Cancer Survivorship

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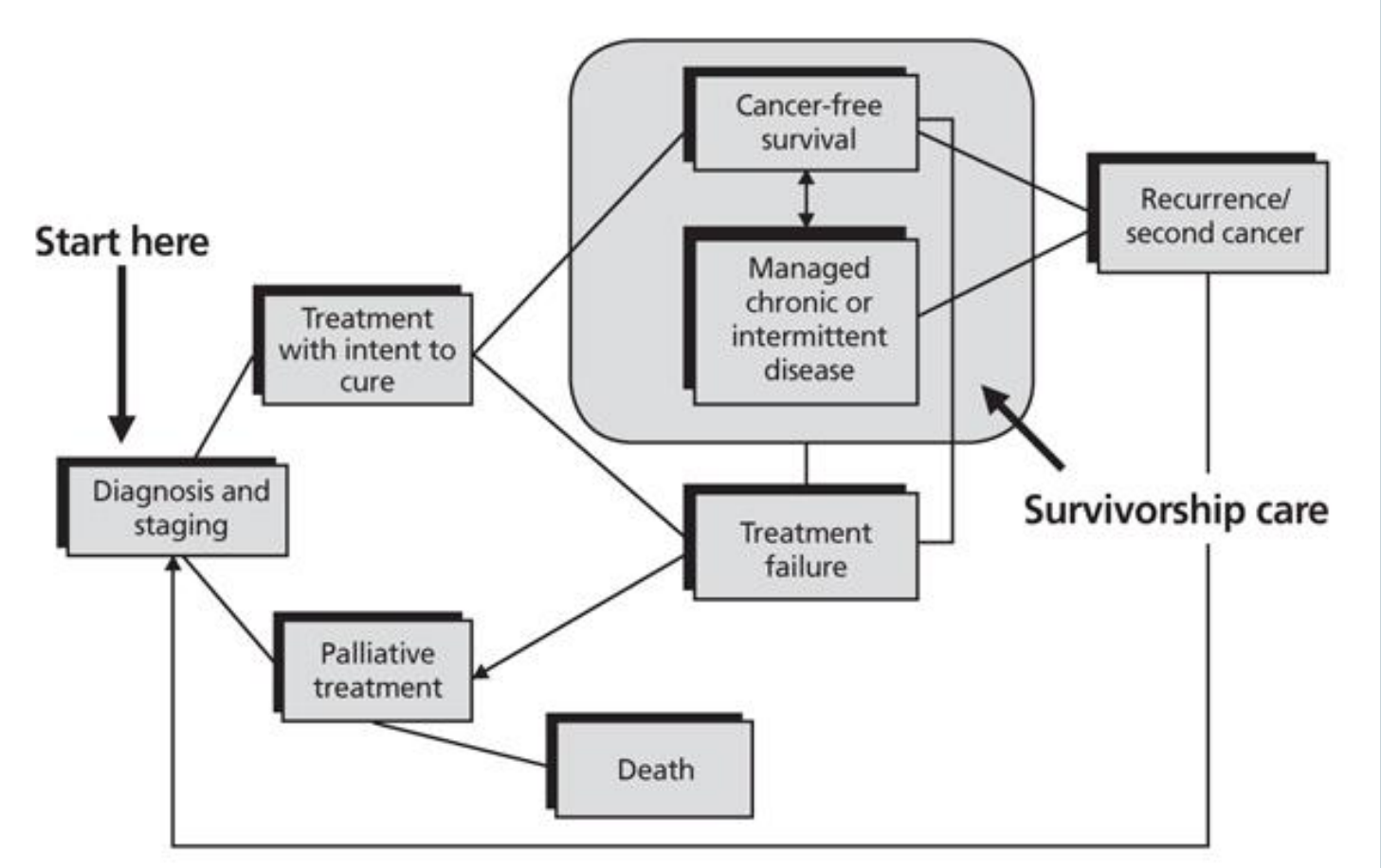
Cancer Care Trajectory



IOM, 2006b.

Why is Cancer Survivorship Research Important?

- The number and rate of 5-year survivors are accelerating.
- Survivors can get lost as they move from a highly structured cancer care system to one where they may have no provider or one who is inadequately equipped to help them with the issues that arise.
- Good post-treatment communication between providers and care can improve patient quality and quantity of life.

