ACS Cancer Conference 2025

March 12–14 | Phoenix, AZ

Common Deficiencies and How to Mitigate Them

Aaron Bleznak, MD, MBA, FACS, FSSO
Chair, CoC Accreditation Committee
Past Chair, Program Review Subcommittee
Site Reviewer, CoC & NAPBC

ACS Cancer Programs
American College of Surgeons

Competition for Attention

POLITICO

Congress | Live updates | Inside Congress newsletter

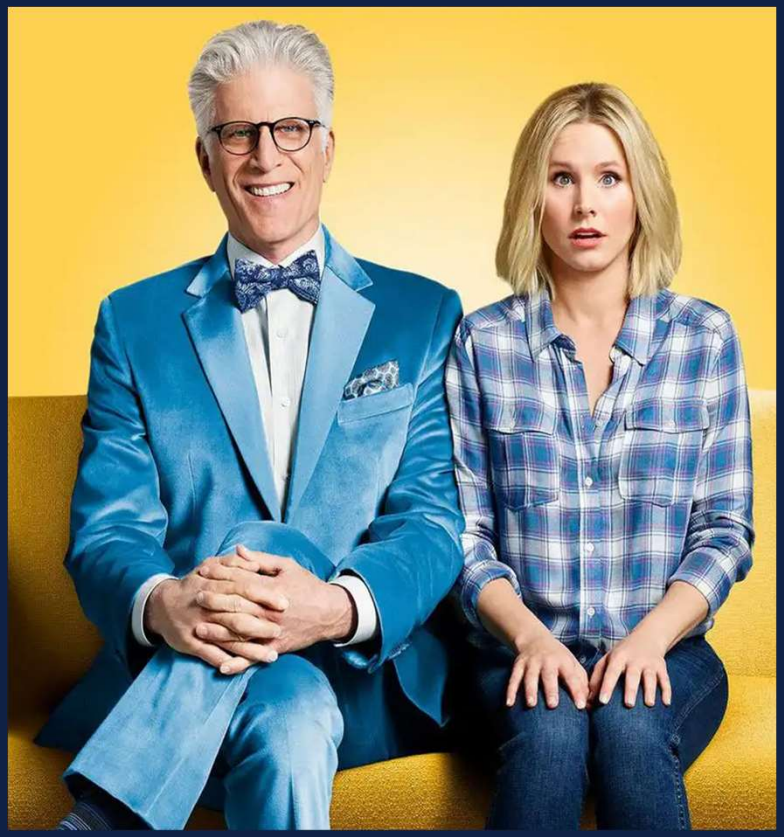
CONGRESS

‘Potty mouth’ Democrats have some new fighting words we can’t put in this headline

Profanity isn’t new in politics. But it’s reaching new heights on the left.

Rep. Jasmine Crockett (D-Texas) dropped an f-bomb in reaction to President Donald Trump’s joint address to Congress on Tuesday evening. | Francis Chung/POLITICO

!#$@&



ACS Cancer Conference 2025

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How to Be Compliant AND Get the Most Out of the Forking Standards

Aaron Bleznak, MD, MBA, FACS, FSSO
Chair, CoC Accreditation Committee
Past Chair, Program Review Subcommittee
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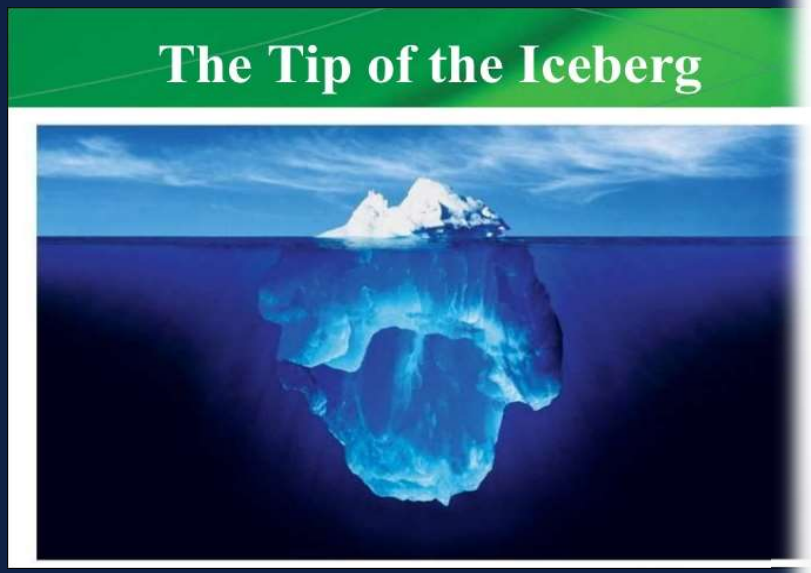
ACS Cancer Programs
American College of Surgeons

Agenda

- Challenges of Accreditation
- Specific Standards (clarifications or best practices)
  - S2.2: Cancer Liaison Physician
  - S2.4: Cancer Committee Attendance
  - S4.4: Genetic Counseling & Risk Assessment
  - S4.8: Survivorship Program
  - S5.2: Psychosocial Distress Screening
  - S5.3-5.8: Operative Standards
  - S6.4/S7.1: RCRS Data Submission & Quality Measures
  - S7.3: Quality Improvement Initiative
  - S8.2/8.3: Cancer Prevention Event & Cancer Screening Event

Challenges of the Accreditation Process



Challenges of the Accreditation Process

Observation

Observation

$ + 

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How I, as a Site Reviewer, Evaluate Your Compliance with the Standards

