The American College of Surgeons does not warrant or make any guarantees or assurances related to outcomes of treatment provided by institutions that have cancer programs approved by the Commission on Cancer.

The examples used herein are to be used as guidelines and are not wholly inclusive of all options.
DEDICATION

This publication is dedicated to individual cancer program team members. Your participation in the Commission on Cancer Approvals Program exemplifies a steadfast commitment to providing the best care possible for your cancer patients and members of your community. Your leadership and expertise contribute to the entire scope, organization, and performance of the cancer program. Your vision is a catalyst for continued growth and improvement to ensure the delivery of quality cancer care.
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The Commission on Cancer is a consortium of professional organizations dedicated to reducing the morbidity and mortality of cancer through education, standard setting, and the monitoring of quality care.

Established by the American College of Surgeons (ACoS) in 1922, the multidisciplinary Commission on Cancer (CoC) sets standards for quality multidisciplinary cancer care delivered primarily in hospital settings; surveys facilities to assess compliance with those standards; collects standardized and quality data from approved facilities to measure treatment patterns and outcomes; and uses the data to evaluate hospital provider performance and develop effective educational interventions to improve cancer care outcomes at the national and local levels.

Commission membership consists of more than 100 individuals representing the multidisciplinary professionals of the cancer care team. Members include representatives from the ACoS and 38 national, professional member organizations. Each representative serves on one standing committee or disease site team that works to reach the Commission’s goals by:

- Establishing standards for cancer programs and evaluating and accrediting programs according to those standards.
- Coordinating the annual collection, analysis, and dissemination of data from CoC-approved cancer programs for all cancer sites and conducting national site-specific studies. Each of these efforts supports the assessment of patterns of care and outcomes of patient management, which lead to improvements in the quality of cancer care.
- Coordinating the activities of a nationwide network of more than 1,500 physician-volunteers who provide state and local support for Commission and American Cancer Society cancer control initiatives.
- Providing oversight and coordination for educational programs of the Commission that are geared toward physicians, cancer registrars, cancer program leadership, and others.
- Providing clinical oversight and expertise for Commission standard-setting activities.

COMMISSION ON CANCER APPROVALS PROGRAM

The Approvals Program encourages hospitals, treatment centers, and other facilities to improve their quality of patient care through various cancer-related programs. These programs are concerned with prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease, support services, and end-of-life care. The availability of a full range of medical services along with a multidisciplinary team approach to patient care at approved cancer programs have resulted in approximately 80 percent of all newly diagnosed cancer patients being treated in Commission on Cancer approved cancer programs.

Obtaining care at a CoC-approved cancer program ensures that one will receive:

- Quality care close to home.
- Comprehensive care offering a range of state-of-the-art services and equipment.
- A multispecialty, team approach to coordinate the best cancer treatment options available.
- Access to cancer-related information, education, and support.
- A cancer registry that collects data on cancer type, stage, and treatment results, and offers lifelong patient follow-up.
- Ongoing monitoring and improvement of care.
- Information about clinical trials and new treatment options.

Approval by the Commission on Cancer is granted only to those facilities that have voluntarily committed to provide the best in cancer diagnosis and treatment and are able to comply with established CoC standards. Each cancer program must undergo a rigorous evaluation and review of its performance and compliance with the CoC standards. In order to maintain approval, facilities with approved cancer programs must undergo an on-site review every three years.

The structure outlined in CoC Cancer Program Standards 2004 ensures that each cancer program seeking approval provides all patients with a full range of diagnostic, treatment, and supportive services either on-site at the facility or by referral.

There are currently more than 1,400 CoC-approved cancer programs in the United States and Puerto Rico, representing close to 25 percent of all hospitals. These programs are supported by a network of more than 1,500 volunteer physician representatives appointed to maintain cancer program approval, or establish a new program, and to work with the local American Cancer Society on cancer-control activities for the community.
BENEFITS OF BEING A COC-APPROVED CANCER PROGRAM

The Commission on Cancer’s Approvals Program offers many notable benefits that will enhance a cancer program and its quality of patient care.

CoC-approved cancer programs:

- Are recognized by other national health care organizations, including the JCAHO, as having established performance measures for high-quality cancer care.
- Serve as a model for organizing and managing a cancer program to ensure multidisciplinary, integrated, and comprehensive oncology services.
- Meet the demands for oncology data from clinicians and other health care professionals, third-party payers and managed care organizations, and the public because of the requirement for a cancer registry.
- Participate in a network of quality cancer programs that provide care to 80 percent of newly diagnosed cancer patients.
- Receive free marketing and national public exposure by partnering with the CoC and American Cancer Society (ACS) in the Facility Information Profile System (FIPS)—an information sharing effort of resources, services, and cancer experience for the ACS National Call Center and Web site.
- Receive an Approved Cancer Program Performance Report that allows a facility to compare its mandatory standard ratings with other approved programs in the state, nationally, and in the same cancer program category to identify quality improvement initiatives.
- Participate in the National Cancer Data Base (NCDB)—a nationwide oncology outcomes database for CoC-approved cancer programs.
- Receive immediate feedback on the quality of data submissions to the NCDB based on national standardized data edit reports.
- Have access to benchmark reports containing national aggregate data and individual facility data to assess patterns of care and outcomes relative to national norms.
- Participate in CoC special studies for the ad hoc collection of specific data to address important cancer problems.

Being a CoC-approved cancer program demonstrates a facility’s ongoing commitment to providing high-quality, multidisciplinary cancer care. The Commission wishes to acknowledge the hard work and dedication these programs put forth in meeting the CoC standards, improving the reliability of cancer data, and enabling the best possible outcomes for today’s cancer patients.

MEMBER ORGANIZATIONS OF THE COMMISSION ON CANCER

American Academy of Hospice and Palliative Medicine (AAHPM)
American Academy of Pediatrics (AAP)
American Association for Cancer Education (AACE)
American Cancer Society (ACS)
American College of Obstetricians and Gynecologists (ACOG)
American College of Oncology Administrators (ACOA)
American College of Physicians-American Society of Internal Medicine (ACP-ASIM)
American College of Radiology (ACR)
American College of Surgeons (ACoS)
American Dietetic Association (ADA)
American Head and Neck Society (AHNS)
American Hospital Association (AHA)
American Joint Committee on Cancer (AJCC)
American Medical Association (AMA)
American Pediatric Surgical Association (APSA)
American Society for Psychosocial and Behavioral Oncology/AIDS (ASPBOA)
American Society of Clinical Oncology (ASCO)
American Society of Colon and Rectal Surgeons (ASCRS)
American Society for Therapeutic Radiology and Oncology (ASTRO)
American Urological Association (AUA)
Association of American Cancer Institutes (AACI)
Association of Cancer Executives (ACE)
Association of Community Cancer Centers (ACCC)
Association of Oncology Social Work (AO SW)
Canadian Society of Surgical Oncology (CSSO)
Centers for Disease Control and Prevention (CDC)
College of American Pathologists (CAP)
Department of Defense (DoD)
Department of Veterans Affairs (VA)
International Union Against Cancer (UICC)
National Cancer Institute: Surveillance, Epidemiology, and End Results (SEER) Program
National Cancer Registrars Association (NCRA)
National Surgical Adjuvant Breast and Bowel Project (N SABP)
North American Association of Central Cancer Registries (N AACCR)
Oncology Nursing Society (ONS)
Society of Gynecologic Oncologists (SGO)
Society of Surgical Oncology (SSO)
Society of Thoracic Surgeons (STS)
## ACKNOWLEDGMENTS

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### SPECIAL ACKNOWLEDGMENTS

Cancer Program Surveyors  
Cancer Program Constituents
THE APPROVALS PROGRAM

Standards for the evaluation of cancer clinics and registries were first published in 1930 by the American College of Surgeons Committee on the Treatment of Malignant Disease. The first surveys of cancer clinics were conducted in 1931. Since that time, the standards for cancer programs have been revised and expanded to reflect both the comprehensive scope of cancer programs and the continuous changes in the health care environment.

The Committee on Approvals administers the activities of the Commission on Cancer (CoC) Approvals Program, which was designed to ensure that the structures and processes necessary for quality cancer care are in place. The CoC standards for cancer programs promote and support the four historic cornerstones of the Approvals Program: multidisciplinary cancer committee, cancer conferences, evaluation of quality outcomes and improvements, and a cancer registry.

Recognizing that cancer is a complex group of diseases, the CoC Cancer Program Standards promote consultation among surgeons, medical and radiation oncologists, diagnostic radiologists, pathologists, and other cancer specialists. This multidisciplinary cooperation results in improved patient care.

ELIGIBILITY

Hospitals, freestanding treatment facilities, and health care networks are eligible to participate in the CoC Approvals Program. Each facility ensures that patients have access to the full scope of services required to diagnose, treat, rehabilitate, and support patients with cancer and their families. Prevention and early detection services are made available to the community. Services are provided on-site, by referral, or are coordinated with other facilities or local agencies.

Five elements are key to the success of a Commission-approved cancer program:

- The clinical services provide state-of-the-art pretreatment evaluation, staging, treatment, and clinical follow-up for cancer patients seen at the facility for primary, secondary, tertiary, or quaternary care.
- The cancer committee leads the program through setting goals, monitoring activity, and evaluating patient outcomes and improving care.
- The cancer conferences provide a forum for patient consultation and contribute to physician education.
- The quality improvement program is the mechanism for evaluating and improving patient outcomes.
- The cancer registry and database is the basis for monitoring the quality of care.

The basic services that must be provided by every Commission-approved cancer program are:

- Diagnostic
  - Clinical laboratory
  - Diagnostic imaging
- Treatment
  - Medical oncology
  - Radiation oncology
  - Surgical procedures
- Other clinical
  - AJCC staging
  - Clinical research
  - Patient guidelines
  - Oncology nursing
  - Pain management
- Rehabilitation
- Support
  - Counseling
  - Discharge planning
  - Hospice care
  - Nutritional support
  - Pastoral care
  - Patient and family support
- Prevention and early detection
• Establishes a reference date and ensures that the cancer registry database includes two complete years of data and one year of follow-up activity.

• Meets the requirements for all standards outlined in Cancer Program Standards 2004.

• Participates in a consultative evaluation of the cancer program performed by a Commission-trained independent cancer program consultant or other cancer registry professional.

• Submits a request for survey to Cancer Programs staff.

• Signs the American College of Surgeons Commission on Cancer Business Associate Agreement in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

• Submits data for all analytic cases for the last completed year to the NCDB.

At the beginning of the survey year, an initial notification is provided to facilities due for survey that year. In preparation for survey, the cancer committee at each Commission-approved facility:

• Assesses program compliance with the requirements for all standards outlined in Cancer Program Standards 2004.

Due to extenuating circumstances, a survey extension may be required. Valid reasons for extensions include, but are not limited to:

• Database conversion

• Extended registry staff shortage

• Hospital mergers

Each request is made in writing to Cancer Programs staff by the Cancer Committee Chair within 60 days of the initial notification. Requests for extension are given individual consideration. A maximum extension of one year may be granted. Facilities are notified of extension decisions, and the new target date for survey is provided.

Cancer Programs staff match a cancer program surveyor to each program due for survey. The facility is notified of the surveyor assignment and target date for survey. The surveyor’s name, credential(s), mailing address, phone number, and e-mail address are provided to the facility. Surveyor curriculum vitae are kept on file and are made available on request by the facility.

The facility may decline the assigned surveyor within 30 days of notification of assignment if a conflict of interest exists. A conflict of interest is defined as:

• Affiliation with the facility being surveyed.

• Affiliation with another facility in direct competition with the facility being surveyed.

The new surveyor assignment will be provided to the facility within 30 days of notification of the conflict of interest.

Selection of a survey date is coordinated among the facility, surveyor, and Cancer Programs staff and must be scheduled within the year the survey is due. Confirmation of the survey date and time is provided to the facility administrator a minimum of 30 days prior to the on-site visit.

THE SURVEY APPLICATION RECORD (SAR)

To facilitate a thorough and accurate evaluation of the cancer program, the facility completes or updates the Web-based Survey Application Record (SAR) 30 days before the scheduled on-site visit. The cancer registrar is provided with password-protected access to the facility’s SAR and notified when the SAR is available for completion.

Completion of the SAR should be a team effort of members of the cancer committee, with one individual chosen to coordinate the activity and complete the SAR. Each year, the facility is notified of the areas requiring annual updates. If not updated on the annual schedule, all information must be provided prior to survey.

In addition to capturing information about cancer program activity, the individual(s) responsible for completing portions of the SAR will perform a self-assessment and rate compliance with each standard using the Cancer Program Standards Rating system.

A portion of the information collected in the SAR describing the facility’s resources and services is automatically shared with the American Cancer Society (ACS) as part of the Facility Information Profile System (FIPS) for posting on the ACS Web site (www.cancer.org). The data sharing activity of the FIPS program is designed to benefit all CoC-approved cancer programs. This facility-specific information is made available to cancer patients, caregivers, and the general public, which enables them to make more informed decisions about their options for cancer care.

The facility can use the SAR or access FIPS directly to update the resource and service information for sharing with the ACS. By accessing FIPS directly, the facility is also provided the option to release annual caseload data as submitted to the CoC’s National Cancer Database (NCDB). This provides the public with site and stage data for cancer patients seen at the facility.

Password-protected access to FIPS is provided to the cancer registrar, cancer committee chair, and Cancer Liaison Physician through an e-mail notification system. The SAR and FIPS are accessed through CoC DataLinks located on the Cancer Programs page of the American College of Surgeons Web site at www.facs.org.

The Cancer Program Surveyor reviews the facility’s Web-based SAR prior to the on-site visit.

DOCUMENTATION OF PROGRAM ACTIVITY

Facilities document cancer program activity and provide the documentation outlined in each standard to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.
Cancer committee minutes are a primary resource for documenting program organization and operation, and monitoring programmatic activity. Other methods or sources of documentation are acceptable and are provided to the surveyor in advance of the on-site visit as specified.

