RACGP

Cancer Survivorship Shared Care

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1. Position

General practitioners (GPs) play an important role in the diagnosis, screening, treatment and care coordination of people with cancer. GPs are also skilled in managing complex and chronic conditions, making them well positioned to support cancer survivors through coordinating general medical care, and providing psychosocial support and preventive advice to help maintain well-being following cancer treatment.

The RACGP:

- calls for a collaborative shared care cancer survivorship model between patients, their GP and the general practice team, specialist cancer services, other healthcare providers and required community services
- supports general practice workforce development and upskilling in cancer survivorship care
- supports appropriate funding for general practices led by GPs to participate to the full scope of their practice in formalised cancer survivorship shared care, being appropriately remunerated to carry out:
    - required assessments and reviews of cancer survivor needs
    - care coordination
    - supporting survivors in accessing appropriate rehabilitation services and other required supportive care
- supports IT infrastructure to allow registries, efficient reminder and recall systems and key clinical information that can be accessed by patients and health team members
- supports system-wide evaluation and research of models of cancer survivorship shared care
- supports remote monitoring systems and flexible reimbursement for telehealth and telephone consultations
- does not support any model that results in fragmentation of care by increasing the number of community-based health service providers providing initial access, assessment, triage and diagnosis

2. A recognised role for general practice

Modern cancer care recognises the importance of general practice and primary care settings in supporting personalised whole-of-person care.[1] A key strength of the health care provided in general practice is that it is patient-centred, continuous, coordinated and comprehensive. GPs can provide support for the growing number of cancer survivors through the coordination of cancer survivorship care, chronic disease management, and secondary prevention while managing complex and chronic conditions.

Whilst evidence supporting specific detail of implementation is still emerging, GPs may provide a key role in the coordination of cancer survivorship care, including:

- Coordination of other medical care and prescribing
- Coordination of ongoing preventive care including immunisation, screening, and healthy behaviours
- Early detection of recurrence and rapid referral to specialist cancer services
- Managing fear of cancer recurrence and cancer-related distress

- Assisting patients with psychosocial aspects such as
    - Returning to work
    - Personal relationships
    - Financial considerations

3. Definitions

Cancer survivorship:

The term cancer survivor encompasses anyone diagnosed with cancer, from the time of diagnosis to the end of life.[2] As cancer care evolves, perspectives of survivorship and ways of defining it become more nuanced. For instance, the binary concept of being cured or not cured of cancer does not capture the experiences and challenges that occur for patients in reality. [3] For the purpose of cancer survivorship shared care, the term survivorship refers to the period following primary cancer treatment, the late and longer-term effects of the cancer, including the effects of the primary cancer treatment itself through to end of life.[4]

Shared care:

Shared care is an agreement of joint participation between all parties involved in patient care, including general practice, specialty care and the patient in the planned delivery of care. A key element is enhanced information exchange, over and above routine discharge and referral notices, and clarification of specific roles and responsibilities.[5] The RACGP position statement Shared Care Model between GP and non-GP specialists for complex chronic conditions outlines proposed solutions to existing barriers in shared care so that all people with complex chronic conditions can benefit from GPs working in coordination with non-GP specialist teams to manage their condition.

4. Background

There is an increasing need for holistic post-cancer care as improvements in the early detection and treatment of cancer have resulted in greater survival rates.[6] A high proportion (up to two thirds) of people who have survived a diagnosis of cancer report having ongoing health care needs that remain unmet.[2, 7, 8]

Cancer survivors are a vulnerable group with increased risk of comorbid chronic conditions such as cardiovascular disease, type 2 diabetes, metabolic syndrome and osteoporosis as well as long-term residual symptoms of the cancer and the effects of its treatment.[6] Cancer disproportionately affects older people, and multimorbidity is often the norm rather than the exception.

Legacy models of cancer care are disease-centric and are focused on highly technical specialist care and monitoring for cancer recurrence, rather than whole-of-person centred care that provides ongoing wellness support.[9] It is recognised that cancer survivors require greater support in areas of health care that focus on their quality of life, their experience of the care process, functional outcomes, and the ongoing management of comorbid conditions.[5]

The impetus for shared care approaches to the care of cancer survivors stems from the need to find sustainable and patient-centred solutions to providing high quality, personalised follow-up care to a growing population of cancer survivors with longer duration of survival.[2, 4, 10] Cancer survivor experience differs greatly between individuals, requiring tailored support across a wider range of health and community services.[2, 3, 5] Contemporary cancer policy recognises the need for shared care approaches in order to achieve this.[4] There is growing evidence that well-designed shared care models for cancer survivorship lead to similar health outcomes, are preferred by patients and are associated with lower healthcare costs.[5]

4. Discussion

Essential elements of a model of shared cancer survivorship care

Whilst a strong evidence-base on how to best implement shared survivorship care is currently emerging, there is stronger evidence in support of models of shared care in general practice more broadly.[4] However, shared cancer survivorship care requires flexible and tailored approaches to care due to the breadth of chronic and complex conditions, as well as wide ranging patient needs which tend to require more complex arrangements across different organisations.

