Section Editors: Theresa Wicklin Gillespie and Constance Visovsky

QUALITY IMPROVEMENT

Advanced Practitioner-Led Shared Visits: A Novel Approach to Cancer Survivorship

DANA McDANIEL, DNP, APRN, FNP-C, AOCNP®

From Mosaic Life Care, Saint Joseph, Missouri

Author's disclosure of conflict of interest is found at the end of this article.

Correspondence to: Dana McDaniel, DNP, APRN, FNP-C, AOCNP®. E-mail: dana.mcdaniel@mymlc.com

https://doi.org/10.6004/jadpro.2022.13.8.3

Abstract

Background: The continued increase in the number of cancer survivors is encouraging and credited to better prevention, screening, and treatment. Cancer care authorities call for survivorship follow-up focusing on surveillance, health behaviors, and lingering effects of treatment. Despite the recommendations, cancer centers struggle to provide cost-effective, time efficient, comprehensive programming to address this call. **Objectives:** The primary objectives of this quality improvement project were to (1) develop and pilot a shared survivorship visit for breast cancer survivors and (2) evaluate the feasibility and acceptability of the program. **Methods:** The participants in this 4-week pilot project included five female breast cancer survivors, ages 18 and older, diagnosed with stage I, II, or III breast cancer within the past year. Each survivor completed a one-time, 2-hour shared survivorship visit. **Results:** The shared, interdisciplinary survivorship visit was directed by an advanced practice nurse. A team of nursing and ancillary experts presented information on their specialized area. Upon completion of the visit, the survivor received an individualized survivorship care plan. There were 21 eligible breast cancer survivors and 5 participants. The pilot was successfully implemented, acknowledged the feasibility, and identified the adaptability to other cancer survivors. An evaluation concluded that the APRN-led, shared survivorship visit model was accepted by the patients and the survivorship team. The shared survivorship visits will be implemented into the cancer care program to address the needs of breast cancer survivors. Furthermore, there will be an expansion of the shared survivorship visits to meet the needs of those with other types of cancers.

Approximately 268,600 cases of invasive breast cancer were diagnosed in the United States in 2019 (National Institutes of Health, 2019). Improvement in prevention, detection, and efficacious treatment translates to more women surviving breast cancer. In the US, there has been a significant increase in breast cancer survivors, with more than 3.8 million women surviving breast can-

J Adv Pract Oncol 2022;13(8):766–774

cer (American Cancer Society, 2019). These women will require treatment for their disease, which can significantly impact physical, psychosocial, and emotional health, leaving them with needs not met by current health-care systems (Lovelace et al., 2019).

The National Academy of Medicine (NAM) proclaimed the need for transition from cancer patient to cancer survivor in 2005. Furthermore, the National Comprehensive Cancer Network (NCCN), American Cancer Society (ACS), and the American Society of Clinical Oncology (ASCO) developed follow-up care guidelines to assist clinicians in addressing long-term health issues breast cancer survivors encounter, including recommendations for monitoring, screening, and managing the potential late and long-term effects of treatment (Table 1). Despite evidence-based recommendations, breast cancer survivors' needs remain unmet.

Up to 90% of breast cancer survivors experience unexpected, long-term sequela resulting from their cancer treatment (Lovelace et al., 2019). Survivors can be left with uncertainty surrounding their treatment and what lies ahead. Women attend regular follow-up appointments to review their physical health status; however, they report little opportunity to discuss their psychological or emotional concerns (Keesing et al., 2019).

The National Academy of Medicine, Commission on Cancer (CoC), ASCO, and NCCN call for survivorship follow-up care focusing on surveillance, health behaviors, and lingering effects of treatment. Despite the recommendations, cancer centers continue to struggle to provide cost-effective, time-efficient, resourceful, comprehensive programming to meet this need.

The delivery of survivorship care plans (SCP) varies significantly among oncology practice, yet they are valued by cancer survivors. Education closer to completion of treatment provides a teachable moment earlier in the survivorship trajectory when survivors are more open to behavioral change for health promotion (Palmer et al., 2015). Furthermore, education improves self-care behaviors, lessens anxiety, improves the patient's ability to cope with adverse treatment effects, and improves overall attitudes and emotions (Lovelace et al., 2019).