The following documentation is provided to the surveyor in advance of the on-site visit:

- A copy of the certificate of accreditation or letter from the accrediting body.
- Bylaws, policies and procedures, or other facility-approved methods used to document the level of responsibility and accountability designated to the cancer committee.
- Copies of all cancer committee minutes from the time of the previous survey through the present date.
- Documentation of subcommittee and workgroup structure and activity.
- Documentation of the annual goals, time frame for evaluation and completion, assigned coordinator, and responsibilities of other committee members through cancer committee minutes or other sources.
- Documentation of the annual frequency and format of cancer conferences, the multidisciplinary attendance requirement for the cancer conferences of the cancer program, the annual case presentation at cancer conferences, and the monitoring of cancer conference activities and corrective action taken through cancer committee minutes or other sources.
- Cancer committee minutes or other sources that show the results of the outcomes analysis and method of dissemination.
- A copy of the published annual report, if appropriate.
- Documentation of referred radiation oncology services and resources.
- Documentation that identifies the medical oncology unit or functional equivalent.
- A copy of the written policy and procedure for physician staging.
- Documentation of annual quality control activities through the cancer committee minutes or other sources.
- Verification of current credentialing from the National Cancer Registrars Association (NCRA) for all CTRs on staff at the facility, or documentation of recruitment efforts and/or plans for current staff certification including, but not limited to, education and training activities and the target date for examination for facilities not staffed by a CTR.
- Documentation of case abstracting by a CTR or data supervision responsibilities of the CTR.
- Documentation that the cancer registry policy and procedure manual or the registry software manual specifies the use of the CoC data standards.
- Documentation of the cancer committee's policies for obtaining follow-up information and a current follow-up report.
- A copy of organizational chart or a staff list noting credentials of the nursing clinical expert(s), documentation of orientation and annual competency evaluation for each oncology nurse, and documentation of nursing management of the medical oncology unit or functional equivalent as appropriate to the category.
- A copy of the pathology report format for the major cancer experience(s) at the facility showing the inclusion of the scientifically proven data elements.
- Documentation of the monitoring of and compliance with the patient management and treatment guidelines currently required by the CoC as well as others adopted and used by the facility.
- A copy of documentation of rehabilitation services available on-site or by referral, the process for access to rehabilitation services, documentation of the annual evaluation of the rehabilitation services, and patient brochures or other materials that outline rehabilitation services.
- Documentation of policies and procedures for providing information about cancer-related clinical trials to patients.
- Documentation of the supportive services offered to patients and their families on-site or by referral. Documentation includes, but is not limited to, published brochures or flyers, meeting schedules, and Internet or Intranet postings.
- Documentation of two annual prevention or early detection programs through cancer committee minutes or other sources.
- Documentation of the methods to monitor and evaluate the community outreach activities.
- Documentation of an annual educational activity, other than cancer conferences, including a published notice or agenda.
- Documentation of continuing education activity for each member of the cancer registry staff.
- Summaries of each year's studies of quality and outcomes, including the study topic, analyses, recommendations, and follow-up.
- Summaries of each year's patient care improvements.

The surveyor will review a minimum of 25 medical records to evaluate AJCC staging by the managing physician, the pathology reports that contain the scientifically validated data items, and the quality of the abstracted data.
The surveyor may also review the following documentation:

- Written policy or plan outlining the system of referral
- Policy and procedure manual for:
  - Nursing
  - Social services
  - Rehabilitation
  - Hospice
  - Discharge planning team
  - Institutional Review Board (if applicable)
- Policy and procedure for peer review (if applicable)

**PAYMENT OF SURVEY FEE**

An invoice for the survey fee will be mailed to the cancer registrar within 30 days of the date of the scheduled survey. Payment of the invoice is due within 30 days of receipt. Survey results will not be released until the survey fee is paid.

Programs are discouraged from canceling or postponing the scheduled survey. If this becomes necessary, the facility must contact Cancer Programs staff and submit a written notification. The facility will be assessed a cancellation fee in addition to nonrefundable fees incurred by the surveyor.

**GUIDELINES FOR ON-SITE REVIEW**

The cancer registrar confirms the agenda for the on-site visit with the surveyor at least 14 days prior to the visit.

The surveyor meets with key members of the program to discuss the facility and the program and to verify data on the SAR. The surveyor's role is to assist in accurately defining the standards and verifying that the facility's cancer program is in compliance with the standards. The surveyor also discusses the goals and responsibilities of the cancer committee in relationship to the cancer program.

At a minimum, the surveyor must meet with:

- Member of Administration
- Cancer Committee Chair
- Cancer Liaison Physician
- Cancer Registrar

The surveyor may also request meetings with other members of the cancer committee or other members of the cancer care team:

- Clinical research
- Hospice services
- Nursing
- Social services
- Quality improvement
- Diagnostic radiology
- Radiation oncology
- Pastoral care
- Discharge planning team
- Public education

Following a review of documentation and discussion with the members of the cancer care team, a wrap-up session will be held with all available members of the cancer care team. The Cancer Program Surveyor will delineate the program's strengths and weaknesses and offer suggestions to correct any noted deficiencies. The Cancer Program Surveyor will respond to questions regarding the standards, SAR, and rating system with program leadership.

**CANCER PROGRAM STANDARDS RATING SYSTEM**

The following rating system is used to assign a compliance rating to each standard:

1+ — Commendation
1 — Compliance
5 — Noncompliance
8 — Not Applicable

Based on the rating criteria specified for each standard, a compliance rating is assigned by the facility, surveyor, and Cancer Programs staff.

A deficiency is defined as any standard with a rating of 5. A deficiency in one or more standards will affect the approval award.

The Commendation rating (1+) is valid for nine (25 percent) of the standards, as follows:

- Standard 2.11 Each year the cancer committee analyzes patient outcomes and disseminates the results of the analysis.
- Standard 3.3 For each year between survey, 90 percent of cases are abstracted within six months of the date of first contact.
- Standard 3.7 Cases submitted to the NCDB for the most recent accession year requested meet the established quality criteria included in the annual Call for Data.
- 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.
- Standard 4.6 The guidelines for patient management and treatment currently required by the CoC are followed.
- Standard 5.2 As appropriate to category, the required percentage of cases is accrued to cancer-related clinical trials on an annual basis.
- Standard 6.2 Each year, two prevention or early detection programs are provided on-site or coordinated with other facilities or local agencies.
- 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.
- Standard 8.2 Annually, the cancer committee implements two improvements that directly affect cancer patient care. The improvements are documented.
Approval awards are based on consensus ratings by the Cancer Program Surveyor, Cancer Programs staff, and when required, the Program Review Subcommittee for the 36 standards.

<table>
<thead>
<tr>
<th>APPROVAL AWARD MATRIX</th>
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<tbody>
<tr>
<td>FULL APPROVAL (THREE YEARS)</td>
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<tr>
<td>THREE-YEAR APPROVAL WITH CONTINGENCY</td>
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<tr>
<td>NONAPPROVAL</td>
</tr>
<tr>
<td>APPROVAL DEFERRED (VALID ONLY FOR NEW PROGRAMS)</td>
</tr>
<tr>
<td>36 Standards</td>
</tr>
</tbody>
</table>

**Full Three-Year Approval** is given to programs, either new or established, that comply with all standards. These programs are surveyed at a three-year interval from the date of the survey.

**Three-Year Approval with Contingency** is given when 1 to 7 standards are rated deficient. The contingency status is resolved by the submission of documentation of compliance within 12 months. Documentation required to resolve the deficiency for each standard is available on the Cancer Programs page of the American College of Surgeons Web site. Full Approval is granted following submission of documentation. These programs are surveyed at a three-year interval from the date of the survey.

**Nonapproval** is given when 8 or more standards are rated deficient. Programs are encouraged to improve their performance and may reapply.

**Approval Deferred** is given when a new program is rated deficient in 1 standard. The deferred status is resolved by the submission of documentation of compliance within 12 months. Documentation required to resolve the deficiency for each standard is available on the Cancer Programs page of the American College of Surgeons Web site. Full Approval is granted following submission of documentation without resurvey. These programs are surveyed at a three-year interval from the date of the submission of documentation. Programs that do not resolve this status at the end of the 12-month period must reapply for survey.

**AWARD NOTIFICATION PROCESS**
Award notification takes place 8–12 weeks following survey. The Approved Cancer Program Performance Report provides a comprehensive summary of the survey outcome and approval award. It provides the facility’s compliance rating for each standard, an overall rating for each section when compared with other approved facilities, a narrative description of deficiencies that require correction, and any commendations awarded. Facilities will be given the option to submit a commentary on the performance report that may include comments and/or corrections. Comments will be reviewed by Cancer Programs staff and all appropriate corrections will be incorporated into the report before it is finalized.

By enabling each facility to compare its ratings for the standards with Approved Programs, the reports will facilitate the identification of areas for program improvement. The report, along with a certificate of approval, press release, and marketing materials, is sent to the cancer registrar with copies provided to the administrator, cancer committee chair, Cancer Liaison Physician, and surveyor. A sample report appears on the Cancer Programs page of the American College of Surgeons Web site.

The facility can appeal the deficiency finding for any standard or the approval award within 60 days of receipt of the Approved Cancer Program Performance Report. The appeal process is outlined in the cover letter that accompanies the Approved Cancer Program Performance Report and also appears on the Cancer Programs page of the American College of Surgeons Web site.

A listing of all CoC-approved cancer programs appears on the Cancer Programs page of the American College of Surgeons Web site.
THE COMMISSION ON CANCER OUTSTANDING ACHIEVEMENT AWARD

The CoC Outstanding Achievement Award will be granted to any cancer program that:

• Receives a commendation rating in all nine defined areas, and
• Receives a compliance rating for all other (27) standards.

The purpose of this award is to:

• Recognize those cancer programs who strive for excellence in providing quality care to the cancer patient.
• Motivate other programs to work toward improving their care.
• Foster communication between award recipients and other programs to:
  - Share best practices
  - Serve as a resource
  - Act as a “champion” for CoC cancer program approval

Awards are granted to each program upon completion of the survey and evaluation of compliance with the established criteria. Cancer programs receiving this award will:

• Receive a letter of recognition from the CoC chair addressed to the CEO/Administrator.
• Receive a specially designed press release, marketing information, and a special certificate.
• Receive CoC publicity via the CoC Flash and the CoC Web site.
• Be acknowledged at a public forum including the CoC Annual Meeting.

THE POSTSURVEY EVALUATION

The postsurvey evaluation is a required part of the cancer program evaluation and is accessed through the SAR. This evaluation captures feedback from the facility, which enables the CoC to evaluate and improve staff and surveyor performance and develop educational training programs for surveyors.

All responses are confidential and will not influence the cancer program evaluation or approval award. Responses on the evaluation form should represent a consensus opinion of the cancer program team about the quality of the Cancer Programs staff support during the survey process and the performance of the surveyor. The postsurvey evaluation is completed within three weeks following the survey date.

GUIDELINES FOR MERGED OR NETWORK PROGRAMS

If the facility has, is, or plans to merge or form a network, the facility must access and review either the Guidelines for Merged Programs or Guidelines for Network Programs located on the Cancer Programs page of the American College of Surgeons Web site (www.facs.org). The Guidelines outline the requirements for cancer program composition as a merged or network program.

Once the respective guidelines have been reviewed, the facility completes and submits a notification form documenting general information about the merger or network. This information will allow Cancer Programs staff to assign a new Facility Identification Number (FIN), cancer program category, approval award designation, and survey target date.

COC RESOURCES AND TOOLS FOR CANCER PROGRAMS

Survey-related resources and tools are available on the Cancer Programs page of the American College of Surgeons Web site (www.facs.org). These resources and tools are listed in the Appendix.
<table>
<thead>
<tr>
<th><strong>Overall definition</strong></th>
<th><strong>Residencies</strong></th>
<th><strong>Key</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization owns multiple facilities providing integrated cancer care and offers comprehensive services. Generally networks are characterized by a network-wide cancer committee or functional equivalent, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners. The network participates in clinical research.</td>
<td>Optional</td>
<td>Optional</td>
</tr>
<tr>
<td>The facility secures a National Cancer Institute peer-reviewed Cancer Center Support Grant and is designated a Comprehensive Cancer Center Program by the NCI. A full range of diagnostic and treatment services and staff physicians with major specialty boards, including those in oncology, where offered, are available. This facility participates in both basic and clinical research.</td>
<td>As required by NCI</td>
<td>Surgery and medicine and any two of the following: diagnostic radiology, family practice gynecology, pathology, radiation oncology, urology, or an oncologic fellowship</td>
</tr>
<tr>
<td>The facility provides a full range of diagnostic and treatment services, on-site or by referral. The medical staff are board-certified in the major medical specialties including those in oncology, where applicable. Participation in clinical research is required.</td>
<td>Optional</td>
<td>Optional</td>
</tr>
<tr>
<td>The facility has limited range of diagnostic and treatment services on-site. Other services are available by referral. Clinical research is not required.</td>
<td>Optional</td>
<td>Optional</td>
</tr>
<tr>
<td>The facility offers a minimum of two treatment modalities and forms a partnership with a hospital facility to provide access to the full range of diagnostic and treatment services. Participation by the integrated facility in clinical research depends on the requirements for the hospital partner.</td>
<td>None</td>
<td>Optional</td>
</tr>
<tr>
<td>The facility offers one treatment modality and forms partnership with a hospital facility to provide access to the full range of diagnostic and treatment services. Clinical research is not required.</td>
<td>Optional</td>
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</tr>
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</table>

