ACCC STANDARDS: PAST, PRESENT, AND FUTURE

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The concept of defining community cancer centers and programs through the development of standards has been an ongoing process parallelling the growth and maturation of ACCC as a leader in the oncology field.

Under the leadership of Dr. Herbert Kerman, the ACCC standards development was initiated in 1981. In 1983, ACCC established a Standards and Guidelines Committee chaired by Dr. Edward Moorhead. Given the magnitude of the effort, it soon became apparent that two separate committees were necessary to formulate standards and guidelines. Standards relate more to the structure, process, and outcome functions of care while guidelines relate to process and outcomes of care. Yet, they share one important common feature: The assurance of high quality care for the cancer patient and family.

At the ACCC annual meeting in March of 1985, a newly formed Ad Hoc Committee on Standards compiled the initial drafts of prior committees and the contributions of individual committee members. By the Fall of that year, the first draft of 13 standards from 15 Delegate institutions was reviewed by the Committee. A second draft was then produced, which consisted of eighteen standards with contributions from twenty Delegate institutions. This second draft was reviewed at the ACCC 1986 annual meeting.

Over the past year, the standards have been expanded, incorporating the responses received from ACCC members. The standards listed on the following pages are the culmination of five years of work and represent the third draft of standards. This draft consists of 20 standards with input from over 30 Delegate institutions.

Earlier this month, ACCC Delegate members were mailed the third draft of standards. The Delegates were asked whether they could meet or, in "standardese," be compliant with any or all of these standards. This evaluation will be the acid test. For it is through this evaluation that the standards will be measured for real world applicability. Once the responses are tabulated, any substantial problem identified will be addressed at two open forums at the ACCC 1987 annual meeting. Finally, the standards will be formally voted upon at the House of Delegates meeting.

Several features of this draft are worthy of comment with regard to the Committee's views and recommendations. To ensure wide applicability of the standards to all cancer care settings, from hospital-based cancer programs to free-standing cancer centers, the words "cancer center/program" were deleted. Fragmentation, or the development of various levels of standards based on the presence or absence of certain components, has been proposed by some standards development committees in the past. The Standards Committee believed this approach to be impractical; thus, generic standards were written. The Committee felt that it was appropriate for accredited organizations to have access to key components, e.g. an FCC may not be involved in research, but it must be able to have access to such a component.

As the Committee edited this draft, great care was taken to keep intact the contributors' concept, although language was altered to ensure uniformity. The overall objective was to develop more flexible and less prescriptive standards. With this in mind, the next step will be to identify critical core services, which are essential or absolutely necessary to define cancer care. Although some overlap may exist between ACCC standards and other existing standards, the Committee tried to avoid duplication. For example, instead of rewriting tumor registry standards, reference was made to the ACoS standards. In other cases, the Committee merely expanded on existing standards, such as those for a Cancer Committee and Tumor Board.

This process of developing and approving standards is similar to the approach utilized by JCAH during the JCAH Hospice Project[1] in 1982, with which we have some familiarity. Although it was a painstaking task, the multiple series of drafts and continuous input from the community assures a cohesive and joint membership effort. Like the Hospice standards, the next logical step after developing and implementing standards is accreditation. Accreditation of community cancer centers and programs is an idea that ACCC has struggled with for some time. How this process will be implemented has not been determined, yet it must be considered despite the financial costs.

Indeed, the benefits of an accreditation program are forthright in regard to credibility and payers. The new JCAH's "Agenda for Change"[2], which emphasizes process and outcome evaluation more than structure evaluation, complements the ACCC initiative. ACCC must maintain its role as the protector of high quality cancer care in the community. Especially in these times of trendy, "cheap" health care, an accreditation program greatly enhances the leadership role of ACCC.

Of course, the standards process must be viewed as dynamic rather than static. As we experiment, we expect to make ongoing changes. Once these standards are actually utilized versus a real world setting, applicability and measurability can be determined. Until then, we have to rely on our existing knowledge.

REFERENCES

1. McCann BA, Enck RE. Standards for Hospice Care: A JCAH Hospice Project Overview. In: Engstrom PF, Anderson PN, Mortenson, LE, eds. *Advances In Cancer Control: Epidemiology and Research.* New York: Alan R. Liss, 1984; 431-440.

2. O'Leary DS. President's Column. **JCAH Perspectives** 1986; 6:2-3.

MULTIDISCIPLINARY TEAM

Standard I
There is a multidisciplinary team approach to planning, implementing, and evaluating the care of cancer patient/families.

Rationale
An organized, consistent team approach to the care of cancer patients/families is necessary to ensure that special needs are identified, interventions planned, and treatments coordinated.

Characteristics
A. Multidisciplinary team services include:
    1. Physician
        a) Attending physician and/or oncology specialists such as medical oncology, radiation oncology and surgical oncology.
        b) Medical director.
    2. Oncology nursing.
    3. Social work services.
    4. Pastoral care services.
    5. Dietetic services.
    6. Pharmacy services.
    7. Rehabilitation services.
B. Multidisciplinary team members have access to emotional support, as necessary. (See Staff Support)
C. Multidisciplinary team members have access to in-service and continuing education programs.

