

Breast cancer survivor satisfaction with NP-delivered follow-up care

By Cathy Friedlander Cole, NP, MPH, CHES, CBPN-IC

Many hospitals offer survivorship programs for women who have completed their course of treatment for breast cancer. Nurse practitioners are often members of the healthcare team that provides this survivorship care.

The author reports the results of her survey ascertaining whether breast cancer survivors are satisfied with follow-up care delivered by NPs.



Fueled by healthcare reform and a consumer-driven environment, patient satisfaction with healthcare delivery is motivating quality ratings and value-based reimbursement for hospitals, physicians, and other healthcare practitioners (HCPs). As a result, patient satisfaction has become a routine measure of quality at many hospitals and other healthcare facilities. Almost all hospitals administer some type of patient satisfaction survey because of the direct correlation between quality of care and patient satisfaction. Some hospitals even offer recognition and reward programs for improved patient satisfaction scores.¹

With this paradigm shift in mind, the author, a breast health nurse practitioner, sought the cooperation of physician faculty at the City of Hope National Medical Center Women's Center in Duarte, California, as well as approval from the Institutional Review Board (IRB). In this setting, the surgical oncology team developed a patient-centric satisfaction survey to address problems and concerns of long-term breast cancer survivors who received care at the center. Because of previously reported patient dissatisfaction engendered by long waiting room times, these survivors—all of whom were ≥ 2 years post-surgery, with no evidence of disease recurrence or

new primary disease—were asked about their willingness to transition to an NP for follow-up care focused on survivor problems and concerns.

Survivorship has become an important phase of cancer care and the topic of much research. Survivorship focuses on physical, psychosocial, and economic concerns, from diagnosis through treatment until the end of life. Although several models for survivorship care are prominent within the cancer literature, few empiric data clearly define the best approach for caring for survivors, particularly in terms of which services should be provided and how the oncology team should best care for this population.² Other survivorship issues include patients' ability to get satisfactory healthcare and follow-up treatment, evaluation of potential late effects of treatment, detection of second cancers, and quality of life.^{3,4}

Literature review

Many breast cancer survivors experience anxiety at the end of treatment, when they suddenly lose a continuous connection to the breast center staff. In addition, survivors may experience dissatisfaction when routine communication with staff members is discontinued. At a 2008 conference sponsored by the Living Beyond Breast Cancer[®] organization, Julia Rowland, MD, spoke of the transition from active treatment to survivorship:

“...as clinicians, we do a good job of supporting patients and families across the treatment continuum, but then, the end of treatment

comes and then what? Patient anxiety begins with ‘What if the cancer comes back now that I am not receiving treatment? And what about re-entry into social life of friends, family, and work? Who is my safety net now?’⁴

Many cancer centers are starting to meet this need through development of survivorship programs. For example, at Memorial Sloan-Kettering Cancer Center (MSKCC) in New York

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City, the survivorship clinic is considered integrated care—part of a multidisciplinary approach among all breast cancer specialists. Recognizing the many HCPs who provide services to patients after the active treatment phase, MSKCC developed a program utilizing NPs to assist female survivors in the transition to long-term care.⁵ This program provides long-term follow-up clinic visits that permit a return to routine health maintenance with the same team of HCPs, as well as opportunity for assessment of potential sequelae of treatment.⁶ In a clinical commentary, McCarthy⁷ noted that

long-term survivorship clinics should include a coordinated effort between clinicians, with goals of detecting loco-regional recurrence, screening for new primary breast cancer, monitoring and managing long-term complications of treatment, and ensuring compliance with current therapy.

When focusing on patient satisfaction within an ambulatory clinic setting, most patients have been pleased with the attention to detail that NPs provide.⁸⁻¹⁵ In a study from the University of Glasgow, Renton et al⁸ reported that 64% of patients were satisfied with an NP-led clinic, and that the frequency of follow-up appointments met their expectations. In a Scandinavian study, Koinberg et al⁹ found that patients readily accepted the professional skills and knowledge of an NP, and patients felt secure and confident in the survivorship care they received from the NP. Discussions, which the patients found helpful, focused on recurrence status and survivorship-related questions.

