Treatment Clinic Model for the Oncology Patient

Carrie Wines-Larch, BSN, RN, ONN-CG

Nurse Navigator & Survivorship Coordinator

CAMC Health System

Vandalia Health

Disclosures

Carrie Wines-Larch, BSN, RN, ONN-CG, has no relevant financial relationships to disclose.

CAMC Health System

Vandalia Health

TIME TRAVEL TIME!

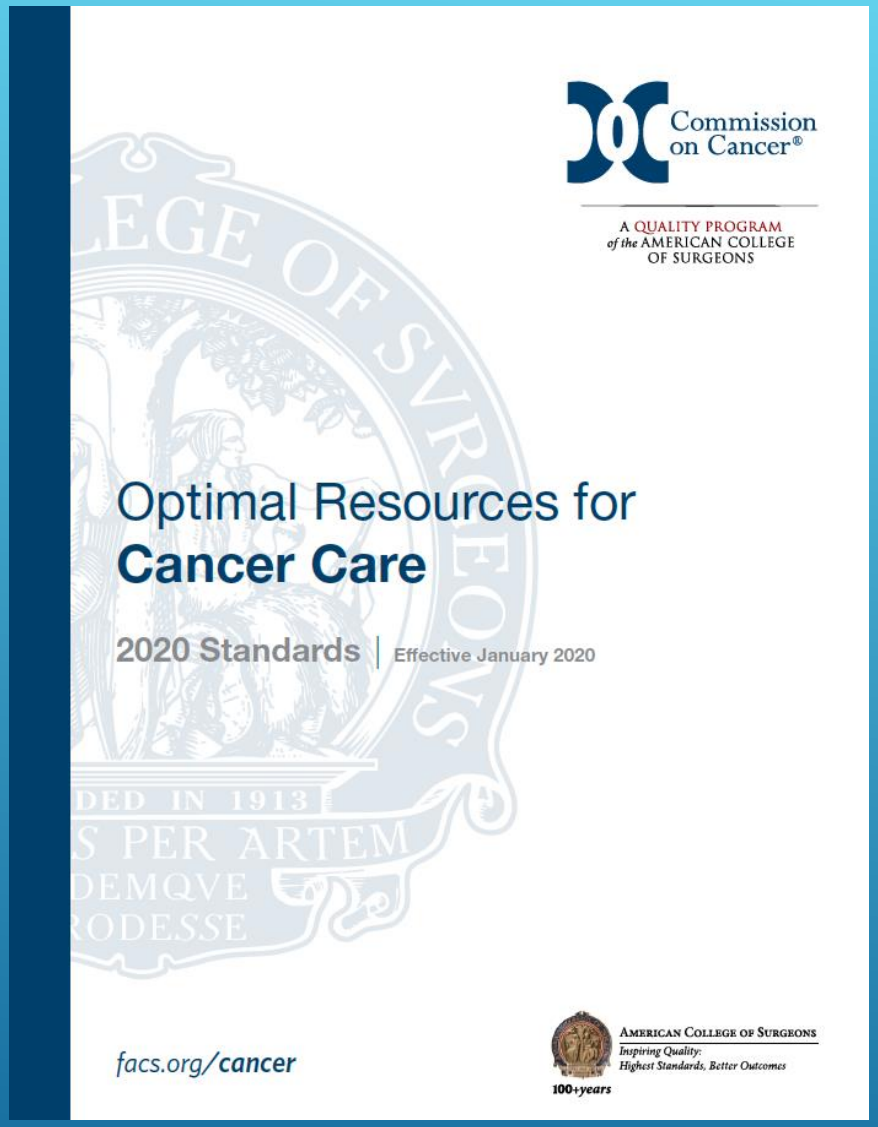
Survivorship Program Timeline

New process implemented

- 2nd year deficiency identified
- EHR enhancement option reviews begin
- CoC released Survivorship Program requirements
- EHR enhancement software approved.
- EHR enhancement & Treatment Clinic project planning begins
- New software education materials reviewed and training begins
- GO-Live date delayed
- GO-Live for treatment clinic featuring PRE & POST appointment types.
- Survivorship Program implementation
- New EHR enhancement software implementation
- Modifications to clinic/program
- Continued evaluation of program success
- 2020 CoC survivorship standard phase-in year ends and 2021 implementation year begins
- **2021**
  - Pre Tx clinic – **259**
  - Post Tx clinic - **113**
- **2022**
  - Pre Tx clinic – **280**
  - Post Tx clinic - **85**
- **Dec 2022 – March 2023 STAIRS PILOT**

