Commission on Cancer State Chair Town Hall

July 30, 2025

CoC State Chair Town Hall

Maria Castaldi, MD, FACS
Chair
Committee on Cancer Liaison

Quan Ly, MD, FACS
Vice-Chair
Committee on Cancer Liaison

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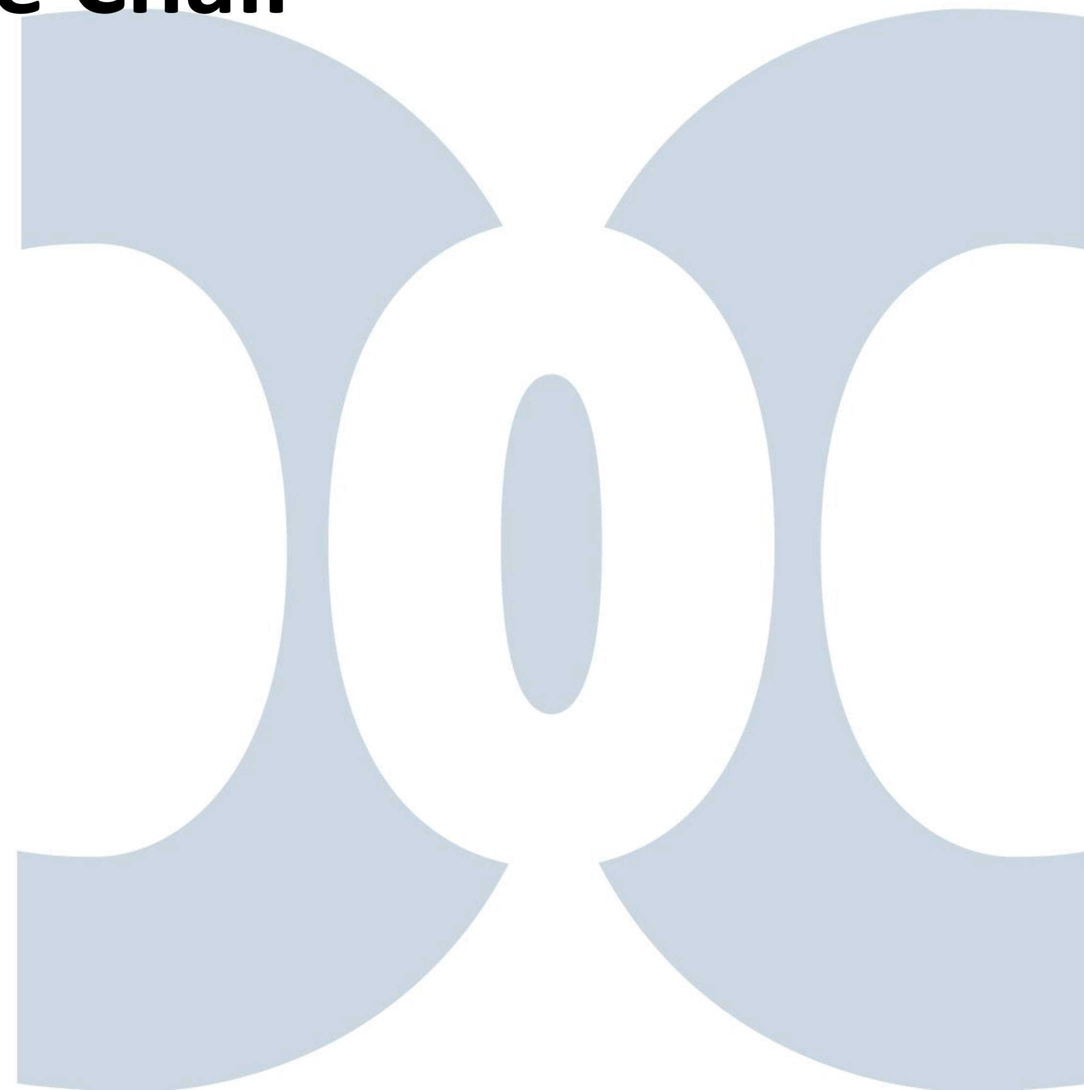
ACS CoC Commission on Cancer
American College of Surgeons

Welcome to New CoC State Chair



Shawn Steen, MD, FACS

Southern California

Commission on Cancer
American College of Surgeons

CoC Update

- Upcoming Meetings:
  - CLP Meeting: September 10
  - State Chair/CLP Accreditation Office Hour: September 25
    - Operative Standards with Dr. Timothy Vreeland
  - ACS Clinical Congress 2025: October 4-7 in Chicago, IL
    - October 4: State Chair Town Hall and CoC Plenary Session

Smoking and Cessation Across the Continuum of Lung Cancer Risk, Treatment, and Survival

Timothy Wm. Mullett, MD, MBA, FACS

Graham Warren, MD, PhD

University of Kentucky

Markey Cancer Center

Markey Cancer Center

An NCI Comprehensive Cancer Center

American Cancer Society

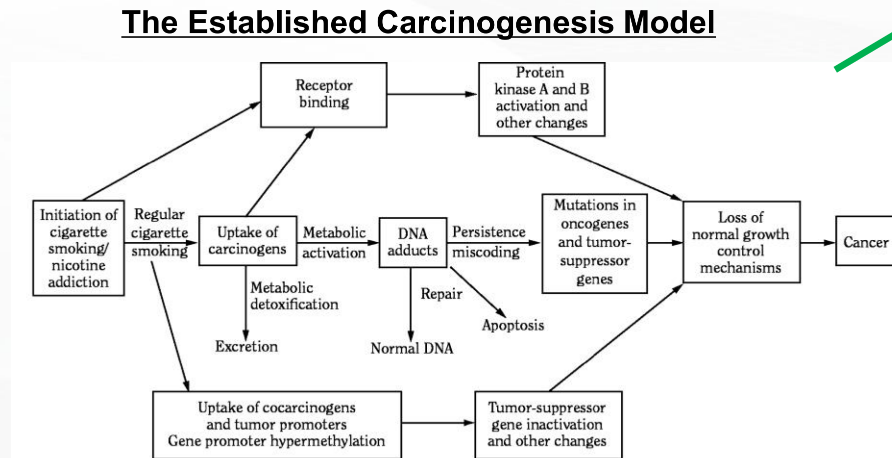
NATIONAL LUNG CANCER ROUNDTABLE

Smoking Across the Continuum of Cancer

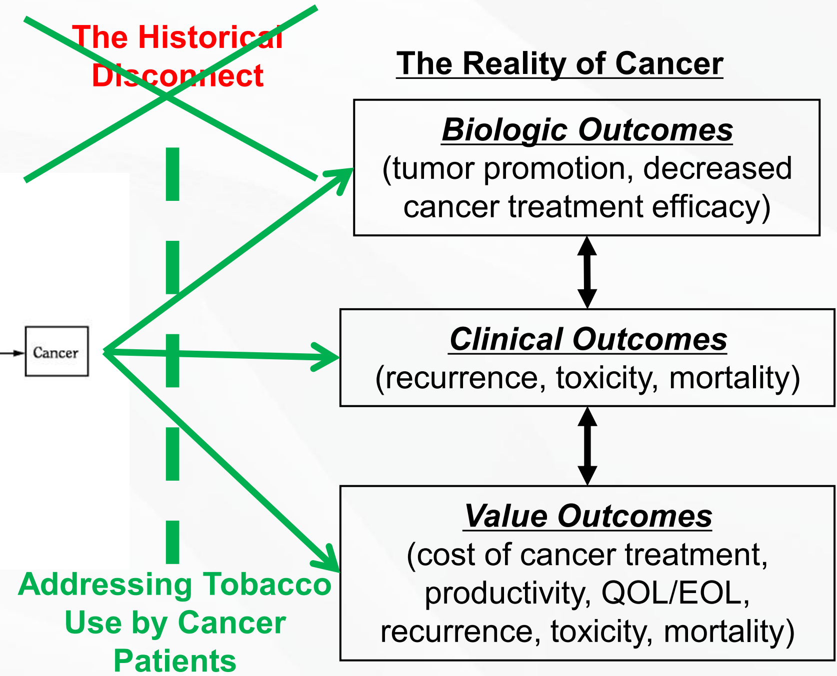
American Cancer Society | National Lung Cancer Roundtable

The biologic basis of smoking is well established (mutations, tumor promotion, tx resistance)

The Established Carcinogenesis Model



2010 Surgeon General's Report, Fig 5.1



I like the new concept from Goddard et al. (JAMA Oncol, Dec 2024)
With my highlight of smoking effects across prevention, screening, and treatment

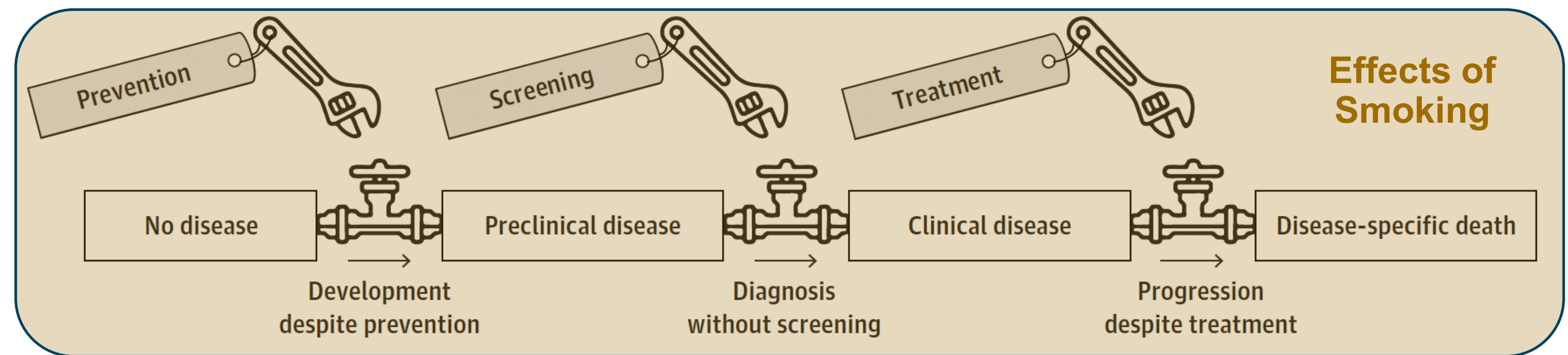


Figure. Opportunities for Averted Cancer Deaths With Prevention, Screening, and Treatment Interventions

