Implementing a Survivorship Care Plan for Patients With Breast Cancer

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The growing number of cancer survivors challenges healthcare organizations to develop programs that support survivors’ transition from active treatments to survivorship care. Many individuals and families continue to face complicated care issues resulting from cancer diagnosis and side effects long after completion of their treatments. This article describes a model of a survivorship care plan, Cancer Treatment Summary and Follow-Up Care Plan, piloted in an outpatient clinical setting in a community hospital for patients with breast cancer. The plan can be expanded to include other cancer types. The intent of the survivorship care plan is to strengthen the care connections and coordination of services for survivors of breast cancer to ensure that continuing care needs are met during the survivorship phase of the cancer trajectory. The survivorship care plan is a unique opportunity for oncology nurses to be catalysts for the interdisciplinary interactions that are required to develop survivorship care plans and to implement a change in oncology nursing practice. The intervention shifts the paradigm of cancer survivorship care from an acute care medical model to a wellness model for cancer survivors in the clinical setting.

Advances in cancer treatments, early detection, and supportive care are increasing the number of cancer survivors living beyond initial diagnosis and treatment (Rowland & Yancik, 2006). In 2006, more than 66% of adults diagnosed with cancer were expected to be living five or more years after diagnosis (National Cancer Institute [NCI], 2007). The American Cancer Society (ACS) (2006) reported that more than 10 million cancer survivors live in the United States, representing a tripling of the number of survivors since 1971 (see Figure 1). The number of survivors is expected to double by 2030 as survival rates improve and the U.S. population ages (ACS; Centers for Disease Control and Prevention [CDC], 2004; National Institutes of Health, 2006).

The increasing number of cancer survivors underscores the need to address their unique needs related to surviving with chronic conditions and manage their care. Treatment completion does not signal the end of the cancer experience; many individuals and families continue to face complicated care issues related to cancer diagnosis and side effects related to treatments. Currently, few cancer therapies are benign, and many carry substantial risk of adverse long-term or latent effects (Aziz, 2006).

Cancer survivors express concerns about continuity of health care as cancer treatments are completed and oncologist visits become less frequent (Lewis, 2006). Because most cancer survivors are referred back to their primary care providers (PCPs), continuity of care is not always a guarantee. After primary oncology treatment ends, the transition of care from an oncology specialty back to a PCP is a critical process that can be improved with a plan for continuing survivorship care. A survivorship care plan provides a cancer survivor with guidance on maximizing personal health outcomes, clarifies the oncologist’s and PCP’s roles and responsibilities, and helps protect against gaps in services (Institute of Medicine [IOM] & National Research Council [NRC], 2006).

At a Glance

✦ The increasing number of cancer survivors living beyond treatment underscores the need to address survivorship care.
✦ This article presents a model for a cancer survivorship care plan to help breast cancer survivors make critical transitions in care from the oncology specialty to their primary care providers.
✦ Oncology nurses play a key role as catalysts for driving interdisciplinary strategic planning necessary for the implementation of survivorship care plans and improving the quality of care for cancer survivors.
This article describes a model for a breast cancer survivorship care plan, *Cancer Treatment Summary and Follow-Up Care Plan*, piloted in an outpatient clinical setting at Memorial Healthcare, a 148-bed community hospital in Michigan. The care plan incorporates key recommendations for survivorship care plans from the President’s Cancer Panel (2004) and the IOM’s & NRC’s (2006) report, *From Cancer Patient to Cancer Survivor: Lost in Transition*: the cancer diagnosis, treatments received and side effects encountered, information regarding follow-up visits and testing, recommendations for preventive practices, and maintenance of personal health and well-being. The template shows a breast cancer survivorship care plan, but it can be modified and expanded for use with other cancer types. The intent of this article is to describe the development, implementation, and evaluation of a breast cancer survivorship care plan to guide others to replicate the program in other clinical areas.

