Q&A

- Please submit all questions concerning the webinar content through the Q&A panel.
- If you have participants watching this webinar at your site, please collect their names and emails.
- We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

FABULOUS PRIZES

GUEST PRESENTERS

- Courtney B. Jagneaux, RHIA, CTR
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Quality in CoC Accreditation

Presented by:
Erin Weber, BS, CTR &
Courtney Jagneaux, RHIA, CTR

RegistryPartners
DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Objectives

- **Provide an overview of 2020 Commission on Cancer Standards that encompass quality**
  - Standard 6.1 Cancer Registry Quality Control
  - Standard 6.4 Rapid Cancer Reporting System (RCRS) Data Submission
  - Standard 7.1 Accountability and Quality Improvement Measures
  - Standard 7.2 Monitoring Concordance with Evidence-Based Guidelines
  - Standard 7.3 Quality Improvement Initiative
  - Standard 7.4 Cancer Program Goal
- **Discuss standard definitions and requirements**
- **Provide tips and best practices for each standard**
- **Review questions from the CAnswer Forum**

References

The content of this presentation is taken from the following:

- Commission on Cancer *Optimal Resources for Cancer Care 2020 Standards*
- American College of Surgeons (facs.org)
- CAnswer Forum
- CoC Datalinks
- Rapid Cancer Reporting System
- Personal Experiences

Standard 6.1
Cancer Registry Quality Control

6.1 Cancer Registry Quality Control

Standard Definition & Requirements

- High-quality cancer registry data are essential to accurately assess treatment outcomes and patient survival
- Each year, the cancer committee implements a policy & procedure to evaluate cancer registry activity and data quality

Quality Control Policy & Procedure

- Elements
  - Review criteria
  - Quality control timetable
  - Specify the methods, sources, and individuals involved
  - Outline activities to be evaluated annually to include casefinding, abstracting timeliness, percentage of unknown data and abstract reviews (10%)
  - Establishes the minimum quality benchmarks and required accuracy
  - How quality control activity documentation will be maintained

6.1 Cancer Registry Quality Control

Specifications for QC Methods, Sources and Individuals

- Random sampling of annual analytic caseload
- Review by designated person(s)
  - Reviewer may be a CTR, Advanced Practice Nurse, Physician Assistant, physician, fellows, or residents
- External Audits may be utilized
  - Example: State or central registry case-finding audits

Abstracting Reviews

- Elements to be reviewed
  - Class of Case
  - Primary Site
  - Histology
  - Grade
  - AJCC (or appropriate) Staging
  - First Course of Treatment
  - Follow up Information

6.1 Cancer Registry Quality Control

Documentation

- Policy and Procedure with all required elements
- Audit reports from state or central registry (if utilized)
- Cancer committee minutes documenting results of annual quality control evaluation

Templates

- PRQ Templates available on datalinks last updated 5/5/2021

Cancer Registry QC Template

6.1 Cancer Registry Quality Control

Cancer Registry Quality Coordinator

- Responsible for overseeing Std 6.1 and Std 4.3 (Cancer Registry Staff Credentials)
- Position can be held by a CTR
- Works with registry staff and other departments to implement quality control policy and procedure
- Monitors cancer registry activity and recommends corrective action plan if needed
- Presents results, recommendations, and outcomes of recommendations to the cancer committee at least annually

6.1 Cancer Registry Quality Control

Notes & Reminders

- CTRs cannot review their own cases
- Patient data reviewed under the cancer registry quality control plan cannot be used as an in-depth analysis review for Standard 7.2 Monitoring Compliance with Evidence-Based Guidelines
- Quality Control should only go back as far as one year

Tips & Best Practices

How to handle small facilities with 1 CTR

- Outsourcing with a vendor
- External audits and reviews
- Physicians or appropriate provider
- CTR Exchange

Tips & Best Practices

Suggestions for multi-CTR teams

- Peer reviews
- Dedicated Quality Manager
- User defined fields
- Registry specific abstract guidelines

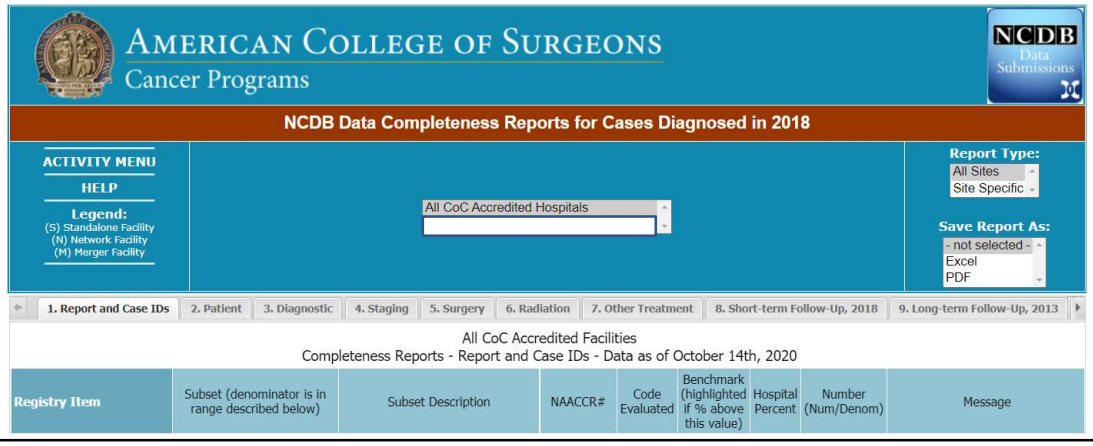
Abstract Guidelines

- Text Policy
  - ALL CAPS
  - MM/DD/YYYY (Facility) Procedure Description
- Non-required Fields
  - Instructions to skip
  - Customize the abstract
- User Defined Fields
  - Facility-specific instructions
- Reminders for Registrars

NCDB Data Completeness Reports

Completeness and Overuse report

- NCDB Data Completeness Reports for Cases Diagnosed in 2018 (As of 10/14/2020)



PDF

Completeness Reports - Short-term Follow-Up, 2018 - Data as of October 14th, 2020

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Readmission to the Same Hospital Within 30 Days of Surgical Discharge	Surgical Procedure of the Primary Site at This Facility (#670) = 20-90	A known surgical resection was performed at the facility	3190	9	1%	None	0 / 164	Should be known for patients who were given surgery at this facility
2. Date of Last Contact or Death	Class of Case (#610) = 00-22	All analytic diagnoses	1750	blank day	1%	None	0 / 370	Should be known for all patients
3. Cancer Status	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1770	9	5%	0.54%	2 / 370	May represent inadequate follow-up

Excel

Completeness Reports - Data as of October 14th, 2020

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark	Hospital Percent	Numerator	Denominator	Message
Sequence Number	Class of Case = 00-22	All analytic diagnoses	560	88, 99	1	0	0	381	High number of unknown Sequence Numbers
Date of First Contact	Class of Case = 00-22	All analytic diagnoses	580	blank day	1	0	0	381	Full date should be known
Primary Payer at Diagnosis	Class of Case = 00-22	All analytic diagnoses	630	99	2	3.41	13	381	High number unknown Primary Payer
NPI - Primary Surgeon	Surgical Procedure of the Primary Site at This Facility (#670) = 10-90	Surgery performed at facility	2485	blank	11	6.1	10	164	Surgeon NPI should be known for surgery at facility
NPI - Physician #3 (Radiation Oncologist)	Location of Radiation Treatment (#1550) = 1	All radiation performed at facility	2495	blank	15	6.29	11	175	Radiation Oncologist NPI should be known for radiation at facility
NPI - Physician #4 (Medical Oncologist)	Chemotherapy at This Facility (#700) = 01-03 OR Hormone Therapy at This Facility (#710) = 01	Known chemotherapy or hormone therapy given at facility	2505	blank	23	4.19	8	191	Medical Oncologist NPI should be known for systemic care at facility
Date Case Completed - CoC	Class of Case (#610) = 00-22	All analytic diagnoses	2092	blank day	0	0	0	381	Full date should be known
Date Case Completed - CoC [minus] Date of First Contact	Class of Case (#610) = 00-22	All analytic diagnoses	2092 (completed), 580 (contact)	>183 days	57	74.54	284	381	Over 57% of cases completed more than 6 months following first contact
Vendor Name	Class of Case (#610) = 00-22	All analytic diagnoses	2170	blank	0	0	0	381	Vendor or hospital programming source not consistently coded.
Class of Case	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	610	10,20	7	4.86	18	370	Are you defaulting Class of Case? Specific codes should be used.

1. Report and Case IDs

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Sequence Number	Class of Case = 00-22	All analytic diagnoses	560	88, 99	1%	0.03%	528 / 1549914	High number of unknown Sequence Numbers
2. Date of First Contact	Class of Case = 00-22	All analytic diagnoses	580	blank day	1%	0.01%	146 / 1549914	Full date should be known
3. Primary Payer at Diagnosis	Class of Case = 00-22	All analytic diagnoses	630	99	2%	1.3%	20194 / 1549914	High number unknown Primary Payer
4. NPI - Primary Surgeon	Surgical Procedure of the Primary Site at This Facility (#670) = 10-90	Surgery performed at facility	2485	blank	11%	8.35%	64960 / 777807	Surgeon NPI should be known for surgery at facility
5. NPI - Physician #3 (Radiation Oncologist)	Location of Radiation Treatment (#1550) = 1	All radiation performed at facility	2495	blank	15%	12.29%	40824 / 332289	Radiation Oncologist NPI should be known for radiation at facility
6. NPI - Physician #4 (Medical Oncologist)	Chemotherapy at This Facility (#700) = 01-03 OR Hormone Therapy at This Facility (#710) = 01	Known chemotherapy or hormone therapy given at facility	2505	blank	23%	18.9%	83124 / 439774	Medical Oncologist NPI should be known for systemic care at facility
7. Date Case Completed - CoC	Class of Case (#610) = 00-22	All analytic diagnoses	2092	blank day	0%	0.92%	14198 / 1549914	Full date should be known
8. Date Case Completed - CoC [minus] Date of First Contact	Class of Case (#610) = 00-22	All analytic diagnoses	2092 (completed), 580 (contact)	>183 days	57%	81.6%	1264717 / 1549914	Over 57% of cases completed more than 6 months following first contact
9. Vendor Name	Class of Case (#610) = 00-22	All analytic diagnoses	2170	blank	0%	0.15%	2361 / 1549914	Vendor or hospital programming source not consistently coded.
10. Class of Case	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	610	10,20	7%	5.33%	74429 / 1397425	Are you defaulting Class of Case? Specific codes should be used.