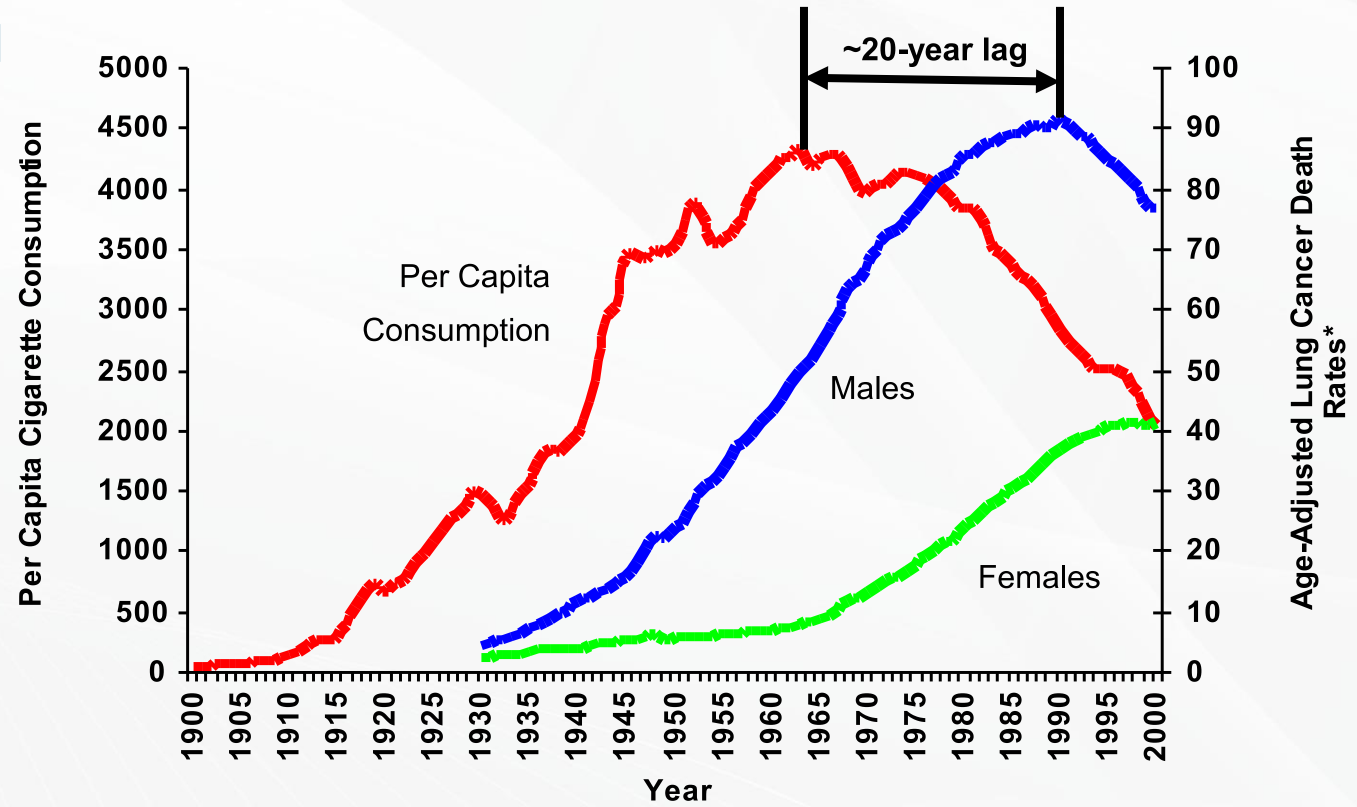
This schematic of cancer progression shows opportunities for prevention, screening (for interception and early detection), and treatment advances to partially or completely interrupt the development and/or progression of disease that would cause death.

American Cancer Society | National Lung Cancer Roundtable

Cessation has a ~20-Year Survival Lag… But is the Largest Preventable Risk Factor

- ~80-85% of lung cancers caused by smoking
- Smoking may mediate risk for other risk factors
- CISNET 1975-2020 prevention, screening, and treatment avert 5.94m cancer deaths*
  - 80% (4.75m) from prevention and screening of which
  - 3.75m from lung cancer
    - 98% from tobacco control
    - 2% from screening (not widely used in this timeframe)

*Goddard et al. JAMA Oncol Dec 2024



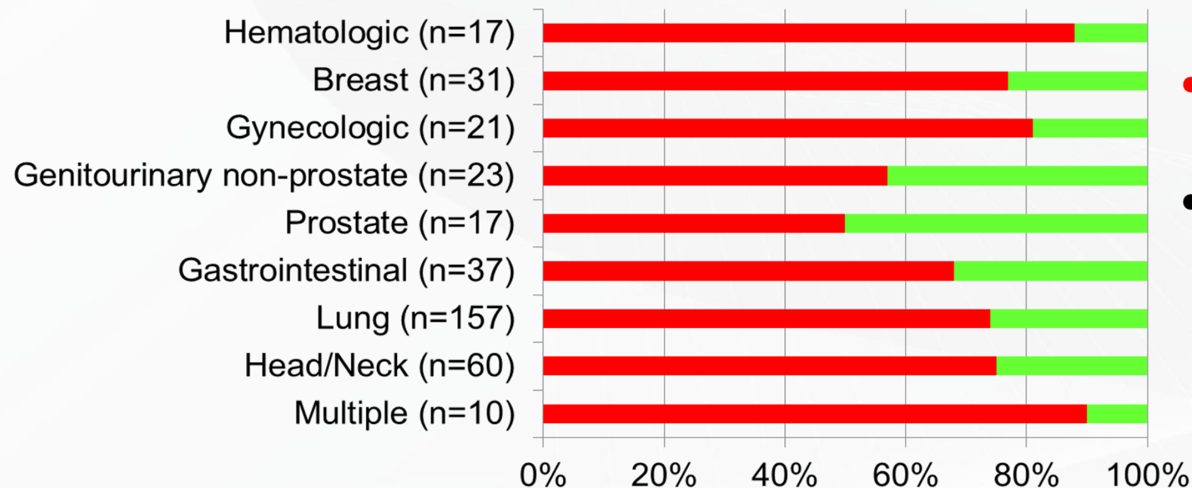
*Age-adjusted to 2000 US standard population.
Source: Death rates: US Mortality Public Use Tapes, 1960-2000, US Mortality Volumes, 1930-1959, National Center for Health Statistics, Centers for Disease Control and Prevention, 2002. Cigarette consumption: US Department of Agriculture, 1900-2000.

Effects of Smoking After a Cancer Diagnosis

American Cancer Society | National Lung Cancer Roundtable

2014 SGR: >400 studies, 500K patients 1990-2012

Effect	Associations	Median RR
Overall Mortality (159 studies)	87%	**Current: 1.51** Former: 1.22
Cancer Mortality (58 studies	79%	**Current: 1.61** Former: 1.03



Overall Mortality Among 129 studies, 2013-17

- Smoking at diagnosis with 61% increased risk
- Smoking at follow-up with 113% increased risk

Financial Effects of Smoking at Diagnosis

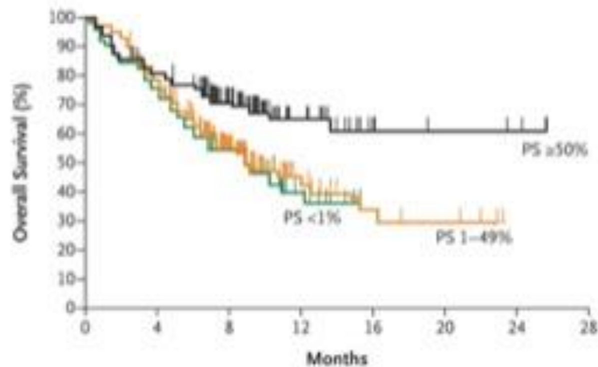
- Smoking after diagnosis adds ~$3.4 billion (US) and $239 million (Canada) in cancer treatment costs annually (2019 estimates)

Benefits of Smoking Cessation

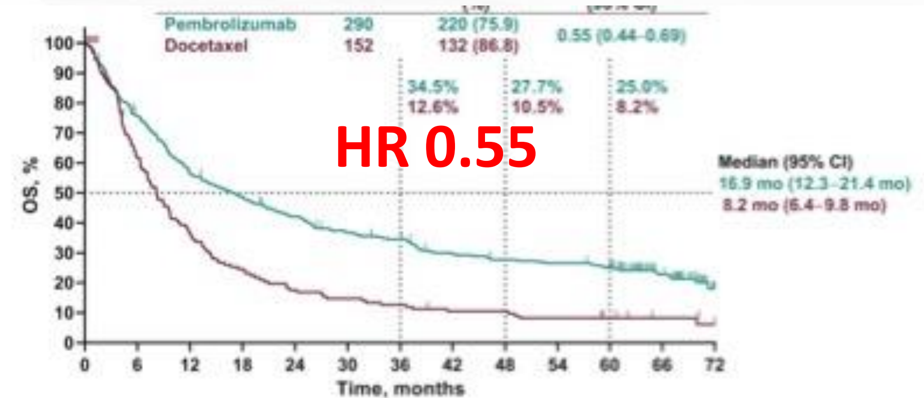
- **Smoking cessation AFTER diagnosis associated with 45% median reduction in mortality**
- Smoking cessation AT ANY TIME reduces non-cancer mortality (heart disease, pulmonary disease, etc.)