Rationale for the Program

Breast cancer survivors attending support groups at Memorial Healthcare wanted more information related to surviving with cancer after treatments were completed, managing long-term side effects, and addressing fears of cancer recurrence. Several research studies confirm such concerns as cancer survivors often continue to search for meaning and a sense of control as they face new challenges after cancer treatments have ended (Vivar & McQueen, 2005; Wilson, Anderson, & Meischke, 2000). Gill et al. (2004) found that many women continued to experience uncertainty about how to interpret and manage long-term treatment-related side effects (i.e., arm swelling, cosmetic changes, fatigue, cognitive recall, and continuing uncertainty about recurrence and secondary cancers). Additionally, Wilson et al. showed that breast cancer survivors experienced poor interactions with their healthcare providers and felt ill-prepared to deal with the long-term consequences of their treatments. Furthermore, studies of surveillance practices in the United States show that follow-up care for breast and colorectal cancer survivors is not meeting suggested evidence-based recommendations (IOM & NRC, 2006). This is evident by less than optimal follow-up rates of annual mammograms by patients with a history of breast cancer, as well as less than optimal follow-up rates of colorectal examinations by patients with a history of colorectal cancer (IOM & NRC).

Clearly, healthcare providers should offer interventions that place an emphasis on wellness and health promotion and that inform patients how to live well with chronic disease. The survivors in the support groups recognized the need to be better informed. During the acute phase of illness, the primary focus of cancer care is diagnosis and treatment. Supportive care assists patients in coping with the immensity of their cancer experiences and the resulting impact of treatments. When treatment is completed, cancer may go into remission or may be considered controlled. That stage can bring mixed feelings: celebration and relief that treatments are completed, plus anxiety and fears about disease- or treatment-related changes (President’s Cancer Panel, 2004). Survivors need guidance and a plan for action to help them cope with their changing conditions and to live well long beyond diagnosis and treatment.

The survivorship care plan provides a strategy to respond to breast cancer survivors during the transition in their care and can be a method to improve quality of care (Rowland, Hewitt, & Ganz, 2006). The survivorship care plan underscores the importance of continued medical surveillance for breast cancer recurrence and incorporates health promotion and living well as a survivor. It documents information about the breast cancer and the care received during treatment and alerts both the survivor and her PCP about existing or potential risks that the survivor may face during the survivorship phase. The care plan connects care across all disciplines and does not isolate survivorship care to the oncology setting. Most importantly, the plan allows breast cancer survivors to partner with their healthcare providers and asks them to be active participants, thereby promoting improved continuity of care.

Developing a Care Plan for Survivors

The survivorship care plan became an opportunity for the healthcare team at Memorial Healthcare to address the supportive care and educational needs that patients were identifying after treatment completion. The first step in designing the plan was to research how leading institutions were developing and implementing survivorship care plans in their specialties because little information existed in the literature regarding implementing such a plan into practice. Several models for survivorship care plans were obtained from other organizations (Dana-Farber Cancer Institute, Memorial Sloan-Kettering Cancer Center, University of Pennsylvania Abramson Cancer Center, and Cook Children’s Health Care System) and provided further guidance for development of the care plan template described in this article (Advisory Board, 2006). The model of the survivorship care plan constructed and piloted at Memorial Healthcare follows the *Cancer Treatment Summary and Follow-Up Plan* template (see Figure 2).

Five breast cancer survivors completing radiation or chemotherapy treatments were selected as the initial patient group for imple-
mentation of the project. That patient population was selected because they represent the largest group of cancer survivors in the Memorial Healthcare outpatient setting and are the largest group of cancer survivors in the United States (Memorial Healthcare, 2006; NCI, 2007) (see Figure 3). The decision to follow patients with breast cancer also was determined by the availability of National Comprehensive Cancer Network (NCCN, 2006) guidelines on breast cancer surveillance. The guidelines provided recommendations for follow-up interventions and preventive measures based on individual survivors’ cancer stages and treatments received.

Memorial Healthcare Cancer Center Cancer Treatment Summary and Follow-Up Plan

Follow-Up Recommendations

Follow-up for potential recurrence of cancer
• Patient to perform monthly breast self-examination
• Clinical breast examination every six months for the remainder of life; annual mammogram
• Monitoring for blood values; if on tamoxifen, order an annual complete blood count and chemistry panel.