ATTENDING PHYSICIAN

Standard I
The medical care of each patient is the responsibility of the attending physician.

Rationale
The attending physician selected by the patient retains responsibility for the care of the patient and participates as a member of the multidisciplinary team.

Characteristics
A. Each patient admitted has a designated attending physician who is currently fully licensed to practice.
B. Written policies and procedures govern the admission and medical treatment of patients.
C. Communication between the attending physician and other members of the multidisciplinary team is ongoing and is documented.
D. The attending physician reviews the multidisciplinary team approach including consultations from various oncology specialties.
E. The attending physician reviews the quality assurance program of those ancillary services, i.e., histo-pathology, cytopathology, diagnostic radiology, and other laboratory services provided for their patients (see Quality Assurance).
F. Provision is made for assuring continuity of medical care.

MEDICAL DIRECTOR

Standard I
A medical director is available, either part-time or full-time.

Rationale
A medical director possessing background, training, and experience in multidisciplinary cancer care is essential to provide the leadership, scientific, and administrative duties for a successful operation.

Characteristics
A. Trained and board certified in a recognized oncology subspecialty.
B. Commitment to, and experience in, the multidisciplinary care of cancer patients.
C. Leadership qualities.
D. Demonstrated scientific and administrative ability.

Standard II
The authority of the medical director is clearly defined by the organization(s).

Rationale
To effectively manage including decision-making, the medical director must be granted clear-cut lines of authority as well as responsibility.

Characteristics
The medical director requires authority in relationship to:
A. Program definition.
B. Recruitment, appointment, and promotion of personnel.
C. Space allocation.
D. Freedom to interact with other organizations.
E. Budgetary and administrative responsibility.

Standard III
The medical director is subject to periodic peer review.

Rationale
Timely review and evaluation of the medical director's management capabilities is necessary and is the responsibility of a suitable peer review group.

Characteristics
The review insures that:
A. Existing resources are properly utilized.
B. Budget and personnel are appropriately managed.
C. Appropriate programs are in place and operating.
D. The operation is cost effective.
E. Future planning is ongoing.

ONCOLOGY NURSING

Standard I
An organized oncology nursing component is in place to meet the nursing care requirements of the cancer patients/families.

Rationale
The complex needs of the cancer patients/families require appropriate oncology nursing in order to achieve optimal care. The oncology nurse must possess specialized knowledge and skill to meet the needs of these patients/families.

Characteristics
A. The oncology nursing component is supervised by a registered nurse who has appropriate experience and educational background to provide effective leadership and direction to nursing service as it relates to oncology nursing.
    1. Master's degree in nursing preferred.
    2. Three years clinical experience required.
B. The oncology nursing component of nursing service provides adequate staffing to meet the defined needs of cancer patients/families. Staffing policies are based on a valid patient classification system and include:
    1. Provision for a sufficient number of oncology nurses on duty at all times according to acuity of nursing care requirements.
    2. Annual review.
C. An appropriate clinical nursing expert is a member of the oncology nursing component:
    1. Oncology clinical nurse specialist, a professional registered nurse

educated at the master's level in nursing with appropriate clinical experience, is recommended.

D. Ongoing staff development, including participation in multidisciplinary team conferences, regularly scheduled in-services and continuing education programs, national and regional professional organizations, and community sponsored programs specific to cancer nursing, is provided with sufficient depth and frequency to meet the needs of oncology nurses. Oncology nurses are required to attend twelve hours of appropriate continuing education programs annually.
E. Policies and procedures are written regarding but not limited to:
   1. Administration and handling of chemotherapeutic agents, including extravasation and disposal policy.
   2. Management of immunocompromised patients.
   3. Oncology nursing staff orientation.
   4. Oncologic emergencies.
   5. Palliative care measures including pain control.
   6. Patient and family education.
   7. Quality assurance.
   8. Nursing research.
   9. Stress management for staff.
   10. Resuscitation.
   11. Blood product administration.
   12. Venous access devices.
   13. Psychosocial support at least annually.
F. Written patient care guidelines, developed, reviewed, and revised by practicing oncology nurses, are available.

SOCIAL WORK SERVICES

Standard I

Qualified individuals provide social work services to meet the psychosocial needs of the patients/families.

Rationale

The oncology social work services provide counselling to cancer patients/families relating to social and emotional adjustment as well as adaptation to the illness and treatment. The goal of counselling is the attainment of optimum mental health with focus on maintaining quality of life.

