SHORE SURGICAL HEALTH OUTCOMES & RESEARCH ENTERPRISE

Are we engaging with survivorship care stakeholders or staying married to our jobs?

Katia Noyes, PhD, MPH

Professor of Surgery & Public Health Sciences

Scientific Director, SHORE

University of Rochester Medical Center

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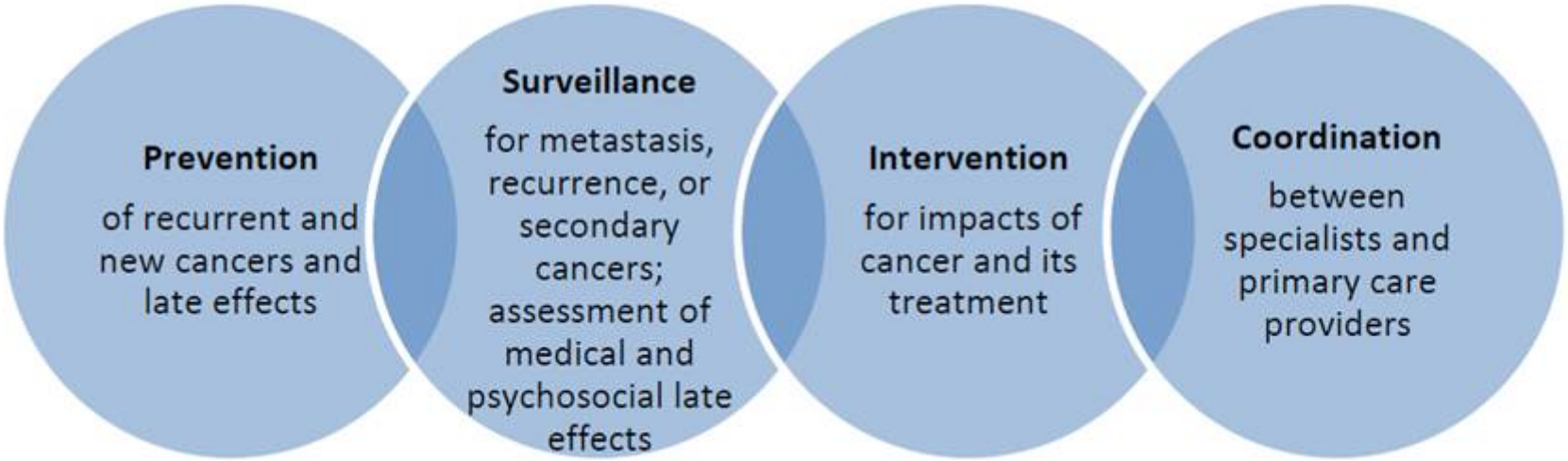
IOM Recommended Components of Survivorship Care



[5] Hewitt M, Greenfield S, Stovall E. From Cancer Patient to Cancer Survivor: Lost in Transition. 2005. Washington, D.C.: The National Academies Press.

