# Cancer Survivorship Project

*Cancer Center of Western WI*

*Westfields Hospital & Clinic*

# Disclosures:

I have no disclosures to report. The information provided in this presentation is meant to be informational.

# Project Team

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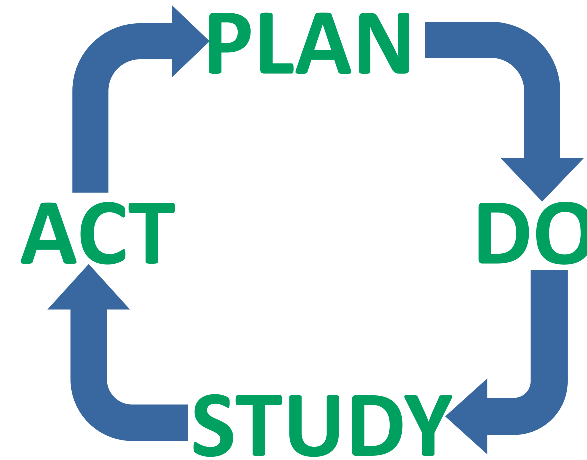
# The Foundation…Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?



# Development Tools

A3 Review

Observations & Visual Mapping

Data Review

Literature or Best Practice Review

# Entire A3 (completion to date)

**A3 Problem Solving Template**

| **1. PROJECT TITLE:** | **Sponsors:** Lisa and Jackie | **Leaders:** Courtney and Andrea | **Coach/PM:** Robin | **Date:** 6/3/19 |
|---|---|---|---|---|
| Survivorship | **Team:** Oncology Providers (Oncologists, NP), Infusion Nurses, Oncology Schedulers, Nurse Navigator, Psychotherapist | | | |

**2. PROBLEM STATEMENT:** *Describe the problem you are trying to solve. Keep it clear, succinct, measurable*

There is no formal survivorship process in place to identify patients in need of survivorship. Specifically breast cancer patients post treatment. There is no process in place to refer or schedule patients. Survivorship visit objectives are also unclear. This leaves patients unsupported with frequent calls and appointments to the cancer center. We currently have 30-35 new breast cancer patients per year (non-metastatic or recurrent) with less than 10 survivorship visits annually.

**3. SCOPE:**

**In Scope:** Breast Cancer Patients with new or existing diagnosis

**Out of Scope:** Other oncology patients, those with metastatic or recurrent breast cancer

**4: TARGET STATEMENT/AIMS** *Describe X by Y in Z time*

- Increase the offering of survivorship care plans by 100% by 12/2020. Implement pilot program by 11/1/ 2019.
- Identify what patients should get a referral 100% of the time.
- Ensure order is placed and visits scheduled 100% of the time.
- Entire Oncology Team is aware of the survivorship care plan and how to access it.

**5. BACKGROUND/CURRENT SITUATION** *Observe and/or map the current process or condition to understand the issues*

We currently have less than 10 identified survivorship visits per year and no formal survivorship process in place, specifically for breast cancer patients to identify patients in need, refer/schedule, or what the expectation of the visit should be.

In 2017-2018 there were a total of 63 new breast cancer consults at Westfields/CCWW not including metastatic and recurrent breast cancer patients. We had 32 in 2017, 31 in 2018 and as of 07/2019 we have currently seen 16 new breast cancer patients at Westfields/CCWW.

Currently our Nurse Practitioner is available at Westfields/CCWW 3-4 days/month, and is never onsite when Oncologist is in clinic.

Patients currently receive an excellent cancer treatment summary from NP which is accessible in EMR. Oncology team is unaware of this care plan and how to access plan.

There is no ownership of the care plan components including tracking patients and ensuring follow-up appointments. There is no standard of work in place for survivorship appointment process.

