

ASSOCIATION OF COMMUNITY CANCER CENTERS  
**Cancer Program Guidelines**





ASSOCIATION OF COMMUNITY CANCER CENTERS

# **Cancer Program Guidelines**

---

The Association of Community Cancer Centers *Cancer Program Guidelines* have been established to assist cancer programs that want to develop and/or maintain a comprehensive interdisciplinary program that meets the needs of cancer patients and their families.

These guidelines were developed to reflect the optimal components for a cancer program. The guidelines are not intended to act as an accrediting or credentialing mechanism and are not a list of standards, such as those published by the American College of Surgeons Commission on Cancer. The guidelines should not be a surrogate for independent medical judgment; they serve only as the term implies: as guidelines to help programs meet the optimal attributes.

Suggestions and comments for future additions are welcome.

## **ASSOCIATION OF COMMUNITY CANCER CENTERS**

### **Vision**

ACCC is the leading national multidisciplinary organization that defines quality care for patients with cancer and influences change to continually improve cancer care.

### **Mission**

ACCC is the national multidisciplinary organization that promotes the entire continuum of quality cancer care for our patients and our communities.

ACCC will fulfill its mission by pursuing the following six strategic objectives: Patient Advocacy, Quality and Economic Issues, Research in the Community, Cancer Program Management, Leadership in Policy Development and Promotion, and Support for Members.

**Guidelines Committee**

Richard B. Reiling, MD, FACS, Chair  
Jeanne Atha  
Monica N. Cook  
Colleen Gill, MS, RD, CSO  
Brenda K. Gordon, MSN, OCN  
Virginia T. Vaitones, MSW, OSW-C  
Alan S. Weinstein, MD, FACP

**Edited by:**

Kim LeMaitre, Director, Educational Services  
Monique J. Marino, Manager, Publications  
Amanda Patton, Manager, Communications

**Designed by:**

Constance D. Dillman



Association of Community Cancer Centers

©Copyright Association of Community Cancer Centers, October 2012

Published March 1988, January 1993, March 2008

Revised January 1997, March 2000, January 2004, March 2006, January 2008, March 2009, March 2012, October 2012

Cover photographs/A meeting at Nebraska Methodist Hospital, Methodist Estabrook Cancer Center, Omaha, Nebr.; Florida Hospital Memorial System, Florida Hospital Cancer Institute, Ormond Beach, Fla.; Tumor Conference at The University of Tennessee Medical Center Cancer Institute in Knoxville, Tenn.; cover background photograph/Fotolia

# Cancer Program Guidelines

---

## CONTENTS

<b>CHAPTER 1 Institutional and Programmatic Resources</b>	<b>5</b>
SECTION 1 Program Leadership	
SECTION 2 Medical Leadership	
<b>CHAPTER 2 Cancer Committee</b>	<b>7</b>
SECTION 1 Cancer Committee Leadership	
SECTION 2 The Multidisciplinary Cancer Conference	
<b>CHAPTER 3 Cancer Data Management and Registry Operations</b>	<b>9</b>
<b>CHAPTER 4 Clinical Management and Supportive Care Services</b>	<b>10</b>
SECTION 1 Multidisciplinary Team	
SECTION 2 Oncology Unit	
SECTION 3 Ambulatory Oncology Services	
SECTION 4 Oncology Nursing Services	
SECTION 5 Pharmacy Services	
SECTION 6 Psychosocial Oncology Care	
SECTION 7 Pain Management	
SECTION 8 Nutrition Services	
SECTION 9 Rehabilitation Services	
SECTION 10 Patient Navigation Services	
SECTION 11 Genetic Risk Assessment, Counseling, and Testing	
SECTION 12 Home Care	
SECTION 13 Palliative Care	
SECTION 14 Hospice	
SECTION 15 Pastoral Care	
SECTION 16 Integrative Care	
SECTION 17 Survivorship Services	
SECTION 18 Patient Advocacy and Financial Services	
<b>CHAPTER 5 Clinical Research</b>	<b>26</b>
<b>CHAPTER 6 Community Outreach</b>	<b>27</b>
SECTION 1 Cancer Education and Resource Program	
SECTION 2 Cancer Control and Detection	
<b>CHAPTER 7 Professional Education and Staff Support</b>	<b>29</b>
<b>CHAPTER 8 Quality Improvement</b>	<b>30</b>
<b>References</b>	<b>31</b>



# CHAPTER I: Institutional and Programmatic Resources

---

## SECTION I

### Program Leadership

---

#### Guideline I

Administrative structure is in place to ensure efficient, appropriate, and effective management of the cancer program and services.

#### Rationale

The administrative leadership is responsible for maintaining high standards of patient care through the use of human, fiscal, and material resources. The administrative leadership must demonstrate commitment to excellence in cancer care, development and growth of multidisciplinary staff, and provision of comprehensive programs and services. The administrative leadership must be accountable for the development of resources to both sustain and increase the program and its capability to meet the needs of the community that it serves.

#### Characteristics

- A. The administrative leadership is appointed by the governing body, hospital, and/or parent organization, and is responsible for the development, implementation, and evaluation of the cancer program.
- B. The administrative leadership, qualified by education and experience, appropriately fulfills designated responsibilities. The administrator should have at least a bachelor's degree in a healthcare profession, business, economics, or related area, *and* 4-6 years of experience in healthcare management. Master's level degree and training in a healthcare field are preferred.
- C. The administrative leadership creates an environment of trust and respect, balancing financial concerns with patient care needs.
- D. The administrative leadership ensures compliance with applicable laws, regulations, and professional accreditation standards.
- E. The administrative leadership:
  1. Creates and facilitates the multidisciplinary team for development of the program's strategic plan throughout the continuum of care
  2. Implements a management structure to develop program goals and objectives, to maintain accountability for outcomes, and to perform cost analysis for cost-effective use of resources
- F. The administrative leadership gathers and assimilates program-related data from appropriate sources and disseminates them in a timely manner to the leadership team and cancer committee for evaluation, review, and revision of goals and objectives annually and as needed.
- G. The administrative leadership assumes accountability for the financial viability of the cancer program; establishes and implements program budget, monitors financial data, and assumes accountability for budget and variances; coordinates effective billing and reimbursement procedures to ensure maximum appropriate reimbursement for services; and secures adequate supplemental funding.
- H. The administrative leadership ensures sound partnership with healthcare providers/professionals by sharing accountability for the overall quality of care and financial viability of the cancer program.
- I. The administrative leadership ensures adequate multidisciplinary staffing to meet the needs of cancer patients and their families.
3. Creates access to financial, human, and material resources necessary for comprehensive service and program planning, implementation, and evaluation.

## SECTION 2

### Medical Leadership

---

#### Guideline I

The program has a designated medical director on a part-time or full-time basis.

#### Rationale

A medical director, with experience in multidisciplinary cancer care, provides medical leadership as well as clinical expertise and administrative competencies for optimal program outcomes.

#### Characteristics

The background of the medical director should include the following:

- A. Documented training, experience, and competence in cancer care, such as board certification in a recognized oncology specialty
- B. Experience in multidisciplinary cancer care and support of such care throughout the cancer program

- C. Demonstrated administrative ability and leadership skills. The medical director assumes appropriate level of authority and accountability for program outcomes.

### **Guideline II**

The authority of the medical director is defined and documented by the sponsoring organization of the program.

#### **Rationale**

The medical director must have a documented job description and/or contract that define lines of authority and responsibility.

#### **Characteristics**

The organization has defined the authority of the medical director in the following suggested areas:

- A. Program definition, vision, mission, goals, planning, implementation, and objectives
- B. Recruitment, appointment, evaluation, and promotion of relevant personnel within the scope of the program
- C. Reporting structure/requirements
- D. Space allocation
- E. Interaction with other departments, organizations, and the public
- F. Budgetary and administrative responsibility appropriate to the structure of the organization
- G. Medical, scientific, research, and other program component decisions
- H. Fundraising
- I. Performance improvement and clinical pathways development
- J. Monitoring of quality of care.

### **Guideline III**

The medical director is subject to a minimum of annual performance review.

#### **Rationale**

Timely evaluation of the medical director's overall performance is the responsibility of the organization's administrative leadership and medical staff and/or review group as defined in the job description.

#### **Characteristics**

The evaluation measures how well the medical director has achieved the following goals:

- A. Assurance that appropriate programs are in place and operating according to standards
- B. Ongoing program planning and implementation
- C. Well-developed, coordinated, and managed relationships with other organizational components, physicians, external organizations, patients, their families, and the public
- D. Establishment, maintenance, and documentation of medical, scientific, and ethical standards
- E. Quality of care
- F. Securing and/or maintaining appropriate certifications, accreditations, and memberships
- G. Cost-effective operations
- H. Efficient and effective management of budget and personnel
- I. Annual, or more frequent, reporting.

Compensation should be considered commensurate with expected time commitment.

# CHAPTER 2: Cancer Committee

---

## SECTION I

### Cancer Committee Leadership

---

#### Guideline I

The Cancer Committee provides program leadership.

#### Rationale

The Cancer Committee develops, approves, and implements the strategic plans, goals, and objectives for new programs and provides oversight for ongoing programs and services.

#### Characteristics

- A. The Cancer Committee is formalized by the medical staff or facility, establishing responsibility, accountability, and multidisciplinary membership required to fulfill its role.
  - B. The Cancer Committee requests administrative leadership to obtain and maintain program approval by the American College of Surgeons Commission on Cancer.
  - C. Cancer Committee members include multidisciplinary representation: physicians, clergy, nurses, social workers, nutritionists, pharmacists, rehabilitation specialists, hospital administrators, diagnostic imaging staff, quality improvement staff, and cancer registry staff. Public representation may be considered.
  - D. The Cancer Committee meets regularly to assure that the administrative responsibilities of the cancer program leadership are carried out. In network programs, these meetings occur at least bi-monthly. In large programs, the Cancer Committee establishes subcommittees to manage specific activities, such as cancer conference activity, quality control of registry data, quality management, community outreach, and research.
  - E. The Cancer Committee functions to:
    1. Promote a coordinated multidisciplinary approach to patient management at all levels.
    2. Assure that consultative services in all disciplines are available and that education and multidisciplinary cancer conference review activities cover all major cancer sites and issues of cancer care.
    3. Initiate patient care audits and review similar data supplied by other hospital committees.
    4. Supervise the cancer registry and assure accurate, timely abstracting, staging, and reporting of data.
5. Set the frequency of the cancer conference, which encourages and helps to assure multidisciplinary involvement. (The minimum percentage of cases required by the American College of Surgeons Commission on Cancer [Standard 2.8] is a criterion for setting the number of conferences.)
  6. Set the attendance requirement for the cancer conference such that multidisciplinary attendance is based on the type of cases seen in the facility and the format of the conference, such as facility- or network-wide, departmental, site focuses, or grand rounds. (The Commission on Cancer [Standard 2.7] requires an annual re-evaluation.)
  7. Evaluate patient care outcomes, financial outcomes, resource utilization, and other designated continuous quality improvement monitors throughout the year; make improvements based on service and program goals.
  8. Review results of treatment at the facility as part of outcomes assessment.
  9. Complete and document studies initiated by the Committee that measure quality and outcomes. (The requirements of the Commission on Cancer [Standards 8.1 and 8.2] are considered such that a minimum of two improvements that directly affect cancer patient care are documented. In addition, the Cancer Committee recommends and supports implementation of program enhancements or new programs. The Cancer Committee should be involved in the planning and implementation of all facility cancer programs.)
  10. Set annual goals and measurable objectives and implement a process for evaluating the effectiveness of its programs. [Commission on Cancer Standard 2.5]
  11. Designate one coordinator for areas of cancer committee activity, to include but not limited to, cancer conference, quality control of cancer registry data, quality improvement, and community outreach. [Commission on Cancer Standard 2.3]. Other coordinators should be designated, especially in large programs, for activities such as research and policy development and renewal.

