Survivorship Care Plan Management
Leveraging Resources To Meet The Standard

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Welcome

Thank you for joining us today for our webinar.

The CoC Standard 3.3- Survivorship Care Plan, has presented challenges to many cancer programs.

Onco Inc will present current information and suggestions to assist you in meeting these challenges.
Goals For Today

Present potential processes and solutions for managing the Survivorship Care Plan standard

Identify ways to leverage your EMR, cancer registry and navigation databases to meet standard 3.3

Present case studies from cancer programs that have implemented processes and are currently meeting the standard

Review the most relevant challenges and frequently asked questions about this standard
We welcome your comments and will take questions or comments at the end of the presentation.

Your experience as patient navigators, cancer registrars, managers and administrators will contribute to building a valuable network to share ideas and information.

“A rising tide raises all ships.”
Where It All Began
The Institute of Medicine report in 2006- *From Cancer Patient To Cancer Survivor: Lost In Transition*


Define quality health care for cancer survivors and identify strategies to achieve it.

Improve the quality of life of cancer survivors through policies to ensure their access to psychosocial services, fair employment practices, and health insurance.

Report focuses on survivors of adult cancer during the phase of care that follows primary treatment.

*From Cancer Patient To Cancer Survivor: Lost In Transition. Executive Summary, Institute of Medicine, 2006.*
Institute of Medicine Report 2006
From Cancer Patient To Cancer Survivor: Lost In Transition

• The transition from active treatment to post-treatment care is critical to long-term health.

• If care is not planned and coordinated, cancer survivors are left without knowledge of their heightened risks and a follow-up plan of action.

• Such a plan is essential so that routine follow-up visits become opportunities to promote a healthy lifestyle, check for cancer recurrence, and manage lasting effects of the cancer experience.

• Recommendations of the elements to be included in the SCP came from the 2006 IOM report.
The IOM Report Recognized This Fact

“Because cancer is a complex disease and its management involves the expertise of many specialists, often practicing in different settings, cancer illustrates well the “quality chasm” that exists within the U.S. health care system.”

From Cancer Patient To Cancer Survivor: Lost In Transition. Executive Summary, Institute of Medicine, 2006.
Barriers facing cancer survivors and their providers in achieving quality survivorship care include

- fragmented and poorly coordinated cancer care system
- the absence of a locus of responsibility for follow-up care
- poor mechanisms for communication
- a lack of guidance on the specific tests, examinations, and advice that make up survivorship care
- inadequate reimbursement from insurers for some aspects of care
- limited experience on the best way to deliver care

From Cancer Patient To Cancer Survivor: Lost In Transition. Executive Summary, Institute of Medicine, 2006.
IOM Report Opened The Door

- National Coalition for Cancer Survivorship
- Lance Armstrong Foundation
- American Society of Clinical Oncologists (ASCO)
- National Cancer Institute (NCI)
- American College of Surgeons Commission on Cancer (CoC)
- NCCN
LIVESTRONG™ Survey Findings

- 99 percent of cancer survivors surveyed experienced a wide array of physical, emotional, and practical issues after a cancer diagnosis.
- 55 percent of cancer survivors who experience emotional concerns received help.
- 40 percent of those with practical concerns received help.
Why Is A Survivorship Care Plan Needed?

As of January 1, 2014, there are more than 14 million cancer survivors in the United States. (cancer.org)

“After the diagnosis and treatment of cancer, survivors and their families must still contend with a host of physical, psychological, and socioeconomic issues. A cancer survivorship care plan is a document that includes a treatment summary, recommendations for follow up and psychosocial care, and other information to enable survivors to anticipate and address the long term and late-term effects of treatment.”

_Cancer Survivorship Care Plans: A Toolkit for Health Care Professionals._
Sacramento, CA: California Department of Public Health, Comprehensive Cancer Control Program, Survivorship Care Plan Advisory Group, & Triage Cancer, June 2015
ACoS Commission on Cancer

In 2012, the Commission on Cancer (CoC), a program of the American College of Surgeons (ACoS), released a new standard focused on the delivery of survivorship care plans in “Cancer Program Standards 2012: Ensuring Patient-Centered Care.”

The 2016 Cancer Program Standards updated the Survivorship Care Plan standard

The standard became effective on January 1, 2015.
2016 CoC Standard 3.3-Survivorship Care Plan

“The cancer committee develops and implements a process to disseminate a treatment summary and follow-up plan to patients who have completed cancer treatment. The process is monitored and evaluated annually by the cancer committee.”