Sept 19 | Oct 19 | Dec 20 | Feb 20 | April 20 | July 20 | Sept 20 | Oct 20 | Dec 20 | Jan 2021

Pandemic



9 SECTIONS WITH 17 STANDARDS REQUIRING ANNUAL REVIEW

https://www.facs.org/quality-programs/cancer/coc/standards/2020

Accreditation Process

Processes for accreditation are detailed and updated on the Commission on Cancer (CoC) website. The CoC reserves the right to revise accreditation processes as needed.

Categories of Cancer Programs

Category designations are made at the time of initial application and are retained unless there are changes to the services provided and/or the facility caseload for three consecutive years. Descriptions and definitions for the following cancer program categories can be found on the CoC website.

- Academic Comprehensive Cancer Program (ACAD)
- Community Cancer Program (CCP)
- Comprehensive Community Cancer Program (CCCP)
- Free Standing Cancer Center Program (FCCP)
- Hospital Associate Cancer Program (HACP)
- Integrated Network Cancer Program (INCP)
- NCI-Designated Comprehensive Cancer Center Program (NCIP)
- NCI-Designated Network Cancer Program (NCIN)
- Pediatric Cancer Program (PCP)
- Veterans Affairs Cancer Program (VACP)

Standards Requiring Annual Review

The following standards require a review of services at least once each calendar year. These reviews must be documented in the cancer committee minutes and must take place within the same year on which they are based or no later than the first quarter of the following calendar year. This requirement applies to the annual review required in:

- Standard 2.5: Multidisciplinary Cancer Case Conference
- Standard 4.4: Genetic Counseling and Risk Assessment
- Standard 4.5: Palliative Care Services
- Standard 4.6: Rehabilitation Care Services
- Standard 4.7: Oncology Nutrition Services
- Standard 4.8: Survivorship Program
- Standard 5.2: Psychosocial Distress Screening
- Standard 6.1: Cancer Registry Quality Control
- Standard 8.1: Addressing Barriers to Care
- Standard 8.2: Cancer Prevention Event
- Standard 8.3: Cancer Screening Event
- Standard 9.1: Clinical Research Accrual

Studies/projects/reports required in the following standards count for the year they are completed and documented in the cancer committee minutes:

- Standard 2.2: Cancer Liaison Physician
- Standard 6.4: Rapid Quality Reporting System (RQRS) Participation
- Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines
- Standard 7.3: Quality Improvement Initiative
- Standard 7.4: Cancer Program Goal

A Standard 7.3 project or Standard 7.4 goal that extends into a second year will only count for the year it is initiated.

PHASE-IN STANDARD

4.8 Survivorship Program

Definition and Requirements

The cancer committee oversees the development and implementation of a survivorship program directed at meeting the needs of cancer patients treated with curative intent.

Survivorship Program Team
The cancer committee appoints a coordinator of the survivorship program per the requirements in Standard 2.1: Cancer Committee.

The Survivorship Program Coordinator develops a survivorship program team. Suggested specialties include physicians, advanced practice providers, nurses, social workers, nutritionists, physical therapists, and other allied health professionals.

The survivorship program team determines a list of services and programs, offered on-site or by referral, that address the needs of cancer survivors. The team formally documents a minimum of three services offered each year. Services may be continued year to year, but it is expected that cancer programs will strive to enhance existing services over time and develop new services.

