



**BC Cancer Agency**

CARE + RESEARCH

*An agency of the Provincial Health Services Authority*

**Family Practice Oncology Network**

# Family Practice Oncology Network

*Dr. Philip White, Chair and Medical Director*

*Survivorship in the primary care setting*

November 2, 2013

[www.fpon.ca](http://www.fpon.ca)

# FPON Objectives

- ▶ *To improve cancer care and survivorship in BC by providing support and connection to physicians in the community.*
- ▶ Resources and tools to enhance primary cancer care
- ▶ Liaison between family physicians and the BC Cancer Agency
- ▶ Established 2002



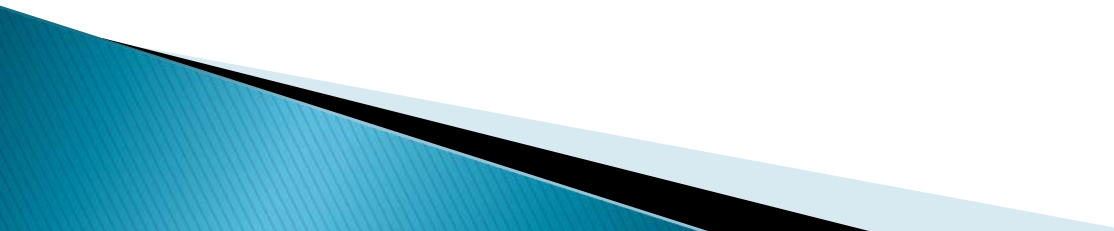
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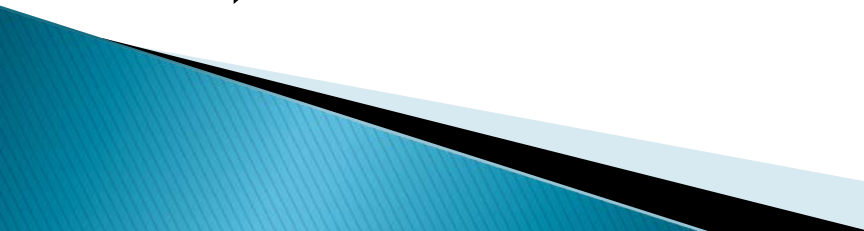
# Background

- ▶ Approximately two-thirds of cancer survivors are over the age of 65. For a GP this means approximately one in six adults over 65 in their practice is likely to be an adult cancer survivor.
  - ▶ The most common cancers in this population are breast, prostate, lung and colorectal.
  - ▶ Survivorship with lung cancer tends to be short
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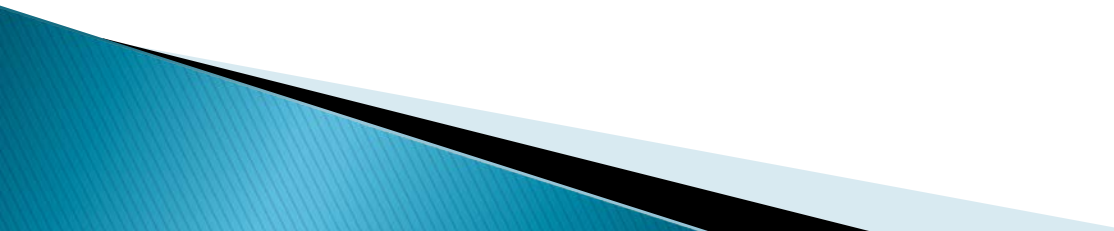
# The Challenge

- ▶ Looking at all types of cancer, two-thirds of patients diagnosed today will survive at least 5 years or more and be long-term survivors.
  - ▶ Cancer care is no longer focused exclusively on treatment and palliation, it must now also consider how best to manage survivorship.
  - ▶ The majority of cancer survivors in BC still have a primary care physician > 90%
  - ▶ Those who do not have a GP and are “unattached” pose a special challenge which is now recognised with steps in place to accommodate
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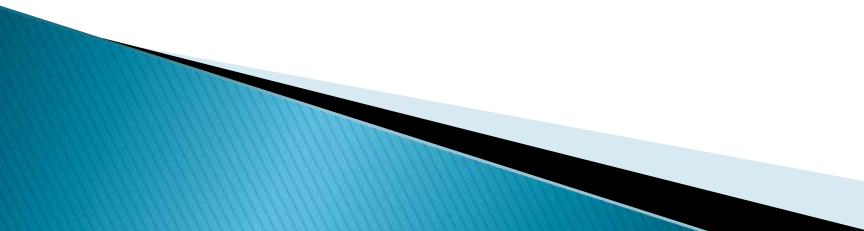
# Current state of care

