ACS Cancer Conference 2025

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# Documenting Program Performance:
## Common Issues and How to Address Them

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# Disclosures

- None

# Objectives

- Resources – Know Where To Find Them
- Common Issues Across All Cancer Programs
- Standards With Common Issues
- Double Dipping
- Alternative Compliance Pathway
- Rapid Cancer Reporting System

# Available Resources

- Standards Manual
- Change Log

Site Information
Site Profile
Site Contacts
Data Platform Contacts
Invoice
Program Enrollment
Schedule Site Visit
PRQ
Networks
Network & Merger Applications
NCDB Reporting Tools
Site Visit History
File Sharing
Resources
Surgical Quality Partner Marketing Resources

ACS CoC
Commission on Cancer
American College of Surgeons

A Cancer Program News archive providing updates regarding the CoC standards is now available at the bottom of this page.

**General Resources**
CoC Quality Portal User Guide
QPort Customer Support FAQ
CoC Accreditation Policies and Processes
Contact Roles for CoC Accreditation Process
Site Information Change Request
Voluntary Withdrawal Request

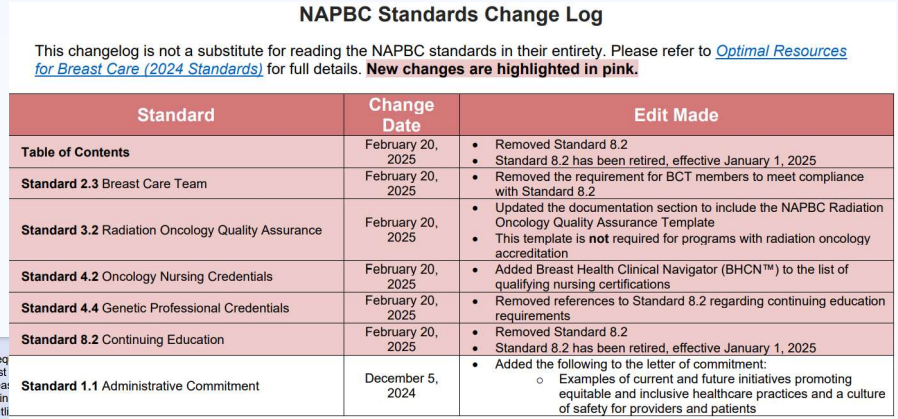
**Financial Resources**
2025 Accreditation Fees
Accreditation Fee FAQ
American College of Surgeons W9

**CoC Standards**
*Optimal Resources for Cancer Care (2020 Standards)*
2020 CoC Standards Implementation Timelines
Change Log

**Standards Resource Library (SRL)**
Standards Resource Library

**Standards Compliance Resources**
American Cancer Society and CoC Resource Intersections Guide
CoC Health Equity Toolkit
COVID-19 Accreditation Tracker (Blank)
COVID-19 Accreditation Tracker (Example)
Accreditation Folder Structure Tutorial PowerPoint
Accreditation Folder Structure Zip File

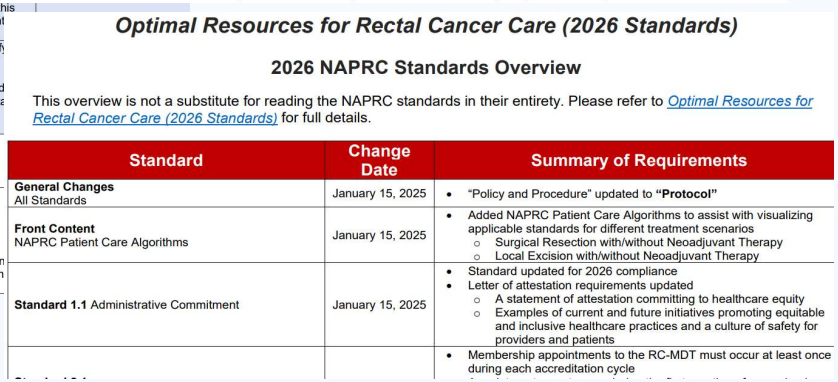
| | | |
|---|---|---|
| **Standard 6.4:** Rapid Cancer Reporting System | December 5, 2024 | cancer committee:<br>• "RCRS data and the req<br>performance rates must<br>cancer committee at lea<br>year and documented in<br>meeting minutes as outli<br>Quality Measures. The reports required by this standard cannot also satisfy the requirement Standard 2.2: Cancer Liaison Physician." |
| **Standard 7.3:** Quality Improvement Initiative | December 5, 2024 | Added the following to the Review of Data to Identify Problem:<br>• Problems identified through review of data related to culture competency, individualized shared decision making, and the implementa of health equity interventions in the cancer program |
| **Accreditation Process** | September 13, 2024 | **Standards Requiring Annual Review:** Reference list of standards requiring review each calendar year updated to include Standard 5.1 and Standard 7.1. |
| **Cancer Program Standards Rating System and Accreditation Awards** | September 13, 2024 | **Not Accredited-Corrective Action Required** ***Initial Applicants Only***<br>Added the following clarification:<br>• Program does not have access to the Nation Cancer Database (NCDB) until accreditation achieved. |