Each year, the survivorship program coordinator gives a report, and the cancer committee reviews the activities of the survivorship program. The report includes:

- An estimate of the number of cancer patients who participated in the three identified services
- Identification of the resources needed to improve the services if barriers were encountered

Survivorship Program Services
Services utilized by the survivorship program may include, but are not limited to:

- Treatment summaries
- Survivorship care plans
- Screening programs for cancer recurrence
- Screening for new cancers
- Seminars for survivors
- Rehabilitation services
- Nutritional services
- Psychological support & psychiatric services
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling
- Financial support services
- Physical activity programs

Survivorship Care Plans (SCP)
The CoC recommends and encourages that patients receive a survivorship care plan (SCP), but delivery of such plans is not a required component of this standard. Delivery of SCPs may be utilized as one of the services offered to survivors to meet the requirements of this standard. If so, then the program defines the population to receive care plans.

Documentation

Submitted with Pre-Review Questionnaire

- Policy and procedure defining the survivorship program requirements
- Cancer committee minutes that document the required yearly evaluations of the survivorship program

Measure of Compliance

Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee identifies a survivorship program team, including its designated coordinator and members.
2. The survivorship program is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes.

Bibliography

Jacobs, LA, Shulman LN. Follow-up care of cancer survivors: Challenges and solutions. *Lancet Oncol*. 2017;18:e19-29.

Mayer DK, Nekhyudov L, Snyder CF, Merrill JK, Wollins DS, Shulman LN. American Society of Clinical Oncology clinical expert statement on cancer survivorship care planning. *J Oncol Practice*. 2014;10:345-351.

Nekhlyudov L, Mollica MA, Jacobsen P, Mayer DK, Shulman LN, Geiger AM. Developing a quality of cancer survivorship care framework: Implications for clinical care, research, and policy. *J Natl Cancer Inst*. 2019.

2018 & 2019 – DEFICIENCY OF STANDARD 3.3; SURVIVORSHIP CARE PLAN DELIVERY

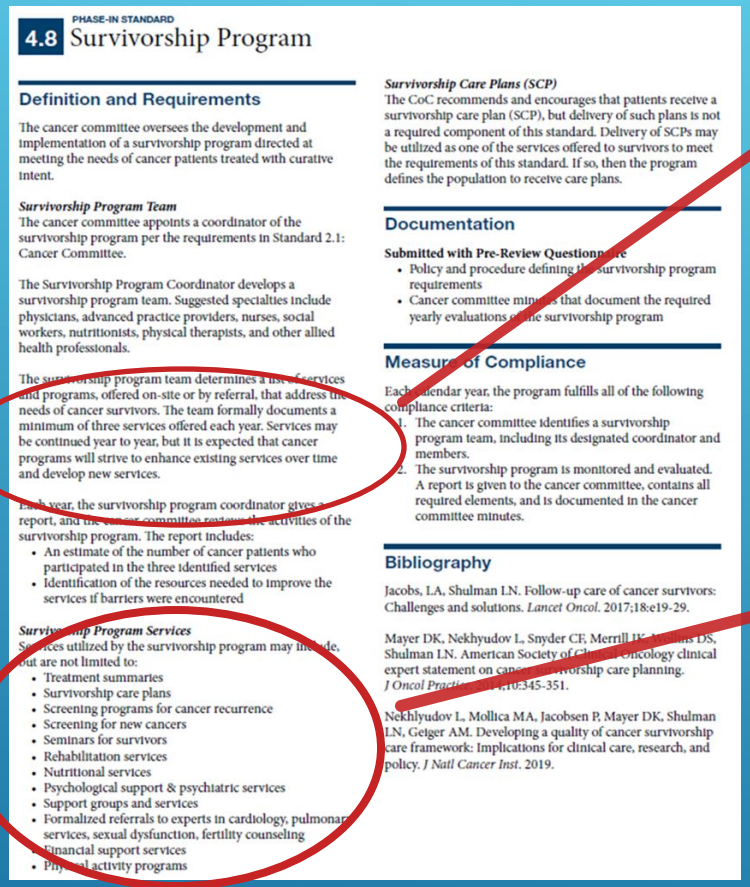
2019 (LATE) – APPROVAL FOR EHR ADD-ON SOFTWARE

