Quality Assessment and Safety Committee

Cancer Survivorship Care – An Emerging Focus for Quality of Cancer Care Delivery

Epidemiology of Cancer Survivorship

As a result of increasingly successful treatment for cancer, the United States (US) healthcare delivery system now manages an unprecedented number of people who are considered "cancer survivors." An estimated 15 million cancer survivors are estimated to be living in the US currently, and this number is expected to increase to 19 million by 2024.[1] With the 5-year survival rate reaching 90% among patients with localized disease, there are an estimated 1.4 million colorectal cancer (CRC) survivors in the US as of 2016 and this number is estimated to increase to 1.8 million over the next 10 years.[2] Recent data documenting a rise in the rate of CRC in young individuals will only accelerate this trend.[3]

Survivorship Care – an Unmet Need

The specific needs of cancer survivors are increasingly recognized as being distinct from those individuals undergoing active treatment for cancer. In particular, the transition from treatment to surveillance can be quite challenging for patients and for health care delivery systems. This challenge was recognized in a landmark monograph released by the Institute of Medicine (IOM) in 2006 - "Lost In Transition".[4] In this piece, the IOM identified 4 domains of survivorship care:

- Prevention: Engagement in routine preventive health measures
- Surveillance: Evidence-based measures to detect recurrent/persistent disease
- Intervention: Identification and management of short-term and long-term effects of cancer and its treatment
- Coordination: Managing communication between cancer treatment providers and primary care/other clinicians

Models for Survivorship Care

While there is considerable controversy regarding when survivorship care begins, it is generally considered to begin at the time of completion of initial treatment (surgery + any adjuvant therapy planned at time of staging). There is no one best way to provide survivorship care, and the pragmatics of care delivery differ between healthcare systems. The most commonly described models used to delivery survivorship care are:[5]

- Transition to Primary Care Model: Patient care is returned back to a primary care physician upon completion of cancer treatment.
- Consultative Clinic Model: Survivorship care is coordinated during a single visit, after which care is transitioned to primary care or specialty care.
- Integrated Care Model: Care provided through oncology clinic.

- Disease-Specific Model: Highly specialized care is provided through a survivorship care clinic that manages subspecialized surveillance/intervention needs.
- Multidisciplinary Clinic Model: Overlapping care is provided through primary care, surgery, and oncology providers.

The Survivorship Care Plan

As part of its Lost in Transition monograph, the IOM identified the Survivorship Care Plan (SCP) as an important element of care that every patient should receive after cancer care is completed. The elements that constitute a SCP include: a treatment summary, cancer stage/biologic characteristics, schedule for surveillance, clinical trial participation, psychosocial supports given, contact information for treating physicians and providers and relevant education regarding treatment-related side effects.

The Commission on Cancer (CoC) and Survivorship Care Plans

The Commission on Cancer (CoC) is a program of the American College of Surgeons (ACS) that is dedicated to improving cancer care within the US. In 2012, the Commission on Cancer formally acknowledged the importance of SCPs as an element of quality of care for patients treated for cancer with curative intent (stage IV cancers are excluded). In their V1.2.1 guidelines, released in 2012, any hospitals that treat cancer were formally expected to "...develop and implement a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment…" **This standard was elucidated further in the 2016 standards with the specification that in 2017 half of patients treated for cancer at a CoC-accredited facility should receive an SCP, and that this requirement will increase to 75% in 2018.[6]**

Resources to Assist with Survivorship Care and Survivorship Care Plans

The process of integrating survivorship care and SCP delivery into a comprehensive cancer treatment program is challenging. There are currently several templates that function separately from the electronic medical record (EMR), and these can help with organizing the elements of a SCP. The American Society of Clinical Oncology (ASCO) has a well-established template that is freely available for clinicians to use, as does Journey Forward (a collaboration of public and private cancer treatment/research organizations).[7, 8] Unfortunately, the time required to complete these templates can be excessive, with nearly an hour required to generate a SCP[9]. Several programs have documented successes with using EMR-based approaches to auto-populate data, dramatically reducing the time required.[10, 11] As recognition of the importance of survivorship care grows, it is likely that the EMR and other technologies will have an expanding role in facilitating survivorship care and the delivery of SCPs.

Summary

Survivorship care is increasingly recognized as an important element of cancer treatment. The Commission on Cancer and the American College of Surgeons are actively promoting survivorship, using the Commission on Cancer accreditation process as a lever. Integrating survivorship care into a multi-disciplinary cancer program is pragmatically challenging, but appropriate integration with an EMR may smooth this transition.

Selected References

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