How to Perform a Yearly Evaluation of Services
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4.4 – Genetic Counseling and Risk Assessment

- Cancer risk assessment and genetic counseling are the processes to identify and counsel people at risk for familial or hereditary cancer syndromes.

- Purposes of cancer genetic counseling are to:
  - Educate patients about their chance of developing cancer
  - Help patients obtain personal meaning from genetic information
  - Empower patients to make educated, informed decisions about genetic testing, cancer screening, and cancer prevention
4.4 – Genetic Counseling and Risk Assessment

- Develop a policy and procedure:
  - Provide cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral
  - Develop a referral relationship to other facilities and/or local agencies for services not provided on site

- The policy and procedure must include information/processes for the following:
  - Criteria for referral for a genetics evaluation
  - Identification of the genetics professionals available on-site and/or by referral
  - Identification of the genetics professionals qualified to perform post-test counseling either on-site and/or by referral

- Cancer risk assessment and genetic counseling are performed by a genetics professional with an educational background in cancer genetics and hereditary cancer syndromes. Specialized training in cancer genetics is required.
4.4 – Genetic Counseling and Risk Assessment

- Genetics professionals may include:
  - An individual board-certified/board-eligible by American Board of Genetic Counseling (ABGC) or American Board of Medical Genetics and Genomics (ABMGG)
  - An Advanced Practice Nurse in Genetics (APNG), or an Advanced Genetics Nursing Certification (AGN-BC) credentialed through the American Nurses Credentialing Center (ANCC), or a Genetics Clinical Nurse (GCN)
  - An advanced practice oncology nurse or physician assistant who is prepared at the graduate level (masters or doctorate) with specialized education in cancer genetics and hereditary cancer predisposition syndromes
    - The Advanced Oncology Certified Nurse Practitioner (AOCNP) or equivalent certification from the Oncology Nursing Certification Corporation (ONCC) is preferred.
  - A registered nurse with specialized education in cancer genetics and hereditary cancer predisposition syndromes

- A board-certified/board-eligible physician with experience in cancer genetics (defined as providing cancer risk assessment on a regular basis and undergoing ongoing continuing medical education in cancer genetics and hereditary cancer predisposition syndromes)
4.4 – Genetic Counseling and Risk Assessment

- While it is expected that programs provide genetics assessment for all relevant cancers on an on-going basis, each calendar year programs must identify a process pursuant to evidence-based national guidelines for genetic assessment for a specific cancer site.

- Each calendar year, the cancer committee:
  - Reviews the policy and procedure for genetic assessment and referral for genetic evaluation/counseling
  - Documents in minutes (all of the following):
    - The number of patients identified as needing referrals for the selected cancer site each year
    - The number of patients identified as needing referrals for the selected cancer site received a referral for genetic counseling

- If available, it is recommended that a genetics professional attend the cancer committee meeting to lead the discussion and provide the report.
4.4 – Genetic Counseling and Risk Assessment

- Documentation to be submitted with the PRQ:
  - Policy and procedure for providing cancer risk assessment, genetic counseling, and genetic testing services on-site or by referral that includes all required elements
  - Cancer committee minutes that document the required yearly evaluations of the genetic counseling and risk assessment services

4.5 – Palliative Care Services

- Palliative care refers to patient- and family-centered care that optimizes quality of life. The availability of palliative care services is an essential component of cancer care, from diagnosis, to treatment and surveillance and, when applicable, during bereavement.

- Palliative care services are available to:
  - Cancer patients
  - Family members of cancer patients
  - Caregivers

- Services are available either on-site or by referral, and are evaluated at least once each calendar year.
4.5 – Palliative Care Services

• Palliative care is provided per evidence-based national treatment guidelines and includes palliative care provided by oncology teams and specialists, as needed. It is recommended that the following specialties participate in providing palliative care services:

- Physicians
- Advanced Practice Providers
- Nurses
- Mental Health Professionals
- Social Workers
- Spiritual Counselors

• Palliative care is integrated in the continuum of cancer care.
• Types of palliative care services include, but are not limited to:
  – Team-based care planning that involves the patient and family
  – Pain and non-pain symptom management
  – Communication among patients, families, and provider team members
  – Education about illness and prognosis
  – Assistance with medical decision making
  – Continuity of care
  – Attention to spiritual needs
  – Psychosocial support for patients and families
  – Bereavement support for families and care team members
4.5 – Palliative Care Services

**The cancer committee will define and identify in a policy and procedure the following:**

- On-site and off-site palliative care services
- The palliative care team available on-site
- Criteria for referral to a palliative care specialist

**Palliative care services not provided on-site at the facility must be provided through a referral relationship to other facilities and/or local agencies.**

- Each calendar year, the cancer committee:
  - Monitors, evaluates, and makes recommendations for improvements to palliative care services
  - Documents the evaluation in the meeting minutes

**During this evaluation, the cancer committee must:**

- Assess the approximate number of cancer patients referred for palliative care services and for what services or resources
- Discuss the criteria utilized to trigger referrals to palliative care services
- Discuss areas of improvement (For example: barriers to access of palliative care services, addition of palliative care services, decreasing emergency department usage, or improving the timeliness of referrals, etc.)

- If available, it is recommended that a palliative care professional attend the cancer committee meeting to lead the discussion and provide the report.
4.5 – Palliative Care Services

- Documentation to be submitted with the PRQ:
  - Policy and procedure for providing palliative care services on-site or by referral
  - Cancer committee minutes that document the required yearly evaluations of the palliative care services

4.6 – Rehabilitation Care Services

- Rehabilitation care optimizes patient functional status and quality of life through several types of interventions, including:
  
  preventive  restorative  supportive  palliative

- Rehabilitation care services are essential to comprehensive cancer care, beginning at the time of diagnosis, throughout treatment, surveillance, and, when applicable, through end of life.

