The Primary Care Collaborative Cancer Clinical Trials Group

DRAFT: Implementing shared care of cancer patients in primary and specialist care setting

A Principles Statement

November 25, 2014

Objectives

The purpose of this statement is to outline the fundamental principles behind the successful implementation and delivery of shared care involving primary and specialist providers for people with cancer. The principles were identified following a process of literature review and stakeholder consultation involving primary care and specialist providers involved in the delivery of shared care. The principles can be used as a framework for design, implementation and evaluation of shared care across different setting and as such can assist in planning research in this area.

The document also defines further work that is required to support the development of shared care in cancer and some areas where further research is needed.

Definition

The multidisciplinary nature of cancer care by definition, implies *sharing* of care with other health professionals but the term "shared care" is usually applied to the sharing of care between cancer specialist and primary care provider (primarily a general practitioner but also community nurses, practice nurses and allied health practitioners) where often similar aspects of care are delivered in two or more settings by two or more professionals. As such, the model of shared care is similar to models applied in other aspects of general practice, for example with chronic disease and shared antenatal care.

Shared care represents one aspect of delivery of effective multidisciplinary care and is distinct from primarily hospital-led care and primary care-led care. It is also distinct from the setting where multiple providers deliver care to same patient without working together or sharing information in the process. In the context of shared care, both the specialist and the primary care provider maintain ongoing involvement in patient care and in doing so, share information and clinical responsibilities and agree on common processes.

While contributing to multidisciplinary care (and sharing in care) could be considered a generic skill for all health professionals, shared care is not just a skill – it is a distinct and well defined process that can be supported by system and skill development.

Scope

In cancer, shared care can be delivered across any aspect of the cancer journey from screening and prevention, early diagnosis, acute care during cancer treatment to follow up care, survivorship care and at the end of life. While traditionally, shared care often involves sharing of similar aspects of care (for example cancer surveillance) it may also involve allocation of

particular tasks to different professionals where both professionals contribute their expertise to shared care i.e. specialist's focus on cancer surveillance and GP focus on general health of the patient.

The core objective of shared care is optimising care of the patient, and thus the scope of a shared care arrangement should be determined and defined through the agreement between the patient and his/her care providers, with this objective in mind.

Potential benefits of shared care in cancer

Shared care offers a number of advantages to patients, including , treatment closer to home and greater engagement of their primary care provider in their care and a more comprehensive and holistic approach to care. A number of randomised clinical trials comparing shared care and specialised care has not shown any difference in outcomes including recurrence rate, cancer survival and quality of life.[1,2]

At the same time, shared care poses challenges and additional burden of care delivery including the need for clearly documented processes for communication between providers, ensuring adequate skill sets to deliver care and clarity of expectations.

In light of growing workforce shortages in the acute specialist cancer services, coupled with the growing numbers of cancer survivors and recognition of their complex health care needs that include cancer and non-cancer related needs, shared care has been identified as a potential strategy to i) increase the capacity for acute cancer services to treat more new patients and ii) deliver more holistic care to cancer survivors. However, this realisation has not yet led to significant uptake of shared care. This may be due to a number of barriers to implementation of shared care including planning, resourcing and support and ensuring buy in from all parties – primary care provider, specialist and the patient.

Shared care principles

1. **Core objective** of shared care is optimising care for the patient through improvement in access, acceptability and quality of care delivered.
2. **Parties involved** in shared care thus include individual patient for whom care is delivered and the care provides – both primary and specialist. Planning and execution of shared care should thus include all parties to ensure that the scope and processes meet needs and are:
    a. **Acceptable –** the approach to shared care has to be acceptable to all parties – primary care providers, specialists and patients, and there is a clear buy-in from all parties to make it work.
    b. **Flexible –** there needs to be flexibility regarding scope, design and processes involved in shared care, and the design needs to be driven by health needs and preferences as defined by involved parties and the demonstrated effectiveness of the proposed approach.
    c. Clear with regards to
        i. Expectations – these relate to both outcomes and processes and should include expectations of deliverables for each party as well as expected responsibilities of each party. Triggers for review and plans for rapid access

into each setting but in particular back into the acute setting should be clearly defined.

ii. **Communication pathways –** this includes clarity and explicit agreement regarding format, frequency and triggers for communication and applies to both providers and patients

iii. **Implementation process –** this includes clarity re process and costs of implementation, including stakeholder engagement, training, required resources (including human and financial), and how these will be met.

iv. **Integration -** The shared care models are integrated into the existing infrastructure and processes and thus align with the existing drivers and enablers of care. This may be aided by targeted use of information technology.

v. **Evaluation** – this is essential to ensure that shared care delivers what it is meant to, including outcomes and processes, identification of problem areas that need modification, and to ensure ongoing quality improvement.

Next steps that may assist in uptake of shared care

1. Encourage and promote shared care through meeting presentations, publication and engage key stakeholders to do the same.
2. Increase access to resources and tools
    a. Establish a clearing house of resources that support these principles of shared care
    b. Identify resources that need to be developed, and partners that can contribute to their development
    c. Develop templates and resources to support the implementation of shared care in cancer
3. Build greater understanding of what works and why
    a. Identify the evaluation elements in a shared care model, the KPIs associated with a well-functioning shared care model, and tools to assist the evaluation of a shared care model in the Australian setting
4. Develop strategies to support research into shared care in cancer

Future research questions

1. How do we address barriers to implementation of shared care from the perspective of different stakeholders – GPs, patients and specialists?
2. What is the role of the patient in shared care planning and design?
3. How can consideration of the shared care option be incorporated into the routine care planning at specialist and primary care level?
4. What are the cost and resource implications of shared care? How can they be measured, monitored and (if necessary), modified?

Acknowledgements

This document was developed by members of the Primary Care Collaborative Cancer Clinical Trials Group (PC4) and involved review of relevant literature and stakeholder meeting held on the 25th of August 2014.

The PC4 Shared Care Working Group

1. Prof Bogda Koczwara (Chair)
2. Prof Kate White
3. Prof Jon Emery
4. Prof Geoff Mitchell
5. Prof Danielle Mazza
6. Prof Patsy Yates
7. Ms Julia Fallon Ferguson

We gratefully acknowledge feedback from attendees at the Stakeholder meeting including Dr Ian Williams, Dr Julie Thompson and Prof Bruce Mann.

References:

1. Emery JD, Shaw K, Williams B, Mazza D, Fallon-Ferguson J, Varlow M, Trevena LJ. The role of primary care in early detection and follow-up of cancer. Nat Rev Clin Oncol. 2014 Jan;11(1):38-48.
2. Emery JD, Shaw K, Williams B, Mazza D, Fallon-Ferguson J, Varlow M, Trevena LJ. The role of primary care in early detection and follow-up in cancer care. A rapid review of best practice models. Sax Institute Report on behalf of the Cancer Institute of NSW. December 2012.