Survivorship Care Plan, the Commission on Cancer Standards and Your Cancer Program

Meeting the Standard for 2015
Welcome

I would like to thank OncoNav for the opportunity to present this webinar to discuss the Survivorship Care Plan Standard 3.3.

Welcome to Matt Amato and Gail Levenelm from OncoNav

Welcome to all of you joining us virtually!
Goals for today

Our goals include an interactive discussion about

- Defining the Survivorship Care Plan standard
- Models for managing survivorship care
- Models for creating the SCP report
- How a documentation platform will facilitate creating Survivorship Care Plan and managing the patient care process
**Why Are We Here Today**

Standard 3.3
Survivorship Care Plan

This standard becomes effective in 2015. But most programs will need to begin developing a survivorship care plan process now. This means that you will want to decide who will take the lead, how to get this process started and what your survivorship care plan will look like.
We welcome your comments and will take questions or comments at the end of the presentation.

Your experience as patient navigators, managers and administrators will

• Contribute to building a valuable network to share ideas and information
• Facilitate a better understanding of the complexities of delivering care to the growing population of cancer survivors
• Drive consensus forward in understanding the need to develop and manage a robust survivorship program that includes a comprehensive document called a care plan.

“A rising tide raises all ships.”
Lets Define Survivorship
What Does It Mean

The National Cancer Institute and the National Coalition for Cancer Survivorship have adopted the definition of cancer survivorship as being from the time of diagnosis, through the balance of life.

The Institute of Medicine (IOM) defines cancer survivor as one who has completed treatment for their initial cancer — this is usually six months post-diagnosis.

The Association of Community Cancer Centers definition is “the experience of living with, through and beyond cancer for both patients and the people in their lives who are impacted by the diagnosis.”
Just the Facts, Please
On Data We Thrive
FACTS AND FIGURES

• Currently, approximately 62% of cancer survivors are expected to live at least 5 years after diagnosis (ACS, 2003).

• 65% of newly diagnosed cancer patients are expected to survive at least 5 years

• As of January 2000, there were approximately 9.6 million cancer survivors in the United States (NCI, 2003a).

• This estimate includes people diagnosed with cancer but does not include others affected by a diagnosis, such as family members and friends.
Lance Armstrong Foundation Poll

Now that patients are living longer from their treatments, the challenges of survivorship are becoming more evident. A poll done by the Lance Armstrong Foundation of 1,020 patients showed the following:

• 54 percent experienced chronic pain
• 70 percent experienced depression
• 43 percent reported decrease in income
• 32 percent reported a lack of advancement, demotion or job loss

Common late medical effects examples include:

• lymphedema
• premature menopause
• infertility
• bone fractures
• chronic pain
The Oncology Roundtable 2008 report: Survivorship

• Findings from a recent Livestrong online poll confirm the need for post treatment support, as 49 percent of survivors identified unmet survivorship needs.

• Specifically, patients felt their oncologists were either unwilling or unable to properly address their needs.

• Physicians are aware of these gaps.

• 74% felt it was their role to provide this care. 31% are committed to this task through provision of health maintenance, screenings and preventative services.

But That’s Not All…..

• Psychological issues include fear, stress, anger, depression, anxiety. Fear of recurrence.

• Social well-being can be affected and include concerns about job security, family dynamics, interactions with friends and community.

• Spirituality can be affected by feeling as if their faith has been tested and wondering “why me”. There may be unresolved grief issues and feelings of survivor guilt.

• Economic costs can be devastating. Insurance co-pays and ongoing medication costs. Time lost from work or loss of a job due to treatment and recovery.

A Message from the Oncology Roundtable report
Delivering Sustainable Survivorship Care: Lessons for Program Design and Implementation, 2011

• Survivors are a diverse population with a vast and varied set of needs
• It is difficult for providers to determine where to focus limited resources
• There is little research to date on what constitutes quality survivorship care.
• Follow-up care has the potential to impact recurrence rates and survivors quality of life but there is no consensus as to the best way to manage patients after the completion of their cancer treatment.
• Cancer providers receive little or no reimbursement for survivorship services, making it difficult to justify investment in this area.
So Now Another Mandate From the CoC....