Similar U.S. studies have shown that NPs can provide the information and emotional support sought by breast cancer survivors.¹⁰⁻¹⁴ In addition, these studies have shown that survivors experience increased satisfaction while under the care of an NP, and that physicians express a high level of satisfaction in having NPs as members of the practice team. A small survey showed that NPs were superior to physicians in terms of listening, providing feedback, explaining things in a way that could be understood, and spending enough time with patients.⁸

The study

Members of the surgical oncology team at the City of Hope National Medical Center Women's Center, a National Cancer Institute-designated comprehensive cancer center near Los Angeles, wished to determine patient satisfaction with clinic services, the quality of care that patients received, and the level of patients' acceptance of NP-led follow-up care. In addition, the team wished to connect survey data to diagnosis data to determine the efficacy and efficiency of the clinic in terms of monitoring for and detecting recurrences and incidences of new disease. The team hoped to link their findings with those of other multidisciplinary centers to enlarge the study of patient satisfaction.

Method — Methodology was qualitative in nature and based on original survey content. After the breast leadership team of the ambulatory clinic reviewed and approved the content of the survey questions, the IRB made final comments and edits before it was sent to patients in an anonymous mailing.

Search strategy. Multiple database sources were searched in Medline, including PubMed and research published by others in ASCO[®], Oncology Nursing Society[®], www.Cancer.Net/Survivorship, and the National Consortium of Breast Centers[®], to identify other cancer centers' utilization of NPs for outpatient care and how patients perceived this care.

Study population. Once patients were stable, with no complications from initial care, they were invited to receive long-term follow-up care at the survivorship clinic. Patients invited

Table 1. Participants' original surgery status

Procedure	N	%
Mastectomy with SLNB/AxLN and/or reconstruction	12	30
Lumpectomy with SLNB/AxLN	20	51
Re-do segmentectomy with/without nodes	4	10
Past recurrence	3	7

AxLN, axillary lymph node; SLNB, sentinel lymph node biopsy.

to participate in the survey were chosen based on the date of the initial diagnosis and their progress through treatment. Each patient was assigned a study number (kept anonymous) and received the survey with a consent form by mail. Patients meeting inclusion criteria who returned completed surveys with a signed consent form to the oncology department were enrolled. The NP researcher was not involved in any of the mailings. All survey data and consent forms were kept in a locked file within the surgical oncology department. Patients who had scheduled appointments at the clinic were approached about the survey and given the forms to complete in person during their clinic visit. All patients were contacted and invited to participate a second time. Patients' surgical histories varied widely (*Table 1*).

A total of 75 surveys were mailed initially to women meeting inclusion criteria. Of 75 potential participants, 39 (52%) returned completed surveys with an IRB-approved consent form. Three patients (7.6%) went on to experience newly identified abnormalities that led to diagnoses of (1) invasive ductal carcinoma (n = 1); (2) stage I

colon cancer (n = 1); (3) ductal carcinoma in situ in the contralateral breast (n = 1); or (4) myelodysplastic disorder (n = 1) (one patient had more than one new diagnosis). All patients diagnosed with recurrences or newly identified metastases were referred to surgical oncology/hematology for evaluation and treatment.

Results — After following patients for 1 year at the survivorship clinic, details about clinic experiences began to emerge. Results were compiled by an administrative assistant (*Table 2*). Most patients were very satisfied with the clinic visit and were willing to continue receiving care from the NP on subsequent visits. *Table 3* lists anecdotal patient responses regarding their satisfaction with clinic visits.