2. Patient

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Race 1	Class of Case (#610) = 00-22	All analytic diagnoses	160	98, 99	3%	2.49%	38544 / 1549914	High number of unknown race
2. Race Coding System - Original	Class of Case (#610) = 00-22	All analytic diagnoses	180	9	0%	0%	16 / 1549914	Race coding system should not be unknown for any currrent case
3. Spanish Origin - All Sources	Class of Case (#610) = 00-22	All analytic diagnoses	190	9	3%	2.16%	33409 / 1549914	High number of unknown if Spanish origin
4. Sex	Class of Case (#610) = 00-22	All analytic diagnoses	220	9	0%	0.01%	202 / 1549914	High number of unknown sex
5. Age at Diagnosis	Class of Case (#610) = 00-22	All analytic diagnoses	230	999	0%	0%	14 / 1549914	High number of unknown age
6. Date of Birth	Class of Case (#610) = 00-22	All analytic diagnoses	240	blank day	0%	0%	13 / 1549914	Full date of birth not systematically recorded
7. City/Town at Diagnosis	Class of Case (#610) = 00-14	Diagnosis at facility	70	blank or "UNKNOWN"	1%	0.05%	511 / 1027824	High number of unknown city at diagnosis
8. State at Diagnosis	Class of Case (#610) = 00-14	Diagnosis at facility	80	"US" or "ZZ"	1%	0.01%	109 / 1027824	High number of unknown state at diagnosis
9. Postal Code at Diagnosis	Class of Case (#610) = 00-14	Diagnosis at facility	100	1st 5 digits = 99999	1%	0.03%	345 / 1027824	High number of unknown ZIP or postal code at diagnosis
10. County at Diagnosis	Class of Case (#610) = 00-14	Diagnosis at facility	90	998 or 999	2%	1.8%	18499 / 1027824	High number of unspecified county at diagnosis

3. Diagnostic

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Date of Initial Diagnosis	Class of Case (#610) = 00-14	Diagnosis at facility	390	blank day	1%	0.09%	910 / 1027824	Full date of diagnosis not systematically recorded
2. Primary Site	Class of Case (#610) = 00-22	All analytic diagnoses	400	C809	2%	1.17%	18194 / 1549914	High number of unknown primary site
3. Laterality	Class of Case (#610) = 00-14	Diagnosis at facility	410	9	2%	1.16%	11934 / 1027824	High number of unknown laterality
4. Histology	Class of Case (#610) = 00-14	Diagnosis at facility	522	8000	2%	1.5%	15427 / 1027824	High number of unknown histology (ICD-O-3)
5. Behavior Code	Class of Case (#610) = 00-14	Diagnosis at facility	523	3	89%	88.78%	912459 / 1027824	High portion malignant may represent inadequate case-finding or defaulting to 3
6. Lymph-vascular Invasion	Surgical Procedure of the Primary Site at This Facility (#670) = 20-90 AND Behavior Code (#523) = 3	Surgical resection performed at facility and cancer is invasive	1182	9	17%	16.88%	111149 / 658410	High percentage unknown for surgery performed on invasive cancer by the facility
7. Site Coding System - Original	Class of Case (#610) = 00-22	All analytic diagnoses	460	9	0%	0%	7 / 1549914	Original site coding system should not be unknown for any current case
8. Morph Coding System - Original	Class of Case (#610) = 00-22	All analytic diagnoses	480	9	0%	0%	21 / 1549914	Original morphology coding system should not be unknown for any current case
9. Diagnostic Confirmation	Class of Case (#610) = 00-14	Diagnosis at facility	490	9	1%	0.24%	2501 / 1027824	High number of unknown method of diagnostic confirmation
10. Secondary Diagnosis #1	Class of Case (#610) = 10-22	At least partial treatment at facility	3780	0	49%	0.12%	1700 / 1397425	Comorbidities and Complications not consistently recorded

4. Staging

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Date of Surgical Diagnostic and Staging Procedure	Surgical Diagnostic and Staging Procedure at This Facility (#740) = 01-07	Surgical diagnostic and staging procedure was performed at facility	1280	blank day	1%	0.07%	457 / 648369	Full date of diagnostic/ staging procedure should be known if done at facility
2. Surgical Diagnostic and Staging Procedure at This Facility	Class of Case (#610) = 10-14	Diagnosis and at least partial treatment at facility	740	09	1%	0.02%	168 / 875335	Should be known when done by facility
3. Surgical Diagnostic and Staging Procedure	Class of Case(#610) = 12	Cases diagnosed and all treatment by the facility	1350	09	1%	0%	1 / 37823	Should be known for cases diagnosed and fully treated at facility
4. Regional Lymph Nodes Positive	Scope of Regional Lymph Node Surgery at This Facility (#672) = 1-7	Regional lymph node surgery peformed at facility	820	99	1%	0.59%	2896 / 489728	High number of unknown positive regional lymph nodes
5. Regional Lymph Nodes Examined	Scope of Regional Lymph Node Surgery at This Facility (#672) = 1-7	Regional lymph node surgery peformed at facility	830	99	1%	0.51%	2501 / 489728	High number of unknown regional lymph nodes examined

5. Surgery

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Date of First Surgical Procedure	Surgical Procedure of the Primary Site (1290) = 10-90	Primary site surgery was performed for the patient	1200	blank day	1%	0.05%	418 / 768582	Full date of surgery not consistently recorded
2. Date of the Most Definitive Resection of the Primary Site	Surgical Procedure of the Primary Site (1290) = 10-90	Primary site surgery was performed for the patient	3170	blank day	1%	0.04%	320 / 777807	Full date of most definitive surgery not consistently recorded
3. Date of Surgical Discharge	Surgical Procedure of the Primary Site at This Facility (#670) = 10-90	A known primary site surgical procedure is performed at the facility	3180	blank day	4%	3.21%	24972 / 777807	Full date of surgical discharge not consistently recorded
4. Surgical Procedure of Primary Site at This Facility	Surgical Procedure of the Primary Site at This Facility (#670) NOT 00 or 98	A surgical procedure was performed at the facility OR it is unknown if one was performed	670	90, 99	1%	0.42%	3281 / 778347	Type of surgery should be known for surgery at facility
5. Surgical Procedure of Primary Site	Surgical Procedure of the Primary Site (#1290) = 10-99	A surgical procedure was performed on the patient OR it is unknown if one was performed	1290	90, 99	2%	1.23%	12748 / 1033551	Large portion of primary site surgical procedures unknown
6. Reason for No Surgery of Primary Site	Surgical Procedure of the Primary Site (#1290) = 00	A surgical procedure of the primary site was not performed on the patient	1340	6, 8, 9	3%	1.92%	9905 / 516793	High portion unknown reason for no surgery may indicate inadequate treatment follow-up
7. Surgical Procedure/Other Site at This Facility	Surgical Procedure/Other Site at This Facility (#674) NOT = 0	A surgical procedure of "other site" was performed at the facility	674	9	6%	4.59%	2081 / 45334	Treatment at this facility should be known
8. Surgical Procedure/Other Site	Surgical Procedure/Other Site (#1294) NOT = 0	A surgical procedure of "other site" was performed on the patient	1294	9	9%	7.85%	4639 / 59114	Large number of procedures unknown

6. Radiation

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Date Radiation Started	Location of Radiation Treatment (#1550) = 1 (all at this facility)	Patient received radiation treatment, all of which was given at the facility	1210	blank day	1%	0.15%	495 / 332289	Full date should be available for radiation at this facility
2. Date Radiation Ended	Location of Radiation Treatment (#1550) = 1 (all at this facility) AND RX Date Rad Ended Flag (#3221) = blank	Patient received all radiation treatment at this facility and the date it ended is at least partially recorded	3220	blank day	1%	0.27%	899 / 327654	Full date should be known for conclusion of radiation at this facility once it has completed
3. Phase I Total Dose	Location of Radiation Treatment (#1550) = 1 (all at this facility) AND RX Date Rad Ended Flag (#3221) = blank	Patient received all radiation treatment at this facility and the date it ended is at least partially recorded	1507	999999	2%	0.5%	1648 / 327654	Should be known for radiation at this facility once it has completed
4. Phase I Radiation Treatment Volume	Location of Radiation Treatment (#1550) = 1 (all at this facility) AND RX Date Rad Ended Flag (#3221) = blank	Patient received all radiation treatment at this facility and the date it ended is at least partially recorded	1504	99	1%	0.05%	159 / 327654	Should be known for radiation at this facility once it has completed
5. Phase I Number of Fractions	Location of Radiation Treatment (#1550) = 1 (all at this facility) AND RX Date Rad Ended Flag (#3221) = blank	Patient received all radiation treatment at this facility and the date it ended is at least partially recorded	1503	999	2%	1.08%	3545 / 327654	Should be known for radiation at this facility once it has completed
6. Phase I Radiation Treatment Modality	Location of Radiation Treatment (#1550) = 1 (all at this facility) AND RX Date Rad Ended Flag (#3221) = blank	Patient received all radiation treatment at this facility and the date it ended is at least partially recorded	1506	98, 99	1%	0.15%	480 / 327654	Should be known for radiation at this facility once it has completed

6. Radiation (con't)

7. Phase II Total Dose	Phase II Total Dose (#1517) NOT = 000000 AND Location of Radiation Treatment (#1550) = 1 or 3 (patient had boost dose at facility) AND RX Date Rad Ended Flag (#3221) = blank	Patient received a phase II total dose treatment at the facility and the date it ended is at least partially recorded	1517	999999	2%	0.13%	283 / 218794	Should be known for phase II total dose once it has completed
8. Phase II Radiation Treatment Modality	Phase II Total Dose NOT = 000000 AND Location of Radiation Treatment (#1550) = 1 or 3 (patient had boost dose at facility) AND RX Date Rad Ended Flag (#3221) = blank	Patient received a phase II total dose treatment at the facility and the date it ended is at least partially recorded	1516	98, 99	1%	0.05%	115 / 218794	Should be known for phase II radiation treatment modality once it has completed
9. Location of Radiation Treatment	Location of Radiation Treatment (#1550) NOT = 0	Patient received radiation treatment	1550	9	4%	2.35%	11438 / 487623	High proportion unknown location for patients treated with radiation
10. Radiation / Surgery Sequence	Radiation/Surgery Sequence (#1380) NOT = 0	Both radiation and surgery performed on patient	1380	9	1%	0.06%	168 / 299251	High proportion unknown for patients treated with both radiation and surgery
11. Reason for No Radiation	Location of Radiation Treatment (#1550) = 0	No radiation treatment was given	1430	6, 8, 9	1%	0.51%	5443 / 1062613	High proportion of patients with an unknown reason for not receiving radiation

7. Other Treatment

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Date of First Course of Treatment	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1270	blank day	5%	5.13%	71732 / 1397425	Full date of first treatment or decision not to treat not consistently recorded
2. Rx Summ - Treatment Status	Class of Case (#610) = 00-22	All analytic diagnoses	1285	9	1%	0.4%	5527 / 1397425	High portion of cases with unknown treatment status
3. Chemotherapy at This Facility	Chemotherapy at This Facility (#700) NOT = 00	Patient was given chemotherapy at the facility or it was unknown	700	86, 88, 99	8%	6.11%	24336 / 398263	High unknown for chemotherapy given at this facility (allows that some 88s may not be given yet)
4. Chemotherapy	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1390	86, 88, 99	2%	1.4%	19529 / 1397425	High unknown for patients who received at least part of their treatment at the facility; may indicate inadequate treatment follow-up
5. Hormone Therapy at This Facility	Hormone Therapy at This Facility (#710) NOT = 00	Patient was given hormone treatment at the facility or it was unknown	710	86, 88, 99	10%	9.07%	19245 / 212263	High unknown for hormone therapy given at this facility (allows that some 88s may not be given yet)
6. Hormone Therapy	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1400	86, 88, 99	2%	1.2%	16802 / 1397425	High unknown for patients who received at least part of their treatment at the facility; may indicate inadequate treatment follow-up

