WELCOME to the

Rural Cancer Survivorship ECHO:
The Cancer Continuum

July 17 – September 25, 2024

This Project is supported by the Centers for Disease Control (CDC) and Preventions' Comprehensive Cancer Program through agreement NU58DP007115 awarded to the New Hampshire Department of Health and Human Services, Division of Public Health Services, Bureau of Prevention and Wellness, Cancer Program. The contents of this website are solely the responsibility of Dartmouth Hitchcock Medical Center and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Series Learning Objectives

At the conclusion of this learning activity, participants will be able to:

- Describe cancer survivorship, including the components of survivorship care planning
- Discuss the roles, importance, and experience of cancer care patients
- Develop strategies to effectively connect cancer survivors with various community resources and services available

Date	Session Title
July 17	Survivorship 101: Definitions and Challenges
July 31	Models of Care
August 14	Assessment and Care Planning
August 28	Care Delivery 1: Practical and Physical
September 11	Care Delivery 2: Psychosocial and Spiritual
September 25	Access to Care and Community Resources

Dartmouth Rural Survivorship Project ECHO

Survivorship 101: Definitions and Challenges

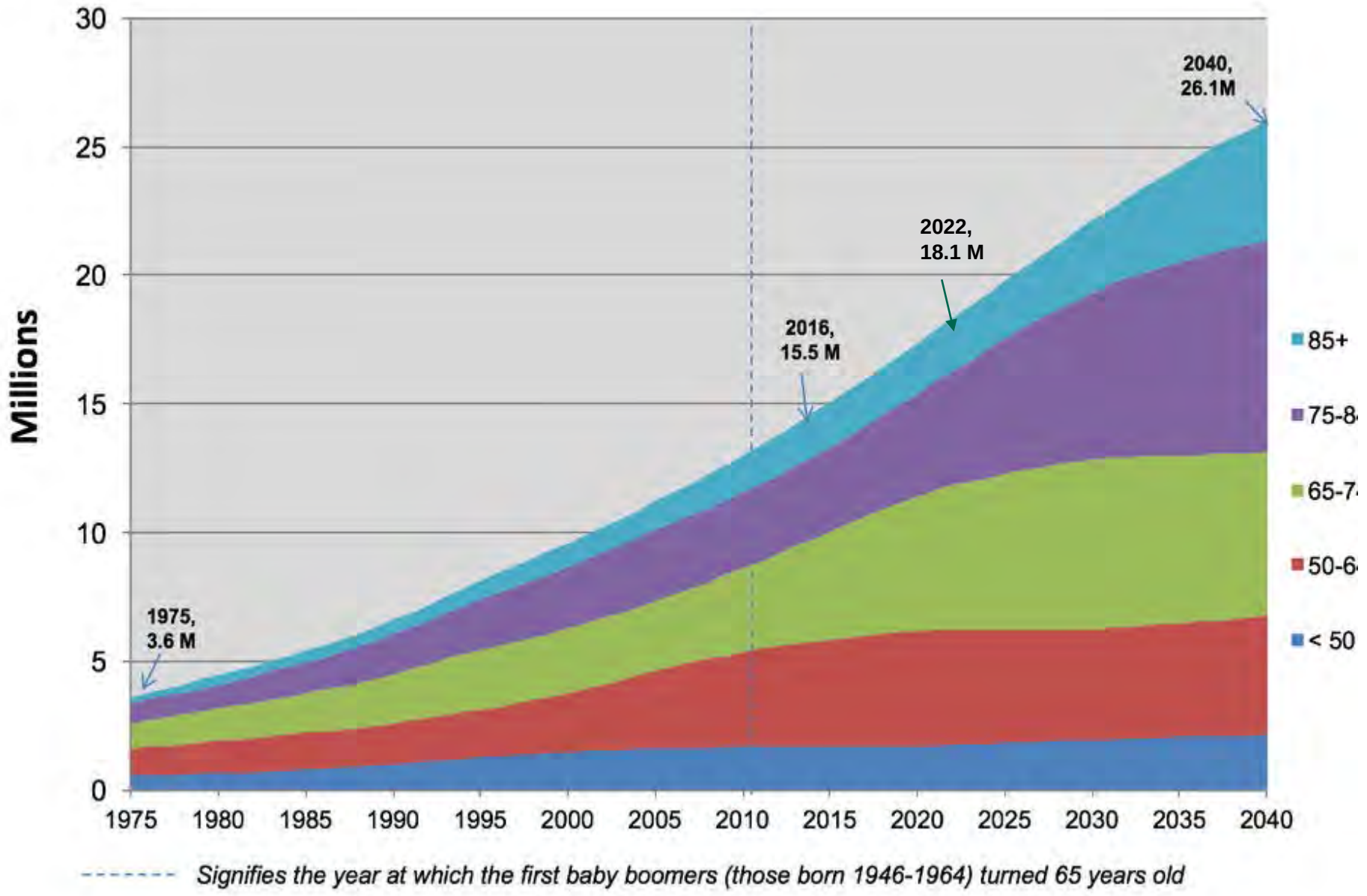
Elizabeth B. McGrath DNP, APRN

Definitions

- An individual is considered a cancer survivor from diagnosis, through the balance of life. This includes survivors living with cancer and those free of cancer.
- Cancer survivors include those who are initiating treatment, in ongoing treatment, have completed cancer treatment, or are in clinical remission

From Hewitt M, Greenfield S, Stovall E. From Cancer Patient to Cancer Survivor: Lost in Transition. Committee on Cancer Survivorship: Improving Care and Quality of Life, Institute of Medicine and National Research Council 2006. Available at: http://www.nap.edu/catalog/11468.html

The Need for Survivorship Care



The Need for Survivorship Care

Survivors experience unmet physical, psychosocial, practical and spiritual needs

Physical Well-Being

- **Functional well-being**
  - 58% patient report functional limitations
- **Fatigue**
- **Symptoms**
- **Risk of secondary malignancy**
- **Sexuality concerns**

Psychosocial

- **Cognitive function**
- **Anxiety/depression**
- **Distress**
- **Fear of recurrence**
- **Risk of secondary malignancy**

The Need for Survivorship Care

Survivors experience unmet physical, psychosocial, practical and spiritual needs

Social Well-Being

- **Family and social concerns**
- **Roles/relationships**
- **Financial concerns**
- **Discrimination concerns**
- **Health disparities**

Spiritual Well-Being

- **Finding meaning**
- **Hope**

A Few Late Effects and Lifestyle Considerations…

Fear of Recurrence

- Reported by up to 70% of cancer survivors
- It is the number one unmet, most common need

https://livingwellblog.co/2016/10/23/late-effects-of-breast-cancer-treatment

A Few Late Effects and Lifestyle Considerations

Fatigue

- Survey of 1569 cancer survivors showed this to be experience by 80% of those who received chemotherapy and/or radiation therapy
- May last up to 1 year following treatment

A Few Late Effects and Lifestyle Considerations

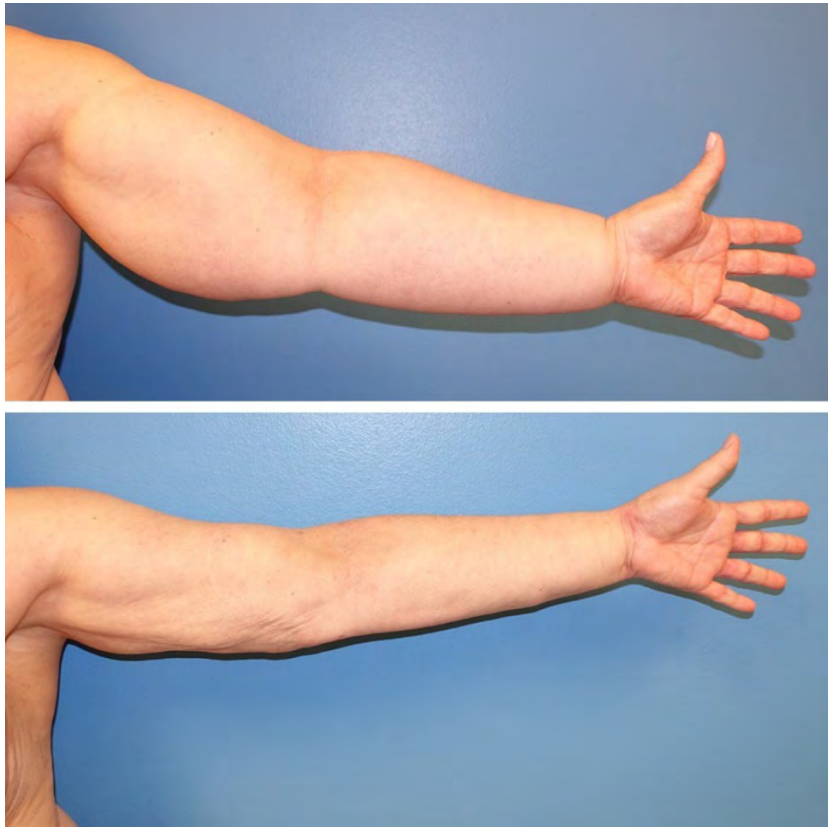
CIPN

- **Overall prevalence from 19% to over 85%, dependent upon the treatment received**
- **May lead to permanent symptoms and disability in up to 40% of cancer survivors**

A Few Late Effects and Lifestyle Considerations

Lymphedema

The 2010 Livestrong Survey reported that of the 14 million cancer survivors at the time, 20% included lymphedema as a physical concern



A Few Late Effects and Lifestyle Considerations

Sexual Dysfunction

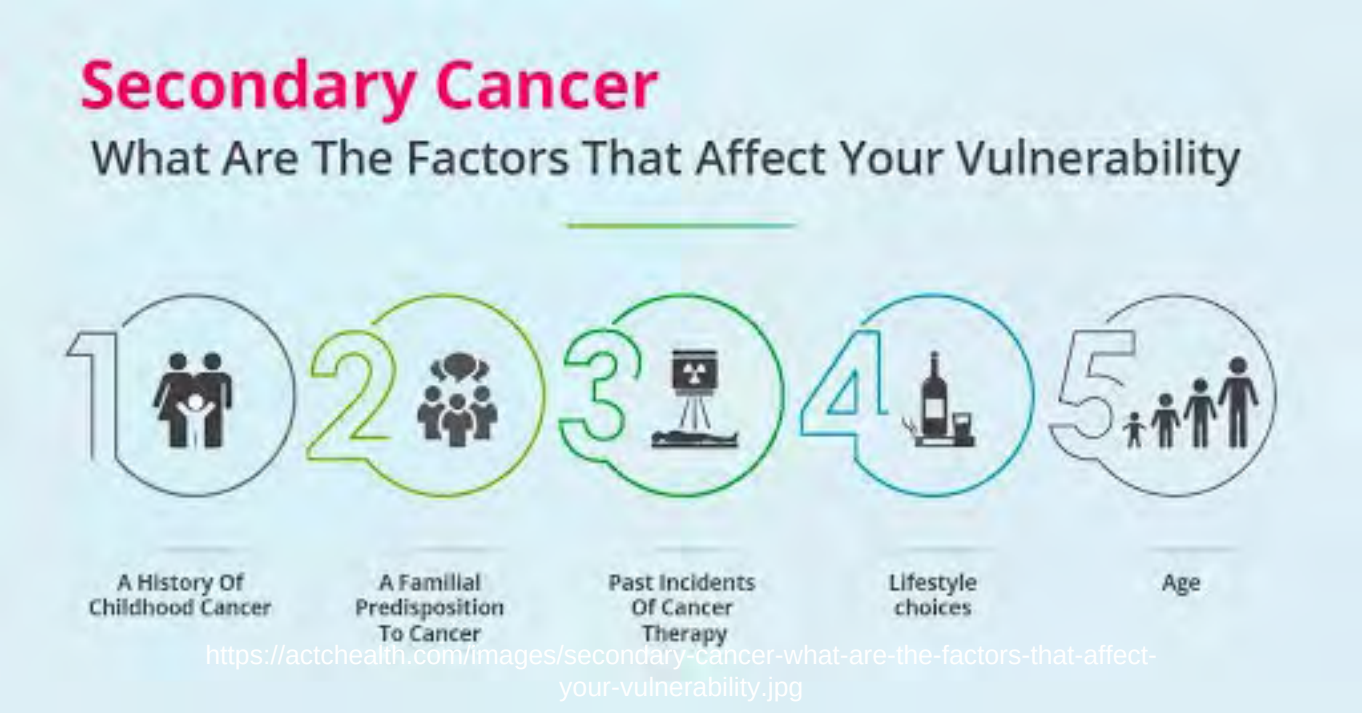
- Affects at least half of men and women treated for pelvic malignancies and over a quarter of people with other types of cancer
- 2010 Livestrong survey: In over 3,000 people, sexual dysfunction was the third most reported concern
- Despite this, less than half received medical care

Schover L., et al. European Journal of Cancer Supplements. 2014.

A Few Late Effects and Lifestyle Considerations

Secondary Malignancies

- Uncommon, But Possible
  - In a cohort of over 2 million survivors, 8.1% developed a secondary primary cancer



https://actchealth.com/images/secondary-cancer-what-are-the-factors-that-affect-your-vulnerability.jpg

The Need for Survivorship Care

- Inconsistent coordination of care and communication between primary care providers and oncologists
- Significant long-term and late effects
- Complexity of care, comorbid conditions
- Second primary cancers

Survivorship Care

Components cancer survivorship care should include:

1. Surveillance for cancer spread or recurrence, and screening for subsequent primary cancers
2. Monitoring long-term effects of cancer, including psychosocial, physical, and immunologic effects
3. Prevention and detection of late effects of cancer and therapy
4. Evaluation and management of cancer-related syndromes, with appropriate referrals for targeted intervention
5. Coordination of care between primary care providers and specialists to ensure that all the survivor's health needs are met
6. Planning for ongoing survivorship care

Survivorship Program Services

- Survivorship care plans/Treatment summaries
- Genetics counseling and testing
- Screening for cancer recurrence/new cancers
- Nutritional services
- Physical activity programs
- Formalized referrals to specialists
- Support groups
- Seminars/education for survivors
- Rehabilitation services
- Financial support services
- Psychiatric services

Survivorship Program Services

Exercise and Weight Management

Healthy lifestyle behaviors were a concern for many survivors:

- Inactivity (59% to 79%)
- Being overweight (52% to 68%)
- Poor diet (45% to 50%)

Can be beneficial for:

- Overall health and fitness
- Symptom management
- Reducing risk of recurrence and mortality

https://cancer.ucsf.edu/support/survivorship/sm_files/SurvivorshipWellness_wheel.png

Survivorship Clinical Practice Guidelines

National Comprehensive Cancer Network (NCCN)	American Society of Clinical Oncology (ASCO)	American Cancer Society (ACS) Survivorship Care Guidelines for Primary Care providers
• Focus on eight common impacts of cancer diagnosis and include a sample assessment tool	• Recommendations for specific areas of cancer	• Detailed recommendations about nutrition and physical activity, cancer testing, management of side effects, and coordination of care

