Advanced Practice Provider
Dedicated Survivorship/
Follow-up Clinics

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Disclosures

• No relevant disclosures
Objectives

• Identify different models of survivorship care delivery
• Review evidence of advanced practice providers in post-treatment survivor surveillance
• Consider future opportunities for APPs to contribute to and improve survivorship care across settings
Exponential growth in cancer survivors

DOI: 10.1200/EDBK_238267 American Society of Clinical Oncology Educational Book 39 (May 17, 2019) 625-639
• Improvements in detection, treatment, supportive care
• ~20 million survivors anticipated by 2025, majority +60 years old
• 5-year survival rates in nonmetastatic disease for breast, colorectal, and prostate cancer are approximately 90%, 80%, and 100%, respectively.
• NCCN: survivorship starts at the time of diagnosis and lasts throughout the lifespan.
  • Cancer survivors include those who are initiating treatment, in ongoing treatment, have completed cancer treatment, or are in clinical remission.
Exponential growth in cancer survivors

• Existing clinics overburdened
• Projected 56% increase in demand for oncology services, but 14% growth in supply
• Enormous lack of number and prepared providers

DOI: 10.1200/EDBK_238267 American Society of Clinical Oncology Educational Book 39 (May 17, 2019) 625-639
Survivorship needs – curative intent

• Sequelae +/- late effects
  • Psychosocial – depression, anxiety, return to work
  • Physical – fatigue, lymphedema, neuropathy

• Active surveillance
  • Physical examination, diagnostic imaging & laboratory monitoring
  • Lifestyle ‘toxicity’ – physical activity, bone health, nutrition, habits
  • Specialty referrals prn

• Pharmacotherapy
  • Hormonal
  • Other

IOM 2005;
Kirkham et al https://doi.org/10.1016/j.pcad.2019.02.002
Specialty Survivorship Clinics

Shared Care Models

Transfer back to Community HCP

• Ongoing access to specialty consults and supportive care
• Dominant model in USA vs other developed countries
• ‘one size fits all’
• Survivors receive less routine noncancer care

• Sustainability - low risk of recurrence, little benefit
• Geography – major academic centers
• Lack of integration with primary HCP
• Unmet needs

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- Collaboration between oncology specialists and community HCP
- Aims to combine both models addressing late effects, high recurrence risk
- Some models include gradual transition to community HCP
- Role confusion, duplication
- Resource intense
- Geographic issues

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• End of oncologic treatment = discharge to community HCP

• Survivorship care integrated with other health surveillance at community level

• Pre-existing relationship with HCP, more accessible

• Equivalent to oncology specialist care

• Perceptions of oncologists and survivors

• Variable access to specialty consults and supportive care
Evidence

• Retrospective review of 622 survivor records (210 breast, 208 prostate, 204 CRC) in a single comprehensive cancer program (MSKCC) showed that NPs can provide surveillance monitoring concordant with IOM recommendations, screen for new cancers, can address symptom management and perform health promotion

• Challenges: large academic center, availability of qualified NPs, patient access, only insured pts

DOI: 10.1200/JOP.18.00359 Journal of Oncology Practice 15, no. 3 (March 01, 2019) e230-e237.
Evidence

- Single institution, experienced NP in close collab with surgeon vs surgeon alone
- Not RCT, enrolment at surgeon discretion, risk imbalance
- Better follow-up compliance, equivalent outcomes
Systematic reviews

• General roles of the GPs* in the provision of follow-up cancer care.
  • 25 quantitative, 33 qualitative
  • Both GPs and survivors supported a greater GP role including care coordination, screening, diagnosis and management of physical and psychological effects of cancer and its treatment, symptom and pain relief, health promotion, palliative care and continuing normal general health care provision.

• Role of GP in psychosocial care
  • 19 observational, 9 interventional, 5 qualitative
  • GPs and patients that GPs are the preferred healthcare provider to manage psychosocial problems.

Pycho-Oncology https://doi-org.login.ezproxy.library.ualberta.ca/10.1002/pon.5612
Cochrane Review 2019

• compare the effect of different follow-up strategies in adult survivors following completion of primary cancer treatment
  • primary outcomes of overall survival and time to detection of recurrence.
  • Secondary outcomes are health-related quality of life, anxiety (including fear of recurrence), depression and cost.

• 53 RCTs, 20,832 participants across 12 cancer sites and 15 countries, mainly in Europe, North America and Australia.

• 17 compared non-specialist-led follow-up with specialist-led follow-up; 24 compared intensity of follow-up; 12 compared patient symptom education or monitoring, or survivorship care plans with usual care.

Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD012425.pub2
Cochrane Review 2019

• Non-specialist- versus specialist-led follow up:
  • Low evidence, unknown re OS, time to recurrence detection
  • may make little or no difference to health-related quality of life at 12 months; probably makes little or no difference to anxiety at 12 months; little or no effect on depression at 12 months.
  • equivalent

• Less intensive versus more intensive follow-up may make little or no difference to overall survival
  • QOL unknown due to low evidence
Personalized survivorship care

• UK: identification of needs and patient capabilities early in active treatment

• Not only risk of recurrence, late effects but holistic health care needs and personal preferences
  • risk of recurrence, new cancers, late effects; comorbid conditions; psychological health; health literacy and the ability to self-manage; social and economic issues; geography; and capacity of health care systems to deliver care.

• Engagement of supportive HCP: rehabilitation, pharmacists, nutrition, psychosocial
Implementing Personalized Pathways for Cancer Follow-Up Care (ACS, ASCO)

• Draws from UK experience

• Recommendations

1. Candidate model (or models) of care delivery that can be tested in varied health care delivery sites

   • Consider type(s) and level(s) of resources needed for long-term care; risk of recurrence/subsequent cancers/late effects (low/medium/high) determined by the literature. Develop and validate model(s).

Implementing Personalized Pathways for Cancer Follow-Up Care (ACS, ASCO)

2. Utilizing the above framework, model the effects of personalized pathways of follow-up care on patient outcomes, workforce and health care resources, and utilization and costs.

3. As prior data evolve, create evidence and consensus-based guidelines to guide the delivery of personalized care pathways

4. identifying and filling research gaps to develop and implement care changes.

Telemedicine

• COVID

• Review of systematic reviews: evaluate the efficacy of, and survivor engagement in, telemedicine interventions in the post-treatment survivorship phase, and to consider implementation barriers and facilitators
  • 29 SRs: benefit of psychosocial and physical effects, esp improving fatigue and cognitive function. No evidence in prevention, surveillance or chronic conditions.
  • Barriers include diverse tech designs; cost of personnel; tech literacy and security; symptoms (fatigue, cognitive) competing priorities in survivors’ lives

Annals Oncology Telemedicine in post--treatment caner survivorship care.
https://doi.org/10.1016/j.annonc.2021.09.001
So where do Advanced Practice Providers fit in?
Advanced Practice Providers (APPs)

• All settings, all models
• Holistic health promotion
• Scope of practice similar to general practitioner
  • May vary depending on the APP, jurisdiction
• Levels of knowledge and confidence
  • Specialist or generalist
  • Urban and/or rural experience
  • Leadership capability
• Survivor complexity and needs
Facilitators and barriers

- Role expectations of various providers
- Communication
  - Technology/EMR
  - Care plans – inconsistent type and utilization
- Resources – urban vs rural
- Historical practice patterns, culture change
- Funding models
Future considerations: technology

- Remote monitoring systems – telemedicine
- Technology evolving rapidly
- EMR connectivity
- Social and geographic issues?
Future considerations: survivorship workforce

• Projected 56% increase in demand for oncology services, but 14% growth in supply
• Incentives for APP training
• Awareness of oncology as an exciting and rewarding practise
• Workplace satisfaction
Future considerations: research

• Candidate model (or models) of care delivery that can be tested in varied health care delivery sites

• Consistent nomenclature and application of model(s) to facilitate national and international database development, research opportunities

• Consistent PROMs across entire disease trajectory to evaluate patient experiences
Future considerations: models of care APPs

• Right patient receiving the right care for the right needs at the right time from the right provider

• Poor use of specialty oncology personnel’s expertise

• By adapting delivery models, can deploy knowledge and expertise efficiently and effectively

• Evaluate accessibility to care, reduction in ER/hospitalizations, cost effectiveness, patient satisfaction, chronic disease outcomes
Alberta Model (and most of Canada)

Transfer back to Community HCP
Cancer Guidelines
Guideline Resource Unit (GURU). Information for Health Professionals

About the Guidelines
Clinical practice guidelines are systematic statements about specific health problems intended to assist in decision making. Guidelines provide health care practitioners with evidence-informed recommendations that reflect best practices. The Guideline Resource Unit (GURU) coordinates the development of guidelines for cancer treatment and follow-up care in collaboration with the thirteen Provincial Tumour Teams (PTT) in Alberta. The recommendations contained in these guidelines are a consensus of the relevant Provincial Tumour Team synthesis of currently accepted approaches to treatment, supportive care and follow up, which have been derived from a review of relevant scientific literature. All cancer drugs described in the guidelines are funded in accordance with the Outpatient Cancer Drug Benefit Program, at no charge, to eligible residents of Alberta, unless otherwise explicitly stated. For a complete list of funded drugs, specific indications, and approved prescribers, please refer to the Outpatient Cancer Drug Benefit Program Master List. For information on our processes please refer to the GURU Guideline Development Handbook.