2014 SGR, 2020 SGR, Warren C3I 2021,
Warren JAMA Netw Open 2019, Irragori Curr Oncol 2020

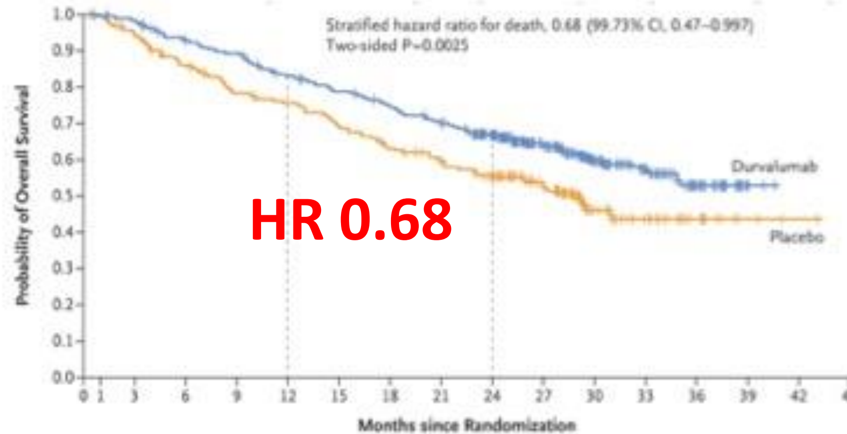
Smoking Cessation in the Context of Lung Cancer Treatment



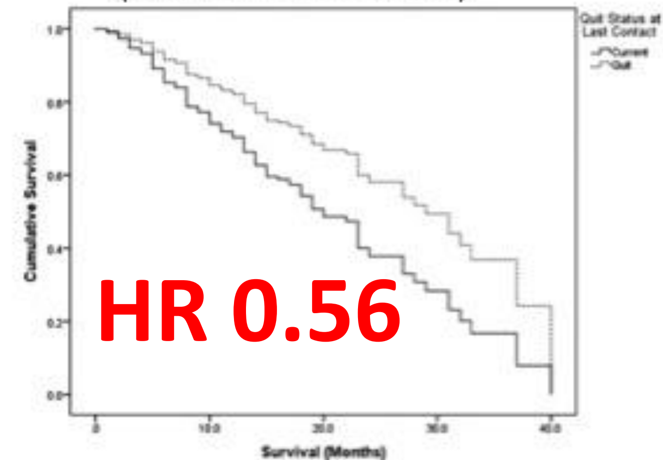
Overall Survival with Pembro by PD-L1 status, Keynote-001
(Garon et al. NEJM 2015)



Overall Survival with Pembro, PD-L1 >50 Keynote-010
(Herbst et al. JTO 2021)



Overall Survival with Duvalumab, Pacific Trial
(Antonia et al. NEJM 2018)



Smoking Cessation added to first line NSCLC treatment
(Dobson-Amato et al. JTO 2015)

Cessation After Diagnosis and Survival

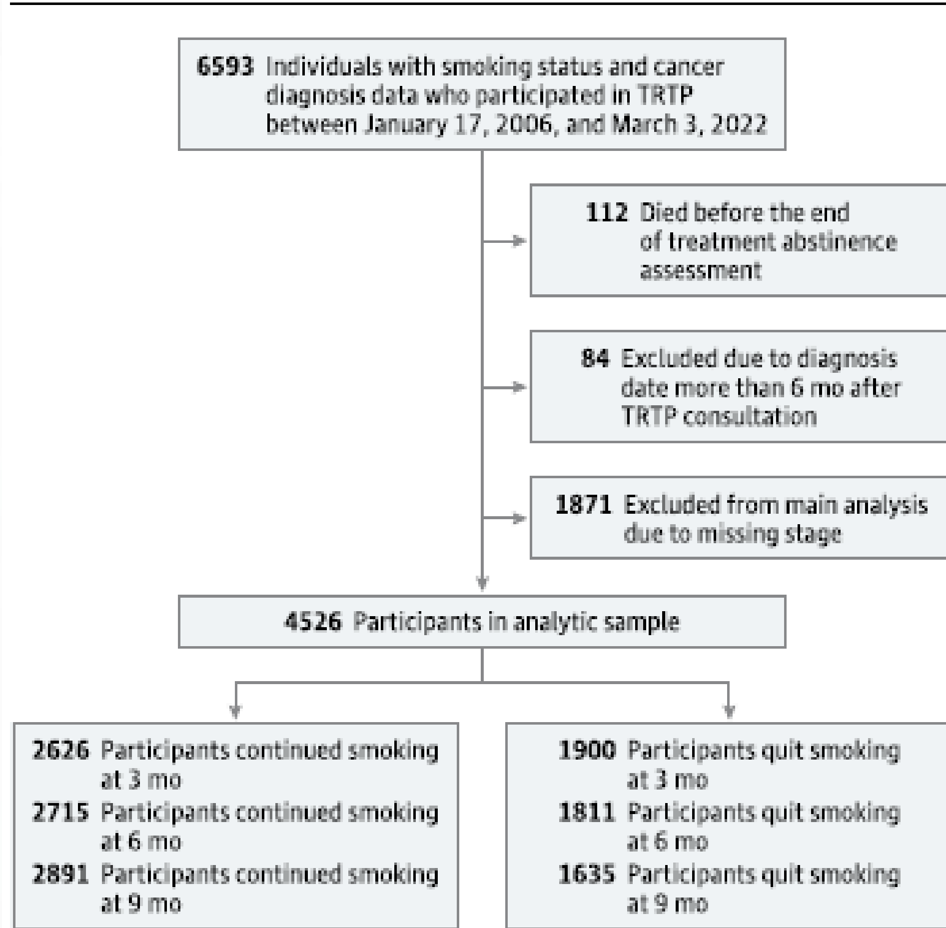


Figure 1. Study Flow Diagram

6593 Individuals with smoking status and cancer diagnosis data who participated in TRTP between January 17, 2006, and March 3, 2022

112 Died before the end of treatment abstinence assessment

84 Excluded due to diagnosis date more than 6 mo after TRTP consultation

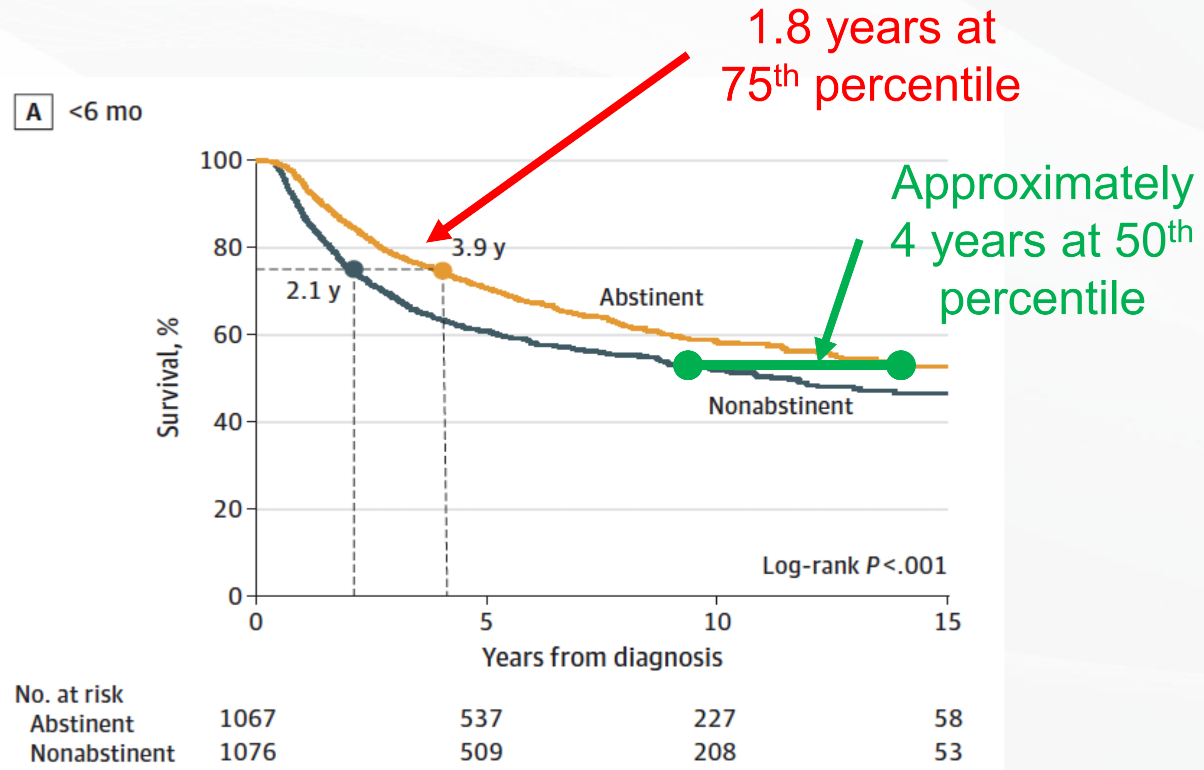
1871 Excluded from main analysis due to missing stage

4526 Participants in analytic sample

2626 Participants continued smoking at 3 mo
2715 Participants continued smoking at 6 mo
2891 Participants continued smoking at 9 mo

1900 Participants quit smoking at 3 mo
1811 Participants quit smoking at 6 mo
1635 Participants quit smoking at 9 mo

Currently smoking patients with cancer in the Tobacco Research and Treatment Program (TRTP) at the University of Texas MD Anderson Cancer Center were enrolled in the study. After the exclusions noted in the flow diagram, 4526 individuals remained in the analytic sample.



