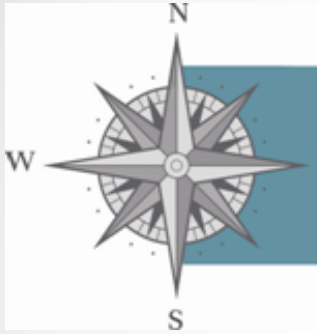


Survivorship Care Plan Project

January 26, 2016

Debbie Webster, BSN, RN, LMSW
Cancer Patient Navigation Consultant
Michigan Department of Health and Human Services

Objectives

- Discuss a Comprehensive Cancer Control approach to the implementation of survivorship care plans in health systems
- Identify 2 important aspects of survivorship care plan implementation

A little history…

- Michigan's Cancer Plan has included "survivorship" objectives since 1998.
- Survivorship care plans were added as a strategy for increasing the quality of life of survivors to Michigan's Cancer Plan in 2009.
- In 2012, the Commission on Cancer (CoC) introduced Standard 3.3 on Survivorship Care Plans.
  - Michigan has 47 accredited caner centers.

- Michigan's Comprehensive Cancer Control organization has 100 member organizations.
- The MCC Survivorship Workgroup identified that cancer centers struggled with the survivorship care plan standard.
    - In 2012, no cancer center were providing care plans to all of its survivors.

How can the MCC help?

1. Develop expert workgroup to develop a recommendation for member organizations

   Problem: Limited expertise - some systems had pilots.

2. Convene interested health systems

   Problem: While health systems could share stories, the stories didn't always help cancer centers know how to approach care plan implementation in their own health system.

3. Develop a Learning Collaborative

   Solution: Research care plan implementation, report process to cancer centers, and allow them to collaborate around implementation.

Collaborative Development

- Small planning group – 3 health systems and an organization with Learning Collaborative experience.
- Survivorship Care Plan Interviews
  - If you had to start over again from scratch what would you do differently to implement the care plan process?
    - What care plan document do you use and why?
    - How do you measure success?
    - What advice do you have for other organizations beginning this process?

Our Disclaimer

- This project and all of its documents have been produced by MDHHS staff through interviews with other organizations and review of literature.

- We are not affiliated in any way with the Commission on Cancer. We are not able to advise you in any way regarding your upcoming survey and what practices will meet Commission on Cancer standards.

- You are advised to speak with the Commission on Cancer as it relates to all questions related to your compliance.

Project Overview

- Problem statement: Accredited Cancer Centers lack a standard process and resources to create and implement survivorship care plans.

- Survivorship Care Plan Project will:
  - Present survey and interview results, as well as published information related to the process of survivorship care plan implementation.
  - Provide opportunities to collaborate with other organizations in Michigan.

Activities:

- Application to Learning Collaborative
- Organizational assessment on survivorship
- Collaborative meetings & calls
- Cancer centers to develop a process for care plan implementation
- Pilot test this process in more than one cancer population
- Develop written policy/procedure for presentation to the Cancer Committee

Comp Cancer Budget

- Biggest expense = Staff time
  - Content interviews and research
  - Collaborative planning
  - Monitoring participant follow through
  - Technical assistance

- One in-person meeting

Application

- Organizations were required to apply for the collaborative
  - All that applied were accepted
  - 22 organizations applied

Survivorship Care Plan Project

Michigan Cancer Consortium

Survivorship Care Plans Learning Collaborative Application

Eligibility. The learning collaborative is open to all cancer centers in Michigan that demonstrate the following:

- ✓ Planning to implement, or are currently implementing within a patient population, survivorship care plans in their institution by January 2015.
- ✓ Willingness to share experiences, both positive and negative, with other collaborative participants and interested organizations.

Expectations of Participants. Participants in the collaborative will be expected to complete the following:

- ✓ Select a champion of the project with knowledge of survivorship care plans.
- ✓ Identify a project lead to serve as the key contact and coordinator.
- ✓ Obtain Cancer Committee support for implementation of survivorship care plans.
- ✓ Build or enhance existing survivorship care plan development and delivery processes.
- ✓ Collect and share aggregated data on utilization and outcomes of survivorship care plans.
- ✓ Send teams of two to three clinical and administrative leaders to the in-person meeting.
- ✓ Participate in monthly group conference calls/webinars, maintaining a spirit of collaborative learning that features open sharing of successes, challenges, and outcomes.
- ✓ Voluntary: Host a site-visit for MDCH staff to assist in policy development.

