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KEY COMPONENTS IN DEVELOPING A **Successful Survivorship Program** IN THE COMMUNITY HOSPITAL

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Thankfully, cancer survivorship is sweeping the country. Advances in screening and early detections, therapeutic interventions and supportive care services are creating a mass of cancer survivors. The American Cancer Society estimates that by 2025 there will be over 20 million cancer survivors nationally.

In response to the 2006 landmark report from the Institute of Medicine, *From Cancer Patient to Cancer Survivor: Lost in Transition*, accrediting bodies such as the American College of Surgeons: Commission on Cancer have enacted standards to ensure that accredited programs include care for this patient population.¹

Standard 3.3 is a survivorship care plan that requires that the survivors be “provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained.”²

Starting in 2015 the College required COC facilities to implement a process to disseminate a comprehensive care summary and follow-up plan to patients completing cancer treatment.

Successfully meeting this standard is a challenge at best, and practical guidance is difficult to obtain. In a recent Oncology Roundtable study of 178 accredited programs, 52% found

achieving Standard 3.3 Survivorship care plan very challenging.³

At Concord Hospital, we found value in leveraging the tumor registry for treatment information and staging. Certified Tumor Registrars have the knowledge, education and skill set to efficiently support the clinical needs. Utilization of established tools such as Journey Forward templates was also beneficial. In our case, as in the case of many community centers, attempts to integrate within existing electronic health records have not yielded efficiencies. The extensive resources required to develop, program, and test queries are often not allocated given the current information technology department demands.

While data abstracting is a challenge, it can be overcome. But determining appropriate timeframes required far more of our attention. Survivorship Care plans are required by the COC to be provided within 12 months of diagnosis and within 6 months of completing definitive treatment. Identifying qualified patients within relatively small timeframes proved to be a significant challenge.

Moving the Cancer Registry to concurrent abstracting and implementing a continual review process was essential to our success. Once identified, the patients were then referred to the clinical team for scheduling, care plan development, and delivery. A Nurse Practitioner-led model allows for payor reimbursement but requires a practitioner who has the knowledge and passion to fill such role.



Reimbursements have not proven to cover the total expense of our Survivorship Program and many cancer centers, including the one at Concord Hospital, must rely on philanthropic support.

Establishing collaboration with specialists is vital to the success of the Survivorship Program. In our experience, surgeons and other clinicians who initiate the referral with their patients early have yielded the highest acceptance rate. Care teams explaining that this is the next phase of treatment also helps garner patient engagement.

Beyond understanding of the diagnosis, treatment, late effects and surveillance, much of the education is centered on supportive care and recurrence prevention. The need for social work to provide wellness education and counseling cannot be understated. Further patient education should address diet, environment, lifestyle modification, and exercise among other concerns.

A structured Survivorship visit bridges an important gap between acute treatment and surveillance. Patients often report feeling disconnected and wondering, “What’s next?”

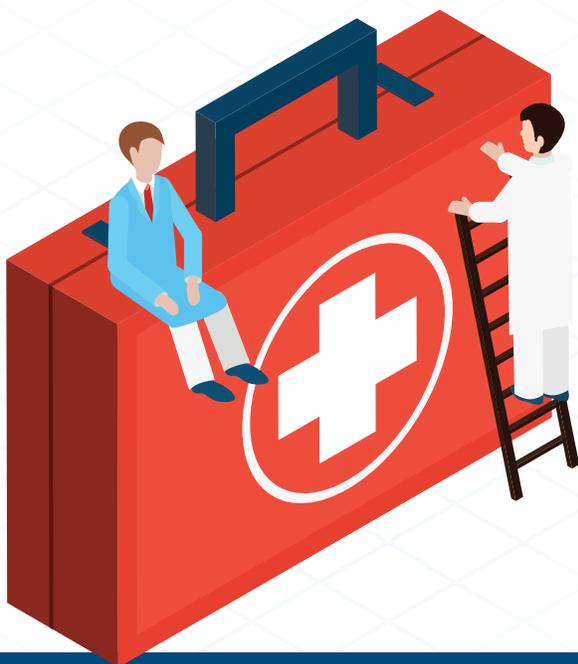
The results of a survivorship visit include a more informed patient, a defined survivorship care plan, and clear patient/PCP/specialist role responsibilities. The question of who is going to initiate imaging studies and screenings, order blood work, and monitor late effects must be addressed. Collaboration with multiple specialists and primary care providers is necessary for improved patient outcomes as well as for program sustainability. Demonstrating value and garnering support requires continual involvement of all stakeholders.

Though there are multiple challenges with identifying survivors, data abstraction, reimbursement, delivery, and distribution of survivorship care plans, solutions and compliance are within your reach.

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Article references:

¹ Hewitt M, Greenfield S, Stovall E. From Cancer Patient to Cancer Survivor: Lost in Transition. 2005. Washington, D.C.: The National Academies Press.

² American College of Surgeons Commission on Cancer. Cancer Program Standards 2012: Ensuring Patient-Centered Care V1.2. 2012. Chicago, IL; American Colleges of Surgeons.

³ Advisory Board: 2017 Trending Now In Cancer Survey: Oncology Roundtable interviews and analysis. Presented by Riley, Ashley: 2019 Association of Cancer Executives Annual Meeting; Assessing the Value of Oncology Accreditations.

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