# Pre-Review Questionnaire (PRQ)

| Standard 1.1 |
| --- |

Link to Standard 1.1

**Provide a letter from facility leadership (CEO or equivalent) that includes all required components and demonstrates the commitment to the Cancer Committee.**

**Program Comments**

| Standard 2.1 |
| --- |

Link to Standard 2.1

**Complete and upload the Cancer Committee template with member names for each year within accreditation cycle to the General Survey Documents section:**

Template

**Indicate the non-required member roles that are on the Cancer Committee:**

Select all that apply:
- ☐ **Palliative care professional**
- ☐ **Genetics professional**
- ☐ **Registered Dietitian Nutritionist**
- ☐ **Rehabilitation services professional**
- ☐ **Pharmacist**
- ☐ **Pastoral care representative**
- ☐ **American Cancer Society representative**
- ☐ **Not Applicable**

**Program Comments**

| Standard 2.2 |
| --- |

Link to Standard 2.2

**Upload CLP reports or presentations that are separate from Cancer Committee Minutes for all years of accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**What is the medical specialty of the current CLP:**

**Currently, is the CLP also the Cancer Committee Chair:**

○ Yes   ○ No   ○ N/A

**Program Comments**

| Standard 2.3 |
| --- |

Link to Standard 2.3

**Complete and upload the Cancer Committee template with meeting dates for each year within accreditation cycle to the General Survey Documents section.**
**Use the Cancer Committee template accessible from Standard 2.1.**

**Currently, what is the frequency of Cancer Committee meetings (do not include subcommittee meetings):**

Select One: ▾

**Do you use subcommittees or workgroups:**

○ Yes  ○ No  ○ N/A

**Indicate the subcommittees or work groups utilized by the Cancer Committee for each year of accreditation cycle:**

Select all that apply:

| 2020 | 2021 |
|---|---|
| ☐ Clinical and translational research activity | ☐ Clinical and translational research activity |
| ☐ Screening and prevention activity | ☐ Screening and prevention activity |
| ☐ Quality control of cancer registry data | ☐ Quality control of cancer registry data |
| ☐ Quality management and improvement activity | ☐ Quality management and improvement activity |
| ☐ Review of policies and procedures | ☐ Review of policies and procedures |
| ☐ Not Applicable | ☐ Not Applicable |
| ☐ Other | ☐ Other |

Other Specify:                    Other Specify:

**Describe the subcommittee or workgroups:**

**2020 2021**

**Program Comments**

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**Standard 2.4**

Link to Standard 2.4

**Complete and upload the Cancer Committee template with meeting attendance for each year within accreditation cycle to the General Survey Documents section.**
**Use the Cancer Committee template accessible from Standard 2.1.**

**Program Comments**

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**Standard 2.5**

Link to Standard 2.5

**Upload the policy and procedure on multidisciplinary cancer case conference:**

**Upload coordinator reports or presentations that are separate from Cancer Committee Minutes for all years of accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**Complete and upload the Multidisciplinary Cancer Case Conference template to the General Survey Documents section for cancer case conference summary information for each year within accreditation cycle:**

Template

**Do you hold a site-specific conference for any of the following:**

Select all that apply:
☐ Breast
☐ Colorectal
☐ Lung

- ☐ **Prostate**
- ☐ **Melanoma**
- ☐ **Not Applicable**

**Do you hold any of the following specialty conferences:**

Select all that apply:
- ☐ **Prognostic factors conferences**
- ☐ **Clinical research**
- ☐ **Genetics conferences**
- ☐ **Not Applicable**

**Program Comments**

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| Standard 3.1 |
| --- |

**Upload current facility accreditation certificates:**

**Indicate current accreditations:**

Select all that apply:
- ☐ **DNV (Det Norske Veritas Healthcare, Inc.)**
- ☐ **The Joint Commission**
- ☐ **State level of accreditation**
- ☐ **AOA (American Osteopathic Association)**
- ☐ **CMS (Centers for Medicare & Medicaid Services)**
- ☐ **Not Applicable**
- ☐ **Other**

**Program Comments**

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| Standard 3.2 |
| --- |

**Provide current accreditation certificates for the diagnostic imaging services, radiation oncology services, and systemic therapy services that are provided onsite:**