7. Other Treatment (con't)

7. Immunotherapy at This Facility	Immunotherapy at This Facility (#720) NOT = 00	Patient was given immunotherapy at the facility or it was unknown	720	86, 88, 99	10%	7.91%	9143 / 115521	High unknown for immunotherapy given at the facility (allows that some 88s may not be given yet)
8. Immunotherapy	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1410	86, 88, 99	1%	0.47%	6541 / 1397425	May indicate inadequate treatment follow-up
9. Hematologic Transplant and Endocrine Procedures	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	3250	86, 88, 99	1%	0.22%	3141 / 1397425	High unknown for patients who received at least part of their treatment at the facility; may indicate inadequate treatment follow-up
10. Other Treatment at This Facility	Other Treatment at This Facility (#730) NOT = 0	Patient was given at least some "Other Treatment" at the facility	730	8, 9	1%	0.66%	64 / 9693	High unknown for patients who received this treatment at the facility (high enough to allow that some 8s may not be given yet)
11. Systemic / Surgery Sequence	Systemic/Surgery Sequence (#1639) NOT = 0	Patient was given both systemic treatment and surgery	1639	9	1%	0.14%	675 / 473474	High unknown for patients treated with both surgery and systemic therapy
12. Palliative Care at This Facility	Palliative Care at This Facility (#3280) NOT = 0	Patient was given palliative care at the facility or it was unknown	3280	9	1%	0.44%	241 / 54212	Should be known for patient who received the treatment at this facility
13. Palliative Care	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	3270	9	1%	0.02%	266 / 1397425	High unknown for patients who received at least part of first course treatment at the facility

8. Short-term Follow-Up, 2018

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Readmission to the Same Hospital Within 30 Days of Surgical Discharge	Surgical Procedure of the Primary Site at This Facility (#670) = 20-90	A known surgical resection was performed at the facility	3190	9	1%	0.43%	3333 / 768582	Should be known for patients who were given surgery at this facility
2. Date of Last Contact or Death	Class of Case (#610) = 00-22	All analytic diagnoses	1750	blank day	1%	0.05%	654 / 1397425	Should be known for all patients
3. Cancer Status	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1770	9	5%	4.66%	65154 / 1397425	May represent inadequate follow-up

9. Long-term Follow-Up, 2013

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Date of Last Contact or Death	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1750	blank day	1%	0.06%	866 / 1422385	Should be known for all patients
2. Cancer Status	Class of Case (#610) = 10-22	At least some treatment was provided at the facility	1770	9	7%	5.37%	76336 / 1422385	May represent inadequate follow-up
3. Date of First Recurrence	Class of Case (#610) = 10-22 AND Type of First Recurrence (#1880) NOT 00 or 70	At least some treatment was provided at the facility, and a recurrence is recorded	1860	blank day	63%	61.23%	144299 / 235674	May represent inadequate follow-up; fact of recurrence recorded, but not date.
4. Type of First Recurrence	Class of Case (#610) = 10-22 AND Type of First Recurrence (#1880) NOT 00 or 70	At least some treatment was provided at the facility, and a recurrence is recorded	1880	88, 99	64%	62.15%	146467 / 235674	May represent inadequate follow-up; fact of recurrence recorded but not type.
5. Type of First Recurrence	Class of Case (#610) = 10-22	At least some treatment was provided at facility.	1880	00, 70	82%	None	0 / 1422385	Few recurrences may represent inadequate follow-up after initial discharge

NCDB Data Completeness Reports

1. Breast | 2. Colon | 3. Rectum | 4. Stomach | 5. Esophagus and EGJ | 6. Lung | 7. Cervical | 8. Endometirum | 9. Ovary

All CoC Accredited Facilities
Completeness Reports - Breast - Data as of October 14th, 2020

Specific Completeness for Female Breast Cancer
For all items in this group (further subsetting is listed in the table below):
1. Primary Site = C50.0, C50.1, C50.2, C50.3, C50.4, C50.5, C50.6, C50.8, C50.9
2. Histology = 8000-8576, 8940-8950, 8980-8981, 9020 (AJCC stageable for breast)
3. Behavior = 2 or 3 (malignant, either in situ or invasive)
4. Sequence Number = 00 or 01 (sole or first tumor)
5. Class of Case = 10-22 (at least some treatment at facility)
6. Age > 17 and is known (not '999')

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Tumor Size Summary	Class of Case (#610) = 10-14 and RX_Hosp_Surg_Prim_Site (#670) = 20-90	Diagnosis and at least some surgery at facility	756	999	0%	5%	5823 / 109179	Large portion with unknown or non-specific tumor size but diagnosis and surgery at facility

NCDB Data Completeness Reports

Specific Completeness for Colon Cancer (excluding Appendix)
For all items in this group (further subsetting is listed in the table below):
1. Primary Site = C18.0, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9
2. Histology = 8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981 (AJCC stageable for colon)
3. Behavior = 2 or 3 (malignant, either in situ or invasive)
4. Sequence Number = 00 or 01 (sole or first tumor)
5. Class of Case = 10-22 (at least some treatment at facility)
6. Age > 17 and is known (not '999')

Registry Item	Subset (denominator is in range described below)	Subset Description	NAACCR#	Code Evaluated	Benchmark (highlighted if % above this value)	Hospital Percent	Number (Num/Denom)	Message
1. Tumor Size Summary	Class of Case (#610) = 10-14 and RX_Hosp_Surg_Prim_Site (#670) = 20-90	Diagnosis and at least some surgery at facility	756	999	0%	5%	1 / 19	Unknown or non-specific tumor size but diagnosis and surgery at facility
2. Surgical Procedure of the Primary Site	RX_Summ_Surg_Prim_Site (#1290) = 10-14, 20-29, 80, 90	Primary site surgery performed; codes in range have specific sub-categories defined	1290	10, 20, 80, 90	12%	None	0 / 0	Over-reliance on broad codes
3. Surgical Procedure of the Primary Site at This Facility	RX_Hosp_Surg_Prim_Site (#670) = 10-14, 20-29, 80, 90	Primary site surgery performed at facility; codes in range have specific sub-categories defined	670	10, 20, 80, 90	9%	None	0 / 0	Specific sub-codes should be known for surgery at facility
4. Date of First Surgical Procedure	RX_Hosp_Surg_Prim_Site (#670) = 10-90	A known primary site surgical procedure is performed at the facility	1200	Day = 01, 15, 30, 31	12%	10%	2 / 21	Are you defaulting the day? Unknown day = blank, but exact day should be known for treatment at facility
5. Date of the Most Definitive Resection of the Primary Site	RX_Hosp_Surg_Prim_Site (#670) = 10-90	A known primary site surgical procedure is performed at the facility	3170	Day = 01, 15, 30, 31	12%	10%	2 / 21	Are you defaulting the day? Unknown day = blank, but exact day should be known for treatment at facility

NCDB Data Completeness Reports

REVIEW	FACILITY_ID	ACCESSION_NBR	SEQUENCE_NBR	SITE_NM	PRIMARY_SITE	HISTOLOGY_ICDO3	AGE	CLASS_OF_CASE_V12	SRGY_PRIMARY_SITE_03	TUMOR_SIZE_SUMMARY
x	123456	201800205	00	Colon	C187	8140	068	12	30	999
	123456	201800002	01	Colon	C186	8140	083	14	40	060
	123456	201800035	00	Colon	C183	8140	058	14	40	060
	123456	201800047	00	Colon	C187	8480	069	14	30	045
	123456	201800063	00	Colon	C180	8140	081	12	40	030
	123456	201800087	00	Colon	C182	8480	075	12	40	090
	123456	201800092	00	Colon	C184	8140	065	14	40	090
	123456	201800092	01	Colon	C184	8140	065	14	40	090
	123456	201800124	01	Colon	C180	8480	069	14	40	085
	123456	201800125	00	Colon	C180	8140	065	14	40	080
	123456	201800156	00	Colon	C184	8140	056	14	40	070
	123456	201800157	00	Colon	C187	8140	067	12	30	025
	123456	201800158	00	Colon	C188	8480	058	14	40	065
	123456	201800203	00	Colon	C182	8480	074	14	40	080
	123456	201800268	00	Colon	C180	8480	064	14	40	110
	123456	201800315	00	Colon	C182	8140	084	14	40	065
	123456	201800329	00	Colon	C189	8140	080	14	32	080
	123456	201800339	00	Colon	C182	8140	073	14	40	040
	123456	201800343	00	Colon	C187	8140	058	11	30	020

FAQ from the CoC

Standard 6.1: Cancer Registry Quality Control	
Question	**Response**
Is this applicable for 2019 cases to be reviewed in 2020?	That would be acceptable. Quality Control should only go back as far as one year, i.e., reporting on 2019 in 2020. Or you can do six months of 2018 (latter half) and six months of 2019 (first half).
How is abstracting timeliness defined and how will that be handled for 2018 cases? There is a 6-9 month delay due to new reporting requirements.	Quality Control should only go back as far as one year, i.e., reporting on 2019 in 2020. Or you can do six months of 2018 (latter half) and six months of 2019 (first half).
Per the webinar; the maximum number of abstracts to be reviewed each year had been reduced (200). For an INCP, the minimum requirement is 10% per facility, which could be higher than the previous maximum of 300, thus increasing rather than decreasing the number for review. Has this been considered? Could there be a maximum set for INCP?	Here is an example from the Forum: In 2020, my same network has 4,000 cases a year with a breakdown of 2,000 at Hospital A, 1,000 at Hospital B, 700 at Hospital C, and 300 at Hospital D, we would need to perform Quality Assurance on 400 cases annually (200+100+70+30 respectively). Reporting out to the cancer committee annually should then include not only the total overall review, but each hospital broken down with its own statistics for the required elements.
Is the requirement for string of unknowns no longer a part of cancer registry quality control?	No. See section D-3 on page 57 of the 2020 Standards manual.

FAQ from the CoC

Standard 6.1: Cancer Registry Quality Control	
Question	**Response**
Has the physician review of abstracts disappeared? Can MSNs or PhDs do QC reviews?	Cancer committee, via the policy and procedure, identifies the designated person(s) to perform the Quality Control reviews.
What is meant by 'abstracting timeliness'? Not specific, need to clarify.	At this time the CoC does not have a requirement for timeliness. This should be decided by your cancer committee.
Can a non-abstracting CTR do the quality review of the registry data annually?	No, the review is to be performed by CTRs, Advanced Practice Registered Nurses, Physician Assistants, physicians, or residents.
Since physician reviews technically are no longer required, there was a post on the Forum that we still need an action plan for how we will review 2019 data. Any ideas on what to include in that action plan? Does our 2019 data still need to follow 2016 standards and be reviewed by physicians?	Correct, physician review is no longer required. Compliance for this standard is not based on the year of the cases reviewed, but rather the year the activity is performed. So, in 2020, for the cases reviewed, follow the 2020 standard criteria.

