ARROWHEAD REGIONAL MEDICAL CENTER

AMBULATORY SERVICES – CANCER PROGRAM

POLICIES and PROCEDURES MANUAL

TABLE OF CONTENTS

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**
SUBJECT:	**CANCER ACCREDITATION**		

APPROVED BY: _____

Associate Administrator, Ambulatory

POLICY

Arrowhead Regional Medical Center (ARMC) strives to provide optimum treatment for the patient with cancer through a multidisciplinary approach to providing care. ARMC established the Oncology Committee to ascertain hospital cancer accreditation based on the American College of Surgeons (ACoS) Commission on Cancer (CoC) Standards for Cancer Care. ARMC utilizes a reference date of January 1, 2013, for all Cancer Registry data and information.

The Cancer Program adheres to the set CoC Standards in order to maintain accreditation. All standards are reviewed per requirements, and ACoS conducts an on-site review of the ARMC Cancer Program every three years to renew accreditation. All cancer program efforts shall be assured under the leadership of the ARMC Oncology Committee.

PROCEDURES

I. **Administrative Commitment:**
   A. ARMC facility leadership (CEO or equivalent) issues a letter of authority demonstrating commitment to the cancer committee.
   B. The letter of authority is submitted to ACoS as part of the Pre-Review Questionnaire.

II. **Oncology Committee Members and Meetings:**
   A. Required oncology committee members and designees are established at the beginning of each calendar year and documented in the Oncology Committee Meeting Minutes. All committee members commit to a full year of participation in the oncology committee. Oncology Committee members are comprised of both physician and non-physician members for a multidisciplinary approach to cancer care.
   B. Oncology committee meetings are held at least one time per quarter and all members, or his/her designee, are to attend at least 75% of the scheduled meetings, as outlined in ACoS CoC Standards.
   C. Oncology Committee Meeting Minutes that identify the required cancer committee members will be submitted with the Pre-Review Questionnaire.

III. **Evaluation and Treatment Services**
   A. ARMC's Cancer Program provides diagnostic imaging services, radiation oncology services, and systemic therapy services on-site or by referral. Quality assurance practices are in place for the required services available on-site. Please view referenced policy and procedures listed below.

IV. **Annual Report**
   A. ARMC's Cancer Program provides an Annual Report for all stakeholders.
   B. The Annual Report is an overview of ARMC's Cancer Program.

C. The report is generated by the Cancer Registry Staff.
D. The Annual Report utilizes data from the previous year and is presented to the Oncology Committee in the final quarter of each year.
E. The Annual Report highlights one or more of the following:
    1. Cancer Prevention and Screening programs
    2. Accountability Measures
    3. Quality Studies, Measures, and/or Improvements
    4. Evidence Based Compliance Monitoring
F. The Annual Report may include the following:
    1. Cancer Registry Primary Site Table
    2. Support Services Information
    3. Community Outreach Information
    4. Education
G. The Annual Report is disseminated to the public via the ARMC website.

REFERENCES: **American College of Surgeons Commission on Cancer, 2020 Standard for Cancer Care**
ARMC Medical Imaging, Quality Assurance and Performance Improvement Policies and Procedures:
RAD Policy No. 300.00 – Performance Improvement Plan
RAD Policy No. 301.00 – Clinac IX: Quality Assurance

DEFINITIONS: N/A

ATTACHMENTS: **None**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 15, v1**
Cancer Registry Policy No. 18, v1
Cancer Registry Policy No. 24, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**
SUBJECT:	**STAFF CREDENTIALS**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

ARMC ensures staff participating in the cancer program maintain discipline specific credentials as required by licensing boards and in alignment with ACoS CoC Standards. The following disciplines involved in evaluation, management, and treatment of cancer patients are required to maintain and provide credentials for cancer accreditation: physician(s), oncology nurse(s) (including registered nurses and advanced practice nurses), and Certified Tumor Registrar(s).

PROCEDURES

I. **Physician Credentials**
   A. All physicians involved in cancer patient evaluation and management, including radiologists, pathologists, surgeons, radiation oncologists, and medical oncologists, must be board certified or demonstrate ongoing cancer-related education as outlined in CoC Standard.
   B. Standard 4.1 does not apply to physicians who are in fellowship or residency or physicians within the five years immediately following graduation from fellowship or residency.
   C. ARMC is accredited by the California Medical Association/Institute for Medical Quality (CCMA/IMQ).
   D. ARMC will submit a roster of the board certification status for all physicians involved in the evaluation and management of cancer patients with the Pre-Review Questionnaire.
   E. ARMC will submit all documentation of 12 annual cancer-related CME hours for all physicians who are not board certified and are involved in the evaluation and management of cancer patients with the Pre-Review Questionnaire.

II. **Oncology Nursing Credentials**
   A. All registered nurses and advanced practice nurses providing direct oncology care must possess specialized knowledge and skills demonstrated by current cancer-specific certification(s) as outlined in CoC Standard.
   B. All registered nurses and advanced practice nurses providing direct oncology care that do not possess cancer-specific certification(s) are required to demonstrate 36 cancer-related continuing education contact hours each accreditation cycle as outlined in CoC Standard.
   C. Standard 4.2 applies specifically to registered nurses and advanced practice nurses in medical oncology who give chemotherapy, nurses in radiation oncology, nurse navigators, and nurses in the cancer clinic. It does not apply to nurses in the hospital who might have occasional contact with cancer patients or to operating or recovery room nurses.
   D. Oncology nursing competencies are evaluated annually per hospital policy.
   E. ARMC will submit a roster of nursing certification status for all nurses providing direct oncology care with the Pre-Review Questionnaire.

F. ARMC will submit all documentation of cancer-related continuing education nursing hours for each nurse providing direct oncology care with the Pre-Review Questionnaire.

III. **Cancer Registry Staff Credentials**

A. All cancer registry staff who abstract cases at ARMC must either hold a current Certified Tumor Registrar (CTR) credential or perform case abstracting under the supervision of a CTR. This requirement applies to staff who are employed by the program and to staff who work on a contract basis.
B. Any non-CTR hired must pass the CTR credentialing examination within three years of hire date.
C. Cancer Registry Staff must participate in on-going cancer-specific education obtaining a minimum of 20 hours of continuing education during the two-year CTR certification cycle.
D. Cancer Registry Staff are responsible for submitting all copies of continuing education certificate(s)/hour(s) earned to Human Resources prior to the end of their two-year certification cycle.
E. ARMC will submit all CTR credentials for all certified cancer-registry staff.
F. ARMC will submit a plan for CTR supervision of non-credentialed staff who perform case abstracting in the cancer registry along, as applicable.
G. ARMC will submit documentation of cancer-related continuing education for non-credentialed members of the cancer registry staff.

REFERENCES: **American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care**
Specialty Care Center Policies and Procedures:
SPC Policy No. 151.10 – Scope of Service Oncology & Infusion Therapy Clinic
Cancer Program Policies and Procedures:
ONC Policy No. 100.03 – Multidisciplinary Cancer Case Conference (Tumor Board)

DEFINITIONS: **CoC – Commission on Cancer**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
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2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**

SUBJECT: **MULTIDISCIPLINARY CANCER CASE CONFERENCE (Tumor Board)**

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

ARMC's Cancer Program shall hold routine multidisciplinary cancer case conferences to evaluate patient management of cancer care as outlined in Commission on Cancer (CoC) Standard. Multidisciplinary collaboration between clinicians provides improved treatment and care associated with improved clinical decision-making, clinical outcomes, and patient experience. The Cancer Registry staff shall coordinate all cancer case conferences and serve as the Cancer Program *Cancer Conference Coordinator* on the Oncology Committee.

PROCEDURES

I. **Multidisciplinary Members and Participation**
   A. Representation shall be required from General Surgery, Surgical Oncology, Medical Oncology, Radiation Oncology, Medical Imaging, and Pathology.
   B. Representation from physician and/or non-physician specialists including but not limited to: clinical research professionals, palliative care providers, psychosocial providers, rehabilitation providers, and support services is highly recommended.
   C. All members/departments will be specifically identified and documented in the minutes of the Oncology Committee's first meeting of each calendar year.
   D. A minimum of 75% attendance is necessary by all required members. Attendance will be documented for all cancer conferences.

