Course Objectives

1. Discuss the current climate of policies and initiatives related to oncology rehabilitation.
2. Describe the alliance and joint programming between APTA, the Oncology Section, and the Commission on Cancer.
3. Identify the criteria outlined by CARF for Cancer Rehabilitation Specialty Programs.
4. Review the eligibility criteria for rehabilitation services as defined by the Commission on Cancer accreditation program.

Cancer Rehabilitation is different

- Globally unique
  - Multi-system involvement
  - Short term and late effects
  - Dynamic disease and treatment process
- High rehabilitation impact potential
  - Population incidence rates
  - Survivorship is increasing
  - Morbidity remains significant
  - Morbidity incurred is amenable to rehabilitation interventions
Cancer Rehabilitation Needs

- Rehabilitation delivery system designed around the cancer continuum
- Pathways for specialty workforce development
- Practice Guidelines
- Standardized clinical measurement tools
  - Screening tools
  - Outcomes measurement tools
- Research funding mechanisms
- Payment models that are aligned with the continuum of care

Environmental Analysis

Policy Drivers
- Institute of Medicine (IOM) Reports
- Agency for Health Care Research and Quality (AHRQ) technical report
  Themes:
  - Deficits in cancer care and recommended solutions
  - Patient engagement, patient centered care
  - Need for quality indicators and outcomes measurement
  - Suggestions for standards in clinical workflow and workforce skills

National Reports

- Institute of Medicine (IOM)
  - 2005 “From Cancer Patient to Cancer Survivor: Lost in Transition”
    - Describes the needs of cancer patients post treatment and deficits that exist in managing care
    - Heavy emphasis on identification of late effects
    - Started the ‘survivorship’ movement

- Institute of Medicine (IOM)
  - 2013 “Delivering Affordable Cancer Care in the 21st Century”
    - Dissemination of recommendations towards improving affordability and quality of cancer care.
    - Novel models of care delivery; medical centered home, bundled payment models
    - Quality indicators

Policy Matters to Cancer Rehabilitation

- Multiple levels of impact on clinical practice, payment and regulatory aspects of care
  - National reports: Institute of Medicine, AHRQ cancer survivorship
  - Accreditation standards: Commission on Cancer, CARF
  - Professional association initiatives: ASCO guidelines, Oncology Section of APTA Specialization, ACRM, NCCN guidelines
  - Regulatory initiatives: CMS functional limitation reporting, Meaningful use criteria, NIH funding

National Reports

- Institute of Medicine (IOM)
  - 2013 “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis”
    - Advocates for patient-centered care
    - Workforce recommendations- training and coordinated care efforts
National Reports

AHRQ 2013

- "Models of Survivorship Care: Technical Brief"
  - Survivorship care is highly-specific to the institution and 'usual care' does not exist
- Concerns raised regarding
  - Payment for care
  - Adequacy of training of health care providers
  - Greater rather than less fragmented care

- http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1440&pageaction=displayproduct

Environmental Analysis

Accreditation Drivers

- CARF Cancer Specialty Program Standards released in 2014
- Commission on Cancer (CoC) Accreditation Standards developed for rehabilitation requirements, deployed 2012, mandated for 2015

Themes:
- Patient engagement, patient centered care
- Need for quality indicators and outcomes measurement
- Movement towards standardized, evidence-based clinical practice
- Suggestions for standards in clinical workflow and workforce skills

Commission on the Accreditation of Rehabilitation Facilities (CARF)

- International Standards Advisory Board (2013)
  - Criteria for CARF accredited Cancer Rehabilitation Programs.
    - The cancer rehabilitation specialty program focuses on strategies to optimize outcomes from the time of diagnosis through the trajectory of cancer in an effort to prevent or minimize the impact of impairments, reduce activity limitations, and maximize participation for the persons served.
    - 35 Standards for programs to meet for accreditation
    - Roll out in 2014

Description of Cancer Rehabilitation Specialty Program

- Personnel demonstrate competencies and application of evidence based practices to deliver services that address:
  - Preventive
  - Restorative
  - Supportive
  - Palliative rehabilitation needs

For more information:

- http://www.carf.org/Programs/Medical/

Chris MacDonell
Medical Rehabilitation Director
CMacDonell@carf.org
Environmental Analysis

Professional Association Initiatives
- Delivery of care models – APTA, ACS, STAR, MOG, LAF
- Practice guidelines – ASCO, NCCN, ONS
- Survivorship care plans - LAF