Survivorship Clinical Practice Guidelines

Health System Policy	Health System Processes	Health System Evaluation/Assessment
The organization has a policy that includes...	**Cancer survivors are...**	**The organization has a process to collect data on...**
establishment or existence of a survivorship program either on-site, through telehealth, or by referral	provided with access and referral to a survivorship program that addresses the needs of cancer survivors either on-site, through telehealth, or by referral	survivors' patient-reported outcomes, including quality of life, and experiences of survivorship care
a framework for the provision of survivorship care informed by survivor stakeholders and relevant survivorship guidelines (e.g., American Society of Clinical Oncology, National Comprehensive Cancer Network, Children's Oncology Group)	assessed at multiple points in their follow-up care for physical effects during and following cancer treatment, including monitoring for late effects and chronic conditions, and provided with treatment and/or referrals	survivors' functional capacity
a description of multidisciplinary care, including each team member's specific roles and responsibilities and workflow(s) for referrals to team members	provided with access to appropriate specialty care services to manage potential late effects (e.g., cardiovascular issues) either on-site, through telehealth, or by referral	survivors' return to previous participation in paid and unpaid work/ school/ productive activities of living
an overview of how to stratify and refer survivors to appropriate models of care based on age, treatments, and risk factors	assessed at multiple points in their follow-up care for emotional and psychological effects of cancer and its treatment and provided with treatment and/or referrals	survival rates (1, 5, and 10-yr) from the time of diagnosis
description of the approach and timing of transitions in survivorship care and shared care (e.g., pediatric to adult providers and settings, oncology team to survivorship team and/or primary care) and efforts to prevent/mitigate loss to follow-up care	assessed for practical and social effects of cancer and its treatment (e.g., social risks, health-related social needs, education and employment/return to work or school) and provided with resources and/or referrals	rate of recurrence
an outline for the provision of information for support services (e.g., navigators, social work, interpreters) for survivors based on their needs (including but not limited to health, insurance, and financial literacy, disability status), including survivors from diverse and underserved backgrounds	assessed for their risk of recurrence or new cancers, including family history and genetic testing, and provided with recommendations and referrals regarding surveillance for recurrence or new cancers	rate of subsequent cancers
identification of an executive-level survivorship care lead (with succession plan) whose role is to ensure compliance with standards, with reporting to an appropriate executive committee	assessed for lifestyle behaviors and provided with recommended strategies for management and appropriate referrals or education as needed (e.g., smoking cessation, diet/nutrition counseling, promoting physical activity)	number and relevant characteristics (demographics, clinical factors) of survivors lost to follow-up
collection of longitudinal data on survivors' experience of survivorship care and patient-reported outcomes	provided with access and referrals to appropriate supportive health services (e.g., nutrition, occupational and physical therapy, rehabilitation, sexual health, fertility services, dental and podiatry services)	caregivers' experiences and unmet needs
requirements and methods for training health care providers (either on-site or through an external training program) to deliver survivorship care within their scope of practice	assessed for financial hardship/toxicity and concerns regarding insurance coverage, and provided with resources and support as needed	number of health professionals trained to provide survivorship care
a business case/plan, including budget, with funding allocated for survivorship care	engaged in the care planning process including discussion of shared goals of care, advanced care planning, and coordination of care with providers and services (e.g., primary care provider, other health professionals, and community-based services) as needed	relevant business metrics to show return on investment of survivorship care to the health care system (e.g., health care utilization, rate of referrals and completion, downstream revenue)

[National Standards for Cancer Survivorship Care | Division of Cancer Control and Population Sciences (DCCPS)]

Barriers to Survivorship

- Lack of Standardized guidance and metrics for the assessment and management of long-term and late effects, models of communication, and medical record technology
- Access to individual and community-level services
- Variations exist in insurance coverage for survivorship services
- Patients may not be aware of the benefit or lack of benefit of routine follow-up for their specific circumstance
- Survivors and care partners may be unsure who serves as lead coordinator

Barriers to Survivorship

- Patients fear of recurrence, late side effects, or potential for another cancer diagnosis may stop them from seeking care
- Patients may lack self-advocacy skills to effectively navigate care or secure services
- Survivors are members of a complex network of individuals including family and caregivers; all members of the community experience stresses from the cancer diagnosis
- Lack of infrastructure
- Demand for oncologists will outweigh the supply of providers

Barriers to Survivorship

Health disparities continue to exist despite advances in treatment

- Racial and Ethnic Disparities
  - Often attributed to advanced stage of cancer at diagnosis
  - When controlled for stage of cancer at diagnosis, survival disparities persist

- Socioeconomic Status Disparities
  - SES impacts ability to purchase health insurance, education and other factors affecting access to healthcare
  - Lower SES more likely to smoke and be obese
  - CRC mortality rates among those younger than 65 yrs are higher in states with lower education rates
  - People with higher levels of education have a lower risk of premature deaths regardless of race/ethnicity
  - Uninsured adults or those insured by Medicare w/o supplemental insurance have inferior access to quality care and have worse outcomes

Barriers to Survivorship

Health disparities continue to exist despite advances in treatment

- Age Disparities
  - Older people often excluded from clinical trials
  - Adults ≥65yrs with comorbidities often excluded from health behavior change studies
  - Higher risk of comorbidities increasing healthcare utilization, financial burden from healthcare, increased family stress

- Geographic Disparities
  - Determines access to quality cancer care, the burden of receiving care, and the distance to receive care

Barriers to Survivorship

Gaps in Survivorship Research

- Survivorship science is evolving
- Screening guidelines for late effects and new cancers are unclear
- Need to establish evidenced-based associations between therapeutic exposures and late effects to identify high-risk populations who would benefit from more frequent screening
- Research in cancer survivors > 65yrs is lacking
- Research is sparse in survivors > 5yrs
- Research needs to be done:
  - To identify essential services
  - Measures to optimize a competent workforce for survivorship care
  - Promotion of optimum care coordination
  - Healthcare utilization
  - Survivorship care planning

Survivor Care Plans

- Advice from healthcare professionals significantly influences adoption of healthy lifestyle behaviors
- Trials show counseling alone correlated with increased physical activity, improved exercise capacity and reduced Framingham heart disease risk score
- Less than 25% of oncologists provide health promotion counseling to patients
- <10% survivors report being asked or advised about diet and exercise

Blanchard Psych and Health 2004
Sabatino JCO 2007
Berra JAMA 2015
Wang Cancer 2014
Frazelle ML, et al. JADPRO. 2016

Research

- Research examples:
  - Cancer Recovery through Rowing CREW
  - SCP: patient, provider, PCP satisfaction
  - Telehealth visits to augment SCP
    - Telepsychiatry
    - Nutritional counseling
    - Ongoing financial support counseling
    - Transition from oncology to primary care
  - QI initiatives
    - Education
    - Survivorship referral order sets
    - SCP templated notes in EMR

WELCOME to the

Rural Cancer Survivorship ECHO:
The Cancer Continuum

Session 2, Models of Care, July 31, 2024

Dartmouth Rural Survivorship Project ECHO

Models of Care

Elaine P. Kuhn, MD, MS

Definition

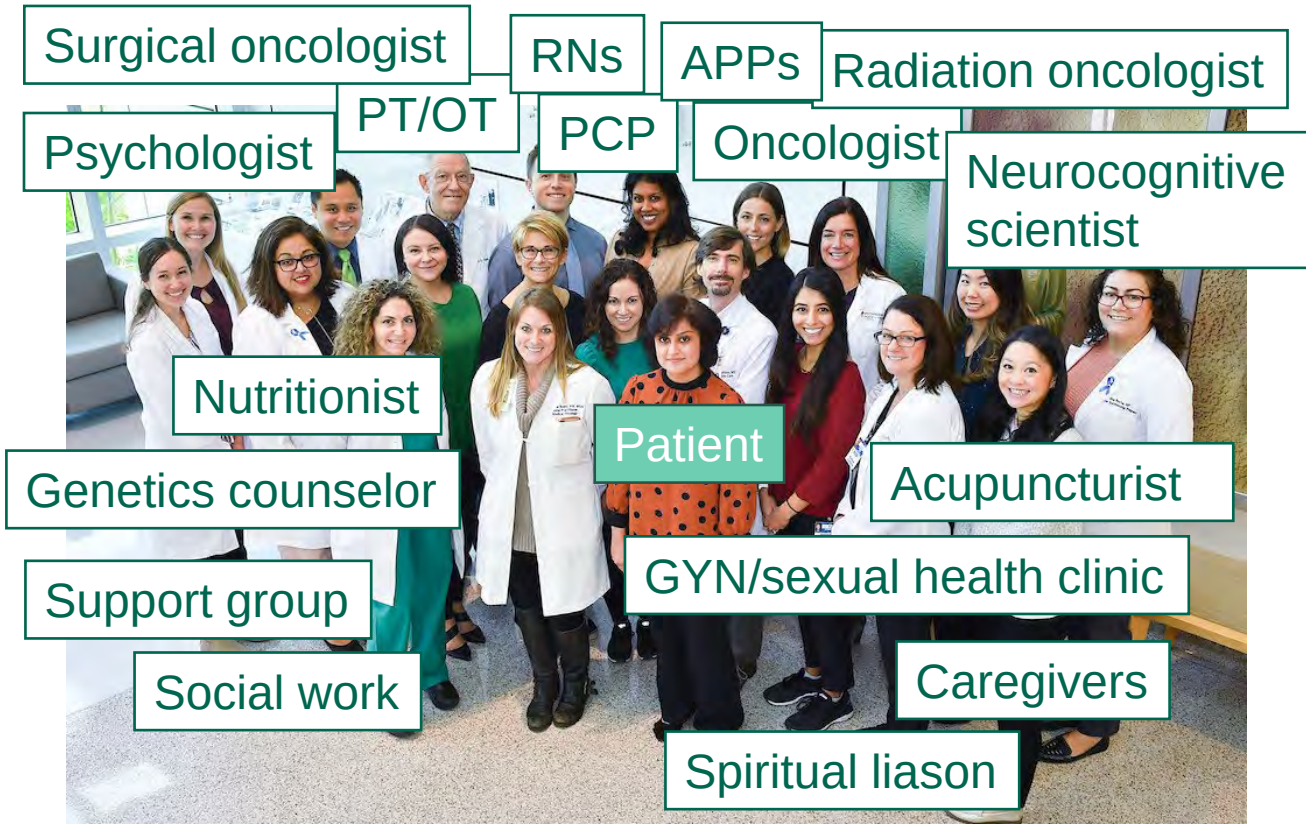
Survivor: anyone living with a cancer diagnosis

- Pre-treatment, during treatment, after treatment
- Regardless of treatment intention – it can be curative or palliative

Survivorship care: all care directed toward the patient, not the cancer

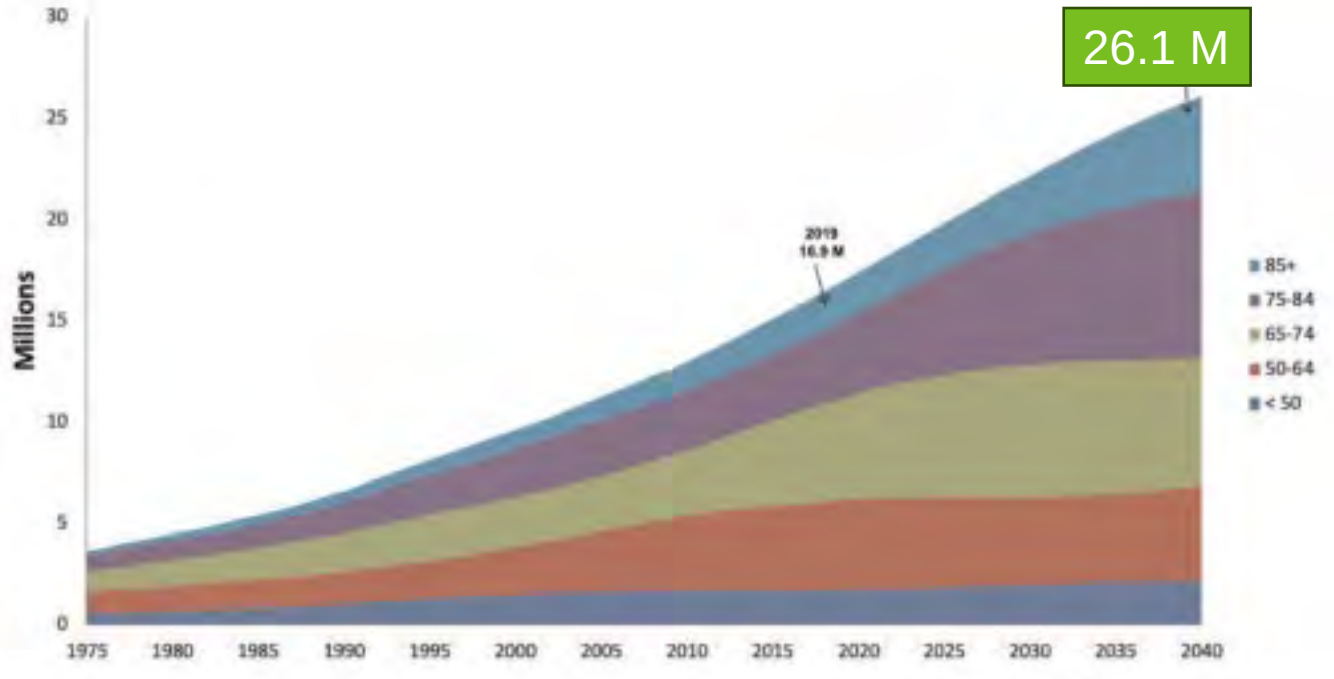
Goals of survivorship care

- Prevention and surveillance for recurrence and new cancers
- Health promotion / preventive care
- Surveillance and management of physical and psychosocial effects of cancer and its treatment



Call To Action

- Increasing number of survivors who need complex care
- Oncology offices are already overwhelmed; seeing every follow-up patient will not be possible in future
- Primary care clinics are currently not equipped to manage the complex care needs of cancer patients
- Innovative care models are needed to maximize resources and control costs while delivering high-quality care to our patients



Models of Survivorship Care

Special topics:

- Risk-stratified survivorship care
- Telehealth

Oncology-Led Models of Care

- Patients stay with us forever – there is no discharge
- Location of care is the oncology clinic (cancer center vs community care)
  - Tumor site specific or modality-specific practices
- Survivorship care can be delivered in a longitudinal/integrated vs consultative fashion
- Care may be delivered by doctors, advance practice providers, nurses, or some combination
- Communication and coordination with PCP occurs on an as needed basis

Oncology-Led: Longitudinal vs Consultative Model

- **Longitudinal care** involves a “transition” to survivorship care
  - Timing of transition varies (for example 2 years after completion of active treatment)
    - Tailored to individual, risk of recurrence
    - Set of guidelines
  - Transition is a choice – some groups historically do not transition (ie CNS tumors, SCT pts)
- **Consultative care** involves a 1-time visit with survivorship provider
  - Oncology providers may refer at any time, usually 6-12 months after completion of treatment
  - During the comprehensive visit, a treatment summary and survivorship care plan is generated
  - Patients return to their primary oncologist for duration of follow-up period

