ASCO® Standards

Telehealth in Oncology: ASCO Standards and Practice Recommendations

Patient Selection and Implementation of Telehealth in Oncology

Standard 1.1. Where appropriate infrastructure and personnel are available, ***telehealth via telephone or videoconferencing***, delivered by certified health professionals participating in routine maintenance of certification activities, is a reasonable option for:

Treatment or long-term management:

- New patient consultations; these may be followed by face to face visits;
- Medication prescribing and management;[1]
- Pre-chemotherapy or other pre-therapy evaluations;
- Acute care issues that could be addressable via routine outpatient care rather than ED visits and admissions;
- Discussion of results, such as lab and imaging studies;
- Supportive care visits including financial, social work, nutrition visits;
- Oral drug compliance and adherence evaluations;
- Distress screening and interventions;
- Chronic care management;
- Patient education on chemotherapy and other treatments;
- Counseling;
- Management of long-term treatment; [1]
- Post-discharge coordination, supported by remote-monitoring capabilities; [1]
- Routine follow-up;
- Survivorship visits;
- Wellness interventions;[1]
- Palliative care, including hospice consults and follow up visits;
- Advance care planning visits.

Other:

- When care access issues exist;
- Consent form discussions pre-research trials prior to signatures;
- Family conferences for when multiple family members would like to join and patient desires;
- Genetic counseling visits and evaluations;
- Second opinion evaluations to facilitate treatment in a timely manner.

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In-person consultations may be preferred by clinicians and or patients for: • Initial consultations; • Initial delivery of antineoplastic treatment;[2] • Delivery of key information, including new cancer diagnosis/treatment plan, disease relapse/progression, and no further cancer treatment decisions;[1] • Complex cancer needs as identified by the health care provider;[1] • Physical examination for diagnosis or follow-up, however where the necessary infrastructure is in place, physical examinations may be performed by local health professionals during a teleconsultation or findings from an examination may be summarized in a referral communication to a specialist prior to the telehealth appointment.[2,3] In addition, some components of the physical examination may be achieved through telehealth. • Patients with hearing, vision, or cognition limitations for which there are no alternative support or technologies available to assist in telehealth encounters; • Patients with inadequate broadband, limited technological capacity, or lower levels of health literacy.
Qualifying statements: • *An assessment of patients' technological capacity to engage in telehealth interventions, e.g., sufficient internet bandwidth, should be conducted, and support may be provided for patients who report technology limitations.[4] A more detailed review of barriers to equal access to telehealth is included in the Discussion section.* • *Where possible, patients may be given the option of in-person or telehealth visits, according to personal preference.*
Standard 1.2. Diagnosis via asynchronous transmission of images: • Skin lesions can be evaluated with sufficient diagnostic accuracy through the asynchronous transmission of images, which may facilitate more timely diagnosis.[2]
Standard 1.3. Practices should develop policies and procedures that outline preferred frequency of telehealth vs. in-person visits during the cancer care continuum, and consider patient preferences. Frequency of telehealth vs. in-person visits may evolve as outcome/impact data become available.
Standard 1.4. All clinical visits conducted via telehealth should be documented, including, but not limited to the following information: • Has the patient agreed to the telehealth visit? (yes/no); • Date of visit; • Location of the visit (health provider office/other location); • Participants attending the visit; • Location of the patient and other caregivers present (home/other location); • Type of visit (audio only/audio and video); • Was the telehealth visit completed? (yes/no);
Standard 1.5. Prior to participation in telehealth visits, individualized orientation should be provided to patients and health care professionals for the specific type of technology that will be used to deliver the intervention (e.g., mobile phone, web-based, etc.) on topics including but not limited to instructions to access the platform, navigation of the platform, provider specific instructions on the video if needed to physically assess an area of the body. *Note: While orientation is required, there is no formal telehealth certification required on the part of health care professionals prior to engaging in telehealth clinical visits with patients. The Expert Panel does not suggest or endorse formal certification for telehealth competencies.*