There are a number of Australian and international trials addressing key questions on post-treatment models of shared care, which include:

- frequency of care-plan review
- how care-plans should be reviewed and by whom
- what investigations should be carried out and when
- how to best screen for survivorship issues
- who should be involved in a post-treatment care team
- who holds the bulk of responsibility for post-treatment care

The successful implementation of a model of shared cancer survivorship is greatly influenced by the existing healthcare system.[11] Australian trials,[12, 13, 14] have listed elements considered essential for success of shared care models for cancer survivorship:

- survivorship care plans – these may be developed by the GP or non-GP specialist (or both) to aid communication between the patient, GP, treating specialist
- role clarification including scheduling of follow-up visits and recommended surveillance tests
- patient-specific guidance on management of common side-effects of treatment
- care coordination, including reminders regarding follow up and monitoring
- process for transfer of care to GP when shared care is no longer required
- rapid re-access to the appropriate part of the health-care system if needed

Additional elements, [5, 15, 16] identified by international researchers include:

- engagement of all stakeholders and secure their ongoing buy-in
- personalised /stratified care pathways – improvement of patient outcomes, more health system efficiencies, reduced costs
- methods to assess patient issues to guide care
- remote monitoring systems
- information for diverse survivor groups; support of patient self-management
- primary care engagement during and post treatment
- workforce development & upskilling
- appropriate funding to support supportive care, rehabilitation services
- flexible reimbursement to accommodate telehealth consultations

Exemplars of shared survivorship care

Full models

As mentioned, there are few examples of full models of shared survivorship care in the Australian setting. However, an Australian evidence base is building. [14, 15, 16] The recently published SCORE (Shared care of colorectal cancer survivors) study (2023)[12] is a full model of shared survivorship care, evaluated in the Australian setting. The evaluation study comprised shared care (GP and oncologist) follow-up compared to usual oncologist follow-up for survivors of colorectal cancer. The study found that the shared care received by survivors was acceptable, feasible and had equivalent outcomes. Patients had a stronger preference for shared care and experienced lower health care costs. This model

differs to typical approaches to shared care that focus only on increasing the involvement of the primary care team and includes the addition of a structured approach to sharing cancer surveillance, management of treatment-related effects and psychosocial support between the hospital and primary care team after the completion of treatment.[15]

Care plans

Whilst care plans are an important aspect of shared care, they comprise just one small part of a full model of shared survivorship care. There are many examples of successful care plans available. Of note is the care plan developed by the Australian Cancer Survivorship Centre.[17] It is a personalised care plan providing a physical record of the patient's care journey and assists them in their communication as they consult with a range of health professionals. The care plan includes a summary of treatments, the possible long term and short term treatment effects, symptoms to be vigilant about, wellbeing advice, resources for ongoing support and follow-up options. The care plan may be uploaded to the patient's My Health Record, and it can be reviewed at any stage. An emphasis of the care plan is the importance of discussing care with the patient's support team, which may include their GP, nurse, cancer specialist, and / or allied health specialist.

Specific shared cancer follow-up and survivorship care plans for early breast cancer and low-risk endometrial cancer are available at the Cancer Australia website.[18]

Barriers to the implementation of shared survivorship care

The influences of broader healthcare system infrastructure and funding can pose limitations to how a model of shared care may operate. GPs undertaking a coordination role require this role to be appropriately funded and supported within the model. Impediments to success of any model of shared care are poor communication and information transfer between GP and specialists.[19, 20]

Specific barriers include:[21]

- Time constraints within the consultation is an important barrier due to the requirement for longer consultations to properly assess the holistic needs of the patient.
- Lack of evidence-based guidance regarding recommended timeframes for follow up monitoring, investigation and specialist review
- Health system funding (Commonwealth versus State & Territory); health provider remuneration structures (fee for service; salary; limitations on MBS items)
- Lack of confidence and empowerment to work in shared care
- Workflow constraints
- Workforce capacity and competency, including the availability and proximity of health and community services, health workforce shortages and maldistribution of the health workforce
- Inadequate communication to support clinical handover, including record keeping and shared patient information
- Timely hand-over from hospital to GP
- Clear health provider role delineation
- Generalists' knowledge gaps around treatments and short- and long-term consequences
- Letters from specialists and hospitals may not be structured to contain the necessary information for effective shared care

5. Conclusion

This position statement highlights the importance of shared care pathways, communication and information exchange, the need for intercollegiate clinical practice guidelines, improved care coordination and continuity between services.

Health professionals alone cannot bring about sustainable change without health system improvements to support them. By establishing more appropriate funding, IT infrastructure and shared care pathways (such as protocols) for care between GPs and non-GP specialists, patients with complex, chronic conditions will achieve better health outcomes.

In addition to the appropriate health infrastructure and funding to support shared care, a cultural shift may also be required to encourage trust and relationship building between hospitals and cancer services with GPs and their multi-disciplinary teams.

6. References

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