Follow-up for secondary malignancies
• Genetic assessment
• Baseline bone density
• Bone density follow-up every year to assess for premature osteoporosis

Plan for follow-up
• Medical oncologist will evaluate physical health status with annual diagnostic mammograms and will perform a clinical breast examination every six months for five years, then annually. Monitoring of bone density will continue with this physician.
• Radiation oncologist will follow patient every six months for the first year, annually thereafter.
• Primary care physician will monitor routine health maintenance as well as all pelvic examinations, signs of hypertension, and hypercholesterolemia.

Special test results: lipid panel, thyroid-stimulating hormone, electrocardiogram/echocardiogram, complete blood count

Identified psychosocial issues (e.g., depression, fatigue, functional status)
• Supportive care
• Support groups

Review of healthy lifestyle and habits
Smoking: 
Health insurance: 
Employment issues:
Nutrition and physical exercise: review of adequate dietary intake of calcium and vitamin D, weight maintenance, exercise programs available in community

Referrals (e.g., medical social worker, physical therapy, legal assistance, fertility studies)

Booklets provided

Signatures and Dates

Patient:
Medical oncologist: 
Radiation oncologist: 
Nurse coordinator: 

Figure 2. Cancer Treatment Summary and Follow-Up Plan Template

Note. Based on information from Institute of Medicine & National Research Council, 2006.
Implementation

The oncology nurse, as a patient care coordinator and educator, played a key role in developing, coordinating, and delivering the survivorship care plan to the breast cancer survivors. The nurse consulted with the medical and radiation oncologists as she developed the template. The overall goal was to create a template that was easy to use but allowed flexibility for data entry because of the variability in treatments and risk for developing long-term problems related to cancer and treatments. Breast cancer follow-up is different for each person; needs are dependent on type and stage of cancer, age of the patient, and treatments provided (CDC, 2004; Houldin, Curtiss, & Haylock, 2006).

Once the nurse identified the key components of the survivorship care plan, she began to coordinate the information required for entry into the document. Preparation for data entry included completing a thorough review of the survivor’s breast cancer treatments and the interdisciplinary support systems used by the survivor during the acute phase of treatment. The survivorship care plan was reviewed by the medical and radiation oncologists, who made additions or corrections. The plan then was integrated into the patient record.

The survivorship care plan contains two parts. The first part details cancer diagnosis, stage, nodal status, hormonal and tumor markers, treatments received and any significant events that occurred during treatments, side effects experienced, and treatment responses. Information is documented for the survivor about personal risk and future need for continued monitoring related to the therapies provided. Contact information is included for each specialist.

Recommendations are discussed regarding the potential for secondary malignancies and the need to be proactive and to seek assessments related to bone density and genetic testing if appropriate (Ganz, 2006; Hillner et al., 2003). Other preventive screening examinations are emphasized, including yearly gynecologic examinations if the survivor still has her uterus and ovaries, and colorectal screening if the survivor still has her colon.

The second part of the plan focuses on follow-up care for the specific cancer type and personal experiences encountered during treatment. Details are given about the timing and content of recommended follow-up visits. Recommendations are recorded regarding the potential for secondary malignancies. Additional recommendations are added to the plan regarding preventive practices for the breast cancer survivor (i.e., what she should self-monitor, topics to discuss with healthcare providers in the future, and how to maintain health and well-being). A current assessment of the survivor’s psychosocial, employment, insurance, and financial issues is included in the second section. Figure 4 provides examples of specific issues that breast cancer survivors may encounter after treatment. Genetic assessment, support groups offered, and referrals are documented to further inform the survivor and the PCP, thus strengthening continuity of care.

A consultation appointment with the nurse is scheduled for the survivor and family members within about two weeks of their last visit with the oncologist. A copy of the survivorship care plan guides the teaching and helps the breast cancer survivor understand the need to be involved in her future care needs and to be an advocate for her own care. Information received from the physician is reinforced, thereby increasing compliance. The nursing intervention is a means to further identify issues before they become crises. The visit allows time to assess how the survivor is coping with the sudden reduction in the intense clinical attention she received during the acute treatment stage.