Characteristics

A. Provide direct social work service individually or in group process under supervision of director of social service.
B. Assess and evaluate psychosocial situations and problem areas as presented by the patient and/or family.
C. With patient and/or family establish treatment goals and provide alternatives to assist in attaining these goals.
D. Identify and refer patient and/or family to appropriate resources in community social, health, and welfare agencies.
E. Interpret psychosocial aspects and needs of patient and/or family to attending physician and other multidisciplinary team members.
F. Develop and maintain good working relationships with medical and hospital staff, community social, health, and welfare agencies.
G. Availability to counsel oncology staff members, individually or in groups, where their needs affect or are affected by their work in oncology units.
H. Serve as a resource and provide in-service educational programs pertaining to oncology social work services for patients/families, oncology staff members, and pertinent community agencies.
I. Attend and participate in conferences, seminars, and in-service programs designed to increase professional knowledge and improve effectiveness.
J. Compile and maintain case records and statistics.
K. Maintain confidentiality of all information and respect patients'/families' rights.
L. Qualifications include a master's degree in social work from an accredited school of social work education and a minimum of two years' experience in a health related agency or completion of a field placement at an acute care hospital.
M. The psychosocial assessment includes but is not limited to:
   1. A social history.
   2. The source and adequacy of environmental resources.
   3. The patients'/families' psychosocial status.
   4. The patients'/families' reaction to the illness.
N. A notation relating to the discharge plan, when appropriate, which reflects participation by patient/family, level of care, appropriate utilization of community resources.
O. Documentation within 48 hours of referral to social work service and is current, notations being made no less than one time per week.
P. Knowledge of reimbursement mechanisms such as medicare, HMO, and other payors.

PASTORAL CARE SERVICES

Standard I

Pastoral care services are available to meet the needs of the cancer patients/families.

Rationale

Because profound spiritual and psychological issues are confronted by patients/families, staff members, and the community-at-large, effective pastoral care is an integral part of relating to such issues. Pastoral care does not violate the personal integrity or religious tradition of the patients/families.

Characteristics

A. Pastoral care is supervised by a qualified clinical chaplain with adequate education (i.e. graduating from college and accredited theological school) and clinical training [i.e., minimum of four units of clinical pastoral education (ACPE)].
B. A clearly defined, functional referral system is established.
C. Pastoral care involves spiritual counselling in keeping with the patients'/families' beliefs.
D. Ongoing staff education and multidisciplinary team participation.
E. Pastoral care provides communication with, and support of, appropriate clergy in the community.
F. Pastoral care is available to staff members through individual counselling and group sessions.
G. There is a provision for bereavement services as indicated.

DIETETIC SERVICES

Standard I

A clinical dietitian works with all cancer patients/families especially those identified as having nutritional problems.

Rationale

The nutritional needs of the cancer patient are unique to each individual. The clinical dietitian works in conjunction with other members of the multidisciplinary team to afford patients the opportunity to maintain an optimal nutritional status throughout the course of their disease.

Characteristics

A. The clinical dietitian is a registered dietitian with education and experience in the specialized nutritional needs of the cancer patient.
B. Staffing is adequate, i.e., one full-time registered dietitian for a 50-bed oncology unit, or one full-time dietitian per 100 beds are staffing approximations.
C. Ongoing staff education including nursing in-service programs and multidisciplinary team participation.

Standard II

The clinical dietitian provides an initial and ongoing nutritional assessment of all referred cancer patients.

Rationale

The cancer patients at varying stages of their disease are high risk for nutritional depletion.

Characteristics

A. The nutritional assessment of the patient includes but is not limited:
    1. Diagnosis.
    2. Prognosis.
    3. Treatment plan.
    4. Pre-illness weight.
    5. Percentage weight loss or gain.
    6. Medications.
    7. Medical history.
    8. Nutritional relevant factors such as anorexia, dysphagia, altered taste, nausea, vomiting, sore mouth, sore throat, recent surgery.
    9. Food intake.
    10. Nutritional markers, i.e., lymphocyte count and serum albumin levels.

Standard III

The clinical dietitian in conjunction with the patient and family manages nutrition and hydration to facilitate optimal health and comfort in the presence of disease and treatment.

Rationale

Optimal nutritional status may favorably influence the tolerance to treatment. The nutritional needs of patients with cancer are increased because of the disease process; recuperative demands following surgery, radiation therapy, and chemotherapy; and stimulation by immunotherapy. Food intake and retention may be altered by cancer therapy or the disease process; common problems include taste changes, anorexia, mucosal irritation, and obstruction of the gastrointestinal tract. Cultural, social, and ethnic influences affect the attitudes individuals have toward eating. Adjustment of eating schedule, types and amounts of food, and quality and quantity of fluids enhance the patient's control over his nutritional state.

Characteristics

A. The clinical dietitian:
    1. Performs an initial diet history with the patient and family.
    2. Counsels the patient and family on the nutritional needs of the cancer patient.
    3. Identifies common nutritional problems that the patient may encounter during the course of their disease.
    4. Outlines the nutritional needs individualized to each patient's plan of care taking into consideration the disease process, nutritional status of the patient, and the treatment regimen.

PHARMACY SERVICES

Standard I

Pharmacy services purchase, store, and prepare chemotherapeutic agents.

Rationale

Chemotherapeutic agents require special storage and preparation procedures to minimize exposure to employees and patients. Pharmacy services establish procedures to optimize safeguards for chemotherapeutic handling.

Characteristics

A. Pharmacy services purchase chemotherapeutic agents and maintain purchasing records.
B. A separate storage area for chemotherapeutic agents is maintained in the pharmacy with appropriate safeguards to prevent breakage of vials and ampules.
C. Preparation policies and procedures for chemotherapeutic agents include but are not limited to:
    1. A class II biological safety hood vented outside the work area.
    2. Protective clothing includes a water resistant long sleeved cuffed gown, latex, or PVC gloves.
    3. Written procedures including the use of hydrophobic filters, filter straws, venting and negative pressure techniques. Specific ampule and vial procedures are included.
    4. Written guidelines for dilution including dilution solutions, concentrations, and stability data.
    5. Appropriate labels indicating a chemotherapeutic drug product.
    6. Disposal procedures for syringes, needles, and drug waste.
    7. Spill procedures and a spill kit at the preparation site.