CAnswer Forum

Case Reviews: Physicians vs Registrars

- **Since the registry quality plan change in 2020 now allows registrars to do the case reviews, we feel strongly that the reviews have a lot more value since the registrars are reviewing each other. It has resulted in some opportunities for improvement for some of the team members, resulting in even better quality work. However, it is taking much more time than it did when we had physicians reviewing the cases. We already have backlog, and these reviews are putting us further behind. I would like to know if there would be consideration of this circumstance if we were to do fewer than the required 200 case reviews (we are at about 120). We have been keeping the cancer committee apprised of this situation, and they understand that we have already implemented changes based on the peer review. I'm not sure how much value the additional case reviews would truly offer. Thank you**

- *Thank you for your comments, This are being shared with leadership. At this time, 200 remains the number of required case reviews.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-6-data-surveillance-and-systems/standard-6-1-cancer-registry-quality-control/114321-case-reviews-physicians-vs-registrars

CAnswer Forum

Standard 6.1

- **Would my facility meet standard 6.1 for 2020 when reviewing cases diagnosed in 2019?**
- **If so, what do we put for the annual analytic case load for 2020 on the PRQ template if we are not finished with 2020 cases?**
- **Is it correct to fill out the PRQ 2020 template with 2019 information?**

- *Yes, 2019 cases can be reviewed in 2020.*
- *You can use the 2019 analytic caseload as an estimate for 2020 cases.*
- *If you are reviewing 2019 cases in 2020 they can be used to fill out the 2020 template.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-6-data-surveillance-and-systems/standard-6-1-cancer-registry-quality-control/112433-standard-6-1

CAnswer Forum

Calculating AJCC Stage Number Compliant

- **On the 2020 Cancer Registry Quality Control Template- Std 6.1-1, how are we to count the number compliant for the AJCC Stage criteria?**
  Do we count only completion of the stage group field? Or is this directed toward counting stage done by a physician?
- *This is really more about the accuracy of the information in the abstracted data, so it should be for stage criteria and group and less so on who completed it. If you find this information consistently missing or incorrect, you may need to track the source.*

- **My question is if clinical stage is wrong but pathological stage is correct how do we count this for QC? Would this case be counted incorrectly if all data elements are correct except cT for example?**
- *It would be counted as incorrect.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-6-data-surveillance-and-systems/standard-6-1-cancer-registry-quality-control/108619-calculating-ajcc-stage-number-compliant

CAnswer Forum

State Audit Report Utilization in Evaluation of Registry Data

- **In the PRQ for 6.1 it says if state audit reports are utilized in the evaluation of registry data the reports are to be uploaded into the PRQ with all PHI removed. The audit reports the state sends to my facility contains so much PHI that if I remove/cross out the information it will be a sheet with just headings and the remainder of the page darkened out. Is this what they want? Or do we answer no that we don't use audit reports from the state?**

- *You can upload the report with the PHI removed or make a comment in the PRQ that the state audit report contains significant PHI, and it will be available to be reviewed on-site.*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-6-data-surveillance-and-systems/standard-6-1-cancer-registry-quality-control/111388-state-audit-report-utilization-in-evaluation-of-registry-data

CAnswer FORUM

Questions for Std 6.1

Standard 6.4
Rapid Cancer Reporting System (RCRS) Data Submission

6.4 Rapid Cancer Reporting System (RCRS) Data Submission

- Changes to Std 6.4 effective 01/01/2021
- RCRS designed to process all data for all disease sites in "real-clinical-time" as CTRs shift towards concurrent abstracting
- New Requirements!

6.4 Rapid Cancer Reporting System (RCRS) Data Submission

Standard Definition & Requirements

- The cancer program actively participates in RCRS, submits all required cases, and adheres to the RCRS terms and conditions.
- All new and updated cancer cases are submitted at least **once each calendar month**
- Once each calendar year, programs submit all complete analytic cases for all disease sites via RCRS as specified by the annual Call for Data.

Documentation

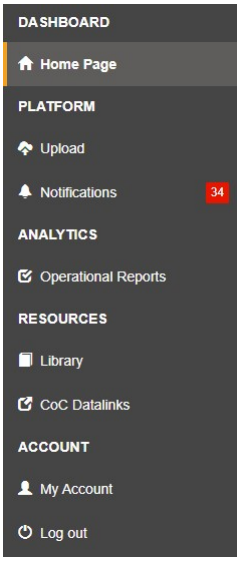
- Cancer committee minutes documenting reports at **two separate meetings** each year on RCRS data and performance

Notes

- The Cancer Liaison Physician may report RCRS data and performance in partial fulfillment of the requirement for Standard 2.2.

General RCRS Information

- In order to update a case within RCRS, the case must be resubmitted – this includes updating sequence numbers
- To resolve an alert, a case resubmission is required
- Submitted cases may be in any stage of abstracting
- Alerts are updated daily
- Information within RCRS is updated within 72 hours of submission
- No longer any timeliness requirements for submission



Concurrent Abstracting

All CTRs are encouraged by ACS/NCDB to develop a concurrent abstracting procedure that works for their hospital, however, there are currently no requirement for concurrent abstracting

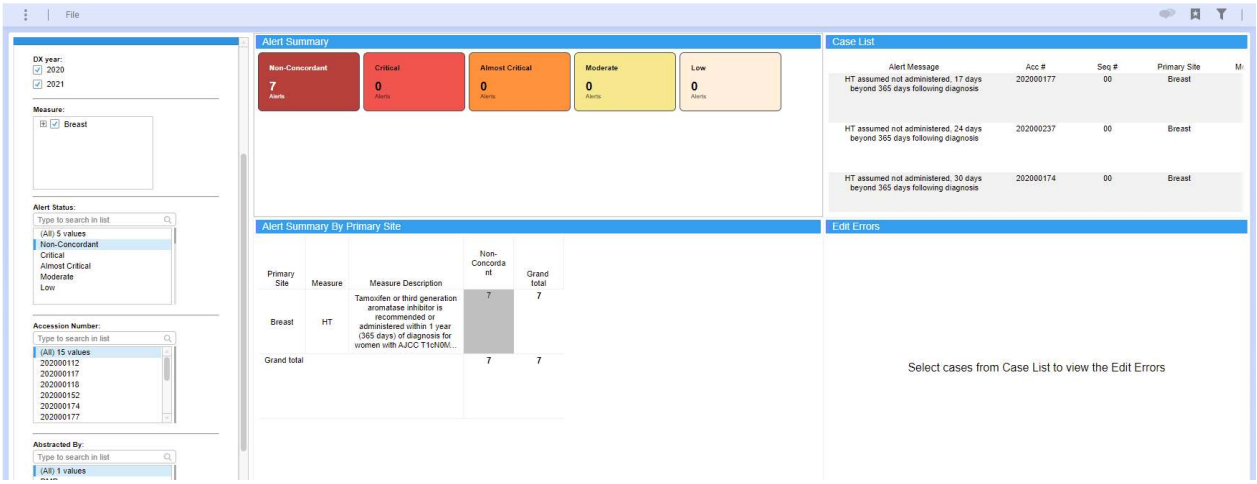
Recommendations for Concurrent Abstracting

- Collect as much information as possible as soon as possible
- Documentation is key
- Careful texting and coding
- One CTR per case
- Use flags or UDFs
- Utilize coding for treatment recommendations
- Track case statuses

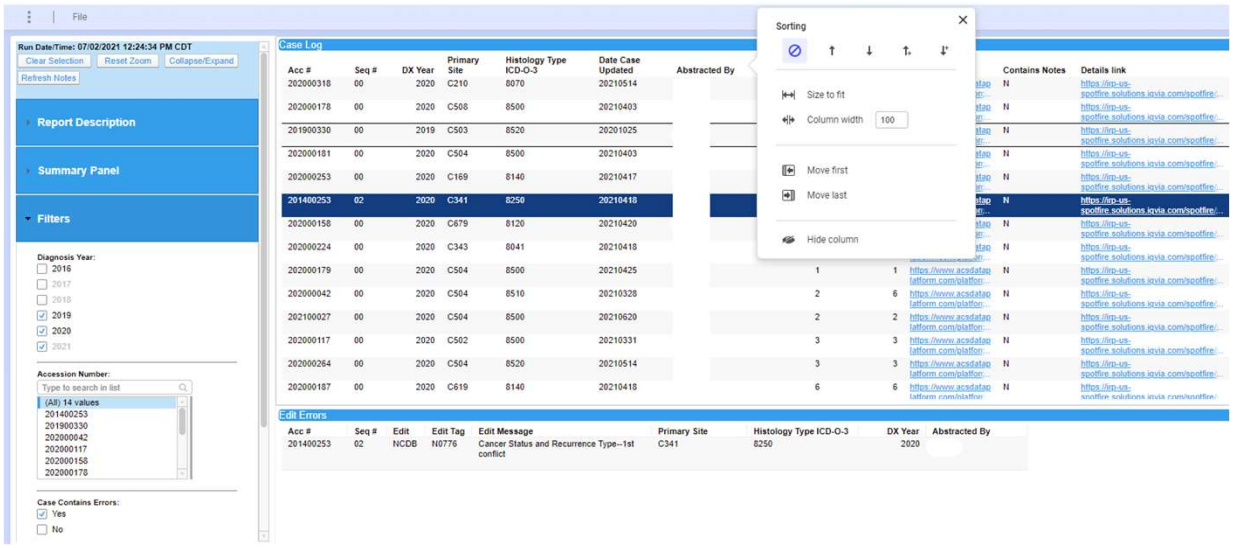
RCRS Operational Reports

RCRS Operational Reports	Report Use	Available Data Display
Alerts Report	Provides an overview as well as detailed information regarding cases with outstanding alerts and the associated edit errors.	Latest 3 Years
Case Log Report	Allows users to view a filtered list of cases, along with case-level edits.	Latest 6 Years
Quality Measures Report	Provides details for all quality measures.	Latest 6 Years
Comparisons Report	Allows users to view different performance rates for quality measures and compare the rates from the users' program to the users' program category to all CoC programs.	Latest 6 Years

