

25<sup>th</sup> World Congress on

## NURSING CARE

July 24-26, 2017 Melbourne, Australia

**Cancer survivorship: Coordinating a complex lifelong journey****Heather J Sobko**

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Survivorship from all form of cancer has increased exponentially during the last decade, but the coordination of care to support patients in addressing short and long term effects of treatment has not kept pace. Established care coordination models generally include case management (designed to assist individuals with complex physical, social and emotional health needs at risk for significant adverse outcomes) and transitional care (processes involved in linking care across settings). These models focus on improving quality while reducing costs and have demonstrated significant success in improving discharge processes, communication across care settings and reduction of preventable re-admissions during the tenuous thirty-day time period post discharge. However, they do not address the life-long follow-up needs of surveillance, health promotion and managing the physical, psychological, spiritual, social and long-term late effects faced by cancer survivors post-treatment. Further, there is increasing need for information to support primary care clinicians who care for survivors after discharge from oncology specialists. The American Cancer Society and the American Society for Clinical Oncology recommend comprehensive survivorship care plans to track details about the care received during treatment and the need for future check-ups, cancer tests and potential long-term late effects of treatment. However, these plans are time consuming and resource intensive and guidelines for addressing these issues by cancer type are limited. Nurse care managers and coordinators are ideally qualified to take the lead in developing survivorship care plans and to generate the evidence needed for standardized guidelines that support patients and their primary care providers during the life-long survivorship journey. To highlight the magnitude and severity of long-term effects of cancer treatment, figure-1 provides an epidemiological overview of the increase of seven selected diseases experienced by adult cancer survivors when compared with adults without a history of cancer.

**Biography**

Heather J Sobko is internationally recognized for her leadership in Nursing Informatics and for developing innovative tools for patient engagement, promotion of patient-centered care, quality improvement, care transitions and advanced illness and multi-morbidities. She is an Associate Professor and Director of Nursing Informatics at the University of Utah, College of Nursing, a Fellow of the National Readmission Prevention Collaborative and the Founder of IVR Care Transition Systems, Interactive Health Robots (i-HEROS) and the Cancer Survivor Research Collaborative. He has numerous publications and is a Reviewer for several peer reviewed journals.

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