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Abstract

PURPOSE:

The LIFE Cancer Survivorship Program at NorthShore University HealthSystem provides risk-adapted visits (RAV) facilitated by an oncology nurse during which a survivorship care plan (SCP) is provided and discussed. In this report, we describe and evaluate RAV in promoting individualized health care and self-management during survivorship transition.

METHODS:

Patients complete a post-RAV questionnaire at their RAV and another ≥1 year after their RAV.

RESULTS:

One thousand seven hundred thirteen (1713) RAVs, majority for breast cancer, occurred from January 2007 to March 2014. One thousand six hundred fifteen (1615) "day-of" post-RAV questionnaires were completed. Respondents scaled statements as strongly agree/agree/disagree/strongly disagree. Combined strongly agree/agree ratings are 94 % felt more confident in communicating information about their treatments to other health care providers, 90 % felt more comfortable recognizing signs/symptoms to report to providers, and 98 % had a better appreciation for community programs/services. Of 488 respondents (RAV January 2007 to December 2012 n = 1366) to a questionnaire at least 1 year after the RAV, nearly 100 % found SCP useful to summarize medical information, 97 % to reinforce follow-up, 85 % to recognize symptoms of recurrence, 93 % to identify healthy lifestyle practices, 91 % to
assist in identifying resources for support, 72% discussed their SCP with their healthcare provider, and 97% made at least one positive lifestyle change.

CONCLUSIONS:

Participation in LIFE RAV following treatment helps survivors to guide future self-care behavior. Data suggest that benefits may persist 1 year after the visit and support the feasibility of a nurse-led RAV to establish a SCP in cancer survivors.

IMPLICATIONS FOR CANCER SURVIVORS:

Combined provision and discussion of SCPs help survivors construct a useful understanding of their cancer experience and may promote long-term self-management.

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