III. Please complete all of the fields.

Organization Name:			
Project Lead			
Name:		**Title:**	
Mailing address:			
Phone:		**Email:**	
Care Plan Champion			
Name:		**Title:**	
Phone:		**Email:**	
What Electronic Medical Record System do you use?			

Commitment	
To build an active and engaged community, we want to be sure participants have support from their organization to participate and openly share in the Survivorship Care Plan Learning Collaborative. **Please answer the following questions:**	
A. Will your organization commit to sending two to three medical and administrative leaders to an in-person meeting on September 5, 2014?	**Yes or No**
B. Will your organization designate a Project Leader to oversee your organization's participation? Will those leaders be allotted time enough to actively participate in the project?	**Yes or No** **Yes or No**
C. Will your organization commit to sharing practical evaluation information about your approaches to developing, implementing, and expanding survivorship care plan processes, as well as aggregated data on utilization and outcomes?	**Yes or No**
D. Does your institution currently implement survivorship care plans? If yes, for which patient populations?	**Yes or No**
E. How long have you had survivorship care plans implemented at your institution for this patient population?	

This project was supported in part by funding from the Centers for Disease Control and Prevention (CDC) Cooperative Agreement 5U55DP003040. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Assessment

- Completed assessments sent to Project Lead staff person (a State employee)
- No data about a health system was ever shared by the state office
- Projects were required to self identify what they learned in the assessment process to their peers in a collaborative meeting

Initial Assessment, Survivorship Care Plans

The first step of the collaborative is to perform an assessment of your Cancer Center. The goal is to identify what resources and supports are in place that can assist with the implementation of survivorship care plans. This assessment is comprehensive so many Cancer Centers will not have all of these supports in place. The questions are organized by category. The questions do not need to be completed in order and there will be times you may skip to the next question. In each section you will proceed down the page unless the → symbol gives you different directions. Check our yes/no boxes by clicking on them.

Current Support: Determine if your organization has established support for survivorship care plans.

I. Survivorship Care Plan Champion:		
A. Do you have a physician champion?	☐ Yes → ☐ No	Name: Click here to enter text. → *skip to Section II.*
1. If no, is there a physician that could be recruited to be a physician champion?	☐ Yes → ☐ No	Name: Click here to enter text. → *skip to Section II.*

Health System Assessment

- Organizations learned:
  - the importance of a multi-disciplinary survivorship care plan process planning team
  - the need to assess and expand resources available to survivors
  - the need for a tracking process on the completion of care plans
  - the Cancer Registry is the only entity that houses all of the patient's treatment information

Collaborative Meetings

- One in-person meeting with participating by webinar an option
- Five monthly webinars to share information and provide opportunity for collaboration

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."

  - Commission on Cancer 2016 Standards Manual

Planning the Process

- *Photo credit- Pinterest – Trainz Discussion Forum*

Survivorship CARE PLAN PROJECT

Michigan Cancer Consortium

Michigan Department of Community Health

Survivorship Care Plan Implementation Guide

This guide can be used to assist with developing a process for implementing survivorship care plans. It is recommended that organizations complete each stage of the process before moving on to the next.

I. Planning

1. Champion and multidisciplinary team identified for planning, implementation and program evaluation
2. Assessment of cancer center resources, patient record systems and current survivorship programming

II. Getting Started

1. Determine a preliminary budget and evaluation criteria for overall process.
2. Determine strategy to deliver care plans, including platform and staffing.
3. Identify scope of care plan implementation, including patient population and time frame.
4. Determine the care plan template.
5. Determine both staff and patient training needs.
6. Determine pilot site and structure the pilot process.
7. Determine final timeline, budget and evaluation criteria for overall process.

