



Team-Based Survivorship & Personalized Follow-Up Care

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Case

57-year-old female presents to my clinic with a new diagnosis of colorectal cancer after presenting to her primary care physician for a routine wellness visit and found to be anemic.

Past medical history: Type 2 diabetes, hypertension, obesity

Family history: sister with colon cancer at age 47

Social: married, 2 children, works in a school, no smoking, daily glass of wine (1-2)

Treatment plan:

Chemotherapy with FOLFOX bevacizumab hoping for conversion to surgery



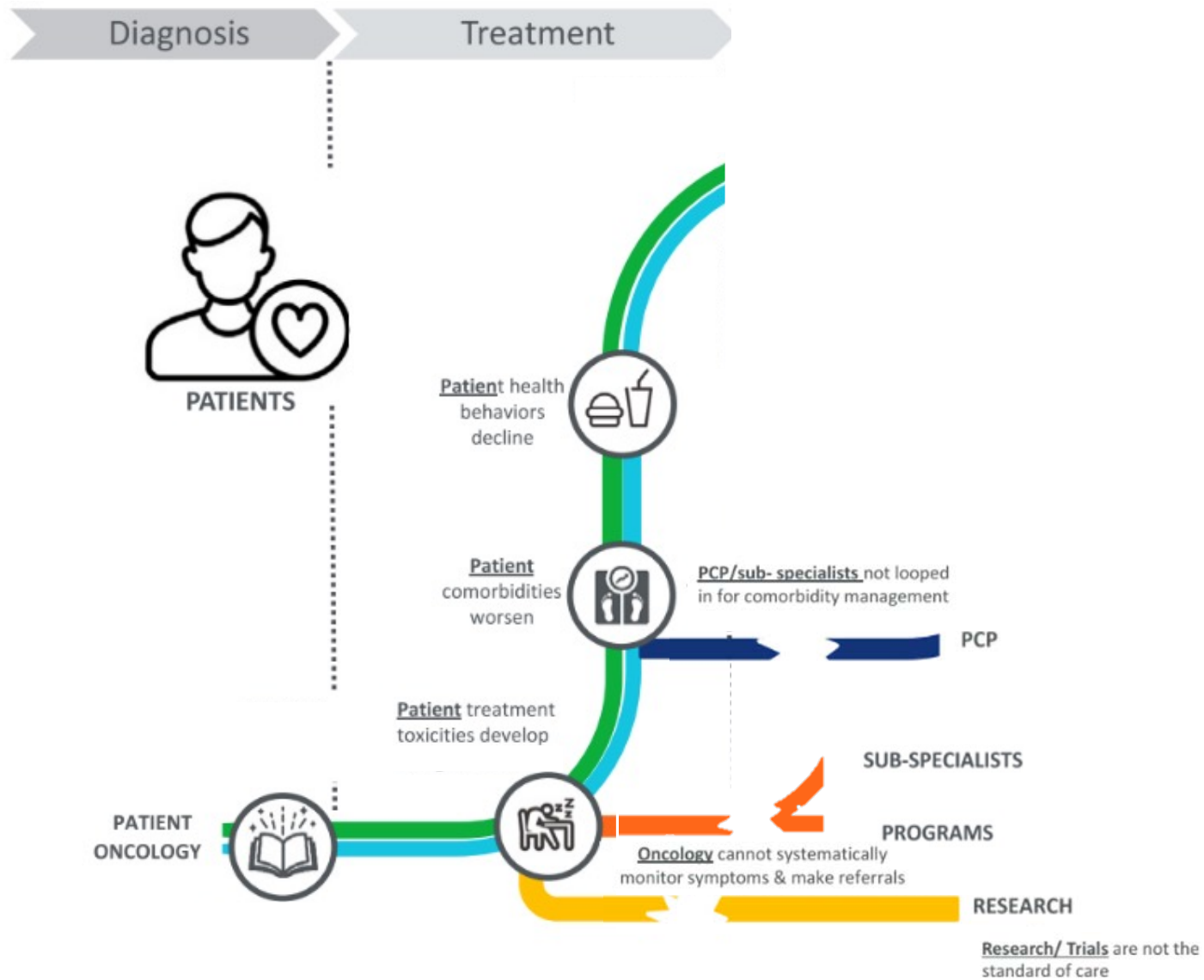
Diagnosis

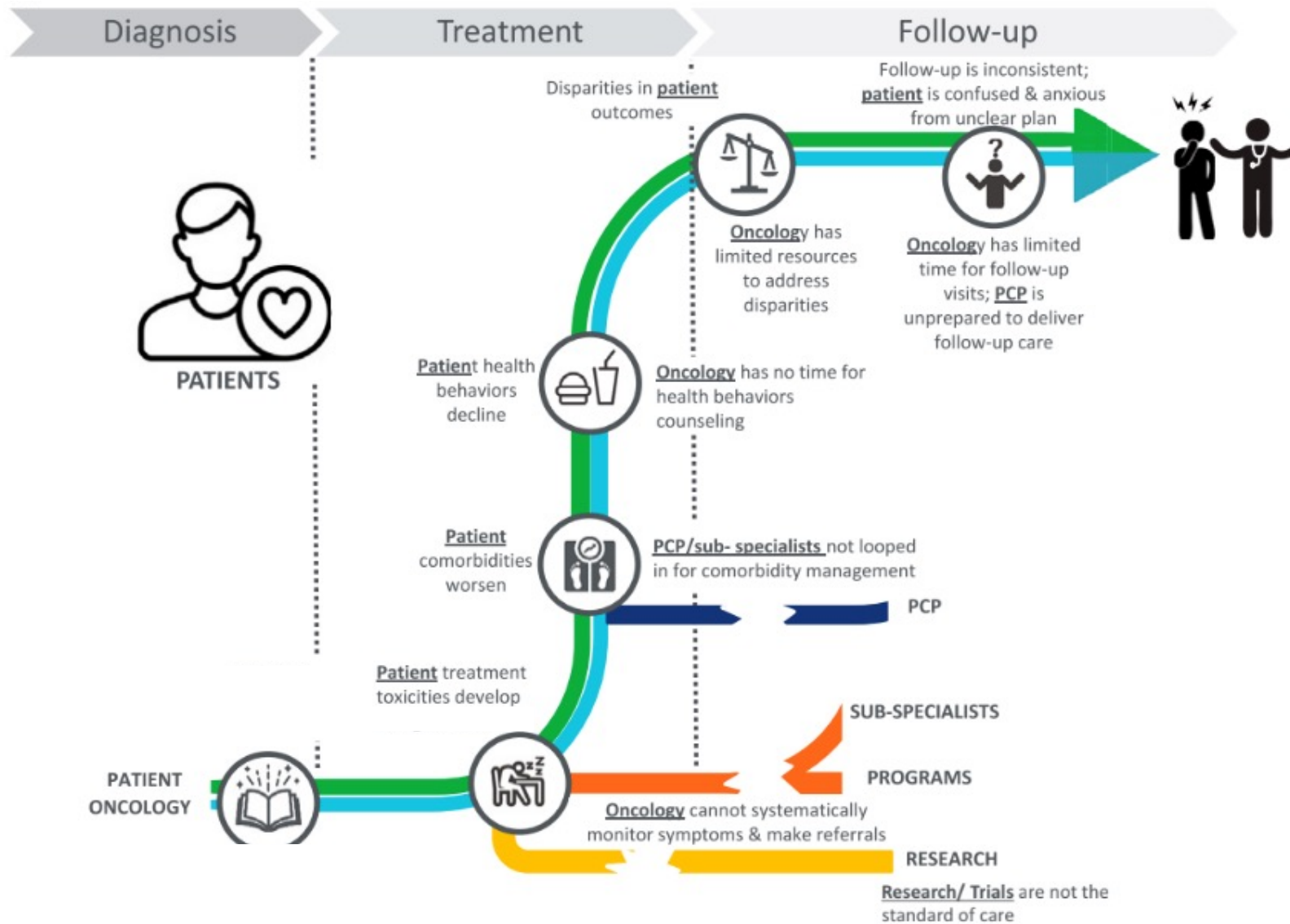


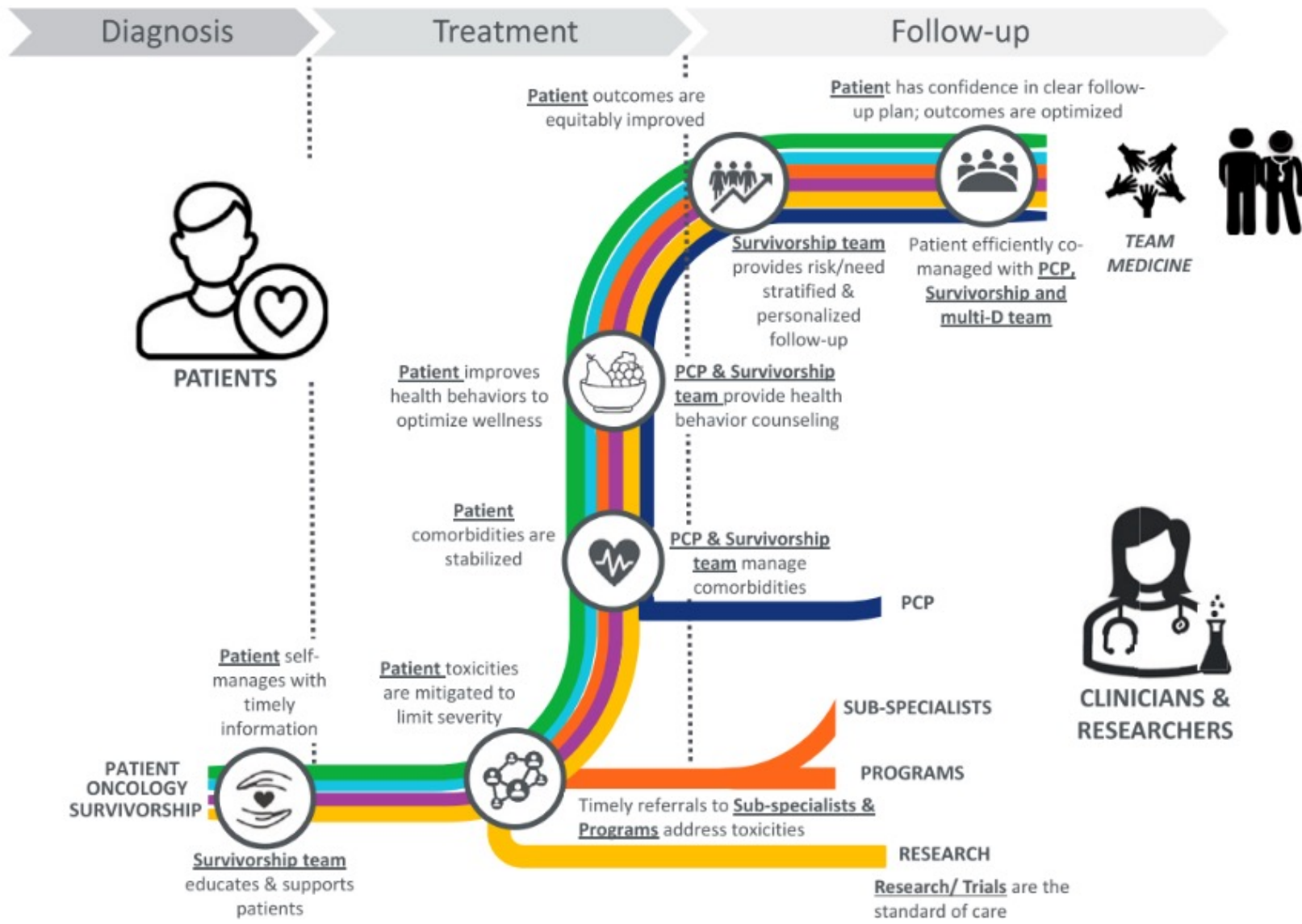