New York State Region

Rural Medicine

Over Supply

No Supply

SHORE SURGICAL HEALTH OUTCOMES & RESEARCH ENTERPRISE

Reasons behind rural-urban disparity in cancer outcomes

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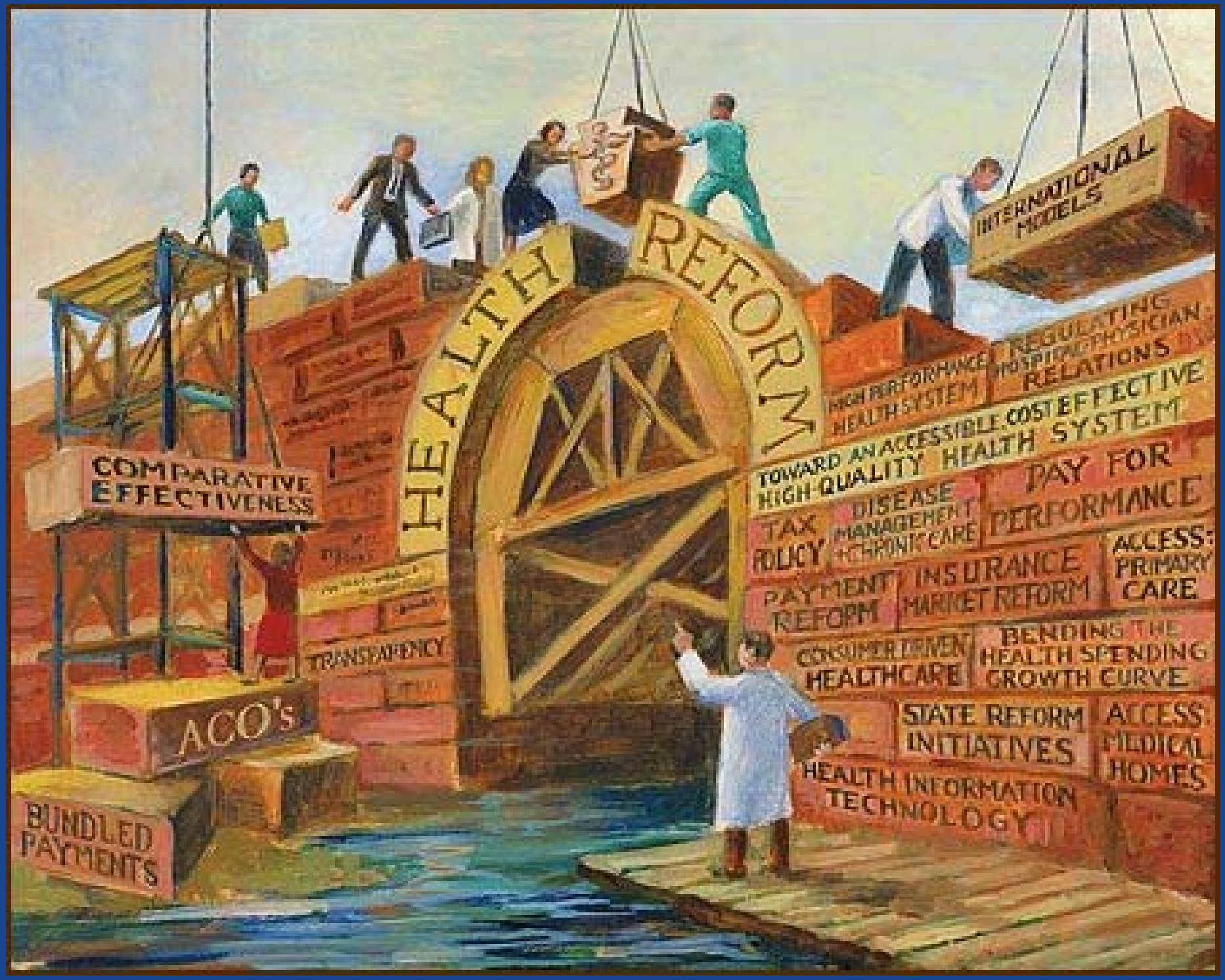
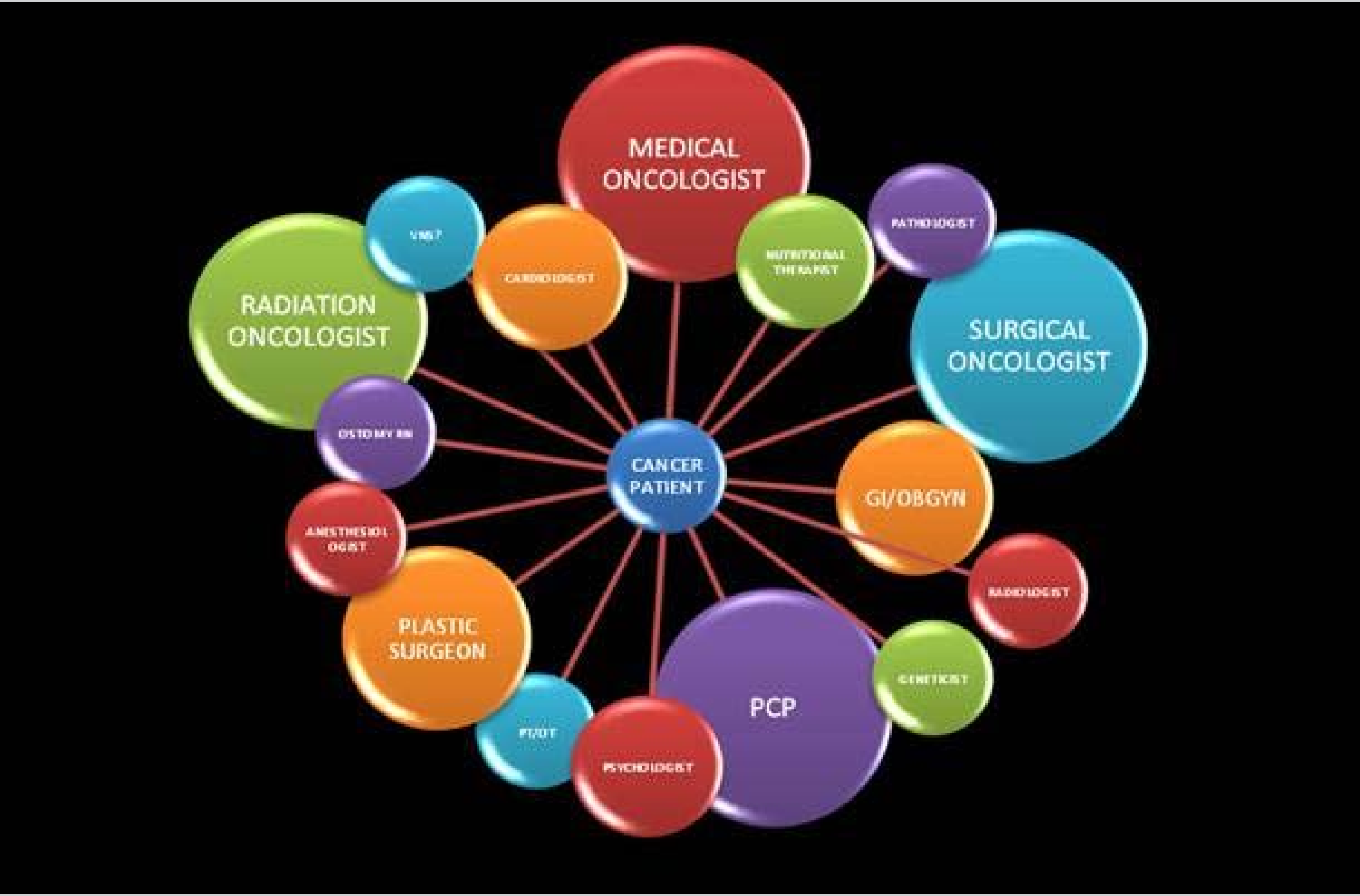
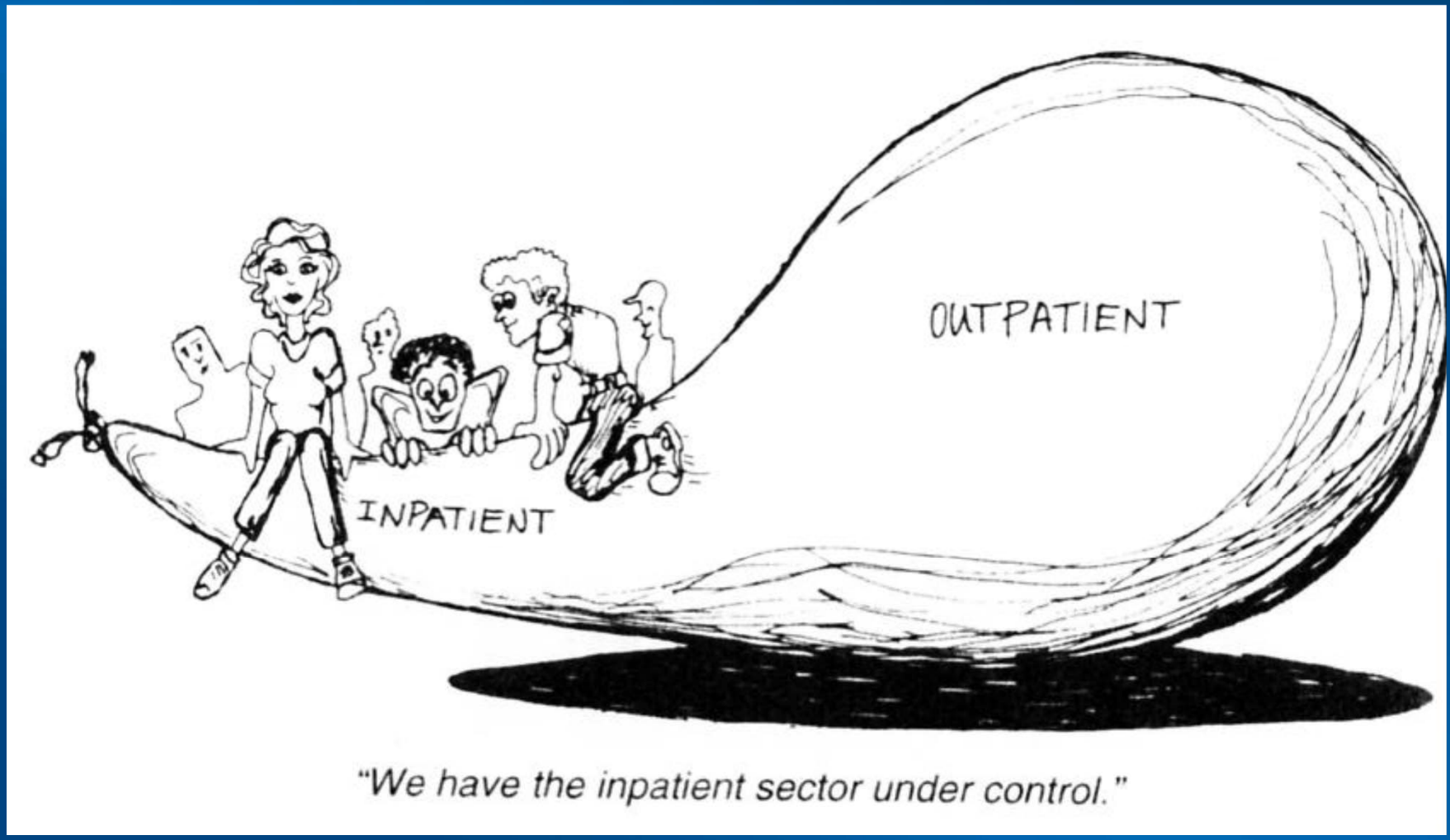