**Upload the policy and procedures covering quality assurance practices for diagnostic imaging services, radiation oncology services, and system therapy services:**

**Do you provide diagnostic imaging services onsite or by referral:**

- ☐ Onsite
- ☐ Referred

**Do you provide radiation oncology services onsite or by referral:**

- ☐ Onsite
- ☐ Referred

**Do you provide systemic therapy services onsite or by referral:**

- ☐ Onsite
- ☐ Referred

**Program Comments**

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| Standard 4.1 |
| --- |

**Complete and upload the Physician Certification Credentials template to the General Survey Documents section for each year within accreditation cycle:**

  **Program Comments**

| Standard 4.2 |
| --- |

**Upload policy and procedure that ensures oncology nursing competency is reviewed each year:**

**Complete and upload the Oncology Nursing Credentials template to the General Survey Documents section for nursing certification status and continuing education hours for each year within accreditation cycle:**

  **Provide the number of certifications for each of the following for each year of accreditation cycle**

| | 2021 |
| --- | --- |
| **Advanced Oncology Certified Nurse Practitioner (AOCNP)** | |
| **Advanced Oncology Certified Clinical Nurse Specialist (AOCNS)** | |
| **Advanced Oncology Certified Nurse (AOCN)** | |
| **Blood & Marrow Transplant Certified Nurse (BMTCN)** | |
| **Certified Pediatric Hematology Oncology Nurse (CPHON)** | |
| **Certified Pediatric Oncology Nurse (CPON)** | |
| **Certified Breast Care Nurse (CBCN)** | |
| **Oncology Certified Nurse (OCN)** | |

  **Program Comments**

| Standard 4.3 |
| --- |

**Upload the plan for CTR supervision of non-credentialed registry staff who abstract:**

**Complete and upload the Cancer Registry Staff Credentials template to the General Survey Documents section for CTR credentials and continuing education for each year within accreditation cycle:**

  **Program Comments**

| Standard 4.4 |
| --- |

**Upload the policy and procedure regarding genetic counseling and risk assessment services that includes all required components:**

**Upload reports or presentations that are separate from Cancer Committee Minutes for each year of accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**Provide the type of genetics professionals currently at your facility:**

Select all that apply:
☐ **ABGC or ABMGG**

☐ **APNG or AHNBC or GCN**

☐ **AOCNP or equivalent certification from ONCC, APON or PA who is at the graduate level with specialized education in cancer genetics and hereditary cancer predisposition syndromes**

☐ **RN with specialized education in cancer genetics and hereditary cancer predisposition syndromes**

☐ **Board-certified/board-eligible physician with experience in cancer genetics**

☐ **Not Applicable**

**Indicate the cancer site selected for each year of accreditation cycle:**

Select all that apply:

| **2020** | **2021** |
|---|---|
| ☐ **Colon** | ☐ **Colon** |
| ☐ **Breast** | ☐ **Breast** |
| ☐ **Ovarian** | ☐ **Ovarian** |
| ☐ **Endometrial** | ☐ **Endometrial** |
| ☐ **Pancreatic** | ☐ **Pancreatic** |
| ☐ **Prostate** | ☐ **Prostate** |
| ☐ **Other** | ☐ **Other** |

Other Specify:        Other Specify:

**Provide the number of patients identified as needing referrals for each year within accreditation cycle:**

| **2020** | **2021** |
|---|---|
|  |  |

**Of those patients identified, how many received a referral for each year within accreditation cycle:**

| **2020** | **2021** |
|---|---|
|  |  |

**Do you provide genetics counseling, cancer risk assessment, and genetic testing services onsite or by referral:**

☐ Onsite
☐ Referred

**Program Comments**

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**Standard 4.5**

Link to Standard 4.5

**Upload the policy and procedure for providing palliative care services with all required components:**

**Upload reports or presentations that are separate from Cancer Committee Minutes for each year within accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**Do you provide palliative care services onsite or by referral:**

