Coordinator Report
The Cancer Conference Coordinator must present an annual report to the cancer committee. The annual report is presented during the first quarter meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the cancer committee meeting minutes.

The Cancer Conference Coordinator's report must include the following elements:

- Cancer case conference frequency
- Multidisciplinary physician specialty attendance depending on the defined requirements in the cancer case conference protocol
- Number of cases presented and percentage of prospective cases

- Elements of the discussion for each case, including, but not limited to, whether the following were discussed:
  - Clinical and/or pathological stage
  - Treatment planning using evidence-based national guidelines
  - Options and eligibility for genetic testing (where applicable)
  - Options and eligibility for clinical research studies (where applicable)
  - Options and eligibility for supportive care services (where applicable)
- An action plan to resolve any areas that do not meet the requirements of the program's protocol

The method to document multidisciplinary cancer case conference activity is left to the discretion of the cancer committee.

Documentation

Reviewed On-Site

- The site reviewer will attend a multidisciplinary cancer case conference.

Submitted with Pre-Review Questionnaire

- The multidisciplinary cancer case conference protocol
- Multidisciplinary Cancer Case Conference Template
- The Cancer Conference Coordinator's report
- Cancer committee meeting minutes documenting the Cancer Conference Coordinator's report

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 all of the compliance criteria:

1. The cancer program has a protocol for multidisciplinary cancer case conference(s) that includes all required information.
2. The Cancer Conference Coordinator monitors and evaluates the multidisciplinary cancer case conference(s) and presents the Cancer Conference Coordinator's report to the cancer committee The Cancer Conference Coordinator's report contains all required elements as outlined and is documented in the cancer committee meeting minutes. The Cancer Conference Coordinator's report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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3 Facilities and Equipment Resources

Rationale

The cancer program must maintain or provide by referral appropriate facilities and equipment for the care of cancer patients. This includes all equipment required to adequately care for the patient through the phases of care.

3.1 Facility Accreditation

Definition and Requirements

If required by state law, the facility must be licensed by the appropriate state licensing authority. If state licensure is not required, the facility is accredited or licensed by a recognized federal, state, or local authority appropriate to facility type.

Documentation

Submitted with Pre-Review Questionnaire

- Health care facility accreditation or licensure certificate or documentation

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The facility is accredited or licensed by a recognized federal, state, or local authority appropriate to the facility type.

3.2 Evaluation and Treatment Services

Definition and Requirements

The program provides diagnostic imaging services, radiation oncology services, and systemic therapy services on-site or by referral.

Quality assurance practices are in place for diagnostic imaging services, radiation oncology services, and systemic therapy services available on-site. Quality assurance is demonstrated by accreditation and/or protocols following recognized guidelines.

Accrediting organizations include, but are not limited to:
- American College of Radiology (ACR)
- American Society for Radiation Oncology (ASTRO)
- American College of Radiation Oncology (ACRO)

Applicable guidelines include, but are not limited to:
- Oncology Nursing Society (ONS)
- American Society for Clinical Oncology (ASCO)
- American Society of Health-System Pharmacists (ASHP)
- The United States Pharmacopeia (USP)
- National Comprehensive Cancer Network (NCCN)

The program must also document accreditation for anatomic pathology from one of the following organizations:
- College of American Pathologists (CAP)
- American Association for Laboratory Accreditation (A2LA)
- Accreditation Commission for Health Care (ACHC)
- The Joint Commission (TJC)
- COLA Laboratory Accreditation

Programs located in New York State (NY), or Washington State (WA), may provide documentation of clinical laboratory quality assurance for anatomic pathology from the New York State Department of Health or the Washington State Department of Health, respectively, in lieu of documentation of anatomic pathology accreditation from one of the organizations listed above.

Documentation

Submitted with Pre-Review Questionnaire
- Certificate(s) of accreditation for diagnostic imaging services, radiation oncology services, and systemic therapy services, and/or protocols covering quality assurance practices for these services
- Certificate of accreditation for anatomic pathology

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:
1. Diagnostic imaging services, radiation oncology services, and systemic therapy services are available on- site or by referral. Quality assurance practices are in place for these services available on-site.
2. Accreditation for anatomic pathology by a qualifying organization.

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4 Personnel and Services Resources

Rationale

Patients with cancer have a multitude of needs. Cancer programs must oversee that patients receive appropriate care by qualified professionals. The facility must maintain optimal resources for the care of patients with cancer.

The responsibility is upon the cancer program to appropriately care for patients and develop criteria relative to the cancer program's available resources and experience.

4.1 Physician Credentials

Definition and Requirements

Cancer patient management is conducted by a multidisciplinary team, including radiologists, pathologists, surgeons, radiation oncologists, and medical oncologists. All physicians involved in the evaluation and management of cancer patients must:

- Be American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board certified (or the equivalent), or
- Demonstrate ongoing cancer-related education by earning 12 cancer-related Continuing Medical Education (CME) hours each calendar year

Scope of Standard

This standard applies to physicians who are involved in the evaluation and management of cancer patients at the accredited facility for at least one calendar year. This standard does not apply to physicians who are in fellowship or residency or physicians within the five years immediately following graduation from fellowship or residency.

Documentation

Submitted with Pre-Review Questionnaire

- Physician Certification Credentials Template
- Documentation of 12 annual cancer-related CME hours for all physicians who are not board certified and are involved in the evaluation and management of cancer patients

Measure of Compliance

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

1. All physicians involved in the evaluation and management of cancer patients must be board certified (or the equivalent).
2. Physicians who are not board certified must demonstrate ongoing cancer-related education by earning 12 cancer-related CME hours.

IMPLEMENTATION DATE: JANUARY 1, 2026

4.2 Oncology Nursing Credentials

Definition and Requirements

Oncology nursing care is delivered by nurses with specialized knowledge and skills in providing care for patients with cancer.

The cancer program must demonstrate compliance with this standard by assessing oncology nursing continuing education and oncology nursing competency for all nurses providing direct oncology care. This is demonstrated through:

- Meeting one of the following:
  - Confirmation of current cancer-specific nursing certification in the nurse's specialty through an accredited certification program
  - Completion of 18 Nursing Continuing Professional Development (NCPD) contact hours each accreditation cycle. The required NCPD contact hours must be relevant to oncology nursing care.

AND

- Completion of oncology nursing competency assessment in the nurse's specialty administered by the CoC-accredited facility each calendar year

Oncology Nursing Protocol

The cancer program must develop and implement a protocol to review and assess oncology nursing continuing education and oncology nursing competency. The protocol must address the following:

- A process for identifying oncology nurses required to hold cancer-specific certification or complete cancer-specific continuing education
- A process for annual assessment of oncology nursing competency for all oncology nurses, including:
  - Methods of assessment for oncology nursing competency and practice skills (e.g., testing, return demonstration, simulation)
  - Competency assessment(s) relevant to oncology nursing specialties and areas of practice
  - Time intervals for competency assessment, including:
    - Required annual assessment
    - Additional assessment intervals (e.g., at initial hire or at the time of transfer to an oncology nursing unit)
- A process for confirming nursing compliance with the protocol, including:
  - A management plan for nurses who do not satisfactorily hold certification or complete continuing education
  - A management plan for nurses who do not satisfactorily complete oncology nursing competency assessment
- A timeline for newly hired or newly onboarded oncology nurses to meet compliance with this protocol, which is no later than one calendar year from the nurse's onboarding to an oncology care position

Oncology Nursing Certifications

Oncology nursing certifications that qualify for this standard include but are not limited to:

- Advanced Oncology Certified Nurse Practitioner (AOCNP®)
- Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
- Advanced Oncology Certified Nurse (AOCN®)
- Blood & Marrow Transplant Certified Nurse (BMTCN®)
- Breast Health Clinical Navigator (BHCN™)
- Certified Pediatric Hematology Oncology Nurse (CPHON®)
- Certified Pediatric Oncology Nurse (CPON®)
- Certified Breast Care Nurse (CBCN®)
- Certified Registered Nurse Infusion (CRNI®)
- Oncology Certified Nurse (OCN®)
- Oncology Nurse Navigator-Certified Generalist℠ (ONN-CG℠)

A certification qualifies under this standard if it is accredited for nursing education and includes cancer-specific criteria. For example, a palliative care certification meets the certification expectations under this standard if it contains cancer-specific criteria.

Reviewing Oncology Nursing Protocol and Competency Assessment

Each accreditation cycle, the cancer committee must review the facility's oncology nursing competency assessment program and its protocol for oncology nursing competency. The content of the review and any recommendations for improvement are documented in the cancer committee meeting minutes.

Each calendar year, the cancer committee must evaluate the facility's current compliance with assessing oncology nursing continuing education and oncology nursing competency. 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.

This evaluation must include the following:

- Total number of oncology nurses required to hold cancer-specific certification or complete cancer-specific continuing education
- Number of oncology nurses who hold cancer-specific certification

- Number of oncology nurses who are not in compliance with the oncology nursing protocol

If the cancer program is not meeting the requirements of its protocol and/or this standard, an action plan must be developed and implemented to improve performance. The action plan must document how the cancer program will investigate and resolve all barriers affecting compliance.

Scope of Standard

This standard applies to all nurses and advanced practice nurses who provide direct oncology care within the CoC-accredited facility. Specifically:

- Nurses in medical oncology
- Nurses who give antineoplastic treatments
- Nurses in radiation oncology
- Clinical trials nurses, nurse navigators, nurses assigned to inpatient units or physician offices that are dedicated or designated to the care of patients with cancer
- Nurses in the cancer center or cancer clinic within the accredited facility

This standard does not apply to:

- Nurses within the CoC-accredited facility who might have occasional contact with patients with cancer
- Operating room or recovery room nurses
- Nurses working in a private practice office
- Nurses who are not employed by the CoC-accredited facility

Documentation

Reviewed On-Site

- The site reviewer will review the facility's documentation confirming oncology nursing continuing education and oncology nursing competency for two pre-selected nurses from the nursing rosters.

Submitted with Pre-Review Questionnaire

- Roster(s) of oncology nurses in each required unit or designated area of the facility
- Oncology nursing protocol
- Cancer committee meeting minutes documenting required cancer committee reviews, including any required action plans

Measure of Compliance

Each accreditation cycle, the program fulfills the compliance criteria:

1. An oncology nursing protocol is in place that includes all required elements.
2. The cancer committee reviews the facility's oncology nursing competency assessment program and the oncology nursing protocol. The review is documented in the meeting minutes.

Each calendar year, the program fulfills the compliance criteria:

1. The facility's current compliance with assessing oncology nursing continuing education and oncology nursing competency is reviewed. The evaluation is presented to the cancer committee. If the requirements of the protocol and/or this standard are not met, an action plan is developed and implemented to improve performance. The review and any required action plans are documented in the meeting minutes. The evaluation meets the requirements outlined on page vii under "Standards Requiring Annual Review."

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4.3 Cancer Registry Staff Credentials

Definition and Requirements

Case abstracting is performed by an Oncology Data Specialist (ODS). Each calendar year, non-ODS members of the cancer registry staff demonstrate completion of cancer-related continuing education applicable to their roles.

ODSs apply knowledge obtained from formal education and work experience to correctly interpret and code cancer diagnosis, stage, treatment, and outcomes information for each case that is seen at the Commission on Cancer (CoC)-accredited program that meets CoC reporting requirements. The ODS credential is granted and overseen by the National Cancer Registrars Association.

All cancer registry staff who abstract cases at a CoC-accredited program must either:

- Hold a current Oncology Data Specialist (ODS) credential, or
- Perform case abstracting under the supervision of an ODS.

These requirements apply to those employed by the program, working on a contract basis, and/or working through a registry service company.

It is encouraged that ODSs attend in-person education at a state, regional, or national level.

Non-Credentialed Registry Staff
A plan for ODS supervision of non-credentialed staff performing abstracting must be established and include the scope of supervision, quality control, education, and training activities for non-credentialed staff.

Any non-ODS hired to perform abstracting under the supervision of an ODS in a CoC-accredited program must pass the ODS examination within three years of the date hired to perform abstracting. If the ODS credential is not successfully obtained within the three-year grace period, then the person may not perform case abstracting at any CoC-accredited program until the credential is obtained.

Non-credentialed cancer registry staff may perform case finding and follow-up, but cannot perform any abstracting on analytic cases unless they are performed under the supervision of an ODS per the documented plan.

Continuing Education Requirements
Each calendar year, members of the cancer registry staff who do not hold an ODS credential must demonstrate completion of three hours of cancer-related continuing education applicable to their roles.

This continuing education requirement applies to all non-credentialed registry staff, including staff abstracting under the supervision of an ODS, staff performing follow-up activities, and registry management or supervisory personnel.

This education includes, but is not limited to, topics in the following areas:

- Advances in cancer diagnosis and treatment
- Changes in cancer program standards
- Changes in data collection requirements

Scope of Standard
The requirement to provide documentation of an ODS's credential and continuing education requirements for a non-ODS apply to those who work in the accredited facility for at least one calendar year.