Quitting smoking as soon as possible after diagnosis results in the highest improved survival

Cinciripini et al. JAMA Oncol Nov 2024

American Cancer Society | National Lung Cancer Roundtable

National Implementation Efforts

- **NCI Smoking Cessation at Lung Examination (SCALE) Initiative**
  - 8 centers funded to implement cessation into LDCT
- **NCI Cancer Centers Cessation Initiative (C3I)**
  - 52 NCI Designated Cancer Centers funded over 2 years to develop clinical cessation programs
- **National Canadian Partnership Against Cancer (CPAC) Initiative**
  - Increased access to cessation support from 26% of centers in 2016 to 95% in 2022
- **American College of Surgeons Commission on Cancer (CoC)**
  - Just ASK: 700+ sites participated in increased identification of tobacco use (yr 1)
  - Beyond ASK: 300+ sites develop cessation approaches (yr 2)

Improving Outcomes

Tobacco Assessment and Treatment In the Cancer Patient

The JustASK and BeyondASK Projects

Cancer PROGRAMS

AMERICAN COLLEGE OF SURGEONS

CANCER PROGRAMS

Study Completed over 2022

Just ASK Quality Improvement Project & Clinical Study

Improving Assessing and Documenting Tobacco Use during Cancer Treatment

CANCER PROGRAMS

Study Completed over 2023

Beyond ASK Quality Improvement Project

Improving Referral to Effective Tobacco Treatment

Improved Care for Nearly 1Million Patients

JustASK (2022)

- Roughly 700 cancer programs
- About 650,000 cancer patients

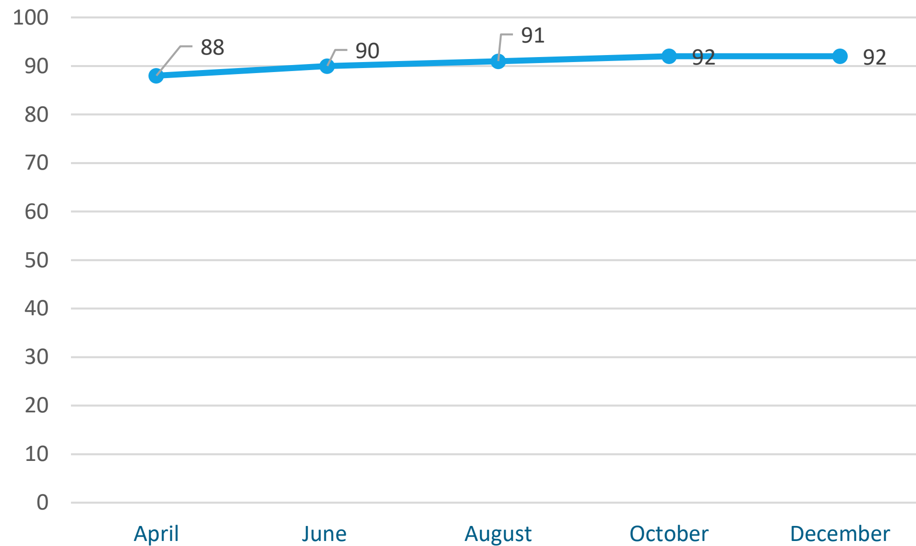
BeyondASK (2023)

- Roughly 300 cancer programs
- About 250,000 cancer patients

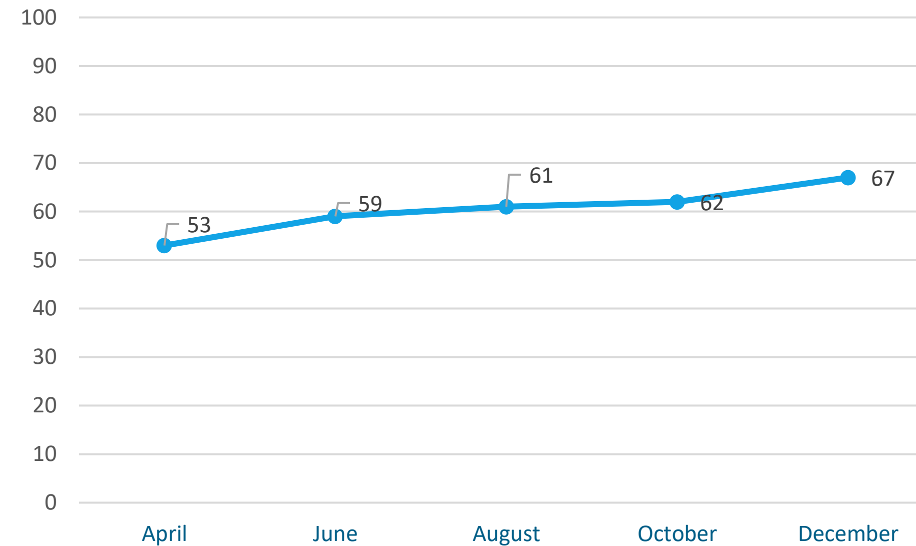
JustASK
Ask and Assist Trends (All)

