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.

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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4.4 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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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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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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