Documentation

Reviewed On-Site

- When applicable, verification of the date of hire for staff to perform case abstracting in the cancer registry

Submitted with Pre-Review Questionnaire

- Cancer Registry Staff Credentials Template
- Plan for ODS supervision of non-credentialed staff who perform case abstracting in the cancer registry
- Documentation of cancer-related continuing education for non-credentialed members of the cancer registry staff

Measure of Compliance

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

1. Case abstracting is performed by an Oncology Data Specialist.
2. Non-credentialed cancer registry staff in the three-year grace period who abstract cases are supervised by an Oncology Data Specialist.
3. All non-credentialed cancer registry staff demonstrate completion of three hours of cancer-related continuing education applicable to their roles.

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4.4 Genetic Counseling and Risk Assessment

Definition and Requirements

Cancer risk assessment and genetic counseling are the processes to identify and counsel people at risk for familial or hereditary cancer syndromes. Purposes of cancer genetic counseling are to: educate patients about their chance of developing cancer, help patients obtain personal meaning from genetic information, and empower patients to make educated, informed decisions about genetic testing, cancer screening, and cancer prevention.

Protocol for Genetic Counseling and Risk Assessment Services
Cancer programs must develop a protocol for providing cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral. Genetic services not provided on-site at the facility must be provided through a referral relationship to other facilities and/or local agencies. The protocol must include information/processes for the following:

- Criteria for referral for a genetics evaluation
- Identification of the genetics professionals available on-site and/or by referral
- Identification of the genetics professionals qualified to perform post-test counseling either on-site and/or by referral

Cancer risk assessment and genetic counseling are performed by a genetics professional with an educational background in cancer genetics and hereditary cancer syndromes. Specialized training in cancer genetics is required. Educational seminars offered by commercial laboratories about how to perform genetic testing are not considered adequate training.

Genetics professionals may include:

- An individual board-certified/board-eligible by American Board of Genetic Counseling (ABGC)
- An individual board-certified/board-eligible by American Board of Medical Genetics and Genomics (ABMGG)
- An individual with an Advanced Genetics Nursing Certification (AGN-BC) from the American Nurses Credentialing Center (ANCC)
- An individual with Advanced Clinical Genomics Nurse (ACGN) credential from the Nurse Portfolio Credentialing Commission (NPCC)
- An individual with Clinical Genomics Nurse (CGN) certification from the Nurse Portfolio Credentialing Commission (NPCC)
- Completion of City of Hope Intensive Course in Genomic Cancer Risk Assessment
- A qualified, licensed, health care professional with Cancer Genetic Risk Assessment (CGRA) certification from the National Consortium of Breast Centers (NCBC)
- A qualified, licensed, health care professional with Advanced Oncology Certified Nurse Practitioner (AOCNP) credentials, or equivalent certification from the Oncology Nursing Certification Corporation (ONCC)
- A board-certified/board-eligible physician with experience in cancer genetics (defined as providing cancer risk assessment on a regular basis and demonstrating completion of two hours of continuing medical education in cancer genetics and hereditary cancer predisposition syndromes each calendar year)

Programs should consider conflict of interest when choosing professionals to provide cancer risk assessment and genetic counseling.

Monitoring Genetic Assessment for a Selected Cancer Site
While it is expected that programs provide genetics assessment for all relevant cancers on an on-going basis, each calendar year programs must identify a process pursuant to evidence-based national guidelines for genetic assessment for a specific cancer site. Some examples include, but are not limited to: colon, breast, ovarian, endometrial, pancreatic, and prostate. The process must address identifying individuals for whom further genetic risk evaluation for the selected cancer site is indicated and making appropriate referrals for genetic evaluation/counseling to see if genetic testing is indicated.

Programs may repeat the same site year to year, but it is encouraged that the program evaluate different sites over time.

Evaluating Genetic Counseling and Risk Assessment Services
Each calendar year, the cancer committee must review the protocol for genetic assessment and referral for genetic evaluation/counseling.

The cancer committee must document an annual report on genetic counseling and risk assessment. The annual report is presented during the first quarter meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the cancer committee meeting minutes.

The genetic counseling and risk assessment report must include the following elements:

- The number of patients identified as needing referrals for the selected cancer site each year, and
- How many patients identified as needing referrals for the selected cancer site received a referral for genetic counseling
  - It is encouraged, but not required, that programs track whether patients who received referrals ultimately had genetic counseling

If available, it is recommended that a genetics professional attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Protocol for providing cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral that includes all required elements
- Cancer committee meeting minutes that document the required annual report of the genetic counseling and risk assessment services.

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 all of the compliance criteria:

1. Cancer risk assessment, genetic counseling, and genetic testing services are provided to patients either on-site or by referral by a qualified genetics professional.
2. A protocol is in place regarding genetic counseling and risk-assessment services and includes all required elements.
3. A process is in place pursuant to evidence-based national guidelines for genetic assessment for a selected cancer site. The process includes all required elements.
4. The annual report on genetic counseling and risk assessment contains all required elements as outlined and is documented in the cancer committee meeting minutes. The genetic counseling and risk assessment annual report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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4.5 Palliative Care Services

Definition and Requirements

Palliative care services are available to cancer patients and their family members or caregivers either on-site or by referral and are evaluated at least once each calendar year.

Palliative care refers to patient- and family-centered care that optimizes quality of life. The availability of palliative care services is an essential component of cancer care, beginning at the time of diagnosis and being continuously available throughout treatment and surveillance and, when applicable, during bereavement.

Palliative care is provided per evidence-based national treatment guidelines and includes palliative care provided by oncology teams and, as needed, consultation with palliative care specialists. It is recommended that the following specialties participate in providing palliative care services: physicians, advanced practice providers, nurses, mental health professionals, social workers, and spiritual counselors.

Palliative care is integrated in the continuum of cancer care. Types of palliative care services include, but are not limited to:

- Team-based care planning that involves the patient and family
- Cultural competency and individualized shared decision making
- Pain and non-pain symptom management
- Communication among patients, families, and provider team members
- Education about illness and prognosis
- Assistance with medical decision making
- Continuity of care across a range of clinical settings and services
- Attention to spiritual needs
- Psychosocial support for patients and families
- Bereavement support for families and care team members

Palliative care services on-site will vary depending on the scope of the program, local staff expertise, and patient population. The cancer committee will define and identify in a protocol the following:

- On-site and off-site palliative care services
- The palliative care team available on-site
- Criteria for referral to a palliative care specialist

Palliative care services not provided on-site at the facility must be provided through a referral relationship to other facilities and/or local agencies.

Evaluating Palliative Care Services

Each calendar year, the cancer committee monitors, evaluates, and makes recommendations for improvements to palliative care services.

The cancer committee must document an annual report on palliative care services. The annual report is presented during the first quarter meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the cancer committee meeting minutes.

The palliative care services report must include the following elements:

- Assessment of the approximate number of cancer patients referred for palliative care services and for what services or resources
- Discussion of the criteria utilized to trigger referrals to palliative care services
- Discussion of areas of improvement
  - Examples include, but are not limited to, barriers to access of palliative care services, addition of palliative care services, decreasing emergency department usage, or improving the timeliness of referrals

If available, it is recommended that a palliative care professional attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Protocol for providing palliative care services on-site or by referral
- Cancer committee meeting minutes that document the required annual report of palliative care services.

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 all of the compliance criteria:

1. Palliative care services are available to cancer patients either on-site or by referral.
2. A protocol is in place regarding palliative care services that includes all required elements.
3. The process for providing and referring palliative care services to cancer patients is monitored and evaluated. The annual report on palliative care services contains all required elements as outlined and is documented in the cancer committee meeting minutes. The palliative care services annual report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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4.6 Rehabilitation Care Services

Definition and Requirements

Protocols are in place to guide referral to appropriate rehabilitation care services on-site or by referral. Rehabilitation care is patient-centered care that optimizes patient functional status and quality of life through preventive, restorative, supportive, and palliative interventions. The availability of rehabilitation care services is an essential component of comprehensive cancer care, beginning at the time of diagnosis and being continuously available throughout treatment, surveillance, and, when applicable, through end of life.

Rehabilitation professionals associated with cancer rehabilitation typically include, but are not limited to:

- Physiatrists
- Physical therapists
- Occupational therapists
- Speech language pathologists

Types of rehabilitative care services may include, but are not limited to:

- Screening, diagnosis, and management of physical dysfunction, impairments, and disabilities
- Interventions to manage identified functional impairments and disabilities
- Screening, diagnosis, and management of pain and non-pain symptoms
- Screening, diagnosis, and management of cognitive function
- Lymphedema management
- Physical activity recommendations during and after treatment
- Vocational rehabilitation

The cancer program defines and identifies in a protocol the rehabilitation care services provided on-site and by referral. Rehabilitation services not available at the facility must be provided through a referral relationship to other facilities and/or agencies. The cancer committee will define and identify in a protocol the following:

- On-site and off-site rehabilitation care services
- The rehabilitation care team available on-site
- Criteria for performing functional assessments
- Criteria for referral to a rehabilitation care specialist

Evaluating Rehabilitation Care Services

Each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements, as needed, to rehabilitation care services and/or referrals.

The cancer committee must document the annual evaluation of rehabilitation care 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 that a rehabilitation professional attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Protocol defining rehabilitation services that are provided on-site and by referral
- Cancer committee meeting minutes that document the required yearly evaluations of the rehabilitation care services

Measure of Compliance

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

1. The cancer committee develops protocols to guide referral to appropriate rehabilitation care services on-site or by referral.
2. The process for referring or providing rehabilitation care services to cancer patients is monitored and evaluated by the cancer committee and documented in the cancer committee meeting minutes. The review meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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4.7 Oncology Nutrition Services

Definition and Requirements

Oncology nutrition services are provided, on-site or by referral, by Registered Dietitian Nutritionists (RDN) with knowledge and skills to address nutrition and hydration requirements and recommendations throughout the continuum of cancer care, including prevention, diagnosis, treatment, survivorship, and palliative care.

Multi-modality cancer treatments can impair a cancer patient's ability to consume, digest, and absorb essential nutrition and hydration. RDNs—also known as Registered Dietitians (RDs)—are uniquely trained to address treatment-related symptom management, nutrition support, and quality-of-life concerns through medical nutrition therapy and education. In addition, RDNs are qualified to discuss diet, nutrition, and lifestyle recommendations for survivorship, health promotion, and disease prevention.

The cancer program defines and identifies the nutrition services provided on-site and by referral. Components of oncology nutrition services include, but are not limited to:

- Screening and nutrition assessment for risk and diagnosis of malnutrition, nutrition-related problems, and overweight and obesity
- Medical nutrition therapy
- Nutrition counseling
- Nutrition education
- Management and coordination of enteral and parenteral nutrition

Nutrition services not available at the facility must be provided through a referral relationship to other facilities and/or agencies.

Evaluating Oncology Nutrition Services
Each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements to on-site oncology nutrition and hydration services and/or referral services.

The cancer committee must document the annual evaluation of oncology nutrition 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 that a RDN attend the cancer committee meeting to lead the discussion and provide the report.

Documentation

Submitted with Pre-Review Questionnaire

- Protocols for providing oncology nutrition services, on-site or by referral, by a Registered Dietitian Nutritionist
- Cancer committee meeting minutes that document the required annual evaluations of the oncology nutrition services

Measure of Compliance

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

1. Oncology nutrition services are provided, on-site or by referral, by a Registered Dietitian Nutritionist.
2. The process for referring or providing oncology nutrition services to cancer patients is monitored and evaluated by the cancer committee and documented in the cancer committee meeting minutes. The evaluation meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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4.8 Survivorship Program

Definition and Requirements

The cancer committee oversees the development and implementation of a survivorship program directed at meeting the needs of cancer patients treated with curative intent.

Survivorship Program Team
The cancer committee appoints a Survivorship Program Coordinator per the requirements in Standard 2.1: Cancer Committee.

The Survivorship Program Coordinator develops a survivorship program team. Suggested specialties include physicians, advanced practice providers, nurses, social workers, nutritionists, physical therapists, and other allied health professionals.

The survivorship program team determines a list of services and programs, offered on-site or by referral, that address the needs of cancer survivors who have completed their first course of treatment. These services and programs must address the needs of patients who have completed their first course of treatment, but may also be utilized by patients in active treatment.

The survivorship program team formally documents and evaluates a minimum of three survivorship services offered each year. Services evaluated to meet this standard cannot be single events, and must be available to patients throughout the calendar year or at specific intervals during the calendar year. Services may be continued year to year, but it is expected that cancer programs will strive to enhance existing services over time and develop new services.

The Survivorship Program Coordinator must present an annual report on the survivorship program to the cancer committee. The annual report is presented during the first quarter meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the cancer committee meeting minutes and must focus only on those patients who have completed their first course of treatment. The survivorship program report must include the following elements:

- An estimate of the number of cancer patients who have completed their first course of treatment and participated in the three identified services
- Identification of the resources needed to improve the services if barriers were encountered
- The same report utilizing data from patients who have completed first course of treatment cannot be used to meet the requirements of more than one standard. For example, a report satisfying the required review of Standard 4.7: Oncology Nutrition Services cannot also be used to meet the requirements of this standard.