**NAPBC Standards Change Log**

This changelog is not a substitute for reading the NAPBC standards in their entirety. Please refer to *Optimal Resources for Breast Care (2024 Standards)* for full details. **New changes are highlighted in pink.**

| Standard | Change Date | Edit Made |
|---|---|---|
| **Table of Contents** | February 20, 2025 | • Removed Standard 8.2<br>• Standard 8.2 has been retired, effective January 1, 2025 |
| **Standard 2.3** Breast Care Team | February 20, 2025 | • Removed the requirement for BCT members to meet compliance with Standard 8.2 |
| **Standard 3.2** Radiation Oncology Quality Assurance | February 20, 2025 | • Updated the documentation section to include the NAPBC Radiation Oncology Quality Assurance Template<br>• This template is **not** required for programs with radiation oncology accreditation |
| **Standard 4.2** Oncology Nursing Credentials | February 20, 2025 | • Added Breast Health Clinical Navigator (BHCN™) to the list of qualifying nursing certifications |
| **Standard 4.4** Genetic Professional Credentials | February 20, 2025 | • Removed references to Standard 8.2 regarding continuing education requirements |
| **Standard 8.2** Continuing Education | February 20, 2025 | • Removed Standard 8.2<br>• Standard 8.2 has been retired, effective January 1, 2025 |
| **Standard 1.1** Administrative Commitment | December 5, 2024 | • Added the following to the letter of commitment:<br>○ Examples of current and future initiatives promoting equitable and inclusive healthcare practices and a culture of safety for providers and patients |



