Recommendations for implementing and delivering shared survivorship care

Summary version

1. Background and purpose
Survivorship care that is shared between primary care and oncology providers may be a suitable model to care for the growing population of cancer survivors, however recommendations supporting implementation of shared care are lacking. The Australian Cancer Survivorship Centre (ACSC) undertook a rigorous exploration of facilitators and barriers to the implementation, delivery and sustainability of shared survivorship care via systematic review and qualitative enquiry. Outcomes were translated into practice and policy recommendations to support broader implementation of the shared care model.

2. Approach

SYSTEMATIC REVIEW
The systematic review included both qualitative and quantitative studies addressing shared cancer care. MEDLINE, Embase and Emcare databases were searched in June 2019, with 13 papers (10 qualitative, 3 quantitative) ultimately included. Data were extracted and synthesised using a mixed methods approach.

QUALITATIVE STUDY
ACSC researchers conducted semi-structured focus groups with a total of 22 health care professionals (HCPs) between November 2018 and February 2019. Participants included both oncology and primary care-based providers. Data were analysed by inductive thematic analysis.

EXPERT CONSULTATION
Based on the systematic review and qualitative study, a draft list of 33 recommendations regarding implementation of shared survivorship care were developed. Recommendations were presented to a multidisciplinary group of 40 HCPs active in cancer survivorship participating in a Victorian Survivorship Community of Practice event in December 2019. Participants were asked to rate each recommendation on a five point scale from 1 – not at all important to 5 – essential. Recommendations that were endorsed (rated as very important or essential) by 75% or more of participants were included in the final guidance document.

3. Recommendations for implementation of shared care
Eighteen final recommendations for implementation of shared survivorship care between oncology and primary care providers are listed below. Providers seeking to implement shared survivorship care may wish to apply these recommendations to their setting.
PLANNING, DESIGN AND PROCESS

1. Undertake engagement activities with both oncology providers and general practitioners (GPs) prior to implementation.
2. Identify one or more senior clinical leads to act as a champion for shared care.
3. Establish rapid referral pathways to oncology providers if recurrence or other serious events are suspected.
4. Establish effective administration systems and processes to support shared care.
5. Consider a dedicated care coordinator role to enable shared care.

HEALTH CARE PROFESSIONALS

6. GPs should be involved as part of the shared care team from the point of diagnosis onwards. This may include GPs attending or dialling in to multidisciplinary meetings if this is practical.
7. Provide a direct line of communication between primary care and oncology providers. It is important to avoid placing responsibility for communication between providers in a shared care team on the patient.
8. GPs should be provided with information about the patient’s diagnosis, treatment history, and expected side effects.
9. GPs should be provided with clear and concise guidance regarding cancer follow-up care, including timelines, actions required and re-entry procedures if recurrence is suspected.

PATIENTS

10. Consider which patients might be suitable for shared care based on factors such as risk of recurrence or new cancers, persistent, complex side effects, personal circumstances and capacity for self-management. Recognising that patient’s circumstances and risk profiles may change over time, it is important to re-assess patients (as appropriate depending on the context) and change the model of care if suitable.
11. Engage patients in shared care by promoting and communicating the benefits of shared follow-up, such as greater continuity of care with their GP, reduced travel and waiting times.
12. Discuss shared care with patients early so they know to expect shared care and consider this standard. When this discussion occurs, it is important for oncology providers to ask patients about their GP; if patients do not have a known or trusted GP, it may be helpful to work with the patient to find a suitable GP for shared care.
13. Educate patients on which HCP to see for different issues they may experience.
14. Provide information resources to patients, but avoid overwhelming patients with too much information. The needs of different patient groups (for example based on health literacy, language spoken, cultural background, sexual orientation) and availability of suitable resources should also be considered when planning shared care.

POLICY

15. Define outcome measures to evaluate effectiveness and cost-effectiveness of shared care, and determine processes for regular and accurate data collection. Regular stakeholder feedback or evaluation may also be considered to facilitate continual improvement and refinement of the shared care model.
16. Establish consistent policy and guidelines regarding shared care and survivorship care plans to reduce variation across settings.
17. Advocate for a policy environment that supports shared care as standard care.
18. Advocate for sustainable funding mechanisms to support shared care. This may also include advocating for compensation mechanisms for GPs providing shared care.

This is a summary version of recommendations for implementing shared survivorship care. If you would like more detail, where each recommendation is expanded on and described, please see the full version for implementing shared survivorship care, available at www.petermac.org/acsc/hp/models-care.