# Georgia Cancer Center for Excellence

#### Survivorship: Up Close and Personal 11/03/16

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ΕN



### **Core Identity**

**Vision:** Grady Health System will be the leading public, academic health system in the United States.

**Mission:** Grady improves the health of the community by providing quality, comprehensive healthcare in a compassionate, culturally competent, ethical and fiscally responsible manner. Grady maintains its commitment to the underserved of Fulton and DeKalb counties, while also providing care for residents of metro Atlanta and Georgia. Grady leads through its clinical excellence, innovative research and progressive medical education

#### **Core Identity for 2016 – 2020:**

• Grady Health System will lead in the transformation of the health and well-being of the populations we serve, advancing health status through access to effective, innovative and efficient care and care coordination across the continuum.

#### Georgia Cancer Center for Excellence Vision Statement



"...The Georgia Cancer Center for Excellence will be the <u>leading</u> <u>public academic provider</u> of patient focused cancer services in the State of Georgia and the Southeastern United States and will be a locus of <u>excellence in</u> <u>cancer related education and</u> <u>research...</u>"

Grady

#### Georgia Cancer Center for Excellence Mission Statement

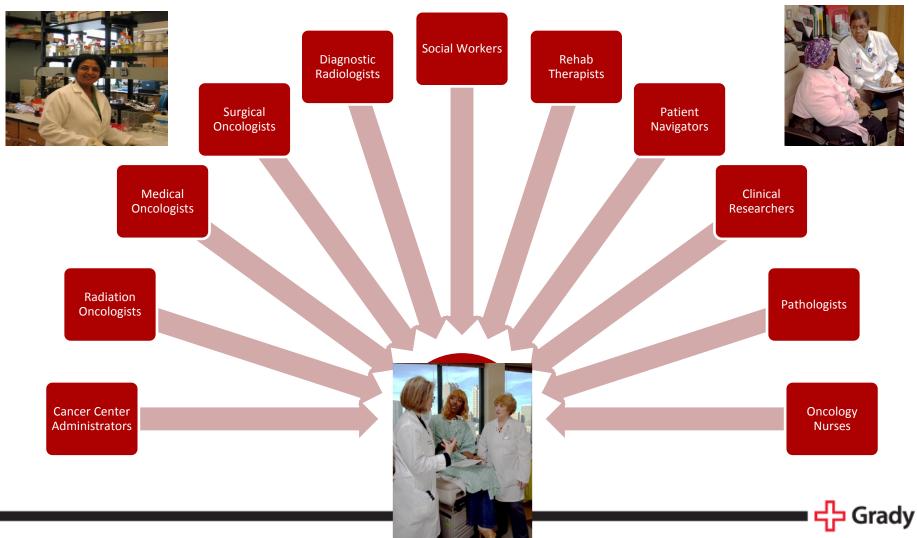
"... is to **reduce the number of lives lost to cancer** in the metropolitan Atlanta area and Georgia through *prevention* and screening, treatment, research, and education. The Center will provide its services in a patient focused manner that stresses access, customer service, cultural competence, the highest level of ethics, and fiscal responsibility. Recognizing that *research is the key to improvements in all* phases of cancer services, emphasis will be placed on research that leads to the reduction of the disparities in outcomes that affect our primary patient population as well as basic scientific, clinical and population based research activities .... "





### Multidisciplinary Team



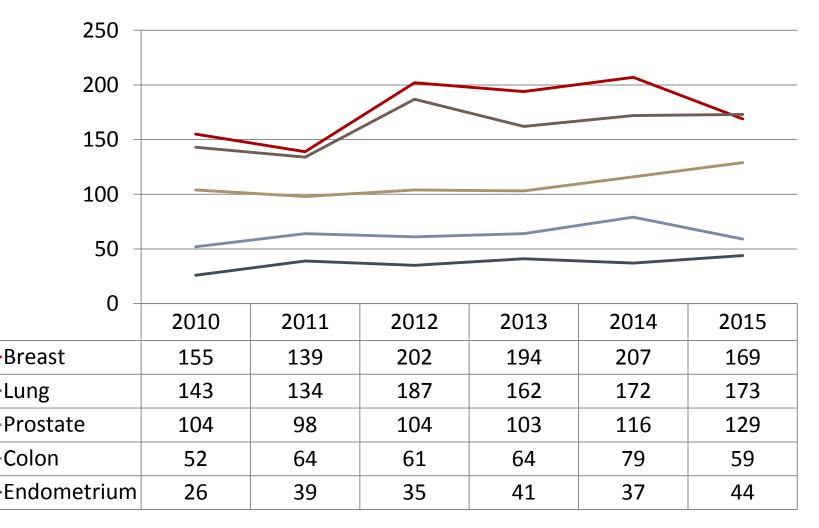


# Georgia Cancer Center for Excellence at a Glance

- Established in 2003
- 1300 total cases annually
- Accredited by ACR, CoC and NAPBC
- MDs from Emory and Morehouse Schools of Medicine
- 22 Subspecialty clinics in the Cancer Center
- Consolidated Cancer Center on the 9<sup>th</sup> and 10<sup>th</sup> floor of the hospital
- Connection and collaboration between Inpatient and Outpatient services
- Dedicated team of social workers
- Both lay and RN navigation