Nurse-patient communication centers on supporting the survivor, and the survivorship care plan is offered as an informational tool that the survivor can use to take control of her health care as she moves into the survivorship phase of the cancer journey (Cox & Wilson, 2003). Part of the communication focuses on how the survivor can self-monitor for breast cancer recurrence. Women who have been treated successfully for one breast cancer need to be informed about their potential risk for a second breast cancer and encouraged to seek preventive screening (Mahon, 2007). Time is spent educating the woman regarding the importance of scheduling a yearly mammogram, maintaining clinical breast examination appointments at least every six months if recommended by the oncologist, and performing monthly self-examination of the breasts. The survivor is reminded to seek prompt medical attention with the oncologist if changes are found in any breast examinations. Information is reinforced regarding how to perform a breast self-examination and what changes to report (i.e., lumps, hard knots, thickening of the skin, swelling of the breast or under the arm, skin irritation, redness, dimpling, an orange peel-like appearance of the skin, nipple pain, and nipple discharge if she is post-menopausal) (NCI, n.d.). Time is spent on reviewing the techniques for breast self-examination and answering questions.

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Health-promotion topics are discussed, such as smoking cessation, second-hand smoke, physical fitness, and weight management. Issues relating to fatigue, breast and arm pain, and problems with lymphedema are the most commonly reported late effects of treatment for young and older women and should be discussed with survivors (Thewes, Butow, Girgis, & Pendlebury, 2004). Weight gain is increasingly recognized as an important health concern, and weight management should be addressed for patients with breast cancer and survivors (Rooney & Wald, 2007). For reasons that are not fully explained, women undergoing breast cancer chemotherapy treatments gain weight, which may be a factor that decreases survival (Rooney & Wald). Weight counseling is included, and survivors are provided brochures on nutrition and information regarding community weight loss groups, dieticians, and exercise programs.

At the conclusion of the consultation, the survivorship care plan is signed by the patient, oncologists, and nurse. Having the survivor sign the plan represents recognition that the survivor is an equal partner of the healthcare team. Inclusion of the cancer survivor’s signature on the plan permits the survivor to take responsibility for her care and to become a better advocate to ensure that appropriate follow-up care is provided (O’Hair et al., 2003). Copies of the plan are provided to the patient and to the survivor’s PCP. Thus, the care summary becomes a part of the patient record, increasing knowledge about survivorship issues related specifically to the survivor’s cancer diagnosis.

### Evaluations

#### Survivor Reactions

During initial implementation, qualitative interviews were conducted before and after the care plan was shared with each patient. The goal was to ask patients questions to discover the meaning of their cancer situations and experiences. Questions were asked during consultation visits to discover what the patients knew about their diagnoses and their ability to successfully transition as survivors to a care level that was independent of the oncology care setting. Based on the interviews, all five survivors reacted positively to the care plans provided to them during their nurse consultation visits.

The following interview questions were used to uncover the meaning of the cancer experience for the patients and their concerns surrounding the transition into survivorship care: What do you know about your cancer diagnosis? Do you know the type of cancer you have? Do you know what treatment you received? Do you fully understand the type of treatments you had, and do you have them recorded in any manner for your personal medical history? Has your doctor discussed with you possible late effects from treatments received? Can you describe what it means for you to be living with cancer? Do you have any concerns that need to be addressed further? Did the information help to reduce any anxieties that you had regarding your future healthcare needs?

Prior to delivery of the care plans, the patients reported that they were confused about the meaning of remission, cure, chronic illness, and follow-up care. Survivors stated that they felt a sense of being overwhelmed after completing therapy and did not know what to ask the oncologist about their continuing care. They were eager for information regarding the cancer experience, and one patient remarked that her stress level was lower now that her treatments were over, which helped her to be more relaxed and receptive to teaching. Survivors stated that they did not know what kinds of information were shared with their PCPs regarding their cancer treatments, nor their specific requirements for follow-up care with each provider.