Survivorship Program Services
Services utilized by the survivorship program may include, but are not limited to:

- Treatment summaries
- Survivorship care plans
- Screening programs for cancer recurrence
- Screening for new cancers
- Seminars for survivors
- Rehabilitation services
- Nutritional services
- Psychological support & psychiatric services
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling
- Financial support services
- Physical activity programs

Survivorship Care Plans (SCP)
The CoC recommends and encourages that patients receive a survivorship care plan (SCP), but delivery of such plans is not a required component of this standard. Delivery of SCPs may be utilized as one of the services offered to survivors to meet the requirements of this standard. If so, then the program defines the population to receive care plans.

Documentation

Submitted with Pre-Review Questionnaire

- Protocol defining the survivorship program requirements
- Cancer committee meeting minutes that document the required annual report of the survivorship program

Measure of Compliance

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

1. The cancer committee identifies a survivorship program team, including its designated coordinator and members.

2. The survivorship program is monitored and evaluated. The Survivorship Program Coordinator presents the annual report to the cancer committee. The annual report on survivorship program services contains all required elements as outlined and is documented in the cancer committee meeting minutes. The survivorship program services annual report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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5 Patient Care: Expectations and Protocols

Rationale

Patient care expectations are the backbone of the accreditation program, ranging from the patient's psychosocial well-being, the quality of the cancer surgery, and to the completeness of operative and pathologic reports.

Standards 5.3 through 5.8 were developed from guidelines described in *Operative Standards for Cancer Surgery* (OSCS), a surgical manual that provides recommendations regarding the effective technical conduct of surgical operations and review of the quality of evidence upon which those recommendations are based. Commission on Cancer (CoC) accreditation reaches approximately 70 percent of patients with newly diagnosed cancer each year. Incorporation of the OSCS recommendations as CoC accreditation standards is a step toward improving oncologic outcomes by reducing the variation in the way cancer operations are performed across the United States.

Standards 5.3 through 5.8 apply to all operations conducted with curative intent. Intent should be assigned postoperatively by the operating surgeon on the basis of preoperative evaluation and intraoperative management, and is to be clearly documented in the operative report for any operation covered by these standards. Curative operations generally include complete resection of the primary tumor and nodal evaluation for therapeutic or staging purposes.* Any operation in which a surgeon deliberately deviates from these standards, as may occur in the setting of patient frailty or comorbidity, would not be considered curative.

* Lymphadenectomy is not performed for certain curative operations, such as resection of a thin melanoma.

These standards are intended solely as qualification criteria for CoC accreditation. They do not constitute a standard of care and are not intended to replace the medical judgment of the physician or health care professional in individual circumstances.

5.1 College of American Pathologists Synoptic Reporting

Definition and Requirements

Each calendar year, the cancer program must conduct an internal audit confirming at least ninety percent (90%) of eligible cancer pathology reports are structured using synoptic reporting as defined by the College of American Pathologists (CAP) cancer protocols, including all core data elements within the synoptic format. The internal audit must evaluate a minimum of 20 total surgical resection cases. The selected cases must include at least three different disease sites. The audit must be performed by a clinician. It is recommended, but not required, that the audit be performed by a pathologist. The results of the internal audit, including any required action plans, must be documented in the cancer committee meeting minutes.

The synoptic format is defined as a structured format that includes all of the following:

- All core elements must be reported whether applicable or not, except for those that are defined as "conditional." Elements identified in the Cancer Protocols as "conditional" only need to be reported if applicable.
- All core elements must be reported in a "diagnostic parameter pair" format, in other words, data element followed by its response (answer).
- Each diagnostic parameter pair must be listed on a separate line or in a tabular format to achieve visual separation (refer to CAP Cancer Protocols for exceptions to this rule).
- All core elements must be listed together in synoptic format in one location in the pathology report.

Please refer to the CAP Cancer Protocols for specific guidance and examples.

For CoC-accredited programs, "eligible cancer pathology reports" are defined as:

- Definitive surgical resection of primary invasive malignancies and ductal carcinoma in situ (DCIS), and
- Definitive surgical resection in patients who have received neoadjuvant therapy AND who have residual tumor

*The following do **not** need to be reported using the CAP Cancer Protocols:*

- Definitive surgical resection in which no residual tumor is present
- Additional surgical procedure performed after definitive resection (for example, resection of positive margins or node biopsy/resection)
- Diagnostic biopsy, cytology specimens, or other diagnostic procedures done before definitive surgical therapy
- Surgical resection for recurrent tumor
- In situ carcinomas (except for DCIS)
- Special studies (for example, biomarker or prognostic testing)

If the audit reveals a compliance rate below ninety percent (90%), an action plan must be developed and implemented to improve performance. The action plan must document how the cancer program will investigate and resolve all barriers affecting the required synoptic reporting format for all eligible cancer pathology reports.

The results of the completed internal audit and any required action plans must be presented to the cancer committee and the presentation must occur during the same calendar year. The results of the audit and any required action plans are documented in the cancer committee meeting minutes.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee meeting minutes documenting the required audit of pathology 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. An internal audit is conducted confirming ninety percent (90%) of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologist (CAP) cancer protocols, including containing all core data elements within the synoptic format. If the ninety percent (90%) compliance rate is not met, the cancer program has implemented an action plan addressing all barriers affecting the required synoptic reporting format for all eligible cancer pathology reports. The results of the internal audit and any required action plans are documented in the cancer committee minutes. The cancer committee report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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5.2 Psychosocial Distress Screening

Definition and Requirements

Psychosocial services are available on-site or by referral. Each calendar year, the cancer committee implements a protocol for providing and monitoring psychosocial distress screening and referral for psychosocial care. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator.

Psychosocial Services Protocol
Services that address physical, psychological, social, spiritual, cultural, and financial needs that result from a cancer diagnosis must be available on-site or by referral with an established protocol in place to inform patients how to access them.

Psychosocial Distress Screening
Cancer programs must implement a protocol for psychosocial distress screening for cancer patients. The process identifies psychological, social, financial, and behavioral issues that may interfere with a patient's treatment plan and adversely affect treatment outcomes. The process also provides patients identified with distress the appropriate resources and/or referral for psychosocial needs.

Timing of Screening
Cancer patients must be screened for distress at least one time during the patient's first course of treatment. Additional screenings may be provided per cancer program or health care provider discretion, but are not required by this standard.

The following patients are not included in compliance for this standard:

- Biopsy only or class of case "00" patients
- Patients who are admitted to the hospital with a history of cancer, but for non-cancer related issues
- Inpatients with a current diagnosis of cancer who are treated for a non-cancer issue and do not receive cancer treatment

Method
The mode of administration (patient questionnaire or clinician-administered questionnaire) is determined by the cancer committee and may be tailored to the workflow of the practice. Medical staff, including medical assistants, nurses, social workers, and physicians who administer or interpret the screening tool must be properly trained.

The protocol must address the sites of service where screenings occur, including at the CoC-accredited facility and/or with designated providers (for example, offices of medical oncologists and/or radiation oncologists affiliated with the CoC program). The protocol must include processes for assessment and treatment (on-site or by referral) appropriate for the source of distress identified by the screening, including the psychosocial, physician, spiritual, and mental health resources available to patients on-site or by referral.

Tools
The cancer committee selects and approves the psychosocial distress screening tool to be administered. Preference is given to standardized, validated instruments or tools with established clinical cutoffs. The cancer committee determines the cutoff score used to identify distressed patients.

Assessment and Referral
If there is clinical evidence of moderate or severe distress based on the results of the distress screening, a member of the patient's oncology team (physician, nurse, social worker, psychologist, and/or contracted mental health professional) must assess the patient (through direct contact) to identify the problems initiating the distress. Direct contact means discussion of the results with the patient face-to-face, by telephone, or by telemedicine. This assessment will confirm the distress screening results and identify the appropriate referrals as needed.

Documentation
The screening process, timing of screening, identified tool, and distress level triggering a referral to services are documented in the protocol.

The distress screening(s) results, referral for provision of care, and any follow-up are documented in the patient medical record to facilitate integrated, high-quality care.

The Psychosocial Services Coordinator must present an annual report on psychosocial services to the cancer committee. The annual report is presented during the first quarter meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the cancer committee meeting minutes.

The psychosocial services report must include the following elements:

- Number of patients screened

- Number of patients referred for distress resources or further follow-up
- Where patients were referred (on-site or by referral)

Documentation

Submitted with Pre-Review Questionnaire

- Protocols that provide patient access to psychosocial services either on-site or by referral
- The psychosocial distress screening protocol
- The psychosocial services annual report that documents all required elements and cancer committee meeting minutes documenting the report

Measure of Compliance

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

1. Protocols are in place to provide patient access to psychosocial services either on-site or by referral.
2. The cancer committee implements a protocol that includes all requirements for providing and monitoring psychosocial distress screening and referral for psychosocial care.
3. Cancer patients are screened for psychosocial distress at least once during the first course of treatment.
4. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator. The psychosocial services annual report contains all required elements as outlined and is documented in the cancer committee meeting minutes. The psychosocial services annual report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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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 non-colored nodes at the end of a colored lymphatic.

When performing a sentinel node biopsy in patients who have received neoadjuvant chemotherapy, removing a clipped node and/or at least two to three sentinel nodes and/or using multiple substrates for sentinel node identification reduces the false negative rate.

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, 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.

Element	Response Options
Operation performed with curative intent.	Yes; No.
Tracer(s) used to identify sentinel nodes in the upfront surgery (non-neoadjuvant) setting *(select all that apply)*.	Dye; Radioactive tracer; Superparamagnetic iron oxide; Other *(with explanation)*; N/A.
Tracer(s) used to identify sentinel nodes in the neoadjuvant setting *(select all that apply)*.	Dye; Radioactive tracer; Superparamagnetic iron oxide; Other *(with explanation)*; N/A.
All nodes (colored or non-colored) present at the end of a dye-filled lymphatic channel were removed.	Yes; No *(with explanation)*; N/A.
All significantly radioactive nodes were removed.	Yes; No *(with explanation)*; N/A.
All palpably suspicious nodes were removed.	Yes; No *(with explanation)*; N/A.
Biopsy-proven positive nodes marked with clips prior to chemotherapy were identified and removed.	Yes; No *(with explanation)*; N/A.

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 eighty percent (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 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 eighty percent (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.

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 tracers or palpation, removed, and subjected to pathologic analysis.
2. Operative reports for sentinel node biopsies for breast cancer document the required elements in synoptic format.
3. Each calendar year, the cancer program conducts an internal audit confirming at least eighty percent (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.
4. 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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5.4 Axillary Lymph Node Dissection for Breast Cancer

Definition and Requirements

Axillary lymph node dissection (ALND) for breast cancer constitutes 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.

ALND is a procedure that serves two purposes: (1) to provide important staging and prognostic information that can inform treatment decisions, and (2) to improve local-regional control in certain settings in which sentinel node biopsy, systemic therapies, and radiotherapy—alone or combined—have not yet been demonstrated to adequately control disease.

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 may also 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, 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.

Element	Response Options
Operation performed with curative intent.	Yes; No.
Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi.	Yes; No *(with explanation)*.
Nerves identified and preserved during dissection *(select all that apply)*.	Long thoracic nerve; Thoracodorsal nerve; Branches of the intercostobrachial nerves; Other *(with explanation)*.
Level III nodes were removed.	Yes *(with explanation)*; No.

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 eighty percent (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 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 eighty percent (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.

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 eighty percent (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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Graversen HP, Blichert-Toft M, Andersen JA, Zedeler K. Breast cancer: Risk of axillary recurrence in node-negative patients following partial dissection of the axilla. *Eur. J. Surg. Oncol.* Oct 1988;14(5):407-412.

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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, 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.

Element	Response Options
Operation performed with curative intent	Yes; No.
Original Breslow thickness of the lesion	Melanoma in situ (MIS); _._ mm *(to the tenth of a millimeter)*.
Clinical margin width *(measured from the edge of the lesion or the prior excision scar)*	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 *(with explanation)*.

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 eighty percent (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 eighty percent (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.

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 eighty percent (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."

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Swetter SM, Tsao H, Bichakjian CK, et al. Guidelines of care for the management of primary cutaneous melanoma. *J Am Acad Dermatol*. 2019;80(1):208-250.

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, the rectal location may not have been anticipated preoperatively. 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.*

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, 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.

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.
Extent of colon and vascular resection *(select all that apply)*	Right hemicolectomy – ileocolic, right colic (if present); Extended right hemicolectomy – ileocolic, right colic (if present), middle colic; Transverse colectomy – middle colic; Splenic flexure resection – middle and ascending left colic; Left hemicolectomy – inferior mesenteric; Sigmoid resection – inferior mesenteric; Total abdominal colectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric; Total abdominal colectomy, with proctectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric, superior and middle rectal; Other *(with explanation)*.