A novel approach to survivorship care is a shared visit (also referred to as a shared medical appointment). A shared visit is when multiple patients are seen as a group for follow-up care or management of a chronic condition. These visits provide an interactive setting in which patients

Table 1. Summary of Follow-Up Care Guidelines for Breast Cancer Survivorship

Professional guideline	History and physical	Mammogram	Treatment-related monitoring	Other
NCCN	1–4 times per year × 5 years, then annually	Annual	• Aromatase inhibitor: baseline bone density and then periodically thereafter • Tamoxifen: age-appropriate gynecologic examination • Patients who received anthracycline-based chemotherapy: consider ECHO within 1 year of completion for high-risk survivors	• Periodic screening for change in family cancer history and genetic testing • Routine imaging of reconstructed breast(s) is not indicated • Laboratory or imaging is not recommended in the absence of clinical signs and symptoms
ASCO	Detailed cancer-related H&P every 3–6 months × 3 years then every 6–12 months × 2 years, then annually	Annual	• Aromatase inhibitor: baseline bone density and then every 2 years • Tamoxifen: annual gynecologic examination for post-menopausal women • Patients who received anthracycline-based chemotherapy: consider ECHO within 1 year of completion for high-risk survivors	• Periodic screening for change in family cancer history and genetic testing • Routine imaging of reconstructed breast(s) is not indicated • Laboratory or imaging is not recommended in the absence of clinical signs and symptoms

Note. Information from ASCO (2019); NCCN (2022).

have access to their provider and benefit from counseling with additional members of a health-care team, such as a behaviorist, nutritionist, or health educator, and can share experiences and advice with one another (American Academy of Family Physicians, 2020). Shared visits are based on a validated conceptual model leading to improved outcomes for both patients and providers. These visits represent a unique approach to delivering health care to a mounting population of cancer survivors. They also address physical and psychological needs, with a focus on prevention, surveillance, and comorbidity care. Furthermore, this approach includes the delivery of SCPs recommended for enhancing communication, coordination, and receipt of appropriate care. Shared visits overcome provider and patient barriers and offer unique benefits to support and enhance patient care and experience (Reed et al., 2015). Group visits are a patient-centered, cost-effective delivery of care that improves access, outcomes, and care quality (Trotter & Schneider, 2012). The application of the concept of a shared visit is unique to cancer survivorship and little literature exists on the subject.

Only 20% of survivors provide their SCPs to their primary care providers (Palmer et al., 2015). This leaves a gap in cancer survivorship care because the patient's PCP does not receive valuable information regarding the patient's past treatments, potential late-effects, and recommended screenings. Failure to comprehensively outline the needs of cancer survivors may contribute to the incomplete transition of care from the cancer specialist to the PCP; this can be a lost opportunity to transfer essential information (Gilbert et al., 2008). In response, the CoC has recently required that a copy of the SCP be sent to the PCP as part of a quality standard (Nekhlyudov et al., 2017).

The literature identifies multiple gaps in cancer survivorship care. National guidelines and accrediting bodies recognize the significance of delivering appropriate care to cancer survivors and provide recommendations for doing so. Unfortunately, there remain many deficiencies and disconnects in post-treatment care for the rising number of cancer survivors.

The purpose of this quality improvement project was to utilize evidence-based literature and clinical guidelines to create, implement, and evaluate an advanced practice registered nurse (APRN)-led, shared, interdisciplinary survivorship visit for female breast cancer survivors. The objectives were to pilot the shared survivorship visits and to evaluate the feasibility and acceptability of the program. This project implemented the current, existing, evidence-based guidelines into clinical practice to provide breast cancer survivors with the optimal survivorship experience.

METHODS

The framework that guided this project was the Plan-Do-Study-Act (PDSA). This model provides a systematic process for gaining knowledge and for the continual improvement of a process or service (The Deming Institute, 2019). The shared care model guided the study because it comprises coordination between health-care providers who have specialized knowledge surrounding oncology care.