II. **Format and Cases Presented**
   A. Multidisciplinary Cancer Case Conference format shall be facility-wide and shall be held weekly, at least 47 weeks annually, unless holidays or other mechanical, staffing, or emergency issues occur.
   B. Cases shall only be presented by physicians, residents, mid-level practitioners, or students who have personally examined the patient.
   C. A Multidisciplinary Cancer Case Conference request should be submitted to the Cancer Registry, via email, including the following information:
      1. Presenting physician/practitioner
      2. Patient Name
      3. Medical Record Number
      4. Diagnosis/Primary Site
      5. Case Summary
      6. Questions for Discussion
   D. A minimum of 15% of the analytic caseload will be presented in Cancer Case Conferences. At least 80% of these cases shall be prospective.
   E. Elements of case discussion will include:
      1. Clinical and/or pathological stage
      2. Prognostic indicators and Treatment planning using evidence-based guidelines

3. Options and availability for genetic testing, where applicable
4. Clinical research studies, where applicable
5. Supportive care services, where applicable

F. All cases shall be reviewed by members prior to Cancer Case Conferences for effective discussion and decision making.
G. Consensus from Cancer Case Conferences should be recorded in the patient Electronic Health Record (EHR) by presenting practitioner.

III. **CME Documentation for Physicians and Staff**

A. Continuing Medical Education (CME) is provided weekly for the physicians at cancer conferences. Continuing Medical Education is provided by ARMC and submitted to contracted vendor for CME verification.
B. CME forms will be provided to all participating physicians by Cancer Registry Staff.
C. Physicians will complete and return CME to the Cancer Registry Staff following case conferences.
D. Cancer Registry Staff will then copy CMEs, attendance record(s), and cancer case selection form(s).
    1. Original CME form(s) and cancer case selection form(s), along with a copy of attendance record(s) are submitted monthly to CME Consultants for processing by the Cancer Registry Staff.
    2. Original attendance record(s), along with copies of CME form(s) and cancer case selection form(s) are kept in the Cancer Registry Department.
    3. Attendance records will also be electronically provided to the GME office.
E. Staff will accrue CME hours by signing a Planner Disclosure Form annually. These forms are kept on file with the CME Consultants with copies kept in the Cancer Registry Department.
F. All CME information is kept for two years. If there are no CME disputes after this time period, files are destroyed.

IV. **Cancer Conference Coordinator**

A. Cancer Registry Staff shall serve as the Oncology Committee Cancer Conference Coordinators.
B. The Cancer Conference Coordinators will coordinate, prepare, document, and follow-up as necessary for all Cancer Conferences by:
    1. Typing the agenda for all cases to be presented including presenting physician/practitioner, patient name, medical record number, diagnosis/primary site, case summary, and questions for discussion.
    2. Email agenda to members attending Multidisciplinary Cancer Case Conferences the day prior to the conference.
        a. All emails sent outside of the ARMC email network shall be encrypted as specified by compliance.
    3. Documentation will not be distributed at Cancer Case Conferences
    4. National Comprehensive Cancer Network (NCCN) guidelines and TNM Staging Manual will be available during the discussion of treatment option.
    5. Assist with set-up and secure any required equipment.
C. Cancer Conference Coordinators shall present a summary of Cancer Case Conference activity to the Oncology Committee no less than annually. The Oncology Committee will address any required areas not meeting minimum standards as outlined in CoC Standard.

REFERENCES:

American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care
Medical Staff Office Continuing Medical Education Policies and Procedures
Medical Staff Committee Manual, 2019
Medical Staff Policies and Procedures
Policy No. 12 – Confidentiality of Medical Staff Files and Records

DEFINITIONS: N/A

ATTACHMENTS: **None**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES:

Cancer Registry Policy No. 13, v1
Cancer Registry Policy No. 26, v1
Patient Navigation Program Policy No. 106, v1

EFFECTIVE: _____

REVISED: _____

REVIEWED: _____

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**

SUBJECT: **GENETIC COUNSELING AND RISK ASSESSMENT**

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

ARMC's Cancer Program provides risk assessment and genetic counseling for patients at risk for familial or hereditary cancer syndromes. The Cancer Program Staff want to support patients through genetic counseling for the purposes of educating patients on risk(s) of developing cancer, obtain personal meaning from genetic information, and empower them to make educated, informed decisions surrounding genetic testing, cancer screening, and cancer prevention.

PROCEDURES

I. **Criteria for referral for a genetics evaluation**
   A. All patients referred to ARMC's Oncology services for cancer related diagnosis or treatment are screened for potential genetic risk(s).
   B. Any patient identified as having genetic risk(s) are referred for testing/evaluation.
   C. National Comprehensive Cancer Network guidelines are followed for all screening, testing, and evaluation for genetic risk of patients.

II. **Process of review of genetics evaluation**
   A. Results are reviewed with patients where all options and presented and discussed.
   B. Necessary treatment plans are developed between patients and practitioners at ARMC.
   C. Referrals to City of Hope Comprehensive Cancer Center in Duarte, CA for any additional, in-depth genetic counseling requested by and/or required for patient(s).

III. **Identification of the genetics professionals**
   A. ARMC Professionals providing post-test counseling include:
      1. A board-certified/board-eligible physician
      2. An advanced practice oncology nurse or physician assistant
      3. A registered oncology nurse with specialized training in cancer genetics
   B. City of Hope Professionals providing post-test counseling include:
      1. A certified genetics counselor
      2. A board-certified/board-eligible physician
      3. An advanced practice oncology nurse or physician assistant
      4. A registered oncology nurse with specialized training in cancer genetics
   C. Patient Navigators assist in coordinating any genetic testing, referrals, tracking, and follow-up.

REFERENCES: **American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care**
National Comprehensive Cancer Network Guidelines
City of Hope Comprehensive Cancer Center Genetic Counseling Program

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

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11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
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2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Patient Navigation Program Policy No. 111, v1**

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**
SUBJECT:	**DEPARTMENTAL CARE SERVICES**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

ARMC provides various levels and modalities of care for cancer patients and family members or caregivers. These services are provided, on-site or by referral. These services are essential components of cancer care, beginning at the time of diagnosis, continuously available throughout treatment, surveillance, and when applicable, through end of life. They include Palliative Care Services, Rehabilitation Care Services, Oncology Nutrition Services, and Social Work Services.

PROCEDURES

I. **Palliative Care Services refer to patient- and family-centered care that optimizes quality of life. Palliative care services are an essential component of cancer care and are available to cancer patients at ARMC.**
   A. The Palliative Care Team includes physicians, nurses, social workers, case managers, chaplains, and pharmacists.
   B. Palliative care services are available to cancer patients and their family members or caregivers.
   C. Palliative care is integrated in the continuum of cancer care.
   D. Palliative care services are available to cancer patients and their family members or caregivers.
   E. ARMC's Oncology Committee monitors, evaluates, and makes recommendations for improvements to palliative care services each calendar year. Content of review and any recommendations are documented in the Oncology Committee meeting minutes.

II. **Rehabilitation Care Services refer to patient-centered care that optimizes patient functional status and quality of life through preventative, restorative, supportive, and palliative interventions.**
   A. Rehabilitation services teams include Physical Therapist, Occupational Therapist, and Speech Language Pathologist. The Rehabilitation Services team works in conjunction with physician(s) as needed to provide appropriate, comprehensive care.
   B. Rehabilitation services are available to cancer patients and is integrated into the continuum of cancer care.
   C. ARMC's Oncology Committee monitors, evaluates, and makes recommendations for improvements to palliative care services each calendar year. Content of review and any recommendations are documented in the Oncology Committee meeting minutes.

III. **Oncology Nutrition Services provided by Registered Dietitians with knowledge and skills to address nutrition and hydration requirements and recommendations throughout the continuum of cancer care.**
   A. Registered Dietitians address treatment-related symptom management, nutrition support, and quality-of-life concerns through medical nutrition therapy and education.

