Practical Strategies for Meeting the Patient Centered Standards of the Commission on Cancer

Iowa Oncology Society Meeting
May 8, 2015

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Objectives:

• Describe one practical strategy that can be implemented in your clinical practice setting related to the Continuum of Care standards of the Commission on Cancer

• Determine how private physician office practices can partner with hospital/health systems to achieve successful implementation of the Commission on Cancer Standards
Updates and Clarifications
CoC’s Continuum of Care Services

1. Standard 3.1 Patient Navigation Process
2. Standard 3.2 Psychosocial Distress Screening
3. Standard 3.3 Survivorship Care Plan
4. Questions
Patient Navigation - Phase in 2015

S3.1 “A patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients. Resources to address identified barriers may be provided either on site or by referral to community–based or national organizations. The navigation process is evaluated, documented, and reported to the cancer committee annually. The patient navigation process is modified or enhanced each year to address additional barriers identified by the community needs assessment.”
Components of the Standard

Community Needs Assessment

1. Serves as the building blocks for the navigation process; [Hiring lay or nurse navigators is not required]

2. Cancer committee defines community to be evaluated, usually your primary and secondary markets

3. Assessment performed at least once during 3-year accreditation cycle

4. Assessment may be delegated - Individual, Subcommittee or Departmental
Components of the Standard

Community assessment results and navigation process reported annually to the cancer committee.

The report includes the following:

1. Identified health care disparities and/or barriers addressed by the navigation process
2. Description of established navigation process (the how)
3. Identification of community served (who and how many)
4. Documentation of activities and metrics
5. Options for future directions: Quality Improvements, enhancements, and future direction
6. Assessment can be used to guide initiatives to comply with community outreach and/or psychosocial services/distress screening
7. Assessment does not represent “study of quality”
Complying with the Standard

All Criteria Fulfilled

1. Conduct a community needs assessment to identify health care disparities once during the 3-year accreditation cycle

Each Year the Cancer Committee:

A. Describes the navigation process annually, populations served, as related to the barriers identified by the needs assessment

B. Describes the provided services on-site or by referral to community-based or national organizations

C. Assesses activities and metrics around the navigation process, as reported to the cancer committee
Compliance

2. Over the three years, demonstrate that you modify or enhance processes to address additional disparities or barriers, as identified in the needs assessment.

3. If the hospital has a current navigation program in place, with the process defined, a community needs assessment must be conducted to comply with standard.
Day of Survey: 2015 Arrives

- Provide the results of the community needs assessment

- Provide a report on the navigation process, with the patients served and barriers addressed as a result of the needs assessment

- Navigation process has been discussed during cancer program surveys in 2013 and 2014 by CoC Surveyors, engaging cancer committee members and individuals involved with the navigation process
Components of a Needs Assessment

- What are the needs of your cancer program patients?
- What are the outcomes you expect to achieve? What are your goals and objectives for the program?
- Who are your stakeholders? Who will benefit most?
- What currently exists and where are the gaps in service?
- What are the barriers and limitations for patients?
- What funding is available? Other resources (staffing)?
- What are reliable sources of data (primary and secondary sources)? Mine your data! Use your C-QUIP Report

**Goal:** Turn data into actionable information
Data Sources for the Needs Assessment

Facility’s CoC Hospital Comparison Benchmark Report, C-QIP Report and your Cancer Registry Data:

1. Patient Age
2. Race/Ethnicity
3. Income
4. Education
5. Insurance Status
6. Travel Distance to Facility
7. Time to First Treatment
Common Barriers

- Lack of insurance coverage
- Out of pocket expenses
- Fear and anxiety (causes vary)
- Transportation
- Distrust of western medicine
- Fearful of technology or prior family experience
- Lack of communication
- Cultural & language barriers
- Health literacy

Why Is a Navigation Process Vital?

- Improved rates of screening and follow-up
- Lower level of clinical stage at diagnosis
- Improvements in completion rates and compliance of treatment regimens
- Improved levels of psychosocial support
- Higher patient satisfaction
- Hospital’s ability to engage, track, and support patients
- Hospital’s ability to develop communication and trust with disadvantaged populations
- Increased enrollment and retention in clinical trials

Navigation Team Varies

- Design it your way, based on organizational structure, community needs, and resources!
- Oncology social workers, nurses, physicians
- Nurse navigators
- Existing community navigators - ACS, Cancer Support Community, LAF
- Hospital staff
- Volunteers

Clarifications

• The intent of the standard is to identify and address a new barrier or disparity each year, however programs are allowed to address the same barrier or disparity for more than one year as long as the following criteria are fulfilled.
Clarification

1. The cancer committee determines that addressing the barrier or disparity is the most important concern for their patients.

2. The cancer committee documents in their minutes that they have put forth significant activity over the year, but that there is an ongoing need to continue addressing the disparity or barrier (i.e. significant progress to address barrier or disparity is still needed).
Clarification

3. The current progress to address the barrier or disparity is reported to the cancer committee annually.

4. The cancer committee decides to continue work to address the barrier or disparity until the issue is resolved, for a period not to exceed the 3 years between CoC program reviews.
Audience Participation

• How have you personally or your practice been involved with navigation services?