Ask Rate

Most programs had participated in JustASK project

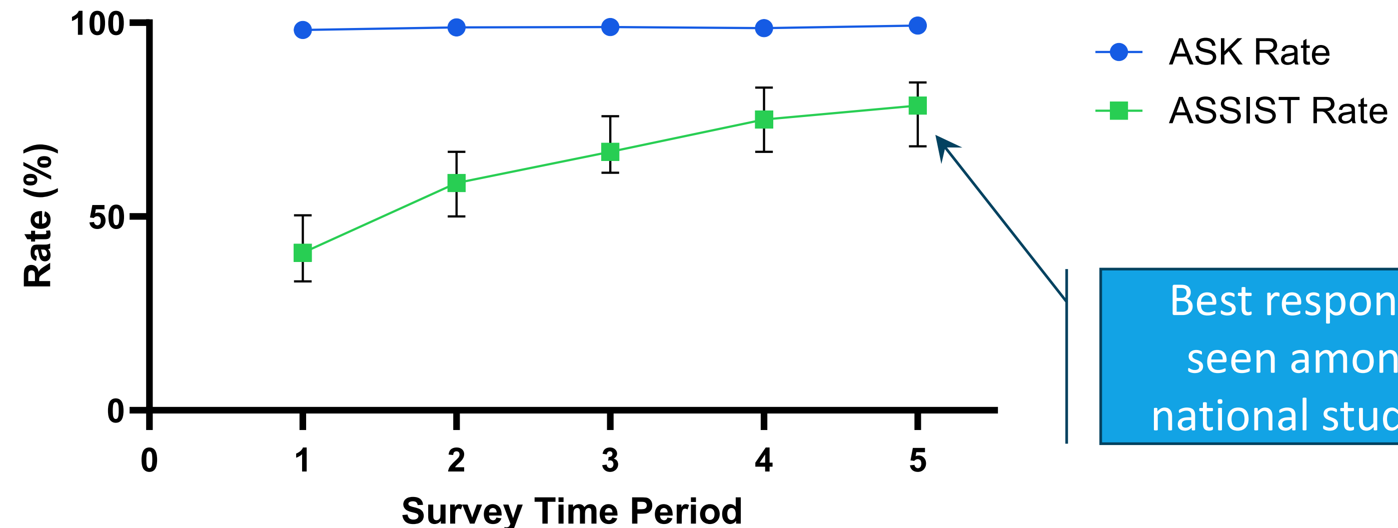


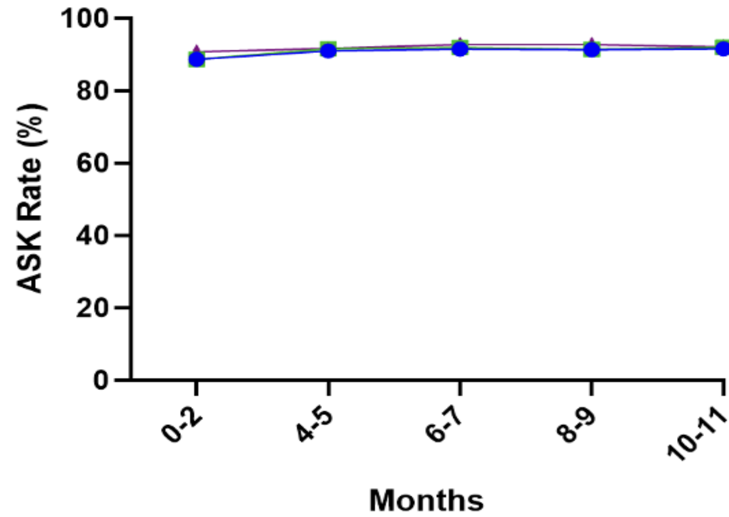
Assist Rate

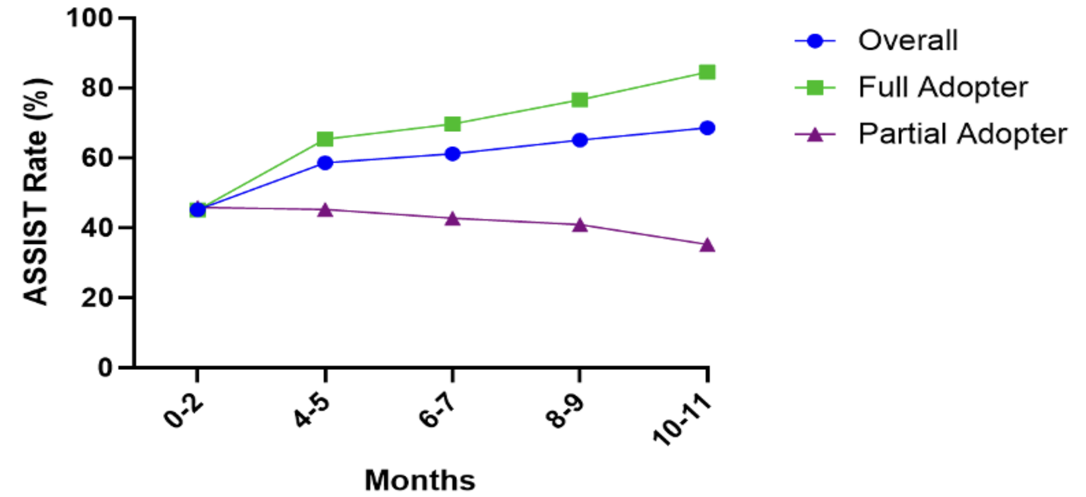


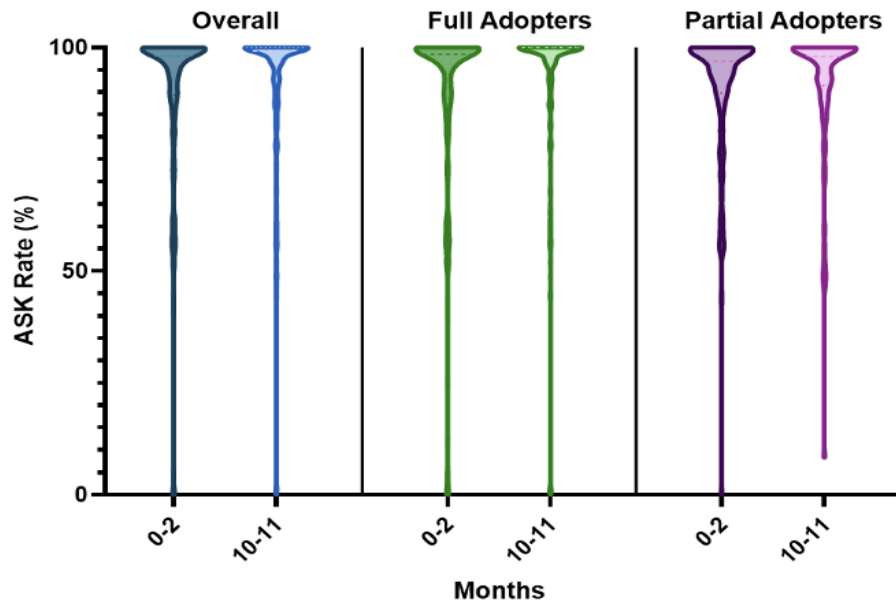
BeyondASK Project Preliminary Results

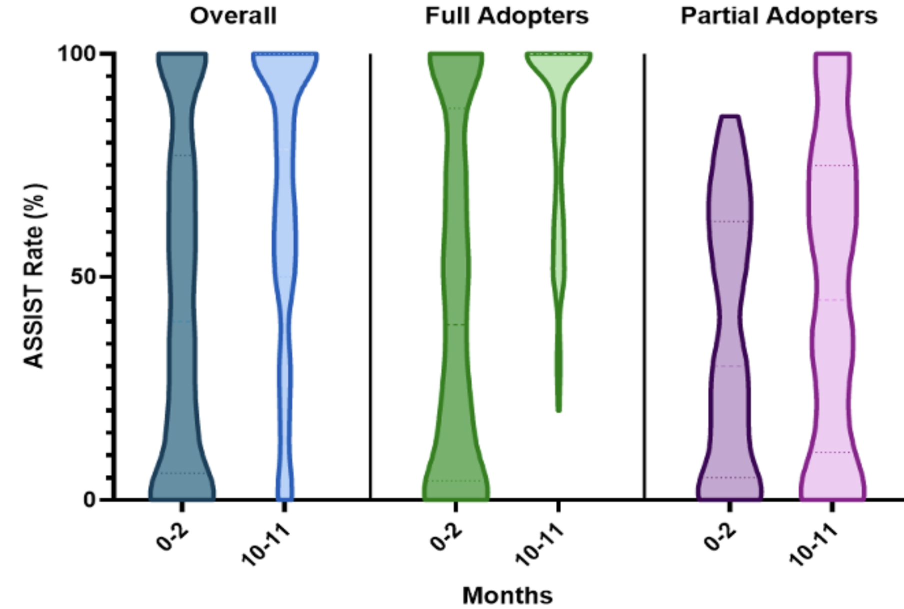
	ASK Rate: Asked / Seen * 100	ASSIST Rate: Assistance / Current Smoking * 100
BASELINE Period 1 (n=327): January 1, 2023-February 28, 2023	Median 98.16% (95% CI: 97.35-98.75)	Median 40.71% (95% CI: 33.33-50.31)
Period 2 (n=317): April 1, 2023-May 31, 2023	Median 98.81% (95% CI: 98.26-99.57)	Median 58.71% (95% CI: 50.0-66.67)
Period 3 (n=314): June 1, 2023-July 31, 2023	Median 98.87% (95% CI: 98.45-99.54)	Median 66.67% (95% CI: 61.29-75.86)
Period 4 (n=307): Aug 1, 2023-Sept 30, 2023	Median 98.67% (95% CI: 97.96-99.46)	Median 75% (95% CI: 66.67-83.33)
Period 5 (n=307): Oct 1, 2023-Nov 30, 2023	Median 99.3% (95% CI: 98.47-100)	Median 78.62% (95% CI: 68.18-84.62)



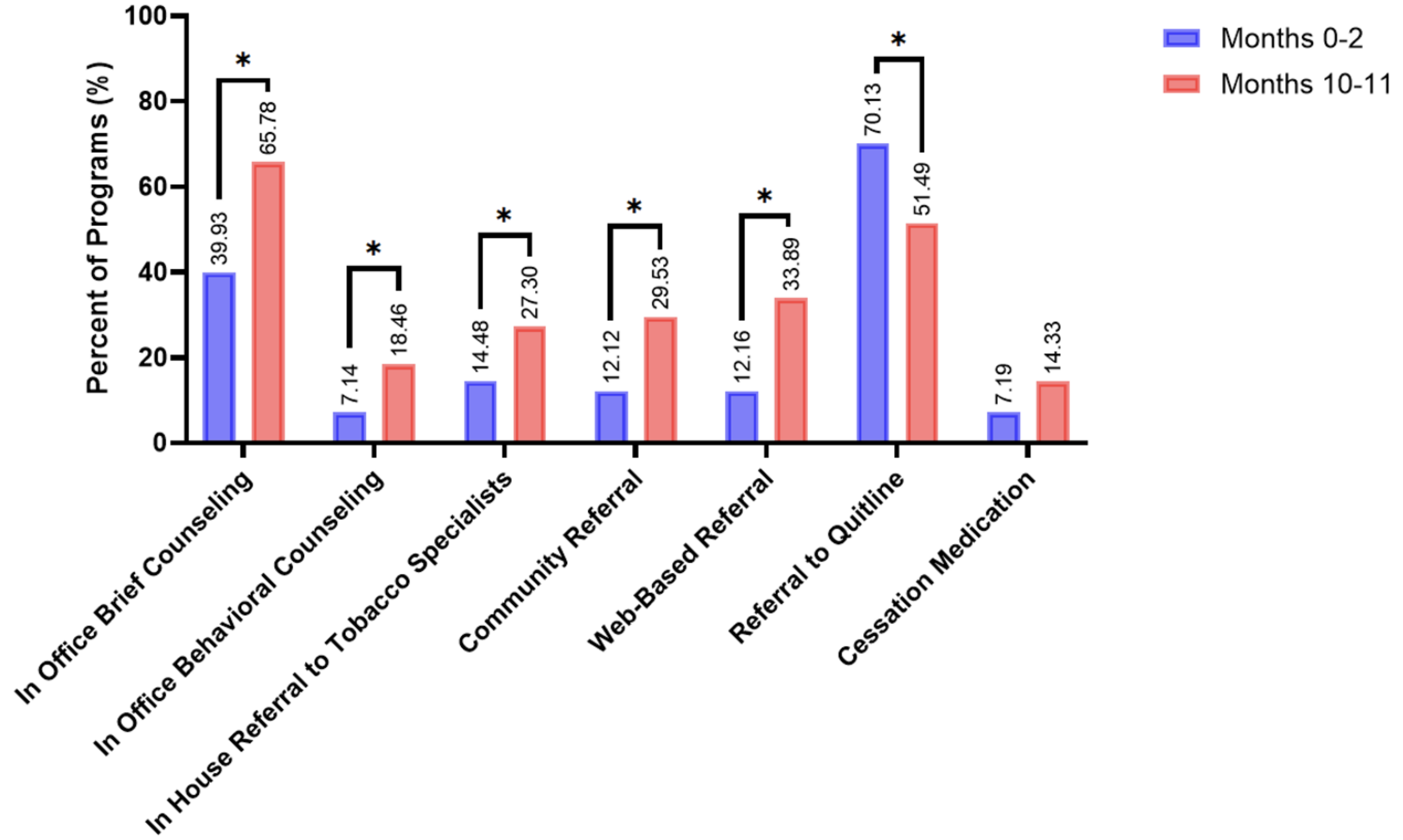








NATIONAL LUNG CANCER ROUNDTABLE



NATIONAL LUNG CANCER ROUNDTABLE

Future Opportunities to Impact Tobacco Treatment in Cancer Survivors

American Cancer Society | National Lung Cancer Roundtable

JustASK Summary Paper Published in JCO

Longitudinal Results from the Nationwide Just ASK Initiative to Promote Routine Smoking Assessment in American College of Surgeons Accredited Cancer Programs