PATIENTS

PATIENT
ONCOLOGY

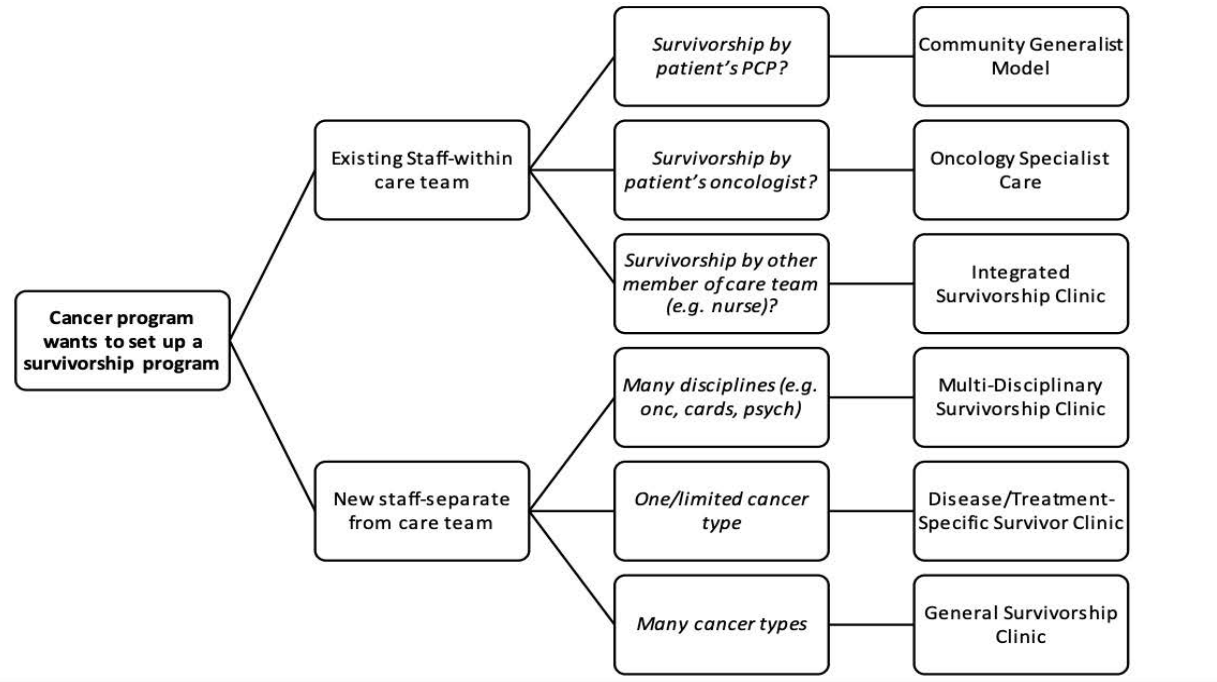








Models of care in survivorship



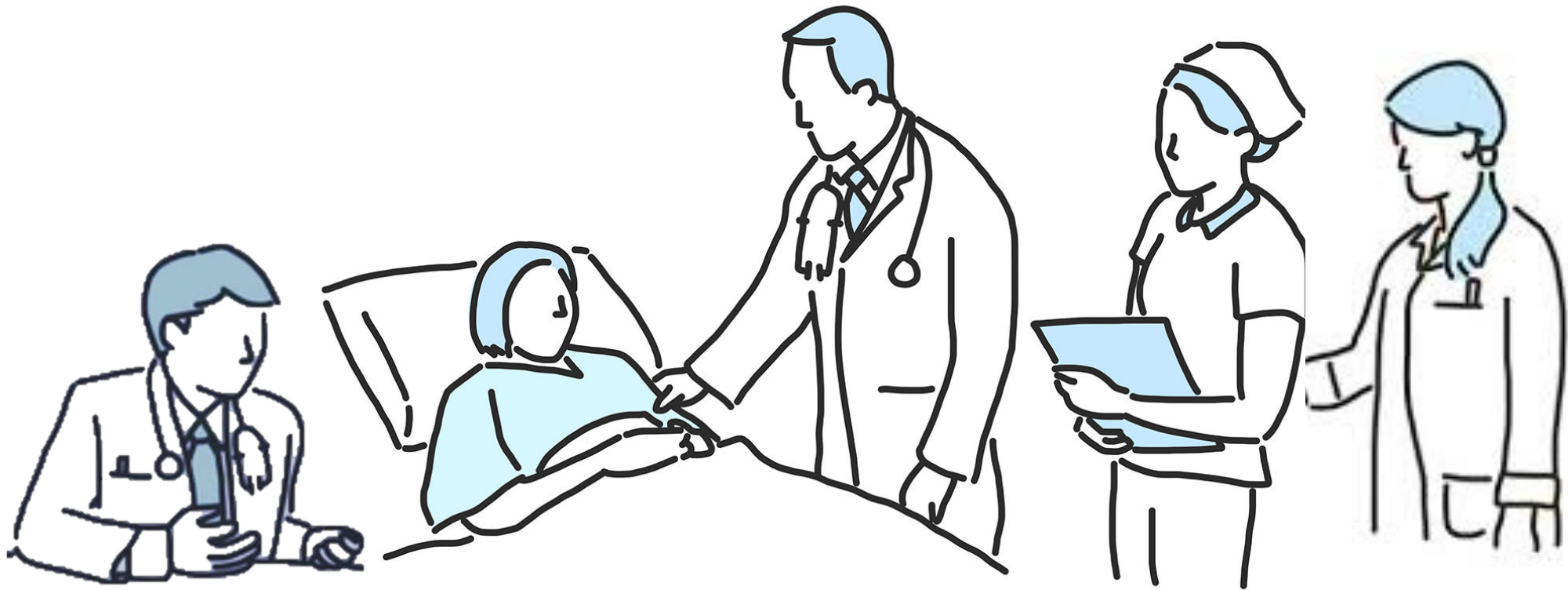
Each model (except the Generalist) can be designed to be either:

1. Consultative- a "one and done" visit
2. Ongoing care
 - With transition of care- at a predetermined timepoint, patients are transitions to primary care alone
 - Without transition of care- there is no predetermined timepoint where patients transition to primary care alone

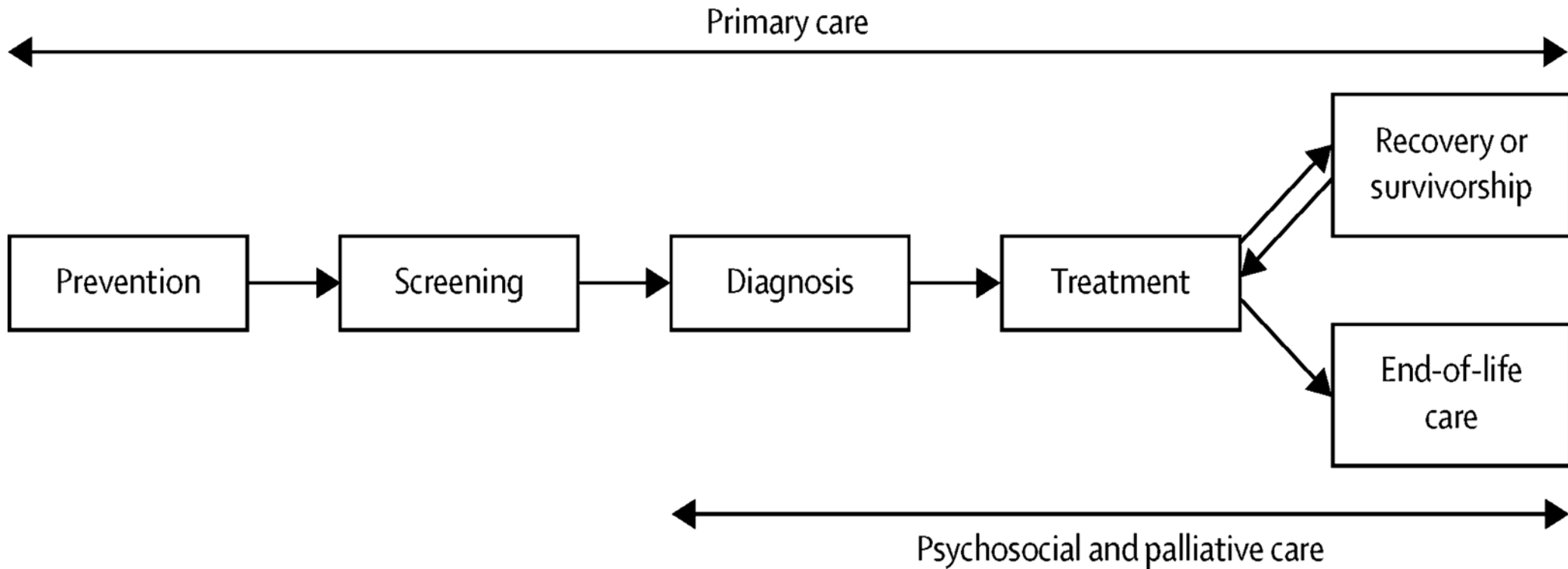
Different models may be best based on malignancy type, stage, treatments received, comorbidity/complexity, resources available

It is clear why team-based care is essential...

Now we need to figure out how?