- Policies and procedures are in place to guide referral to appropriate rehabilitation care services on-site or by referral.
4.6 – Rehabilitation Care Services

- Rehabilitation professionals associated with cancer rehabilitation typically include, but are not limited to:
  - Physiatrists
  - Physical Therapists
  - Occupational Therapists
  - Speech Language Pathologists

4.6 – Rehabilitation Care Services

- Types of rehabilitative care services may include, but are not limited to:
  - Screening, diagnosis, and management of:
    - physical dysfunction/impairments/disabilities
    - pain and non-pain symptoms
    - cognitive function
  - Interventions to manage identified functional impairments and disabilities
  - Lymphedema management
  - Physical activity recommendations during and after treatment
  - Vocational rehabilitation
4.6 – Rehabilitation Care Services

• The cancer committee will define and identify in a policy and procedure the following:
  - On-site and off-site rehabilitation care services
  - The rehabilitation care team available on-site
  - Criteria for performing functional assessments
  - Criteria for referral to a rehabilitation care specialist

• Each calendar year, the cancer committee must:
  - Monitor, evaluate, and make recommendations for improvements, as needed, to rehabilitation care services and/or referrals
  - Document the review and any recommendations for improvement in the meeting minutes

• If available, it is recommended that a rehabilitation professional attend the cancer committee meeting to lead the discussion and provide the report.
4.6 – Rehabilitation Care Services

• Documentation to be submitted with the PRQ:
  – **Policy and procedure** defining rehabilitation services that are provided on-site and by referral
  – **Cancer committee minutes** that document the required yearly evaluations of the rehabilitation care services

4.7 – Oncology Nutrition Services

• Multi-modality cancer treatments can impair a cancer patient’s ability to **consume**, **digest**, and **absorb essential nutrition** and hydration.

• **Registered Dietitian Nutritionists (RDNs)** — also known as Registered Dietitians (RDs) — are uniquely trained to use medical nutrition therapy and education to address:
  – Treatment-related symptom management
  – Nutrition support
  – Quality-of-life concerns
4.7 – Oncology Nutrition Services

- **Oncology nutrition services** are provided, on-site or by referral, by RDNs who:
  - Address nutrition and hydration requirements, and
  - Make recommendations throughout the continuum of cancer care, including:
    - [prevention]
    - [diagnosis]
    - [treatment]
    - [survivorship]
    - [palliative care]

- The cancer program defines and identifies the nutrition services provided on-site and by referral.

- Components of oncology nutrition services include, but are not limited to:
  - **Screening and nutrition assessment** for risk and diagnosis of malnutrition, nutrition-related problems, and obesity
  - **Medical nutrition therapy**
  - **Nutrition counseling**
  - **Nutrition education**
  - **Management and coordination** of enteral and parenteral nutrition
4.7 – Oncology Nutrition Services

- Nutrition services not available at the facility must be provided through a referral relationship to other facilities and/or agencies.

- Each calendar year, the cancer committee must:
  - Monitor, evaluate, and make recommendations for improvements to on-site oncology nutrition and hydration services and/or referral services
  - Document the review and any recommendations for improvement in the meeting minutes

- If available, it is recommended that a RDN attend the cancer committee meeting to lead the discussion and provide the report.

4.7 – Oncology Nutrition Services

- Documentation to be submitted with the PRQ:
  - Policies and procedures for providing oncology nutrition services, on-site or by referral, by a Registered Dietitian Nutritionist
  - Cancer committee minutes that document the required yearly evaluations of the oncology nutrition services
7.2 – Monitoring Concordance with Evidence-Based Guidelines

- Each calendar year, a physician performs an in-depth analysis of the diagnostic evaluation and treatment of individual patients to determine whether it is concordant with recognized evidence-based national guidelines.

- The study must be a retrospective review of individual patient evaluation and treatment information, which includes a patient medical record review.

- The study and results are presented to the cancer committee and documented in cancer committee minutes.

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7.2 – Monitoring Concordance with Evidence-Based Guidelines

- The annual in-depth analysis must include all of the following components:
  1. The choice of a patient population to review. Sources for the assessment must include one of the following study topics:
     - All cases from a specific cancer site (or stage within that site), to a maximum of 100 cases
     - An identified need or concern within a specific cancer site or stage of cancer
7.2 – Monitoring Concordance with Evidence-Based Guidelines

2. A determination whether the **pre-treatment** initial diagnostic evaluation process is concordant with evidence-based national treatment guidelines for each patient being reviewed.
   - Initial evaluation should include recommendations within the specific guideline(s) for:
     - pathology
     - diagnostic imaging
     - laboratory tests
     - consultations

3. A determination whether the **first course of treatment** is appropriate for the stage of disease or prognostic indicators and is concordant with evidence-based national treatment guidelines for each patient being reviewed.

4. A **reporting format** that does all of the following:
   - Permits analysis
   - Provides an opportunity to recommend performance improvements based on data from the analysis

5. A **presentation of a report** detailing all required elements of the study, including the results of the analysis, to the cancer committee. The report is documented in the cancer committee minutes. The documentation includes any recommendations for improvement.
7.2 – Monitoring Concordance with Evidence-Based Guidelines

• **Exceptions:** Analysis and treatment discussions for patients at multidisciplinary cancer case conferences do not fulfill the requirements for Standard 7.2.

7.2 – Monitoring Concordance with Evidence-Based Guidelines

• **Documentation to be submitted with the PRQ:**
  
  – A **report of the in-depth analysis** which documents the completed analysis, including identification of the patient population reviewed, methodology, and results
  
  – **Cancer committee minutes** that document that the conclusions and the results of the analysis were reported and any recommendations for improvement