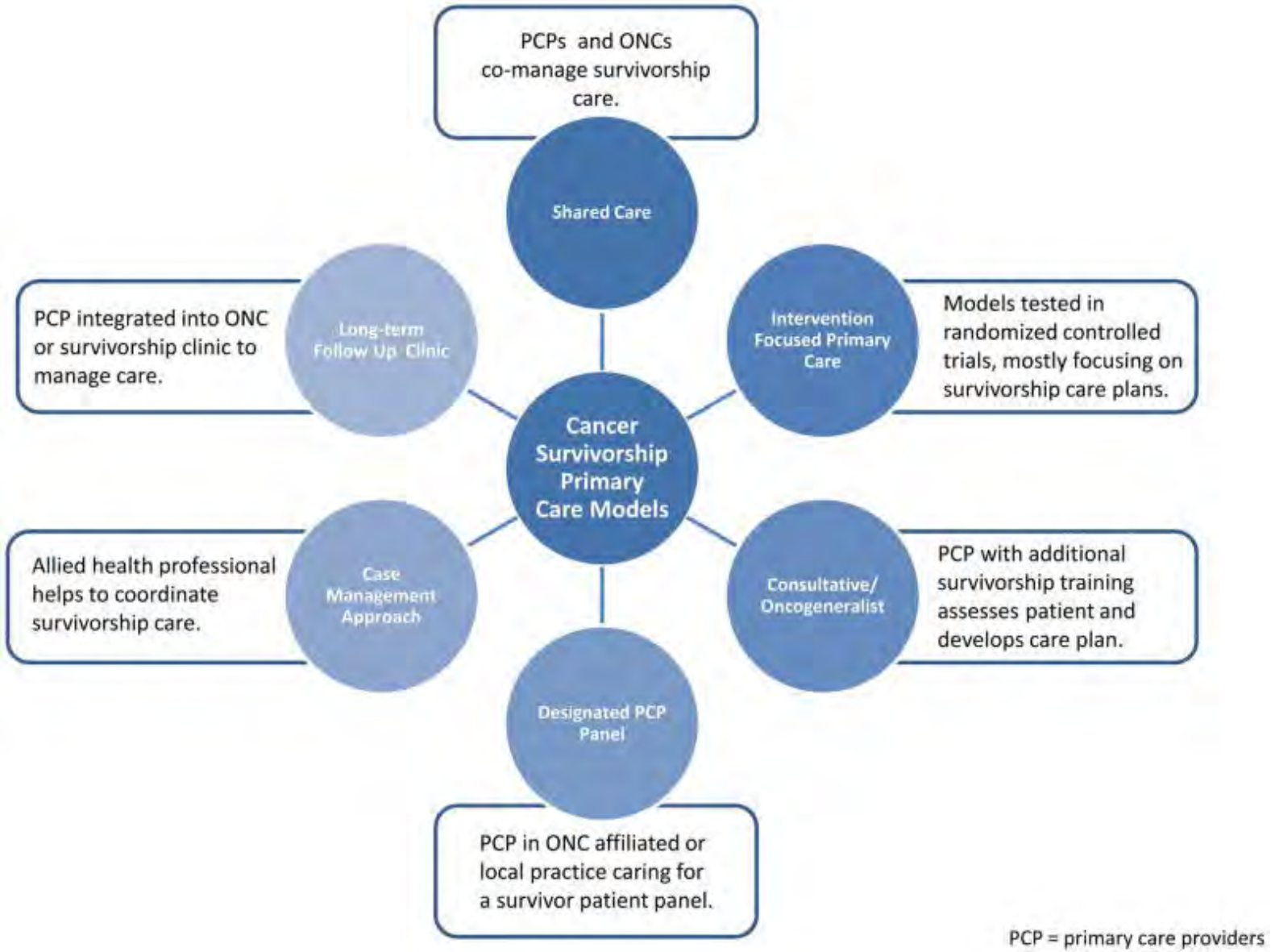
Oncology-Led: Multidisciplinary clinics

- Large centers funded by large grants and foundations
  - DFCI Adult Survivorship Program
  - Minnesota Survivorship Program
  - UCLA Survivorship Center of Excellence
- Offering cutting edge comprehensive services under one roof, with opportunities for participation in research
- Many challenges to development and sustainment of cancer survivorship programs, even in NCI-designated comprehensive centers
- As delivery of cancer care services expands into integrated large health care systems, innovative strategies are needed to deliver high quality, accessible care regardless of zip code

Primary Care-Led

- PCP role already well developed in prevention and early detection of cancer
- As emphasized in ‘From Cancer Patient to Cancer Survivor: Lost in Transition,’ With the growing number of cancer survivors, we need to establish the role of PCP
- Roles range from:
  - Providing primary care without attention to survivorship care
  - Providing survivorship care under guidance of expert (ie – survivorship care plans)
  - Active members of the cancer survivorship team
  - Main provider of survivorship care (oncogeneralist or onco-primary care)
- Barriers include capacity and education

Nekhlyudov, L., O’Malley, D. M., & Hudson, S. V. (2017). Integrating Primary Care Providers in the Care of Cancer Survivors: Gaps in Evidence and Future Opportunities. *The Lancet. Oncology*, *18*(1), e30–e38. https://doi.org/10.1016/S1470-2045(16)30570-8



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Example 1: The Cancer Screening and Survivorship Program at Roswell Park Comprehensive Cancer Center

- Freestanding centralized clinic within an academic medical center, with providers dispersed in other clinical areas as well (two disease-specific sites)
- Led by an onco-generalist – an internal medicine trained physician serving all cancer disease sites
  - Team consists of 4 full-time APPs, 2 RNs, 2 clinical liasons
- Research related to patient needs and barriers to care, overall quality of life, health promotion and prevention, education and training to build a more robust cancer survivorship workforce
- Partnership with community outreach and engagement
- PCP outreach and education in a shared-care model

Flores, T., Crabtree-Ide, C. R., Glaser, K. M., & Reid, M. (2024). The Cancer Screening and Survivorship Program at Roswell Park Comprehensive Cancer Center. *Journal of Cancer Survivorship: Research and Practice*, *18*(1), 11–16. https://doi.org/10.1007/s11764-023-01521-y

Example 1: The Cancer Screening and Survivorship Program at Roswell Park Comprehensive Cancer Center

- ~3000 patients per year, 36.9% breast, 10.3% gyn, 9% hematologic
- 85% of visits are comprehensive and billable; Additional funding from Roswell Park Alliance Foundation
- Acupuncture (self-supported), PT and rehabilitation, psychology, social work, support groups, cardiology, clinical genetics, smoking cessation, GI, pulmonology, integrative medicine and comprehensive screening for 2nd cancers and long-term surveillance
- Onco-fertility care through partnership with local fertility clinic
- Recent additions: sexual health, intimacy and sleep health
- Use of SurvivorPlan® to generate streamlined SCPs
- Option for one-time consult for SCP or transition to long-term follow-up

Example 1: The Cancer Screening and Survivorship Program at Roswell Park Comprehensive Cancer Center

- Challenges
  - The program still only cares for a modest fraction of patients that are eligible for survivorship care, despite support of leadership at all levels
    - Automatic referrals for consultation or messages suggesting a transfer to survivorship in the EHR are potential solutions on the horizon
  - Reaching the ‘hard to reach’ rural communities
    - COE needs to engage with local community stakeholders to consolidate resources and tailor the program based on feedback
    - Expansion to the community is planned for improved access to services regardless of zip code
    - Regular outreach and education programs are underway; currently conducting quarterly outreach visits to PCP offices

Example 2: Cancer Survivorship at Stanford Cancer Institute

- Focus on primary care-survivorship collaboration for patients undergoing active cancer care requiring co-management
- Embedded survivorship clinics within disease groups in outpatient clinics
- Novel clinics to address unmet needs (ie – sexual health) and those who are high risk due to genetics
- Ongoing education for PCPs including online course, textbook, lecture series, rotations for medical trainees
- Research efforts:
  - Oncofertility
  - Targeted digital interventions for improved QoL
  - Increasing capacity to care for survivors
  - Strengthening collaborations with community partners

Smith, S. M., Steele, N., Kim, J., Yurkiewicz, I. R., Benedict, C., Trivedi, R., Heathcote C., Simon, P. J., Bugos, K., Clayton, A., Palesh, O., & Schapira, L. (2024). Cancer Survivorship at Stanford Cancer Institute. *Journal of Cancer Survivorship: Research & Practice*, *18*(1), 53–58. https://doi.org/10.1007/s11764-023-01523-w

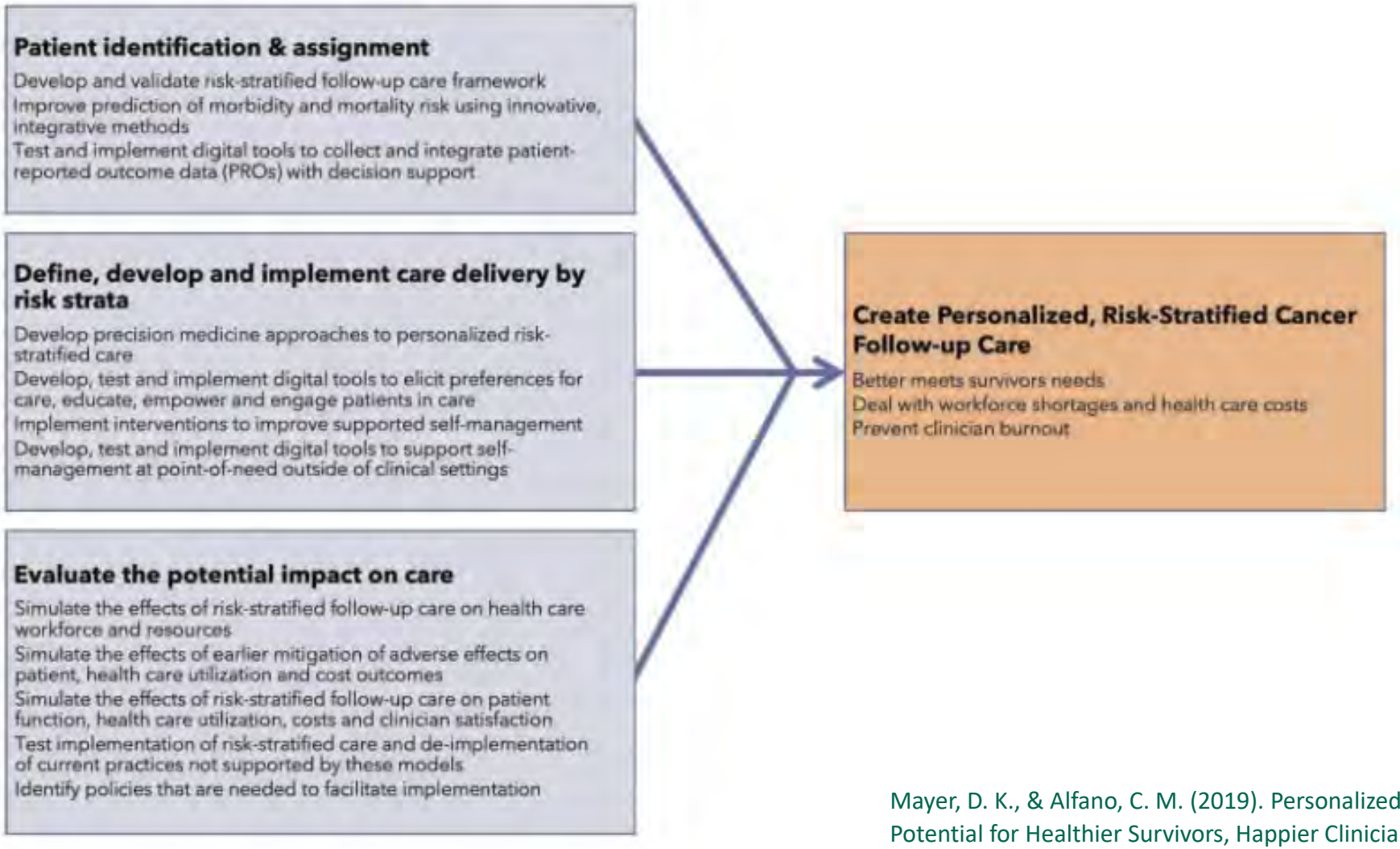
Example 2: Cancer Survivorship at Stanford Cancer Institute

- Disease-specific clinics in breast, GYN, heme, lymphoma, GI and BMT
  - Led by APPs
  - Referrals from oncologists were limited → consolidated general clinic → high attrition → bolster efforts to train APPs within disease groups in 2019
    - Identifying champions within disease groups was instrumental to their success
- Primary care-based survivorship clinics
  - Collaboration between oncology and primary care led to a subspecialized faculty practice
  - Three PCPs in the practice received training in survivorship, one is board-certified in oncology and hematology
  - Huge demand – shifted from having patient panels to consultative model
    - During visits, discuss survivorship topics and develop SCPs for PCPs
    - “For PCPs, by PCPs”; referrals come from oncologists who appreciate a warm hand off to PCPs with experience in treating this population – in future, hoping to expand referrals to include community PCPs looking for advice regarding patients who are cancer survivors

Risk Stratified Models of Care

- One size does not fit all
- A personalized approach in which cancer survivors are triaged to distinct care pathways based on the complexity of their needs and the types of providers their care requires.
- Implementation of this approach is under investigation with support from several initiatives by the NCI
  - Lack of evidence-based algorithms to risk stratify survivors in most types of cancers
    - Existing algorithms need more robust validation of outcomes

Risk Stratified Model of Care



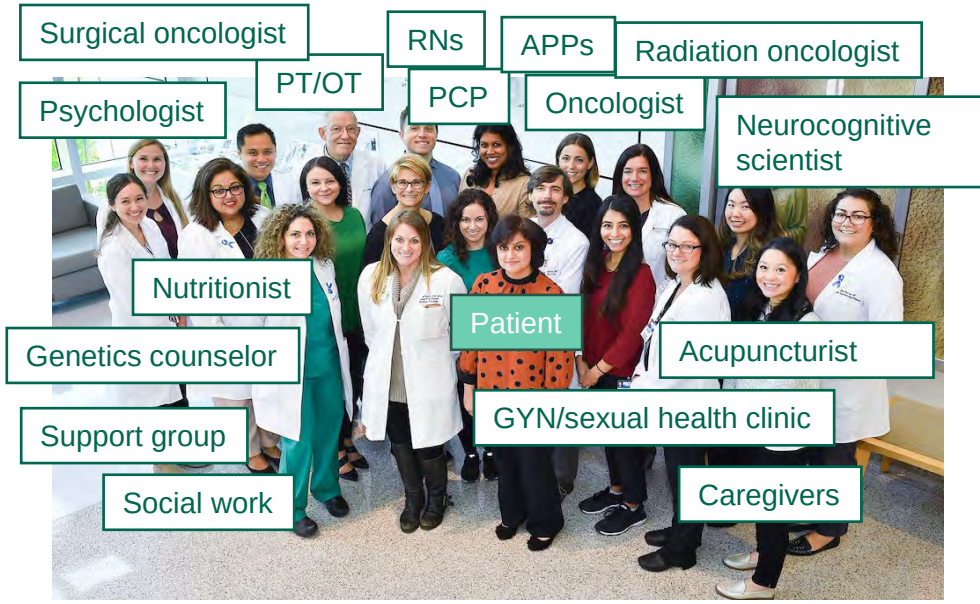
Mayer, D. K., & Alfano, C. M. (2019). Personalized Risk-Stratified Cancer Follow-Up Care: Its Potential for Healthier Survivors, Happier Clinicians, and Lower Costs. *JNCI Journal of the National Cancer Institute*, *111*(5), 442–448. https://doi.org/10.1093/jnci/djy232

Telehealth

- Substantial increase in telehealth use since the pandemic
- Telehealth can save people with cancer time, travel and money
- Research shows that telehealth can improve health care access and quality, patient-provider communication and health outcomes
- NCI's Telehealth Research Centers of Excellence (TRACE) supported by Cancer Moonshot, funds multiple centers to rapidly develop evidence base of telehealth approaches to cancer care
  - STELLAR program (Northwestern) – automated referrals for cancer risk behaviors as assessed by the EHR, physical inactivity, obesity and smoking

Conclusion

- Substantial variation in survivorship care models
- The optimal version will depend on contextual features
- Regardless of model, the biggest challenge we face is communication and coordination among multiple providers and services
- Our goals are the same:
  - Prevention and surveillance for recurrence and new cancers
  - Surveillance and management of physical and psychosocial effects of cancer and its treatment
  - Health promotion / preventive care
- Sustainability is key – we need to invest in development of risk-stratified models and use of telehealth to deliver equitable value-based care regardless of zip code



Cancer Survivorship Education and Training Resources for PCPs

- **American Society of Clinical Oncology** Online educational programs on a variety of topics related to cancer. Several programs in cancer survivorship are available. http://university.asco.org/
- **Survivorship Care Compendium** – a resource developed to serve as a repository of tools and resources to enable oncology providers to implement or improve survivorship care within their practices. Also with useful information for the primary care providers. http://www.asco.org/practice-research/asco-cancer-survivorship-compendium
- **Cancer Survivorship Symposium: Advancing Care and Research: A Primary Care and Oncology Collaboration** A collaboration among the American Academy of Family Physicians, the American College of Physicians, and the American Society of Clinical Oncology provides information about survivorship issues for primary care physicians and oncologists. http://survivorsym.org/
- **Memorial Sloan-Kettering Cancer Center** Videos intended for patients that may be helpful and informative for the primary care provider. http://www.mskcc.org/cancer-care/survivorship/videos-survivors

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Cancer Survivorship Education and Training Resources for PCPs

- ***Dana-Farber Cancer Institute*** Links to videos on a variety of topics in cancer survivorship, some geared toward patients, but very relevant to the primary care provider. http://www.dana-farber.org/newsroom/videos.aspx?tag=Survivorship http://www.dana-farber.org/For-Adult-Cancer-Survivors/Experts-Speak-on-Survivorship-Topics.aspx

- ***The University of Texas MD Anderson Cancer Center*** Links to educational programs taught by faculty on topics including overview, psychosocial issues, physical symptoms, among others. http://www.mdanderson.org/education-and-research/resources-for-professionals/professional-educational-resources/professional-oncology-education/survivorshi/index.html

- ***The National Cancer Survivorship Resource Center*** A George Washington University Cancer Institute program developed in collaboration with the American Cancer Society and the CDC. *Addressing Cancer Survivors' Needs After Treatment: An Introduction* This 45-minute, pre-recorded training webinar (initally targeting navigators) offers information on the top issues cancer survivors face after completing treatment and a discussion of resources that may be used to assist survivors transitioning from active treatment. https://gwnursing.adobeconnect.com/_a824683337/p3rfwq7z95x/?launcher=false&;fcsContent=true&pbMode=normal

- ***The Cancer Survivorship E-Learning Series*** is a free continuing education program that provides a forum to educate primary care providers to better understand and care for survivors in the primary care setting. Several modules have been released, others are in development. https://cancersurvivorshipcentereducation.org/

WELCOME to the

Rural Cancer Survivorship ECHO: *The Cancer Continuum*

Session 3, Assessment and Care Planning, August 14, 2024

Dartmouth Rural Survivorship Project ECHO

Assessment and Care Planning

Philip Lawson MD
Palliative Medicine Consultant
Littleton Regional Healthcare

LITTLETON REGIONAL HEALTHCARE
Where good health begins.