## SECTION 2

# The Multidisciplinary Cancer Conference

### Guideline I

The Cancer Committee assumes accountability and responsibility for multidisciplinary cancer conference(s). Multidisciplinary cancer case presentations are conducted on a timely basis to ensure that all patients and practitioners have access to consultative services.

#### Rationale

A multidisciplinary cancer conference provides prospective patient case review and assures quality of care evaluation related to diagnosis, treatment, symptom management, follow-up, rehabilitation, and supportive care.

#### Characteristics

- A. Patient management discussion includes, but is not limited to:
  1. Multidisciplinary participation
  2. Sharing of expert clinical opinions and treatment recommendations
  3. Treatment decision made by the attending physician and patient
  4. Opportunities for participation in clinical trials.
- B. The cancer conference is organized as described in Section 1 of this chapter:
  1. Accountability is assumed by the Cancer Committee.
  2. Responsibility for organizing the cancer conference(s) is designated by the Cancer Committee. This responsibility should rest with an individual, such as conference chairman, or the designated coordinator as described in Section 1 of this chapter. Alternatively, it could rest in the department, such as the Cancer Registry.
  3. The cancer conference meets a minimum of monthly, more frequently if accreditation is sought through the American College of Surgeons. (See References, page 30 for additional information.)
  4. Site-specific conferences are conducted where there are sufficient cases.

### Guideline II

Cancer conference case presentation is prospective in nature and influences treatment choices.

#### Rationale

Prospective case presentation assures that patients newly diagnosed or under treatment and requiring review have access to multidisciplinary evaluation, including staging, treatment management, and follow-up evaluation.

#### Characteristics

- A. Cases presented must be representative of the disease processes managed at the cancer center.
  1. All disciplines managing cancer must regularly present cases in a timely fashion and manner as stated in Guideline I of this section.
  2. All caregivers should have the opportunity to present and discuss individual cases in a timely fashion.
- B. Case presentations at conferences include:
  1. Comprehensive clinical summary provided by attending physician or designee
  2. Review of radiologic films
  3. Review of pathology slides
  4. Clinical management discussion and recommendation(s) sought
  5. Consideration for clinical trials.
- C. A record of conference dates, disease sites presented, and type of review (prospective or not) is maintained.

### Guideline III

The cancer conference contributes to the education of all healthcare providers.

#### Rationale

Prospective, multidisciplinary case review and discussions generate new knowledge; provide a review of basic clinical management principles; provide opportunities for discussion of research eligibility; improve effectiveness of cancer care; identify areas for audit review; identify possible community needs for education, screening, detection, and prevention; and provide a mechanism for physicians and healthcare providers in outlying communities to access information.

#### Characteristics

Cancer conferences:

- A. Provide prospective case review
- B. Are comprised of no more than 25 percent didactic lectures
- C. Are based on recent literature and new information
- D. Provide review of basic cancer management principles
- E. Provide education of health professionals
- F. Are considered for CME and other education credits.

# CHAPTER 3: Cancer Data Management and Registry Operations

## Guideline I

A cancer registry will be maintained to meet and preferably exceed the minimum requirements of the Commission on Cancer of the American College of Surgeons.

## Rationale

A cancer registry is an important program component for the evaluation of cancer care. Accurate and timely collection of cancer patient data with appropriate follow-up is required by the Commission on Cancer. The cancer registry contributes to administrative and programmatic planning, patient treatment planning, research, staging, and continuity of care through data retrieval and monitoring of outcomes through annual analysis, and long-term follow-up.

## Characteristics

- A. Case abstracting is performed or supervised by a Certified Tumor Registrar (CTR).
- B. The institution's Cancer Committee monitors the activities of the cancer registry.
- C. An accurate and current database is maintained.
  - 1. All standards of the Commission on Cancer are rigidly followed.
  - 2. Data submission to the National Cancer Data Base (NCDB) and all other required sources are accurate and timely.
  - 3. Continuous quality improvement of the registry and data is a regular function of the registry and is documented.
- D. Data are reported regularly to the medical and hospital staff members.
  - 1. The data are regularly, at least annually, presented to the Cancer Committee, which assures the quality of the registry.
  - 2. The Cancer Committee also receives an annual overview for each calendar year, which may occur as part of an annual report.
- E. Cancer registry data are confidential.
  - 1. Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations is assured.
  - 2. Legitimate usage of the registry data for patient management is assured and provided in a timely fashion.
  - 3. Usage of the registry data for other purposes is encouraged, but confidentiality must be maintained.
  - 4. Research use of the data should be approved by an Institutional Review Board.

# CHAPTER 4: Clinical Management and Supportive Care Services

## SECTION I

### Multidisciplinary Team

#### Guideline I

There is a coordinated multidisciplinary team approach to planning, implementing, and evaluating the care of cancer patients—inpatient and outpatient—and their families.

#### Rationale

An organized, consistent multidisciplinary team approach to the care of cancer patients and their families is necessary to ensure that needs are identified, interventions are planned, treatments are coordinated, and care is monitored and evaluated.

#### Characteristics

- A. Multidisciplinary services include, but are not necessarily limited to:
1. Physician services
    - a) Attending physician and/or oncology specialists such as medical oncologists, radiation oncologists, surgical oncologists, and other physicians from medical specialties involved in the care of cancer patients and their families
    - b) Medical director or physician leader
  2. Oncology nursing services (See Chapter 4, Section 4, Oncology Nursing Services)
  3. Pharmacy services (See Chapter 4, Section 5, Pharmacy Services)
  4. Psychosocial oncology care (See Chapter 4, Section 6, Psychosocial Oncology Care)
  5. Pain management services (See Chapter 4, Section 7, Pain Management)
  6. Nutritional support services (See Chapter 4, Section 8, Nutrition Services)
  7. Rehabilitation services (See Chapter 4, Section 9, Rehabilitation Services)
  8. Case management services
  9. Discharge planning services
  10. Cancer data management and registry (See Chapter 3, Cancer Data Management and Registry Operations)
  11. Child life services for pediatric programs
  12. Cancer education and resources (See Chapter 6, Section 1, Cancer Education and Resource Program)
  13. Cancer control and detection programs (See Chapter 6, Section 2, Cancer Control and Detection)
  14. Genetic risk assessment, counseling, and testing services (See Chapter 4, Section 10, Genetic Risk Assessment, Counseling, and Testing)
  15. Clinical research (See Chapter 5, Clinical Research)
  16. Home care (See Chapter 4, Section 11, Home Care)
  17. Palliative care (See Chapter 4, Section 12, Palliative Care)
  18. Hospice (See Chapter 4, Section 13, Hospice)
  19. Pastoral care (See Chapter 4, Section 14, Pastoral Care)
  20. Integrative Care (See Chapter 4, Section 15, Integrative Care)
  21. Survivorship (See Chapter 4, Section 16, Survivorship Services).
- B. Multidisciplinary team members have access to in-service and continuing education programs with appropriate credit (CME I is preferred) for program attendance. (See Chapter 7, Professional Education and Staff Support.)

## SECTION 2

### Oncology Unit

---

#### Guideline I

An inpatient oncology unit, or functional equivalent general medical/surgical unit, is designed for the care of patients with cancer and their families.

#### Rationale

The inpatient oncology unit is a dedicated area developed to adequately and competently meet the complex and unique needs of cancer patients in a safe setting.

#### Characteristics

- A. Written policies and procedures document the philosophy, mission, and goals for patient care on the inpatient unit. Admission criteria, discharge criteria, and patient care policies and procedures are also documented.
- B. Nurses, pharmacists, dietitians, and therapists specialized in oncology provide expert care to patients and their families; staff are sufficient to meet care needs. (See Chapter 4, Sections 4-9).
- C. Space is provided for cancer patients needing isolation for infection control or for radiation implants, as well as for comfort and privacy for family and friends through the terminal stages of disease.
- D. Multidisciplinary team services are provided to the patient and family, including self-care proficiency, discharge planning and referral to home health, hospice, homemaker services, psychosocial services, and rehabilitation services.
- E. Referral mechanisms for services not readily available are documented.
- F. Comprehensive performance improvement plans are implemented and results reported to staff, administration, and the Cancer Committee on a monthly, quarterly, and yearly basis.
- G. Structure and function of the unit are centered around creating an ambiance of patient-centered care and include liberal visiting hours, family room, access to food pantry, and educational and support activities.
- H. Access to medical records to both read and contribute by all members of the multidisciplinary team.
- I. Accreditation by the Joint Commission, American College of Surgeons Commission on Cancer, and other accreditation as required for licensure.
- J. Patient education is provided and reinforced to ensure the patient and family understand therapy options, participate in therapy selection and plan, and are observed to demonstrate understanding and sufficiency in self-administration of therapy, self-monitoring, and adherence to the therapy plan.

## SECTION 3

### Ambulatory Oncology Services

---

#### Guideline I

An outpatient facility or office is available and dedicated to outpatient cancer care.

#### Rationale

A dedicated site for ambulatory cancer care allows optimal coordination of care, consolidation of qualified staff, and easy access to efficient services through focused facility design and operations.

#### Characteristics

- A. An ambulatory facility includes, but is not limited to:
  1. Qualified and experienced oncology staff, including registered nurses and other licensed professionals experienced in oncology, as required
  2. Adequate facilities for all or some of the following:
    - a) Drug storage, preparation, dispensing, and disposal of cancer therapeutic agents and other pharmaceuticals following all regulatory agency guidelines (Hospital-based ambulatory services must include a licensed pharmacy.)
    - b) Drug administration
    - c) Diagnostic tests and procedures (e.g., bone marrow biopsies, endoscopies)
    - d) Radiation treatments (addressed in more detail in Guideline II, page 12)
    - e) Complementary and alternative therapies
    - f) Patient education
  3. Protocols and facilities for managing all or some of the following:
    - a) Complications such as anaphylaxis and cardiac arrest
    - b) Moderate sedation
  4. Adequate number and design of exam and procedure rooms to handle nursing home, bed-bound, wheelchair-bound, and ambulatory patients
  5. Convenient access to clinical laboratory services
  6. Convenient access to routine diagnostic services
  7. Medical records area and services
  8. Availability of physician(s) at ordinary and publicized hours

9. Availability of multidisciplinary consultation services, patient education, and supportive care programs for patients, families, and staff (adequate space and budget are allocated)
  10. Availability of a survivorship program
  11. Adequate parking and comfortable waiting areas
  12. Designated telephone number(s) for patients and families to use for questions and problems on a 24-hour basis
  13. Accreditation by the Joint Commission and American College of Surgeons Commission on Cancer.
6. Quality control mechanisms to eliminate errors in treatment
  7. Availability of multidisciplinary consultative services, patient education, supportive care programs, pain management, nutrition, and other symptom management for patients, families, and staff.
- B. A comprehensive quality control program for treatment planning and delivery by the physicians with support from physics and other personnel.

## **Guideline II**

A radiation oncology facility is available for treatments.

### **Rationale**

Radiation therapy is one of the treatment modalities for cancer and is available to patients on an inpatient and outpatient basis.

### **Characteristics**

- A. A radiation oncology facility includes:
1. A team of board-certified radiation oncologist(s), board-certified physicist(s), registered dosimetrist(s), registered radiation therapist(s), and nursing support
  2. American College of Radiology (ACR) or American College of Radiation Oncology (ACRO) accreditation recommended (In lieu of accreditation, program should adhere to the standards for accreditation of ACR or ACRO. In addition, accreditation by The Joint Commission and the American College of Surgeons Commission on Cancer, as appropriate, is recommended.)
  3. Linear accelerator with treatment planning, conformal therapy and/or IMRT planning
  4. Brachytherapy, isotope, and ‘seed’ therapy availability, preferably onsite
  5. Access to research protocols (See Chapter 5, Clinical Research)

## **Guideline III**

Integration of oncology services for optimal treatment planning, evaluation, and follow-up.