After care plans were shared with the survivors, the survivors were asked to evaluate whether the plans were effective, clearly written, and helpful to them as they faced their transitions as survivors. All five survivors remarked favorably that the summary
information clarified several issues regarding their cancer histories and the treatments they received, and they found that receiving written information was helpful. Their visits allowed them to better understand terminology, and their written care plans informed them of community resources, educational support groups, and timing of follow-up appointment schedules. Each breast cancer survivor was particularly interested in information regarding her cancer pathology and the meaning of staging for the disease. Cancer stage and diagnostic details were made known to the patients by the oncologist earlier in treatments but often were overshadowed by reactions the individuals had regarding the immediate impact of a cancer diagnosis and necessary adjustments for their treatments. The care plans provided practical guidance for survivors by organizing the requirements for follow-up with oncologists and PCPs. Survivors were reminded that they are their own best advocates and need to maintain the timing recommended for future appointments with the oncologist for continued surveillance of cancer recurrence and second cancers. Survivors stated that care plans helped them understand the expectations of them and recognize their responsibility for maintaining appointments and seeking prompt evaluation and timely treatment from providers if they became concerned about breast cancer recurrence in the future.

The women were grateful to be able to participate in the project. The time spent delivering a care plan to a survivor averaged one hour. The tool was viewed as something very personal, and the survivors were actively interested in survivorship care. Each breast cancer survivor had different interests in the document, but each was able to see that ongoing care would continue with their active participation.

Reactions From Primary Care Providers

PCPs do not consistently receive timely or comprehensive clinical information related to the cancer experience of the patients they serve. Quality of care suffers when patients and providers do not know what is expected after primary treatment ends (Earle, 2006). This lack of clinical information requires PCPs to ask survivors about their current situations to become better informed about their histories and cancer experiences. The PCPs who received care plans were asked during telephone interviews to evaluate the care plans to establish whether they were an effective communication tool and resource for their practice. The PCPs evaluated the care plans positively and stated that the intervention was valuable and should be promoted and sustained as a standard in practice for the benefit of the survivors and the teams involved in their care. The PCPs stated that the care plans contributed to their knowledge of the patients’ health status and clarified the treatments the patients received from specialists. The care plans enabled the PCPs to integrate the work of the specialists and to interact with the survivors in a more informed manner. For example, the care plan identified which provider would monitor a survivor for pelvic examinations and mammograms. The PCPs found that information useful for optimizing care by avoiding duplication of services and gaps from unclear expectations of provider services. They agreed that sharing the care plans with the breast cancer survivors engaged the women in their care and began an important dialogue about addressing the different roles of each provider involved with follow-up survivorship care.

The overall comments from the PCPs were supportive and stated that the information was concise and offered a snapshot of treatment information located in one format, which allowed for easy retrieval of information during clinical visits. The care plan became a tool that strengthened collaborative communication among disciplines and placed survivorship care as a central focus for the survivors’ future care management.

Implications for Clinical Practice

Teachable Moments

Nursing has a central role in all phases of the cancer trajectory, including survivorship. Nurses are able to assess and address the multidimensional spectrum of needs for those faced with cancer (Ferril, Virani, Smith, & Juarez, 2005). Nurses encounter patients with cancer in a variety of areas, such as hospitals, outpatient settings, and homes. Oncology nurses are able to provide care plans in clinical settings and to bridge patients’ care from active treatments to survivorship care.

This intervention allows nurses to implement an approach to care that permits patients to get involved in decisions made regarding their health issues. Nursing observations made during the pilot project revealed that the survivors recognized that the level of care was changing by the types of questions the survivors asked during their consultation visits. The nurse consultation visit clearly is a teachable moment for survivors and caregivers. Nurses are able to connect what happened to survivors during their courses of treatment, and the survivorship care plan opens the way for patients entering an unfamiliar area that can be marked by uncertainty. According to Ganz (2005), teachable moments exist in clinical practice and can be found during the period of time when people face cancer diagnosis and when they transition to cancer survivorship. The teachable moments have the potential to motivate individuals to consider and adopt behavioral and lifestyle changes. Consultation visits provided an opportune time to continue the therapeutic relationship and to provide information to help survivors assume greater control of the decision making related to care after treatment completion. Providing care plans to survivors allows nurses to participate in shifting the paradigm of care from an acute care model to one that focuses on chronic care issues with a wellness component (Haylock, 2006).