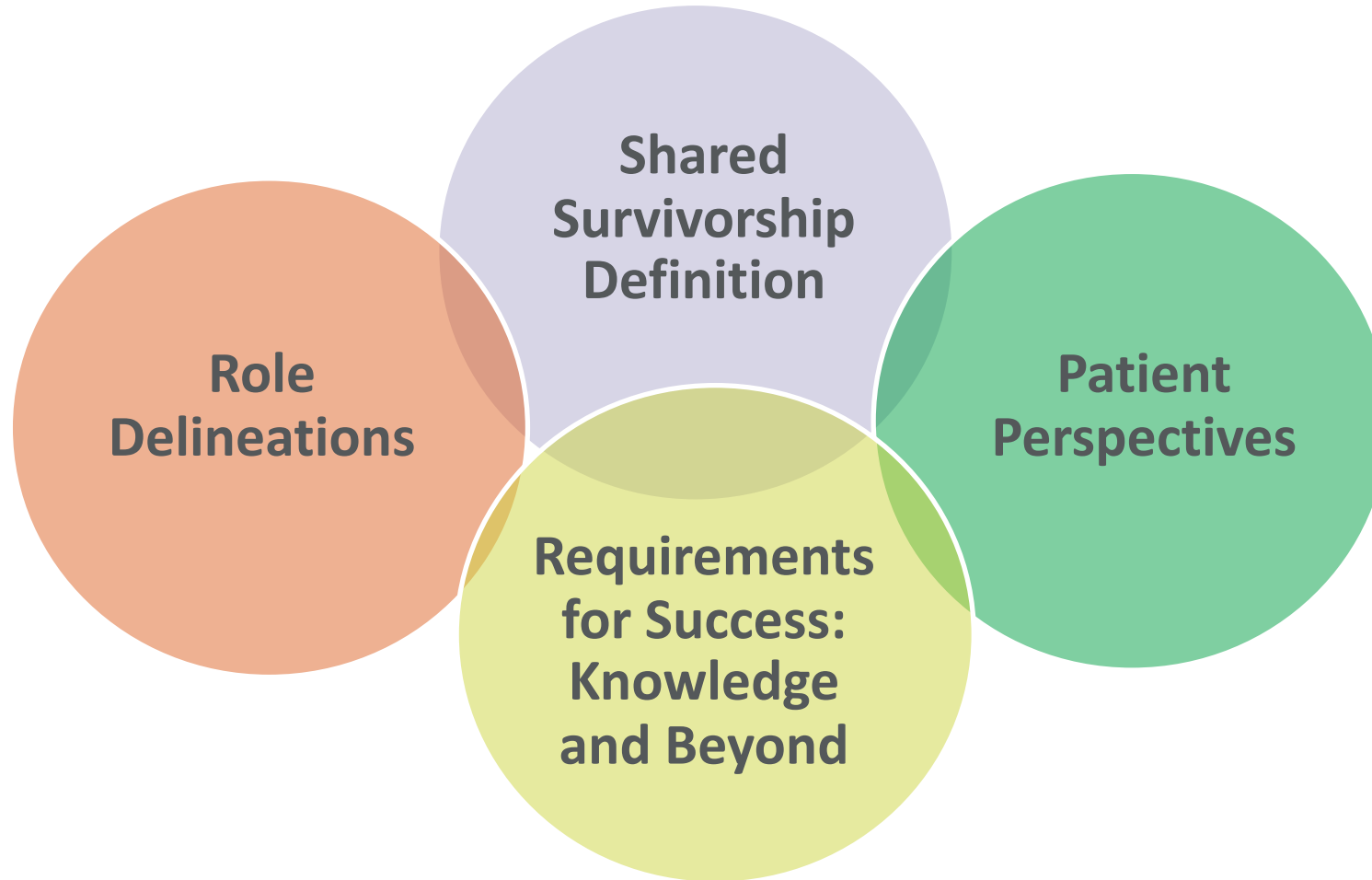


Examining the Role of Primary Care Clinicians



Considerations

Survivorship Care Plans are Necessary but Not Sufficient



Crabtree BF, et al. (2015). Cancer Survivorship Roles for Primary Care Physicians. *Annals of Family Medicine*.

Smith TG, et al. (2019). Understanding Long-Term Cancer Survivors' Preferences for Ongoing Medical Care. *JGIM*.

Rubinstein EB, et al. (2017). Cancer Survivorship Care in Advanced Primary Care Practices, *JAMA Int Med*.