Scope of Standard
This standard applies to all resections performed with curative intent for patients with colon adenocarcinoma, and applies to all operative approaches.

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 eighty percent (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 eighty percent (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.

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).
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 eighty percent (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."

Bibliography

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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 near-complete 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

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:

1. 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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De Lacy FB, Chadi SA, Berho M, et al. The future of rectal cancer surgery: A narrative review of an international symposium. *Surg Innov*. 2018;25(5):525-535.

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), or 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.

For current implementation information, visit *facs.org/cocstandardsupdates*

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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IMPLEMENTATION DATE: JANUARY 1, 2026

5.9 Smoking Cessation for Patients with Cancer

Definition and Requirements

Cigarette smoking by patients with cancer and survivors causes adverse health outcomes. Smoking cessation at or following a cancer diagnosis improves cancer outcomes and enhances quality of life.

The cancer committee must implement a process for patients with newly diagnosed cancer to be screened for current smoking. Patients who report current smoking must receive or be referred for smoking cessation treatment consistent with evidence-based guidelines. Services to deliver evidence-based smoking cessation treatment must be available on site or by referral (for example to the state quitline).

For purposes of this standard, current smoking is limited to cigarette smoking.

Screening
Screening for smoking must be performed for patients newly-diagnosed with cancer at an initial patient encounter or consultation within the accredited program for cancer treatment. Continued screening during follow-up visits is encouraged but not required by this standard.

Screening for smoking must identify patients as currently smoking, formerly smoking, or never smoking (options mutually exclusive). For this standard, current smoking is defined as any smoking within the past 30 days.

Timing of Screening
Cancer programs must conduct and document screening for current smoking at the patient's first encounter or an initial consultation at the accredited cancer program for cancer treatment.

Method of Screening
Cancer programs may utilize standardized screening protocols available through most medical record systems. Documentation must be in a structured, accessible format (ideally, a core data element in the electronic medical record). Programs that screen using paper-based methods must be able to evaluate data to provide an annual report to the cancer committee.

Assessment and Referral
All patients who report current smoking must be referred or receive access to evidence-based smoking cessation treatment within 30 days of the screening for smoking status. Evidence-based smoking cessation treatment must be available either on site or by referral with an established protocol.

Cancer programs must provide access to smoking cessation treatment, either on-site or by referral, consisting of core elements of behavioral counseling and pharmacotherapy, which must include one or more of the following:

- Individual counseling by certified Tobacco Treatment Specialists
- Physicians or healthcare providers providing counseling concordant with evidence-based smoking cessation guidelines.
- Referral to on-site smoking cessation group or classes
- Referral to state quitlines or other community resources such as Health Departments or the American Cancer Society smoking cessation program
- Prescription of FDA-approved smoking cessation medication
- Enrollment in established mobile health program (example: SmokefreeTXT)
- Combination of the above treatment approaches

Providing brochures with patient education without referral to treatment does not meet the standard. Additionally, verbal suggestions for smoking cessation without evidence-based concordant counseling does not meet the standard.

Tools
The Cancer Committee selects and approves the local method for screening, documentation, and referral using evidence-based approaches. Screening must use standardized assessments, cannot rely simply on reviews of prior assessments (copy forward), and must be documented in the medical record. Smoking status from primary care visits or other non-cancer visits do not meet the requirements of the standard.

Smoking cessation treatment should include core elements of behavioral counseling and pharmacotherapy.

Protocol for Identifying and Referring Patients who Smoke
A protocol must be in place for identifying and referring patients with newly diagnosed cancer who currently smoke to evidence-based smoking cessation treatment. The protocol must outline the methods of treatment available on-site or by referral.

Auditing Smoking Cessation Process
Each calendar year, the cancer committee must conduct an internal audit of a minimum of 20 patients with newly diagnosed cancer to determine:

- The number of patients with newly diagnosed cancer screened
- The number of patients with newly diagnosed cancer who reported current smoking

- The number of patients with newly diagnosed cancer who reported current smoking who received or were referred to smoking cessation treatment

The internal audit must include, at a minimum, 10 patients who currently smoke to determine whether they were referred. If the initial 20 medical records reviewed do not include 10 patients who currently smoke, additional medical records must be reviewed until at least 10 patients who currently smoke and their referral status are identified.

A refusal of a referral by the patient counts as a referral for purposes of the internal audit.

An action plan must be documented in the cancer committee meeting minutes if:

- Less than 90% of patients with newly diagnosed cancer received current smoking status screening, **and/or**
- Less than 80% of patients with newly diagnosed cancer who reported current smoking were treated or referred to smoking cessation treatment

For cancer programs that use multiple smoking cessation methods, programs are encouraged, but not required, to document how many patients use each method of treatment.

The results of the completed internal audit, including any action plans, must be presented to the cancer committee and the presentation must occur during the same calendar year. The results of the internal audit and any required action plans are documented in the cancer committee meeting minutes.

Documentation

Submitted with Pre-Review Questionnaire

- Protocol for smoking screening and providing access to smoking cessation treatment
- Cancer committee meeting minutes documenting the required internal audit of the smoking cessation process each calendar year, including any required action plans

Measure of Compliance

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

1. Implement a protocol for identifying and referring patients who currently smoke to evidence-based smoking cessation treatment.
2. The cancer committee reviews the results of the internal audit. The internal audit contains all required elements as outlined and is documented in the cancer committee meeting minutes.
3. If the internal audit demonstrates the required thresholds were not met, then an action plan must be documented in the cancer committee meeting minutes and implemented by the cancer program.
4. The internal audit and any required action plans meet the requirements outlined on page vii, "Standards Requiring Annual Review."

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6 Data Surveillance and Systems

Rationale

High-quality data are critical to inform quality improvement and measure the performance of programs. All required cases must be submitted to the National Cancer Database (NCDB) using nationally standardized data item and coding definitions.

Data are validated through multiple mechanisms that are continuously updated to optimize the quality of the data collected.

6.1 Cancer Registry Quality Control

Definition and Requirements

High-quality cancer registry data are essential to accurately assess treatment outcomes and patient survival. Each calendar year, the cancer committee implements a protocol to annually evaluate the quality of cancer registry data and activity, including procedures to monitor and evaluate each required control component.

The Cancer Registry Quality Coordinator works cooperatively with registry staff and other applicable departments to implement the quality control protocol. The coordinator must monitor each area of cancer registry activity and recommends corrective action if any area falls below the measures specified in the plan. The results of the completed audit, recommendations, and outcomes of recommendations must be presented to the cancer committee and the presentation must occur during the current calendar year. The results of the audit are documented in the cancer committee meeting minutes.

The quality control protocol includes the following, at a minimum:

A. Sets the review criteria
B. Sets the quality control timetable
C. Specifies the quality control methods, sources, and individuals involved. Specifications include:
   - Random sampling of annual analytic caseload
   - Review by designated person(s)
     - Reviewer(s) may be ODS(s), Advanced Practice Registered Nurse(s), Physician Assistant(s), physician(s), fellow(s), or resident(s)
     - ODSs cannot review their own cases
   - External audits (such as state or central cancer registry case-finding audits) may be used to fulfill part of this requirement
D. Identifies the activities to be evaluated for all cases each year:
   1. Case finding
   2. Abstracting timeliness
   3. The percentage of information coded as unknown (usually coded as 9 or a string of 9s)
E. Identifies the activities to be evaluated each year for the accuracy of abstracted data. A review of a minimum of 10 percent of the annual analytic caseload (up to 200 cases annually) is required each year for the accuracy of the following:
   1. Class of case
   2. Primary site
   3. Histology
   4. Grade
   5. American Joint Committee on Cancer (AJCC) Stage or other appropriate staging system as appropriate for cancer site
   6. First course of treatment
   7. Follow-up information, specifically:
      - Date of first recurrence
      - Type of first recurrence
      - Cancer status
      - Date of last cancer status
F. Establishes the minimum quality benchmarks and required accuracy. Cancer registry data submitted to the NCDB meet the established quality and timeliness criteria.
G. Maintains documentation of the quality control activity:
   - Review criteria
   - Cases reviewed
   - Identified data errors and resolutions
   - Reports the percentage of accuracy to the cancer committee annually of the review of elements listed in sections D and E above. The report must be documented in the cancer committee meeting minutes.

Patient data reviewed under the cancer registry quality control plan for Standard 6.1 cannot be used as an in-depth analysis review for compliance to Standard 7.2: Monitoring Compliance with Evidence-Based Guidelines.

Documentation

Submitted with Pre-Review Questionnaire

- A quality control protocol, which includes the process for resolving conflicts identified during the quality control review.
- Cancer Registry Quality Control Template
- If utilized, any audit reports from the state or central registry that were used in the evaluation of the cancer registry data
- Cancer committee meeting minutes documenting that the results of the annual quality control evaluation were presented and reviewed by the cancer committee

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 all of the compliance criteria:

1. The cancer committee implements a quality control protocol to evaluate the required areas of the cancer registry.
2. The Cancer Registry Quality Control Coordinator, under the direction of the cancer committee, performs or oversees the required quality control review as outlined in the protocol.
3. The results, recommendations, and outcomes of recommendations are reported to the cancer committee and documented in the cancer committee meeting minutes. The report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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STANDARD RETIRED IN 2021

6.2 Data Submission

Definition and Requirements

Data submitted to the National Cancer Database (NCDB) are used to provide feedback to assess the quality of patient care. This feedback enables cancer programs to compare treatment and outcomes with regional, state, and national patterns of care.

The NCDB is a nationwide oncology outcomes database used as a clinical surveillance mechanism to monitor changes and variations in patterns of cancer care and patient outcomes. NCDB data serves as useful benchmarks for patient care and continuous quality improvement for cancer programs.

Each calendar year, complete data for all requested analytic cases are submitted to the NCDB in accordance with the annual Call for Data. Data submission to the NCDB must be performed by using the Commission on Cancer's secure online data submission application in accordance with the annual Call for Data specifications.

After the initial site visit of a new program is completed and accreditation is awarded, the program submits data to the NCDB for all applicable years currently accepted by the NCDB. New programs will submit all analytic cases for any diagnosis years beginning with its Reference Date. Data are submitted, and errors and rejected records are corrected (Standard 6.3).

Documentation

The facility submits data as required for compliance by the NCDB.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. Complete data for all requested analytic cases are submitted to the NCDB in accordance with the annual Call for Data specifications.

STANDARD RETIRED IN 2021

6.3 Data Accuracy

Definition and Requirements

Accurate data are necessary for meaningful comparison of treatment and patient outcomes. These data are the basis for the feedback provided to cancer programs.

As part of its annual Call for Data, the National Cancer Database (NCDB) will document the conditions that will cause the cases submitted to the NCDB to be rejected. Rejected cases do not meet specified data quality criteria. Standardized, nationally accepted data edits are applied to all analytic cases submitted. The reporting registry is notified of the problematic cases through an edit report. The reporting registry must correct outstanding data quality errors and resolve errors resulting in rejected records.

Each year, the cases satisfy the established quality criteria by the deadline specified in each Call for Data specification. Problematic cases are corrected and resubmitted according to the Call for Data specifications. The cancer committee monitors the resolution and resubmission of problematic cases (Standard 6.1).

Documentation

The facility submits data as required for compliance by the NCDB.

Measure of Compliance

The cancer program fulfills all of the compliance criteria:

1. The cases meet the quality criteria as defined in the annual Call for Data specifications on the initial submission.
2. If cases submitted do not meet the quality criteria on initial submission then identified errors in submitted cases and rejected records are corrected and resubmitted by the due date specified.

6.4 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 performance rates for each CoC quality measure 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 RCRS, submits all required cases, and adheres to the RCRS terms and conditions. All new and updated cancer cases are submitted at least once each calendar month according to the RCRS terms and conditions. A calendar month is defined as the first day of the month through the last day of the month (for example, March 1 to March 31). Once each calendar year, programs submit all complete analytic cases for all disease sites via RCRS as specified by the annual Call for Data.

Programs must actively participate in RCRS submissions and adhere to the RCRS requirements through the entire accreditation cycle. The full details for RCRS participation are provided in the RCRS terms and conditions available on the National Cancer Database website.

RCRS data and the required quality measure performance rates must be reported to the cancer committee at least twice each calendar year and documented in the cancer committee meeting minutes. The reports required by this standard cannot also satisfy the requirements for Standard 2.2: Cancer Liaison Physician.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee meeting minutes documenting reports at two separate meetings each year on RCRS data and performance

Measure of Compliance

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

1. All new and updated cancer cases are submitted at least once each calendar month.
2. All complete analytic cases for all disease sites are submitted via RCRS as specified by the annual Call for Data.
3. Rapid Cancer Reporting System data and required quality measure performance rates are reviewed by the cancer committee at least twice each calendar year and are documented in the cancer committee meeting minutes. The annual reports meet the requirements outlined on page vii, "Standards Requiring Annual Review."

6.5 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 percent follow-up rate is maintained from the most current year of completed cases through 15 years before or the program's first accreditation date, whichever is shorter. A 90 percent follow-up rate is maintained from the most current year of completed cases through five years before or the program's first accreditation date, whichever is shorter.

