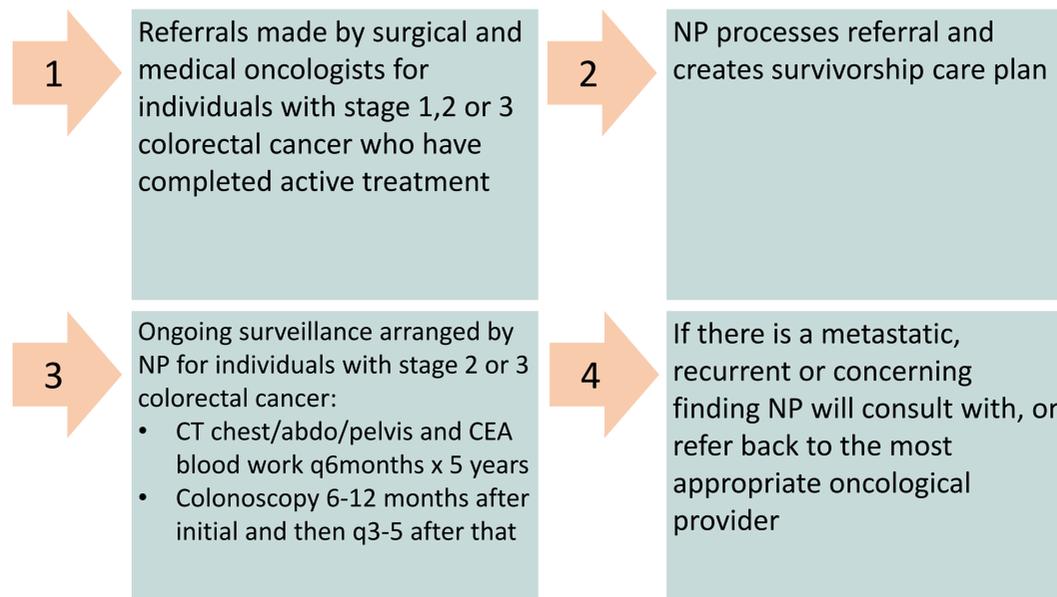


Bringing Cancer Survivorship to the Community: An NP-led initiative

Allison McCreary MN, NP-PHC, Amy Allen MN, NP-PHC, Kimberly Wintemute MD CCFP, Medical Director NYFHT, Susan Griffis Executive Director NYFHT

Program Overview

The needs of cancer survivors are broad and range from physical care and informational needs to support and counselling around issues such as diet, sexuality, mood, anxiety and family functioning (Howell et al. 2011). Evidence suggests that these needs, as well as routine cancer surveillance can be effectively address at the primary care level (Howell et al. 2011). The broad scope of NP practice, combined with a holistic approach to care, makes NPs well-suited to provide effective, evidence-based cancer survivorship care. This NP-led program centralizes cancer survivorship in the primary care setting, thus eliminating duplication of expensive and potentially harmful tests, allows for increased capacity for oncologists to see newly diagnosed patients in a timely manner and shifts the focus of survivorship care from that of strictly cancer surveillance to one that could encompass health promotion and holistic wellbeing.



Program Objectives

1. Transition colorectal cancer survivors from the acute care setting back into primary care to increase capacity for oncologists and surgeons to see newly diagnosed patients in a timely manner.
2. Detect cancer recurrence and expedite care back to oncology.
3. Improve continuity of care for colorectal cancer survivors.
4. Provide patient centered, evidence based care.
5. Decrease duplication of services.

Nurse Practitioner Practice Domains

Health Assessment and Diagnosis	<ul style="list-style-type: none"> • Perform health history and physical exams. • Interpret laboratory results. • Review CT scan reports. • Communicate diagnoses related to abnormal findings.
Therapeutic Management	<ul style="list-style-type: none"> • Manage long-term side effects of colorectal cancer treatment. • Address psychosocial survivorship issues. • Provide diet and lifestyle counselling.
Interprofessional Care	<ul style="list-style-type: none"> • Work collaboratively oncologists. • Ensure ongoing communication with primary care providers. • Access community resources/supports.
Health Promotion	<ul style="list-style-type: none"> • Engage in tertiary prevention through early detection of disease recurrence. • Increase awareness of colorectal cancer screening recommendations for family members.

Short Term Outcomes of an NP-led Model of Care in Colorectal Cancer Survivorship

- Time to Re-Entry into Oncology Care**
- 15 recurrences out of 302 enrolled patients were detected from Apr 2012 - Aug 2014
 - Average length of time from detection by nurse practitioner to first appointment with oncologist was 13 days

Implications: This finding suggests that access to timely and appropriate specialist care is maintained within this primary care-based program.

- Physician Consultation**
- 992 patient encounters took place from April 2012 – August 2014
 - 6% of encounters required physician consultation
 - Reasons for consultation including suspicious CT finding, rising CEA and concerning symptoms

Implications: This data suggests that nurse practitioners have the knowledge and training necessary to play an integral role in surveillance care

Patient Satisfaction

- Patient Satisfaction**
- Email and written surveys were conducted between August to November of 2014.
 - 53 responses were received.
 - 92% of patients identified that they always/often had the opportunity to ask questions
 - 100% of patients identified that they were always/often involved in decisions about their care
 - 96% of patients identified that their nurse practitioner always/often spent enough time with them
 - 100% of patients identified that they would recommend the program to their family and friends

Implications: This data suggests patient acceptance and overall satisfaction is high with the transition of their follow-up care from specialists to nurse practitioners within the primary care setting.

Knowledge Translation and Practical Applications

- Where practice guidelines are available this program model may be utilized within other primary care settings (ie. FHTs, CHCs) to improve quality of care and potentially offload follow-up care from oncologists.
- Survivorship care can be operationalized either as a “central program” or as an initiative that is embedded in the primary care office.
- Through data standardization with diagnostic codes within electronic medical records, a registry of individuals who have had cancer can be developed. Using practice guidelines NPs can provide survivorship care to individuals in the rural setting for whom it may not be practical to return to their oncologist on a regular basis.

