Ensuring patients receive the right care at the right time and the right place
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Standard 4.2: The Oncology Medical Home practice establishes relationships for effective communication with outside providers for the appropriate management of patient care.

Standard 4.3: The Oncology Medical Home practice shares diagnosis, treatment, and follow-up data on mutual patients with Commission on Cancer accredited cancer programs.

Standard 4.4: All patients are provided on-site psychosocial distress screening and referral for the provision of psychosocial care, as needed.

Standard 4.5: The Oncology Medical Home practice develops and implements a process to disseminate a treatment summary and survivorship care plan to patients within 90 days of the completion of treatment.

CHAPTER 5: QUALITY IMPROVEMENT

Standard 5.1: Each calendar year, the Oncology Medical Home practice records, reviews, and monitors completeness of clinical data for initiating quality improvement activities.

Standard 5.2: The Oncology Medical Home practice administers a patient satisfaction survey to cancer patients at least twice each calendar year. The results of the survey are analyzed and used to guide quality improvement activities.

Standard 5.3: Each calendar year, the Oncology Medical Home Practice develops, analyzes, and documents at least one quality improvement study associated with improving clinical outcomes and implements at least one quality improvement based on study results.

GLOSSARY OF TERMS

REFERENCES
The Commission on Cancer (CoC) acknowledges the many contributions of the following people who participated in the creation and revision of the Oncology Medical Home (OMH) Accreditation Program Standards Manual.

In addition, the CoC is thankful to the representatives of the CoC, Community Oncology Alliance, and the members of the OMH Standards Manual Workgroups and Steering Committee for their efforts to establish patient-centered standards. Finally, the CoC acknowledges the constituents from OMH practice across the country that provided comments and suggestions for the standards.

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**COMMISSION ON CANCER MISSION**

The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.

**COMMISSION ON CANCER BACKGROUND**

The Commission on Cancer and its standards for cancer care originated with the American College of Surgeons (ACoS). Since its foundation in 1913, the ACoS has focused on improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment. Because surgery was the only available treatment for cancer at that time, the ACoS took the lead to improve cancer care by establishing the Committee on the Treatment of Malignant Diseases in 1922. Over time, the Committee has transformed a surgical focus into one that involves all aspects of cancer care. In order to recognize this transformation, the name of the Committee was changed to the Commission on Cancer in the mid-1960s.

The initial work was focused on establishing cancer clinics within hospitals where patients could expect to receive consistent diagnostic and cancer treatment services. By 1930, the first set of standards was published, and an accreditation program that evaluated a cancer clinic’s performance against the standards had been established. Since then, the number of CoC-accredited programs has slowly and steadily increased to encompass approximately 1,500 hospitals, freestanding cancer centers, and cancer program networks nationwide.
ONCOLOGY MEDICAL HOME BACKGROUND

A Medical Home, also referred to as a Patient-Centered Medical Home (PCMH), is a team-based health care delivery model led by a physician. The model provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. The Medical Home model has been in existence for more than 40 years and was originally focused on the primary care physician as the coordinator of patients’ medical care.

The purposes of a Medical Home include:

• Improved access to health care
• Improved patient experience
• Improved medical outcomes
• Efficient delivery of care and reduced costs

Providing well-coordinated care, an essential component of a Medical Home, requires an organized infrastructure with highly trained staff and robust health care technology. Increased and improved infrastructures provide services that may not be covered by the current “Fee-for-Service System”; therefore, new payment models are being analyzed and developed.
THE IMPORTANCE OF ONCOLOGY MEDICAL HOMES

A significant amount of sophisticated care is necessary to keep cancer patients out of the hospital. This is where the need for an Oncology Medical Home (OMH) model becomes evident, with the specific goal of providing better access to cancer care for patients by a physician-led care team.

An ideal cancer care team is focused on providing the right care at the right time and at the right place. When a person is diagnosed with cancer, the treatment of the cancer becomes the primary focus of medical care. Other medical care needs have to be coordinated in the context of the primary goal of treating the cancer, so patients look to their oncology team to provide the coordination of their care. The complexity of care and potential for treatment side effects often overwhelms the primary care physician, who lacks the infrastructure to manage these complicated problems in the outpatient setting.

FIVE KEY ELEMENTS TO AN EFFECTIVE ONCOLOGY MEDICAL HOME

1. **Patient Engagement:** The goals of an OMH are to enhance patient care experiences, clinical outcomes, quality of life, and patient satisfaction. These goals may be accomplished by the oncology practice staff providing patient education to empower the patient with knowledge about his or her disease so that expectations are realistic and shared by the team throughout the treatment plan. Understanding the side effects patients may encounter and knowing who and when to call a health care professional have been found to significantly reduce costs of care by keeping patients out of the emergency department (ED) and the hospital as much as possible. An OMH should also have staff to provide financial counseling and access to financial assistance programs. Lastly, patients should have online access to their personal medical record, plan for treatment, and educational materials.

2. **Expanded Access:** Data suggests that the lack of access to the patient’s oncology practice when the patient has symptoms during the day, in the early evening, and on weekends leads to more ED visits and unplanned hospitalizations. An oncology practice is required to develop the capability to provide urgent care through same day, early evening, and weekend access for appointments. This capability is more than simply having a physician on call. Ideally labs, imaging, hydration, antibiotics, and other symptom management medications are available on-site or at least in a coordinated, expedited manner. Patients are informed that they can go to the practice when they don’t feel well instead of going to the ED.

3. **Evidenced-Based Medicine:** The report, *Ensuring Quality Cancer Care*, written by the Institute of Medicine (Institute of Medicine, 1999) identified specific ways to improve cancer care. The report noted that cancer care is optimally delivered in systems that have implemented standardized, evidence-based treatment guidelines. Cancer care that is optimized based on evidence-based medicine has been shown to produce higher quality outcomes for patients. An OMH practice must use standardized evidence-based guidelines consistent with National Comprehensive Cancer Network (NCCN) or American Society of Clinical Oncology (ASCO) guidelines. The evidence-based guidelines must also demonstrate safe medication administration and appropriate utilization of laboratory and imaging study resources. Lastly, for an oncology practice to meet OMH requirements, it must have the ability to demonstrate a process to either refer patients to or enroll patients in clinical trials.

4. **Comprehensive Team-Based Care:** Within the practice, the team is created by determining the medical, psychosocial, economic, and support needs of the patient; determining how the practice can meet those needs and assigning the team member with the appropriate level of education to perform the services. Each member of the team must be able to tell from the electronic medical record that the patient’s needs were met. In addition, data to
evaluate the outcomes of all facets of treatment must be available in real time to allow the practice to improve on
the services given. Within the oncology practice itself, a team is led by a physician and comprised of nurses, pharmacists, medical technicians, care coordinators and first responders (telephone operators), and other
appropriate team members. All members work together to deliver medical care in an outpatient setting to avoid ED
and hospital admissions. The disease management, patient education and on or near site laboratory, imaging and pharmacy services are all delivered in a caring environment that enhances patient satisfaction.

Not all the care needed can be delivered within the walls of the practice, so the oncology practice must have
established relationships with outside physicians to refer the patient, when needed, for the management of non-
cancer symptoms. The care coordination also includes coordination with the patient’s primary care provider(s),
other specialists, hospitals, and hospice. There are established communication processes in place to keep other
physicians informed of the patient’s treatment plan and current health care status.

