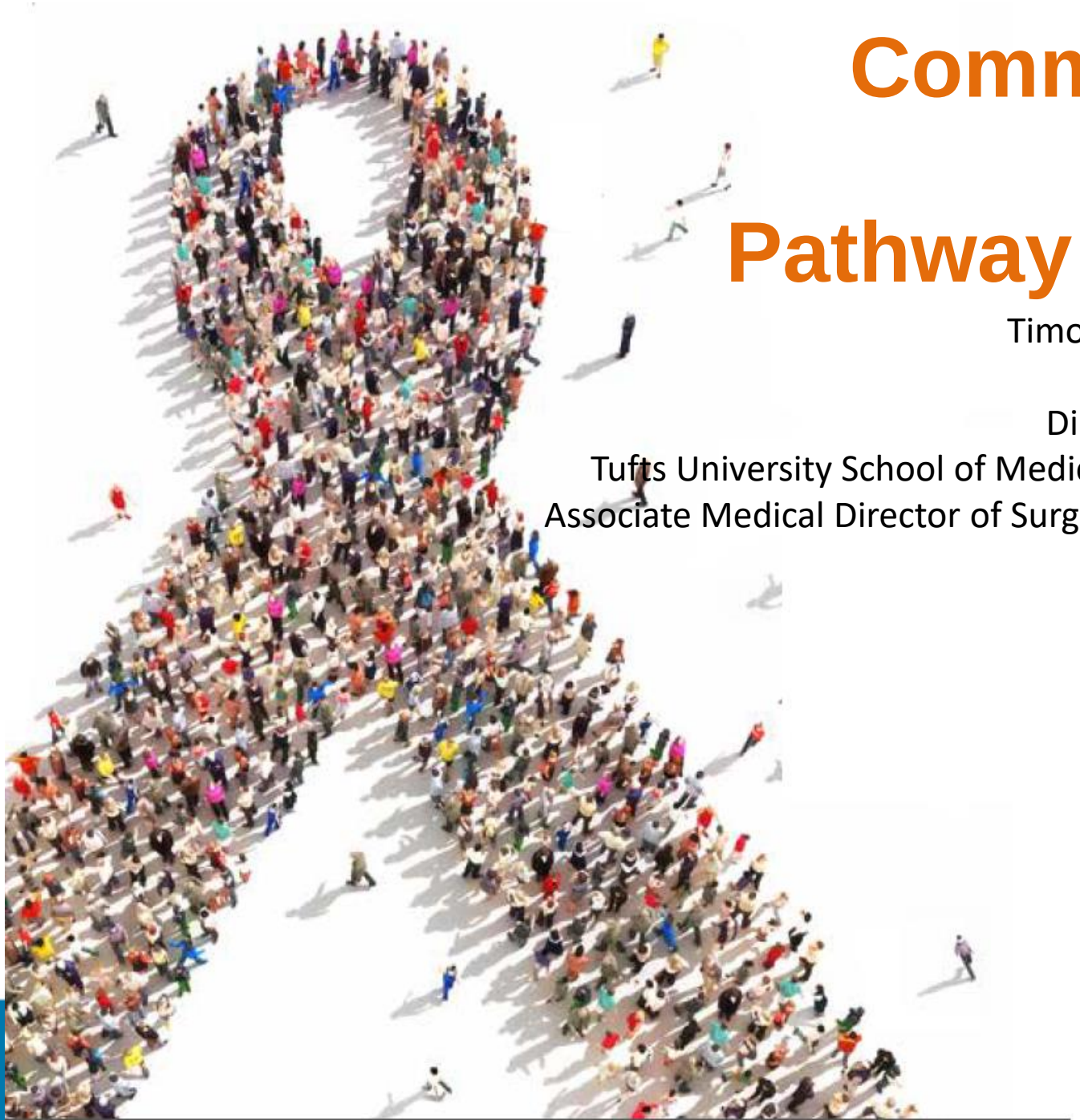


Commission on Cancer Pathway to Quality

Timothy L. Fitzgerald, MD, FACS
Professor of Surgery
Director of Surgical Oncology
Tufts University School of Medicine-Maine Medical Center
Associate Medical Director of Surgical Oncology MaineHealth

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes
100+*years*

Approximately 1500 CoC-Accredited Cancer Programs

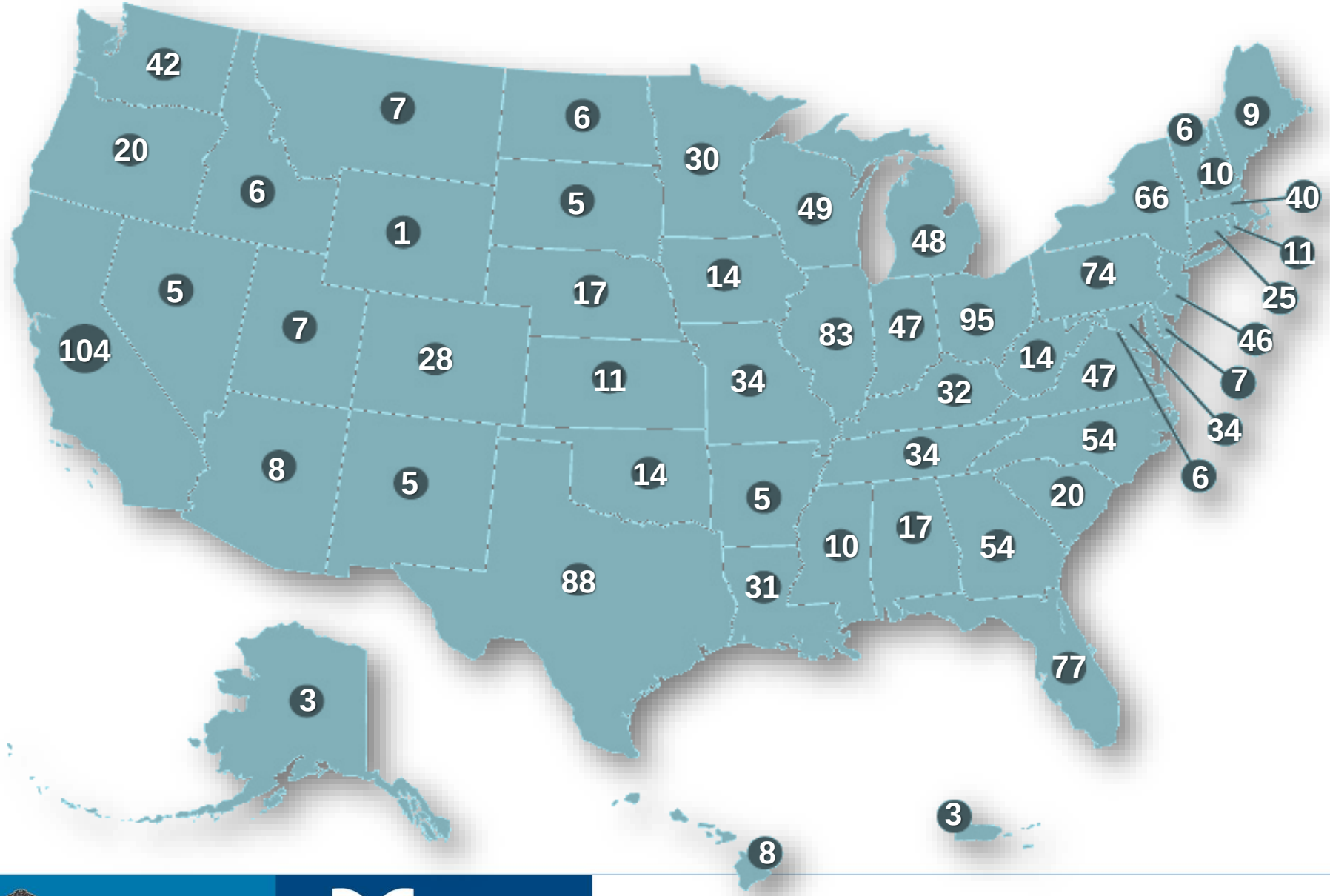
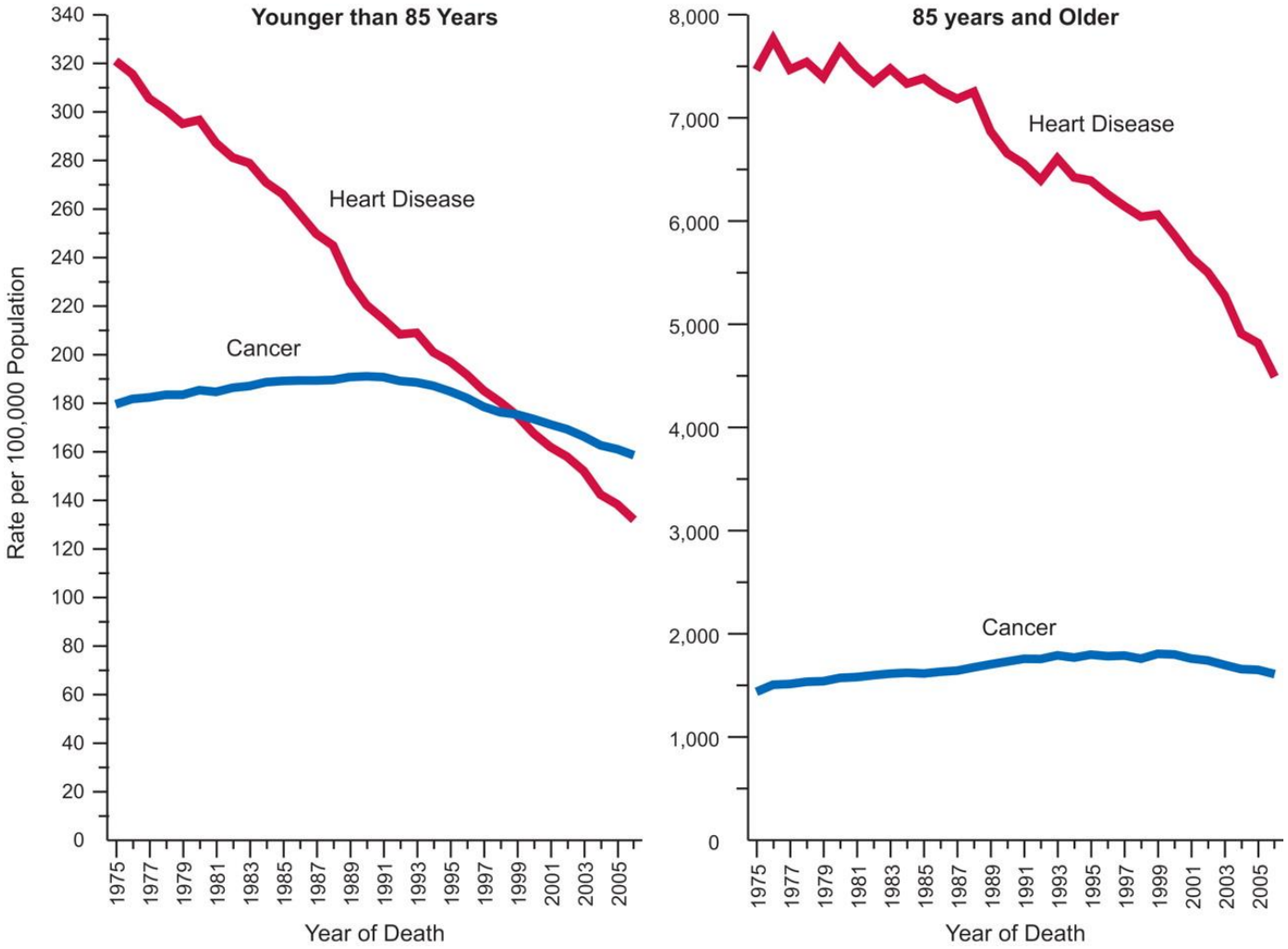


FIGURE 6 Death Rates* For Cancer and Heart Disease for Ages Younger Than 85 Years and 85 Years and Older, 1975 to 2006