☐ Onsite
☐ Referred

**Provide the number of cancer patients that were referred for each year within accreditation cycle:**

| **2020** | **2021** |
|---|---|
|  |  |

**What is the area of improvement for each year within accreditation cycle:**

Select all that apply:

| 2020 | 2021 |
|------|------|
| ☐ Barriers to access palliative care services | ☐ Barriers to access palliative care services |
| ☐ Addition of palliative care services | ☐ Addition of palliative care services |
| ☐ Decreasing emergency department usage | ☐ Decreasing emergency department usage |
| ☐ Improving the timeliness of referrals | ☐ Improving the timeliness of referrals |
| ☐ Other | ☐ Other |

Other Specify:                              Other Specify:

**Program Comments**

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**Standard 4.6**

[Link to Standard 4.6](#)

**Upload the policy and procedure defining rehabilitation services:**

**Upload reports or presentations that are separate from Cancer Committee Minutes for each year within accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**Do you provide rehabilitation services onsite or by referral:**

☐ Onsite
☐ Referred

**Program Comments**

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**Standard 4.7**

[Link to Standard 4.7](#)

**Upload the policy and procedure for providing oncology nutrition services:**

**Upload reports or presentations that are separate from Cancer Committee Minutes for each year within accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**Do you provide nutrition services onsite or by referral:**

☐ Onsite
☐ Referred

**Program Comments**

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**Standard 4.8**

[Link to Standard 4.8](#)

**Upload the policy and procedure defining the survivorship program requirements:**

**Upload coordinator reports or presentations that are separate from Cancer Committee Minutes for each year within accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**Which services from your survivorship program are provided onsite:**

Select all that apply:
- ☐ **Treatment summaries**
- ☐ **Survivorship care plans**
- ☐ **Screening programs for cancer recurrence**
- ☐ **Screening for new cancers**
- ☐ **Seminars for survivors**
- ☐ **Rehabilitation services**
- ☐ **Nutritional services**
- ☐ **Psychological support & psychiatric services**
- ☐ **Support groups and services**
- ☐ **Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling**
- ☐ **Financial support services**
- ☐ **Physical activity programs**
- ☐ **Other**

(Other Specify:)

**Which three services did you report on for each year of accreditation cycle and what is the estimated number of patients who participated in each service that was reported on each year within accreditation cycle:**

                                        **2021**

**1**

**2**

**3**

**Identify the resources needed to improve the services if barriers were encountered for each year within accreditation cycle:**

**If you provide Survivorship Care Plans, what patient population are you providing these plans to:**

**Identify the survivorship program team for each year within accreditation cycle: (names and titles)**

**Program Comments**

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**Standard 5.1**

Link to Standard 5.1

**Follow accession/patient list instructions located on the Pathology Report Review Template.**
**Complete cancer program section of template by following instructions located on first tab in Pathology Report Review Template.**
**Eligible cases include Class of Case 10-22 from years within Accreditation Cycle.**
**20 pathology reports will be reviewed by the Site Reviewer. (20 reports per facility for INCPs)**
**Cases are to be selected by Site Reviewer and appropriate fields in template are to be completed by the cancer program <u>before</u> day of site visit.**

Template

**What pathology accreditations does your site hold:**

Select all that apply:
- ☐ **A2LA (clinical laboratory accreditation)**
- ☐ **American Association of Blood Banks (AABB) (blood banking)**

☐ American Association for Laboratory Accreditation (A2LA) (clinical laboratory accreditation)

☐ Accreditation Association for Hospitals and Health Systems/Healthcare Facilities Accreditation Program (AAHHS/HFAP) (accrediting body of AOA)

☐ American Society for Histocompatibility and Immunogenetics (ASHI)

☐ Centers for Medicare and Medicaid Services (CMS)

☐ Commission on Office Laboratory Accreditation (COLA) (clinical pathology only)

☐ College of American Pathologists (CAP)

☐ Joint Commission

☐ Not Applicable

**How do your pathologists currently report on their cancer cases?**

Select all that apply:
☐ Dictation

☐ Word or other macro-enabled forms

☐ Templates created on-site

☐ CAP electronic Cancer Checklists (eCC) through electronic health record (EHR), laboratory information system (LIS), or middleware vendor

☐ Unknown

☐ Other

**What tools or resources would be or are currently helpful to you to aid in compliance for pathology synoptic reporting?**