Standard II

Pharmacy services store and maintain all investigational chemotherapeutic agents.

Rationale

Regulation of investigational chemotherapeutic agents require a perpetual inventory system, which is maintained by the pharmacy for each investigator. Chemotherapeutic agent information is retrievable for the physician, pharmacist, and nurse for each patient admission.

Characteristics

A. Documentation of receipt and use of each investigational product is maintained.
B. A current list of principal investigators and protocols are available in the pharmacy department.
C. The pharmacy stores investigational chemotherapeutic agents separate from all other drug products.
D. A perpetual inventory log of each product for each investigator is maintained in the pharmacy. The log indicates date, patient name, drug strength, amount prepared, protocol designation, lot number, and expiration dating of the product.
E. The pharmacy ensures that each investigator's chemotherapeutic agent supply is dispensed only upon the order of the investigator or his designee.
F. All investigational protocols are available in the pharmacy for use by the pharmacist, physician, or nurse.

Standard III

Pharmacy and oncology nursing services prepare extravasation guidelines and drug kits for use by the nursing department.

Rationale

Guidelines for treatment of extravasation of chemotherapeutic agents are necessary to protect the patient from undue harm. The pharmacy and oncology nursing services prepare a list of appropriate drug treatments

for each chemotherapeutic agent known to be hazardous upon extravasation. A kit containing the appropriate drugs for treatment is available in the pharmacy and nursing services.

Characteristics
A. Extravasation guidelines include a list of chemotherapeutic agents known to cause tissue damage upon extravasation. Appropriate treatments for *each drug extravasation are listed.*
B. Extravasation kits are available at all times in the pharmacy and on the oncology unit(s).

Standard IV
Pharmacy services maintain current information on the safe handling of chemotherapeutic agents and prepare information documents for employees involved in preparation and administration of these agents.

Rationale
The procedures for handling chemotherapeutic agents are continually evaluated and modified in the literature. Pharmacy services review and revise the preparation procedures for these agents on a biannual basis. Current literature and procedural changes are communicated to employees to maintain a safe working environment.

Characteristics
A. A literature file on safe handling of chemotherapeutic agents is maintained in the pharmacy department for use by medical staff and employees.
B. Procedures for handling of chemotherapeutic agents are reviewed every six months to comply with the current literature or government regulations.
C. Procedures and policies are distributed to employees with each revision. Employees involved in preparation of cytotoxic agents receive appropriate training for each procedural change.

REHABILITATION SERVICES

Standard I
Rehabilitation services are available to cancer patients/families.

Rationale
Since cancer is a chronic disease requiring acute care treatments, patients and families face changing needs both physically and emotionally. A variety of health care professionals and volunteers are needed to address this broad range of needs.

Characteristics
A. Types of rehabilitation services available include but are not limited to:
   1. A qualified nurse to address: chronic physical needs such as skin care; bowel and bladder care; medication management; pain control education; and overall assessment of rehabilitation requirements including coordination of discharge needs.
   2. A qualified physical therapist to address: strength and endurance; mobility and activity level; need for assistive devices; range of motion, balance and stability; and evaluation and education in home care needs.
   3. A qualified occupational therapist to address: energy conservation; upper extremity strength and function; self-care and homemaking skill; need for assistive devices; perceptual evaluation and guidance; evaluation and education in home care needs and adaptation.
   4. Social work services.
   5. A qualified psychologist to address: complex emotional needs for patient and family; provide other team members with guidance in emotional care of patients and families; provide comprehensive psychological testing for differentiating diagnosis.
   6. Pastoral care services.
   7. Dietetic services.
   8. A qualified speech language pathologist to assess and plan program for expressive, receptive, and normal communication needs as well as eating and swallowing functions.
B. The following are optional but suggested services if not provided by others:
   1. A qualified recreational therapist to address: adaptation of leisure skills; provide diversional activities, socialization opportunities; instruct in relaxation exercises and stress management; and assist in establishing a therapeutic environment.
   2. A qualified discharge planner to assist with arranging home care service networking to community services, or placement in an extended care facility.
   3. Pharmacy services.
   4. A qualified enterostomal therapist to prepare patients/families for an ostomy, provide instruction and support in learning ostomy care, and to address skin care problems.
   5. Qualified volunteers to provide a sounding board mechanism of support as well as an advocacy service for patients/families.
C. Each health care discipline is represented to allow continuity of care, to foster rehabilitation services identity, and to develop experience in cancer care.
D. Rehabilitation services have a clear organizational structure.
E. Services provided are documented by needs identified and subsequent outcome.
F. Ongoing educational opportunities are available to members of the rehabilitation services.

STAFF SUPPORT

Standard I
A structured program of staff support is available to health care providers.