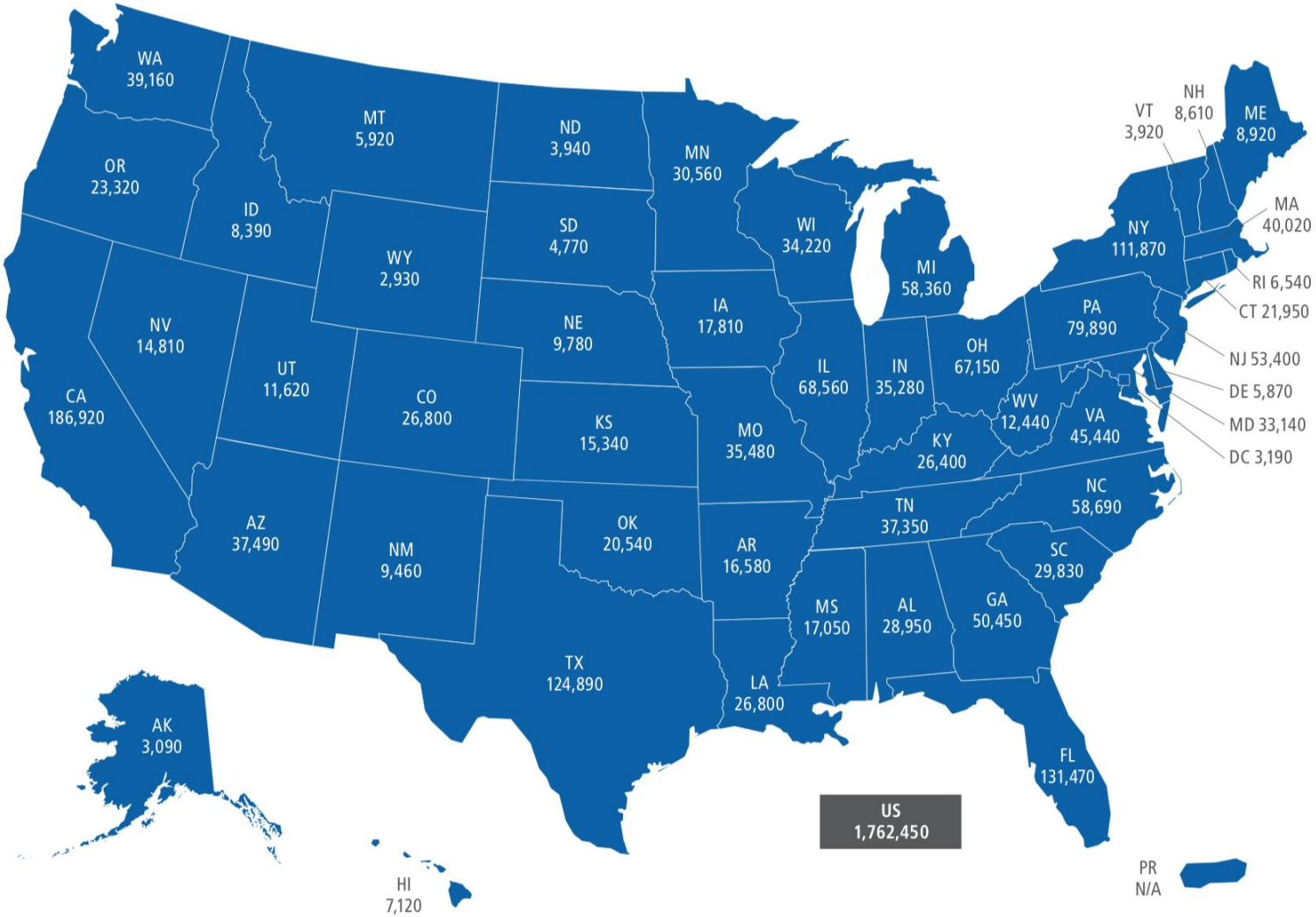


From Jemal, A. et al.
CA Cancer J Clin 2010;0:caac.20073v1

CA
A Cancer Journal for Clinicians

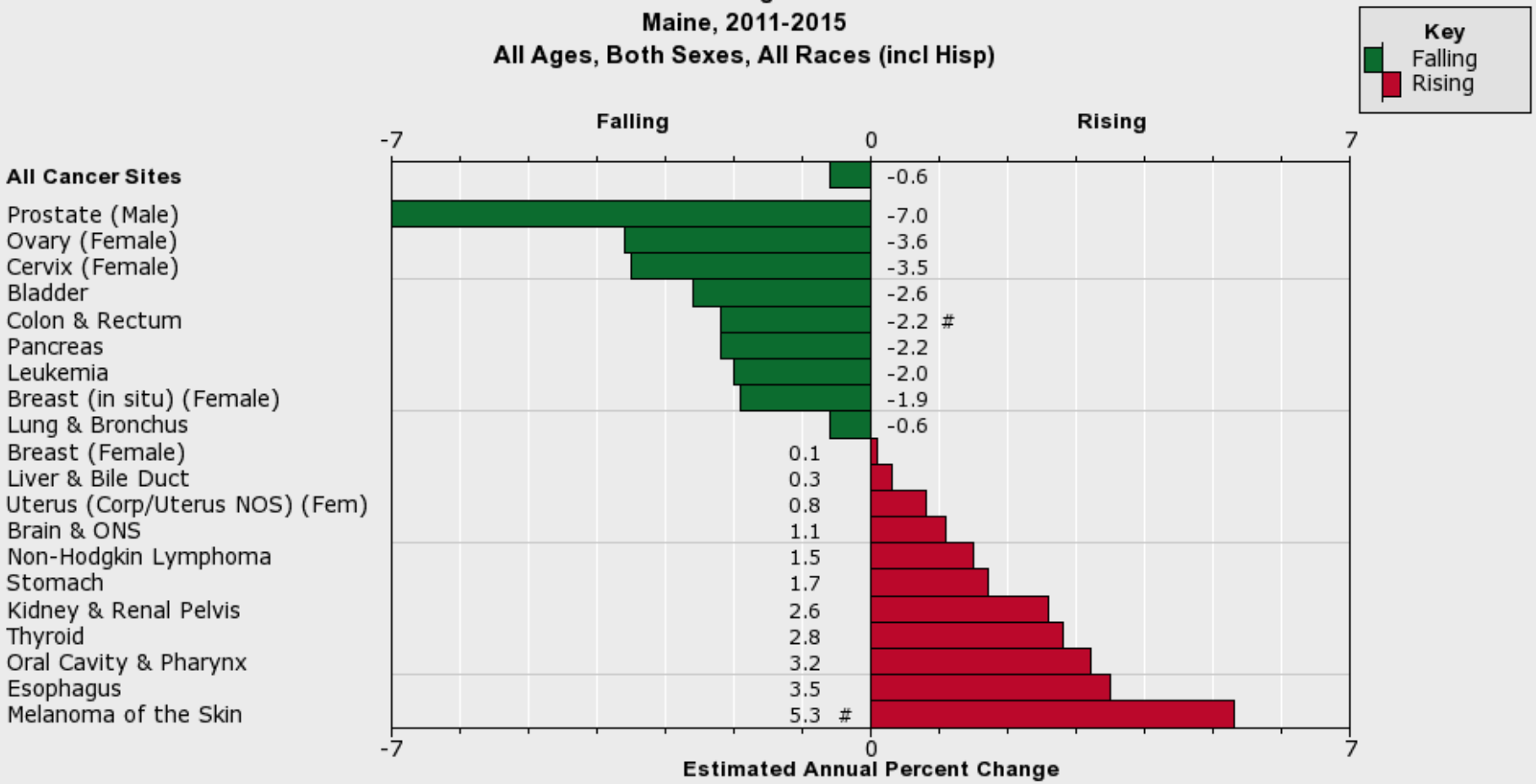
Cancer Facts & Figures 2019

Maine
New
Cancers
8,920



ME Leading Causes of Death, 2014	Deaths	Rate***	State Rank*	U.S. Rate**
1. Cancer	3209	170.3	14th	161.2
2. Heart Disease	2776	147.9	36th (tie)	167.0
3. Chronic Lower Respiratory Disease	896	48.1	16th	40.5
4. Accidents	690	45.8	24th	40.5
5. Stroke	628	33.2	33rd	36.5
6. Alzheimer's disease	434	22.7	39th	25.4
7. Diabetes	414	22.4	18th	20.9
8. Flu/Pneumonia	258	13.7	36th (tie)	15.1
9. Kidney Disease	223	11.7	30th	13.2
10. Suicide	220	15.7	20th (tie)	13.0

5-Year Rate Changes - Incidence
Maine, 2011-2015
All Ages, Both Sexes, All Races (incl Hisp)



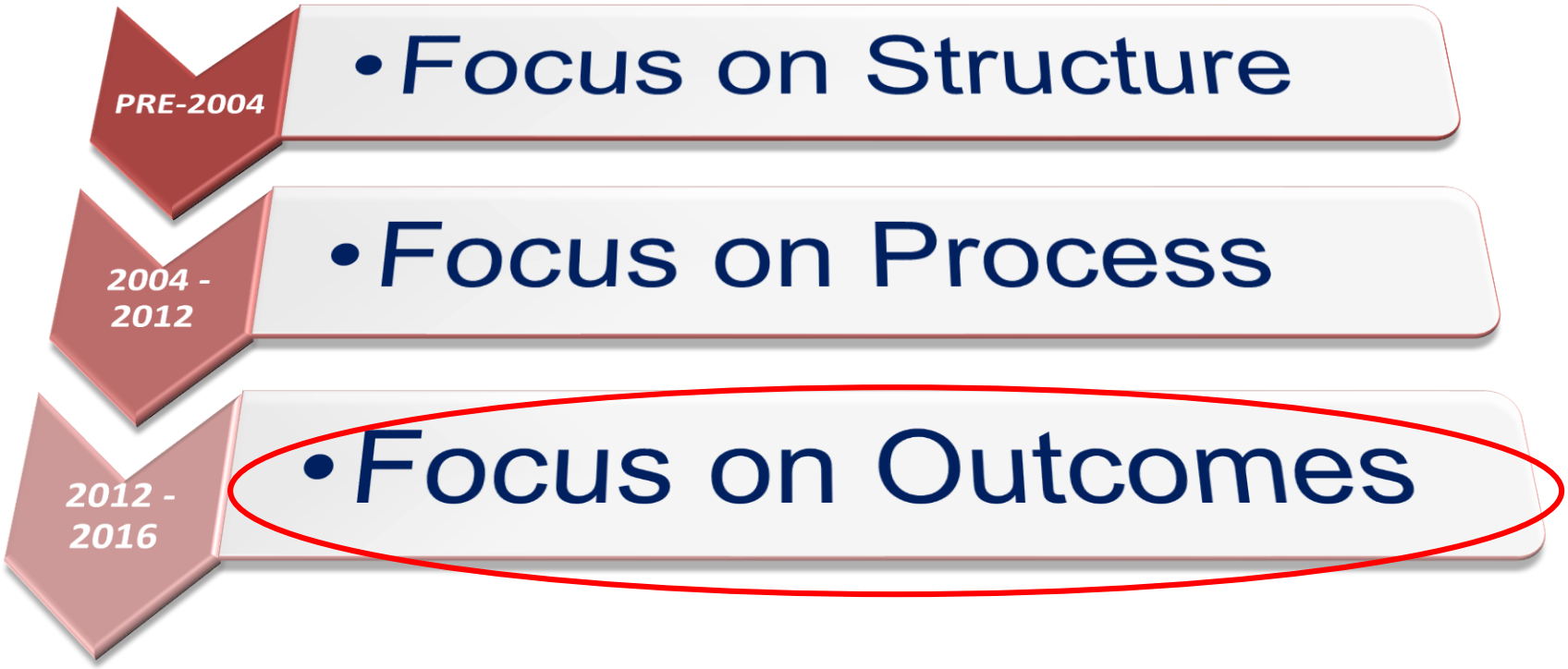
Created by statecancerprofiles.cancer.gov on 04/21/2019 8:02 pm.

Source: Incidence data provided by the National Program of Cancer Registries (NPCR). EAPCs calculated by the National Cancer Institute using SEER*Stat. Rates are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84,85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Population counts for denominators are based on Census populations as modified by NCI. The 1969-2015 US Population Data File is used with NPCR November 2017 data.

Please note that the data comes from different sources. Due to different years of data availablility, most of the trends are AAPCs based on APCs but some are EAPCs calculated in SEER*Stat. Please refer to the source for each graph for additional information.