B. Registered Dietitians discuss diet, nutrition, and lifestyle recommendations for survivorship, health promotion, and disease prevention.
C. ARMC's Oncology Committee monitors, evaluates, and makes recommendations for improvements to palliative care services each calendar year. Content of review and any recommendations are documented in the Oncology Committee meeting minutes.

IV. **Clinical Social Work Services provided by Social Service Practitioner(s) conduct critical psychosocial assessments of patients diagnosed with and receiving cancer care/treatment at ARMC.**
A. The psychosocial distress screening addresses a patient's mental status, ability to cope with medical diagnosis and potential care needs.
B. The intent is to improve or resolve patients' psychosocial issues/concerns related to medical care and resume maximum functioning.

V. **Additional Departments providing care and support within the Cancer Program include:**
A. Cancer Registry Department – compile data on treatment, diagnosis and patient history for all cancer patients playing a critical role in cancer surveillance in our efforts to reduce the cancer burden.
1. Department Policies and Procedures listed in section 101
B. Patient Navigation Program Services – provide optimum care and assistance to reduce barriers to cancer treatment.
1. Department Policies and Procedures listed in section 102

REFERENCES:

American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care
Administrative Policies and Procedures: Patient Care:
Policy No. 610.15 – Palliative Care: Scope of Practice
Policy No. 610.16 – Palliative Care: Referral Process
Policy No. 610.17 – Palliative Care: Palliative Care Committee
Policy No. 610.18 – Palliative Care: Care Planning
Policy No. 610.19 – Palliative Care: Assessment and Treatment of Physical and Emotional Symptoms
Policy No. 610.20 – Palliative Care: Pain Management and Opioid Prescribing
Policy No. 610.22 – Palliative Care: Pastoral Care Priorities
Rehabilitation Services Policies and Procedures: Patient Care:
Policy No. 400 – Access to rehabilitation Services Treatment Areas
Policy No. 401 – Referral to Rehabilitation Services Department
Policy No. 405 – Patient Assessment and Plan of Care
Policy No. 406 – Patient Prioritization
Policy No. 409 – Provision for Patient & Family Education
Nutrition Services Policies and Procedures: Clinical
Policy No. 900.00 – Manual of Clinical Nutrition
Policy No. 901.00 – Nutrition Screening
Policy No. 902.00 – Nutrition Assessment
Policy No. 904.00 – Consults – Nutrition
Policy No. 906.00 – Modification of Oral Diet by Registered Nutritionist
Policy No. 908.00 – Patient Nutrition Education and Discharge Planning
Policy No. 909.00 – Enteral Preparation, Storage, Delivery and Administration
Clinical Social Work Department Policies and Procedures: Staffing/Unit Description
Policy No. 039 – Outpatient Clinics
Cancer Program Policies and Procedures, Subsection: Cancer Registry 101
Cancer Program Policies and Procedures, Subsection: Patient Navigation 102

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**
SUBJECT:	**SURVIVORSHIP PROGRAM**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

Arrowhead Regional Medical Center (ARMC) Oncology Committee will establish a survivorship program directed at meeting the needs of cancer patients treated with curative intent. The Oncology Committee will develop survivorship programs/services relative to available resources and experience.

PROCEDURES

I. **Survivorship Program Coordinator**
   A. The survivorship program coordinator is appointment by the Oncology Committee and is a required member of the Oncology Committee.
   B. The coordinator will develop a survivorship team that should consist of multidisciplinary medical and allied health professionals as outlined in CoC Standard.
   C. At least annually, the coordinator will provide a report to the Oncology Committee reviewing activities of the survivorship program and documented in meeting minutes as outlined in CoC Standard.

II. **Survivorship Program Team**
   A. The team determines a list of services and programs, offered on-site or by referral that address the needs of cancer survivors.
   B. The team formally documents a minimum of three services offered each year.
   C. All programs will define the population to receive services, the process for referral services, and any required follow-up, if applicable.
   D. Each year the team will document enhancement(s) to current services and/or addition(s) of new services offered through the survivorship program.
   E. All programs will define services offered

REFERENCES: **American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 12, v1**

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**
SUBJECT:	**CANCER REGISTRY QUALITY CONTROL**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

As an essential aspect of the ARMC Cancer Program, high-quality cancer registry data is maintained to accurately assess treatment outcomes and patient survival. The Cancer Registry Staff shall follow quality control measures ensuring standards of excellence. A Cancer Registry Quality Control Coordinator will oversee this process and report to the Oncology Committee.

PROCEDURES

I. **All cases meeting case eligibility criteria shall be abstracted within six months of the date of first diagnosis for class of case 00-22 and within six months of presentation to Arrowhead Regional Medical Center for class of case 30-49 and 99.**

II. **Review of Cancer Registry coding of abstract(s) shall be done quarterly for evaluation of data accuracy. An accuracy rate of at least 97% will be maintained.**

III. **The Cancer Registry Staff will randomly select 10% of analytic cases abstracted annually for quality review.**
   A. Cases can be reviewed by any of the following designated staff members: Certified Tumor Registrar(s) (CTR), Advanced Practice Registered Nurse(s), Physician Assistant(s), physicians(s), fellow(s), or resident(s).
      1. CTR(s) cannot review their own cases.
   B. Quality review will evaluate case finding, abstracting timeliness, and percentage of information coded as unknown.
   C. Cancer Registry staff will provide reviewer a copy of the cancer registry abstract for each case requiring review.
   D. The reviewer will complete and sign the Quarterly Abstract Review form indicating if the recorded data items and staging accurately correspond to standardized staging as set by the American Joint Committee on Cancer (AJCC) and TNM Classifications.
   E. The Quarterly Abstract Review(s) will be returned to Cancer Registry Control Coordinator.
   F. Identified problems/data errors and recommendations are discussed with the Cancer Registry Quality Control Coordinator where coordinator will follow-up with cancer registry staff.

IV. **Abstracted Data Accuracy Quality Review:**
   A. A review of a minimum of 10 percent of the annual analytic caseload (up to 200 cases annually) is required each year for the accuracy as outlined in CoC Standard.
   B. Information to be included and reviewed in abstracts include: class of case, primary site, histology, grade, AJCC stage, first course of treatment, and follow-up information.
      1. American Joint Committee on Cancer (AJCC) staging shall be performed on all analytic cases, where applicable. This shall include T, N, and M designations

as well as clinical and/or pathological stage groupings in accordance with the guidelines set forth by AJCC.

2. Non-analytic cases are not required to be staged, but all other information available on staging at diagnosis shall be included on the abstract, when available.
3. Follow-up information shall include date of first recurrence, type of first recurrence, cancer status, and date of last cancer status

V. **Cancer Registry Quality Control Coordinator**

A. Coordinator will work cooperatively with the cancer registry staff and other departments as applicable to implement quality control procedures.
B. Coordinator will monitor each area of cancer registry activity, implement and monitor any corrective action, and ensure specified measures are met.
C. Coordinator will provide recommendation to corrective action if any area falls below the specified measures for quality control.
D. The coordinator will report results, recommendations, and outcomes of recommendations to the Oncology Committee as least one time annually. This report will be documented in the Oncology Committee Meeting minutes.

VI. **Upon successful achievement of ACoS CoC Cancer Program Accreditation, ARMC's Oncology Program will participate in submission of all data to the National Cancer Database (NCDB) in accordance with the annual Call for Data as well as Rapid Quality Reporting System (RQRS) participation.**

REFERENCES: **American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care**
Cancer Program Policies and Procedures, Subsection Cancer Registry:
ONC Policy Number 101.03 – Data, Documentation, and Reporting
ONC Policy Number 101.04 – Cancer Case Identification
ONC Policy Number 101.05 – Cancer Casefinding and Suspense
ONC Policy Number 101.06 – Cancer Case Abstracting
ONC Policy Number 101.07 – Quality Control

DEFINITIONS: **TNM – extent of the tumor (T), extent of spread to lymph nodes (N), presence of metastasis (M)**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
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2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 05, v1**
Cancer Registry Policy No. 06, v1
Cancer Registry Policy No. 07, v1
Cancer Registry Policy No. 11, v1
Cancer Registry Policy No. 23, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Accreditation**
SUBJECT:	**CLINICAL RESEARCH ACCRUAL**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

Research is a valuable tool in the development of cancer care and treatment. ARMC's Cancer Program participates in research through partnership with City of Hope. For patients diagnosed with and/or are receiving treatment for cancer at ARMC will be screened for eligibility and provided information on clinical research studies. Reports on clinical trial enrollment and participation will be provide to the Oncology Committee.

