CoC Cancer Program Standards
Clarifications and Modifications Made Since the January 2004 Implementation

**Standard 1.1: The facility is accredited by a recognized authority appropriate to the facility type.**

*Cancer Program Standards 2004* sets forth the eligibility requirements for CoC-approved cancer programs and facilities that are applying for approval. Two additional accreditation methods have been recognized as meeting the eligibility requirement.

State Accreditation or Licensure: Accreditation or licensure of a hospital through a state agency allows the facility to receive Medicare payments and is equivalent to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA) accreditation.

American College of Radiation Oncology (ACRO): The ACRO practice accreditation fulfills the eligibility requirements for freestanding cancer center programs and integrated cancer programs offering radiation oncology services. *(CoC Flash, July 2004)*

**Standard 2.3: One coordinator is designated for each of the four areas of cancer committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach.**

The following Frequently Asked Questions clarify the requirements for Standard 2.3.

**Question:** Since we have the four coordinators, does this mean we no longer need to have a committee chair?

**Answer:** No. Standard 2.3 was created to promote team involvement and shared responsibility. Standard 2.2 states the specific requirements for cancer committee membership and requires a committee chair.

**Question:** Are the four coordinators required to be physicians or can they be from the general hospital staff?

**Answer:** The coordinators are chosen on the basis of their specialty, knowledge, and skills. Both physician and non-physician members of the committee may be selected as coordinators. The Community Outreach Coordinator role must be assigned to the cancer liaison physician. The roles and responsibilities are defined by the cancer committee.

**Question:** Does the Community Outreach Coordinator have to be the cancer liaison or can the cancer committee assign another physician?

**Answer:** The Commission on Cancer requires that the cancer liaison physician be the Community Outreach Coordinator.
Question: If I am the cancer liaison physician and we have an Outreach Coordinator who is an active cancer committee member and engaged with local ACS cancer control staff, do I need to assume this role to meet the new standards? Can we establish co-coordinator roles so that I can be a partner making sure we are in compliance, remaining active, and visible at events?

Answer: In some facilities, the coordinator(s) work cooperatively with established departments or staff leadership to coordinate, monitor, and recommend improvements to the assigned area(s) or programs. In this instance, the Community Outreach Coordinator acts as a liaison with the established departments or staff leadership and the cancer committee.

Question: What are examples of the cancer liaison physician activities for community outreach?

Answer: Activities of the cancer liaison physician include: 1. Developing goals for the community outreach program to include the provision of support services and prevention and early detection programs; 2. Working with the local American Cancer Society representatives on strategies to accomplish community outreach goals and other cancer control projects of interest to the facility; 3. Using NCDB Hospital Comparison Benchmark Reports to study patterns of care at the facility and quality improvement initiatives targeted at improving identified gaps in care. (CoC Flash, April 2004)

**Standard 2.3 Coordinators**

Working with the Committee on Approvals, the Committee on Cancer Liaison voted to add additional flexibility to the Cancer Liaison Physician participation in the Coordinator role.

Effective immediately, the Cancer Liaison Physician is no longer required to be appointed as the Community Outreach Coordinator. This is especially appropriate in facilities with a community outreach department or those with staff in one or more departments who are responsible for community outreach activities.

In these cases, the Cancer Liaison Physician could serve as a facilitator for community outreach who would work to foster involvement by the American Cancer Society. The Cancer Liaison Physician could also select another coordinator role (such as the quality of cancer registry data) in an area of their particular interest.

The Committee on Cancer Liaison will be establishing a task force to further define and clarify the Cancer Liaison Physician role to include establishing a definition for Community Outreach facilitator. (CoC Flash, June 2005)

**Standard 2.6: The cancer committee establishes the cancer conference frequency and format on an annual basis.**

The cancer committee is to establish and document both the cancer conference frequency and format on an annual basis. The frequency refers to the number of times the conference will be held for the year. The format types include: network-wide, facility-wide, departmental, and site-focused. Both are to be established for each type of cancer conference held by the facility.
Please see the SAR Training Guide for further definitions. *(CoC Flash, June 2004)*

**Standard 2.7: The cancer committee establishes the multidisciplinary attendance requirements for cancer conferences on an annual basis.**

The cancer committee is to designate the specialties that are required to attend, as well as the frequency (how often) each specialty is required to attend. Both are to be established for each type of cancer conference held by the facility.