If a patient needs to be hospitalized, the team-based care focuses on an established inpatient care plan where
the oncologist either manages the patient or co-manages the patient with hospitalists and the patient’s primary
care physician.

5. Quality Improvement: Cancer care that is continuously improved by measuring and benchmarking results against
physicians within the same practice (peer review), as well as, against other oncology groups, helps to ensure
continuous improvement and adoption of best practices. As quality goals are achieved or as standards of care
evolve, those measures should be retired and replaced with new measures. Doing so, continues to “raise the bar” in
care delivery. In order to capture and exchange information for practices to continually monitor, report and improve
processes and outcomes, a practice must have a fully implemented certified Electronic Health Records (EHR) system.

Oncology practices that wish to achieve OMH accreditation will be required to submit data to be used to monitor
compliance with mandatory quality measures. Another area of quality improvement will be the continued
administration and monitoring of a validated oncology-specific patient satisfaction survey. Patient satisfaction
surveys are to be continuously reviewed and results acted upon if changes are warranted. The goals of the surveys are
to educate and inform the practices of any patient concerns and to focus and facilitate quality improvement efforts.

SUSTAINABILITY OF AN ONCOLOGY MEDICAL HOME

To sustain the OMH infrastructure which provides the right care at the right time and at the right place to cancer patients,
a new payment model must be developed. A shared savings model is needed to compensate the oncology practice for
assuming responsibility for managing high-cost cancer patients in an outpatient setting. An OMH can provide significant
cost savings to Medicare and to commercial payers by reducing ED visits and in-patient hospitalizations. A new payment
model may be generated by demonstrated achievement in a well-managed OMH.
SURVEY PROCESS

OMH-accredited practices are surveyed on a triennial basis. In preparation for survey, the Practice Oversight Committee (POC) is required to:

1. Assess and demonstrate program compliance with all eligibility requirements and standards outlined in the OMH Accreditation Program Standards Manual.
2. Confirm the survey date and agenda with their assigned surveyor.
3. Submit payment for the annual accreditation fee.
4. Review and complete the web-based OMH Survey Application Record (SAR) as required by the Commission on Cancer (CoC).

Each year, an initial e-mail notification is provided to all practices due for survey in the upcoming calendar year. Later that same year, practices are notified of their assigned CoC/OMH-trained surveyor for their survey in the upcoming year. The selection of a survey date is coordinated between the practice and the surveyor. Surveys are to be scheduled during the month the survey is due.

The surveyor profiles, which include a photograph and brief biography, are available on the OMH web page.

SURVEY EXTENSIONS

When extenuating circumstances affect practice activity, a survey extension may be appropriate. Survey extension requests will be granted in these instances at the discretion of the CoC. The usual extension is three months. A longer extension may be available given individual circumstances.

Valid extenuating circumstances that warrant a survey extension include, but are not limited to:

- Natural disasters (hurricane, earthquake, tornado, flood) that directly affect the practice
- Other anthropogenic hazards (such as fire, industrial accidents)

Examples of circumstances that do not warrant a survey extension include, but are not limited to:

- Software conversions or information technology issues
- Staff absences, turnovers, or resignations
- Delayed abstracting or missing data
- Standard deficiencies
- Survey extensions for these or similar reasons will not be accommodated.

The OMH Practice Leader or the administrator must submit a formal request for an extension via e-mail to OMHAccreditation@facs.org. The request must include details of the rationale for the extension request, proposed plan, and timeline to resolve the issue necessitating the extension request. Practices will be notified of the extension request decision within 14 days of receipt of the written request by the CoC.

Practices are discouraged from canceling or postponing the scheduled survey. However, if survey cancellation or postponement of a survey becomes necessary after the survey date is confirmed, the practice must contact CoC staff and submit a written notification. The practice will also be invoiced a cancellation fee and will be responsible for any non-refundable travel expenses incurred by the surveyor.
ACCREDITATION FEE

An invoice for the annual accreditation fee is e-mailed annually to the OMH practice approximately 60 days prior to the accreditation due month. Payment of the invoice is due within 30 days of receipt. No Performance Report will be provided to a practice that has not paid accreditation fees.

SURVEY APPLICATION RECORD

The Survey Application Record (SAR) is an online reporting tool that is available and utilized during the year due for accreditation survey to demonstrate compliance of OMH Eligibility Requirements and Standards.

Once the survey has taken place, the SAR will close and a Program Activity Record (PAR) will then be available throughout the three-year accreditation period (non-survey years) for use as a record-keeping tool to document program activity. The SAR and PAR are essentially the same forms, but the SAR is used only during the year of survey and the PAR is used for non-survey years.

Access to the SAR/PAR is provided through CoC Datalinks. CoC Datalinks is a password-protected, web-based portal. Access to the SAR/PAR is provided to the OMH Practice Leader. Additional users can be identified by the program and added through the Manage Staff Contacts link located on the Main Activity Menu of CoC Datalinks.

To facilitate a thorough and accurate evaluation of the practice during the survey, the practice completes or updates the SAR at least 30 calendar days before the scheduled on-site visit. Completion of the SAR/PAR should be a team effort of members of the POC. The SAR will close 14 calendar days before the on-site visit. The practice’s surveyor reviews the SAR before the on-site visit to assess compliance with the standards and to become familiar with the resources and services offered at the practice and the POC activity.

Other helpful features available in the SAR/PAR include:
- Help and FAQ icons, which contain information on each standard
- Electronic submission of Appeals and Deficiency Resolutions
- Printing capabilities of the SAR/PAR

REQUIRED DOCUMENTATION

OMH-accredited practices document practice activity using multiple sources, including policies, procedures, manuals, tables, and grids. The practice oversight committee minutes are a primary resource for documentation of POC and practice activity. All meeting minutes should contain sufficient detail to accurately reflect the activities of the POC as well as demonstrate compliance with OMH standards. Consent agendas are not permitted.

In preparation for the on-site visit, documentation must be uploaded into the SAR. The documentation can be attached throughout the three-year accreditation period but must be completed within 30 calendar days of the confirmed survey date so that the documentation is available for surveyor review in preparation for the visit. The documentation required for each standard is included in the specifications for the standard.

SURVEY AGENDA

A member of the POC confirms the agenda for the survey with the surveyor(s) at least 14 days before the on-site visit. The surveyor’s role is to assist in accurately defining the standards and verifying that the practice is in compliance.

To accomplish these tasks on the day of survey, the surveyor(s) will:
- Meet with key members of the practice’s administrative leadership and provide education on the value of OMH accreditation and how to market this achievement.
- Meet with the POC to discuss the activities and responsibilities of the POC in relationship to the practice(s) and to verify the accuracy of the data recorded in the SAR.
• Meet with the OMH Practice Leader to discuss his or her role and responsibilities, including the quality measure data for performance improvement.
• Tour of the practice (optional).
• Conduct a chart review to determine standard compliance.
• Provide a summation.