How I Evaluate Your Compliance

- Benefits patients
- Provides value
- Compliance next accreditation cycle

How I Evaluate Your Compliance

2025

Continue Same Work

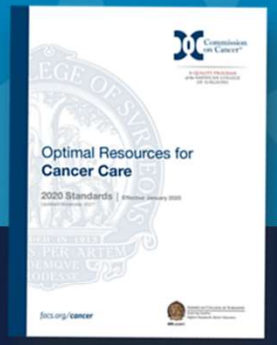
2028

ACS CoC Commission on Cancer
American College of Surgeons

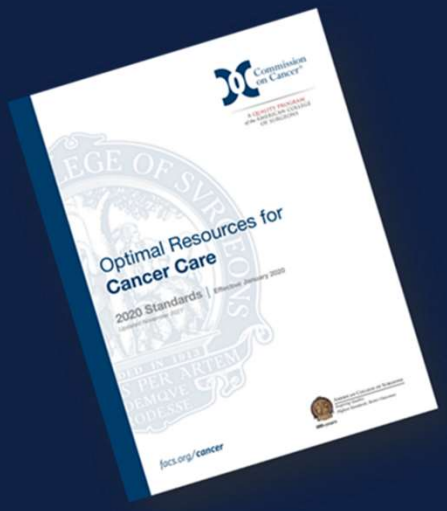
Meeting the Standards: What Every CoC Program Needs to Know

September 24, 2024

12:00 Noon Central/1:00 PM Eastern

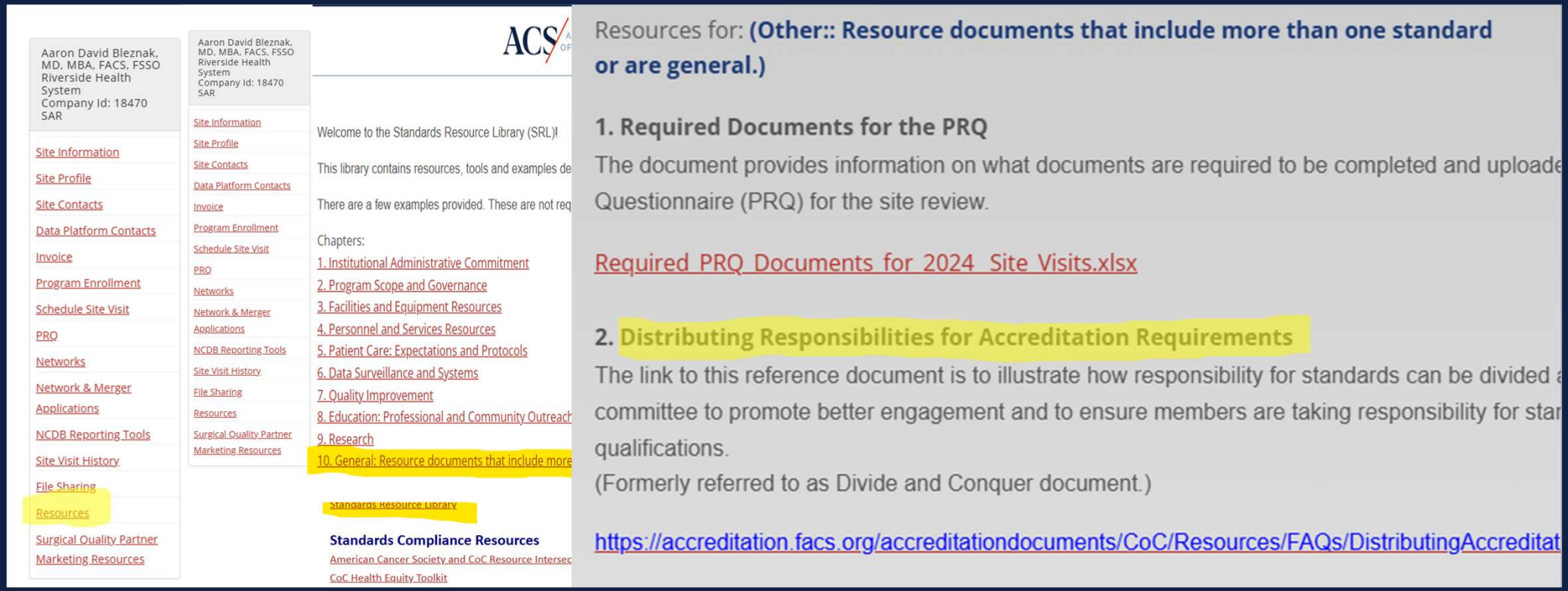


Step 1: Read the FORKing Manual



- A LOT of material for 1-2 people
- Consider distributing the responsibility to those doing that work

Step 2: Distribute the responsibility to those doing that work



Step 2: Distribute the responsibility to those doing that work (& hold them accountable)

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Distributing Responsibility for Accreditation Requirements
Divide And Conquer
Optimal Resources for Cancer Care 2020

The following information is not a substitute for reading the requirements detailed in *Optimal Resources for Cancer Care 2020 Standards*. Each cancer committee coordinator and member must review the standard for which he or she is responsible and demonstrate compliance as required in the manual. information is a reference to illustrate how responsibility for standards can be divided across the cancer committee to promote better engagement and to ensure members are taking responsibility for standards specific to their qualifications.

The following chart details cancer committee roles as defined in Standard 2.1: Cancer Committee. The appointed coordinators are responsible for compliance with the designated standards.

Cancer Committee Role	Standard	Meetings Requirements
Cancer Liaison Physician	2.2 7.3	• At least **two** meetings each calendar year. • Report may include an annual review of compliance with EPR (Standard 7.1: Quality Measures) as part of reporting requirements for Standard 2.2: Cancer Liaison Physician. • At least **two** meetings each calendar year along with the Quality Improvement Coordinator.
Cancer Conference Coordinator	2.5	At least one meeting each calendar year.
Quality Improvement Coordinator	7.3	At least **two** meetings each calendar year.
Cancer Registry Quality Coordinator	6.1 4.3	At least one meeting each calendar year (Standard 6.1: Cancer Registry Quality Control only.)
Clinical Research Coordinator	9.1	At least one meeting each calendar year.
Psychosocial Services Coordinator	5.2	At least one meeting each calendar year.
Survivorship Program Coordinator	4.8	At least one meeting each calendar year.