III. Testing the Plan

1. Implement pilot on a small group of patients.
2. Track potential problems, issues and concerns.

IV. Evaluating your Progress

1. Conduct chart audit for quality assurance purposes.
2. Refine process as necessary.
3. Implement changes (if necessary).
4. Re-evaluate the changes added to the process.

V. Rolling out the Plan

1. Expand the pilot to include a new group and larger sample size of patients.

VI. Evaluating the Outcomes

1. Identify what worked well and what could be improved.
2. Finalize the metrics for ongoing quality monitoring.
3. Identify check points to review metrics and to determine process improvement.

Project Tools

Best Practice Document
Getting Started

Getting Started:

- Just start. There is no perfect tool. There is no perfect process.
- Begin small.
- Expect things to go differently than you planned.
- The process of creating a care plan process will take time. Record your actions as you set up this process. Include these in your reporting to the Cancer Committee.

Multidisciplinary Team
Start with the right people choosing people that represent your entire system. Your representation should meet your needs but it might include: nursing, medical oncology, radiation oncology, and other

Project Tools

Best Practice Document
Who Completes Care Plans?

Throughout the country there are many different ways that Survivorship Care Plans are being implemented. Your approach will be based on your budget, your resources and your cancer center's overall approach to survivorship care. Care plans can be a resource intensive project. Your challenge will be to examine your system in order to streamline this process.

This best practice document will provide information on how care plans are being completed in other organizations. Remember to think about all cancer types as you develop your model. If you only have nurse navigators in 1 or 2 cancer types a nurse navigator model may not be the best implementation choice unless you plan to add nurse navigators to cover all cancers.

How Do We Decide What Model to use?
Questions to Consider
• Are treatment summaries/clinical summaries being completed?   ○ Are there summaries of treatment being completed by modality (e.g., radiation therapy)?

Project Tools

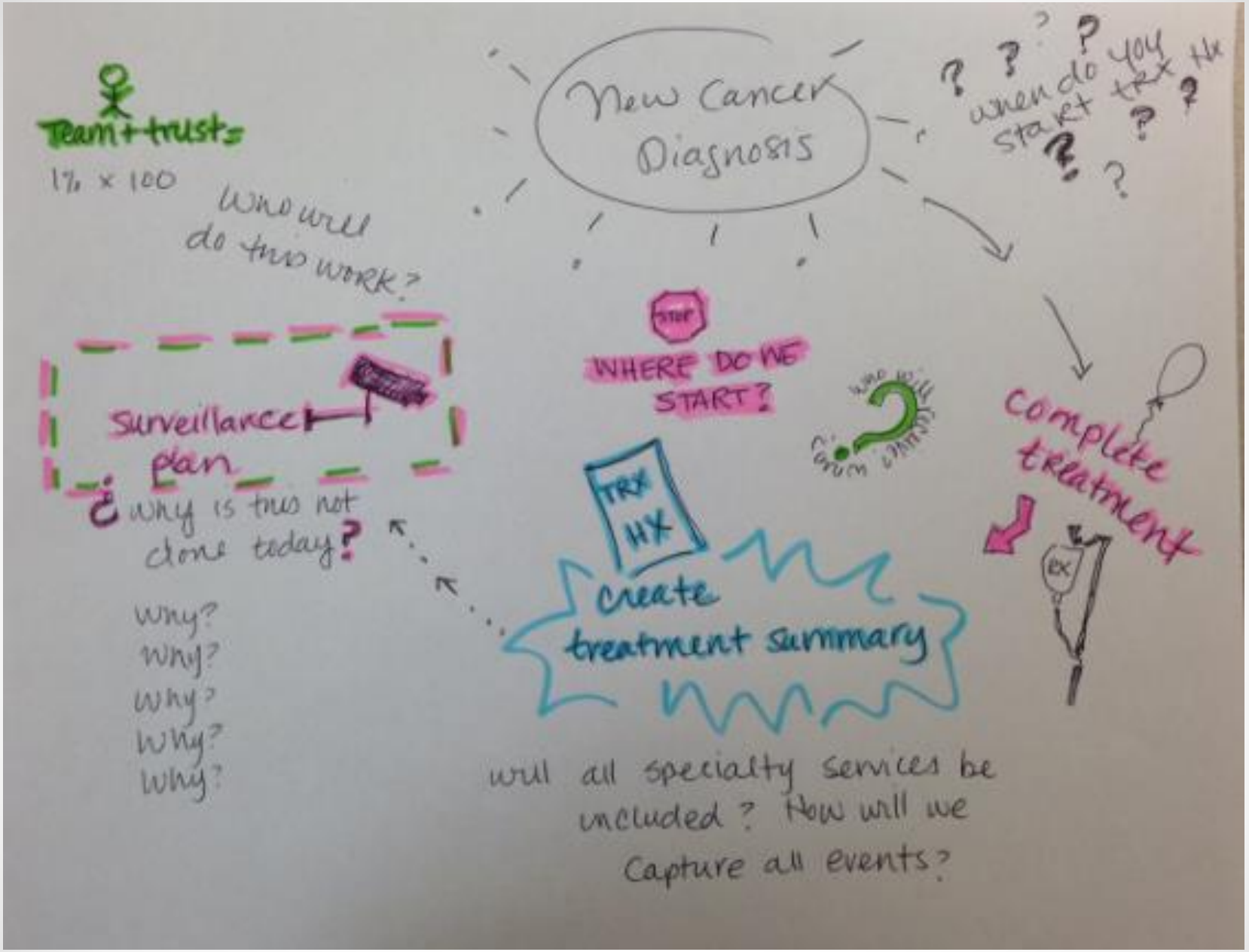
Best Practice Document
Survivorship Care Plan Tools

