Evolving strategies in followup for cancer patients

A collaborative model provides a bridge between tertiary and primary care

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Abstract

The number of patients requiring followup care after treatment for cancer is increasing. New models of care are needed to relieve the burden on tertiary cancer centres and assure access for new patients. There is much debate about how followup care should be provided and who should provide it. In Ottawa, a pilot project was initiated in 2014 to integrate cancer assessment and followup expertise into a community clinic. The objective is to ensure that patients discharged from the cancer centre receive high-quality care in the community setting to meet both cancer and non-cancer needs. Shared information and established relationships help to expedite referrals back to the cancer centre when needed.

Keywords: followup cancer care, community oncology, oncology in primary care

Introduction

The increasing incidence of cancer and availability of new effective therapies in adjuvant and metastatic disease have increased the need for followup care of cancer survivors. This development brings with it questions about how the workload involved in providing followup care might best be distributed. There is much debate around the most appropriate models of care for patients who have completed treatment and are well, but require ongoing surveillance for possible recurrence and late side effects, along with general health care. Questions arise ever more frequently about whether cancer survivor care should be led by nurses, oncologists, primary care physicians or in a shared-care model.

Current practice that concentrates care and followup in tertiary centres entails significant costs and results in delays for new patient evaluations (notably diagnostic imaging and procedures), the provision of treatment, and followup care. It is becoming clear that some of this care could be provided in other settings, presenting the possibility of improving cost effectiveness without compromising quality, and freeing up time and space in tertiary centres to facilitate access for new patients and active cancer care.

Oncologists, Primary Care Providers or Both?

In January 2016, a Cancer Survivorship Symposium was held in San Francisco. The title of the meeting was: “Who is caring for cancer survivors: Oncologists or Primary Care Physicians (PCPs)?” The PCPs surveyed in one study reported at the meeting\(^1\) (see Oncology Exchange, May 2016) preferred that oncologists take primary responsibility for followup care. In contrast, oncologists preferred a model of shared responsibility. Oncologists were concerned that many of these patients had chronic problems unrelated to their malignancy that PCPs are more skilled to address, and also felt that PCPs had, or could develop, the skills required for followup cancer care. There appeared to be agreement at the meeting that a shared program of followup care was the appropriate solution, leaving open the question of how such a model might be designed and delivered.

While the article mentioned above is based on US experience, the message is one that the St Laurent Medical Centre in Ottawa took to heart 2 years earlier as it endeavored to find ways to implement shared care in the Canadian context. The intention was to provide an alternative setting for high-quality followup of cancer survivors in a community clinic, to lighten the load in tertiary care settings, allowing the cancer centre to focus on new patients, active treatment and followup of complex cases.

An Innovative Model

The Ottawa model of shared followup care between primary care providers and oncologists was initiated in 2014 as a collaboration between the Ottawa Regional Cancer Centre (ORCC) and an Ottawa community clinic. The initial pilot project was designed based on expressions of interest by medical oncology staff operating at the ORCC. The setting for the experiment is a large primary care clinic

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facility, the St Laurent Medical Centre (SLMC), a multi-disciplinary clinic with 25 examining rooms, a busy walk-in clinic open from 9 a.m. to 8 p.m., a pharmacy, and laboratory and ultrasound services.

THE SLMC CANCER ASSESSMENT AND FOLLOWUP CLINIC
In 2014, the SLMC established a Cancer Assessment and Followup Clinic staffed by a multidisciplinary team of specialists, including radiation and medical oncologists, hematologists and general practitioners in oncology (GPOs), who practice at both the ORCC and SLMC. Oncologists work at the SLMC on a fee-for-service basis according to a schedule that does not conflict with their contractual obligations to the ORCC, and provide services for patients at both ends of the cancer continuum.

FOLLOWUP FOR CANCER SURVIVORS
The Clinic provides an alternative care program for the management of patients registered at the ORCC who have completed their primary therapy and require ongoing followup. The program operates in close collaboration with the ORCC. Following diagnostic procedures and tests, patients who show signs of cancer recurrence are then referred back to ORCC for more complex diagnostic procedures and treatment as appropriate. Collaboration involves information sharing between the 2 sites. Results from radiology and diagnostic procedures undertaken at the ORCC are readily available at SLMC, and vice-versa. The SLMC is fully equipped with an electronic medical record and on-site server.

EXPEDITED DIAGNOSIS OF NEW CANCERS
The Clinic also enables oncologists to provide a first stage of cancer assessment for primary care patients at SLMC with a suspected new cancer. This helps general practitioners expedite diagnostic procedures needed to confirm or rule out a suspected cancer. The GPOs and on-site oncologist can arrange necessary investigations such as computed tomography (CT) scans, magnetic resonance imaging (MRI), ultrasound, fine needle aspiration biopsy, and laboratory assessment for cancer biomarkers. If the investigations prove positive, a referral can then be made to the ORCC for an expedited appointment. The expertise of oncologists working at the Clinic and their established relationship with the ORCC provides a valuable bridge that helps patients proceed to treatment more rapidly.

