Best Practice Document
Who Completes Care Plans?

Throughout the country there are many different ways that Survivorship Care Plans are being implemented. Your approach will be based on your budget, your resources and your cancer center's overall approach to survivorship care. Care plans can be a resource intensive project. Your challenge will be to examine your system in order to streamline this process.

This best practice document will provide information on how care plans are being completed in other organizations. Remember to think about all cancer types as you develop your model. If you only have nurse navigators in 1 or 2 cancer types a nurse navigator model may not be the best implementation choice unless you plan to add nurse navigators to cover all cancers.

How Do We Decide What Model to use?

Questions to Consider

- Are treatment summaries/clinical summaries being completed?
  - Are there summaries of treatment being completed by modality (e.g., radiation therapy)?
  - Does the summary information available vary by patient population?
  - Who is completing these summaries?
- What is the role of the primary care provider after treatment?
  - Is care typically transferred back to primary care providers?
  - Are oncologists primarily continuing care with your survivors?

Commission On Cancer- Standard 3.3

"Process Requirements

(a) A survivorship care plan is prepared by the principal provider(s) who coordinated the oncology treatment for the patient with input from the patients other care providers.

(b) The survivorship care plan is given to the patient on completion of treatment."

** American College of Surgeons: Cancer Programs (2012) retrieved on July 8, 2014 from http://www.facs.org/cancer/coc/programstandards2012.pdf PDF page 78*

Questions to consider:

- Who are principal providers in your organization?
- How is the completion of treatment defined in your organization?

Implementation Options

Utilizing Current Structure & Staff

In this model, a nurse, nurse navigator or mid-level provider who is currently employed with other duties is tasked with survivorship care plan completion.

Tips and Tricks from the Field:

Advantage:	Disadvantage:
• Often this person will have an existing relationship with the patient and access to health records • No new costs	• No matter what staff person you utilize, there will be issues with adding responsibilities to already assigned duties. o Navigators typically have high caseloads. Adding care plans will limit their ability to navigate patients through treatment. o Unless given dedicated time, oncology nurses are typically pulled back into patient care.

Develop New Structure

Advantage:	Disadvantage:
• A process is developed specifically to address care plan implementation. • Current staff are not being tasked with additional responsibilities they may not have time to complete.	• Increased cost or redirection of resources to support new workflows and staff.

Nurse Models

Nurse models assume that the assigned nurse is in communication with oncology providers. Records will need to be obtained from all oncology providers and follow-up care determined. Some of these providers may be external to the system and an agreement will need to be made about how that data will be provided.

Questions to consider:

- Will the records be shared?
- Will a nurse at the provider's office complete part of the care plan?

Nurse Navigators

Nurse Navigators have been utilized in many systems to complete care plans. The navigator prepares a treatment summary and care plan in cooperation with the patient's providers and presents the care plan to patient during a teaching visit.

Tips and Tricks from the Field:

Model Advantage:	Model Disadvantage:
• Nurse Navigators may have a relationship with patients and physicians based on the time of treatment.	• Most health systems do not have nurse navigators available for all cancer types. • Time spent on care plans limits time

• May cost less than other models.	navigators have for patient education and barrier reduction. • Cannot bill for services provided by navigators.

Survivorship Coordinator – RN

The goal of this position is to assist patients into survivorship. The nurse may meet with the patient one or two times during treatment to introduce survivorship. At a specified time after treatment ends the nurse will complete a care plan in cooperation with the patient's providers and present it to the patient during a survivorship teaching visit. An assessment of survivorship needs is typically done with appropriate referrals to supportive services.

Tips and Tricks from the Field:

Model Advantage:	Model Disadvantage:
• Cost effective. • The survivorship concept is introduced during treatment by the Survivorship Coordinator.	• Person completing care plan has limited knowledge of the patient. • Up to patient to complete recommended care. • Cannot bill for services provided by nurses.

