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Using Implementation Science to Initiate Survivorship Care Plan Practice Change

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Using Implementation Science to

Initiate Survivorship Care Plan Practice Change

Cancer survivors must deal with a multitude of highly impactful late/chronic effects of treatment/cancer. The number of cancer survivors will increase to a projected 20 million by 2026. Failure to address coordination of survivorship care can result in physical disability, emotional distress, increased healthcare costs, and greater strain on healthcare systems. In recognizing the need to improve care coordination among cancer survivors, the Institute of Medicine put forth recommendations, which provided the foundation for this practice change.

Background & Clinical Problem:

Survivorship care after cancer treatment is important to optimize long-term outcomes. Every survivor has to figure out how to return to everyday life while adjusting to the effects of cancer and its treatment. The Institute of Medicine's report, From Cancer Patient to Cancer Survivor: Lost in Transition, recommended each cancer patient receive a Survivorship Care Plan (SCP) to help them and their healthcare team navigate health after cancer treatment (IOM, 2006). SCPs are a communication tool that empowers cancer patients to self-advocate and strengthens the relationship between oncology and primary care providers (PCPs). SCPs summarize healthcare providers involved in patients' cancer care, cancer diagnosis, cancer treatment, late and long term side effects, cancer surveillance/follow-up schedule, and health promotion/cancer prevention activities. Oncology organizations, including American Society Clinical Oncology (ASCO), American College of Surgeons Commission on Cancer, and National Comprehensive Cancer Network (NCCN), also recommend integrating SCPs into cancer patients' care.

The Centers for Medicare & Medicaid Services (CMS) also aims to provide higher quality, more coordinated oncology care through the Oncology Care Model (OCM). Willamette Valley Cancer Institute (WVCI) participates in the Oncology Care Model (OCM). OCM payment arrangements include financial and performance accountability per episodes of care. WVCI is accountable for providing care coordination and navigation services to OCM patients, including offering Survivorship Care Plans (SCPs) to patients treated with curative intent.

Aims of the Project:

- Achieve compliance in offering SCPs to eligible OCM patients.
- Improve Patient and Primary Care Provider (PCP) perception of care coordination.

Evidence for Innovation:

Research shows PCPs who received an SCP from an Oncology clinic were nine times more likely to discuss survivorship issues with the patient (Blanch-Hartigan et al., 2014). PCPs reported SCPs helped them better understand cancer treatments (94%) and cancer treatment side effects (89%) (Tevaarwerk et al., 2014). Literature review reveals SCPs enhance care coordination efforts by clarifying locus of responsibility for healthcare and communicating guidelines for follow up care (Palmer et al., 2015). SCPs are an evidence-based intervention that improves care coordination by informing patients and PCPs of

cancer history, potential late/long term treatment side effects, cancer surveillance guidelines, and which healthcare provider has locus of responsibility for cancer surveillance testing.

Methods:

- Barriers and facilitators (Flottorp et al., 2013) to WVCI SCP innovation identified.
- Strategies developed to minimize implementation barriers (Powell et al., 2012).
- Quality Implementation Framework (Meyers, Durlak, & Wanderman, 2012) used to guide implementation process.
- MDs asked to review ASCO disease-specific SCP templates and offer edits.
- SCP templates for Breast, Colorectal, Diffuse Large B Cell Lymphoma, Non-Small Cell Lung, Small Cell Lung, Prostate, Hodgkin Lymphoma, and Anal cancers created in the electronic medical record, iKnowMed (iKM).
- Nurse Practitioner (NP) trained on how to fill out SCP template in iKM.
- SCP innovation introduced at the January 2018 WVCI all employee meeting.
- Patient Navigators and Oncologists identified eligible patients and entered an order for "Return to Clinic NP/Physician's Assistant (PA-C) SCP visit," in iKM.
- NP or PA-C completed Survivorship Care Plan in iKM.
- Patients met with NP/PA-C to review SCP and receive a copy of the SCP
- After signing informed consent document, patients completed patient satisfaction and perception of care coordination questionnaires.
- SCP electronically sent to patients' PCP.
- PCPs mailed an SCP innovation information sheet and questionnaire evaluating impact and usability of SCP, to complete and return.
- After NP and PA-C conducted their third SCP visit, they completed an SCP process/workflow questionnaire.

Results:

<u>Achieve compliance offering SCPs to eligible OCM patients:</u>

Twenty-two patients were eligible for SCP visit between January 29th and April 23rd and 17 visits occurred (77%). Three patients declined SCP visits because they "felt fine" or lived "too far away." Two patients have not yet been scheduled for their SCP visit.

<u>Improve Patient and Primary Care Provider (PCP) perception of care coordination:</u>

<u>Prior to practice change:</u>

- In 2005 the IOM first reported many cancer survivors felt "lost in transition" from cancer patient to cancer survivor and PCPs reported feeling unfamiliar with the consequences of cancer treatment.

<u>Post-practice change implementation:</u>

Patients: 17 of 17 patients completed post-SCP visit patient satisfaction and perception of care coordination questionnaires (100% participation).