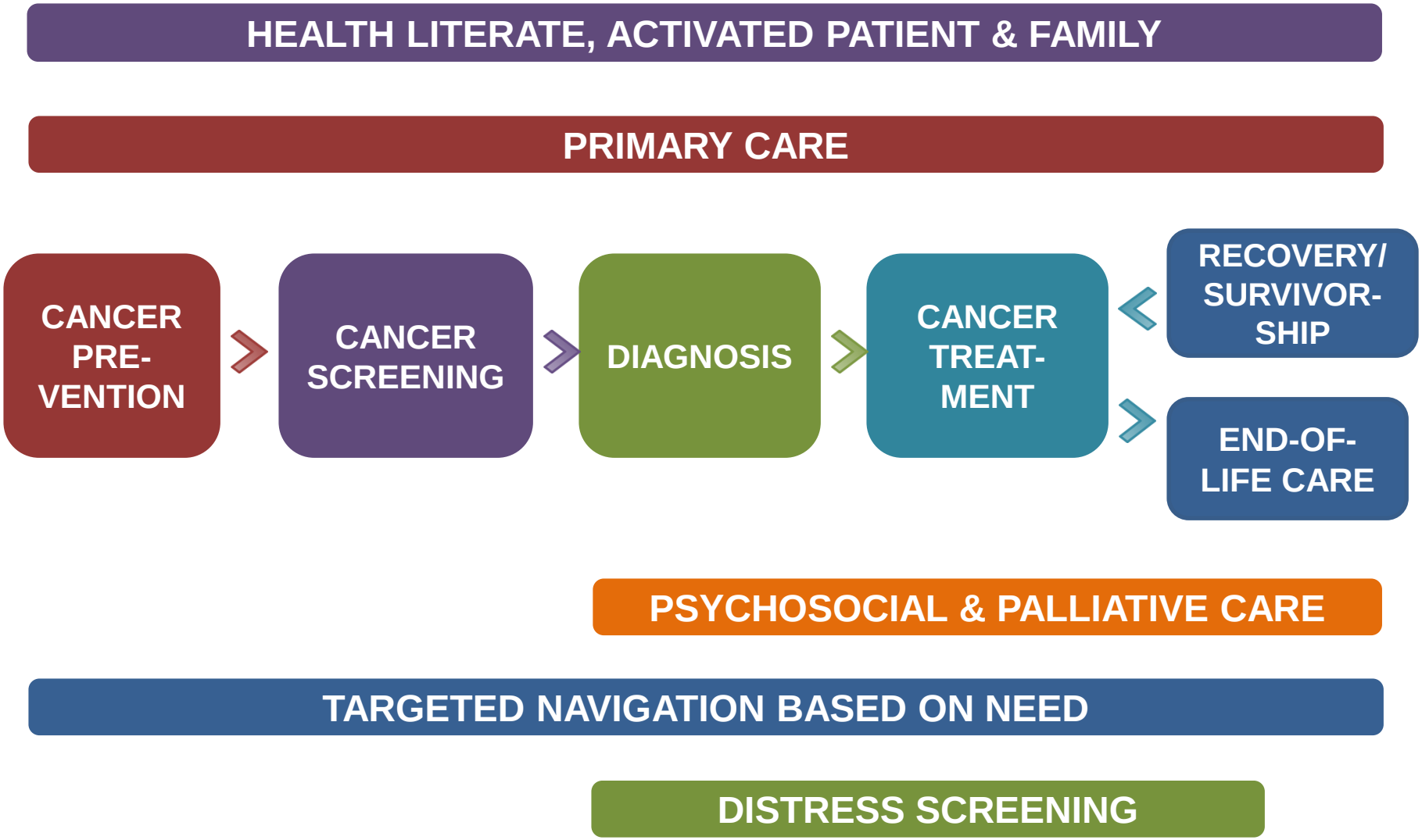
- The annual percent change is significantly different from zero (p<0.05).

Evolution of CoC Standards



Commission on Cancer®

CoC Standards = Patient-Centered Care



Standard 1.3 and 1.4- Cancer Committee Attendance

Each required cancer committee member or the member's designated alternate attends at least 75 percent of the cancer committee meetings held each calendar year.

Only the required cancer committee member names entered in Standard 1.2 will automatically copy over to Standard 1.3. The names will appear in the table AFTER you have selected a meeting date. When an initial appointed member is replaced during the year, add the replacement member's name in the same field as the initial member's name.

1 or 5

Standard 1.5- Cancer Program Goals

Each calendar year, the cancer committee establishes, implements, and monitors at least one clinical and one programmatic goal for endeavors related to cancer care. Each goal is evaluated at least twice annually. The evaluation is documented in cancer committee minutes.

- *1 or 5*
- *If the is a box in SAR, fill it out*

Definitions

Goal: A cancer program goal is an end-result that the cancer committee envisions, plans, and commits to achieve in a set time frame (does not need to be based on a study).

Quality Study: a formal analysis of an (already) identified **problem** by the cancer committee.

Quality Improvement: An effort that is implemented by the cancer committee based. Unlike the goal, at least one QI must be based on the results of a quality study or another study source.

Clarifications and Common Rating Oversights

STANDARD 1.5: Cancer program Goals

-How many goals are required?

One programmatic and one clinical goal are required. The program may set additional goals if desired.

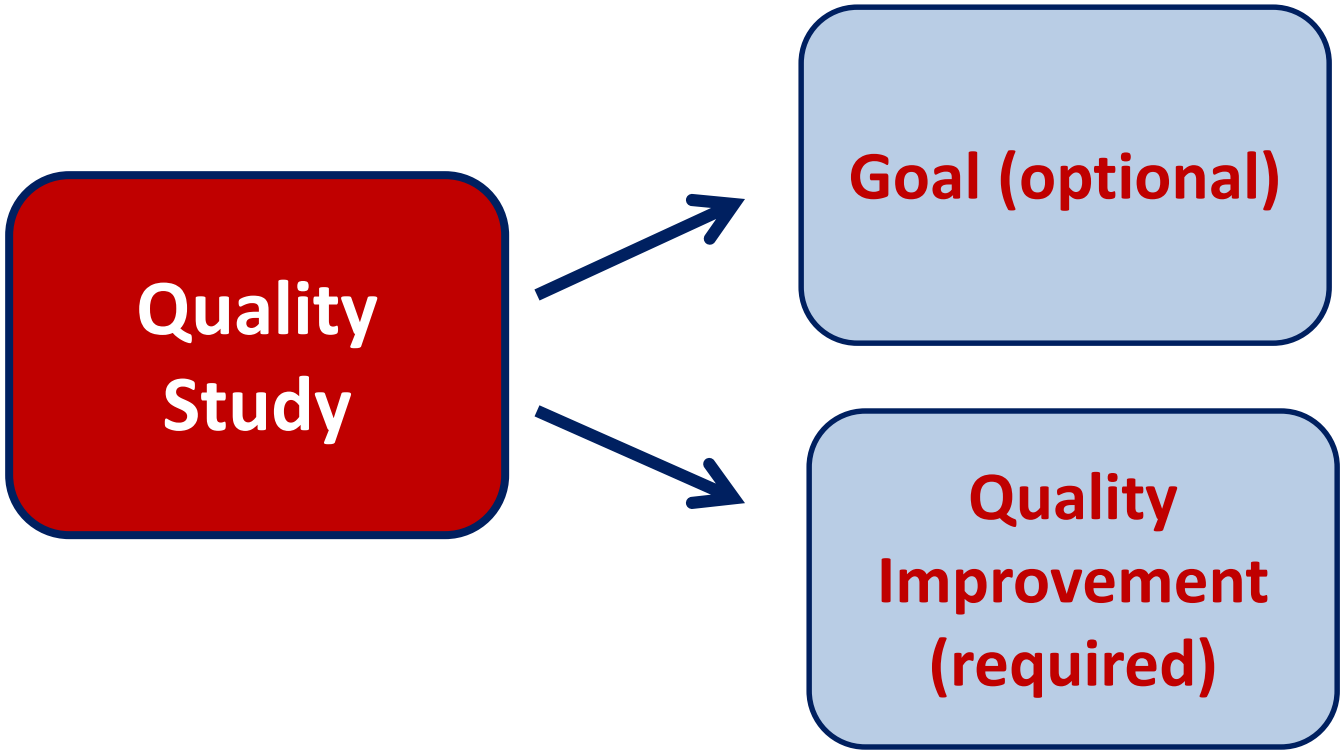
-What is the requirement for setting and reviewing goals?

Goals need to be set early in the year (1st or 2nd meeting) and reviewed by the cancer committee during two subsequent meetings within same calendar year.

-Can receiving accreditation by an outside organization (i.e. NAPBC, NAPRC, OMH, QOPI) be used as a goal?

Yes, but only once. Must be a cancer related accreditation

A goal can come as the result of data obtained from the completion of a quality study from Standard 4.7.



Standard 1.9- Clinical Research Accrual

As appropriate to the cancer program category, the required percentages of patients are accrued to cancer-related clinical research studies each calendar year. The clinical trial coordinator documents and reports clinical research study enrollment information to the cancer committee annually.

- *1, 5, or 1+*
- *Can use different types of studies*

TAPUR (Targeted Agent and Profiling Utilization Registry) Study

- First clinical trial conducted by the American Society of Clinical Oncology (ASCO)
  - Collaboration with Jackson Labs

- Adults with advanced cancer for whom standard treatment hasn't worked, standard treatment has stopped working, or there is no standard treatment for that type and stage of cancer

- All approved for specific types of cancer
  - Drugs might work in treating other types of cancer too
  - Each patient who enrolls in the TAPUR Study will be matched up with a targeted therapy based on his or her tumor's specific genomic variation
  - https://www.cancer.net/research-and-advocacy/clinical-trials/what-tapur-study

Standard 1.10 Clinical Educational Activity

Each calendar year, the cancer committee organizes and offers at least one cancer-related educational activity, other than cancer conferences, to physicians, nurses, and other allied health professionals. The activity is focused on the use of American Joint Committee on Cancer (AJCC) or other appropriate staging in clinical practice, which includes the use of appropriate prognostic indicators and evidence-based national guidelines used in treatment planning.

- *1 or 5*

MD Anderson Video Series

- Dr. Abigail Caudle, MD, FACS from M.D. Anderson
- An educational video designed to be disseminated tumor board setting
  - The current video was on breast cancer management
  - Second video regarding pancreatic cancer

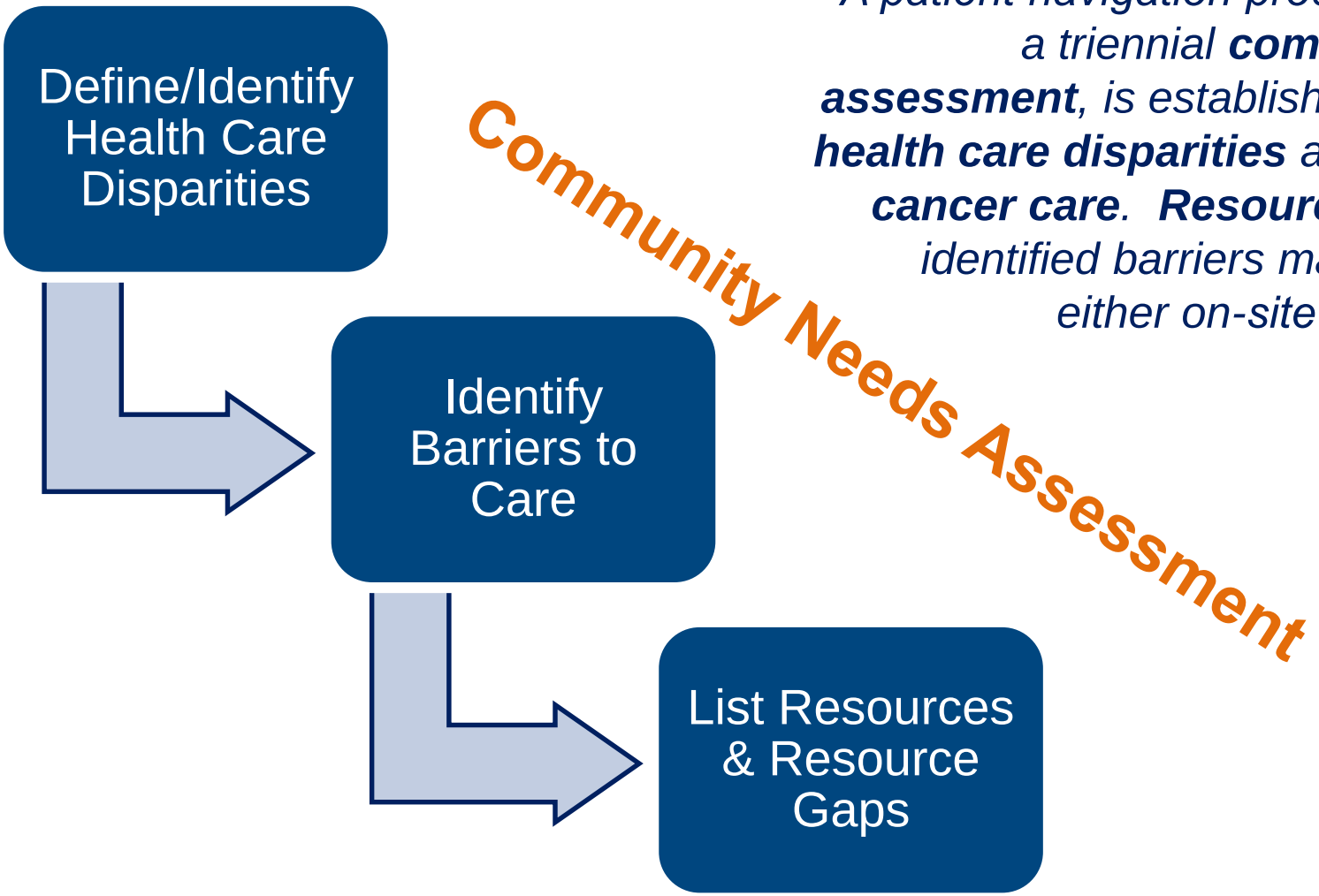
- Paige Teller, Director of Breast Surgical Oncology at MMC

Standard 3.1- Patient Navigation Process

A patient navigation process, driven by a triennial Community Needs Assessment, is established to address health care disparities and barriers to cancer care. Resources to address identified barriers may be provided either on-site or by referral to community-based or national organizations. The navigation process is documented and reported to the cancer committee each calendar year. The patient navigation process is modified or enhanced each year to address additional barriers identified by the Community Needs assessment.