2020 – PHASE IN YEAR / PANDEMIC

* IMPLEMENTATION OF SOFTWARE (FEB W/ GO-LIVE DATE JULY (SEPT))

* TREATMENT CLINIC (TREATMENT PLAN, NUTRITIONAL EVAL, FINANCIAL SUPPORT & PSYCHOLOGICAL SUPPORT)

2021 – IMPLEMENTATION YEAR



PHASE-IN STANDARD

4.8 Survivorship Program

Definition and Requirements

The cancer committee oversees the development and implementation of a survivorship program directed at meeting the needs of cancer patients treated with curative intent.

Survivorship Program Team
The cancer committee appoints a coordinator of the survivorship program per the requirements in Standard 2.1: Cancer Committee.

The Survivorship Program Coordinator develops a survivorship program team. Suggested specialties include physicians, advanced practice providers, nurses, social workers, nutritionists, physical therapists, and other allied health professionals.

The survivorship program team determines a list of services and programs, offered on-site or by referral, that address the needs of cancer survivors. The team formally documents a minimum of three services offered each year. Services may be continued year to year, but it is expected that cancer programs will strive to enhance existing services over time and develop new services.

Each year, the survivorship program coordinator gives a report, and the cancer committee reviews the activities of the survivorship program. The report includes:
- An estimate of the number of cancer patients who participated in the three identified services
- Identification of the resources needed to improve the services if barriers were encountered

Survivorship Program Services
Services utilized by the survivorship program may include, but are not limited to:
- Treatment summaries
- Survivorship care plans
- Screening programs for cancer recurrence
- Screening for new cancers
- Seminars for survivors
- Rehabilitation services
- Nutritional services
- Psychological support & psychiatric services
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling
- Financial support services
- Physical activity programs

Survivorship Care Plans (SCP)
The CoC recommends and encourages that patients receive a survivorship care plan (SCP), but delivery of such plans is not a required component of this standard. Delivery of SCPs may be utilized as one of the services offered to survivors to meet the requirements of this standard. If so, then the program defines the population to receive care plans.

Documentation

Submitted with Pre-Review Questionnaire
- Policy and procedure defining the survivorship program requirements
- Cancer committee minutes that document the required yearly evaluations of the survivorship program

Measure of Compliance

Each calendar year, the program fulfills all of the following compliance criteria:
1. The cancer committee identifies a survivorship program team, including its designated coordinator and members.
2. The survivorship program is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes.

Bibliography

Jacobs, LA, Shulman LN. Follow-up care of cancer survivors: Challenges and solutions. *Lancet Oncol.* 2017;18:e19-29.

Mayer DK, Nekhyudov L, Snyder CF, Merrill JK, Wollins DS, Shulman LN. American Society of Clinical Oncology clinical expert statement on cancer survivorship care planning. *J Oncol Pract.* 2014;10:345-351.

Nekhlyudov L, Mollica MA, Jacobsen P, Mayer DK, Shulman LN, Geiger AM. Developing a quality of cancer survivorship care framework: Implications for clinical care, research, and policy. *J Natl Cancer Inst.* 2019.

The survivorship program team determines a list of services and programs, offered on-site or by referral, that address the needs of cancer survivors. The team formally documents a minimum of three services offered each year. Services may be continued year to year, but it is expected that cancer programs will strive to enhance existing services over time and develop new services.

Survivorship Program Services
Services utilized by the survivorship program may include, but are not limited to:
- Treatment summaries ★
- Survivorship care plans ★
- Screening programs for cancer recurrence
- Screening for new cancers
- Seminars for survivors
- Rehabilitation services
- Nutritional services ★
- Psychological support & psychiatric services ★
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling ★
- Financial support services ★
- Physical activity programs

Palliative Care ★

CURRENT SERVICES OFFERED:

PRE-TX CLINIC APT – NURSE NAVIGATION, FINANCIAL NAVIGATION, NUTRITIONAL SCREENING, PSYCHOSOCIAL SUPPORT, NP EVALUATION, PALLIATIVE CARE EVALUATION & TX PLAN.