OBJECTIVES

1. Differentiate person centered and disease centered cancer care
2. State 2 questions that elicit patient goals and values
3. List 3 components of assessment of a cancer survivor
4. State at least 2 medical professionals who can assist patients in devising and following cancer survivor care plans in underserved and rural areas
5. Describe palliative care
6. List 3 components of a cancer survivor care plan

Definition

Survivor: anyone living with a cancer diagnosis

- Pre-treatment, during treatment, after treatment
- Regardless of treatment intention – it can be curative or palliative

Survivorship care: all care directed toward the patient, not the cancer

Assessment and Planning for Survivorship Care

1. Pretreatment:

- Planning and Decision Making Regarding Treatment Choices
- Recruiting Supports – Financial, Social, Psychological, Spiritual
- Setting goals for expected, acceptable and unacceptable outcomes

Survivorship care: all care directed toward the patient (*for the person*), not the cancer

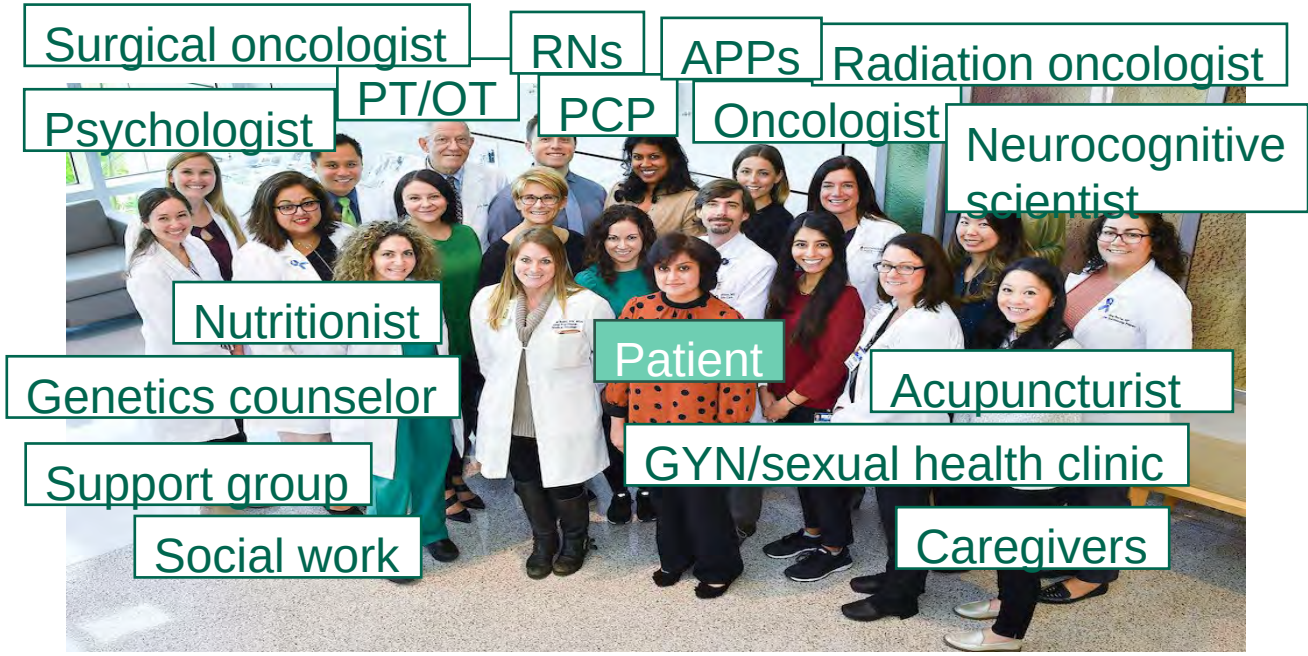
Assessment and Planning for Survivorship Care

2. Ongoing Treatment:

- Management of the Burdens of Treatment
- Balancing Burdens vs Benefits of Treatment
- Maintaining Supports

Survivorship care: all care directed toward the patient (*for the person*), not the cancer

Assessment and Planning for Survivorship Care



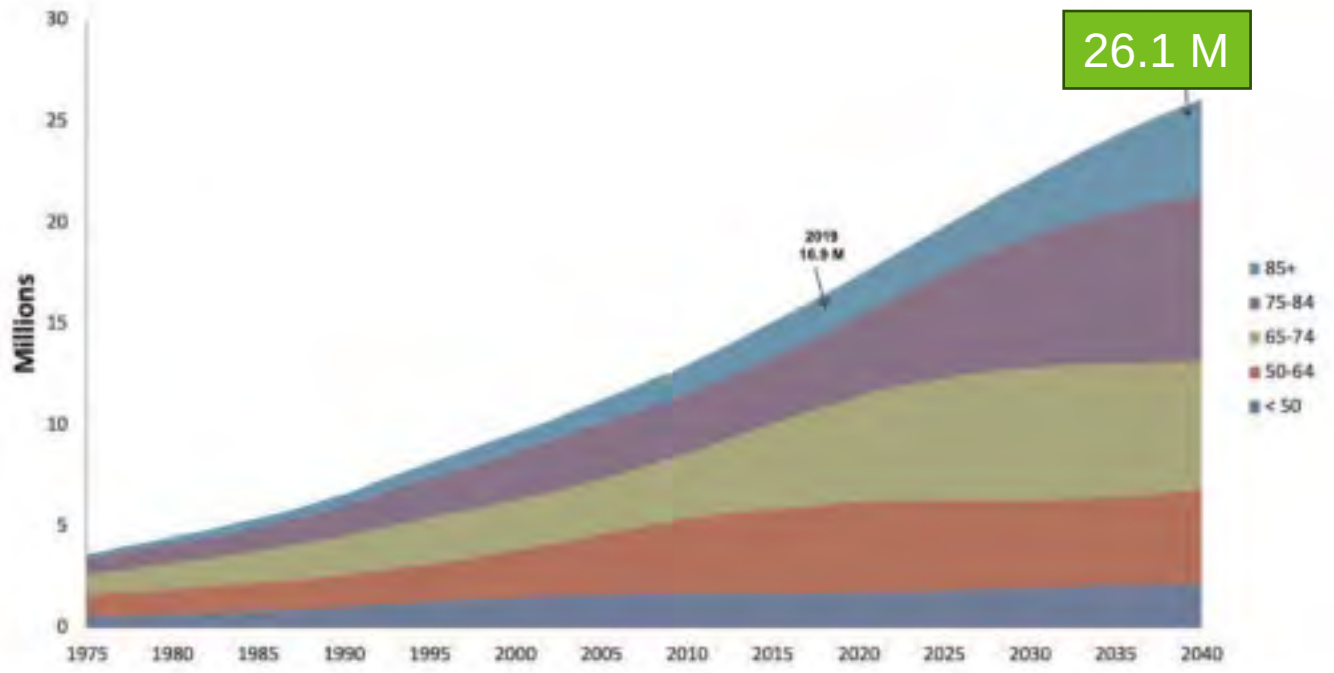
3. Post Treatment:

- Surveillance for Recurrence (oncology)
- Surveillance for New Cancers (primary care, +/- oncology)
- Ongoing Health Promotion (primary care)
- Management of the Residual Physical Effects (primary care, palliative care, oncology)
- Management of the Residual Psychological, Social and Spiritual Effects (primary care, palliative care, available community based consultants)

Survivorship care: all care directed toward the patient (*for the person)* not the cancer

Call To Action

- Increasing number of survivors who need complex care
- Oncology offices are already overwhelmed; seeing every follow-up patient will not be possible in future
- Primary care clinics are currently not equipped to manage the complex care needs of cancer patients
- Innovative care models are needed to maximize resources and control costs while delivering high-quality care to our patients



The Rural and Underserved Perspective

- Primary Care
  - Needs:
    - A clear survivorship care plan
    - An available consultant (oncologist, survivorship generalist….) for support as needed
- Palliative Medicine
- An engaged Navigator, Case Manager or Community Support Person
- A generalist with interest (ie Internist, Family Medicine or other)
- The patient/consumer and their support system

Survivorship care: all care directed toward the patient *(for the person)*, not the cancer

Palliative Medicine: What it is and is not….

"Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual." World Health Organization, 8/5/2020

What Palliative Care is NOT

- Hospice
- When you stop cancer treatment
- Accepting that you are dying
- Starting morphine and other drugs that will make you less functional
- Giving up

Effect on mortality

1. Temel J et al. Early Palliative Care for Patients with Non Small Cell Lung Cancer, NEJM. 363: 733-42; Aug 19,2010
2. Liu X et al. Effects of hospital based palliative care on health, length of stay and in hospital mortality across intensive and non intensive settings. A meta analysis. Palliative & Supportive Care , Volume 15 , Issue 6 , December 2017 , pp. 741 – 752
3. Connor S et al. Comparing hospice and non hospice patient survival among patients who die within a 3 year window. J Pain and Symptom Mgt. Vol 3 (33); March 2007. 238-246.

What Palliative Care IS

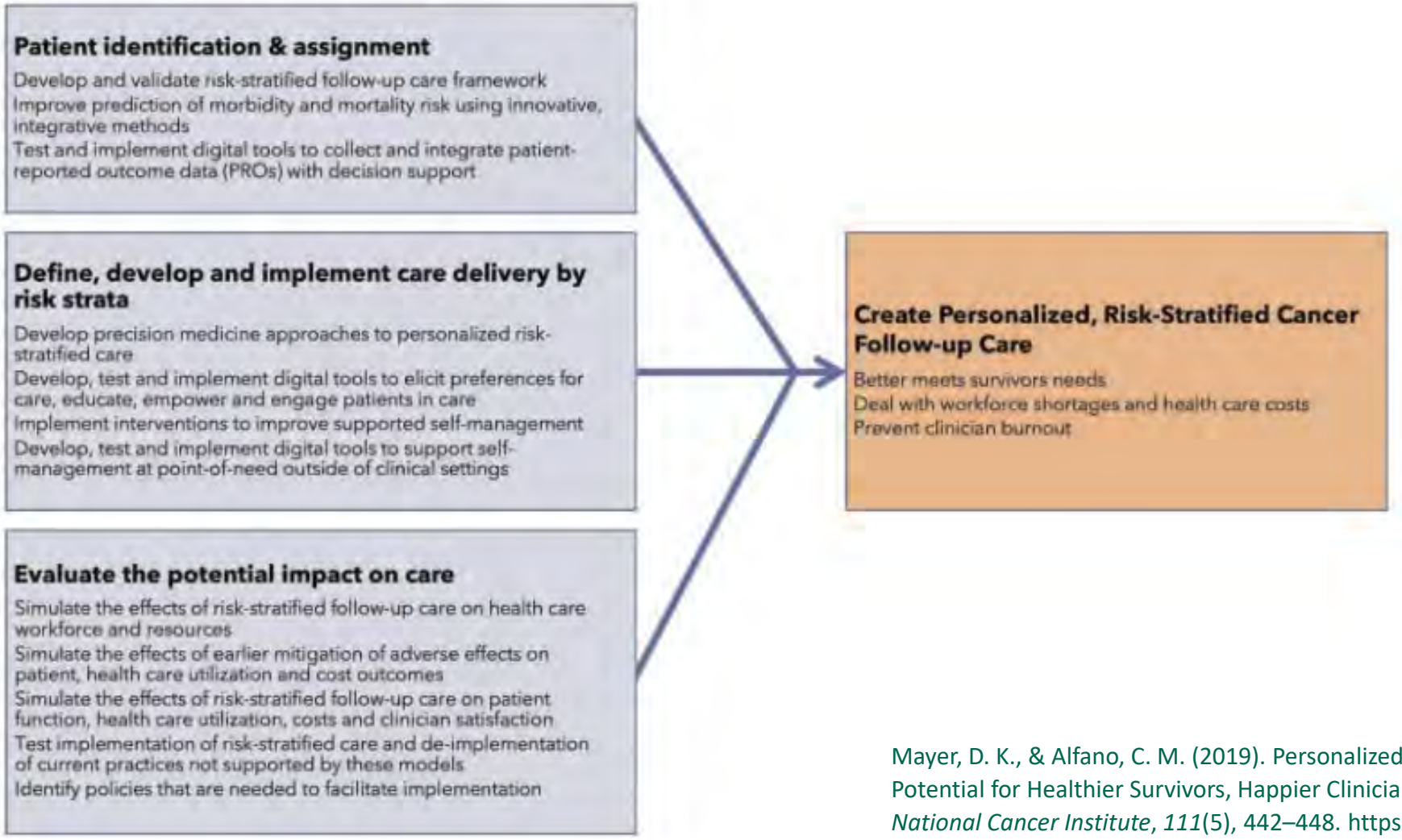
- Patient centric and focused on personal goals and values
- Holistic in approach
- Support to assist in complex person centric medical decisions regarding care
- Skilled in symptom management
- Skilled in communication regarding all options for care including finding hope and meaning in any choice

What Palliative Consultation Includes

- Exploration of Goals and Values including acceptable, unacceptable and expected outcomes
- Holistic Symptom management
- Exploring preferences for the process of decision making
  - Advance Directive completion
- Medical Order Sets for those wishing limits on treatment
  - P-DNR, POLST

Ozdemir S et al. Goals of care amongst patients and their family caregivers in the last years of life. JAMA. April 11, 2024. doi:10.1001/jamanetworkopen.2024.5866

Risk Stratified Model of Care



Mayer, D. K., & Alfano, C. M. (2019). Personalized Risk-Stratified Cancer Follow-Up Care: Its Potential for Healthier Survivors, Happier Clinicians, and Lower Costs. *JNCI Journal of the National Cancer Institute*, *111*(5), 442–448. https://doi.org/10.1093/jnci/djy232

Assessment and Care Planning

1. Patient Centric Model of Care
   - Exploring Goals and Values
     - "What activities do you most enjoy?"/ "What do you like to do?"
     - "What does a good day look like for you?"/ "Describe a best possible day? What would it include?"
     - "At this time in your life, what is most important to you?/ Of what are you most proud?"
     - "What makes you feel most well/ at peace/ yourself?"
   - Understanding Unacceptable Outcomes
     - "In regards to quality of life, are there situations or outcomes (assuming they could not improve) that you would find unacceptable?"
   - Exploring preferred processes for decision making

Survivorship care: all care directed toward the patient *(for the person)*, not the cancer

Cancer Survivorship: Assessment and Care Planning

2. Coping with Cancer Treatment: pre, during and post treatment
   a. Physical Symptoms: lymphedema, neuropathy, cardiac dysfunction, sexual dysfunction, hormonal regulation and fertility, radiation effects: www.nccn.org
   b. Social challenges – financial, transportation, housing
   c. Psychological Symptoms –
      i. anxiety/depression (@ 30%)- PHQ-2 (Kroenke, Spitzer, Williams et al, The Patient Health Questionnaire-2. Validity of a 2 item Depression Screener, Medical Care, 2003. 41: 1284-1294)
      ii. memory impairment: Mini-cog (Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. J Am Geriatr Soc 2003;51:1451–1454)
   d. Spiritual care: FICA (Puchalski, C., & Romer, A. L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. Journal of palliative medicine, 3(1), 129-137).