All members of the Practice Oversight Committee should attend and participate in the accreditation survey visit. At a minimum, the surveyor(s) must meet with the following staff:
  • Chief Executive Officer and/or other high-level administrators
  • OMH Physician Practice Leader
  • Practice Oversight Committee Chair
  • Medical Oncologist Representative
  • Financial Counseling Representative
  • Triage Nurse/Urgent Care Representative

POST-SURVEY EVALUATION
The Post-Survey Evaluation (PSE) is a required component of the OMH practice survey. The PSE captures feedback from the practice, which enables the CoC to evaluate and improve the survey process and surveyor performance, and to develop educational materials and training programs for surveyors and participating practices. Practices complete the PSE electronically within the SAR.

All responses are confidential and will not influence the practice evaluation or accreditation award. Responses on the evaluation form should represent a consensus opinion of the POC team. The PSE is required to be completed within 14 days of the survey.

NOTIFICATION OF SURVEY RESULTS
Accreditation status and Performance Report (PR) notifications are distributed via email within 45 days following the completed survey. The OMH Practice Leader receives an e-mail when the completed PR is posted electronically to CoC Datalinks. The posted PR is accessible to all CoC Datalinks users at the practice.

The accreditation survey PR provides the following:
  • A comprehensive summary of the survey outcome and accreditation award
  • The practice’s compliance rating for each standard
  • A narrative description of deficiencies that require correction
  • Suggestions to improve or enhance the practice

If accredited without contingency, access for ordering the Certificate of Accreditation is provided to the practice administrator following posting of the PR to CoC Datalinks. The practice may appeal a finding for any standard or the accreditation award within 30 days of posting of the PR. The appeals process is outlined in the appeal guidelines on the OMH website.

MARKETING AND VISIBILITY OF OMH ACCREDITATION
Only accredited practices have access to the web-based Marketing Resources Page within CoC Datalinks. The CoC encourages practices to use these tools to explain what OMH accreditation means for patients, payers, and the general public.

The materials on the marketing web page were designed for use by public relations and/or marketing departments and include:
  • “How to Market Your OMH Accreditation” PowerPoint presentation
  • Access to The Award Group to order OMH accreditation certificates, banners, pins, and other promotional items
  • OMH accreditation logo and use policy
  • Sample press releases and approved marketing statements
ONCOLOGY MEDICAL HOME PRACTICE STANDARDS RATING SYSTEM

The following rating system is used to assign a compliance rating to each standard:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Compliance</td>
</tr>
<tr>
<td>5</td>
<td>Noncompliance</td>
</tr>
<tr>
<td>8</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Based on the rating criteria specified for each standard, a compliance rating of “1” is assigned by the surveyor(s) and Commission on Cancer (CoC) staff. A deficiency is defined as any standard with a rating of “5”.

ACCREDITATION AWARDS

Accreditation awards are based on consensus ratings by the practice’s assigned surveyor, CoC staff, and, when required, the Program Review Subcommittee. A practice receives one of the following Accreditation Awards following survey:

THREE-YEAR ACCREDITATION is conferred to practices that comply with all standards and eligibility requirements with no deficiencies at the time of the accreditation survey. This award is also applied to practices that received and resolved a deficiency for one or more standards following the results of the survey. A certificate of accreditation is issued, and these practices are surveyed at three-year intervals.

THREE-YEAR ACCREDITATION WITH CONTINGENCY is conferred to practices when one to six standards are rated deficient and the practice does not meet one or more of the eligibility requirements at the thresholds set by the CoC. The contingency status must be resolved within 12 months. Practices follow the guidelines for deficiency resolution. Practices submit proper documentation to resolve the contingency status directly through the Survey Application Record (SAR). A certificate of “Three-Year Accreditation” is granted following submission and evaluation of resolution documentation.

NON-ACCREDITATION is conferred to practices when seven or more standards are rated deficient. CoC staff will work directly with these practices to assist them with deficiency resolution to reinstate accreditation. Practices may also choose to withdraw from the accreditation program to improve their performance and then reapply for accreditation as a new practice.

INFORMATION FOR PRACTICES PURSUING INITIAL ONCOLOGY MEDICAL HOME ACCREDITATION

To be considered for initial accreditation, the Practice Oversight Committee (POC) is required to:

- Ensure that the clinical services and POC are in place at the practice.
- Meet all eligibility requirements outlined in the Oncology Medical Home Accreditation Program Standards Manual.
- Meet the requirements for all required standards as outlined in the Oncology Medical Home Accreditation Program Standards Manual.
• Complete the online application for accreditation and provide main contact information for the practice.
• Submit the new practice application fee.
• Sign the American College of Surgeons Business Associate and Data Use Agreement in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

REFERENCES

The references, located at the back of this manual, provide definitions and examples of terms used throughout the Oncology Medical Home Standards Manual.
Eligibility Requirements

The following Eligibility Requirements (ER) address administrative activities required before an Oncology Medical Home (OMH) is eligible to be surveyed for Commission on Cancer’s OMH accreditation.

The Practice Oversight Committee (POC) within the OMH practice documents these processes and activities, and confirms each eligibility requirement annually. Each calendar year, the practice uploads current and required compliance documentation to the Program Activity Record (PAR) and the Survey Application Record (SAR) for the year of survey.

**ER1: The Oncology Medical Home (OMH) practice leadership, including administrators and physicians, supports the OMH concept and adopts policies and procedures to achieve OMH accreditation.**

The OMH practice orients current physicians, allied health professionals, and administrative staff on the importance and significance of OMH principles. New physicians and staff are oriented to OMH practices and standards when joining the practice.

The OMH practice designates one physician as the OMH Program Leader. The OMH Program Leader chairs the Practice Oversight Committee (POC) and ensures OMH policies and procedures are followed by the practice. In addition to the POC, practices may choose to establish subcommittees or workgroups to manage specific activities, noting that activities and reports must be presented and approved by the POC.

The OMH Program Leader oversees:
- Annual review and revision of policies and procedures that address OMH standards.
- Audit of compliance with OMH standards in each OMH chapter.
- Evaluation of compliance and monitoring of OMH performance measures.

**DOCUMENTATION**

The OMH practice identifies the OMH Program Leader in the OMH Survey Application Record (SAR). Annually, the practice uploads policies and procedures relating to the OMH standards and POC meetings.
ER2: The Oncology Medical Home practice utilizes a certified Electronic Health Record as defined by the Centers for Medicare & Medicaid Services (CMS).

There are a number of benefits using an Electronic Health Record (EHR), including improved care coordinator and patient satisfaction, improved diagnostics and cost savings.

“In order to capture and share patient data efficiently, providers need an EHR that stores data in a structured format. Structured data allows patient information to be easily retrieved and transferred, and it allows the provider to use the EHR in ways that can aid patient care.”

— Centers for Medicare & Medicaid Services (CMS, 2014)

CMS requires each eligible practice to provide a CMS EHR Certification ID that identifies the certified EHR technology being used to demonstrate meaningful use.

**DOCUMENTATION**

The OMH practice records the CMS EHR Certification ID in the OMH SAR and uploads the certificate for the current period.
ER3: Each calendar year, the Oncology Medical Home practice submits applicable data for all mandatory performance measures as indicated by the Commission on Cancer.

The OMH practice implements tools and methods to record and track EHR data that are needed to evaluate the OMH mandatory performance measures. Data results are applied to the quality improvement process to improve performance and patient outcomes.

**DOCUMENTATION**

Each calendar year, the practice reports performance measures as required.