- ▶ A) Prevention, screening, case finding and diagnosis remain principally at the level of primary care.
  - ▶ B) Treatment occurs through cancer agencies either in centre or community based
  - ▶ C) Survivorship is back to primary care
  - ▶ D) Information back to primary care is inconsistent sometimes inadequate and not standardised
  - ▶ E) How do we best link B) and C) ?
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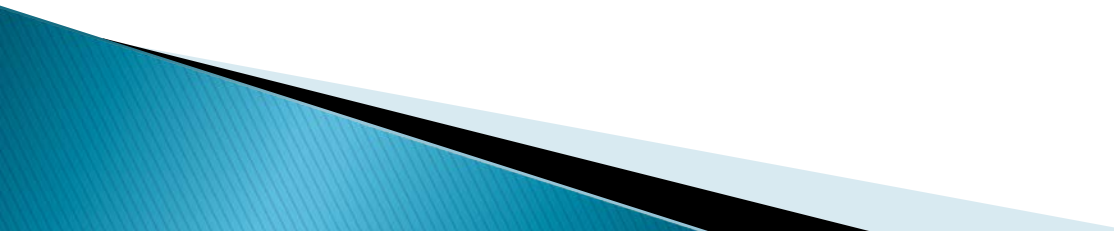
# Survivorship in primary care

- ▶ Medical management of cancer survivors requires cancer-specific follow-up care.
  - ▶ Follow-up care consists of periodic routine visits and tests to detect recurrence, monitor effects of treatment, screen for new primary cancers (higher risk of second cancer) and provide psychosocial support.
  - ▶ The frequency of visits and tests required vary according to the type of cancer.
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# Survivorship in primary care

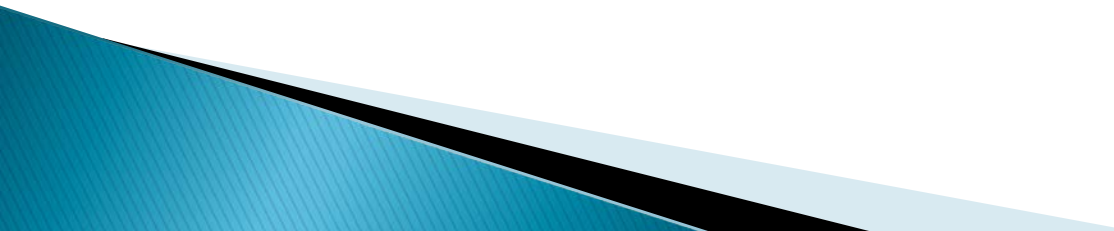
- ▶ How do we derive the appropriate information to manage all of this?
  - ▶ Currently the information will usually come from the oncologist by way of a letter or discharge summary which may or may not provide adequate information to encompass all that we need
  - ▶ Sometimes parts of the follow up are done by the oncologist with scheduled visits leaving other parts to the GP. This can lead to confusion as to who is responsible for what.
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# A better transition?

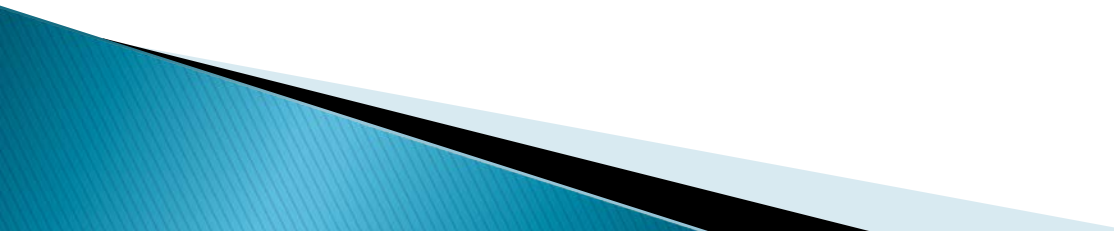
- ▶ It has now been shown in two randomised controlled trials — one conducted in the UK and one in Canada — that primary care-based follow-up of breast cancer patients is a safe alternative to specialist follow-up as measured by a range of outcomes, such as delay in diagnosing recurrence, the rate of recurrence-related serious clinical events, health-related quality of life and patient satisfaction. (Dr.Eva Grunfeld)
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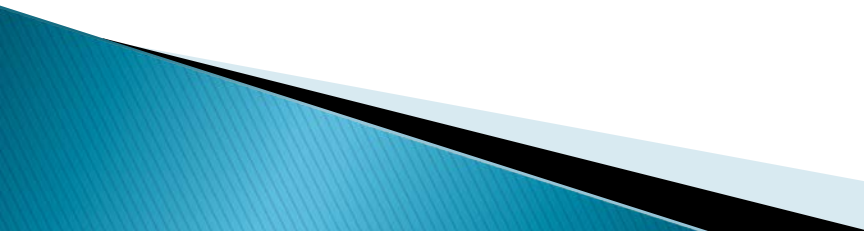
# A better transition?