A synthesis of the literature was conducted, and evidence-based implementation strategies were key to the success of this program. Use of the NCCN and ASCO guidelines and a review of the literature guided the timing, content, and presenters for the shared survivorship visits. The proposed project was approved by the project committee and Institutional Review Board.

A survivorship team was formed, consisting of the project director, APRN, clinic manager, clinical trial nurse, registered nurses from medical and radiation oncology, social worker, dietician, counselor, financial navigator, chaplain, access representative, and medical assistant. The survivorship team conducted biweekly meetings (and as needed) to provide input and gain full understanding of the pilot. During meetings, the group reviewed guidelines and literature and discussed clinical experience. After multiple meetings, a detailed, written process was compiled and provided to the oncology staff. The content and order of the visit was followed by the survivorship team (Appendix A). The APRN's role was to explain the purpose of the visit, discuss signs and symptoms of recurrence, prevention of recurrence and secondary cancers, appropriate age-related screenings, guidelines, healthy behaviors, and importance of follow-up.

One week prior to the initiation of the project, the team met for a simulated visit. The flow of the

shared visit and content of the presentation were reviewed by all team members. Upon completion of the simulation, the team members completed a survey about the visit (Appendix B). The project director corresponded via email with each team member, providing feedback and recommendations on their presentation based on evidence-based literature.

The project director disseminated education about the purpose and process of the pilot throughout the cancer center. Furthermore, the survivorship team was responsible for reenforcing the education and answering questions from the staff, patients, and families. Ancillary staff aided in the pilot: The informatics team helped develop a template for the breast SCP while the marketing team assisted with the development of an informational card for patients about the survivorship visit.

The proposed delivery of a shared survivorship visit was implemented. After the pilot was completed, the project director reviewed and analyzed the collected data per the data-analysis plan. Results were compiled and presented to the improvement team. The group reviewed the results and compared them to the aims designated for the project.

Administrative support was vital to the success of the pilot. Adding additional staff to implement the project was not fiscally feasible so utilizing current staff was crucial. Administration supported the project by relieving staff from some of their primary duties, allowing them to participate in the meetings and the visits. As with any new program, barriers were encountered. The greatest barrier was establishing an effective way to identify patients for the visits. This was overcome by creating an activity of "breast survivorship eligible" in the EMR, allowing a report to be run and displayed for the access representative to schedule. The interdisciplinary survivorship approach required coordination of schedules and reduced time from the team's primary duties. Another notable barrier was patients' unfamiliarity with the term "survivorship" and purpose of the survivorship visit, which were addressed with detailed education and communication.

The project setting was an oncology clinic in the Midwest. This clinic employs eight providers (two radiation oncologists, three medical oncologists, and three APRNs) and serves adult patients receiving medical and radiation oncology services care for all types of cancer.

A convenience sample of five female breast cancer survivors diagnosed with stage I, II, or III breast cancer within the past year who completed definitive, adjuvant therapy within the prior 6 months were selected for this project. Participants for this project were limited to female subjects 18 years of age and older. Exclusion criteria included in-situ disease, metastatic disease, and male birth sex and gender. The confidentiality of the patients who participated in the project was protected.

Upon completion of definitive treatment, the provider (physician or APRN) or registered nurse educated the patient that they would be scheduled for a survivorship visit. The access representative scheduled the patient for the survivorship visit and provided a written information card about what to expect at the visit and the date and time of the appointment.

After arrival to the clinic, the survivor was checked in and then brought to an exam room to obtain their weight and vital signs. Next, they were directed to the conference room and provided with the survivorship questionnaire for completion. Social distancing and masks were enforced due to the COVID-19 pandemic. A review of the questionnaire assisted the APRN to focus on any specifics during the presentation and/or to address individually with the patient. The questionnaire was then uploaded into the EMR.

The 2-hour, APRN-directed, shared survivorship visit was conducted in the conference room of the oncology clinic. Five patients participated in the pilot (Table 2). The APRN, nurses, dietician, chaplain, social worker, financial navigator, and clinical research nurse sequentially presented information on their specialized area. The content included in the shared survivorship visit was pulled from the guidelines and a literature review. Throughout the visit, the survivors had the opportunity to ask questions.