**6. PROBLEM ANALYSIS:** *What are the root causes for the key issues identified? What is the evidence?*

- This leaves patients unsupported with frequent calls and appointments to the cancer center.
- Also, providers do not know at what point to refer to the survivorship program.
- There is no survivorship visit type currently in EPIC which makes it difficult to track data, manage patient's expectations, and schedule a dedicated survivorship appointment.
- We don't have any systems in place to support a successful sustainable survivorship program.
- We have no patient education or staff education on survivorship to determine the value/benefit of such a program to create buy-in.
- CPT codes are unknown, so as of now survivorship is currently billed as a revisit appointment and requires a separate provider visit.

**7. FUTURE STATE/SOLUTIONS:** *Describe or map future state and identify solutions that address root causes*

- *Stakeholder Meeting is scheduled on Thursday 9/19/19.*
- *Individual team meeting with Nurse Practitioner on 9/17/19.*
- *Referral Order exists in Epic- not yet built for WF Location*

**8. IMPLEMENTATION:** *List the major tasks or milestones. Attach or link full project plan if needed.*

| WHAT | WHO | WHEN | STATUS (R/Y/G/B/W) |
|---|---|---|---|
| 1. Follow-up with Vicki in Rev. Cycle/Billing regarding this process | Lisa/Courtney | G | R |
| 2. Reach out to Health East Survivorship Program regarding model | Andrea | G | Y |
| 3. Review/Update Fishbone with Stakeholders | Courtney/Andrea | Y | G |
| 4. Implement Pilot start date on 11/1/19 | Team | R | B |
| 5. | | | W |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

**9: FOLLOW UP:** *How do you plan to sustain the gains? What are the three key metrics? Include pilot metrics is applicable.*

| Key Measures | | Baseline | (insert date) | (insert date) | (insert date) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

# Visual Map Review

**VALUE STREAM MAP (VSM)**

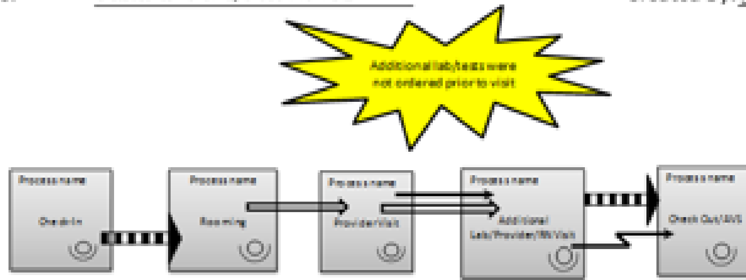
Department: Cancer Center

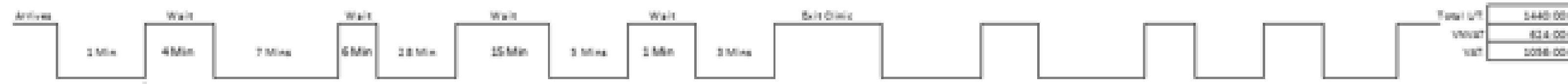
Visit Type: Breast Cancer Follow-up and Survivor Visits

Version and Date: Version #2 7/17/19

Created By: Andrea and Courtney

| Summary of Demand & Takt Time | | | |
|---|---|---|---|
| | Mon | Tue-Fri | Sat/Sun |
| Demand (Avg Visits/Day) | | | |
| Hours of Operation (Min/Day) | | | |
| Avg Takt Time | | | |



# Data Review

- Observations of provider visits
- Site Visits to Marshfield Medical Center
- Interview with Health East Survivorship Nurse Coordinator
- Interview with PN/HP Director of Oncology Systems (Regions and Methodists Hospitals in MPLS/St. Paul, MN)