***Optimal Resources for Rectal Cancer Care (2026 Standards)***

**2026 NAPRC Standards Overview**

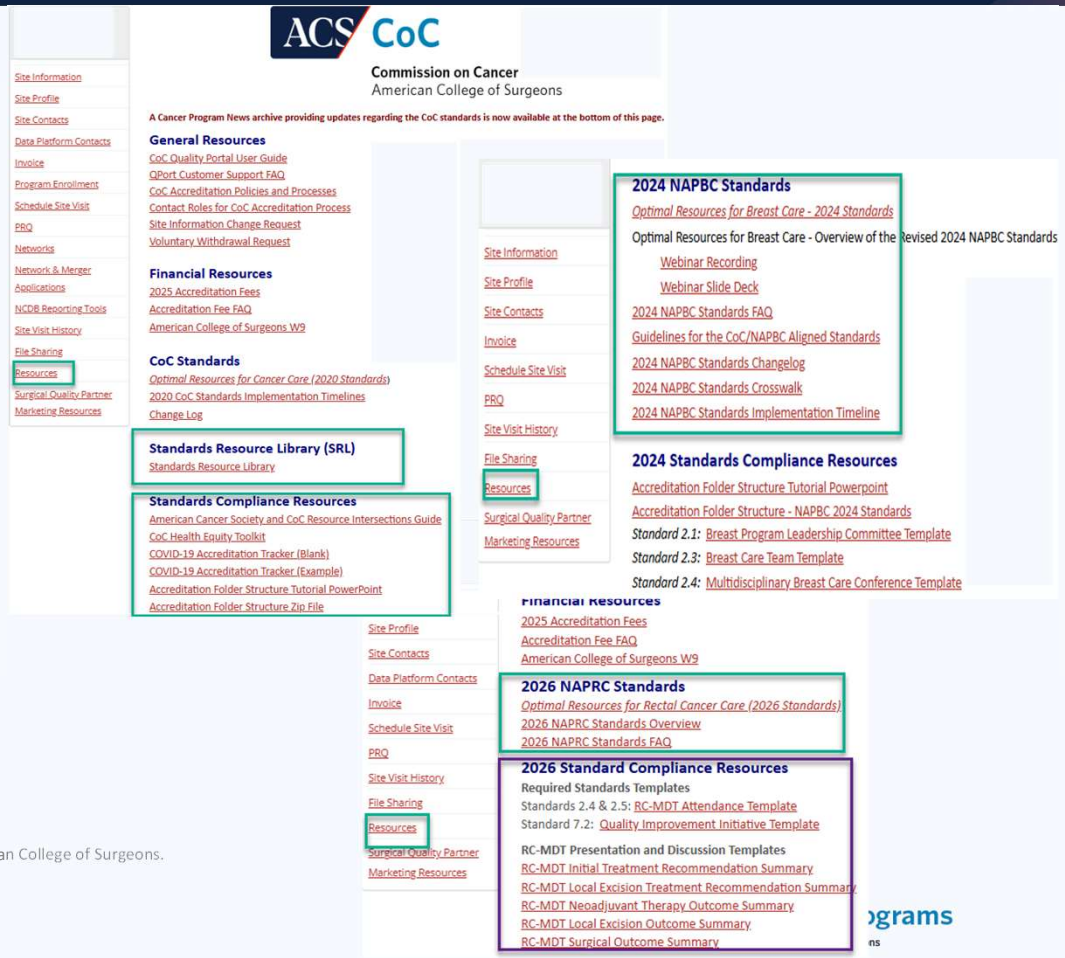
This overview is not a substitute for reading the NAPRC standards in their entirety. Please refer to *Optimal Resources for Rectal Cancer Care (2026 Standards)* for full details.

| Standard | Change Date | Summary of Requirements |
|---|---|---|
| **General Changes**<br>All Standards | January 15, 2025 | • "Policy and Procedure" updated to **"Protocol"** |
| **Front Content**<br>NAPRC Patient Care Algorithms | January 15, 2025 | • Added NAPRC Patient Care Algorithms to assist with visualizing applicable standards for different treatment scenarios<br>○ Surgical Resection with/without Neoadjuvant Therapy<br>○ Local Excision with/without Neoadjuvant Therapy |
| **Standard 1.1** Administrative Commitment | January 15, 2025 | • Standard updated for 2026 compliance<br>• Letter of attestation requirements updated<br>○ A statement of attestation committing to healthcare equity<br>○ Examples of current and future initiatives promoting equitable and inclusive healthcare practices and a culture of safety for providers and patients |
| | | • Membership appointments to the RC-MDT must occur at least once during each accreditation cycle |

# Available Resources

## Resources in the Quality Portal (QPort)

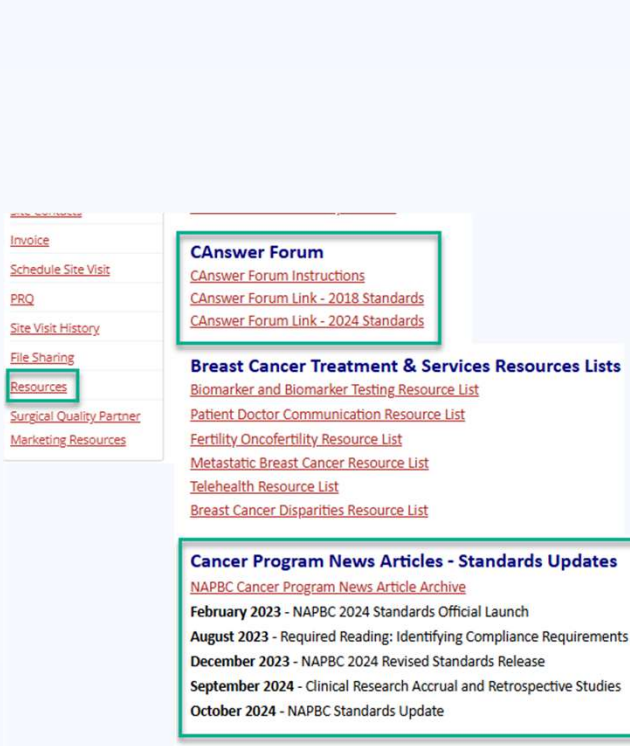
- Standards Resource Library
  - FAQs
  - Tips
  - Sample documentation
- Compliance Resources
- Site Visit Resources
- Templates
- Corrective Action Resource