PROCEDURES

I. **Clinical Research Process and Approval**
   A. ARMC Institutional Review Board (IRB) exists to review and approve research before it begins.
   B. The IRB assures research complies with Department of Health and Human Services regulations.
   C. Protected Health Information (PHI) may not be used or disclosed for research purposes without the prior approval from the ARMC IRB.
   D. City of Hope shall submit all research studies/clinical trials involving patients at the hospital to the ARMC IRB for approval prior to implementation at ARMC.

II. **Clinical Research Screening, Information, and Accrual**
   A. The Cancer Program/Oncology Department will screen any patient newly diagnosed with cancer for eligibility in clinical trials.
   B. Eligible patients will be referred to City of Hope for enrollment into clinical trial(s).
   C. Information on availability of cancer-related clinical trials/research studies will be provided to all patients.
   D. Patients will be provided with American Cancer Society resources regarding clinical trials, and additional information will be posted in various locations throughout ARMC providing oncology services
   E. All enrolled patients are added to the Oncology Clinical Trials list.
   F. Per CoC Standards, a minimum of four percent (4%) of all analytical cases enrolled in clinical trial(s) are required to complete the study in order to maintain compliance.

III. **Clinical Research Coordinator**
   A. Evaluates and assesses the eligibility and screening processes to identify and address barriers to enrollment and participation.
   B. Provides a report to the Oncology Committee, at least annually.
   C. Report will include clinical research information, annual enrollment in, and percentage of participation in clinical trials.

1. It is not required, but beneficial to discuss with the Oncology Committee any identified barriers and recommendation(s) or change(s) made to address said barriers.

REFERENCES:

American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care
City of Hope Medical Foundation and ARMC contractual agreement
Health Information Management:
HIM Policy No. 324.00 – Accounting of Disclosures
Administrative Policies and Procedures:
ADM Policy No. 1000.26 – Use and Disclosure of Protected Health Information for Research Purposes
Institutional Review Board Policies and Procedures:
Policy No. 101 – Scope and Authority
Policy No. 102 – Regulatory Compliance and Ethical Guidelines
Policy No. 103 – Federal Reporting Requirements
Policy No. 202 – Conflict of Interest
Policy No. 401 – Investigator Qualifications
Policy No. 402 – Investigator Responsibilities
Policy No. 403 – Study Submission
Policy No. 407 – Access to Medical Records

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 14, v1**
Cancer Registry Policy No. 14a, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **Cancer Program** **SUB SECTION:** **Cancer Registry**

SUBJECT: **ORGANIZATION STRUCTURE, FUNCTION, AND PROVISION OF SERVICES**

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

The Cancer Registry Department is an integral part of Arrowhead Regional Medical Center and the Cancer Program. The department promotes and supports compassionate, patient-centered care that is appropriate and effective for the treatment of cancer.

The Cancer Registry shall conform to the standards of the American College of Surgeons, Commission on Cancer (ACoS, CoC) as best practice as well as fulfill the mandate of California Health and Safety Code, section 103885.

PROCEDURES

I. **Goals and Objectives**
   A. The goal of the Cancer Registry Staff is to promote and support compassionate, patient-centered care that is appropriate and effective for the treatment of the cancer patient through tracking and reporting cancer case data.
   B. The Cancer Registry Department is responsible for collecting, analyzing, managing, and reporting data on cancer patients and survivors. ARMC's Cancer Registry ensures health officials have accurate and timely information on cancer incidence, treatment, and survivorship in support of providing optimal care for patients diagnosed with cancer.

II. **Data Collection, Quality, and Reporting**
   A. Cancer Registry Staff will conduct patient data collection, actively participate in the ARMC Oncology Committee, and support the Multidisciplinary Cancer Case Conferences in accordance with standards set forth by the Commission on Cancer.
      1. Patient Information Data Collection shall include:
         a. Demographic information
         b. Diagnosis, including date, place, primary site, histopathology, extent of disease, and diagnostic procedure(s)
         c. All modalities of treatment
         d. End results, including annual lifetime follow-up
   B. The Cancer Registry shall assist in evaluating the quality of care and patient outcomes through studies as directed by the Oncology Committee and with the Commission on Cancer standards.
   C. The Cancer Registry shall contribute data to the medical staff for educational and research purposes and to hospital administration for cancer program management as requested**.**

III. **The Cancer Registry Program**

A. Cancer Registry Staff are in place to ensure timely quality data collection, analyzation, and submission.
B. The Cancer Registry Staff work under the direction of the Ambulatory Care Healthcare Program Administrator, Associate Hospital Administrator, Ambulatory Services.
C. All staff within the department have a position description which identifies the essential functions, qualifications, duties, responsibilities, physical demands, and working conditions.
D. The scope of an individual's duties is defined by a job description, which identifies essential job duties, minimum job requirements, competencies, necessary skills, education, and licensure requirements. Cancer Registry Staff are required to demonstrate annual competencies per hospital policy.

IV. **New Hire Orientation**

A. Each new member of the Cancer Registry Department is oriented to the program, its scope of service, goals and objectives, and policies and procedural competencies and functional responsibility to the organization as a whole.
B. Existing Cancer Registry Department members will familiarize new employees with processes for case-finding, abstracting, follow-up, and all other tasks required of the CTR.
C. Existing Cancer Registry Department members will familiarize new employees with geography of the campus as well as other departments involved in the Cancer Program including but not limited to various oncology services, Oncology Clinic, Pathology, and Patient Navigation.
D. Orientation and competencies will be conducted/evaluated during the initial probationary period and annually thereafter per hospital policy. Competencies to be conducted will:
    1. Assess and confirm employee's experience, education, and abilities
    2. Evaluate level of practice/performance and guide technical/clinical experience to enhance self-development
    3. Ensure completion of an orientation process that is both area and classification specific

REFERENCES:

California Health and Safety Code, section 103885
ARMC Cancer Program Department Operations Manual
Human Resources Policies and Procedures:
ADM Policy No. 200.01 – Human Resources Operations
ADM Policy No. 200.10 – Confidentiality
ADM Policy No. 200.22 – Standards for Employee conduct
ADM Policy No. 220.02 – Orientation – New Employee
ADM Policy No. 220.05 – Licenses, Certificates, Registration – Verification of
ADM Policy No. 230.01 – Work Performance Evaluations – Standards for
ADM Policy No. 230.02 – Performance Review – Competence Assessment
ADM Policy No. 230.03 – Work Performance Evaluation (WPE) Report and Timelines

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Program Policy No. 15, v1**

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Registry**
SUBJECT:	**Software Reporting Systems**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

The ARMC Cancer Registry Staff are required to collect and report cancer related data accurately and timely. Data is collected, analyzed, and reported electronically utilizing cancer-specific software. All information is documented and reported utilizing current standards of practice in-line with American College of Surgeons (ACoS), Commission on Cancer (CoC), and the Cancer Registry of Greater California (CRGC).

PROCEDURES

I. **Cancer Case Transmission(s)**
- A. All reportable cases shall be transmitted to the Cancer Registry of Great California (CRGC) via the CRGC portal.
- B. The CRGC portal is also used to upload Shared Follow-up files and Pathology Resolution reports (missed cases identified by CRGC).
- C. The Cancer Registry staff shall transmit completed cases to CRGC, at least monthly, via the portal.
- D. Instructions for transmission can be found in the Cancer Program Department Operations Manual.