Breast

Treatment Guidelines
- Adjuvant Radiotherapy for Invasive Breast Cancer
- Adjuvant Radiotherapy for Ductal Carcinoma in Situ
- Breast Reconstruction in Patients Undergoing Prophylactic or Therapeutic Mastectomy
- Phyllodes Tumour of the Breast
- Systemic Therapy for Early Breast Cancer - Quick Reference Guide
  - Breast Cancer Molecular Testing – October 2017

Follow-up, Surveillance and Symptom Management
- Follow-Up Care for Early Stage Breast Cancer
  - Sample Transfer of Care Physician Letter: Early Breast Follow-up
  - Sample Transfer of Care Patient Letter: Early Breast Follow-up
  - Sample End of Treatment Physician Letter: Early Breast Follow-up
  - Sample End of Treatment Patient Letter: Early Breast Follow-up
  - Sample Physician Letter: DCIS Follow-up
  - Sample Patient Letter: DCIS Follow-up
Transfer of Care Letter

Breast Cancer

Physician
Surveillance for Breast Cancer Recurrence

We ask that you now organize:

- **Diagnostic mammography** of intact breast(s) should be performed annually. First post-treatment mammogram should be 1 year after diagnostic mammogram (and at least 6 months after radiotherapy). Reconstructed breasts (autologous tissue or implants) or non-reconstructed chest wall post-mastectomy do not require any form of imaging surveillance.

- **Periodic clinical examination** should specifically include examination of the breast(s)/chest wall, supraclavicular and axillary lymph nodes in addition to routine clinical examination. Clinical examinations should be performed every 6 months for 2 years then annually thereafter.

- Patients may perform **self-examination** of their breasts and axillae every month.

- No other routine surveillance investigations (e.g. lab work, tumour markers, diagnostic imaging) are recommended for asymptomatic patients.

Please be aware of these potential symptoms of breast cancer recurrence and recommended actions:

<table>
<thead>
<tr>
<th>Symptoms / Signs</th>
<th>Actions / Investigations</th>
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<tbody>
<tr>
<td>• new mass in breast</td>
<td>mammography +/- ultrasound (+/- biopsy)</td>
</tr>
<tr>
<td>• new suspicious rash or nodule on chest wall</td>
<td>refer to surgeon, dermatology or interventional radiology for consideration of biopsy</td>
</tr>
<tr>
<td>• new palpable lymphadenopathy</td>
<td>refer to surgeon or interventional radiology for biopsy</td>
</tr>
<tr>
<td>• new persistent bone pain</td>
<td>plain x-ray of affected site(s) and bone scan</td>
</tr>
<tr>
<td>• new persistent cough or dyspnea</td>
<td>chest x-ray and/or CT chest</td>
</tr>
<tr>
<td>• new hepatomegaly or RUQ abdominal pain or jaundice</td>
<td>ultrasound and/or CT scan of abdomen and liver enzymes</td>
</tr>
<tr>
<td>• new persistent headache or new concerning neurologic deficits</td>
<td>CT/MRI brain</td>
</tr>
<tr>
<td>• new onset seizures</td>
<td>seizure management (as required) and CT/MRI brain</td>
</tr>
</tbody>
</table>
Follow-up Appointments and Tests

Since we feel you are doing well, we will use a Primary Care model for your follow-up. This means that your primary health care provider (family doctor or nurse practitioner) can safely do your breast cancer follow-up from now on.

For your breast cancer follow-up:

- **Have a mammogram** of your breast(s) every year. If you’ve had a complete mastectomy or complete mastectomy with reconstruction, mammograms are not needed on that side.
- **An exam** of your breast(s) and/or chest wall (mastectomy site) and armpits every 6 months for 2 years, and then once a year after that.
- If you wish, you can perform a self-examination of your breast(s), chest wall, and armpits every month.
- Tell your doctor immediately about any new worrisome breast lumps, skin lumps, or other symptoms that do not go away.

**Remember, it is your responsibility to book your follow-up visits with your primary care provider so they can arrange the tests you need.**

We will send them a summary of your cancer treatment and follow-up recommendations so they are aware of what to do for follow-up.

If you need a family doctor, you can find one by calling Health Link Alberta (811) or going to: [www.ahs.ca/709.asp](http://www.ahs.ca/709.asp). Once you have a doctor, let them know they can view the health care provider follow-up recommendations at [www.ahs.ca/guru](http://www.ahs.ca/guru).
Thank you!

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