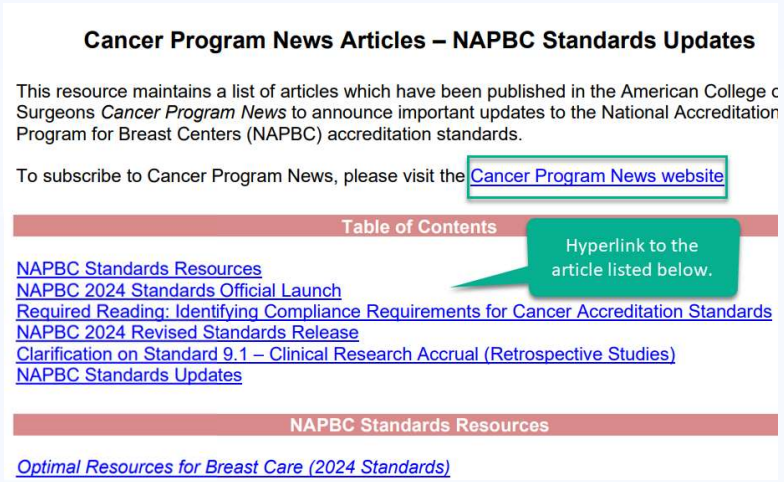


# Available Resources

## Cancer Program News

- Twice a month



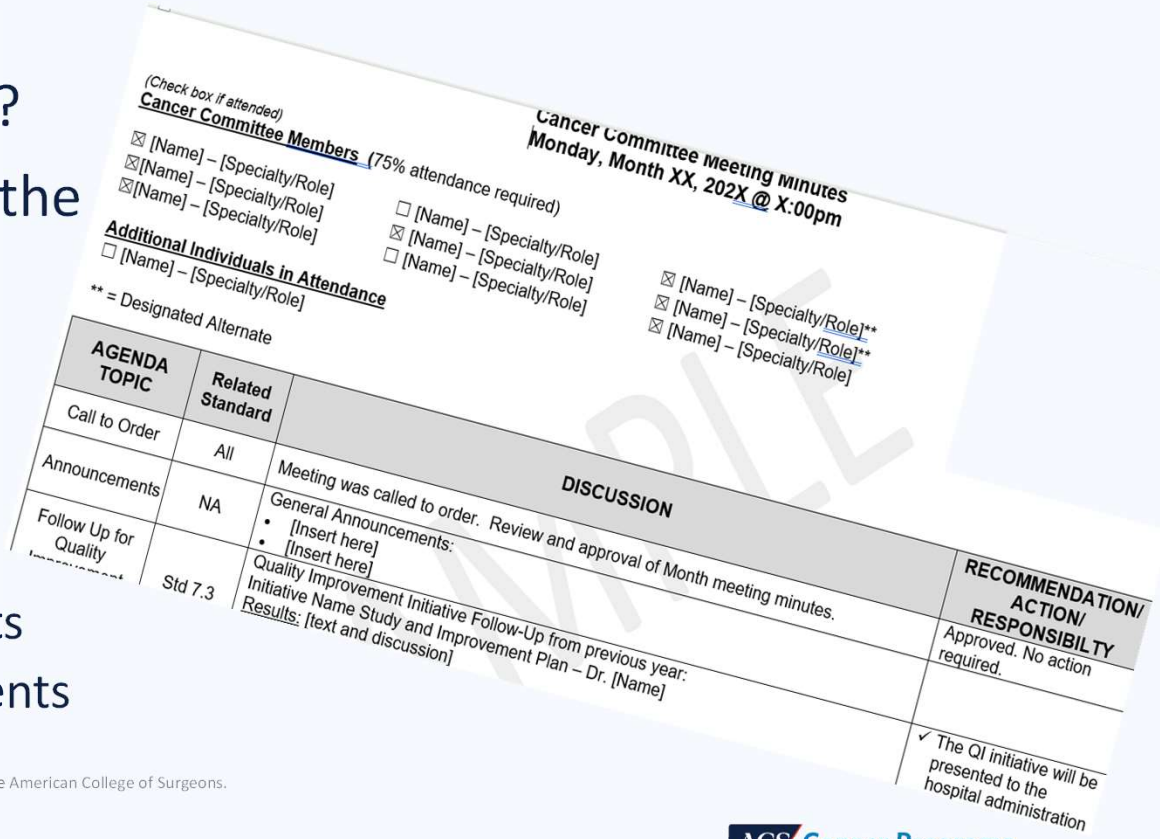

## CAnswer Forum

- Instructions
- Individual User Access
- Specific Forums
  - Chapters
  - Standards

# Common Issues Across All Programs

## Minutes

- Why are they so important?
- Template does not replace the minutes
- Avoiding common errors
  - Keep them concise
  - Know what must be documented
  - Upload relevant attachments
  - Confirm embedded documents can be opened



(Check box if attended)
**Cancer Committee Members** (75% attendance required)
☒ [Name] – [Specialty/Role]
☒ [Name] – [Specialty/Role]
☒ [Name] – [Specialty/Role]
☐ [Name] – [Specialty/Role]
☒ [Name] – [Specialty/Role]
☐ [Name] – [Specialty/Role]
☒ [Name] – [Specialty/Role]**
☒ [Name] – [Specialty/Role]**
☒ [Name] – [Specialty/Role]

**Additional Individuals in Attendance**
☐ [Name] – [Specialty/Role]

** = Designated Alternate

**Cancer Committee Meeting Minutes**
**Monday, Month XX, 202X @ X:00pm**

| AGENDA TOPIC | Related Standard | DISCUSSION | RECOMMENDATION/ ACTION/ RESPONSIBILTY |
|---|---|---|---|
| Call to Order | All | Meeting was called to order. Review and approval of Month meeting minutes. | Approved. No action required. |
| Announcements | NA | General Announcements:<br>• [Insert here]<br>• [Insert here] | |
| Follow Up for Quality | Std 7.3 | Quality Improvement Initiative Follow-Up from previous year:<br>Initiative Name Study and Improvement Plan – Dr. [Name]<br>Results: [text and discussion] | ✓ The QI initiative will be presented to the hospital administration |

# Why is Documentation Important?

- Supports compliance with the standard
- Provides a record of important information and cancer program activity
- Allows the site reviewer to verify the accuracy and completeness of your cancer program activity
- Helps the cancer committee stay organized and on track
- Provides clear information, minimizing errors and misunderstandings
- Ensures the cancer program and cancer committee maintains accountability

