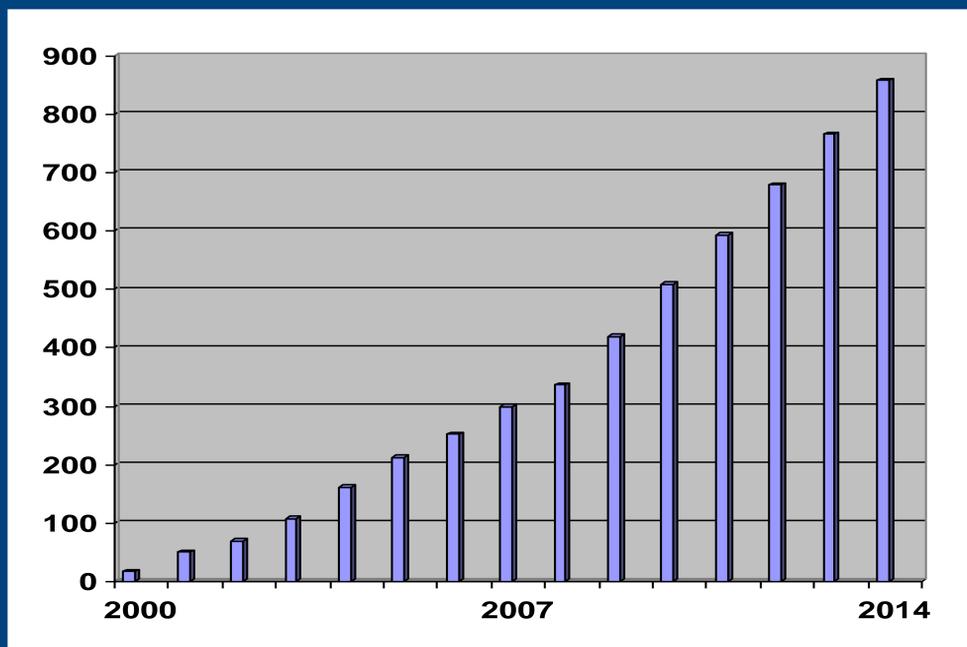


Sharing the care: an innovative model of care for GP and specialist collaboration in the management of late effects of cancer treatment.

Josie Samers, Natalie Goroncy, Mary Dwyer and Greg Wheeler
Late Effects Service, Peter MacCallum Cancer Centre, Victoria, Australia.

With improved survival rates and increasing awareness of the potential late complications of complex cancer treatments, innovative models of care need to be developed to provide evidence-based surveillance, prevention and ongoing management of long term cancer survivors. Since being established in 2000, the Peter MacCallum Cancer Centre (PMCC) Late Effects service has rapidly expanded from one clinic held every second month, to a weekly clinic at Peter Mac East Melbourne site, and satellite clinics held twice yearly in Bendigo and Hobart.

Total number of patients in PMCC Late Effects database 2000 – 2014



As an area of evolving medical knowledge, robust follow up mechanisms are required to ensure best practice management as new late effects are identified. Additionally, travel considerations for rural and interstate patients, patient reluctance to return to a 'cancer hospital' when cured, and medical issues including neurocognitive effects can pose additional challenges to effective long term management.

Strategy.

Whilst the identification of risk arising from cancer and its management including chemotherapeutic agents, radiotherapy, surgery and bone marrow transplantation is often highly specialised, the resulting need for screening, chronic disease management, lifestyle modification and psychosocial support is often best managed in primary care. Additionally, General Practitioners (GPs) provide ongoing, coordinated, accessible 'whole person' care to patients in their local community.

In 2010, with 509 patients in the Late Effects database, each requiring at least annual review, and in excess of 80 new referrals each year, the demand for appointments was exceeding capacity. Consequently, the PMCC Late Effects service established its shared care program whereby a patient's regular GP provides ongoing management of long term cancer survivors in collaboration with the multidisciplinary specialist team.

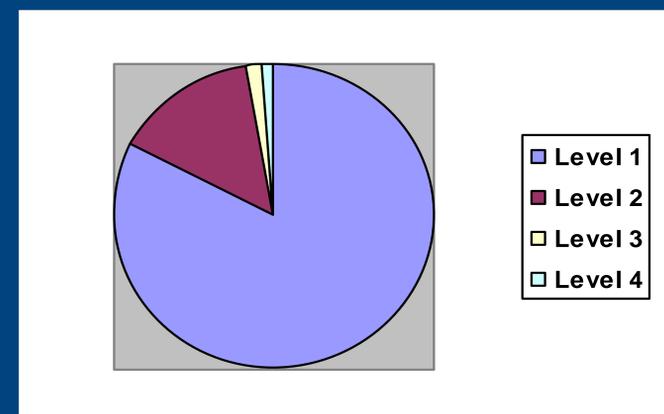
Methods.

A GP Liaison position was established in 2009, and guidelines for long term follow up were developed. At each clinic multidisciplinary team meeting, patients are allocated to a surveillance level (see table) and, with the patient's consent, may be allocated to GP follow up. The following year, these patients and their GP then receive a reminder phone call and letter, including a Survivorship Care Plan, which outlines the patient's management.

Surveillance level	Features	Follow up recommendations
Level 1	Patients with ongoing, complex and multidisciplinary medical issues related to their past cancer treatment	Require at least annual review in Late Effects Clinic (LEC) and communication with GP
Level 2	Patients with less complex or uni-system issues	Annual follow up required, alternating between LEC and GP, with appropriate advice and support
Level 3	Patients are cared for mainly by their GP with intermittent review in LEC	Review by GP as needed with 3-5 yearly investigations coordinated and reviewed in LEC
Level 4	Patients who do not require LEC follow up	<ul style="list-style-type: none"> Surveillance program undertaken by GP as recommended by LEC Recall as required should review or alerts become indicated based on emerging information

Since 2010, 239 patients have been allocated to GP follow up, improving clinic capacity. Whilst 82% of patients still require at least annual clinic review, 15% have been allocated to level 2 follow up (alternating annual clinic and GP review); 2% level 3, and 1% of patients have been discharged from the clinic to the care of their GP. Overall patient willingness to participate in GP follow up and subsequent satisfaction for both patients and their GPs has been high. The quality of correspondence from the clinic has also significantly improved.

LEC patients by surveillance level Oct 2010 to March 2014



Findings.

- Culture change was required for the specialists in the LE team to hand over management of their long-term patients.
- Some GPs were initially concerned that the management would be complex, but were reassured by effective communication and clear management plans, and very happy to undertake follow up.
- Although a small proportion of patients were reluctant to attend the clinic less often, many preferred the convenience of less travel, shorter waiting times, and the less intimidating environment they experienced when visiting their GP.
- Clear, concise correspondence was essential to outline the GP management required.
- Patients who did not have a regular GP were assisted in finding one.
- More than 20% of patients had changed GPs in the 12 months since their last clinic appointment, emphasising the importance of checking GP details.
- The lack of certainty that a patient has attended their GP for follow up, and obtaining 'cc'd' copies of investigation results for patients in the community is an ongoing challenge.

Where to next?

The service has now established a telehealth service for complex rural patients, whereby the patient attends their GP and a video consultation is undertaken with one of the LEC specialists. The utilisation of the PCEHR is also being considered to facilitate information sharing between the patient, their GP and specialist.