QI Data has been foundational in a *highly scored, likely fundable* NCI R01 Grant Application

Our collaboration has contributed to the development of a 6-year grant application to be reviewed in March

The Accreditation Committee has approved a NEW CoC Standard on Smoking Cessation

NEW CoC STANDARD 5.9

Standard for Commission on Cancer
Smoking Cessation for Patients with Cancer

Programs will have to implement process & do audit in 2026 to establish baseline

Measured for compliance in 2027 Site Reviews

All newly diagnosed patients with cancer in CoC Accredited facility

↓

Assess for tobacco use in the last 30 days

Determine the ASK Rate	Threshold for compliance = 90%

↓

Assist patients found to be POSITIVE in Tobacco Use to EFFECTIVE tobacco treatment

Determine the ASSIST Rate	Threshold for compliance = 80%

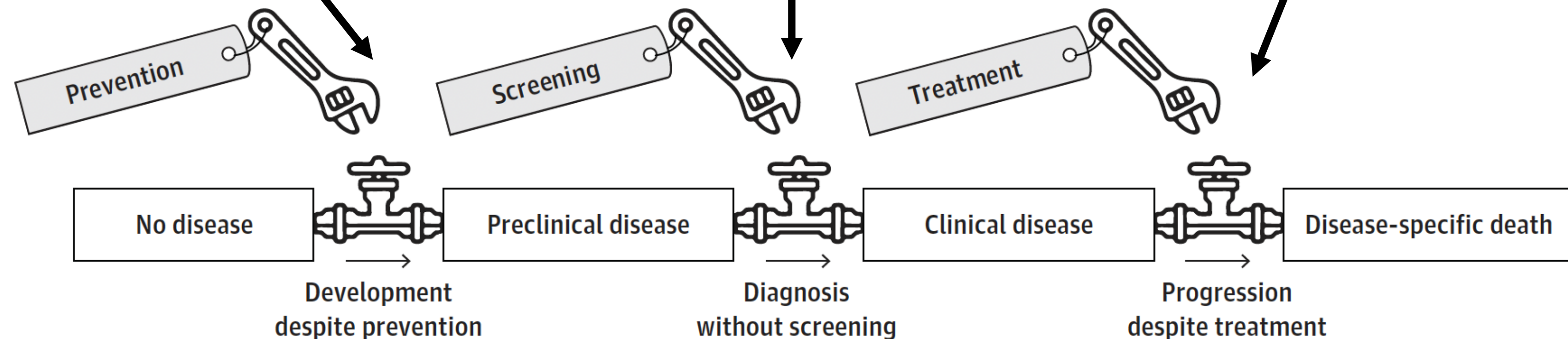
Smoking Must be Addressed with All Steps of the Lung Cancer Continuum

American Cancer Society | National Lung Cancer Roundtable

Tobacco control and early cessation reduces risk (largest benefit)

Effective cessation with screening

Effective cessation after diagnosis



Smoking cessation may be the EASIEST, CHEAPEST, and LOWEST TOXICITY approach to significantly improve patient outcomes

Summary

- **Smoking is the largest preventable risk factor for lung cancer**
- **Tobacco control (primary and smoking cessation) is a proven method to reduce lung cancer incidence and mortality**
- **Smoking/tobacco may interact with other risk factors**
    - Mixed vs. pure risk factors
- **Clear evidence supports clear clinical benefits for smoking cessation across the entire spectrum of lung cancer risk, diagnosis, treatment, and survival**

Efforts to address lung cancer must consider smoking and cessation

ACS CoC Commission on Cancer
American College of Surgeons

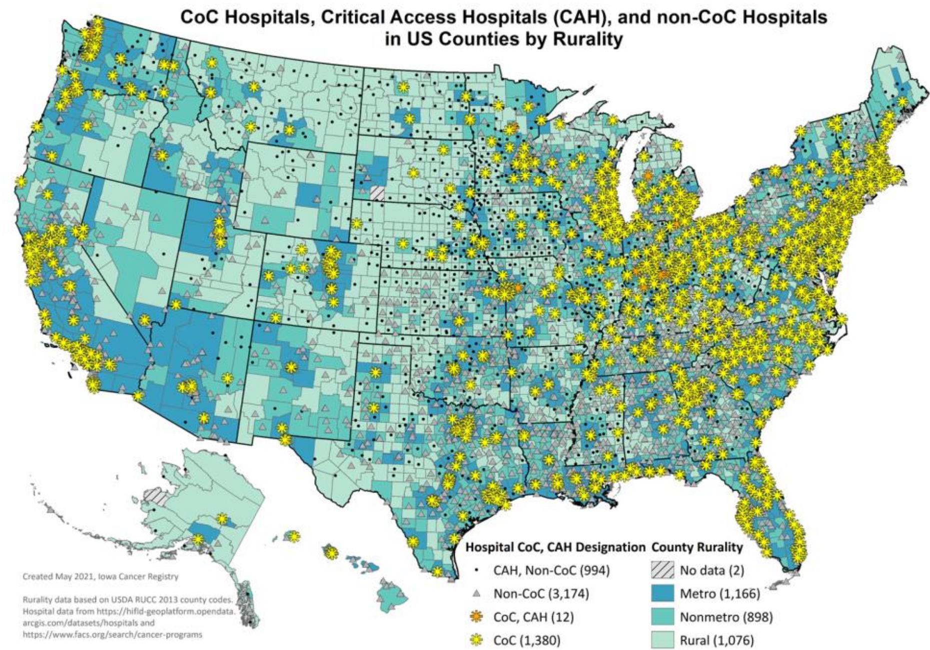
Supporting Cancer Care in the Rural Setting through Accreditation

Ingrid Lizarraga MBBS, FACS

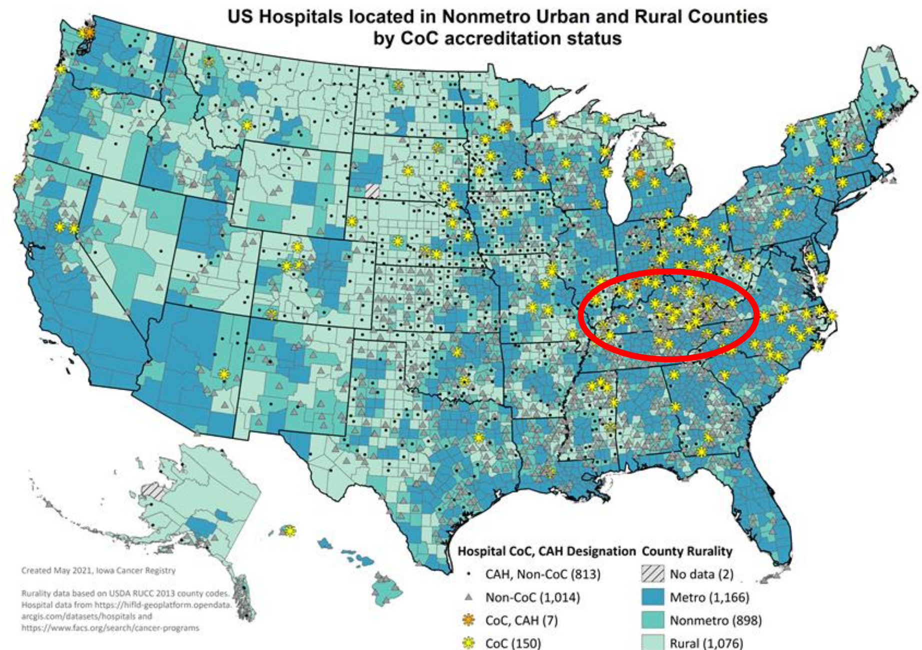
July 29, 2025

Rural urban differences in Commission on Cancer (CoC) accreditation

All CoC Hospitals



Rural CoC Hospitals



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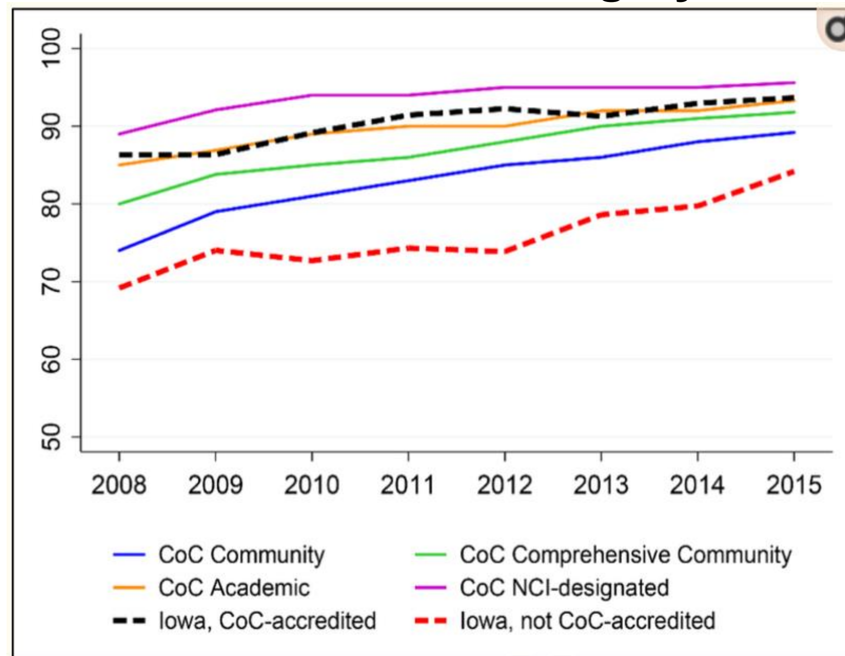
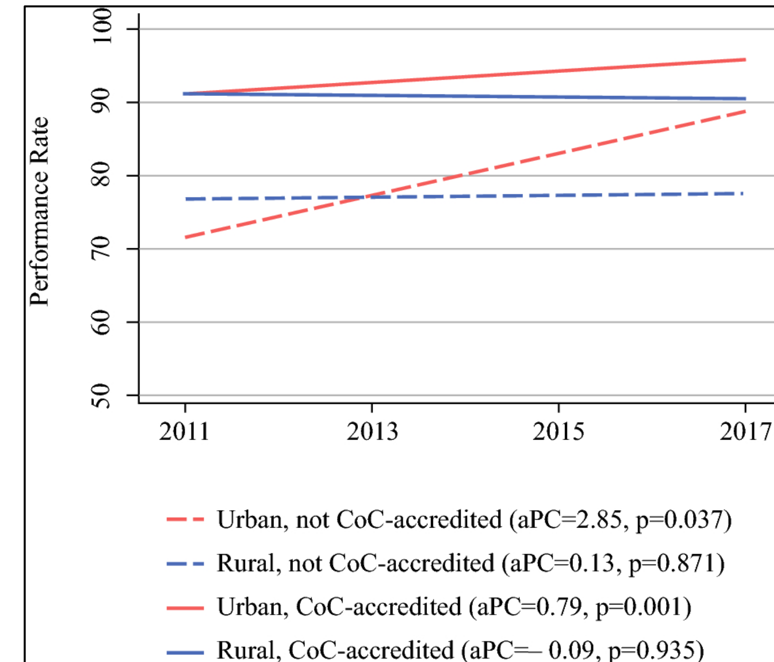
Compliance with Quality Measures is Worse in rural Non-CoC Hospitals

