



SURVIVORSHIP CARE PLANS—A MANDATE

Linda Lee, RN
Community Educator
WellStar Cancer Network



WellStar Cancer Network

- 5 hospitals (4 with Cancer Accruals: ~3,000 new cases annually)
 - Kennestone (largest number of cases)
 - Outpatient Infusion
 - Inpatient Unit
 - Radiation Therapy (WellStar owned)
 - 1st in Georgia to have CyberKnife radiosurgery
 - Cobb Hospital (2nd largest number of cases)
 - Outpatient Infusion
 - Inpatient Unit
 - Radiation Therapy (privately owned)
 - Douglas Hospital
 - Outpatient Infusion
 - Paulding Hospital
 - Outpatient Infusion
 - Radiation Therapy (WellStar owned)



The Mandate

- Mandate (phase in by 2015) by AcoS—process started by 2012
- Cancer Committee develops (process documented in CC minutes)
 - Implements process to disseminate
 - Comprehensive Care Summary
 - F/U plan to patients who are completing first course of treatment
 - Incorporating available & recognized evidence-based standards of care, when available
- Process requirements
 - Care plan is prepared by the principal provider(s) who coordinated the oncology treatment for the patient
 - Survivorship Care Plan given to patient on completion of tx
 - Survivorship Care Plan is
 - Record of care received, important disease characteristics
 - Suggests: IOM Cancer Survivorship Care Planning
 - Include: Possible long-term side effects from treatment, provider to contact, and symptoms; possibility of cancer recurrence; wellness plan; coordination with Primary Care Provider (don't forget GYN's)

Survivorship Definitions

- NCI: An individual is considered a cancer survivor from the time of cancer diagnosis, through the balance of his or her life. <http://cancercontrol.cancer.gov/ocs>
- Three Stages of Survivorship (from *National Action Plan for Cancer Survivorship: Advancing Public Health Strategies*)
 - Living **with** cancer—Experience of receiving cancer diagnosis & any treatment that may follow.
 - Living **through** cancer—Period following treatment in which the risk of cancer recurring is fairly high.
 - Living **beyond** cancer—Post-treatment & long-term survivorship.
 - **Why do we need Survivorship**—to prevent having cancer patients and their families from being “Lost in Transition” from treatment to post-treatment. To help people know “What Do I Do Now?”

What Survivorship Care Plan Should We Use?

Ideally Should Be Started with Initial Visit to Provider

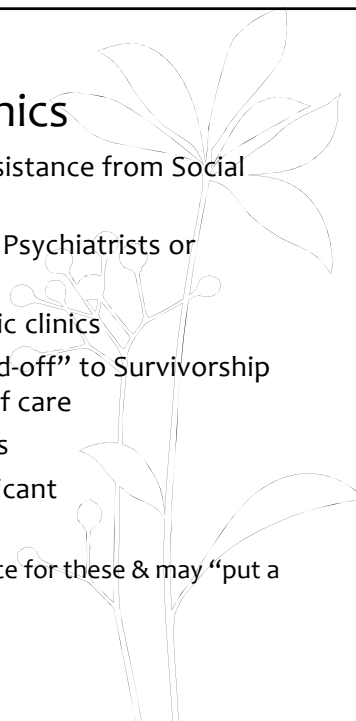
- Depends on your own needs and resources
 - Paper
 - Initiated by Primary Provider
 - Patient/family responsible for holding original
 - Then meets with Nurse Navigator
 - Online
 - Initiated by patient/family
 - Example: www.livestrongcareplan.org
 - EMR-based
 - GASCO & others
 - Depends on all computers talking to each other!
 - **ONE THAT WILL BE USED**



Survivorship Navigators/Clinics

- Many led by Nurse Practitioners with assistance from Social Workers
- Some led by Internal Medicine, some by Psychiatrists or Psychologists
- Some are an extension of disease-specific clinics
- Nurse Navigators for Disease Sites “hand-off” to Survivorship Navigator/Clinic to maintain continuity of care
- Build support and trust from Oncologists
- Type of oncology practices can be significant
 - Much easier in hospital-owned practices
 - Private practitioners may not feel importance for these & may “put a wrench” into the process

Advisory Board



Finally

- By using the Care Plan Process
 - We can also build loyalty from patients and family members
 - We continue that “safety net” that patients feel during treatment when they get to see their providers so often
 - We can continue to interact with our “Family” that we have come to know during the whole cancer journey

“What is as important as Knowledge?” asked the Mind.

“Caring, and Seeing with the Heart,” answered the Soul.