- *1 or 5*

Standard 3.1: Patient Navigation Process



*"A patient navigation process, driven by a triennial **community needs assessment**, is established to **address health care disparities** and **barriers to cancer care**. **Resources** to address identified barriers may be provided either on-site or by referral."*

Patient-Centered Barriers

- Cost
- Insurance coverage
- Transportation
- Language
- Literacy
- Disability
- Social support
- Comorbidities
- Childcare
- Travel time
- Housing
- Family
- Time off work
- Too busy
- Fear
- Perceptions & beliefs

Provider-Centered Barriers

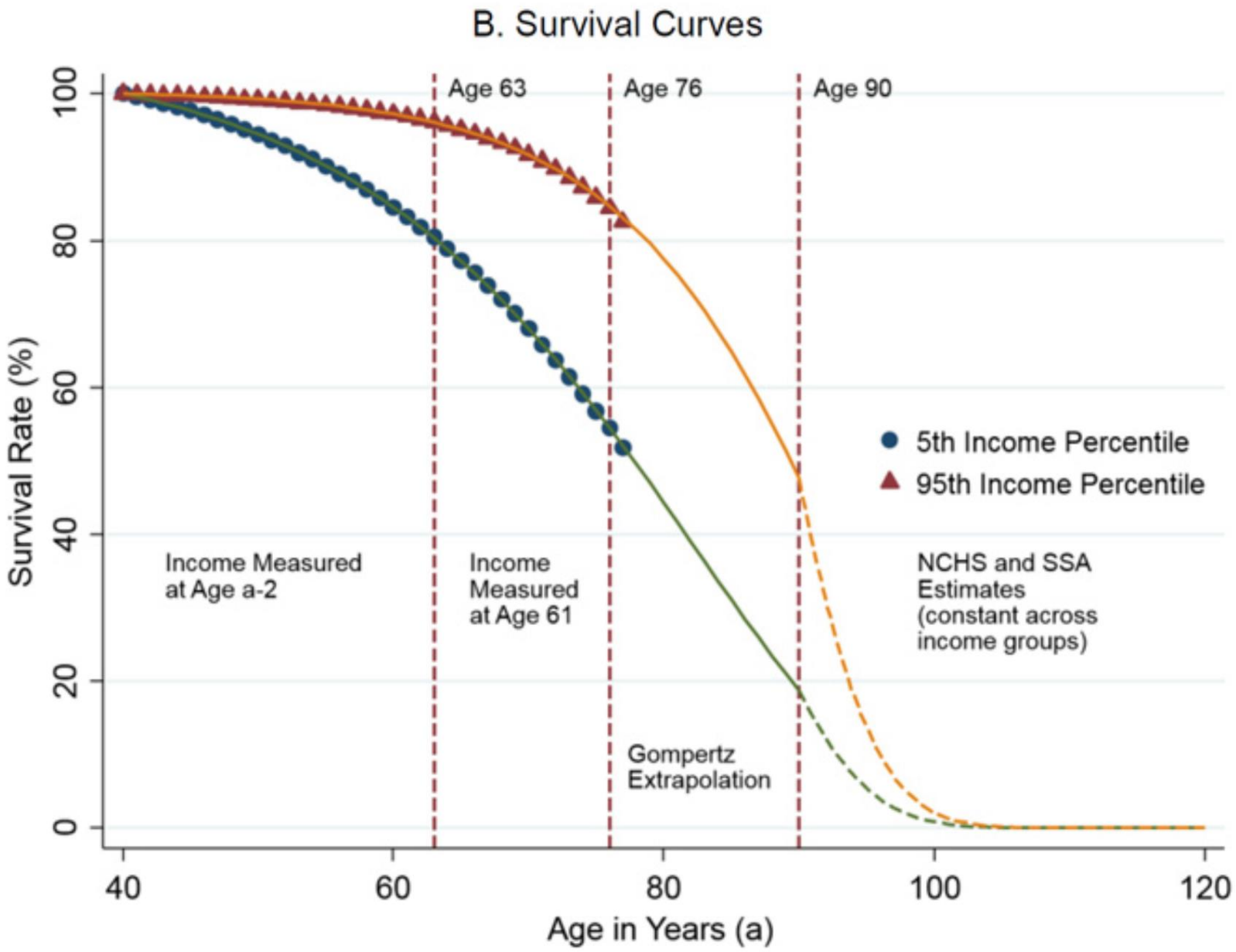
- Perceptions
- Time constraints
- Provider communication
- Lack of familiarity or trust
- Adequate supply of clinicians
- Clinician gender or ethnicity
- Clinician attitudes

Health System Barriers

- Fragmented medical system
- Missed appointments
- Lost results
- Scheduling
- Hours of operation
- Clinic neighborhood

Identify Resources and Resource Gaps

- Cancer Information
- Legal
- Financial Navigation
- Survivorship
- Rehabilitation
- Supportive Care
- Transportation
- Translation Services
- Housing


B. Survival Curves
Age 63
Age 76
Age 90
Survival Rate (%)
0
20
40
60
80
100
40
60
80
100
120
Age in Years (a)
5th Income Percentile
95th Income Percentile
Income Measured at Age a-2
Income Measured at Age 61
NCHS and SSA Estimates (constant across income groups)
Gompertz Extrapolation

Standard 3.2 - Psychosocial Distress

Each calendar year, the cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.

- *1 or 5*

Standard 3.2: Psychosocial Distress Screening

"Each calendar year, the cancer committee develops and implements a process to integrate and monitor ***on-site psychosocial distress screening*** *and referral for the provision of psychosocial care."*

Screen for prospectively identifying and triaging cancer patients at risk for illness-related psychosocial complications.

Financial Toxicity of Cancer

"Insured patients seeking copayment assistance experience considerable subjective financial burden.

They may alter care to defray out-of-pocket expenses.

Health Insurance does not eliminate financial distress or health disparities among cancer patients."

The Financial Toxicity of Cancer Treatment: A Pilot Study Assessing Out-of-Pocket Expenses and the Insured Cancer Patient's Experience

S. Yousuf Zafar[a], Jeffrey M. Peppercorn[a], Deborah Schrag[b], Donald H. Taylor[c], Amy M. Goetzinger[d], Xiaoyin Zhong[a] and Amy P. Abernethy[a]

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Disclosures of potential conflicts of interest may be found at the end of this article.

Abstract

Purpose. Cancer patients carry rising burdens of health care-related out-of-pocket expenses, and a growing number of patients are considered "underinsured." Our objective was to describe experiences of insured cancer patients requesting copayment assistance and to describe the impact of health care expenses on well-being and treatment.

Methods. We conducted baseline and follow-up surveys regarding the impact of health care costs on well-being and treatment among cancer patients who contacted a national copayment assistance foundation along with a comparison sample of patients treated at an academic medical center.

Results. Among 254 participants, 75% applied for drug copayment assistance. Forty-two percent of participants reported a significant or catastrophic subjective financial burden; 68% cut back on leisure activities, 46% reduced spending on food and clothing, and 46% used savings to defray out-of-pocket expenses. To save money, 20% took less than the prescribed amount of medication, 19% partially filled prescriptions, and 24% avoided filling prescriptions altogether. Copayment assistance applicants were more likely than nonapplicants to employ at least one of these strategies to defray costs (98% vs. 78%). In an adjusted analysis, younger age, larger household size, applying for copayment assistance, and communicating with physicians about costs were associated with greater subjective financial burden.

Conclusion. Insured patients undergoing cancer treatment and seeking copayment assistance experience considerable subjective financial burden, and they may alter their care to defray out-of-pocket expenses. Health insurance does not eliminate financial distress or health disparities among cancer patients. Future research should investigate coverage thresholds that minimize adverse financial outcomes and identify cancer patients at greatest risk for financial toxicity.

Medical Costs are the leading cause of personal bankruptcy in the United States

> “Bankruptcies are three times more common in individuals with cancer than in those without, after matching for confounding variables.”

August 28, 2012, 11:30 AM

New Help for Distressed Cancer Patients

Article | Comments (1)

By Laura Landro

A A

Causes for Concern

A diagnosis of cancer often triggers a whole slew of negative emotions, from sadness to panic. Below, some top patient concerns:

Source: Cancer Support Community: sample of 251 patients
The Wall Street Journal

New distress-screening programs for cancer patients aim to help with emotional and psychological issues that can interfere with treatment and adversely affect outcomes, as WSJ's Informed Patient column reports today.

One new program gaining interest from cancer-care providers is CancerSupportSource, a screening and referral program designed by the nonprofit Cancer Support Community.

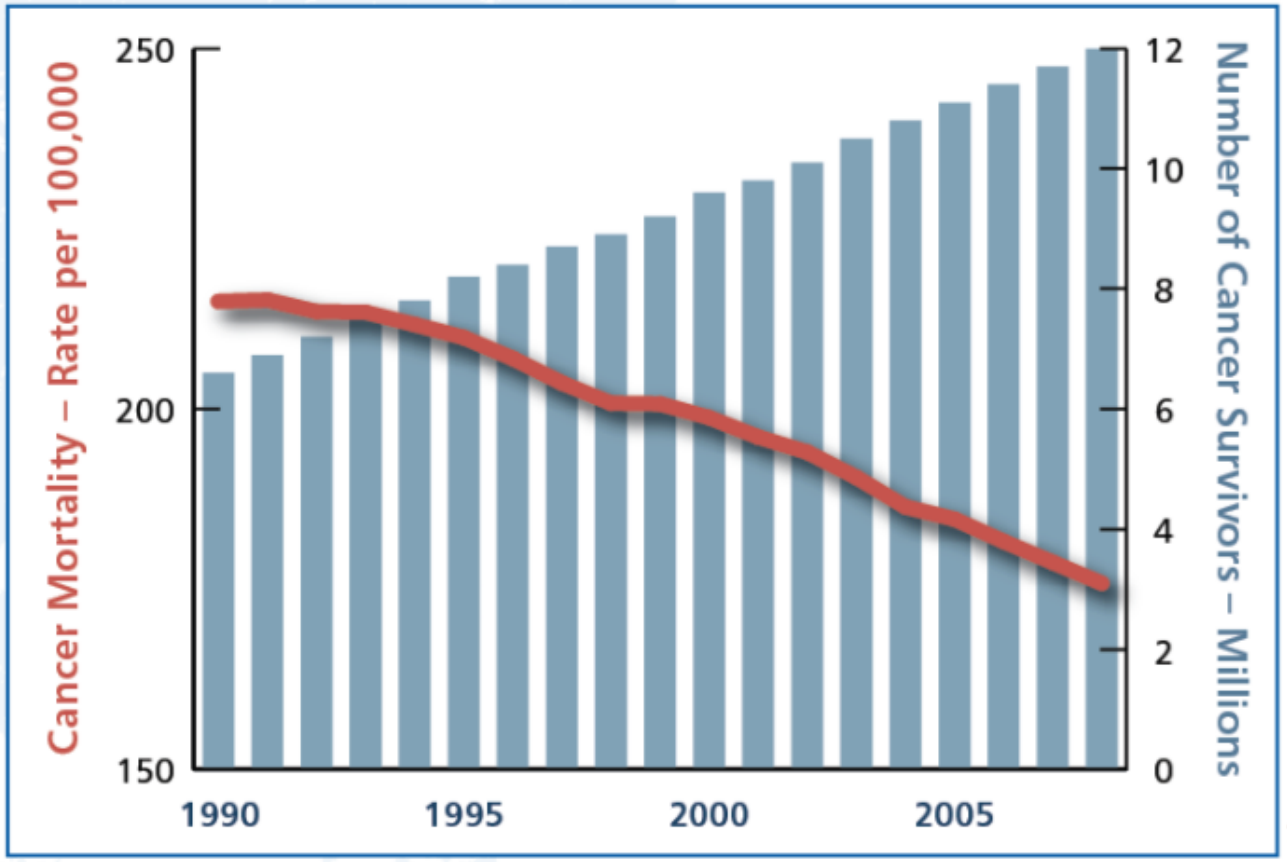
Kim Thiboldeaux, chief executive of the Cancer Support Community — formed in 2009 by the merger of Gilda's Club and the Wellness Community — tells the Health Blog that with the program, distress screening and referral can be easily done at oncology practices and hospitals where

Standard 3.3- Survivorship Care Plan

The cancer committee develops and implements a process to disseminate a treatment summary and follow-up plan to patients who are completing cancer treatment. Each calendar year, the process is monitored, evaluated, and presented to the cancer committee and documented in minutes.

- *1 or 5*
- *Standard is likely to change from required number of pts to program available (similar to navigation)*

Cancer in the United States, 1990-2008: *Survival Rising, Mortality Decreasing*



71

Source: Data from the National Cancer Institute on estimated number of cancer survivors and age-adjusted cancer deaths per 100,000 people

USA 2019 estimates

CANCER INCIDENCE	1,762,450
CANCER DEATHS	606,880
CANCER SURVIVORS	≈ 19 Million

1662 Cancer Deaths per Day or 1+ per minute

1/3 OF DEATHS ARE RELATED TO

OBESITY, INACTIVITY & POOR NUTRITION

Cancer Survivorship E-Learning Series

bit.ly/PCPE-Learning

Survivorship Continuing Education

GW Cancer Institute
THE GEORGE WASHINGTON UNIVERSITY

Cancer Survivorship E-Learning Series for Primary Care Providers

The Cancer Survivorship E-Learning Series is a **continuing education program offered at no cost** that provides a forum to educate primary care providers (e.g., general medicine physicians, geriatricians, gynecologists, physician assistants, nurse practitioners, nurses) who may have patients who are cancer survivors about how to better understand and care for survivors in the primary care setting.

