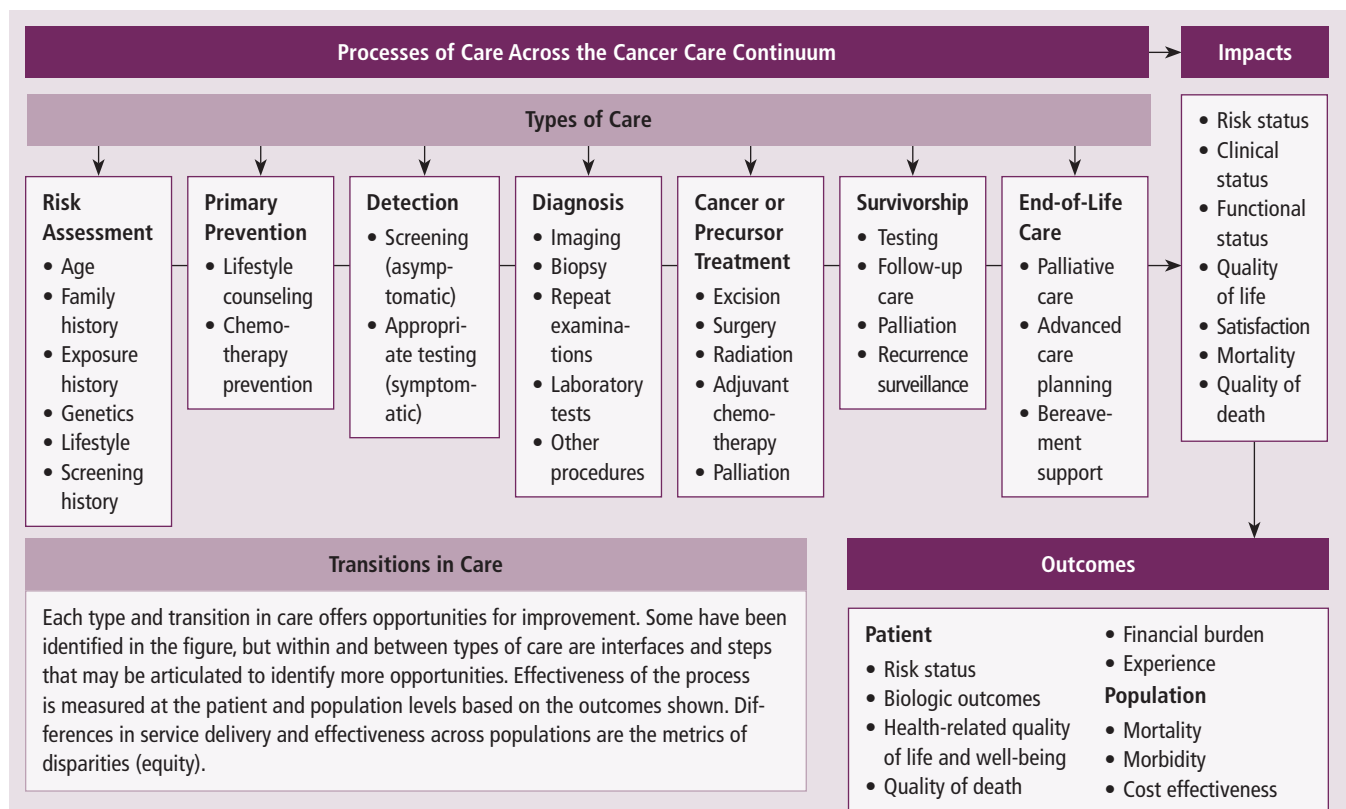# Survivorship Care Plans: Necessary But Not Sufficient?

The Institute of Medicine's (IOM's) report *From Cancer Patient to Cancer Survivor: Lost in Transition* (Hewitt, Greenfield, & Stovall, 2006) was a seminal event for survivorship care, drawing attention to the myriad issues survivors face once treatment ends. The report included 10 recommendations, and one of them focused on survivorship care plans (SCPs), which include a treatment summary and follow-up care plan (IOM, 2005). This was a consensus-based recommendation to facilitate coordination of cancer care between specialists and primary care providers, an essential component of survivorship care (IOM, 2005). Since then, the implementation of this recommendation has been sporadic at best, being adopted by some practices and providers for some patients some of the time (Birken, Mayer, & Weiner, 2013; Forsythe et al., 2013). Reasons for poor adoption have included the length of time it takes to complete SCPs, lack of systems to make the process easier, and lack of reimbursement.