Upon completion of the visit, the survivor received an individualized, printed SCP. Educational materials, information on breast cancer support groups, and each of the presenters' business cards for follow-up contact, if desired, were supplied. To close the communication gap, the APRN requested approval by the patient to share the completed

Table 2. Pilot Participants

Age	Race	Stage of disease	Hormonal status	HER2 status	Treatment
66	White	II	ER/PR positive	HER2 negative	Mastectomy, docetaxel/cyclophosphamide, anastrozole
62	White	I	ER/PR positive	HER2 negative	Lumpectomy, doxorubicin/cyclophosphamide, radiation therapy, tamoxifen
55	White	I	ER/PR positive	HER2 negative	Lumpectomy, radiation therapy, anastrozole
60	White	II	ER/PR positive	HER2 negative	Lumpectomy, doxorubicin/cyclophosphamide, paclitaxel, radiation therapy, anastrozole
53	White	II	ER/PR positive	HER2 negative	Lumpectomy, doxorubicin/cyclophosphamide, paclitaxel, radiation therapy, anastrozole

SCP to their PCP via fax. All participants in the pilot consented to sharing of the SCP with their PCP. To conclude, the survivors were presented a survivorship coin to commemorate their survivorship.

Throughout the pilot, reasons for declining participation by eligible subjects was monitored. There were 21 eligible survivors and five actual participants. The primary reason for non-participation was pandemic related (fear of contracting the virus, infection of COVID-19, and social distancing). In order to reduce traffic and decrease the potential risk of exposure to COVID-19 for patients and caregivers, there were months when patients who were not receiving treatment were limited to virtual visits, thereby decreasing the ability to accrue patients to the pilot.

The project staff and project director met to determine if the project would continue as a new practice for the clinic. The group evaluated the data and determined that this method of shared interdisciplinary survivorship visits was effective and will be implemented into practice. Further steps are to develop policies and procedures to standardize the care processes and to continue to evaluate metrics and monitor the process. The shared visit method will be incorporated into the clinic's practice.

DATA COLLECTION

At the end of the visit, survivors were asked to complete a confidential evaluation (Appendix C). The evaluation summoned responses about the content of the visit, the presenters, and their perceived benefit of the visit and the SCP. The evaluation was completed by paper and secured in a private, locked file cabinet housed in the director's office.

Upon completion of the pilot, staff members on the team completed the survivorship team evaluation for a second time (Appendix B). This evaluation inquired about the content presented, interaction of patients, and flow of the visits. Survivor and team data were reviewed to make suggestions for improvements to the program.

RESULTS

Survivor Data

As mentioned previously, the sample was limited due to the COVID-19 pandemic. Among the 21 survivors eligible for the pilot, reasons for declining a survivorship visit were tracked. Most survivors cited the reason for declining was related to COVID-19. The second most common reason stated was the timing of the visit (Figure 1). The reason for survivors declining a visit was recorded to identify any opportunity for future improvements.

The survivor evaluation was completed by all participants in the pilot at the end of the visit. The evaluation included questions about satisfaction, using a five-point Likert scale and open-ended questions. Table 3 demonstrates the findings.

One hundred percent of the survivors either strongly agreed or agreed that the format of the shared visit was beneficial, and the information received during their visit was useful. Additionally, the survivors were satisfied that their questions were answered.

The qualitative segment of the survivor evaluation provided insight into the survivors' acceptability of the pilot. The written comments were

condensed into three main areas: speaker, duplicate information, and education about long-term effects of treatment. Sixty percent of the participants suggested including a survivor as a speaker who could share her experiences and answer questions. Twenty-five percent of the group reported receiving duplicate information from the presenters. Lastly, the participants thought it was most important to learn from the nurses about longer-lasting effects of chemotherapy and radiation therapy.

Survivorship Team Data

There was consensus among the survivorship team members that a shared survivorship visit format was effective and efficient. Additionally, all agreed that this format can be adapted in the future to patients who are survivors of other cancers. Two members stated that the visit could be improved by providing an outline of the presentation, so they could make notes and take them home for their review. Most presenters felt they could have been more engaging in their presentation and all enjoyed seeing the patients as survivors and in a much more positive environment.