All reportable cases are followed up, except the following:

- Residents of foreign countries
- Cases reportable by agreement
- 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

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.

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 percent follow-up rate is maintained for all eligible analytic cases from the most current year of completed cases through 15 years before or the program's first accreditation date, whichever is shorter.
2. A 90 percent follow up rate is maintained for all analytic cases diagnosed from the most current year of completed cases through five years before or the program's first accredited date, whichever is shorter.

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7 Quality Improvement

Rationale

Problem resolution, outcomes improvement, and assurances of patient safety must be readily identifiable through structured quality improvement initiatives. In support of these efforts, the cancer program must develop a culture of collaboration in order to analyze and implement strategies based on data to drive improvement in the quality of care. Continuous quality improvement must be reflected in the results of such efforts.

7.1 Quality Measures

Definition and Requirements

The Commission on Cancer (CoC) requires accredited cancer programs to treat cancer patients according to nationally accepted quality measures indicated by the CoC quality reporting tool.

The cancer committee monitors the program's expected Estimated Performance Rates for quality measures selected annually by the CoC. Details on the quality measures for this standard may be referenced on the National Cancer Database (NCDB) website which includes quality measure specifications, years for performance evaluation, and quality measure performance thresholds for this standard. Facility performance rates for these quality measures will be extracted from the NCDB reporting tools.

If the cancer program is not meeting the expected EPR of a quality measure(s), then an action plan must be developed and implemented in order to improve performance. The action plan must document how the program will investigate the issue(s) for each quality measure with the goal of resolving all barriers and improving compliance.

The cancer committee's review of compliance with required quality measures and monitoring activity is conducted each calendar year and documented in the cancer committee meeting minutes. The action plan and any corrective action taken are included in the documentation.

Programs with no cases eligible for assessment in a selected quality measure are exempt from requirements for that individual measure.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee meeting minutes documenting the presentation and review of required quality measures, 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 all of the compliance criteria:

1. The cancer committee monitors the program's expected Estimated Performance Rates for quality measures selected by the CoC.
2. For each quality measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the expected EPR specified by the CoC.
3. If the expected EPR is not met, the program has implemented an action plan that reviews and addresses program performance below the expected EPR.
4. The monitoring activity, including any required action plans, are documented in the cancer committee meeting minutes. The monitoring activity meets the requirements outlined on page vii, "Standards Requiring Annual Review."

7.2 Monitoring Concordance with Evidence-Based Guidelines

Definition and Requirements

Each calendar year, a physician performs an in-depth analysis of the diagnostic evaluation and treatment of individual patients to determine whether it is concordant with recognized evidence-based national guidelines. The study must be a retrospective review of individual patient evaluation and treatment information, which includes a patient medical record review. The completed study results are presented to the cancer committee during the same calendar year the study was conducted. The study results are documented in the cancer committee meeting minutes.

The annual in-depth analysis must include all of the following components:

1. The choice of a patient population to review. Sources for the assessment must include one of the following study topics:
   - All cases from a specific cancer site (or stage within that site), to a maximum of 100 cases OR
   - An identified need or concern within a specific cancer site or stage of cancer
2. Through a review of each patient, which includes review of the medical record, a determination whether the pre-treatment initial diagnostic evaluation process is concordant with evidence-based national treatment guidelines for each patient being reviewed.
   Initial evaluation indicated will differ by cancer site. However, review of the initial evaluation should include pathology, diagnostic imaging, laboratory tests, and consultations recommended within the specific guideline(s) being reviewed.
3. Through a review of each patient, which includes review of the medical record, a determination whether the first course of treatment is appropriate for the stage of disease or prognostic indicators and is concordant with evidence-based national treatment guidelines for each patient being reviewed.
4. A reporting format that permits analysis and provides an opportunity to recommend performance improvements based on data from the analysis.
5. A presentation of a report detailing all required elements of the study, including the results of the analysis, to the cancer committee. The report is documented in the cancer committee meeting minutes. The documentation includes any recommendations for improvement.

Analysis and treatment discussions for patients at multidisciplinary cancer case conferences do not fulfill the requirements for Standard 7.2. Any problems identified with the diagnostic evaluation or treatment planning process may serve as a source for a quality project under Standard 7.3: Quality Improvement Initiative.

Documentation

Submitted with Pre-Review Questionnaire

- Monitoring Concordance with Evidence-Based Guidelines Template
- A report of the in-depth analysis which documents the completed analysis, including identification of the patient population reviewed, methodology, and results
- Cancer committee meeting minutes that document that the conclusions and the results of the analysis were reported and any recommendations for improvement

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 all of the compliance criteria:

1. A physician conducts an in-depth analysis to determine whether initial diagnostic evaluation and first course of treatment provided to patients is concordant with evidence-based national treatment guidelines.
2. The report detailing all required elements of the study, including the results of the analysis and any recommendations for improvement, are reported to the cancer committee and documented in the cancer committee meeting minutes and meet all the requirements outlined on page vii, "Standards Requiring Annual Review."

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7.3 Quality Improvement Initiative

Definition and Requirements

Under the guidance of the Cancer Liaison Physician (CLP), the Quality Improvement Coordinator, and the cancer committee, the cancer program must measure, evaluate, and improve its performance through at least one cancer-specific quality improvement initiative each year.

This quality improvement (QI) initiative requires the program to identify a problem, understand what is causing the identified problem through use of a recognized performance improvement methodology, and implement a planned solution to the problem. Reports on the status of the QI initiative must be given to the cancer committee at least twice each calendar year and documented in the cancer committee minutes.

Quality Improvement Initiative Required Components

1. **Review Data to Identify the Problem**

The QI initiative must be focused on an already identified, quality-related problem specific to the cancer program.

The following (in order of preference) may be used to identify the focus of the QI initiative:

- Problems identified in a National Cancer Database (NCDB) quality measure
- Problems identified in a Standard 7.2: Monitoring Compliance with Evidence Based Guidelines study
- Problems identified through annual review of clinical services in other CoC standards (for example, palliative care services, genetics services, operative standards)
- Problems identified through National Accreditation Program for Rectal Cancer or National Accreditation Program for Breast Centers accreditation initiatives
- Problems identified through review of NCDB data, including Cancer Quality Improvement Program (CQIP)
- Problems identified through the review of data related to cultural competency, individualized shared decision making, and the implementation of health equity interventions in the cancer program
- Any other cancer-specific, quality-related problem determined by the cancer committee

2. **Write the Problem Statement**

The QI initiative must have a problem statement. The problem statement must identify:

- A specific, already identified, quality-related problem specific to the cancer program to solve through the QI initiative
- The baseline and goal metrics (must be numerical)
- Anticipated timeline for completing the QI initiative and achieving the expected outcome

The problem statement cannot state that a study is being done to see if a problem exists, rather it must already be known that a problem exists.

3. **Choose and Implement Performance Improvement Methodology and Metrics**

The Quality Improvement Coordinator and the CLP must identify the content experts needed to execute the QI initiative. For example, if the QI initiative is on the BCSRT quality measure, then at least one breast surgeon and one radiation oncologist are included on the initiative team.

A recognized, standardized performance improvement tool must be chosen and used to conduct the QI initiative (for example, Lean, DMAIC, or PDCA/PDSA).

In line with the performance improvement tool selected, the team conducts analysis to identify all possible factors contributing to the problem. This may involve a literature review and/or a root-cause analysis. Based on the results, an intervention is developed that aims to fix the cause of the problem being studied.

It is recommended that a project calendar is identified, which includes the initiative's launch date, when status updates will be given at cancer committee meetings, and a goal wrap-up date.

QI initiatives should last approximately one year. But if additional time is needed, it may be extended for a second year (for a total of two years). However, a new initiative must be started at the beginning of each calendar year even if a previous QI initiative is still in progress. If the QI initiative will extend into the second year, then a status update to the cancer committee must be given before or during the last cancer committee meeting of the calendar year the QI initiative was implemented. The status update to extend the QI initiative into a second year must be documented in the cancer committee meeting minutes.

4. Implement Intervention and Monitor Data

The intervention chosen in step three must be implemented. If oversight of the implementation suggests the intervention is not working, then it must be modified.

5. Present Quality Improvement Initiative Summary

Once the initiative has been completed, a document summarizing the initiative and the results must be presented and discussed with the cancer committee and documented in the cancer committee minutes. If possible, results are compared with national data.

The summary presentation must include:

- Summary of the data reviewed to identify the problem
- to study
- The problem statement
- The QI initiative team members
- Performance improvement tool utilized
- The intervention implemented
- If applicable, any adjustments made to the intervention
- Results of the implemented intervention

Cancer Committee Reports

The CLP or the Quality Improvement Coordinator must provide updates to the cancer committee on the QI initiative's status at least twice each calendar year. Status updates, at a minimum, indicate the current status of the QI initiative and any planned next steps. The final summary and results report may qualify as one of the required reports. If the QI initiative was extended into a second year, the summary and results report must be given in the subsequent calendar year after the QI initiative is completed.

NAPBC and NAPRC Quality Improvement Initiatives

Each accreditation cycle, cancer programs that are also accredited by the National Accreditation Program for Breast Centers (NAPBC) and/or the National Accreditation Program for Rectal Cancer (NAPRC) may count one complete breast-specific quality improvement initiative and/or one complete rectal-specific quality improvement initiative towards compliance with CoC Standard 7.3.

The complete quality improvement initiatives must meet compliance with their respective quality improvement initiative standard as required by the NAPBC and/or the NAPRC.

Documentation

Reviewed On-Site

- Documentation of QI initiative team's work from throughout the initiative (for example, minutes, literature used).

Submitted with Pre-Review Questionnaire

- Quality Improvement Initiative Template
- Cancer committee minutes documenting required status updates and presentation of the QI initiative summary

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 all of the compliance criteria:

1. One quality improvement initiative based on an identified quality-related problem is initiated each year. The QI initiative documentation includes how it measured, evaluated, and improved performance through implementation of a recognized, standardized performance improvement tool.
2. Status updates are provided to the cancer committee two times. Reports are documented in the cancer committee minutes.
3. A final presentation of a summary of the quality improvement initiative is presented after the QI initiative is complete. The summary presentation includes all required elements and meets all the requirements outlined on page vii, "Standards Requiring Annual Review."

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7.4 Cancer Program Goal

Definition and Requirements

Annual goal setting provides direction for the strategic planning of cancer program activities. Each calendar year, the cancer program establishes, and documents in the cancer committee minutes, one cancer program goal appropriate and relevant to the cancer program and its patient population.

It is recommended the goal-setting tool known as SMART (Specific, Measurable, Achievable, Realistic, and Timely) be used when establishing the goal. Goals must be directed toward the scope, coordination, practices, processes, and provision of services for cancer care at the program.

The cancer committee must document substantive status updates on goal progress at two subsequent meetings after the goal's establishment in the same calendar year. For example, the status update may include any progress made, road blocks encountered, or a description of any necessary next steps.

Goals should last approximately one year. If additional time is needed, a goal may be extended for a second year (for a total of two years). However, a new goal must be established at the beginning of each calendar year even if a previous goal is still in progress. If the goal will extend into the second year, then a status update must be provided before or during the last cancer committee meeting of the year the goal was implemented. The status update to extend the goal into a second year must be documented in the cancer committee meeting minutes. Additionally, there must be at least one additional status update documented in the cancer committee minutes during the second year. By the end of the second year, the cancer program must document in the cancer committee minutes that the goal is either completed or retired.

A goal established under this standard cannot duplicate requirements or be an improvement on requirements from another standard or be a program or initiative submitted to meet requirements of another standard.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer Program Goal Template
- Cancer committee minutes documenting the establishment and status updates of the cancer program goal

Measure of Compliance

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

1. One cancer program goal is established and documented in the cancer committee minutes.
2. At least two substantive status updates on goal progress are documented in the cancer committee minutes in the same calendar year as its establishment. The status updates meet all the requirements outlined on page vii, "Standards Requiring Annual Review."
3. For any goal extended into a second year, at least one status update is documented in the minutes during the second year to indicate whether the goal was completed or retired.

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8 Education: Professional and Community Outreach

Rationale

Part of being a quality cancer program is not only addressing the program's current patients, but also those in the community who may develop cancer or have difficulty receiving cancer treatment.

Outreach to the community through screening and prevention events aids in reducing the risk of developing cancer and in diagnosing cancer at an earlier stage than it might be otherwise.

8.1 Addressing Barriers to Care

Definition and Requirements

Each calendar year, the cancer committee identifies at least one patient-, system-, or provider-based barrier to accessing health and/or psychosocial care that its patients with cancer are facing and develops and implements a plan to address the barrier.