If the investigation of a suspected cancer by Clinic oncologists turns out negative, the patient returns to the family physician, who receives full reports of the assessment and results of completed tests. In case of equivocal results, repeat investigations are scheduled ahead of time to assure that the patient does not fall through the cracks.

A few examples serve to illustrate the role collaborative care at SLMC plays in improving the cancer trajectory:

Example 1: A 42-year-old man was referred to the Clinic by his SLMC family physician when he presented with an enlarging submandibular mass. The investigations, including biopsy, took approximately 2 1/2 weeks to complete and resulted in a diagnosis of tonsillar cancer. He was referred with complete documentation to the ORCC for expedited treatment that was able to eradicate the cancer.

Example 2: A 20-year-old woman presented to her general practitioner at SLMC with vague abdominal pain. Assessment by the medical oncologist and ultrasound raised suspicions of possible pancreatic involvement. The investigation completed in less than 2 weeks proved negative for cancer, much to the relief of the young patient and her family.
The patients mentioned above continue to be followed at SLMC. In the patient with tonsillar cancer, followup 1 year after completion of his treatment detected likely colon cancer, which was investigated at the Clinic and, once again, the patient was referred in an accelerated manner to ORCC for prompt treatment.

**A BRIDGE TO SMOOTH TRANSITIONS**

The Clinic is available to patients who have completed their course of treatment at the ORCC and have been discharged to their GP at SLMC, who is supported by the Clinic’s experienced oncologists. Patients benefit from receiving, in one location, primary care for non-cancer conditions, ongoing monitoring of cancer-related issues that is supported by Clinic GPOs and oncologists, and a fast track back to the ORCC should they experience recurrence or develop a new malignancy. Transitions become smoother as information is readily available to care teams at both sites, and investigations are less likely to be repeated as the ORCC recognizes the expertise available at the Clinic. Resource use and care trajectories are streamlined to optimize quality and efficiency.

In one example, a 55-year-old man was referred to SLMC after completing treatment for testicular cancer and being discharged from ORCC care. His annual CT scan, undertaken as part of followup monitoring by the SLMC Clinic, showed possible metastatic involvement in his lung. In less than 24 hours, the patient was referred back to his original radiation oncologist at the ORCC with the results of the CT scan. This collaborative approach to cancer investigation and followup can only be achieved in a setting designed to provide an intermediary step between tertiary care hospitals and primary care physicians.

**A HOME FOR ORPHAN PATIENTS**

Additionally, the SLMC Clinic agreed to provide a followup option for patients who have been discharged from the ORCC and have no regular physician to look after them afterwards. The SLMC program assures care and followup for patients referred to the Wellness Beyond Cancer Program (see box below) who have been discharged from the ORCC but are having difficulty accessing a primary care physician. At SLMC, oncologists and primary care providers cover both the general health and cancer followup needs of these patients.

**THE FUTURE**

The Cancer Assessment Clinic and Follow-Up Clinic at SLMC was established in 2014 as a means of increasing efficiency, cost effectiveness and quality of care for cancer patients who have completed treatment. In the pilot stage of the program, only ORCC patients who had colorectal cancer were being referred to SLMC, but later this evolved and expanded to include other tumour sites. An evaluation will be conducted to assess satisfaction among general practitioners and patients with this new model of care. The results of the evaluation and assessment of system benefits from the pilot program will be used to determine whether it could be extended to other tertiary medical specialties.

**References**

2. The Ottawa Hospital Cancer Centre (2012) Guide: Wellness Beyond Cancer Program. Available at: http://ottawahospital.on.ca/wps/wcm/connect/05d357004ba05b4191d6dd5b8a72a08/WBCP+Booklet.pdf?MOD=AJPERES

**WELLNESS BEYOND CANCER PROGRAM**

Patients at the Ottawa Regional Cancer Centre are referred to the Wellness Beyond Cancer Program once active treatment is complete. Patients and their oncologist discuss followup needs and determine the best healthcare provider to lead their ongoing care. The followup plan is individualized to meet the particular needs of each patient. The guide describes the purpose of followup to patients in the following way:

No further treatment is needed at this time at the Cancer Centre. You will, however, need ongoing followup. The purpose of followup is to:

1. Monitor for cancer spread and detect early recurrence of the cancer you have had;
2. Enable early detection of other cancers;
3. Look for and manage late and long-term effects of cancer and its treatment;
4. Provide emotional and informational support;
5. Promote healthy lifestyle behaviours and encourage regular cancer screening.