Implementation schedule as follows:
2015- 10% of eligible patients
2016- 25% of eligible patients
2017- 50% of eligible patients
2018 and beyond- 75% of eligible patients
Eligibility Criteria

• Eligible (included) Patients
  • Analytic cases with Stage I, II or III cancers
  • Who are treated with curative intent for initial cancer occurrence
  • Who have completed active therapy

• Ineligible (excluded) Patients
  • Stage 0 or IV or metastatic disease
  • Pathologically diagnosed but never treated or seen for follow-up by the accredited program
Standard 3.3 - Survivorship Care Plan

RATING COMPLIANCE

Compliance: Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee develops a process to generate and disseminate a comprehensive treatment summary and survivorship care plan to eligible cancer patients who have completed cancer treatment.

2. The process is monitored, evaluated, and presented to the cancer committee annually, and documented in the minutes.

3. The number of eligible patients who received a survivorship care plan meets the implementation criteria.
How Do We Get There From Here
From The Start

• Collaboration Is Key

• Cancer Committee buy-in and oversight

• Develop ownership of the process

• Assess resources - both available and needed

• Establish timelines and reporting expectations
Collaboration Is Key

• Cancer Committee owns the standard
  • Appoint committee member with oversight of the standard

• Determine schedule to report to Cancer Committee

• Appoint a multidisciplinary workgroup to drive the work flow
  • Physician(s), administrator/manager, nurse navigator, CTR, oncology social worker, IT support, APP

• Workgroup will identify each part of the process needing to be developed
  • Policies and procedures

  • SCP format to be used

  • Tracking compliance

  • Identify provider responsible for approving and discussing the SCP with the patient
Barriers

• Time-to create, track, give, follow-up

• Resources needed to track eligibility, create document, provide to patient, document

• Lack of defined process-policy, procedure, accountability, ownership

• Understanding of standard due to lack of specificity in requirements, lack of understanding among stakeholders

• No reimbursement for time needed to create the SCP, give the SCP

• Fractured system of care-private practice, academic setting, availability geographically

• Patient compliance

• Ownership of standard
Breaking It Down To:

✓ Who

✓ What

✓ When

✓ Where

✓ How
Cancer Committee Role

- Cancer Committee owns the process and provides guidance and leadership

- Assign timeline for reporting progress back to Cancer Committee

- Cancer Committee approves process, policy and procedure

- Assign reporting timeline for Cancer Committee oversight

- Assign person responsible for the reporting to Cancer Committee at least annually
Multidisciplinary Workgroup Determines

- Who will track eligibility
  - Cancer registrar
  - Nurse Navigator
  - Office Nurse
  - Other or combination

- Who will initiate/create the SCP
  - Cancer registrar
  - Nurse Navigator
  - Social worker
  - Other or combination

- Who will deliver the SCP to the patient
  - APP
  - Navigator
  - Physician
  - Survivorship Coordinator
  - Other
Multidisciplinary Workgroup Determines

- Who is appointed as the primary oncology provider?
  - Private practice
  - Academic setting
  - Multi-facility providers

- Who will track the process
  - Cancer Registry
  - Navigator
  - Survivorship Coordinator
  - Other

- Who will monitor compliance with the standard
  - Cancer Registry
  - Survivorship Coordinator
  - Navigator
  - Process Owner
Multidisciplinary Workgroup

• What format will be used?
  • ASCO
    • Breast
    • Prostate
    • Small cell lung
    • Non-small cell lung
    • Colorectal
    • Diffuse Large B Cell Lymphoma
• Journey Forward
  • Requires an application download
• Homegrown
• Other
Multidisciplinary Workgroup

• When will the SCP be generated
  • At the time the abstract is completed
  • When the end of treatment date is determined

• When will it be given
  • last appointment at end of active treatment
  • first follow-up visit
  • survivorship clinic visit
  • other

• Where will the SCP reside?
  • EMR
  • Navigation software
  • Cancer Registry
Multidisciplinary Workgroup

How

• Will compliance be tracked, monitored, reported
  • Electronically
  • Excel spreadsheet

• Develop policies and procedures
  • All of the above processes
Case Studies
Case Study
Cancer Program A

- Eligible patients are identified by the clinical staff
- Cancer Registry is notified and the designated CTR abstracts record ASAP
- Navigator retrieves the treatment summary from a share drive
- Mid-level provider completes it and delivers it to the patient at the next follow up visit
- Clinician tracks delivered SCP using Excel
- Cancer Registry documents delivery of SCP via a user defined field-Ad Hoc report
Case Study
Cancer Program B

- 6,200 cases per year
- Uses a combination of Oncolog and Epic/Onbase
- Process was FTE neutral
- A site specific multidisciplinary team developed the templates
- User defined fields and ad-hoc filter identify eligible patients
- The “last treating physician” is identified and responsible for delivery to the patient
- To obtain the “end of treatment” date a tickler file was established and monitored
- Treatment summary data is passed into Epic/Onbase where SCP is auto-populated with additional information such as side effects and follow-up
- The registry reviews the SCP for completeness and data quality and routes to the designated clinician
- Following delivery of the SCP to the patient the SCP is routed back to the registry where compliance is tracked and documented on Oncolog
Case Study
Cancer Program C

