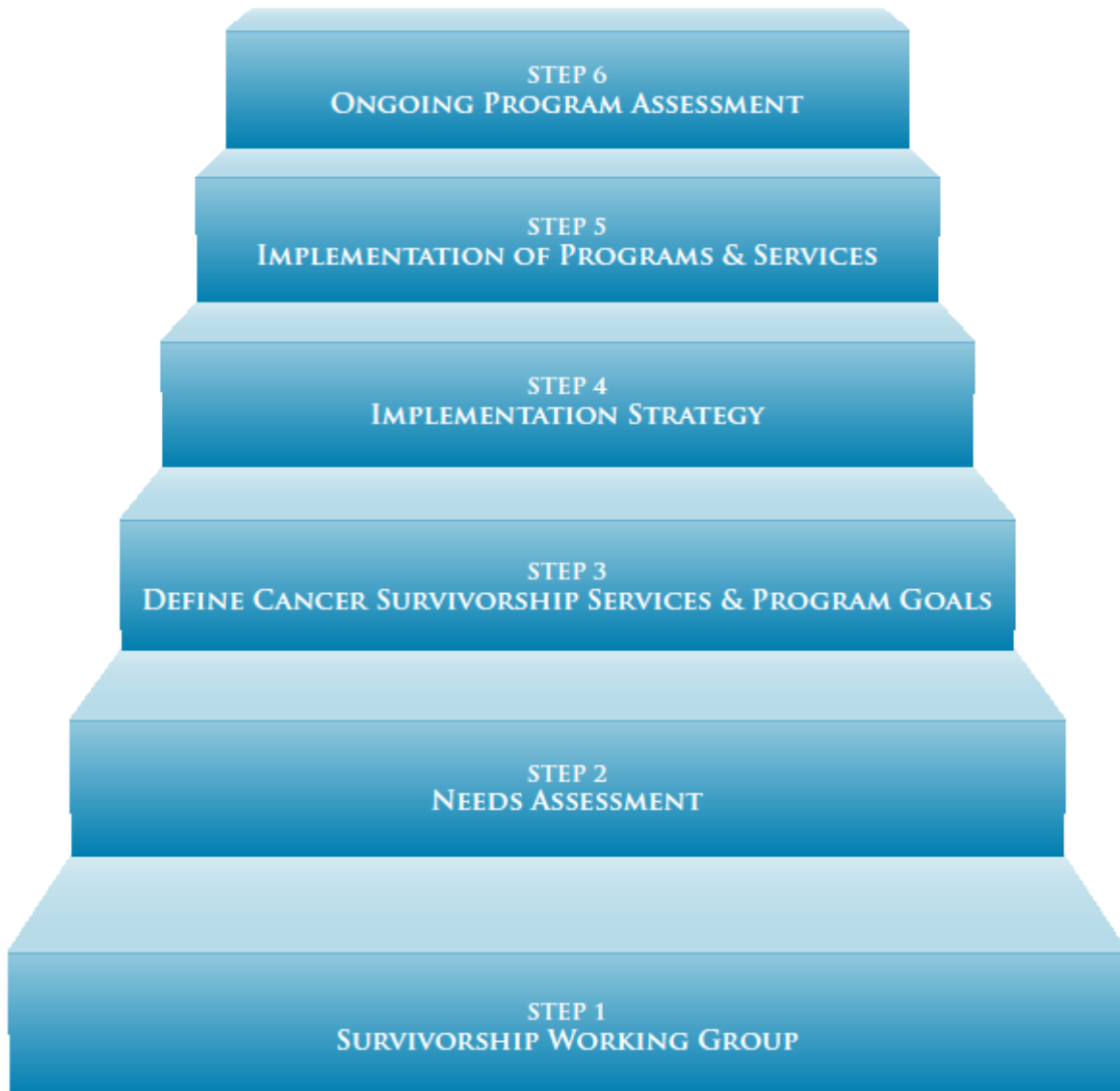


IMPLEMENTING A SURVIVORSHIP PROGRAM: A STEP-WISE PROCESS



❑ STEP 1: SURVIVORSHIP WORKING GROUP

Developing a Survivorship Working Group helps to ensure a cohesive team approach while communicating what survivorship care should look like for your patients. Bringing together key stake holders from all departments and collaborative practice settings is vital for a successful and productive working group. (ie., clinicians, oncology nursing, cancer rehabilitation (PT, OT, Speech), scheduling & registration, patient support services (psycho-oncology, social work, dietetics), administration, etc....).