Rationale
Health care providers offer a wide range of services and perform many care giving activities for cancer patients/families. However, their work may produce stress and have a negative impact on their own emotional well-being. By recognizing the high stress factors and providing sound instruction and experience in self-care and relationship management, it is possible to prevent severe episodes of "burnout" and enable those in the midst of stressful periods to cope more effectively.

Characteristics
A. A written plan for staff support, which is revised and reviewed on an annual basis.
B. The written plan includes but is not limited to:
   1. Scope of the program including goals and objectives.
   2. Assessment of environmental and personnel variables.
   3. Description of programs and services offered.
   4. Specified budget to accomplish goals.
   5. Outcome evaluation of programs and services.
C. *Presence of a designated committee* with primary responsibility to

oversee the implementation of the staff support plan. This committee is composed of at least three persons, representing different health care disciplines, which will serve as an advisor to administration relative to staff support needs and concerns.

ONCOLOGY UNIT

Standard I
An oncology unit is used for the specialized care of cancer patients.

Rationale
The oncology unit is a specialized area of care necessary due to the intensity of service required as well as the severity of illness of cancer patients.

Characteristics
A. A written plan is present, which defines the objectives, criteria for patient selection, procedures, and policies of the unit.
B. The director or other qualified physician designee in charge of the unit has special training, experience, and demonstrated competence in cancer treatment, such as board certification in a recognized oncology specialty. Appropriate professional consultation is available at all times. In the absence of qualified housestaff, the director of the unit assures that there is sufficient medical coverage at all times.
C. Nursing care is supervised by a registered nurse with education, experience, and documented current competence in the nursing care of patient undergoing oral and parenteral chemotherapy, including intravenous, intrathecal, intracavitary routes of administration as well as patients undergoing radiation therapy. Expertise in both pulse therapy and infusion therapy is demonstrated as well as familiarity with various infusion pumps. Competence in nursing functions relative to immunotherapy, hormonal therapy, radioisotope therapy, hemapheretic procedures, management of clotting disorders, intra-arterial, and intra peritoneal routes of chemotherapy administration is demonstrated as appropriate.
D. Within the policies and procedures that govern patient care in the unit as approved by the medical staff, the oncology nursing component will:
   1. Administer, monitor, and handle chemotherapeutic agents including disposal.
   2. Initiate measures in the event of oncologic emergencies or extravasation of necrotizing medications.
   3. Administer intravenous medications for control of hyperemesis and pain.
   4. Maintain and utilize various vascular access catheters and ports as well as educate patients and family members in care of these devices.
   5. Participate in professional education activities including staff development, in-service training, regional, and national organizations.
   6. Conduct and document patient and family education in a routine manner.
E. Adequate space is provided for the isolation of patients for infection control as well as radiation protection.
F. The oncology unit provides multidisciplinary team services including appropriate pharmacy services support; dietetic services including food supplements, parenteral feedings and enteral feedings; rehabilitation services such as occupational therapy, physical therapy, enterostomal therapy, and speech therapy; support groups; psychosocial services; and pastoral care oriented toward the needs of the cancer patients/families.
G. The oncology unit provides appropriate comprehensive, multidisciplinary discharge planning such as referral to home health, homemaker services, rehabilitation services, and the like, as appropriate.
H. Documentation of appropriate referral mechanisms for services not readily available, i.e., cancer research protocols, bone marrow transplantation, hyperthermia, and other state-of-the-art therapy, is in place.

OUTPATIENT ONCOLOGY SERVICES

Standard I
An outpatient medical oncology facility is available as the focal point for outpatient cancer care.

Rationale
An identifiable location provides a site for coordinating the many outpatient activities required for optimal care of the cancer patient. Such a site provides ready access for both patients and health professionals and concentrates oncology skills for maximal levels of patient care.

Characteristics
A. A separate and distinct facility exists which includes but is not limited to:
   1. Adequate parking facilities and comfortable waiting areas.
   2. Adequate examining room facilities.
   3. Adequate facilities for drug preparation and chemotherapy administration.
   4. Protocols and facilities for the management of complications such as anaphylaxis, cardiac arrest, etc.
   5. Patient education facilities and programs.
   6. Convenient access to clinical laboratory services.
   7. Convenient access to routine diagnostic radiologic services.
   8. Medical records facilities.
   9. Designated telephone number(s) are provided to patients/families for access to appropriate personnel for questions and problems on a 24-hour basis.
   10. Availability of physician(s) at all times.

Standard II
A radiation oncology facility is available for outpatient treatments.

Rationale
Radiation oncology programs make this modality readily available to cancer patients on an outpatient basis.

Characteristics
A. Adequate parking and waiting facilities.
B. Radiation therapy equipment with access to computerized treatment planning.
C. Adequate programs for patient education.

Standard III
Integration of outpatient oncology services into the overall care plan.

Rationale
There is continuity of all aspects of care, i.e., inpatient and outpatient, medical, surgical, radiation, and supportive. There are also appropriate data collection facilities and follow-up procedures.

Characteristics
A. Patients are entered into an ACOS-approved tumor registry.
B. Clinical research protocols are available whenever possible.
C. Access to multidisciplinary tumor board consultation for patient management.
D. Patient management site-specific guidelines are available whenever possible.

Standard IV
Multidisciplinary team services are available to patients undergoing outpatient treatment.