- ▶ While these two trials studied breast cancer patients the findings can be arguably viewed as proof of principle for the other most prevalent cancers. Previous research has suggested that family physicians wish to be more involved in the ongoing care of their patients with cancer.
  - ▶ These two trials have shown that not only are GPs willing to assume primary responsibility for follow-up care, but that they can do so with outcomes similar to specialist care. (Dr. Eva Grunfeld)
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# How do we achieve a better transition?

- ▶ One of the objectives of the Family Practice Oncology Network (FPON) is to improve the patient experience in all aspects of survivorship
  - ▶ Keys to this are information, affiliation and integration with others involved in survivorship (oncologists, agency staff, community teams, e.g. palliative care, NPs and others) and empowerment of patients
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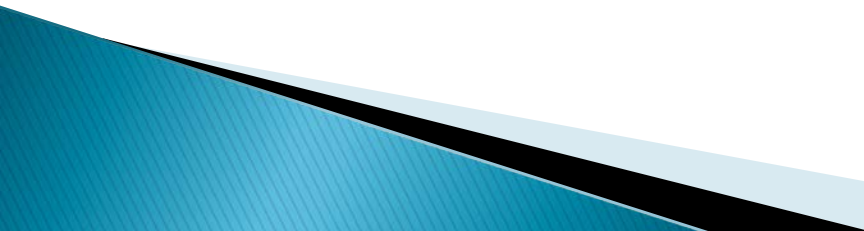
# How do we achieve a better transition?

- ▶ FPON is achieving some of these objectives by producing cancer specific primary care guidelines in conjunction with the Guidelines and Protocols Joint committee of the MSC and BCMA
  - ▶ These guidelines contain the necessary clinical information for screening, diagnosis and follow up and integrate a follow up flow sheet for post treatment care as well as a patient information sheet to inform patients as to what care is required and when.
  - ▶ They are produced by a team of oncologists and primary care givers.
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# How do we achieve a better transition?

- ▶ These FPON guidelines which currently encompass a suite of 3 palliative care guidelines (The approach to care, Pain and symptom management and Bereavement), 2 Colorectal Cancer guidelines ( Screening and Follow up) Breast guidelines and Female Genital tract, soon to be published, as well as many others about to be developed for the more common cancers, go some way to bridging the care and information gaps for transition.

# What else is needed?

- ▶ If we look at what is required we also need to look at how we integrate that into our normal workflow
  - ▶ CPGs such as the FPON guidelines help but we also require a standardised format for receiving information from oncologists and the agency that succinctly provides the required information. This needs to be available at least for a while in paper format with integration into EMRs (more of that a little later) possible too.
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# How do we achieve a better transition?

- ▶ We need the patient's to be informed and part of the process so that they can truly share the responsibility for their care
  - ▶ We need information about programs at the agency to do with survivorship and the ability to easily navigate the agency world to obtain the right information at the right time if problems arise.
  - ▶ We need information on community resources.
  - ▶ We need information on what to do with unattached patients (NPs and programs)
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# How do we achieve a better transition?

- ▶ Thankfully the whole survivorship world has “come alive” in the recent past and new and better initiatives are underway in all aspects of survivorship to improve the patient experience and, yes, survivorship.
- ▶ You will hear of some of this this morning but I would like to mention the electronic information initiative for EMRs in the North headed by Dr. Jaco Fourie, Dr. Dan Horvat’s initiatives in Northern health as well and all of the work going on inside the cancer agency that you will hear about from presenters today

# The Future

- ▶ Recognition that survivorship is principally a primary care responsibility and that the right approach to survivorship is of paramount importance as our population ages has finally arrived
  - ▶ There are multiple initiatives afoot to ensure that we do it right.
  - ▶ Today's conference will highlight what we are currently doing and how we hope to do it better in the future.
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