

Beyond the Checkbox: Delivering Meaningful Cancer Survivorship Care in a Community Setting

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Survivorship Program Coordinator

- I have no conflicts of interest to disclose



Objectives

- Review existing paradigms of survivorship care.
- Review CoC and NAPBC Standards for survivorship care.
- Describe considerations programs can include when designing/implementing survivorship programs.
- Describe the development and delivery of survivorship care services at a community cancer center.
- Explore opportunities to address research and practice gaps in survivorship care delivery.

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- BFA 2001 Art Academy of Cincinnati
- BSN 2006 Northern Kentucky University
- DNP 2016 University of Kentucky
- ANCC certified AGCNS-BC
- ONCC certified AOCNS
- Certified Tobacco Treatment Specialist, NCTTP
- Respecting Choices trained in First Steps, Next Steps and Advanced Steps – Shared Decision Making in Serious Illness
- 2017-2018 LGBT Health Certificate with U of L


NCCS Defines a Survivor as:

An individual
from the time
of diagnosis
through the
balance of
their life.









survivorship

 (ser-VY-ver-ship)

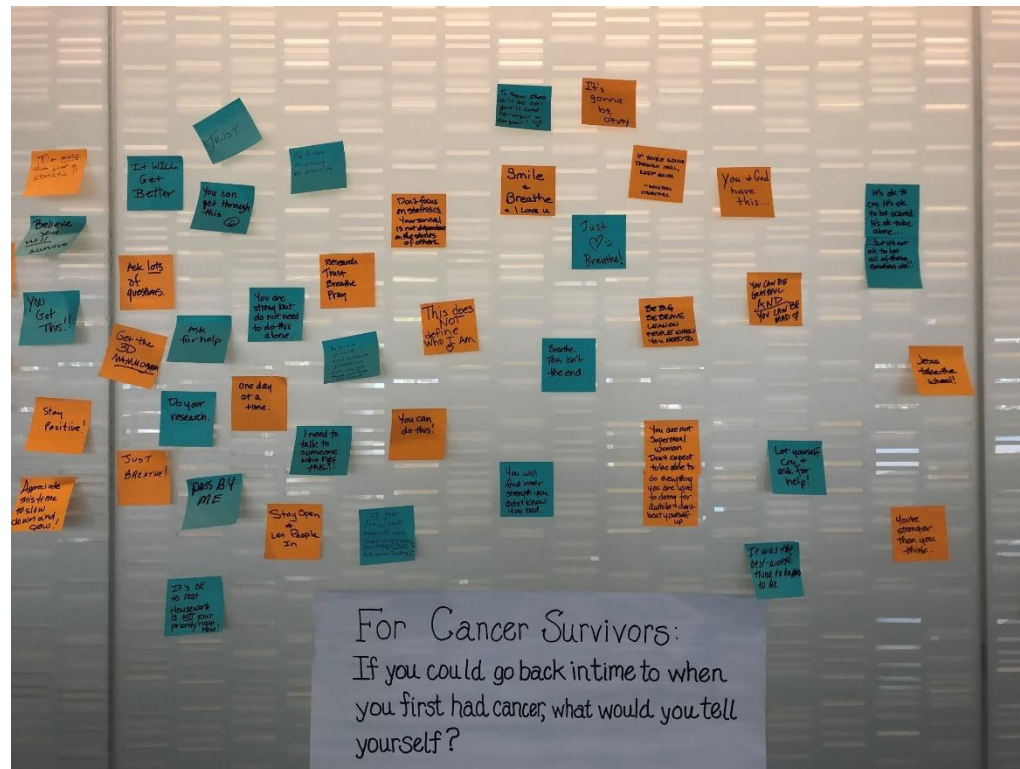
In cancer, survivorship focuses on the health and well-being of a person with cancer from the time of diagnosis until the end of life. This includes the physical, mental, emotional, social, and financial effects of cancer that begin at diagnosis and continue through treatment and beyond. The survivorship experience also includes issues related to follow-up care (including regular health and wellness checkups), late effects of treatment, cancer recurrence, second cancers, and quality of life. Family members, friends, and caregivers are also considered part of the survivorship experience.

Cancer treatment and survivorship statistics, 2019

	Male			Female	
As of January 1, 2019	Prostate	3,650,030	 	Breast	3,861,520
	Colon & rectum	776,120		Uterine corpus	807,860
	Melanoma of the skin	684,470		Colon & rectum	768,650
	Urinary bladder	624,490		Thyroid	705,050
	Non-Hodgkin lymphoma	400,070		Melanoma of the skin	672,140
	Kidney & renal pelvis	342,060		Non-Hodgkin lymphoma	357,650
	Testis	287,780		Lung & bronchus	313,140
	Lung & bronchus	258,200		Cervix	283,120
	Leukemia	256,790		Ovary	249,230
	Oral cavity & pharynx	249,330		Kidney & renal pelvis	227,510
	All sites	8,138,790		All sites	8,781,580
<hr/>					
	Male			Female	
As of January 1, 2030	Prostate	5,017,810	 	Breast	4,957,960
	Colon & rectum	994,210		Uterine corpus	1,023,290
	Melanoma of the skin	936,980		Thyroid	989,340
	Urinary bladder	832,910		Colon & rectum	965,590
	Non-Hodgkin lymphoma	535,870		Melanoma of the skin	888,740
	Kidney & renal pelvis	476,910		Non-Hodgkin lymphoma	480,690
	Testis	361,690		Lung & bronchus	398,930
	Leukemia	352,900		Kidney & renal pelvis	316,620
	Lung & bronchus	325,680		Ovary	297,580
	Oral cavity & pharynx	315,750		Uterine cervix	288,710
	All sites	10,995,610		All sites	11,174,200



Living well *with, through* and *beyond* a cancer experience.



