



The focus of this column is to present topics of interest from a variety of journals to Oncology Nursing Forum readers. The topic of this issue is the transition from patient to survivor and the clinical use of survivorship care plans.



Bridging the Transition From Patient With Cancer to Survivor

The purpose of this pilot study was to test the feasibility of a telephone counseling program for cancer survivors. The Cancer Survivor Telephone Education and Personal Support (C-STEPS) program was developed to address psychosocial and health behavior outcomes among cancer survivors. According to Garrett et al. (2013), this was the first telephone counseling intervention to simultaneously address psychosocial and health behavior in this patient population.

In this study, participants (N = 66) were recruited from two Colorado hospitals. C-STEPS was evaluated using a single-arm, intervention-only research design, and participants served as their own controls. Eligibility criteria included having stage I, II, or III disease; having the last treatment or follow-up within the past year; not receiving active treatment and no recurrence; being aged 21 years or older; being able to speak, read, and write English; and having the ability to comprehend and sign consent. The theoretical model of C-STEPS was based on the Transactional Model of Stress and Coping (TMSC) and motivational interviewing (MI). TMSC supports the premise that responses to potentially stressful events depend on primary and secondary appraisal as well as coping efforts. MI is a style of interviewing that encourages individual adaptation toward healthy behaviors.

C-STEPS ranged from three to six sessions and included two modules presented over three months. The themed modules were Meet the Challenge, which focused on facing uncertainty and stress management after cancer, and Healthy Options, which highlighted

balanced nutrition and physical activity post-treatment. During an initial orientation telephone call, participants were asked to choose one or both modules. Support materials were given to participants to guide the telephone counseling, to establish rapport between the psychosocial oncology counselors and the participants, and to facilitate realistic goal setting.

Study participants were aged from 22–80 years, with a mean age of 59.5 years. Gender was equally represented, and the majority of participants were Caucasian, married, educated, either employed or retired, and had health insurance. Most cancer sites were solid stage II tumors. Of the initial 66 participants enrolled, 13 declined to participate before choosing the intervention modules. Of the 46 participants who completed at least one module and the follow-up assessment, 21 selected both modules, 13 selected stress and coping, and 12 selected healthy behaviors.

Overall, participants were highly satisfied with the program, with a mean overall satisfaction rating of 9 on a scale of 1–10. Participant's rated the usefulness of telephone counseling at a mean of 8.8. Cancer-specific distress was assessed using the Impact of Event Scale (IES). On the IES intrusion subscale, 67% of participants reported moderate distress or higher at baseline. Among all participants, a significant decrease in mean cancer-specific intrusive thoughts was observed, going from 10.2 to 6.5 ($p < 0.001$). On the IES avoidance subscale, 59% of participants reported moderate levels of distress at baseline, as indicated by cancer-specific avoidance behavior. Participants who chose the Healthy Options module ($n = 33$) showed a statistically significant increase in daily consumption of fruits and vegetables, going from 3.8 to 4.6 daily servings ($p =$

0.02). For all participants ($n = 46$), an increase in physical activity was noted, going from 166.8 to 242 minutes per week ($p = 0.006$).

This study successfully tested the feasibility of focused telephone counseling to facilitate the adaptation from patient with cancer to survivor. The findings indicated that C-STEPS provides a viable telephone counseling program with the capacity to address cancer-related distress and promote healthy lifestyle initiatives for survivors. Cancer programs in the United States seeking accreditation by the American College of Surgeons will soon require mandatory distress screening and services for patients with cancer. With that in mind, psychosocial telephone counseling, such as C-STEPS, may become integral models for cancer survivorship programs.

Garrett, K., Okuyama, S., Jones, W., Barnes, D., Tran, Z., Spencer, L., . . . Marcus, A. (2013). Bridging the transition from cancer patient to survivor: Pilot study results of the Cancer Survivor Telephone Education and Personal Support (C-STEPS) program. *Patient Education and Counseling*, 92, 266–272. doi:10.1016/j.pec.2013.04.002

Survivorship Care Plans and Support From Providers

This study aimed to describe barriers to the clinical implementation of survivorship care plans (SCPs), strategies to support the use of SCPs by healthcare providers, and issues related to the relevance of SCPs. An SCP is a personalized, portable document used to facilitate continuous comprehensive medical care following cancer treatment and is used by patients and primary care providers. Although primary care providers and survivors have embraced the concept of SCPs, Salz et al. (2014) recognized that SCPs have not been widely used because of significant barriers. Therefore, the purpose of this study was to survey National Cancer Institute–designated Community Cancer Centers

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Program (NCCCP) hospitals about the use, perception, barriers, and strategies to implementation, as well as the role of staff and the content of SCPs.

Fourteen NCCCP sites participated in the study. Participants included medical and radiation oncologists, nurse practitioners, clinical nurse specialists, and physician assistants. The study instrument was a questionnaire that asked providers opinions about use, value, and barriers to the use of SCPs. Salz et al. (2014) focused the content of the questionnaire on topics outlined by the Institute of Medicine, which included cancer diagnosis and treatment and the specifics of continued care plans. The use of SCPs was assessed by asking about belief, commitment, and responsibility placed on acquiring SCPs by healthcare providers. Barriers to use and strategies for implementation were included in the pilot-tested questionnaire. Surveys were acquired over a 10-month time period from September 2011 to June 2012. Descriptive statistics were used to report results of the questionnaire. Differences in responses between physicians and nonphysicians were determined with Student's *t* tests and chi-square statistics.

At the 14 sites, 245 of the eligible providers completed the survey. No significant difference was found in profession between participants and

nonparticipants ($p > 0.5$). Less than 50% of the respondents reported providing patients with summaries of diagnosis, treatment, recommendations for ongoing care, or plans for continued care. The study showed that 128 (50%) providers reported offering any component of an SCP to patients, and that did not vary by profession. Of the respondents, 183 (75%) reported that they or another team member provided any component of an SCP to patients. Importance of SCPs ranged between 58%–65% of respondents, and 60%–65% believed that providing summaries of each topic was the responsibility of oncology providers, with 33%–38% having mixed feelings about this.

The greatest barriers to implementing SCPs were adequate personnel required to complete the SCP ($n = 170$, 69%) and time to collect information to complete the SCP ($n = 156$, 64%). Additional barriers included creation of the report template, patient indifference, and lack of understanding of SCP relevance. The most commonly used strategy ($n = 73$, 40%) for SCP implementation was to delegate the completion of an SCP to a single person in the oncology practice. The most widely endorsed strategy ($n = 58$ of 62 respondents who used the strategy) was the use of a template with pre-specified fields.

The perceived value of SCPs by oncology providers is high; however, in the sample of NCCCP hospitals, oncology providers were not integrating SCPs into clinical practice with regularity. That has also been found at other National Cancer Institute–designated cancer centers. Barriers to implementation (e.g., lack of adequate and appropriately trained staff, time constraints, tension of perceived importance) must be addressed to achieve a majority buy-in. In addition, a need for outcomes research focusing on evidence to support the clinical benefit of SCPs is needed for healthcare providers to prioritize health consequences of cancer survivors.

Salz, T., McCabe, M.S., Onstad, E.E., Baxi, S.S., Deming, R.L., Franco, R.A., . . . Oeffinger, K.C. (2014). Survivorship care plans: Is there buy-in from community oncology providers? *Cancer*, 120, 722–730. doi:10.1002/cncr.28472

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