# Protected Health Information

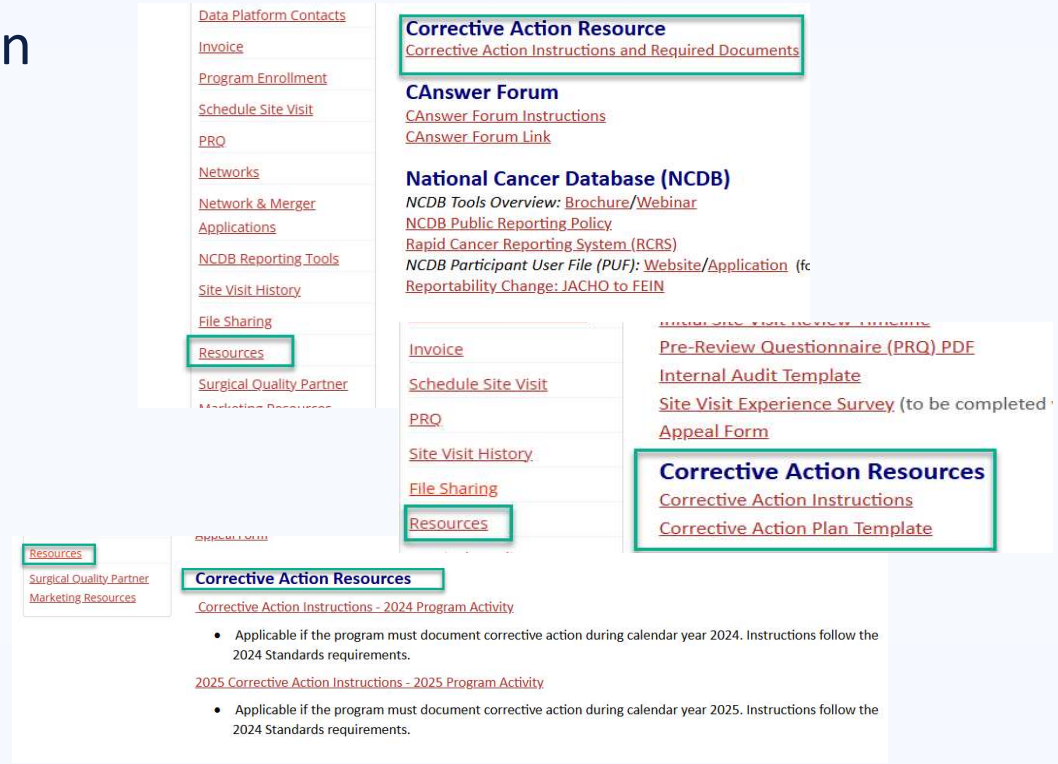
**Reminder:** Protected Health Information (PHI) should NOT be included in any documentation uploaded to the Quality Portal or PRQ

- Patient names, including initials
- Medical record numbers
- Social security numbers
- Treatment dates
- All other patient identifiers

# Corrective Action Documentation

## Corrective action documentation

- Separate resource for each Cancer Program (CoC, NAPBC, NAPRC)
- Specific requirements for full resolution, may include:
  - Action Plan(s)
  - Annual Reporting
  - Audits
  - Minutes
  - Completed templates



# Common Issues Across All Programs

## Annual Reviews and Annual Reports

- Read the entire standard!
- Know the standard requirements
- Did process or protocol demonstrate understanding and compliance?
- *Documentation* and *Measure of Compliance* sections not meant to replace *Definition and Requirements*

- **Definitions and Requirements**
  - Purpose of the standard
  - Detailed requirements
    - Elements of a protocol
    - Elements required for annual reporting
- **Documentation**
  - Materials supporting compliance with standard
    - Submitted with the PRQ
    - Reviewed on-site
- **Measures of Compliance**
  - Actionable items required to meet the standard

# Common Issues Across All Programs

## Annual Review

- Review all standard requirements
  - Did your process or protocol address all requirements?
  - Was there leadership review of your program activity
  - Were barriers identified in the process?
    - How were they addressed?
    - Monitoring continued and reported?
  - Was all discussion documented?

# Common Issues Across All Programs

## Annual Report

- Review all standard requirements
- Did your process or protocol address all requirements?
- Was there leadership review of your program activity?

# Common Issues Across All Programs

## Annual Report (cont'd)


- Metrics – based on full calendar year
  - Number of patients
  - Number of referrals
  - Services utilized
  - On-site or by referral
- Reports presented in Q4 or no later than Q1 of following calendar year
  - Were barriers identified in the process?
    - How were they addressed?
    - Monitoring continued and reported? Was all discussion documented?

# Common Issues Across All Programs

## Protocols/Policies and Procedures

- Not a restatement of the standard or guideline
- Must include all required elements
  - Outlined in standard
- Reviewed by the Cancer Committee, BPLC, or RC-MDT
  - Documented in the minutes

# Common Issues Across All Programs

## Quality Improvement Initiatives

- **Common Stumbling Blocks**
  - Identified problems have no baseline data
  - There is no identified problem
  - A QI Initiative *looking to see if a problem exists* **does not** meet compliance
  - Intervention must be measured, monitored and drive improvement
    - How do you know your intervention was successful?
    - Must be measurable against baseline data
  - Interventions may need to be adjusted