Clinicians can learn about caring for survivors of adult-onset cancers through a series of ten enduring online educational modules.

For more information visit: CancerSurvivorshipCenterEducation.org

- **Module 1:** Current Status of Survivorship Care and the Role of Primary Care Providers
- **Module 2:** Late Effects of Cancer and its Treatments: *Managing Comorbidities and Coordinating with Specialty Providers*
- **Module 3:** Late Effects of Cancer and its Treatments: *Meeting the Psychosocial Health Care Needs of Survivors*
- **Module 4:** The Importance of Prevention in Cancer Survivorship: *Empowering Survivors to Live Well*
- **Module 5:** A Team Approach: *Survivorship Care Coordination*
- **Module 6:** Cancer Recovery and Rehabilitation
- **Module 7:** Spotlight on Prostate Cancer Survivorship: *Clinical Follow-Up Care Guideline for Primary Care Providers*
- **Module 8:** Spotlight on Colorectal Cancer Survivorship: *Clinical Follow-Up Care Guideline for Primary Care Providers*
- **Module 9:** Spotlight on Breast Cancer Survivorship: *Clinical Follow-Up Care Guideline for Primary Care Providers*
- **Module 10:** Spotlight on Head and Neck Cancer Survivorship: *Clinical Follow-Up Care Guideline for Primary Care Providers*

CONTINUING EDUCATION
Visit our website for more information about continuing education credits for physicians, nurse practitioners, physician assistants, nurses and Certified Health Education Specialists.

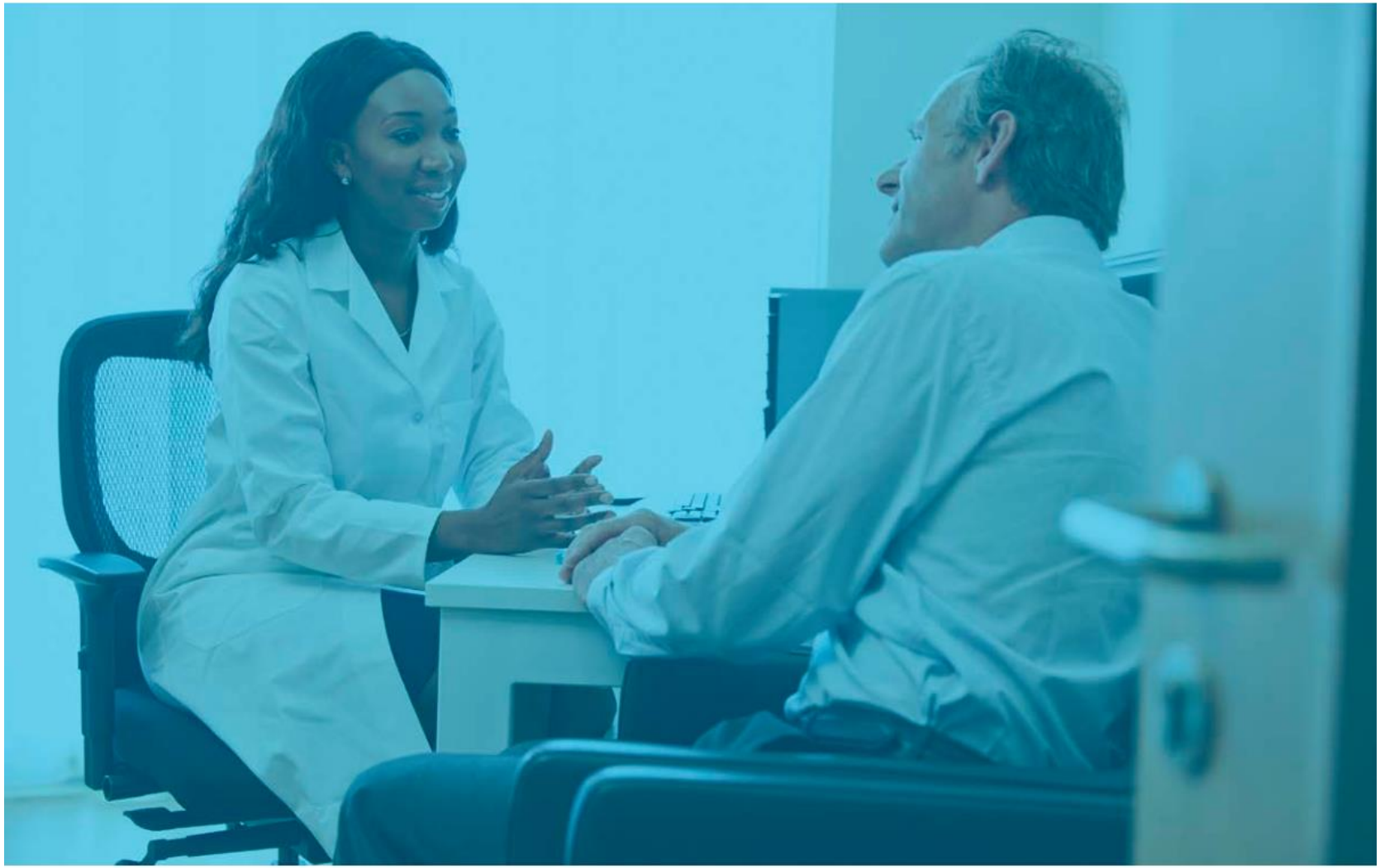
PROGRAM SUPPORT
The Cancer Survivorship E-Learning Series for Primary Care Providers is supported by Cooperative Agreement #5U55DP003054 from The Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

American Cancer Society® CDC Centers for Disease Control and Prevention

National Cancer Survivorship Resource Center Toolkit

Provider Tools

Implementing Clinical Practice Guidelines for Cancer Survivorship Care



100+years

GW Cancer Center

GW Cancer Institute

THE GEORGE WASHINGTON UNIVERSITY

CDC

Centers for Disease Control and Prevention

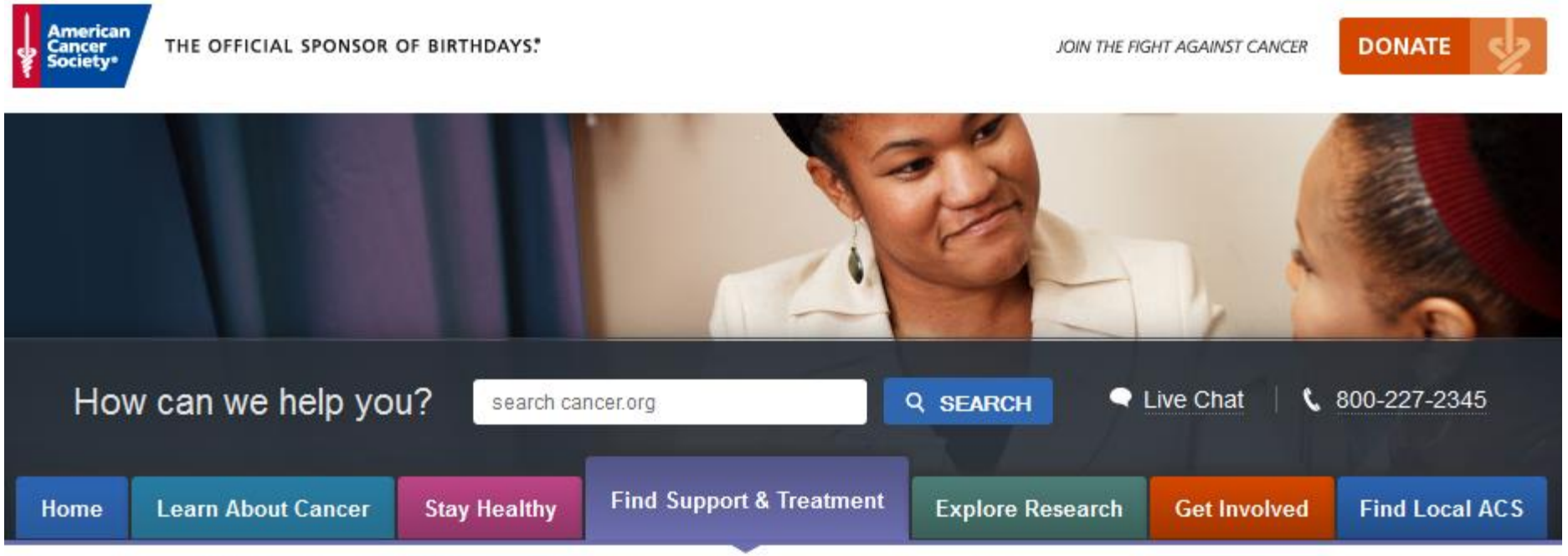
American Cancer Society®

American Cancer Society Head and Neck Cancer Survivorship Care Guideline

American Cancer Society/American Society of Clinical Oncology Breast Cancer Survivorship Care Guideline

American Cancer Society Colorectal Cancer Survivorship Care Guidelines

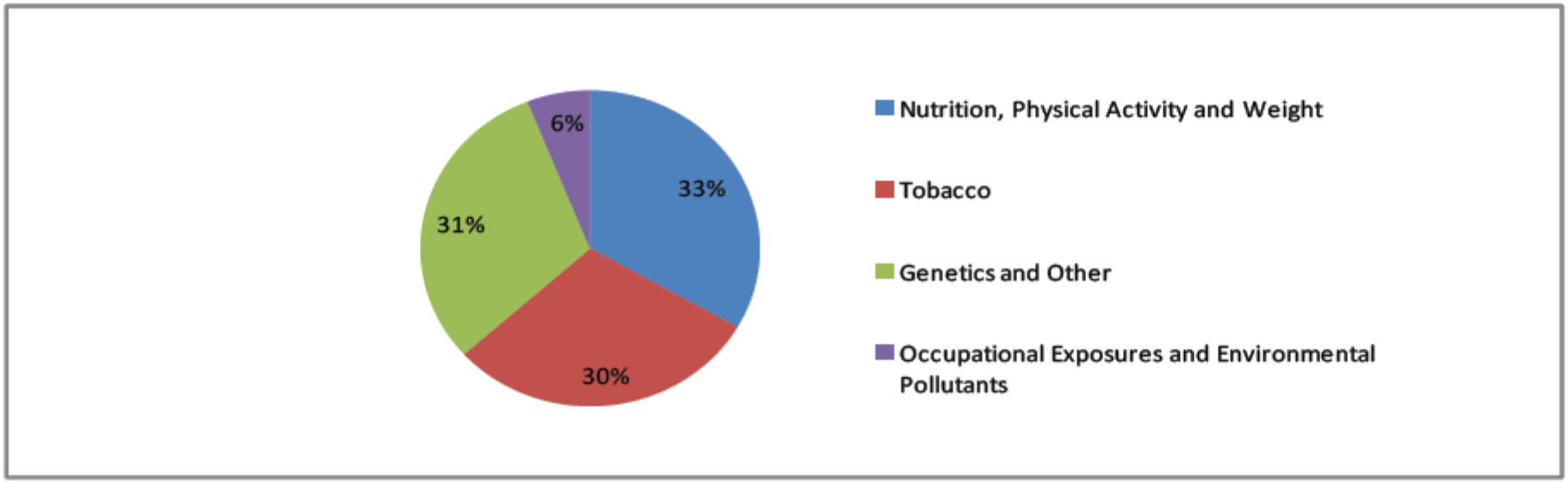
American Cancer Society prostate cancer survivorship care guidelines