### **Rationale**

There is continuity of the full continuum of care in multiple settings. There are appropriate data collection facilities and follow-up procedures.

### **Characteristics**

- A. Patients are entered into an American College of Surgeons Commission on Cancer-approved cancer registry.
- B. Institutional Review Board (IRB)-approved clinical research protocols are made available on site or by referral for all cancer care settings. (See Chapter 5, Clinical Research.)
- C. Providers have access to multidisciplinary cancer conference consultation for patient management. (See Chapter 2, Section 2, The Multidisciplinary Cancer Conference.)
- D. Patient care guidelines are developed, implemented, and evaluated annually.
- E. Patients have access to multidisciplinary team services for consultation, support, and education. (See Chapter 4, Section 1, Multidisciplinary Team.)

## SECTION 4

# Oncology Nursing Services

---

### Guideline I

Nursing care of the cancer patient is provided by nurses with specialized knowledge and skill in oncology.

#### Rationale

The complex needs of patients with cancer and their families require specialized oncology nursing knowledge and skills to achieve optimal care outcomes.

#### Characteristics

- A. The oncology nurse is integral to the multidisciplinary team.
- B. Oncology nursing services are coordinated by an experienced oncology nurse who has the appropriate level of education, management, and leadership skills to effectively direct the oncology staff.
  1. Three years of clinical experience is required with at least one year of oncology nursing.
  2. Bachelor's degree in nursing (BS) recommended; master's degree in nursing (MS) preferred.
  3. Certification in oncology nursing by the Oncology Nursing Certification Corporation (ONCC) is recommended.
  4. Management experience is recommended.
- C. Oncology nursing services provide adequate staffing to meet the needs of patients and their families:
  1. The facility determines and justifies nurse staffing according to a patient care acuity system.
  2. Staffing levels and services to fulfill standards are reviewed annually.
- D. An appropriate clinical nursing expert is a member of oncology nursing services or is available on a consultant basis.
  1. A master's prepared oncology clinical nurse specialist or nurse practitioner is available to medical staff, patients, and families.
  2. The nursing expert is available for team consultation, education, research activities, and case management.
- E. A plan is in place regarding ongoing staff development, including participation in multidisciplinary team conferences, regularly scheduled in-service and continuing education programs, national and regional professional organizations, and community-sponsored programs specific to oncology nursing. Oncology nursing certification is encouraged and recognized.
- F. Oncology nursing practice policies and procedures are written and approved by nursing and include, but are not limited to:
  1. Administration, monitoring, and safe disposal of cytotoxic and biological agents
  2. Management of oncologic emergencies, including extravasation guidelines
  3. Management of side effects of disease and treatment, including vomiting, pain, fatigue, and mucositis
  4. Management of vascular access devices and education of patients and family in the care of these devices
  5. Facilitation of a comprehensive approach to care, including physical, functional, psychosocial, spiritual, and financial aspects throughout the continuum of care; availability of referrals as needed
  6. Staff orientation, education, and certification standards
  7. Management of patients undergoing radiation, internal and external therapy
- G. Written patient care guidelines, which are culturally sensitive, developed, reviewed, and revised annually by practicing oncology nurses with input from the multidisciplinary oncology team
- H. References to Oncology Nursing Society standards and guidelines for all aspects of patient care, professional practice, research, education, and administrative components when developing same within individual programs.
- I. Patient and family education relative to all aspects of oncology care including discharge tracking.

## SECTION 5

### Pharmacy Services

---

#### Guideline I

Pharmacy Services pertain to those staff who are responsible for any aspect of drug therapy, from procurement to final disposition and documentation. A pharmacist should be available to the cancer program, either as an employee, or as a consultant to train, certify, or advise the staff responsible for Pharmacy Services.

#### Rationale

Pharmacy Service standards and guidelines are addressed by several regulatory agencies and professional organizations. Standards and guidelines sometimes apply to a specific setting (e.g., The Joint Commission for hospitals), but the principles pertaining to quality, safety, and effectiveness of cancer care should be considered in all settings.

#### Guideline II

Pharmacy Services will be responsible for the procurement, storage, preparation, distribution, and disposal of commercial and investigational cancer chemotherapy and other medications in a safe and accurate manner.

#### Rationale

Pharmacy Services institute safeguards that will protect patient safety, ensure accuracy and clinical appropriateness, and provide safe handling to minimize environmental and personnel exposure to cancer medications.

#### Characteristics

- A. Pharmacy Services obtain commercial and investigational cancer chemotherapy. All staff involved with receiving cancer therapeutic agents are trained for the appropriate procedure in the event of breakage, leakage, or other product damage.
- B. All commercial and investigational drugs and pharmaceuticals are stored and labeled to conform with all regulations for security, storage conditions, and safety (e.g., cancer therapeutic drugs will be labeled “chemotherapy” and separated from other inventory; investigational drugs will be stored separately in a locked area).
- C. Documentation of receipt and distribution of investigational agents is maintained on a perpetual inventory log.

- D. Only chemotherapy-trained personnel will prepare and dispense cancer chemotherapy. Chemotherapy training, competency assessment, and re-certification are provided to personnel on annual basis by review of policies and procedures and updated to conform to new literature and standards for preparation, aseptic technique, and safe handling. Competency is based on observation of personnel work practices and their understanding of policy.
- E. Preparation policies and procedures include, but are not limited to:
  1. An appropriate environment, employee garb, work process, and environmental testing that conform to current USP Chapter 797 regulations
  2. Established and available standards for dilution of solutions, concentrations, compatibility, and stability, along with current reference information
  3. Appropriate labels indicating a “chemotherapy” and/or “investigational” medication, all contents, final volume, and other ancillary information as required
  4. Disposal procedures for syringes, needles, and drug waste that conform to OSHA, EPA and other regulatory agencies
  5. Spill procedures and a spill kit at the preparation site
  6. Redundant checks in place to ensure the accuracy of the final product, and the appropriateness of the therapy and dose, including the scheduling of the current therapy (e.g., this is not the second day of a single-day therapy)
  7. For infusion bags, tubing is attached and purged prior to the addition of cancer chemotherapy.
- F. Extravasation guidelines are available which include, but are not limited to:
  1. A list of cytotoxic vesicants/irritants (medications known to cause tissue damage upon extravasation)
  2. A list of antidote and other treatments for each cytotoxic vesicant (e.g., heat/cold therapy)
  3. Extravasation kits available at the administration site
- G. Investigational medications will be dispensed following federal, IRB, and study sponsor requirements, including:
  1. All inventory tracking requirements
  2. Verification of informed consent prior to preparation of the drug
  3. Investigational protocol, which is available to all staff involved with preparing, administering, or monitoring the drugs and agents that are involved.

### **Guideline III**

Clinical Pharmacy Services will be established to ensure the appropriateness and safety of therapy.

#### **Rationale**

A multidisciplinary approach should be used in assessing the patient, obtaining medication history, and developing a therapy plan based on the patient's current condition, physiological changes, and reaction to previous therapy. Current medication plans will be reconciled with other providers to ensure coordination and optimizing of the patient's total care.

#### **Characteristics**

- A. All cancer-related medications should be ordered on hospital-approved chemotherapy treatment order form(s), or equivalent electronic record, that is signed by an authorized physician prior to preparation or treatment.
  1. Pharmacists, working with the multidisciplinary team, should develop pre-printed or computer-embedded order sets (protocols) that include all medications, required monitoring, other orders that are required, and conditions for administration (e.g., lab values).
  2. Individual orders should be linked in a time sequence beginning with pre-medication and hydration therapy. Protocols that extend over several days should clearly state which day the therapy is (e.g., Day 2 of 5).
  3. Orders should include the course of therapy (e.g., Cycle 2 of 6).
  4. Orders should indicate the time interval between cycles.
  5. Orders should include the protocol name, course of therapy, diagnosis, dosing weight, and references for the therapy.
  6. Patient-specific information should include actual weight, height, allergies, adverse reactions, age, and sex.
  7. Verbal orders for chemotherapy are not acceptable.
  8. All orders should conform to current National Patient Safety Goals (NPSG), and Institute for Safe Medication Practices (ISMP) recommendations for medication ordering safety.
  9. An informed consent is completed and recorded if required.
  10. A process should be in place to ensure that the appropriate infusion line or port is designated and utilized at the time of drug administration.
- B. All medication orders will be evaluated, including, but not limited to, the following:  
(Pharmacy Services will have full access to the medical record including charting privileges for licensed staff.)
  1. Verifying patients' height, weight, and body surface area (BSA).
  2. Determining and documenting the dosing weight for each chemotherapy agent as; actual, lean, or calculated. If calculated, indicate the exact formula.
  3. Evaluating renal, hepatic, and hematologic laboratory profiles.
  4. Verifying treatment regimen and/or protocol dosages.
  5. Ensuring maximum chemotherapy doses are not exceeded.
  6. Maintaining cumulative doses for doxorubicin, daunorubicin, bleomycin, mitoxantrone, and idarubicin, and other drugs as may be appropriate.
  7. Ensuring route of administration, base fluids, drug concentrations, and infusion rates are accurate.
  8. Evaluating other medications and therapy the patient might be taking for appropriateness with respect to the oncology-related treatment plan, including taking or reviewing a comprehensive medication history.
- C. All patients will be monitored for the overall use of cancer chemotherapy and other agents in the treatment of cancer patients, adverse effects (adverse drug reactions, medication errors), and patient outcomes in collaboration with the medical and nursing staff.
- D. Current clinical information should be available for commercial and investigational cancer chemotherapy pertaining to safety, dosing, therapeutic uses, and toxicity.
- E. Pharmacy Services will establish criteria to ensure that The Joint Commission and other standards that promote medication reconciliation are met by providing the following. This includes all prescription and alternative medication, vitamin, nutritional, and herbal products.
  1. Comprehensive review of medication history
  2. Assessing patients' understanding of why they are taking their therapy, and what conditions they are being treated
  3. Reconciling current medication plan with therapy that will be continued

4. Educating patients and ensuring they understand what medication will be continued, what will be discontinued, what the new plan includes, and why they are receiving the therapy
5. Contacting other providers who provide care before, after, or concurrently to ensure they also reconcile the patients' total therapy needs
6. Ensuring thorough documentation in the patient medical record.

#### **Guideline IV**

Appropriate drug-related education will be provided to patients and staff.

#### **Rationale**

It is important to incorporate new scientific discoveries and standards into practice as soon as possible, by educating patients and members of the multidisciplinary team. Training new staff and retraining established staff on a regular basis are important. Specific areas of focus include pharmacology, pharmacokinetics, pharmacodynamics, drug compatibility, drug administration, drug therapy interactions in patients taking multiple therapeutic agents, adverse effects of medication, medication outcomes, and taking comprehensive medication histories.

#### **Characteristics**

- A. Staff should follow The Joint Commission Medication Reconciliation requirements to ensure a complete medication history upon admission, that the patients understand their therapy plan and their therapy, and that medication is reviewed between each site of care. Patients should understand their medication prior to discharge, and the medication records should be available to other practitioners providing care to the patients.
  1. Patients should understand their medication sufficiently to participate in therapy decisions.
  2. Patients should understand the importance of compliance, how to monitor for therapy effectiveness or adverse effects, and the appropriate course of action.
- B. Current and appropriate drug information and other related compendia are available for all members of the institution/practice.
- C. Regular education is provided to other members of the healthcare team in a timely manner.
  1. Therapy updates from the literature or institutional committees, such as the Pharmacy and Therapeutics Committee

2. Results of institutional decisions, studies, and evaluations.
3. FDA-related information such as new drug approval, changes in indications, warnings, recalls, or discontinuation of availability.
4. Pharmacy Services should participate in multidisciplinary rounds, committees, and conferences.

#### **Guideline V**

Pharmacy Services should contribute to the financial and legal requirements associated with the patient's therapy.