When the American College of Surgeons Commission on Cancer released their new standards in 2012, they called for the implementation of SCP in accredited programs by 2015. Specifically, standard 3.3 listed the following requirement:

- An SCP is prepared by the principal provider(s) who coordinated the oncology treatment for the patient with input from the patient's other care providers.
- The SCP is given to the patient on completion of treatment.
- The written or electronic SCP contains a record of care received, important disease characteristics, and a follow-up



**Processes of Care Across the Cancer Care Continuum** → **Impacts**

**Types of Care**

| Risk Assessment | Primary Prevention | Detection | Diagnosis | Cancer or Precursor Treatment | Survivorship | End-of-Life Care |
|---|---|---|---|---|---|---|
| • Age<br>• Family history<br>• Exposure history<br>• Genetics<br>• Lifestyle<br>• Screening history | • Lifestyle counseling<br>• Chemotherapy prevention | • Screening (asymptomatic)<br>• Appropriate testing (symptomatic) | • Imaging<br>• Biopsy<br>• Repeat examinations<br>• Laboratory tests<br>• Other procedures | • Excision<br>• Surgery<br>• Radiation<br>• Adjuvant chemotherapy<br>• Palliation | • Testing<br>• Follow-up care<br>• Palliation<br>• Recurrence surveillance | • Palliative care<br>• Advanced care planning<br>• Bereavement support |

**Impacts**
- Risk status
- Clinical status
- Functional status
- Quality of life
- Satisfaction
- Mortality
- Quality of death

**Transitions in Care**

Each type and transition in care offers opportunities for improvement. Some have been identified in the figure, but within and between types of care are interfaces and steps that may be articulated to identify more opportunities. Effectiveness of the process is measured at the patient and population levels based on the outcomes shown. Differences in service delivery and effectiveness across populations are the metrics of disparities (equity).

**Outcomes**

**Patient**
- Risk status
- Biologic outcomes
- Health-related quality of life and well-being
- Quality of death

- Financial burden
- Experience

**Population**
- Mortality
- Morbidity
- Cost effectiveness

*Note.* Arrows represent transitions in care.

**FIGURE 1. Opportunities to Influence the Process of Care Across the Cancer Continuum**

*Note.* From "Introduction: Understanding and Influencing Multilevel Factors Across the Cancer Continuum," by S. Taplin, R. Price, H. Edwards, M. Foster, E. Breslau, V. Chollette, . . . J. Zapka, 2012, *Journal of the National Cancer Institute. Monographs, 44,* p. 3. Copyright 2012 by National Cancer Institute. Adapted with permission.

*Note.* From "A Framework for Improving the Quality of Cancer Care: The Case of Breast and Cervical Cancer Screening," by J.G. Zapka, S.H. Taplin, L.I. Solberg, and M.M. Manos, 2003, *Cancer Epidemiology, Biomarkers, and Prevention, 12,* p. 5. Copyright 2003 by the American Association of Cancer Research. Adapted with permission.
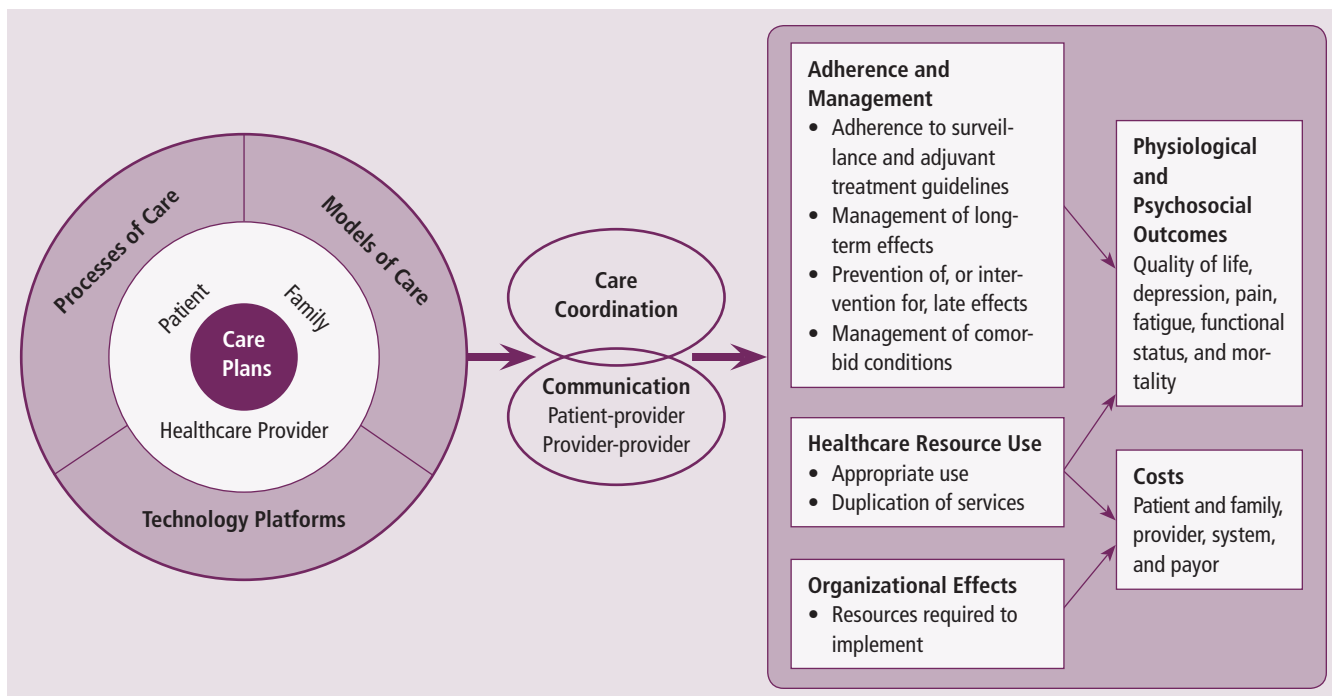
**FIGURE 2. Conceptual Framework for Survivorship Care Planning Research**