Table continues on following page
<table>
<thead>
<tr>
<th>Cancer Program Category</th>
<th>(NCIP) NCI-Designated Comprehensive Cancer Program</th>
<th>(THCP) Teaching Hospital Comprehensive Cancer Program</th>
<th>(COMP) Community Hospital Comprehensive Cancer Program</th>
<th>(CHCP) Community Hospital Associate Cancer Program</th>
<th>(HACP) Hospital Associate Cancer Program</th>
<th>(AFCP) Affiliate Hospital Cancer Program</th>
<th>(ICP) Integrated Cancer Program</th>
<th>(FCCP) Free-Standing Cancer Center Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseload requirements based on analytic caseload</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>650 or more</td>
<td>100–649</td>
<td>50–99</td>
<td>1–49</td>
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<td>Standard 1.1: Accrediting body</td>
<td>JCAHO AOA</td>
<td>JCAHO AOA</td>
<td>JCAHO AOA</td>
<td>JCAHO AOA</td>
<td>JCAHO AOA</td>
<td>JCAHO AOA</td>
<td>JCAHO AOA</td>
<td>JCAHO AOA</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>Network administrator</td>
<td>Clinical research data manager or nurse</td>
<td>Pain control/palliative care physician</td>
<td>Pain control/palliative care physician</td>
<td>Pain control/palliative care physician or specialist</td>
<td>No additional members</td>
<td>No additional members</td>
<td>Representative from hospital partner</td>
</tr>
<tr>
<td>Standard 2.2: Cancer Committee membership (additional members)</td>
<td>Ambulatory oncology nurse</td>
<td>Pain control/palliative care physician</td>
<td>Pain control/palliative care physician or specialist</td>
<td>Pain control/palliative care physician or specialist</td>
<td>Pain control/palliative care physician or specialist</td>
<td>No additional members</td>
<td>For centers providing radiation oncology: dosimetrist or radiation physicist</td>
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</table>
## CANCER PROGRAM CATEGORY DEFINITION AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Standard 2.4: Cancer Committee meeting schedule and structure</th>
<th>Every other month</th>
<th>Quarterly</th>
<th>Quarterly</th>
<th>Quarterly</th>
<th>Quarterly</th>
<th>Quarterly</th>
<th>Quarterly</th>
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<tbody>
<tr>
<td>Recommended subcommittee or workgroups</td>
<td>Recommend</td>
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<td>Optional</td>
<td>Optional</td>
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<tr>
<td>Weekly Network-wide, site-focused</td>
<td>Weekly</td>
<td>Departmental, site-focused, or grand rounds</td>
<td>Weekly</td>
<td>Departmental, site-focused, or facility-wide</td>
<td>Monthly</td>
<td>Facility-wide</td>
<td>Monthly</td>
<td>Facility-wide</td>
<td>Monthly with hospital partner</td>
</tr>
<tr>
<td>Chapter 2 (continued)</td>
<td></td>
<td></td>
<td></td>
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<td>Facility-wide</td>
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<table>
<thead>
<tr>
<th>Standard 2.6: Cancer Conference frequency and format</th>
<th>Weekly Network-wide, site-focused</th>
<th>Weekly Departmental, site-focused, or grand rounds</th>
<th>Weekly Departmental, site-focused, or facility-wide</th>
<th>Monthly Facility-wide</th>
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<th>Monthly with hospital partner Facility-wide</th>
<th>Monthly Facility-wide</th>
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<tr>
<td>Weeklies, Site-focused, or Grand Rounds</td>
<td>Weeklies, Site-focused, or Grand Rounds</td>
<td>Weeklies, Site-focused, or Grand Rounds</td>
<td>Weeklies, Site-focused, or Grand Rounds</td>
<td>Weeklies, Site-focused, or Grand Rounds</td>
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<table>
<thead>
<tr>
<th>Standard 4.2: Inpatient medical oncology unit or functional equivalent</th>
<th>Required</th>
<th>Required</th>
<th>Required</th>
<th>Required</th>
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</table>

<table>
<thead>
<tr>
<th>Standard 4.5: Oncology Nurse Manager</th>
<th>Oncology Nurse Manager</th>
<th>Oncology Nurse Manager</th>
<th>Oncology Nurse Manager (designated unit) or Registered Nurse (functional equivalent)</th>
<th>Registered Nurse</th>
<th>Registered Nurse</th>
<th>Exempt</th>
<th>Exempt</th>
<th>Exempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Inpatient medical oncology unit or functional equivalent</td>
<td>Required Inpatient medical oncology unit or functional equivalent</td>
<td>Required Inpatient medical oncology unit or functional equivalent</td>
<td>Required Inpatient medical oncology unit or functional equivalent</td>
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<td>Required Inpatient medical oncology unit or functional equivalent</td>
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<td>Required Inpatient medical oncology unit or functional equivalent</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 5</th>
<th>6% of the number of annual analytic cases</th>
<th>10% of the number of annual analytic cases</th>
<th>4% of the number of annual analytic cases</th>
<th>2% of the number of annual analytic cases</th>
<th>Exempt</th>
<th>Exempt</th>
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</thead>
<tbody>
<tr>
<td>Standard 5.2: Percentage accrual to clinical trials</td>
<td>Standard 5.2: Percentage accrual to clinical trials</td>
<td>Standard 5.2: Percentage accrual to clinical trials</td>
<td>Standard 5.2: Percentage accrual to clinical trials</td>
<td>Standard 5.2: Percentage accrual to clinical trials</td>
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Table continues on following page
<table>
<thead>
<tr>
<th>CANCER PROGRAM CATEGORY DEFINITION AND REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(NCP) Network Cancer Program</td>
</tr>
<tr>
<td>(NCIP) NCI-Designated Comprehensive Cancer Program</td>
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<td>(THCP) Teaching Hospital Comprehensive Cancer Program</td>
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</tr>
<tr>
<td>(ICP) Integrated Cancer Program</td>
</tr>
<tr>
<td>(FCCP) Free-Standing Cancer Center Program</td>
</tr>
</tbody>
</table>

Chapter 8

**Standard 8.1: Studies of quality**
- 1 study based on registry data
- 2 additional studies
- 1 study based on registry data
- 2 additional studies
- 1 study based on registry data
- 1 additional study
- 1 study based on registry data
- 1 additional study
- 1 study on any topic in cooperation with hospital partner
- 1 study based on registry data
- 1 additional study
- 1 study based on registry data
- 1 additional study

**Standard 8.2: Quality improvements**
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements
- 2 quality improvements

2 quality improvements
2 quality improvements
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2 quality improvements
2 quality improvements
2 quality improvements
Institutional and Programmatic Resources

**Purpose:** The standard confirms the accreditation standing for the facility or facilities.

### FACILITY ACCREDITATION

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

#### DEFINITION AND REQUIREMENTS

Accreditation ensures that care is provided in a safe environment. The boundary of the cancer program approval is established by the facility(ies) and/or locations included in the accreditation.

The accrediting organizations recognized by the Commission on Cancer (CoC) are:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- American Osteopathic Association (AOA)
- Accreditation Association of Ambulatory Healthcare Agencies (AAAH C)
- American College of Radiology (ACR)
- Health facility licensure agency (usually located within the State Department of Health)

No survey will be performed if the facility is not accredited by a recognized authority.

#### SPECIFICATIONS BY CATEGORY

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ACCEPTED ACCREDITING BODIES BY CATEGORY</th>
<th>REQUIRED ACCREDITATION (one of the following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Cancer Program (NCP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AOA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facility licensure agency</td>
</tr>
<tr>
<td>NCI-designated Comprehensive Cancer Program (NCIP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AOA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facility licensure agency</td>
</tr>
<tr>
<td>Teaching Hospital Cancer Program (THCP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AOA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facility licensure agency</td>
</tr>
<tr>
<td>Community Hospital Comprehensive Cancer Program (COMP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AOA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facility licensure agency</td>
</tr>
<tr>
<td>Community Hospital Cancer Program (CHCP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AOA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facility licensure agency</td>
</tr>
<tr>
<td>Hospital Associate Cancer Program (HACP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AOA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facility licensure agency</td>
</tr>
<tr>
<td>Affiliate Hospital Cancer Program (AFCP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AOA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health facility licensure agency</td>
</tr>
<tr>
<td>Integrated Cancer Program (ICP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AAAHC</td>
</tr>
<tr>
<td>Freestanding Cancer Center Program (FCCP)</td>
<td></td>
<td>JCAHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AAAHC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ACR</td>
</tr>
</tbody>
</table>
DOCUMENTATION
The facility completes the Survey Application Record (SAR). A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with a copy of the certificate of accreditation or letter from the accrediting body.

RATING
(1) Compliance: The facility is accredited by a recognized accrediting organization.
(5) Noncompliance: The facility is not accredited, or is accredited by an organization not recognized by the CoC. No survey will take place.
Cancer Committee Leadership

**Purpose:** The standards establish the cancer committee's leadership responsibility and accountability for cancer program activities at the facility.

**LEVEL OF RESPONSIBILITY AND ACCOUNTABILITY**

**Standard 2.1** The organizational structure of the facility or medical staff gives the cancer committee responsibility and accountability for the cancer program activities.

**DEFINITION AND REQUIREMENTS**

Leadership is the key element in an effective cancer program and program success depends on an effective cancer committee (or a functional equivalent). The cancer committee is responsible for goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the facility.

The facility or medical staff formally establishes the responsibility, accountability, and multidisciplinary membership required for the cancer committee to fulfill its role. The facility documents the cancer committee's responsibility and accountability using a method appropriate to the facility's organizational structure. Examples include, but are not limited to:

- The facility bylaws designate the cancer committee to be a standing committee with authority defined.
- The medical staff bylaws designate the cancer committee to be a standing committee with authority defined.
- Policies and procedures for the facility define authority of the cancer committee.
- Policies and procedures for the medical staff define the authority of the cancer committee.
- Other methods that are consistent with the facility organization and operation are acceptable.

**SPECIFICATIONS BY CATEGORY**

All cancer programs must fulfill this standard.

**DOCUMENTATION**

A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with a copy of the bylaws, policies and procedures, or other facility-approved methods used to document the level of responsibility and accountability designated to the cancer committee.

**RATING**

(1) Compliance: The cancer committee's responsibility and accountability are documented in bylaws, policies and procedures, or other facility-approved methods.

(5) Noncompliance: The cancer committee's responsibility and accountability are not documented.

**MEMBERSHIP**

**Standard 2.2** The cancer committee membership is multidisciplinary, representing physicians from the diagnostic and treatment specialties and nonphysicians from administrative and supportive services.

**DEFINITION AND REQUIREMENTS**

Cancer patient care requires a multidisciplinary approach and encompasses numerous physician and nonphysician professionals. The committee responsible for program leadership is multidisciplinary and represents the full scope of care. Required members include at least one physician representing each of the diagnostic and treatment services. Required nonphysician representatives from each of the administrative, clinical, and supportive services available at the facility are also to be members of the committee. The committee fulfills the attendance and quorum requirements set by the facility.

Required physician members:

- Diagnostic radiologist
- Pathologist
- General surgeon
- 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, then a cancer committee member from radiation oncology is recommended, but not required.)
Required nonphysician members:
- Cancer program administrator
- Oncology nurse
- Social worker or case manager
- Certified Tumor Registrar (CTR)
- Performance improvement or quality management professional

Additional physician or nonphysician cancer committee members are required for specific categories. These include, but are not limited to:
- Hospice/home care nurse or administrator
- Pain control/palliative care physician or specialist
- Clinical research data manager or nurse

The Cancer Liaison Physician must be a member of the cancer committee. The Cancer Liaison Physician may also fulfill the role of one of the required physician specialties. The cancer committee chair is a physician who may also fulfill the role of one of the required physician specialties.

Each facility should assess the scope of services offered and determine the need for additional cancer committee members based on the major cancer sites seen by the facility. Additional members may include, but are not limited to:
- Specialty physicians representing the major cancer experience(s) at the facility
- Dietary/nutrition specialist
- Pharmacist
- Pastoral care representative
- Psychiatric or mental health professional
- American Cancer Society Cancer Control representative
- A public member of the community served

SPECIFICATIONS BY CATEGORY

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ADDITIONAL REQUIRED CANCER COMMITTEE MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Cancer Program (NCP)</td>
<td>Network administrator</td>
</tr>
<tr>
<td></td>
<td>Oncology nurse from the ambulatory care setting</td>
</tr>
<tr>
<td></td>
<td>Clinical research data manager or nurse</td>
</tr>
<tr>
<td></td>
<td>Pain control/palliative care physician</td>
</tr>
<tr>
<td></td>
<td>Pharmacist</td>
</tr>
<tr>
<td></td>
<td>Dietary/nutrition specialist</td>
</tr>
<tr>
<td></td>
<td>Hospice nurse or administrator</td>
</tr>
<tr>
<td>NCI-designated Comprehensive Cancer Program (NCIP)</td>
<td>Clinical research data manager or nurse</td>
</tr>
<tr>
<td></td>
<td>Pain control/palliative care physician</td>
</tr>
<tr>
<td>Teaching Hospital Cancer Program (THCP)</td>
<td>Clinical research data manager or nurse</td>
</tr>
<tr>
<td></td>
<td>Pain control/palliative care physician or specialist</td>
</tr>
<tr>
<td>Community Hospital Comprehensive Cancer Program (COMP)</td>
<td>Pain control/palliative care physician or specialist</td>
</tr>
<tr>
<td>Community Hospital Cancer Program (CHCP)</td>
<td>None</td>
</tr>
<tr>
<td>Hospital Associate Cancer Program (HACP)</td>
<td>None</td>
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<td>Affiliate Hospital Cancer Program (AFCP)</td>
<td>Representative from hospital partner</td>
</tr>
<tr>
<td>Integrated Cancer Program (ICP)</td>
<td>None</td>
</tr>
<tr>
<td>Freestanding Cancer Center Program (FCCP)</td>
<td>For Freestanding Cancer Centers providing radiation oncology: dosimetrist or radiation physicist</td>
</tr>
</tbody>
</table>

DOCUMENTATION
The facility completes the Survey Application Record (SAR). The surveyor will evaluate cancer committee membership by reviewing cancer committee minutes.

RATING
(1) Compliance: All required cancer committee members are appointed.
(5) Noncompliance: One or more of the required cancer committee members are not appointed.
PROGRAM ACTIVITY COORDINATORS

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.

