Using Survivorship Care Plans to Enhance Communication and Cancer Care Coordination: Results of a Pilot Study

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Purpose/Objectives: To compare a structured cancer survivorship care plan (SCP) transition visit versus an SCP transition visit coupled with a coordinated follow-up visit from the primary care provider (PCP).

Design: Pilot randomized, controlled study.

Setting: REX Cancer Hospital, a community cancer center in Raleigh, North Carolina.

Sample: 34 adults completing treatment with curative intent.

Methods: Patients and PCPs completed measures at baseline and at six weeks. Wilcoxon signed rank and rank sum tests were used for comparisons of SCP only versus SCP with PCP follow-up visit, as well as between high- and low-activated patients.

Main Research Variables: Confidence in survivorship information and survivor concerns.

Findings: The intervention was feasible and acceptable to patients and their PCPs. All patients (N = 34) had less contradictory information about care after SCP receipt. PCPs reported improved confidence in patients, regardless of intervention arm. Highly activated or empowered patients benefited more and had increased confidence and fewer concerns about cancer care.

Conclusions: The SCP interventions led to increased confidence in survivorship information, but some benefits were greater for highly activated patients. PCPs also had improved confidence in survivorship care after SCP receipt, whether or not they saw the patient in follow-up. A larger study is needed to further explore these findings and the changes over time.

Implications for Nursing: Nurses can be instrumental in facilitating the development and delivery of SCP to survivors and PCPs.

The report, *From Cancer Patient to Cancer Survivor: Lost in Transition* (Hewitt, Greenfield, & Stovall, 2005) provides direction for delivering care to survivors by defining four essential components of survivorship care: (a) prevention of recurrence, new primary cancers, or late effects of treatment; (b) surveillance for recurrence, metastases, new primary cancers, and physical or psychosocial late effects of treatment; (c) interventions for physical, psychosocial, and practical consequences of cancer and its treatment; and (d) coordination of care to execute prevention, surveillance, and interventions, specifically between survivors' primary care providers (PCPs) and oncologists. Hewitt et al. (2005) highlighted the important role of care coordination for the cancer survivor, which should include the patient, the interdisciplinary oncology team, and the patient's PCP. A survivorship care plan (SCP) was recommended as a tool to facilitate this coordination. Cancer