*Note.* From "Can't See the Forest for the Care Plan: A Call to Revisit the Context of Care Planning," by C. Parry, E. Kent, L. Forsythe, C. Alfano, and J. Rowland, 2013, *Journal of Clinical Oncology, 31*, p. 2. Copyright 2013 by American Society of Clinical Oncology. Reprinted with permission.

care plan incorporating available and recognized evidence-based standards of care, when available. The minimum care plan standards are included in *Fact Sheet: Cancer Survivorship Care Planning* from the IOM (Commission on Cancer, 2012; IOM, 2005).

Greater attention is now being paid to implementation issues, such as who should get an SCP, when it should be delivered, and who should develop and deliver it. In addition, questions have arisen about the need to include all the items identified in the original IOM fact sheet, which may make it more difficult to complete.

The original recommendations were based on the consensus that this would be good clinical practice. And this idea has been endorsed by many through surveys and focus groups. In fact, survivors have said that an SCP is necessary but not sufficient to meet their needs (Mayer, Gerstel, Leak, & Smith, 2012). They also would like to receive a written treatment plan at the time of diagnosis. Because many transitions exist in care along the cancer trajectory (see Figure 1), there may be other needs that variations of the SCP could help address.

Two articles appear in this section of the supplement; one provides a review of SCPs and the other describes one cancer program's approach to delivering survivorship care, including the delivery of the SCP. They are being offered to give you the tools to address the Commission on Cancer's SCP standard.

We also must keep in mind that the SCP is a tool meant to facilitate communication and coordination of survivors' care (see Figure 2). Only then will we be able to ask meaningful outcome questions. In the meantime, we must prepare to meet the 2015 standards as a step toward ensuring patient-centered cancer care.

## References

Birken, S.A., Mayer, D.K., & Weiner, B.J. (2013). Survivorship care plans: Prevalence and barriers to use. *Journal of Cancer Education, 28*, 290–296.

Commission on Cancer. (2012). Cancer program standards 2012, version 1.2: Ensuring patient-centered care. Retrieved from http://www.facs.org/cancer/coc/programstandards2012.html

Forsythe, L.P., Parry, C., Alfano, C.M., Kent, E.E., Leach, C.R., Haggstrom, D.A., . . . Rowland, J.H. (2013). Use of survivorship care plans in the United States: Associations with survivorship care. *Journal of the National Cancer Institute, 105*, 1579–1587.

Hewitt, M., Greenfield, S., & Stovall, E. (2006). *From cancer patient to cancer survivor: Lost in transition.* Washington, DC: National Academies Press.

Institute of Medicine. (2005). *Cancer survivorship care planning fact sheet.* Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2005/From-Cancer-Patient-to-Cancer-Survivor-Lost-in-Transition/factsheetcareplanning.pdf

Mayer, D.K., Gerstel, A., Leak, A.N., & Smith, S. (2012). Patient and provider preferences for survivorship care plans. *Journal of Oncology Practice, 8*, e80–e86.

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