
THE CHALLENGES OF THE INTEGRATION OF CANCER SURVIVORSHIP CARE PLANS WITH ELECTRONIC MEDICAL RECORDS

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OBJECTIVES: *To provide an overview of issues and challenges associated with integrating development of survivorship care plan processes with electronic medical records (EMRs).*

DATA SOURCES: *Published peer-reviewed literature.*

CONCLUSION: *Evidence seems to indicate that survivorship care plans have value to survivors, oncology specialist providers, and primary care providers. Yet, the existence of cost and time restraints are major barriers to creation and use of survivorship care plans, and the expectations that EMR can simplify and expedite survivorship care plan development have yet to be realized.*

IMPLICATIONS FOR NURSING PRACTICE: *Nurses participating in the development of survivorship programs can contribute to successful implementation of EMR-facilitated survivorship care plans by involvement in strategic planning processes, and establishment of reasonable timelines to address the known and unknown barriers, and assuring the resulting EMR product includes essential data and information.*

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IN 2012, the Commission on Cancer (CoC) of the American College of Surgeons (ACoS) established new standards of care that require patient navigation, distress screening and cancer survivorship care plans (CSCPs) to create a “patient-centered focus.”¹ However, the ACoS does not provide implementation guidance. Operationalization of these standards is a significant challenge to oncology providers. This article examines development of the CSCP process that addresses the physiological, psychological, and social needs of patients, and explores the challenges of using electronic medical records (EMRs) to meet ACoS CoC accreditation standards and provide high-quality patient-centered care.

BACKGROUND

The early study of psychological responses to cancer survivorship and appropriate physiological and psychosocial interventions has expanded to include time points well beyond the initial diagnosis.²⁻⁵ As patients move through the early reactions, they gain experience as cancer survivors. Survivorship begins on the day of diagnosis as patients with cancer begin to redefine all aspects of their lives.⁶ While many patients and family members strive to regain a sense of normalcy, many experience intense feelings of distress exacerbated by the physical trauma associated with cancer therapies. For the most part, patients are forced to acknowledge that their lives will never again be the same. Patients and family members experience disruptions of their day-to-day routines, and fear of recurrence or the actual event further complicates the psychosocial course for each patient.⁷ During the course of therapy, patients gain critical information and knowledge concerning their disease process and treatments. Knowledge and support from the cancer care team enable patients to anticipate and understand their course of treatment and the complex problems associated with movement across the disease continuum.

Beginning in 1997, the National Comprehensive Cancer Network established a panel (consisting of oncology professionals [medical, nursing, social work, counseling, psychiatry, psychology, and clergy]) to focus on barriers to psychosocial care, how to address these barriers, and to develop spe-

cific guidelines for management of distress that were published in 1999.⁸ These guidelines were revised over the next decade. In 2007, the Institute of Medicine (IOM) published its report, *Cancer Care for the Whole Patient*, which supports the National Comprehensive Cancer Network guidelines, but recommends a model of care that includes screening for distress and psychosocial needs, generating treatment plans, referring to appropriate resources, and evaluation of this process for effectiveness.⁹ Psychological distress was defined as “an unpleasant emotional experience of a psychological, social, and/or spiritual nature that interferes with the ability to cope effectively with cancer and its treatments. Distress extends along a continuum, ranging from common normal feelings of vulnerability and sadness to problems that can be disabling, such as depression, anxiety, and social isolation.”¹⁰ Casual interactions with patients suggest that all patients experience some level of distress to normalize early reactions to cancer diagnoses. However, patients who cannot adapt to their clinical circumstances challenge the health care team to respond to a multitude of psychological and social problems. For nearly one third of newly diagnosed cancer patients, the vulnerability associated with these problems generates significant psychological distress that may not manifest itself to the health care team until the patient reaches an observable crisis event.¹¹

In 2012, the ACoS CoC established new standards of care that require patient navigation (Standard 3.1), distress screening (Standard 3.2), and CSCPs (Standard 3.3) to create a “patient-centered focus.”¹ However, the ACoS does not provide guidance as to how to implement these three standards, resulting in significant developmental and implementation challenges to oncology providers.

Following distress screening, a CSCP could be developed and implemented during the first 2 weeks of care, and revised accordingly at 3 months, 6 months, and 1 year post-diagnosis. This sequence could optimize the desired active participation of patients and families in care as opposed to the CSCP being implemented at the completion of cancer therapies, which for most cancer patients occurs approximately 6 months after initial diagnosis.¹² Throughout this process, the potential role for EMRs are essential. Given

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