Cancer Survivorship Assessment and Care Plan

3. Recurrence surveillance / ongoing restaging: NCCN guidelines

4. New cancer surveillance: US Preventive Services Task Force (AHRQ) and NCCN treatment related cancer screening guidelines

5. Health Promotion:

- lifestyle and risk reduction:

Recommendation regarding counseling	Strength of Evidence
Tobacco cessation and limiting alcohol	B
75-150 min mod-vigorous physical activity + 2 sessions strength training/ week (customized)	B
Plant based diet with legumes, fiber and limit saturated fats, red meat, processed foods	B
Written survivorship care plans	C

Adapted from: Carek S, Emerson JF, Patel J. Primary Care of Adult Cancer Survivors, AFP. July 2024. 37-44

Survivorship Assessment and Care Planning

6. The Survivorship Care Plan
   - A patient centric working document to guide cancer related care
7. Care Coordination and Communication
   - Clear understanding of who is responsible for what

Survivorship Care Plans

What might be included:

1. Patient primary goals and values:
   - “to remain independent”, “in my home with my family”, “able to meaningfully communicate with family”, “ambulatory”, “not become a burden on my family”
2. Brief cancer history and treatment:
   - i.e. Stage 4 NSCLC tx with partial pneumonectomy April 2020, Radiation 60 cGy ended Dec 2020, and FOLFOX and Pembro x 6 cycles ended Sept 2021
3. Ongoing Treatment Plan if active: oncology

Cancer Survivorship Care Plans

3. Screening recommendations:
   - Surveillance and new cancers:
     - Who is responsible/ coordinating, what is the test, and what is the recommended intervals
4. Follow up appointments
5. Ongoing treatment side effects:
   - Side effect severity, trials of treatment to date with response (i.e. neuropathy, cough, dyspnea…)
   - Psychological challenges: (depression, anxiety about recurrence, frequent ED visits for chest pain…)
   - Social challenges: (fatigue, sexual dysfx, maintenance of weight, alcohol use, smoking cessation)

Cancer Survivorship Care Plans

6. Care Coordination: who is managing what, how does a survivor access care
7. Survivorship Care Plan:
   - American Society of Clinical Oncology (ASCO): www.cancer.org/cancer/survivorship/long-term-health-concerns/survivorship -care-plans.html

Cancer and Palliative Medicine Survivorship Resources

- National Comprehensive Cancer Network: www.nccn.org, search survivorship
  - Updated March 29, 2024 and includes:
    - Cancer Treatment guidelines
    - Treatment related cancer surveillance guidelines
    - Screening tools
    - Care Plan
- Center to Advance Palliative Care (CAPC): www.capc.org
  - Organizational support
- Palliative Fast Facts. www.mypcnow.org/fast-facts
  - Point of care clinical decision aid

Cancer Survivorship Education and Training Resources for PCPs

- **American Society of Clinical Oncology** Online educational programs on a variety of topics related to cancer. Several programs in cancer survivorship are available. http://university.asco.org/
- **Survivorship Care Compendium** – a resource developed to serve as a repository of tools and resources to enable oncology providers to implement or improve survivorship care within their practices. Also with useful information for the primary care providers. http://www.asco.org/practice-research/asco-cancer-survivorship-compendium
- **Cancer Survivorship Symposium: Advancing Care and Research: A Primary Care and Oncology Collaboration** A collaboration among the American Academy of Family Physicians, the American College of Physicians, and the American Society of Clinical Oncology provides information about survivorship issues for primary care physicians and oncologists. http://survivorsym.org/
- **Memorial Sloan-Kettering Cancer Center** Videos intended for patients that may be helpful and informative for the primary care provider. http://www.mskcc.org/cancer-care/survivorship/videos-survivors

Nekhlyudov, L., O'Malley, D. M., & Hudson, S. V. (2017). Integrating Primary Care Providers in the Care of Cancer Survivors: Gaps in Evidence and Future Opportunities. *The Lancet. Oncology*, *18*(1), e30–e38. https://doi.org/10.1016/S1470-2045(16)30570-8

Cancer Survivorship Education and Training Resources for PCPs

- ***Dana-Farber Cancer Institute*** Links to videos on a variety of topics in cancer survivorship, some geared toward patients, but very relevant to the primary care provider. http://www.dana-farber.org/newsroom/videos.aspx?tag=Survivorship http://www.dana-farber.org/For-Adult-Cancer-Survivors/Experts-Speak-on-Survivorship-Topics.aspx

- ***The University of Texas MD Anderson Cancer Center*** Links to educational programs taught by faculty on topics including overview, psychosocial issues, physical symptoms, among others. http://www.mdanderson.org/education-and-research/resources-for-professionals/professional-educational-resources/professional-oncology-education/survivorshi/index.html

- ***The National Cancer Survivorship Resource Center*** A George Washington University Cancer Institute program developed in collaboration with the American Cancer Society and the CDC. *Addressing Cancer Survivors' Needs After Treatment: An Introduction* This 45-minute, pre-recorded training webinar (initially targeting navigators) offers information on the top issues cancer survivors face after completing treatment and a discussion of resources that may be used to assist survivors transitioning from active treatment. https://gwnursing.adobeconnect.com/_a824683337/p3rfwq7z95x/?launcher=false&;fcsContent=true&pbMode=normal

- ***The Cancer Survivorship E-Learning Series*** is a free continuing education program that provides a forum to educate primary care providers to better understand and care for survivors in the primary care setting. Several modules have been released, others are in development. https://cancersurvivorshipcentereducation.org/

Dartmouth Health

Project ECHO®

WELCOME to the

Rural Cancer Survivorship ECHO:
The Cancer Continuum

Session 4, Care Delivery 1: Practical and Physical, August 28, 2024

CANCER REHABILITATION

PART OF THE CARE TEAM

Valerie Nichols, PT, DPT

ReVital™
Cancer Rehabilitation

Why Cancer Rehabilitation?

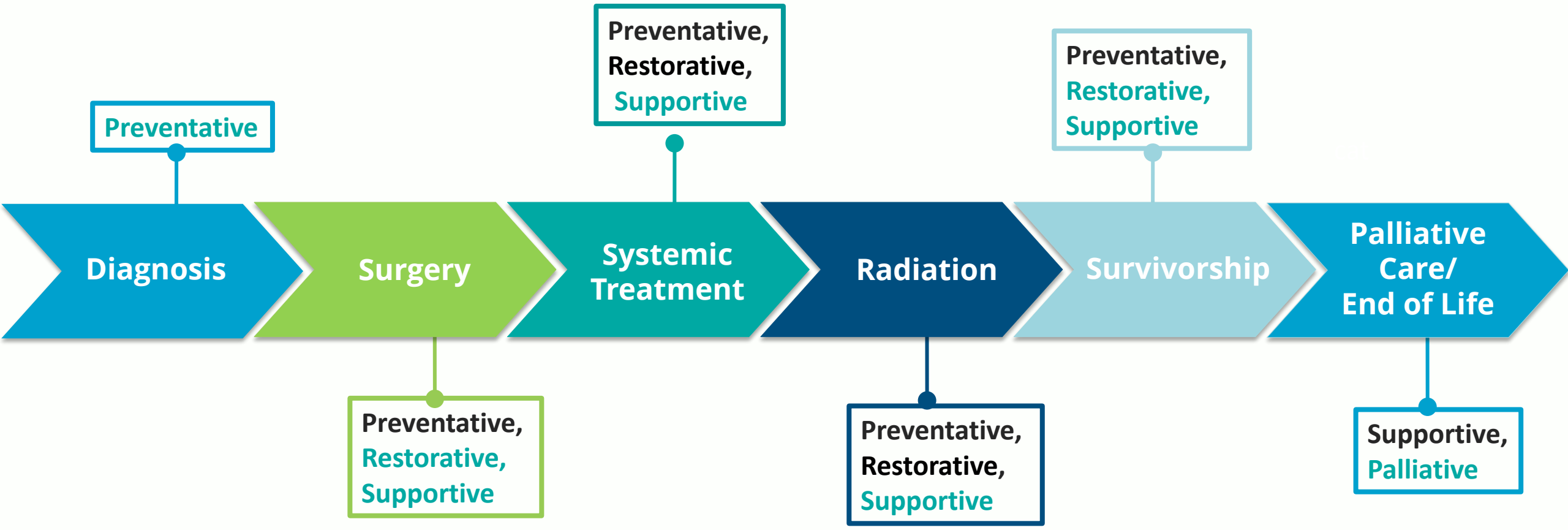
60-90% of individuals impacted by cancer have at least one need for specialized rehabilitation

Less than 2% of rehabilitation needs are addressed

Cheville, A. L., Troxel, A. B., Basford, J. R., & Kornblith, A. B. (2008). Prevalence and treatment patterns of physical impairments in patients with metastatic breast cancer. Journal of clinical oncology: official journal of the American Society of Clinical Oncology, 26(16), 2621.; Pergolotti, M., Deal, A.M., Lavery, J., Reeve, B., & Muss, H.B. (2015). The Prevalence of Potentially Modifiable Functional Deficits and the Subsequent Use of Occupational and Physical Therapy by Older Adults with Cancer. Journal of Geriatric Oncology, 6 (3), 194-201. doi: 10.1016/j.jgo.2015.01.00

CANCER REHAB

Through the Cancer Continuum



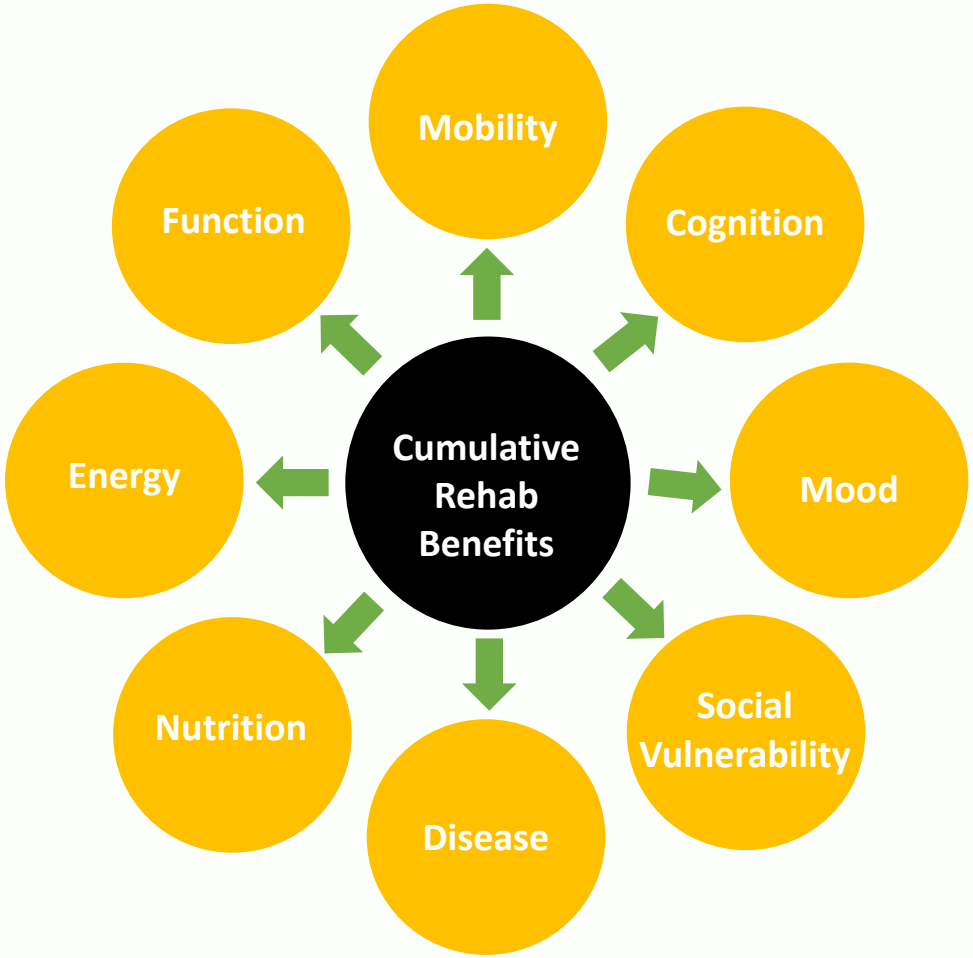
ReVital™ Cancer Rehabilitation

WHY CANCER REHABILITATION?

Some common impairments:

- Pain
- Cancer-related fatigue
- Weakness
- Deconditioning
- Numbness/pain in hands or feet
- Trouble walking or with balance
- Falls or near falls
- Arthralgia (joint pain)
- Soft tissue changes
    - Scarring, Radiation fibrosis
- ADL impairment
- Lymphedema
- Pelvic floor dysfunction

REHAB IMPROVES CANCER OUTCOMES



Impact on cancer outcomes:

- Performance status
- Suitability for cancer treatment
- Length of hospital stay
- Frailty level & determinants
- Physical functioning
- Functional capacity
- Dyspnea
- Physical activity level


Journal of the American Geriatrics Society

CLINICAL INVESTIGATION

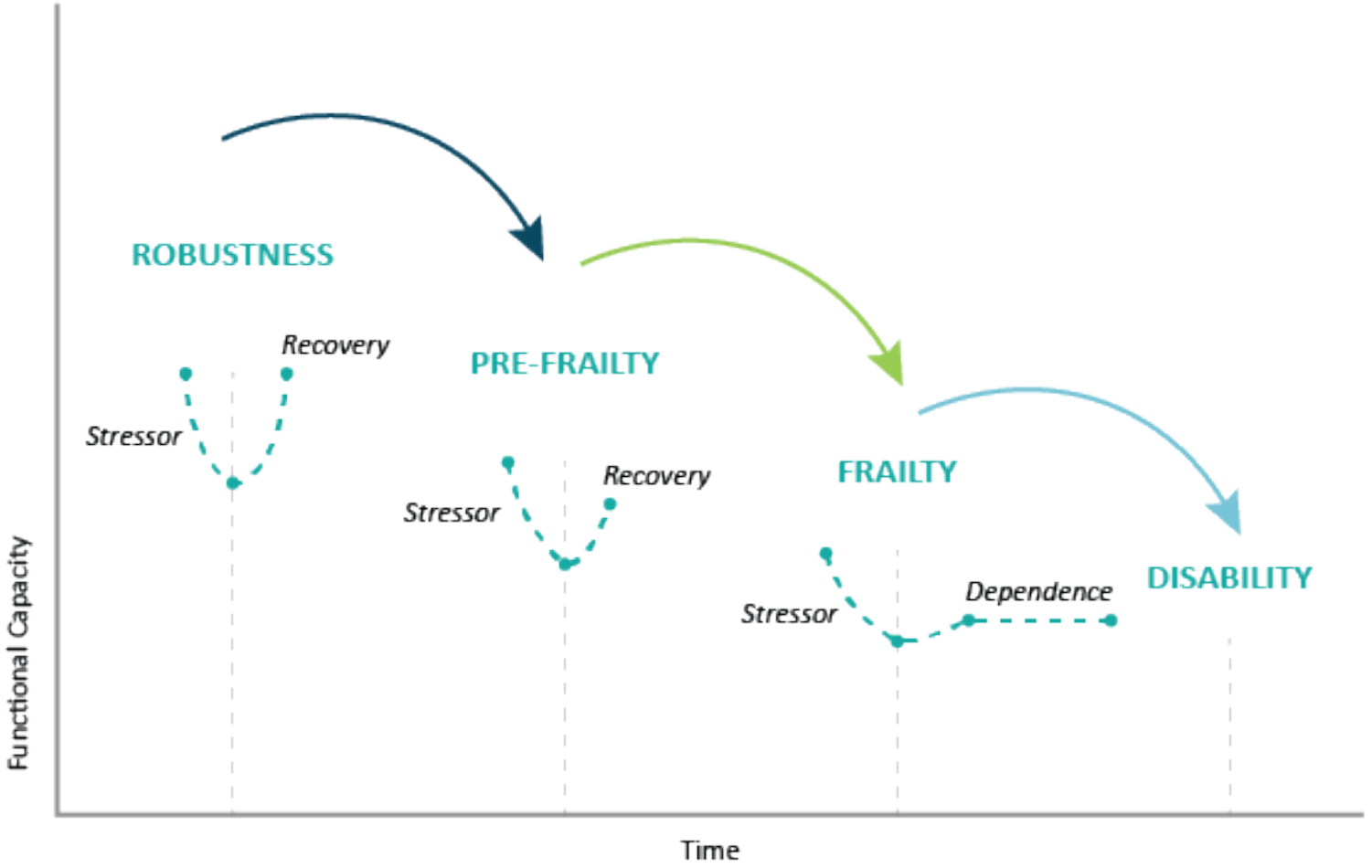
Older Adults with Cancer: A Randomized Controlled Trial of Occupational and Physical Therapy