Cancer Barriers Analysis
The cancer committee reviews and analyzes the strengths and barriers of the cancer program. Resources for identifying strengths and barriers may include, but are not limited to:

- Cancer Quality Improvement Program (CQIP) reports
- Cancer patient satisfaction surveys
- Patient focus groups
- Use of state cancer registry data compared to cancer program data
  - Is the cancer program treating the main cancers that occur in its area?
  - Are vulnerable populations being reached?
- Population health resources from public health work done locally and regionally
- Community Needs Assessment
- Analysis of unique features of the cancer program and/or state (for example, affordable or adequate lodging for patients receiving care at a rural facility)

Identification of Barriers
Each calendar year, the cancer committee identifies barriers that are specific to the cancer program and chooses one to focus on for the upcoming year. Examples include, but are not limited to:

- Gaps in community resources
- Identified populations in need
- Uninsured or underinsured
- Health care provider shortages

The cancer committee must document the annual evaluation of identified barriers. 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 and includes the following elements:

- What barrier was chosen
- What resources/processes were utilized to identify and address this barrier
- Metrics related to outcomes of reducing the chosen barrier

Documentation

Submitted with Pre-Review Questionnaire

- Addressing Barriers to Care Template
- Cancer committee minutes documenting the required annual evaluation of identified barriers

Measure of Compliance

Each calendar year, the program fulfills the compliance criteria:

1. The cancer committee identifies at least one barrier to focus on for the year and identifies resources and processes to address the barrier.
2. The cancer committee evaluates the resources and processes adopted to address the barrier to care and identifies strengths and areas for improvement.
3. The annual evaluation is documented in the cancer committee meeting minutes and includes all required elements. The cancer committee minutes include all required elements. The report meets the requirements outlined on page vii under "Standards Requiring Annual Review."

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8.2 Cancer Prevention Event

Definition and Requirements

According to the National Cancer Institute, cancer prevention is "action taken to decrease the chance of getting a disease or condition. For example, cancer prevention includes avoiding risk factors (such as smoking, obesity, lack of exercise, and radiation exposure) and increasing protective factors (such as getting regular physical activity, vaccination, staying at a healthy weight, and having a healthy diet)."

The cancer committee holds at least one event each year focused on decreasing the number of diagnoses of cancer. It is recommended, but not required, that the cancer committee partner with a community organization to hold the event. Examples of community organizations include, but are not limited to, a church, a school, the American Cancer Society, or a health district.

Prevention events focus on at least one of two intended results: (1) a change in behavior that reduces the risk a cancer will develop, and/or (2) an increase in the participant's knowledge and awareness of cancer risks.

Examples of behavioral risk reduction events include, but are not limited to:

- Smoking/tobacco/vaping cessation
- Alcohol avoidance
- Nutrition, physical activity, and weight loss programs
- HPV vaccinations
- Radon exposure reduction
- Avoidance of sun exposure
- Chemoprevention

Cancer education and risk awareness lectures or events are considered a prevention activity when they address one of the above behavioral risk reduction areas.

The planned event must be consistent with evidence-based national guidelines and interventions, where applicable. Potential sources for evidence-based national guidelines and interventions include, but are not limited to:

- Agency for Healthcare Research and Quality
- American Cancer Society
- Cancer Control P.L.A.N.E.T.
- National Cancer Institute
- Centers for Disease Control and Prevention
- American Institute for Cancer Research/World Cancer Research Fund
- U.S. Preventive Services Task Force Recommendations

Examples of non-compliant events include, but are not limited to:

- Programs held only on the Internet, through social media, or through a mail campaign without real-time interaction with participants
- Prevention education given in the regular course of business
- Events or programs that educate about cancer screening or reduction of late-stage at diagnosis

Cancer Committee Report

A summary of the event must be presented to and discussed by the cancer committee within the same calendar year the prevention event is held. The summary presented to the cancer committee must include the following elements:

- The cancer site(s) on which the event focused
- The partnering community organization (where applicable)
- Target audience
- Guideline(s) used in planning the prevention event (where applicable)
- The type of prevention event held (behavioral risk reduction or cancer education/risk awareness lecture)

While it is encouraged that cancer programs hold as many cancer prevention events as appropriate for their needs, only one event is submitted for purposes of this standard.

Documentation

Submitted with Pre-Review Questionnaire

- Prevention Community Outreach Template
- Cancer committee minutes that document all required elements of the cancer prevention event

Measure of Compliance

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

1. The cancer committee offers at least one cancer prevention event.
2. Where applicable, the cancer prevention event is consistent with evidence-based national guidelines and interventions.
3. A summary of the cancer prevention event is presented to the cancer committee and documented in the cancer committee minutes. The summary meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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8.3 Cancer Screening Event

Definition and Requirements

Cancer screening events apply screening guidelines to detect cancers at an early stage, which improves the likelihood of increased survival and decreased morbidity.

The cancer committee holds at least one event each year focused on decreasing the number of individuals who present with late-stage cancer. It is recommended, but not required, that the cancer committee partner with a community organization to hold the event. Examples of community organizations include, but are not limited to, a church, a school, the American Cancer Society, or a health district.

Examples of screening events include, but are not limited to:

- Breast (imaging and physical examination)
- Colon (colonoscopy, flexible sigmoidoscopy, fecal immunochemical testing, or fecal occult blood testing)
- Cervical (Papanicolaou testing with or without HPV DNA testing)
- Skin (clinician-directed total body skin exams)
- Lung (low-dose computed tomography)
- Head and neck (oral examination)

The planned event must be based on evidence-based national guidelines and interventions, where applicable, and have a formal process for follow up on all positive findings.

Resources for evidence-based national guidelines and interventions include, but are not limited to:

- Agency for Healthcare Research and Quality
- American Cancer Society
- American Society of Clinical Oncology
- National Comprehensive Cancer Network
- National Cancer Institute
- National Colorectal Cancer Roundtable

Examples of non-compliant programs/events include, but are not limited to:

- Screening programs performed in the regular course of business
- Events or programs that educate about cancer screening or reduction of stage at diagnosis that do not provide an actual screening

Cancer Committee Report

A summary of the event must be presented to and discussed by the cancer committee within the same calendar year the screening event is held. The summary presented to the cancer committee must include the following elements:

- The cancer site on which the event focused
- The partnering community organization (where applicable)
- Target audience
- Guideline(s) used in planning the screening event (where applicable)
- The process for follow up for all positive findings

While it is encouraged that cancer programs hold as many cancer screening events as appropriate for their needs, only one event is submitted for purposes of this standard.

Documentation

Submitted with Pre-Review Questionnaire

- Screening Community Outreach Template
- Cancer committee minutes that document all required elements of the cancer screening event

Measure of Compliance

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

1. The cancer committee offers at least one cancer screening event.
2. Where applicable, the cancer screening event is consistent with evidence-based national guidelines and interventions.
3. The cancer screening event has a process for follow up on all positive findings.
4. A summary of the cancer screening event is presented to the cancer committee and documented in the cancer committee minutes. The summary meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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9 Research

Rationale

Clinical research advances science and assists with ensuring that patient care approaches the highest possible level of quality.

9.1 Clinical Research Accrual

Definition and Requirements

As prescribed for cancer program category, the required percentage of subjects is accrued to eligible cancer-related clinical research studies each calendar year. The Clinical Research Coordinator documents and reports clinical research information and the annual enrollment in clinical research studies to the cancer committee each calendar year.

Clinical Research Information and Screening Processes
The cancer program must establish a screening protocol to identify participant eligibility for clinical research studies and how to provide clinical research information to subjects. Through the Clinical Research Coordinator, the cancer committee evaluates and assesses the eligibility and screening processes to identify and address barriers to enrollment and participation.

Cancer-Related Research Studies Eligible for Accrual
Clinical research studies eligible to count for accrual must meet the following requirements:

1. Be related to cancer
2. Be approved by an internal or external Institutional Review Board (IRB) that is responsible for the review and oversight of the research study, and
3. Have informed, written subject consent (unless consent is waived by the IRB)

Categories of cancer-related clinical research studies eligible for accrual:

- Basic Science
- Device Feasibility
- Diagnostic
- Health Services Research
- Prevention
- Screening
- Supportive Care
- Treatment

Definitions for these categories may be found on the National Cancer Institute Clinical Trial Reporting Program User Guide (see Primary Purpose Value Definitions).

Additional categories of cancer-related clinical research studies for accrual:

- Cancer-specific biorepositories or tissue banks
  - Such biobanks must collect cancer tissue or blood samples specifically for use in clinical trials and/or clinical research
- Economics of cancer care
  - Studies that assess the costs and effectiveness of cancer interventions and/or analyze the financial impact of cancer care on patients
- Genetic studies
  - Studies that examine contributing genes or how different exposures modify the effect of a gene mutation that may be at risk for cancer development, or
  - Studies that examine genetic polymorphisms and mutations for early risk assessment
- Patient registries with an underlying cancer research focus
  - Such registries must be used in clinical trials and/or clinical research
- Epidemiological studies with an underlying cancer research focus

Humanitarian Use Devices studies cannot be counted as an accrual under this standard.

Calculating Compliance
Compliance with this standard is calculated using the number of subjects enrolled in eligible clinical research studies (numerator), and the total number of annual analytic cancer cases (denominator).

To count for accrual, subjects enrolled in eligible clinical research studies must fall into at least one of the following categories:

- Diagnosed and/or treated at your program or facility and enrolled in a cancer-related clinical research study within your program or facility
- Diagnosed and/or treated at your program or facility and enrolled in a cancer-related clinical research study within a staff physician's office of your program or facility
- Diagnosed and/or treated at the program or facility, then referred by your program or facility for enrollment onto a cancer-related clinical research study through another program or facility
- Referred to your program or facility for enrollment onto a cancer-related clinical research study through another program or facility

Researchers and clinical trial investigators who accept referral of subjects from other programs for the purpose of participation in a cancer-related clinical research study must cooperate with the data management team of the cancer program from which the subject was referred.

If one subject is enrolled in two different trials or studies, that subject may be counted twice for accrual. However, if one subject is enrolled in two arms of a protocol, or enrolled in a sub-study of a protocol, the subject only counts once for accrual.

Minimum required accrual percentages each calendar year:

Category	Percentage Requirement
ACAD	6
CCCP	4
CCP	2
FCCP	2
HACP	Exempt
INCP	6
NCIP	Exempt
PCP	50
VACP	2

Clinical Research Coordinator
The Clinical Research Coordinator must present an annual report on clinical research activity to the cancer committee. The annual report is presented during the first quarter meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the cancer committee meeting minutes.

The clinical research activity annual report must contain the following elements:

- The specific clinical research studies where subjects were accrued, including the trial/study name and, when applicable, the clinicaltrials.gov trial number
- Number of subjects accrued to each individual clinical research study
- Open clinical research studies with identification of those with a nearing end date
- New trials that will be added
- If the required accrual percentage is not met, the report identifies contributing factors and identifies an action plan to address those factors

The report and analysis must be documented in the cancer committee minutes.

Documentation

Reviewed On-Site

- Tracking documents that detail the number of subjects accrued to specific clinical research studies

Submitted with Pre-Review Questionnaire

- Clinical Research Accrual Template
- Cancer committee minutes documenting the Clinical Research Coordinator's report that includes all required elements
- Protocol for screening patients for clinical research studies and for providing subjects with information on clinical research studies

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 all of the compliance criteria:

1. The program has a screening protocol to identify participant eligibility for clinical research studies and how to provide clinical trial information to subjects. These processes are assessed to identify and address barriers to enrollment and participation.
2. The number of accruals to cancer-related clinical research studies meets or exceeds the required percentage.
3. The Clinical Research Coordinator presents the annual report to the cancer committee. The annual report on clinical research activity contains all required elements as outlined and is documented in the cancer committee meeting minutes. The clinical research activity annual report meets the requirements outlined on page vii, "Standards Requiring Annual Review."

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9.2 Commission on Cancer Special Studies

Definition and Requirements

Hypothesis-based special studies are designed to evaluate patient care, set benchmarks, and provide feedback to improve patient care in cancer programs.

The Commission on Cancer (CoC) will periodically design and conduct special studies. Based on study criteria, selected accredited programs will be required to participate in each study for standard compliance.

The cases included in the study and due date will be specified in the study documentation provided by the CoC.

To fulfill the standard, all selected programs must submit all requested information for the cases identified by the specified deadline.

Documentation

The program uploads all required documentation or data as required for the special study.

Measure of Compliance

As requested, the cancer program fulfills all of the compliance criteria:

1. The program participates in each special study.
2. Complete data and documentation are submitted by the established deadline for each special study.

Specifications by Category

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

For new INCPs and NCINs, the following specifications were effective beginning January 1, 2022.
For established INCPs and NCINs, the following specifications were effective beginning January 1, 2023.
Unless stated otherwise, the following specifications apply to both INCPs and NCINs.

STANDARD 1.1: Administrative Commitment The letter is accompanied by a descriptive document that addresses the organizational structure of the network. It specifically addresses:

- The organizational structure of the network, including the facilities within the network,
- The distribution of cancer services across the network and its facilities,
- Processes that facilitate integration, coordination, and collaboration across the facilities in the network.

STANDARD 2.1: Cancer Committee The network cancer committee has a single chair and required members that serve as representatives across the entire network. The required members are listed in Standard 2.1. Additionally, the network cancer committee must include one representative from each facility within the network and a process must be developed that defines how information will flow from each facility within the network to the network cancer committee and back to the individual facilities within the network.