Quality Improvement and Patient Satisfaction

Raising awareness of needs following cancer treatment helps survivors and healthcare providers and improves the quality of care offered in oncology settings. If survivorship care is not planned or coordinated with other healthcare providers, then survivors are left without knowledge or resources to seek help regarding personal health issues related to cancer recurrence, secondary cancers, or other risk factors (IOM & NRC, 2006). The survivorship care plan can be a means to encourage patients to be actively involved in their own care, which also meets the Joint Commission’s 2007 National Patient Safety Goals.

The review of a survivor’s health history and clinical information by an oncology nurse prior to completing a care plan is an
opportunity to audit the clinical chart and complete a quality check to evaluate that all assessments are completed and documented. The consultation visit allows additional time to assess a survivor’s needs for further intervention and coordinate referrals to appropriate support systems (IOM & NRC, 2006).

From a patient satisfaction standpoint, the nurse consultation visit provides an additional means to improve patient-centered care offered in the clinic. Improving patient-centered care can lead to improved patient satisfaction scores, which is a key factor in driving choice for treatment locations by newly diagnosed patients with cancer. The type of attention paid to survivors at the end of treatment can be a marketing tool that demonstrates that a cancer center delivers high-quality patient care and addresses coordination of care, as well as the emotional needs of patients (Sohn, 2007).

Challenges

The reality of incorporating survivorship care plans into a busy clinical setting presents many challenges. Survivorship care needs to be standard for all patients with cancer, and this can be done only if care plans are accepted into practice and become routine.

Need for Interdisciplinary Teams

Nurses have an opportunity to work collaboratively with physicians to improve care provided to patients through the entire cancer experience, including survivorship care. Oncologists’ workloads may be significant in coming years because of time constraints and the rise of the oncology population (IOM & NRC, 2006). Nurses can be catalysts to drive interdisciplinary strategic planning, implement interventions necessary to improve cancer survivorship outcomes, and reach consensus in their own clinical settings. This intervention in clinical practice is an important tool for promoting nurse-physician team discussions regarding survivorship issues.

Care planning can be enhanced only by increased interdisciplinary team communication and clear definition of the needs of survivors related to surveillance and monitoring for recurrence and secondary cancers (Carroll-Johnson, 2001; IOM & NRC, 2006). This involves decision making regarding clarification of roles, including who is primarily responsible for patient care, referral procedures, timing of appointments, and the necessary feedback to the PCP.

Nursing brings a different perspective to the care planning process by shifting the care plan from a purely surveillance model to a more supportive, patient-centered, and coordinated model (Cox & Wilson, 2003). The shift in focus can be achieved only through joint collaboration between nurses and physicians. In this pilot project, this was accomplished by the nurse scheduling time to meet with each specialty (i.e., medical and radiation oncologists) to gain their perspectives of the survivors’ continuing care needs and asking them to review the written care plans prior to sharing the information with the patients. Through open communication, the nurse and physicians were able to reach a common understanding of expected components for the care plan and to personalize care for each survivor. Another method that can be constructive is to structure weekly interdisciplinary team conferences for collaborative review of treatment schedules for newly admitted patients with breast cancer and for survivors completing treatments. During the meetings, each discipline can review care plans for survivors and provide valuable input for the care summaries.

Lack of Survivorship Guidelines

Each breast cancer survivorship care plan should be based on the survivor’s personal cancer diagnosis and staging and be linked to evidence-based research and national guidelines for patients with breast cancer. In this pilot project, the template used for the breast cancer survivorship care plans followed current NCCN breast cancer guidelines (NCCN, 2006). The guidelines cover issues related to the detection of recurrence and second cancer but need further definition regarding the full spectrum of breast cancer survivorship care. Overall, evidence-based guidelines are absent for monitoring and managing the problems of adult survivors with all cancer diagnoses (IOM & NRC, 2006; Lewis, 2006).