• What barriers have you encountered in completing the community needs assessment and/or navigation services?

• What has “worked” in your programs?

• Other sharing?
Psychosocial Distress Screening

• S3.2 “The cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.”
Clarifications

• The cancer committee defines one or more medical visits that are part of a pivotal time for distress screening.

• The process developed by the cancer committee should address screening at the CoC accredited facility and/or with the designated provider (such as offices of physicians) who are part of the program (e.g. medical oncologists and/or radiation oncologists).

• The screening for distress must be discussed at a medical visit.
Clarifications for Distress Screening

- Questionnaires or forms that are distributed or returned by mail and/or phone interviews without discussion at a pivotal medical visit do not meet the intent of the standard.

- For those programs utilizing a patient portal, patients may complete the distress screening tool through the electronic patient portal, but the screening results must be reviewed and discussed with patients face to face at a pivotal visit.

- The process developed by the cancer committee includes treatment or referral for treatment for distress identified by the screening.
Audience Participation

• How have you personally or your practice been involved with psychosocial distress screening?

• What barriers have you encountered in implementing this process?

• What has “worked” in your programs?

• Other sharing?
Survivorship Care Plan

• S3.3 “The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the cancer committee and documented in the minutes.”
Survivor Data

• Currently there are nearly 14.5 million children and adults with a history of cancer (as of January 1, 2014)
• By January 1, 2024, it is estimated that the population of cancer survivors will increase to almost 19 million
• Prostate (43%), colon and rectum (9%) and melanoma (8%) – most common among males
• Breast (41%), uterine (8%) and colon and rectum (8%) – most common among females

Why the New Standard?

2005 IOM Report, From Cancer Patient to Cancer Survivor: Lost in Transition.
“An individual is considered a cancer survivor from the time of cancer diagnosis through the balance of his or her life” *
Why the New Standard?

- The National Cancer Institute (NCI) describes cancer survivorship as covering “the physical, psychosocial, and economic issues of cancer, from diagnosis until the end of life. It focuses on the health and life of a person with cancer beyond the diagnosis and treatment phases.

- Survivorship includes issues related to the ability to get health care (may be relieved with ACA) and follow-up treatment, late effects of treatment, second cancers and quality of life.

- Family members, friends and caregivers are also part of the survivorship experience” (ACS, 2012)

Cancer Survivors’ Quality of Life

The increasing number of Americans aged 65 or older (expected to be 1 in 5 by 2030) is likely to increase the economic burden of cancer. People in this age group account for 57% of cancer cases and 71% of cancer deaths. They also are more likely to have other health problems and special challenges to receiving care, due to physical or psychological problems of their caregivers and limited finances.

Cancer Survivors’ Quality of Life: It’s Complicated

Physical Well-being
- Functional status
- Fatigue & sleep
- Overall physical health
- Fertility
- Pain

Psychological Well-being
- Control
- Anxiety
- Depression
- Fear of recurrence
- Cognition/attention

Social Well-being
- Family distress
- Roles and relationships
- Affection/sexual function
- Appearance
- Isolation
- Finances/employment

Spiritual Well-being
- Meaning of illness
- Religiosity
- Transcendence
- Hope
- Uncertainty
- Inner strength

Cancer Survivors’ Quality of Life

This combination of factors will cause the direct costs of cancer care to reach $158 billion to $173 billion by 2020. The largest components of this increase are expected to arise from the continuing phase of care for prostate cancer and female breast cancer survivors, our two top cancer diagnoses.

CoC Survey results on Survivorship

Questions asked:

• Overall, how confident are you that your program will be able to implement standard 3.3 by 2015? (686 responded)

• 37% completely confident
• 47% somewhat confident
• 14% not at all confident
• 2% not sure
The CoC heard you!
# Challenges to Implementing the Survivorship Standard

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Standard 3.1 Navigation</th>
<th>Standard 3.3 Survivorship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough staff</td>
<td>50%</td>
<td>53%</td>
</tr>
<tr>
<td>Financial</td>
<td>42%</td>
<td>40%</td>
</tr>
<tr>
<td>Time</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Identifying the right tools</td>
<td>31%</td>
<td>43%</td>
</tr>
<tr>
<td>Training of staff</td>
<td>29%</td>
<td>35%</td>
</tr>
<tr>
<td>Technology</td>
<td>20%</td>
<td>32%</td>
</tr>
<tr>
<td>Not enough time to address the standard</td>
<td>19%</td>
<td>22%</td>
</tr>
<tr>
<td>All of the above</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>None of the above</td>
<td>11%</td>
<td>8%</td>
</tr>
</tbody>
</table>
CoC Working Definition of Survivorship

- **Treated with curative intent**, and have completed active therapy (other than long-term hormonal therapy)