Mackenzi Pergolotti, PhD, OTR/L,*†‡ Allison M. Deal, MS,* Grant R. Williams, MD,*§ Ashley L. Bryant, PhD, RN,* Lauren McCarthy, MS,* Kirsten A. Nyrop, PhD,* Kelley R. Covington, MS,† Bryce B. Reeve, PhD,*¶ Ethan Basch, MD,* and Hyman B. Muss, MD*

Silver JK (2015) Cancer prehabilitation and its role in improving health outcomes and reducing health care costs. Semin Oncol Nurs 31:13–30. https://doi.org/10.1016/j.soncn.2014.11.003; Goldsmith I, Chesterfield-Thomas G, Toghill H (2020) Pre-treatment optimization with pulmonary rehabilitation in lung cancer: Making the inoperable patients operable. EClinicalMedicine 0:100663. https://doi.org/10.1016/j.eclinm.2020.100663; 1. Chen BP, Awasthi R, Sweet SN, et al (2017) Four-week prehabilitation program is sufficient to modify exercise behaviors and improve preoperative functional walking capacity in patients with colorectal cancer. Support Care Cancer 25:33–40. https://doi.org/10.1007/s00520-016-3379-8

ReVital™ Cancer Rehabilitation

PREVENTION OF FUNCTIONAL DECLINE



- *E. Dent, J.E. Morley,et al. (2019). PHYSICAL FRAILTY: ICFSR INTERNATIONAL CLINICAL PRACTICE GUIDELINES FOR IDENTIFICATION AND MANAGEMENT. J Nur Health Aging.*

Recommendations

Moderate Aerobic Exercise
At least **150-300** minutes per week
OR
Vigorous Aerobic Exercise
At least 75-150 minutes per week
+
Resistance Exercise
2 x per week

Different Levels of Care

	Cancer Rehabilitation	Clinically-Supervised Exercise	Supervised, Cancer-Specific Community-Based	Unsupervised or Generic Community-Based
Brief description (Alfano et al., 2016)	"Impairment-driven care, complicated"	"Impairment-directed care, uncomplicated"	"General conditioning activities, specialized"	"General conditioning, unspecified"
Typical setting	Outpatient rehabilitation clinic	Outpatient location *typically affiliated with university, cancer center or other medical clinic	Community sites *not typically affiliated with medical institution	Home-based or any community-based setting
Delivery personnel (minimum requirements)	Board certified rehabilitation clinician(s) with cancer-specific training	Nurse, exercise or other clinician(s) with minimum B.S. and relevant certification and/or cancer-specific training.	Exercise professional(s) with minimum of B.S. and relevant certification(s) and/or cancer-specific training.	**UNSUPERVISED:** Exercise prescription/support may be provided by 3rd party **GENERIC:** Exercise professional(s) with a high school degree and site-required certification.
Goal of care	Enhanced functional status and quality of life to support transition to less specialized service.	Improve functional fitness and ability to self-monitor during exercise and set/achieve exercise goals. Transition to less specialized service.	Improve functional fitness and ability to self-monitor during exercise and set/achieve exercise goals. Transition to less specialized service.	Maintain or improve functional fitness and quality of life via routine exercise and physical activity

(Alfano et al., 2016; Covington et al. 2020)

Research: The Benefits of Cancer Rehabilitaiton

Improved functional ability

In a series of studies including 417 breast cancer and 84 gynecologic cancer survivors, attending rehabilitation was associated with *diminished upper extremity and functional disability*.
(Wood, 2022a; Wood, 2022b)

Improved health-related quality of life (HRQOL)

In a series of studies including more than 5,000 total cancer survivors, attending ReVital PT/OT was associated with *significant improvement in HRQOL outcomes* including physical health, mental health, physical function, and ability to participate in social roles and activities.
(Pergolotti, 2021; Wood, 2023; Pergolotti, 2023a; Pergolotti, 2023b)

Improved ability to work

In a study including over 898 working age breast cancer survivors, attending ReVital PT/OT was associated with *significant improvement in physical, mental and overall*

Thank You

603-368-9971

ValNichols@sacobaypt.com

767 Islington St Suite 1C
Portsmouth, NH 03801

Sacobaypt.com

revitalcancerrehab.com

Dartmouth Health

Project ECHO®

WELCOME to the

Rural Cancer Survivorship ECHO:
The Cancer Continuum

Session 5, Care Delivery 2: Psychosocial and Spiritual, September 11, 2024

Dartmouth Rural Survivorship Project ECHO

Psychosocial and Spiritual Concerns

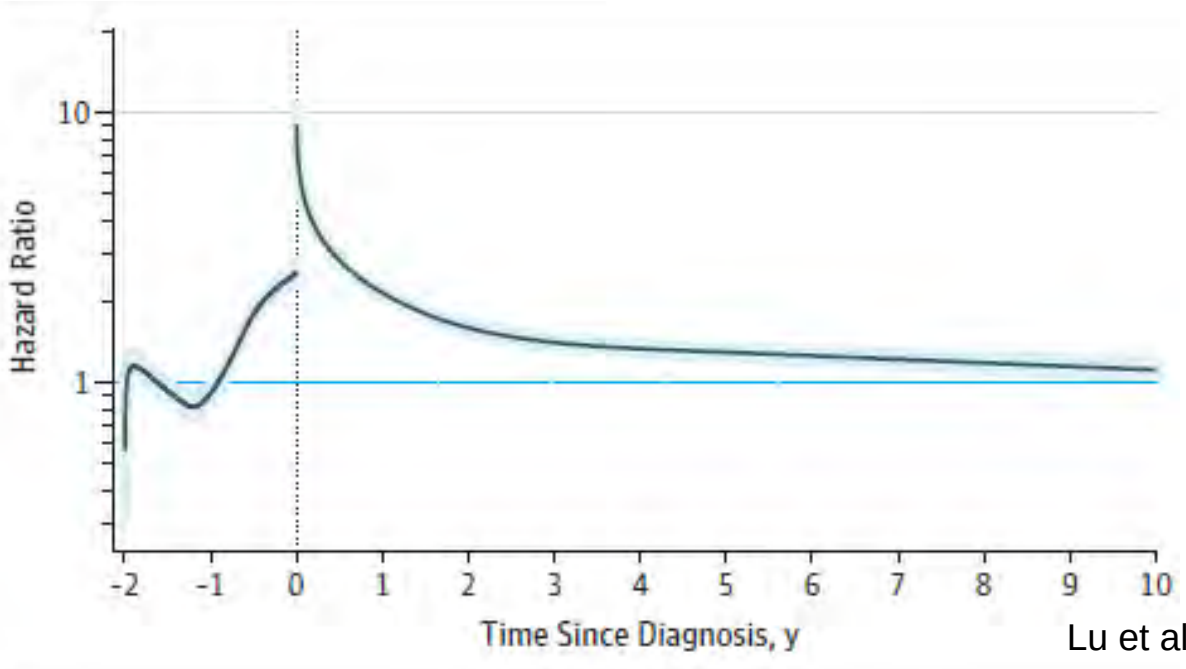
Sivan Rotenberg PhD
Clinical Health Psychologist, Psycho-Oncology Program
Dartmouth Cancer Center

Dartmouth Health

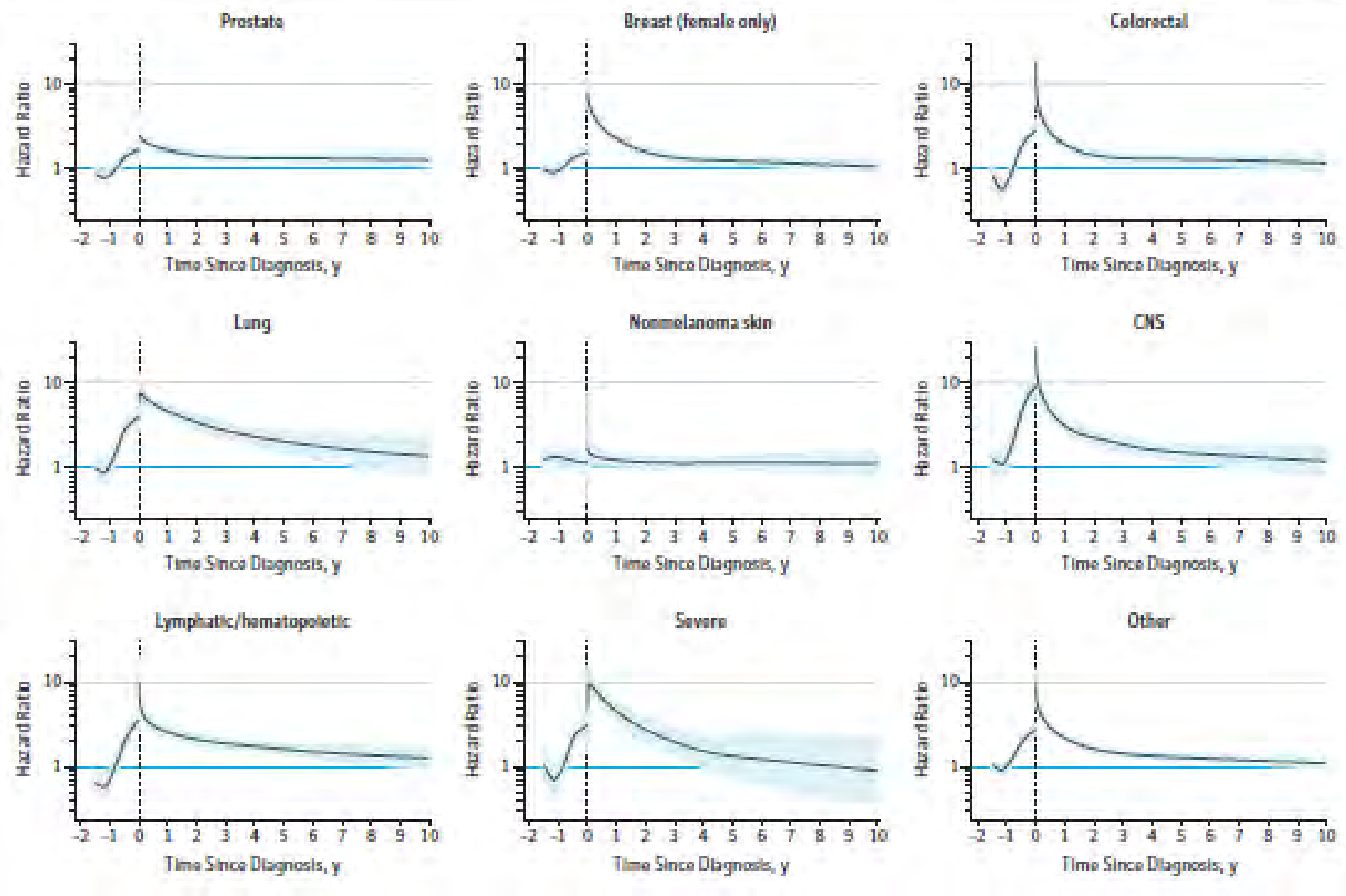
Project ECHO

Psychosocial Concerns Pre & Post Diagnosis

- The diagnostic workup for cancer is associated with increased anxiety and overall distress (Brett et al., 2005; Awsare et al., 2008; Lu et al., 2016)
- Mental health disorders rise during the pre-diagnostic phase and peak shortly after diagnosis
  - Depression
  - Anxiety
  - Substance abuse
  - Stress reaction

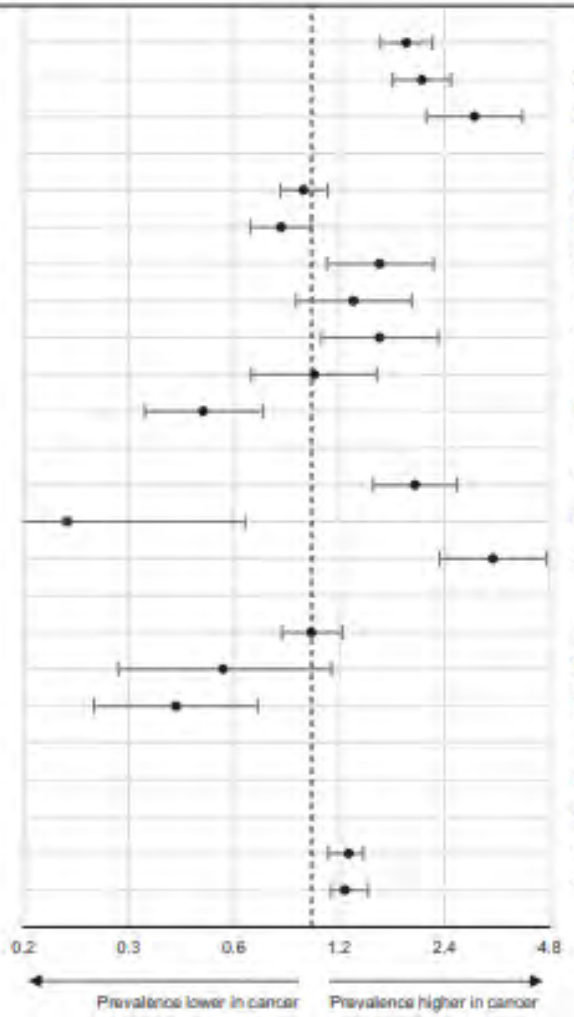


Lu et al., 2016


Prostate
Breast (female only)
Colorectal
Lung
Nonmelanoma skin
CNS
Lymphatic/hematopoietic
Severe
Other
Hazard Ratio
Time Since Diagnosis, y

Lu et al., 2016

Diagnosis	CANCER Prevalence (%)	CONTROLS Prevalence (%)	OR	95%CI
Any mood disorder	12.6	7.1	1.87***	1.58-2.22
Major depressive episode	10.3	5.2	2.07***	1.71-2.51
Dysthymia	4.4	1.5	2.93***	2.13-4.02
Any manic or bipolar disorder	0.0	0.6	n.a.	n.a.
Any anxiety disorder	12.2	12.7	0.95	0.81-1.11
Specific phobia	6.8	8.2	0.82*	0.67-1.00
Posttraumatic stress disorder	2.6	1.7	1.57*	1.11-2.23
Generalized anxiety disorder	2.1	1.6	1.32	0.90-1.94
Social phobia	2.1	1.4	1.57*	1.07-2.31
Panic disorder without agoraphobia	1.6	1.6	1.02	0.67-1.54
Agoraphobia with panic disorder	1.5	3.0	0.49***	0.33-0.73
Somatoform disorders				
Pain disorder	4.7	2.4	1.98***	1.50-2.61
Somatization disorder	0.1	0.7	0.20**	0.06-0.65
Any mental disorder due to g. medical condition	3.7	1.2	3.31	2.32-4.71
Substance use disorders				
Nicotine dependence	7.3	7.3	1.00	0.82-1.22
Alcohol abuse	0.5	0.8	0.56	0.28-1.14
Alcohol dependence	0.7	1.8	0.41**	0.24-0.70
Eating disorders				
Anorexia	0.0	0.5	n.a.	n.a.
Bulimia	0.0	0.1	n.a.	n.a.
Any mental disorder	24.8	20.5	1.28***	1.12-1.41
Any mental disorder (with nicotine dependence)	29.1	24.6	1.25***	1.14-1.45



Vehling et al., 2022

Other common psychosocial challenges

- Fear of recurrence
- Cognitive Changes
- Sleep Disturbance
- Body Image Concerns
- Sexual/Intimacy Concerns
- Existential Distress
- Spiritual Concern/Pain

How can we help?