Select all that apply:
☐ Required element cheat-sheet

☐ Web-based synoptic report generator

☐ Report completeness validation-checker

☐ FAQs regarding synoptic reporting definition and accreditation requirements

☐ Other

**Program Comments**

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**Standard 5.2**

Link to Standard 5.2

**Upload the policy and procedure that ensures patient access to psychosocial services either on-site or by referral and the psychosocial distress screening policy and procedure:**

**Enter the annual analytic caseload for 2019, 2020, and 2021:**

| **2019** | **2020** | **2021** |
|---|---|---|
|  |  |  |

**Indicate the visit type where you administer distress screening:**

Select all that apply:
☐ Consult or visit before diagnosis

☐ First visit with a medical oncologist to discuss treatment

☐ Infusion visit

☐ Other medical oncologist visit

☐ Post-chemotherapy follow-up visit

☐ Post-surgical visit

☐ Referral to palliative care

☐ Routine visit with a radiation oncologist

☐ Survivorship care planning

☐ Time of diagnosis

☐ Transitions during treatment

☐ Transitions off treatment

☐ Other

(Other Specify:)

**What tool(s) do you utilize for distress screening:**

Select all that apply:
☐ Brief Symptom Inventory (e.g., BSI-18)
☐ Distress Thermometer with problem list
☐ Distress thermometer without problem list
☐ Edmonton Symptom Assessment System
☐ Hospital Anxiety and Depression Scale (HADS)
☐ Patient Health Questionnaire (e.g., PHQ-9, PHQ-4, PHQ-2)
☐ Other
(Other Specify:)

**Number of cancer patients that received distress screening for each year within accreditation cycle:**

| 2020 | 2021 |
|------|------|
|      |      |

**Of those screened, how many cancer patients were referred to a specific service for each year within accreditation cycle:**

| 2020 | 2021 |
|------|------|
|      |      |

**Number of cancer patients eligible for distress screening for each year within accreditation cycle:**

| 2020 | 2021 |
|------|------|
|      |      |

**What percentage of cancer patients had distress screening for each year within accreditation cycle, based on the overall number of cancer patients eligible for distress screening:**

| 2020 | 2021 |
|------|------|
| %    | %    |

**Who administers the distress screening in your program:**

Select all that apply:
☐ Case Manager/Care Coordinator
☐ Mental/Behavioral Health professional
☐ Mid-level nurse practitioner/physician's assistant
☐ Nurse or Nurse Navigator
☐ Nutrition/Dietary
☐ Oncology Social Worker
☐ Outpatient Rehab
☐ Palliative care provider
☐ Patient Navigator
☐ Physician
☐ Self-administered through online surveys
☐ Spiritual Care Provider/Chaplain
☐ Other
(Other Specify:)

**Indicate which services are provided onsite or by referral?**

| | Onsite | Referred |
|---|---|---|
| **Adjustment to illness counseling** | ☐ | ☐ |
| **Advanced Directive/Care Planning** | ☐ | ☐ |
| **Art therapy** | ☐ | ☐ |
| **Biopsychosocial assessment** | | |

|  |  |  |
|---|:---:|:---:|
|  | ☐ | ☐ |
| **Care coordination and/or patient navigation** | ☐ | ☐ |
| **Caregiver and family counseling** | ☐ | ☐ |
| **Child life program** | ☐ | ☐ |
| **Complementary medicine program** | ☐ | ☐ |
| **Dietician/Nutrition** | ☐ | ☐ |
| **Facilitation of patient/family/provider communication** | ☐ | ☐ |
| **Fertility counseling** | ☐ | ☐ |
| **Financial resources, e.g., SSI, disability, employment, household, insurance, FMLA** | ☐ | ☐ |
| **Genetics counseling** | ☐ | ☐ |
| **Home care program** | ☐ | ☐ |
| **Hospice and end of life planning** | ☐ | ☐ |
| **Housing assistance** | ☐ | ☐ |
| **Inpatient psychiatric consultations** | ☐ | ☐ |
| **Medication/pharmacy access** | ☐ | ☐ |
| **Music therapy** | ☐ | ☐ |
| **Pain and palliative care program** | ☐ | ☐ |
| **Patient resource center or library** | ☐ | ☐ |
| **Pastoral care/chaplain** | ☐ | ☐ |
| **Pet therapy** | ☐ | ☐ |
| **Psychoeducation to enhance coping skills** | ☐ | ☐ |
| **Sexuality counseling** | ☐ | ☐ |
| **Support and education related to parenting through cancer** | ☐ | ☐ |
| **Survivorship program** | ☐ | ☐ |
| **Transportation assistance** | ☐ | ☐ |
| **Wellness program** | ☐ | ☐ |
| **Other** | ☐ | ☐ |