Alerts Report

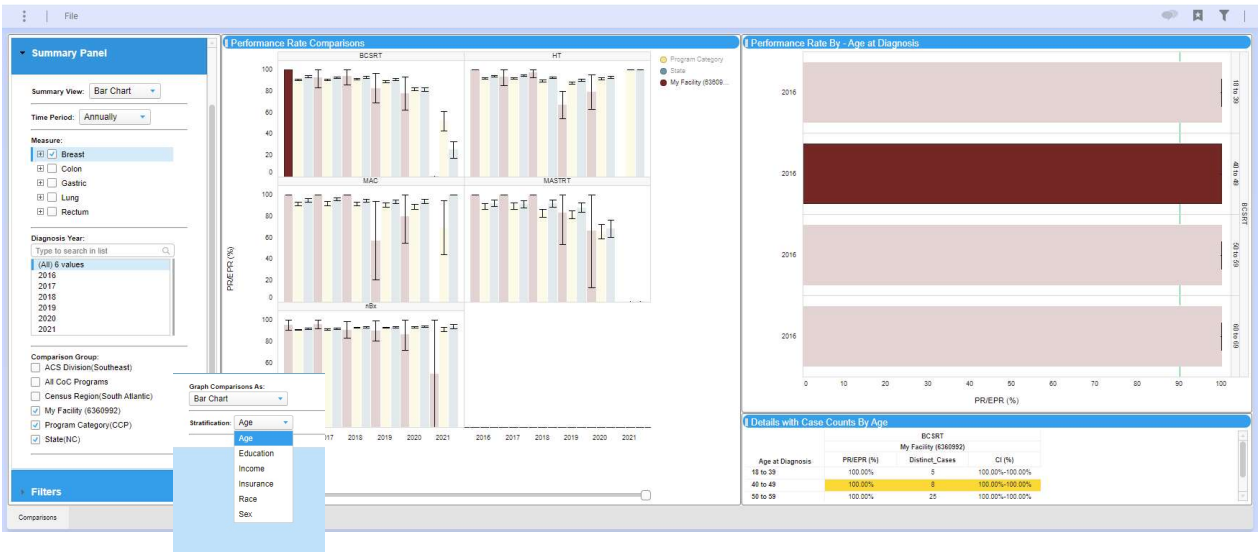


Case Log Report



Quality Measures Report

Comparisons Report



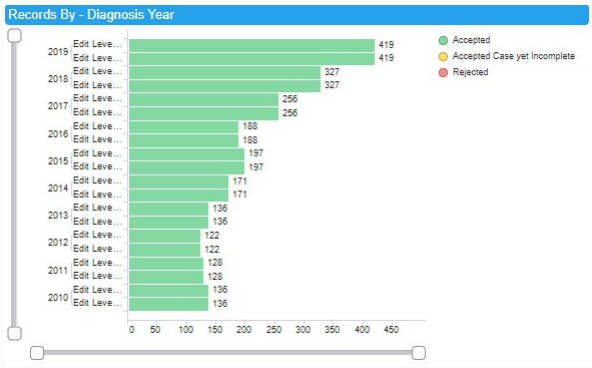
Call for Data

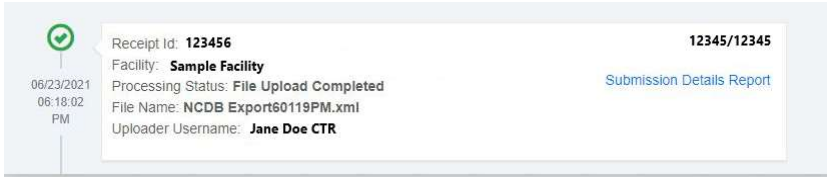
Preparation for Your Call for Data Submission

- Stay in contact with your registry software provider
- Complete all updates on cases being submitted
- Carefully review Call for Data instructions
- Run frequency counts on FIN, and NPI numbers
- Utilize Count Tracker by Diagnosis Year
- Use edit sets provided by your software vendor and double check them with GenEDITS Plus
- Always double check your files and case counts
- Carefully name your files and pay attention to your file format

C4D Case Counts Tool

Call for Data





CAnswer Forum

Compliance with monthly submission requirement

- **For the RCRS monthly submission requirement for compliance, what if we have a rejected file in our monthly submission? For example, if 1 ourtof 1000 files is rejected does that 1 rejected file have to be resubmitted and accepted by RCRS *in the same month* for compliance with the standard to be achieved?**
- *All new and updated cancer cases are submitted at least once each calendar month. If a case is rejected, you can review, fix, and submit with your next submission*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-6-data-surveillance-and-systems/standard-6-4-rapid-quality-reporting-system-rqrs-participation/117759-compliance-with-monthly-submission-requirement

CAnswer FORUM

CAnswer Forum

Rolling Year EPR in Quality Measures Report

- **Which time period is reflected in the "Rolling Year EPR" column in the Quality Measures report?**

- *Breast (HT, BCSRT, MASTRT) – 24 months from diagnosis date to current date*
- *Breast (ACT), Colon (MAC) – 16 months from diagnosis date to current date*
- *Colon (12 RLN), Gastric (15 RLN) – 12 months from diagnosis date to current date*
- *Lung (LCT, LNoSurg) – 12 months from diagnosis date to current date*
- *Rectal (RECRCT) – 12 months from diagnosis date to current date*
- *Breast (nBX) – 12 months from diagnosis date to current date*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-6-data-surveillance-and-systems/standard-6-4-rapid-quality-reporting-system-rqrs-participation/117443-rolling-year-epr-in-quality-measures-report

CAnswer FORUM

CAnswer Forum

MAC & ACT

- **Are we no longer required to report out on the MAC & ACT measures?**

- *To view the Breast MAC and Colon ACT measures, please change the measure group from "CoC Accreditation" to "All Measure Groups". Both MAC and ACT measures do not have a CoC set benchmark percentage to meet but should continue to be monitored as both are still accountability measures.*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-6-data-surveillance-and-systems/standard-6-4-rapid-quality-reporting-system-rqrs-participation/115626-mac-act

CAnswer FORUM

Questions for Std 6.4

Standard 7.1
Accountability and Quality Improvement Measures

7.1 Accountability and Quality Improvement Measures

Standard Definition & Requirements

- The cancer committee monitors the expected Estimated Performance Rates (EPR) for accountability and quality improvement measures selected annually by the CoC
- If the cancer program is not meeting the expected EPR, then a corrective action plan must be developed and executed to improve performance

Notes

- The corrective action plan must document how the program will investigate the issue for each measure with the goal of resolving the deficiency and improving compliance
- Programs with no cases eligible for assessment are exempt from that measure

Documentation

- The presentation and review of required measures as well as required action plans must be recorded in the cancer committee minutes

2022 Site Visits

For 2020 and 2021, the program's performance rate for this Standard is expected to be equal to or greater than the expected rate specified by the CoC, or the upper confidence interval should cross that expected rate nine (9) measures. These performance rates will be reviewed during site visits beginning in 2022.

Quality Measure Types

Measure Type	Measure Definition and Use
Accountability	High level of evidence supports the measure, including multiple randomized control trials. These measures can be used for such purposes as public reporting, payment incentive programs, and the selection of providers by consumers, health plans, or purchasers.
Quality Improvement	Evidence from experimental studies, not randomized control trials supports the measure. These are intended for internal monitoring of performance within an organization.
Surveillance	Limited evidence exist that supports the measure or the measure is used for informative purposes to accredited programs. These measures can be used for to identify the status quo as well as monitor patterns and trends of care in order to guide decision-making and resource allocation.

National Quality Forum

NQF-Endorsed Measures of the CoC	Initial Endorsement Year	Endorsement Category
(NQF #0219) Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.	2007	Accountability
Combination chemotherapy or chemo-immunotherapy (if HER2 positive) is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or stage IB - III hormone receptor negative breast cancer.	2007	Accountability
(NQF #0220) Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor-positive breast cancer.	2007	Accountability
(NQF #0223) Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.	2007	Accountability
At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	2007	Quality Improvement

Breast

Breast Measure	Measure Type	Expected EPR	Measure Description	Initial Measure Release
BCSRT	Accountability	90%	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.	2006
HT	Accountability	90%	Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor positive breast cancer.	2006
MASTRT	Accountability	90%	Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with ≥ 4 positive regional lymph nodes.	Spring 2014
nBx	Quality Improvement	80%	Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer.	Spring 2014

Colon

Colon Measure	Measure Type	Expected EPR	Measure Description	Initial Measure Release
2RLN	Quality Improvement	85%	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	2006

Gastric

Gatric Measure	Measure Type	Expected EPR	Measure Description	Initial Measure Release
G15RLN	Quality Improvement	80%	At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer.	Fall 2014

Lung

Lung Measure	Measure Type	Expected EPR	Measure Description	Initial Measure Release
LCT	Quality Improvement	85%	Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is recommended for surgically resected cases with pathologic, lymph node-positive (pN1) and (pN2) NSCLC.	Fall 2014
LNoSurg	Quality Improvement	85%	Surgery is not the first course of treatment for cN2, M0 lung cases	Spring 2015

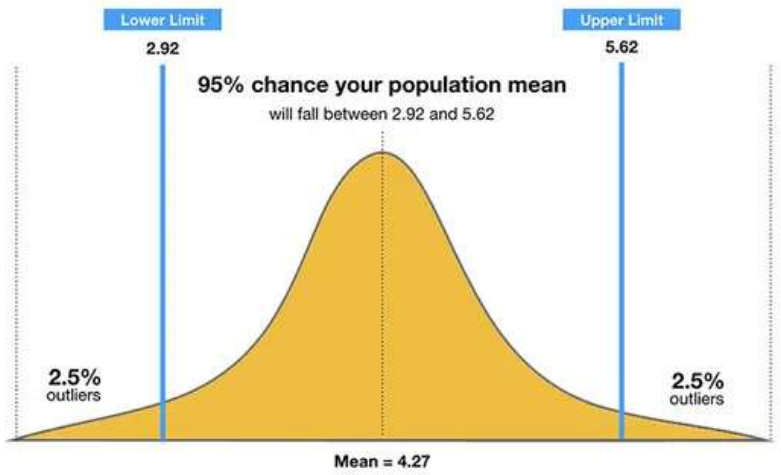
Rectum

Rectum Measure	Measure Type	Expected EPR	Measure Description	Initial Measure Release
RECRTCT	Quality Improvement	85%	Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or Postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is recommended; for patients under the age of 80 receiving resection for rectal cancer.	Spring 2015

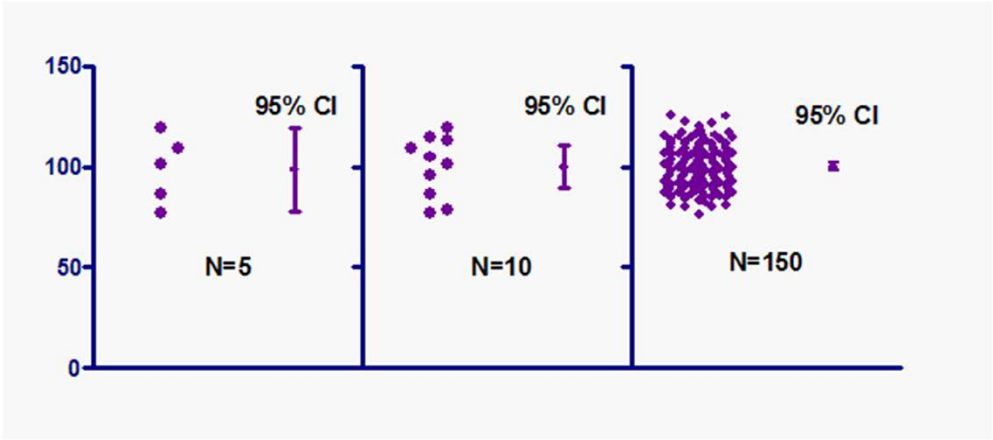
FAQ from the CoC

Standard 7.1: Accountability and Quality Improvement Measures	
Question	**Response**
Should the CLP report on Standard 7.1 be part of the required CLP report in Std 2.2?	It can be part of the CLP report for Standard 2.2, but it is not required.
Is an action plan needed if we are below the EPR but within it with CI?	No. If the EPR is technically below the threshold, but your upper confidence interval is above the threshold, then you are technically compliant with the standard and do not need an action plan. If the cancer program is not meeting the EPR or within the Confidence Interval, then a corrective action plan must be developed and executed in order to improve performance.
Our program received a deficiency because our QI study & subsequent action plan was deemed to be part of another standard. How can we differentiate what is an acceptable study/plan when the CoC standards are so broad/encompassing of many topics we need to improve?	Starting in 2020, problems identified in NCDB accountability or quality improvement measures or through annual review, of clinical services and other CoC standards may be used as a topic for the QI initiative under Standard 7.3. (See page 70)