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The following chart provides suggestions for cancer committee members who may be appropriate champions for the remaining standards that do not require a specific member to coordinate the standard.

Potential Person Responsible	Standards	Meetings Requirements
Facility Leadership	1.1	None
Cancer Committee Chair	2.1	First quarter of the first calendar year of the accreditation cycle. Changes in members or alternates should be documented in minutes throughout the years of the accreditation cycle.
Facility Leadership	3.1	None
Representatives from diagnostic imaging, radiation oncology, and system therapy services	3.2	None
Cancer Committee Chair	4.1	None
Oncology Nursing Representative	4.2	None
Genetics Professional or Cancer Committee Chair	4.4	Fourth quarter of each calendar year of the accreditation cycle.*
Palliative Care Professional or Cancer Committee	4.5	Fourth quarter of each calendar year of the accreditation cycle.*
Rehabilitation Professional or Cancer Committee	4.6	Fourth quarter of each calendar year of the accreditation cycle.*
Registered Dietician Nutritionist or Cancer Committee	4.7	Fourth quarter of each calendar year of the accreditation cycle.*
Cancer Registrar	6.2 6.3	None
CLP or Cancer Registrar	6.4	Two times each calendar year of the accreditation cycle.
Cancer Registry Quality Coordinator or Cancer Registrar	6.5	None
Cancer Registrar	7.1	Each calendar year of the accreditation cycle.

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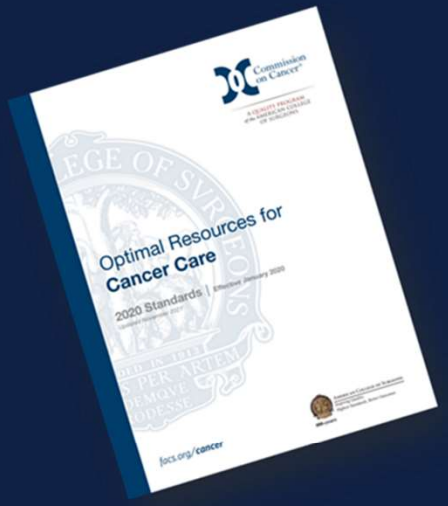
Potential Person Responsible	Standards	Meetings Requirements
Cancer Committee Chair or designated physician	7.2	Each calendar year of the accreditation cycle.
Cancer Committee Chair	7.4	At least **three** meetings each calendar year of the accreditation cycle.
Patient Navigator	8.1	Each calendar year of the accreditation cycle.
Community Outreach Representative	8.3	Fourth quarter of each calendar year of the accreditation cycle.*

*Annual report may also be presented at the first meeting of the following calendar year. Please see page v of the *Optimal Standards for Cancer Care 2020 Standards* for guidance and a summary of standards that require at least an annual review.

Step 3: Think of the Standards as a Tool for Improving How Your Program Functions (& not as a barrier to accreditation)



Put a good person in a bad system and the bad system wins, no contest.

W. Edwards Deming

Step 4: Think of the required work as a CQI process

Step 5: Plan Meeting Schedule to Allow Time to Discuss Annual Reports

Actions that lead to Noncompliance Ratings

- Not distinguishing between EVENT and SERVICE
  - An **event** is a single episode of contact with patient(s); e.g.: S8.2 or S8.3
  - A **service** is an ongoing activity(ies); e.g.: S4.8
- Not carefully reading the ENTIRE standard
  - For which standard(s) is DATA needed and WHAT data is required?
  - What is the TIMEFRAME for data or observations or activities?
  - What is SCOPE of activity to be reviewed (e.g.: S7.2 requires compliance with both evaluation and treatment?
- Not planning your calendar of meetings to adhere to required reporting TIMEFRAMES
  - **Page v** (Forward to Standards)

Annual Report Requirements

- Must be documented in the cancer committee minutes
- Must take place within the same calendar year on which it is based or no later than the first quarter of the following calendar year
- Should include a calendar year worth of data or observations

- Standard 2.5: Multidisciplinary Cancer Case Conference
- Standard 4.4: Genetic Counseling and Risk Assessment
- Standard 4.5: Palliative Care Services
- Standard 4.6: Rehabilitation Care Services
- Standard 4.7: Oncology Nutrition Services
- Standard 4.8: Survivorship Program
- Standard 5.1: CAP Reporting
- Standard 5.2: Psychosocial Distress Screening
- Standard 6.1: Cancer Registry Quality Control
- Standard 8.1: Addressing Barriers to Care
- Standard 8.2: Cancer Prevention Event
- Standard 8.3: Cancer Screening Event
- Standard 9.1: Clinical Research Accrual

No Double Dipping

Standard 7.4: "A goal established under this standard cannot duplicate requirements or be an improvement on requirements from another standard or be a program or initiative submitted to meet the requirements of another standard."

No Double Dipping

Other examples we have seen:

- Submitting the same or similar report for either Oncology Nutrition (4.6) or Rehabilitation Care Services (4.7) and Survivorship Program (4.8)
- The same event is used to meet the Survivorship Program (should be a service) and the Cancer Screening Event
- A tobacco cessation program is used to meet both Standard 7.4: Cancer Program Goals and Standard 8.2: Cancer Prevention Event

Exceptions:

1. Standard 7.3 QI Initiative can impact compliance with another standard
2. Review of RCRS measures for S6.4 can also be review required for S7.1

Standard 2.2 Cancer Liaison Physician

- Present NCDB data twice annually to CC
  - Hospital Compare, Survival, CQIP are required data sources
- Should identify and report on areas of <u>low performance</u>
- CLP cannot present RCRS data alone for S2.2 reports
  - Can present RCRS data for S6.4 reports
  - Can present RCRS quality metrics for S7.1 report

Reminder regarding "double dipping" CoC Standard Compliance

Work to obtain compliance in one Commission on Cancer (CoC) standard may not replace, duplicate, or augment the work required to obtain compliance with another standard. The sole exception to this rule is Standard 7.3: Quality Improvement Initiative.