DEFINITION AND REQUIREMENTS
To promote team involvement and shared responsibilities, one member of the cancer committee is designated to coordinate one of the four major areas of program activity. The Cancer Liaison Physician is assigned to coordinate the community outreach activities. The other coordinators are chosen on the basis of their specialty, knowledge, and skills. Both physician and nonphysician members of the committee may be selected as coordinators.

Coordinator roles and responsibilities are defined by the cancer committee. These include, but are not limited to:

- Contributing to the development of the annual goals and objectives of the cancer committee.
- Monitoring the activity of the assigned area of responsibility.
- Reporting regularly to the cancer committee.
- Recommending corrective action if activity falls below the annual goal or requirements.

Cancer committee minutes identify the designated coordinators, their assigned area of activity, and the defined duties and responsibilities. The minutes also document the reported results of activities and recommendations for corrective action.

In some facilities, the coordinator(s) works cooperatively with established departments or staff leadership to coordinate, monitor, and recommend improvements to the assigned areas or programs. In this instance, the coordinator(s) acts as the cancer committee liaison to the established departments or staff leadership.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR.

RATING
(1) Compliance: A coordinator is designated for each of the four specified areas of activity.
(5) Noncompliance: A designated coordinator is not appointed for one or more of the four specified areas of activity.

MEETING SCHEDULE
Standard 2.4  The cancer committee meeting schedule and structure fulfill the requirements for the category.

DEFINITION AND REQUIREMENTS
Regular meetings assure that administrative responsibilities related to cancer program leadership are carried out.

In Network Cancer Programs, the cancer committee meets every other month to complete the administrative responsibilities related to cancer program leadership. In all other categories, the cancer committee meets at least quarterly. More frequent meetings may be required to meet the overall program needs.

In larger programs, the cancer committee establishes subcommittees or workgroups to manage specific activities. Subcommittees may include, but are not limited to:

- Cancer conference activity
- Quality control of registry data
- Quality management activity
- Community outreach
- Review of policies and procedures

The subcommittees and workgroups may call on physicians and nonphysicians outside of the cancer committee to accomplish their assignment. The assigned coordinator chairs the appropriate subcommittee or workgroup. Other subcommittee or workgroup chairs are chosen from the members of the cancer committee.

Meetings of subcommittees and workgroups do not constitute meetings of the full cancer committee.
The facility completes the SAR. A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with copies of all cancer committee minutes from the time of the previous survey through the present date, and documentation of subcommittee and workgroup structure and activity through minutes or other sources.

**RATING**
(1) Compliance: The cancer committee fulfills meeting requirements specified for the category.
(5) Noncompliance: The cancer committee does not fulfill meeting requirements specified for the category.

**DEFINITION AND REQUIREMENTS**
Annual goals provide direction for cancer program activities and serve as the basis for cancer program evaluation. The cancer committee establishes goals appropriate to the facility. The scope of this activity and method of documentation will vary, depending on the size of the facility; however, goals must be documented in cancer committee minutes.

Examples of goals include, but are not limited to:
- **Clinical Goal:** Improve turn-around time for chemotherapy administration in the outpatient infusion center.
- **Community Outreach:** Improve follow-up of positive findings from the prostate screening program.

**Standard 2.5** The cancer committee develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.

- **Quality Improvement:** Implement the use of a staging form in the medical record.
- **Programmatic:** Earn the CoC Outstanding Achievement Award.

The cancer committee chair is responsible for guiding the committee through the development and evaluation of the annual goals. The cancer committee establishes a time frame for achieving each goal. Frequent monitoring and evaluation are necessary.

**SPECIFICATIONS BY CATEGORY**
All cancer programs must fulfill this standard.
The facility completes the SAR. The facility provides the surveyor with copies of cancer committee minutes or other sources that document the annual goals, time frame for evaluation and completion, assigned coordinator, and responsibilities of other committee members.

**Rating**

1. Compliance: Annual cancer program goals are documented and evaluated.
2. Noncompliance: Annual cancer program goals are not developed and/or documented.

---

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

**Definition and Requirements**

Setting the cancer conference frequency and format allows for prospective review of cancer cases that encourages multidisciplinary involvement. Cancer conferences are integral to improving the care of cancer patients by contributing to the patient management process and outcomes and providing education to physicians and other staff in attendance.

The annual cancer conference frequency and format are documented in cancer committee minutes. The cancer committee considers the minimum percentage of cases to be presented at cancer conferences (Standard 2.8) when determining the cancer conference frequency.

Frequency and format should be based on the following:

- Category
- Number of annual analytic accessions

**Specifications by Category**

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommended Minimum Frequency</th>
<th>Recommended Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Cancer Program (NCP)</td>
<td>Weekly</td>
<td>Network-wide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Site-focused</td>
</tr>
<tr>
<td>NCI-designated Comprehensive Cancer Program (NCIP)</td>
<td>Weekly</td>
<td>Departmental</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Site-focused</td>
</tr>
<tr>
<td>Teaching Hospital Cancer Program (THCP)</td>
<td>Weekly</td>
<td>Departmental</td>
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<td>Site-focused</td>
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<td>Grand rounds</td>
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<td>Community Hospital Comprehensive Cancer Program (COMP)</td>
<td>Weekly</td>
<td>Departmental</td>
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<td></td>
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<td></td>
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<td>Facility-wide</td>
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<td>Community Hospital Cancer Program (CHCP)</td>
<td>Monthly</td>
<td>Facility-wide</td>
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<td>Hospital Associate Cancer Program (HACP)</td>
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<tr>
<td>Affiliate Hospital Cancer Program (AFCP)</td>
<td>Monthly with hospital partner</td>
<td>Facility-wide</td>
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<td>Integrated Cancer Program (ICP)</td>
<td>Monthly with hospital partner</td>
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<tr>
<td>Freestanding Cancer Center Program (FCCP)</td>
<td>Monthly</td>
<td>Facility-wide</td>
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The cancer committee establishes the multidisciplinary attendance requirements for cancer conferences on an annual basis.

DEFINITION AND REQUIREMENTS
Setting the multidisciplinary attendance requirement for cancer conferences encourages multidisciplinary involvement in prospective discussion of cancer cases. Cancer conferences are integral to improving the care of cancer patients by contributing to the patient management process and outcomes and providing education to physicians and other staff in attendance.

Consultative services are optimal when physician representatives from diagnostic radiology, pathology, surgery, medical oncology, and radiation oncology participate in facility-wide or network-wide cancer conferences.

The multidisciplinary cancer conference attendance requirement is established by the cancer committee and documented in cancer committee minutes.

The minimum multidisciplinary attendance should be based on:
- Types of cases seen by the facility
- Format of conferences (facility-wide or network-wide, departmental, site-focused, grand rounds)

Multidisciplinary physician attendance at departmental or site-focused conferences or grand rounds will depend on the diagnostic and treatment needs of the sites presented. On an annual basis, the cancer committee defines the multidisciplinary attendance for each departmental or site-focused conference held at the facility. The cancer committee may modify the multidisciplinary attendance requirement for these conferences.

Network-wide cancer conferences involve physicians from all sites within the network who provide diagnostic and treatment services. All members of the medical staff of the Cancer Program Network are actively involved in network-wide cancer conferences.

SPECIFICATIONS
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR. A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with copies of cancer committee minutes or other documentation showing the multidisciplinary attendance requirement for the cancer conferences of the cancer program.

A cancer conference grid, calendar, or tracking tool that shows the multidisciplinary attendance is recommended.

RATING
(1) Compliance: The multidisciplinary conference attendance requirement is established and documented by the cancer committee on an annual basis.

(5) Noncompliance: The cancer committee does not establish and document the multidisciplinary conference attendance on an annual basis.

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<table>
<thead>
<tr>
<th>CONFERENCE TYPE</th>
<th>RECOMMENDED MULTIDISCIPLINARY ATTENDANCE</th>
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<tr>
<td></td>
<td>Diagnostic Radiology</td>
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<tr>
<td>Leukemia</td>
<td>x</td>
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<tr>
<td>Brain/CNS</td>
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</table>
Standard 2.8 The cancer committee ensures that the required number of cases are discussed at the cancer conference on an annual basis and that at least 75 percent of the cases discussed are presented prospectively.

DEFINITION AND REQUIREMENTS
Cancer conferences are an essential forum to provide multidisciplinary consultative services for patients as well as offer education to physicians and allied health professionals. The number of cases presented each year at cancer conferences is a percentage of the number of annual analytic cases added to the cancer registry database.

Programs accessioning 3,000 or more cases annually present 300 cases each year at cancer conferences. All other programs present at least 10 percent of the number of annual analytic cases seen at the facility each year. In Network Cancer Programs, the cases selected ensure equal representation of each network site.

To provide a consultative service for patients and physicians, 75 percent of the cases presented must be discussed prospectively, that is, addressing patient management issues. Cases selected for discussion include the five major sites seen at the institution, as well as cases with unusual sites and/or histologies and challenging management issues. The number of cases presented at each conference is monitored to ensure adequate time for thorough discussion.

Prospective cases include, but are not limited to:
- Newly diagnosed and treatment not yet initiated.
- Newly diagnosed and treatment initiated, but discussion of additional treatment is needed.
- Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed.
- Previously diagnosed, and discussion of supportive or palliative care is needed.

SPECIFICATIONS BY CATEGORY
All programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR. A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with copies of cancer committee minutes or other documentation showing the annual case presentation at cancer conferences.

A cancer conference grid, calendar, or tracking tool that shows the annual conference schedule and format is recommended.

RATING
(1) Compliance: Presentation of 10 percent of the annual analytic caseload or 300 cases annually and 75 percent of the cases presented are discussed prospectively.

(5) Noncompliance: Presentation of less than 10 percent of the annual analytic caseload or 300 cases annually or less than 75 percent of the cases presented are discussed prospectively.

Standard 2.9 The cancer committee monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.

DEFINITION AND REQUIREMENTS
Monitoring of cancer conference activity assures that conferences provide consultative services for patients as well as offer education to physicians and allied health professionals. Monitoring cancer conference activity also ensures that the educational and consultative goals of the cancer program are fulfilled. The cancer committee monitors cancer conference activity through the work of the cancer conference coordinator.

Routine evaluation of cancer conference activity in each of four areas is essential to ensure compliance with the requirements set by the cancer committee:
- Conference frequency
- Multidisciplinary attendance
- Total case presentation
- Prospective case presentation

The methods used to monitor cancer conference activity are set by the cancer committee and documented in cancer committee minutes.

The assigned coordinator monitors each area of cancer conference activity, reports regularly to the cancer committee, and recommends corrective action if any area falls below the annual goal or requirements. The results and recommendations are documented in cancer committee minutes.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with copies of cancer committee minutes or other documentation showing the monitoring of cancer conference frequency, multidisciplinary attendance, total case presentation, prospective case presentation, and corrective action taken for any area that falls below the annual goal.

A cancer conference grid, calendar, or tracking tool that shows the annual conference schedule and format is recommended.
RATING
(1) Compliance: The four areas of the cancer conference activity are monitored and evaluated by the cancer committee on an annual basis.

(5) Noncompliance: The four areas of the cancer conference activity are not monitored and evaluated by the cancer committee on an annual basis.

Standard 2.10 The cancer committee establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis. The plan includes procedures to monitor casefinding, accuracy of data collection, abstracting timeliness, follow-up, and data reporting.

DEFINITION AND REQUIREMENTS
High quality cancer registry data are essential to accurately assess treatment outcomes and patient survival. The cancer committee ensures the quality of cancer registry data by establishing and implementing a quality control plan to monitor multiple areas of cancer registry activity and the accuracy and completeness of abstracted data.

The quality control plan:

1. Sets the review criteria
2. Sets the quality control time table
3. Specifies the quality control methods and individuals involved

   Required activities
   Random sampling of annual analytic caseload
   Physician review (residents and other physicians may be included)

4. Identifies the activities to be evaluated

   Required activities
   Casefinding
   Abstracting timeliness
   Accuracy of abstracted data
   Class of Case
   Primary site
   Histology
   First course of treatment
   Follow-up information
   Completion and accuracy of AJCC staging by the managing physician
   NCDB data submission, correction of data errors, and resubmission of corrected data

5. Defines the scope of the evaluation

   Required scope
   Minimum: 10 percent of annual analytic caseload
   Maximum: 300 cases annually

6. Establishes the minimal quality benchmarks

   Required accuracy
   Cancer registry data submitted to the NCDB meet the established quality criteria included in the annual Call For Data

   Recommended accuracy
   90 percent of AJCC staging assigned by the managing physician is accurate

7. Maintains documentation of the quality control activity

   Required documentation
   Review criteria
   Cases reviewed
   Identified errors and resolutions
   Reports to the cancer committee

The assigned coordinator works cooperatively with registry staff or other departments to implement the quality control plan. The assigned coordinator monitors each area of cancer registry activity, reports regularly to the cancer committee, and recommends corrective action if any area falls below the annual goal. The results and recommendations are documented in the cancer committee minutes or other sources.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
At the on-site visit, the facility provides the surveyor with documentation of annual quality control activities through the cancer committee minutes or other sources. The surveyor discusses the cancer registry quality control activities and results with the quality control coordinator and other members of the cancer committee during the on-site visit.

RATING
(1) Compliance: The cancer committee establishes and implements a plan to evaluate the required areas of cancer registry activity on an annual basis.

(5) Noncompliance: The cancer committee does not establish and implement a plan to evaluate the required areas of cancer registry activity on an annual basis.
Standard 2.11 Each year, the cancer committee analyzes patient outcomes and disseminates the results of the analysis.

DEFINITION AND REQUIREMENTS
Clinically meaningful analyses of patient diagnosis, treatment, and outcomes are necessary to ensure that quality care is administered to cancer patients.

A survival analysis of one cancer site is the preferred method; however, other outcome measures may be selected at the discretion of the cancer committee.

This analysis includes the facility’s experience and comparison to NCDB data through benchmark reports. Additional sources of comparative data may also be used.