Confidence Intervals



Confidence Intervals



CAnswer Forum

Confidence Interval

- **If our hospitals fall within the confidence interval for both accountability and quality improvement measures will this satisfy compliance for this standard?**
- *I apologize for the erroneous responses. I have verified that the following response is correct with the NCDB. The previous response will be removed so others are not misguided.*
- *The CI allow the user to assess the hospital's performance rate and is an approximate and conservative indicator of whether a hospital's rate is statistically (higher) or (lower) than (the rate for all of the CoC hospital). The program must meet the EPR set by the CoC for each accountability and quality improvement measure in order to meet compliance. However, When the EPR for a measure appears to be non-compliant, review of the 95% confidence intervals (CI) for the cancer program's EPR is necessary, and an action plan will need to be put in place.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-1-accountability-and-quality-improvement-measures/107693-confidence-interval

CAnswer Forum

Data Tools to Monitor EPR

- **Are there any other reporting tools our facility can/should be using to monitor our EPRs for Standard 7.1 other than RCRS? If not, how does reporting differ between Standards 6.4 and 7.1?**
- *Standard 6.4 is in regards to participation (however with change from RQRS to RCRS monthly submissions must be performed). Standard 7.1 is regards to meeting/monitoring the Quality Measures. The Measure of Compliance that is noted for each standard in the CoC Standards Manual outlines the difference between the two standards.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-1-accountability-and-quality-improvement-measures/113021-data-tools-to-monitor-epr

CAnswer Forum

Data Tools to Monitor EPR

- **Should our facility be reviewing RCRS data for Standard 6.4 as well at our cancer committees along with monitoring the EPRs for Standard 7.1? If yes, how do these two activities differ?**

- *Yes, all quality measures are now in RCRS. RCRS 6.4 states submission is monthly and review the quality measures which historically were colon and breast. Standard 7.1 states review of the quality measures which historically was in CP3R. RCRS is a migration of both RQRS and CP3R, therefore the program will need to review the quality measures in RCRS. The program can choose to review the historical colon breast for 6.4 and the remaining measures for 7.1. The program not NCDB or CoC will need to determine which measures to review.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-1-accountability-and-quality-improvement-measures/113021-data-tools-to-monitor-epr

CAnswer Forum

Quality Measures Report. What Years to Review? Abstracting Lag Time

- **What years data should we be reviewing at our committee meetings this year? Last year we reviewed 2017 CP3R data. This year, since we have real-time data, should we review strictly 2020 data from the quality measures report? Also, since we are reviewing real-time data, we have less patients for review given the lag in abstracting time. For example, we had 22 BCSRT patients in 2017; we currently only have 6 BCSRT 2020 patients, 1 non-concordant (who refused radiation). We will have more once we get done abstracting all 2020 patients. So 5/6 concordant patients is 83%, which means we need an action plan. But it's hard to make an action plan if the patient refused treatment; and we will most likely have more patients by the end of 2020 and our performance rate will most likely raise above 90%....**

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-1-accountability-and-quality-improvement-measures/110333-quality-measures-report-what-years-to-review-abstracting-lag-time

CAnswer Forum

Quality Measures Report. What Years to Review? Abstracting Lag Time

- *The program should be reviewing and discussing all the years/measures. Review the data on the dashboard for surveys and quality measure for historical and new cases. You can use the 2019 analytic caseload as an estimate for 2020 cases.*
- *Program should be reviewing and discussing all the years/measures and reviewing the data on the dashboard for surveys and quality measure for historical and new cases. If the performance rate does not meet or exceed the benchmark then an action plan should be implemented and monitored for improvement. Quality measure compliance for standard 7.1 is rated on the last complete submission year of data from the Call for Data the year before the site visit. For example, for site visits in 2021, compliance is evaluated from data submitted to the Call for Data in 2020, which includes diagnosis years 2018, 2017 and 2016.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-1-accountability-and-quality-improvement-measures/110333-quality-measures-report-what-years-to-review-abstracting-lag-time

CAnswer Forum

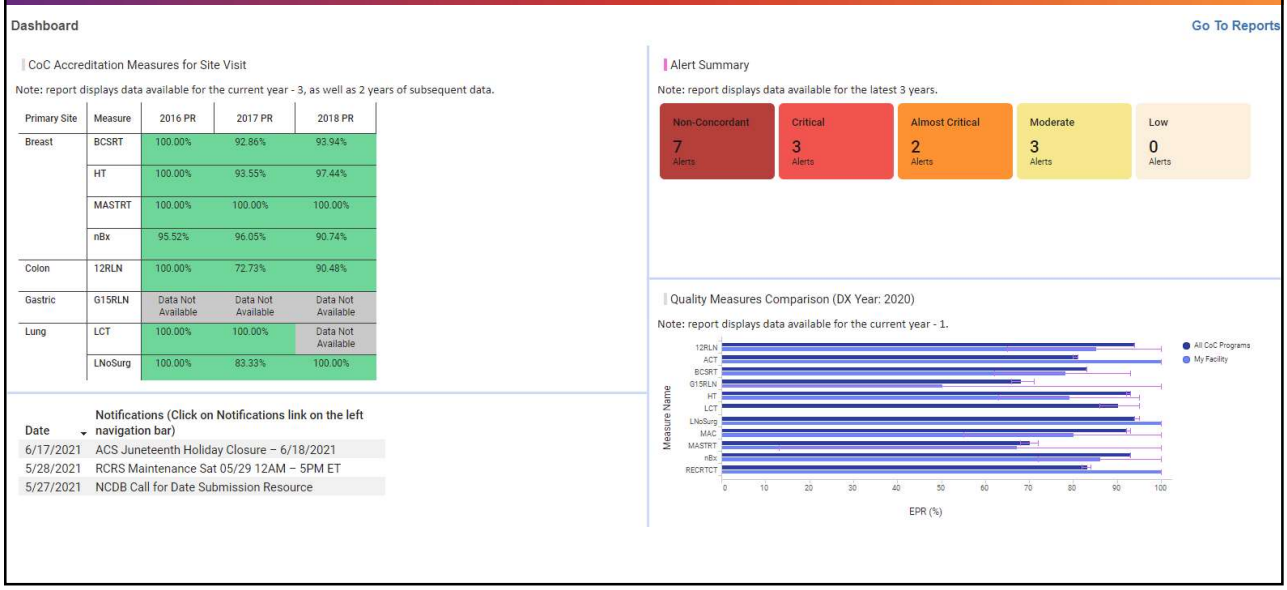
Reporting the RCRS Dashboard

- **Someone else asked if we report the dashboard or the quality measures comparison report and the answer given was report the dashboard.**
- **The dashboard has four quadrants: CoC Accreditation Measures for Surveyor, Notifications, Alert Summaries, Most Recent Quality Measure Data Available (DX Year: 20XX).**
- **So you are saying we need to show our cancer committees all four quadrants of the dashboard?**
- *Yes, that is what needs to be shared with the Cancer Committee.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-1-accountability-and-quality-improvement-measures/110471-reporting-the-rcrs-dashboard

RCRS Dashboard



Tips & Best Practices

Recommended and/or Administered vs Administered Only

- Pay close attention to measure descriptions
- Document carefully in text
- Use codes designated for "recommended, not given"
- Add notes into RCRS early and often

Questions for Std 7.1

Time for a break!

Standard 7.2
Monitoring Concordance with Evidence-Based Guidelines

7.2 Monitoring Concordance with Evidence-Based Guidelines

Standard Definition & Requirements

- Annually a physician performs an in-depth analysis of the diagnostic evaluation and treatment of individual patients to determine whether it is concordant with recognized evidence-based national guidelines
- Study must be retrospective and includes a medical record review
- Results must be presented to the cancer committee and documented in the cancer committee meeting minutes

7.2 Monitoring Concordance with Evidence-Based Guidelines

Process of Review & Required Components

- Choose population to review
  - All cases from a specific cancer site (or stage within that site)
    OR
  - An identified need or concern within a specific cancer site or stage of cancer
- For each patient being reviewed
  - Determine whether pre-treatment initial diagnostic evaluation process is concordant with evidence-based national treatment guidelines
  - Determine whether first course of treatment is appropriate for stage of disease or prognostic indicators and is concordant with evidence-based national treatment guidelines
- Use a reporting format that permist analysis and provides an opportunity to recommend performance improvements based on data from analysis

7.2 Monitoring Concordance with Evidence-Based Guidelines

Documentation

- Report detailing all required elements of the study, including results of the analysis
- Cancer committee minutes that document that conclusions and results of analysis were reported and any recommendations for improvement

Templates

- Required PRQ template available on datalinks (last updated 5/5/2021)

Template

Tips & Best Practices

Sample Data Entry Spreadsheet for Stage III Colon Cancer Cases Created Bases on NCCN Guidelines

Patient Demographics & Cancer Information												
Date of Initial Diagnosis	Date of 1st Contact	Accession Number	Sequence Number	Class of Case	Last Name	First Name	Medical Record Number	Primary Site	Histo/Behavior ICD-O-3	Clinical Grade	Pathological Grade	Stage

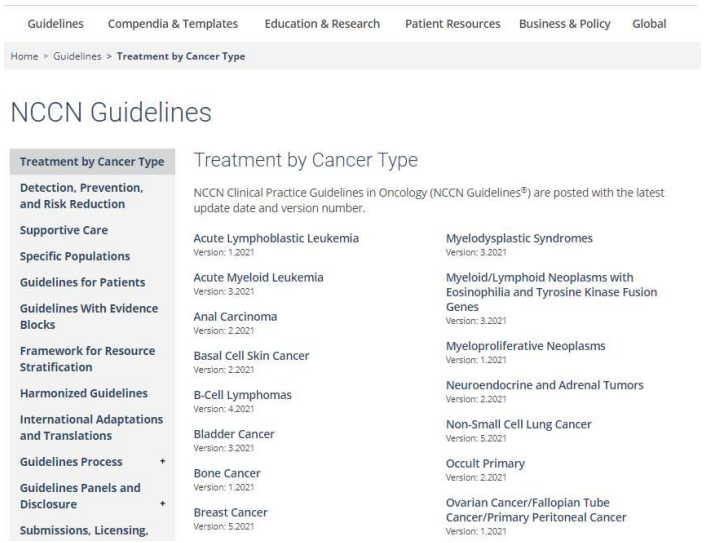
Work-Up								
Biopsy (Y/N)	MMR/MSI Testing (Y/N)	Pathology Review (Y/N)	Colonoscopy (Y/N)	Abd/Pelvis MRI (Y/N)	CBC, Chem, CEA (Y/N)	Chest/Abd /Pelvis CT (Y/N)	Enterostomal therapist for pre-op marking of site (Y/N/NA)	Fertility risk discussion/ counseling (Y/N/NA)

Treatment				
Colectomy (Y/N)	En bloc removal of regional LNs (Y/N)	Resection with diversion (Y/N/NA)	Neoadjuvant Chemotherapy (Y/N/NA)	Adjuvant Chemotherapy (Y/N)