II. **Coding Systems**
- A. The Cancer Registry shall utilize the coding systems required by the ACoS and California Health and Safety Code, section 103885.
- B. The Cancer Registry shall follow the general principles in coding set forth in the Standards for Oncology Registry Entry (STORE) Manual, utilizing the most current version and the California Cancer Registry, Volume 1 & 2.
- C. The coding topography (primary site) and morphology (histology) shall follow the guidelines listed in the International Classification of Diseases for Oncology (ICD-O), utilizing the most current version and updates.
- D. References for site-specific data items (SSDI) coded include but are not limited to the North American Association of Central Cancer Registries (NAACCR), Surveillance, Epidemiology, and End Result Extent of Disease (SEER EOD), and Standards for Oncology Registry Entry (STORE), and the California Cancer Registry, Volume 1 & 2.

III. **CNExT Software for Cancer Registry Reporting**
- A. ARMC's Cancer Registry Department utilizes the CNExT Cancer Reporting software to collect and report the incidents of cancer.
- B. CNExT is a multipurpose software system that assists in the review of various analytic and non-analytic data-defined analysis and quality reporting.
- C. Collected and reported incidents include first detected and/or recurrent and progressive requiring further treatment.

1. Recurrent and progressive cancers are only tracked if cancer patient is receiving treatment at ARMC. Otherwise, it is considered a non-reportable case.

D. Instructions for accessing CNExT can be found in the Cancer Program Department Operations Manual.

IV. **Cancer Alert System (CAS) for Case Finding**

A. CAS is a supplemental software system that allows all cancer diagnoses to be identified in ARMC's electronic medical record and recorded on the suspense list in the CNExT system for CTR review.
B. The Cancer Registry Staff view both pathology reports and disease index reports for case finding.
C. Instructions for accessing and utilizing CAS can be found in the Cancer Program Department Operations Manual.

V. **Disaster Recovery**

A. In the event of an internal or external disaster resulting in loss of data, the Cancer Registry shall contact the Information Management Department.
B. The Cancer Registry data shall be backed up every evening, according to Information Management guidelines and procedures.
C. A copy of the backed up data shall be stored on-site for immediate use in the event of data loss.
D. An additional copy of the backed up data shall be stored off-site in a secure location in the event the on-site copy is damaged, destroyed, or otherwise unrecoverable.
E. The Cancer Registry Staff will have Citrix access to work remotely in the event the data registry is not accessible to ensure reporting timelines are met per state reporting requirements.

REFERENCES: **ARMC Cancer Program Department Operations Manual**
American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care
Standards for Oncology Registry Entry Manual, most current version
California Cancer Registry, Volumes 1 & 2
North American Association of Central Cancer Registries
Surveillance, Epidemiology, and End Result Extent of Disease
CNExT Software Operating Manual

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:		
	N/A	**Policy, Procedure and Standards Committee**
	11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
	3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
	2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
	2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
		Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 02, v1**
Cancer Registry Policy No. 06, v1
Cancer Registry Policy No. 08, v1
Cancer Registry Policy No. 16, v1
Cancer Registry Policy No. 17, v1
Cancer Registry Policy No. 25, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Registry**
SUBJECT:	**DATA, DOCUMENTATION, AND REPORTING**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

Cancer Registry data collection is used to conduct clinically meaningful analyses of patient diagnosis, treatment, and outcomes as necessary to ensure that quality care is administered to cancer patients. The Cancer Registry will utilize ARMC's reference date, January 1, 2013, to maintain necessary information in the registry database. Cancer specific data and information directly related to Cancer Registry is maintained by the Cancer Registry Department. All other documentation and reporting will be kept in accordance with hospital policies.

The Oncology Committee shall analyze patient outcomes and disseminate results on an annual basis.

PROCEDURES

I. **Cancer Registry Data Requests**
   A. All data requests are maintained by the Cancer Registry Department.
   B. Maintained data requests must include the following information:
      1. Date of request
      2. Topic of report, including period covered
      3. Variables included in the report
      4. Person(s) requesting report
      5. Purpose of report (i.e. study, paper, oral presentation)
      6. Final disposition of report
   C. As appropriate, the Cancer Registry shall comply with all requests from the National Cancer Data Base (NCDB), in accordance with American College of Surgeons (ACoS) Standards.
      1. Reports send from NCDB to ARMC shall be used, when available, in preparation of statistical reports, including the Annual Report.
   D. As appropriate, the Cancer Registry shall comply with all requests from the Cancer Registry of Greater California (CRGC), in accordance with the California Cancer Registry.
   E. Cancer Registry Data shall be transmitted to the Cancer Registry of Greater California at least monthly.

II. **Pathology Data Review**
   A. The College of American Pathology (CAP) cancer protocols provide a consistent and meaningful analysis of clinical data for improving patient care.
   B. All incoming pathology reports for resection are reviewed by the CTRs.
   C. Quarterly, the Cancer Registry staff select 25 pathology resections for review by the Pathologist.
   D. The Pathologist will assess the resection report and record finding on the *CAP Element Review* form.

E. The results of the CAP protocol review will be returned to the Cancer Registry Staff for reporting to the Oncology Committee.

III. **Cancer Registry Files**

A. All Cancer Registry files are maintained through the Cancer Registry software systems.
B. All files are available for review at any time.
C. Information in the files can be filtered for review.
D. Instructions for reviewing files can be found in the Cancer Program Department Operations Manual.

IV. **Retention of Documents**

A. Abstracted data for cases diagnosed and/or treated at the facility after the Cancer Registry reference date shall be retained in perpetuity. All other documentation for the Cancer Program and Cancer Registry shall be kept in accordance with hospital policy.
B. Documentation includes but is not limited to the following:
    1. Oncology Committee Meeting Minutes
    2. Multidisciplinary Cancer Case Conference documentation
    3. Quality Control reports/results
    4. Outcome analysis and reports
    5. Results of Cancer Related Studies

REFERENCES: **ARMC Cancer Program Department Operations Manual**
American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 05, v1**
Cancer Registry Policy No. 07, v1
Cancer Registry Policy No. 10, v1
Cancer Registry Policy No. 18, v1
Cancer Registry Policy No. 19, v1
Cancer Registry Policy No. 21, v1
Cancer Registry Policy No. 23, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Registry**
SUBJECT:	**CANCER CASE IDENTIFICATION**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

The Reference Date for the Cancer Registry at Arrowhead Regional Medical Center is January 1, 2013. All cancer cases presented at ARMC from Reference Date forward will be evaluated for case eligibility and reporting through the use of accession and suspense practices.

PROCEDURES

I. **Case Eligibility Criteria – All cancer cases meeting case eligibility, for state and national reporting, shall be included in the Cancer Registry. Case eligibility is as indicated below:**
   A. All patients (inpatient, outpatient, and family health center patients) receiving a clinical diagnosis of cancer determined by a physician, including those not histologically confirmed, meet case eligibility, and are included in the registry.
   B. Patients diagnosed by a physician in an outside facility and referred to ARMC for definitive therapy are considered to be diagnosed at the hospital, meet case eligibility, and are included in the registry.
   C. Only patients diagnosed with cancer and having active disease on or following the Reference Date meet case eligibility.
      1. Cancer Registry Staff track both analytic and non-analytic cases to determine case eligibility.
      2. Any cases with an initial diagnosis date prior to the Reference Date are not included in the cancer registry database but retained for historical purposes.
   D. Cases of cancer diagnosed at autopsy meet eligibility and are included in the registry. However, these cases are not included in survival analyses.
   E. Cancer patients seen for “consult only” or have cancer “by history” but are disease free shall not be included in the registry. “Consultation only” cases shall be reported to the Cancer Registry of Greater California via a Confidential Morbidity Report (CMR).

II. **Reportable List:**
   A. The list of reportable diagnoses is identified by the International Classification of Disease for Oncology.
   B. All reportable cases included in the cancer registry can be found in the Cancer Program Department Operations Manual.
   C. CTRs will maintain current and accurate knowledge of diagnoses included in reportable lists as determined by national and/or state standards for cancer reporting.