POST-TX CLINIC APT - NURSE NAVIGATION, FINANCIAL NAVIGATION, NUTRITIONAL SCREENING, PSYCHOSOCIAL SUPPORT, NP EVALUATION & SCP.

BREAST CENTER – SCP SCHEDULING TO POST-TX CLINIC

Treatment Clinic

- Breast, Colon, Head & Neck and Lung diagnosis
- **Two** appointment types
  - **PRE TX visit** (Approx. 1 wk. after initial oncologist visit)
    - Tuesday & Wednesday
    - Multidiscipline
      - Nurse Navigator, Dietitian, Social Work, Financial Navigator & Nurse Practitioner (Psychologist available)
      - Palliative care services available same day on Wednesdays
    - Treatment Care Plan (Carevive)
      - Electronic version available
  - **POST TX visit** (Approx. 6-8 wks. Post therapy completion)
    - Tuesdays
    - Multidiscipline
      - Nurse Navigator, Nurse Practitioner (Dietitian, Social Work, Financial & Psychologist available
    - Survivorship Care Plan (Carevive)
      - Electronic version available
      - Copy provided to PCP/Family Physician

CAMC Health System

Vandalia Health

PRE-TX Visit

- Patient completes electronic patient survey that assists with pulling tailored educational needs based on responses.
  - Mobile/desktop at home
  - Tablet same day
- Multidisciplinary team barrier evaluations & treatment regimen education
  - Nurse navigation, dietitian, social work, financial, NP
- Treatment plan generated & reviewed, labs drawn, scheduling coordination of any further needed referrals, prescriptions are provided, palliative care services introduced

- **Patient quality improvements:**
  - Streamlined multidisciplinary services being provided in one visit.
  - Provided an electronic or written treatment plan document that includes education and resources in addition to any other referrals for services. Plans can be shared with caregivers/family.
  - Visit types include in-person or telehealth.
  - Reduction in delay of care for those receiving IV infusion treatment.
  - Patient reported satisfaction that includes decrease in anxiety associated with starting treatment.

- **Departmental quality improvements:**
  - Streamlined workflows of multiple disciplines.
  - 16% reduction in delay of care for IV infusion scheduling.

CAMC Health System

Vandalia Health

POST TX Visit

- Patient completes electronic patient distress screening survey that assists with pulling tailored educational needs based on responses.
  - Mobile/desktop at home
  - Tablet same day
- Survivorship Nurse Navigator & NP (referral to other disciplines as needs are identified)
  - Survivorship care plan are reviewed, and physical/emotional side effects addressed.
    - Focus on details of diagnosis and completed TX, ongoing physical/emotional side effect management strategies, follow-up schedule and health promotion suggestions.
- Survivorship Care Plan
  - Patient
  - PCP/Family Physician

Patient quality improvements:

- Streamlined multidisciplinary services being provided in one visit.
- Provided an electronic or written treatment plan document that includes education and resources in addition to any other referrals for services. Plans can be shared with caregivers/family.
- Visit types include in-person or telehealth.

Departmental quality improvements:

- Streamlined workflows of multiple disciplines.

CAMC Health System

Vandalia Health

Goals/Success Metrics

Treatment Education

- 100% of the Breast, Lung, Colorectal and H&N patients seen via a pre-treatment clinic visit at the Treatment Clinic.
- Educational document created and reviewed in detail with patient at the pre-treatment clinic visit appointment.
    - Available in paper and electronic formats

Survivorship Care Planning

- 100% of patients treated with a curative intent that have a diagnosis of Breast, Lung, Colorectal and H&N who are seen via pretreatment get an appointment for post treatment clinic where a survivorship care plan is given.
    - Available in paper and electronic formats

Distress Screenings

- 100% of Breast, Lung, Colorectal and H&N Patients seen via a pre-treatment and post treatment clinic visit at the Treatment Clinic.
- Schedule follow-up intervals of distress screening throughout treatment and survivorship phases
- Collection of data referral outcomes

CAMC Health System

Vandalia Health

Goals/Success Metrics

Patient Engagement (Surveys)

- Addressing of barriers to care earlier on in treatment journey
- Care coordination: tracking of referrals (genetic counseling, palliative care, primary care, etc.)