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Standard 1.6. For clinical visits conducted via synchronous videoconferencing, a staff member or external technology support person should be available to troubleshoot technology issues, potentially via telephone, and to facilitate workflow.
Qualifying statements: • *A support person should be available to oncologists or other health care professionals in a ratio that allows for quick access to support for each telehealth encounter.* • *Practices should offer a videoconferencing practice session with each patient to test technical equipment at the beginning of the initial remote clinical visit.*
Standard 1.7. Practices should evaluate key performance indicators for oncology telehealth initiatives and quality of care.
Qualifying statement: • *The Future Research section notes significant gaps in published research related to telehealth in oncology, therefore, efforts should be made to publish the results of these evaluations in peer-reviewed journals whenever possible.*
Standard 1.8. For interventions delivered asynchronously, e.g., online patient symptom reporting systems, standard operating procedures should be in place that outline appropriate and timely responses to patient-reported outcomes.
Standard 1.9. In order to optimize adherence to and minimize discontinuation of treatment regimens, asynchronously delivered interventions, such as automated reminders delivered via text message, should be tailored to the individual patient.
Qualifying statement: • *Reading, healthcare, and technological literacy level of participants should be considered when tailoring the intervention to the individual patient.*
Standard 1.10. Where possible, patients and caregivers should be involved in user testing of new interventions (e.g. apps).[5]
Establishment of the Doctor-Patient Relationship
Standard 2.1. State and federal policies permitting telemedicine to cross state lines should include a provision requiring that the doctor-patient relationship be established prior to provision of any telemedicine service.[6]
Qualifying statements: • *The doctor-patient relationship should mandatorily include the usual follow up and physician responsibilities in caring for the patient, including delivering care consistent with community standards.* • *The establishment of the doctor-patient relationship should include the opportunity for in-person visits at the physical location of the physician practice, when necessary.*
Advanced Practice Providers
Standard 3.1. Practices should develop standards, algorithms, or policies that govern when patients may see an advanced practice provider or require a physician telehealth visit based on disease, treatment or decision inflection points.
Qualifying statement: • *Practices should review state and/or local regulations for supervision of APPs, including regulatory requirements for how APPs and physicians form teams.*

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Allied Health Professionals
Standard 4.1. The ASCO Telehealth Standards Expert Panel endorses the recommendations from the COSA Tele-oncology Guidelines.[2] These recommendations are reproduced subsequently: 1. Telephone-based support systems are feasible and can help facilitate changed behaviors (e.g., diet, exercise), improved function (e.g., fitness, health related function), and improved psychological/psychosocial states. 2. Computerized screening/assessment is feasible and can be used as a model of care to collect information on patient status and assist referral to allied health oncology services. 3. Hybrid tele-practice systems can offer alternative models of care for the provision of allied health education and support to oncology patients. 4. Videoconferencing services can be used to deliver allied health assessment and treatment services for oncology patients.
Virtual Multidisciplinary Cancer Conferences

Standard 5.1. Where appropriate technology and supports are in place, such as those outlined below, virtual multidisciplinary cancer conferences via videoconferencing are recommended.
The Expert Panel endorses the following recommendations from Dharmarajan et al[7] for implementation of a virtual MCC meeting:
• Agenda and cases to be discussed should be finalized at least a day in advance.
• Participants must have access to secure videoconferencing software.
• It may be necessary to allow more time than would be needed for in-person meetings.
• Prioritize more advanced or complicated cases earlier in the meeting as they may take more time and members are more likely to be available.
• Documentation of discussion must be systematic, included in patient's electronic medical record (EMR), and be accessible to members who could not make the call.
• Consider including assessments and evaluations of the multidisciplinary team (MDT) using a validated tool, such as the Cancer Multidisciplinary Team Meeting Observational Tool (MDT-MOT).[8]
• In addition, the ASCO Expert Panel recommends:
    ○ That decisions regarding maximum number of participants be left to the discretion of local institutions; and
    ○ That the discussion be directed by the individual who is responsible for presenting the case.

Qualifying statement: Similar to face-to-face MCC discussions, follow the institution guidelines for documentation of discussion. The ASCO Expert Panel does not recommend recording of the MCC or tumor board discussion without prior legal review.

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Tele-trials and/or Virtual Participation in Oncology Clinical Trials

Standard 6.1. Tele-trials and/or virtual participation in oncology clinical trials are recommended as a method of increasing recruitment and reducing the burden of trial participation on patients.

- To facilitate the conduct of tele-trials, the following are recommended:
  - Virtual initial discussion of trial and eligibility assessment
  - Incorporating remote methods of reviewing symptoms and adverse events, such as patient portals, e-email, telephone, and video;[9]
  - Remote study initiation and monitoring from sponsors and contract research organizations;[10]
  - Shipping oral drugs directly to patients with a follow up call to ensure the delivery and integrity of the agents and patient comprehension of the dosing schedule;[10]
  - Increasing support for secure virtual platforms;[11]
  - Allowing laboratory e.g., blood tests and biopsies to be conducted at a site that is local to the trials participant; [11]
  - Reconsidering the necessity of frequent testing, including imaging; [11]
  - Increasing the use of patient-reported outcomes as study outcomes.[11]

Qualifying statements:

- *This recommendation applies beyond the timeframe of the period of restrictions necessitated by the COVID-4 pandemic.*
- *Consider a hub and spoke model to improve participation among rural and remote populations (see: Australasian Tele-trial Model).[8]*

References

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