Abstract #: 37

Development and implementation of "advanced cancer shared care letters" to improve shared care between oncologists and family physicians

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PaCES
PALLIATIVE CARE EARLY AND SYSTEMATIC

BACKGROUND

Optimal care of advanced cancer patients requires a collaborative approach between oncologists and family physicians, starting early in the disease trajectory.

OBJECTIVE

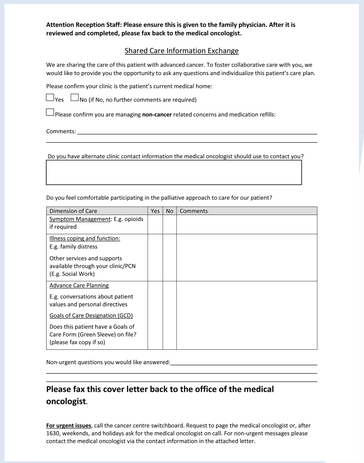
To develop and implement **"advanced cancer shared care letters"** for people living with advanced colorectal cancer, with the aim to improve communication, collaboration and role clarity amongst physicians.

METHODS

- Letters were developed with input from family physicians, oncologists, palliative care clinicians, and patient advisors
- Letter is ordered by the oncologist when a patient is determined to have advanced (i.e. incurable) cancer
- Letter outlines components of shared care and suggested division of responsibilities
- A fax-back sheet is provided for family physicians to confirm their involvement, their comfort level with providing a palliative approach to care (e.g. advance care planning, managing symptoms), and ask questions
- Letters were implemented in 9 gastrointestinal oncology outpatient clinics over 5 months

Physician-to-physician "advanced cancer shared care letters" **increase communication and care coordination** between family physicians and oncologists sharing the care of people living with advanced colorectal cancer.

Scan to view the clinical practice guideline "Metastatic Colorectal Cancer: Early Palliative Approach" and sample shared care letters (available at www.ahs.ca/guru), under Palliative & Supportive Care.



Attention Reception Staff: Please ensure this is given to the family physician. After it is reviewed and completed, please fax back to the medical oncologist.

Shared Care Information Exchange

We are sharing the care of this patient with advanced cancer. To foster collaborative care with you, we would like to provide you the opportunity to ask any questions and individualize this patient's care plan.

Please confirm your clinic is the patient's current medical home:

☐Yes ☐ No (if No, no further comments are required)

☐Please confirm you are managing **non-cancer** related concerns and medication refills:

Comments: _____

Do you have alternate clinic contact information the medical oncologist should use to contact you?

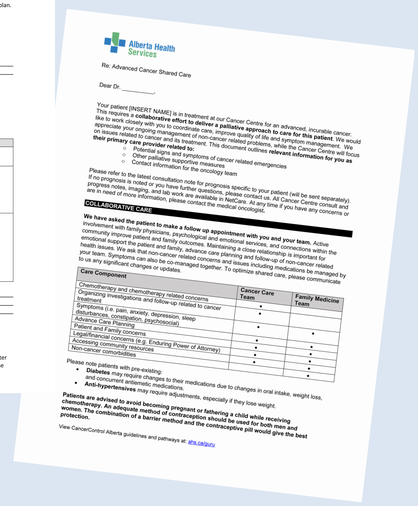
Do you feel comfortable participating in the palliative approach to care for our patient?

Dimension of Care	Yes	No	Comments
Symptom Management: E.g. opioids if required			
Illness coping and function: E.g. family distress Other services and supports available through your clinic/PCN (E.g. Social Work)			
Advance Care Planning E.g. conversations about patient values and personal directives Goals of Care Designation (GCD) Does this patient have a Goals of Care Form (Green Sleeve) on file? (please fax copy if so)			

Non-urgent questions you would like answered: _____

Please fax this cover letter back to the office of the medical oncologist.

For urgent issues, call the cancer centre switchboard. Request to page the medical oncologist or, after 1630, weekends, and holidays ask for the medical oncologist on call. For non-urgent messages please contact the medical oncologist via the contact information in the attached letter.