#### **Rationale**

A complete and accurate patient bill is important to ensure reimbursement. Pharmacy systems should be designed to ensure that required billing information is complete and accurate in the patient record. All required records should be complete and meet legal requirements for required information and confidentiality (HIPAA). Pharmacy Services can also contribute to the development of budgets, influence effective cost management, and perform cost/outcome analysis of therapy.

#### **Characteristics**

- A. The drug therapy indication is appropriate for the patient diagnosis and is documented during the ordering process.
- B. References are provided for drugs being used outside of indications that have already been approved by payers.
- C. Appropriate billing codes and dosing increments are used as determined by the payer.
- D. Systems are in place to identify and enroll patients into "manufacturer patient assistance programs" and other charitable programs when appropriate.
- E. Pharmacy Services will assist with developing budgets related to the procurement and provision of drug therapy.
- F. All pharmacy and medication records should meet all legal standards including, but not limited to, HIPAA.
- G. Pharmacy Services will assist with assessing patient outcomes and developing cost-based analysis of outcomes.

## SECTION 6

# Psychosocial Oncology Care

---

### Guideline I

Psychosocial oncology services, also called psychosocial distress management services\* are provided to address the psychological, emotional, spiritual, social, and practical aspects that patients and their families have as a consequence of cancer and its treatment.

\* Distress management is the term developed by the National Comprehensive Cancer Network (NCCN) in its series of *Clinical Practice Guidelines*. Patients and families may find Distress Management less threatening and more understandable than psychosocial oncology care, so its use is appropriate when developing an individual program.

### Rationale

The diagnosis and treatment of cancer cause levels of distress that vary from normal to severe and may interfere with treatment. The continuum of feelings experienced by cancer patients and their families range from normal feelings of vulnerability, sadness, and fears to problems that are disabling, such as depression, anxiety, panic, and feelings of isolation or spiritual crisis. Distress, like pain, should be promptly recognized and managed. Referral to qualified professionals (including clergy for those in spiritual crisis) can help provide an optimal quality of life. Since patients and their families are more likely to understand the term “distress management” than psychosocial oncology care, its use is appropriate and may encourage self-reporting.

### Characteristics

- A. Psychosocial care includes, but is not limited to:
  - 1. Oncology social work services in which
    - a) Patients and their families are screened for psychosocial distress and further evaluated if required for advocacy, education, and case management in solving the concrete everyday needs that may be exacerbated by their cancer diagnosis.
    - b) Patients and their families are screened for psychosocial distress and further evaluated if required for education, counseling, support, and advocacy for their psychosocial problems, including conflict/isolation, treatment decisions, quality-of-life issues and transitions in care, advance directives, domestic violence, coping/communication, and functional changes.
    - c) Support groups are offered or referrals are made to a group that meets the patient’s and family’s needs.

- d) Complementary programs are provided or can be referred to.
    - e) Patients and their families are evaluated, referred, and managed for psychological/ psychiatric disorders, including adjustment, anxiety, and personality disorders, and substance abuse.
  - 2. Pastoral counseling services (See Chapter 4, Section 14, Pastoral Care)
- B. The Cancer Committee is responsible for:
  - 1. The quality of psychosocial oncology services provided
  - 2. Implementation of standards of care as defined in clinical practice guidelines
  - 3. Assurance that distressed patients and families are identified and treated promptly and appropriately per NCCN Distress Screening Guidelines
  - 4. Establishing or approving protocols for rapid screening and evaluation per NCCN Distress Screening Guidelines
  - 5. Assuring proper qualifications and credentials of the providers.

### Guideline II

Psychosocial care of cancer patients and their family is provided by oncology social workers with specialized knowledge and skills in oncology.

### Rationale

The complex psychosocial needs of patients with cancer and their families require specialized oncology social work knowledge and skills to achieve optimal care outcomes.

### Characteristics

- A. The oncology social worker is an integral part of the multidisciplinary team.
- B. Oncology social workers have master’s degrees in social work.
- C. Certification in oncology social work (OSW-C) is recommended and recognized.
- D. Oncology programs provide adequate oncology social work staff to meet the needs of patients and their families.
- E. A plan is in place regarding on-going staff development, including participation in multidisciplinary team conferences, regularly scheduled in-services, and continuing education programs, specific to oncology social work.
- F. Association of Oncology Social Work standards and guidelines for all aspects of patient care, professional practice, research, education, and administrative components should be referenced when developing individual programs.

## SECTION 7

### Pain Management

---

#### Guideline I

Acute and chronic cancer pain management guidelines are available to assist professional staff in alleviating patient suffering and improving quality of life.

#### Rationale

Cancer patients are entitled to quality pain management consisting of appropriate assessment and reassessment of pain through collaborative care guided by evidence-based treatment customized to patient needs. Treatment of cancer pain should be efficacious, cost-conscious, culturally appropriate, and safe. When difficulties arise, access to specialty care should be available.

#### Characteristics

- A. The Cancer Committee is charged with developing standards of practice that define policies and procedures designed to improve pain assessment and treatment.
- B. Treatment standards should assess current pain management practices and seek to improve them by:
  1. Establishing clearly defined accountability for the assessment and treatment of pain.
  2. Developing multimodal approaches to pain treatment that integrate evidence-based standards for pharmacologic and non-pharmacologic pain treatment.
  3. Educating patients and families about pain resources available and helping them to achieve realistic goals that meet their specific needs based on the clinical disease and the impact of the disease on the patient and family members.
  4. Assessing and reassessing pain treatment to include efficacy defined by change in visual analogue score, timeliness, improvement in functional capacity and safety, and customization of therapy defined by establishing treatment goals with the patient and family and readjustments determined by changes in the patient's disease or through shared decision making with the patient and family.
- C. Methodology should be established to monitor processes and outcomes of pain management. Quality outcomes measurement should include practice patterns and patient outcomes that are goal oriented and easy to collect.
- D. Clinical experts in pain management should be identified and available for consultation.

- E. Patient education and treatment planning should include the family or care providers.
- F. Physician and staff education is provided to ensure clinical competency in pain assessment and management.
- G. Staff is encouraged to become involved in local and national advocacy and legislative efforts addressing barriers to pain relief.

## SECTION 8

### Nutrition Services

---

#### Guideline I

A nutrition professional is available to work with patients and their families, especially patients identified at risk for having nutritional problems or special needs.

#### Rationale

Nutritional status can be adversely affected by the disease process, including the symptoms and side effects of cancer and its treatment (e.g., chemotherapy, surgery, immunotherapy, and radiation therapy). The nutrition professional works with patients, families and/or caregivers, physicians, and other members of the oncology multidisciplinary team to help maintain optimal nutritional status throughout the continuum of care (prevention, treatment, survivorship, palliative care, and hospice).

#### Characteristics

- A. The nutrition professional is a registered dietitian and maintains registration through the Commission on Dietetic Registration (CDR). Certification in oncology nutrition as a Certified Specialist in Oncology Nutrition (CSO) through the CDR is recommended.
- B. The nutrition professional has education and experience in the specialized nutritional needs of patients with cancer, side-effect management, and in minimizing the risk of cancer through nutritional counseling and education.
- C. Staffing of nutrition professionals is adequate to meet the needs of cancer patients and their families in a timely manner.
- D. The nutrition professional provides education and guidance to physicians and other members of the oncology team to assure appropriate screening, assessment, and referral of patients.
- E. The nutrition professional participates in oncology multidisciplinary team conferences and the institutional Cancer Committee.
- F. Oncology nutrition standards for all aspects of patient care and professional practice are guided by the

Academy of Nutrition and Dietetics\* Standards of Practice and Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Oncology Nutrition Care.

- G. A plan is in place regarding ongoing professional development for the nutrition professional, including regularly scheduled in-service and continuing education programs through national and regional professional organizations (e.g., the Oncology Nutrition Dietetic Practice Group of the Academy of Nutrition and Dietetics) and community-sponsored programs specific to oncology nutrition. \*Effective January 2012, Academy of Nutrition and Dietetics (AND) became the new name for the American Dietetic Association.

### **Guideline II**

The nutrition professional with the patient, family, and the oncology team manages issues involving the patient's nutrition and hydration status through appropriate nutrition screening, assessment, and intervention across the care continuum.

#### **Rationale**

The nutritional needs of patients are unique to each individual.

#### **Characteristics**

As part of the nutrition care process, the nutrition professional:

- A. Develops and implements a screening program to identify and prioritize patients at risk for malnutrition.
- B. Formulates an individualized nutrition care plan based on assessment findings.
- C. Provides anticipatory guidance, identifying common nutritional problems the patient may encounter during the course of his/her disease and treatment.
- D. Addresses side-effect management, complementary and alternative medicine (CAM) issues (e.g., herbs, supplements, vitamins, and minerals) in the context of evidence-based nutrition care, and services across the care continuum (prevention, treatment, survivorship, palliative care, and hospice).
- E. Monitors the patient's progress and provides follow-up nutrition care, as needed.
- F. Assesses the patient's and/or family's ability to understand and comply with nutritional education and instruction and modifies interventions appropriately.

- G. Collaborates in the patient's care with his/her physician(s) and other members of the oncology team.
- H. Evaluates nutrition care outcome indicators.

### **Guideline III**

The nutrition professional serves as a resource and provides nutrition and diet information about reducing cancer risk and cancer recurrence risk through educational program materials and services to the community.

#### **Rationale**

Lifestyle interventions that are associated with reduced cancer risk also address chronic disease as a whole, improving the health and knowledge base of the community that the cancer center serves.

#### **Characteristics**

- A. The nutrition professional provides dietary and lifestyle guidance associated with reduced cancer risk through the delivery of educational materials, programs, and services to the community.
- B. The nutrition professional works with health professionals and educators to provide evidence-based information about lowering cancer risk, both for primary prevention and to prevent recurrence and secondary cancers in survivors.

### **Guideline IV**

The nutrition professional manages nutrition and diet-related needs specific to each patient's individualized survivorship plan.

## **SECTION 9**

### **Rehabilitation Services**

---

#### **Guideline I**

Comprehensive rehabilitation services are available to cancer patients and their families through the entire cancer care continuum from diagnosis through survivorship.

#### **Rationale**

Cancer is a chronic disease that may require adjustment in the physical, social, financial, and emotional aspects of life in order to maximize independence and quality of life within medical status. Professionals experienced in rehabilitation are best suited to meet these needs of cancer patients.

### Characteristics

- A. Rehabilitation includes, but is not limited to:
  - 1. Patient and family
  - 2. Attending physicians
  - 3. Oncology nursing services (See Chapter 4, Section 4, Oncology Nursing Services.)
  - 4. Psychosocial services (See Chapter 4, Section 6, Psychosocial Oncology Care.)
  - 5. Nutritional support services (See Chapter 4, Section 8, Nutrition Services.)
  - 6. Pharmacy services (See Chapter 4, Section 5, Pharmacy Services.)
  - 7. Pastoral care services (See Chapter 4, Section 14, Pastoral Care.)
  - 8. Physical, occupational, and recreational therapy services
  - 9. Speech pathology services
  - 10. Comprehensive, multidisciplinary lymphedema services
  - 11. Enterostomal therapy services
  - 12. Discharge planning services to address home care, community, and/or extended care facility services and needs
  - 13. Qualified volunteer services to provide support and advocacy for cancer patients and their families
  - 14. Other complementary services, such as music/art therapy, relaxation, massage, and others may be used in conjunction with rehabilitation disciplines.
- B. Each healthcare discipline is available on staff or by consult to facilitate continuity of care for rehabilitation services. All outsourced services should be provided by properly credentialed individuals whose performance is reviewed annually.
- C. Mechanisms exist, when necessary, to review the rehabilitation plan and coordinate communication among the various members of the rehabilitation team.
- D. Rehabilitation services are a part of the organizational structure of the program, follow proper policies and procedures, and are available to cancer patients and their families throughout their continuum of care.