There was a discordance in the survivor and the caregiver view regarding duration of the visit. In the survivor group, 40% felt that a 2-hour visit was too long while 100% of the survivorship team felt a 2-hour visit was just right.

Upon review of the patient and survivorship team data, the project aims of feasibility and acceptability of a shared survivorship visit were met. The project was successfully developed and implemented. The providers and caregivers were supportive of the project and the survivors expressed the benefit of the pilot. The project director has examined the patients' and team members' input and identified ways to further improve this project.

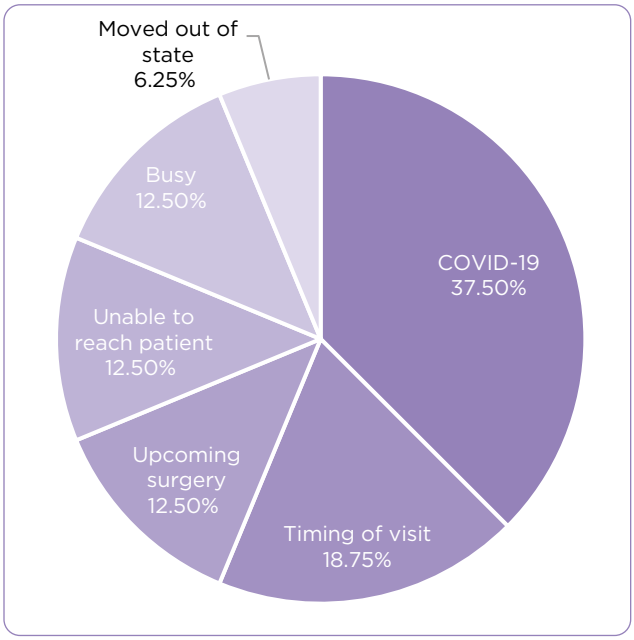

Figure 1. Reason for declining a survivorship visit.

The pilot project was slated to begin April 8, 2020, with the time for completion to be June 13, 2020. Due to the pandemic, the project was delayed. The pilot began on September 9, 2020, and was completed on September 30, 2020. Adapting the face-to-face visits to virtual visits was considered; however, this was not implemented since the intent of the pilot from the beginning was to be face-to-face and the literature, although limited, was most representative of in-person visits. The survivorship group consensus advised visits remain in-person, although virtual visits would be an option given the patient has access to the appropriate technology.

Survivors' comments resonated with findings in the literature that patients feel lost in the transition between treatment and survivorship. One survivor stated she would have benefited from a phone call 2 weeks after treatment, while two

Table 3. Participant Satisfaction

Question	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I had a good understanding about what to expect during this visit prior to my appointment today.	20%	60%	20%	0%	0%
I feel the information I gained at this visit was useful.	80%	20%	0%	0%	0%
I feel the shared format of this visit was beneficial.	80%	20%	0%	0%	0%
All my questions were answered during this visit.	80%	20%	0%	0%	0%

survivors mentioned the visit would have been more beneficial closer to the completion of treatment. This leaves an opportunity to reach out to those patients who are in transition and complete the survivorship visits between the 6- to 12-week mark after definitive adjuvant therapy.

As a significant amount of participants reported the 2-hour visit was too long and there was duplication in the presentations, the survivorship team was able to assess the content and remove duplicated content to reduce the length of the visit. The team also considered the feedback of participants and recognized room for improvement regarding a more interactive presentation.

The interdisciplinary nature of the visit was appreciated by the survivors and the survivorship team. Two survivors benefited from the financial navigator presentation and assistance. Both provided positive comments about the explanation of the 340B program along with the list of pharmacies that participate in the program, to allow for cost-effective medications. One survivor had the opportunity to meet with the financial navigator following the session to discuss her bill, which led to a referral to patient financial assistance.

One survivor provided valuable feedback recommending inclusion of mastectomy and breast prosthesis. The APRN added content to her presentation to address this need. Furthermore, the patient was referred to a local medical supply store to assist her with the fitting and purchasing of a breast prosthesis.

