

Patients with Cancer, Comorbidities, and No Primary Care Provider





Embedding a PCP in oncology helps one program soar to new heights

Not too long ago, the Helen F. Graham Cancer Center and Research Institute of ChristianaCare shared the success of its Supportive Care of Oncology Patients (SCOOP) program at the 2018 ASCO Quality Care Symposium and with *Oncology Issues*.^{1,2} The SCOOP program implemented a clinical care pathway based on the working hypothesis that, for select patients with advanced disease, integration of supportive care management along with nurse navigator access to electronic aids for care coordination could result in both cost savings and an enhanced patient experience. A cross-disciplinary team, including leaders from Organizational Excellence, Medical Oncology, Radiation Oncology, Inpatient Oncology Nursing, Supportive and Palliative Care, IT, and Psychosocial Oncology, designed the SCOOP pathway. Patients with potentially curable thoracic, colorectal, or head and neck cancers diagnosed in the cancer center's multidisciplinary clinics were eligible to participate in the SCOOP pathway, which was implemented in November 2016.

During the program's first year, 59 patients enrolled in the clinical pathway. Of these, 32 percent had emergency department visits, compared with 54 percent of patients in the control group (non-SCOOP patients). Hospital admissions were 25 percent for the SCOOP cohort vs. 34 percent for the control group; 20 percent of SCOOP patients experienced readmission vs. 32 percent of non-SCOOP patients. Over a three-year period (2016-2019), the

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SCOOP program enrolled 143 patients and realized a total cost savings of \$220,850.

"As the program matured, it became obvious that by doing this multi-factorial set of interventions, we were actually able to diminish ED [emergency department] visits and [hospital] admissions substantially," said Christopher Koprowski, MD, MBA, associate cancer community of practice leader at the Helen F. Graham Cancer Center and Research Institute. "We were able to administer [enhanced] care to patients without increasing costs and give them a better experience."



Debra Delaney, MSN, FNP-BC

Addressing the Lack of a Primary Care Provider

Building on the success of the SCOOP pathway, cancer service line leadership zeroed in on another challenge ripe for interdisciplinary, cross-department collaboration: care coordination for patients with cancer, comorbidities, and no primary care provider (PCP).

The problem is described by Sarfati and colleagues in the article, “The Impact of Comorbidity on Cancer and Its Treatment.”

The presence of comorbidity poses substantial challenges for traditional models of care. Because of the complexity of health needs that must be addressed, a greater diversity of expertise is required for optimal management. Delivery of care to patient [sic] with multiple problems requires significant care coordination within the cancer setting as well as within the broader health care context, including community care.³

The challenge becomes even more complex when patients in active treatment for cancer have no established primary care provider with whom the oncology care team can coordinate the management of pre-existing comorbid conditions.

Despite advances in information technology, electronic health records, multiple virtual platforms for collaboration, and the development of quality metrics and measures, in the fragmented U.S. healthcare system, achieving seamless care coordination can appear to be a Sisyphean task. Beyond care coordination and communication among and between oncology specialists from different disciplines, there is communicating and connecting across settings of care—inpatient, outpatient, and freestanding programs—and more. Ideally, patients with cancer and existing comorbidities connect the cancer care team to their primary care provider so that these physicians can communicate regarding management of the patient’s comorbidities and be prepared to take over the patient’s care once the treatment for cancer has ended. But what happens to care coordination when patients in active treatment for cancer have no PCP? Or when patients whose high blood pressure, hyperlipidemia, chronic obstructive pulmo-

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nary disease, or diabetes need to be managed while they are receiving anti-cancer therapy?

In 2019, results from a brief general survey revealed that about 15 percent of gynecologic oncology patients coming to the cancer center lacked a PCP. In follow-up conversations with the cancer program’s medical and surgical oncologists, service line leadership found that these providers believe that the percentage of those without PCPs among their patient populations was probably even higher.