Mid-Level Provider Models

Nurse Practitioners & Physician Assistants

Mid-level providers are able to bill for certain aspects of the care plan process, provided they perform a billable service (see citation below for possible codes). At times, these mid-level providers are part of the practice setting and other times they are hired specifically to provide survivorship services.

A mid-level provider typically conducts a history and physical, makes referrals for supportive care and screenings, educates the patient, and prepares the treatment summary and care plan coordinating with oncologist and the primary care provider.

- In some models, the patient is asked to complete a medical history and lifestyle questionnaire prior to meeting with the mid-level provider to assist in informing the provider of the patient's needs and concerns.
- When survivorship is initiated at diagnosis, one model utilized a mid-level provider to address quality of life issues throughout the treatment phase.
    - The mid-level provider meets with the patient prior to the first treatment to review the treatment plan and explain the treatment and its possible effects. Patient concerns are identified and psychosocial distress screening is administered. A quality-of-life plan is then put in place to maintain quality-of-life throughout treatment.
    - During each visit, nurses address the patient's level of distress and implement the quality-of-life plan.
    - At the completion of treatment, distress screening is again completed and incorporated into the survivorship care plan which is developed by the mid-level provider. Appropriate referrals are made to address quality-of-life issues.

*Parman, C. (2013) Billing Challenges for Survivorship Services. *Oncology Issues*, 2013 (May-June): 8-12. http://www.accc-cancer.org/oncology_issues/articles/MayJune2013/MJ13-Parman.pdf

Tips and Tricks from the Field:	
Model Advantage:	Model Disadvantage:
• Mid-level providers can seek reimbursement for certain aspects of the care plan process • Facilitates transition back to primary care	• Difficult to make financially self-sustaining • Requires clinic space

Physician Models

A Physician Team

In this model from Colorado, physicians work as a team to complete care plans. As physicians end their care with a patient, they complete the information on the treatment summary and care plan that pertains to the patient care provided.

For example, if the surgeon completes care with the patient first, he or she will populate the parts of the care plan related to the surgical care provided and follow-up recommendations. If the patient is being seen by a Radiation Oncologist, she or he will populate the portions of the care plan related to radiology care and follow-up recommendations. The same is true for a Medical Oncologist.

The last physician to complete care with the patient is responsible for reviewing the document for integrity of information provided across multiple providers, assuring that the care plan document is complete and providing the document to the patient.

Tips and Tricks from the Field:	
Model Advantage:	Model Disadvantage:
• Patient will receive a comprehensive care plan completed by each of his or her oncology providers. • The meeting regarding survivorship care is held between physician and patient.	• May be difficult to get physician buy-in. • In many instances, this places the burden of the care plan on the Medical Oncologists. • Without a coordinated EMR system, the sharing of this patient document could be complicated.

Private Practice Physician Offices

This model uses the following ways to address survivorship care plans in systems with external group practices. Tips from the field include developing agreements with external group practices to:

- Have nurses within the physician office complete the plan based on the oncologist's interaction with the patient. This partial care plan is sent to the cancer center for finalization and is given to the patient during a survivorship visit.
- Have a RN at the cancer center complete the survivorship care plan based on records available in the cancer center and send the plan to the provider office for completion and review with patient.

When working with multiple private practice offices you will need a plan regarding how to develop these agreements. Suggestions from the field include:

- Have your registrar pull the patient medical records seen by private physicians who treat the largest number of patients in your system. Develop a first tier of implementation based on this data.

- These physicians/physician groups can then be targeted with education and data sharing interventions. By solving the issue with these physicians first you impact a high volume of patients.
- Do you have a champion within that group practice? Or do you think a champion can be developed within that group practice?
- Use and apply the lessons learned in working with this first tier group towards the 2nd and 3rd tier groups.

Tips and Tricks from the Field:	
Model Advantage:	Model Disadvantage:
• Patient will receive a comprehensive care plan.	• Protected Health information is being passed between health system and providers, the release of information process will need to be updated. • Provider agreement may still be difficult to obtain.