HEALTH REFORM
INTERNATIONAL MODELS
COMPARATIVE EFFECTIVENESS
HIGH PERFORMANCE HEALTH SYSTEM
REGULATING HOSPITAL-PHYSICIAN RELATIONS
TOWARD AN ACCESSIBLE, COST EFFECTIVE HIGH-QUALITY HEALTH SYSTEM
TAX POLICY
DISEASE MANAGEMENT + CHRONIC CARE
PAY FOR PERFORMANCE
PAYMENT REFORM
INSURANCE MARKET REFORM
ACCESS: PRIMARY CARE
TRANSPARENCY
CONSUMER-DRIVEN HEALTHCARE
BENDING THE HEALTH SPENDING GROWTH CURVE
ACO's
STATE REFORM INITIATIVES
ACCESS: MEDICAL HOMES
HEALTH INFORMATION TECHNOLOGY
BUNDLED PAYMENTS

Appointment roaster for a new breast cancer patient

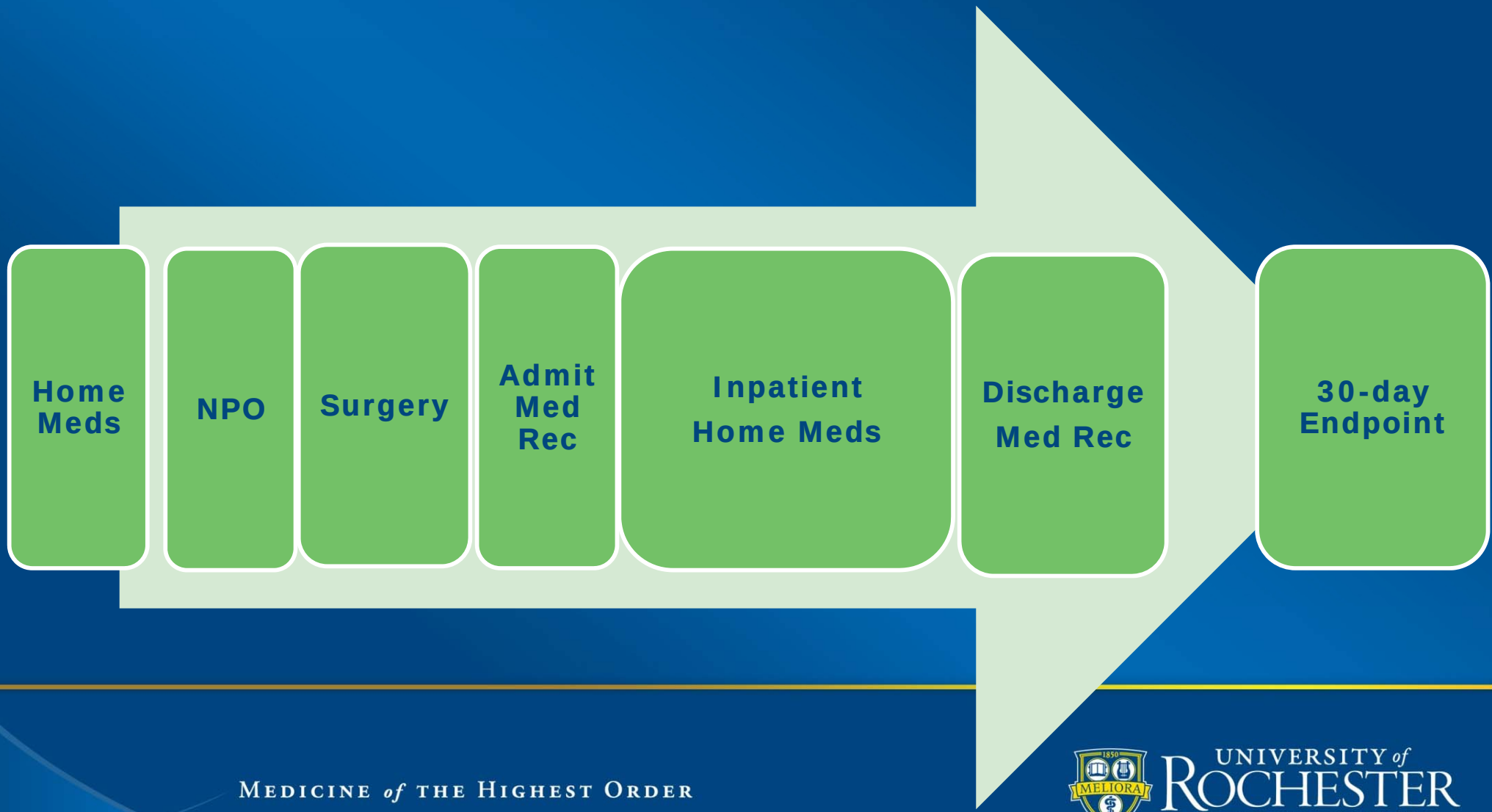


[Lack of] Continuity of Care



"We have the inpatient sector under control."

Patient Hospital Journey



Learning Objectives

1. Learn about the key stakeholder groups and their roles in cancer survivorship care.

2. Understand the key principles of stakeholder engagement and teamwork in cancer survivorship care.

Model of Engagement

TIME WELL SPENT®

by Tom Fishburne

WORKFORCE MANAGEMENT DOESN'T HAVE TO BE SO HARD

KRONOS

KRONOS.COM/TIMEWELLSPENT

Cancer Survivorship Care Stakeholders

Physicians (oncology specialists and PCPs)

Advance Practice Partners (NPs, social work, behavioral health, nursing)

Payers

Departments of Health & Social services

Community health organizations (vising and skilled nursing, pharmacy, transportation, CAM)

Community non-healthcare partners (social services, transportation, exercise, wigs and prosthetics)

Patients and caregivers

Patient navigators & advocates

"Coming together is the beginning.
Keeping together is progress.
Working together is success"

Henry Ford

Principles of Stakeholder Engagement

Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial

J Am Geriatr Soc 52:675–684, 2004.