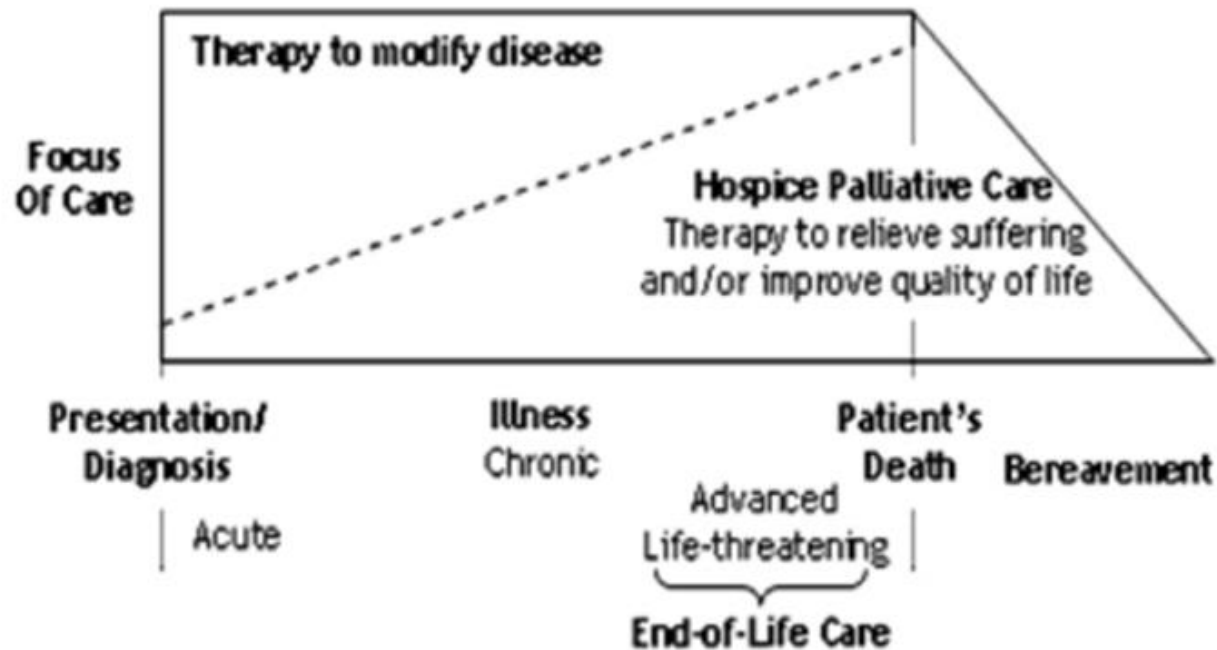


Fig. 1. Canadian Hospice Palliative Care Association model.

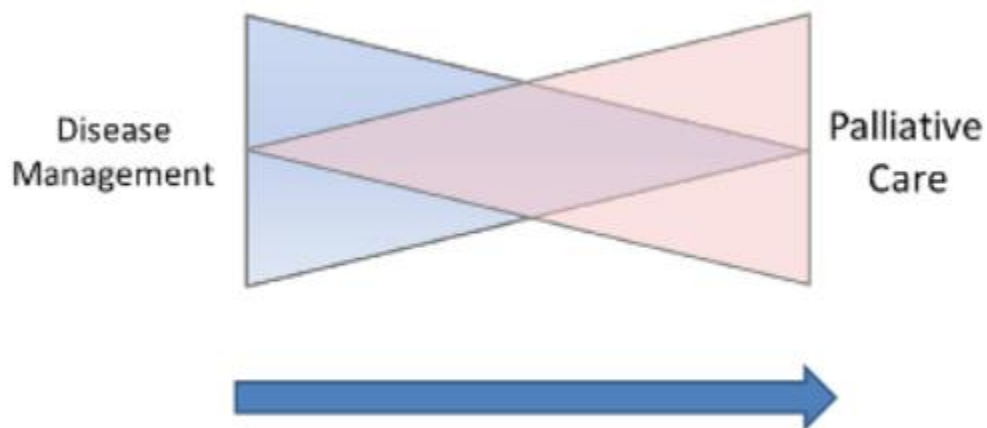


Fig. 2. Basic model of integrated palliative care.

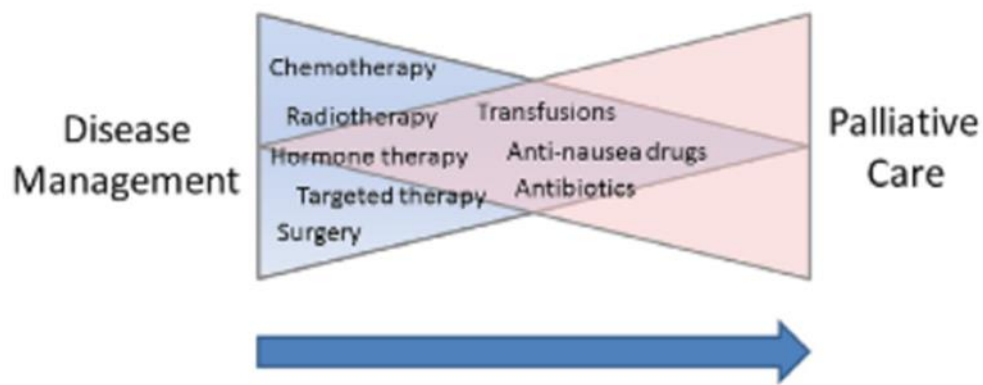


Fig. 3. Disease management-enhanced model.

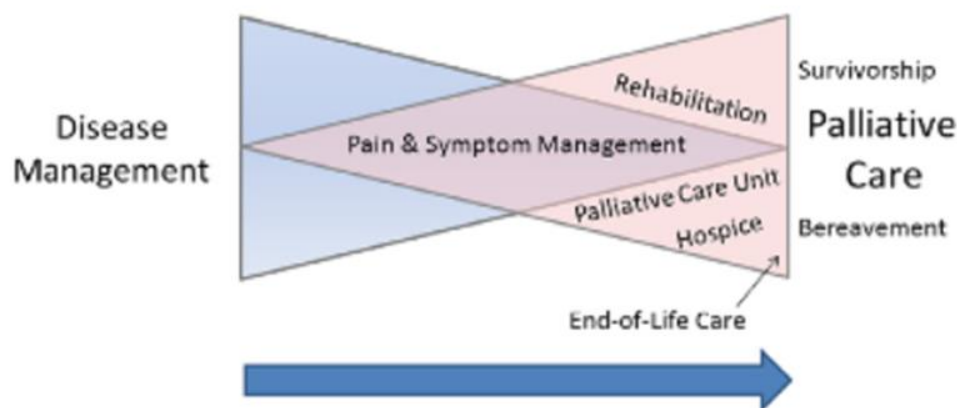


Fig. 4. Palliative care-enhanced model.