- E. Ongoing educational opportunities are available to members of rehabilitation services.
- F. A mechanism is in place to inform patients and family members of the services available.

## SECTION 10 Patient Navigation Services

---

### Guideline I

A patient navigation program is available for patients, their families, and caregivers to help “overcome health care system barriers and facilitate timely access to quality medical and psychosocial care from pre-diagnosis through all phases of the cancer experience.” \*

### Rationale

The diagnosis and treatment of cancer and living with the disease may be confusing, intimidating, and overwhelming for an individual, family member, or caregiver. Cancer programs have a responsibility to assist our patients, their families, and caregivers to navigate the continuum of care through a navigation program developed by the cancer program or via a partnership with a community agency that utilizes patient navigators. Since each cancer program understands its unique patient population and its community, individual programs or health systems can best create a navigator system that suits its needs.

### Characteristics

- A. Patient navigation may include but is not limited to oncology social worker(s) and nurse(s) who may:
  - 1. Act as a coordinator to ensure the patient, their family members, and caregivers move through the complexities of the system in a timely fashion
  - 2. Provide psychosocial services to patients, families, and caregivers or refer to oncology social worker for psychosocial care
  - 3. Link patients, families, and caregivers with appropriate community resources (i.e., financial, transportation, translation services, and hospice)
  - 4. Provide education to the patient, families, and caregivers throughout the continuum of care

\*From a definition created by C-Change, May 20, 2005. Permission granted. “Patient navigation in cancer care refers to individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care from pre-diagnosis through all phases of the cancer experience.”

5. Link patients, families, and caregivers with appropriate post-treatment follow-up care.
- B. Trained volunteers and non-clinical paid staff may provide some of the navigator activities and functions under defined conditions and with professional oversight.
  1. Cancer programs may choose to select, train, and oversee their own volunteers or non-clinical paid staff.
  2. Cancer programs may choose to partner with an organization that employs patient navigators or uses volunteers.
    - a) The cancer program will help determine who will oversee these navigators.
    - b) The cancer program will develop a contract between the navigator(s) and the program that clearly outlines the role the navigator(s) will have with patients and families.
    - c) The cancer program will develop an orientation and training program that the navigators must attend.
    - d) The cancer program will provide an ongoing in-service education program for the navigators.
  3. The program should provide adequate space for confidential interviews and counseling.
  4. Navigators should receive training in ethnic, cultural, and religious diversity as well as ethics.
  5. Mechanisms exist, when necessary, to review the plans and coordinate among team members.
  6. Navigators should facilitate communication between patient and providers.

Navigators should educate the oncology staff about the navigator program and how it will be integrated into the oncology program.

## SECTION II

### Genetic Risk Assessment, Counseling, And Testing

#### Guideline I

Genetic risk assessment programs are available, or referral relationship exists, for people at risk for inherited cancers. These programs assess medical and family history and provide genetic counseling tailored to individual or family risk of cancer.

#### Rationale

Identifying familial cancer patterns can be useful in recommending early detection and prevention strategies for affected individuals.

#### Characteristics

- C. Genetic risk assessment programs include the following elements:
  7. Identification of the high-risk client through personal medical history, family history (paternal and maternal), pedigree construction, and additional information to confirm cancer diagnoses.
  8. Facilitation of client referral to specialists, client-and/or family-specific education and counseling by healthcare providers trained in genetics, follow-up care, and post-test counseling.
  9. Provision of information about early detection, risk reduction, and preventive strategies that are personally tailored to the client as well as the general public.
- D. Risk assessment involves a genetics team of healthcare professionals including: physicians and nurses trained in genetics, board-certified genetic counselors, psychologists, and other specialists.

#### Guideline II

Genetic predisposition testing is available for individuals who have undergone thorough risk assessment and counseling by the genetics team and are considered appropriate candidates for testing.

#### Rationale

Genetic testing, a multi-step process, is fundamentally different from other clinical tests because of its inherent complexities. It is *one* component of a comprehensive cancer risk assessment plan.

#### Characteristics

- A. Individuals seeking genetic testing should be considered according to the following criteria:
  1. There is a reasonable likelihood (based on risk assessment) of carrying an altered cancer susceptibility gene.
  2. A genetic test is available that can be adequately interpreted.
  3. Results will influence management. (See References, page 31 for additional information.)
  4. The individual wants genetic susceptibility information.
- A. Genetic counseling by a qualified healthcare professional is a crucial component of genetic testing.

- E. Genetic testing has implications for the entire family, such as disclosure of results, breach of confidentiality, and clarifying each family member’s risk and options for testing.
- F. Testing will, ideally, begin with a family member affected with cancer.
  1. Motivations for testing will be carefully considered.
  2. Informed consent procedures will be strictly enforced and include the potential benefits, risks, and limitations of genetic testing.
  3. Post-test counseling and longitudinal follow-up will be part of the testing process.

## **SECTION 12**

### **Home Care**

---

#### **Guideline I**

A home health agency or referral relationship exists to provide professional services to cancer patients and their families in the home.

#### **Rationale**

Cancer is a chronic disease with intermittent, acute episodes resulting in care being delivered in various settings, such as in primary, tertiary, ambulatory, rehabilitation, extended care, and home settings.

#### **Characteristics**

- A. A home health agency must be accredited by a national organization such as The Joint Commission and can be owned by or have a referral relationship with the hospital to provide the following multidisciplinary professional services:
  1. Oncology nursing
  2. Clinical nutrition
  3. Pharmacy
  4. Psychosocial services
  5. Rehabilitation services
  6. Spiritual support
- B. Home health aide and homemaker services are available.
- C. The home health agency has written policies and procedures for care of the cancer patient, which are compatible with those of the referring institution.
- D. A physician-authorized plan of treatment specific to each patient is established.

#### **Guideline II**

The home health agency staff is capable of providing appropriate and competent care for cancer patients and their families at any stage of the disease.

#### **Rationale**

Oncology care of the cancer patient requires specialized knowledge. Experienced oncology nurses and oncology social workers should be available to care for or consult on the care of the cancer patient at home. (See Chapter 4, Section 4, Oncology Nursing Services and Section 6, Psychosocial Oncology Care.)

#### **Characteristics**

- A. Access to oncology nurse experts or an oncology clinical nurse specialist, or an established oncology nursing team should be provided within the home health agency.
- B. Oncology nurses in home care should demonstrate competence and expertise in the following areas:
  1. Knowledge of all treatment modalities, side effects of diseases and treatments, stages of disease, and subsequent outcomes
  2. Administration and safe disposal of cytotoxic drugs
  3. Appropriate referral to other professional services and community-based resources
  4. Assessment of and intervention for oncologic emergencies
  5. Assessment and management of pain, nausea, vomiting, malnutrition, fatigue, dehydration, and other side effects of treatment and disease
  6. Skin and wound care
  7. Management of vascular access devices.
- C. Ongoing staff education in the area of cancer services should be provided to oncology staffs in home care.
- D. Access to oncology social work experts or an established oncology social worker should be provided within the home health agency.
- E. Oncology social worker in home care should demonstrate competence and expertise in the following areas: resource development, advocacy, education, psychosocial assessment, and counseling.

## **SECTION 13**

### **Palliative Care**

---

#### **Guideline I**

Appropriate policies and procedures for providing palliative care are available to professional staff to assist patients in achieving maximum comfort and relief of suffering at the end of life.

### **Rationale**

Palliative care is the active intervention to achieve the maximum comfort and function of the total patient. Palliation (relief of symptoms) should always be an important part of patient care. In the advanced cancer patient, it may be the only care when curative care is no longer the goal. Palliative care should attend to the physical, emotional, psychological, social, cultural, and spiritual needs of the patient.

### **Characteristics**

- A. Palliative care is an integral part of the comprehensive spectrum of patient care.
- B. Palliative care is available when curative treatment is no longer considered a goal.
- C. Professional staff is educated about the physical, emotional, spiritual, and psychosocial components of palliative care in relieving suffering and providing comfort at the end of life.
- D. Palliative care is a multidisciplinary effort, involving physicians, nurses, social workers, clergy, and other members of the healthcare team, to maximize comfort and support that respects the patient's wishes, values, culture, and traditions.
- E. Palliative care requires continuous, effective communication with the patient and his or her family to ensure that goals are mutually set and understood by the multidisciplinary team, the patient, and his or her family.
- F. Professional staff has a responsibility to discuss, with the patient and his or her family, issues such as withholding/withdrawing various therapeutic measures, artificial feeding and hydration, cardiopulmonary resuscitation, and any other measures that may impact the patient's quality of life.

## **SECTION 14 Hospice**

---

### **Guideline I**

A hospice program exists to provide professional and volunteer services to patients with cancer in the terminal stage of disease and their families. Bereavement support for families is provided for a minimum of six months.

### **Rationale**

The palliative and supportive services of a hospice program provide physical, psychosocial, and spiritual care for patients with terminal cancer diagnoses and their families.

### **Characteristics**

- A. Multidisciplinary hospice services are available to dying patients and their families and include home-based hospice, inpatient hospice, residential hospice or respite

care. Services provided include medical, nursing, psychosocial, spiritual, and bereavement. Services may be provided by hospice program staff, volunteers, or through a written agreement(s) with an individual, institution, or agency.

- B. The hospice program assures continuity of care through assessment of the patient and family needs, development and review of the care plan, and management of care needs until discharge or until death and the bereavement period.
- C. Hospice services are available 24 hours a day, 7 days a week.
- D. Homemaker and home health aide services are available.
- E. Acute and chronic cancer pain management is available to all patients. (See Chapter 4, Section 7, Pain Management.)
- F. A medical staff or director is responsible for the supervision and quality of hospice services.
- G. Hospice services are provided with sufficient nursing personnel to meet the level of care required by hospice patients.
- H. Respite care is available to family and other caregivers.
- I. The hospice program meets appropriate licensing and accreditation requirements.
- J. Policies and procedures are established for all hospice components including: admission and discharge criteria, bereavement care, and psychosocial, medical and nursing care management.

## **SECTION 15 Pastoral Care**

---

### **Guideline I**

Pastoral care services are available to meet the needs of all patients and their families with consideration of diversity in religious preferences.

### **Rationale**

Spiritual and psychological issues are confronted by cancer patients and their families, staff members, and the community at-large; therefore, effective pastoral care is an integral part of relating to such issues. Staff respects the personal integrity, spiritual beliefs, and traditions of each individual and assists in creating an environment of acceptance, reflection, and expression of spiritual needs.

### **Characteristics**

- A. Pastoral care is supervised by a qualified professional chaplain with appropriate education (college and accredited theological school) and clinical training (four units of clinical pastoral education are preferred).
- B. Spiritual needs may be identified and referred to a professional chaplain by all members of the oncology team.

- C. Spiritual assessment by a professional chaplain is incorporated into basic patient assessment.
- D. A clearly defined and functional referral system is established and maintained.
- E. Pastoral care involves sacramental, liturgical, and counseling services in keeping with the beliefs of patients and their families.
- F. Spiritual guidance in decision making related to patient care and biomedical ethics is available to patients and their families as well as to caregivers.
- G. Ongoing multidisciplinary staff education and support is provided.
- H. Pastoral care recognizes diversities of faith, culture, and race. (A professional chaplain, as defined by the Joint Commission for Accreditation of Pastoral Services (JCAPS) standards, is equipped with the knowledge and sensitivity to deal with the diversity of faith, culture, and racial traditions.)
- I. Pastoral care staff communicates with and supports clergy in the community.
- J. Pastoral care is available to staff members through individual counseling and group sessions.
- K. Bereavement care and services are available to patients and their families.
- L. Pastoral care adheres to the “Standards for Accrediting Pastoral Services” (Council on Ministry in Specialized Settings Network’s Joint Commission for Accreditation of Pastoral Services.)