The following members described in Standard 2.1 as "recommended members" are required members of the network cancer committee: Specialty physicians representing the five major cancer sites across the network, palliative care professional, genetics professional, registered dietitian nutritionist, rehabilitation services professional, pharmacist, and spiritual care representative. An American Cancer Society representative is recommended, but not required.

NCIN facilities are exempt from this standard of accreditation.

STANDARD 2.2: Cancer Liaison Physician 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).

STANDARD 2.4: Cancer Committee Attendance NCIN facilities are exempt from this standard of accreditation.

STANDARD 2.5: Multidisciplinary Cancer Case Conference The network cancer conference protocol must document how multidisciplinary cancer case conferences are conducted throughout and across the network facilities and it addresses the items outlined in Standard 2.5. The network cancer conference coordinator monitors and evaluates the multidisciplinary cancer case conference(s) across the network and presents a report to the network cancer committee that includes all required elements. The report is documented in the network cancer committee minutes.

NCIN facilities are exempt from this standard of accreditation.

STANDARD 3.1: Facility Accreditation The network provides accreditation or licensure certificates for each facility within the network.

NCIN facilities provide documentation from the National Cancer Institute P30 grant that substitutes for documentation of facility accreditation. The NCIP uploads a copy of the grant award letter or other applicable documentation from the NCI. The grant must include all facilities included in the NCIN.

STANDARD 4.1: Physician Credentials **NCIN** facilities are exempt from this standard of accreditation.

STANDARD 4.4: Genetic Counseling and Risk Assessment The protocol must document how cancer-specific services are organized either centrally at the network level or at the individual facilities within the network. In either case services must meet the criteria set forth in Standard 4.4. For services provided at the network level through a centralized structure, details on how the needs of the patients at each facility within the network are being met must be documented. Reports to the network cancer committee must be comprehensive and represent compliance across the network.

Specifications by Category

STANDARD 4.5: Palliative Care Services The protocol must document how cancer-specific services are organized either centrally at the network level or at the individual facilities within the network. In either case services must meet the criteria set forth in Standard 4.5. For services provided at the network level through a centralized structure, details on how the needs of the patients at each facility within the network are being met must be documented. Reports to the network cancer committee must be comprehensive and represent compliance across the network.

STANDARD 4.6: Rehabilitation Care Services The protocol must document how cancer-specific services are organized either centrally at the network level or at the individual facilities within the network. In either case services must meet the criteria set forth in Standard 4.6. For services provided at the network level through a centralized structure, details on how the needs of the patients at each facility within the network are being met must be documented. Reports to the network cancer committee must be comprehensive and represent compliance across the network.

STANDARD 4.7: Oncology Nutrition Services The protocol must document how cancer-specific services are organized either centrally at the network level or at the individual facilities within the network. In either case services must meet the criteria set forth in Standard 4.7. For services provided at the network level through a centralized structure, details on how the needs of the patients at each facility within the network are being met must be documented. Reports to the network cancer committee must be comprehensive and represent compliance across the network.

STANDARD 4.8: Survivorship Program The protocol must document how services are organized either centrally at the network level or at the individual facilities within the network. In either case services must meet the criteria set forth in Standard 4.8. For services provided at the network level through a centralized structure, details on how the needs of the patients at each facility within the network are being met must be documented. Reports to the network cancer committee must be comprehensive and represent compliance across the network.

STANDARD 5.1: College of American Pathologist Synoptic Reporting The network cancer program must conduct an internal audit of cancer pathology reports which includes a minimum of 20 eligible surgical resection pathology reports from each facility within the network. The audit(s) must comply with the standard as written.

STANDARD 5.2: Psychosocial Distress Screening The protocol must document how cancer-specific services are organized either centrally at the network level or at the individual facilities within the network. In either case services must meet the criteria set forth in Standard 5.2. For services provided at the network level through a centralized structure, details on how the needs of the patients at each facility within the network are being met must be documented. Reports to the network cancer committee must be comprehensive and represent compliance across the network.

STANDARD 5.3: Sentinel Node Biopsy for Breast Cancer The network cancer program must conduct an internal audit of sentinel node biopsy operative reports which includes a minimum of 30 eligible operative reports from each facility within the network. The audit(s) must comply with the standard as written.

STANDARD 5.4: Axillary Lymph Node Dissection for Breast Cancer The network cancer program must conduct an internal audit of axillary lymph node dissection operative reports which includes a minimum of 30 eligible operative reports from each facility within the network. The audit(s) must comply with the standard as written.

STANDARD 5.5: Wide Local Excision for Primary Cutaneous Melanoma The network cancer program must conduct an internal audit of wide local excision for primary cutaneous melanoma operative reports which includes a minimum of 30 eligible operative reports from each facility within the network. The audit(s) must comply with the standard as written.

STANDARD 5.6: Colon Resection The network cancer program must conduct an internal audit of colon resection operative reports which includes a minimum of 30 eligible operative reports from each facility within the network. The audit(s) must comply with the standard as written.

STANDARD 5.9: Smoking Cessation for Patients with Cancer The network cancer program must conduct an internal audit for each facility within the network. The audit(s) must comply with the standard as written.

STANDARD 6.1: Cancer Registry Quality Control Each facility within the network must conduct a review of the accuracy of abstracted data for a minimum of 10% of its total analytic caseload each calendar year. The total number of cases reviewed across the network is capped at 500 cases per calendar year. If application of the 10% requirement to each facility would result in more than 500 total cases across the network, the total number of cases reviewed is limited to 500. In such instances, the number of cases reviewed at each facility must be proportional to that facility's share of the network's total annual analytic caseload.

Specifications by Category

STANDARD 7.1: Quality Measures The network cancer committee will annually monitor expected Estimated Performance Rates (EPRs) for quality measures selected by the CoC for each individual facility within the network and across the network as a whole. If the expected EPR is not met by an individual facility and/or across the network, an action plan must be developed and implemented and reported to the network cancer committee.

STANDARD 7.2: Monitoring Concordance with Evidence-Based Guidelines One study is completed at the network level. The choice of a patient population to review must be representative of and include the individual facilities within the network.

NCIN facilities are exempt from this standard of accreditation.

STANDARD 7.3: Quality Improvement Initiative Two quality improvement initiatives are required each year that include all required elements in Standard 7.3; one that includes all facilities within the network and one that is relevant to one or more facilities within the network.

STANDARD 7.4: Cancer Program Goal Two cancer program goals are required each year that meet the requirements of Standard 7.4; one network-wide goal that impacts coordination of care across the network and one that is relevant to one or more facilities within the network.

STANDARD 8.1: Addressing Barriers to Care Each facility within the network must address barriers to care in their demographic and geographic area and individually fulfills the specifics outlined in Standard 8.1. This can be a network-wide identified barrier to be addressed within each facility.

STANDARD 8.2: Cancer Prevention Event Each facility in the network must offer a prevention event that meets the needs of the demographic and geographic area and individually fulfills the specifics outlined in Standard 8.2. This can be a network-wide defined initiative implemented within each facility.

NCIN programs are exempt from this standard of accreditation.

STANDARD 8.3: Cancer Screening Event Each facility in the network must offer a screening event that meets the needs of their demographic and geographic area and individually fulfills the specifics outlined in Standard 8.3. This can be a network-wide defined initiative, implemented within each facility.

NCIN facilities are exempt from this standard of accreditation.

STANDARD 9.1: Clinical Research Accrual The network has a screening protocol to identify participant eligibility for clinical research studies and how to provide clinical trial information to patients across the network. These processes are assessed to identify and address barriers to enrollment and participation. Clinical research accrual percentages are calculated based on a cumulative accrual percentage met collectively across the network facilities. Within a network, individual patient accruals can only be counted once (if the patient is on a clinical trial but has been seen at more than one facility in the network, they can only be counted once).

NCIN facilities are exempt from this standard of accreditation.

National Cancer Institute (NCI)-Designated Comprehensive Cancer Center Program (NCIP)

STANDARD 2.1: Cancer Committee NCIP facilities are exempt from this standard of accreditation.

STANDARD 2.4: Cancer Committee Attendance NCIP facilities are exempt from this standard of accreditation.

STANDARD 2.5: Multidisciplinary Cancer Case Conference NCIP facilities are exempt from this standard of accreditation.

STANDARD 3.1: Facility Accreditation Documentation from the National Cancer Institute P30 grant substitutes for documentation of facility accreditation. The NCIP uploads a copy of the current grant award letter or other applicable documentation from the NCI.

Specifications by Category

STANDARD 4.1: Physician Credentials NCIP facilities are exempt from this standard of accreditation.

STANDARD 7.2: Monitoring Compliance with Evidence-Based Guidelines NCIP facilities are exempt from this standard of accreditation.

STANDARD 8.2: Cancer Prevention Event NCIP programs are exempt from this standard of accreditation.

STANDARD 8.3: Cancer Screening Event NCIP programs are exempt from this standard of accreditation.

STANDARD 9.1: Clinical Research Accrual NCIP programs are exempt from this standard of accreditation.

Hospital Associate Cancer Program (HACP)

STANDARD 2.1: Cancer Committee HACP facilities are exempt from the requirement to have a Clinical Research Coordinator as a member of the Cancer Committee.

STANDARD 9.1: Clinical Research Accrual HACP facilities are exempt from this standard of accreditation.

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

The following specifications apply to standalone Pediatric Cancer Programs (PCP) and to programs adding a specialty pediatric accreditation category to an existing CoC accreditation. The following specifications were effective beginning January 1, 2023.

If a standard is not referenced in this list, PCPs must meet the standard as written. CoC-PS programs do not need to demonstrate compliance with standards not referenced below.

STANDARD 1.1: Administrative Commitment The letter must address how pediatric care is administered relative to the rest of the cancer program (if applicable).

STANDARD 2.1: Cancer Committee Cancer committee includes either:
Pediatric subspecialists with applicable specialty pediatric certification/licensure (or other documented training) to include:

- Pediatric surgical specialist
- Pediatric hematology/oncology
- Pediatric radiology
- Pediatric pathology
- Pediatric oncology nurse

OR create a pediatric subcommittee that reports to the cancer committee to include the disciplines listed above.

NOTE: Radiation oncology is recommended, but not required under either structure.

STANDARD 2.2: Cancer Liaison Physician 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 Cancer 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.

STANDARD 2.3: Cancer Committee Meetings If a pediatric subcommittee is developed to meet Standard 2.1, it must meet quarterly.

STANDARD 2.4: Cancer Committee Attendance If a pediatric subcommittee is developed to meet Standard 2.1, the 75% attendance requirement must be met for both the cancer committee and the pediatric subcommittee. The attendance requirement is applied separately to each committee (in other words, the members of the cancer committee must attend 75% of the cancer committee meetings. Members of the subcommittee must attend 75% of the subcommittee meetings).

Specifications by Category

STANDARD 2.5: Multidisciplinary Cancer Conference For pediatric cancer conferences or for discussion of pediatric cancer patients, the following specialties must be represented:

- Pediatric surgical specialist
- Pediatric hematology/oncology
- Pediatric radiology
- Pediatric pathology
- Radiation oncology with experience treating pediatric patients.

Clinical and/or pathological staging discussions for pediatric patients must utilize standard staging methods for pediatric cancers.

STANDARD 3.2: Evaluation and Treatment Services There must be a radiologist available for referral to address side effects or complications of radiation exposure during cancer care for pediatric patients.

Required protocols must address pediatric cancer care, where applicable. Examples of quality assurance guidelines for pediatric care include: American Society of Pediatric Hematology/Oncology (ASPHO) and Association of Pediatric Hematology/Oncology Nurses (APHON).

STANDARD 4.1: Physician Credentials Pediatric cancer patient management must be conducted by a multidisciplinary team including physicians with pediatric training in surgery, hematology/oncology, radiology, and radiation oncology. Physicians are either board certified or demonstrate ongoing pediatric cancer-related education by earning 12 cancer-related CME hours each calendar year.

STANDARD 4.4: Genetic Counseling and Risk Assessment The process in place pursuant to evidence-based national guidelines for genetic assessment addresses pediatric malignancies such as hypodiploid acute lymphoblastic leukemia, choroid plexus tumor, hepatoblastoma, and anaplastic embryonal rhabdomyosarcoma. In creating the protocol, 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.

Programs adding a specialty pediatric accreditation to an existing CoC accreditation must complete two reviews by the cancer committee for "Evaluating Genetic Counseling and Risk Assessment Services" each calendar year: one for the adult cancer program, and a second review for the Pediatric Cancer Program.

STANDARD 4.6: Rehabilitation Care Services Protocols are in place to guide referral to appropriate pediatric rehabilitation care services on-site or by referral. The availability of pediatric rehabilitation care services is an essential component of comprehensive cancer care, beginning at the time of diagnosis and being continuously available throughout treatment, surveillance, and, when applicable, through end of life. Pediatric rehabilitation care services provide individualized therapies to pediatric and young adult patients appropriate to their developmental level and functional goals.