Themes:
- Evidence for impairment management
- Screening for impairments throughout treatment and survivorship
- Streamlined, interdisciplinary care
- Need to develop workforce
- Lack of global outcomes measure
- Lack of screening tools for common late effects

Dietz Model – care delivery framework

Cancer Rehabilitation Model Across the Care Continuum

Professional Association Initiatives
- APTA Novel Models of Care for ACOs
  - Prospective Surveillance Model for Cancer Rehabilitation
    - Based on PSM research in breast cancer
    - Identifies an optimal role for PT along the cancer continuum: from Diagnosis through Survivorship

More on Prospective Surveillance
- APTA Video series on Emerging Models of Care
  http://www.apta.org/ACO/InnovativeModels/
- American Cancer Society – Supplement to Cancer April 6, 2012 "A Prospective Surveillance Model for Rehabilitation for Women with Breast Cancer.”
Integrated Models of Care

- The Oncology Rehab Partners STAR Program® Certification (Survivorship Training and Rehabilitation)
  - training, protocols and tools needed to deliver evidence-based cancer exercise and rehabilitation services. There are over 140 programs certified nationwide at over 400 facilities
- The Medically Oriented Gym (MOG)
  - specialty care programs for cancer survivors with exercise and physical activity engagement protocols using an interdisciplinary model of care, to create individualized fitness and wellness guidance in a community-based setting. The MOG cancer exercise programs are staffed with cancer exercise specialists and are located across 10 states in the US
- LIVESTRONG at the YMCA
  - Twelve-week, small group program designed for adult cancer survivors. Targets exercise and physical activity interventions

For more information:

- http://www.oncologyrehabpartners.com/star-certifications/star-program/
- http://www.livestrong.org/What-We-Do/Our-Actions/Programs-Partnerships/LIVESTRONG-at-the-YMCA
- http://themoggroup.com/

Professional Association Initiatives - Workforce

- Oncology Section of APTA Specialization
  - Goal of the initiative: Achieve ABPTS recognition as an area of PT specialty practice
  - Description of Advanced Practice
    - Knowledge areas
      - Ex: Histology and pathology of disease, medical interventions, physiology, hematology, blood chemistry
    - Professional roles, responsibilities and values
      - Ex: EBP, consultant role, professional org. participation
    - Practice expectations for the clinical specialist
      - Ex: tests and measures, communication, specialized interventions

Professional Association Initiatives - Practice Guidelines

- American Society of Clinical Oncology (ASCO)
  - Depression and Anxiety
  - Fatigue
  - Chemotherapy-induced neuropathy
- National Comprehensive Cancer Network (NCCN)
  - Fatigue guidelines
  - Survivorship guidelines
- American Cancer Society
  - Nutrition and physical activity guidelines
- American College of Sports Medicine
  - Exercise guidelines for the cancer survivor

Why Oncology Specialization?

- Goal: Provide a specialty care provider who is dedicated to the special needs of this population
- GOAL: Create and perpetuate a workforce of PT’s who are specialists in this domain and participate in development of the field through practice, education and research
Professional Association Initiatives – Interdisciplinary practice and research

- American Congress of Rehabilitation Medicine (ACRM) Cancer Rehabilitation Networking Group
  - Stood up in 2013
  - Over 150 members from 6 countries
  - Focus on collaboration for research and practice
  - Continuous track cancer rehabilitation programming in 2014 with over 14 lectures
  - October 2015 – Dallas Texas

National Institutes of Health: Initiative in Cancer Rehabilitation

- Lead by the Rehabilitation Medicine Department at the Clinical Center with collaboration of National Center for Medical Rehabilitation Research (NCMRR) and the National Cancer Institute (NCI)
- Subject Matter Expert interdisciplinary consortium has been created
- Nationally recognized experts in practice and research both internal and external to NIH

National Institutes of Health: Initiative in Cancer Rehabilitation

- 4 working groups have been created from the SME group
  1: Rehabilitation Clinical Models for Cancer Care
  2: Screening for impairment and toxicity that impact function across the continuum
  3: Functional outcomes measures
  4: Interdisciplinary integration of rehabilitation and shared decision making