Rationale
Outpatient cancer treatment requires the involvement of a number of dedicated health care personnel.

Characteristics
Multidisciplinary team includes but is not limited to:
A. Physician
   1. Attending physician.
   2. Oncology specialist such as medical oncology, radiation oncology, and surgical oncology.
B. Oncology nursing.
C. Social work services.
D. Pastoral care services.
E. Dietetics services.
F. Pharmacy services.
G. Rehabilitation services.
H. Continuing education for the multidisciplinary team members.

HOME CARE

Standard I
A home health agency exists to provide professional services to cancer patients/families in the home.

Rationale
Because cancer is increasingly recognized as a chronic disease with intermittent acute, episodes, professional services to cancer patients must be carried out in primary, acute, and long-term care settings including the home.

Characteristics
A. A home health agency that is either owned and/or operated by an institution, or a home health agency with a contractual agreement with an institution.
B. The following multidisciplinary professional services are available from the home health agency: nursing, clinical social services (counselling), physical, occupational and speech therapy services, and clinical nutrition.
C. Home health aide and homemaker services are available.
D. The home health agency meets the appropriate licensing and accreditation requirements.
E. Written policy and procedures are established for the care of the cancer patient, which are compatible with the home health agency and the referring institution's policies and procedures.
F. Physician authorized plan of treatment specific to each patient is established.
G. There is a designated medical director for the home health agency.
H. There is an established interaction with the institution's hospice program, or defined interaction with an area hospice program.

Standard II
The home health agency provides home care nurses and professional staff with the ability to meet the special needs of the cancer patients/families at any stage of the disease requiring professional intervention at home.

Rationale
Because oncology nursing is a distinct specialty within nursing, additional education and training of all professional staff is necessary in order to provide care, which promotes optimal functioning of the patient and family.

Characteristics
A. The nurse providing care to cancer patients demonstrates ability and expertise in the following areas:
   1. Administration of chemotherapy and assessment of side effects.
   2. Lab specimen procurement such as phlebotomy.
   3. Appropriate referral to other professional services.
   4. Provide psychosocial support, assessment, and intervention in pain control.
   5. Assessment of, and intervention for, oncologic emergencies.
B. Evidence of ongoing staff education in the area of cancer services.
C. Availability of an oncology clinical nurse specialist as a resource, or an established oncology nursing division of the home health agency.
D. Written agency policies, procedures and/or standardized procedures for:
   1. Pain assessment in cancer patients.
   2. Chemotherapy administration, regardless of route.
   3. Extravasation of chemotherapeutic drugs.
   4. Handling of chemotherapy including disposal.
   5. Infection control.
   6. Physician reporting mechanisms.
   7. Patient rights to information concerning their disease.
   8. Specialized procedures.

CANCER COMMITTEE

Standard I
The cancer committee provides programmatic leadership.

Rationale
The cancer committee plans, implements, and evaluates all cancer activities within the institution.

Characteristics
A. The cancer committee is a standing committee within the hospital.
B. Members include board certified physicians from all medical specialties involved in the care of cancer patients.
C. Nonphysician members include the representatives from nursing service, social service, hospital administration, and tumor registry.
D. The committee meets at least quarterly exclusive of other cancer conferences and/or tumor boards. Activities and attendance are documented.
E. The cancer committee functions to:
   1. Promote a coordinated multi-disciplinary approach to patient management at all levels.
   2. Assure that consultative services in all disciplines are available to patients.
   3. Assure that educational activities cover the entire spectrum of cancer.
   4. Assure an active support system for patients, families, and staff members.

5. Initiate audits regarding patient care and review similar data supplied by other hospital committees.
6. Supervise activities of the tumor registry.
7. Assure quality control of abstracting, staging, and reporting of data.
8. Assure regular attendance at weekly tumor board by all participating physicians.

TUMOR BOARD

Standard I
A multidisciplinary cancer case review (tumor board) is available to ensure cancer patients' access to consultative services in all disciplines.

Rationale
A multidisciplinary tumor board providing case review for cancer patients assures patient access to a system for quality of care evaluation with regard to diagnosis, treatment, follow-up, and rehabilitation.

Characteristics
A. Patient management includes but is not limited to:
   1. Multidisciplinary scope.
   2. Treatment recommendation nonbinding.
   3. Final treatment decision made by the attending physician and patient.
B. Membership is dependent on specialties and case mix.
   1. Permanent:
      a) Pathology including cytology.
      b) Diagnostic radiology and nuclear medicine.
      c) Surgery or surgical oncology if available.
      d) Medical oncology.
      e) Radiation oncology.
   2. Desirable but not required:
      a) Pulmonary medicine.
      b) Gastroenterology.
      c) Thoracic surgery.
      d) Gynecology.
      e) Urology.
      f) ENT.
      g) Nursing.
      h) Data Manager.
      i) Family practice.
C. Organization
   1. Under the auspices of the cancer committee.
   2. Representatives of tumor board also comprise medical staff membership on cancer committee.
   3. Meet a minimum of monthly, and preferably, more frequently.
   4. Establish procedures to include departmental responsibility, case identification, scheduling, case presentation, and recommendations.