Clinic Models

Survivorship Clinic

Multidisciplinary team members may include physicians, mid-level providers, social workers, dieticians, physical therapists and pharmacists. Each meets individually with patients to provide care and referrals. After meeting with the patient they collectively develop a treatment summary and care plan which is later presented to patient.

- In this model, a designated staff person, typically a nurse or mid-level provider, drafts the care plan prior to the clinic visit using historical treatment data for the team to complete after visiting with the patient.
- Often the survivorship care plan is verbalized to the patient during the visit with the written version mailed to the patient.

Tips and Tricks from the Field:	
Model Advantage:	Model Disadvantage:
• Very comprehensive approach to care. • Clinic visits may be reimbursed.	• Resource intense. • Difficult to make financially self-sustaining. • Requires clinic space.

Consultative Clinic

A Consultative Clinic typically is a variation on the mid-level provider model. The intent of this clinic is to assist in transitioning patients back to their primary care provider. Patients are seen in a one-time consult visit to cover general survivorship issues and distribute treatment summaries/care plans. At this time, referrals are made to follow-up on identified survivorship issues. The mid-level provider provides in-depth education about late and long term effects post treatment, screening for recurrence and secondary cancers.

Model Advantage:	Model Disadvantage:
• Referrals to follow-up services can be made within your health system	• It can be difficult for providers to be an expert on long-term follow-up issues for

(nutrition, psychological services, rehabilitation). • Visits are billable if a billable service is provided. • All cancers can be served.	all cancer types. • Oncology buy-in may be difficult to obtain. • This model may be difficult to make self-sustaining.

Team Models

Multiple team member approach (scope of practice)

In this model, the care plan is completed according to scope of practice. Clerical staff can initiate the care plan and enter demographic information. The nurses or mid-level providers gather data and complete the care plan. The provider can either approve the care plan for presentation by a nurse or mid-level provider or can choose to be the one to complete the patient visit.

Tips and Tricks from the Field:

Model Advantage:	Model Disadvantage:
• All tasks are completed according to the scope of practice with no employee performing a task that is below their scope of practice.	• Coordination of care plan completion will be more difficult.

Tips from the Field

Cancer Committee Assistance

Seek the input of the medical oncology representative on the cancer committee. This physician may be able to help define what processes will work for your cancer center and also address the concerns that medical oncology may have in the process.

Survivorship Care Plan as a "Living Document"

Consider building a process so that information can be collected and added to the care plan throughout the course of treatment. This will save time with collecting information at the end. This can be done by each provider as they conclude treatment by nursing staff involved throughout the process.

Billing

If a mid-level model is being used for billing purposes – provide training about the billing process.

- What CPT/ICD-9 code is being utilized? What does the provider need to do in order to be reimbursed for that code?
- What task does the provider need to complete in order for the billing process to be initiated?
- By looking at these types of process development steps in advance, the provider can focus on the patient and the care plan process and not the details related to billing and reimbursement.
- Write this all down as a process step so that, as the model is extended to new sites with new providers, the institutional knowledge of the process is included in the training.

Work from a Systems Perspective – Patient Records

Instead of finding records patient by patient, work with departments, where possible, to organize needed documents for easy retrieval. This will assist in lowering the time of completion.

- An example: In a radiology department, different physicians had different places they placed information needed for the care plan. Through a system intervention it was agreed that reports would be saved in the same location – every time. This decreased document retrieval time and saved the organization time and money.

Know Your Resources

Identify your referral resources in advance. This can be organized as general survivorship resources but also resources specific to cancer type. With this, you will have a list of services both in your institution and the community that you can refer patients to for follow-up.

Establish a mechanism for checking the availability of current resources or identifying new resources on a continual basis.

Our Disclaimer

- This project and all of its documents have been produced by MDHHS staff through interviews with other organizations and review of literature.
- We are not affiliated in any way with the Commission on Cancer. We are not able to advise you in any way regarding your upcoming survey and what practices will meet Commission on Cancer standards.
- You are advised to speak with the Commission on Cancer as it relates to all questions related to your compliance.

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