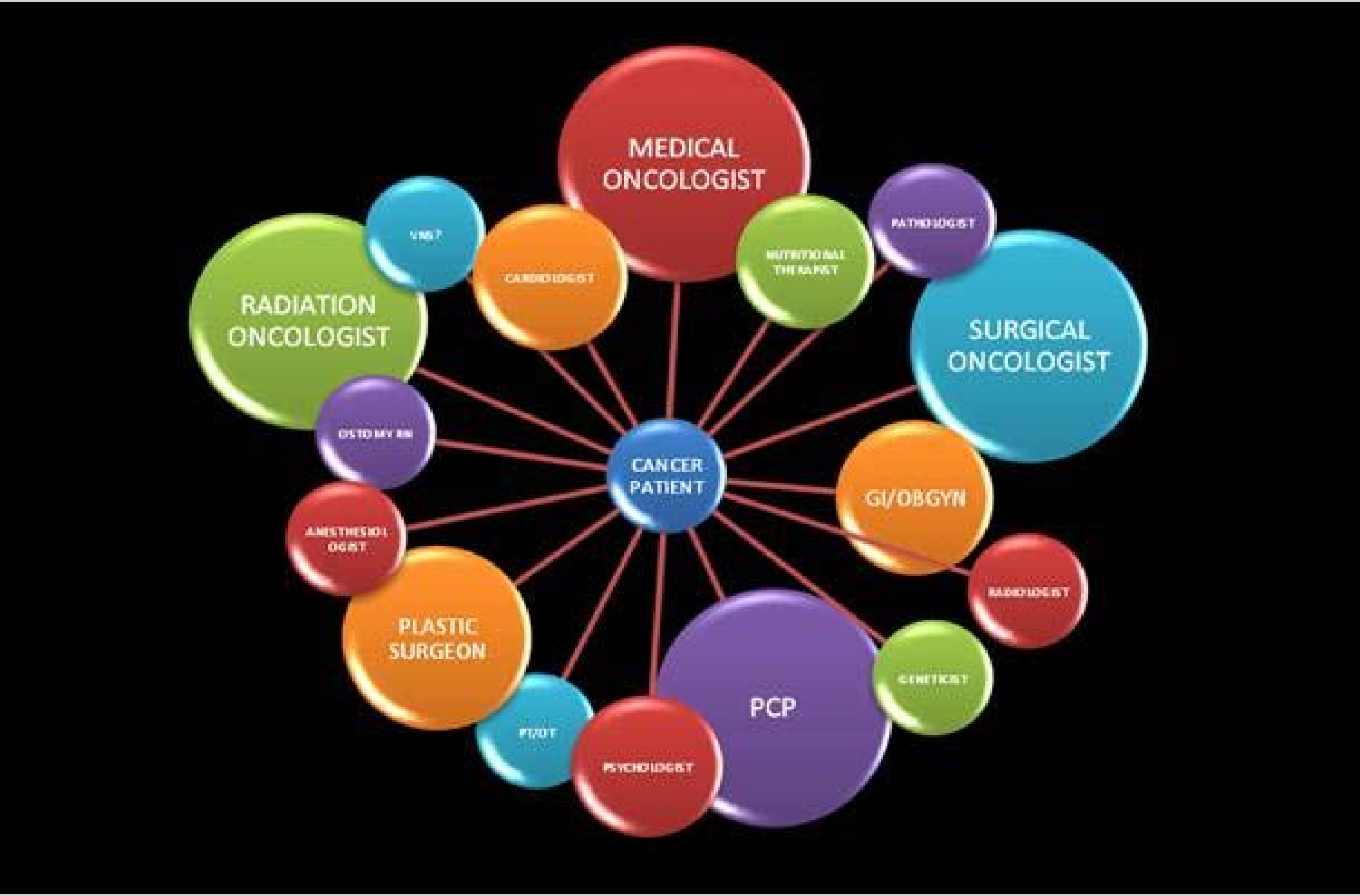
Mary D. Naylor, PhD,[*†] *Dorothy A. Brooten, PhD,*[‖] *Roberta L. Campbell, PhD,*[*] *Greg Maislin, MS, MA,*[¶] *Kathleen M. McCauley, PhD,*[*] *and J. Sanford Schwartz, MD*[†‡§]

Intervention Activities: Patient Checklist

Before I leave the care facility, the following task should be completed:

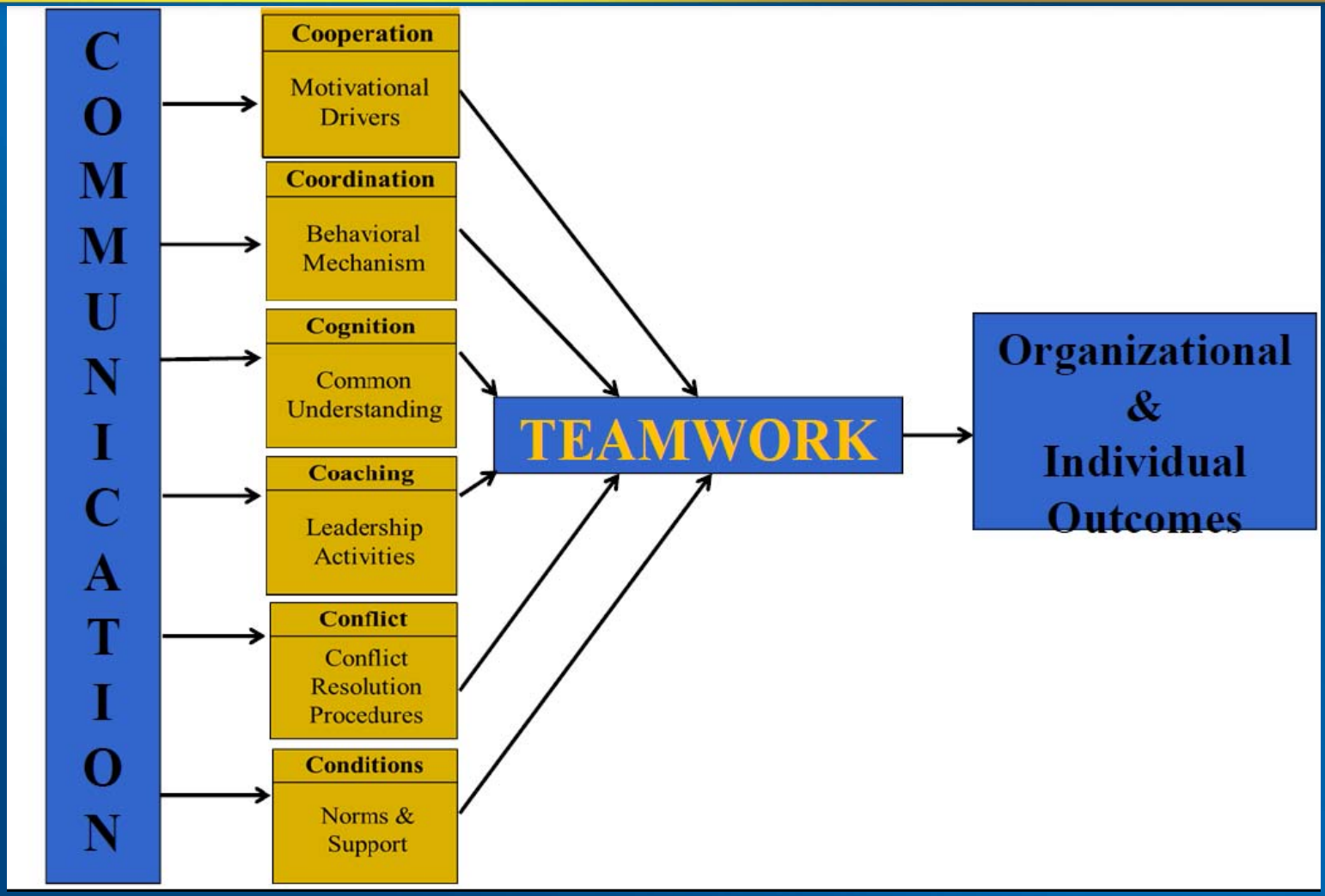
- ☐ I have been involved in decisions about what will take place after I leave the facility
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive
- ☐ I have the name and phone number of a person I should contact if a problem arises during/after my transfer and discharge.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom to call if I experience them.
- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to my leaving the facility
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

Appointment roaster for a new breast cancer patient



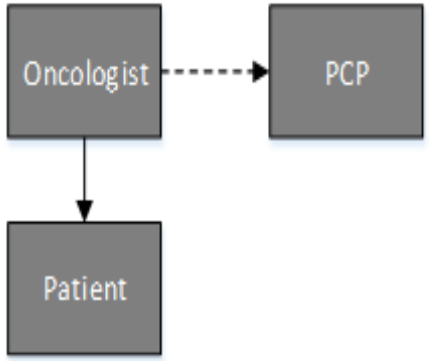
Taplin, S.H., et al., Teams and teamwork during a cancer diagnosis: interdependency within and between teams. J Oncol Pract, 2015. 11(3): p. 231-8.

"*Teams* are defined as two or more people who interact dynamically, interdependently, and adaptively to achieve a common, valued goal."