The analysis includes the program’s experience with:
- Diagnostic evaluation
- Treatment modalities
- Prognostic factors
- Survival data by AJCC stage of disease
- Comparison with NCDB benchmarks and other comparative data

The results of the cancer committee’s analysis are shared with the medical staff and administration annually. Acceptable methods for disseminating results include, but are not limited to:
- Written reports
- Presentation at cancer committee meetings or cancer conferences
- Presentations at lectures or workshops
- Electronic postings on internal or external Web sites

Dissemination of results is documented in cancer committee minutes.

An annual report may be published at the discretion of the cancer committee. If an annual report is published, the cancer committee is responsible for determining the report content and publication schedule. The cancer committee’s analysis of patient outcomes must be included.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR. A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with copies of cancer committee minutes or other sources that show the results of the outcomes analysis and method of dissemination.

If an annual report is published, a copy is provided to the surveyor a minimum of 2 weeks (14 days) prior to the on-site visit.

RATING
(1+) Commendation: Documentation and dissemination of an analysis of more than one site of cancer annually, or an annual report of cancer program activity is published.

(1) Compliance: The cancer committee documents and disseminates results of a patient outcome analysis with the medical staff and administration annually.

(5) Noncompliance: The cancer committee does not document and disseminate results of a patient outcome analysis with the medical staff and administration annually.
Cancer Data Management and Cancer Registry Operations

**Purpose:** The standards ensure accurate and timely collection of cancer patient data, which allow for the evaluation of patient outcomes and identification of opportunities for improvement. Lifetime follow-up of patients included in the database encourages clinical follow-up and surveillance of additional primaries.

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**STAFF QUALIFICATIONS**

**Standard 3.1** Case abstracting is performed or supervised by a Certified Tumor Registrar (CTR).

**DEFINITION AND REQUIREMENTS**
To positively impact cancer patient care, the facility must ensure that case abstracting is performed or supervised by a CTR. Successful operation of the cancer registry requires credentialed staff who are trained and knowledgeable in all aspects of oncology data collection and case abstracting.

The recognized credential for a cancer registry professional is CTR, which is granted through the National Cancer Registrars Association (NCRA). Details on eligibility, testing, and recredentialing are available from the NCRA.

Methods to ensure case abstracting by a CTR include, but are not limited to:
- Facility-employed CTR
- Contracted data collection, using a registry service agency or company or independent contractor
- Enabling current staff to earn the CTR credential

In all instances, case abstracting must be performed or supervised by a CTR. The case abstracting or data supervision responsibilities of the CTR are documented.

All cancer programs approved by the Commission on Cancer (CoC) must comply with this standard by January 1, 2006. Programs surveyed prior to January 1, 2006, that are working toward compliance with this standard, must show documentation of recruitment efforts and/or plans for current staff certification. This includes, but is not limited to:

- Education and training activities
- The target date for examination

The same applies to positions vacant at the time of survey. New programs must comply with this standard at the time of the initial survey.

**SPECIFICATIONS BY CATEGORY**
All cancer programs must fulfill this standard.

**DOCUMENTATION**
The facility completes the Survey Application Record (SAR). During the on-site visit, the facility provides the surveyor with verification of current credentialing from NCRA for all CTRs on staff at the facility. During the on-site visit, the facility also provides the surveyor with documentation showing that the case abstracting or data supervision is performed by the CTR.

Facilities not staffed by a CTR show documentation of recruitment efforts and/or plans for current staff certification.

**RATING**
(1) Compliance: Case abstracting is performed or supervised by a CTR, or documentation of recruitment efforts and/or a plan for current staff certification is in place.

(5) Noncompliance: Case abstracting is not performed or supervised by a CTR, and no recruitment efforts and/or plans for current staff certification are in place.
**DATA COLLECTION**

**Standard 3.2** CoC data standards and coding instructions are used to describe all reportable cases.

**DEFINITION AND REQUIREMENTS**
CoC data standards ensure consistent and accurate hospital cancer registry data that support the meaningful evaluation of patient diagnosis and treatment. All CoC-approved cancer programs use the data standards defined by the CoC appropriate for the year of diagnosis for that case.

Cancer registries may be required to comply with additional mandates pertaining to case and data reporting established by the federal or state government, or by the facility’s cancer committee.

**SPECIFICATIONS BY CATEGORY**
All cancer programs must fulfill this standard.

**DOCUMENTATION**
During the on-site visit, the facility provides documentation that the cancer registry policy and procedure manual or the registry software manual requires the use of the CoC data standards. The surveyor confirms the use of CoC data standards and coding instructions during the on-site visit.

**RATING**

1) Compliance: Appropriate CoC data standards and coding instructions are used to describe all reportable cases.

5) Noncompliance: The cancer registry does not use appropriate CoC data standards and coding instructions to describe all reportable cases.

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

**DEFINITION AND REQUIREMENTS**
Ongoing timely abstracting is essential for accurate data collection, evaluation, and reporting of outcomes.

Abstracting timeliness is calculated from the “Date of First Contact” (see definition in current version of CoC data standards) to the date the case is abstracted. Abstracting timeliness is maintained throughout the survey cycle.

Abstracting timeliness can be estimated by using the following formula:

- Total cases for last completed accession year = 1,200
- Monthly case average: 1,200 ÷ 12 = 100
- If the date is January 1, then approximately 600 cases (100 × 6 = 600) from the previous year should be abstracted.

**SPECIFICATIONS BY CATEGORY**
All cancer programs must fulfill this standard.

**DOCUMENTATION**
The facility completes the SAR. The surveyor will verify the abstracting currency during the on-site visit through a review of a random sample of cancer registry abstracts.

**RATING**

1) Commendation: More than 90 percent of cases are abstracted within six months of the date of first contact for each year between survey.

1) Compliance: For each year between survey, 90 percent of cases are abstracted within six months of the date of first contact.

5) Noncompliance: For each year between survey, fewer than 90 percent of cases are abstracted within six months of the date of first contact.

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**TARGETED ABSTRACTING TIME LINE FOR THE MONTH OF SURVEY**

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<tr>
<th>MONTH OF SURVEY</th>
<th>TARGETED ABSTRACTING TIME LINE</th>
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<tbody>
<tr>
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<td>August 1 of previous year</td>
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<td>July</td>
<td>January 1 of current year</td>
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<tr>
<td>December</td>
<td>June 1 of current year</td>
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Standard 3.4 An 80 percent follow-up rate is maintained for all analytic patients from the cancer registry reference date.

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.

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

All reportable cases are followed, except:
- Residents of foreign countries
- Cases that are reportable-by-agreement
- Patients whose age exceeds 100 years and who are without contact for more than 12 months

Methods to obtain follow-up information include, but are not limited to:
- Letters or phone calls to the physician(s)
- Letters or phone calls to the patient or the patients’ next of kin
- Admission or readmission to the facility
- Pathology reports
- Clinic and outpatient visits
- Internet sources
- Death certificate matches
- Review of newspaper obituary columns

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill these standards.

DOCUMENTATION
The facility completes the SAR. During the on-site visit, the facility provides the surveyor with a copy of the cancer committee's policies for obtaining follow-up information from the cancer registry policy and procedure manual. The facility also provides a current follow-up report to the surveyor on the day of the on-site visit.

RATING
Standard 3.4
(1) Compliance: An 80 percent follow-up rate is maintained for all analytic patients from the cancer registry reference date.
(5) Noncompliance: A follow-up rate of less than 80 percent is maintained for all analytic patients from the cancer registry reference date.

Standard 3.5
(1) Compliance: 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.
(5) Noncompliance: A follow-up rate of less than 90 percent is maintained for all analytic patients diagnosed within the last five years, or from the cancer registry reference date, whichever is shorter.

DATA REPORTING
Standard 3.6 Complete data for all analytic cases are submitted to the National Cancer Data Base (NCDB) in accordance with the annual Call for Data.

DEFINITION AND REQUIREMENTS
Data submitted to the 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.

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 are useful benchmarks for patient care and continuous quality improvement for cancer programs.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
Data submission history is confirmed by the CoC.
RATING

(1) Compliance: Complete data for all analytic cases are submitted to the NCDB for each call year between survey in accordance with the annual Call for Data.

(5) Noncompliance: Incomplete data for all analytic cases are submitted or no data are submitted for one or more years between survey in accordance with the annual Call for Data.

Standard 3.7 Cases submitted to the NCDB for the most recent accession year requested meet the established quality criteria included in the annual Call for Data.

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 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.

Beginning with the 2003 NCDB Call for Data for cases accessioned during the year 2002, cancer programs must do the following:

- Resolve errors resulting in rejected records
- Correct outstanding data quality errors

Problematic cases are corrected and resubmitted in accordance with the annual Call for Data. The cancer committee monitors the resolution and resubmission of problematic cases (Standard 2.10).

SPECIFICATIONS BY CATEGORY

All cancer programs must fulfill this standard.

DOCUMENTATION

Resubmission history is confirmed by the CoC.

RATING

(1+) Commendation: Cases for the most recent accession year requested meet the quality criteria for the annual Call for Data on initial submission.

(1) Compliance: Cases for the most recent accession year requested meet the established quality criteria by September 1 of the year following the Call for Data. New programs correct and resubmit cases prior to scheduling the initial survey.

(5) Noncompliance: Cases for the most recent accession year requested do not meet the established quality criteria by September 1 of the year following the Call for Data.

SPECIAL STUDIES

Standard 3.8 The facility participates in special studies as requested by the CoC.

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.

Based on study criteria, the CoC will determine if CoC-designed special studies will fulfill the requirements for Standard 8.1. This information will be documented in CoC communications and provided to programs selected to participate.

The CoC will design and conduct at least two special studies annually. Based on study criteria, select approved programs will participate in each study. Facilities keep a record of all communication(s), and information/data provided to the CoC for these special studies.

SPECIFICATIONS BY CATEGORY

Upon request, all cancer programs must fulfill this standard.

DOCUMENTATION

The facility completes the SAR. Participation in CoC special studies is confirmed by the CoC.

RATING

(1) Compliance: Complete data are submitted for each special study in which the facility is requested to participate.

(5) Noncompliance: Incomplete or no data are submitted for each special study in which the facility is requested to participate.

(8) Not applicable: The facility was not requested to participate in special studies.
CANCER REGISTRY OPERATIONS
The Commission on Cancer has established these operational requirements for hospital-based cancer registries.

CANCER REGISTRY
The cancer registry is a component of the cancer program designed to accession, abstract, and conduct follow-up for reportable primaries diagnosed and/or initially treated at the facility since the registry reference date. The cancer registry database is a vital tool for programmatic and administrative planning and research and for monitoring patient outcomes.

Data are collected according to the current CoC data standards and coding instructions. These data include patient identification, cancer identification, stage of disease at diagnosis, first course of treatment, outcomes, and administrative information. Facility-defined data items and/or benign or borderline histologies are also included, as requested by the cancer committee.

Network Cancer Programs establish a uniform data repository with the means to enter data from each of the network service locations. A system is in place to provide for unduplicated data.

CoC-approved cancer programs routinely communicate with the cancer registry software provider to assure changes in data and cancer program requirements are appropriately reflected in the cancer registry software.

PROCEDURE MANUAL
A procedure manual is necessary to document policies and procedures for the daily operations of the cancer registry and may also include policies and procedures for the cancer program. The cancer committee reviews and updates the procedure manual annually. Changes to policies and procedures are approved by the cancer committee and documented in the cancer committee minutes.

The cancer registry procedure manual includes, but is not limited to:
- Abstracting
- Case accessions
- Case eligibility
- Casefinding
- Coding references
- Confidentiality and release of information
- Dates of implementation or changes in policies or registry operations
- Follow-up
- Job descriptions
- Maintaining and using the suspense system
- Quality control of registry data

- Reference date
- Reporting requirements and mechanisms
- Retention of documents
- Staging systems

Areas of program activity include, but are not limited to:
- Cancer committee meetings
- Cancer conference activities
- Cancer program objectives
- Policy for AJCC staging
- Studies of quality and quality improvement system

REFERENCE DATE
The reference date is the date after which all eligible cases must be included in the registry. A reference date is established by the cancer committee prior to the initial survey. The reference date is January 1 of the specified year.

Once approved, programs cannot change the reference date unless circumstances cause a need to petition the CoC for a change. Each request is given individual consideration based on changes in the patient population or hospital census, flaws or lapses in data collection, changes in data acquisition methods, or a high lost-to-follow-up rate due to the longevity of the registry.

One disadvantage of changing the reference date is that cases accessioned prior to the new reference date are deleted or become non-analytic (Class of Case 4) and are not included in outcomes analysis.

The reference date is documented in the cancer registry policy and procedure manual.

CASE ELIGIBILITY
The CoC requires registries in approved cancer programs to accession, abstract, and conduct follow-up for reportable primaries diagnosed and/or initially treated at the facility. The tumors must meet the criteria for analytic cases (Class 0, 1, or 2). Both pathologically and clinically diagnosed cases are included.

Please refer to the current CoC data standards and coding instructions for specific requirements describing:
- Ambiguous terminology
- Cases reportable-by-agreement
- Case eligibility
- Class of Case
- Tumors accessioned, abstracted, and followed

The case eligibility criteria are documented in the cancer registry policy and procedure manual.
CASEFINDING
Casefinding is a systematic method of identifying all eligible cases that are included in the cancer registry database. All points of service in the health care delivery system must be included in the casefinding process. Casefinding will identify both new cases and those already included in the cancer registry database. Information about cases that are already included in the registry can be used for follow-up.

Multiple sources are used to identify eligible cases. Primary sources include, but are not limited to:
- Disease index
- Medical oncology log
- Operative reports
- Pathology reports
- Radiation oncology log

Secondary sources include, but are not limited to:
- Cytology reports
- Diagnostic/medical imaging
- Discharge log
- Other outpatient logs

The casefinding procedures are documented in the cancer registry policy and procedure manual.

SUSPENSE SYSTEM
A suspense system provides temporary storage for potential cases and those cases that have not been completely abstracted. A case is entered into the suspense system during the casefinding process and remains there until case abstracting is completed.