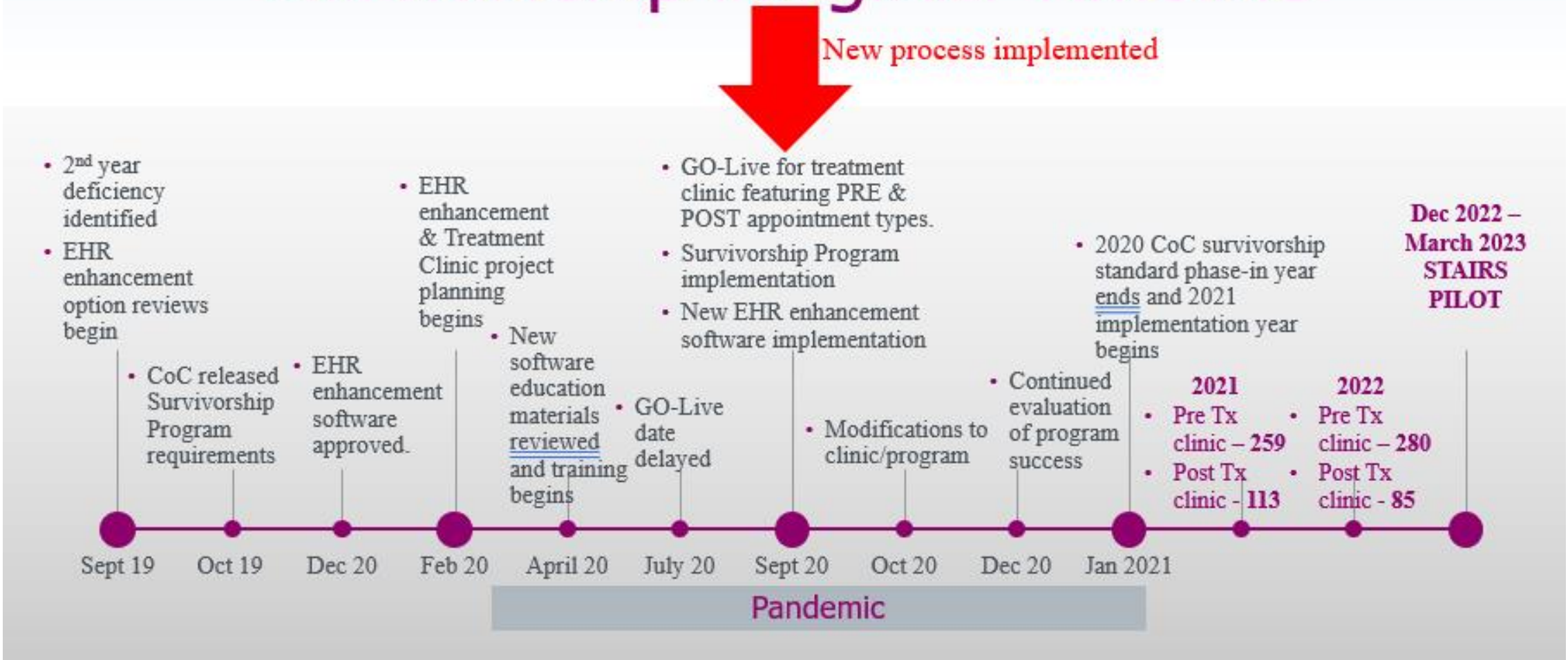
Reporting

- Cancer Committee (CoC standards 4.6, 4.7, 4.8 & 5.2)
- QOPI Certification
- Breast Program Leadership Committee (NAPBC Accreditation)
- Monthly Team meeting/Survivorship Program meeting