The Helen F. Graham Cancer Center currently cares for more than 70 percent of all patients with cancer in Delaware, and cancer is a disease most often seen in the elderly, a patient population more likely to have one or more of the most common co-occurring conditions—hyperlipidemia, hypertension, and/or diabetes.

Nicholas Petrelli, MD, medical director of the Helen F. Graham Cancer Center and Research Institution, had a solution in mind. Why not embed a PCP on-site at the cancer center? Just as the cancer center’s Oncology Express Unit streamlines access to emergent care for patients with cancer, a PCP embedded in the cancer center could provide patients in active treatment who lacked a PCP with the care needed to manage their comorbidities and maintain ongoing communication with the multidisciplinary oncology team. Even if a patient had a PCP, this position within the cancer center would enhance provider-to-provider communication during the patient’s treatment for cancer.

In late spring 2019, Dr. Petrelli discussed the concept with Lisa Maxwell, MD, MHCDS, chief clinical transformation officer at ChristianaCare. Dr. Maxwell was enthusiastic about the concept and even recognized future potential for a primary care/oncology fellowship, if the initiative was successful. Dr. Petrelli and Dr. Cydney Teal, service line leader of Primary Care and Community Medicine and chair of the Department of Family and Community Medicine at ChristianaCare, met to discuss the primary care in oncology concept. In the meantime, Dr. Koprowski proposed that the initiative’s pilot could be launched using a seasoned primary care advanced practice provider (APP) in a half-time capacity, rather than a full-time PCP position. Overall, the clinical leadership group met more than a dozen times to flesh out the program and develop the position description for the APP who would initiate the pilot. Dr. Teal helped recruit a highly experienced primary care APP for the position and suggested that, when appropriate, virtual primary care could be an option as well.

Serendipitously, Debra Delaney, MSN, FNP, had recently spoken with Dr. Teal about her interest in returning to primary care practice. Ms. Delaney became an APP in 2009, joining the trauma service at ChristianaCare. “Similar to the oncology patients we were encountering, a lot of trauma patients did not seem to have a primary care provider,” she said, “which is how I got started in primary care.” She moved from the trauma service to a ChristianaCare primary care practice and then to a ChristianaCare Urgent Care. Here, too, she saw patients without PCPs who relied on urgent care centers for many of their health issues. “So primary care has been a part of every position that I’ve held as an advanced practitioner,” she said.

Ms. Delaney was confident in her skills as an advanced primary care and trauma practitioner but understood that this new position in the cancer center would offer her exceptional learning opportunities.

In late January 2021, she inaugurated the new primary care position in the cancer center. The full time equivalent position is split 50-50 between the cancer center and ChristianaCare’s Virtual Primary Care Department. In this role, she reports to Cindy Waddington, MSN, RN, AOCN, NE-BC, clinical director of the Helen F. Graham Cancer Center; Weston Riesselman, MHA, program manager, Center for Virtual Health Operations; and Cydney Teal, MD (her collaborative physician). The primary care APP is on-site at the cancer center, Monday through Wednesdays and Fridays from 8:00 AM to 12 PM. On Thursdays, the primary care APP is scheduled at the cancer center from 11:00 AM to 3:00 PM.

How Patients Access the PCP

When oncology physicians have a patient with comorbidities in treatment who has no PCP, they refer the patient to Debra Delaney. In the six months since the pilot’s start, she has had more than 70 patient referrals. The number of patients in the practice fluctuates as cancer treatment is completed or, in some cases, as end of life occurs. To date the most common comorbidities seen have been hypertension, hyperlipidemia, and diabetes. Ms. Delaney works with these individuals to keep their comorbidities under control while they are in active treatment for cancer.

Communication is at the heart of this new role, Delaney notes. Because she is embedded in the cancer center, she has quick access to oncology providers should questions arise. As all of the providers are on the same electronic health record, she can also connect rapidly with specialists if she needs to discuss a specific issue, such as blood sugar control in a patient with diabetes. To further her integration with the cancer care team, when possible, she attends the cancer center’s disease-specific multidisciplinary conferences. This not only expands her knowledge of oncology but also provides another opportunity for her to connect with physicians who may have a patient who could benefit from a referral to her.