Alberta Health Services

Re: Advanced Cancer Shared Care

Dear Dr. _____,

Your patient [INSERT NAME] is in treatment at our Cancer Centre for an advanced, incurable cancer. This requires a **collaborative effort to deliver a palliative approach to care for this patient**. We would like to work closely with you to coordinate care, improve quality of life and symptom management. We appreciate your ongoing management of non-cancer related problems, while the Cancer Centre will focus on issues related to cancer and its treatment. This document outlines **relevant information for you as their primary care provider related to:**

- Potential risks and symptoms of cancer related emergencies
- Other palliative supportive measures
- Contact information for the oncology team

Please refer to the latest consultation note for prognosis specific to your patient (will be sent separately). If no prognosis is noted or you have further questions, please contact us. All Cancer Cares consult and progress notes, imaging, and lab work are available in Netcare. At any time if you have any concerns or are in need of more information, please contact the medical oncologist.

COLLABORATIVE CARE

We have asked the patient to make a follow up appointment with you and your team. Active involvement with family physicians, psychological and emotional services, and connections within the community improve patient and family outcomes. Maintaining a close relationship is important for emotional support for the patient and family, advance care planning and follow-up of non-cancer related health issues. We ask that non-cancer related concerns and issues including medications be managed by your team. Symptoms can also be co-managed together. To optimize shared care, please communicate to us any significant changes or updates.

Care Component	Cancer Care Team	Family Medicine Team
Chemotherapy and chemotherapy related concerns	•	
Organizing investigations and follow-up related to cancer treatment	•	
Symptoms (i.e. pain, anxiety, depression, sleep disturbances, constipation, psychosocial)	•	•
Advance Care Planning	•	•
Patient and Family concerns		•
Legal/financial concerns (e.g. Enduring Power of Attorney)	•	•
Accessing community resources	•	•
Non-cancer comorbidities	•	•

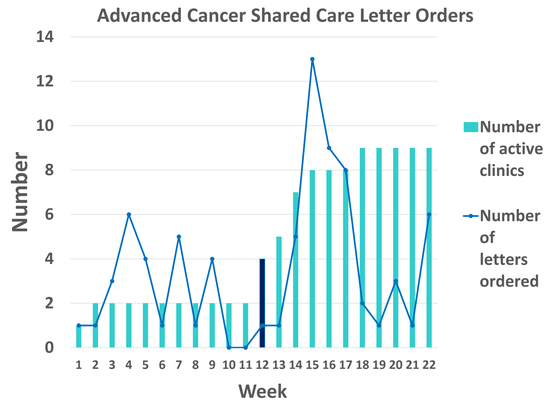
Please note patients with pre-existing:

- **Diabetes** may require changes to their medications due to changes in oral intake, weight loss, and concurrent antiemetic medications.
- **Anti-hypertensives** may require adjustments, especially if they lose weight.

Patients are advised to avoid becoming pregnant or fathering a child while receiving chemotherapy. An adequate method of contraception should be used for both men and women. The combination of a barrier method and the contraceptive pill would give the best protection.

View CancerControl Alberta guidelines and pathways at: ahs.ca/guru

RESULTS



- Weeks 1-11: Letters piloted in 2 clinics
- Weeks 12-22: Letters rolled out to remaining 7 clinics
- Total letters ordered = 76. In 5 cases, a family physician was not identifiable.
- Fax-back sheets were returned by 39/71 (55%) of family physicians. Content included prognosis questions, goals of care conversations, capacity to manage symptoms (e.g. opioid prescribing), and requests to engage palliative care services.
- Implementation challenges included frequent changes in clerical staff and management, electronic chart challenges, and variable adoption.

ACKNOWLEDGEMENTS

The Palliative Care Early and Systematic (PaCES) program is supported by grants from Alberta Health and the Canadian Institutes of Health Research.

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