**Documentation:**

The Survey Application Record (SAR) and/or the cancer conference grid alone do not meet the criteria for documenting cancer committee involvement in these activities. Formal documentation of these activities is required in either the cancer committee minutes, Cancer Program policy and procedure, or other source that is reviewed annually by the committee.

Deficiencies will be given to programs surveyed during 2004 if there is no formal documentation of activities in these four areas (conference frequency, conference format, physician specialty attendance, and physician attendance frequency). However, this deficiency can be appealed within 90 days of receiving the Performance Report if the 2004 cancer committee minutes show that the cancer committee established each of the cancer conference requirements. *(CoC Flash, June 2004)*

**Standard 3.3: For each year between survey, 90 percent of cases are abstracted within six months of the date of first contact.**

The January 2004 issue of *CoC Flash* clarified the abstracting extension granted to CoC-approved programs and the deadline for completion of the 2003 abstracting. Cancer registries in approved programs were allowed to delay the start of abstracting for the 2003 cases until January 1, 2004, and were expected to complete the 2003 abstracting on time (June 30, 2004).

**Problem:** While this time frame and up-to-date abstracting are needed for timely data submission to the NCDB and to meet the requirement for Standard 3.3, the deadline resulted in a significant increase in workload for many approved programs. It could also lead to an increased number of deficiency awards for Standard 3.3.

**Action:** The Committee on Approvals has extended the 2003 abstracting completion deadline to September 30, 2004. The Committee on Approvals clarified that abstracting of 2004 cases must begin and end on time (July 1, 2004 - June 30, 2005), and that abstracting of 2004 cases is expected to comply with the stated requirement- "90 percent of cases are abstracted within six months of the date of first contact."

The 1+ (Commendation) rating is not applicable for surveys performed during 2004, and will not be used during 2004 to calculate the CoC Outstanding Achievement Award. *(Special Edition, CoC Flash, May 14, 2004)*

**Standard 3.5: A 90 percent follow-up rate is maintained for all analytic patients diagnosed within the last five years, or from the cancer registry reference date, whichever is shorter.**
To calculate compliance with this standard prior to June 30, 2004, use January 1, 1998, unless your reference year is more recent. After July 1, 2004, then January 1, 1999 should be used. (CoC Flash, January 2004)

**Standard 4.2 Inpatient medical oncology unit**

Effective immediately, additional flexibility was added to the requirements so that facilities categorized as Teaching Hospital Cancer Programs (THCP) with a smaller caseload and limited resources can meet the standard by either referring patients needing inpatient medical oncology care to a larger facility with an inpatient medical oncology unit or by establishing a functional equivalent. This modification most often applicable to VA facilities, but applies to all programs. (CoC Flash, June 2005)

**Standard 4.3: AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on 90 percent of eligible annual analytic cases.**

The *Cancer Program Standards 2004* publication specifies that, "Staging elements or stage group assigned by medical students or residents, cancer registrars, or other nonphysician professionals and recorded on the staging form in the medical record do not meet the requirement for this standard."

Residents and fellows provide patient care under the supervision of faculty or attending physicians and, in some facilities, are considered to be the patient's managing physician. Residents and fellows are authorized to record information and sign forms in the patient's medical record.

**Problem:** By restricting the participation of residents and fellows in the staging process, we do not reinforce the importance of physician staging, and limit the practical education of new physicians in the appropriate use of the AJCC staging schema.

**Action:** The Committee on Approvals has modified this standard to allow residents and fellows to assign the staging elements and stage group on the staging form in the medical record with a co-signature by the faculty or attending physician. The Executive Committee of the American Joint Committee on Cancer (AJCC) also supports this change.

The *Cancer Program Standards 2004* will be modified to read, "Staging elements or stage group assigned by residents or fellows and recorded on the staging form in the medical record, and co-signed by a faculty or attending physician, meets the requirement for this Standard. Staging elements or stage group assigned by medical students, cancer registrars, or other nonphysician professionals and recorded on the staging form in the medical record do not meet the requirement for this Standard." (Special Edition, CoC Flash, May 14, 2004)

**Standard 4.3: AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on 90 percent of eligible analytic cases.**

**Problem:** The requirement for staging to appear on a form in the medical record was established to assist the physician with correctly assigning staging by providing staging details for each site
and to standardize the location for staging within the medical record; thereby simplifying the monitoring of compliance with the standard by both programs and cancer program surveyors. Not considered at the time Standard 4.3 was established was the impact of requiring a staging form in many facilities.