But remember

A rising tide raises all ships
Meeting the Long Term Needs of Cancer Survivors: The Institute of Medicine report "From Cancer Patient to Cancer Survivor: Lost in Transition"

1. Prevention of recurrent and new cancers

2. Surveillance for cancer spread, recurrence, or new cancers, and assessment of medical and psychosocial late effects.

3. Intervention for consequences of cancer and its treatment

4. Coordination of care between specialists and primary care providers.
Doing the Right Thing

“Survivorship is life.”
Liz, Cancer Survivor

“Survivorship means coming out of my cancer experience as a whole person and being able to make it an important and positive part of who I am.”
Octavio, Cancer Survivor

“Survivorship has given me a more complete sense of the gift of life.”
Bart, Cancer Survivor

“Survivorship is far more than living through cancer treatment – it’s who I am.”
Daniel, Two-time Lymphoma Survivor

A National Action Plan for Cancer Survivorship
Cancer Program Standards 2012: Ensuring Patient-Centered Care

Dedication

The Commission on Cancer dedicates the new cancer program standards to those individuals who trust their care to providers at CoC-accredited facilities.

We dedicate these standards to all those treated in the past, to those under treatment now, and to those who will grant us the great privilege of treating them in the years to come.

Volunteers and CoC staff worked together to develop these standards with the solitary goal of ensuring that patients with cancer will receive the highest quality care close to home.
The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment.

The process is monitored, evaluated, and presented at least annually to the cancer committee and documented in minutes.
Process Requirements

(a) A survivorship care plan is prepared by the principal provider(s) who coordinated oncology treatment for the patient with input from the patient’s other care providers.

(b) The survivorship care plan is given to the patient on completion of treatment.

(c) The written or electronic care plan contains a record of care received, important disease characteristics, and a follow-up care plan incorporating available and evidence-based standards of care, when available. The minimum care plan standards are included in the Fact Sheet: Cancer Survivorship Care Planning, from the IOM.
Process Requirements

Additional resources are available to assist programs with the development of these tools, including care planning templates. Care planning templates are available from, for example, the American Society of Clinical Oncology, National Coalition for Cancer Survivorship and the Lance Armstrong Foundation.

Compliance
The program fulfills the following criteria:
1. The cancer committee has developed a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment.

2. Each year, the process is implemented, monitored, evaluated and presented to the cancer committee.
Until 2015

Programs that are due for survey before 2015 will still be expected to address this standard.

The surveyor will want to review the work plan that describes process being used to implement the standard.
How To Get There From Here

Plan | Drive | Arrive
Map It Out
This report recommends that patients with cancer who are completing the first of course treatment be “provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained.”

The CoC standard states:

The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment.
You Will Need

• A policy to define compliance with the Survivorship Care Plan standard
  • Describe the process for obtaining the care plan
  • Identify the primary provider
  • State the source for evidence based standards being used
  • Identify the important disease characteristics
  • Describe follow-up care plan implementation
  • Describe the process for Cancer Committee annual review

• A written or electronic document format for the survivorship care plan

• A process for giving the care plan to the patient
IOM Fact Sheet- Cancer Survivorship Care Planning

The plan should include, at a minimum:

• Likely course of recovery from treatment and need for ongoing health maintenance/adjuvant therapy

• Recommended cancer screening and other testing and the schedule on which they should be performed

• Possible late or long term effects of treatment and symptoms

• Signs of possible recurrence and second tumors

• Possible effects on partner relationships, sexual function, work, parenting, and need for psychosocial support
IOM Fact Sheet- Cancer Survivorship Care Planning

• Specific recommendations for healthy behaviors

• Appropriate info on genetic counseling and high risk surveillance

• Info on known effective chemoprevention strategies

• Referrals to specific follow-up providers, support groups and PCP

• List of cancer related resources and info
The Survivorship Care Plan

- Determine what format you want to use
  - Electronic
  - Written

- Who is responsible for creating it
  - The primary physician
  - The navigator

- Who is responsible for presenting it
  - The physician
  - The navigator
  - The survivorship coordinator
The Survivorship Care Plan

- When will it be presented to the patient
  - When will the patient actually transition into survivorship care e.g.
    - End of active treatment
    - End of first year post-treatment

- Who is responsible for managing follow-up e.g.
  - Oncologist
    - Is there a survivorship clinic
    - Will a mid-level provider be used
  - Primary care physician
    - How will communication be managed from the team to the PCP

- How will individual patient needs be determined
  - Initially
  - Ongoing
Models of Care

One-time, consultative visit model.
Survivors attend a comprehensive program and receive a detailed follow-up plan that is implemented by their primary care physician.