For all patients, regardless of whether or not they are struggling with a clinically diagnosable mental health disorder, here are my top 5 tips:

1. Remember, there is no *right* way to think or feel
   - Beware of supporting toxic positivity

How can we help?

For all patients, regardless of whether or not they are struggling with a clinically diagnosable mental health disorder, here are my top 5 tips:

1. Remember, there is no *right* way to think or feel
2. Help people develop a coping plan – what has helped them get through hard things in the past?

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3. Shift from worrying to problem solving
   - Help people develop a plan to control the controllable

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4. Encourage people to have fun – have conversations/do activities that have nothing to do with cancer
5. Promote support networks
   - many fear of being a burden yet most care-partners appreciate knowing what to do
   - support groups can help decrease isolation

WELCOME to the

Rural Cancer Survivorship ECHO:
The Cancer Continuum

Session 6, Access to Care and Community Resources, September 25, 2024

Vermonters Taking Action Against Cancer (VTAAC)

September 25, 2024

Hanna Snyder, VTAAC Coordinator, UVM Cancer Center

What is Comprehensive Cancer Control?

CDC funding - collaborating to prevent and control cancer

- Funds 66 programs in U.S. (states, territories, & tribes)
- Develop & implement cancer plans
- Support active cancer coalitions
- Address health equity
- Tackle cancer across the continuum
  (prevention, early detection, treatment, survivorship/end of life)
- Cancer surveillance and program evaluation

Vermont's Comprehensive Cancer Control (CCC) Approach

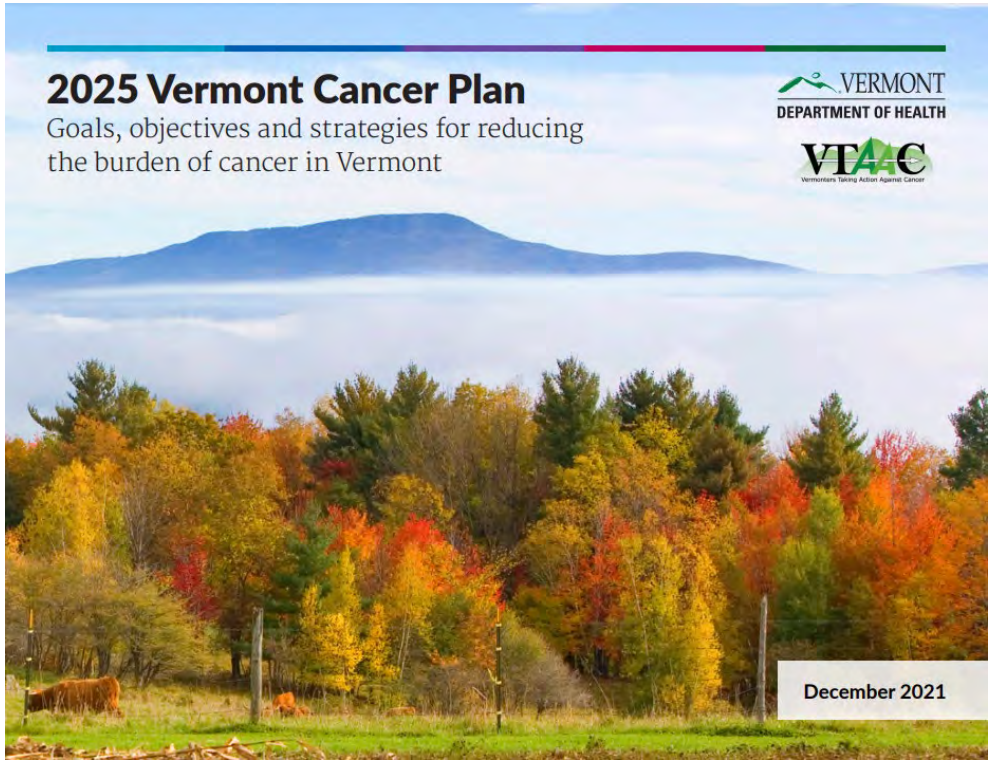
- The **Vermont Cancer Plan** is the guide for cancer control practices across Vermont
- Statewide Cancer Coalition **Vermonters Taking Action Against Cancer (VTAAC)** coordinates implementation of Cancer Plan
- **VT Dept of Health CCC** (supports and helps to guide VTAAC and Cancer Plan activities
- **Evaluation** is a key component of the Vermont CCC approach

VERMONT
DEPARTMENT OF HEALTH

VTAAC
Vermonters Taking Action Against Cancer

The 2025 Cancer Plan is Vermont's 5th cancer plan.

- The Vermont Department of Health and VTAAC worked together in 2020 and 2021 to develop the 2025 Cancer Plan.
- Partner input was collected through meetings, surveys, and other opportunities.
- Over 200 individuals participated in the process.
- The plan includes **14 goals**, **40 objectives**, and **78 strategies** to address cancer across the continuum



https://www.healthvermont.gov/wellness/reports/cancer

2025 Vermont Cancer Plan Goals

Health Equity

Ensure that all Vermonters have a fair and just opportunity to be healthy.

Cancer Prevention

FOCUS AREAS: Tobacco, Physical Activity and Nutrition, Human Papillomavirus (HPV) and Environmental Hazards

Cancer Early Detection

FOCUS AREAS: Colorectal, Cervical, Breast, Lung and Prostate Cancers.

Cancer Directed Therapy & Supportive Care

FOCUS AREAS: Cancer Directed Therapy, Integrative Medicine and Palliative Care.

Survivorship & Advanced Care Planning

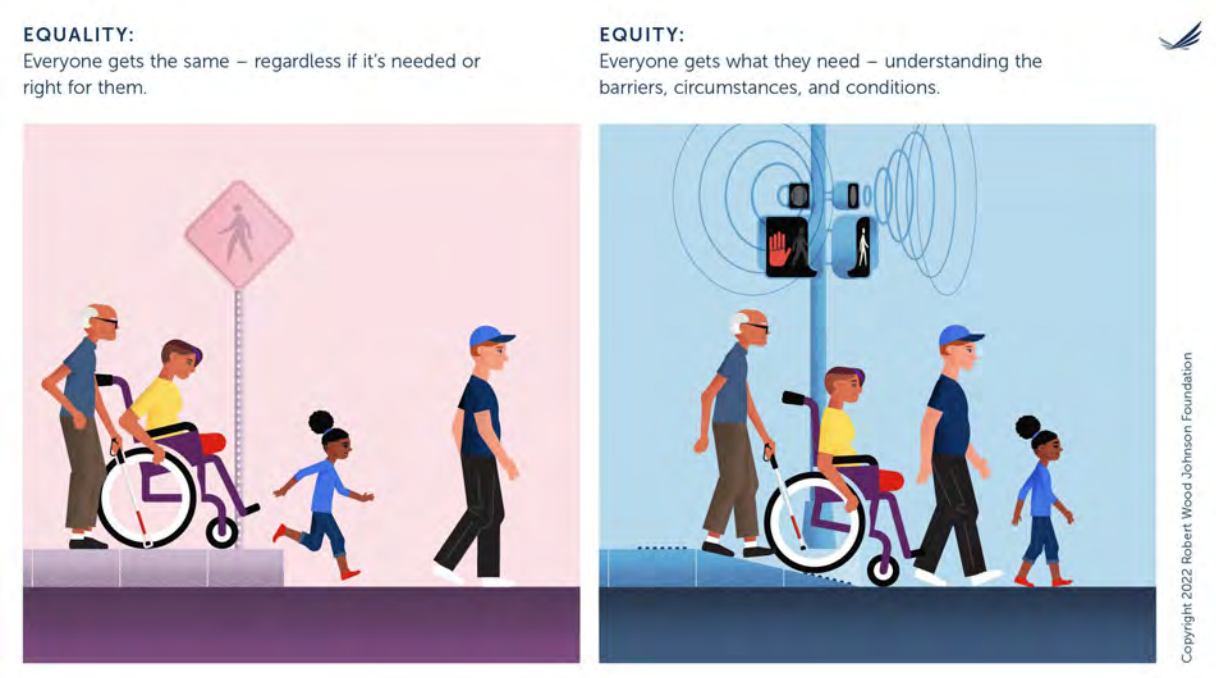
FOCUS AREAS: Optimal Physical and Emotional Health, Hospice Care and Advanced Care Planning

Goal: Health Equity

Ensure that all Vermonters have a fair and just opportunity to be healthy

Populations of Focus

- Black, Indigenous and people of color (BIPOC) Vermonters
- Lesbian, gay, bisexual, transgender and queer (LGBTQ) Vermonters
- Vermonters living with disabilities
- Low-income Vermonters



Quality of Life Goals

- Improve access to optimal cancer-directed therapy for Vermonters
- Improve access to integrative medicine and palliative care for Vermonters diagnosed with cancer
- Promote optimal health for Vermonters with cancer throughout their lives
- Improve use of hospice care and advanced care planning for Vermonters diagnosed with cancer

Vermont Cancer Plan Survivorship-Focused Goals

Goals

Objectives

Strategies

Cancer-Directed Therapy & Supportive Care

Goal 11. Improve access to optimal cancer-directed therapy for Vermonters.

Objectives	Measures BASELINE (YEAR)	TARGET (2025)
11.1 Increase % of cancer survivors who are living five years or longer after diagnosis (VCR‡).	**66%** (2009–2015)[38]	**69%**
11.2 Decrease the overall cancer death rate (Per 100,000 persons) (Vermont Vital Statistics).	**162.4** (2014–2018)[39,40]	**154.3**

Strategies

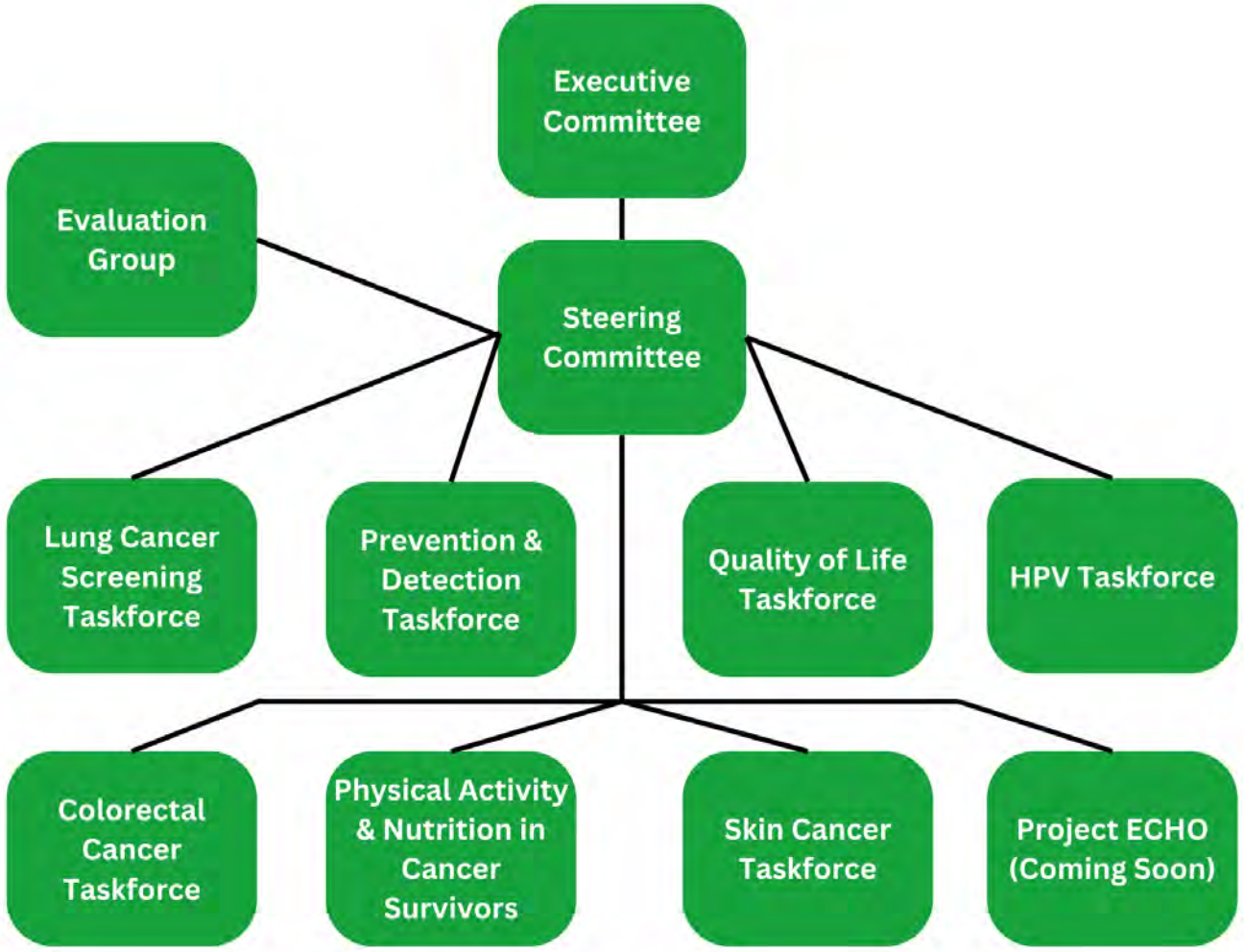
HEALTH EQUITY

- Ensure Vermonters facing health inequities (BIPOC, LGBTQ+ Vermonters, people living with disabilities and low-income Vermonters) have equitable access to quality cancer care.
- Improve outreach, coordination and implementation of new approaches to address gaps in care, including patient navigation, guest housing near cancer treatment facilities, transportation to medical appointments and rural treatment opportunities such as mobile chemotherapy units.
- Increase patient awareness and access to financial supports and counseling assistance.
- Raise awareness of clinical trials among institutions, providers, patients, families and caregivers.
- Monitor policy changes that may affect clinical trial accrual, and support efforts to educate and advocate for policies that increase accrual.

Vermonters Taking Action Against Cancer (VTAAC)

- VTAAC is responsible for putting the Vermont Cancer Plan into action by preventing overlap and directing resources to where they matter most in our state.
- Activities are focused on reaching our ultimate goal: reducing the burden of cancer in Vermont.
- VTAAC is a growing network of groups and individuals that speaks with one voice
- Visit our website at www.VTAAC.org or on Facebook at @VermontersTakingActionAgainstCancer

VTAAC Organizational Chart



How are community partners collaborating across the state to address survivorship and bridge the gap in resources?