**PERFORMANCE MEASURES REFERENCE GRID**

<table>
<thead>
<tr>
<th>Standard 2.1: New and established patients can easily access the Oncology Medical Home practice and their providers.</th>
<th>Number of emergency department visits per chemotherapy patient per calendar year.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of hospital admissions per chemotherapy patient per calendar year.</td>
</tr>
<tr>
<td>Standard 3.1: Evidence-based treatment guidelines and/or pathways are used for treatment planning.</td>
<td>Percentage of patients treated according to scientifically validated evidence-based guidelines each calendar year.</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients with high emesis risk receiving anti-emetics each calendar year.</td>
</tr>
<tr>
<td></td>
<td>Percentage of chemotherapy patients with greater than 20 percent risk for neutropenia receiving white blood cell growth factor each calendar year.</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients with Stage 0, I or II node negative breast cancer who undergo advanced imaging each calendar year.</td>
</tr>
<tr>
<td></td>
<td>Percentage of new patients with staging documentation in the EHR prior to initiation of treatment each calendar year.</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients with performance status documentation in the EHR prior to treatment each calendar year.</td>
</tr>
<tr>
<td>Standard 4.4: All patients are assessed for psychosocial distress, and provided or referred to psychosocial services for intervention.</td>
<td>Percentage of patients receiving at least one psychosocial distress screening each calendar year.</td>
</tr>
<tr>
<td>Standard 4.5: The Oncology Medical Home practice develops and implements a process to disseminate a treatment summary and survivorship care plan to patients who are completing cancer treatment.</td>
<td>Percentage of patients receiving a survivorship plan within 90 days of completion of treatment each calendar year.</td>
</tr>
<tr>
<td></td>
<td>Percentage of Stage IV patients with advanced care plan discussions documented in the EHR each calendar year.</td>
</tr>
<tr>
<td><strong>Additional Measures</strong></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>Survival rates for breast, colon and non-small cell lung cancer patients by stage each calendar year.</td>
<td></td>
</tr>
<tr>
<td>Average number of day's from hospice referral to date of death each calendar year.</td>
<td></td>
</tr>
<tr>
<td>Number of patients receiving chemotherapy given within 30 days of end of life each calendar year.</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who die in the acute care setting each calendar year.</td>
<td></td>
</tr>
</tbody>
</table>
Standard 1.1: All patients are provided education on the Oncology Medical Home practice and concept.

STANDARD DEFINITION AND REQUIREMENTS

The practice ensures that a process is in place to educate all cancer patients regarding the specific Oncology Medical Home (OMH) cancer care concept and to understand their responsibilities within the OMH model.

Educational information to be provided includes, but is not limited to:
- Definition, goals, and importance of an OMH.
- The importance of the medical oncologist as the principal care coordinator for patients during active treatment and regarding concerns related to their cancer care.
- Information on how and when to contact the medical oncologist, including evenings and weekends, with issues that need to be addressed.
- Definition of the responsibilities of the patient and the practice.
- Direct contact information for patients’ principal care team.

DOCUMENTATION

The practice must complete all required fields in the OMH Survey Application Record (SAR).

Each calendar year, the practice uploads the following documentation:
- Policies and procedures for providing all patients with education on the OMH practice and a copy of the educational materials used
- Documentation in all patients’ Electronic Health Record (EHR) indicating that OMH education was provided

During the on-site visit, the surveyor will discuss the processes for patient education and review the requested number of charts selected from all eligible patients to verify compliance with the standard.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills all of the compliance criteria:
   1. The practice establishes and implements policies and procedures on OMH education.
   2. The practice provides all patients with education on the OMH practice.

(5) Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 1.2: Patient financial counseling services are available within the Oncology Medical Home practice.

STANDARD DEFINITION AND REQUIREMENTS

Financial counseling assists patients with understanding and addressing financial concerns during cancer treatment and care. Counseling includes patient and caregiver education on financial responsibility and the availability of resources, if needed. The Practice Oversight Committee (POC) reviews the policies and procedures for financial services and monitors the available resources and funds for patients.

STANDARD SPECIFICATIONS

- Financial counseling services are available to all patients.
- Patients receive information about financial assistance programs.
- When available, medication assistance programs are shared with patients.
- Practice provides information about financial assistance from other sources.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:
- Policies and procedures for financial counseling services
- Current list of financial and medication-related assistance programs available to patients
- POC minutes documenting that the results of the annual financial assistance programs evaluation were presented and reviewed by the POC

During the on-site visit, the surveyor will discuss the financial counseling process and review reports of financial and medication-related assistance programs provided to patients.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills all of the compliance criteria:
   1. The practice establishes and implements policies and procedures to provide financial counseling services to all patients.
   2. The practice monitors the financial counseling services policies and procedures, including documentation of the amount of financial assistance provided to patients annually.
   3. An annual review of the financial counseling services policies and procedures is performed and policies are improved, as needed, by the POC.
   4. The discussion and findings of the annual review are documented in the POC minutes.

(5) Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 1.3: All patients are provided with education on their cancer diagnosis and an individualized treatment plan.

STANDARD DEFINITION AND REQUIREMENTS

Ongoing communication with patients and caregiver(s) is essential to keep patients engaged and informed about their cancer care. Practices must provide all patients with education and information regarding their disease and treatment plan. Indication that education and a treatment plan was provided is documented in the patients’ EHR. The POC develops and annually reviews the policies and procedures on new patient education.

STANDARD SPECIFICATIONS

The patient and caregiver(s) are educated and provided with a treatment plan prior to receiving cancer treatment. The education and treatment plan include, but are not limited to:

• Diagnosis
• Prognosis
• Intent of treatment (curative or palliative)
• Treatment recommendations
• Side effects
• Implications on quality of life
• Cancer-related resources and information

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the policies and procedures on patient and caregiver education pertaining to cancer-specific diagnosis and treatment, including:

• Example of cancer education material and treatment plans.
• Communication standards to ensure timely and comprehensive education to the patient and the caregiver(s).
• Patient call-back procedures, including adherence rates (for example, time call received and time call returned). Adherence rates are monitored annually.
• POC minutes documenting that the results of the annual evaluation were presented and reviewed by the POC.

During the on-site visit, the surveyor will discuss the processes for education and treatment planning, and review the requested number of charts selected from eligible patients to verify compliance for providing education and a treatment plan prior to receiving treatment.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills all of the compliance criteria:

1. The practice establishes and implements policies and procedures on patient education and treatment plans.
2. Provision of patient education and a treatment plan are documented in patients’ EHR.
3. An annual review of the policies and procedures to educate patients and provide an individualized treatment plan is performed; and processes are improved, as needed, by the POC.
4. The discussion and findings of the annual review are documented in the POC minutes.

(5) Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 1.4: The Oncology Medical Home practice provides a secure patient portal.

STANDARD DEFINITION AND REQUIREMENTS

Providing online resources for patients facilitates education, communication, and care coordination. Patients should have secure online access to their personal health information through a patient portal to help them understand and manage their disease and secure online access to their personal health information. Practices provide education to patients on how to access and use the patient portal.

Each calendar year, the POC will monitor and review usage of the patient portal system and facilitate discussion on improving functionality or increased usage by patients.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:

- Annual patient portal usage statistic report
- POC minutes documenting discussion on increasing patient portal usage and functionality

During the on-site visit, the surveyor will view a demonstration of the patient portal system.