Standard 4.1 Cancer Prevention Programs

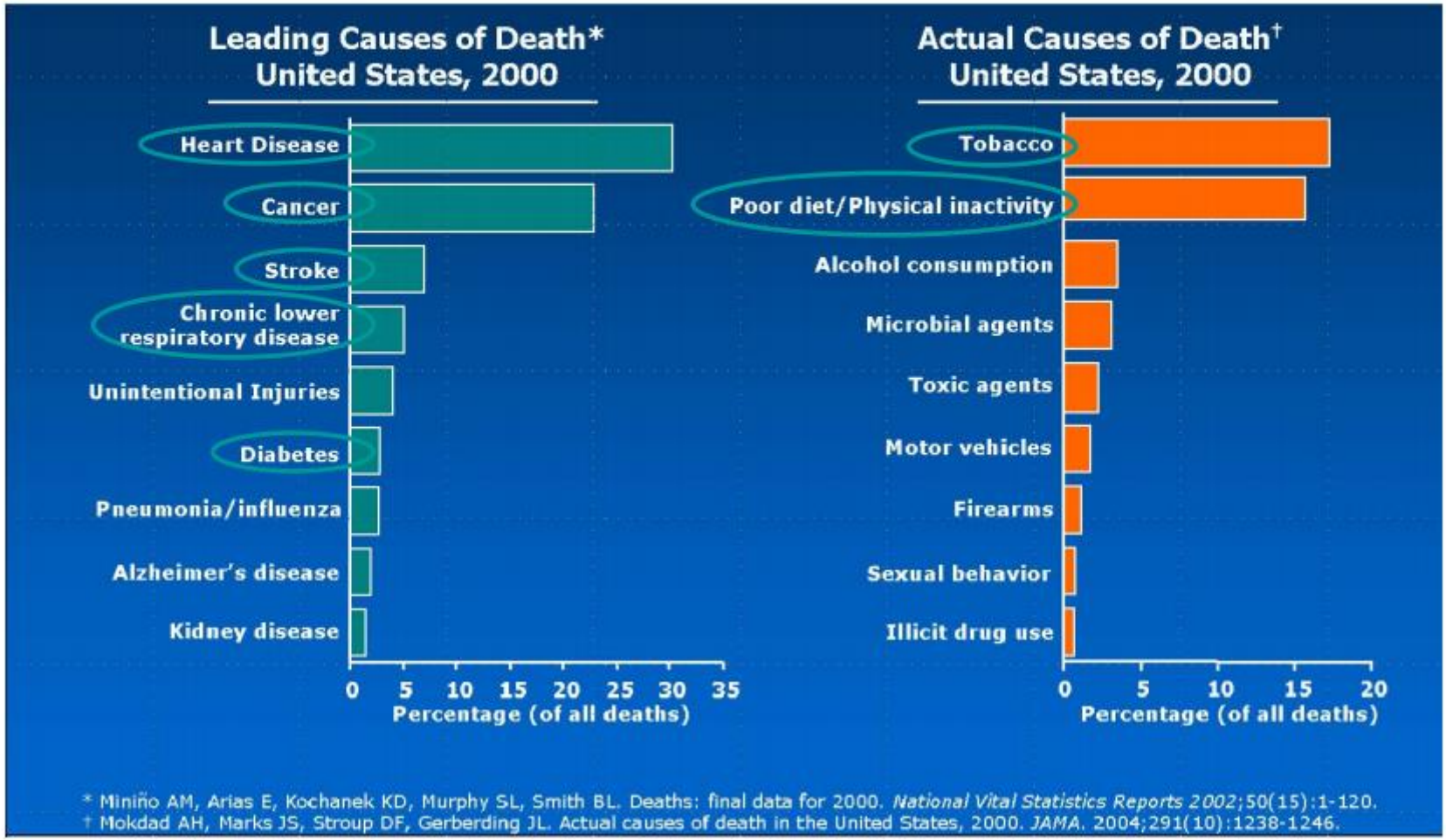
Each calendar year, the cancer committee organizes and offers at least one cancer prevention program designed to **reduce the incidence** of a specific cancer type and **targeted to meet the prevention needs** of the community. Each prevention program is consistent with evidence-based **national guidelines** for cancer prevention.

Figure 4. Proportion of Cancers Attributable to Specific Risk Factors



Data source: American Cancer Society. Cancer Facts & Figures 2010.

Leading vs. Actual Causes of Death in U.S.



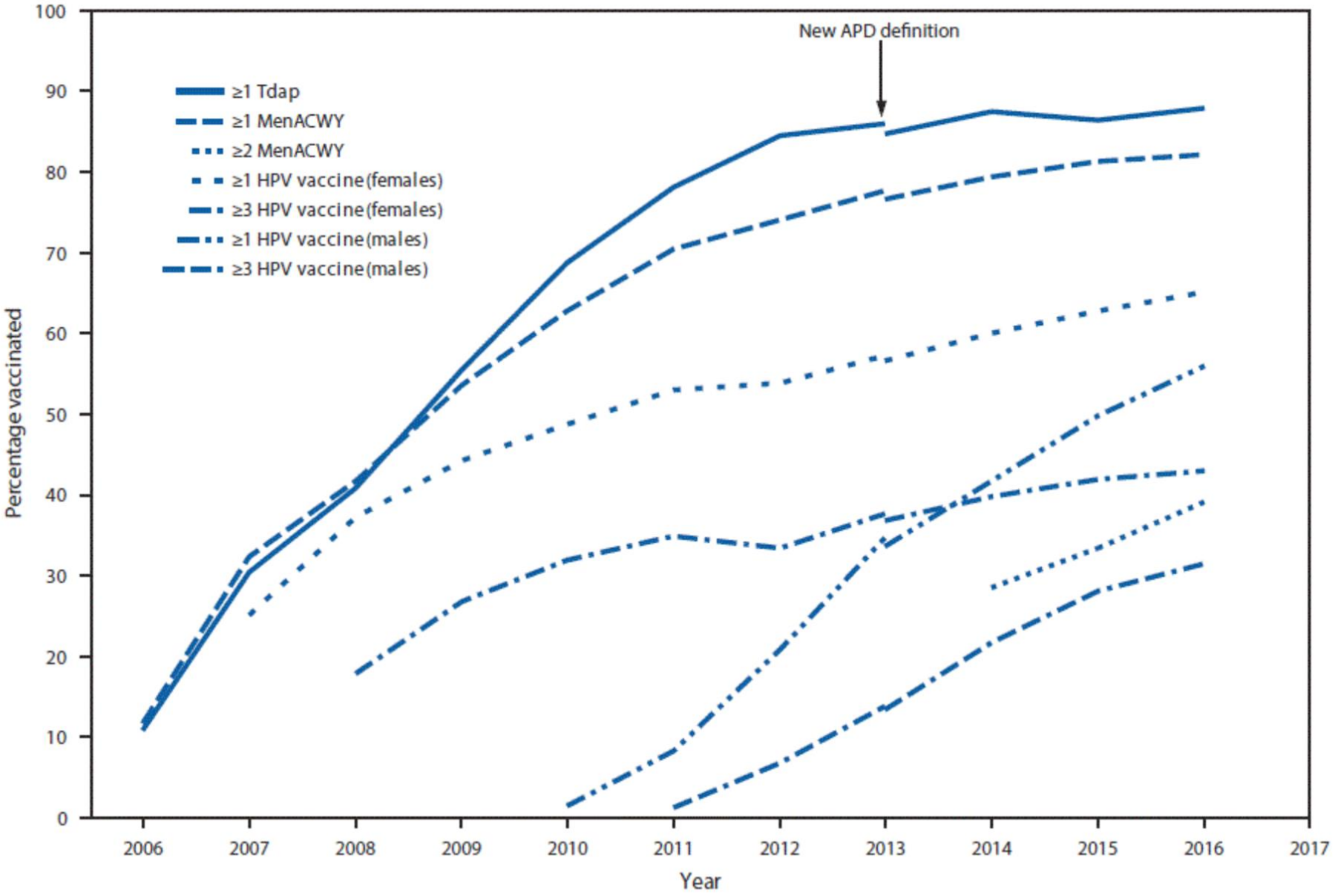
50% OF CANCERS CAN BE PREVENTED

800+ Avoidable Deaths per Day

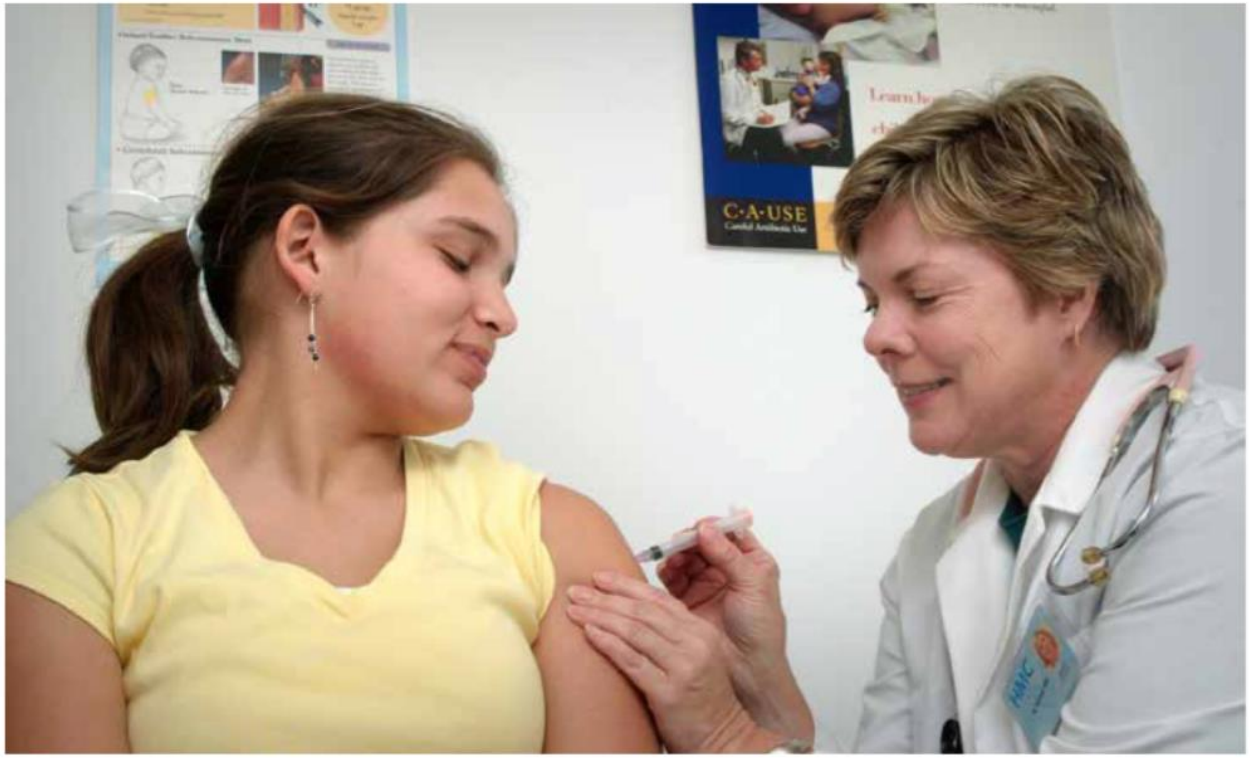
TOBACCO	LUNG, ORAL, ESOPHAGUS, UROTHELIAL
ALCOHOL EXCESS	BREAST, ESOPHAGUS, LIVER
SUN EXPOSURE	MELANOMA, NON-MELANOMA SKIN
PHYSICAL INACTIVITY	→ COVARIANT OBESITY
POOR NUTRITION	ESOPHAGUS, STOMACH, ORAL
INFECTIOUS AGENTS	LIVER, STOMACH, ORAL, CERVIX, ANAL, LYMPHOMA
OBESITY	UTERINE, COLON, KIDNEY, ESOPHAGUS POSTMENOPAUSAL BREAST
SCREENING	COLORECTAL

Return to Top

FIGURE 1. Estimated vaccination coverage with selected vaccines and doses* among adolescents aged 13–17 years, by survey year — National Immunization Survey–Teen (NIS-Teen), United States, 2006–2016 †



Abbreviations: ACIP = Advisory Committee on Immunization Practices; APD = adequate provider data; HPV = human papillomavirus; MenACWY = quadrivalent meningococcal conjugate vaccine; Tdap = tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine.



HUMAN PAPILLOMAVIRUS (HPV) VACCINE

American Cancer Society
New Initiative

MISSION: HPV CANCER FREE

80% HPV vaccination rates
of 13 year olds by 2026

CDC estimates that increasing HPV vaccination rates to 80% would prevent an additional 53,000 future cervical cancer cases. (President's Cancer Panel Annual Report 2012-2013)

Evidence-Based National Guidelines

Prevention

- Agency for Healthcare Research and Quality
- American Cancer Society
- Cancer Control PLANET
- Centers for Disease Control and Prevention
- National Cancer Institute
- The Community Guide
- US Preventive Services Task Force recommendations

Screening

- Agency for Healthcare Research and Quality
- American Cancer Society
- ASCO
- NCCN
- National Cancer Institute
- National Colorectal Cancer Roundtable
- US Preventive Services Task Force recommendations