Percent of colon cases compliant with lymph node measure by CoC accreditation category



Shulman et al. 2019. Compliance with Cancer Quality Measures Over Time and Their Association with Survival Outcomes: The CoC's Experience with the Quality Measure Requiring >12 Regional Lymph Nodes to be Removed and Analyzed with Colon Cancer Resections.

Percent of colon cases compliant with lymph node measure by hospital rurality and CoC accreditation status



Schroeder, M.C., Gao, X., Lizarraga, I. *et al.* The Impact of Commission on Cancer Accreditation Status, Hospital Rurality and Hospital Size on Quality Measure Performance Rates. *Ann Surg Oncol* **29**, 2527–2536 (2022). https://doi.org/10.1245/s10434-021-11304-3

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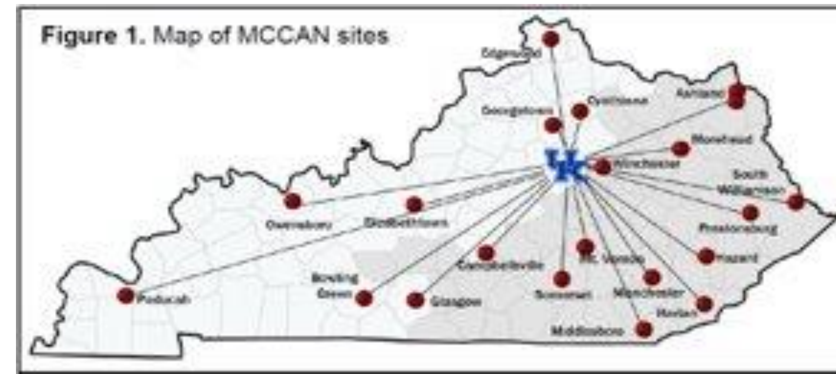
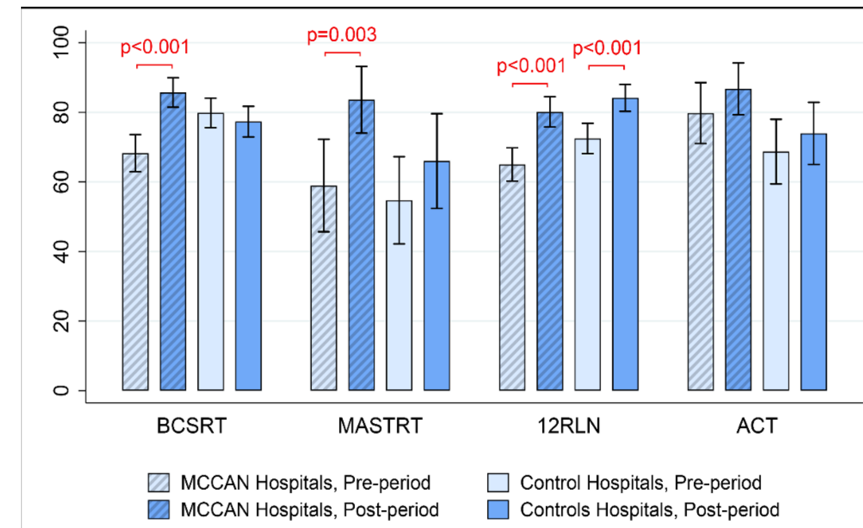
Improving Rural Cancer Care: Network Model

- Since 2006, Markey has extended their resources across Kentucky through a **collaborative network of hospitals**
- MCCAN assists hospitals in achieving the CoC standards through:
  - Tailored programs and resources
  - Supporting data collection
  - Consultative expertise
  - Guidance and templates
  - QI assistance
  - Maintaining accreditation





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Effectiveness and implementation of a health system intervention to improve quality of cancer care for rural, underserved patients

Objectives:

1. Determine the core functions (what makes the intervention effective) of the MCCAN model, and document the specific strategies or activities that may be customized to Iowa and are needed to carry out the core functions
2. Implement a collaborative network adapted for Iowa to make achievement of the CoC standards more feasible for rural community hospitals
3. Measure progress towards achievement of CoC standards and impact on quality measures of cancer care

Mary Charlton PhD
Professor of Epidemiology
College of Public Health
University of Iowa

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What we've learned

- Challenges – workforce shortages, physician retention, payor mix, less access to services, less favorable patient population
- Using the CoC accreditation standards has improved ability to deliver comprehensive cancer care
  - Tumor board
  - Cancer committee
  - Supportive services
- Some standards are prohibitively challenging for rural hospitals
  - Access to clinical trials
  - Genetic counseling
  - Palliative care
  - Data collection

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Rural Accreditation Track

- Informed by findings of study
- Tailored to needs and resources of rural hospitals
- Focused on the standards shown to have maximum impact on quality of care

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Standards Unchanged from Original Track

- 1.1 Administrative Commitment
- 2.2 Cancer Liaison Physician (CLP)
- 2.3 Cancer Committee Meetings
- 2.4 Cancer Committee Attendance
- 3.1 Facility Accreditation
- 3.2 Evaluation and Treatment Services
- 4.3 Cancer Registry Staff Credentials
- 4.6 Rehabilitation Services
- 4.1 Physician Credentials
- 8.2 Cancer Prevention Event
- 8.3 Cancer Screening Event
- 5.1 CAP
- 5.2-5.8 Surgical Synoptic Reporting

Standards Different from Original Track

- 2.1 Cancer Committee
- 2.5 Multidisciplinary Cancer Case Conference (Tumor Board)
- 4.5 Palliative Care Services
- 6.1 Cancer Registry Quality Control (exempt for initial visit)
- 4.4 Genetic Counseling and Risk Assessment
- 4.7 Oncology Nutrition Services
- 7.3 Quality Improvement Initiative
- 8.1 Addressing Barriers to care (exempt for initial visit)
- 4.2 Oncology Nursing Credentials
- 4.8 Survivorship Program
- 5.2 Psychosocial Distress Screening
- 7.2 Monitoring Concordance w/EBG
- 9.1 Clinical Research Accrual

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2.1 Cancer Committee

Standard Track

- Establish/state required members & coordinators with alternates
- **Required physician and non-physician members:**
    - Cancer Committee Chair, Cancer Liaison Physician, Diagnostic radiologist, Pathologist, Surgeon, Medical oncologist, Radiation oncologist, Cancer Program Administrator, Oncology nurse, Social worker, Oncology Data Specialist
- **Required Coordinator Members:**
    - Cancer Conference Coordinator, Quality Improvement Coordinator, Cancer Registry Quality Coordinator, Clinical Research Coordinator, Psychosocial Services Coordinator, Survivorship Program Coordinator

Rural Track

- At minimum, the cancer committee must consist of at least the following members:
    - **3 physicians representing 3 different medical disciplines**
    - **2 healthcare professionals representing different disciplines related to the management and/or care of patients with cancer**
    - **Cancer program Administrator**
    - **Cancer Registry Quality Coordinator**
    - **Cancer Conference Coordinator**
    - **Survivorship Program Coordinator**

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2.5 Tumor Board

Standard Track

- **Policy and procedure to govern tumor board activity addressing**:
- Elements of discussion; required to discuss clinical/pathological stage, treatment planning using EB guidelines, options and availability for genetic testing, clinical research studies, and supportive care (where applicable)
- **Attendance must include a representative from surgery, pathology, radiology, radiation oncology, and medical oncology.**
- **Cancer conference coordinator must evaluate and report annually to the cancer committee on required elements**

Rural Track

- Before the initial site visit as a Rural Cancer Program, it is strongly recommended that a multidisciplinary cancer conference be established at the applicant program. **At a minimum, the cancer program must demonstrate that at least one oncology physician is presenting at a multidisciplinary cancer case conference externally**
- Before the first reaccreditation visit, there must be a multidisciplinary cancer conference established at the accredited program, as required by the standard, for at least the last six months of the accreditation cycle

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4.2 Oncology Nursing Credentials

Standard Track

- Roster of nurses with certification status. Policy on nursing competency.
- All registered nurses and advanced practice nurses providing direct oncology care must demonstrate:
  - Current cancer-specific certification in the nurse's specialty by an accredited certification program, or
  - Ongoing education by earning 36 cancer-related Nursing Continuing Professional Development (NCPD) contact hours each accreditation cycle
- This standard applies to registered nurses and advanced practice nurses who provide direct oncology care in the accredited facility for at least one calendar year.