(Other Specify:)

**Program Comments**

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**Standard 5.3**

Link to Standard 5.3

**Do you currently have synoptic operative reports for Breast Sentinel Node Biopsy:**

○ Yes   ○ No   ○ N/A

**Number of Breast Sentinel Node Biopsies performed in 2021:**

[                    ]

**Describe your plan for implementing the Operative Standard 5.3 by 2022. The comments will not be rated, but will be used to discuss progress with the Site Reviewer.**

**Program Comments**

**Standard 5.4**

**Do you currently have synoptic operative reports for Breast Axillary Dissection:**

○ Yes  ○ No  ○ N/A

**Number of Breast Axillary Dissections performed in 2021:**

[                    ]

**Describe your plan for implementing the Operative Standard 5.4 by 2022. The comments will not be rated, but will be used to discuss progress with the Site Reviewer.**

**Program Comments**

**Standard 5.5**

**Do you currently have synoptic operative reports for Primary Cutaneous Melanoma:**

○ Yes  ○ No  ○ N/A

**Number of wide local excisions for Primary Cutaneous Melanoma performed in 2021:**

[                    ]

**Describe your plan for implementing the Operative Standard 5.5 by 2022. The comments will not be rated, but will be used to discuss progress with the Site Reviewer.**

**Program Comments**

**Standard 5.6**

**Do you currently have synoptic operative reports for Colon Resection:**

○ Yes  ○ No  ○ N/A

**Number of Colon Resections performed in 2021:**

[                    ]

**Describe your plan for implementing the Operative Standard 5.6 by 2022. The comments will not be rated, but will be used to discuss progress with the Site Reviewer.**

**Program Comments**

**Standard 5.7**

**Use the Pathology Report Review Template that is accessible from Standard 5.1.**

**Total number of Total Mesorectal Excisions performed in 2021:**

[                    ]

**Program Comments**

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**Standard 5.8**

**Use the Pathology Report Review Template that is accessible from Standard 5.1.**

**Number of Pulmonary Resections performed in 2021:**

[                              ]

**Program Comments**

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**Standard 6.1**

**Upload the quality control policy and procedure that includes the process for resolving conflicts identified during the quality control review:**

**If you utilize audit reports from the state or central registry in the evaluation of registry data, upload the state or central registry report used in the review from each year within accreditation cycle.**

**Upload the results of the annual quality control evaluation, if separate from Cancer Committee Minutes for each year within accreditation cycle: (Please remove all PHI in the reports or presentations.)**

**Complete and upload the Cancer Registry Quality Control template to the General Survey Documents section for the annual quality review reports for each year within accreditation cycle:**

Template

**Do you utilize audit reports from the state or central registry in the evaluation of registry data:**

○ Yes ○ No ○ N/A

**Percent of unknowns for the cancer registry from the completeness report for each year within accreditation cycle:**

| **2020** | **2021** |
|---|---|
| [                    ] % | [                    ] % |

**Briefly describe how you monitor the use of unknowns:**

**Do you link with the state registry for case finding?**

○ Yes ○ No ○ Do Not Know

**Do you link with state registry to capture Hispanic Origin?**

○ Yes ○ No ○ Do Not Know

**Program Comments**

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**Standard 6.2**

**Program Comments**

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**Standard 6.3**

**Program Comments**

| Standard 6.4 |
| --- |

**Program Comments**

| Standard 6.5 |
| --- |

**Upload (on day of site visit) the current report on follow-up from the registry database:**

**Indicate the methods to obtain follow-up:**

Select all that apply:
- ☐ **Following or managing physician(s)**
- ☐ **Program inpatient or outpatient services**
- ☐ **Pathology reports or death certificates**
- ☐ **Patient or patient's family**
- ☐ **Internet sources (i.e., death index, patient locator software, obituary listings)**
- ☐ **Communication with other facilities**
- ☐ **Linkage with State Cancer Registries' Date of Last Contact**
- ☐ **Other**