Multi-visit model.
The oncologist and primary care provider share patient care. The role of each provider is clearly defined, with the primary care provider seeing the patient on an ongoing basis, while the oncologist typically sees the patient on an annual basis.

Ongoing model.
The survivor is followed through a specialized, academically based program—often nurse-led or provided by a multidisciplinary team.

Integrated model.
The patient’s primary oncology team provides survivorship care until it is deemed appropriate to transition the patient to the primary care provider.

Oncology Issues May-June, 2010 pg. 40
Examine the Options

Transitioning care to the Primary Care Provider

• Needs include:
  • Excellent communication between oncology team and PCP
  • Educational sessions for the PCP

• Advantages:
  • Convenience for the patient
  • More engaged PCP
  • Facilitates transition back to primary care

• Disadvantages:
  • PCP questions about late effects/management
  • Inability to track patient compliance
  • Potential lost revenue

Delivering Sustainable Survivorship Care; The Oncology Roundtable, 2011
Examine the Options

Clinic Setting

• Advantages:
  • Continuity of care with treatment team
  • Ability to monitor compliance with follow up care
    • Patient satisfaction that their needs are met by a team of familiar providers

• Disadvantages:
  • Reimbursement low or non-existent
  • Takes time away from patients in active treatment
  • Requires clinic space

Delivering Sustainable Survivorship Care; The Oncology Roundtable, 2011
Challenges

• Finite resources to manage the process
• Lack of supporting scientific data
• Lack of reimbursement for preparation time to create report
• Cancer as a chronic disease that needs to be managed
• Continuing problem related to disparities in health care
Not One, But Two Reports

The Institute of Medicine recommends that in order to address the communication gaps between healthcare providers and its impact on coordination of care, that two reports be prepared.

1. A treatment summary
   Provides details about type of treatment received as well as any complications or side effects that the patient experienced.

2. A survivorship care plan
   Provides information about the plan for follow-up to include screening recommendations and possible late side effects.
Care Plan Models

Journey Forward-National Coalition for Cancer Survivorship

ASCO

LIVESTRONG
Resources

American Society of Clinical Oncology (ASCO)
www.asco.org

Journey Forward
www.journeyforward.org

LIVESTRONG
www.livestrong.org

National Coalition for Cancer Survivorship
www.canceradvocacy.org

Institute of Medicine
www.IOM.edu

Oncology Roundtable
www.advisory.com/Research/Oncology-Roundtable

ACoS Commission on Cancer
www.facs.org/cancer
OncoNav’s Approach to Survivorship
Survivorship in OncoNav

**Advantages:**

- Save Time and reduce redundancy in generating the care plan.

- Streamline the care of patients using a single system through multiple phases of care.

- Manage the Survivorship Follow Up Care of patients and track the impact of your efforts.

- Measure the ROI of Survivorship Care at your program!
Managing Survivorship Care Plan in OncoNav

• Create the Survivorship Care Plan straight from the OncoNav patient navigation record.

• Customized with each client’s branding and preferred layout.

• Implemented based on industry standard guidelines (e.g. ASCO, NCCN, etc.) that your facility uses.

• Manage survivorship follow up care using pre-built templates.
Customize & Select the Information Presented to Your Patients

• Treatment summary, list of patient concerns, & care team included in OncoNav records & Survivorship Care Plan.

• Ability to customize specific information per survivorship guidelines (e.g. chemo dose information).

• Attach relevant documentation to the care plan for the patient including educational material and effective next steps.
Manage Patient Follow Up Care

- Assign pre-built survivorship care templates to patients.

- Customize care templates at any time to meet patient specific needs.

- Easily track patients on survivorship to ensure they are returning for follow up care.
Questions, Comments, & Discussion!
Thank you to OncoNav

We hope you found this information useful and will feel more confident in addressing the CoC Survivorship Standards at your program.

Thank you to everyone for taking the time to be here today.

Have a good day!