➤ **Champions and Collaborators** promote internal support for a cancer survivorship program as well as identify essential multidisciplinary care providers. Internal support is mandatory and without it a functioning and effective program cannot be established.

➤ **Identify program leadership** and who will be responsible for overseeing the program development and initiation

❑ STEP 2: NEEDS ASSESSMENT

Implementing cancer survivorship care is best begun with a needs assessment. Patient, staff and provider input will be instrumental while determining where gaps of care may be occurring and where appropriate modes of survivorship care are already in place and working well.

➤ Patients

- Services currently utilized
- Services not available or patients not aware of services but would like to utilize
- Payment of service: no-charge, out-of-pocket, insurance reimbursement

➤ Providers

- Services identified and referred by clinicians
- Services patients request
- Services not available but needed in patient population serve

➤ Staff

- Current roles filled (actual and cross-reference with job description)
- Service gaps- Where are existing staff compensating due to a lack of resources?
- Review of internal and external existing resources and services
- Develop a list of current services available within the practice setting that can be considered survivorship care (long-term survivorship care, social work, financial counselors, dietetics, support groups, lymphedema clinic, just to name a few)
- Understand the patient population cared for in your practice setting
- Query tumor registry and patient registrar to better understand the volume, cancer diagnosis, treatment, and survival statistics of the patient population served within your practice setting

❑ STEP 3: DEFINE CANCER SURVIVORSHIP SERVICES & PROGRAM GOALS

Once a needs assessment is completed, it is important to define **achievable** program goals and objectives. Preparing a timeline with due dates for objectives is a helpful way to maintain momentum for the project.

- Utilize needs assessment data to identify services gaps
- Agree upon organizational definitions of survivorship care across the cancer care trajectory
- Define Objectives and Goals
 - Program focus and services
 - Accreditation guidelines:
 - Treatment Summary
 - ASCO's Quality Oncology Practice Initiative (QOPI); Oncology Care Model (OCM)
 - Survivorship Care Planning
 - American College of Surgeons Commission on 2016 Cancer's Program Standards
 - Coordination of Care
 - Survivorship care delivery team members
 - Direction: integrated care delivery is ideal
 - Fit within the systems organizational chart
 - Identify potential collaborators: internal, external (specialists, primary care, community organizations)
- Targets for Survivorship care- services delivery
- Organize existing resources or services under Survivorship umbrella
- Develop a timeline working towards program implementation

❑ STEP 4: IMPLEMENTATION STRATEGY

- Determine program scope, cost, reimbursable services and strategy for implementation
 - Identify potential barriers to implementation
 - Strategies for dismantling organizational barriers
 - Reimbursable vs. non-reimbursable
 - Connect with potential collaborators to define the program goals and illicit support and formal collaboration
 - Define formal pathway for referral
 - Facilitate an in-service for providers and staff, encourage continuing education with a focus on cancer survivorship
 - Patient scheduling system
 - Medical records documentation (integration in the electronic health record)

- Development of collateral materials – website content, flyers, brochures, newsletters, patient referral forms
- Determine data points and how these will be collected (i.e., Excel or Access) for timely reporting of outcomes

❑ STEP 5: IMPLEMENTATION OF PROGRAMS & SERVICES

- Use the timeline to keep development moving forward
- Expect barriers and obstacles, these can be overcome by working with your working group
- Outreach: disseminate collateral material throughout the practice setting, community, and provider network, and via local support groups, professional meetings, and other means for communicating to both patients and providers
- Utilize referral pathways and ensure information flow goes both ways- referral out and patient report/notes in return (patient documentation must be incorporated into the medical record)
- Ongoing data collection of outcome variables (ie, patient served, referrals (internal & external), services used (ie, screening, endocrinology, cardiology, etc...), cost, providers involved in survivorship care

❑ STEP 6: PROGRAM ASSESSMENT

Ongoing program assessment is essential to success. Monitoring the program's effectiveness and making modifications when necessary will only serve to improve survivorship care. There is not one right way to deliver quality survivorship care!

- Timely reporting to the working group, staff and administration at 3 months, 6 months & 12 months,
- Identify strategies that are working and those that continue to meet obstacles,
- Meeting standards for national accreditation,
- Modify services /program when necessary.

McClellan W, Fulbright JM, Klemp JR, Alzman K, Doolittle GC, Ryan R, Nelson EL, Stegenga K, Krebill H, Al-hihi E, Heiman A, Lowry B. A Collaborative Step-Wise Process to Implementing an Innovative Clinic for Adult Survivors of Childhood Cancer. Journal of Pediatric Nursing. 2015; 30: 147-155