Subject Matter Expert Consortium

- Dr. Andrea Cheville MD – Mayo Clinic – Rochester
- Dr. Michael Stubblefield MD – Kessler Institute for Rehabilitation
- Dr. Julie Silver MD – Harvard Medical School
- Dr. Vishwa Raj MD – Carolinas HealthCare System
- Dr. Lynn Gerber MD – George Mason University
- Dr. G. Steve Morris PT, PhD – Wingate University
- Dr. Kari Ness PT, PhD – St Jude Children’s Research Hospital
- Dr. Laura Gilchrist PT, PhD – St. Catherine University
- Dr. Tim Wolf OT, PhD – Washington University St. Louis
- Brad Baveman OT – MD Anderson Cancer Center
- Dr. Mary Radomski OT, PhD – Courage Kenny Rehabilitation Center
- Dr. Lee Jones PhD – Memorial Sloan Kettering Cancer Center
- Dr. Kerri Winters-Stone PhD – Oregon Health and Science University

National Institutes of Health: Initiative in Cancer Rehabilitation

- National Survey of Cancer Rehabilitation practice will be conducted in collaboration with ACRM
- Dissemination of Findings:
  - NIH/RMD Cancer Rehabilitation Symposium; June 2015
  - Publication(s) of findings
  - Collaboration with national associations
  - Seek inter-institute collaborations in cancer rehabilitation initiatives to promote extra-mural funding vehicles
NIH Initiative in Cancer Rehabilitation

SAVE THE DATE
June 8-9, 2015
Natcher Auditorium, NIH Campus
Bethesda, MD
FREE to attendees

Environmental Analysis

- Research
  - Measurement of outcomes
  - Quality indicators
  - Value of services

Themes:
- No standardized screening tools exist
- Outcomes are measured in disparate ways using a variety of disparate tools
- Clinically meaningful thresholds are unknown to gauge quality of care
- What is the value proposition of cancer rehab?

Value Proposition Road Map: Identification of Best Practices

Move from here...
- Creation of Best Practice Guidelines
- Identifying clinical models of care for intervention
- RCT's or cohort studies

...to here
- Promote high value, effective care delivery models
- Community-based/Home-based assessment tools
- Education models towards early identification and risk reduction
- Best practice condition management
- Data contributions to national registry for population data
- Use of valid outcomes measures

Value Proposition Road Map: Adoption of Best Practices

Move from here...
- Defining a standard of care
- Promulgating equivalency studies of treatment techniques

...to here
- Documenting clinical judgment
- Generating translational research evidence
- Comparative effectiveness studies

Value Proposition Road Map: Provider Performance Measurement

Move from here...
- Defining a level of education for providers
- Concern only with our 'episode of care'

...to here
- Participate in quality reporting mandates
- Adoption of Health IT
- Actively promote specialization standards in clinical practice
- Assess outcomes measures for their ability to distinguish quality between providers
- Understand how outcomes impact the totality of and individuals health
Value Proposition Road Map: Cost Effectiveness

Move from here… …to here
- Capturing direct costs
- Cost comparisons
- Identify meaningful outcomes and analyze the relationship between outcomes and cost
- Generate rehabilitation-centric cost effectiveness evidence

Value Proposition Road Map: Policy Development

Move from here… …to here
- Reacting to policy changes
- Provide data that drives change in policy
- Advocate as an individual using tools from your professional association
- Integrate cancer rehabilitation professionals on regulatory advisory boards

What is our Value Proposition?

To improve access to quality services and lower costs while requiring greater accountability on the part of all stakeholders within the health care system to provide cancer patients with optimal rehabilitation services.

- Stakeholder accountability to implement best practices
- Reducing variation in practice
- Improving the patient experience
- Reducing total cost
- Improving the health of the population

Thank You!

Questions?
Course Objectives

1. Discuss the current climate of policies and initiatives related to oncology rehabilitation.
2. Describe the alliance and joint programming between APTA, the Oncology Section, and the Commission on Cancer.
3. Review the eligibility criteria for rehabilitation services as defined by the Commission on Cancer accreditation program.
Commission on Cancer

Charles L. McGarvey PT MS DPT FAPTA
APTA and Oncology Section Representative
Commission on Cancer (CoC)
Chronology of Association

• December, 2012, Dr. Lisa VanHoose, President of the Oncology Section of the American Physical Therapy Association (APTA) contacted Dr. Charles L. McGarvey regarding his interest/consent to be considered as a nominee to serve as a representative of the APTA to the CoC.

• Dr. McGarvey consented to serve and the nomination was forwarded to the APTA.

• On April 1, 2013, Dr. Paul Rockar, President of the APTA informed Dr. Charles L. McGarvey that he had been selected to serve as the APTA’s nominee member organization representative to the CoC.

• Dr. McGarvey was informed on April 12, 2013 by the CoC of his election to serve as the APTA representative for a 3 year term effective 4/01/2013-10/01/2016.

• Dr. David P. Winchester MD FACS, Medical Director, Cancer Programs, American College of Surgeons (ACS) was identified as Dr. McGarvey’s mentor.

• Dr. McGarvey was appointed to serve on the CoC Accreditation Committee. The first meeting attended by Dr. McGarvey was the CoC Spring Meeting 2013.
Presentation Objectives

- Overview the purpose, objectives and structure of the CoC
- Describe the purpose and goals of the CoC.
- Provide a high-level overview of current CoC initiatives
- Identify future opportunities for APTA and Oncology Section
Commission on Cancer Mission

The 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.
CoC Objectives

- Establish standards to ensure quality, multidisciplinary, and comprehensive cancer care delivery in healthcare settings.
- Conduct surveys in healthcare settings to assess compliance with those standards.
- Collect standardized, high quality data from CoC-accredited healthcare settings to measure cancer care quality.
- Use data to monitor treatment patterns and outcomes and enhance cancer control and clinical surveillance activities.
- Develop effective educational interventions to improve cancer prevention, early detection, care delivery, and outcomes in healthcare settings.
## Commission on Cancer Membership

54 professional organization representatives

<table>
<thead>
<tr>
<th>Surgeons</th>
<th>Nurses</th>
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<tr>
<td>Radiologists/Oncologists</td>
<td>Social Workers</td>
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<td>Medical Oncologists</td>
<td>Administrators</td>
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<td>Cancer Registrars</td>
<td>Surveillance</td>
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<td>Hospice &amp; Palliative Care</td>
<td>Government</td>
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<td>Patient Advocacy Groups</td>
<td>Genetics</td>
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Accreditation Committee

*Chair* – Linda Ferris, PhD

*Staff Liaison* – Allison Knutson

- Establishes and reviews standards for quality cancer program management, services, and delivery of care
- Oversees accreditation surveys of cancer programs to assess and verify compliance with standards
- Promotes accreditation and recruitment of new cancer programs
- Oversees three subcommittees and one workgroup
New Accreditation Programs

• Oncology Medical Home Accreditation
  - First draft of Standards manual completed
  - Pilot surveys of 7 sites in 1st quarter of 2015

• Expansion of Pediatric Accreditation
  - Pediatric specific standards
  - Pediatric quality measures

• International accreditation
  - NAPBC has done their first international accreditation surveys
  - Significant interest in CoC accreditation in several countries

• Rectal Cancer accreditation program
  - Standards being developed
  - Will require CoC accreditation from participating facilities
Other Accreditation Committee Initiatives

• Standardized process to update standards each year

• Clarification and education to programs on Chapter 3 - Continuum of Care Standards
  - ACS Webinars
  - Special CoC source articles
CoC-Accredited Cancer Programs

Approximately 1500 CoC-accredited cancer programs in US and Puerto Rico
Benefits of CoC Accreditation

- Demonstrates commitment to high quality cancer care.
- Improved patient outcomes across all domains of cancer care.
- Dedicated resources to provide the screening, prevention treatment and support services.
- Use of NCDB applications to serve as the basis for quality improvement.
- Improved transparency and accountability.
What is the NCDB?

- A nationwide cancer treatment and outcomes database
- Represents patients treated at more than 1,500 CoC-accredited cancer programs
- Collects over a million new cancer cases annually
- Represents 71% of total cases in U.S.
- Data used to explore patterns and trends in cancer care and quality improvement opportunities
- Jointly supported by CoC and ACS
How Does NCDB Collect Its Data?

- From all CoC accredited hospital registries
  - Analytic cases: diagnosed, first course treatment in facility
  - Record care given elsewhere, annual follow-up
- Annual submission in January
  - Diagnosis year that ended full year prior (in January 2014, will collect 2012 diagnoses for the first time)
  - From program’s Reference Date forward, all newly-abstracted and updated cases
- Secure online transmission, automated processing
National Cancer Data Base Activities

- Maintain CoC Data Reporting Requirements – FORDS Manual
- Generate annual Call for Data from CoC-accredited cancer programs
- Provide access to Participant User Files (PUFs)
- Maintain reporting and quality improvement tools for use by CoC-accredited cancer programs
  - Hospital Comparison Benchmark Reports
  - Survival Reports
  - Cancer Program Practice Profile Reports (CP³R)
  - Rapid Quality Reporting System (RQRS)
- Conduct special studies and participate in collaborative research efforts
- Publish numerous research papers
National Cancer Data Base
Tools and Resources

- Hospital Comparison Benchmark Reports
- Survival Reports
- Cancer Program Practice Profile Reports (CP³R)
- Rapid Quality Reporting System (RQRS)
- CQIP
Rapid Quality Reporting System

- Promotes & facilitates evidence-based cancer care at CoC-accredited cancer programs in “real clinical time”
- Immediate case ascertainment
  - Case tracking
  - Ongoing reporting of quality metrics
  - Integration with survivorship plans and patient reported data
- Includes National Quality Forum-endorsed accountability and quality measures: 3 are for breast cancer, 2 colon cancer measures, and 1 surveillance measures - rectal
  - Planned expansion with additional QI measures for other cancer sites
Quality Integration Priorities

- NCDB Reporting Tools
  - Updated with 2011 data
  - Moving to common interface/look and feel in 2013
- Modernizing Facility Oncology Registry Data Standards (FORDS)
  - Over a decade old
  - Review of data items is due
- Harmonization of quality measures with other professional societies.
Quality Integration Priorities

• New measures to be introduced into CP³R and RQRS
  – 4 Non-small cell lung, 2 gastric, 1 esophageal, 1 revision of the rectal measure.
  – Need to move to other sites and other types of measures
    • Patient experience
    • Quality of life
    • Cost
• Continuation of the Cancer Quality Improvement Report (CQIP) with other disease sites highlighted.
Quality Integration Priorities

Participant Use File (PUF)

• >200 applications received in 2014
• New policies and procedures developed for PUF’s
• New round of applications open to all accredited programs in 2015 (may expand to biannual applications)
Current Commission on Cancer Initiatives

• Expand current and develop new Accreditation Programs
  • Pediatrics
  • Oncology Medical Home
  • International Accreditation
  • Rectal Cancer Accreditation Program
• Expand quality tools and measures
• Increase utilization of RQRS
• Public reporting of outcomes
• Expand collaboration with Alliance for Clinical Trials in Oncology
EXPANSION OF THE USE OF THE RAPID QUALITY REPORTING SYSTEM (RQRS)

“The future of cancer reporting”

New commendation standard for programs enrolling in RQRS

Over 1000 cancer programs now enrolled
Public Reporting / Transparency

- Central to quality care
- Consumers, payers, and regulators deserve and want transparency
- Affordable Care Act requires public reporting
- New commendation standard added for public reporting
- Exploring public reporting strategies
  - Pilot project with Pennsylvania Health Care Quality Alliance
Alliance for Clinical Trials in Oncology

• Merger of CALGB, NCCTG and ACOSOG
• American College of Surgeons Clinical Research Program (ACSCRP)
• Mission – To reduce the impact of cancer by...
  • Engaging a broad oncology community in cancer clinical trials
  • Reducing the time from trials reporting to practice implementation
  • Developing “best cancer practices” and standardize cancer practices
  • Creating novel programs of research in comparative effectiveness and emerging technologies
• Two PCORI Grants received to perform special studies with COC examining post-treatment surveillance in breast and colon cancer
Challenges Facing the CoC

Support for accredited programs

- CQIP; quality measures; best practices
- Program recruitment and retention
- Provide good customer service to our programs

Address concerns of stakeholders

- Need for transparency and reporting – biggest issue
- Meaningful quality measures

Enhance perception of public/payers/regulatory organizations of the value of accreditation
Meetings and Communications

• 2015 Meetings
  – CoC Committees and State Chair Meetings
    • May 7 – 9 – American College of Surgeons, Chicago, IL
    • Committee conference calls quarterly or as needed
  – CoC Annual Meeting and Cancer Liaison Physicians Meeting
    • October 3 – 4 during the American College of Surgeons Clinical Congress, Chicago, IL

• Communications
  – CoC Source email newsletter – distributed last day of each month
  – CoC Member Updates
  – Website – www.facs.org/quality-programs/cancer
The American College of Surgeons Cancer Programs benefit an array of health care professionals, patients, and facilities through standard-setting, accreditation, and educational activities. Representing leaders in cancer care and aiming to improve cancer patient care, our nationally recognized programs—the Commission on Cancer, the National Accreditation Program for Breast Centers, the National Cancer Data Base, the American Joint Committee on Cancer—all work toward helping your program provide high-quality cancer care.

We strive to develop the best educational resources, offer useful training opportunities, advocate for you and your patients, and stay up to date on the latest cancer care trends and treatments. Learn more about what we have to offer your cancer program and the patients you serve.
Potential Opportunities for the APTA and Oncology Section of the APTA:

• 1.) Webinar: Within the next 3 years, the APTA will have the opportunity to introduce and showcase the role of physical therapy in the assessment and treatment of patients with cancer.

• 2.) Cancer Care Initiatives: Each member organization is requested to participate in a survey which describes its mission goals and accomplishments. Done

• 3.) Article for the CoC newsletter: Member organizations are offered the opportunity to provide an article for the CoC newsletter which is sent out on-line to all (1500+) CoC accredited and participating organizations.

• 4.) CoC exhibition at professional conference: The CoC has resources to exhibit at professional conferences (i.e. Combined Sections and/or Annual Meetings)

• 5.) Press Release: The CoC has materials and resources in place to assist in any press releases as appropriate.
Potential Opportunities for the APTA and Oncology Section of the APTA:

6.) Platform and Poster presentation at CoC Spring meeting (2015 or 2016): Member organization are encouraged to present platform and poster presentations at the Spring CoC meeting. Done

7.) Cancer Quality Improvement Program (CQIP): Opportunity to identify clinical outcomes related to functional metrics which could be objectively measured and documented for accreditation.

8.) Cancer Program Standards (Currently 2014: Standard 3.3 Survivorship Care Plan) Opportunity to identify clinical outcomes related to functional metrics which could be objectively measured and documented for accreditation. (See handout)

9.) Patient Portal for Survivors: Opportunity to respond to patient queries related to questions of cancer treatment and intervention from a rehabilitation need or perspective.

10.) Payer Relations: Identification of the value of physical therapy and rehabilitation in the assessment and intervention of patients with cancer.
Potential Opportunities for the APTA and Oncology Section of the APTA:

11.) Government Relations: Opportunity to participate with the CoC in lobbying efforts through the organization One Voice Against Cancer. Opportunity to provide information or participation in meetings with CMS/NCI/VA/FDA.

12.) Clinical Trials: Opportunity to participate in clinical trials to assess function and quality of life issues related to the treatment of cancer patients.

13.) National Cancer Data Base (NCDB): Opportunity to participate in request for proposals to access the NCDB to conduct retrospective analysis of data compiled by the CoC and ACS. Access to data compiled by various quality measurement systems including: Quality Integration, C-QIPS, National Quality Forum (NQF), Cancer Practice Program Profile Reports (CP3R) and Rapid Quality Reporting System (RQRS).
Questions
Accreditation Committee Clarifications for
Standard 3.3 Survivorship Care Plan

This is the second in a series of two communications that addresses clarifications made by the CoC Accreditation Committee for the phase in standards in Chapter 3 of Cancer Program Standards, 2012: Ensuring Patient-Centered Care, v. 1.2.1. This communication addresses Standard 3.3 Survivorship Care Plan.

In late summer of 2013, the CoC Member Organizations conducted a readiness survey that asked CoC-accredited programs to report their implementation activities for Standards 3.1 Patient Navigation process, 3.2 Distress Screening, and 3.3 Survivorship Care Plan. The published implementation date for Standard 3.3 is January 1, 2015.

The survey results indicated that only 37 percent of responding cancer programs felt “completely confident” that their program would be able to implement Standard 3.3 by 2015; only 40 percent of respondents are addressing the entire Standard; of the 60 percent not addressing the entire standard help was needed in the following areas: information about how to evaluate survivorship care plan processes, tools that could be used for a comprehensive care plan and follow-up plan, additional information about what is required to successfully implement [the Standard], and recommendations for organizations that could help them implement the Standard. Furthermore, only 21 percent indicated that a survivorship care plan process has been developed. Finally, 63 percent believed that Standard 3.3 is the most difficult to implement, compared to Standard 3.1 and 3.2.

The Accreditation Committee is providing additional clarifications to assist with comprehension of Standard 3.3 in order to meet compliance.

1. Who is a cancer survivor?

The definition of “survivor” in the Institute of Medicine (IOM) Report, From Cancer Patient to Cancer Survivor: Lost in Transition, states that “[an] individual is considered a cancer survivor from the time of cancer diagnosis through the balance of his or her life, according to the National Coalition for Cancer Survivorship and the NCI Office of Cancer Survivorship”.