III. **Accessioning Cases – all cases are accessioned automatically in the registry database via the Cancer Registry software system(s).**
   A. Reportable cases entered into the Cancer Registry software system is assigned the next available accession number for the year.
   B. A patient can have only one accession number.

C. If a patient is already in the registry, the case being abstracted is identified as the new primary diagnosis using the original accession number with the sequence number reflecting the order of the primary malignancy.
D. The accession register is an annual, sequential listing of all eligible cancer cases included in the cancer registry database. Additional information on the accession register can be found in the Cancer Program Department Operations Manual.

REFERENCES: **Cancer Registry of Greater California**
ARMC Cancer Program Department Operations Manual

DEFINITIONS: **Analytic Cases** – case for which the registry has information on the original diagnosis and/or the first course of treatment at reporting facility.
Non-Analytic Cases – all cases for which the reporting facility was not responsible for the original diagnosis and/or first course of treatment.

ATTACHMENTS: **Confidential Morbidity Report**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 01, v1**
Cancer Registry Policy No. 04, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Registry**
SUBJECT:	**CANCER CASEFINDING AND SUSPENSE**		
APPROVED BY:	_____		
	Associate Administrator, Ambulatory		

POLICY

Arrowhead Regional Medical Center's Certified Tumor Registrars conduct casefinding in order to identify all cases of an eligible cancer disease to be included in the registry database for patients diagnosed and/or referred for definitive therapy of active disease to ARMC.

PROCEDURES

I. **Type of Casefinding:**
   A. ARMC's CTRs utilize a combination of both active and passive casefinding.
      1. Active casefinding is performed by registry staff who personally screen source documents.
      2. Passive casefinding is performed by other healthcare professionals whom the registry relies on to notify the registrar of potentially reportable cases.

II. **Using/Maintaining Suspense System – the Cancer Registry shall maintain a suspense system consisting of all cases not yet abstracted into the registry database.**
   A. Cases are added to the suspense list as identified through casefinding procedures.
   B. Specific patient and cancer identifiers are recorded in the Cancer Registry software system.
   C. A review of the suspense list is conducted at the beginning of each month.
   D. Cases added to the suspense do not require thorough review as that will occur in the casefinding process.

III. **Casefinding Procedures:**
   A. Cancer cases will be identified in the Electronic Medical Record (EMR) via the assistance of the cancer registry software system(s) and automatically populated on a suspense list for further review.
   B. Cancer Registry Staff will review all cases on the suspense list for criteria of reportable cases as outlined by governing entities.
   C. Cases will be identified as abstract, follow-up, recurrence or subsequent treatment and will be processed accordingly.
   D. Cancer Registry staff will perform a monthly review of the suspense files to ensure there are no missed abstract cases. Staff will also review all accession numbers to ensure maintenance of accurate case counts.
   E. Cases are not reported if determined to be a physician only, consult only, or Multidisciplinary Case Conference only case(s).
   F. If a case is determined to be for stabilization due to urgent non-cancerous conditions and no additional cancer treatment or services were performed, a Confidential Morbidity Report (CMR) is completed and sent to the Cancer Registry of Greater California.
   G. CTRs will review all cases within the software system, suspension list, and through passive sources. These sources include but are not limited to:

1. Pathology Department
2. Medical Records Disease Indices reports for inpatients and outpatients, including the Family Health Centers
3. Radiation Therapy Department
4. New Patient Consults/visits from Medical Oncology
5. Monthly Death Logs
6. Obituaries from outside sources
7. Cancer Conference schedule

REFERENCES: **Cancer Program Policy and Procedures:**
ONC Policy No. 101.04 – Cancer Case Identification
ARMC Cancer Program Department Operations Manual

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 02, v1**
Cancer Registry Policy No. 03, v1
Cancer Registry Policy No. 04, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: Cancer Program **SUB SECTION:** Cancer Registry

SUBJECT: CANCER CASE ABSTRACTING

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

Certified Tumor Registrars utilize abstracting as a means for collecting and recording pertinent cancer data. Abstracts organize, summarize, and categorize crucial information in a patient's medical records for each reportable tumor. All cancer cases meeting case eligibility criteria shall be abstracted and stored in the Cancer Registry database.

PROCEDURES

I. **Abstracting**
   A. All eligible cases shall be abstracted within six (6) months of the date of first diagnosis for class of case 00-22 and within six (6) months of presentation to Arrowhead Regional Medical Center for class of case 30-49 and 99.
   B. All cases are abstracted based on current standards of practice as set by federal and state regulatory/licensing bodies.
   C. The California Cancer Registry Reporting Standards, in conjunction with the American College of Surgeons, data standards and coding instructions are used to describe all reportable cases, as mandated by law.
   D. A list of guidelines for selected data items for initial diagnosis and treatment and autopsy are found in the Cancer Program Department Operations Manual.

II. **Documentation of First Course of Treatment**
   A. Every effort will be made to record complete and accurate information on the first course of treatment.
   B. At time of abstracting, the CTR shall document all cancer directed therapy administrated as part of the first course of treatment. This includes any therapeutic procedure directed at cancer tissue, whether in a primary or metastatic site, whatever the mode of treatment, and regardless of the sequence and degree of completion of any component part.
   C. If all or a portion of the first course of treatment is known to have been administered at an outside facility, the CTR shall make every effort to obtain the treatment information, and record it on the Cancer Registry Abstract.
      1. Abstracted cases that have not finished the first course of treatment prior to transmit date are noted as pending documentation and flagged for follow-up after abstracted case transmission.
   D. The Cancer Registry is required to make Rapid Quality Reporting System (RQRS) submissions as outlined in the ACoS, CoC standards. The Cancer Registry will monitor and update case records and use the alerts and case listing feature of the RQRS to manage and facilitate any necessary updates.

III. **Follow-up**

A. Cancer Case follow-up is an organized system of long-term surveillance of cancer patients. Follow-up is a process for obtaining updated information regarding a patient's health status after discharge. This process is completed annually to ensure continued medical surveillance.
B. Follow-up is performed on all cases registered as class of case 10 to 22 only.
C. Follow-up information includes:
    1. Date of last contact (required)
    2. Vital Status of Patient (required)
    3. Dates and types of treatment for recurrent disease
    4. Site(s) of distant metastases
    5. Site and histology of subsequent primaries
D. ARMC's Cancer Program Follow-up rate is calculated monthly
E. Follow-up rates should align with ACoS, CoC standards.
F. The Cancer Registry will present follow-up rates to the Oncology Committee for review.
G. For any rates not meeting indicated standards, recommendations for corrective action should be presented and discussed by the Oncology Committee.

REFERENCES:

ACoS STORE Manual, current version
American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care
American Joint Committee on Cancer (AJCC Cancer Staging Manual)
ARMC Cancer Program Department Operations Manual
California Cancer Registry, Volumes 1 & 2
Cancer Registry of Greater California, Cancer Reporting in California
CNExT User Manual, current version
NAACCR SSDI and Grade Coding manuals, current version
NAACCR Solid Tumor primary and histology rules
SEER EOD coding manual, current version
SEER Hematopoietic and Lymphoid Neoplasm Data Base
SEER Rx Interactive Antineoplastic Drugs Data Base
SEER summary manual, current version
WHO ICD-0-3 Site and Histology Manual, current version

DEFINITIONS:

Class of Case – divides cases into 2 groups, analytic cases (codes 00-22) and nonanalytic cases (codes 30-49 and 99). This reflects a facility's role in managing the cancer, whether the cancer is required to be reporting, and whether the case was diagnosed after the program's Reference Date.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **Cancer Registry Policy No. 04, v1**
Cancer Registry Policy No. 05, v1
Cancer Registry Policy No. 06, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Cancer Registry**
SUBJECT:	**QUALITY CONTROL**		

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

The Cancer Registry Department shall maintain the following quality control measures to ensure standards of excellence.