**Action:** The CoC Executive Committee voted to modify Standard 4.3 as follows:

AJCC staging (T, N, M elements and Stage Group) is assigned by the managing physician and recorded in a standardized location(s) in the medical record on 90 percent of eligible analytic cases.

The definition and requirement for the standard will now include the following statement: "The cancer committee develops a staging policy and procedure and works cooperatively with other facility committees or departments to establish a standardized location(s) for staging to be recorded in the facility's medical record. The standardized location(s) is documented in the facility's AJCC Staging Policy and Procedure."

There is no change to the statement currently in Cancer Program Standards 2004, "Use of the AJCC staging forms is highly recommended."

This change enables facility-based flexibility, but still achieves the overall goal which is to standardize the location(s) for staging information. The change in this standard will be effective January 1, 2005, to allow programs adequate time to modify their AJCC Staging Policy and Procedure.

In each case, the rating definition for this standard will be modified to replace the reference to the staging form.

Rate (1+) Commendation: The managing physician assigns AJCC staging and records it in a standardized location(s) in the medical record for more than 95% of eligible analytic cases.

Rate (1) Compliance: The managing physician assigns AJCC staging and records it in a standardized location(s) in the medical record for 90 percent of eligible analytic cases.

Rate (5) Noncompliance: The managing physician assigns AJCC staging and records it in a standardized location(s) in the medical record for less than 90 percent of eligible analytic cases.

*(CoC Flash, October 2004)*

**Standard 4.6: The guidelines for patient management and treatment currently required by the CoC are followed.**

The Cancer Program Standards 2004 publication specifies that the CoC requires that 90 percent of pathology reports that include a cancer diagnosis will contain the scientifically validated data elements outlined on the surgical case summary checklist of the College of American Pathologists (CAP) publication, *Reporting on Cancer Specimens.*
**Problem:** Cancer Programs staff have received numerous questions about what information or data must be included in the microscopic description of cancer-related pathology reports and the form that must be used to show this information.

**Action:** The Committee on Approvals has clarified that all of the scientifically validated data elements enumerated in the site-specific, specimen-appropriate College of American Pathologists guidelines must be included in cancer-directed surgical specimens, except for cytologic specimens, diagnostic biopsies, palliative resection specimens, and special studies.

Further, the Committee has clarified that:

1) A specific style of report is not required. Both synoptic or narrative reporting are acceptable, however, synoptic reporting is preferred.
2) There is no set order in which the elements must appear.
3) No specific location for the scientifically validated elements within the pathology report has been set. For example, the scientifically validated data elements may be reported in either the macroscopic [Gross] description, the Microscopic description, the Pathologic Diagnosis, or the Special Studies section of the report.

**Standard 7.2:** Other than cancer conferences, all members of the cancer registry staff participate in a local, state, regional, or national cancer-related educational activity each year.

The 1+ (Commendation) rating for this Standard specifies that, "The cancer registry staff who are CTRs attend a national cancer-related educational activity annually."

The standard was established to encourage education for all members of the cancer registry staff. The 1+ (Commendation) rating was established to recognize the strategic educational and networking opportunities provided by attendance at national meetings.

Cancer Programs staff have previously clarified that a national meeting is one sponsored by a national organization and targeted to a national audience. Examples include, but are not limited to, the National Cancer Registrars Association (NCRA) Annual Meeting and Workshop held this year in Portland, OR as well as Commission on Cancer Survey Savvy workshops held in conjunction with another meeting (NCRA) or in Chicago, IL.

**Problem:** As written, the 1+ (Commendation) rating could have an impact on effective registry operations as well as operational budgets. It may place an undue burden on registries with more than one CTR if there are multiple staff absences due to annual attendance at a national meeting.

**Action:** The Committee on Approvals has changed the definition of the 1+(Commendation) rating for Standard 7.2 to read, "The cancer registry staff who are CTRs attend a national cancer-related educational activity once every three years."

**2004 Rating Modifications for Standard 7.2:**
The 1+ (Commendation) rating is not applicable for surveys held during 2004, and will not be used during 2004 to calculate the CoC Outstanding Achievement Award. (Special Edition, CoC