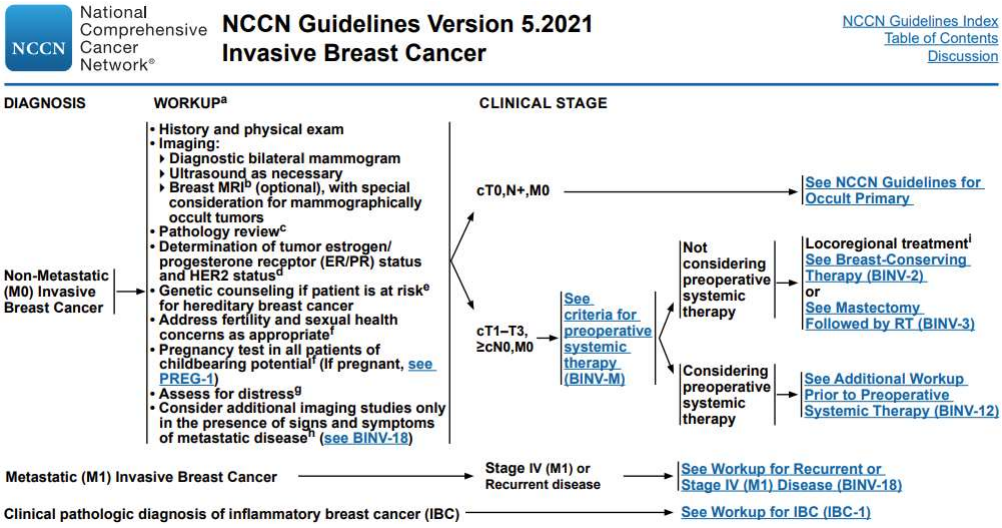
Surveillance Recommendations			
H&P q 3-6 mos for 2 yrs, then every 6 mos for total of 5 yrs (Y/N)	CEA q 3-6 mos for 2 yrs, then every 6 mos for total of 5 yrs (Y/N)	CT chest/abd/pelvis q 6-12 mos for total of 5 years (Y/N)	Colonoscopy in 1 yr after surgery (Y/N/NA)

NCCN Guidelines

National Comprehensive Cancer Network®



NCCN Guidelines



Tips & Best Practices

Notes

- Tumor Board reviews will not fulfill this standard
- Be sure to include a review of the patient's diagnostic work-up
- Case reviews should include a review of the patient's medical record

Tips & Best Practices

Common Topics For Study

- Breast
- Lung
- Colon
- Pancreas
- Cervix
- Bladder
- Surgical Melanomas
- Multiple Myeloma
- Kidney
- Thyroid

FAQ from the CoC

Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines	
Question	**Response**
Does the physician need to do the 100 cases review comprehensively? Or can it be structured with assistance of the PI Dept., Cancer Registry, or other department to support the review, data analysis and putting together presentation?	The review must be done by a physician. It can be any physician in the program, including residents.
Must the program review elements of evaluation and treatment – not just one aspect of care?	Yes, please see the five required elements that must be part of the in-depth analysis on page 68 of the 2020 Standards manual.
How do you handle Urology patients if they are private practice?	The cancer site utilized to review for this standard is chosen at the discretion of the program.
Please clarify: does the standard requires both or one of the two? - evaluation of diagnostic process -determination about first course treatment being concordant	Both are required. Please see the five required elements that must be part of the in-depth analysis on page 68 of the 2020 Standards manual.
How many patients are to be included in the review?	All patients of the chosen patient population should be reviewed up to a maximum of 100 cases.
Where is the information for standard 7.2 required to come from? Is there a requirement for how to gather the information?	As stated in #2 of Definition and Requirements; review includes the medical record, pathology, diagnostic imaging, laboratory tests, and consultations recommended within the specific guidelines being reviewed.

Sample Size

$$\text{Sample size} = \frac{\frac{z^2 \times p\,(1-p)}{e^2}}{1 + \left(\frac{z^2 \times p\,(1-p)}{e^2 N}\right)}$$

CAnswer Forum

7.2 Study: Class of Case

- **In addition to primary site and stage, are we permitted to use registry class of case to define our study group?**
- **For example, would it be acceptable to include only class 14 and 22 since our hospital was responsible for all of their first line therapy?**

- *The Standard does not exclude patients based on class of case. Patients that did not continue their treatment with the facility should be reviewed up until the time that patient went elsewhere for treatment, given the parameters of the Standard.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/116002-7-2-study-class-of-case

CAnswer Forum

Repeat Analysis Using New Year of Data

- **Would a program be compliant if they repeated an analysis in a subsequent year, but used a new year of data? Or does the analysis have to be a new topic each year?**
- *No, it should be a new cancer site, different study, each year within the accreditation cycle.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/115589-repeat-analysis-using-new-year-of-data

CAnswer Forum

Clarification 'Results of pre-tx initial dx evaluation process review' needed

- **This year for standard 7.2 a physician is going to review pancreatic stage I-III cases. The physician would like to clarify that by, 'Results of pre-treatment initial diagnostic evaluation process review with evidence-based national treatment guidelines' means to confirm how staging was decided. Please provide guidance. Thanks.**
- *While this may be part of the analysis, the review must be over whatever the evidence-based guidelines recommends for pre-treatment initial diagnostic evaluation process.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/115612-clarification-results-of-pre-tx-initial-dx-evaluation-process-review-needed

CAnswer Forum

Retrospective and how far back to go?

- **Is it acceptable to look at cases from CY 2019 for this standard? I hesitate to investigate compliance to guidelines in patients diagnosed in CY 2020 due to the myriad of disruptions from Covid.**
- *Yes, looking at 2019 cases would be acceptable, you could include the first half of 2020 as well. I suggest not go back further than 2018. You want to be close to current as possible so that you can make appropriate changes to the processes if need be.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/112961-retrospective-and-how-far-back-to-go

CAnswer Forum

Standard 7.2 Completion by end of year

- **For Standard, 7.2, can the data analysis of this standard be presented at our 1st quarter meeting in 2021 instead of our last meeting for 2020? Our physician reviewer who is conducting this study and providing the data has asked for an extension. Our last meeting for 2020 is November 9th. We are already in the process of choosing another site for review for this standard for the 2021 calendar year.**
- *Yes, it is acceptable to review during the 1st quarter meeting in 2021. Please be sure to still put standard 7.2 on the agenda for your November 9th meeting and provide details as to it being reported on in the 1st quarter of 2021.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/109838-standard-7-2-completion-by-end-of-year

CAnswer Forum

Additional Guidance for Number of Cases to Include for Std. 7.2

- **My program would like to perform an in-depth analysis on patients with pancreatic cancer. Over the last 6 years, the number of cases per year ranges from 6 to 9. Given these very low numbers, an analysis of one year of cases likely would not provide much value…**
- *The CoC does not have a target number for you to review. The only guidance is if it less than 100 cases you would conduct an depth review of them all.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/106914-additional-guidance-for-number-of-cases-to-include-for-std-7-2

CAnswer Forum

7.2 Patient Population

- **We have a high percentage of under 50 colorectal cases. A Physician wants to review under 50 colorectal cases for our 7.2, we would look at the work up and first course for that specific population.**
- **Is that too narrow using age? Does it need to be a stage of colorectal instead?**
- *The standard states that one of the following must be chosen for the in-depth study:*
- *1) all cases from a specific cancer site (or stage)*
- *2) an identified need or concern within a specific cancer site or stage.*
- *It sounds like your study would meet #2, along with analysis of diagnostic evaluation and treatment of patients to determine whether the cases are concordant with evidence-based national treatment guidelines.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/117255-7-2-patient-population

CAnswer Forum

Does the physician reviewer have to be a member of cancer committee?

- **Standard 4.6 of the 2016 standards states that the person completing this study needs to be a physician member of cancer committee.**
- **Standard 7.2 says that a physician performs an in-depth analysis…does that mean the MD does not have to be a member of cancer committee?**
- *Correct. The physician reviewer does not need to be a part of the cancer committee.*

CAnswer FORUM

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-2-monitoring-concordance-with-evidence-based-guidelines/103701-does-the-physician-reviewre-have-to-be-a-member-of-cancer-committee

Questions for Std 7.2

Standard 7.3
Quality Improvement Initiative

7.3 Quality Improvement Initiative

Standard Definition & Requirements

- Each year, under guidance of the CLP, Quality Improvement Coordinator and the cancer committee, the program must measure, evaluate, and improve the performance through at least **one** cancer-specific quality improvement initiative.

Required Components

- Review Data to Identify the Problem
- Write the Problem Statement
- Choose and Implement Performance Improvement Methodology and metrics
- Implement Intervention and Monitor Data
- Present Quality Improvement Initiative Summary

7.3 Quality Improvement Initiative

Review Data to Identify the Problem

- Must focus on an already identified quality-related problem specific to the cancer program.
- Resources to identify QI Initiative focuses

Write the Problem Statement

- Problem statement must identify a specific, already identified, quality-related problem to be solved through the initiative.
- Baseline and goal metrics (must be numerical)
- Anticipated timeline to complete the initiative and achieve the expected outcome
- Cannot state that the study is being done to see if a problem exists, rather it must already be known that a problem exists

7.3 Quality Improvement Initiative

Choose & Implement P.I. Methodology and Metrics

- QI Coordinator and CLP identify content experts to execute the initiative
- Must utilize a recognized, standardized performance improvement tool such as: Lean, DMAIC, or PDCA/PDSA
- Analyze factors contributing to problem and develop an intervention to fix the problem.

Implement Intervention and Monitor Data

- Intervention chosen in step 3 must be implemented and monitored.
- If it is found the intervention is not working, then it should be modified

7.3 Quality Improvement Initiative

Present Quality Improvement Initiative Summary

- A document to summarize the initiative and results must be presented and should include:
  - Summary of the data utilized to identify the problem
  - Problem statement
  - QI initiative team members
  - Performance improvement tool used
  - Intervention that was implemented
  - Any adjustments made to the intervention (if applicable)
  - Results of the Intervention

QI Initiative Template

7.3 Quality Improvement Initiative

Documentation

- CLP and Quality Improvement Coordinator provide updates to the cancer committee **at least twice** each calendar year.
- Status updates should include, at a minimum, the current status and planned next steps.
- Final summary may qualify as a required report.