A suspense system typically includes:
- Patient name
- Patient identifier
- Date of diagnosis or date of first contact
- Primary site

Most cancer registry software includes an automated suspense system. If the cancer registry software does not include a suspense system, a spreadsheet can be used to track cases held in suspense.

Cases are listed by the date of diagnosis or date of first contact and cases are abstracted in date order to ensure that abstracting timeliness is maintained.

The policies and procedures for the suspense system are documented in the cancer registry policy and procedure manual.

ACCESSION REGISTER
The accession register is an annual, sequential listing of all eligible cases included in the registry database. The accession register includes, but is not limited to:
- Accession and sequence number
- Date of initial diagnosis
- Patient name
- Primary site

The accession register is used to:
- Assess registry workload
- Audit other registry files
- Monitor casefinding
- Plan cancer conferences
- Select cases for quality control review

If a registry serves multiple facilities, the accession register includes facility identifiers.

The policies and procedures for the accession register are documented in the cancer registry policy and procedure manual.

PATIENT INDEX
The patient index is an alphabetical list of each patient entered into the registry since the reference date. The typical index includes, but is not limited to:
- Date of birth
- Date of diagnosis
- Date of last contact or death
- Histology
- Laterality
- Medical record number
- Patient name
- Primary site(s)
- Sequence number
- Sex

For patients with multiple reportable primaries, the patient index also includes, but is not limited to, the following for each primary:
- Date of diagnosis
- Histology
- Laterality
- Primary site
- Sequence number

If a registry serves multiple facilities, the patient index includes facility identifiers.

The policies and procedures for the master patient index are documented in the cancer registry policy and procedure manual.

ABSTRACT
The abstract is a summary of pertinent information about the patient, cancer diagnosis and treatment, and patient follow-up. Accurate and complete registry data allow for optimal cancer program and administrative planning to allocate hospital resources. The cancer registry database is also a valuable resource for research investigations, studies of quality, and outcome evaluation.

An abstract must be completed for all reportable primaries diagnosed and/or initially treated at the facility since the registry reference date. If a patient has multiple cancers, an abstract must be prepared for each reportable primary diagnosed or treated at the reporting institution after the reference date.
The components of an abstract are outlined in the current CoC data standards and include:

- Patient identification
- Cancer identification
- Stage of disease at diagnosis
- First course of treatment
- Outcomes
- Case administration descriptors

Refer to Standard 3.3 for specific requirements regarding abstracting timeliness.

The policies and procedures for abstracting are documented in the cancer registry policy and procedure manual.

**RETENTION OF DOCUMENTS**

Abstracted data for cases diagnosed and/or treated at the facility after the cancer registry reference date are retained in perpetuity. If the reference date is changed, abstracted data for cases diagnosed and/or treated at the facility prior to the new reference date are deleted or archived.

All other documentation of cancer program and cancer registry activity meet the facility standard for retention of documents or five years, whichever is longer.

This includes, but is not limited to:

- Cancer conference documentation or grids
- Minutes of cancer committee meetings
- Outcome analysis and reports
- Results of quality control of cancer registry data
- Results of studies of quality

The policy for retention of documents is documented in the cancer registry policy and procedure manual.

**QUALITY CONTROL OF CANCER REGISTRY DATA**

The cancer committee is responsible for supervising the cancer registry and quality control of cancer registry data. The quality control plan and cancer committee involvement in quality control activities are outlined in Standard 2.10.

The cancer registry staff is responsible for visual review of abstracts and the accession register and periodic reabstracting of cases. The cancer registry staff is also responsible for reviewing edit reports from central registries, state registries, and the National Cancer Data Base, and for correcting and resubmitting cases to these agencies.

The policies and procedures for quality control of cancer registry data are documented in the cancer registry policy and procedure manual.

**LIFETIME FOLLOW-UP**

Lifetime follow-up collects information about the cancer and patient status throughout the life of the patient. Follow-up data include:

- Cancer status
- Date of first recurrence
- Date of last contact or death
- Following registry
- Follow-up source
- Type of first recurrence
- Vital status

Refer to Standards 3.4 and 3.5 for specific requirements regarding follow-up rates.

The policies and procedures for follow-up are documented in the cancer registry policy and procedure manual.

**CONFIDENTIALITY, RELEASE OF INFORMATION, AND REQUEST LOG**

The cancer registry activities and database meet the patient confidentiality standards defined by the facility as well as state and federal regulations. These policies and procedures address the following:

- Data release criteria
- Informed consent and authorization
- Patient rights

Data requests are documented in a data request log that includes, but is not limited to:

- Copy of data provided
- Data requested
- Date request was fulfilled
- Intended use of data
- Request date
- Requestor’s name or organization

The policies and procedures for confidentiality, release of information, and the request log are documented in the cancer registry policy and procedure manual.
Clinical Management

**Purpose:** The standards identify the minimum scope of clinical services needed to provide high-quality cancer care to patients. The managing physician is essential to coordinating a multidisciplinary team approach to patient care including the accurate and complete staging of each patient.

**Clinical Services**
Cancer patients require specialized diagnostic and therapeutic services. Care often continues for weeks or months following diagnosis. Depending on the facility, some services may be provided by referral, including the administration of chemotherapy and radiation therapy.

The minimum scope of clinical services is available to patients diagnosed and treated at the cancer program. Referral services and sources are documented for internal use and the information is available to patients.

**Diagnostic Services**
- Clinical laboratory
- Diagnostic imaging

**Treatment Services**
- Surgical procedures
- Radiation treatment
- Systemic therapy

**Other Clinical Services**
- AJCC staging
- Oncology nursing
- Patient guidelines
- Rehabilitation

**Treatment Services**

**Standard 4.1 Radiation treatment services are available on-site or by referral.**

**Definition and Requirements**
Radiation therapy is a primary component of multimodality treatment. Radiation therapy services are available on-site or by referral to one or more locations. Information on referral services and locations are provided to patients seen at the facility.

**Specifications by Category**
All cancer programs must fulfill this standard.

**Documentation**
The facility completes the Survey Application Record (SAR). A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with documentation of referred radiation oncology services and locations. The surveyor confirms radiation therapy services available at the facility, and through referral, with members of the cancer program team during the on-site visit. The surveyor examines the methods for distributing information to patients.

**Rating**
(1) Compliance: Radiation therapy services are available on-site or by referral.
(5) Noncompliance: Radiation therapy services are not available on-site or by referral.

**Standard 4.2 Based on the category, an inpatient medical oncology unit or a functional equivalent exists to provide specialized care to patients.**

**Definition and Requirements**
Medical oncology (systemic therapy) is a primary component of multimodality treatment. Patients needing hospitalization for chemotherapy or as a result of treatment are assured of receiving comprehensive and specialized cancer-related care in a safe environment.

Based on the category, the facility may designate one or more inpatient areas as a medical oncology unit. Smaller facilities may set aside certain beds or an area of an inpatient unit as a functional equivalent of a medical oncology unit. In this instance, specialized care is provided to the patient regardless of the location.
Policies and procedures address the special needs of the patients cared for on the medical oncology unit or functional equivalent. These include, but are not limited to:

- Adequate nursing coverage
- Criteria for patient admission
- Management of immunocompromised patients
- Nursing staff orientation and training
- Safe handling and disposal of chemotherapy agents

**SPECIFICATIONS BY CATEGORY**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>INPATIENT MEDICAL ONCOLOGY SERVICE REQUIREMENT BY CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Cancer Program (NCP) unit(s)</td>
<td>One or more designated inpatient medical oncology services</td>
</tr>
<tr>
<td>NCI-designated Comprehensive Cancer Program (NCIP)</td>
<td>Designated inpatient medical oncology unit</td>
</tr>
<tr>
<td>Teaching Hospital Cancer Program (THCP)</td>
<td>Designated inpatient medical oncology unit</td>
</tr>
<tr>
<td>Community Hospital Comprehensive Cancer Program (CHCOP)</td>
<td>Designated inpatient medical oncology unit or a functional equivalent</td>
</tr>
<tr>
<td>Community Hospital Cancer Program (CHCP)</td>
<td>Functional equivalent</td>
</tr>
<tr>
<td>Hospital Associate Cancer Program (HACP)</td>
<td>Functional equivalent</td>
</tr>
<tr>
<td>Affiliate Hospital Cancer Program (AFCP)</td>
<td>Exempt</td>
</tr>
<tr>
<td>Integrated Cancer Program (ICP)</td>
<td>Functional equivalent</td>
</tr>
<tr>
<td>Freestanding Cancer Center Program (FCCP)</td>
<td>Exempt</td>
</tr>
</tbody>
</table>

**DOCUMENTATION**

The facility completes the SAR. A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with documentation that identifies the medical oncology unit or functional equivalent. The surveyor visits the medical oncology unit or functional equivalent during the on-site visit.

**RATING**

(1) Compliance: Depending on the category, an inpatient medical oncology unit or a functional equivalent is in place at the facility.

(5) Noncompliance: Depending on the category, an inpatient medical oncology unit or a functional equivalent is not in place at the facility.

(8) Not applicable: Facility is exempt from this standard.

**OTHER CLINICAL SERVICES**

**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.

**DEFINITION AND REQUIREMENTS**

Proper staging of cancer allows the physician to determine appropriate treatment. Staging enables the reliable evaluation of treatment results and outcomes reported from various institutions on a local, regional, and national basis.

The cancer committee develops and documents a staging policy and procedure. The policy and procedure guidelines include, but are not limited to:

- Acceptable methods for completion and signature
- Definition of the managing physician
- Placement of the staging forms in the medical record
- Quality control of completeness and accuracy
- Requirements for completion (if applicable)
- Resolution of staging differences

The managing physician assigns the AJCC stage to 90 percent of the annual analytic cases for which a staging scheme exists.

Either clinical or pathologic staging is assigned to each primary. Both should be assigned if appropriate. Use the criteria for clinical and pathologic staging outlined in the current edition of the *AJCC Cancer Staging Manual* to determine the appropriate stage.

Beginning January 1, 2005, a staging form is used to document staging in the medical record. Use of the AJCC staging forms is highly recommended.

The term “managing physician,” for the purposes of recording staging in the medical record, must be defined by the cancer committee. More than one specialty may be involved in staging, depending on the need for multimodality treatment.

The patient’s managing physician evaluates all available staging information (x-rays, scans, lab tests, and operative and pathology reports), records the staging elements (staging classification, T, N, M, and stage group) on the staging form in the medical record, and signs or initials the form. Electronic signatures are acceptable.
CLARIFICATION OF STAGING ROLES

In the medical record:
The managing physician records the staging elements T, N, and M, and the stage group on the staging form in the medical record. The managing physician signs the staging form. Forms that do not include the elements T, N, and M; the stage group; and the signature of the managing physician do not meet the requirement for this standard.

The pathologist can contribute to the staging process by recording the elements T, N, or M in the pathology report of the specimen being examined and on the staging form in the medical record. The pathologist, however, cannot assign the stage group or sign the form.

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.

In the cancer registry database:
If the managing physician records the staging elements T, N, and M on the staging form, but has not recorded a stage group, then the cancer registrar can assign a stage group based on the staging elements and record this information in the cancer registry database. Complete staging information in the cancer registry database does not meet the requirement for this standard.

Accurate staging is essential for accurate evaluation of patient outcomes. The cancer committee should monitor and improve the accuracy of AJCC staging assigned by the managing physician and recorded on a staging form in the medical record so that 90 percent of the cases are staged correctly. Staging accuracy is not rated at this time.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR. A minimum of 2 weeks (14 days) prior to the on-site visit, the facility provides the surveyor with a copy of the written policy and procedure for physician staging. During the on-site visit, the facility provides medical records and abstracts for a random sample of analytic cases from the last complete year of abstracting for review by the surveyor during the on-site visit. A minimum of 25 medical records will be reviewed.

RATING
(1+) Commendation: The managing physician assigns AJCC staging and records it on the staging form in the medical record for more than 95 percent of eligible annual analytic cases.

(1) Compliance: The managing physician assigns AJCC staging and records it on the staging form in the medical record for 90 percent of eligible annual analytic cases.

(5) Noncompliance: The managing physician assigns AJCC staging and records it on the staging form in the medical record for less than 90 percent of eligible annual analytic cases.

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**Standard 4.4**  
Nursing care is provided by nurses with specialized knowledge and skills in oncology. Competency is evaluated annually.

**Standard 4.5**  
An Oncology Nurse Manager or a Registered Nurse (RN) provides direction to the inpatient medical oncology unit or the functional equivalent as appropriate to the category.

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**DEFINITION AND REQUIREMENTS**

The complex needs of cancer patients and their families require specialized oncology nursing knowledge and skills to achieve optimal patient care outcomes.

The oncology nurse is an integral member of the multidisciplinary team. Oncology nursing services are managed by a registered nurse who has appropriate experience and educational background to provide effective leadership and direction to the nurses providing care to cancer patients and their families.

A clinical expert in oncology nursing can be:
- A master's prepared oncology clinical nurse specialist
- A nurse practitioner
- An Oncology Certified Nurse (OCN)

As appropriate to the category, an oncology nurse manager provides day-to-day direction to staff of the medical oncology unit. An oncology nurse manager is an RN with three years' clinical experience and at least one year in oncology nursing. An OCN is preferred. An RN provides day-to-day direction to staff of a functional equivalent.

Orientation and annual competency of oncology knowledge and skills are documented for nurses providing care to oncology patients. Adequate staffing by oncology nurses is provided to meet the needs of cancer patients and families. Staffing needs are evaluated by the nursing administration at least annually.