## SECTION 16

### Integrative Care

---

#### Guideline I

Integrative care services are utilized to treat the whole person – mind, body and spirit – to enhance the quality of the patient’s life during the patient’s experience with cancer.

#### Rationale

Integrative care programs provide comprehensive services that promote access to care – biomedical, palliative, supportive, and complementary. The goal is to increase the efficacy of conventional cancer treatments, alleviate symptoms, and improve the patient’s overall quality of life. Integrative care attends to the physical, emotional, psychological, social, cultural, and spiritual needs of the patient.

#### Characteristics

- A. Integrative care is a multidisciplinary effort utilizing the wide variety of palliative, psychosocial and complementary care services in conjunction with disease-specific therapies.
- B. Integrative care requires communication with patients and families to ensure that goals are mutually set and understood by the multidisciplinary team, the patients, and their families.
- C. Integrative cancer care programs are designed to help patients with cancer to live better.
- D. Integrative care services are designed to treat the whole person – his or her mind, body, and spirit.
- E. Complementary therapies are evidence-based practices applied in conjunction with standard conventional therapies.
- F. Complementary therapies are provided in parallel with the conventional treatment plan and also when curative treatment is no longer considered a goal.
- G. Complementary therapies should be provided by the cancer facility whenever possible. In addition to or as an alternative, the cancer facility may seek collaborative agreements with credible community agencies and individual reputable providers to help patients access appropriate care. When working with outside providers, the facility needs to do due diligence in order to endorse the particular providers.
- H. Professional staff performing complementary services and therapies should be licensed healthcare providers to the extent dictated by individual state licensure requirements.
- I. Traditional practitioners have the responsibility to endorse complementary services that the program determines have medical credibility and should advise their patients against seeking alternative care (used instead of conventional evidence-based therapies) or treatments that may minimize the effectiveness of their current conventional therapies.

## SECTION 17

### Survivorship Services

---

#### Guideline I

Information and programs specific to survivorship issues are available to cancer patients and their families.

#### Rationale

Survivorship is defined as the experience of living with, through, and beyond cancer for both patients and the people in their lives who are impacted by the diagnosis. It comprises the physical, psychological, emotional, social, spiritual, and economic aspects of life that may be influenced by cancer at any time from diagnosis through treatment and all remaining years of life.

#### Characteristics

- A. Programs and educational resources for survivors and their families should include but are not limited to the following:
  1. A written cancer treatment summary and follow-up care plan that would include a summary of the cancer treatment, recommended follow-up for cancer surveillance, late and long-term effects of their disease and its treatment(s), symptom management, as well as psychosocial, spiritual, and financial concerns. Access to information about cancer prevention, early detection, genetics, disease treatment, symptom management and psychosocial, spiritual, financial concerns through written materials and/or referrals via the Internet, other experts, or support organizations
  2. Information about local, regional, and national resources on survivorship and survivorship research via written materials and/or referrals through the Internet, other experts, or support organizations for any aspect of their cancer, cancer care, research, advocacy, and survivorship
  3. Access to support groups either on-site or by referrals to local or web-based support groups and other support mechanisms, such as telephone connection programs linking survivors together
  4. Information about specific survivorship issues, such as employment rights, insurance coverage, late and long-term effects of disease and treatment, advance directives, living will and durable power of attorney, estate planning, options for recurrent disease management, and end-of-life care planning
  5. Programmatic opportunities to participate with the care team to develop community outreach education and support programs for quality cancer care in the community and to educate professional staff about the cancer experience.
- B. Resources are allocated to provide a robust survivorship program.
- C. National standards for survivorship will be incorporated into program planning, implementation, and evaluation.

## SECTION 18

### Patient Advocacy and Financial Services

---

#### Guideline I

Patient advocate is available to assess and explain insurance benefits and coverage eligibility to patients and their families.

#### Rationale

The diagnosis and treatment of cancer can cause levels of distress that vary from normal to severe and may interfere with the ability of patients and families to process complex information related to insurance benefits and coverage.

#### Characteristics

- A. Depending on the cancer program and the patient population, patient advocacy and financial services may be performed by office staff, nurses, social workers, case managers, and/or professional or lay patient navigators. Ongoing training is important to maintain a thorough knowledge base.
- B. The patient advocate will develop a system or tools to manage and track all interactions with third-party payer(s), including Medicare and Medicaid, as well as patient assistance, drug replacement and grant sites.
- C. Patient advocate performs insurance verification with all third party payers.
- D. Patient advocate ensures all demographic, insurance, and eligibility information is obtained and current. Patient advocate will develop a system to track and update insurance information, including policies related to medical necessity, prior or pre-authorizations, and appeals.
- E. Patient advocate obtains initial and subsequent pre-authorizations. Patient advocate will track the number of treatments permitted before pre-authorizations must be renewed and ensure that pre-authorizations do not run out or expire.

#### Guideline II

Patient advocate is available to assess and explain treatment costs to patients and their families.

#### Rationale

The diagnosis and treatment of cancer can cause levels of distress that vary from normal to severe and may interfere with the ability of patients and families to process complex financial information related to the cost of treatment.

#### Characteristics

- A. Depending on the cancer program and the patient population, patient advocacy and financial services may be performed by office staff, nurses, social workers, case managers, and/or professional or lay patient navigators. Ongoing training is important to maintain a thorough knowledge base.
- B. Patient advocate meets with the patient and family prior to the start of treatment to discuss the costs of the prescribed treatment regimen.
- C. At this face-to-face meeting, the patient advocate identifies all out-of-pocket costs for the patient. These out-of-pocket expenses can include: co-insurance, deductibles, and co-pay amounts.
- D. If necessary, the patient advocate will work with the patient and family to outline a payment plan for the costs of treatment. This plan should be a written agreement that is signed by the patient.
- E. Patient advocate will work with patients and families to identify other costs, such as expenses related to transportation, childcare, and lodging, if patient must travel to receive treatment.
- F. If necessary, the patient advocate will work with the patient and family to identify patient assistance programs that can help with non-treatment-related costs. If patients are eligible, the patient advocate will help patients and families apply to these program(s).

#### Guideline III

Patient advocate is available to screen patients and, when necessary, to help patients and families apply to appropriate federal- or state-run program(s).

#### Rationale

The diagnosis and treatment of cancer can place an undue financial burden on patients and their families. Lack of insurance, high co-pays, and high deductibles may result in patients choosing not to seek treatment, to stop treatment, or to delay treatment.

#### Characteristics

- A. Depending on the cancer program and the patient population, patient advocate and financial services may be performed by office staff, nurses, social workers, case managers, and/or professional or lay patient navigators.

Ongoing training is important to maintain a thorough knowledge base.

- B. Patient advocate will gather information about federal and state programs, such as Medicaid, including eligibility requirements and information about the application process.
- C. If patients are eligible, the patient advocate will help patients and families apply to federal and/or state programs.

#### **Guideline IV**

Patient advocate is available to screen patients and, when necessary, to help patients and families apply to appropriate patient assistance program(s).

##### **Rationale**

The diagnosis and treatment of cancer can place an undue financial burden on patients and their families. Lack of insurance, high co-pays, and high deductibles may result in patients choosing not to seek treatment, to stop treatment, or to delay treatment.

##### **Characteristics**

- A. Depending on the cancer program and the patient population, patient advocacy and financial services may be performed by office staff, nurses, social workers, case managers, and/or professional or lay patient navigators. Ongoing training is important to maintain a thorough knowledge base.
- B. Patient advocate will gather information about patient assistance programs, both manufacturer patient assistance programs and non-profit and/or Foundation patient assistance programs, including eligibility requirements and information about the application process.
- C. For uninsured patients, patient advocate will help patients and families identify appropriate patient assistance programs to help pay for treatment-related costs. The patient advocate will then help patients and families fill out applications and serve as a liaison between the patient, the cancer program, and the patient assistance program(s).
- D. For under-insured patients and patients who cannot afford the cost of treatment, patient advocate will help patients and families identify appropriate patient assistance programs, usually referred to as “co-pay programs.” The patient advocate will then help patients and families fill out applications and serve as a liaison between the patient, the cancer program, and the patient assistance program(s).
- E. Patient advocate will develop a system or tools to manage and track all interactions with patient assistance

#### **Guideline V**

Patient advocate is available to screen patients for financial needs not directly related to oncology diagnosis and treatment and, when necessary, to help patients and families apply to appropriate patient assistance program(s) and/ or make appropriate support referrals.

##### **Rationale**

The diagnosis and treatment of cancer can place an undue financial burden on patients and their families. Many patients and families may have finance-related needs prior to a cancer diagnosis that are either increased or compounded by a cancer diagnosis. These finance-related needs may result in patients choosing not to seek treatment, to stop treatment, or to delay treatment. They may also increase the stress levels of the patient and family which could affect outcomes.

##### **Characteristics**

- A. Depending on the cancer program and the patient population, patient advocacy and financial services may be performed by office staff, nurses, social workers, case managers, and/or professional or lay patient navigators. Ongoing training is important to maintain a thorough knowledge base.
- B. Patient advocate will gather information about local, state, national and private support programs available to their oncology population, including services, contact information, any eligibility requirements, information about the application process and any other pertinent information.
- C. Patient advocate will help patients and families identify appropriate support and patient assistance programs. to help pay for treatment-related costs. The patient advocate will then help patients and families fill out applications and serve as a liaison between the patient, the cancer program, and the patient assistance program(s) as appropriate.
- D. Patient advocate will develop a system or tools to manage and track all interactions with patient assistance

## CHAPTER 5: Clinical Research

---

### Guideline I

Cancer patients are provided access to clinical research programs.

### Rationale

The great majority of cancer patients receive their care from community oncologists and community cancer centers. All cancer patients and their physicians should have access to clinical trials, which often provide the most advanced and promising new therapeutic options. In many cases, the best treatment plan for a cancer patient is a well-designed clinical study. Clinical trials typically address important clinical questions and bring the latest basic science discoveries to the patient. They frequently represent the best pathway for advancement of knowledge while protecting the safety, prerogatives, and confidentiality of the patient.

Research by community oncologists and community cancer centers also involves treatment, prevention, diagnostic, screening, and quality of life (supportive care) trials, all of which should be available to patients with cancer or those at high risk for cancer.

The mechanism for providing information to patients in the community setting regarding the availability of appropriate clinical trials should be established and documented.

### Characteristics

- D. The research conducted is in the best interest of the patient. Providers in the community setting should demonstrate an understanding of the scientific research process before engaging in clinical research.
- E. An Institutional Review Board (IRB) is responsible for the review and approval of all protocols involving human subject participation.

- F. Information on the availability of clinical trials, in general, and information on specific clinical trials, in particular, should be offered to patients as appropriate.
- G. Participation in clinical trials may include:
  - 1. Participation in National Cancer Institute-sponsored programs such as the Community Clinical Oncology Program (CCOP) or Clinical Trials Support Unit (CTSU)
  - 2. Participation in cooperative trials groups
  - 3. Participation in comprehensive cancer center or university-related research
  - 4. Participation in industry-sponsored pharmaceutical or biotechnological research
  - 5. Development and participation in locally generated, peer-reviewed, scientifically sound, and rigorously managed research studies.
- H. Cancer research may include, but is not limited to:
  - 1. Treatment-related clinical trials
  - 2. Quality-of-life evaluation and recommendations
  - 3. Symptoms management
  - 4. Economics of cancer care
  - 5. Survivorship issues
  - 6. Outcome evaluation of all research efforts
  - 7. Effectiveness of psychosocial interventions
  - 8. Hospice and terminal care
  - 9. Diagnostic trials
  - 10. Screening trials.
- I. The Cancer Committee is responsible for assuring accrual to clinical trials of the minimum percentage of annual analytic cases, as defined by the cancer program category of the American College of Surgeons Commission on Cancer. In lieu of an active research program, the Cancer Committee assures that patients have information about and access to other avenues for accessing clinical trials.

