Personalized Electronic Survivorship Care Plans:

Transforming Care to Prevent Lost in Transition

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Cancer Care Ontario: Disease Pathway Management
https://www.cancercare.on.ca/ocs/qpi/dispathmgmt/

Need

- Few cancer survivors receive any comprehensive post-treatment survivorship care
- Patients report that not knowing what to expect post-treatment

What symptoms should I be concerned about?

How often will I be seeing my oncologist?

How often should I be seeing my family physician?

How can I stay healthy?

Pan-Canadian Guideline and Survivorship Services Recommendations (Howell 2010)

Recommendation # 2: Individuals completing cancer treatment should receive individualized information and support in consultation with a designated and skilled member of the health care team.

Recommendation #3: All patients should receive a treatment summary and follow-up care plan in the form of a written Survivorship Care Plan.

Survivorship Care Plans

SCPs are a communication tool for patients and defined as a dynamic, comprehensive care summary and follow-up plan written by the principal provider(s) of oncology treatment. Provides standardized information on:

1) Disease information
2) Treatment information
3) Surveillance Plan
4) Persistent and late effects and their management
5) Symptoms to report
6) General health and wellness information

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TRANSITIONING PATIENTS TO POST-TREATMENT SURVIVORSHIP

Principal Investigators:

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MULTI-DISCPLINARY PROJECT TEAM

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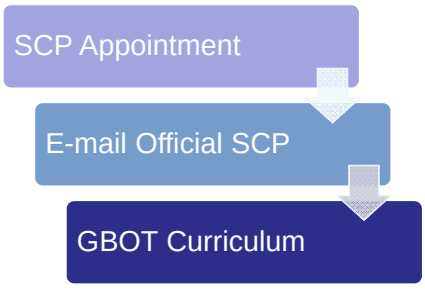
MODEL OF DELIVERY



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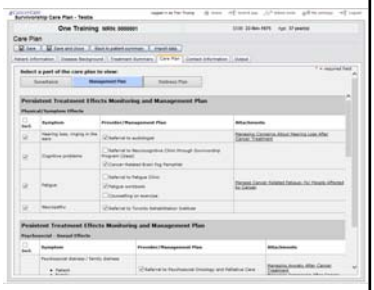
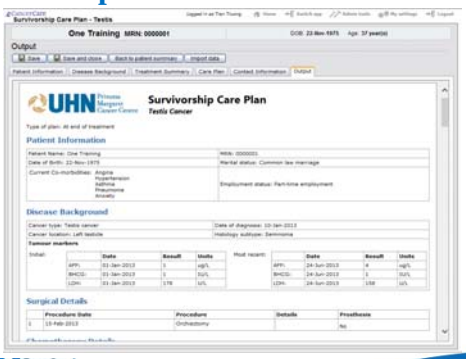
30 min SCP appointment with clinic nurse



Email/mailed pdf with links

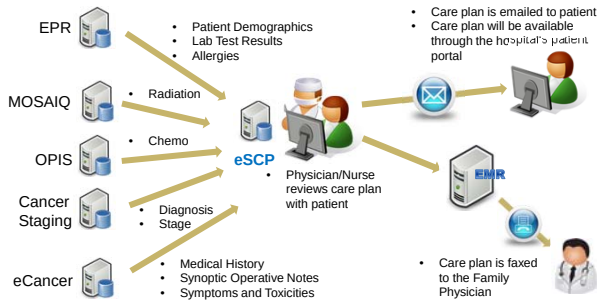


On-line Education

SYSTEM DESIGN CONSIDERATIONS

- **CUSTOMIZED** per cancer disease site
- **PERSONALIZED** for each patient
- **INTEGRATED** with other hospital systems
- **MULTI-DISCIPLINARY** review and sign-off
- **SCALABLE** to other disease sites and multi-institutional deployment
- **USER FRIENDLY**

eSCP Integration



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Pilot Implementation

- Pilot completed in two disease sites: Testes cancer & Endometrial cancer
- Multi-disciplinary users: Nurses, Radiation Oncologists, Surgical Oncologists, Medical Oncologists
- Feedback collected from clinical users and patients

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Feed back from pilot

- Ability to override the calculated surveillance protocols
- Provide patients with approximate dates for the surveillance visits
- Interface with the cancer staging application to auto populate histology and TNM stage data
- Ability to provide the family and referring physicians with a copy of the electronic care plan

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What's next

- At the Princess Margaret Care Centre we are working with the GI and Kidney Cancer groups to develop the content of their Care Plan
- Integration with the patient portal
- National SCP initiative for Kidney Cancer Patients, which will integrate with Canadian Kidney Cancer Information System (CKCIS)

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Discussion

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