Supporting Cancer Patients as PCPs

http://www.bccancer.bc.ca/health-professionals/professional-resources/survivorship-primary-care

General Survivorship Care Components

- These are from the GWU National Cancer Survivorship Resource Center Toolkit
- Surveillance and Screening – late effects management and surveillance for recurrence and second cancers
- Care Coordination – between PCPs and specialists
- Assessment and Management of Physical and Psychosocial Impacts – treating consequences of cancer and its treatments
- Health Promotion – to improve quality of life

Project Descriptions

- Project 1 - The project involves surveying primary care patients who are cancer survivors to determine their experiences with their oncologist and PCP after treatment. We have finished laying the groundwork for the project and are in the process of administering surveys and conducting interviews.
- Project 2 – I have been process mapping OUMC's implementation of survivorship care plans.

- Project 1 – Patient Transition to Survivorship in Primary Care Study

Purpose

- The purpose of this study is to explore the experiences and perceptions of cancer survivors about their transition from active treatment with curative intent to follow-up (survivorship) care within the primary care system.
- The eventual goal is to conceptualize and develop an intervention to improve the quality and patient experience of cancer survivors in a primary-care setting.

Patient Screening

- The first steps we needed to complete this summer were to obtain provider consent and choose patients to contact based on the inclusion criteria
- Inclusion criteria
  - 18 to 80 years old
  - Active primary care patient with a regularly scheduled appointment at FMC in the forthcoming 3 weeks
  - Have cancer diagnosis and have completed active cancer treatment a minimum of 1 year prior