Oncology Nursing Society standards and guidelines for all aspects of patient care, professional practice, research, education, and administrative topics should be used when developing the facility standards and guidelines. Oncology nursing policies and procedures are documented and approved by the nursing administration in consultation with the cancer committee. Standards are reviewed and revised by the nursing administration in consultation with the cancer committee as needed on an annual basis.
Policies and procedures include, but are not limited to:
- Administration and safe handling of cytotoxic agents
- Blood product administration
- Care of immunocompromised patients
- Management of vascular access devices
- Oncologic emergencies
- Radiation safety
- Symptom management

SPECIFICATIONS BY CATEGORY

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>STANDARD 4.4</th>
<th>STANDARD 4.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Cancer Program (NCP)</td>
<td>Required</td>
<td>Oncology Nurse Manager</td>
</tr>
<tr>
<td>NCI-designated Comprehensive Cancer Program (NCIP)</td>
<td>Required</td>
<td>Oncology Nurse Manager</td>
</tr>
<tr>
<td>Teaching Hospital Cancer Program (THCP)</td>
<td>Required</td>
<td>Oncology Nurse Manager</td>
</tr>
<tr>
<td>Community Hospital Comprehensive Cancer Program (COMP)</td>
<td>Required</td>
<td>Oncology Nurse Manager (designated unit) or Registered Nurse (functional equivalent)</td>
</tr>
<tr>
<td>Community Hospital Cancer Program (CHCP)</td>
<td>Required</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Hospital Associate Cancer Program (HACP)</td>
<td>Required</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Affiliate Hospital Cancer Program (AFCP)</td>
<td>Required</td>
<td>Exempt</td>
</tr>
<tr>
<td>Integrated Cancer Program (ICP)</td>
<td>Required</td>
<td>Exempt</td>
</tr>
<tr>
<td>Freestanding Cancer Center Program (FCCP)</td>
<td>Required</td>
<td>Exempt</td>
</tr>
</tbody>
</table>

DOCUMENTATION
The facility completes the SAR. During the on-site visit, the facility provides the surveyor with:
- An organizational chart or staff list noting credentials of the clinical expert(s).
- Documentation of orientation and annual competency evaluation for each oncology nurse.
- Documentation of nursing management of the medical oncology unit or functional equivalent as appropriate to the category.

RATING

Standard 4.4
(1) Compliance: Nurses with specialized oncology knowledge and skills in oncology are available at the facility. Documentation is available to verify annual competency.
(5) Noncompliance: Nurses with specialized oncology knowledge and skills in oncology are not available at the facility and/or documentation is not available to verify annual competency.

Standard 4.5
(1) Compliance: Based on the category, an oncology nurse manager provides day-to-day direction for the inpatient medical oncology unit, or an RN provides day-to-day direction to the functional equivalent.
(5) Noncompliance: Based on the category, an oncology nurse manager does not provide day-to-day direction for the inpatient medical oncology unit, or an RN does not provide day-to-day direction to the functional equivalent.
(8) Not Applicable: The facility is exempt from this standard.

DEFINITION AND REQUIREMENTS

Patient management and treatment guidelines promote an organized approach to providing quality care.

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.

In addition to CoC required guidelines, the cancer committee should review and consider adoption of other guidelines appropriate to the patients diagnosed and treated by the facility.

National organizations have developed cancer-focused guidelines. These organizations include, but are not limited to:
- American Cancer Society
- American College of Surgeons
- American Head and Neck Society
- American Society of Clinical Oncology
- American Urological Association

Standard 4.6
The guidelines for patient management and treatment currently required by the CoC are followed.
• Association of Community Cancer Centers
• College of American Pathologists
• The National Cancer Institute
• The National Comprehensive Cancer Network
• Oncology Nursing Society
• Society of Surgical Oncology

Other guidelines adopted by the cancer committee for use by the facility are documented in cancer committee minutes.

The cancer committee monitors and reports compliance with the patient management and treatment guidelines currently required by the CoC as well as others adopted for use by the facility. At a minimum, the pathology reports for a random sample of 10 percent of the annual analytic cases or a maximum of 300 cases are reviewed each year to document compliance with this standard.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR. During the on-site visit, the facility provides the surveyor with:
• The pathology report format for the major cancer experience(s) at the facility showing the inclusion of the scientifically proven data elements.

RATING
(1+) Commendation: Ninety (90) percent of cancer pathology reports include the scientifically validated data elements as outlined in the CAP protocols, and guidelines from national organizations (other than CAP) are followed.
(1) Compliance: Ninety (90) percent of cancer pathology reports include the scientifically validated data elements as outlined in the CAP protocols.
(5) Noncompliance: Ninety (90) percent of cancer pathology reports do not include the scientifically validated data elements as outlined in the CAP protocols and/or not all of the scientifically validated data elements as outlined in the CAP protocols are included on cancer pathology reports.

Standard 4.7  Rehabilitation services are provided on-site or by referral. This is evaluated on an annual basis.

DEFINITION AND REQUIREMENTS
Rehabilitation services help patients cope with activities of daily living affected by the cancer experience and enables them to resume normal activities. The cancer committee documents policies and procedures to access rehabilitation services.

Rehabilitation services include, but are not limited to:
• Career counseling
• Physical therapy
• Speech therapy
• Stomal therapy

The cancer committee evaluates the needs of their patients on an annual basis and offers services that can be used by a majority of patients as well as those targeting special populations. Results of the annual evaluation are documented in cancer committee minutes.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes SAR. During the on-site visit, the facility provides the surveyor with:
• Documentation of rehabilitation services available on-site or by referral.
• The process for access to rehabilitation services.
• Documentation of the annual evaluation of the rehabilitation services.
• Patient brochures or other materials that outline rehabilitation services.

RATING
(1) Compliance: Rehabilitation services are provided on-site or by referral, and documentation of the annual evaluation of these services is available.
(5) Noncompliance: Rehabilitation services are not provided on-site or by referral, and/or documentation of the annual evaluation of these services is not available.
Research

Purpose: The standards promote advancement in cancer treatment through the provision of clinical trial information and patient accrual to cancer-related clinical trials.

CLINICAL TRIAL INFORMATION

Standard 5.1 Information about the availability of cancer-related clinical trials is provided to patients through a formal mechanism.

DEFINITION AND REQUIREMENTS
By providing information about the availability of cancer-related clinical trials, the facility offers patients the opportunity to participate in the advancement of evidence-based medicine.

A formal mechanism is established to provide information about cancer-related clinical trials to patients seen at the facility.

Methods to provide information include, but are not limited to:
- Access to the Internet or Internet search services through the patient library
- Articles in facility newsletters
- Pamphlets or brochures in patient waiting rooms or patient information packets

The cancer committee documents the mechanism and monitors the effectiveness of the formal mechanism annually, making revisions as needed. The review is documented in cancer committee minutes.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes the Survey Application Record (SAR). During the on-site visit, the facility provides the surveyor with documentation of policies and procedures for providing information about cancer-related clinical trials to patients or samples of written/printed information provided to patients to the surveyor during the on-site visit.

RATING
(1) Compliance: A formal mechanism is used to provide information to patients about cancer-related clinical trials.

(5) Noncompliance: A formal mechanism is not used to provide information to patients about cancer-related clinical trials.

CLINICAL TRIAL ACCRUAL

Standard 5.2 As appropriate to the category, the required percentage of cases is accrued to cancer-related clinical trials on an annual basis.

DEFINITION AND REQUIREMENTS
Clinical research advances science and ensures that patient care approaches the highest possible level of quality.

Facilities that accrue patients to cancer-related clinical research enter at least the minimum percentage based on the category and number of annual analytic accessions.

Patients eligible to meet this standard are those:
- Seen at the facility for diagnosis and/or treatment and placed on a trial through the facility.
- Seen at the facility for diagnosis and/or treatment and placed on a trial through the office of a staff physician.
- Seen at the facility for diagnosis and/or treatment and placed on a trial through another facility.
- Seen at the facility for any reason and placed on a prevention or cancer control trial.

Basic scientific research is generally conducted in cancer centers supported by grants from the National Cancer Institute (NCI) or in academic health centers. Research in community hospitals typically involves cancer control protocols or treatment trials.

Treatment-related clinical trial groups include, but are not limited to:
- NCI-sponsored programs such as the Community Clinical Oncology Program (CCOP) or Cooperative Group Outreach Program (CGOP)
- Cooperative Trial Groups such as the American College of Surgeons Oncology Group (ACOSOG)
- University-related research
- Pharmaceutical company research (Phase IV)
- Locally developed, peer-reviewed studies

Cancer control research studies include, but are not limited to:
- Primary prevention (ie, Study of Tamoxifen and Raloxifene [STAR])
- Early detection
- Quality of life
- Economics of care

Facilities participating in clinical research show that an independent peer review mechanism consistent with national standards is in place and used. Research projects involving participation by human subjects must be approved by an internal or external Institutional Review Board (IRB). Patients participating in clinical trials must give their informed consent.

A data manager is available to assist with enrolling patients, monitoring patient accrual, and identifying and providing information/education about new trials in Network Cancer Programs, NCI-designated Comprehensive Cancer Programs, and Teaching Hospital Cancer Programs. A data manager may also be available at facilities in other categories accrue a large number of patients to cancer-related clinical trials.

Patient accrual is monitored and the results are documented in cancer committee minutes.

### SPECIFICATIONS BY CATEGORY

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MINIMUM REQUIRED PERCENTAGE ACCRUAL TO CLINICAL TRIALS</th>
<th>COMMENDATION PERCENTAGE ACCRUAL TO CLINICAL TRIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Cancer Program (NCP)</td>
<td>6% of the number of annual analytic cases</td>
<td>8% of the number of annual analytic cases</td>
</tr>
<tr>
<td>NCI-designated Comprehensive Cancer Program (NCIP)</td>
<td>10% of the number of annual analytic cases</td>
<td>15% of the number of annual analytic cases</td>
</tr>
<tr>
<td>Teaching Hospital Cancer Program (THCP)</td>
<td>4% of the number of annual analytic cases</td>
<td>6% of the number of annual analytic cases</td>
</tr>
<tr>
<td>Community Hospital Comprehensive Cancer Program (COMP)</td>
<td>2% of the number of annual analytic cases</td>
<td>4% of the number of annual analytic cases</td>
</tr>
<tr>
<td>Community Hospital Cancer Program (CHCP)</td>
<td>Exempt</td>
<td>2% of the number of annual analytic cases</td>
</tr>
<tr>
<td>Hospital Associate Cancer Program (HACP)</td>
<td>Exempt</td>
<td>2% of the number of annual analytic cases</td>
</tr>
<tr>
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<td>Exempt</td>
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<tr>
<td>Integrated Cancer Program (ICP)</td>
<td>Exempt</td>
<td>2% of the number of annual analytic cases</td>
</tr>
<tr>
<td>Freestanding Cancer Center Program (FCCP)</td>
<td>Exempt</td>
<td>2% of the number of annual analytic cases</td>
</tr>
</tbody>
</table>

### DOCUMENTATION

The facility completes the SAR. The surveyor discusses the clinical trials program with the cancer program team during the on-site visit.

### RATING

1. **Commendation**: The commendation percentage of cases for the category is accrued to cancer-related clinical trials each year.
2. **Compliance**: The required percentage of cases for the category is accrued to cancer-related clinical trials each year.
3. **Noncompliance**: Less than the required percentage of cases for the category is accrued to cancer-related clinical trials each year.
4. **Not Applicable**: The facility is exempt from this standard.
Community Outreach

Purpose: The standards ensure that supportive services and prevention and early detection opportunities are provided to cancer patients and their families.

SUPPORTIVE SERVICES

Standard 6.1 Supportive services are provided on-site or coordinated with local agencies and facilities.

DEFINITION AND REQUIREMENTS

Total patient care extends beyond that provided by physicians and nurses. Supportive services help patients and their families cope with changes resulting from a cancer diagnosis.

Supportive services address the needs of the majority of patients as well as provide for special populations or needs. The supportive services offered on-site will vary depending on the scope of the facility, local staff expertise, and patient mix. Supportive services not provided on-site are provided through referral to other facilities and/or local agencies such as the American Cancer Society.

Supportive services include, but are not limited to:
- Genetic testing and counseling
- Grief counseling
- Home care and/or hospice
- Nutritional counseling
- Pastoral services
- Reference library
- Support groups

Patient assessment, discharge planning, and referral should begin on the day of admission and is documented in the patient chart and/or in team minutes.

Procedures are followed to ensure that patient needs are anticipated and managed. The process includes the mechanism to:
- Evaluate patient needs
- Facilitate direct access or referral
- Monitor quality
- Evaluate the effectiveness of the access and referral process

SPECIFICATIONS BY CATEGORY

All programs must fulfill this standard.

DOCUMENTATION

The facility completes the Survey Application Record (SAR). During the on-site visit, the facility provides the surveyor with documentation of the supportive services offered to patients and their families available on-site or by referral. Documentation includes, but is not limited to:
- Published brochures or flyers
- Meeting schedules
- Electronic media such as Internet or Intranet postings

The surveyor will discuss the community outreach program with the designated coordinator (Cancer Liaison Physician) and cancer committee members during the on-site visit.

RATING

(1) Compliance: Supportive services are available on-site or coordinated with other facilities or local agencies.

(5) Noncompliance: Supportive services are either not available on-site or not coordinated with other facilities or local agencies.

PREVENTION AND EARLY DETECTION PROGRAMS

Standard 6.2 Each year, two prevention or early detection programs are provided on-site or coordinated with other facilities or local agencies.

DEFINITION AND REQUIREMENTS

Prevention programs use strategies to modify attitudes and behaviors to reduce the risk of developing a malignancy. Early detection discovers cancer at an early stage when the application of prompt treatment can increase survival and decrease morbidity.

Prevention and early detection programs are offered at scheduled intervals as defined by the cancer committee and the designated Community Outreach Coordinator. Prevention and early detection programs are provided on-site or coordinated with other facilities and/or local agencies such as the American Cancer Society.
Prevention programs include, but are not limited to:
- Chemoprevention programs (i.e., Study of Tamoxifen and Raloxifene [STAR])
- Skin cancer prevention (i.e., Slip, Slap, Slop)
- Smoking cessation
- Smoking prevention in adolescents

Early detection programs include, but are not limited to:
- Breast care education
- Colonoscopy, flexible sigmoidoscopy, or H. E. moccult stool testing
- PAP testing
- Prostate exams with or without PSA testing
- Screening mammography and clinical exams
- Skin surveys
- Surveillance of high risk groups

SPECIFICATIONS BY CATEGORY
All programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR. During the on-site visit, the facility provides the surveyor with documentation of any two annual prevention or early detection programs through cancer committee minutes or other sources. The surveyor will discuss the community outreach program with the designated coordinator (Cancer Liaison Physician) and cancer committee members during the on-site visit.