Tips & Best Practices

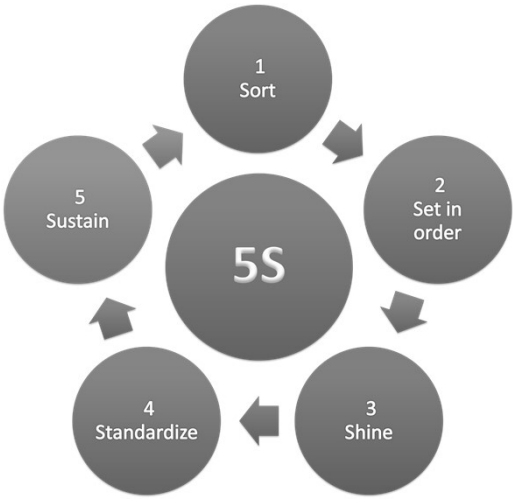
Notes

- The problem statement cannot be that a study is being performed in order to determine that there is a problem
- Project calendar recommended with launch date, planned status updates, and end goal
- Initiatives should last approximately one year, but may be extended for a second year (2 year maximum)
- CLP should be actively involved in the Quality Improvement Initiative

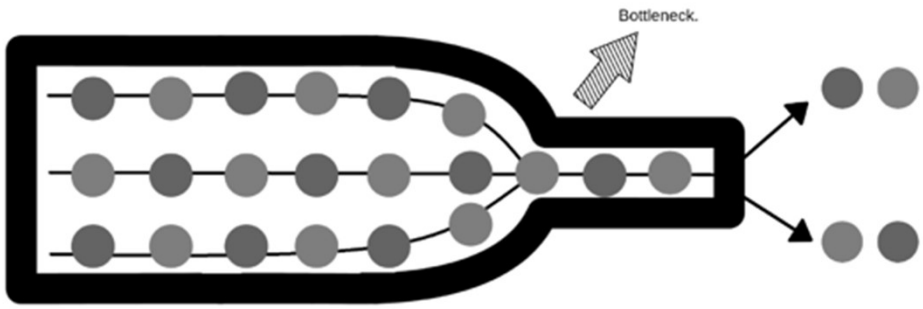
Lean Tools

Gemba

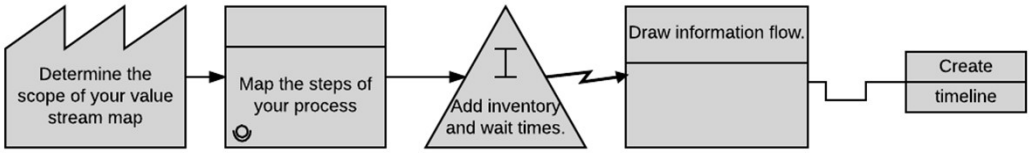
5S Method



Bottleneck Analysis



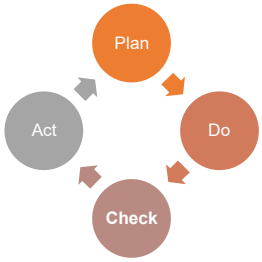
Value Stream Mapping (VSM)



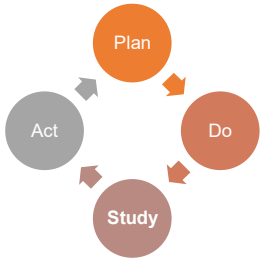
DMAIC

- **D** • **DEFINE** the project goals
- **M** • **MEASURE** the process to determine current performance and quantify the problem
- **A** • **ANALYZA** and determine the root causes(s) of the defects
- **I** • **IMPROVE** the process by eliminating defects
- **C** • **CONTROL** the future process performance so improved process doesn't degrade

PDCA/PDSA



- Find a process to improve
- Understand causes of process variation
- Identify how to reduce variations
- Begin the cycle



- What do we want to achieve?
- How do we know if a change is an improvement?
- What change will result in improvement?
- Begin the cycle

PDSA Collaborative Project

Return to Screening PDSA and Clinical Study

- An Elective Quality Improvement Project and Clinical Study Open to All CoC & NAPBC Sites
- Completion of the PDSA fulfills Std 8.3 & Std 7.3
- Completion the IRB exempt clinical study gives local PI status, publication authorship and full credit for standard 9.1 Clinical Research Accrual

https://www.facs.org/quality-programs/cancer/coc/resuming-care

Return to Cancer ening PDSA QI Prc

Tips & Best Practices

Ideas for Improvements

- Time from diagnosis to treatment
- Biosimilar drug availability for patients
- Pathology turnaround times
- Lab turnaround times
- Improve compliance with completion of preop CEA being drawn (Result of last year's Std 4.6).
- Lung timeliness from biopsy to treatment is being considered after review of previous year's KPI measures
- Treatment delays for Head/Neck Cancer patients in Radiation Oncology
- Improve documentation of fertility counseling for premenopausal breast cancer patients

Tips & Best Practices

Consider Re-Categorizing

- Evaluate referral and treatment of patients with lymphedema (4.6 Rehab Care Services)
- Clinical services issue with providing nutritional consults to outpatients (4.7 Oncology Nutrition Services)
- Improve timeliness of end stage 4 lung cancer patients to enter hospice care (4.5 Palliative Care Services)
- Process flow of genetics counseling referrals (4.4 Genetic Counseling and Risk Assessment)
- Increase palliative care referrals higher stage cancers (4.5 Palliative Care Services)
- Referrals to Palliative Care for stage IV patients (4.5 Palliative Care Services)

FAQ from the CoC

Standard 7.3: Quality Improvement Initiative	
Question	**Response**
Does a Quality Improvement based on CP3R data falling below EPR count as an action plan?	Yes, the Quality Improvement meeting the requirements of Standard 7.3 would be acceptable as an action plan.
Could a Quality Improvement project be improving breast or lung cancer care continuum from screening through diagnosis and treatment?	This question cannot be addressed as there is no problem statement on which to base the Quality Improvement initiative.

CAnswer Forum

Using a problem found in Std 7.2 Study

- **Can we use a problem found in a physician review study from a previous year? (example: In 2021, could we use a problem found in our 2020 physician study? Likewise for 2020 - could we use a problem found in a 2019 study?)**
- *Yes, you may use a problem identified in a previous year's study.*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-3-quality-improvement-initiative/97215-using-a-problem-found-in-std-7-2-study

CAnswer FORUM

CAnswer Forum

Quality Improvement Initiative Team

- **The standard mentions that the Coordinator and the CLP must identify the content "Experts" needed to execute the QI initiative. Then the example gives those that should be included on the "Initiative Team". What is this team and where do we find more information on it since this seems to be the first time we have heard this?**
- *The team is different for each QI Initiative as it is based on content experts needed to execute the initiative. The team must have at least the CLP and QI Coordinator. The team should be documented as part of the study.*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-3-quality-improvement-initiative/98464-quality-improvement-initiative-team

CAnswer FORUM

CAnswer Forum

National Guideline

- **Could you tell me if we are required to have national benchmarks or national guidelines for the QI Initiative?**
- *As mentioned under #5 within Standard 7.3, if possible, results are compared with national data. It is strongly recommended if national data is available.*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-3-quality-improvement-initiative/98464-quality-improvement-initiative-team

CAnswer FORUM

CAnswer Forum

2020 QI Initiative carried over to 2021?

- **I am seeking guidance if our 2020 QI initiative can be carried over into 2021?**
- **The 2020 QI initiative was based on a quality study in 2019 to improve the timeliness of lung cancer patients' time of diagnosis to time of treatment. With the impact of Covid-19 the project was shelved due to the significant delays due to covid restrictions for the remainder of 2020.**
- **Would it be compliant to carry this project over into 2021 or will we need to come up with a new QI initiative for 2021?**
- *Per the standard, you can carry over a study from Std 7.3 into the next year (1 additional year only), but you still need to perform a new study for 2021 in addition. You need to continue to document in the minutes the progress of the 2020 study.*

https://cancerbulletin.facs.org/forums/forum/commission-on-cancer-coc-2020-standards/chapter-7-quality-improvement/standard-7-3-quality-improvement-initiative/113104-2020-qi-initiative-carried-over-to-2021

CAnswer FORUM

Questions for Std 7.4

Standard 7.4
Cancer Program Goal

7.4 Cancer Program Goals

Standard Definition & Requirements

- Cancer Committee sets one annual goal directed toward the scope, coordination, practices, processes and provision of services for cancer care.
- It is recommended to use the SMART (Specific, Measurable, Achievable, Realistic, and Timely) tool.

Documentation

- Cancer Committee minutes must include substantive status updates twice a year in the same calendar year that a goal is created

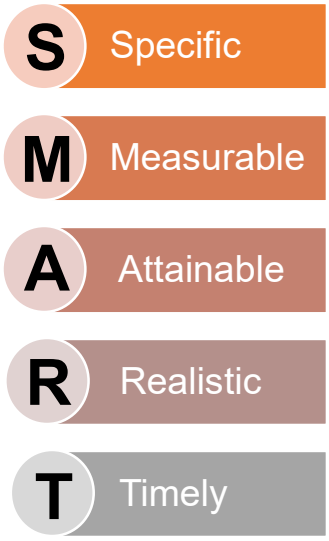
Notes

- Goals should last 1 year, however, should a goal go over 1 year it can only be extended 1 additional year with at least 1 additional status update. A new goal must be established during the second year.
- Goals cannot duplicate another standard requirement or improvement.
- Updates must be **substantive** and could include progress, roadblocks or next steps.

Tips & Best Practices

- Set goals at **FIRST** meeting of the year
- Use **SMART** template
- Minutes should document discussion of why a goal is selected
- Be sure to review goals at 2 subsequent meetings

Cancer Program Goal Template



Tips & Best Practices

Ideas for Goals

- Implement an adaptive therapy program in radiation oncology
- Construction and flow improvements to breast center
- Improve the process for ensuring patients have some type of advanced directive in place and documented after a cancer diagnosis has been made.
- Develop and implement a multidisciplinary urology cancer clinic process whereby newly diagnosed urology cancer patients see all involved disciplines as well as navigator, financial counselor, social worker, etc., same day
- Improve access available to COVID vaccines for cancer patients
- Ensure patients are screened for pain control. Each new patient to be screened and assessed for pain control, with the medical provider creating pain management plans as needed.
- Develop a process for oncology patients to receive blood transfusions through short stay visits
- Develop a ColoRectal Pathway (multidisciplinary colorectal cancer clinic, tumor conference, navigation)

Tips & Best Practices

Ideas for Goals

- Bringing into conception a bioimpedance device as a screening for lymphedema and thereby developing protocols for referrals to lymphedema specialists
- Expand oncology services by opening a second clinic/infusion center
- Meet USP 800 requirements for oncology pharmacy infusion
- Implementation of Care giver support group
- Implementation of Oral Oncolytics Program
- To improve physician documentation of staging and documentation of NED
- Develop and implement a patient outcome tool for patients receiving immunotherapy to identify and intervene in adverse events related to immunotherapy
- Hire a Financial Counselor
- Performing "Reflex" Tumor Markers on specific cancer specimens.
- ACR Accreditation for Radiation Oncology.

Tips & Best Practices

Consider Re-Categorizing

- Improve the number of cancer care patient referrals to Palliative Care as indicated per physician approved screen and patient departure referral option. (Std 4.5 Palliative Care Services)
- Establish cancer support groups onsite (Std 4.5 Palliative Care Services)

FAQ from the CoC

Standard 7.4: Cancer Program Goal	
Question	**Response**
Is it acceptable to perform strategy and goal setting at the sub-committee level?	Yes, as long as the goal is reported to the cancer committee meeting once established and evaluations are documented as required.
If a goal from 2018 was not met and rolled into 2019, can it be retired in 2020?	As long as you have documented in the minutes, throughout those years, the progress/barriers and the end result, yes. The goal only counts for 2018.
If a goal is reported complete at the first status update to the committee, must there be a second update?	Yes, this would be acceptable only if the goal is 100% complete. Keep in mind that goals set by the committee should be substantive enough to last approximately one year.
Is it mandatory to set goal at the first quarter meeting or can we set it by the second quarter?	It is strongly recommended that goals be established at the first quarter cancer committee meeting.

CAnswer Forum

Common Answers

- Goal topics cannot be preapproved by the CoC Staff on the CAnswer Forum
- A goal cannot be an improvement or restatement of another standard
- It is up to your cancer committee to decide if the goal is appropriate

CAnswer FORUM

Questions for Std 7.4

Thank you!

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FABULOUS PRIZES

COMING UP!

- 8/5/21 Breast 2021
  - Vicki Hawhee, M.Ed, CTR
- 9/2/21 Coding Pitfalls 2021
  - Janet Vogel, CTR

CE'S

- Phrase
- Link
  - https://survey.alchemer.com/s3/5729181/Quality-in-CoC-Accreditation-2021

THANK YOU

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HTTPS://WWW.NAACCR.ORG/