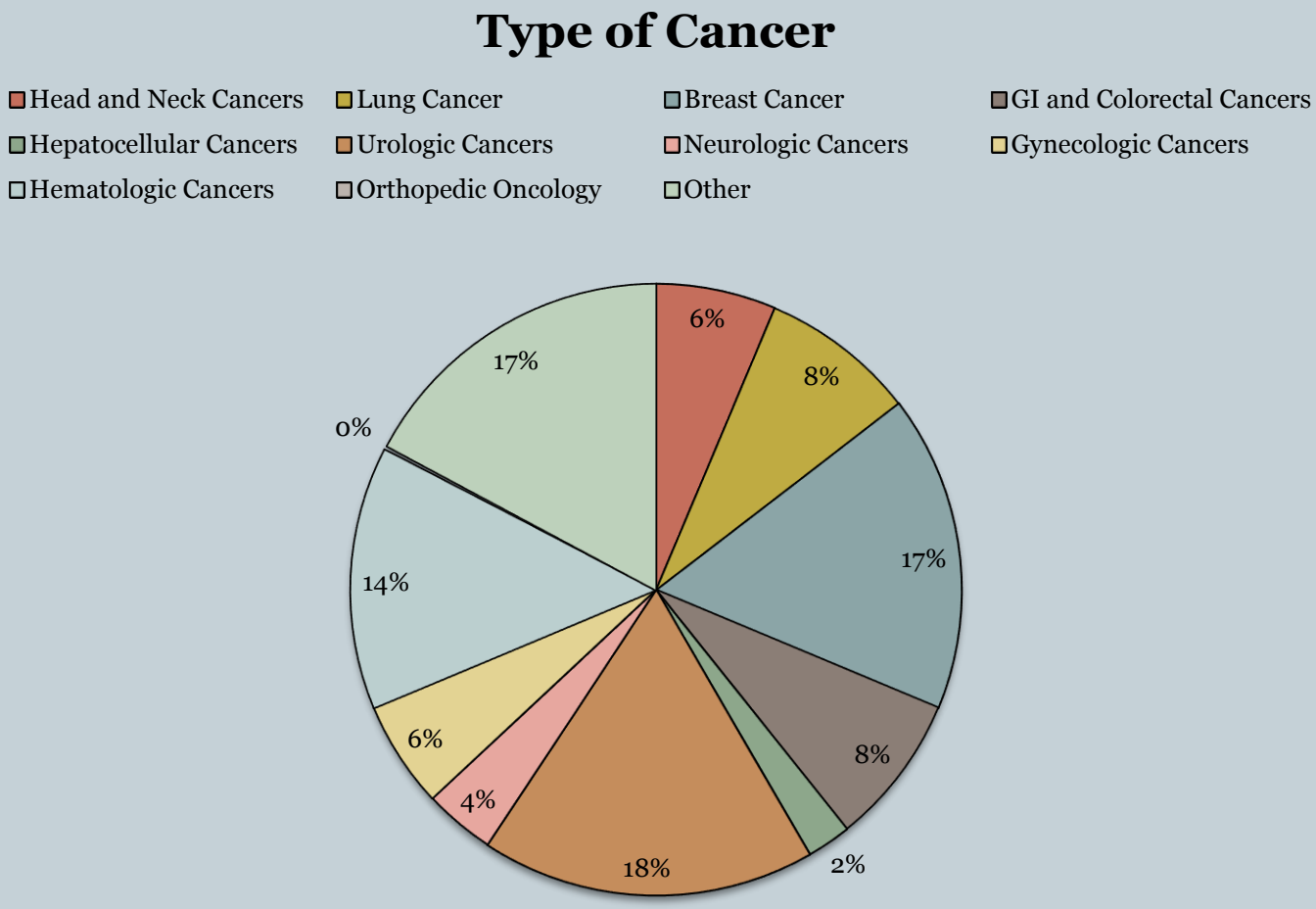
Obtaining Provider Consent

- We needed to obtain consent from residents and clinical faculty before we started screening patients and contacting them.
- Dr. Norton spoke to the faculty and residents on June 29th at Grand Rounds.
- We were able to track down almost all the residents (22/24) and almost all of the clinical faculty (15/16)

Screening and Selecting Patients

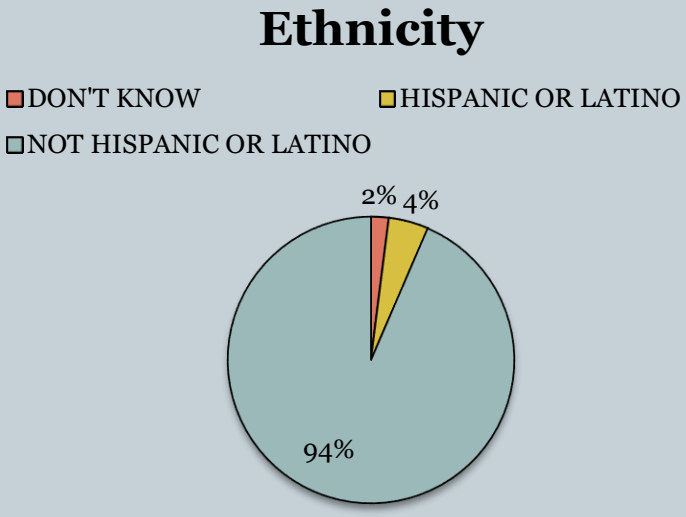
- With help from the Family Medicine Departmental Billing Manager, we got a list of patients that met our criteria (active family medicine patients with cancer diagnosis)
- In this screened patient information, we received information about cancer diagnosis, health insurance, ethnicity, race, and age.
- I've gone through and calculated statistics for this information.

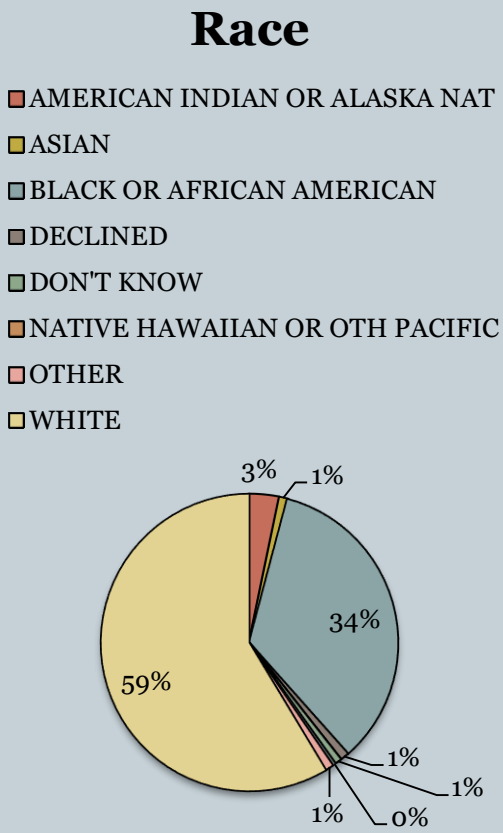
Screened Patient Information - Diagnosis