PROCEDURES

I. **Cancer Registry Data – the following standardized rules shall be consistently followed to maintain quality:**
   A. Visual review of all completed abstracts shall be performed by registry staff. This is done to ensure any incorrect visual edits are identified and corrected prior to transmission to the Cancer Registry of Greater California (CRGC).
   B. The Cancer Registry software completes an edit of abstracts prior to assigning a completed status to the abstract.
      1. Edits used are mandated by regulatory/licensing agencies and updated annually.
   C. Any discrepancies between the visual and software edits are addressed by the Cancer Registry staff and are transmitted to the CRGC for visual editing.
   D. Any discrepancies noted from the CRGC are returned to the registry for correction or challenged for accuracy.
   E. Cancer Registry staff will perform a monthly audit of the suspense files to ensure no cases were missed in abstracting. They will also review all accession numbers to ensure maintenance of accurate case counts.
   F. Upon receiving ACoS Cancer Accreditation, ARMC Cancer Program will participate in the National Cancer Data Base Call for Data, RQRS submissions, and other quality of care measures as outlined in CoC standards. This will assist in gauging program evaluation and accuracy on a national level.

II. **Cancer Registry Abstracting**
   A. A review of 10% of all analytic case abstracts will be done by a Certified Tumor Registrar (CTR) determine accuracy, annually.
      1. A CTR cannot review his/her own abstract in the review process.
      2. Any discrepancies will be discussed at time of review.
      3. These cases, once coded and completed, are subject to a review of the data for accuracy.
   B. Accuracy rates will be maintained to the minimum level as outlined by any regulatory/licensing agency. These rates are described in the Cancer Program Department Operations Manual.
   C. All analytic cases shall be staged by the managing physician and are subject to random review for accuracy in data collection and reporting. Discrepancies will be discussed with the managing physician.

D. The American Joint Committee on Cancer (AJCC) TNM staging shall be performed on all analytic cases where applicable.
E. Non-analytic cases are not required to be staged, but all other information available on staging at diagnosis shall be included on the abstract when available.
F. Non-analytic cases are not subject to physician review; however, for cases transmitted to the CRGC, they are subject to review by CTR.
G. The Quarterly Abstract Review shall be retained in the Cancer Registry Department with accuracy being reported to the Oncology Committee on a quarterly basis.

REFERENCES:

ACoS STORE Manual, current version
AJCC TNM Manual for Staging Cancer, current version
American College of Surgeons Commission on Cancer, 2020 Standards for Cancer Care
ARMC Cancer Program Department Operations Manual
California Cancer Registry, Volumes 1 & 2
Cancer Registry of Greater California, Cancer Reporting in California
CNExT Solutions User Manual, current version
NAACCR Hematopoietic MP/H Rules
NAACCR Solid Tumor primary and histology rules
NAACCR SSDI and Grade Coding manuals, current version
SEER EOD coding manual, current version
SEER Hematopoietic and Lymphoid Neoplasm Database
SEER Rx Interactive Antineoplastic Drugs Database
SEER summary manual, current version
WHO ICD-0-3 Site and Histology Manual, current version

DEFINITIONS:

Quality Control – ensuring procedures for collecting, analyzing, and reporting all data meet set cancer registry database standards
Quality of Data – directly relates to the quality of the content of data as mandated by rules and regulations by and submitted to governing bodies

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
3/9/2021	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
2/4/2021	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES:

Cancer Registry Policy No. 09, v1
Cancer Registry Policy No. 10, v1
Cancer Registry Policy No. 12, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **Cancer Program** **SUB SECTION:** **Patient Navigation**

SUBJECT: **ORGANIZATIONAL STRUCTURE, FUNCTION, AND PROVISION OF SERVICES**

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

The Patient Navigation Program is an integral part of Arrowhead Regional Medical Center. Patient Navigators facilitate individualized, patient-centered care promoting timely cancer diagnosis and treatment. Patient Navigators aim to ensure seamless, coordinated care and services while assisting patients, families, and caregivers to overcome healthcare system barriers.

PROCEDURES

I. **Goals and Objectives**
- A. Patient Navigation Program (PNP) Services provide optimum care and assistance to reduce barriers to cancer treatment.
- B. PNP promotes timely diagnosis and treatment aiming to ensure seamless, coordinated care and services including but not limited to:
    1. Reducing healthcare disparities
    2. Eliminating barriers to timely care across the healthcare continuum
    3. Identifying patient/family needs
    4. Directing patients to resources for emotional, financial, administrative, spiritual, or cultural support
- C. The Patient Navigators shall evaluate, document, and report to the Oncology Committee annually as set forth by the Commission on Cancer.
    1. PNP cancer control efforts are assured under the leadership of the Oncology Committee.
- D. The Categories of staff assigned for the Patient Navigation Program are:
    1. Patient Navigation Program Coordinator
    2. Patient Navigator

II. **Scope of Service**
- A. Patient Navigators facilitate and coordinate patient care to ensure that patients receive timely diagnoses and treatment.
- B. Patient Navigators promote health and comfort through each stage of patient diagnosis and treatment.
- C. Patient Navigators work with the healthcare team to coordinate patient care and improve the patient experience.
- D. Patient Navigators are the link between the patient and the healthcare system.
- E. Patient Navigators are the liaison between the patient and provider.

III. **New Hire Orientation**
- A. Each new Patient Navigator's scope of duties is defined and outlined in his/her job description.

B. Each new Patient Navigator is oriented to the program, its scope of service, goals and objectives, and policies and procedural competencies and functional responsibility to the organization as a whole.
C. Existing Patient Navigators will familiarize new employees with processes for formal and informal notification mechanisms.
D. Existing Patient Navigators will familiarize new employees with geography of the campus as well as other departments involved in the Cancer Program including but not limited to various oncology services, Oncology Clinic, Pathology, Specialty Clinics, and Cancer Registry Staff.
E. Orientation and competencies will be conducted/evaluated during the initial probationary period and annually thereafter per hospital policy. Competencies to be conducted will:
    1. Assess and confirm employee's experience, education, and abilities
    2. Evaluate level of practice/performance and guide technical/clinical experience to enhance self-development
F. Ensure completion of an orientation process that is both area and classification specific.

IV. **Committees, Conferences, and Meetings**

A. Patient Navigators will attend and participate in scheduled department meetings in an effort to grow the Cancer Program Service line and improve cancer care for patients at ARMC.
B. Patient Navigators will attend and participate in quarterly Oncology Committee Meetings supporting a multidisciplinary approach to cancer care and treatment.
    1. Patient Navigators will also attend and participate in Oncology Committee workgroups and subcommittees to support the efforts of the committee in attaining and maintaining cancer accreditation status.
C. Patient Navigators will attend and participate in Multidisciplinary Cancer Case Conferences as appropriate to reduce barriers and ensure seamless, coordinated care and services are provided to patients with cancer.

REFERENCES: **ARMC Cancer Program Department Operations Manual**
Cancer Program Policies and Procedures:
ONC Policy 100.03 – Multidisciplinary Cancer Case Conferences (Tumor Board)
Human Resources Policies and Procedures:
ADM Policy No. 200.01 – Human Resources Operations
ADM Policy No. 200.10 – Confidentiality
ADM Policy No. 200.22 – Standards for Employee conduct
ADM Policy No. 220.02 – Orientation – New Employee
ADM Policy No. 220.05 – Licenses, Certificates, Registration – Verification of
ADM Policy No. 230.01 – Work Performance Evaluations – Standards for
ADM Policy No. 230.02 – Performance Review – Competence Assessment
ADM Policy No. 230.03 – Work Performance Evaluation (WPE) Report and Timelines

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/12/2020	**Oncology Committee** Applicable Administrator, Hospital or Medical Committee
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2/25/2021	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
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REPLACES: **Patient Navigation Policy No. 100, v1**
Patient Navigation Policy No. 101, v1
Patient Navigation Policy No. 103, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION:	**Cancer Program**	**SUB SECTION:**	**Patient Navigation**
SUBJECT:	**ONCOLOGY CLINIC AND PATIENT PROCESSING**		
APPROVED BY:	_____ Associate Administrator, Ambulatory		

POLICY

The Patient Navigation Program promotes timely diagnosis and treatment for those with cancer. It is the function of this program and its staff to ensure seamless, coordinated care and services by identifying and mitigating barriers to cancer care and providing resources and assistance for patients diagnosed with cancer.