RATING COMPLIANCE

1. Compliance: Each calendar year, the practice fulfills all of the compliance criteria:
   1. The practice provides all patients with access to a patient portal system.
   2. The POC monitors patient portal usage and functionality at least annually.
   3. The discussion and findings of the annual review are documented in the POC minutes.

5. Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 1.5: Oncology nursing care is provided by nurses with specialized knowledge and skills. Nursing competency is evaluated each calendar year.

STANDARD DEFINITION AND REQUIREMENTS

The treatment of cancer is a dynamic patient care process characterized by the continuous introduction of new cancer treatments, treatment protocols, and delivery methods. The evolving body of knowledge and inherent risks associated with cancer treatments require ongoing education and an evaluation process for oncology nurses.

Nursing Education

Oncology nursing education focuses on the knowledge base needed to administer cancer treatments in a safe and consistent manner and to care for patients with cancer across the continuum of care. Nursing education is provided through the Oncology Nursing Society (ONS) or Oncology Nursing Certification Corporation (ONCC). Educational courses provided by these organizations may include:

- ONS Cancer Basics Course
- ONS Chemotherapy Basics Course
- ONS/ONCC Chemotherapy Biotherapy Certificate Course
- ONS/ONCC Radiation Therapy Certificate Course

The nursing education focuses on the knowledge base needed to administer cancer treatments in a safe and consistent manner and to care for patients with cancer across the continuum of care. OMH practice support for oncology nursing continuing education is strongly encouraged.

Nursing Competency

Oncology nursing education and competency evaluations are required for all areas of the practice where cancer care is provided. Annual nursing competency evaluation of oncology knowledge and skills is completed and documented according to organizational policy, is approved by the POC, and is documented in the POC minutes.

Oncology nursing certification for all nurses providing oncology care is strongly encouraged. All nurses who administer chemotherapy to patients need documented certification of chemotherapy training.

Oncology nursing certifications include, but are not limited to:

- Oncology Certified Nurse (OCN®)
- Advanced Oncology Certified Nurse (AOCN®)
- Certified Pediatric Oncology Nurse (CPON®)
- Certified Pediatric Hematology Oncology Nurse (CPHON™)
- Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
- Advanced Oncology Certified Nurse Practitioner (AOCNP®)
- Certified Breast Care Nurse (CBCN™)

Each calendar year the credentials of oncology nursing personnel will be verified by nursing leadership, reported to the POC, and documented in the POC minutes.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:

- Oncology nursing competency policies or procedures
- POC minutes that document the committee’s review of the competency training results
During the on-site visit, the surveyor will discuss with the oncology nurse manager the availability of oncology nursing education curricula and review the organizational policies for evaluating nursing competency, including safe medication administration, and managing medication crisis (consistent with ONS guidelines).

**RATING COMPLIANCE**

(1) **Compliance:** Each calendar year, the practice fulfills all of the compliance criteria:
   1. Nurses with specialized oncology knowledge and skills are available at the practice.
   2. Organizational policies and procedures are in place to evaluate oncology nursing competency, including safe medication administration, utilization of nursing pathways followed, and managing medication crisis.
   3. Oncology nursing competency for all oncology nurses employed by the practice (including full-time and part-time) is evaluated each calendar year under the direction of the practice’s nursing leadership.
   4. Annual oncology nursing competency is reported to the POC and documented in the minutes.

(5) **Noncompliance:** The practice does not fulfill one or more of the compliance criteria each calendar year.
Chapter 2: Expanded Access

Standard 2.1: The Oncology Medical Home practice institutes expanded access and a triage system to ensure that patients can easily access the practice and their providers.

STANDARD DEFINITION AND REQUIREMENTS

The heart of the Oncology Medical Home (OMH) practice is patient accessibility when a medical problem arises that can be successfully and safely addressed in the physician’s office. OMH practices must ensure that new and established patients have access to their own physician(s) and care team when they require oncology-related care. The OMH practice establishes specific processes to expedite appointments for new patients, as medically required or requested. Urgent appointments must be made available at the practice.

OMH practices offer extended coverage or expanded access during morning, evening, and/or weekend hours so patients requiring care can be seen either at the practice or another location thus avoiding unnecessary emergency department (ED) visits.

A triage system is in place to support active symptom management of patients and is the command center of the OMH practice. Traditional triage systems where clinical staff may provide advice over the phone with the intention of keeping the patient home are replaced in the OMH model with a triage system that intends to bring patients into the office for active and effective early symptom management.

Policies and procedures are established to standardize the triage system management of walk-in patients. The patients are to be educated and repeatedly encouraged to contact the practice early to address symptoms that can be managed before the patient requires hospitalization or ED use.

Triage system infrastructure and policies to be formulated and reviewed by the POC must include, but are not limited to:

- Extended hours and weekend availability to manage patient issues and reduce ED visits and hospitalizations (weekend infusions, injections, extended practice hours, and on-call physician access)
- At least one oncologist on call over night and on weekends to manage emergencies
- Urgent and emergency patient access for new and established patients
- Availability to schedule same-day appointments for patients requiring urgent care
- Accommodation of walk-in patients
- Policy and procedures for direct admissions (bypassing the ED when medically appropriate)
- Specific policies and procedures that expedite appointments for new patients. These policies and procedures should include a provision for urgent scheduling of appointments based on medical need or patient anxiety

STANDARD EXCEPTIONS

Expanded Access: Some OMH practices may not find it financially feasible to offer extended office hours for a number of reasons, including small practice size, several oncology medical homes in local area leading to redundancy of infrastructure or rural populations that are unlikely to drive to a centralized clinic during evening hours. For this reason, the definition of extended hours is purposefully broad and could include weekend injection clinic, full extended practice hours or physician and staff on call and able to see patients presenting with medical problems in a lower-cost site of care compared with an ED.
DOCUMENTATION

The practice must complete all required fields in the OMH Survey Application Record (SAR).

Each calendar year, the practice uploads the following documentation:
- Triage system policies and procedures containing the minimum criteria listed above
- Policies and procedures regarding the availability and scheduling of same day appointments
- Log of ED visits of patients on active chemotherapy each calendar year
- Policies and procedures related to direct admissions
- Policies and procedures related to patient call-back policies; this policy should include a maximum call back time for urgent and non-urgent patients appropriate to the medical condition.

During the on-site visit, the surveyor will review the processes for new and established patient access to the OMH and their providers, and discuss patient access and the triage system with the Practice Oversight Committee (POC).

RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills all of the compliance criteria:
1. The practice has a triage system and processes for urgent (same-day) appointments for patients.
2. The POC performs an annual review of patient access and triage systems within the practice and documents the review in the minutes. The review must include the following:
   a. Availability of urgent (same-day) appointments
   b. Utilization of urgent (same-day) appointments
   c. Expanded weekend and evening access
   d. Number of annual ED visits of patients on active chemotherapy
3. The discussion and findings of the annual review are documented in the POC minutes.

(5) Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Chapter 3: Evidence Based Medicine

Standard 3.1: Evidence-based treatment guidelines and/or pathways are used for treatment planning.