Assessing Needs of the Community - Prevention

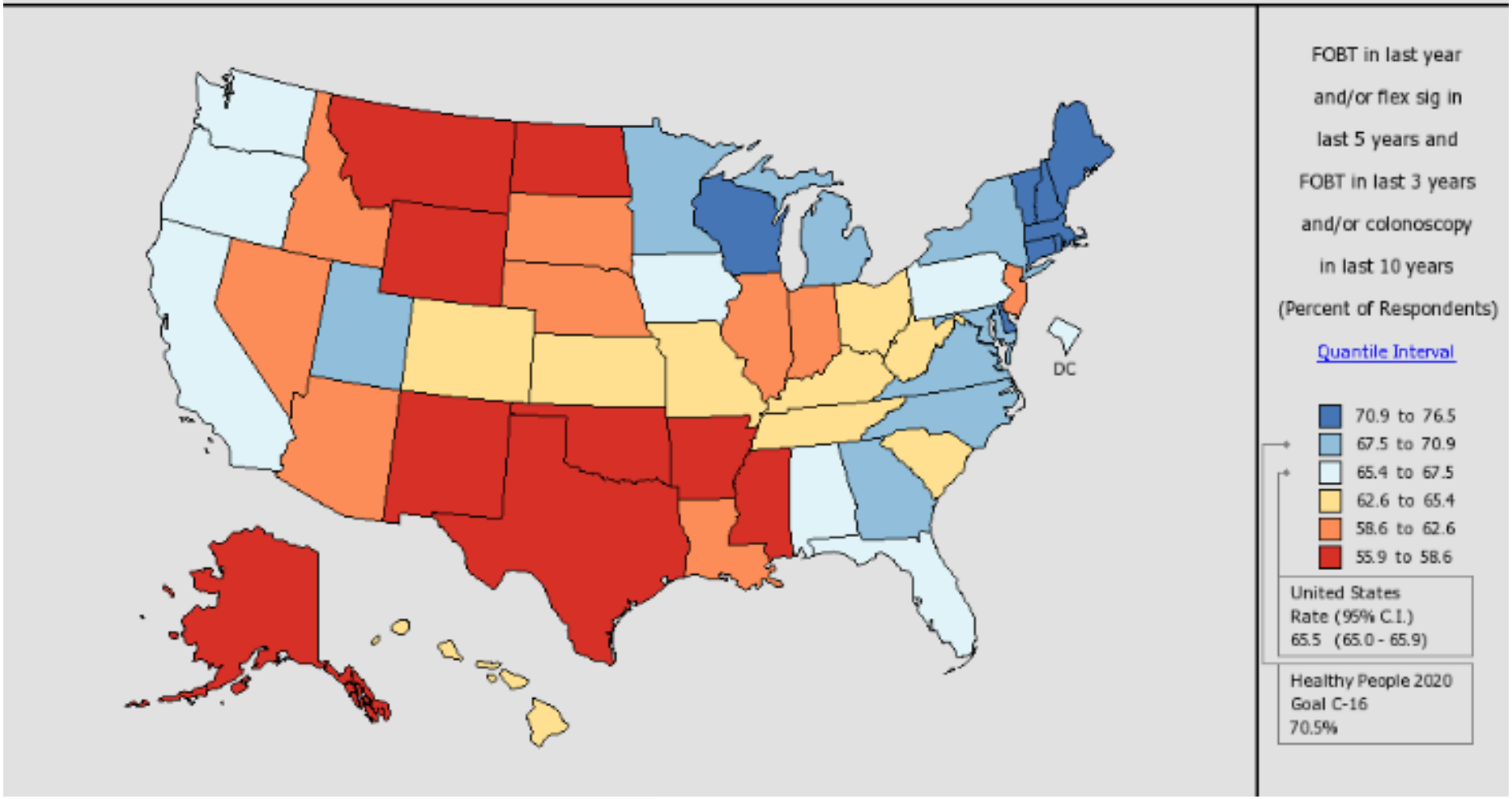
- Determine
  - Cancer incidence rates by sites within community
  - Factors that contribute
- Behavioral risk factors and prevalence in the community
  - Tobacco use
  - Obesity rate and nutritional factors
  - HCV
  - Alcohol
  - Physical inactivity
  - HPV vaccination rates
- Environmental factors such as sun exposure or radon
- Community demographic data to identify specific groups within the community at risk

Standard 4.2 Screening Programs

Each calendar year, the cancer committee organizes and offers at least one cancer screening program that is designed to **decrease** the number of patients with **late stage disease** and is **targeted to meet the screening needs of the community**. Each screening program is consistent with evidence based **national guidelines and interventions** and must have a formal process developed to follow up on all positive findings.

Screening and Risk Factors for United States

(Directly Estimated 2012 BRFSS Data)
FOBT in last year and/or flex sig in last 5 years and FOBT in last 3 years and/or colonoscopy in last 10 years
All Races (includes Hispanic), Both Sexes, Ages 50-75



What are the Components of Guideline?

- Cancer Committee identifies needs of the community via a study
- Cancer Committee organizes and offers prevention or screening intervention
  - An activity with evidence that it is effective
  - Expected result of the activity – goal
- Analysis of results
  - Goal achieved
  - Improve the results
  - Continuing need

Assessing Needs of the Community–Screening Program

- Identify sites with advanced stages of disease and the groups of individuals within those sites that are at risk
- NCDB
  - Benchmark reports
  - Comparative studies
  - Number of variables
- Resources to improve access to screening activities and any subsequent management required

Cancer Prevention and Screening Programs

Prevention

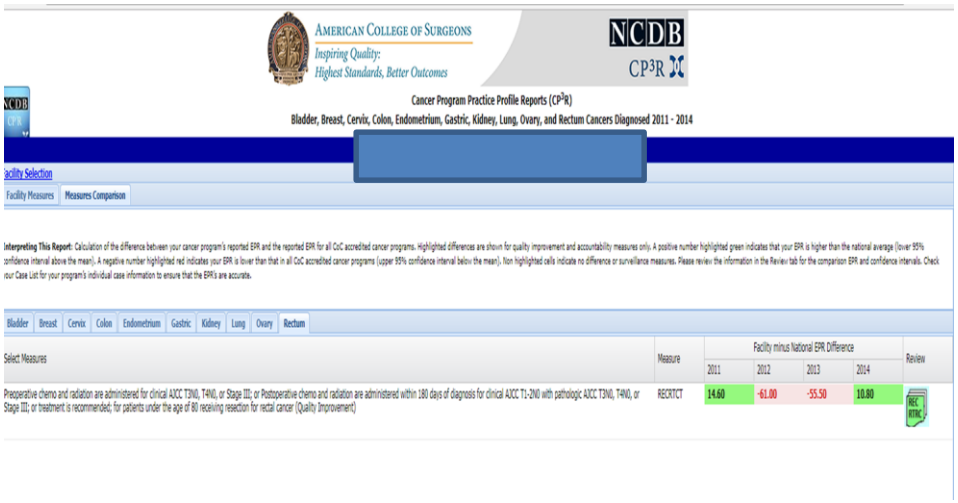
- Risk Reducing Activities
  - Smoking/tobacco cessation
  - Alcohol avoidance
  - Nutrition, physical activity, and weight loss programs
  - HPV vaccination
  - Others based on study findings
- Education/Cancer Risk Awareness Program
  - Need has been identified
  - A specific site
  - Group within community

Screening

- Breast screening
- Colon
  - Colonoscopy,
  - Flexible sigmoidoscopy
  - Fecal occult blood testing
- Cervical
  - Pap testing (with or without HPV testing
- Skin (physician guided)
- Lung (low dose CT)

Standard 4.4 - Accountability Measures

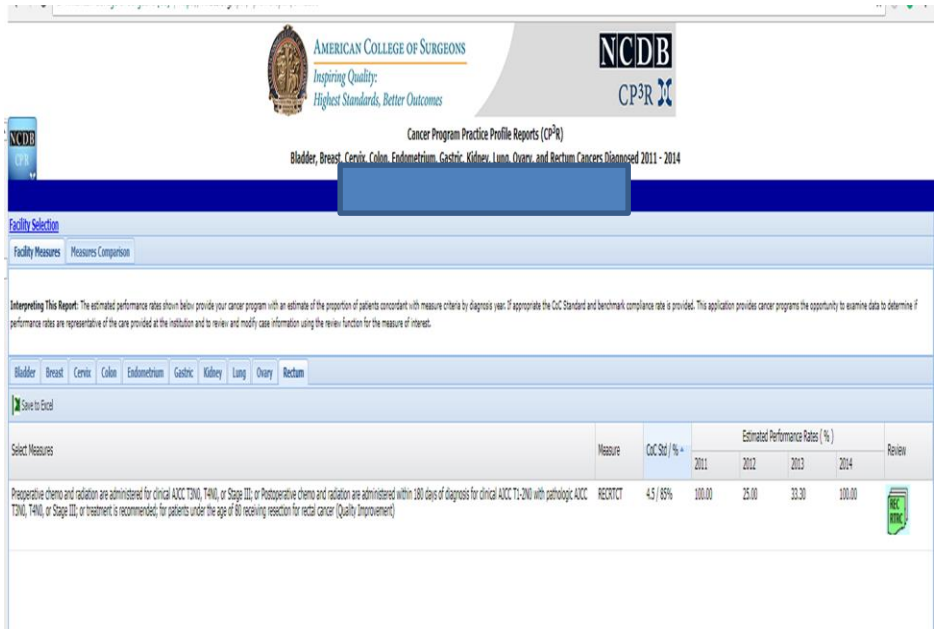
- **Each calendar year, the expected Estimated Performance Rates (EPR) is met for each accountability measure as defined by the Commission on Cancer.**
- *1 or 5*



Standard 4.5 - Quality Improvement

- **Each calendar year, the expected Estimated Performance Rates (EPR) is met for each quality improvement measure as defined by the Commission on Cancer.**

- *1 or 5*



Standard 4.6 - Monitoring Compliance with Evidence-Based Guidelines

- Each calendar year, the cancer committee designates a physician member to complete an in-depth analysis to assess and verify that cancer program patients are evaluated and treated according to evidence-based national treatment guidelines. Results are presented to the cancer committee and documented in cancer committee minutes.
- *1 or 5*

Clarifications and Common Rating Oversights

STANDARD 4.6: MONITORING COMPLIANCE WITH EVIDENCE BASED GUIDELINES

-Who should perform the study?

The standard specifies that the study should be conducted by a physician member of the cancer committee.

-What documentation is required?

Topic study, purpose of study, results, recommendations for improvement.

Standard 4.7- Studies of Quality

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, develops, analyzes, and documents the required number of studies (based on the program category) that measure the quality of care and outcomes for cancer patients.

- *1 or 5*

Defining a "Quality Study"

A detailed investigation and analysis of an **issue or problem.**

Studies provide a **mechanism to investigate a problem**, measure quality, and an opportunity to correct or enhance care and quality outcomes.

If applicable, can study **various aspects of cancer care**, including diagnosis, treatment, and supportive care; issues related to structure, process, and/or outcomes.

Quality Study Idea Sources

Does your cancer program have:

- Gaps in patient/family resources?
- Gaps in clinical or supportive care services?
- Gaps in healthcare technology?
- Issues from patient satisfaction survey results?
- Safety and cleanliness problems?
- Educational gaps/needs for staff or patients?
- Delays in appointments, treatment, tests, results, etc.?
- Concerns from data in the NCDB Hospital Comparison Benchmark Reports (*not CP3R or RQRS*)?

Clarifications and Common Rating Oversights

STANDARD 4.7: STUDIES OF QUALITY

-What should cancer programs be studying to meet this standard?

They must study an area of concern within their cancer program.

-Can programs use outside QI programs such as QOPI to meet the standard?

No, these are external QI programs and not based on an identified area of concern within the cancer program.

-What if no benchmarks are available for comparison of their results?

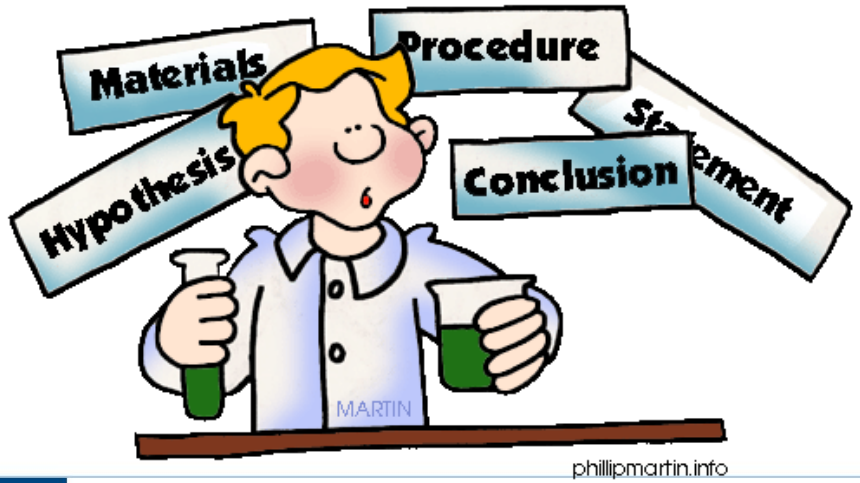
Benchmarks are not always available for every study. This does not invalidate the study but surveyors should encourage programs to identify benchmarks or refer to published articles whenever available.

Cont'd.

Clarifications and Common Rating Oversights

STANDARD 4.7: STUDIES OF QUALITY

RATIONALE FOR THE STANDARD: This standard is a very important quality improvement tool for cancer programs. It requires an assessment to determine an area needing improvement within the program and allows the program to study the issue, evaluate the data and make changes that will result in improvements.



