The revised American College of Surgeons (ACOS) Commission on Cancer standards (2012) include a requirement that cancer centers have a process that provides a summary of care and healthcare follow-up recommendations to all patients who are completing oncology treatments. The seed for the establishment of this standard has its roots in the concerns that cancer survivors that have completed the active treatment portion of care and are now beginning a new phase of health may get lost in the various transitions during such a pivotal time.

While the ACOS has set these standards there was considerable "wiggle room" given to the providing cancer centers on how to achieve these standards. As a result the Elliot Regional Cancer Center formed a committee to review the ACOS standards to develop a formal plan/process to achieve them. The committee, comprised of the Center’s lead social worker Christine Howard, its IT Manager Eddie Reiter and Clinical Leader Steve Paradis studied the requirements and attended educational forums on survivorship, and used this information to develop a program that is now in place for all patients treated at its Center.

At the completion of treatment, a nurse meets with patients and provides them with a Treatment Summary that gives detailed information about the treatment they have just received. This includes information about their cancer diagnosis and its staging, some demographic information, a listing of all the patient’s health care team members and contact numbers. A detail of the radiation dose they have received: what area has been treated with the cGy dose given, when treatment began and ended and the number of fractions (treatments) is provided. Also included is how to get information on chemotherapy given for this diagnosis and all surgical treatments performed related to this diagnosis. For certain cancers there is also information about genetic risk factors.

The patients are also provided with specific discharge instructions that are tailored to their diagnosis which includes activity information, skin care, and any special instructions. The document also includes information regarding possible long term or late side effects of their treatments. A Follow-Up Care Plan guides the patient as to "what happens next." Information on adjuvant treatment and who to contact, and when the next follow up appointment is also provided. A key piece is the cancer surveillance or other related tests section which provides established recommended guidelines for follow-up care and management of long term side effects of treatment, such as a mammogram within 6-12 months after completion of treatments for breast cancer.

The final part of the Survivorship Care Plan includes a list of resources that remain available post treatment and the patient is encouraged to take full advantage of them. Resources such as Support Groups, Practical Needs such as completing Advanced Directives, or employment issues are included. Help with financial assistance, rehabilitation, exercise programs, nutrition, smoking cessation, emotional support, palliative care and spiritual support along with a listing of other useful web site resources are provided.

Producing such a comprehensive document that the patient can use in their post active treatment phase and beyond takes considerable effort. Our IT Manager was crucial in helping to utilize our software capabilities to auto down load as much information to complete the documentation. Helping to provide structure and format that resulted in a neat, easy to read and useful document was critical to the success of this endeavor. As a result, we have a process in which all the oncology nurses in the Cancer Center are able to utilize in order to provide each patient with a comprehensive document that helps our patients prepare for life after cancer treatment.