There are many survivorship care plan tools available that are currently available for use. There is no perfect or even preferred Survivorship Care Plan tool, each tool has its advantages and disadvantages. The tool your team selects should be one that will accomplish what you need it to do and works best for your system.

How Do We Decide?
Review your Assessment Questions
Review your assessment for guidance on what tools may work best for your organization. For example: • Does your Electronic Medical Record (EMR) system suggest the use of a specific care plan tool type?

A word about process

- This standard is a process statement
  - Your tool (EMR, ASCO, build your own, Journey Forward) is only that, a tool.
    - It will not solve the process components
- You have to focus on:
  - Who will complete the form
  - How is it going to be given to the patient
  - Who is going to talk to the patient
- Many people think the tool will solve the problem ("Once we get our EMR….")
  - The EMR cannot address the process questions



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The Pilot Process

- A pilot population allows you to test your process and make small changes before spreading it to encompass larger patient populations.

- Will be using the Institute for Healthcare Improvement (IHI) model for quality improvement: Plan-Do-Study-Act (PDSA).

Completed Plans

- Determine where completed plans will be stored.
  - How will you know it is complete? Will other staff know it is completed?
  - How will other staff who may be able to utilize the plan at a follow-up appointment know where it is?

Tips From the Field

- Use an already scheduled appointment to go over the care plan with the patient and take notes during your conversation. Update the care plan with necessary resources from the meeting and mail the completed plan to the patient.

- Create a letter to accompany the survivorship care plan to the primary care physician so they understand what the care plan is and how to use it.

Tips From the Field

- Use a quality of life assessment for the patient at each visit and continue to add resources based on the patient's level of distress and reported concerns.

- Create a "master list" of resources which can be used to pull information from for individual patients depending on their needs.

Definitions

Defining survivorship: Cancer committee can define who receives care plans and who is excluded from receiving care plans:

- For example, stage 4 metastatic patients will never leave treatment and therefore will not be referred back to primary care; so therefore, they do not require a care plan.
- This type of definition will NOT allow you to exclude cancer types or only provide care plans to a select few.

Defining when treatment ends: The cancer committee can define when survivorship care plans are completed by defining when treatment ends:

- Consider how specific and how vague to make your procedure as defined by the cancer committee.
- Does treatment end with the last dose is given or the first appointment after the last dose?

Tips From the Field

- Incorporate survivorship care plans from the beginning of your process.
  - By collecting necessary information throughout the treatment process, time was saved because staff did not have to search for the information when treatment was completed.

Key Concepts in Implementation

- DO NOT design your care plan process utilizing only one cancer type.