As she pilots this new role, Ms. Delaney is finding that she is another care touchpoint for patients. She can listen to their concerns and challenges as they go through treatment and help connect them to any support or resources needed to keep them




Delaney visits with a patient.



Primary care provider leadership at the Helen F. Graham Cancer Center and Research Institute.

engaged with the care process. Patients have expressed their appreciation for this added support and attention to their co-existing health concerns as they move through cancer treatment.

When patients complete active treatment, if they would like to continue to receive primary care at ChristianaCare, Delaney connects them with a PCP. She also has resources in the community to which she can refer patients.

For patients with comorbidities who are in active treatment for cancer and who report having no primary care, having an embedded PCP where they receive their cancer therapy is a patient-centered model that brings across-the-board benefits. Although the pilot intervention is in its early phase, this cross-departmental collaboration is viewed as a win-win-win by patients, the oncology service line, and the Department of Family Medicine at ChristianaCare. Stay tuned for updates. 

Debra Delaney, MSN, FNP-BC, is the primary care nurse practitioner; Christopher Koprowski, MD, MBA, is the associate cancer community of practice leader; and Nicholas J. Petrelli, MD, is the medical director at the Helen F. Graham Cancer Center and Research Institute, ChristianaCare Health System, Newark, Del.; Cydney Teal, MD, is the service line leader of Primary Care Community Medicine and chair of the Department of Family and Community Medicine at ChristianaCare in Newark, Del.

References

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Strategies to Address Comorbidity Among Patients with Cancer³

- Improving the **evidence base** from which to make cancer treatment decisions for those with comorbidity
- Improving the **measurement** of comorbidity among patients with cancer
- Improving **integration and coordination** of care
- Preventing the occurrence of **new comorbidities** and limiting **exacerbations** of existing conditions
- Developing **better tools** for clinicians
- Facilitating **skill development** for clinicians
- Building **research** collaborations

Patient Case Study

K.W. is female in her mid-30s with a history of squamous cell carcinoma of the cervix. The cancer was diagnosed in 2018, and the patient was treated with a course of chemotherapy and vaginal brachytherapy in 2019. Unfortunately, the cervical cancer recurred, and in 2019 the patient underwent a radical hysterectomy. In 2020, due to persistent disease spread, she had anterior pelvic exenteration surgery and a percutaneous nephrostomy tube placed. To be closer to family, the patient moved to Delaware in 2021. She established care at the Helen F. Graham Cancer Center and with the cancer center's embedded primary care practice.

Having access to primary care at the cancer center saved the patient the time and energy of trying to find a PCP who was within her network and accepting new patients. During the initial examination, the embedded primary care APP created a plan of care based on the patient's concerns and medical diagnoses.

K.W. was already scheduled for chemotherapy through the Oncology Department. The embedded APP was able to quickly obtain an appointment with urology for management of a nephrostomy tube (the patient required a tubing change when she arrived in Delaware).

With the primary care APP, the patient was able to talk about her emotional state and began a medication treatment plan for her anxiety and depression along with a referral to a behavior health provider while at the cancer center. The primary care APP advised the patient to reach out with any questions and helped the patient navigate healthcare in Delaware. Over the course of her treatment, the patient connected with the primary care APP multiple times with questions about her healthcare journey. The primary care APP was helpful in providing contact information for the local school district when the patient had difficulty enrolling her son in school. The primary care APP reaches out to K.W. monthly to check in. The patient is currently stable.

As a small practice, the primary care APP embedded within the cancer center can provide quality time to individual patients. This whole-patient model can make a world of difference to patients who are dealing with multiple appointments while feeling absolutely worn out from ongoing cancer treatment.