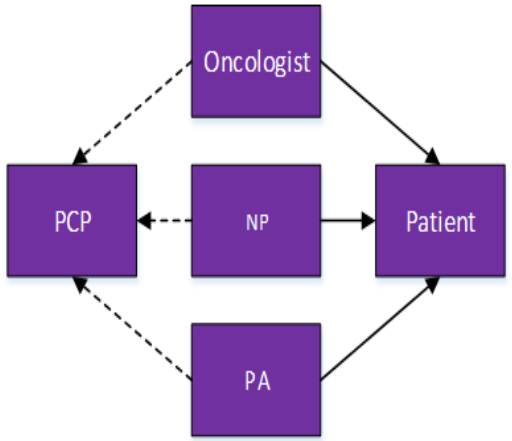

COMMUNICATION
Cooperation
Motivational Drivers
Coordination
Behavioral Mechanism
Cognition
Common Understanding
Coaching
Leadership Activities
Conflict
Conflict Resolution Procedures
Conditions
Norms & Support
TEAMWORK
Organizational & Individual Outcomes

Models of Cancer Survivorship Care Delivery

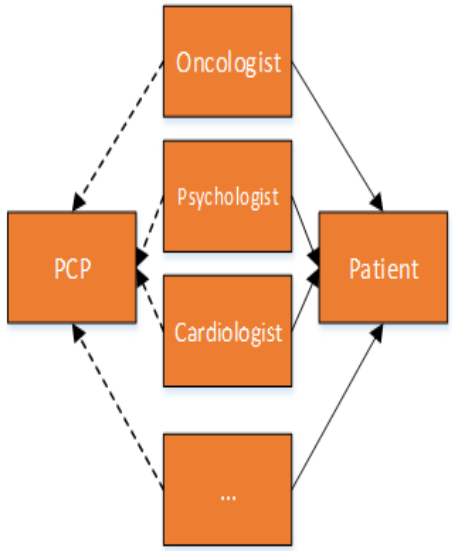
- Oncology Specialty Care



- Disease/treatment-Specific Survivor Clinic



- Multi-disciplinary Survivorship Clinic



http://www.asco.org/practice-research/models-long-term-follow-care

Table 2: Models of Survivorship Care

MODEL/SUBTYPE	EXAMPLES
Academic/Oncology-Based Care	*Cancer centers, community oncology practices*
• Disease-Based Programs	Breast cancer, prostate cancer, adult survivors of childhood cancer
• Treatment-Based Programs	Radiation therapy, hematopoietic cell transplant
• Comprehensive Programs	All cancer survivors regardless of diagnosis, age, or treatment
Community-Based Care	*Primary care practices*
• Family Practice/Internal Medicine–Based	Survivors of adult and childhood cancers
• Pediatric-Based	Young childhood cancer survivors
Shared Care	*Shared primary and oncology care*
• Without transition	Survivor is seen periodically at the cancer center and co-followed by the PCP for primary care needs (eg, intercurrent illness, health promotion, management of comorbidities)
• With transition	Survivor is followed by cancer center for a set time period and then care in its entirety is transferred to the PCP, who maintains periodic contact with the cancer center

Table 3: Survivorship Care Systems of Delivery

CARE DELIVERY TYPE	EXAMPLES
Consultative	
• One-time comprehensive visit	Survivor attends a specialized long-term follow-up program for a one-time comprehensive visit and receives a detailed follow-up plan which is then implemented by the PCP
•Multi-visit	Care is shared between oncology specialist and primary care provider; roles and responsibilities are clearly delineated; survivor typically seen by oncology provider yearly and by PCP on ongoing basis
Ongoing	Survivor is followed in an academically based specialized program for cancer survivors; care is often nurse-led or provided by a multidisciplinary team
Integrated	Survivorship care is embedded with the primary oncology treatment team; care may be ongoing, or transition to PCP may occur when deemed appropriate

http://www.cancernetwork.com/oncology-nursing/survivorship-care-essential-components-and-models-delivery/page/0/1

Why should you care?

1. Improved communication between/among providers and cancer patients:
   - less potential for errors,
   - easier to f/u patients
   - complete long-term data on costs, bundles, outcomes
2. Improves patient satisfaction scores:
   - Reduce patient anxiety
   - Reduce unnecessary travel and appointments
3. Improves outcomes
   - Patient outcomes (satisfaction, fatigue, behavioral health, ADLs)
   - Provider outcomes (number of patients seen, staff turn over, market share)
   - Population health

Katia Noyes, PhD, MPH

585-275-8467

Katia_noyes@urmc.rochester.edu

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