PROCEDURES

I. **Oncology Clinic Responsibilities – Patient Navigators are responsible for tracking and removing any barriers to treatment and services. Patient Navigators:**
   A. Are present when patients are undergoing examination
   B. Meet personally with each patient immediately before and after examination by the healthcare provider to remove any barrier(s) to timely completion of recommendations made during appointment
   C. Follow-up with any pertinent abnormal findings such as laboratory results, medical imaging, and pathology results
   D. Follow-up on authorizations and referrals to specialty clinics such as Surgery, Oncology, and Radiation to facilitate and coordinate patient care
   E. Promote and provide patient/family with reliable education, information, and support to make informed decisions
   F. Confirm that the patient understands the healthcare provider's treatment recommendations
      1. Authorized/licensed interpreters will be utilized when necessary/appropriate

II. **Patient Workflow/Processing – Patient Navigators facilitate and coordinate cancer care ensuring patients find resolution through timely diagnosis and treatment while preventing/eliminating barriers to quality care including but not limited to:**
   A. Maintaining communication and collaboration between patients and cancer care team members
      1. Cancer care team members include but are not limited to physicians, nurse practitioners, physician assistants, registered nurses, patient navigators, social workers, registered dieticians, other allied healthcare professionals
      2. Monitor patient's behaviors, check on appointments, and arrange assistance when needed
   B. Assisting with patient appointment(s), follow-up care, and services
      1. Ensuring Medical Records are available at scheduled appointment(s)
      2. Ensure follow-up appointments are scheduled and patients are aware of appointment date(s)/time(s).
      3. Ensure patients can access needed services to attend appointments.

4. Contacting patients considered “at risk” who missed appointment(s) and assist in rescheduling appointment

C. Providing education and resources during scheduled appointments
D. Promote health and comfort through each stage of patient diagnosis and treatment
   1. Provide health information, screening services, and clinical trial(s) information
   2. Assist patients in sourcing palliative (pain-easing) or hospice (end-of-life) care
E. Empower patients to navigate the healthcare system on their own.
   1. Coach patients to become advocates for their own care.
   2. Empower patients to self-navigate the healthcare system.

REFERENCES: **ARMC Cancer Program Department Operations Manual**
Administrative Policies and Procedures:
ADM Policy No. 900.02 – ADA-Effective Communication for the Deaf or Hard of Hearing
ADM Policy No. 900.05 – Limited English Proficiency Effective Communication

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
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	Board of Supervisors Approved by the Governing Body

REPLACES: **Patient Navigation Policy No. 102, v1**
Patient Navigation Policy No. 104, v1
Patient Navigation Policy No. 109, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **Cancer Program** **SUB SECTION:** **Patient Navigation**

SUBJECT: **SUPPORT GROUPS AND EDUCATIONAL RESOURCES**

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

The Patient Navigation Program facilitates support groups and provides reliable educational material to patients, family members, and caregivers offering support through all stages of cancer diagnosis and treatment.

PROCEDURES

I. **Cancer Support Groups – Patient Navigation staff facilitate groups providing a place for patients, family members, and caregivers to connect with one another and receive information on community resources and support.**
   A. Support Groups offered include but are not limited to:
      1. Breast Cancer Support Group – is for patients with active disease or survivors of Breast Cancer. This group allows patients the ability to connect and discuss the realities of living with/surviving a breast cancer diagnosis.
      2. General Cancer Support Group – is for patients diagnosed with or family members/caregivers providing support to patients diagnosed with any cancer diagnosis. This group allows members of this community to connect and discuss the realities of cancer and support one another through the different stages of the disease.
      3. New Patient and Family Orientation – is for newly diagnosed patients and his/her family members/caregivers. This group provides an overview of ARMC, services available for various cancer treatments, an opportunity to meet staff involved in cancer care and treatment, and become familiar with the hospital and various areas patients will receive care and treatment.
   B. Patient Navigator(s) are required to reserve a conference room on campus on a monthly basis for scheduled support group meetings.
   C. Patient Navigator(s) obtain and complete catering request forms for support groups on a yearly basis, when applicable/necessary.
   D. Patient Navigator(s) provide the support groups with speakers when available and attempt to have one speaker at least quarterly.
   E. Patient Navigator(s) are responsible to promote Cancer Support Groups throughout the community via marketing efforts including but not limited to flyers, posters, ARMC website and social media pages.
   F. Efforts should be made to offer support group connections via virtual platform(s) for patients unable to attend groups in person or during times of minimizing social gatherings in cases such as COVID-19.

II. **Educational Resources – Patient Navigation staff provide cancer patients with reliable patient education and information to support informed decision-making.**
   A. Educational/informational resources shall be available upon request from patients, family members, or caregivers
      1. All resources shall be available in English and Spanish, at minimum
   B. All patients are invited to participate in the new patient and family orientation group upon receiving a new cancer diagnosis.
   C. All patients receiving cancer care and treatment are provided with a comprehensive educational resource packet upon their initial visit.
   D. Educational information is provided to patients who require peg tube and/or port-a-catheter placement as a part of cancer treatment. Patient Navigator(s) assist with arranging any additional consults or referrals needed to ensure patient(s) receive the necessary education/training for specific medical devices.
   E. Additional information provided to patients include but is not limited to:
      1. Information regarding the American Cancer Society
      2. Information regarding state programs that support cancer care and treatment
      3. ARMC's Support Groups
      4. Any additional treatment options, programming, or events

III. **Support groups and educational resources and material are enhanced through ARMC's partnership with the American Cancer Society.**
   A. Patient Navigator(s) will work with the American Cancer Society to provide additional support and resources to cancer patients.

REFERENCES: **ARMC Cancer Program Department Operations Manual**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

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	Board of Supervisors Approved by the Governing Body

REPLACES: **Patient Navigation Policy No. 105, v1**
Patient Navigation Policy No. 110, v1
Patient Navigation Policy No. 112, v1

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **Cancer Program** **SUB SECTION:** **Patient Navigation**

SUBJECT: **TRACKING, DOCUMENTATION, AND REPORTING**

APPROVED BY: _____
Associate Administrator, Ambulatory

POLICY

ARMC's Patient Navigation Program utilizes tracking tools to identify patient and community needs and barriers to care as well as establish and address healthcare disparities. Documentation and reporting of such tracking ensure collaboration in the multidisciplinary efforts for providing and improving cancer care and treatment.

PROCEDURES

I. **Patient Navigation Tracking**
   A. Information tracked by Patient Navigator(s) includes but is not limited to:
      1. Identifying barriers to care
      2. Identifying healthcare disparities
      3. Evaluate organizational efficiency, timely services, and patient satisfaction
   B. Tracked information will be reported to the Cancer Program Department at least quarterly
   C. Recommendations for decreasing healthcare disparities, overcoming barriers, and overall improvement of the cancer service line shall be presented with quarterly reports.

II. **Breast Pathway Log – used to track timeliness of care from abnormal mammogram/ultrasound results to biopsy procedure.**
   A. Breast Pathway Log shall be used as a tool to ensure collaboration between Patient Navigator(s) and Medical Imaging staff
   B. Patient Navigator(s) monitor the Breast Pathway Log and assist the Medical Imaging staff with updating data (e.g. insurance, orders, pathology results, and scheduled biopsy dates)
   C. Patient Navigator(s) continue to follow patients and assist in reducing/eliminating barriers to continued cancer care

III. **Oncology Committee Report**
   A. Addressing Barriers to Care – Oncology Committee, provided annually during last quarterly meeting

REFERENCES: **ARMC Cancer Program Department Operations Manual**
American College of Surgeons Commission on Cancer, 2020 Standards of Cancer Care

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

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REPLACES: **N/A**

EFFECTIVE: _____

REVISED: **N/A**

REVIEWED: **N/A**