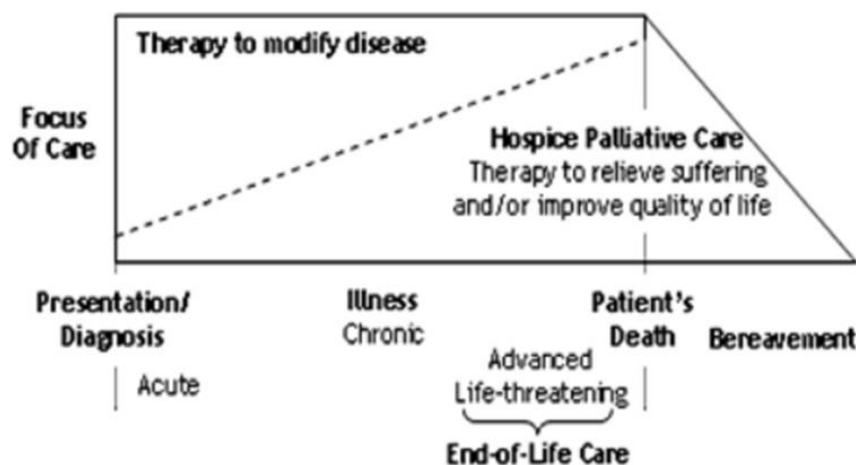
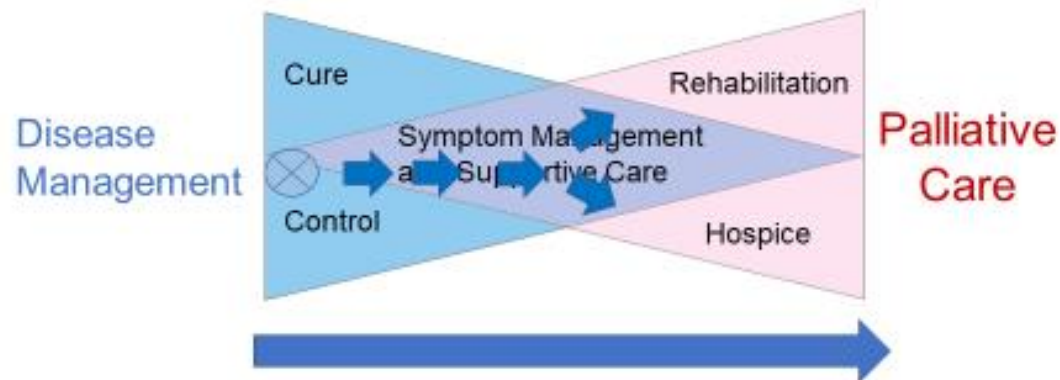


Fig. 1. Canadian Hospice Palliative Care Association model.

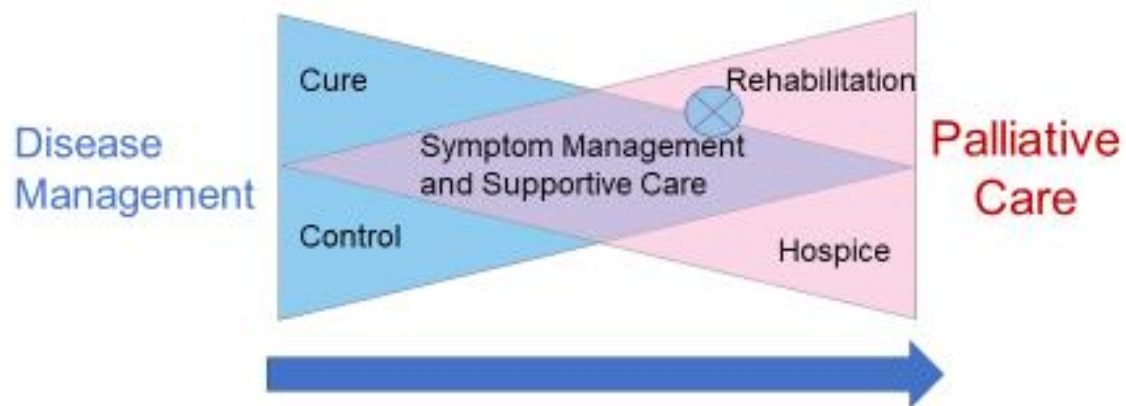
This is where you are now.....



From: The Bow Tie Model and Survivorship NOSM April 2022

Pippa Hawley FRCPC
 Clinical Professor, Dept. of Medicine, UBC
 Medical Director: BC Cancer Pain & Symptom Management/Palliative
 Care Program

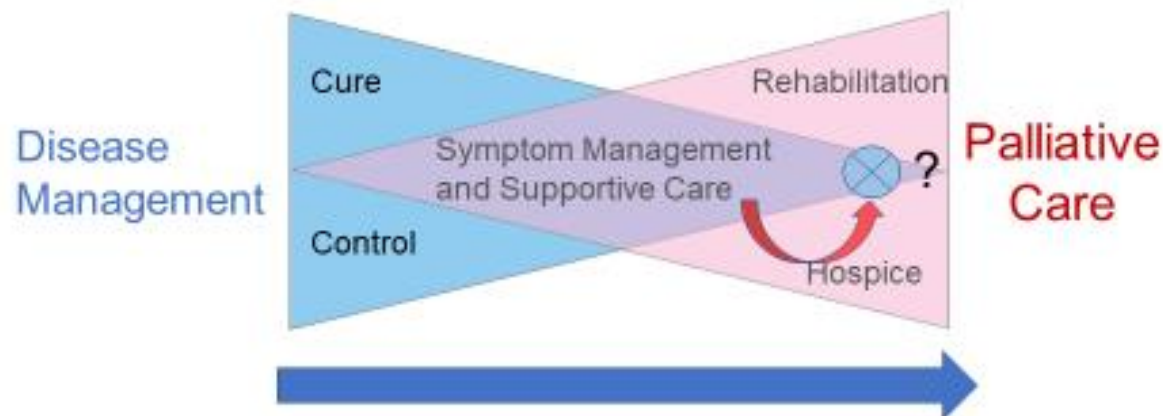
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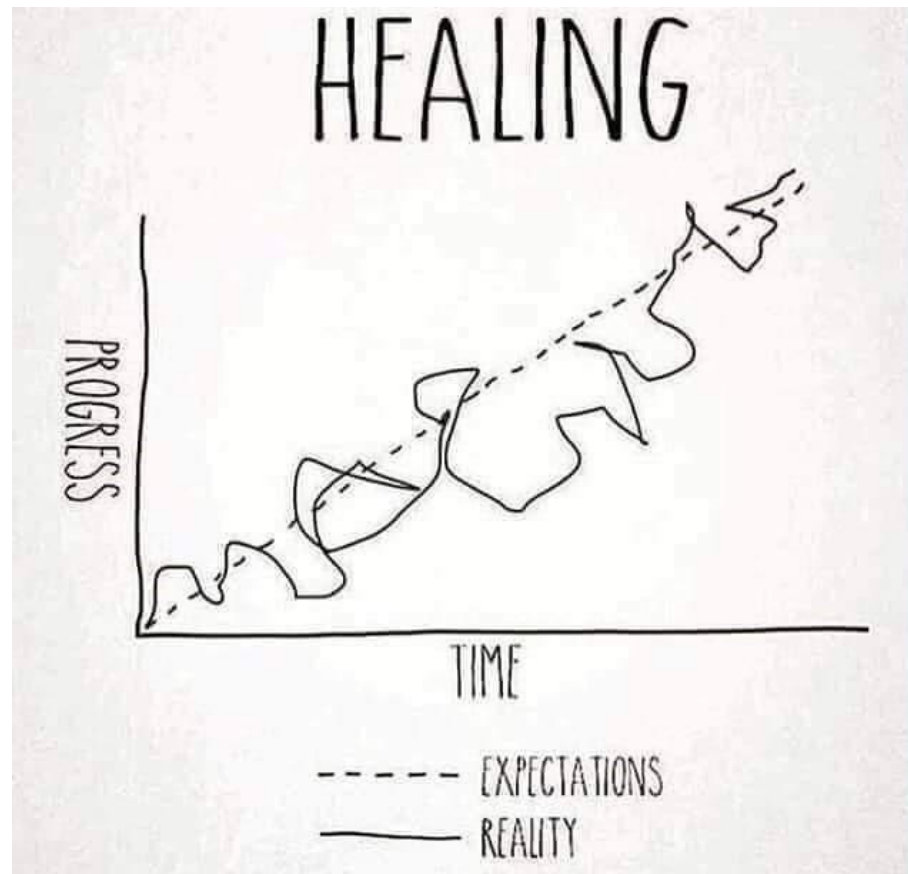
“We can never be 100% certain what will happen”



From: The Bow Tie Model and Survivorship NOSM April 2022

Pippa Hawley FRCPC
Clinical Professor, Dept. of Medicine, UBC
Medical Director: BC Cancer Pain & Symptom Management/Palliative
Care Program

Delivery of Survivorship Care



Evolving Standards

Comparison of the Commission on Cancer (CoC) and National Accreditation Program for Breast Centers (NAPBC) Survivorship Care Plans with 2016 Revisions

Standard	CoC 3.3 Survivorship Care Plan	NAPBC 2.20 Breast Cancer Survivorship Care
Requirement	<ul style="list-style-type: none"> A comprehensive survivorship care plan (SCP) and treatment summary including ASCO data elements will be completed on patients with curative intent and have completed therapy (other than hormonal). 	<ul style="list-style-type: none"> A comprehensive breast cancer survivorship care process, including a survivorship care plan (SCP) with accompanying treatment summary, is in place within 6 months of completing active treatment and no longer than 1 year from date of diagnosis. The survivorship care process is evaluated annually by the Breast Program Leadership Committee (BPLC - formerly the Breast Program Leadership [BPL]).
Documentation Required	<ul style="list-style-type: none"> Within the SCP processes are policies and procedures (as approved by the Cancer Committee) identifying the appropriate healthcare provider(s) from the patient's oncology care team who will be responsible for approving and discussing the SCP. Providers who are part of the team that are appropriate include: Physicians, registered nurses, advanced practice nurses, nurse practitioners, physician assistants, credentialed clinical navigators (does not include lay navigators). Numerous specifics to be documented. 	<ul style="list-style-type: none"> SCP approved by the breast program medical director (BPMD) and documented in the minutes. Documentation in the BPLC minutes of the SCP delivery process for (i.e., who delivers, timing). Methodology to monitor percentage of patients receiving SCPs. Annual Breast Program Leadership Committee review of the SCP documented in the minutes. If compliance is less than 100% documentation of the exception must exist in each case. Beginning in 2017, SCPs may be delivered by a credentialed member of the care team such as: oncology certified nurses, advanced practice nurses, nurse practitioners, physician assistants, clinical nurse navigators, and/or the physician. SCPs cannot be delivered by lay navigators or others not part of the care team.
Phase-in Implementation	<ul style="list-style-type: none"> January 1, 2015: Implement a pilot survivorship care plan process involving 10% of eligible patients. End of 2016: Provide survivorship plans to 25% of eligible patients. End of 2017: Provide survivorship plans to 50% of eligible patients. End of 2018 and beyond: Provide survivorship plans to 75% of eligible patients. January 1, 2019: Provide survivorship plans to 75% of eligible patients and beyond. 	<ul style="list-style-type: none"> December 2014 to March 2015: No minimum requirement. April 2015 to December 2015: 50% of eligible patients receive a SCP to be compliant with standard. Two charts showing delivery of the SCP will be reviewed. The center will self-select the charts. Surveyor will review as part of the medical record review at on-site visit. January 2016 and beyond: 100% of eligible patients must receive a SCP for standard compliance as of January 2016. Patients who do not receive a SCP must have documentation in their record as to why.
Key Elements of the SCP	<ul style="list-style-type: none"> Comprehensive Care/Treatment Summary Follow up care plan 	<ul style="list-style-type: none"> Treatment summary Follow-up care

The 2016 CoC Cancer Program Standards can be found at: <https://www.facs.org/quality-programs/cancer/coc/standards>

The 2014 NAPBC accreditation standards can be found at: <https://www.facs.org/quality-programs/napbc/standards>



2.20

Breast Cancer Survivorship Care

STANDARD 2.20 A comprehensive process to prepare and disseminate a breast cancer survivorship care plan, with accompanying treatment summary, to all eligible patients within six (6) months of completing active treatment and no later than one year (365 days) from date of diagnosis is developed and implemented.

DEFINITION AND REQUIREMENTS

The Institute of Medicine (IOM) report *From Cancer Patient to Cancer Survivor* outlines the importance of providing cancer survivors with a comprehensive treatment summary and follow-up plan (in other words, a survivorship care plan) that addresses follow-up care to improve health and quality of life. This document serves as a communication and education tool that survivors can provide to all of their health care providers in various disciplines.

The **Survivorship Care Plan (SCP)** is the record of a patient's breast cancer history, what transpired during active treatment, current continued long-term treatment (in other words, hormonal and targeted therapy), recommendations for follow-up care and surveillance testing/examination, referrals for support services the patient may need going forward, and other information pertinent to the survivor's short- and long-term survivorship.

2.20

Implementation processes to monitor the preparation and dissemination of SCPs. SCPs are typically prepared by the health care provider(s) who coordinate the patient's care, with input from the patient's other care providers. Providers who are responsible for implementation and appropriate under this standard to deliver the SCP.

Summary and SCP.

The Breast Program Leadership Committee (BPLC) in the meeting minutes.

The number of SCPs provided during the medical records review portion of the site visit. The SCPs should discuss the SCP and the implemented survivorship care process, as well as the SCP.

Ineligible Patients and Timeline Extension

- Patients diagnosed with Stage IV breast cancer are not required to have a SCP, as they are assumed to be under continuous treatment. However, consideration should be given to providing these patients with ongoing treatment summaries for their use and to be shared with their primary care physician (PCP), including a listing of common potential late effects and their possible timing.
- The one-year-from-diagnosis requirement to provide a SCP is extended to 18 months for patients receiving hormonal and targeted therapy.

Elsewhere	None	Your Center	Yes
Elsewhere	Elsewhere	Your Center	Yes
Elsewhere	None	None	Yes
Your Center	Your Center	Your Center	Yes
Your Center	Elsewhere	Your Center	Yes
Your Center	Your Center	Elsewhere	Yes
Elsewhere	Your Center	Your Center	Yes
			No
			No
			No

SCP, [during-and-after-treatment/survivorship-care-plans.html](#)
[Policy Cancer Treatment and SCP,](#)
[after-cancer-treatment/asco-cancer-treatment-and-survivorship-care-plans](#)

Measure of Compliance

Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee identifies a survivorship program team, including its designated coordinator and members.
2. The survivorship program is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes.

4.8 Survivorship Program

Definition and Requirements

The cancer committee oversees the development and implementation of a survivorship program directed at meeting the needs of cancer patients treated with curative intent.

Survivorship Program Team

The cancer committee appoints a coordinator of the survivorship program per the requirements in Standard 2.1: Cancer Committee.

The Survivorship Program Coordinator develops a survivorship program team. Suggested specialties include physicians, advanced practice providers, nurses, social workers, nutritionists, physical therapists, and other allied health professionals.

The survivorship program team determines a list of services and programs, offered on-site or by referral, that address the needs of cancer survivors. The team formally documents a minimum of three services offered each year. Services may be continued year to year, but it is expected that cancer programs will strive to enhance existing services over time and develop new services.

Each year, the survivorship program coordinator gives a report, and the cancer committee reviews the activities of the survivorship program. The report includes:

- An estimate of the number of cancer patients who participated in the three identified services
- Identification of the resources needed to improve the services if barriers were encountered

Survivorship Program Services

Services utilized by the survivorship program may include, but are not limited to:

- Treatment summaries
- Survivorship care plans
- Screening programs for cancer recurrence
- Screening for new cancers
- Seminars for survivors
- Rehabilitation services
- Nutritional services
- Psychological support & psychiatric services
- Support groups and services
- Formalized referrals to experts in cardiology, pulmonary services, sexual dysfunction, fertility counseling
- Financial support services
- Physical activity programs

Survivorship Care Plans (SCP)

The CoC recommends and encourages that patients receive a survivorship care plan (SCP), but delivery of such plans is not a required component of this standard. Delivery of SCPs may be utilized as one of the services offered to survivors to meet the requirements of this standard. If so, then the program defines the population to receive care plans.

Documentation

Submitted with Pre-Review Questionnaire

- Policy and procedure defining the survivorship program requirements
- Cancer committee minutes that document the required yearly evaluations of the survivorship program

Measure of Compliance

Each calendar year, the program fulfills all of the following compliance criteria:

1. The cancer committee identifies a survivorship program team, including its designated coordinator and members.
2. The survivorship program is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes.

Bibliography

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Nekhyudov L, Mollica MA, Jacobsen P, Mayer DK, Shulman LN, Geiger AM. Developing a quality of cancer survivorship care framework: Implications for clinical care, research, and policy. *J Natl Cancer Inst*. 2019.



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Survivorship Care Plan (SCP)

- The record of a patient's cancer history:
 - what transpired during active treatment.
 - current continued long-term treatment (ie hormonal and targeted therapy).
 - recommendations for follow-up care and surveillance testing/examination.
 - referrals for support services the patient may need going forward, and other information pertinent to the survivor's short and long-term survivorship care.
 - It is to stipulate specifically what surveillance is to be performed, at what frequency, by whom, and when.



ASCO Treatment Summary and Survivorship Care Plan

General Information		
Patient Name:		Patient DOB:
Patient phone:		Email:
Health Care Providers (Including Names, Institution)		
Primary Care Provider:		
Surgeon:		
Radiation Oncologist:		
Medical Oncologist:		
Other Providers:		
Treatment Summary		
Diagnosis		
Cancer Type/Location/Histology Subtype:		Diagnosis Date (year):
Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> Not applicable		
Treatment		
Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		Surgery Date(s) (year):
Surgical procedure/location/findings:		
Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No	Body area treated:	End Date (year):
Systemic Therapy (chemotherapy, hormonal therapy, other) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of Agents Used		End Dates (year)
Persistent symptoms or side effects at completion of treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (enter type(s)) :		
Familial Cancer Risk Assessment		
Genetic/hereditary risk factor(s) or predisposing conditions:		
Genetic counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No		Genetic testing results:
Follow-up Care Plan		
Need for ongoing (adjuvant) treatment for cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional treatment name	Planned duration	Possible Side effects
Schedule of clinical visits		
Coordinating Provider	When/How often	

ASCO Survivorship Care Plan


Updated based on consensus conference held on 9.27.13 and the ASCO Survivorship Committee


Cancer surveillance or other recommended related tests	
Coordinating Provider	What/When/How Often
Please continue to see your primary care provider for all general health care recommended for a (man) (woman) your age, including cancer screening tests. Any symptoms should be brought to the attention of your provider:	
1. Anything that represents a brand new symptom; 2. Anything that represents a persistent symptom; 3. Anything you are worried about that might be related to the cancer coming back.	
Possible late- and long-term effects that someone with this type of cancer and treatment may experience:	
Cancer survivors may experience issues with the areas listed below. If you have any concerns in these or other areas, please speak with your doctors or nurses to find out how you can get help with them.	
<input type="checkbox"/> Emotional and mental health <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight changes <input type="checkbox"/> Stopping smoking <input type="checkbox"/> Physical Functioning <input type="checkbox"/> Insurance <input type="checkbox"/> School/Work <input type="checkbox"/> Financial advice or assistance <input type="checkbox"/> Memory or concentration loss <input type="checkbox"/> Parenting <input type="checkbox"/> Fertility <input type="checkbox"/> Sexual functioning <input type="checkbox"/> Other	
A number of lifestyle/behaviors can affect your ongoing health, including the risk for the cancer coming back or developing another cancer. Discuss these recommendations with your doctor or nurse:	
<input type="checkbox"/> Tobacco use/cessation <input type="checkbox"/> Diet <input type="checkbox"/> Alcohol use <input type="checkbox"/> Sun screen use <input type="checkbox"/> Weight management (loss/gain) <input type="checkbox"/> Physical activity	
Resources you may be interested in:	
Other comments:	
Prepared by:	Delivered on:

- This Survivorship Care Plan is a cancer treatment summary and follow-up plan is provided to you to keep with your health care records and to share with your primary care provider.
- This summary is a brief record of major aspects of your cancer treatment. You can share your copy with any of your doctors or nurses. However, this is not a detailed or comprehensive record of your care.



Who Should Be Offered Survivorship Services?

- 
- Patients who have finished their treatment?
 - Patients with advanced disease?
 - Patients who have had surgery?
 - Patients whose disease treatment ends?
 - Patients who we “know” will “survive”?



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Older Adult Oncology

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Smoking Cessation

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Treatment Summary Visit

- Billable service
- Arrive a few minutes early to complete Distress Tool, PHQ9, GAD7
- History and brief physical exam
- Review of treatment summary and care plan document
- The rest of the visit is tailored to the patient needs:
 - Discussion of common late or long term effects of treatment or illness.
 - Discussion of serious late or long term effects of treatment, prevention and management
 - Individualized discussion of patient needs identified on Distress Tool, PHQ9, GAD7
 - Discussion of NCCN guidelines for surveillance of treated cancer.
 - Prevention and screening of other cancers, and healthy lifestyle.

Survivorship Care Plan (SCP)

- The record of a patient's cancer history:
 - what transpired during active treatment.
 - current continued long-term treatment (ie hormonal and targeted therapy).
 - recommendations for follow-up care and surveillance testing/examination.
 - referrals for support services the patient may need going forward, and other information pertinent to the survivor's short and long-term survivorship care.
 - It is to stipulate specifically what surveillance is to be performed, at what frequency, by whom, and when.

Treatment Summary & SCP Visit

- Referrals to resources available at Baptist:
 - Lymphedema clinic
 - Physical/Occupational Therapy
 - Oncology Nutrition
 - Smoking Cessation
 - Psychiatry and psychosocial oncology
 - Oncology Social Work
 - Genetics (it's back!)
 - Exercise programs (CARE at Milestone)
 - Sleep medicine
 - Primary Care referral line
 - Massage/Reiki Therapy
 - Cancer screening
 - Support groups and psychoeducation (Cancer University)
 - Sharing Our Stories
 - Young Women's Series: Living Beyond Breast Cancer
 - Grief support group

Treatment Summary & SCP Visit

- Referrals to community resources
 - Kentucky Cancer Program
 - Kentucky African Americans Against Cancer
 - Kentucky Cancer Link
 - Gilda's Club
 - American Cancer Society
 - Leukemia and Lymphoma Society
 - Friend for Life
 - Go2 Foundation
 - Acupuncture
 - Community Mental Health Services
 - LiveStrong at the YMCA
 - Cancer and Careers
 - A Time to Heal
 - Survivorship
 - Brain Fog Program
 - Queering Cancer
 - Kentucky Trans Health Advocacy Program
 - Sex therapy referrals for individuals and partners
 - Pelvic floor therapy (BH FLO)



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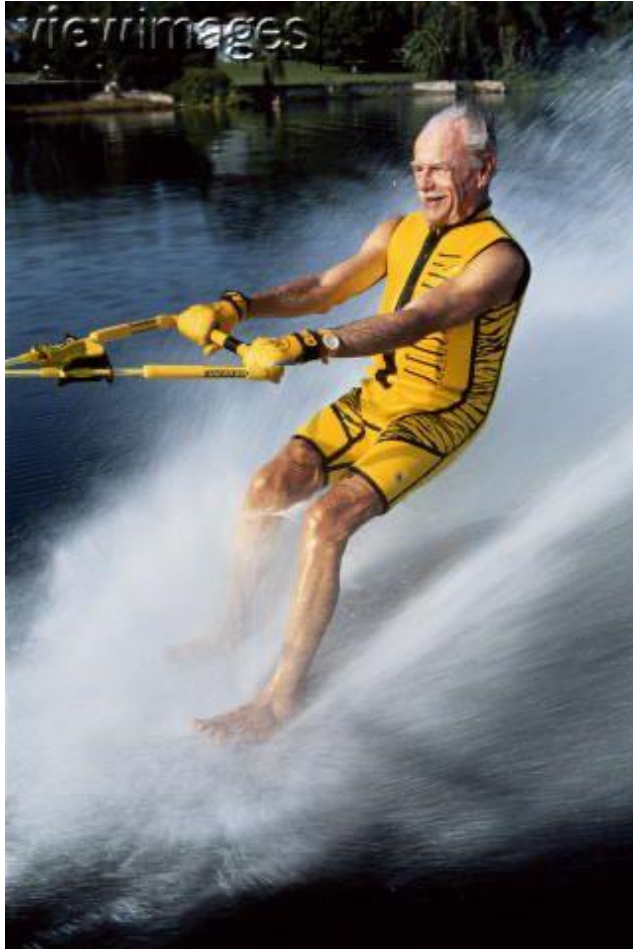
Older Adult Oncology

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Chronological Age = 82



Older Adult Functional Assessment

- A multidimensional, interdisciplinary patient evaluation that leads to the identification of patient problems and the development of a plan for resolving these problems
- Reasons to perform a geriatric assessment:
 - Detection of unidentified problems
 - Better estimation of residual life expectancy
 - Prediction of adverse outcomes
 - Improvement of care quality

Older Adult Functional Assessment

- Billable service.
- Eligible patients are age 65 or older with a cancer diagnosis, or younger than 65 with multiple co-occurring physical, psychosocial or spiritual concerns.
- Patients will receive a comprehensive geriatric assessment with special focus on any of the following:
 - Prediction of chemotherapy treatment toxicity for medical decision making
 - Functional and/or cognitive assessment
 - Psychosocial assessment
 - Tobacco use assessment
 - Advance care planning and goals of care assessment
- Follow up visits are completed as appropriate for continuity of care.

Older Adult Functional Assessment

- Minimum assessment dimensions for older adults:
 - Social Resources
 - Functional Status
 - Physical Function
 - Nutrition Status
 - Psychological reserve
 - Medications
 - Medical conditions

Advance Care Planning

- Can be facilitated by Supportive Onc APRNs or Social Work:
 - Completing Kentucky or Indiana Living Will directive
 - MOST/POLST shared decision making
 - Monthly one hour class offered via zoom
 - 4th Wednesday of the month from 1pm-2pm
 - Individual appointments



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NCCN Guidelines Version 1.2021 Smoking Cessation

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GENERAL PRINCIPLES OF THE SMOKING CESSATION GUIDELINES

These guidelines are focused on smoking cessation recommendations for patients with cancer and cancer survivors. There are health benefits to smoking cessation even after a cancer diagnosis, regardless of site, stage, or prognosis, namely improvement in cancer treatment outcomes, primary cancer recurrence, and secondary cancers. It is never too late for patients with cancer to stop smoking cigarettes and experience health benefits. Nicotine addiction is a chronic relapsing disorder. People with cancer who smoke often demonstrate high-level nicotine dependence. The NCCN Panel recommends that treatment plans for all people with cancer who smoke include the following:

- Evidence-based motivational strategies and behavior therapy,
- Evidence-based pharmacotherapy, and
- Close follow-up with retreatment as needed.

Clinical Recommendations:

- Combining pharmacologic therapy and behavior therapy is the most effective approach and leads to the best results for smoking cessation.
 - ▶ The two most effective pharmacotherapy agents are combination nicotine replacement therapy^a (NRT) or varenicline.
 - ▶ Behavior therapy with multiple counseling sessions is most effective, and at least a minimum of brief counseling is highly recommended. Quitlines may be used as an adjunct, especially in lower-resource settings.
- Smoking status should be documented in the patient health record. Patient health records should be updated at regular intervals to indicate changes in smoking status, quit attempts made, and interventions utilized.
- Smoking relapse and brief slips are common and can be managed. Providers, the health care team, and tobacco treatment specialists should discuss this and provide guidance and support to encourage continued smoking cessation attempts. Smoking slips are not necessarily an indication to try an alternative method. It may take more than one quit attempt with the same therapy to achieve long-term cessation.
- Smoking cessation should be offered as an integral part of oncology treatment and continued throughout the entire oncology care continuum, including surgery, radiation therapy, systemic therapy, and end-of-life care. An emphasis should be put on patient preferences and values when considering the best approach to fostering smoking cessation during end-of-life care.
- Despite emerging evidence, there is still insufficient evidence to recommend the use of e-cigarettes in smoking cessation, alone or in combination with evidence-based smoking cessation methods. There is also insufficient evidence regarding the safety and efficacy of e-cigarette use in patients with cancer. Thus, patients should be counseled toward the use of evidence-based smoking cessation methods.

^a Combination NRT = Nicotine patch + short-acting NRT (ie, lozenge, gum, inhaler, nasal spray).

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

Tobacco Treatment Services

- Individual Consultations
 - In person, by video or phone
 - Billable visit
 - Intake visit (prefer in person)
 - Follow up visits as needed for ongoing monitoring and support
 - Medication management and monitoring

Clinical Case #1

- 72 year old with adenocarcinoma of the prostate Gleason 4+3=7
- Completed radiation treatment course 7/1/2020
- Survivorship visit 4/20/2021
 - CC: dysuria, frequency, dribbling urine, syncopal episodes, frequent falls, incontinence of bowel, poor appetite with 30lb weight loss since completion of XRT, mood disturbance.

Clinical Case #1

- EXAM: Orthostatic hypotension, near syncopal episode on scale, weakness, Distress score: 9; PHQ9 score 14; GAD7 score 5.
- Patient Goals of Care:
 - 1. Improvement of strength and stamina with target of return to playing golf and spending time with grandchildren and spouse.
 - 2. Urination without pain or passing out.
- PLAN:
 - Patient scheduled with urology – indwelling Foley to TURP, residual incontinence, working with pelvic floor therapist
 - Referral to oncology nutrition – gain 17pounds since July, BMs regular
 - Referral to oncology social work
 - Zoloft per PCP – dose 100 mg daily, mood improved
 - Blood sugars per PCP
 - BP per Cardiology
 - Fall safety at home, education – falls stopped after Foley placed and Flomax stopped
 - Refer to PT/OT – returned to former activities
 - Advance Care Planning – copy requested

Clinical Case #2

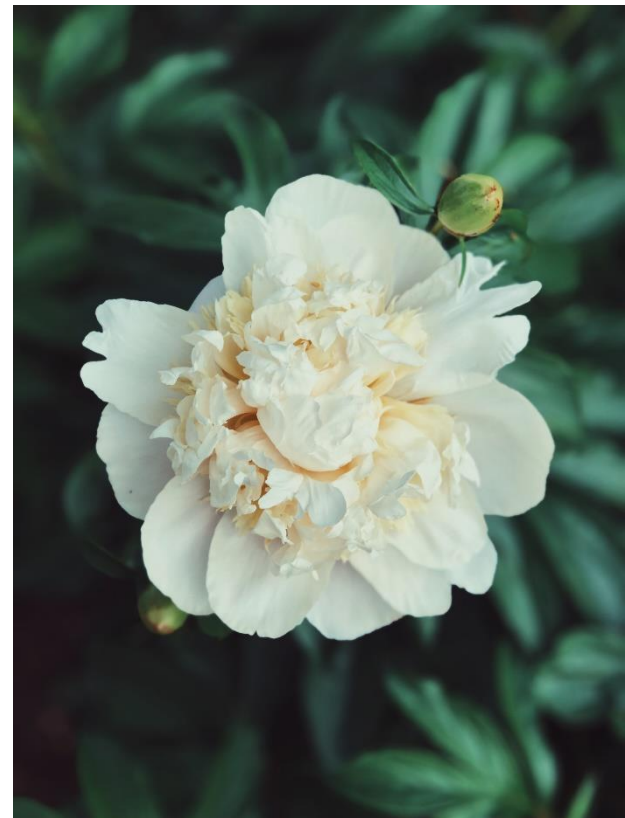
- 28 year old patient s/p brachytherapy with 5 cycles cisplatin with concurrent brachytherapy 7/2018, now NED
- Survivorship visit 9/23/2021
 - CC: Early menopause with hot flashes, mood changes (tearfulness), eczema, fatigue, fecal urgency with incontinence, bloating, loss of appetite, weight gain. Single parent. Unsuccessful connection with community based mental health since treatment completion.
 - ESAS: tiredness, nausea, anxiety, drowsiness, lack of appetite, wellbeing, other (fecal incontinence)

Clinical Case #2

- EXAM: A&O, anxious appearing, abd distention noted. Distress score 8, PHQ9 score 14, GAD7 score 11.
- PLAN:
 - Referral to pelvic floor therapy
 - Referral to oncology nutrition
 - Referral to Friend for Life
 - Provided community referrals to mental health
 - Advance care planning

Survivorship is a Team Sport

- Hospital based services
- Community partners
- Talk to patients
- What do treatment team members wish they had?





Ideal “Bow Tie Model” Palliative Care Service

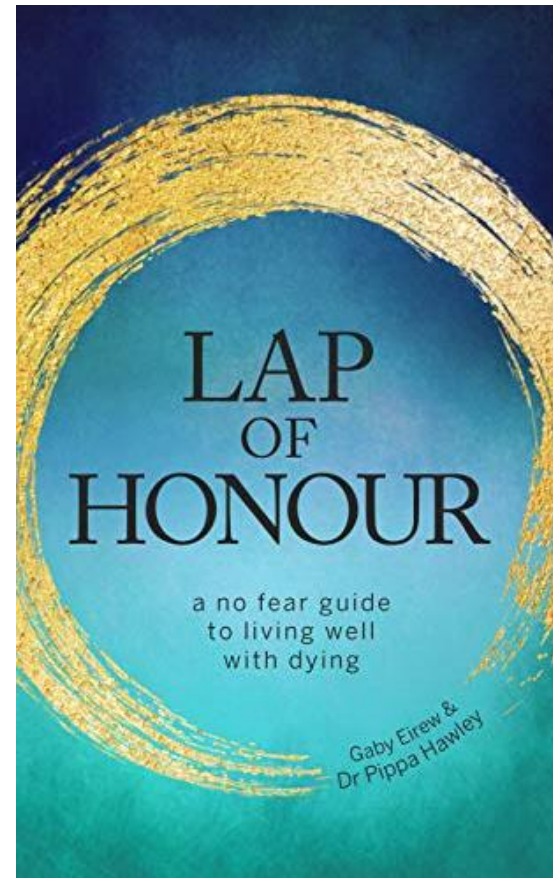
- Services available early in course of illness
- Services 'dip' in and out when need arises
- Open door accessibility, preferably 24/7
- Co-location with disease-specific services for patient-centred care provision
- Clear role definitions
- Multidisciplinary team functioning, with team meetings and excellent communication
- Close links with community hospice (or palliative care) services and rehabilitation services

From: The Bow Tie Model and Survivorship NOSM April 2022

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Thank you Dr Hawley

- For patients and their families living with serious illness
- Designed to be used from time of diagnosis



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