# CHAPTER 6: Community Outreach

---

## SECTION I

### Cancer Education and Resource Program

---

#### Guideline I

Education and educational resources are provided for cancer patients and their families, friends, and caregivers through structured programs defined in an educational plan.

#### Rationale

Education enables cancer patients and their families, friends, and caregivers to make informed decisions about their treatment and symptom management and improves their quality of life.

#### Characteristics

- A. The patient education plan includes, but is not limited to:
  1. Program mission, goals, and objectives
  2. Policy and procedures
  3. Methodology for determining topics
  4. Description of programs and services offered
  5. Appropriate resources to accomplish goals
  6. Outcome evaluation of programs and services.
- B. Patient and family education is centralized and available within the facility.
- C. Patient and family education programs are based on patient and family needs, changes in clinical care, evidence-based complementary services, research, and local/state/national issues.
- D. Programs are developed and implemented by members of the multidisciplinary team or selected experts, including patients and families in the development process.
- E. Appropriate resources are committed to develop and provide patient and family education.
- F. The programmatic content of patient education programs should include, but is not limited to:
  1. Cancer therapy
  2. Side effects and symptom management
  3. Nutrition
  4. Venous access devices
  5. Coping with cancer
  6. Location and availability of community resources (e.g., screening mammography) for early detection
  7. Rehabilitation
  8. Pain control
  9. End-of-life/quality-of-life issues
  10. Complementary treatment methods (guided by policy)
  11. Survivorship issues.
- G. A list of available cancer education programs and resources is developed and made available to medical staff, patients, and the community. Efforts are made to coordinate programs and/or services with relevant community agencies, resources, cooperative groups, and other health care entities.
- H. An oncology professional is accountable for patient and family education programs.
- I. A cancer-related resource center (library) is available to the public, patients, and their families, friends, and caregivers.
- J. Access to an on-line education center designed to offer a complete set of cancer information to bring patients, families, and community members the latest news and information about cancer. The site should offer a comprehensive collection of cancer education resources including the latest treatment news, in-depth information on specific cancer types, message boards, newsletters and support groups and feature articles, and inspirational stories, cancer dictionary, and consumer drug guide.
- K. A quarterly patient newsletter is provided, designed to enhance knowledge of services available to help support cancer patients, their families, and caregivers with the cancer experience.

## SECTION 2

# Cancer Control and Detection

---

### Guideline I

Cancer control and detection programs are available to reduce risk of developing cancer, teach self-examination and symptom identification techniques, provide screening guidelines, and communicate the availability of community resources for early detection.

#### Rationale

Cancer control and detection include education about high-risk behaviors, environmental and lifestyle modifications, and methods to reduce risk of developing cancer. Early detection is the discovery of cancer at an early stage, maximizing potential for cure.

#### Characteristics

- A. Primary prevention programs focus on interventions that reduce the risk of cancer through:
  1. Eliminating or limiting exposure to causative factors
  2. Promoting protective factors
  3. Reducing high-risk behaviors
  4. Cancer prevention and control research.
- B. Cancer control recognizes that *prevention* of cancer is at best anecdotal and while there are research findings that have identified some chemical actions/reactions that appear to have prevented cancer, there are few actions that a person can take that will *prevent* the disease. Cancer control includes public education about high-risk behaviors and the use of protective factors or the elimination of exposure to causative factors along with education related to early detection.
- C. Early detection programs include the following elements:
  1. Identification and surveillance of high-risk groups
  2. Promotion of reliable and valid screening techniques for cervical, breast, colorectal, oral, skin, testicular, prostate, and any other cancers that have tumor markers and/or screening tests.

### Guideline II

Public education programs and materials are available and presented throughout the community on a regular basis. Teaching plans incorporate sensitivity to the cultural, religious, and ethnic beliefs of high-risk groups.

#### Rationale

Public awareness is important in the prevention and early detection of cancer.

#### Characteristics

- A. Community outreach education should increase awareness of the following:
  1. Control techniques to reduce the risk of developing cancer
  2. Self-examination and symptom-identification techniques
  3. Screening guidelines for the public
  4. Access to community resources for early detection.
- B. The Cancer Committee is responsible for periodically assessing the needs of the community and the outcomes of current programs to define which early detection programs are needed.
- C. The public education program includes, but is not limited to:
  1. Program mission, goals, and objectives
  2. Policy and procedures
  3. Methodology for determining topics
  4. Description of programs and services offered
  5. Appropriate resources to accomplish goals
  6. Outcome evaluation of programs and services.
- D. Documentation of all public education activities is maintained and shared with the Cancer Committee.
- E. An oncology professional is accountable for public education programs.

## CHAPTER 7: Professional Education and Staff Support

---

### **Guideline I**

All professionals involved in the care of patients with cancer assure the Cancer Committee of periodic educational activities that are cancer specific.

### **Rationale**

Cancer care is complex and constantly changing. The physicians, nurses, and allied personnel should renew their knowledge and skill bases to remain current.

### **Characteristics**

- A. The Cancer Committee assures that all physicians, nurses, and allied personnel are participating in continuous medical education directed at all aspects of cancer care in which the individual participates. Ideally the Cancer Committee should review such activity on a yearly basis.
- B. The Cancer Committee assures that the Multidisciplinary Conferences fulfill Category I CME and CNU requirements.
- C. The Cancer Committee sponsors at least one educational activity, in addition to the conferences, yearly. These activities ideally should result from outcomes analysis and evidence-based care. The Cancer Committee should assess all aspects of care and provide educational activities as indicated. This assessment should be presented and documented at the regular meetings. The assessment should be followed with a plan to assure currency and eliminate deficiencies.

### **Guideline II**

All professionals are supported by the facility in their continuous education.

### **Rationale**

The facility needs to provide adequate time away from clinical activities and financial support for educational activities.

### **Characteristics**

- A. The facility provides paid time, or appropriate leave, for all personnel to participate in educational activities.
- B. The facility financially supports all personnel in at least one educational opportunity yearly.

### **Guideline III**

All cancer registry personnel are encouraged to participate in local, state, and national meetings.

### **Rationale**

The specific activities of cancer registrars are such that only at meetings with peers can appropriate educational activities occur.

### **Characteristics**

- A. The Cancer Committee assures that all cancer registry personnel are participating in at least one local meeting yearly. Participation at state and national meetings is encouraged.
- B. All cancer registrars must attend a national activity on a schedule in compliance with the Standards of the Commission on Cancer (Standard 7.2).

## CHAPTER 8: Quality Improvement

---

### Guideline I

Patient care is monitored and evaluated for the quality of services. Quality improvement plans are developed to address priority improvement opportunities in the cancer program. Multidisciplinary teams may be formed to address improvement opportunities generated from quality review data, including attributes of timeliness, appropriateness of care, clinical outcomes, and effective management of disease sequelae and treatment toxicities.

### Rationale

Quality patient care depends on the contributions of the healthcare team and the organization's care guidelines and policies. The Cancer Committee approves these guidelines and policies as well as all quality improvement plans to ensure that improvement priorities are appropriately addressed.

### Characteristics

- A. The Cancer Committee establishes the program's mission, goals, and objectives, and it prioritizes and plans for continuous performance improvement in program goals.
- B. Examples of opportunities for improvement may include, but are not limited to:
  1. Enhanced accuracy and/or efficiencies in patient care processes
  2. Development of treatment guidelines
  3. Implementation of community-wide initiatives
  4. Enhancement of access
  5. Increased patient satisfaction
  6. Risk reduction.
- C. The quality improvement plan is defined, documented, and reviewed for relevance and efficiency at least annually by the Cancer Committee.
- D. All service locations, whether owned and operated by the facility/network, contracted to the facility/network, or part of a documented referral process, are reflected in the written quality improvement plan.
- E. The quality improvement plan is implemented by facility-provided support staff with expertise. The administrative leader assumes accountability for successful implementation.
- F. Quality outcome measures are defined in the quality improvement plan. Outcome measures for a quality improvement plan address key components of patient care delivery, processes, or disease/treatment management, such as clinical or financial, psychosocial support, survival, length of stay, satisfaction, and other issues.
  1. Data are retrieved consistently and accurately, compiled, analyzed, reviewed, and reported to the Cancer Committee.
  2. Based on the data and reports, the Cancer Committee approves quality improvement plans and their implementation. Data should be retrieved again and reported to assess the improvements' (evaluations') success and the need for further intervention.
  3. The quality improvement plans and reports are regularly forwarded to a facility and/or board quality committee.
  4. Examples of methods to evaluate data can be, but are not limited to: 1) statistical analysis and 2) comparison to "best practices," to literature, or to regional or national data (National Cancer Data Base [NCDB]; Surveillance, Epidemiology, and End Results [SEER] Registry).

## References

Please note: While every attempt has been made to ensure the accuracy of the publications, addresses, phone numbers, and websites, ACCC cannot ensure that this information has not changed. Web addresses, in particular, change frequently. If you find that a web address has changed, try to locate the publication name through an online search engine.

### CHAPTER 2: Cancer Committee

1. American College of Surgeons. Commission on Cancer. *Cancer Program Standards*. Revised Edition. Available at: <http://www.facs.org/cancer/coc/programstandards.html>. Phone: 312.202.5000 or 800.621.4111.
2. National Cancer Registrars Association. <http://www.ncra-usa.org>. Phone: 703.299.6640.

### CHAPTER 3: Cancer Data Management and Registry Operations

1. American College of Surgeons. Commission on Cancer. *Cancer Program Standards*. Available at: <http://www.facs.org/cancer/coc/programstandards.html>. Phone: 312.202.5000 or 800.621.4111.
2. National Cancer Registrars Association. <http://www.ncra-usa.org>. Phone: 703.299.6640.

### CHAPTER 4: Clinical Management and Supportive Care Services

#### Section 1: Multidisciplinary Team

1. American College of Surgeons. Commission on Cancer. *Cancer Program Standards*. Available at: <http://www.facs.org/cancer/coc/programstandards.html>. Phone: 312.202.5000 or 800.621.4111.

#### Section 3: Ambulatory Oncology Services

1. American College of Radiology. "Compliance Program Guidelines for Radiologists and Radiation." Available at: <http://www.acr.org>. Phone: 703.648.8900.
2. The Joint Commission. "Comprehensive Accreditation Manual for Ambulatory Care." Available at: <http://www.jointcommission.org/AccreditationPrograms/Ambulatory-Care/Standards/FAQs/default.htm>. Phone: 630.792.5000.

#### Section 4: Oncology Nursing Services

1. Oncology Nursing Society position papers. Available at: <http://www.ons.org/publications/positions>. Including position papers on cancer pain management, oncology services in the ambulatory practice setting, end-of-life care, and mammography screening. Phone: 866.257.4667.

#### Section 5: Pharmacy Services

1. Polovich M., ed. *Safe Handling of Hazardous Drugs*. Developed by the Oncology Nursing Society. Available at: <http://www.ons.org/publications>. Phone: 866.257.4667.
2. The Joint Commission. *Standards*. Available at: [www.jointcommission.org/Standards](http://www.jointcommission.org/Standards). Phone: 630.792.5000.
3. *Best Practices for Health-System Pharmacy: Positions and Guidance Documents of ASHP*. Available at: <http://www.ashp.org/Import/PRACTICEANDPOLICY/PolicyPositionsGuidelinesBestPractices.aspx>. Phone: 301.657.3000.
4. *Safety and Health Topics: Healthcare Facilities*. Available at: [www.osha.gov/SLTC/healthcarefacilities/index.html](http://www.osha.gov/SLTC/healthcarefacilities/index.html). Phone: 1.800.321.OSHA (6742).
5. US Pharmacopeia. "Pharmaceutical Compounding – Sterile Preparations, Chapter 797." Available at: <http://www.uspnf.org/USPNF/pf/generalChapter797.html>.

