Title: Cancer nurses can bridge the gap between the specialist cancer care and primary care settings to facilitate shared-care models

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With advances in anti-cancer treatment, overall survival rates have dramatically improved over recent years. The global overall cancer mortality rate is reducing by 1% each year\textsuperscript{1}. In 2012, the estimated number of people living who had been diagnosed of cancer within the preceding five years was 32.6 million\textsuperscript{2}. Cancer survivors, however, experience a wide range bio-psycho-social late effects and impaired quality of life from their cancer diagnosis and treatment, often in the context of comorbid conditions\textsuperscript{3, 4}. For many countries, the acute cancer care system is not the most ideal setting to meet the long-term needs of cancer survivors with multiple chronic conditions and other psychosocial problems\textsuperscript{5}. Ensuring best outcomes and efficient use of resources by implementing patient-centred integration between the acute and primary care system is the hallmark of high-quality care, and a well-functioning and sustainable health system\textsuperscript{5}. The 2005 Institute of Medicine seminal report \textit{From Cancer Patient to Cancer Survivor: Lost in Translation}\textsuperscript{5} emphasises the importance of effective care coordination between specialists (e.g., oncologists, cancer nurses) and primary care providers (i.e., PCPs), which is likely to lead to increased patient convenience, reduced costs, reduced burden on specialists, and greater continuity of care\textsuperscript{6, 7}.

A number of barriers to shared-care between the acute cancer care setting and PCPs have been reported\textsuperscript{8, 9}. These include but not limited to insufficient or delayed communication between cancer specialists and PCPs, a lack of familiarity of PCPs with the highly specialised treatments and associated complications, and specialists’ uncertainty about the potential role of the PCP in follow-up care\textsuperscript{8, 9}. All of these barriers could likely be overcome if a specialist cancer nurse can facilitate effective and timely care coordination, and communication by acting as the conduit between the specialist cancer multidisciplinary team (MDT) and the PCPs at key transition time points (such as completion of adjuvant and definitive primary treatment). Nurses have assumed the role of care coordination and navigation for many years\textsuperscript{10}, and are therefore
the most logical solution to overcome these barriers and facilitate well-integrated, shared-care models.

One key element to facilitate well integrated survivorship care between the specialist MDT and the PCPs is the implementation of survivorship care plans. While the sharing of survivorship care plans with the PCP has been proposed\textsuperscript{11-13}, there is limited research identifying and evaluating the best process to facilitate the negotiation between the specialist, the PCP and the patient about the PCP’s role in the context of developing a true collaborative survivorship care plan. A formal process including communication between cancer specialists and PCPs to clarify roles and expectations is essential\textsuperscript{7}. To enable collaborative care planning between all stakeholders, the specialist cancer nurse can make use of face-to-face or video-case conferencing. A single case conference between acute care health professionals and PCPs has been shown to improve patient- and system-level outcomes in other populations receiving palliative care\textsuperscript{14, 15}. These opportunities should be explored and evaluated in the cancer survivorship setting.

Three recent survey studies involving cancer nurses\textsuperscript{16, 17} and oncology practitioners\textsuperscript{18} identified a strong level of agreement amongst nurses that coordination of care including facilitation of integrated care with PCPs falls within their responsibility. Despite this, the nurses in these studies do not frequently coordinate care or communicate with PCPs\textsuperscript{16-18}. Nurses’ perceived barriers to delivery of survivorship care were ‘lack of time’, ‘lack of dedicated end-of-treatment consultation with the patient’, and ‘not a priority for the cancer centre’\textsuperscript{16-18}. These findings suggest that dedicated cancer nursing roles are required to facilitate effective communication and coordination between the acute care and primary care settings. More research is required to propose and evaluate the role of cancer nurses in facilitating the collaborative care planning
and negotiation of care providers’ responsibilities between cancer specialists and PCPs. The scope of these facilitation roles should also include interventions that aim to encourage patients to schedule post-treatment follow-up appointments with PCPs as per the survivorship care plan. While some patients may have preferences for which provider (oncologist vs PCP) they want to handle their survivorship care after primary treatment\textsuperscript{19}, the specialist cancer nurse can provide education regarding the PCP’s role and the potential benefits of greater involvement of the PCP\textsuperscript{19}. With the ever-rising incidence of cancer and number of cancer survivors, the cancer nursing community should take the lead in ensuring a sustainable health care system and own the implementation of integrated cancer survivorship care. It is also important that we use a wide range of pragmatic trial designs to generate high-level evidence to inform practice and policy development in this area.
References:


