Crosswalk of the Commission on Cancer Optimal Resources for Cancer Care 2020
And the
CARF 2020 Medical Rehabilitation Standards

Commission on Cancer Optimal Resources for Cancer Care 2020 Standards	CARF 2020 Medical Rehabilitation Standards
1. Institutional Administrative Commitment	
1.1 Administrative Commitment	1.A.1. The organization identifies: a. Its leadership structure. b. The responsibilities of each level of leadership. 1.A.2. A person-centered philosophy: a. Is demonstrated by: (1) Leadership. (2) Personnel. b. Guides the service delivery. c. Is communicated to stakeholders in an understandable manner. 1.A.3. The identified leadership guides the following: a. Establishment of the: (1) Mission of the organization. (2) Direction of the organization. b. Promotion of value in the programs and services offered. c. Achievement of outcomes in the programs and services offered. d. Balancing the expectations of the persons served and other stakeholders. e. Financial solvency. f. Risk management. g. Ongoing performance improvement. h. Development of corporate responsibilities. i. Implementation of corporate responsibilities. j. Compliance with: (1) All legal requirements. (2) All regulatory requirements. k. Ongoing review of the organization's policies in accordance with organizational needs. l. Health and safety. m. Succession planning. n. Strategic planning. o. Technology planning.

	1.A.4. The leadership of the organization is accessible to: a. Persons served. b. Personnel. c. Other stakeholders. .
2. Program Scope and Governance	
2.1. Cancer Committee	2.B.9. The team: a. Is determined by: (1) The assessment. (2) The individual planning process. (3) The predicted outcomes of the person served. (4) The strategies utilized to achieve the outcomes predicted. b. Includes: (1) The person served. (2) Members of the family/support system, as appropriate. (3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas: (a) Behavior. (b) Cognition. (c) Communication. (d) Functional. (e) Medical. (f) Pain management. (g) Physical. (h) Psychological. (i) Recreation and leisure. (j) Social. (k) Spiritual. (l) Vocational. c. Provides services that address: (1) Impairments. (2) Activity limitations. (3) Participation restrictions. (4) Environmental needs. (5) The personal preferences of the person served.

	2.B.11. The medical director for the inpatient program: a. Is certified in his or her specialty area by a nationally recognized board. b. Demonstrates appropriate experience and training to provide rehabilitation physician services through one or more of the following: (1) A formal residency in physical medicine and rehabilitation. (2) A fellowship in rehabilitation for a minimum of one year. (3) A minimum of two years' experience as a collaborative team member providing rehabilitation services in an inpatient rehabilitation program. c. Maintains his or her: (1) Licensure. (2) Certification. (3) Privileges in the organization. d. Participates in active clinical practice that relates to the population served. e. Demonstrates currency in medical practice concerning the persons served. f. Demonstrates active learning and involvement in the professional community. 2.B.12. The medical director for the inpatient program: a. Has a written agreement with the organization that outlines his or her responsibilities. b. Actively participates in: (1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel. (2) The development of ongoing relationships with the medical community. (3) Educational activities with the program personnel. (4) The establishment of policies and written procedures that identify the functions and responsibilities of the rehabilitation physician. (5) Performance improvement activities.

(6) Advocacy activities.
(7) Program development and modification.
(8) Establishing the program's policies and procedures.
(9) Resource utilization management.
(10) Stakeholder relationship management.
(11) Marketing and promoting the program.
(12) Strategic planning.
(13) Financial planning and decision making.

2.B.13. For programs other than inpatient programs, ongoing medical input:

a. Is provided by a physician who:
(1) Is qualified by virtue of his or her training and experience in rehabilitation.
(2) Serves the program as at least one of the following:
(a) Medical director.
(b) Chair or member of a professional advisory committee.
(c) A consultant with a formal arrangement.
(d) Medical liaison.
(3) Participates in active clinical practice that relates to the population served.
(4) Demonstrates currency in medical practice concerning the persons served.
(5) Demonstrates active learning and involvement in the professional community.

b. Addresses, but is not limited to:
(1) Development of ongoing relationships with the medical community.
(2) Establishment of policies and written procedures that address health issues, including surveillance.
(3) Performance improvement activities.

4.D.5. The program demonstrates efforts to:

a. Influence outcomes for the persons served, including, but not limited to:
(1) Collaboration with acute and/or palliative services.
(2) Exchange of information on factors facilitating the achievement of optimal outcomes.

	(3) Exchange of information on barriers to the achievement of optimal outcomes. (4) Participating in and supporting evidence-based practice. (5) Participation in research, if applicable. (6) Participation as a team member with the acute providers, as feasible. (7) Collaboration with physicians on the selection and timing of medical interventions. b. Collaborate with primary care, palliative care, and specialty physicians after discharge. 4.D.6. For each person served, the cancer rehabilitation specialty program identifies: a. The physician(s) who is providing medical management for the person served. b. The rehabilitation professional who is providing rehabilitation management for the person served. c. Mechanisms for coordination, communication, and collaboration when these are not the same individuals.
2.2. Cancer Liaison Physician	2.B.11. The medical director for the inpatient program: a. Is certified in his or her specialty area by a nationally recognized board. b. Demonstrates appropriate experience and training to provide rehabilitation physician services through one or more of the following: (1) A formal residency in physical medicine and rehabilitation. (2) A fellowship in rehabilitation for a minimum of one year. (3) A minimum of two years' experience as a collaborative team member providing rehabilitation services in an inpatient rehabilitation program. c. Maintains his or her: (1) Licensure. (2) Certification. (3) Privileges in the organization. d. Participates in active clinical practice that relates to the population served.

e. Demonstrates currency in medical practice concerning the persons served.

f. Demonstrates active learning and involvement in the professional community.

2.B.12. The medical director for the inpatient program:

a. Has a written agreement with the organization that outlines his or her responsibilities.

b. Actively participates in:

(1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel.

(2) The development of ongoing relationships with the medical community.

(3) Educational activities with the program personnel.

(4) The establishment of policies and written procedures that identify the functions and responsibilities of the rehabilitation physician.

(5) Performance improvement activities.

(6) Advocacy activities.

(7) Program development and modification.

(8) Establishing the program's policies and procedures.

(9) Resource utilization management.

(10) Stakeholder relationship management.

(11) Marketing and promoting the program.

(12) Strategic planning.

(13) Financial planning and decision making.

2.B.13. For programs other than inpatient programs, ongoing medical input:

a. Is provided by a physician who:

(1) Is qualified by virtue of his or her training and experience in rehabilitation.

(2) Serves the program as at least one of the following:

(a) Medical director.

(b) Chair or member of a professional advisory committee.

(c) A consultant with a formal arrangement.

	(d) Medical liaison. (3) Participates in active clinical practice that relates to the population served. (4) Demonstrates currency in medical practice concerning the persons served. (5) Demonstrates active learning and involvement in the professional community. b. Addresses, but is not limited to: (1) Development of ongoing relationships with the medical community. (2) Establishment of policies and written procedures that address health issues, including surveillance. (3) Performance improvement activities. 3.A.3. The organization's privileging process defines: a. Which professionals require privileges to provide services in the comprehensive integrated inpatient rehabilitation program. b. Qualifications. c. Specific privileges granted. d. Specific responsibilities in accordance with the privileges granted. e. A system to monitor performance in executing the privileges granted. f. A system to address modification or withdrawal of privileges. g. A mechanism to demonstrate current competency relative to the privileges granted. h. A system to ensure that practice is consistent with the privileges granted.
2.3. Cancer Committee Meetings	
2.4. Cancer Committee Attendance	
2.5. Multidisciplinary Cancer Case Conference	2.B.9. The team: a. Is determined by: (1) The assessment. (2) The individual planning process. (3) The predicted outcomes of the person served. (4) The strategies utilized to achieve the outcomes predicted.

b. Includes:
    (1) The person served.
    (2) Members of the family/support system, as appropriate.
    (3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas:
        (a) Behavior.
        (b) Cognition.
        (c) Communication.
        (d) Functional.
        (e) Medical.
        (f) Pain management.
        (g) Physical.
        (h) Psychological.
        (i) Recreation and leisure.
        (j) Social.
        (k) Spiritual.
        (l) Vocational.
c. Provides services that address:
    (1) Impairments.
    (2) Activity limitations.
    (3) Participation restrictions.
    (4) Environmental needs.
    (5) The personal preferences of the person served.

2.B.10. To ensure the achievement of predicted outcomes, the person who coordinates the provision of care for each person served:
a. Demonstrates appropriate competencies as defined by the program.
b. Is identified to:
    (1) The person served.
    (2) The family/support system.
c. Has the authority to coordinate the provision of care.
d. Is knowledgeable about the rehabilitation program being provided to the person served.
e. Is available to interact with:
    (1) The person served.
    (2) The team of the person served.
    (3) The family/support system.
    (4) Other stakeholders.

f. Facilitates orientation for the person served that is appropriate to the services and the outcomes predicted.
g. Is responsible for ensuring communication with:
(1) External sources.
(2) Internal sources.
h. Brings forward to the team the available financial information to facilitate decision making about the following processes:
(1) Intake.
(2) Assessment.
(3) Service planning.
(4) Service provision.
(5) Discharge/transition planning.
(6) Long-term follow-up.
i. Facilitates the involvement of the person served throughout the rehabilitation process.
j. Facilitates the gathering of information to assist the organization in follow-up activities for its analysis of program performance.
k. Ensures that discharge/transition arrangements are completed.
l. Ensures that discharge/transition recommendations are communicated to appropriate stakeholders.
m. Facilitates the implementation of discharge/transition recommendations.

2.B.23. The team meets at a frequency appropriate to meet the needs of:
a. The persons served.
b. The program.
c. External stakeholders.

2.B.24. The program demonstrates that the persons served make measurable progress toward accomplishment of their predicted outcomes in accordance with predicted timeframes.

2.B.26. Family/support system conferences, if appropriate:
a. Are documented.
b. Are held at a frequency consistent with the needs of:
(1) The person served.
(2) The family/support system.
c. Are scheduled at a time that is convenient for:
(1) The person served.
(2) The family/support system.

	d. Include those team members who are necessary to communicate: (1) Diagnoses. (2) Impairments, activity limitations, participation restrictions, and environmental needs. (3) Results of treatment. (4) Recommendations for further care required. (5) Issues of importance to the family/support system.
3. Facilities and Equipment Resources	
3.1 Facility Accreditation	
3.2 Evaluation and Treatment Services	3.A.1. To facilitate the disclosure of accurate information, the comprehensive integrated inpatient rehabilitation program documents and shares information about its specific arrangements for: a. Medical services. b. Diagnostic imaging. c. Laboratory services. d. Pharmacy services. e. Including for each: (1) Availability on site. (2) Capacity. (3) Timeliness of response to orders. (4) Timeliness of results to the clinician who is making a decision based on those results. 4.D.12. Based on the individual needs of the persons served, the program provides or arranges for: a. Services to address identified needs in the following areas: (1) Behavioral. (2) Cognitive. (3) Communication. (4) Comorbid conditions. (5) Cultural. (6) Decision-making capacity. (7) Developmental. (8) Educational. (9) Functional. (10) Leisure/recreational activities. (11) Medical management.

	(12) Physical. (13) Psychological. (14) Sexual. (15) Social. (16) Spiritual. (17) Vocational. b. Health promotion. c. Services that prevent illness. 4.D.13. Based on the individual needs of the persons served, the cancer rehabilitation specialty program provides or arranges for resources, services, supports, and/or interventions: a. In the following areas: (1) Advocacy. (2) Communication. (3) Driving. (4) Falls. (5) Insight of the person served. (6) Leisure. (7) Life roles. (8) Nutrition. (9) Parenting skills. (10) Peer support. (11) Physical activity. (12) School continuance or re-entry. (13) Socialization. (14) Spouse/significant other relations. (15) Supervision needs. (16) Transportation needs. (17) Volunteerism. (18) Wellness. (19) Work continuance or re-entry. b. At each of the following times: (1) Beginning of services. (2) Appropriate intervals. (3) Discharge/transition.
4. Personnel and Services Resources	

4.1 Physician Credentials	1.I.10. As applicable, the organization demonstrates a process to address the provision of services by the workforce consistent with relevant: a. Regulatory requirements. b. Licensure requirements. c. Registration requirements. d. Certification requirements. e. Professional degrees. f. Training to maintain established competency levels. g. On-the-job training requirements. 3.A.3. The organization's privileging process defines: a. Which professionals require privileges to provide services in the comprehensive integrated inpatient rehabilitation program. b. Qualifications. c. Specific privileges granted. d. Specific responsibilities in accordance with the privileges granted. e. A system to monitor performance in executing the privileges granted. f. A system to address modification or withdrawal of privileges. g. A mechanism to demonstrate current competency relative to the privileges granted. h. A system to ensure that practice is consistent with the privileges granted.
4.2 Oncology Nursing Credentials	1.I.10. As applicable, the organization demonstrates a process to address the provision of services by the workforce consistent with relevant: a. Regulatory requirements. b. Licensure requirements. c. Registration requirements. d. Certification requirements. e. Professional degrees. f. Training to maintain established competency levels. g. On-the-job training requirements.

4.3 Cancer Registry Staff Credentials	1.I.10. As applicable, the organization demonstrates a process to address the provision of services by the workforce consistent with relevant: a. Regulatory requirements. b. Licensure requirements. c. Registration requirements. d. Certification requirements. e. Professional degrees. f. Training to maintain established competency levels. g. On-the-job training requirements.
4.4 Genetic Counseling and Risk Assessment	
4.5 Palliative Care Services Palliative care is integrated in the continuum of cancer care. Types of palliative care services include, but are not limited to: • Team-based care planning that involves the patient and family	2.B.9. The team: a. Is determined by: (1) The assessment. (2) The individual planning process. (3) The predicted outcomes of the person served. (4) The strategies utilized to achieve the outcomes predicted. b. Includes: (1) The person served. (2) Members of the family/support system, as appropriate. (3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas: (a) Behavior. (b) Cognition. (c) Communication. (d) Functional. (e) Medical. (f) Pain management. (g) Physical. (h) Psychological. (i) Recreation and leisure. (j) Social. (k) Spiritual. (l) Vocational.

c. Provides services that address:
(1) Impairments.
(2) Activity limitations.
(3) Participation restrictions.
(4) Environmental needs.
(5) The personal preferences of the person served.

2.B.10. To ensure the achievement of predicted outcomes, the person who coordinates the provision of care for each person served:

a. Demonstrates appropriate competencies as defined by the program.
b. Is identified to:
(1) The person served.
(2) The family/support system.
c. Has the authority to coordinate the provision of care.
d. Is knowledgeable about the rehabilitation program being provided to the person served.
e. Is available to interact with:
(1) The person served.
(2) The team of the person served.
(3) The family/support system.
(4) Other stakeholders.
f. Facilitates orientation for the person served that is appropriate to the services and the outcomes predicted.
g. Is responsible for ensuring communication with:
(1) External sources.
(2) Internal sources.
h. Brings forward to the team the available financial information to facilitate decision making about the following processes:
(1) Intake.
(2) Assessment.
(3) Service planning.
(4) Service provision.
(5) Discharge/transition planning.
(6) Long-term follow-up.
i. Facilitates the involvement of the person served throughout the rehabilitation process.
j. Facilitates the gathering of information to assist the organization in follow-up activities for its analysis of program performance.

• Pain and non-pain symptom management • Communication among patients, families and provider team members	k. Ensures that discharge/transition arrangements are completed. l. Ensures that discharge/transition recommendations are communicated to appropriate stakeholders. m. Facilitates the implementation of discharge/transition recommendations. 2.B.21. The program addresses the impact of the following areas on the rehabilitation process of each person served: a. Allergies. b. Current medications, including: (1) Medication sensitivities and adverse reactions. (2) Why each medication is prescribed. (3) Side effects. (4) Drug interactions. (5) Implications of abrupt discontinuation of medications. (6) Compliance. c. The etiology of the impairment. d. The results of relevant diagnostic interventions. e. The results of relevant therapeutic interventions. f. Comorbid conditions. g. Nutrition. h. Pain. i. Risk factors. j. Signs and symptoms of emergent medical conditions. 2.B.9. The team: b. Includes: (3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas: (f) Pain management. 2.B.16. Discharge/transition planning is done in collaboration with: a. The persons served. b. Families/support systems. c. Providers in the continuum of services. d. Other relevant stakeholders.

	2.B.18. When there is a change in the discharge/transition plan there is a mechanism to notify: a. The persons served. b. Their families/support systems. c. Other relevant stakeholders. 2.B.19. Decisions reflect the personal preferences of the person served and are: a. Made in collaboration with the persons served. b. Formulated with input from a variety of sources. c. Documented in the records of the persons served. 2.B.20. In order to communicate and facilitate an integrated approach, the interdisciplinary team, including team members working on all shifts and days, as well as the person served and his or her family/support system: a. Are: (1) Aware of the plan of care for the person served. (2) Implementing the plan of care for the person served. (3) Modifying the plan of care as the status of the person served changes. b. Participates in making interdisciplinary team decisions concerning the rehabilitation process for the person served. c. Ensures that decisions are communicated to the entire interdisciplinary team. d. Considers the impact of its decisions on: (1) The individual care plan of the person served. (2) The entire interdisciplinary team. (3) The family/support system. 2.B.25. The interdisciplinary team involves and considers the family/support system, as appropriate, as a partner throughout the rehabilitation process through the following: a. Ongoing assessments that consider: (1) The family/support system's: (a) Ability and willingness to support and participate in the plan. (b) Composition. (c) Communication. (d) Contingency plans for care. (e) Coping.

(f) Expectations of the program.
(g) Expectations regarding transition of the person served to other components of the continuum of services or the discharge location.
(h) Educational needs.
(i) Insight.
(j) Interpersonal dynamics.
(k) Learning style.
(l) Problem solving.
(m) Responsibilities.

(2) Cultural, financial, literacy, or social factors that might influence the program.

(3) The health status of the primary caregiver.

b. The provision or arrangement of services for each family/support system, as needed, including:

(1) Advocacy education.
(2) Assistive technology.
(3) Counseling/support services.
(4) Education.
(5) Reasonable accommodations.
(6) Respite.
(7) Support, including:
(a) Spouse-to-spouse interactions.
(b) Family-to-family interactions.

2.B.26. Family/support system conferences, if appropriate:

a. Are documented.

b. Are held at a frequency consistent with the needs of:

(1) The person served.
(2) The family/support system.

c. Are scheduled at a time that is convenient for:

(1) The person served.
(2) The family/support system.

d. Include those team members who are necessary to communicate:

(1) Diagnoses.
(2) Impairments, activity limitations, participation restrictions, and environmental needs.
(3) Results of treatment.
(4) Recommendations for further care required.

(5) Issues of importance to the family/support system.

2.B.29. The program fosters a continuous learning environment:

a. By providing educational opportunities for:
   (1) The persons served.
   (2) Families/support systems.
b. That recognizes and respects individual:
   (1) Learning styles.
   (2) Needs.
   (3) Strengths.
   (4) Preferences.
c. That assesses the effectiveness of the education provided.
d. That addresses performance improvement, as needed.

2.B.30. Depending upon individual needs, the program provides education and training to each person served that addresses:

a. Prevention related to:
   (1) Recurrence of the impairment, injury, or illness.
   (2) Potential risks and complications due to impairment.
b. Primary healthcare.
c. Utilization of healthcare resources.
d. Health promotion.
e. The skill sets necessary to be successful in the discharge/ transition environment for:
   (1) The persons served.
   (2) Their families/support systems.
f. A mechanism to demonstrate the skills achieved prior to discharge/transition by:
   (1) The person served.
   (2) The family/support system.
g. Transition to other components of the continuum of services or discharge location.

2.B.32. The program provides education on medication, as appropriate:

a. To:
   (1) The persons served.
   (2) Their families/support systems.
b. That addresses:
   (1) Actions to take in case of an emergency.
   (2) Administration.

	(3) Dispensing. (4) Errors. (5) Identification, including why each medication is prescribed. (6) Implications for management of multiple medications. (7) Implications of abrupt discontinuation. (8) Indications and contraindications. (9) Obtaining medication. (10) Side effects. (11) Storage. (12) Understanding of the education provided. 4.D.2. The program facilitates collaboration with the person served and family/support system in decision making through the following: a. Accessible information. b. Timing for provision and exchange of information. c. Identification of their understanding of the rehabilitation process. 4.D.9. In accordance with the preference of the person served, the person's primary care physician, oncologist, and/or specialty physician is informed of the status of the person served at the time of: a. Initial assessment. b. Significant changes. c. Discharge/transition. 4.D.10. Prior to the implementation of specific rehabilitation treatments, personnel: a. Provide the rationale for those treatments to the: (1) Person served. (2) Family/support system. b. Provide options, as appropriate, based on the feedback received. 4.D.15. On an ongoing basis, the program addresses for each person served, the impact of behavior, cognition, communication, medical, and sensory deficits on the following areas: a. Physical function. b. Psychological function. c. Social function. d. Vocational function. e. Ability to learn.

• Education about illness and prognosis • Assistance with medical decision making	f. Family dynamics. g. Participation. 4.D.16. On an ongoing basis, the program addresses the impact of cancer on the family/support system of the person served, including, but not limited to his or her: a. Children. b. Siblings. c. Spouse/significant other. d. Parents. e. Other members of the support system. 4.D.21. The cancer rehabilitation specialty program demonstrates how education for the persons served and families/support systems: a. Is coordinated. b. Is reinforced: (1) Throughout the rehabilitation process. (2) Among members of the interdisciplinary team. c. Is age appropriate. d. Is culturally appropriate. e. Fosters self-management. f. Addresses, as appropriate to the needs of each person served and family/support system: (1) Physical effects of cancer and its treatment. (2) Psychological/emotional effects of cancer and its treatment. (3) Social effects of cancer and its treatment. (4) Utilization of equipment. (5) Health behaviors.
• Continuity of care across a range of clinical settings and services	4.D.23. To promote seamless service delivery for the persons served: a. The cancer rehabilitation specialty program proactively coordinates, facilitates, and advocates for appropriate transitions. b. Discharge/transition planning addresses: (1) Expectations of the: (a) Person served. (b) Family/support system. (c) Relevant stakeholders.

• Attention to spiritual needs	(2) The environment of the next component of the continuum of services or discharge location, including: (a) Facilitating factors. (b) Barriers. (3) The understanding of the family/support system regarding the current status of the person served. (4) Aging with disability. (5) Life routines and participation. (6) Contingency plans. (7) Self-advocacy. (8) Capability of the family/support system. (9) Financial resources. (10) Access to healthcare. (11) Transportation. (12) Emergency preparedness. (13) Identification of resources in the community that are or will be involved with the person served. (14) Mechanisms for coordination with other resources. (15) A follow-up plan for each person served. (16) Follow-up services, including services for persons who leave the program's geographic service area. (17) Designation of the individual(s) who will be responsible for coordination of the follow-up plan of the person served. 4.D.12. Based on the individual needs of the persons served, the program provides or arranges for: a. Services to address identified needs in the following areas: (1) Behavioral. (2) Cognitive. (3) Communication. (4) Comorbid conditions. (5) Cultural. (6) Decision-making capacity. (7) Developmental. (8) Educational.

• Psychosocial support for patients and families	(9) Functional. (10) Leisure/recreational activities. (11) Medical management. (12) Physical. (13) Psychological. (14) Sexual. (15) Social. (16) Spiritual. (17) Vocational. b. Health promotion. c. Services that prevent illness. 2.B.25. The interdisciplinary team involves and considers the family/support system, as appropriate, as a partner throughout the rehabilitation process through the following: a. Ongoing assessments that consider: (1) The family/support system's: (a) Ability and willingness to support and participate in the plan. (b) Composition. (c) Communication. (d) Contingency plans for care. (e) Coping. (f) Expectations of the program. (g) Expectations regarding transition of the person served to other components of the continuum of services or the discharge location. (h) Educational needs. (i) Insight. (j) Interpersonal dynamics. (k) Learning style. (l) Problem solving. (m) Responsibilities. (2) Cultural, financial, literacy, or social factors that might influence the program. (3) The health status of the primary caregiver.

• Bereavement support for families and care team members	b. The provision or arrangement of services for each family/support system, as needed, including: (1) Advocacy education. (2) Assistive technology. (3) Counseling/support services. (4) Education. (5) Reasonable accommodations. (6) Respite. (7) Support, including: (a) Spouse-to-spouse interactions. (b) Family-to-family interactions. 4.D.19. The program: a. Gives opportunities for expression of final wishes concerning end of life to: (1) The persons served. (2) Families/support systems. b. Honors wishes concerning end-of-life issues. c. Provides education, if needed, regarding end-of-life choices. d. Facilitates access to related services, as appropriate. 4.D.20. When a person served dies, opportunities are provided: a. To: (1) Other persons served. (2) The family/support system. (3) Personnel. b. To express grief and remembrance. c. To develop and participate in: (1) Memorial services. (2) Memorial rituals. (3) Other forms of grief expression.
4.6 Rehabilitation Care Services	
Policies and procedures are in place to guide referral to appropriate rehabilitation care services on-site or by referral. Rehabilitation care is patient-centered care that optimizes patient functional status and quality of life through preventive, restorative, supportive and palliative interventions. The availability of rehabilitation care services is an essential component of comprehensive cancer care, beginning at the time of diagnosis and being continuously available throughout treatment, surveillance, and, when applicable, through end of life.	Description A person-centered cancer rehabilitation specialty program utilizes a holistic interdisciplinary team approach to address the unique rehabilitation needs of persons who have been diagnosed with cancer. A cancer rehabilitation specialty program may be provided in a variety of settings, including hospitals, healthcare systems, outpatient clinics, or community-based programs. Personnel demonstrate competencies and

	the application of evidence-based practices to deliver services that address the preventive, restorative, supportive, and palliative rehabilitation needs of the persons served. Cancer rehabilitation is an integral component of quality cancer care. 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. The program communicates and collaborates with healthcare providers to deliver coordinated care and promote seamless transitions in care. The program is guided by the individual preferences, strengths, and needs of the persons served and their families/support systems. A cancer rehabilitation specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles. The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons who have been diagnosed with cancer. Through the use of performance indicators the program measures the effectiveness of services across the continuum offered. A cancer rehabilitation specialty program advocates on behalf of persons who have been diagnosed with cancer to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A cancer rehabilitation specialty program translates current research evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in cancer research.
Rehabilitation professionals associated with cancer rehabilitation typically include, but are not limited to: • Physiatrists • Physical therapists • Occupational therapists • Speech language pathologist	2.B.9. The team: a. Is determined by: (1) The assessment. (2) The individual planning process. (3) The predicted outcomes of the person served. (4) The strategies utilized to achieve the outcomes predicted.

	b. Includes: (1) The person served. (2) Members of the family/support system, as appropriate. (3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas: (a) Behavior. (b) Cognition. (c) Communication. (d) Functional. (e) Medical. (f) Pain management. (g) Physical. (h) Psychological. (i) Recreation and leisure. (j) Social. (k) Spiritual. (l) Vocational. c. Provides services that address: (1) Impairments. (2) Activity limitations. (3) Participation restrictions. (4) Environmental needs. (5) The personal preferences of the person served.
Types of rehabilitative care services may include, but are not limited to: • Screening, diagnosis, and management physical dysfunction, impairments and disabilities • Interventions to manage identified functional impairments and disabilities • Screening, diagnosis, and management of pain and non-pain symptoms • Screening diagnosis, and management of cognitive function • Lymphedema management • Physical activity recommendations during and after treatment • Vocational rehabilitation	4.D.12. Based on the individual needs of the persons served, the program provides or arranges for: a. Services to address identified needs in the following areas: (1) Behavioral. (2) Cognitive. (3) Communication. (4) Comorbid conditions. (5) Cultural. (6) Decision-making capacity. (7) Developmental. (8) Educational. (9) Functional.

	(10) Leisure/recreational activities. (11) Medical management. (12) Physical. (13) Psychological. (14) Sexual. (15) Social. (16) Spiritual. (17) Vocational. b. Health promotion. c. Services that prevent illness. 4.D.13. Based on the individual needs of the persons served, the cancer rehabilitation specialty program provides or arranges for resources, services, supports, and/or interventions: a. In the following areas: (1) Advocacy. (2) Communication. (3) Driving. (4) Falls. (5) Insight of the person served. (6) Leisure. (7) Life roles. (8) Nutrition. (9) Parenting skills. (10) Peer support. (11) Physical activity. (12) School continuance or re-entry. (13) Socialization. (14) Spouse/significant other relations. (15) Supervision needs. (16) Transportation needs. (17) Volunteerism. (18) Wellness. (19) Work continuance or re-entry. b. At each of the following times: (1) Beginning of services. (2) Appropriate intervals. (3) Discharge/transition.

	4.D.14. In response to the preferences of the person served, the cancer rehabilitation specialty program: a. Assesses the person's use of complementary health approaches. b. Educates the person served on the efficacy and safety of interventions. c. Provides information and resources on integrative health, as appropriate. 4.D.15. On an ongoing basis, the program addresses for each person served, the impact of behavior, cognition, communication, medical, and sensory deficits on the following areas: a. Physical function. b. Psychological function. c. Social function. d. Vocational function. e. Ability to learn. f. Family dynamics. g. Participation. 4.D.18. Wellness for the persons served is promoted through activities that: a. Are based on input from the persons served. b. Consider input from families/support systems. c. Consider prior level of fitness of the persons served. d. Provide for daily structured and unstructured activities. e. Promote healthy behavior. f. Reflect their choices. g. Align with their cognitive capabilities. h. Align with their communication capabilities. i. Align with their physical capabilities. j. Promote their personal growth. k. Promote self-responsibility. l. Enhance their self-image. m. Improve or maintain their functional levels. n. Allow for social interaction. o. Allow for autonomy. p. Include opportunities for community inclusion. q. Are documented in the individual plan for each person served.

4.7 Oncology Nutrition Services	2.B.9. The team: a. Is determined by: (1) The assessment. (2) The individual planning process. (3) The predicted outcomes of the person served. (4) The strategies utilized to achieve the outcomes predicted. b. Includes: (1) The person served. (2) Members of the family/support system, as appropriate. (3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas: (a) Behavior. (b) Cognition. (c) Communication. (d) Functional. (e) Medical. (f) Pain management. (g) Physical. (h) Psychological. (i) Recreation and leisure. (j) Social. (k) Spiritual. (l) Vocational. c. Provides services that address: (1) Impairments. (2) Activity limitations. (3) Participation restrictions. (4) Environmental needs. (5) The personal preferences of the person served.

4.8 Survivorship Programs	4.D.23. To promote seamless service delivery for the persons served: a. The cancer rehabilitation specialty program proactively coordinates, facilitates, and advocates for appropriate transitions. b. Discharge/transition planning addresses: (1) Expectations of the: (a) Person served. (b) Family/support system. (c) Relevant stakeholders. (2) The environment of the next component of the continuum of services or discharge location, including: (a) Facilitating factors. (b) Barriers. (3) The understanding of the family/support system regarding the current status of the person served. (4) Aging with disability. (5) Life routines and participation. (6) Contingency plans. (7) Self-advocacy. (8) Capability of the family/support system. (9) Financial resources. (10) Access to healthcare. (11) Transportation. (12) Emergency preparedness. (13) Identification of resources in the community that are or will be involved with the person served. (14) Mechanisms for coordination with other resources. (15) A follow-up plan for each person served. (16) Follow-up services, including services for persons who leave the program's geographic service area. (17) Designation of the individual(s) who will be responsible for coordination of the follow-up plan of the person served.
5. Patient Care: Expectations and Protocols	
5.1 College of American Pathologists Synoptic Reporting	

5.2 Psychosocial Distress Screening	
5.3 Breast Sentinel Node Biopsy	
5.4 Breast Axillary Dissection	
5.5 Primary Cutaneous Melanoma	
5.6 Colon Resection	
5.7 Total Mesorectal Excision	
5.8 Pulmonary Resection	
6. Data Surveillance and Systems	
6.1 Cancer Registry Quality Control	
6.2 Data Submission	
6.3 Data Accuracy	
6.4 Rapid Quality Reporting System Participation	
6.5 Follow-Up of Patients	4.D.23. To promote seamless service delivery for the persons served: b. Discharge/transition planning addresses: (2) The environment of the next component of the continuum of services or discharge location, including: (a) Facilitating factors. (b) Barriers. (15) A follow-up plan for each person served. (16) Follow-up services, including services for persons who leave the program's geographic service area. (17) Designation of the individual(s) who will be responsible for coordination of the follow-up plan of the person served. 1.M.3. The organization implements a performance measurement and management plan that: a. Addresses: (3) The collection of data about the persons served at: (d) Point(s) in time following services.
7. Quality Improvement	
7.1 Accountability and Quality Improvement Measures	1.M.1. The leadership demonstrates accountability for performance measurement and management in: a. Service delivery. b. Business functions.

	1.M.2. The organization identifies gaps and opportunities in preparation for the development or review of a performance measurement and management plan, including consideration of: a. Input from: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. The characteristics of the persons served. c. Expected results. d. Extenuating and influencing factors that may impact results. e. The comparative data available. f. Communication of performance information. g. Technology to support implementation of the performance measurement and management plan. 1.M.3. The organization implements a performance measurement and management plan that: a. Addresses: (1) Collection of relevant data on the characteristics of the persons served. (2) For each program/service seeking accreditation, identification of measures for service delivery objectives, including, at a minimum: (a) Results achieved for the persons served (effectiveness). (b) Experience of services received and other feedback from the persons served. (c) Experience of services and other feedback from other stakeholders. (d) Resources used to achieve results for the persons served (efficiency). (e) Service access. (3) The collection of data about the persons served at: (a) The beginning of services. (b) Appropriate intervals during services. (c) The end of services. (d) Point(s) in time following services. (4) Identification of priority measures determined by the organization for business function objectives.

	(5) The extent to which the data collected measure what they are intended to measure (validity). (6) The process for obtaining data: (a) In a consistent manner (reliability). (b) That will be complete. (c) That will be accurate. (7) Extenuating and influencing factors that may impact results. (8) Timeframes for the: (a) Analysis of data. (b) Communication of results. (9) How: (a) Data are collected. (b) Data are analyzed. (c) Performance improvement plans are developed. (d) Performance improvement plans are implemented. (e) Performance information is communicated. b. Is reviewed at least annually for relevance. c. Is updated as needed. 1.M.4. To measure its results achieved for the persons served (effectiveness), each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

	1.M.5. To measure experience of services received and other feedback from the persons served, each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.6. To measure experience of services and other feedback from other stakeholders, each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.7. To measure the resources used to achieve results for the persons served (efficiency), each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom or what the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected.

	(4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.8. To measure service access, each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom or what the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.9. To measure its business function, the organization documents: a. Objectives in priority areas determined by the organization. b. For each objective, a performance indicator(s), including: (1) To what the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or that is based on an industry benchmark. 1.M.10. Personnel are provided with documented education and training in accordance with their roles and responsibilities for performance measurement and management.

	1.N.1. The analysis of service delivery performance: a. Is documented. b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan. c. Addresses service delivery indicators for each program/service seeking accreditation, including, at a minimum: (1) Results achieved for the persons served (effectiveness). (2) Experience of services received and other feedback from the persons served. (3) Experience of services and other feedback from other stakeholders. (4) Resources used to achieve results for the persons served (efficiency). (5) Service access. d. Incorporates the: (1) Characteristics of the persons served. (2) Impact of extenuating or influencing factors. e. Includes: (1) Comparative analysis. (2) Identification of trends. (3) Identification of causes. f. Is used to: (1) Identify areas needing performance improvement. (2) Develop an action plan(s) to address the improvements needed. (3) Implement the action plan(s). (4) Determine whether the actions taken accomplished the intended results. 1.N.2. The analysis of business function performance: a. Is documented. b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan. c. Addresses priority business function indicators determined by the organization. d. Incorporates the:

	(1) Characteristics of the persons served, if applicable. (2) Impact of extenuating or influencing factors. e. Includes: (1) Comparative analysis. (2) Identification of trends. (3) Identification of causes. f. Is used to: (1) Identify areas needing performance improvement. (2) Develop an action plan(s) to address the improvements needed. (3) Implement the action plan(s). (4) Determine whether the actions taken accomplished the intended results. 1.N.3. The results of performance analysis are used to: a. Improve the quality of programs and services. b. Facilitate organizational decision making regarding: (1) Service delivery. (2) Business functions. c. Guide changes to the performance measurement and management plan. 1.N.4. In accordance with the performance measurement and management plan, the organization communicates accurate performance information: a. To: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. According to the needs of the specific group, including: (1) Content. (2) Format. (3) Timing.
7.2 Monitoring Concordance with Evidence-Based Guidelines	1.A.8. Leadership provides resources and education for personnel to stay current in the field in order to demonstrate program strategies and interventions that are based on accepted practices in the field and current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

	2.A.5. Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus. 4.D.3. The program demonstrates knowledge and application of evidence-based practices in the field of cancer rehabilitation.
7.3 Quality Improvement Initiative	1.M.1. The leadership demonstrates accountability for performance measurement and management in: a. Service delivery. b. Business functions. 1.M.2. The organization identifies gaps and opportunities in preparation for the development or review of a performance measurement and management plan, including consideration of: a. Input from: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. The characteristics of the persons served. c. Expected results. d. Extenuating and influencing factors that may impact results. e. The comparative data available. f. Communication of performance information. g. Technology to support implementation of the performance measurement and management plan. 1.M.3. The organization implements a performance measurement and management plan that: a. Addresses: (1) Collection of relevant data on the characteristics of the persons served. (2) For each program/service seeking accreditation, identification of measures for service delivery objectives, including, at a minimum: (a) Results achieved for the persons served (effectiveness). (b) Experience of services received and other feedback from the persons served. (c) Experience of services and other feedback from other stakeholders.

	(d) Resources used to achieve results for the persons served (efficiency). (e) Service access. (3) The collection of data about the persons served at: (a) The beginning of services. (b) Appropriate intervals during services. (c) The end of services. (d) Point(s) in time following services. (4) Identification of priority measures determined by the organization for business function objectives. (5) The extent to which the data collected measure what they are intended to measure (validity). (6) The process for obtaining data: (a) In a consistent manner (reliability). (b) That will be complete. (c) That will be accurate. (7) Extenuating and influencing factors that may impact results. (8) Timeframes for the: (a) Analysis of data. (b) Communication of results. (9) How: (a) Data are collected. (b) Data are analyzed. (c) Performance improvement plans are developed. (d) Performance improvement plans are implemented. (e) Performance information is communicated. b. Is reviewed at least annually for relevance. c. Is updated as needed.

	1.M.4. To measure its results achieved for the persons served (effectiveness), each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.5. To measure experience of services received and other feedback from the persons served, each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.6. To measure experience of services and other feedback from other stakeholders, each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected.

	(4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.7. To measure the resources used to achieve results for the persons served (efficiency), each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom or what the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark. 1.M.8. To measure service access, each program/service seeking accreditation documents: a. An objective(s). b. A performance indicator(s), including: (1) To whom or what the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

	1.M.9. To measure its business function, the organization documents: a. Objectives in priority areas determined by the organization. b. For each objective, a performance indicator(s), including: (1) To what the indicator(s) will be applied. (2) The person(s)/position(s) responsible for collecting the data. (3) The source(s) from which data will be collected. (4) Identification of relevant timeframes for collection of data. (5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or that is based on an industry benchmark. 1.M.10. Personnel are provided with documented education and training in accordance with their roles and responsibilities for performance measurement and management. 1.N.1. The analysis of service delivery performance: a. Is documented. b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan. c. Addresses service delivery indicators for each program/service seeking accreditation, including, at a minimum: (1) Results achieved for the persons served (effectiveness). (2) Experience of services received and other feedback from the persons served. (3) Experience of services and other feedback from other stakeholders. (4) Resources used to achieve results for the persons served (efficiency). (5) Service access. d. Incorporates the: (1) Characteristics of the persons served. (2) Impact of extenuating or influencing factors. e. Includes: (1) Comparative analysis. (2) Identification of trends.

	(3) Identification of causes. f. Is used to: (1) Identify areas needing performance improvement. (2) Develop an action plan(s) to address the improvements needed. (3) Implement the action plan(s). (4) Determine whether the actions taken accomplished the intended results. 1.N.2. The analysis of business function performance: a. Is documented. b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan. c. Addresses priority business function indicators determined by the organization. d. Incorporates the: (1) Characteristics of the persons served, if applicable. (2) Impact of extenuating or influencing factors. e. Includes: (1) Comparative analysis. (2) Identification of trends. (3) Identification of causes. f. Is used to: (1) Identify areas needing performance improvement. (2) Develop an action plan(s) to address the improvements needed. (3) Implement the action plan(s). (4) Determine whether the actions taken accomplished the intended results. 1.N.3. The results of performance analysis are used to: a. Improve the quality of programs and services. b. Facilitate organizational decision making regarding: (1) Service delivery. (2) Business functions. c. Guide changes to the performance measurement and management plan.

	1.N.4. In accordance with the performance measurement and management plan, the organization communicates accurate performance information: a. To: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. According to the needs of the specific group, including: (1) Content. (2) Format. (3) Timing.
7.4 Cancer Program Goal	
8. Education: Professional and Community Outreach	
8.1 Addressing Barriers to Care	1.L.1. The organization's leadership: a. Assesses the accessibility needs of the: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. Implements an ongoing process for identification of barriers in the following areas: (1) Architecture. (2) Environment. (3) Attitudes. (4) Finances. (5) Employment. (6) Communication. (7) Technology. (8) Transportation. (9) Community integration, when appropriate. (10) Any other barrier identified by the: (a) Persons served. (b) Personnel. (c) Other stakeholders.

8.2. Cancer Prevention Event	4.D.27. Within its scope of practice and expertise, the cancer rehabilitation specialty program acts as a resource to providers from acute through community-based services regarding: a. Evidence-based practice. b. Development of service models and programs for persons served. c. Outreach and support. d. Training of personnel in cancer rehabilitation. 4.D.29. To advance the field of cancer rehabilitation, leadership supports: a. Outreach and education initiatives promoting integration of cancer rehabilitation services. b. The program's participation in research opportunities. c. The provision of information: (1) To persons served. (2) To families/support systems. (3) About available: (a) Research opportunities. (b) Clinical trials.
8.3 Cancer Screening Event	
9. Research	
9.1 Clinical Research Accrual	4.D.29. To advance the field of cancer rehabilitation, leadership supports: a. Outreach and education initiatives promoting integration of cancer rehabilitation services. b. The program's participation in research opportunities. c. The provision of information: (1) To persons served. (2) To families/support systems. (3) About available: (a) Research opportunities. (b) Clinical trials.
9.2 Commission on Cancer Special Studies	