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Interprofessional Management of Cancer Survivorship: New Models of Care

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Objective: *To examine interprofessional models of care and care delivery for cancer survivorship, focusing on nursing as key providers of care.*

Data Sources: *National summary statements and literature review.*

Conclusion: *The need for cancer survivorship care is established. Treatment summaries and survivorship care plans are mandated documents expected to guide the delivery of survivorship care. However, the optimal delivery method, infrastructure, provider, and (cost-) effectiveness for the delivery of cancer survivorship care is unknown. Utilizing commonly occurring scenarios in cancer survivorship, this article discusses the visit structure, content care delivery structure, and possible care providers.*

Implications for Nursing Practice: *These real-life situations can help the cancer care community to develop optimal algorithms of care and identify members of the interprofessional team for the survivorship care delivery.*

Key Words: *survivorship, care delivery, advanced practice nursing, cancer care teams.*

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Cancer survivorship care is increasingly complex. As the number of cancer survivors grow, partially fueled by the success of pediatric malignancy treatment, the demand for evidence to guide survivorship practice, and the tools by which a coordinated survivorship plan can be implemented, are needed.[1] Historically,cancer care, and particularly cancer survivorship care, has been poorly coordinated, leaving patients and their future care providers without appropriate information regarding past cancer treatment and potential problems for which individual patients are at risk.[2] Consensus opinion, stated in the 2005 Institute of Medicine (IOM) Report, *From Cancer Patient to Cancer Survivor: Lost in Transition,* states that the delivery of health care services specifically designed for cancer survivors ideally includes: prevention of new (primary) and recurrent cancers and other late effects; surveillance for recurrence or new cancers; interventions for illnesses secondary to cancer and cancer treatment (including physical consequences of symptoms such as pain and fatigue, psychological distress experienced by cancer survivors and their caregivers, and concerns related to employment, insurance, and disability); and coordination between specialists and primary care providers (PCPs).[3] These mandates present challenges. The American Society of Clinical Oncology (ASCO) addressed some of these challenges by outlining several models for cancer survivorship care delivery.[4] These care models are not particularly visionary, generally delineated according to the physical place of care delivery, including academic cancer centers, community cancer centers, and primary care, with consultation from cancer care providers when needed.[4]

Academic models offer a variety of options. Some specialized cancer clinics continue to see survivorship patients mixed with active treatment patients and really do not address survivorship issues as a spate entity. Some academic centers merely extend survivorship care into specialty clinic visits and others transition patients to a survivorship clinic within that academic medical setting.

The community cancer setting, where most of the cancer care in the United States is delivered, has developed models similar to the academic setting. While some community centers offer expanded survivorship services and education, most provide care to survivors in the same fashion as patients receiving active treatment. This can result in the needs of survivors being over shadowed by the acute needs of those receiving active treatment.

Another model in the ASCO review highlighted integrated cancer care with primary care.[4] This model presents the largest challenge in the delivery of cancer survivorship care. Integrating cancer care into already overburdened primary care practices requires coordination and effort on the part of the cancer care team and the PCPs. These efforts are labor intensive for the cancer providers because they need to provide the necessary information regarding the cancer, treatment, potential long-term toxicity, and likely recurrent presentation scenarios. There are also challenges on the part of the PCP practices.[5,6] PCPs providing survivorship care in Vermont (N = 39) cited poor reimbursement (18%), lack of survivorship guidelines (47%), and lack of specific patient information (49%) as common barriers to the implementation of survivorship care.[6]

Encouraging adherence to cancer survivorship care can be enhanced through navigation. Each of these models, the academic, community, and PCP models can singularly or in combination include patient navigators, a lay/peer health partner who serves as a resource to the patient about survivorship care and as a liaison between the patient and the medical team and services. A large 2010 online survey from LIVESTRONG ($N = 3854$) found that patients were most compliant with all aspects of survivorship care (medical appointments and cancer screening) when survivorship care planning and education were paired with patient navigation.[7]

Survivorship Care Planning and Implementation Challenges

Regardless of the survivorship care delivery setting, the cancer care summary and survivorship care plan is recognized as the ideal means of coordinating and personalizing care among all providers.[8,9] The Institute of Medicine formalized this recommendation in 2005.[3] While this recommendation for written care synopsis and future care planning is widely accepted in theory, the realities of the implementation continues to challenge cancer care providers (see Table 1).

A major obstacle to the implementation of the survivorship care plan and treatment summary is the lack of evidence supporting their collective impact on survivorship outcomes. Although there

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