Without clear guidelines, nurses and physicians should communicate effectively as a team, build consensus, and create a workable tool for follow-up care. Interdisciplinary communication is vitally important for determining the frequency of return visits for patients because of the recognizable variance in the present guidelines for visits after treatments are finished. For example, a breast cancer survivor can be followed by several specialists after treatment (e.g., medical oncologist, radiation oncologist, surgeon, PCP). Continuing care visits are very important to breast cancer survivors for their well-being and monitoring for cancer recurrence. According to the NCCN guidelines (2006), women with invasive breast cancer should return to a specialist for a review of their interval history and a clinical examination every four to six months for five years, then every year thereafter. If the NCCN guidelines are followed according to those recommendations, a breast cancer survivor would need to make 10–15 visits to each care specialist over the course of five years. That can be overwhelming and problematic for patients. Return visits to each specialist can be variable, depending on the physician’s evaluation and decision making regarding each survivor’s situation, and if care is not shared or coordinated among providers, the survivor can be lost to follow-up care in the process or offered too much care, leading to unnecessary and expensive care (IOM & NRC, 2006).

A challenge and potential barrier for this project was finding time in an already busy clinical day to discuss with each oncologist the plan for follow-up care for each patient. A way to improve communication is to have care plan forms available on patient charts at the time of diagnosis. This would enable physicians to enter information in a timely manner, lessen their work interruptions, and inform all disciplines about needed follow-up scheduling for patients once treatments are completed.

Technology

Technology can help to integrate information, streamline transitions in care, and support quality monitoring for patients’ adherence to survivorship care (Feifer, Ornstein, Nietert, & Jenkins, 2001). The development of electronic medical records
(EMRs) would improve the facilitation of communication and rapid retrieval of pertinent information. EMRs can reduce time spent locating key information and reduce nurses' labor hours collecting information from various resources (e.g., key pathology reports, genetic studies, dates of chemotherapy infusion, radiation oncology reports). Building a system where key information is entered early in EMRs during the acute phase of cancer diagnosis by all disciplines can lessen the intensity of work required to compile a summary of treatment and develop a final survivorship care plan for a survivor.

The consultation visit related to survivorship care presents a change in the process of care delivery and adds another point of care for each patient. A challenge and potential barrier is that a patient consultation visit could be overlooked and not scheduled. This was evident in this project because radiation services were performed in another institution. The challenge was to be organized and use a backup calendar system to mark key dates for potential completion of radiation treatment for patients with breast cancer. The extra step could be alleviated by technology. A computer system could support a trigger or flag system to alert office staff that a consultation visit will be needed for survivorship care. The trigger could notify the nurse and the physician that a consultation visit will be needed and allow time for a nurse to complete the record review and schedule the patient for the care plan encounter.

Reimbursement

Nurses must be knowledgeable about cancer treatments, side-effect management, and interventions. The preparation and consultation visit can be demanding and time intensive for a nurse (Boyle, 2006). This project demanded extensive time for chart review, communication with providers, and sharing survivorship care plans with survivors. At present, consultation visits that address survivorship care are not reimbursed. To ensure that the practice is sustained in the clinical setting, creative strategies are needed to seek reimbursement and to build systems where nursing can coordinate the services required for long-term survivorship care.

Future Studies

According to Stille, Jerant, Bell, Meltzer, and Elmore (2005), providing survivorship care plans and including survivors in the process of coordination may improve their access to care, allow for more timely care, provide more accurate plans to their PCPs, reduce medical errors, and increase patient participation and satisfaction. Although the current intervention was on a small scale, future evaluations of the effectiveness of survivorship care plans in clinical practice addressing such quality endpoints will be needed to help sustain this tool for survivorship care.

Conclusion

Survivorship care is based on a continuous healing relationship with patients. The intent of the survivorship care plan is to anticipate survivors' needs as they transition to a different level of care, rather than simply reacting to their needs in the subsequent months. The plan strengthens care connections for cancer survivors. It addresses long-term follow-up care and empowers patients to maximize personal health outcomes. This template is a unique opportunity to begin the process for change in oncology practice and improve the way health care is delivered to patients completing treatment. This intervention shifts the paradigm of cancer survivorship care from an acute care medical model to a wellness model for women with breast cancer in the clinical setting.

The Cancer Treatment Summary and Follow-Up Plan provides a stepping stone for the development of summary plans for other cancer types. The impact of the tool can be fully realized if the project is carried out over a longer period of time. This intervention is a starting point that can be replicated for other cancer diagnoses and used in other organizations.

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The shifting paradigm of cancer care: The many needs of cancer survivors are starting to attract attention. 


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