RATING
(1) Compliance: Community outreach activities are monitored each year and the findings are documented.
(5) Noncompliance: Community outreach activities are not monitored each year and/or the findings are not documented.

MONITORING COMMUNITY OUTREACH

DEFINITION AND REQUIREMENTS
Supportive services, prevention, and early detection programs are monitored to ensure that appropriate services are provided to patients and the community.

Both the scope of services and the methods to access services and programs are evaluated annually. The methods used to monitor outreach activity are set by the cancer committee and are documented in cancer committee minutes.

The assigned coordinator (Cancer Liaison Physician) monitors outreach activity, reports regularly to the cancer committee, and recommends corrective action if activity falls below the annual goal or requirements. The results and recommendations are documented in cancer committee minutes.

In some facilities, the community outreach coordinator works cooperatively with established departments or staff leadership to coordinate, monitor, and recommend improvements to community outreach programs. In this instance, the Cancer Liaison Physician acts as the cancer committee liaison to the established departments or staff leadership.

SPECIFICATIONS BY CATEGORY
All cancer programs must fulfill this standard.

DOCUMENTATION
The facility completes the SAR. During the on-site visit, the facility provides the surveyor with copies of cancer committee minutes or other sources that document the methods to monitor and evaluate the community outreach activities. The surveyor will discuss the community outreach program with the designated coordinator (Cancer Liaison Physician) and cancer committee members during the on-site visit.

RATING
(1) Compliance: Three or more prevention or early detection programs are offered each year either on-site or coordinated with other facilities or local agencies.
(1) Compliance: Two prevention or early detection programs are offered each year either on-site or coordinated with other facilities or local agencies.
(5) Noncompliance: Two prevention or early detection programs are not offered each year either on-site or coordinated with other facilities or local agencies.
Professional Education and Staff Support

**Purpose:** The standards promote increased knowledge through annual educational programs and registry staff participation in local, regional, or national educational activities.

### FACILITY-BASED EDUCATION

**Standard 7.1** Other than cancer conferences, the cancer committee offers one cancer-related educational activity each year.

**DEFINITION AND REQUIREMENTS**

Educational activities ensure that members of the cancer care team possess current knowledge of cancer prevention, early detection, diagnosis, treatment, and follow-up care. The cancer committee offers a cancer-related educational activity to all members of the medical staff and allied health professionals each year. As appropriate, AJCC staging is part of the cancer-related educational activity. The cancer committee may coordinate this activity with the facility’s continuing education department, medical staff office, or other department as appropriate.

This includes, but is not limited to:
- An educational symposium
- A lecture on a cancer-related topic
- A video conference

**SPECIFICATIONS BY CATEGORY**

All programs must fulfill this standard.

**DOCUMENTATION**

The facility completes the Survey Application Record (SAR). During the on-site visit, the facility provides the surveyor with documentation of an annual educational activity other than cancer conferences, including a published notice or agenda.

**RATING**

(1) Compliance: Other than cancer conferences, the cancer committee offers a cancer-related educational activity each year.

(5) Noncompliance: Other than cancer conferences, the cancer committee does not offer a cancer-related educational activity each year.

### CANCER REGISTRY STAFF EDUCATION

**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.

**DEFINITION AND REQUIREMENTS**

Ongoing cancer-related education enhances knowledge and skills. To facilitate accurate data collection and gain or maintain their credentials, all members of the cancer registry staff participate in ongoing cancer-related education at the local, state, regional, or national level. This includes, but is not limited to:
- Advances in cancer diagnosis and treatment
- Changes in cancer program standards
- Changes in data collection requirements

Educational activities include, but are not limited to:
- A cancer-related lecture
- A local, state, regional, or national meeting or workshop
- A video conference
- A Web-based training module

**SPECIFICATIONS BY CATEGORY**

All programs must fulfill this standard.

**DOCUMENTATION**

The facility completes the Survey Application Record (SAR). During the on-site visit, the facility provides the surveyor with documentation of continuing education activity for each member of the cancer registry staff.

**RATING**

(1) Commendation: The cancer registry staff who are CT Rs attend a national cancer-related educational activity annually.

(1) Compliance: Other than cancer conference, all members of the cancer registry staff participate in a local, state, regional, or national cancer-related educational activity annually.

(5) Noncompliance: Other than cancer conference, all members of the cancer registry staff do not participate in a local, state, regional, or national cancer-related educational activity annually.
Quality Improvement

**Purpose:** The standards ensure that cancer services, care, and patient outcomes are evaluated and improved so that patients receive care that is comparable to national standards.

**STUDIES OF QUALITY AND OUTCOMES**

**Standard 8.1** Each year, based on category, the cancer committee completes and documents the required studies that measure quality and outcomes.

**DEFINITION AND REQUIREMENTS**

The annual evaluation of services and care provides a baseline to measure quality and an opportunity to correct or enhance patient outcomes.

The cancer committee focuses on quality-related issues relevant to the facility and local patient population and any area of cancer program activity. Studies of quality should include patient outcomes, if appropriate. Survival analysis is the preferred method; however, other outcome measures may be selected at the discretion of the cancer committee.

For each quality study, the cancer committee is responsible for:
- Establishing the study topic.
- Defining quality measures to evaluate the topic.
- Evaluating the data related to the quality measures.
- Designing and initiating actions based on the evaluation of the data.
- Monitoring the effectiveness of action plans and all cancer-related quality improvement activities at the facility.

Examples of study topics include, but are not limited to:
- What is the processing turnaround for ERA/PRA results on breast cancer specimens, and does this meet the needs of the physician?
- Why are cases not staged using the AJCC system?
- Is the evaluation and management of pain adequate in our patient population?
- Is the same level of care provided to English and non-English-speaking patients?

Considering the following questions may help to design, conduct, and evaluate a study.

**What is the problem?** How is quality measured? How are problems defined? What is the scope of the problem? Why are outcomes affected by the problem? What is the source of the problem?

**What should be done to address the problem?** What initiatives/interventions are needed?

**How effective was the intervention, and how could further improvements be made in the future?** Were goals accomplished? What was learned?

A summary of each study's findings, analysis, recommendations, and the process to implement changes in program activity is documented in cancer committee minutes. The documentation includes:
- The study topic
- Criteria for evaluation
- A summary of the findings
- The actions recommended
- Follow-up steps to monitor the actions implemented

The methods used to monitor studies of quality are set by the cancer committee and documented in cancer committee minutes.

The assigned coordinator monitors activity related to studies of quality, reports regularly to the cancer committee, and recommends corrective action if any area falls below the annual goal or requirements. The results and recommendations are documented in cancer committee minutes.

Note that duplicated study topics and criteria, and ongoing monitoring without analysis of the findings, does not fulfill this standard. Based on study criteria, the CoC will determine if CoC-designed special studies will fulfill this standard. This information will be documented in CoC communications to programs selected to participate.

Examples of studies of quality and outcomes appear at the end of this chapter.
### SPECIFICATIONS BY CATEGORY

**THE NUMBER AND TYPE OF STUDIES TO BE COMPLETED EACH YEAR FOR EACH CATEGORY**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>NUMBER AND TYPE OF STUDIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Cancer Program (NCP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>2 additional studies</td>
</tr>
<tr>
<td>NCI-designated Comprehensive Cancer Program (NCIP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>2 additional studies</td>
</tr>
<tr>
<td>Teaching Hospital Cancer Program (THCP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>1 additional study</td>
</tr>
<tr>
<td>Community Hospital Comprehensive Cancer Program (COMP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>1 additional study</td>
</tr>
<tr>
<td>Community Hospital Cancer Program (CHCP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>1 additional study</td>
</tr>
<tr>
<td>Hospital Associate Cancer Program (HACP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>1 additional study</td>
</tr>
<tr>
<td>Affiliate Hospital Cancer Program (AFCP)</td>
<td>1 study of any topic in cooperation with hospital partner</td>
</tr>
<tr>
<td>Integrated Cancer Program (ICP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>1 additional study</td>
</tr>
<tr>
<td>Freestanding Cancer Center Program (FCCP)</td>
<td>1 study based on registry data</td>
</tr>
<tr>
<td></td>
<td>1 additional study</td>
</tr>
</tbody>
</table>

**DOCUMENTATION**

The facility completes the Survey Application Record (SAR). During the on-site visit, the facility provides the surveyor with summaries of each year’s studies, analyses, recommendations, and follow-up.

**RATING**

(1) Compliance: Each year, the cancer committee completes and documents the required studies that measure quality and outcomes as appropriate to category.

(5) Noncompliance: Each year, the cancer committee does not complete and/or document the required studies that measure quality and outcomes as appropriate to category.

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**PATIENT CARE IMPROVEMENT**

**Standard 8.2** Annually, the cancer committee implements two improvements that directly affect cancer patient care. The improvements are documented.

**DEFINITION AND REQUIREMENTS**

Quality or performance improvements are the actions taken, processes implemented, or services created to improve patient care. Implementation of improvements demonstrates a program’s continuous commitment to providing high-quality cancer care. The results of a study of quality provide a baseline to measure and improve quality.

Sources for improvements include, but are not limited to:

- Actions based on analysis of a study
- Actions to address undesirable performance
- Changes to improve acceptable performance
- Additional programs or services addressing patient needs or staff concerns

The methods used to monitor the quality improvement program are set by the cancer committee and documented in cancer committee minutes.

The assigned coordinator monitors activity related to the quality improvement program, reports regularly to the cancer committee, and recommends corrective action if any area falls below the annual goal or requirements. The results and recommendations are documented in cancer committee minutes.

**SPECIFICATIONS BY CATEGORY**

All programs must fulfill this standard.

**DOCUMENTATION**

The facility completes the SAR. During the on-site visit, the facility provides the surveyor with summaries of each year’s patient care improvements.

**RATING**

(1*) Commendation: More than two improvements that directly affect patient care are implemented and documented each year.

(1) Compliance: Two improvements that directly affect patient care are implemented and documented each year.

(5) Noncompliance: Two improvements that directly affect patient care are not implemented and/or documented each year.
## SAMPLE STUDY 1: STUDY USING FACILITY DATA

**Study topic:** Are treatment alternatives for prostate cancer patients available at this facility? Presented to cancer committee 3/02.

**Criteria:** Investigate the number of patients with local prostate cancer who would be eligible for seed implants as an alternative to surgery.

**Findings:** 115/127 (90 percent) patients diagnosed in 2001 were eligible for seed implants. Reviewed the number of cases from 1995–2000 treated with surgery that were eligible for alternative therapy. Found 455/645 (70 percent) eligible for the surgical alternative. Results presented to the cancer committee 12/02.

**Recommendations:** The cancer committee recommended that a seed implant program for prostate cancer and multidisciplinary prostate clinic program be established.

**Improvement:** Beginning in January 2003, urology worked with radiation oncology to develop a seed implant program for prostate cancer patients. Budget requests were approved and renovations begun. A multidisciplinary prostate clinic was opened in August 2003. Marketing undertook promotional efforts (informational pamphlets and newspaper articles) announcing the new clinic.

## SAMPLE STUDY 2: STUDY USING THE NATIONAL CANCER DATA BASE (NCDB) BENCHMARK REPORTS

**Study topic:** Are patients with ductal carcinoma in situ (DCIS) receiving breast conservation services? Presented to cancer committee 1/03.

**Criteria:** Breast-conserving surgery along with postoperative radiation is the treatment of choice for DCIS.

**Methodology:** Analyzed the cancer registry data to compare percentages of patients who received breast conservation surgery to those who had more radical surgical treatment by residence within hospital market.

**Findings:** 15/25 (60 percent) of the DCIS patients were treated with breast conserving surgery (BCS) in 2001. When broken down by residence within hospital market, that percentage is higher (13/18 or 72.2 percent). Seven patients were referred from outside the facility’s market area. Two of these patients were located in markets with radiation facilities available; five were from rural locations, more than 50 miles from any facility to which they could be referred for radiation therapy postoperatively.

**Recommendations:** The cancer committee reviewed the findings in light of the benchmark established within the 1999 NCDB. That percentage was reported to be 69 percent, up slightly from 68.8 percent in 1998. Last year, the Cancer Committee recommended expansion of radiation services for breast cancer patients seen at the facility.

**Improvement:** The clinic added evening hours during the week and is now open on Saturday. Since this change, treatment of breast cancer patients has increased by 30 percent in the last year.
CoC Resources and Tools for Cancer Programs

The following are resources and tools for cancer programs available on the Cancer Programs pages of the American College of Surgeons Web site (www.facs.org).

SURVEY-RELATED RESOURCES
- Appeals Process
- CoC-Trained Independent Cancer Consultant List
- Deficiency Resolution Documentation
- Guidelines for Merged Programs
- Guidelines for Network Cancer Programs
- Information for CoC Special Studies
- NCDB Case Submission, Transmission File Specifications/Format
- NCDB Hospital Edit Report Documentation
- Sample Approved Cancer Program Performance Report

CANCER PROGRAM TRACKING TOOLS
- AJCC Staging Quality Control Tool
- Cancer Conference Grid
- Cancer Registry Abstracting Quality Control Tool
- Pathology Report Quality Control Tool

OTHER CANCER PROGRAM RESOURCES
- ACS Publications and Services Catalog
- Benefits of Being an Approved Cancer Program
- Benefits of Being an Approved Cancer Program Network
- Cancer Liaison Physician Membership Criteria and Membership Application
- CoC Cancer Program Data Standards
- Facility Information Profile System (FIPS)
- Find an Approved Cancer Program Near You
- How are Cancer Programs Approved?
- How to Start an Approved Cancer Program
- Inquiry and Response (I&R) System
- NCDB Benchmark Reports
- Quality Improvement Best Practices in CoC-Approved Cancer Programs
- What is an Approved Cancer Program?