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Treatment Plan and Summary Templates: The Experience of One Practice

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The concept of a written treatment plan template and summary provided to the patient and referring physicians came as a complete surprise to the physicians in my practice. Treatment plans and summaries were originally piloted in our office as part of a voluntary effort with ASCO. The usual reluctance to take on any additional paperwork was voiced by everyone involved. However, it quickly became obvious that the use of a formal treatment plan template had broad benefits. Discussions with patients became more fruitful, and decisions—not only those between the physician and the patient but also those among the physicians within the practice—became clearer. Treatment plans were rapidly adopted for routine use as part of a formal chemotherapy teaching session for patients beginning therapy, regardless of disease histology or treatment intent.

Before the use of a written treatment plan, a patient who was seen for a new diagnosis of cancer would meet with the physician to discuss the natural history of the disease and develop a plan outlining potential options for therapy and follow-up. The patient might be given written information, usually in the form of drug information sheets or pamphlets about the disease itself. He or she might meet with one of the chemotherapy nurses to discuss issues regarding venous access and to review in broad terms the adverse effects of treatment discussed in the initial visit with the oncologist. The patient would then return for chemotherapy treatment, at which point issues regarding the acute adverse effects of chemotherapy would be discussed again by the oncology certified nurse administering treatment.

With the advent of treatment planning, issues regarding the natural history of the disease continue to be discussed in the first visit with the physician, but far more focused issues surrounding the stage of the disease and the goals of therapy have become the bulk of the initial discussion. In the second visit, a treatment plan is given to the patient as part of a formal chemotherapy teaching session. This session may be led in our office by either a physician or a nurse practitioner. Patients have often stated that they absorbed only part of what was discussed during the first visit with the physician. In the second visit, the patient is in a better place to ask questions regarding the natural history of the disease, the risk of recurrence, and the intent of the treatment, as well as to formally review the acute adverse effects of chemotherapy and discuss the late and long-term effects of che-

motherapy. A follow-up plan is discussed in the context of treatment. This may include survivorship planning, restaging intervals for the patient with a palliative-intent treatment plan, or scans and interventions for the patient with a curative-intent treatment plan.

The benefit of discussing long-term effects of chemotherapy in a setting separate from the initial visit became immediately obvious to all involved, as patients discussed their disease in the context of the health continuum rather than in terms of an immediate and imminently fatal event. Patients have recounted that it was helpful to see their physicians thinking of their disease in the context of their overall lives rather than as an acute traumatic event. The ability to communicate information to patients in a written form has also produced tangible benefits. Patients have often returned for subsequent visits either during their course of therapy or after completion of treatment with questions about disease stage, initial intent of therapy, and potential long-term adverse effects that they might otherwise not have brought to medical attention. For example, early discussion of the potential cognitive effects of chemotherapy now often leads to additional discussion many months after completion of treatment of issues the patient might otherwise have been reluctant to share with his or her provider. Patients have recounted not feeling “foolish” about subtle cognitive issues—which they may previously have ignored—causing anxiety about disease recurrence.

Reproductive discussions and discussions regarding sexual health were often avoided by both patient and physician in the long-term follow-up of patients who had received adjuvant chemotherapy. However, with written treatment plans and summaries detailing late and long-term effects, patients now understand that these are areas open for discussion and spontaneously begin discussions about these effects far more frequently. Appropriate referrals can be made early in the course of survivorship to address these issues.

Similarly, recording in a written form the intent of therapy, whether curative or palliative, often prompts patients to initiate discussions later in the treatment course. Particularly in the event of palliative therapy, end-of-life wishes and planning are addressed at the same time as benefits and limits of chosen

treatments. Rather than being addressed in one complex and difficult visit, end-of-life and do-not-resuscitate issues are now topics in a more fluid and ongoing discussion. Physicians and nonphysician practitioners in our practice have reported less stress surrounding such discussions because they now occur in the context of care rather than as defined events.

The ability to communicate all of this information to the primary care physician in a comprehensive and meaningful way has been uniformly welcomed. At the chemotherapy teaching visit, when the written treatment plan is provided to the patient, a calendar is also created, and copies of all of these documents are routinely provided to the primary care physician as well as to the surgeons, radiation oncologists, and other physicians who are key figures in the health care of the patient. By engaging all of the physicians in the plan, we can make sure they know at which points in the cycle of therapy patients may present to them. We have had experiences including a primary care physician contacting our office stating that a patient had called with upper respiratory tract symptoms; this would otherwise have been treated as a community acquired viral infection, but having received the treatment plan and calendar, the physician was aware of the neutropenic effects of chemotherapy. Although we have not studied this in a systematic way, it has been our experience that adverse effects in patients are minimized with the use of treatment plans, and we hope that hospitalization and emergency room visits are diminished. Primary care physicians have reported the ability to better assist in end-of-life discussions with their patients, with the knowledge that the patients have received written plans including intent of therapy.

Although the administrative burden of preparing adequate treatment plans and summarizing treatment therapy has not been met with open arms, in our practice, the benefits have outweighed the costs. The issue of reimbursement for this added service to patients is being debated at present. One tangible benefit we have noticed is the ability to take adequate time to confirm that patients have sufficient insurance coverage not only for parenteral chemotherapy but for supportive care drugs and co-pay and deductible costs as well. In treatment planning visits, patients often disclose to the nurse practitioners issues about cost they felt were not appropriate to discuss with physicians in the context of an initial visit. This lead time has allowed us to integrate patient advocates and social services into care before patients find themselves in financial crisis midway into treatment, as had happened in the past.

In the context of a single comprehensive visit, adequate discussion of the stage of disease, natural history of disease, goal of treatment (whether palliative or curative), acute adverse effects of chemotherapy, and late and long-term effects of chemotherapy and other treatments is difficult to deliver. The additional visit for treatment planning has allowed the conversation between the patient and care provider to occur in the context of

Chemotherapy Treatment Plan and Summary Templates

The ASCO chemotherapy treatment plan and summary templates were developed to help improve documentation and coordination of cancer treatment and survivorship care. They are intended to facilitate provider-to-provider and provider-to-patient communication and may be distributed to patients or providers as records of the care planned and received. It is important to note that the treatment plans and summaries are not intended to replace detailed chart documentation, such as complete patient histories and chemotherapy flow sheets.

Treatment summaries are not intended to be, and should not be considered, substitutes for written or verbal communication, physical examinations and histories, or reviews of complete medical records. Because the treatment summaries synopses elements of patients' medical records and treatment plans, they should be treated as confidential and used or disclosed only in accordance with federal and state privacy laws.

ASCO has developed treatment plan and summary templates for breast cancer, colon cancer, non-small-cell lung cancer, and small-cell lung cancer, as well as a generic template that can be used for any cancer diagnosis. These templates can be downloaded and customized for your practice; they are available at www.asco.org.

the health continuum. This has both empowered our patients and produced tangible benefits for the physicians involved. The written treatment plan template has enabled communication with colleagues both inside and outside the practice, which has led to better coordination of care. Patients have reported greater satisfaction in their discussions with their care providers, not only about what is happening now but also about what to expect in the future as they transition from patients to survivors.

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