# Common Issues Across All Programs

## Quality Improvement Initiatives

- QI initiatives must
  - Be **data-driven**
  - Based on an **identified problem known to exist** within the accredited program
- A problem statement must be fully developed
  - Include baseline data
  - Demonstrate a need for improvement

# Common Issues Across All Programs

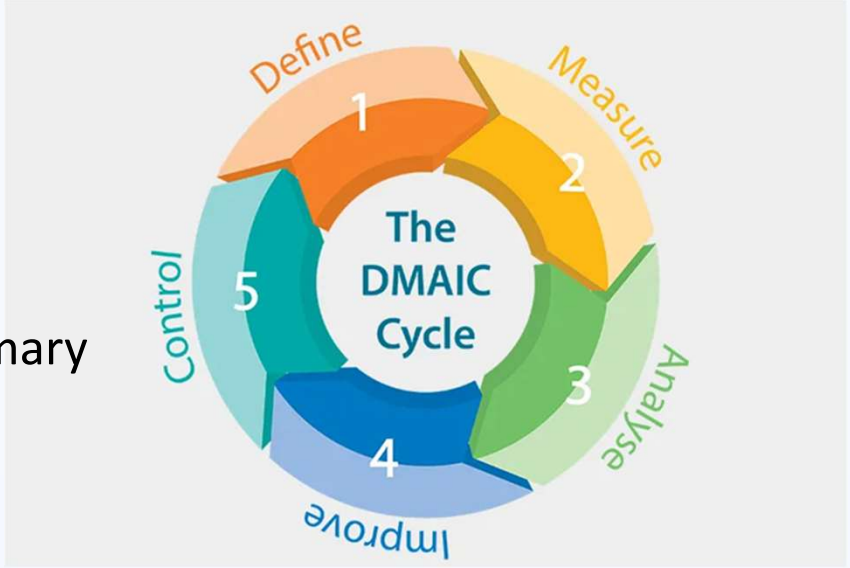
## Quality Improvement Initiatives

- Interventions implemented to drive improvement
  - Must be measurable
  - Compared against baseline data
- Interventions may need to be adjusted
  - Did the intervention achieve its intent
  - If no, what needs to be adjusted

# Common Issues Across All Programs

## The Structure of Quality Improvement

- QI Initiative Requirements
  1. Review Data to Identify the Problem
  2. Write the Problem Statement
  3. Choose QI Methodology and Metrics
  4. Implement Intervention and Monitor Data
  5. Present Quality Improvement Initiative Summary



# Standards With Common Issues

## Survivorship Program - CoC

- Identify 3 services or programs offered onsite/offsite
  - Document in the minutes
- Single/one-time events do not meet the standard
  - Must be ongoing throughout the year
- Year-end report must reflect identified 3 services
  - Number of patients who participated in the services
    - *Survivors are patients who have completed first course of treatment*
  - Discussion or evaluation of effectiveness of the services provided
  - Identification of barriers
  - Resources recommended to improve services

# Standards with Common Issues

## Survivorship Program - CoC

- Services do not include:
  - Distribution of educational materials
  - Handouts
  - Booklets or toolkits
  - Referrals to website
- "*Planning to establish*" a service does not meet the standard
- Providing "numbers" for all survivorship services does not fully meet the intent of the standard
- No discussion or evaluation of effectiveness of the services provided

# Other Common Issues - What To Avoid

## Double Dipping

- Work to obtain compliance in one CoC standard may not replace, duplicate, or augment the work required to obtain compliance with another standard
  - The sole exception to this rule is CoC Standard 7.3: Quality Improvement Initiative
- Reports cannot be the same or like reports used to meet other standards
  - Example: Report satisfying the required review of Standard 4.7: Oncology Nutrition Services cannot also be used to meet the requirements of Standard 4.8
- Reports for CoC Standard 2.2 cannot be used to meet CoC Standard 6.4
  - Consider use of RCRS Submission Report

# Alternative Compliance Pathway (5.3-5.6)

The program should perform an internal audit of compliance for 5.3, 5.4, 5.5, and/or 5.6 AND create an action plan addressing the issues impacting compliance