- VTAAC quality of life activities
- VT and NH resources
- Other resources

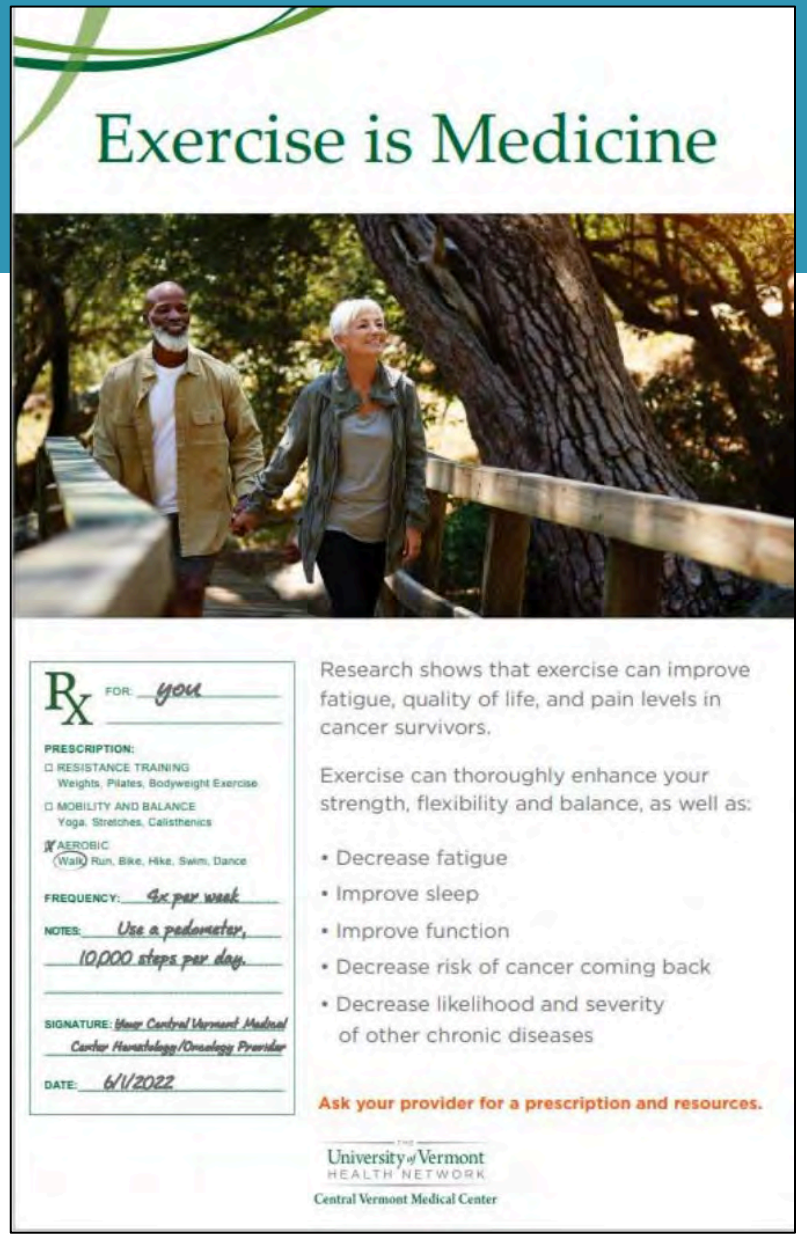
Physical Activity and Nutrition in Cancer Survivors Project

- **Chair**: Sharon Mallory, Comprehensive Cancer Control Program Director, Vermont Department of Health

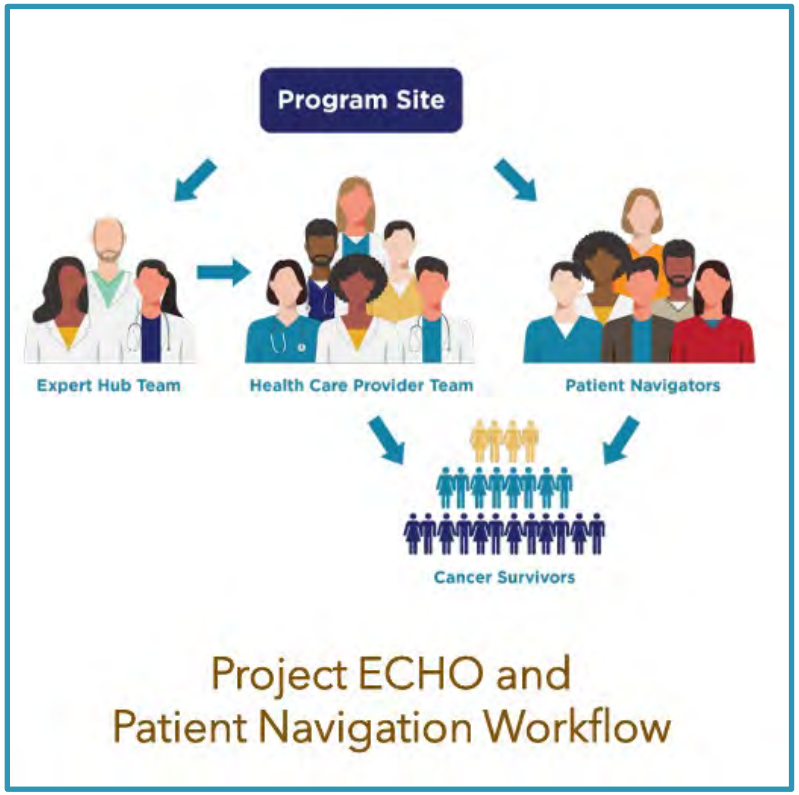
- Project to encourage provider training around physical activity and nutrition in cancer survivors and the promotion of educational tools (physical activity “prescriptions”).

- CVMC and UVM implemented this project during the beginning of COVID.

- 2024: A lot of staff turnover so the group is figuring out how best to move forward. Will support the VTAAC Project ECHO next spring.



Rural Survivorship Project ECHO & Patient Navigation



Project ECHO (Extension for Community Healthcare Outcomes)

- Goal to improve and increase medical and social support to survivors in rural areas.
- Provide education on the needs and issues faced by rural cancer survivors. Planning team is working to identify topics & speakers.
- Tentative - Four to six sessions in Spring 2025.

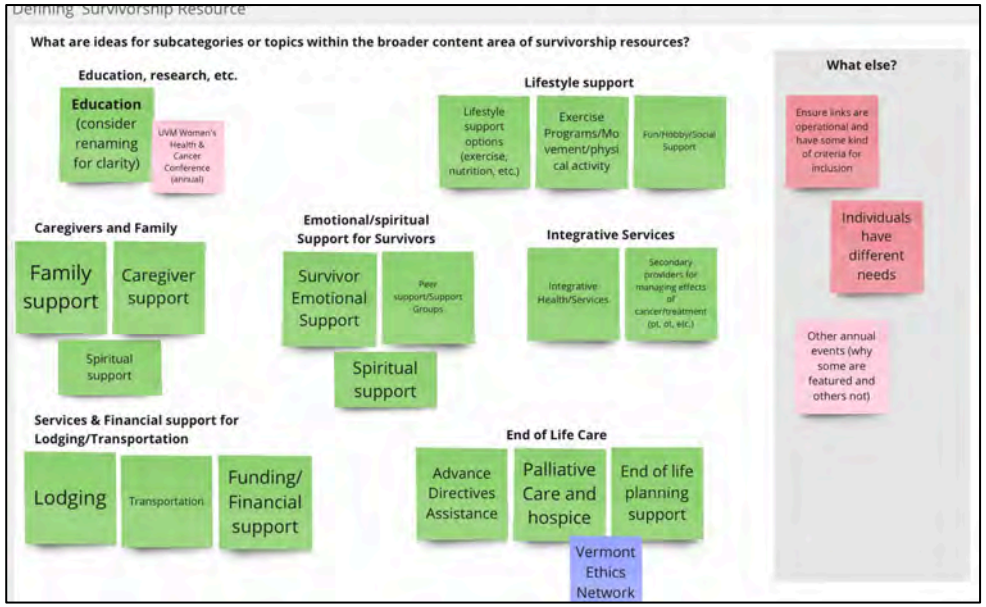
Patient Navigation

- Working with Southwestern Vermont Medical Center on replicating a RN-Driven Survivorship Program – creating a follow-up protocol with patients once they have transitioned out of treatment and are not seeing their oncology team as often.
- Support/promote survivorship patient navigators to refer cancer survivors to wellness supports and programs

Quality of Life Taskforce

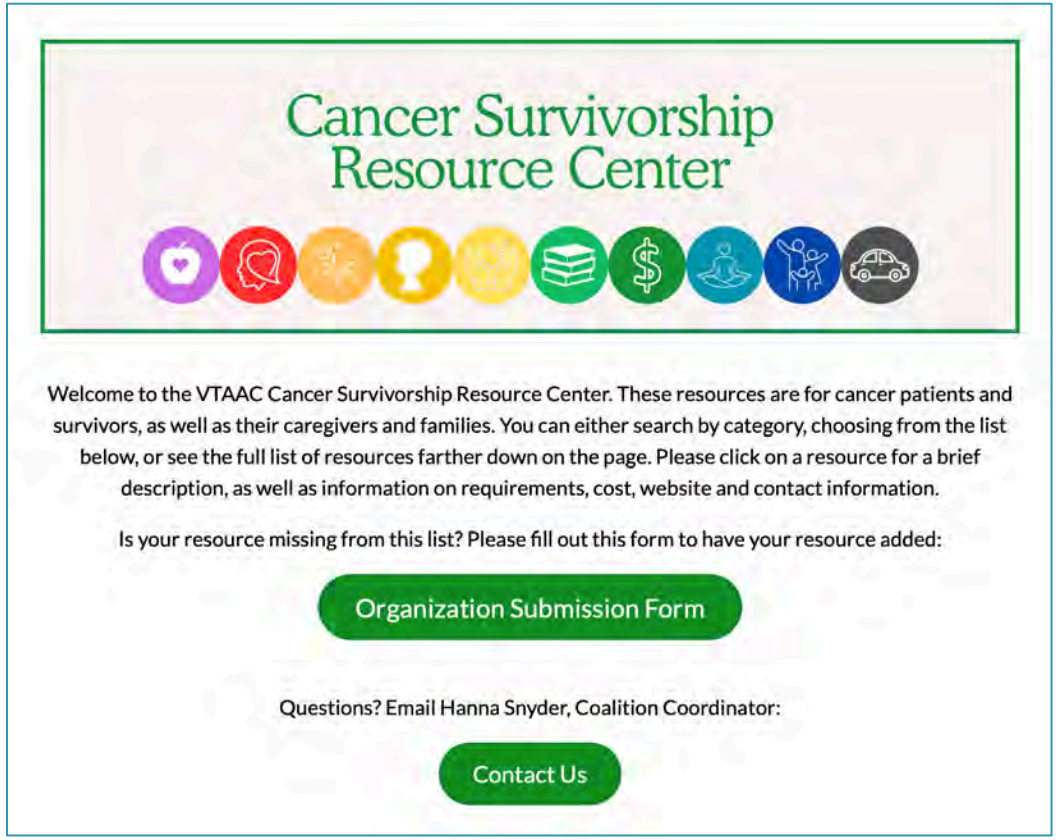
- Members make up a variety of community cancer organizations in VT, as well as providers at VT health systems.
  - A significant focus of these meetings is supporting outreach and engagement of these organizations to the broader community and to VT health systems.

- VTAAC applied for the $25,000 supplemental funding opportunity for Year 2 of the workplan to support a survivorship-focused project. The taskforce determined that some of the funds would be spent on building out a new survivorship resource page on VTAAC's website with this group's support.



Cancer Survivorship Resource Center

- The Survivorship Resource Center: www.vtaac.org/resourcecenter.
- Intended for all cancer patients, care partners, and providers.
- Resources searchable by category or alphabetically
- Organizations looking to be included must be:
  - A cancer-specific resource/organization
  - Vermont-focused (some national organizations may included if they have VT resources)
  - No events (except under limited circumstances if events are Vermont-specific, free and open to the public)
  - The VTAAC Executive Committee gives final approval for organizations included in the Resource Center.



Some Local Survivorship Community Resources

Vermont resources:

- Cancer Patient Support Foundation
- You First (Breast and Cervical Cancer Screening Program)
- 802Quits (Vermont's tobacco quit line)
- Community Health Workers of Vermont
- Osher Center for Integrative Health at UVM
- Pride Center of Vermont
- VTAAC

New Hampshire resources:

- ConnectShareCare (Dartmouth Health)
- Community Action Partnership of NH
- Family Resource Centers Family Page (NH DHHS)
- ServiceLink (NH DHHS)
- Dartmouth Cancer Center Food Pantry
- NH Cancer Partnership

This is not an exhaustive list!

Some Survivorship Resources and Community Resources

National/Other Resources:

- Comprehensive Cancer Control Program and State Cancer Plan in your jurisdiction
- American Cancer Society – Resource Database
- National Coalition for Cancer Survivorship
- Community Health Workers Association
- Local health offices
- Local libraries
- Local food shelves

This is not an exhaustive list!

What other survivorship resources are in your area? What resources are patients and care partners looking for?

Thank you!

Let’s stay in touch.

Email: hanna.snyder@med.uvm.edu

Dartmouth Health

Project ECHO

Case Presentation/ Resources and Programs

- Sarah Wallace-Brodeur, ED of Cancer Patient Support Foundation, will share her work
- Julia Boger-Hawkins- Overview of the Food Pantry at DH
- Edward Daniels - Share overview of MIH at Littleton Regional Healthcare and how it can support those who are living with/being treated for cancer.

- Our Mission: To serve Vermont cancer patients and their families in a time of extraordinary need by providing financial assistance and support during diagnosis, treatment and recovery.
- Our Vision: All can face cancer with dignity, confidence and serenity.

Cancer Patient Support
FOUNDATION

Since CPSF was formed in 2001, we have supported over 12,000 patients and their families and have awarded over $3 million to cancer patients. In 2023 we awarded $156, 513 to 514 patients.

Emergency Fund

- Provides financial assistance to Vermont cancer patients and a small number of Northern New York patients who are receiving treatment at UVM Medical Center.
- Patients are referred to the Emergency Fund through a portal on our website by their medical social worker or health provider.
- Helps to pay for patient's basic needs such as transportation, housing, fuel, utilities, groceries, prescriptions, out of pocket medical expenses, specialty clothing, wigs, integrative health, childcare while at treatment and caregiver care.
- In our most recent patient survey, 91% felt the fund reduced their level of stress and 86% felt their quality of life improved.

Maggie Card

- Provides discounts for cancer patients and their families at participating businesses.
- Discounts are on health and wellness, clothing and jewelry, transportation, food and lodging, arts and fun, home and finance, beauty, and pets.
- 75 participating Vermont businesses.
- There are over 500 Maggie Card holders.

Healing Harvest (formerly the DCC Food Pantry)

- Started in 2021 by Catherine Reed, MSW
- Addressing financial toxicity patients experience over the course of treatment
- We provide free grocery delivery to cancer patients and their households any time they visit DHMC
- Work with community partners to provide a balance of fresh, shelf-stable, medically recommended, and culturally preferred foods
- Program is rapidly expanding; rebrand, new space, onboarding more providers and patients
- Many volunteers are survivors and/or supporters of cancer research through the Prouty!
- Ultimate goal is to serve cancer patients across all DH locations

Dartmouth Health

Project ECHO

What is Mobile Integrated Healthcare, and how can it help?

(AKA: MIH, Community Paramedicine, EMS home care)

- Intention
  - Utilize local EMS agencies to perform home visits to support chronic care management of residents in their region.
- Goals
  - Reduce unnecessary 911 activations, ED visits, hospital readmission.
  - Improve overall system inpatient/outpatient care and coordination (resource mapping).
- Challenges/Limitations
  - Referral's (EMS primarily is activated via 911)
  - Oversight; Pt must have a PCP for follow-up reporting
  - EMS provider scope of practice (EMT vs. Paramedic)
  - Sustainability / Funding (EMS can only bill for transport)

MOBILE INTEGRATED HEALTHCARE - REFERRAL

Referring Entity: _____

Name of person referring: _____

Contact information (phone/email): _____

Patient Information

Name: _____

Street Address: _____

City: _____ State: **NH** Zip Code: _____

Date of Birth: _____

Phone Number: _____

PCP Name: _____

Time/timeframe the MIH visit is requested: _____

REASON FOR REFERREL:

☐Home Safety Concern

☐Medication Compliance

☐Telehealth appointment assist

☐Specimen/Lab Collection

☐Point of Care Acquisition (12 Lead ECG, BGL, other)

☐Other _____

SERVICES REQUESTED:

☐Patient Physical Assessment ☐Patient Needs Assessment

☐Home Safety Assessment ☐A.D.L (Activities of daily life) Assessment

☐Medication inventory, reconciliation, and compliance ☐Wound Check/Care; Suture Removal

☐Vital Signs ☐Weight ☐BGL ☐12 lead ECG

☐Lab Collection BMP CBC COAGS Other: _____

☐Other Specimen Collection _____

☐Other _____