**Program Comments**

| Standard 7.1 |
| --- |

**Upload an action plan for any measure not meeting the Estimated Performance Rate (EPR) for each year within accreditation cycle, if required, that are separate from the Cancer Committee Minutes:**

**Program Comments**

| Standard 7.2 |
| --- |

**Complete and upload the Monitoring Concordance with Evidence-Based Guidelines template to the General Survey Documents section for the in-depth analysis reports for each year within accreditation cycle:**

**What is the patient population selected for the review for each year within accreditation cycle:**

| **2020** | **2021** |
| --- | --- |
| Select from the following: ▾ | Select from the following: ▾ |

(Other Specify:)

(Other Specify:)

**Describe the reason you selected the patient population to review from each year within accreditation cycle:**

 **2020 2021**

**Program Comments**

| Standard 7.3 |
| --- |

**Complete and upload the Quality Improvement Initiative template to the General Survey Document section with completed studies from each year within accreditation cycle:**

 **What are the standardized performance improvement tools used:**

Select all that apply:
- ☐ Lean
- ☐ DMAIC
- ☐ PDCA/PDSA
- ☐ Other

**Program Comments**

| Standard 7.4 |
| --- |

**Complete and upload the Quality Improvement Cancer Program Goal template with the established cancer program goals and evaluations for each year within accreditation cycle to the General Survey Documents section:**

 **Program Comments**

| Standard 8.1 |
| --- |

**If separate from the Cancer Committee minutes, upload the required report from each year within accreditation cycle:**

 **Indicate the barrier(s) to accessing health and/or psychosocial care your Cancer Committee selected to focus on for each year within accreditation cycle**

Select all that apply:

| 2020 | 2021 |
| --- | --- |
| ☐ Child-care issues | ☐ Child-care issues |
| ☐ Comorbidities or disabilities | ☐ Comorbidities or disabilities |
| ☐ Family, social or aftercare support issues | ☐ Family, social or aftercare support issues |
| ☐ Fear/anxiety | ☐ Fear/anxiety |
| ☐ Healthcare costs | ☐ Healthcare costs |
| ☐ Housing issues | ☐ Housing issues |
| ☐ Uninsured or underinsured | ☐ Uninsured or underinsured |
| ☐ Language or literacy issues | ☐ Language or literacy issues |

| | |
|---|---|
| ☐ **Time off work** | ☐ **Time off work** |
| ☐ **Transportation/travel time issues** | ☐ **Transportation/travel time issues** |
| ☐ **Adequate clinician resources** | ☐ **Adequate clinician resources** |
| ☐ **Gaps in community resources** | ☐ **Gaps in community resources** |
| ☐ **Access to appropriate services** | ☐ **Access to appropriate services** |
| ☐ **Other** | ☐ **Other** |

Other Specify:                      Other Specify:

**Program Comments**

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| **Standard 8.2** |
|---|

[Link to Standard 8.2](#)

**Complete and upload the Community Outreach template with required components for each year within accreditation cycle to the General Survey Documents section:**

[Template](#)

 **Program Comments**

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| **Standard 8.3** |
|---|

[Link to Standard 8.3](#)

**Complete and upload the Community Outreach template with required components for each year within accreditation cycle to the General Survey Documents section.**
**Use the Cancer Committee template accessible from Standard 8.2.**

 **Program Comments**

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| **Standard 9.1** |
|---|

[Link to Standard 9.1](#)

**Category accrual requirements, click [here](#)**
**Definitions for categories of cancer-related clinical research studies, click [here](#)**

**Complete and upload the Clinical Research Accrual template with cancer-related clinical research study categories and numbers of patients accrued for each year within accreditation cycle to the General Survey Documents section:**

[Template](#)

**If separate from Cancer Committee minutes, upload the coordinator's annual report with required components for each year within accreditation cycle:**

 **Program Comments**

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| **Standard 9.2** |
|---|

[Link to Standard 9.2](#)

**Program Comments**