- Think of this as a process…
  - Who is doing what?
  - When is it being done?
  - Where is information found?
  - How are you tracking care plan completion?
- Identifying your care plan tool – ASCO, Journey Forward, build your own…
  - This is step 1, most systems think this is the core decision

Key Concepts in Implementation

- Multi-disciplinary team
  - Care plans cannot be developed in isolation
- Break down the implementation process into smaller steps
  - How will the treatment summary be completed?
  - How will the follow-up plan be completed?
  - Who will meet with the patient?
  - What resources do we have to offer survivors as a part of the follow-up plan?

Benefits to Participants

- Collaborating with other cancer centers on how best to provide a survivorship care plan to patients
- Reasonable time frame and goals established which propelled development of the survivorship care plan program
- Establishing a clear survivorship care plan process
- Raised awareness around the need for a survivorship care plan

Benefits to the Coalition

- One new Michigan Cancer Consortium Member
- Allowed the Michigan Cancer Consortium to provide a valuable product to coalition members
- New relationships within and outside of the Michigan Cancer Consortium

Reported outcomes

- Made survivorship care plans a priority
- Implementing survivorship care plan to more than one cancer type
- Increased communication
- Increased teamwork
- Focused on the system change process of implementing new programming by breaking down implementation into smaller manageable pieces
- Decreased isolation

Ongoing Challenges

- System "by-in" - "Sally" is working on that
  - Isolation can be dangerous in care planning
- Finding an engaged team – the right people with enough time
- Getting information from private physicians
- Physician "buy-in"
- Tracking completed care plans – When are they done? Was it given to patient? How do we track that?

CoC Implementation Timeline

- January 1, 2015 – Implement a pilot survivorship care plan process involving 10% of eligible patients
- January 1, 2016 – Provide a survivorship care plan to 25% of eligible patients
- January 1, 2017 – Provide a survivorship care plan to 50% of eligible patients
- January 1, 2018 – Provide a survivorship care plan to 75% of eligible patients
- January 1, 2019 – Provide a survivorship care plan to 100% of eligible patients