- 94% of patients agreed/strongly agreed with the statement, "My health care providers work together as a team to ensure my needs are met."
- 100% of patients agreed/strongly agreed with the statement, "My health care providers have informed me of what my follow up care should be."

- 81% of patients disagreed/strongly disagreed with the statement, “The healthcare providers who treated me for cancer do not communicate well with my PCP.”
- 100% of patients agreed/strongly agreed with the statement, “I would recommend that other patients receive a similar care plan after cancer treatment.”

PCPs: Four out of 17 PCPs completed SCP questionnaires (23.5% participation).

- All PCPs reported SCP “Helped them better understand cancer treatment given and side effects.”
- Three PCPs agreed with the statement, "For this patient, the SCP helps me coordinate follow-up care." One PCP reported neutral feelings toward the statement.
- Three PCPs agreed with the statement, "For this patient, the SCP helps me provide better care," while one PCP reported neutral feelings toward the statement.
- Three PCPs reported SCP was easy to use, did not disrupt clinic workflow, or take too much time. One PCP reported neutral feelings toward the above.

NP & PA-C: Two out of the two advance practice providers completed the SCP questionnaire (100% participation).

- Both reported appreciation for SCP templates however they reported it would be helpful if more SCP data sections auto-populated from iKM, so the information did not have to be manually entered.

Conclusion:

Despite the IOM’s endorsement and evidence supporting the use of SCPs there remains limited implementation of SCPs in oncology clinics. Only 20% of oncologist report sending a follow up care plan to their patients’ PCP (Blanch-Hartigan et al., 2014). The failure of many evidence based interventions can occur due to inadequacies in implementation. The use of implementation science, frameworks and strategies that help address contextual and processes, could improve use of SCPs in oncology clinics (Selove et al., 2016).

Utilizing the Quality Implementation Framework (QIF) (Meyers, Durlak, & Wanderman, 2012), resulted in successful implementation of SCPs at WVCI. Conducting a needs assessment prior to implementation helped identify barriers that could be remedied prior to the SCP practice change. QIF process evaluation and ongoing implementation support strategies such as; more iKM training for the NP & PA-C, adding more macros to the iKM SCP template, and clarifying billing documentation, strengthened practice change sustainability.

Data collection demonstrated evidence that SCPs achieved care coordination and patient satisfaction. While the IOM found cancer survivors felt “Lost in Transition” following cancer treatment, the WVCI SCP intervention demonstrates patients feel informed of follow-up care and agree their healthcare providers work as a team. SCPs enhanced PCPs’ understanding of cancer treatment and side effects which could increase likelihood PCPs discuss survivorship issues, as demonstrated in literature.

Title:

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Keywords:

Coordination of Care, Implementation Science and Survivorship Care Plan

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Abstract Summary:

Survivorship Care Plans are a communication tool that empowers cancer patients to self-advocate and strengthens the relationship between oncology providers and primary care. This presentation will describe the process, implications, findings, and lessons learned when implementing SCPs at an outpatient oncology clinic.

Content Outline:

Using Implementation Science to Initiate Survivorship Care Plan Practice Change

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Sigma Theta Tau Rising Star

Content Outline

I.) Understanding Cancer Survivorship Issues

- Late/Chronic effects of treatment/cancer
- Increasing number of cancer survivors
- Impact of not addressing survivorship needs

II.) Background of Survivorship Care Plans (SCPs)

- Recommended by IOM in 2006
- Limited implementation of SCP
- Implementation Science could improve SCP implementation

III.) Evidence supporting SCPs

- Impact of SCPs on Primary Care Providers (PCPs) behavior
- Perception of coordination of care
- SCP patient satisfaction

IV.) Method to Implement SCPs

- Utilize Quality Implementation Framework (QIF)
- SCP implementation timeline
- SCP workflow

V.) Results

- Patient SCP satisfaction
- Patient perception of care coordination
- PCP perception of care coordination
- PCP understanding of cancer treatment & side effects

VI.) Discussion

- Impact of QIF on implementation
- Results vs. current literature
- SCPs ability to achieve IOM goal

VII.) Recommendations for Implementation Site

- Referral compliance
- SCP visit setting
- Maintaining current surveillance guidelines
- Marketing opportunities

VIII.) Lessons Learned

- Barriers and Facilitators of SCP implementation

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Professional Experience: Betty Goracke Olguin has been a nurse for 19 years, the past 13 years have been in oncology. She currently works at Willamette Valley Cancer Institute (WVCI) as a research nurse. She has maintained certification as an Oncology Nurse since 2007 and certification as a Clinical Research Coordinator since 2010. Betty is enrolled at the University of Portland's DNP-FNP program, expected graduation date May 2019.

Author Summary: Betty Goracke Olguin saw her cancer patients struggle emotionally and physically following curative treatment. After starting the DNP-FNP program at University of Portland, Betty read the Institute of Medicine's From Cancer Patient to Cancer Survivor: Lost in Transition, recommending cancer survivors be given a survivorship care plan (SCP). For her DNP project Betty implemented an SCP program at Willamette Valley Cancer Institute and studied patient and primary care provider perceptions of care coordination.