Rehabilitation professionals associated with cancer rehabilitation typically include, but are not limited to, pediatric trained:

- Physiatrists and advanced practice providers
- Physical therapists and physical therapy assistants
- Occupational therapists and occupational therapy assistants
- Speech language pathologists.

Programs adding a specialty pediatric accreditation to an existing CoC accreditation must complete two reviews by the cancer committee for "Evaluating Rehabilitation Care Services" each calendar year: one for the adult cancer program, and a second review for the Pediatric Cancer Program.

Specifications by Category

STANDARD 4.7: Oncology Nutrition Services Pediatric oncology nutrition services are provided, on-site or by referral, by Registered Dietitian Nutritionists (RDN) with knowledge and skills to address nutrition and hydration requirements and recommendations throughout the continuum of cancer care, including prevention, diagnosis, treatment, survivorship, and palliative care. In particular, nutrition services need to focus on the growing child and recognize all the phases of growth and development from infant to young adult.

Programs adding a specialty pediatric accreditation to an existing CoC accreditation must complete two reviews by the cancer committee for "Evaluating Oncology Nutrition Services" each calendar year: one for the adult cancer program, and a second review for the Pediatric Cancer Program.

STANDARD 4.8: Survivorship Program The Survivorship Program Coordinator develops a survivorship program team. Suggested specialties include pediatric physicians, advanced practice providers, nurses, social workers, psychologists, registered dietitians, physical therapists, and other allied health professionals. The survivorship program team determines a list of services and programs, offered on-site or by referral, that address the needs of pediatric cancer survivors.

Programs adding a specialty pediatric accreditation to an existing CoC accreditation must complete two reports to the cancer committee evaluating the activity of the survivorship program each calendar year: one for the adult cancer program, and a second report for the Pediatric Cancer Program. The survivorship program report for the specialty accreditation Pediatric Cancer Program only needs to evaluate one survivorship program service each calendar year.

Standalone Pediatric Cancer Programs must evaluate three survivorship program services each calendar year, as outlined in Standard 4.8.

STANDARD 5.1: College of American Pathologist Synoptic Reporting PCPs comply with this standard as written for eligible pediatric surgical resection pathology reports. Programs adding a specialty pediatric accreditation to an existing CoC accreditation must complete two internal audits that both comply with the standard as written. One audit for eligible adult surgical resection pathology reports, and a second audit for eligible pediatric surgical resection pathology reports.

STANDARD 7.2: Monitoring Concordance with Evidence-Based Guidelines One pediatric-focused study must be completed per standard requirements once each accreditation cycle. A study must be completed per standard requirements for an initial site visit.

STANDARD 8.1: Addressing Barriers to Care The barrier chosen is focused on pediatric cancer care. For programs adding a specialty pediatric accreditation to an existing CoC accreditation—If a barrier identified by the adult cancer program applies to pediatric cancer care, the same barrier can be used for both adult and pediatric compliance. The barrier and related standard compliance must be presented to each committee and documented in the cancer committee meeting minutes.

STANDARD 8.2: Cancer Prevention Event Starting in 2026, a prevention event is 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 cancer program is applicable to children and/or young adults, it can be used to support compliance for both the adult and pediatric compliance.

STANDARD 8.3: Cancer Screening Event A pediatric cancer screening event is not required for the Pediatric Cancer Program.

Programs adding a specialty pediatric accreditation to an existing CoC accreditation must comply with this standard as written, and offer a cancer screening event each calendar year for the adult cancer program.

Both PCPs and programs adding a specialty pediatric accreditation to an existing CoC accreditation must conduct screening and active surveillance of syndromic patients (Li-Fraumeni, Beckwith-Wiedemann, DICER1 among others) through an organized program in association with genetics.

STANDARD 9.1: Clinical Research Accrual The number of accruals to cancer-related clinical research studies meets or exceeds the required percentage of fifty percent. This could include non-Children's Oncology Group (COG) studies. In addition, COG membership is required.

Determining inclusion criteria (such as patient age) to calculate compliance with pediatric patient accrual to clinical research studies may follow the program's own definition for a pediatric patient. Programs adding a specialty pediatric accreditation to an existing CoC accreditation may only count a patient for accrual to a clinical research study one time. A single patient *cannot* count for both pediatric and adult accrual.

Programs adding a specialty pediatric accreditation to an existing CoC accreditation must complete two reports to the cancer committee evaluating clinical research accrual each calendar year: one for the adult cancer program, and a second report for the Pediatric Cancer Program.

Specifications by Category

The following standards are exempt for standalone Pediatric Cancer Programs (PCP) and will not be addressed at the CoC-PS visit:

- Standard 5.3: Sentinel Node Biopsy for Breast Cancer
- Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer
- Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma
- Standard 5.6: Colon Resection
- Standard 5.7: Total Mesorectal Excision
- Standard 5.8: Pulmonary Resection
- Standard 5.9: Smoking Cessation for Patients with Cancer
- Standard 7.1: Quality Measures

Programs Undergoing Initial Site Visit for Accreditation

STANDARD 2.2: Cancer Liaison Physician While the requirement to report NCDB data two 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 twice per year.

STANDARD 4.2: Oncology Nursing Credentials At the initial site visit for accreditation, nurses who do not have current cancer-specific certification must demonstrate ongoing education with documentation of six cancer-related Nursing Continuing Professional Development (NCPD) contact hours.

STANDARD 5.1: College of American Pathologists Synoptic Reporting If the internal audit reports compliance below the ninety percent (90%) compliance threshold, the site reviewer may request to review pathology reports as part of the compliance evaluation for this standard.

STANDARD 6.2: Data Submission Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 6.3: Data Accuracy Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 6.4: Rapid Cancer Reporting System: Data Submission Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 6.5: Follow-Up of Patients Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 7.1: Quality Measures Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

STANDARD 9.2: Commission on Cancer Special Studies Programs in all categories undergoing initial site visit for accreditation are exempt from this standard of accreditation.

Rural Cancer Program

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

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 an 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 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.

Glossary

ABCG: American Board of Genetic Counseling

ABMGG: American Board of Medical Genetics and Genomics

ABMS: American Board of Medical Specialties

ACAD: Academic Comprehensive Cancer Program

Accreditation report: Document released to cancer programs at the conclusion of the initial or reaccreditation site visit. The accreditation report includes rating compliance for each applicable standard and may include specific comments regarding the cancer program's performance. The accreditation report also states the assigned accreditation award and, if applicable, the corrective action due date.

ACGN: Advanced Clinical Genomics Nurse

ACR: American College of Radiology

ACRO: American College of Radiation Oncology

AGN-BC: Advanced Genetics Nursing Certification

AJCC: American Joint Committee on Cancer

Analytic case: Cases for which the hospital provided the initial diagnosis of cancer and/or for which the hospital contributed to first course treatment, if those cancers were diagnosed on or after the hospital's Reference Date and are diseases the CoC requires to be abstracted

ANCC: American Nurses Credentialing Center

Annually: Activity performed or monitored at least once every calendar year

AOA: American Osteopathic Association

AOCN®: Advanced Oncology Certified Nurse

AOCNP®: Advanced Oncology Certified Nurse Practitioner

AOCNS®: Advanced Oncology Certified Clinical Nurse Specialist

APRN: Advanced Practice Registered Nurse

ASCO: American Society for Clinical Oncology

ASHP: American Society of Health-System Pharmacists

ASTRO: American Society for Radiation Oncology

ALND: Axillary lymph node dissection

Barriers to care: Challenges to health care service delivery. May include patient-, system-, or provider-based barriers to accessing health and/or psychosocial care.

BMTCN®: Blood & Marrow Transplant Certified Nurse

Calendar year: January 1–December 31

Cancer Committee: The multidisciplinary group responsible for leading the cancer program and ensuring the compliance with CoC Standards

ACoS Cancer Programs: American College of Surgeons' programs focused on improving care and treatment for patients with cancer, including Commission on Cancer, National Accreditation Program for Breast Centers, National Accreditation Program for Rectal Cancer, the National Cancer Database, American Joint Committee on Cancer, and the Clinical Research Program

CAP: College of American Pathologists

CBCN®: Certified Breast Care Nurse

CCCP: Comprehensive Community Cancer Program

CCP: Community Cancer Program

CGN: Clinical Genomics Nurse

CGRA: Cancer Genetic Risk Assessment certification

CLP: Cancer Liaison Physician

CoC: Commission on Cancer

Corrective action: The process by which a cancer program shows they have met a standard(s) that was noncompliant at the time of the site visit

CME: Continuing Medical Education

CP³R: Cancer Program Practice Profile Reports

CPA: Cancer Program Administrator

CPHON®: Certified Pediatric Hematology Oncology Nurse

CPON®: Certified Pediatric Oncology Nurse

Glossary

CQIP: Cancer Quality Improvement Program, a report provided to accredited programs by the National Cancer Database that includes short-term quality and outcome data and long-term data, including five-year survival rates for commonly-treated malignancies

CTR: Certified Tumor Registrar, retired, *see* ODS

DMAIC: Acronym for Define, Measure, Analyze, Improve, and Control; DMAIC is a quality improvement method

DCIS: Ductal carcinoma in situ

Expected Estimated Performance Rate (EPR): A performance rate that a cancer program is expected to meet for an NCDB quality measure

FCCP: Freestanding Cancer Center Program

HACP: Hospital Associate Cancer Program

HPV: Human papillomavirus infection

INCP: Integrated Network Cancer Program

IRB: Institutional Review Board

NAPBC: National Accreditation Program for Breast Centers

NAPRC: National Accreditation Program for Rectal Cancer

NCCN: National Comprehensive Cancer Network

NCDB: National Cancer Database

NCI: National Cancer Institute

NCIN: NCI-Designated Network Cancer Program

NCIP: NCI-Designated Comprehensive Cancer Center Program

NCPD: Nursing Continuing Professional Development

NPCC: Nursing Portfolio Credentialing Commission

NSCLC: Non-small cell lung cancer

OCN®: Oncology Certified Nurse

ODS: Oncology Data Specialist

ONS: Oncology Nursing Society

OSW-C: Oncology Social Worker certified by the Board of Oncology Social Work.

ONCC: Oncology Nursing Certification Corporation

On-site: The accredited facility or off-campus locations that are owned or part of the hospital licensure

OSCS: *Operative Standards for Cancer Surgery;* a surgical manual published by the American College of Surgeons that provides recommendations regarding the effective technical conduct of surgical operations and review of the quality of evidence upon which those recommendations are based

PA: Physician Assistant

PCP: Pediatric Cancer Program

PDCA: Acronym for Plan, Do, Check, Act or Plan, Do, Check, Adjust; PDCA is a quality improvement method

PDSA: Acronym for Plan, Do, Study, Act; PDSA is a quality improvement method

Phase-in standard: Standard with a unique implementation timeline. More information may be found on the CoC website.

Policy and procedure: Retired terminology. See "Protocol"

Pre-Review Questionnaire (PRQ): An online reporting tool that is utilized to demonstrate compliance with CoC standards; formally known as the "Survey Application Record (SAR)"

Protocol: Previously referred to as "policies and procedures" in past versions of the CoC Standards, a protocol is a structured and consistent process crafted by the cancer program to help implement the required compliance criteria for specific CoC standards. Protocols must be written and documented in a manner that demonstrates compliance with whichever CoC standard the protocol is designed to address. Additionally, all protocols must be approved by the Cancer Committee. Identical protocols that apply to multiple sites within a CoC network are acceptable. Such protocols must be specifically stylized for each network site, as applicable. Protocols do not need to be officially-recognized hospital or institutional policies.

Glossary

QI: Quality improvement

Reference date: Start date established for CoC accredited registries

RD: Registered Dietitian

RDN: Registered Dietitian Nutritionist

Referral: Services provided to the patient at a facility or physician office external to the cancer program

RCRS: Rapid Cancer Reporting System

SCLC: Small-cell lung cancer

SCP: Survivorship Care Plan

Site visit: An on-site visit by a CoC site reviewer to review cancer program data to aid in determining compliance with CoC standards and the respective accreditation award. After initial accreditation, the on-site visit occurs once every three years. Formally known as the "survey."

Site Reviewer: CoC-trained professional who conducts on-site visits and reviews cancer program activity documentation. The site reviewer assists in verifying whether the cancer program is in compliance with the CoC standards. Formally known as the "surveyor."

SMART: Acronym for "Specific, Measurable, Achievable, Realistic, and Timely"; SMART format is a goal-setting method

Standard: Qualification criteria for CoC accreditation (not standard of care)

Synoptic format: A structured format that includes all of the following:

- All core elements must be reported (whether applicable or not),
- All core elements must be reported in a "diagnostic parameter pair" format, in other words, data element followed by its response (answer),
- Each diagnostic parameter pair must be listed on a separate line or in a tabular format to achieve visual separation, and
- All core elements must be listed together in one location in the pathology or operative report

TME: Total mesorectal excision

USP: United States Pharmacopeia

VACP: Veteran Affairs Cancer Program

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