#### **Top 5 Primary Sites**



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#### **The Journey**



#### Georgia Cancer Coalition *Strengthening Bridges* Survivorship Program Feb 1, 2011- June 30, 2012

Program Overview



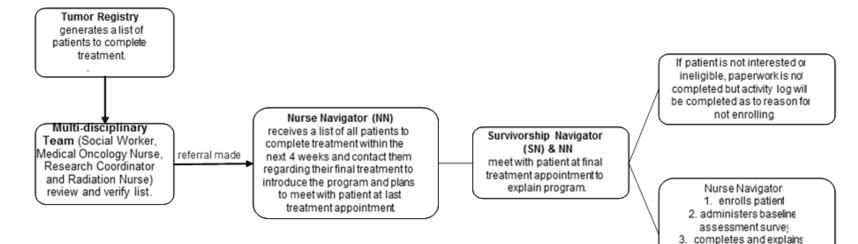
- Hospital based program for Breast and Gynecological cancer patients
- Collaborative effort between:
  - Georgia Cancer Coalition
  - Emory University Winship Cancer Institute
  - Emory University Schools of Public Health & Medicine
  - Grady Health System



# **Specific Aims**

- Implement a Survivorship Patient Navigation Program (SPNP) through the use of a survivorship care plan that incorporates *Journey Forward* material and direct access to psychosocial and support services for patients and their families;
- Define how the information in the survivorship care plan will be obtained, who will complete and communicate the survivorship care plan to the survivor;
- Pilot the SPNP at the Georgia Cancer Center of Excellence (GCCE) with 20 breast cancer survivors and 10 GYN cancer survivors and evaluate the process of survivorship care plan completion from the providers' perspective and the understandability and utility from the survivors' perspective;
- Conduct a monthly education and support group for survivors.
- Disseminate knowledge gained from this intervention, including suggesting future outcome measures and studies.

# Strengthening Bridges Survivorship Patient Navigation Program Flowchart



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 cancer survivorship care plan
4. administers an immediate follow-up assessmen

SN will have continual contact with survivors over the phone, in person at their home, hospital or other locations. Final follow-up survey will be administered by another SN during final follow-up session with NN.

## **Program Overview**

Medical education & follow-up with Nurse Practitioner Navigator

- Developed patient Survivorship Care plan with the Journey Forward© online program
  - Designed for physicians and their patients who have recently completed active treatment for cancer
  - These plans, completed by the Survivor's oncology team, give clear steps for care after active treatment
- Monthly educational support groups (e.g. Sexuality Issues, Legal Aid, Late Effects of Cancer Treatment, etc.)
- Support and psychosocial resources through Survivorship Patient Navigators





# **Patient Navigators**

#### Nurse Patient Navigation

- Clinically trained oncology nurse
  - Coordinates services ordered by providers
  - Provides medical information and follow-up to patients & families
  - Facilitates decision-making
  - Advocates in the patient's interest
  - Supports patient from point of entry through follow-up and continued care

#### Survivorship Patient Navigation

- Utilizes a lay person that is a breast and/or gynecological cancer survivor – Survivorship Patient Navigators (SPNs)
  - Uses members from the target community to deliver health education
  - Provide overall support (emotional, informational) to patients post treatment
  - Assist in identifying and alleviating barriers
  - Make referrals to resources within and outside of hospital system
  - Serve as a personal living testimony

#### Strengthening Bridges Program Outcomes

- 31 participants recruited & screened
- Each participant received Journey Forward Survivorship Care Plan from the oncology nurse
- 14 support group meetings on 10 topics attended by up to 10 participants
- Identified social services needs
- Assessed quality of life
- Assessed Late Effects Knowledge at three time points and found that program increased Late Effects Knowledge

# Strengthening Bridges Program Outcomes (cont.)

- Assessed Late Effects Experienced by the participants through survey
  - Many late effects were still experienced at the end of the study.
  - Inability to have sexual intercourse and concerns about appearance declined
- Assessed Late Effects Experienced through Patient Navigators
  - Fatigue and Chest pain were most often mentioned
  - Neuropathy, bone pain and insomnia were also mentioned frequently

# Strengthening Bridges Program Outcomes (cont.)

- Many referrals (N = 98) were made by the Patient Navigators, e.g. to the Grady Social worker (N = 34), a nurse (21), a doctor (18)
- Barriers and Stressors were documented by the Patient Navigators. Most often, participants reported
  - Being anxious/depressed/lonely (18.8%)
  - Money problems (13.4%)
- The quantitative results were supported by the qualitative results from the focus groups with patients and providers.
- Providers offered several suggestions for possible program expansion
- Information provided to GCCE of potential elements to include in the design of the Survivorship Clinic.

# The New You Survivorship Clinic

- Implemented in 2014 (breast patients identified through weekly conference list and referrals)
- Survivorship 2015 Statistics:
  - # COC Analytic Cases: 804
  - # NAPBC Analytic Cases: 162
  - # Survivorship Care Plans: <u>96</u>

**12%** ACS CoC cases (Meets the 10% Requirement for 2015) **58%** NAPBC cases (Meets the 50% Requirement for 2015)

Grady News

The New You Survivorship Support Group

16 May 2016 1:00 pm

The New You Survivorship Support Group is designed to assist survivors to cope with the various physical and emotional changes that have occurred as a result of treatment. Group meets the third Monday of every month. Location: Georgia Cancer Center for Excellence 9E002 Contact: Patricia Kim NP (404) 489-9003



#### The New You Survivorship Clinic Cont.

- 1. 1.0 FTE, dedicated NP
- 2. Supervising MD
- 3. Partly grant funded by Georgia Core
- 4. Supported by Financial Counselor, Social Worker and other support staff
- 5. Considered a pivotal visit for psychosocial assessment and follow-up

#### **Lessons Learned**

- Referral process
- Care plan completion
- Staff engagement
- Patient perception of importance of visit/ possible collaboration with clinics
- Valuable patient insights for future consideration

#### **THANK YOU and QUESTIONS?** *"Change is the only Constant"*