# Literature or Best Practice Review

- Researched current QOPI and COC Credentialing Guidelines

# Survivorship Improvement Event

**Considerations:**

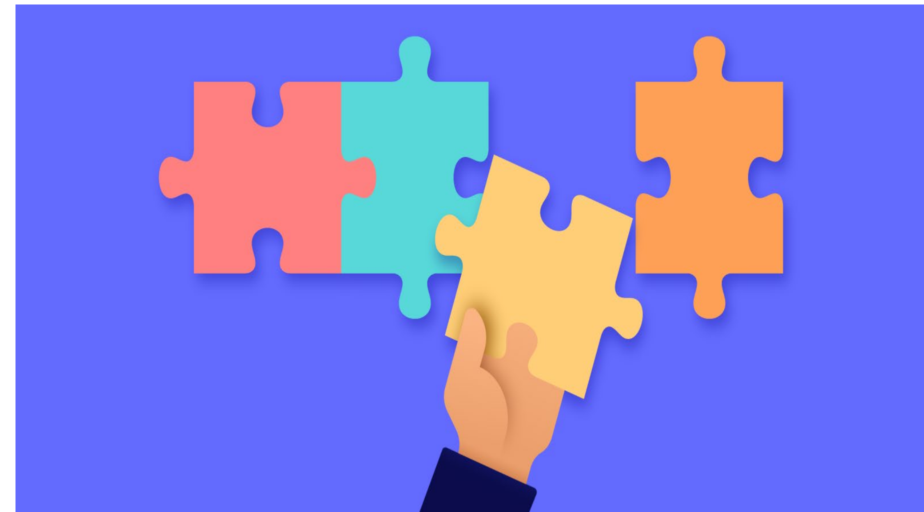
1) Who are the stakeholders who need to be involved to provide ideas?

Process/Department owners

- Decision makers
- Team members

2) Possible factors to pick solutions

- Impact
- Cost
- Time
- Authority
- Reliance on technology



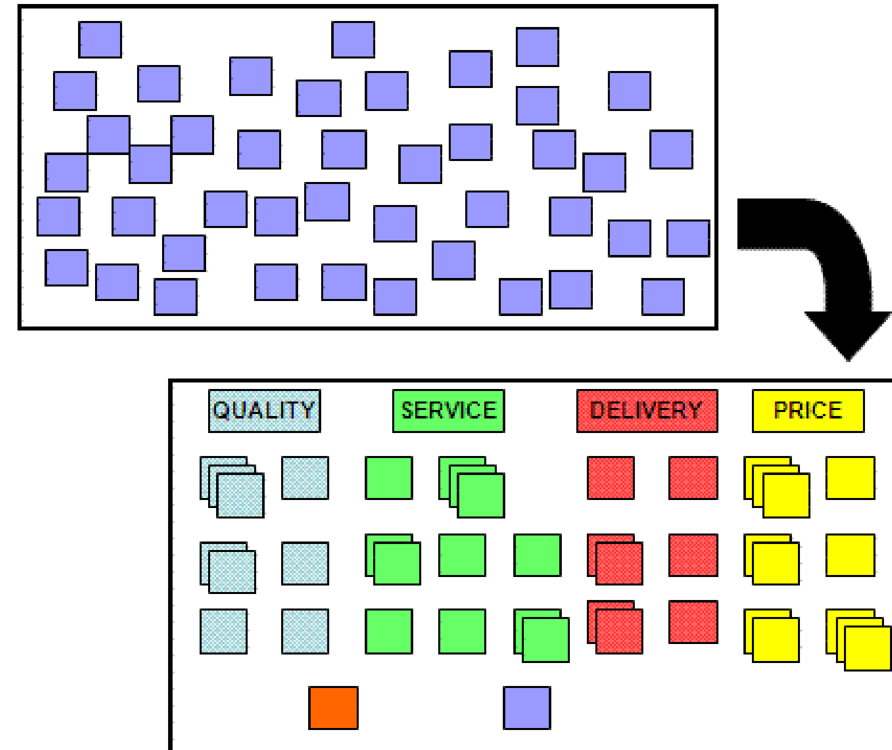
# Survivorship Improvement Event
## Stakeholders:

- Oncology RN (2)
- Oncologist
- RN Navigator
- Social worker
- Oncology Nurse Manager
- Oncology patients (2)
- Primary care clinic staff
- Patient caregivers
- Administrative staff (outside view)