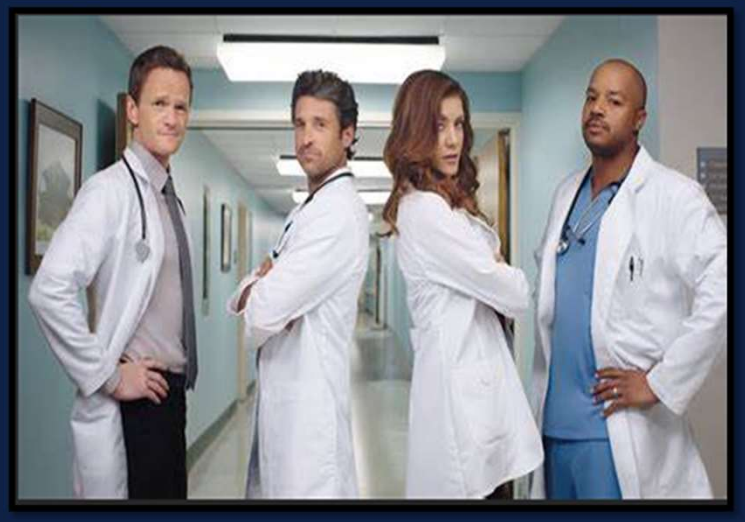
Please note: restrictions against using the same report for Standard 2.2: Cancer Liaison Physician and Standard 6.4: Rapid Cancer Reporting System will not be enforced until 2025.

The following are some examples of **non**compliance:

- Program initiates a prehabilitation program for patients preparing to undergo oncologic surgery. It reviews and reports this for Standard 4.6: Rehabilitation Care Services but, because the program designates survivorship as beginning at the time of diagnosis, also considers and reports this under Standard 4.8 as one of three survivorship services.
- Program focuses on screening for recurrent/new primary malignancies for breast cancer survivors, estimates number of patients receiving that service in a calendar year, and reports this as one of its three survivorship services for Standard 4.8. It has a one-day event offering breast cancer education and screening to survivors and reports this as their Standard 8.3 screening event.
- Program currently refers patients to off-site location for all genetic testing. The program makes a goal for Standard 7.4: Cancer Program Goal to hire a genetics professional so that services can be offered on-site. This is considered meeting the requirements of Standard 4.4: Genetic Counseling and Risk Assessment that genetic services be offered on-site of by referral.
- The CLP presents a report of quality measures from the Rapid Cancer Reporting System (RCRS) with the intent of satisfying the requirements for both Standard 2.2: Cancer Liaison Physician and Standard 6.4: RCRS: Data Submission. Standard 2.2 CLP reports cannot duplicate the RCRS report for Standard 6.4.

Standard 2.4 Cancer Committee Attendance

- Compliance defined as each required member or the designated alternate attends at least 75% of the cancer committee meetings held.