CAMC Health System

Vandalia Health

Survivorship Program Timeline



CAMC Health System

Vandalia Health

carevive **STAIRS™**

RESPONSE ⋯⋯→ EHR

INTERVENTION

ASSESSMENT

TRIAGE

SYMPTOM

Carevive PROMPT®
Evidence-Based Symptom Screening & Triage

Carevive STAIRS™
Evidence-Based Symptom Assessment & Management

CAMC Health System

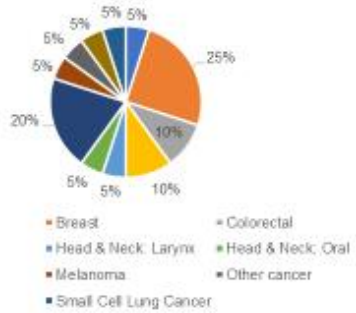
Vandalia Health

CAMC Patient Engagement

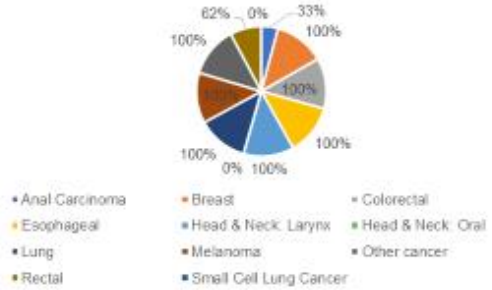
A More Connected Care Experience

Data as of Pilot Go Live 12/6/22

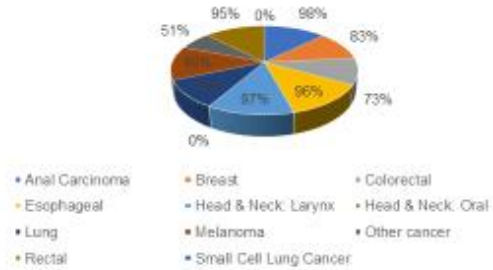
PROmpt™ Enrollments
Total=20



Compliance Rate
How many surveys patients are completing out of how many surveys they have been assigned



Average Completion
How many questions within each survey patients are answering

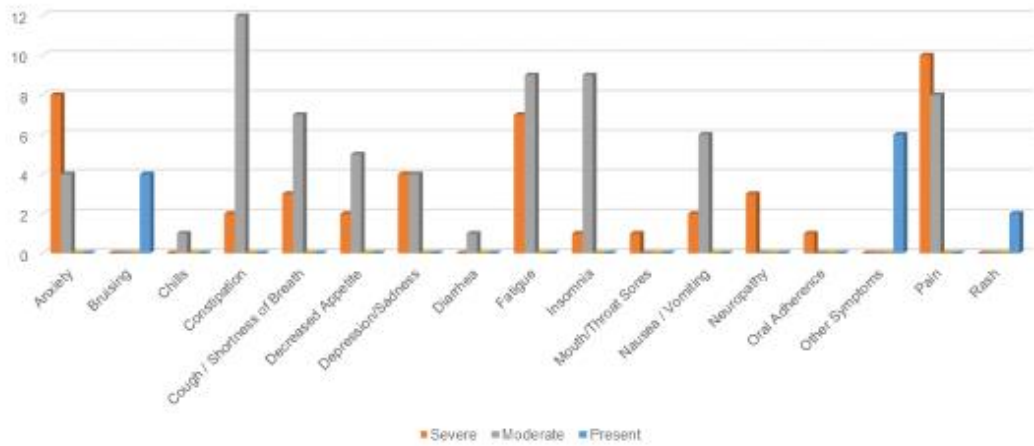


Time to Alert Acknowledgment

89% of alerts closed within 24 hours and 91% closed within 48 hours

GO TEAM!

Alert Types
Total patients: 25
Total alerts=122



CAMC Health System

Vandalia Health

CAMC
Health System

Vandalia Health