### Section 6: Psychological Oncology Services

1. Association of Oncology Social Work. *Standards of Practice in Oncology Social Work*, 2001. Available at: <http://www.aosw.org>. Phone: 215.599.6093.
2. National Comprehensive Cancer Network. *NCCN Practice Guidelines for Distress Management*. Available at: [http://www.nccn.org/professionals/physician\\_gls/PDF/distress.pdf](http://www.nccn.org/professionals/physician_gls/PDF/distress.pdf). Phone: 888.909.6226 (patients); 215.690.0300 (cancer care professionals).

### Section 7: Pain Management

1. National Comprehensive Cancer Network. *NCCN Practice Guidelines for Supportive Care: Adult Cancer Pain*. Available at: [http://www.nccn.org/professionals/physician\\_gls/PDF/pain.pdf](http://www.nccn.org/professionals/physician_gls/PDF/pain.pdf). Phone: 888.909.6226 (patients); 215.690.0300 (cancer care professionals).
2. The Joint Commission. *Pain Assessment and Management Standards for Hospitals*. Available at: <http://www.jcinc.com>. Phone: 630.792.5900.
3. Agency for Healthcare Research and Quality (AHRQ) of the Public Health Service. "Management of Cancer Pain." Available at: <http://www.ahrq.gov/clinic/epesums/canpainsum.htm>. Phone: 301.427.1364.
4. Additional resources may be obtained from: American Society for Pain Management Nursing at: <http://www.aspmn.org>. Phone: 888.342.7766. The American Pain Society at: <http://www.ampainsoc.org>, phone: 847.375.4715.

### Section 8: Nutrition Services

1. National Comprehensive Cancer Network. *NCCN Practice Guidelines in Oncology*. [www.nccn.org](http://www.nccn.org). Phone: 888.909.6226 (patients); 215.690.0300 (cancer care professionals)
2. Robien K, et al. American Dietetic Association: revised standards of practice and standards of professional performance for registered dietitians (generalist, specialty, and advanced) in oncology nutrition care. *J Am Diet Assoc*. 2010; 110:310-317.
3. American Dietetic Association/Commission on Dietetic Registration. Code of ethics for the profession of dietetics and process for consideration of ethics issues. *J AM Diet Assoc*. 2009; 109:1461-1467.
4. American Dietetic Association. Evidence Analysis Library/Oncology Toolkit: Oncology Evidence-Based Nutrition Practice Guideline. Chicago, IL: American Dietetic Association, 2010.
5. American Dietetic Association. International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process, 3rd edition. Chicago, IL: American Dietetic Association, 2011.

### Section 9: Rehabilitation Services

1. American Physical Therapy Association. <http://www.apta.org/>. Phone: 800.999.2782.
2. American Occupational Therapy Association. <http://www.aota.org>. Phone: 301.652.2682.
3. American Speech-Language Hearing Association. <http://www.asha.org>. Phone: 800.638.8255.
4. National Lymphedema Network. <http://www.lymphnet.org>. Phone: 800.541.3259.
5. Society for the Arts in Healthcare. <http://www.thesah.org/template/index.cfm>. Phone: 202.299.9770.

### Section 10: Patient Navigation Services

1. C-Change. "Cancer Patient Navigation Toolkit." Available at: <http://www.cancerpatientnavigation.org>.

2. Association of Oncology Social Work. <http://www.aosw.org>. Phone: 215.599.6093.
3. Oncology Nursing Society. <http://www.ons.org>. Phone: 866.257.4661.
4. American Cancer Society. <http://www.cancer.org>. Phone: 1-800-227-2345.
5. Molloy, K. et al., *Oncology Issues*, September/October 2007. "Patient Navigation & Cultural Competency in Cancer Care." Available at: [http://www.accc-cancer.org/oncology\\_issues/articles/sepoc07/molloy.pdf](http://www.accc-cancer.org/oncology_issues/articles/sepoc07/molloy.pdf).
6. Davis, T. et al., *Oncology Issues*, September/October 2007. "Clearing the Way: Practical Strategies for Improving Health Literacy and Cancer Communication." Available at: [http://www.accc-cancer.org/oncology\\_issues/articles/sepoc07/davis.pdf](http://www.accc-cancer.org/oncology_issues/articles/sepoc07/davis.pdf).

## Section II: Genetic Risk Assessment, Counseling, and Testing

1. American Society of Clinical Oncology. *Genetic Testing for Cancer Susceptibility (Policy Statement Update)*. Available at: [http://www.asco.org/asco/downloads/Genetic\\_Testing.pdf](http://www.asco.org/asco/downloads/Genetic_Testing.pdf). Phone: 703.299.0150.
2. Oncology Nursing Society. *Cancer Predisposition Genetic Testing and Risk Assessment Counseling, 2004*. Available at: <http://www.ons.org/publications/positions/CancerPredisposition.shtml>. Phone: 866.257.4661.
3. National Comprehensive Cancer Network. *NCCN Practice Guidelines for Genetic/Familial High Risk Assessment: Breast and Ovarian, 2006*. Available at: [http://www.nccn.org/professionals/physician\\_gls/PDF/genetics\\_screening.pdf](http://www.nccn.org/professionals/physician_gls/PDF/genetics_screening.pdf). Phone: 888.909.6226 (patients); 215.690.0300 (cancer care professionals).

## Section I2: Home Care

1. The Joint Commission. *2005 Standards*. Available at: <http://www.jointcommission.org/Standards>. Phone: 630.792.5900.

## Section I3: Palliative Care

1. National Comprehensive Cancer Network. *NCCN Practice Guidelines for Supportive Care: Palliative Care, 2005*. Available at: <http://www.nccn.org>. Phone: 888.909.6226 (patients); 215.690.0300 (cancer care professionals).
2. The Center to Advance Palliative Care. "Building a Hospital-based Palliative Care Program." Available at: <http://www.capc.org>. Phone: 212.201.2670.

## Section I4: Hospice

1. Hospice Foundation of America. [www.hospicefoundation.org](http://www.hospicefoundation.org). Phone: 1.800.854.3402.
2. The National Hospice and Palliative Care Organization. <http://www.nhpco.org>. Phone: 800.646.6460.

## Section I5: Pastoral Care

1. The Council on Ministries in Specialized Settings (COMISS) Commission on Accreditation of Pastoral Services (CCAPS). Approved Oct. 2000. <http://www.comissnetwork.org/>. Phone: 757.388.2850.
2. National Association of Catholic Chaplains (NACC). <http://www.nacc.org>. Phone: 414.483.4898.
3. Association of Professional Chaplains (APC). <http://www.professionalchaplains.org>. Phone: 847.240.1014.
4. National Association of VA Chaplains (NAVAC). <http://www.navac.net>.
5. National Association of Jewish Chaplains. <http://www.najc.org>. Phone: 973.736.9193.

6. American Association of Pastoral Counselors. <http://www.aapc.org>. Phone: 703.385.6967.
7. Association for Clinical Pastoral Education, Inc. <http://www.acpe.edu>. Phone: 404.320.1472.

## Section I6: Integrative Care

1. Guba, S. "New Perspectives on Developing a Cost-effective Holistic, Integrative Medicine Program," *Oncology Issues*, November/December 2007. Available at: [www.accc-cancer.org](http://www.accc-cancer.org).

## Section I7: Survivorship Services

1. National Coalition for Cancer Survivorship. <http://www.canceradvocacy.org/resources>. Phone: 877.622.7937.
2. National Coalition for Cancer Survivorship. "The Cancer Survivor Toolbox." Available at: <http://www.canceradvocacy.org/programs/toolbox>. Phone: 877.622.7937.
3. Association of Community Cancer Centers. "Cancer Survivorship Resources." Available at: <http://www.accc-cancer.org/education/cancerSurvivorship-Overview.asp>.
4. Association of Community Cancer Centers. "Comprehensive Survivorship Services." Available at: <http://www.accc-cancer.org/education/cancerSurvivorship-Guide.asp>.
5. Hoffman, B, ed. *A Cancer Survivors' Almanac: Charting Your Journey. National Coalition for Cancer Survivorship*. Available at: <http://www.canceradvocacy.org/resources/guide/a-cancer-survivors-almanac-charting-your-journey.html>. Phone: 877.622.7937.
6. Cancer Care, Inc. Publications. <http://www.cancercare.org/reading.html>. Phone: 800.813.4673.
7. Additional resources may be obtained from patient advocacy organizations, including The National Patient Advocate Foundation at <http://www.patientadvocate.org>. Phone: 800.532.5274. American Cancer Society at <http://www.cancer.org>. Phone: 800.ACS.2345.

## Section I8: Patient Advocacy and Financial Services

1. Association of Community Cancer Centers. Financial Information Learning Network. Available at: [www.accc-cancer.org/FILN](http://www.accc-cancer.org/FILN).
2. Association of Community Cancer Centers. 2012 Patient Assistance and Reimbursement Guide. Available online at: [www.accc-cancer.org/publications/PatientAssistance-Guide.asp](http://www.accc-cancer.org/publications/PatientAssistance-Guide.asp).
3. Guidi TU, Tobias, PF. Adding dedicated financial specialists to your team. *Oncol Issues*. 2004;19(4):22-25. Available at: [www.accc-cancer.org](http://www.accc-cancer.org)
4. Selle C. Improving revenue charge capture. *Oncol Issues*. 2005;20(1)24:30. Available at: [www.accc-cancer.org](http://www.accc-cancer.org)
5. Borsellino M. A model oncology patient assistance program. *Oncol Issues*. 2006;21(5):22-25. Available at: [www.accc-cancer.org](http://www.accc-cancer.org)
6. Shaffer J, Tanner M, Davenport-Ennis N. Co-pay Relief: a lifeline for cancer patients. *Oncol Issues*. 2006;21(5):26-27. Available at: [www.accc-cancer.org](http://www.accc-cancer.org)
7. Modlin J, Wilson DB. Tackling Chemotherapy Reimbursement. *Oncol Issues*. 2007;22(3):22-27. Available at: [www.accc-cancer.org](http://www.accc-cancer.org)
8. Knapp V. The oncology social worker's role in the reimbursement process. *Oncol Issues*. 2007;22(3):28-29. Available at: [www.accc-cancer.org](http://www.accc-cancer.org)

## CHAPTER 5: Clinical Research

1. American College of Surgeons. Commission on Cancer. *Cancer Program Standards 2004*. Revised Edition. Available at: <http://www.facs.org/cancer/coc/cocprogramstandards.pdf>. Pages 41-42. Phone: 312.202.5085.

## CHAPTER 6: Community Outreach

### Section 1: Cancer Education and Resource Program

1. National Cancer Institute. *Cancer Topics*. Available at: <http://www.cancer.gov/cancertopics>. Phone: 800.422.6237.

### Section 2: Cancer Control and Detection

1. American College of Surgeons. Commission on Cancer. *Cancer Program Standards 2012, Version 1.1. Ensuring Patient-Centered Care*. Available at <http://www.facs.org/cancer/> Pages 43-44. Phone: 312.202.5085.
2. Oncology Nursing Society. *Clinical Practice: Detection/Prevention, 2003*. Available at: <http://www.ons.org/clinical/PreventionDetection.shtml>. Phone: 866.257.4667.
3. National Comprehensive Cancer Network. *NCCN Practice Guidelines for Detection, Prevention, and Risk Reduction 2006*. Available at: [http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines.asp#detection](http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#detection). Phone: 888.909.6226 (patients); 215.690.0300 (cancer care professionals).

## CHAPTER 8: Quality Improvement

1. The Joint Commission. *Standards*. Available at: <http://www.jointcommission.org/Standards>. Phone: 630.792.5900.







**ASSOCIATION OF COMMUNITY CANCER CENTERS**

**11600 Nebel Street, Suite 201**

**Rockville, MD 20852**

**301.984.9496**

**[www.accc-cancer.org](http://www.accc-cancer.org)**