STANDARD DEFINITION AND REQUIREMENTS

All patients are to be treated in accordance with principles of evidence-based medicine measured by the highest-quality data available. This requirement can be achieved by applying national, evidence-based clinical practice guidelines and/or pathways based on cancer stage, appropriate biomarkers, and patient performance status, as appropriate for individual clinical circumstances. Using and measuring care against evidence-based guidelines has been shown to improve care quality and outcomes while reducing overall cost of care due to reduction in variation.

Practices utilize scientifically validated, evidence-based guidelines and/or pathways for:
- Treatment planning
- Safe medication administration
- Appropriate utilization of resources, laboratory, and imaging studies

STANDARD EXCEPTIONS

- Documentation in the Electronic Health Record (EHR) that patient was offered guideline-adherent care but declined.
- The patient’s clinical circumstances (performance status, comorbidities) make guideline-adherent care inappropriate for the patient. Reason(s) for deviations from standard pathways and/or guidelines should be documented in the patient’s HER.
- The patient’s clinical circumstances are not included in the guidelines’ recommendations.

DOCUMENTATION

Each calendar year, the practice must complete all required fields in the OMH Survey Application Record (SAR).

Each calendar year, the practice uploads the following documentation:
- Policies and procedures on the utilization of treatment guidelines and/or pathways for patient care
- Policies and procedures of evidenced-based, appropriate resource utilization and compliance for:
  - Chemotherapy patients with moderate or high emesis risk receive anti-emetics
  - Chemotherapy patients with greater than 20 percent risk for neutropenia receive white blood cell growth factor
  - Minimizing advanced imaging in stage I or II breast cancer
- Policies and procedures for physician documentation standards requiring:
  - Staging completed and entered into an EHR-structured data field before initiation of treatment
  - Performance status evaluated and entered into an EHR structured data field before initiation of treatment

During the onsite visit, the surveyor reviews the requested number of charts selected from eligible treated patients to verify compliance of the standard.
RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills all of the compliance criteria:
   1. The practice establishes and implements policies and procedures on the utilization of treatment guidelines and/or pathways.
   2. Documentation in patients' EHR that treatment plans follow evidence-based nationally recognized guidelines and/or pathways.
   3. An annual review of treatment planning monitoring and EHR documentation is reported to the POC; and improved, as needed.
   4. The discussion and findings of the annual review are documented in the POC minutes.

(5) Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 3.2: Patients are provided clinical research study information by the Oncology Medical Home practice, and the required percentages of patients are accrued to clinical trials each calendar year.

STANDARD DEFINITION AND REQUIREMENTS

Clinical research advances science and ensures that patient care approaches the highest possible level of quality. Providing information about the availability of cancer-related clinical research studies offers patients the opportunity to enroll in treatment or observational research studies and trials. Policies and procedures outline the process of providing clinical research information and available studies that are open for enrollment.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads a copy of the most recent policies and procedures regarding availability of cancer-related research information for patients for on-site studies or studies by referral.

During the on-site visit, the surveyor discusses the process to provide cancer-related clinical research study information to patients.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the program fulfills the compliance criteria:

Each calendar year, the practice establishes and implements policies and procedures for providing cancer-related research information and availability to patients for on-site studies or studies by referral.
Standard 4.1: A medical oncologist directs the patient’s care team within the Oncology Medical Home practice and manages or co-manages the inpatient team-based care.

STANDARD DEFINITION AND REQUIREMENTS

Care coordination is an essential component of the Oncology Medical Home (OMH) model. A newly diagnosed cancer patient is often overwhelmed with tests, treatments, appointments, communications, and instructions between the various teams of providers who are entrusted with their care. Under the OMH model, the medical oncologist is responsible for the coordination of oncology care.

Oncology care is coordinated with the patient’s primary care provider (PCP) as well as outside agencies, such as, home care agencies, rehabilitation, and/or hospice. Communication processes through a patient’s lead medical oncologist are established to keep other providers informed of a mutual patient’s treatment plan and current status. The process is monitored and findings are reported to the Practice Oversight Committee (POC).

DOCUMENTATION

The practice must complete all required fields in the OMH Survey Application Record (SAR).

Each calendar year, the practice uploads the following documentation:

- Policies and procedures on medical oncologist-directed care, including:
  - Communication standards to ensure timely and comprehensive communications to referring physicians, PCPs, palliative care/symptom management, and hospice teams.
  - Process for timely ordering of tests and tracking results with communication to patients.
  - POC minutes documenting that the results of the annual evaluation of the policies and procedures that were presented and reviewed by the POC.

RATING COMPLIANCE

1. Compliance: Each calendar year, the practice fulfills all of the compliance criteria:
   1. The practice establishes and implements policies and procedures that demonstrate that medical oncology is responsible for the oncology care coordination for patients, including communication with referring physicians and primary care providers.
   2. The practice establishes and implements policies and procedures for timely ordering of tests and tracking results with communication to patients.
   3. An annual review of the policies and procedures is performed; and policies are improved, as needed, by the POC.
   4. The discussion and findings of the annual review are documented in the POC minutes.

5. Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 4.2: The Oncology Medical Home practice establishes relationships for effective communication with outside providers for the appropriate management of patient care.

STANDARD DEFINITION AND REQUIREMENTS

As a component of patient-centered care, the practice must coordinate effective communication and referrals to outside providers and ancillary services, as needed. This coordination includes, but is not limited to:

- Updating referring physicians and primary care providers
- Clear communication with consulting physicians and services
- Arrangement of needed ancillary services, such as home health, hospice, and outside testing services
- Expediting patient referrals to outside providers while monitoring the completion of and findings from the referrals

Additionally, policies and procedures are in place to ensure that the patients follow through with testing, referrals, and future appointments with physicians outside of the practice as well as monitoring incomplete referrals. Mechanisms are in place to retrieve the information from outside providers (tests, consults, documents, and so on) and communicate them to the appropriate provider in a timely manner.

As medically appropriate, the practice provides the following services on-site or by referral:

- Rehabilitation
- Nutritional support/counseling
- Surgical and radiation oncology
- Diagnostic imaging
- Laboratory studies
- Psychosocial evaluation and support
- Genetic counseling
- Palliative care/symptom management
- Home care

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice indicates the clinical and ancillary services that are available either on-site or by referral and uploads the policies and procedures for scheduling the on-site services or the referral process for outside services.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills all of the compliance criteria:

1. The practice establishes policies and procedures for referral or scheduling to diagnostic, treatment, supportive, and end-of-life care, as medically appropriate.
2. The practice establishes policies and procedures to ensure communication with physicians and care providers outside of the practice.
3. An annual review of the policies and procedures is performed; and policies are improved, as needed, by the POC.
4. The discussion and findings of the annual review are documented in the POC minutes.

(5) Noncompliance: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 4.3: The Oncology Medical Home practice shares diagnosis, treatment, and follow-up data on mutual patients with Commission on Cancer accredited cancer programs.

STANDARD DEFINITION AND REQUIREMENTS

As a requirement of Commission on Cancer (CoC) accreditation, all CoC accredited cancer programs must submit cancer registry data on all patients evaluated and/or treated in their facility annually to the National Cancer Data Base (NCDB). Collection of cancer patient data ensures evaluation of outcomes to improve cancer care. OMH practices that provide treatment and follow-up data to CoC-accredited cancer programs help improve the tracking of quality care provided to patients.