The physical assessment consisted of an evaluation of vital signs and current medications and a physical examination by the NP. The routine physical exam included a thyroid exam; an evaluation of supraclavicular and infraclavicular lymph node status; a clinical breast exam; and assessment of heart, lungs, abdominal, and extremity status. Appropriate recommendations

Table 2. Survey questions and results

Survey questions	Yes	No	Percentage yes/no
Was this your first visit with an NP?	30	9	76.9/23.1
Did you have any health concerns this visit? If so, please indicate what was discussed.	22	17	56.4/43.6
Did the NP need to consult with a doctor during your visit?	6	33	15.4/84.6
Did the NP order any tests during this visit?	25	12	64.1/35.9
Were you called back by the NP with results?	25	12	64.1/35.9
Were all of your questions answered during this visit and were you satisfied with the answers you received?	39	0	100/0
Would you recommend a visit with an NP to others?	39	0	100/0
Do you feel the necessity of returning to the physician-led clinic after seeing the NP?	0	39	0/100

Table 3. Anecdotal patient responses to satisfaction with clinic visits

“The NP is a good listener and answers all of my questions.”

“The NP is caring and concerned about my health.”

“I couldn’t ask for better care.”

“My visit was helpful, courteous, and smooth.”

“I appreciate your professional attention.”

“Wonderful and very helpful.”

“I look forward to my visits.”

“The visit feels like meeting a good friend.”

for screening tests such as mammography, colonoscopy, and bone density measurement were provided, and referrals to specialists were made as needed.

Any findings outside the scope of NP practice were discussed with a breast surgeon and/or medical oncologist colleague. If necessary, patients could be seen that day or re-

ferred to the surgeon or oncologist for new or more complex health problems. Abnormal test results were discussed by the NP with the patient, and appropriate follow-up testing or consultations were initiated. On occasion, it was necessary to review findings with the original oncologic surgeon, who would advise on the case. The NP then

continued to provide follow-up care on her own. Of note, no patient indicated on the survey that she wished to return to the surgeon after the initial visit with the NP. Knowing that the team would still be in place to address any further treatment gave patients confidence to continue in the transition of care. Building a trusting relationship between NP and patient engendered a favorable experience at follow-up healthcare visits.

Time and efficiency studies were reviewed retrospectively (Table 4). The NP-led long-term follow-up breast care clinic, compared with the physician-led clinic, was associated with shorter patient wait times and a more efficient communication of results.

Discussion — The sample size of this pilot study was small; conclusions could not be drawn from this cohort alone. The author recommends that other studies of similar nature be undertaken and evolve as breast cancer patients’ needs expand. Pooling of data from other centers would add strength to the results and perhaps result in improved follow-up care. Further studies should assess cost-benefit ratios to determine the cost efficacy of the NP-led clinics.

Implications for practice

In busy surgical oncology centers, re-conceptualizing the NP role in caring for breast cancer survivors is important, especially in the current era of health-care reform. The foundation of NP education, which includes physical assessment skills and knowledge about pathophysiology, pharmacology, and health promotion, makes transition to

an NP-focused survivor clinic a reasonable approach.

In this study, breast cancer survivors were very satisfied with care provided at an NP-led clinic, and they found it both expedient and convenient. These returning disease-free patients were seen more quickly than in the surgical service. For busy women who have little extra time in their schedules, this service represents quality improvement. In addition, survivors who spend less time in the waiting room have more time to discuss follow-up concerns such as sexuality, return to hormone therapy, side effects of treatment, and depression.

The American Society of Clinical Oncology established new guidelines in 2006 for the management of breast cancer patients.¹⁵ These guidelines include careful history taking, physical examination, and routine breast imaging, all of which can be managed by an NP with breast health education and knowledge. These findings underscore the need for a universally accepted definition of cancer survivorship, and support a model for delivering care to survivors that is a blend of the disease-specific and comprehensive survivorship programs. Within the healthcare arena, feedback and customer satisfaction information should be used to improve the healthcare processes and protocols within practices and organizations by becoming more patient-centric, resulting in an improvement to the reputation and profitability of the healthcare organization itself.¹⁶

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Table 4. Average clinic wait times

Week	NP clinic	MD clinic
1	10 minutes	40 minutes
2	10 minutes	45 minutes
3	12 minutes	85 minutes
4	6 minutes	25 minutes

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