- Both may be considered by site reviewer upon rating the standard
- Action plan must outline specific issue(s) impacting compliance and the interventions to be implemented to achieve compliance
- Action plan must be documented for **each** potentially non-compliant standard
- Internal audit **and** resulting action plan **must be documented in cancer committee meeting minutes**

# Alternative Compliance Pathway (5.3-5.6) cont'd

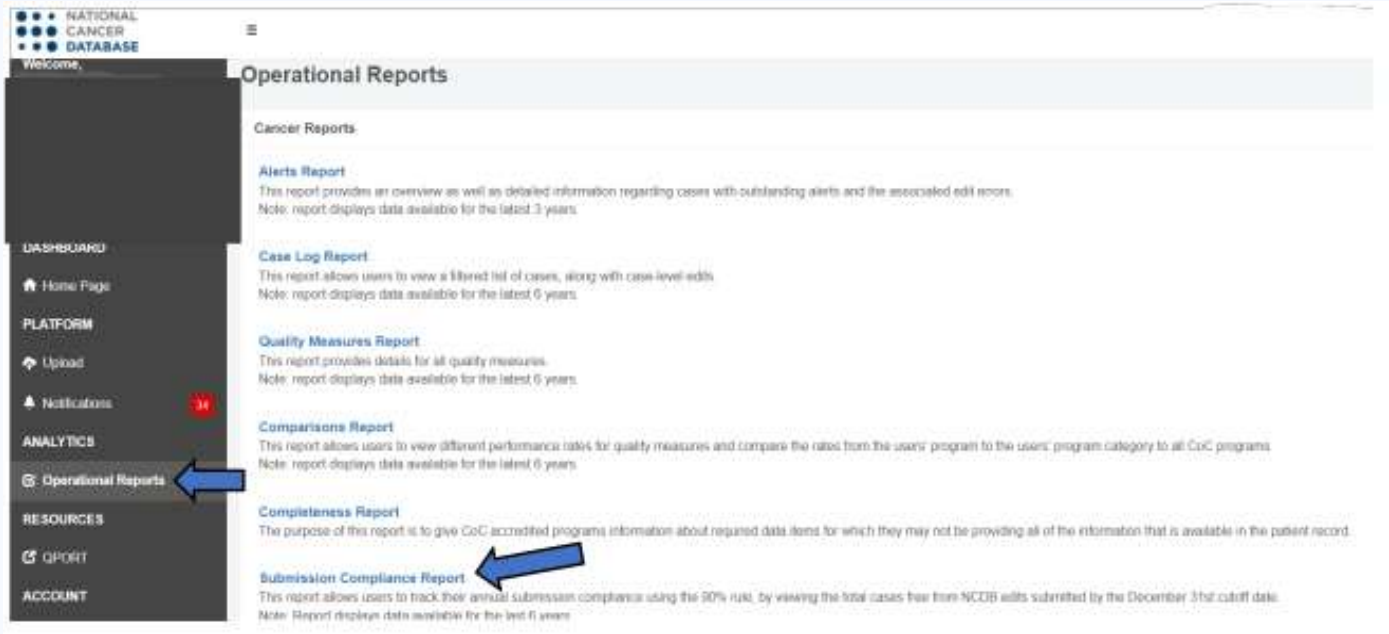
- Compliance audit and action plan must have been completed and reported to cancer committee prior to site reviewer selection of cases
  - Cancer committee meeting in previous year
  - Year of site visit, prior to site reviewer case selection
- Applicable for site visits occurring in 2025 and 2026
- Does not apply for Standards 5.7 or 5.8

# Rapid Cancer Reporting System

## Data Submission – 6.4

- Multiple compliance criteria
  - All new and updated cancer cases are submitted at least once each calendar month
  - Participation in March 2024 Call for Data
  - RCRS data and required QM performance rates
    - Reviewed by cancer committee twice annually
    - Review documented in cancer committee minutes

# Submission Compliance Report



# Key Takeaways

- Resources – Know Where To Find Them
  - Get to know the Standards
  - Definition and Requirements
  - Documentation
  - Measure of Compliance
- Register for ***Cancer Program News***
  - Sent twice per month
  - Provides reminders and updates
- Use QPort Resources
- Register for CAnswer Forum

# Thank you!