# Idea Generation/Brainstorming

Steps for creating affinity diagrams:

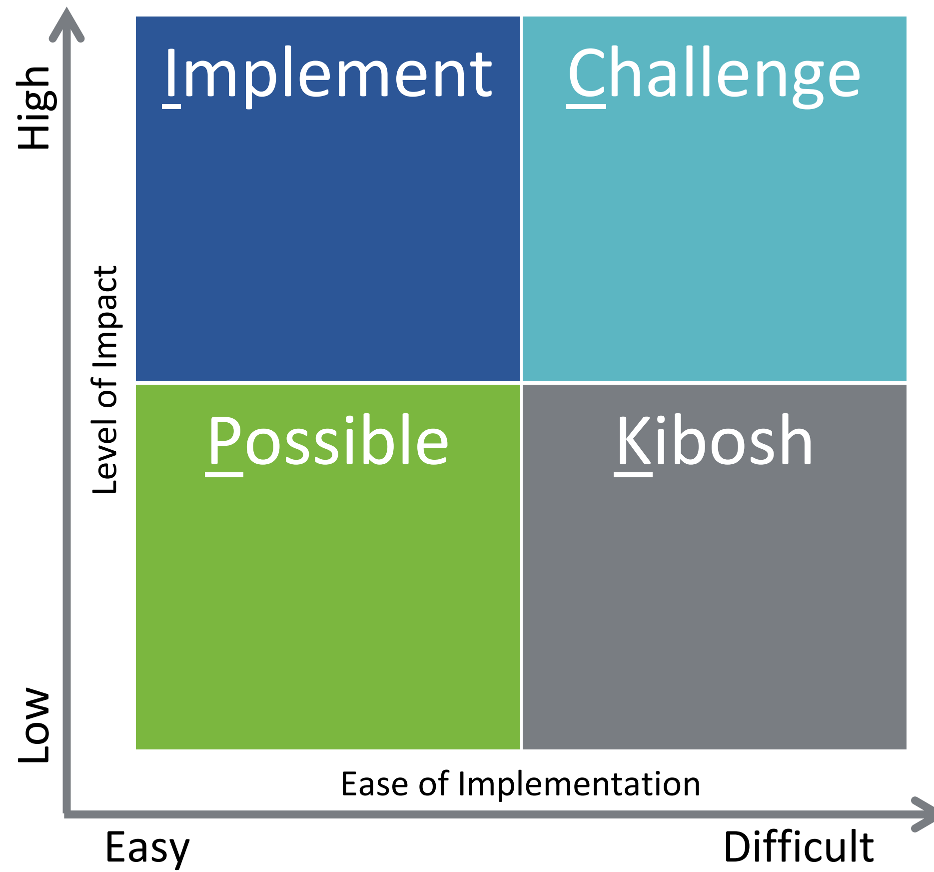
1. Clarify
2. Combine duplicates
3. Categorize



# Current State of Survivorship Care Issues Identified with Multi-Voting

1) No Dedicated staff educating patients about survivorship prior to the visit.
2) No timeframe identified for patients to receive a survivorship visit/care plan.
3) No one identified to manage survivorship patient resources.
4) Patients are not getting the resources they need in a timely manner and best time to give resources is not identified.