Acknowledgements

- MCC Workgroup for Survivorship Care Plans:
  - Deb Bisel, Spectrum Health Cancer Program, Grand Rapids
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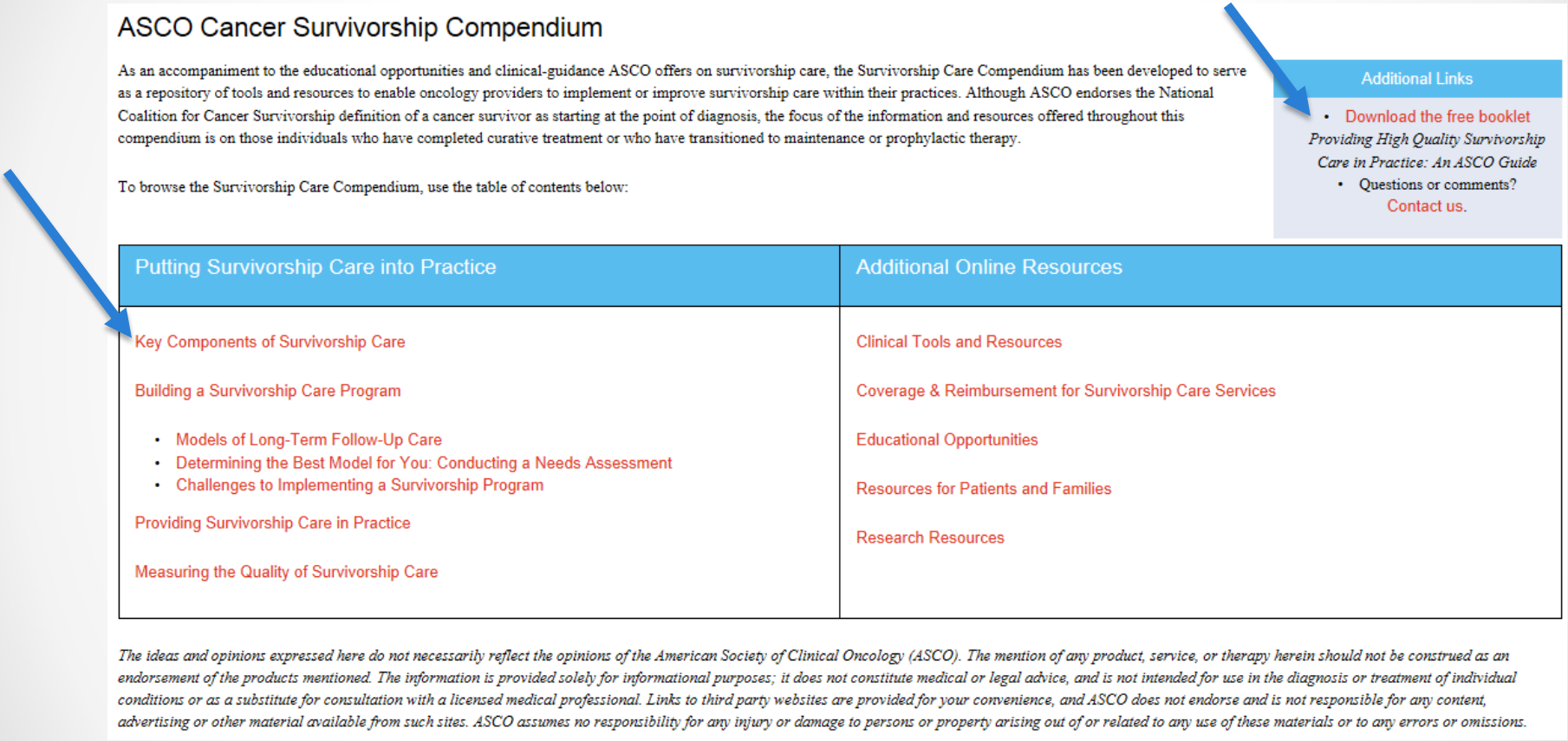
  - Debbie Webster, Michigan Department of Health & Human Services
  - Laura Petersen, Michigan Oncology Quality Consortium
  - Jamie Lindsay, Michigan Oncology Quality Consortium

ASCO Survivorship Compendium



ASCO Cancer Survivorship Compendium

As an accompaniment to the educational opportunities and clinical-guidance ASCO offers on survivorship care, the Survivorship Care Compendium has been developed to serve as a repository of tools and resources to enable oncology providers to implement or improve survivorship care within their practices. Although ASCO endorses the National Coalition for Cancer Survivorship definition of a cancer survivor as starting at the point of diagnosis, the focus of the information and resources offered throughout this compendium is on those individuals who have completed curative treatment or who have transitioned to maintenance or prophylactic therapy.

To browse the Survivorship Care Compendium, use the table of contents below:

Additional Links

- Download the free booklet *Providing High Quality Survivorship Care in Practice: An ASCO Guide*
- Questions or comments? Contact us.

Putting Survivorship Care into Practice	Additional Online Resources
Key Components of Survivorship Care	Clinical Tools and Resources
Building a Survivorship Care Program • Models of Long-Term Follow-Up Care • Determining the Best Model for You: Conducting a Needs Assessment • Challenges to Implementing a Survivorship Program	Coverage & Reimbursement for Survivorship Care Services
Providing Survivorship Care in Practice	Educational Opportunities
Measuring the Quality of Survivorship Care	Resources for Patients and Families Research Resources

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- http://www.asco.org//practice-research/asco-cancer-survivorship-compendium

For More Information

- Michigan Cancer Consortium
  - http://www.michigancancer.org/AboutTheMCC/CurrentProjects-SCP.html

- Debbie Webster
  - WebsterD1@michigan.gov

Questions

References & Credits

References:

- American College of Surgeons. (2015) *Cancer Program Standards: Ensuring Patient-Centered Care. Chicago, IL*
- American Society of Clinical Oncology. (2015) ASCO Survivorship Compendium. Retrieved on June 8, 2015 from http://www.asco.org/practice-research/asco-cancer-survivorship-compendium

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- White Board: Care Plan Development. Michigan Oncology Quality Consortium
- All other photos from personal collection