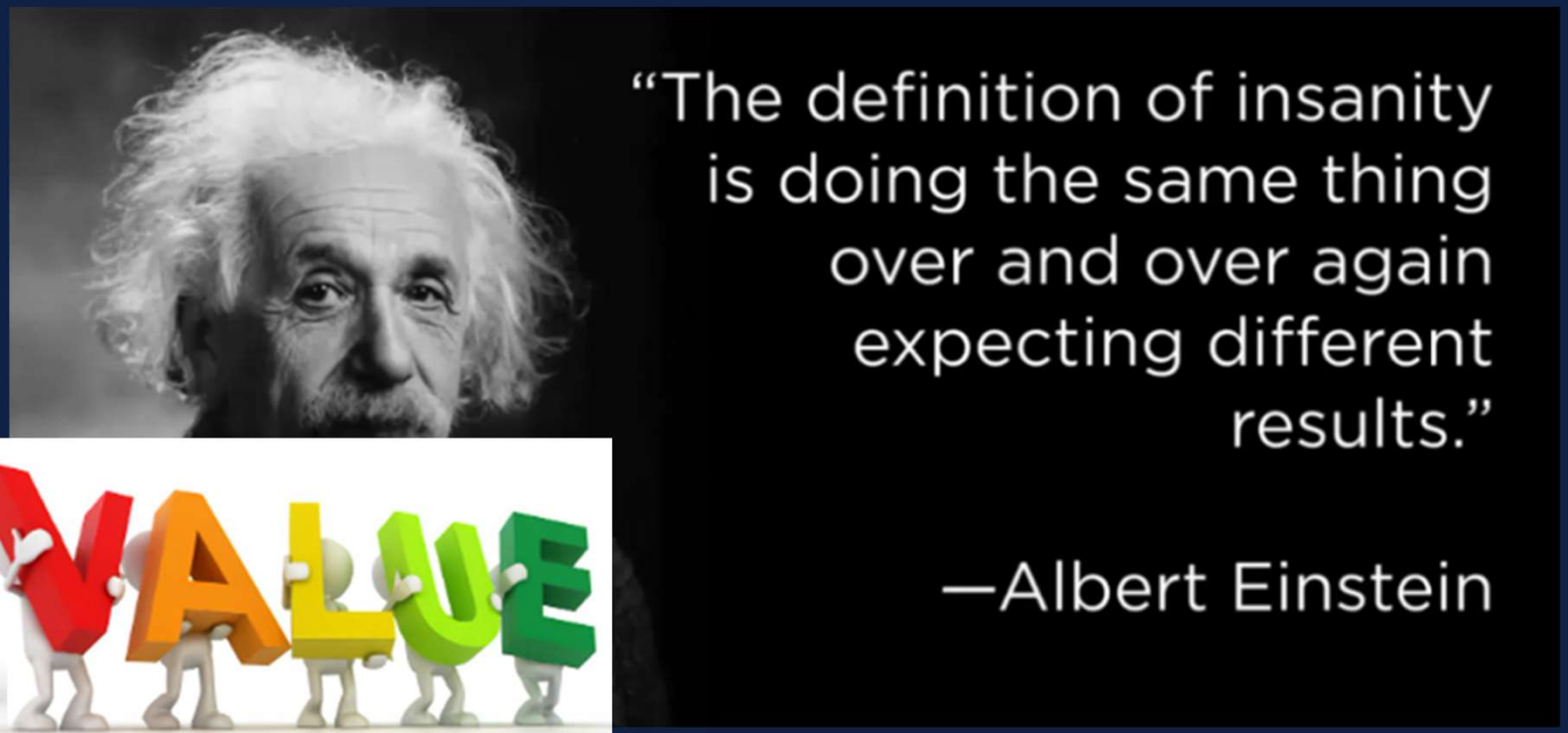


Standard 2.4 Cancer Committee Attendance

- Required members and any alternates must be appointed at least once during the accreditation cycle
  - Changes to membership including alternates must be noted in the cancer committee minutes
- Appoint members with INTENT
  - Choose physician members who are engaged/wish to engage with the cancer program
  - Replace members who are repeatedly not present
- Designating alternates is OPTIONAL.
  - Alternates must be qualified for the role
  - Appointed members can be alternates to other roles but that may not always be optimal

  Alternates should be available to attend meetings*

Standard 4.4: Genetic Counseling & Risk Assessment (applies to other standards as well)



Standard 4.8 Survivorship Program

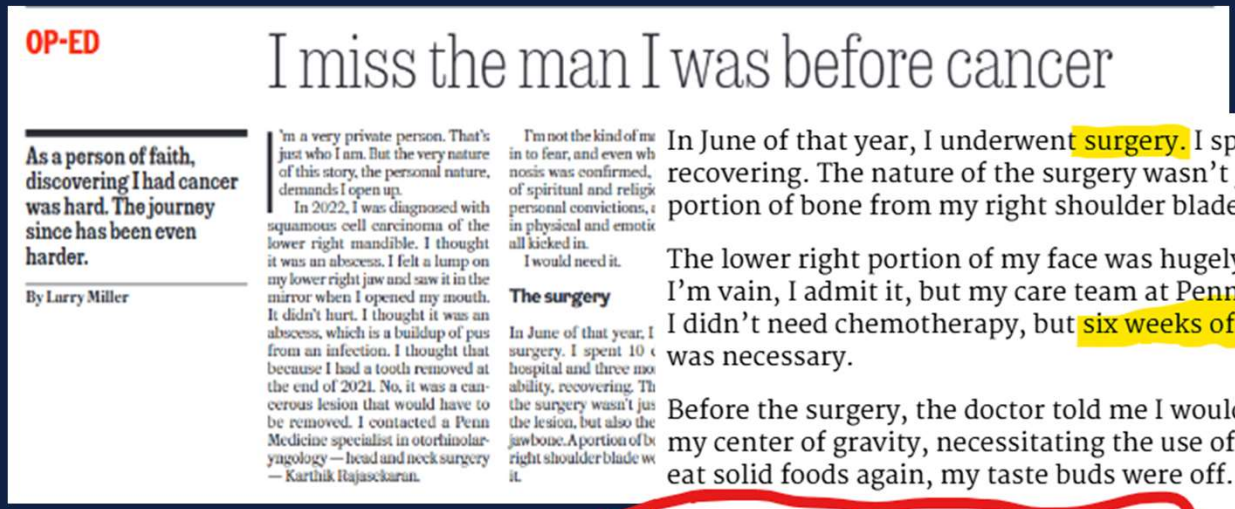
CHANGE YOUR PERSPECTIVE

- NOT about your survivorship services
- NOT about how you define survivorship

- This standard is about EVALUATING the survivorship services you offer to patients who have completed first course of treatment

Standard 4.8 Survivorship Program

No other standard directly addresses THIS population of patients



OP-ED

I miss the man I was before cancer

As a person of faith, discovering I had cancer was hard. The journey since has been even harder.

By Larry Miller

'm a very private person. That's just who I am. But the very nature of this story, the personal nature, demands I open up.

In 2022, I was diagnosed with squamous cell carcinoma of the lower right mandible. I thought it was an abscess. I felt a lump on my lower right jaw and saw it in the mirror when I opened my mouth. It didn't hurt. I thought it was an abscess, which is a buildup of pus from an infection. I thought that because I had a tooth removed at the end of 2021. No, it was a cancerous lesion that would have to be removed. I contacted a Penn Medicine specialist in otorhinolaryngology — head and neck surgery — Karthik Rajasekaran.

I'm not the kind of m in to fear, and even wh nosis was confirmed, of spiritual and religi personal convictions, in physical and emoti all kicked in.

I would need it.

The surgery

In June of that year, I surgery. I spent 10 hospital and three mo ability, recovering. Th the surgery wasn't jus the lesion, but also the jawbone. A portion of b right shoulder blade w it.

In June of that year, I underwent surgery. I spent 10 days in the hospital and three months on disability, recovering. The nature of the surgery wasn't just removing the lesion, but also the lower right jawbone. A portion of bone from my right shoulder blade would replace it.

The lower right portion of my face was hugely swollen after surgery and permanently slightly disfigured. I'm vain, I admit it, but my care team at Penn Medicine assured me the swelling would go down, and it did. I didn't need chemotherapy, but six weeks of targeted radiation therapy at the Abramson Cancer Center was necessary.

Before the surgery, the doctor told me I wouldn't be able to turn or lift my head. The procedure changed my center of gravity, necessitating the use of a cane sometimes, and as if that wasn't enough, when I could eat solid foods again, my taste buds were off.

That was the easy part of this journey.

The road to recovery

This is a journey in and through the dark places of the heart, mind, and soul. Really dark places.