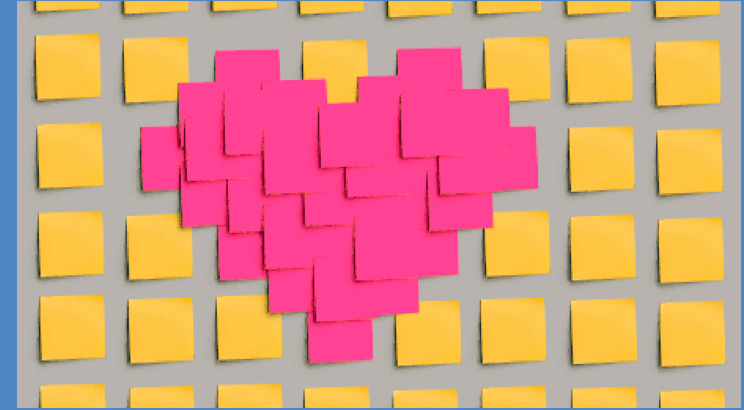
# Prioritize



# *How did We put our Ideas to Work?*

- Met with Oncology NP & Oncologists to review team meeting findings and ideas based on what was identified as problems and solutions.
- Generated what ideas fit into the categories of "high impact for change" and "easy to implement" and developed a proposed plan.
- Discussed with team members -who has the scope, time, and resources to take on new tasks.
- Met with oncologist and oncology nursing to review proposed plan and discuss how we will begin implementation process.

# *Where are we today?*



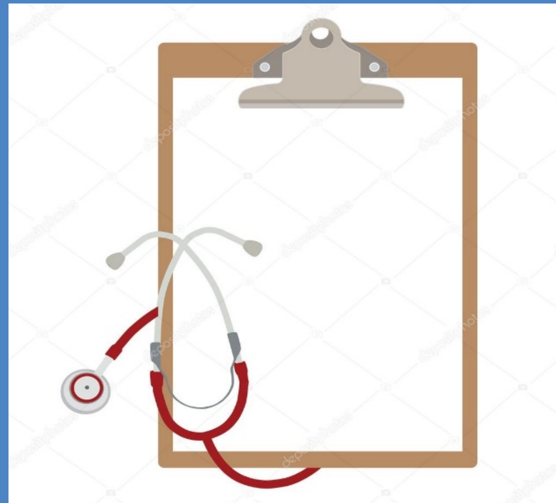
**Nurse Navigator:**

- Uses spreadsheet to track breast cancer survivorship care
  - All new breast cancer consults added
  - Treatment start dates and tentative end dates tracked
- Ensures Oncologists are requesting the survivorship appointment at the appropriate time
- Tracks that the survivorship appointment occurred, tracks careplan was given to patient and notes this in EMR

# Where are we today?!

**Nurse Practitioner:**

- Dedicated time for to create/complete survivorship care-plan.
- Completes initial survivorship visits at indicated timeframe.
- Reviews and gives patient individualized survivorship care-plan.
- Will schedule follow up survivorship visits if indicated by her or the patient.
- Makes appropriate supportive referrals if needs are identified at the survivorship visit.



# Where are we today?!

**Medical Oncologist:**

- Orders survivorship consult-typically once patient has completed active treatment (surgery, radiation, and chemo) but prior to patient going into long-term treatment (continued AI, Herceptin).
- Patients who are not receiving chemo are typically referred to survivorship approx. 4-6 weeks after starting AI/consult.
- Patients who decline a survivorship appt will continue to follow with oncologist and be assessed by physician for ongoing needs.

# What work needs to still be done!

- 2020 Audit to Assess Effectiveness of Improvements:
    - Are all breast cancer patients being tracked?
    - Is the Nurse Practitioner completing more survivorship visits per year than she was previously?
    - Is the Nurse Practitioner making referrals to supportive services so that patients get the services they need?
    - Are oncologists referring at the appropriate times?
    - Are patients feeling that their survivorship needs are met?

# What work needs to still be done!

- Gaps or problems identified so far:
  - Patients on regimens of chemotherapy for several months may need survivorship assessment and resources earlier than at the end of active treatment.
  - How do we get resources to patients (form and content) and how do we maintain resources without causing waste.
- Work as a team to find solutions to the issues at hand and issues that will come out of the end of year audit.

# GOALS to Work Toward:

- Successfully complete year end audit
- Work with team to plan solutions and next steps to the problems identified already and over the first year
- Once program is functioning and deemed successful, develop plans to grow the program
  - Expand to other cancer diagnoses (lung, colon, head and neck, etc)
  - Expand resources and supportive measures