When requested, the OMH practice complies with a CoC-accredited hospital cancer registry data request for patient diagnosis, treatment, and follow-up data on mutual patients with CoC-accredited cancer programs.

Under the Health Insurance Portability and Accountability Act (HIPAA) Final Privacy Rule, private practice physicians may disclose patient-protected health information to the hospital for purposes of treatment, payment, and health care operations. A business associate agreement is not needed in this instance.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:
- Policies and procedures for sharing diagnosis, treatment, and follow-up data for mutual patients with CoC-accredited cancer programs
- List of CoC-accredited cancer programs where the majority of the practice's cancer patients are treated

During the on-site visit, the surveyor will discuss the data sharing process, timeliness for providing data, how and how often data is shared, and how the data sharing process is monitored.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills the compliance criteria:
- The practice establishes and implements policies and procedures to provide diagnosis, treatment, and follow-up data for mutual patients to CoC-accredited cancer programs as requested.

(5) Noncompliance: The practice does not fulfill the compliance criteria each calendar year.
Standard 4.4: All patients are provided on-site psychosocial distress screening and referral for the provision of psychosocial care, as needed.

STANDARD DEFINITION AND REQUIREMENTS

To address the psychosocial issues experienced by patients with cancer, the 2007 report of the Institute of Medicine (IOM), Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs, emphasizes the importance of screening patients for distress and psychosocial health needs as a critical first step to providing high-quality cancer care. In addition, this report emphasizes that all patients with cancer need to be referred for the appropriate provision of care and that high-quality psychosocial cancer care includes systematic follow-up and reevaluation.

Practices must develop a process to incorporate the screening of distress into the standard care of oncology patients. The process will identify psychological, social, financial and behavioral issues that may interfere with a patient’s treatment plan and adversely affect treatment outcomes. The process must provide the appropriate resources and/or referral to address the patients’ psychosocial needs. Distress should be recognized, monitored, and documented and treated at all stages of cancer.

PROCESS REQUIREMENTS

(a) **Timing of Screening:** All cancer patients must be screened for distress a minimum of one time during a pivotal medical visit as determined by the practice. The POC defines one or more medical visits that are part of a pivotal time for the distress screening process. Examples of a “pivotal medical visit” may include postsurgical visits, first visit with a medical oncologist to discuss chemotherapy, routine visit with a radiation oncologist, or a post-chemotherapy follow-up visit. Preference should be given at a pivotal medical visits when there are known times of greatest risk for distress, such as at the time of diagnosis, transitions during treatment (such as from chemotherapy to radiation therapy), and completion of treatment.

(b) **Method:** The mode of administration (i.e. patient questionnaire or clinician-administered questionnaire) is to be determined by the POC and may be tailored to the workflow of the practice. Medical staff, including medical assistants, nurses, and physicians must be trained to properly administer the screening tool.

(c) **Tools:** The POC selects and approves the screening tool to be administered to screen for current distress. Preference should be given to standardized, validated instruments or tools with established clinical cutoffs. The POC determines the cutoff score used to identify distressed patients.

Questionnaires or forms that are distributed or returned by mail and/or phone interviews without discussion at a medical visit do not meet the standard because this method does not allow for immediate attention for severe distress or suicidal ideation, if patient reported, and does not allow for active dialogue with the patient. Practices may have patients complete the distress screening tool through a patient portal or electronic screening method within 24 hours of the pivotal medical visit as long as the screening results are reviewed and discussed with the patient face-to-face at the visit.

(d) **Assessment and Referral:** The distressing screening results must be discussed with the patient at the medical visit. If there is clinical evidence of moderate or severe distress based on the results of the distress screening, a member of patient’s oncology team (physician, nurse, social worker, and/or psychologist) must identify and examine the psychological, behavioral, financial and/or social problems instigating the distress. This evaluation will confirm the presence of physical, psychological, social, spiritual, and financial support needs. The process developed by the POC includes the psychosocial services or resources available to patients on-site or by referral.
(e) **Documentation**: The screening process, timing of screening, identified tool, and distress level triggering a referral to services are documented in the POC minutes.

The distress screening(s) results, referral for provision of care, and any follow-up measures are documented in the patient medical record to facilitate integrated, high-quality care.

**DOCUMENTATION**

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:

- Policies and procedures that outline the process requirements for psychosocial distress screening and resulting interventions.
- POC minutes documenting the annual review and monitoring by the POC of the psychosocial distress screening policies and procedures each year.

During the on-site visit, the surveyor will review the requested number of charts selected to confirm the completion of psychosocial screenings and referral to services for interventions when necessary.

**RATING COMPLIANCE**

(1) **Compliance**: Each calendar year, the practice fulfills the compliance criteria:

1. The practice develops and implements a process to perform and monitor on-site psychosocial distress screening for all patients and has an established process for providing psychosocial care or the referral for the provision of psychosocial care for patients as identified by the screening that require assistance with psychosocial issues.
2. The process of psychosocial distress screening is reviewed, evaluated, and reported to the POC; processes are improved, as needed.
3. The discussion and findings of the annual review are documented in the POC minutes.

(5) **Noncompliance**: The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 4.5: The Oncology Medical Home practice develops and implements a process to disseminate a treatment summary and survivorship care plan to patients within 90 days of the completion of treatment.

STANDARD DEFINITION AND REQUIREMENTS

The 2005 Institute of Medicine report, *From Cancer Patient to Cancer Survivor*, outlines the importance of providing cancer survivors a comprehensive care summary and follow-up plan once they complete their primary cancer care that reflects the treatment they received and addresses post-treatment needs and follow-up care to improve health and quality of life.

The Survivorship Care Plan (SCP) is a record that summarizes and communicates what transpired during active cancer treatment, recommendations for follow-up care and surveillance testing/examination, referrals for support services the patient may need going forward, and other information pertinent to the survivor’s short- and long-term survivorship care.

Oncology Medical Home practices must develop and implement a process to monitor the dissemination of a SCP as a part of the standard care for all cancer patients who are treated with curative intent for initial cancer occurrence and who have completed active therapy (other than long-term hormonal therapy). If two different practices or facilities are providing treatment, both practices should work together to collaborate in providing a completed SCP. The practice providing follow-up and monitoring of the patient (i.e. medical oncology) should provide the SCP. In all cases, facilities and practices should work together to provide the information necessary for completion of a SCP that contains all required information.

The American Society of Clinical Oncology (ASCO) has defined the minimal data elements to be included in a treatment summary and survivorship care plan (Mayer DK, et al. American Society of Clinical Oncology Clinical Expert Statement on Cancer Survivorship Care Planning. *Journal of Oncology Practice*, 2014). This core set of data elements and templates are available on the ASCO website and in the References section of this manual. At a minimum, all SCPs should include ASCO-recommended elements to be included in the treatment summary and follow-up care plan to meet compliance for this standard.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:

- Policies and procedures for generating and providing a treatment summary and survivorship care plan for all eligible patients
- A sample treatment summary and survivorship care plan that contains the required data elements
- POC minutes that document the annual evaluation of the process and the outcomes of the evaluation

During the on-site visit, the surveyor will review the requested number of charts selected to confirm the provision of a treatment summary and survivorship care plan to patients within 90 days of the completion of treatment.