CONCLUSION

The cancer survivor population is growing, and their needs are often overlooked. Despite evidence-based recommendations and guidelines focused on providing survivors with desired and needed information to transition from a person with cancer to a survivor, providers are often not adequately addressing these needs. Ample literature describes the multifaceted needs of the cancer survivor; however, there remains a lack of emphasis on survivorship care in many cancer care systems.

This quality improvement pilot project embraced the guidelines for cancer survivorship care and integrated a novel, shared survivorship approach to promote an optimal survivor experience in a Midwest cancer program. Quality, patient-centered care was delivered while maximizing available resources. Shared survivorship visits will be implemented into the cancer care program to address the needs of breast cancer survivors. Furthermore, there will be an expansion of the shared visits to address survivors of other types of cancer, with lung cancer survivorship on the horizon.

The shared survivorship model is an effective way to utilize the APRN to close the gap in survivorship care. This model also provides generalizability to all cancer survivors and adaptability to each practice setting.

Acknowledgment

The author would like to thank the survivorship team for their work on this quality improvement project and their dedication to patients.

Disclosure

The author has no conflicts of interest to disclose.

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Appendix A. Content and Flow of the Shared Survivorship Visit

Project Director
- Introduction
- COVID safety

APRN
- Overview of the visit: What is survivorship?
- Concern for recurrence (What are the signs?)
- Prevention of new cancer
- Screenings (dental, lung, mammogram, c-scope, breast exams, pap/pelvic, skin)
- Healthy behaviors (sunscreen, avoid tanning, limit alcohol, avoid smoking/vaping, seatbelt use, immunizations)
- Importance of following up with PCP

Radiation and medical oncology RNs
- Hormonal agent side effects (hot flashes, arthralgias, vaginal dryness, bone loss)
- Radiation side effects
- Late chemo effects (cardiac, neuropathy)
- Lymphedema
- Overcoming fatigue
- Sexual function

Dietician
- Weight management (explain healthy BMI)
- Healthy diet
- Exercise
- Provide a healthy snack and bottled water

Chaplain
- Mindfulness
- Spirituality
- Fear and anxiety of recurrence
- Stress reduction
- Discussion of services

Financial counselor
- Medication resources
- Returning to work
- Medical debt
- List of 340B participating pharmacies

Social worker
- Discussion of Cancer Support Community (CSC) with registration forms for CSC
- Support groups
- Resources

Clinical trial manager
- Educate on available and upcoming clinical trials for survivors

Project director
- Presentation of survivorship coin to each survivor
- Delivery of patient evaluation.

Appendix B. Survivorship Team Evaluation

Thank you for taking the time to complete this evaluation of the shared survivorship clinic visit. Your feedback will help with planning for future survivorship programs.

Name: _____

Title: _____

1. The interprofessional team approach in a shared visit was beneficial for the patients.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

2. The interprofessional format for the shared visit helped with teamwork and collaboration.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

3. Do you believe this shared visit promoted patient engagement?

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

4. Please circle one choice below. Did you feel like the 2-hour visit was:

Too long Just right Too short

5. What content or activities do you think were not helpful (if any)?

6. What content or activities should be incorporated in future programs?

7. Please provide any additional information that you feel would be helpful.

Appendix C. Survivor Evaluation

Thank you for taking the time to complete this evaluation. Your information will be used as part of a pilot study to better understand if the needs of breast cancer survivors are being met and will be used to improve future shared survivorship visits. Your identity will be kept anonymous and if you do not want to continue completing the evaluation, you may stop. The completion of this survey is voluntary. Completion of this evaluation is your consent to participate.

Please answer the following questions by circling one response for each question.

1. I had a good understanding about what to expect during this visit prior to my appointment today.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

2. I feel the information I gained at this visit was useful.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

3. I feel the shared format of this visit was beneficial.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

4. All my questions were answered during this visit.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

Please answer the following questions.

1. What was the most beneficial topic for you during this visit? Why?

2. Was there any information you would have liked to be included during this visit?

3. What was the least helpful information/topic provided during this visit? Why?

4. Please circle one choice below. Did you feel the 2-hour visit was:

Too long Just right Too short

Please provide any additional comments, suggestions, and recommendations about the shared survivorship visit.