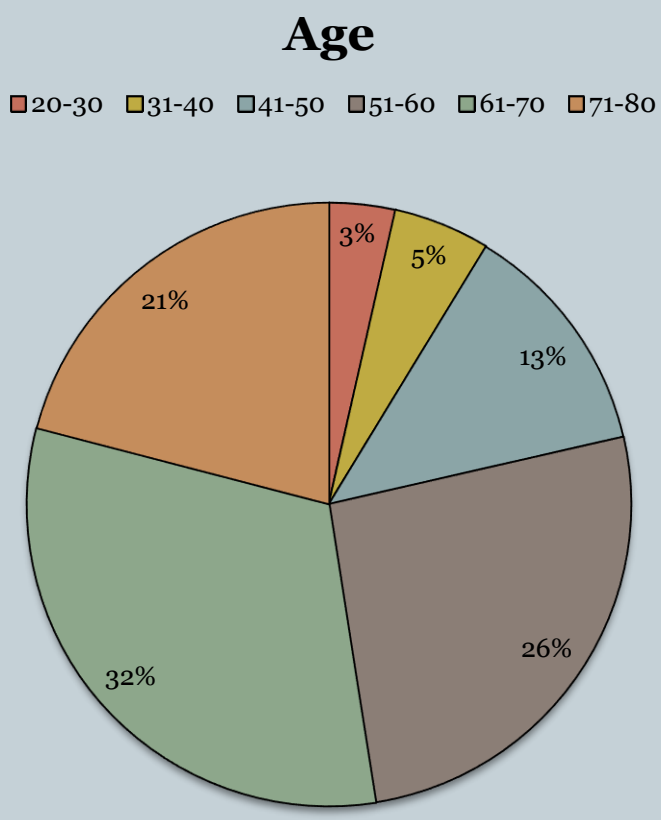
Screened Patient Information - Insurance

Screened Patient Information – Race and Ethnicity





Screened Patient Information - Age



Paper Survey

- The first data collection step will involve the use of a paper survey with 25 FMC patients asking questions about survivorship care and coordination, along with demographic information and health status.
  - 24 questions about survivorship care
  - 10 demographic questions
  - 13 items about patient's cancer and health status
  - Will require approximately 30 minutes to complete

Phone Interview

- 10 patients who have already completed the survey and indicated that they would be willing to do a phone interview can then do a follow-up, semi-structured, phone interview.
- The phone interview is to provide a more in-depth understanding of the care coordination of cancer survivors after treatment.

Current Results

- At this point, we have finished all the groundwork of screening the patients and obtaining patient consent.
- I have administered the survey to one patient, and she is scheduled for a follow-up phone interview this upcoming Monday.
- This project will be continuing until we have surveys from 25 patients and follow-up phone calls with 10 patients.

- Project 2 – Using Process Mapping to Improve the Implementation of Survivorship Care Plans at OUMC

Introduction

- Survivorship Care Plan – a document given to cancer patients that contains information about given treatments, the need for future check-ups and cancer tests, the potential late/long-term effects of treatment, and ideas for improving health

- Process Mapping – an exercise to identify all the steps and decisions in a process within a diagram

Implementing SCP at OU

- At OUMC, 25% of cancer patients need to have cancer survivorship care plans by October 2016.
- This standard is important for accreditation and is set by the American College of Surgeons
- OUMC will be making their survivorship care plans using the Cancer Care Plan Builder tool from the Journey Forward website.
  - Journey Forward is a collaboration of organizations with the goal of improving survivorship care.