Standard II
Tumor board case review is prospective in nature unless it results in unnecessary delay in patient treatment management.

Rationale
Prospective case review assures the newly diagnosed patient access to multidisciplinary pretreatment evaluation, accurate staging of disease, treatment management, and follow-up evaluation.

Characteristics
A. Case identification includes:
   1. Pathology review of all invasive non-skin cases.
   2. Problem cases but exclusion of cases for which "standard approaches" have been covered.
   3. Any case recommended by the attending physician.
B. Case presentation in advance of tumor board meeting:
   1. Case summaries dictated by attending physician and distributed.
   2. Pathology and cytology reviewed by tumor board pathologist.
   3. Radiologic review by tumor board radiologist.
C. Case presentation at tumor board meeting:
   1. Case presentations by attending physician (physician responsible for case).
   2. Review of actual radiologic films.
   3. Review of pathology slides.
   4. Treatment management decision, by consensus, if possible.
   5. No formal vote.
   6. If no agreement, document alternatives.
D. Case documentation after presentation at tumor board:
   1. Copy of tumor board proceedings to involved physician(s).
   2. Copy of proceedings to tumor board records.
   3. No copy to hospital chart.

Standard III
The tumor board contributes to the education of physicians and allied health professionals.

Rationale
Prospective, multidisciplinary case review, and management decision generate new knowledge, provide a review of basic cancer management principles, identify areas for audit review, provide opportunities for discussion of research eligibility, improve effectiveness of allied health personnel in caring for cancer patients, identify possible community needs for education, screening, detection and prevention clinics, and provide a mechanism for physicians in outlying communities to access information.

Characteristics
A. Non-didactic.
B. Based on recent literature and new information.
C. Review of basic cancer management principles.
D. Education of allied health personnel.
E. Community-wide dissemination of information.

Standard IV
Tumor board provides a mechanism for review of professional practices within the hospital for the purpose of reducing morbidity and mortality through outcome analysis.

Rationale
Tumor board provides a system for quality assurance through peer review of professional practices.

Characteristics
A. Tumor board minutes are confidential.
B. Tumor board recommendations are nonbinding.

CONTINUITY OF CARE

Standard I
Continuity of patient care in the outpatient as well as the inpatient setting is assured.

Rationale
Continuity of care is a comprehensive approach to assessing, planning for, and meeting cancer patients' needs in all care settings including outpatient and inpatient. Effective administration and coordination of oncology services can assure that quality care is maintained in both settings.

Characteristics

A. A multidisciplinary team approach is developed for each patient with a resultant treatment plan.
   1. The plan is based on multidisciplinary consultations.
   2. In addition, the plan includes documentation of at least the following:
      a) Identified patient problems and needs.
      b) Identified goals and objectives that are realistic and achievable.
B. If a patient is transferred from the outpatient to the inpatient service, or vice versa, the service that is transferring care provides a summary that includes but need not be limited to the following:
   1. The services provided.
   2. Specific medical, psychosocial, or other problems necessitating intervention or follow-up.

CANCER PREVENTION AND DETECTION

Standard I

Primary and secondary prevention programs are available to promote awareness of cancer prevention and detection.

Rationale

Primary prevention efforts through modification of attitudes and behaviors result in the promotion of general health practices and the institution of specific measures to reduce the risk of developing cancer.

Secondary prevention is defined as early detection and treatment. The goals of secondary prevention include cure, slowing disease progression, preventing complications, and limiting disability.

Characteristics

A. Primary prevention programs focus on interventions that include but are not limited to:
   1. Smoking cessation programs.
   2. Public education for environmental and occupational hazards.
   3. Nutritional counselling.
B. Secondary prevention include the following elements:
   1. Identification and surveillance of high risk groups.
   2. Promotion of guidelines such as the American Cancer Society guidelines for Pap testing, mammography, and colorectal screening.
   3. Screening programs.
   4. Outreach educational programs.

Standard II

Public education programs are available.

Rationale

Public awareness is an important component in prevention and early detection. It increases appropriate utilization of health care resources and assists in decreasing cancer related anxieties that may inhibit proper care and treatment.

Characteristics

A. A written plan for public education, which is revised and reviewed on an annual basis.
B. The written public education plan includes but is not limited to:
   1. Scope of the program including goals and objectives.
   2. Methodology for determining topics.
   3. Description of programs and services offered.
   4. Specified budget to accomplish goals.
   5. Outcome evaluation of programs and services.
C. Presence of a designated committee composed of a minimum of five persons, at least three of which represent different health care disciplines.
D. Documentation of efforts to coordinate programs and services with community resources, including but not limited to other health care facilities and/or agencies.
E. Documentation of all public education activities completed.
F. Designated person with overall responsibilities for the public education program.

RESEARCH

Standard I

Cancer patients/families are provided access to participation in clinical research programs including treatment oriented clinical trials and cancer control.

Rationale

Research in the community is generally clinical in nature rather than basic science. The community lacks appropriate resources including the technology, personnel, financial support as well as the scientific interest to pursue basic science research. Clinical trials of treatment oriented protocols are only one facet of clinical research. These trials cannot be substituted for cancer control because other control components are not part of their design.