- 7000 analytic cases
- Uses Oncolog Cancer Registry software
- 2 cancer registry FTE’s as Survivorship Care Plan coordinators/Initially grant funded
- Case finding used to:
  - Identify patients who meet SCP criteria
  - Estimate end of treatment date using NCCN guidelines for treatment
- User defined fields track end of treatment estimated date
- Expeditied abstracting for these patients at end of treatment
- Treatment summary is created and placed into the SCP
- SCP placed into a shared network drive
- Each practice has a folder in the network drive
- Practice nurse accesses folder, reviews, edits, prints it out for the patient delivery and returns SCP to share drive
- SCP is uploaded into Oncolog
- Practice nurse uses Excel to document when SCP was given to patient
- SCP Coordinator reviews spreadsheet and enters “treatment summary given” into Oncolog via a user defined field.
Learning Through Networking
Commonalities Among Case Studies

- Cancer Committee provides leadership and has oversight
- Multidisciplinary team defines process
- Begin with one disease site as pilot
- Cancer Registry manages several parts of the process
- Cancer Registry implements user defined fields specific to SCP process
- Estimate end of treatment date to facilitate triggering SCP process
  - Use NCCN guidelines to predict end of treatment time frame
  - Prioritize abstracting for patients reaching end of treatment
- Share drives used to facilitate access to treatment summary
- Excel spreadsheets track SCP delivery
- Navigation is in place
Key Take-Aways

- Establish Cancer Committee ownership
- Leadership approval of process, policies and procedures
  - Ongoing oversight
    - Establish reporting timelines
- Collaborate with cancer program oncology providers
  - Create understanding and buy-in
- Create multidisciplinary site specific teams
  - Establish standard of care follow-up
  - Care plan content consensus
- Leverage internal and external resources
  - Navigators
  - Advanced practice providers
  - ASCO, ACS, NCCN resources
  - Electronic databases
Leverage Electronic Databases

- EMR
- Cancer Registry software
  - Required cancer registry fields that can be incorporated into the treatment summary
    - Primary site
    - Date of Diagnosis
    - Site specific factors
    - AJCC stage
    - Date(s)/Types(s) of treatment(s)
    - Providers
    - User Defined fields and an ad hoc query to identify eligible patients
- Navigation software
  - Treatment summary
  - Follow up care plan
  - Education
  - Tracking of the process
- Data warehouse
- Share drive
Numerator and Denominator (January 3, 2017)

To calculate the denominator you need to know the number of patients for whichever year you are calculating that:

(1) were an analytic case
(2) received treatment with curative intent for initial cancer occurrence
(3) were Stage I, II, III
(4) completed treatment in whichever year you are calculating.

The SCP counts in the year it was given to the patient.

The numerator is the number of SCP’s given to patients in whichever year you are calculating.
Affiliated physicians and patient eligibility

Physicians who are employed by, contracted with or have privileges at an accredited facility are required to provide an SCP to eligible patients. Physicians are expected to “work together to compile the necessary information for the SCP”

Eligible patients are:
- Stage I, II, III or class of case
- Treated with curative intent
- Have completed active treatment
Non-affiliated physicians and patient eligibility

If an eligible patient has surgery at an accredited program (denominator), then the patient is referred to private MO and RO offices that are not representatives on the accredited facility’s cancer committee, not employed/contracted, nor have privileges at the accredited facility, the accredited program will provide all applicable treatment i.e. surgery information that would be included in the SCP to the referral location(s).
CAnswer Forum is an interactive virtual Bulletin Board for Commission on Cancer (CoC) constituents to ask questions, search topics, and connect with the latest CoC activities.

Cancer Treatment Plans and Summaries: ASCO
Free downloadable treatment summary templates for breast, colon, lung, and lymphoma cancers. Survivorship Care Plans and ASCO's follow-up guidelines are also available.

From Cancer Patient to Cancer Survivor: Lost In Transition Cancer Fact Sheets and Reports and downloadable document: Institute of Medicine of the National Academies

Journey Forward: Survivorship Care Plan Builder 5.0 This product requires a download.

LIVESTRONG Care Plan: The LIVESTRONG Care Plan is a "survivorship care plan" that is individualized based on answers provided in a brief questionnaire.

Cancer Survivorship Care Plans: A Toolkit for Health Care Professionals.
Sacramento, CA: California Department of Public Health, Comprehensive Cancer Control Program, Survivorship Care Plan Advisory Group, & Triage Cancer, June 2015
Thank you

To the programs that allowed us to share their processes with you.
Thank you

We appreciate your time today.

Have a great day.

To schedule a demo of Oncolog Registry software or speak to someone, please call 800-345-6626.
Visit us at www.oncolog.com

To schedule a demo of OncoNav Nurse Navigation software or speak to someone, please call 888-369-1791
Visit us at www.onco-nav.com