Standard 4.8 Survivorship Program

Standard requirements:

- Designate **leader** of survivorship program
- Identify team & services/programs offered to address needs of cancer survivors
- Annually **evaluate** 3 services impacting cancer survivors

Services may include:

- SCP & treatment summaries
- Screening for recurrence & new cancers
- Education & seminars
- Rehabilitation services
- Nutrition services
- Psychological support & psychiatric services
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling
- Financial support services
- Physical activity

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- Psychological support & psychiatric services
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling
- Financial support services
- Physical activity

Potential Issues with S4.8

The following are not services appropriate for evaluation under this standard:

- One-time event (usually)
- Distributing brochures or providing website for patients to view
- Events/celebrations for cancer survivors
- Booths at a health fair

But you can still offer them

Potential Issues with S4.8

You CANNOT use a report from another standard (e.g.: nutrition) as the report for one of your three survivorship services!

1. No “double dipping”
2. Need discussion of how any service chosen for review is tailored to patients who have completed first course of treatment

Standard 4.8: Required Annual Report

Standard 4.8: Required Annual Report

Patients in treatment

Patients post first course treatment

Standard 5.2: Psychosocial Distress Screening

Policy for providing/monitoring psychosocial services & distress screening

Cancer program chooses distress screening **tool** & identifies cutoff

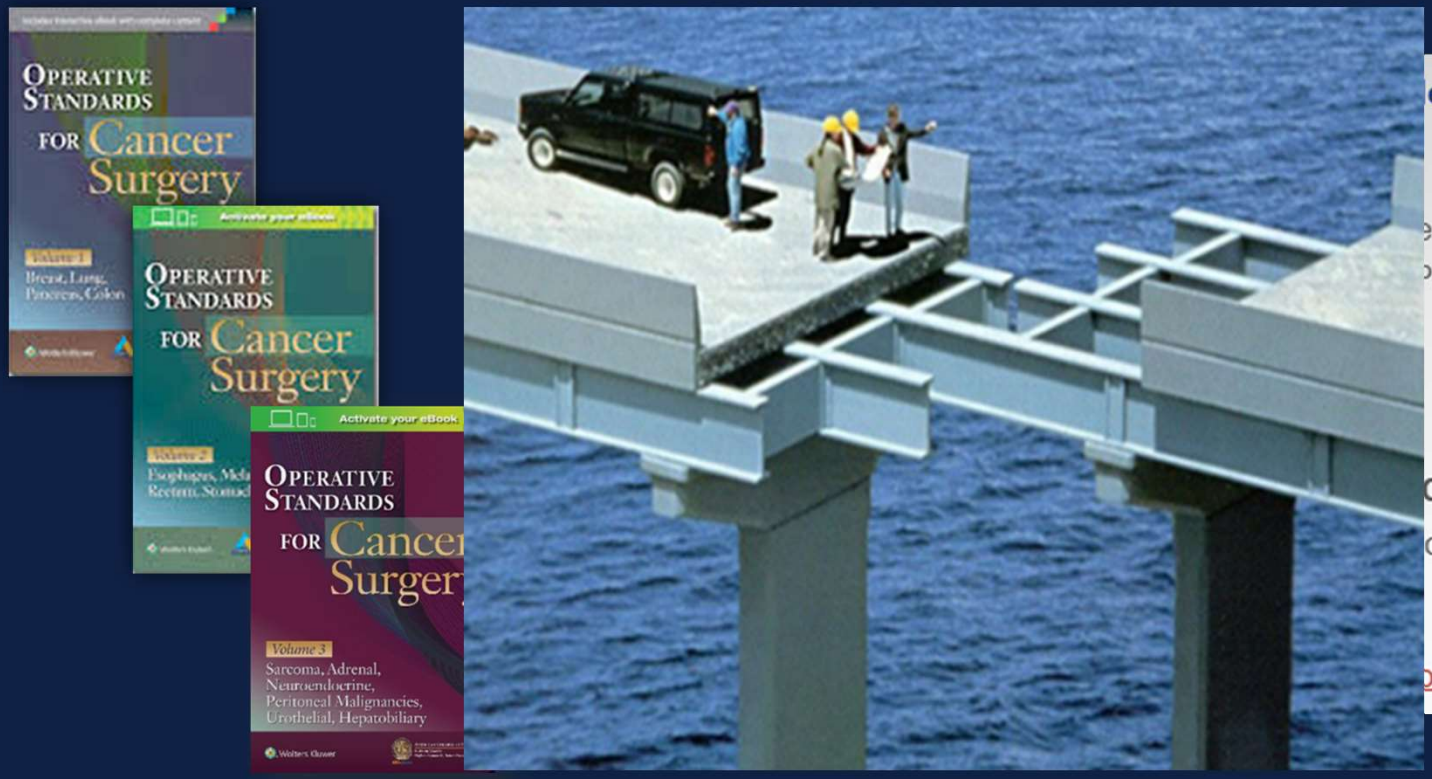
Cancer patients screened for distress at least once during 1st course of treatment

Program **evaluates** process annually and **suggests improvements**

Standard 5.2: Required Report

- Psychosocial Distress Screening Coordinator reports to the cancer committee each year
- Must include a FULL CALENDAR YEAR'S worth of data and report must take place by the end of the first quarter of the following calendar year.
- Report must include:
  - Number of patients screened
  - Number of patients referred for distress resources or further follow up
  - Where patients are referred (on-site or by referral)

Operative Standards



e Biopsy)