- Includes patients from all disease sites

- Patients with metastatic disease, though survivors by some definitions, are not targeted for delivery of comprehensive care summaries and follow-up plans under Standard 3.3
Summary and Plan

Provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained.
Required Data Elements

- ASCO has identified a process, with broad-based input from multiple stakeholders, including patients, that have defined what they believe are minimal data elements to be included in a treatment summary and survivorship care plan
Data Elements

• The Commission on Cancer Executive Committee voted to accept the ASCO data set as the minimum data set for Standard 3.3

• This does not preclude programs from adding additional data elements in their documents
Key Components of the Treatment Summary

- Contact information of the treating institutions and providers
- Specific diagnosis, including histologic subtype when relevant
- Stage of disease at diagnosis
- Surgery (yes/no). If yes, surgical procedure with location on the body
- Date(s) of surgery (year required)
Key Components of Treatment Summary

- Chemotherapy (yes/no). If yes, names of systemic therapy agents administered (listing names rather than regimes)
- End date(s) of chemotherapy treatment (year required)
- Radiation (yes/no). If yes, anatomical area treated by radiation
- End date(s) of radiation treatment (year required)
Treatment Summary

• Ongoing toxicity or side effects of all treatments received (including those from surgery, systemic therapy and/or radiation) at the completion of treatment. Any information concerning the likely course of recovery from these toxicities should also be covered.

• For selected cancers, genetic/hereditary risk factor(s) or predisposing conditions and genetic testing results if performed.
Key Components of the Follow-up Care Plan

- Oncology team member contacts with location of the treatment facility

- Need for ongoing adjuvant therapy for cancer (therapy name, planned duration and expected side effects)

- Schedule of follow-up related clinical visits (to be presented in table format to include who will provide the follow-up visits, how often and where it will take place)
Key Components of the Follow-up Care Plan

- Cancer surveillance tests for recurrence (to be presented in a table format to include who is responsible for ordering/carrying out the test, the frequency of testing, and where this will take place)

- Cancer screening for early detection of new primaries - to be included only if different from the general population (to be presented in a table format to include who is responsible for carrying out, the frequency of testing and where this will take place)
Key Components of the Follow-up Care Plan

- Continue all standard non-cancer related health care with your primary care provider, with the following exceptions (if there are any)

- Any new, unusual and/or persistent symptoms should be brought to the attention of your provider
Key Components of the Follow-up Care Plan

• A list of likely or rare but clinically significant late-and/or long term effects that a survivor may experience based on his or her individual diagnosis and treatment if known (including symptoms that may indicate the presence of such conditions)

• A list of psychosocial issues indicating that survivors have experienced these issues in these areas and that the patient should speak with his or her oncologist and/or PCP. Include a list of psychosocial services available within their treatment setting, local and national resources to assist the patient obtain proper services
Key Components of Follow-up Care Plan

• A general statement emphasizing the importance of healthy diet, exercise, smoking cessation and alcohol use reduction may be included. Statements may be tailored if particularly pertinent to the individual
Preparation and Delivery

• The standard currently reads: “A survivorship care plan is prepared by the principal providers(s) who coordinated the oncology treatment for the patient with input from the patient’s other providers”
Preparation and Delivery

• The Cancer Committee develops a policy of identifying a physician team member or advanced practice partner who would be responsible for discussing the care plan with a patient

• The goal is to allow programs some flexibility in the formulation and implementation of their own policies and procedures
Targeted phase-in

- Remember that number: 37% felt confident they would meet the January 2015 deadline for implementation

- You asked for a working definition of “survivor”

- What specific information would be required to meet the standard
Phase In Time Table

• 2015 - Implement a pilot survivorship care plan process involving 10% of eligible patients
• 2016 – Provide survivorship care plans to 25% of eligible patients
• 2017 – Provide survivorship care plans to 50% of eligible patients
• 2018 – Provide survivorship care plans to 75% of eligible patients
• 2019 – Provide survivorship care plans to all eligible patients
Phase In Time Table

• Cancer programs should concentrate on their most common disease site cancers; breast, colorectal, prostate, early stage lung and lymphoma

• Programs that have fully implemented the standard within the 3 year launch, will receive special recognition in their Performance Report at the time of their next survey
Monitoring Compliance

(1) Compliance: The program fulfills the following criteria:

- The Cancer Committee has developed a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment.

- Each year, the process is implemented, monitored, evaluated and presented to cancer committee.
Monitoring Compliance

(5) Noncompliance:

The program does not fulfill 1 or more of the following criteria:

• The cancer committee has not developed a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment

• Each year, the process is not implemented, monitored, evaluated or presented to the cancer committee
Audience Participation

• How have you personally or your practice been involved with developing survivorship services?

• What barriers have you encountered in implementing survivorship services?

• What has “worked” in your programs?

• Other sharing?
Recognition and Thanks

• Virginia (Ginny) Vaitones, MSW, OSW – C who originally developed portions of this presentation and who served in many different capacities and for many years representing the AOSW at the Commission on Cancer
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