Study Methodology

- Observing and recording well-defined events (e.g., counting the number of patients waiting in emergency at specified times of the day)
- Obtaining relevant data from management information systems or medical records
- Administering surveys (e.g., face-to face and telephone interviews, questionnaires, etc.)
- Observational methods
- Document reviews

MD Anderson Video Series

- Dr. Abigail Caudle, MD, FACS from M.D. Anderson
- An educational video designed to be disseminated tumor board setting
  - The current video was on breast cancer management
  - Second video regarding pancreatic cancer

- Paige Teller, Director of Breast Surgical Oncology at MMC

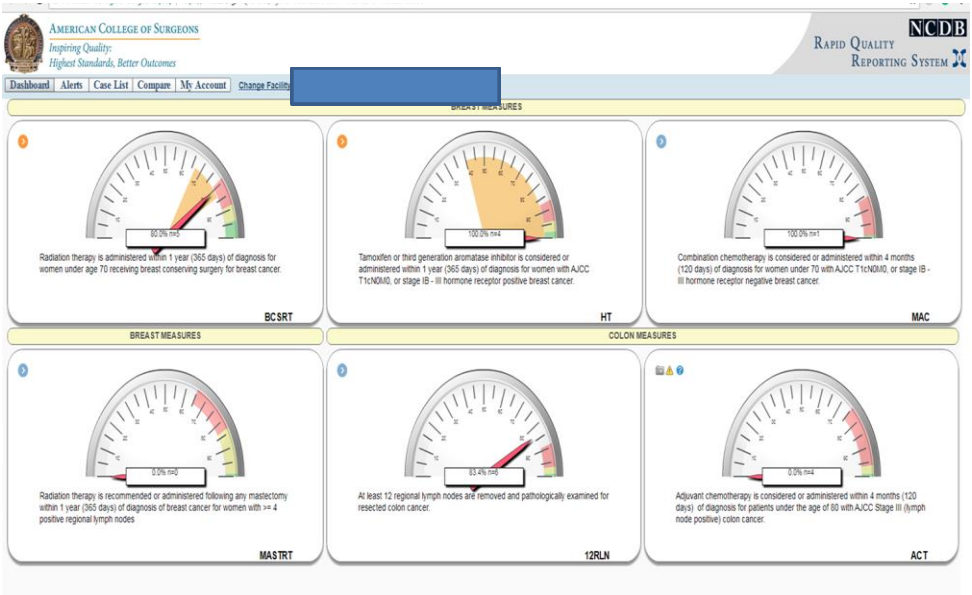
Standard 4.8- Quality Improvement

Each calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, implements two cancer care improvements. One improvement is based on the results of a quality study completed by the cancer program that measures the quality of cancer care and outcomes. One improvement can be based on a completed study from another source. Quality improvements are documented in the cancer committee minutes and shared with medical staff and administration.

- *1 or 5*
- *Make sure there is linkage*

2019

- **Standard 5.2 RQRS**
  - **Rapid Quality Reporting System (RQRS) Participation**: The cancer program actively participates in RQRS
  - **For Commendation**
    - Submits all new and updated cancer cases at least once each calendar month.
    - All cancer cases submitted to RQRS with edit errors are corrected and resubmitted.
    - QRS data and performance reports are reviewed by cancer committee at least quarterly and documented in the cancer committee minutes.



2019

- **Standard 5.4 NCDB Data reporting**
  - **Follow-up of Recent Patients:** A 90 percent follow-up rate is maintained for all eligible analytic cases diagnosed within the last 5 years or from the cancer registry reference date, whichever is shorter.
  - ***All programs will receive a rating of 8, Not Applicable.***
  - If your program has already been surveyed in the first quarter of 2019, a rating adjustment will be made to reflect a rating of 8, Not Applicable.

Draft: New Standards

- 9 chapters
  - Rehabilitation Care Services
  - Oncology Nutrition Services
  - Survivorship Program
  - Accountability and Quality Improvement Measures
  - Quality Improvement Project
  - Cancer Program Goal
  - Addressing Barriers to Care

6 new standards based on the publication: Operative standards in Cancer Surgery

Breast Sentinel Node Biopsy

All sentinel nodes for breast cancer must be identified, removed, and subjected to pathologic analysis to ensure that sentinel lymph node mapping and sentinel lymphadenectomy provide accurate information for breast cancer staging.

Breast Axillary Dissection

Axillary dissection for breast cancer constitutes removing level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and lastissimus dorsi, while preserving key neurovascular structures.

Primary Cutaneous Melanoma

Margin width for wide local excision of melanoma is 1 cm for melanomas <1 mm thick, 1 to 2 cm for melanomas 1 to 2 mm thick, and 2 cm for melanomas > 2 mm thick. The margin width for wide local excision of a melanoma in situ is at least 5 mm.

Colon Resection

Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s).

Total Mesorectal Excision

Total mesorectal excision (TME) is performed for all patients with middle (5-10 cm) and low (0-5 cm) rectal cancers. This maneuver includes a complete removal of the rectum including all mesorectal lymph nodes.

Pulmonary Resection

The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.

ONCOLOGY MEDICAL HOMES → MOVING FROM VOLUME TO VALUE BASED CARE

RESTRUCTURING REIMBURSEMENT AROUND THE FULL RANGE OF SERVICES

PILOT PROGRAM RESULTS:

30 D READMIT RATES ↓ 11.7%

ER VISITS ↓ 6.6%

INPATIENT HOSPITAL ADMISSIONS ↓ 12.5%

OVERALL COST OF CARE ↓ 7.2%

PATIENT SATISFACTION 91+ %

Early results from the pilot program show that the rate of 30-day hospital readmissions have dropped by 11.7%, emergency department visits are down by 6.6%, inpatient hospital admissions have declined by 12.5%, and the overall cost of care has been reduced by 7.2%.
All seven practices have also maintained a high patient satisfaction rate, averaging rates of 91.3% to 98.1%, throughout the entire COME HOME Program grant period.

Commission on Cancer®
NATIONAL ACCREDITATION PROGRAM FOR RECTAL CANCER

A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

THE NATIONAL ACCREDITATION PROGRAM FOR RECTAL CANCER STANDARDS MANUAL

2017 EDITION

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

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Inspiring Quality:
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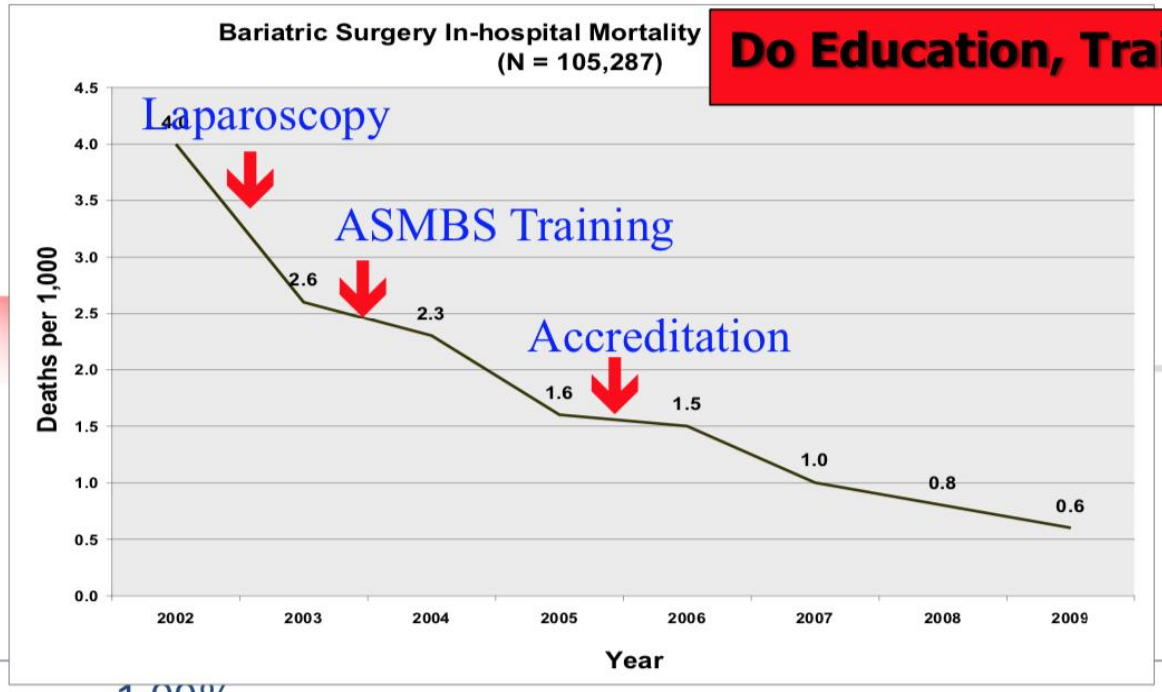
100+years

Do Education, Training, Verification Matter



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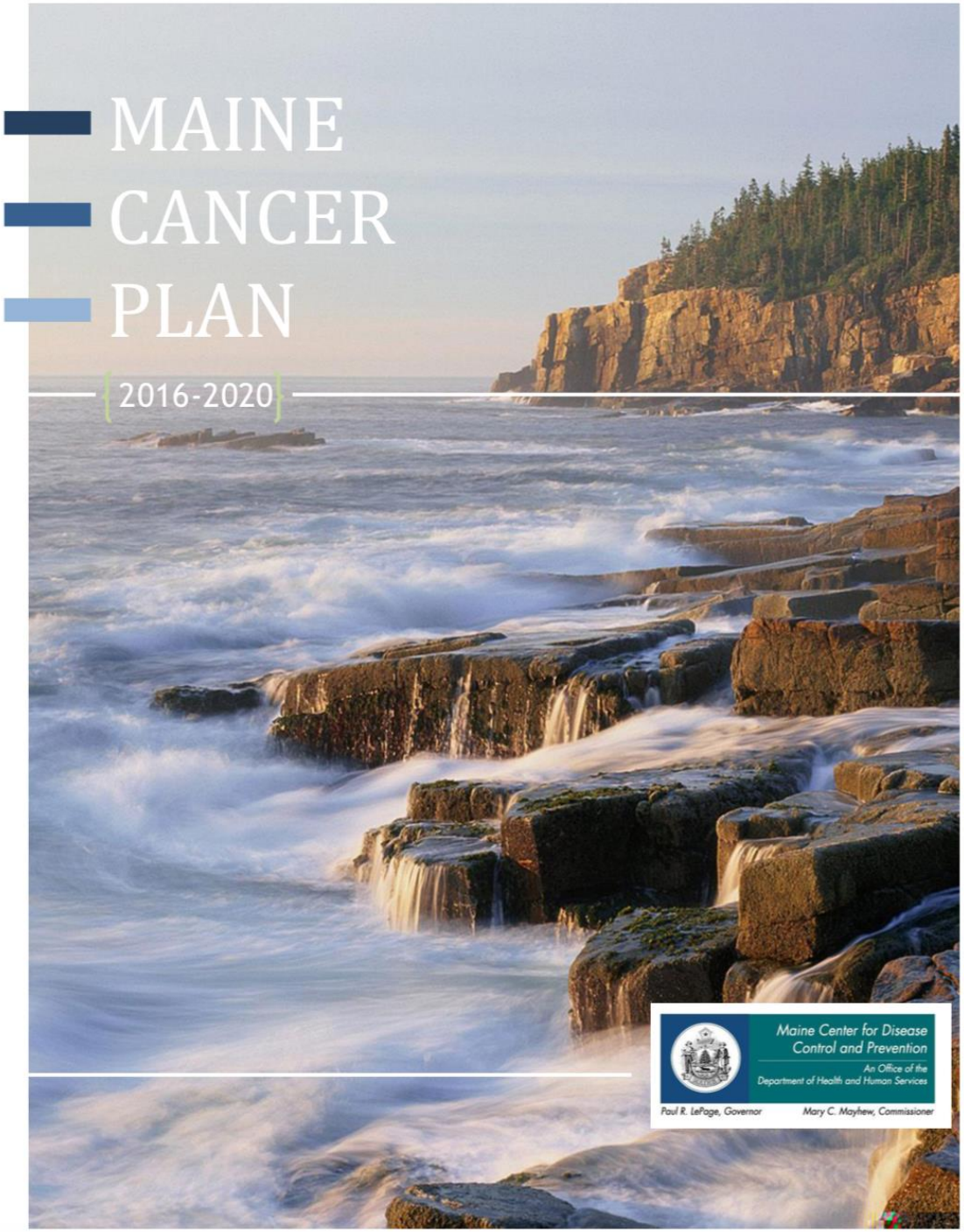
MBSAQIP
METABOLIC AND BARIATRIC SURGERY ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM


MAINE
CANCER
PLAN
2016-2020
Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

Summary

- Lots of standards
- New standards for surgery are coming
- Some changes 2019
- Revised standards are being worked on at CoC

Commission on Cancer Resources

Standard 1.2: Cancer Committee Job Descriptions (Detailed job descriptions for cancer committee members)

Divide and Conquer: Distributing Responsibility for Accreditation Requirements (This is a chart which shows who must or should be responsible for specific CoC Standards.)

Standard 1.3: Rules and Examples for Designated Alternates on the Cancer Committee

Standard 1.4: Tips for Cancer Committee Agenda and Minutes/Templates (examples to set up their cancer committee meeting minutes)

Commission on Cancer Resources

Standard 1.8: How a Community Outreach Coordinator Can Ensure Compliance (Help Community Outreach Coordinator and the cancer committee understand what is required for evaluating your Standards 4.1 and 4.2 programs in order to comply with Standard 1.8)

Community Outreach Activity Summary Template (Template developed by the CoC to assist programs in providing all required information in the end-of-the-year Community Outreach Activity Summary.)

Standard 4.7: Steps for Standard 4.7 Compliance (Detail the requirements of quality studies. Pages 1-3 provide explicit details and helpful tips regarding compliance for each step. The final page is an easy-to-follow flow chart to illustrate all required steps.)

Utilizing CoC Resources

Annual Conferences

National Cancer Database and CoC websites

CAnswer Forum

Standard Resource Library

"Contact CoC" form

CoC Source, CLiPs, and The Brief (e-newsletters)

Resource webpage:
https://www.facs.org/quality-programs/cancer/coc/info/resources