RATING COMPLIANCE

(1) **Compliance:** Each calendar year, the practice fulfills the compliance criteria:

1. The practice establishes and implements policies and procedures to generate and disseminate a treatment summary and survivorship care plan to patients within 90 days of completion of treatment.
2. Survivorship care plan processes are reviewed, evaluated, and reported to the POC; and processes are improved, as needed.
3. The discussion and findings of the annual review are documented in the POC minutes.

(5) **Noncompliance:** The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 5.1: The Oncology Medical Home practice records, reviews, and monitors completeness of clinical data for initiating quality improvement activities.

STANDARD DEFINITION AND REQUIREMENTS

Internal policies and procedures within the practice must identify for physicians and other clinicians the specific clinical data elements that must be captured within the Electronic Health Record (EHR). As a commitment to the process, practices must implement, maintain, and monitor EHR documentation to ensure the completeness of clinical data in searchable areas of the practice health data system(s).

Certain data elements are essential for data-driven, continuous quality improvement. Quality improvements are the actions taken and processes implemented to improve the documentation of the required clinical data elements. The methods used to monitor the EHR data and action plans to correct problematic findings are set by the Practice Oversight Committee (POC). The findings of the studies are documented in the POC minutes and shared with the staff at the practice.

DOCUMENTATION

The practice must complete all required fields in the Oncology Medical Home (OMH) Survey Application Record (SAR).

Each calendar year, the practice uploads the specific reporting requirements for clinical data needed for compliance monitoring and quality improvements, including but not limited to:

- Staging
- Performance status
- Molecular biomarker
- Treatment intent/type
- Other elements to be defined by the Commission on Cancer (CoC) to support OMH performance measures

During the on-site visit, the surveyor will review the requested number of charts selected to confirm the presence of the required clinical data elements and discuss the clinical data monitoring and outcomes with the POC.

RATING COMPLIANCE

(1) **Compliance:** Each calendar year, the practice fulfills all of the compliance criteria:
1. The practice establishes and implements policies and procedures on completeness of clinical data elements.
2. The required clinical data elements are recorded in patients’ EHR.
3. The POC actively monitors and corrects any identified missing required EHR clinical data elements as quality improvements.
4. The discussion and findings of the annual review are documented in the POC minutes.

(5) **Noncompliance:** The practice does not fulfill one or more of the compliance criteria each calendar year.
Standard 5.2: The Oncology Medical Home practice administers a patient satisfaction survey to cancer patients at least twice each calendar year. The results of the survey are analyzed and used to guide quality improvement activities.

STANDARD DEFINITION AND REQUIREMENTS

Patient satisfaction is an important component for measuring health care quality due to the impact on patient outcomes. Patients place a high value on the interaction and communication with their providers. In addition, the management of their issues, such as psychosocial distress, pain, and depression, improves patient satisfaction. Oncology Medical Home practices must administer patient satisfaction surveys using a validated, oncology-specific patient satisfaction tool that includes benchmarks.

Practices will evaluate and take actions to improve cancer patient satisfaction scores. The results of patient satisfaction surveys are reviewed by the practice and utilized for clinical and quality improvement activities. The practice documents its activities, improvements, and benchmarks in the POC minutes.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:
- Biannual patient satisfaction surveys with benchmarked results
- A copy of the validated oncology-specific patient satisfaction tool and benchmarks
- POC minutes that document the review of survey results and discussion of the quality improvement activities implemented to improve patient satisfaction

During the on-site visit, the surveyor reviews reports of the biannual patient satisfaction results and discusses the quality improvement activities by the POC.

RATING COMPLIANCE

(1) Compliance: Each calendar year, the practice fulfills all of the compliance criteria:
   1. The practice administers a patient satisfaction survey with documented benchmarks at least twice each calendar year.
   2. The practice reviews the survey results and implements quality improvements to increase patient satisfaction.
   3. The survey results, discussion, and quality improvement activities are documented in the POC minutes.
Standard 5.3: Each calendar year, the Oncology Medical Home Practice develops, analyzes, and documents at least one quality improvement study associated with improving clinical outcomes and implements at least one quality improvement based on study results.

STANDARD DEFINITION AND REQUIREMENTS

Annual evaluations and quality improvements provide a baseline to measure practice quality and an opportunity to correct or enhance care and outcomes. Quality improvement efforts focus on evaluating areas of cancer care and must include multidisciplinary representation from clinical, administrative, and patient perspectives.

Quality improvements are the actions taken, processes implemented, or services created to improve cancer care. The results of a cancer-related quality study provide a baseline to measure and improve quality.

The goal of quality improvement in health care is to improve the overall care and outcomes for patients and providers. Key performance measures for health care quality include:

• Safety and outcomes of care
• Timely and appropriate care
• Care provision is efficient and equitable
• Care is patient centered

Each calendar year, the POC develops, analyzes, and documents at least one quality improvement study associated with improving clinical outcomes and implements at least one quality improvement based on study results.

Study topics must be selected based on a problematic quality-related issue relevant to the practice and local cancer patient population, and is aimed at continuous quality improvement. For example:

• Demonstrated use of reporting/benchmarking within the Quality Oncology Patient Initiative or
• Meaningful quality improvement study with implementation of clinical improvement based on identified need for improvement in one or more of the OMH performance measures
• Quality studies can evaluate various spectrums of cancer care, including diagnosis, treatment, and supportive care of patients; within that spectrum can be issues related to structure, process, and outcomes

Each calendar year, at least one quality improvement is fully implemented as a result of data collected from a quality study as directed by the POC. The recommendations and improvements are reported to the POC and are documented in the POC minutes.

DOCUMENTATION

The practice must complete all required fields in the OMH SAR.

Each calendar year, the practice uploads the following documentation:

• Documentation of the completed quality study, including the methodology, summary, analysis, recommendations, and follow-up
• Documentation for the implementation of the quality improvement
• POC minutes that document the review of the quality study results and quality improvement implementation

During the on-site visit, the surveyor reviews reports of the quality study and improvement and the POC meeting minutes.
RATING COMPLIANCE

(1) **Compliance:** Each calendar year, the practice fulfills all of the following criteria:
   1. The practice develops and conducts at least one quality study associated with improving clinical outcomes.
   2. At least one measurable quality improvement in patient care is fully implemented.
   3. The results of the quality study and improvement are reviewed by the POC and documented in the meeting minutes.

(5) **Noncompliance:** The practice does not fulfill one or more of the compliance criteria each calendar year.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACoS</td>
<td>American College of Surgeons</td>
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<tr>
<td>ASCO</td>
<td>American Society of Clinical Oncology</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>CoC</td>
<td>Commission on Cancer</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
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<td>NCCN</td>
<td>National Comprehensive Cancer Network</td>
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<td>OMH</td>
<td>Oncology Medical Home</td>
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<td>ONS</td>
<td>Oncology Nursing Society</td>
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<td>PAR</td>
<td>Program Activity Record</td>
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<td>PCMH</td>
<td>Patient-Centered Medical Home</td>
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<td>Primary Care Physician</td>
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<td>Practice Oversight Committee</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<td>QOPI</td>
<td>Quality Oncology Patient Initiative</td>
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<tr>
<td>SAR</td>
<td>Survey Application Record</td>
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