Standard 3.3, though, is focused on the subset of survivors who are treated with curative intent, and have completed active therapy (other than long-term hormonal therapy). This includes patients with cancer from all disease sites.

Patients with metastatic disease, though survivors by some definitions, are not targeted for delivery of comprehensive care summaries and follow-up plans under Standard 3.3.

2. What data elements are to be included in the treatment summary and survivorship care plan?

The standard requires that the survivors be “provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained” however, debate remains on what data fields should populate such a document.
The American Society of Clinical Oncology (ASCO) has concluded a process, with broad-based input from multiple stakeholders, including patients, that has defined what they believe are the minimal data elements to be included in a treatment summary and survivorship care plan. It is anticipated that this document will be published shortly.

The Accreditation Committee determined that the ASCO data set will be the minimal content for the treatment summary and survivorship care plans required by Standard 3.3. This does not preclude programs from adding additional data elements.

The core set of data elements, as recommended by ASCO, are:

**TREATMENT SUMMARY**

Contact information of the treating institutions and providers

Specific diagnosis (e.g. breast cancer), including histologic subtype (e.g. non-small cell lung cancer) when relevant

Stage of disease at diagnosis (e.g. I-III)

Surgery (yes/no). If yes,
   a. Surgical procedure with location on the body
   b. Date(s) of surgery (year required, month optional, day not required)

Chemotherapy (yes/no). If yes,
   a. Names of systemic therapy agents administered (listing individual names rather than regimens)
   b. End date(s) of chemotherapy treatment (year required, month optional, day not required)

Radiation (yes/no). If yes,
   c. Anatomical area treated by radiation
   d. End date(s) of radiation treatment (year required, month optional, day not required)

Ongoing toxicity or side-effects of all treatments received (including those from surgery, systemic therapy and/or radiation) at the completion of treatment. Any information concerning the likely course of recovery from these toxicities should also be covered.

For selected cancers, genetic/hereditary risk factor(s) or predisposing conditions and genetic testing results if performed

**FOLLOW-UP CARE PLAN**

Oncology team member contacts with location of the treatment facility [repeat if separate document]

Need for ongoing adjuvant therapy for cancer
   a. Adjuvant therapy name
b. Planned duration
c. Expected side effects

Schedule of follow up related clinical visits (to be presented in table format to include who will provide the follow-up visit and how often and where this will take place)

Cancer surveillance tests for recurrence (to be presented in table format to include who is responsible for ordering/carrying out the test, the frequency of testing, and where this will take place)

Cancer screening for early detection of new primaries – to be included only if different from the general population (presented in table format to include who is responsible for carrying out, the frequency of testing, and where this will take place)

Other periodic testing and examinations (rather than outlining specific testing, the group suggested an inclusion of a general statement to “continue all standard non-cancer related health care with your primary care provider, with the following exceptions: [if there are any]”)

Possible symptoms of cancer recurrence (rather than including a list of possible symptoms, the group suggested inclusion of a general statement, “Any new, unusual and/or persistent symptoms should be brought to the attention of your provider.”)

A list of likely or rare but clinically significant late- and/or long-term effects that a survivor may experience based on his or her individual diagnosis and treatment if known (including symptoms that may indicate the presence of such conditions).

A list of items (e.g. emotional or mental health, parenting, work/employment, financial issues, and insurance) should be covered with standard language stating that survivors have experienced issues in these areas and that the patient should speak with his or her oncologist and/or PCP if having related concerns. Include a list of local and national resources to assist the patient obtain proper services.

A general statement emphasizing the importance of healthy diet, exercise, smoking cessation and alcohol use reduction may be included. Statements may be tailored if particularly pertinent to the individual.

3. Which health care provider(s) should gather the requisite information and which health care provider(s) should deliver the information to the patient?

The verbiage in the Standard currently states, “A survivorship care plan is prepared by the principal provider(s) who coordinated the oncology treatment for the patient with input from the patient’s other care providers.”

It is well-recognized that models of health care delivery vary across the nation and often within institutions. In some instances, for example, programs have established APRN-led, multidisciplinary clinics to serve their cancer survivor cohorts. Although existing guidelines do not unequivocally endorse a singular “best practice” that would fit all programs, there appears to be consensus that the treating physician(s) is central to the process.
In the context of multidisciplinary care teams it would appear reasonable that the cancer committee develop a policy of identifying a physician team member or advanced practice partner (such as an APRN member of the treatment team) who would be responsible for discussing the care plan with a patient.