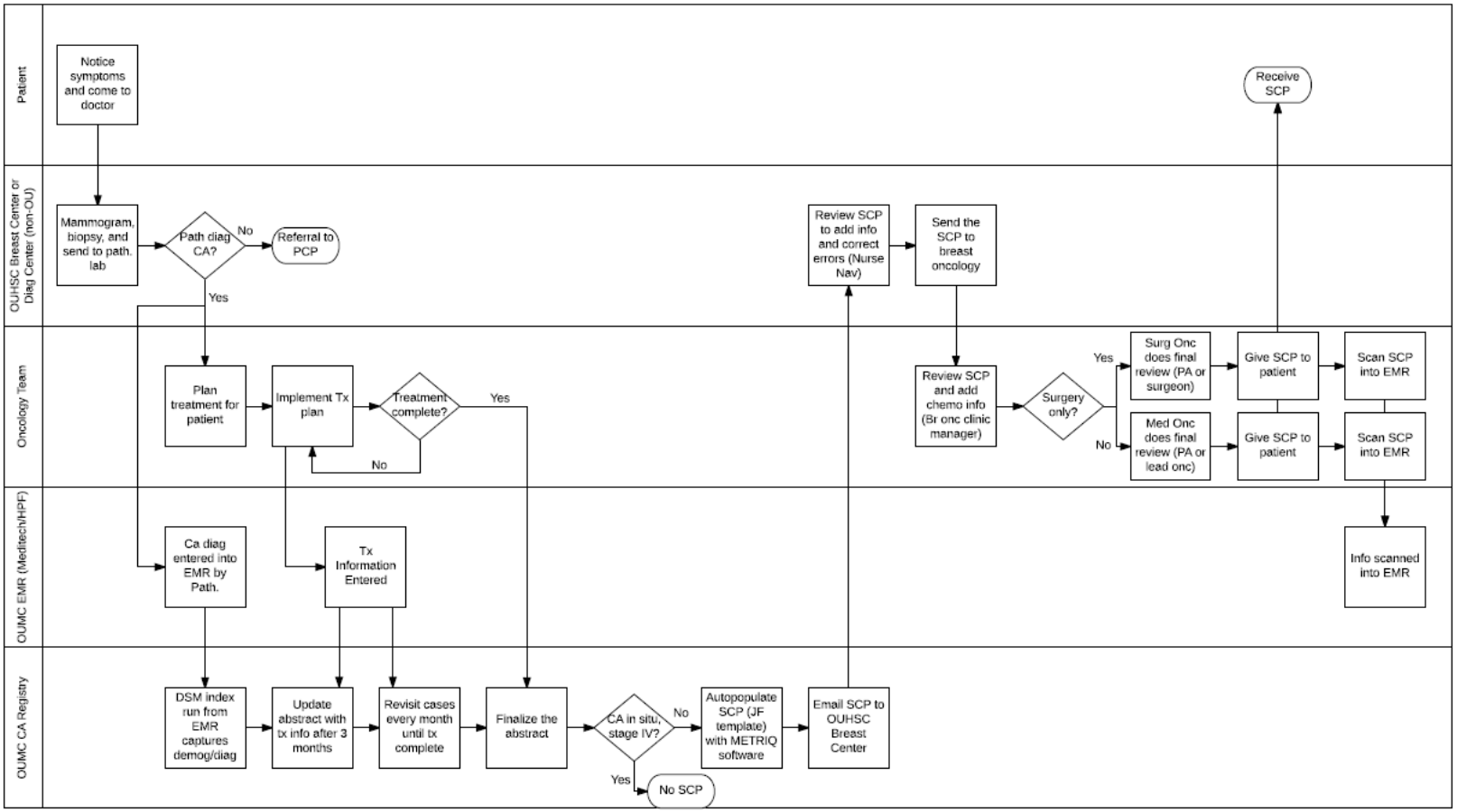
Methods

- The first step that I had to go through for this project was to become more familiar with process mapping.
- I also learned how to use the diagram application Lucidchart.

Methods

- I made the process map based on meetings with several people who are involved in implementing the survivorship care plans at OU.
- People I met with included a consultant who was helping with the cancer registry, the Vice President of Operations for OUMC, a Nurse Navigator at the OU Breast Institute, and a Clinic Manager at the Breast Cancers Clinic at the Stephenson Cancer Center.

Current Version of the Process Map



What Works Well in Current Implementation

- The cancer registry can directly obtain demographic and diagosis information from the EMR, and this information can autopoulate the SCP (using METRIQ software).
- The process has already created a survivorship dialogue and interface between the Stephenson Cancer Center and OU Medical Center. This focus on survivorship did not exist before.

Challenges

- Even though the SCP can be autopopulated, it still includes missing sections and errors, both of which need to fixed manually.
- Primary care physicians currently have no way of accessing the SCP – the patient would have to bring in a paper copy for them to look at.
- There is no good spot on the EMR for SCPs
- For right now, in situ cancers and Stage IV cancers are not being included – the eventual goal will be to get one to every cancer patient.

Things I Have Noticed

- The implementation of these survivorship care plans hasn't been very organized.
- Although 25% of cancer patients need to have survivorship care plans by October 2016, currently 0 have been finished and delivered to the patient.
- The final part of the process hasn't been completely figured out yet, which made mapping it more difficult.
- It seems like it would be much more efficient to get the entire process well organized beforehand

Questions?