Characteristics

A. The conducted research is in the best interest of cancer patients.
B. An institutional review board (IRB) or similar structure is in place and functioning to review and approve all protocols involving human subject participation.
C. Clinical trial treatment oriented research may include:
   1. Participation in National Cancer Institute-sponsored programs such as the Community Clinical Oncology Program (CCOP) or Cooperative Group Outreach Program (CGOP).
   2. Participation in comprehensive cancer center or university-related research.
   3. Participation in pharmaceutical company research.
   4. Development and participation in locally generated research studies.
D. Cancer control research may pertain but need not be limited to:
   1. Cancer prevention and detection, including identification and screening of high risk groups.
   2. Nutrition.
   3. Chemoprevention.
   4. Hospice and terminal care including pain control and symptom management.
   5. Economics of cancer care.
E. Outcome evaluation of all research efforts.

MANAGEMENT/ADMINISTRATION

Standard I

Management is effective and efficient.

Rationale

Management is responsible for using limited resources efficiently while maintaining high standards of patient care commensurate with currently available clinical knowledge and skills. Commitment and appropriate qualifications on the part of the individuals in management positions, as well as effective and efficient systems for supporting patient care, are essential to fulfilling these responsibilities.

Characteristics

A. A director is appointed by the governing body or its appropriate administrative representative and is responsible for the operation of the program.
B. The director is qualified by education and experience that is appropriate to the fulfillment of the designated responsibilities and may be a physician (see Medical Director) or nonphysician.
C. Management and administrative staff develop mechanisms to implement relevant governing body policies.
D. Management and administrative staff take all reasonable steps to provide compliance with applicable laws and regulations.
E. Management and administrative staff provide for the following:
    1. The implementation of organized management and administrative functions including the delineation of responsibility and accountability of staff.
    2. The establishment of services necessary for the effective and efficient function.
    3. The designation of an individual to act in the program director's absence.
    4. The establishment of internal controls to safeguard physical, financial, and human resources.
    5. The control of inventories and purchasing procedures.
    6. The implementation of a comprehensive management reporting system to account to the governing body.
    7. The coordination of services with the identified needs of the patient population served.
F. The management and administrative staff provide for personnel policies and practices that pertain to the following:
    1. The employment of personnel, without regard to sex, race, creed, national origin, or handicap, whose qualifications are commensurate with anticipated job responsibilities.
    2. Orientation of all new employees including personnel policies.
    3. The maintenance of an accurate, current, and complete personnel record for each employee.
    4. The verification of applicable current licensure/certification of personnel.
    5. A periodic performance evaluation of each employee based on a job description.
G. The management and administrative staff provide for the implementation of financial policies and practices that pertain to the following:
    1. A formal budget.
    2. Monitoring of the accuracy and reliability of financial data.
H. Management and administrative staff provide sufficient and timely data for use in planning and evaluation.
    1. The data are sufficient to keep responsible persons adequately and currently informed.

QUALITY ASSURANCE

The provision of high quality patient care through the monitoring and evaluation of the quality and appropriateness of services provided is assured.

Rationale

The results of patient care depend on the interrelated contributions of a variety of health care services and personnel. A major component of the multidisciplinary team's endeavors to deliver patient care that is optimal within available resources and consistent with achievable goals is the operation of a quality assurance program.

Characteristics

A. Management and administrative staff are responsible for assuring the implementation and maintenance of a planned and systematic process for identifying problems that affect patient care and clinical performance, as well as opportunities to improve patient care.
B. The objectives, methods of implementation, responsibilities for the monitoring and evaluation, and a mechanism(s) for reporting and for follow-up activities are specified in a written plan.
C. The monitoring and evaluation of the quality and appropriateness of patient care encompass all services provided to patient in all care settings. Monitoring and evaluation are accomplished through the following means:
    1. Routine collection of information concerning various aspects of the delivery of care especially high risk and high volume services. Such information may pertain but need not be limited to:
        a) Utilization review findings.
        b) Patient care evaluation and clinical outcomes.
        c) Functioning of the multidisciplinary team.
    2. Periodic assessment of the information collected in order to identify:
        a) Important problems in the direct delivery of multidisciplinary team services in all care settings.
        b) Opportunities to improve patient services.
    3. In 1 and 2 above, the use of clinical indicators and objective criteria that reflect current standards of practice in cancer care.
D. When important problems in the delivery of services or opportunities to improve patient services are identified:
    1. Actions are taken.
    2. The effectiveness of actions taken is evaluated.
E. There is evidence that the findings of the quality assurance program are the basis of action taken in:
    1. Patient/family services.
    2. Management or supervision.
    3. Inservice or continuing education.
F. Relevant findings of the quality assurance activities are used in evaluating the clinical performance of the providers of direct patient/family care.
G. The findings from, and conclusions of, the monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported as defined in the written plan.
H. The actions taken to resolve problems and improve patient services and information about the impact of actions taken are documented and, as appropriate, are reported as defined in the written plan.
I. The effectiveness of the monitoring, evaluation, and problem-solving activities is evaluated at least annually.
J. The findings from, and conclusions of, the monitoring, evaluation, and problem-solving activities are coordinated, to the degree possible, with other organizations or services involved in the provision of care to the patients.