Rural Track

- All registered nurses and advanced practice nurses providing direct oncology care must demonstrate one of the following:
  - **Current cancer-specific certification in the nurse's specialty by an accredited certification program, or**
  - **Ongoing education by earning 18 cancer-related Nursing Continuing Professional Development contact hours each accreditation cycle.**

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4.4 Genetic Counseling and Risk Assessment

Standard Track

- Policy/Procedure
- Select a cancer site to audit
- The number of patients identified as needing referrals for the selected cancer site each year
- How many patients identified as needing referrals for the selected cancer site received a referral for genetic counseling

Rural Track

- Rural Cancer Programs are not required to complete the requirements under "Monitoring Genetic Assessment for a Selected Cancer Site" and the related annual reporting requirements to the cancer committee.
- Instead, **each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements, as needed, to genetic counseling and risk assessment services and/or referrals.** The content of the review and any recommendations for improvement are documented in the cancer committee minutes.
- The policy and procedure for genetic counseling and risk assessment is evaluated at least once each accreditation cycle.

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Standard Track

4.5 Palliative Care Services

- Palliative care services available to cancer patients either on-site or by referral
- Policy/Procedure
- Annual report evaluating the number of patients referred for services, what services, criteria utilized to trigger referrals, and areas for improvement

4.7 Oncology Nutrition Services

- Policy/Procedure
- Annual review of the services.

5.2 Psychosocial Distress Screening

- Policy/Procedure
- Annual summary of services including the number of patients screened, referred, or further follow-up, and where patients referred

Rural Track

- **Before the initial site visit, the Rural Cancer Program complies with one of the following standards: 4.5, 4.7, or 5.2. By the reaccreditation visit, the Rural Cancer Program must comply with at least two of the following standards: 4.5, 4.7, or 5.2.**
- For the selected standard(s), **the required annual review is limited to monitoring, evaluating, and making recommendations for improvements, as needed, to the required services and/or referrals for the selected standard.** The content of the review and any recommendations for improvement are documented in the cancer committee minutes. The policy and procedure for the selected standards are evaluated at least once each accreditation cycle.

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4.8 Survivorship Program

Standard Track

- Policy/Procedure
- The survivorship program team formally documents and evaluates a minimum of three survivorship services offered each year.
- Annual review of the program

Rural Track

- **Only one service must be reviewed each year.** It is not required that the number of participants be reported. **The remainder of the standard is complied with as written.**
- The policy and procedure is evaluated at least once during the accreditation cycle.

6.1 Cancer Registry Quality Control

Standard Track

- Policy/Procedure
- Annual Quality Control Evaluation
- Cancer Registry Quality Control Template

Rural Track

- **Exempt for initial site visit**
- Must comply with standard as written for first reaccreditation visit

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7.2 Monitoring Concordance w/EBG

Standard Track

- Report of the in-depth analysis with all required elements.
  - A physician conducts an in-depth analysis to determine whether initial diagnostic evaluation and first course of treatment provided to patients is concordant with evidence-based national treatment guidelines.

Rural Track

- **One study must be completed per standard requirements once each accreditation cycle.**

7.3 Quality Improvement Initiative

Standard Track

- Perform a quality improvement initiative
- New QI project required annually
- CLP or QI Coordinator provides updates to cancer committee at least twice each calendar year indicating current status and planned next steps. Final summary and results report counts towards this number.

Rural Track

- **This standard is exempt for initial site visits**.
- **For each calendar year after initial accreditation, the rural cancer program must be actively engaged in a quality improvement (QI) initiative**. Programs may choose to complete a new project each year or work on one project over multiple years.
- At least two status updates must be provided to the cancer committee on the QI initiative each calendar year.

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8.1 Addressing Barriers to Care

Standard Track

- The cancer committee identifies at least one barrier to focus on for the year and identifies resources and processes to address the barrier.
- The cancer committee evaluates the resources and processes adopted to address the barrier to care and identify strengths and areas for improvement

Rural Track

- **This standard is exempt for initial site visits**.
- Each calendar year after initial accreditation, the standard must be complied with per standard requirements

9.1 Clinical Research Accrual

Standard Track

- Screening Policy/Procedure
- The number of accruals meets or exceeds the required percentage
- Annual report to cancer committee by Clinical Research Coordinator

Rural Track

- Screening Policy/Procedure, evaluated at least once during the accreditation cycle
- **Rural Cancer Programs are exempt from demonstrating accruals and the Clinical Research Coordinator reporting requirements.**

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Accreditation Tailored to Rural Programs

Eligibility: Hospital is located in a county that is designated RUCC 4-9

- RUCC: Metric that differentiates counties by their population size, degree of urbanization, and adjacency to a metro area

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Rural-Urban Continuum Codes

Updated: 1/7/2025 **Contact:** Austin Sanders or John Cromartie

In this section
Overview
Documentation

The 2023 Rural-Urban Continuum Codes distinguish U.S. metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by their degree of urbanization and adjacency to a metro area. The division of counties as either metro or nonmetro, based on the 2023 Office of Management and Budget (OMB) delineation of metro areas, is further subdivided into three metro and six nonmetro categories. Each county and census-designated county-equivalent in the United States, including those in outlying territories, is assigned one of these nine codes. The codes allow researchers, policy makers, and others to view county-level data by finer residential groups—beyond metro and nonmetro—when analyzing trends related to population density and metro influence.

Developed in 1974, the Rural-Urban Continuum Codes have been updated each decade since (1983, 1993, 2003, 2013, 2023). Changes in the criteria used to define urban and metro areas over time has reduced the comparability of the Rural-Urban Continuum Codes over each of the past five decades. For the 2023 version, the threshold for urban area population was raised from at least 2,500 to 5,000 people, reflecting changes to urban area qualification introduced by the U.S. Census Bureau in 2020.

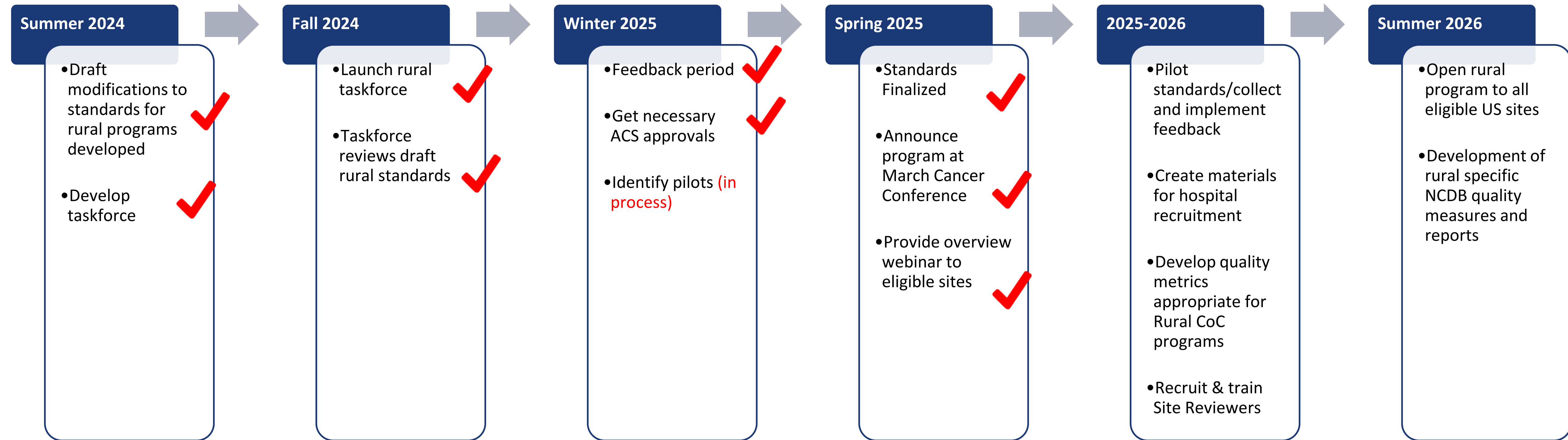
See the Documentation for details and a map of the codes.

File Downloads

2023 Rural-Urban Continuum Codes
Download XLSX | Download CSV
Last Updated 1/22/2024

https://www.ers.usda.gov/data-products/rural-urban-continuum-codes

CoC Rural Program Timeline



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ACS CoC Commission on Cancer American College of Surgeons

Share Our Webinar about the NEW CoC Accreditation for Rural Hospitals!

In this 30-minute webinar, attendees will learn:

- What Commission on Cancer (CoC) accreditation is and how it impacts care for patients with cancer
- Why CoC accreditation is important for hospitals in rural areas
- About a new set of CoC accreditation requirements designed for hospitals in rural counties

Access the Recording!

Questions or know of an interested hospital?
Please email CoC@facs.org.

Help us finalize our Rural Cancer Program Designation!

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Commission on Cancer
American College of Surgeons

State Chair/American Cancer Society Spotlight

Julie Shaver, MPH

Senior Director, Cancer Center Partnerships

American Cancer Society

New Jersey: Ravi Chokshi, MD, FACS and Maureen Kuhn

New Hampshire: Jessica Ryan, MD, FACS and Amy Deavitt

ACS CoC Commission on Cancer
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Open Forum

Thank you!

Questions?

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facs.org/quality-programs/cancer-programs/

ACS Cancer Programs

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