An overarching goal is to allow each cancer program some flexibility in the formulation and implementation of their own policies and procedures in this regard.

4. When is standard 3.3 to be implemented?

The Accreditation Committee made the following changes to the established time frame and scope of implementation for Standard 3.3.

January 1, 2015 – Implement a pilot survivorship care plan process involving 10% of eligible patients.
January 1, 2016 – Provide survivorship care plans to 25% of eligible patients.
January 1, 2017 – Provide survivorship care plans to 50% of eligible patients.
January 1, 2018 – Provide survivorship care plans to 75% of eligible patients.
January 1, 2019 – Provide survivorship care plans to all eligible patients.

During the implementation period, cancer programs should initially concentrate on their most common disease sites, such as breast, colorectal, prostate, early-stage bronchogenic, and lymphoma.

Cancer Programs that have fully implemented the Standard by the time of their on-site visit during the 2015, 2016, 2017 survey cycle, will receive special recognition in their Performance Reports at the time of their next survey.

Questions about this and other standards are to be submitted to the CAnswer Forum.

Linda W. Ferris, PhD
Chair, Accreditation Committee

Danny Takanishi, MD, FACS
Vice Chair, Accreditation Committee

Lawrence Shulman, MD, FACS
Chair, Quality Integration Committee
Member Organization Representative, American Society of Clinical Oncology (ASCO)
Preliminary ASCO Guidelines

Key Guideline Recommendations

For anxiety and depression:• All patients should be periodically evaluated for depression and anxiety symptoms using validated protocols. • Treatment of patients with depression or anxiety should be tailored based on severity of symptoms and history of depression. Follow-up of patients is crucial, as many symptomatic patients are less likely to comply with referrals and treatments. • Health care providers should be aware of their institutions’ resources for treatment of depression and anxiety and should have patients make use of supportive care services, including those that facilitate prevention and mitigation of symptoms.

For fatigue:• Regular screening is highly recommended, starting at the time of diagnosis and continuing after completion of primary treatments, at least annually and using semi-quantitative or quantitative measures. • Patients should be offered education and advice about managing fatigue following treatment. Maintaining adequate levels of physical activity are encouraged, particularly walking. • Other non-drug treatments such as psychosocial interventions and mind-body interventions (yoga, acupuncture) are encouraged. • Pharmacological interventions for post-treatment patients are not encouraged, as there is limited evidence that drugs are effective in reducing fatigue in those who have completed therapy and are currently disease-free.

For neuropathy:• Duloxetine is recommended for treatment of chemotherapy-induced peripheral neuropathy (CIPN). • No agents are recommended for prevention of CIPN during active chemotherapy treatment. • No strong clinical evidence for benefits from other agents such as tricyclic antidepressants, gabapentin, and topical gels containing baclofen, amitriptyline HCL, and ketamine are seen, but they may be tried in certain patients. –

See more at: http://www.cancernetwork.com/survivorship/asco-guidelines-address-key-symptoms-affecting-cancer-survivors?GUID=1D4F296F-E286-4763-89AF-925C6366D69B&rememberme=1&ts=01052014#sthash.ogQHHlwQ.dpuf
THE IMPACT OF NATIONAL MANDATES FOR ONCOLOGY REHABILITATION ON THE PROFESSION

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Indianapolis, IN

Course Objectives

1. Discuss the current climate of policies and initiatives related to oncology rehabilitation.
2. Describe the alliance and joint programming between APTA, the Oncology Section, and the Commission on Cancer.

How do these mandates affect the profession?

- Current Number of Physical Therapy (PTs) = 182,000
- APTA Membership = 52,152 APTA PTs, 122,448 Non-APTA PTs
- Oncology as Primary Clinical Focus (Membership Renewal) = 3.5% or 3,065, 3.5% or 4,286

How do these mandates affect me?

- Certification
  - Competency in a specific job role
  - Certification can be a component of specialization
- Specialization
  - Job role competency in a specific area
- Certification
  - STAR = Oncology Rehabilitation Partners
  - Certified Cancer Exercise Trainer = American College of Sports Medicine
  - Physiological Oncology Rehabilitation Institute (J. Osborne)
  - PINC or Steel
  - Rocky Mountain Cancer Rehabilitation Institute
- Specialization
  - American Physical Therapy Association Oncology Section
THE IMPACT OF NATIONAL MANDATES FOR ONCOLOGY REHABILITATION ON THE PROFESSION

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References