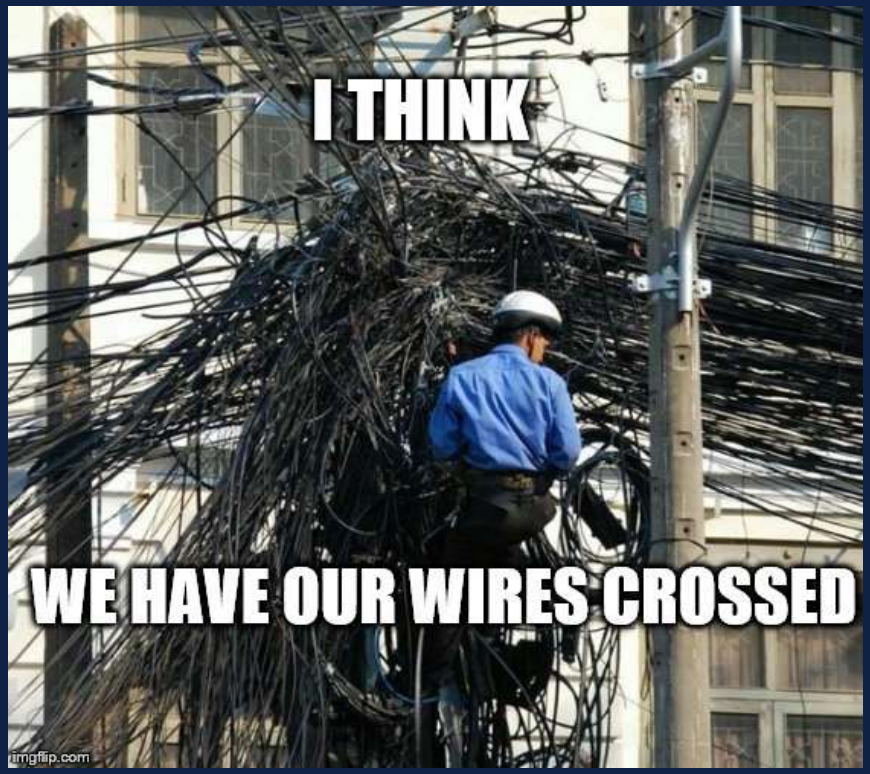
e and access content on the CoC
Program (CSSP) has created a new

Cancer Form

oC-accredited programs to meet the

oC St 5.3.pdf

Operative Standards

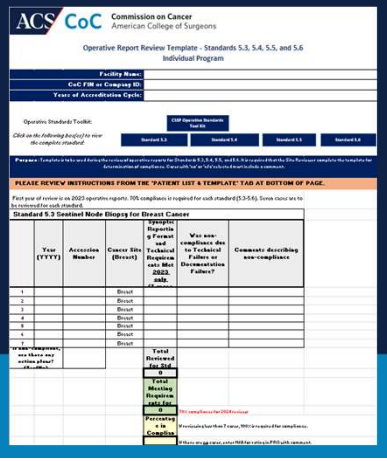


Operative Standards

Standard 5.3-5.6: Operative Standards Alternative Compliance Pathway

- Effective for **2025 and 2026** Site Visits, alternative compliance pathway for Operative Standards 5.3-5.6
  - Does **not** apply to Standards 5.7 and 5.8

- Applicable ONLY if program does not meet compliance based upon medical record review
  - 80% out of review of 15 charts maximum
  - We will **still** review operative reports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Operative Report Review Template - Standards 5.3, 5.4, 5.5, and 5.6
Individual Program

Facility Name:
CoC FIN or Company ID:
Years of Accreditation Cycle:

Operative Standards Toolkit:
CSP Operative Standards Tool Kit

Click on the following box(es) to view the complete standard:
Standard 5.3 | Standard 5.4 | Standard 5.5 | Standard 5.6

Purpose - Template is to be used during the review of operative reports for Standards 5.3, 5.4, 5.5, and 5.6. It is to assist the Site Reviewer complete the template for determination of compliance. Cases with "no" or "n/a" only in the Comments column.

PLEASE REVIEW INSTRUCTIONS FROM THE "PATIENT LIST & TEMPLATE" TAB AT BOTTOM OF PAGE.

First year of review is on 2023 operative reports. 70% compliance is required for each standard (5.3-5.6). Some cases are to be reviewed for each standard.

Standard 5.3 Sentinel Node Biopsy for Breast Cancer

	Year (YYYY)	Accession Number	Cancer Site (Breast)	Synoptic Reporting Format and Technical Requirements Met 2023, only	Was non-compliance due to Technical Failure or Documentation Failure?	Comments describing non-compliance
1			Breast			
2			Breast			
3			Breast			
4			Breast			
5			Breast			
6			Breast			
7			Breast			
If less than seven, are there any notes about the cases?				Total Reviewed for Std	0	
				Total Meeting Requirements for Std	0	
				Percentage for Compliance	n/a	

Operative Standards Case Selection Process

Program provides list of ALL cases for the respective disease site to the site reviewer

Site reviewer selects 15 cases (or maximum available) for each standard

Program reviews selections and informs site reviewer of any cases for which the standard is not applicable*

Site reviewer will select REPLACEMENT cases ONCE. After that, any cases that are not applicable will be scored N/A

Standard 5.3-5.6: Alternative Pathway for Compliance

This is only considered if the site review is N/C

Conduct an **internal audit** and develop an **action plan** to achieve compliance

- Separate audits a… potentially non-compliant standa…
- Can be complete… ation cycle or the year of the site visit
  - Providing that c… s of the results of the audit and the action … te reviewer

Action plan must a… nce and the interventions imple…

- Be specific!
- Plans can includ… pplicable

Standards 5.3 – 5.8 Operative Standards

- **Curative intent** element must be included in synoptic operative reports for 5.3-5.6
- **All elements** must be listed even if response is N/A
- S5.3: If bilateral axillary surgery for breast cancer, a separate synoptic format with all required elements must be listed for each side with laterality designated.
- S5.4: If SLN biopsy and subsequent ALND are both performed during the same operation, a synoptic report with all required elements must be listed for each procedure.
- S5.5: Wide local excisions for melanoma performed by any provider within the accredited program is considered a case applicable for review during the site visit.
- S5.6: If resection for colon cancer of 2 lesions within one resection, only one synoptic report with all required elements is needed. However, if resecting 2 colon cancers in 2 separate resections, a synoptic report with all required elements for each is required.
- S5.7: Only rectal cancers at/below peritoneal reflection are eligible for TME and this standard. Proximal/upper rectal cancers will be deemed N/A.

Standard 7.1: Quality Measures

Definition and Requirements

The Commission on Cancer (CoC) requires accredited cancer programs to treat cancer patients according to nationally accepted quality measures indicated by the CoC quality reporting tool.

The cancer committee monitors the program's expected Estimated Performance Rates for quality measures selected annually by the CoC. Details on the quality measures for this standard may be referenced on the National Cancer Database (NCDB) website which includes quality measure specifications, years for performance evaluation, and quality measure performance thresholds for this standard. Facility performance rates for these quality measures will be extracted from the NCDB reporting tools.

If the cancer program is not meeting the expected EPR of a quality measure(s), then a corrective action plan must be developed and implemented in order to improve performance. The corrective action plan must document how the program will investigate the issue(s) for each quality measure with the goal of resolving all barriers and improving compliance.

The cancer committee's review of compliance with required quality measures and monitoring activity is documented in the cancer committee minutes. The action plan and any corrective action taken are included in the documentation.

Programs with no cases eligible for assessment in a selected quality measure are exempt from requirements for that individual measure.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer committee minutes documenting the presentation and review of required quality measures; documentation includes any required action plans

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. The cancer committee monitors the program's expected Estimated Performance Rates for quality measures selected by the CoC.
2. The monitoring activity is documented in the cancer committee minutes.
3. For each quality measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the expected EPR specified by the CoC.
4. If the expected EPR is not met, the program has implemented an action plan that reviews and addresses program performance below the expected EPR.

Quality Measures

Primary Site	Measure	Measure Description	Label
Breast	BCSdx	For patients with AJCC Clinical Stage I-III breast cancer, the first therapeutic surgery in a non-neoadjuvant setting is performed within and including 60 days of diagnosis	PR/EPR 95% CI Benchmark
Colon	ACT	For patients under the age of 80 with surgically-managed pathologic stage III colon cancer (N>0), adjuvant chemotherapy is initiated within 4 months (120 days) of diagnosis, or recommended	PR/EPR 95% CI Benchmark
	C12RLN	For patients undergoing a colon resection for colon cancer, at least 12 regional lymph nodes are removed and pathologically examined at time of resection	PR/EPR 95% CI Benchmark
Lung	LCT	For patients with surgically managed NSCLC, pathologically staged T2 and >4cm, or T>=3, or N>0, systemic therapy (chemotherapy, immunotherapy or targeted therapy) was initiated within the 3 months prior to surgery or after surgery, or was ...	PR/EPR 95% CI Benchmark

- Announcement February 2025

Standard 7.1: Quality Measures

Actual Performance ≥ EPR

Actual Performance < EPR but 95% CI ≥ EPR

Actual Performance < EPR 95% CI < EPR

Quality Measures

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	C12RLN	For patients undergoing a colon resection for colon cancer, at least 12 regional lymph nodes are removed and pathologically examined at time of resection	PR/EPR 95% CI Benchmark
Lung	LCT	For patients with surgically managed NSCLC, pathologically staged T2 and >4cm, or T>=3, or N>0, systemic therapy (chemotherapy, immunotherapy or targeted therapy) was initiated within the 3 months prior to surgery or after surgery, or was ...	PR/EPR 95% CI Benchmark

- EPRs will be announced May 2025
- Q3 2025: RCRS will be updated showing **performance vs. EPR** for these four measures only

Standard 7.3: QI Initiative

A QI initiative can impact compliance with another standard!

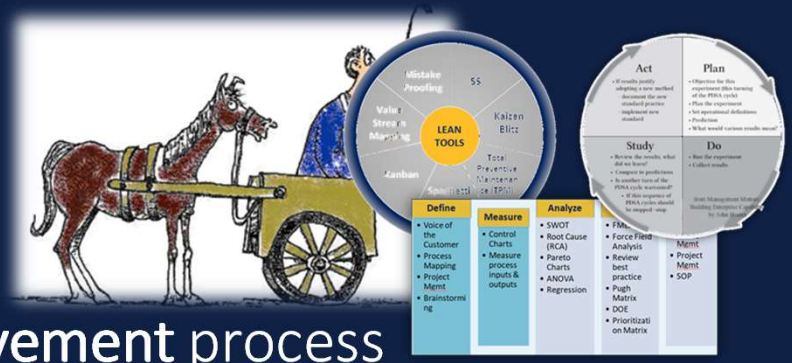
Standard 7.3 Errors

- Lack of problem statement
- Problem statement discusses performing a study to identify issue
- Problem statement suggests that solution is already known prior to QI effort

The QI initiative must have a problem statement. The problem statement must identify:

- A specific, already-identified, quality-related problem specific to the cancer program to solve through the QI initiative,
- The baseline and goal metrics (must be numerical), and
- Anticipated timeline for completing the QI initiative and achieving the expected outcome.

The problem statement cannot state that a study is being done to see if a problem exists, rather it must already be known that a problem exists.



- Failure to describe or use a **quality improvement** process
- Initiative starts too late in year to accumulate sufficient numbers to determine if implemented improvements are effective
- QI initiative carried over into a second year without a final report in second year

Announcements

- S4.2: **Oncology Nursing Credentials**
  - Proposed update was open for comments (THANK YOU)
  - Work group will now consider comments prior to submitting any changes to Accreditation Committee and Executive Committee
  - Proposed update does not change expectations of the standard but only how compliance is determined.
- **Smoking Cessation Standard** (in Chapt. 5)
  - Proposed new standard was open for comments (again, THANK YOU)
  - Work group will now consider comments prior to submitting any changes to Accreditation Committee and Executive Committee
  - Go Live date not yet determined

Thank You for your Attention