A Quality Approach to Survivorship Implementation in the Northeast

Mark Hartman RVP Northeast
June 2017
Evidence for a New Model of Care

**CCO Position Statement:** The evidence supports the fact that for most breast, colorectal and prostate cancer patients, well follow-up care can be safely provided by primary care physicians.
Survivorship: Follow-up Visit with Specialist in Regional Cancer Centre

Figure 5: Percentage of breast cancer patients diagnosed in 2010 who attended at least 1 routine follow-up with a specialist at a regional cancer centre in the second (25–36 months from diagnosis) and third (37–48 months from diagnosis) follow-up years, by regional cancer centre.

Regional Cancer Centre

- Second follow-up year
- Third follow-up year

Report Date: January 2016
Source: OCR, ALR, DAD, NACRS, RPDB, CSI
Prepared by: Cancer Analytics, Analytics and Informatics, Cancer Care Ontario
Optimized Survivorship Model

Medical & Radiation Oncologist

Discharge after Active Treatment

Rapid System Re-Access

General Practitioner

Discharge & Treatment summary to GPO
Surveillance recommendations

Transition class Psychosocial services

Rapid System Re-Access to Specialists & Tests

Community Supportive Care

Cancer Centre Supportive Care

1-800 and Revise New Patient Referral form

E-mail or fax with 48h response time

Surveillance & treatment side effect guidelines

Community-based & NECC supportive care. Patient passport guidelines

Revise New Patient Binder
Early discussion and needs assessment

Revise New Patient Referral form

Medical record
Treatment summary
Surveillance & treatment side effect guidelines

Responsive

Accessible

Optimized Survivorship Model

North East Regional Cancer Program
in partnership with Cancer Care Ontario
Effective: Informing Primary Care

Breast Cancer Well Follow-Up Care
A Guide for Primary Care Providers in North East Ontario
November 2015

Colorectal Cancer Well Follow-Up Care
A Guide for Primary Care Providers in North East Ontario
April 2016
Effective: Primary Care Professional Development

Colorectal and Breast Cancer Well Follow-Up Care

Clinical Pearls for Primary Care

THIS GROUP LEARNING PROGRAM HAS BEEN CERTIFIED BY THE COLLEGE OF FAMILY PHYSICIANS OF CANADA FOR UP TO 6 MAINPRO+ CREDITS.
### Effective: Needs stratification

**TRANSITION — DISCHARGE PATHWAY FOR BREAST CANCER FOLLOW-UP**

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Intervention</th>
</tr>
</thead>
</table>
| 0 Month  | Oncology Consult  
- Expected discharge timeline communicated (print and verbal)  
- ESAS at all visits with PSO team consult if needed  
- Baseline BMD if to be on AI  
| Group 1 "High Risk"  
(15%) (15-50)  
| Group 2 "Intermediate Risk"  
(40%) (20-80)  
| Group 3 "Low Risk"  
(45%) (10-70)  |
| *6 month if HR+ may be later  
Completed adjuvant chemo & RT treatment if HR+  
- Oncology Discharge visit (MO and RO) for Group 2 & 3 if no ongoing treatment toxicities  
- Referral to TRANSITION CLINIC  
- Online referral to TRANSITION CLASS  
- TREATMENT SUMMARY and patient education materials provided  
| Attending oncologists  
| Attending oncologists  
| Attending oncologists  |
| *6 month if HR+ may be later  
PSO care may continue after D/C from GPO and /or oncologist  
| PSO team  
| PSO team  
| PSO team  |
| *7-8 month TRANSITION CLASS  
- All patients referred after completion of adjuvant RT and systemic – F2F or OTN  
| RN and social  
| RN and social  
| RN and social  |
| **12 months** History & P/E  
First Mammogram  
EMD if on AI; next BMD per guidelines  
| GPO  
| GPO  
| GPO  |
| 18 months History & P/E  
| FCP  
| FCP  
| FCP  |
| 24 months History & P/E  
Annual Mammogram  
| GPO  
| GPO  
| GPO  |
| 30 months History & P/E  
Annual Mammogram  
| GPO-change AET if sequential at 30-36 months  
| FCP, or GPO-change AET if sequential at 30-36 months  |
| 36 months History & P/E  
Annual Mammogram  
| GPO-change AET if sequential at 30-36 months  
| FCP, or GPO-change AET if sequential at 30-36 months  |
| 42 months History & P/E  
Annual Mammogram  
| GPO to re assess for extended AET  
| GPO to reassess for Extended AET  |
| 48 months History & P/E  
Annual Mammogram  
| GPO or FCP  
| GPO or FCP  |
| 54 months History & P/E  
Annual Mammogram  
| FCP  
| FCP  |
| 60 months History & P/E  
Annual Mammogram  
| FCP  
| FCP  |
| 72 months History & P/E  
Annual Mammogram  
| FCP  
| FCP  |
| **Annual visits to 10 years** History & P/E  
Annual Mammogram  
| FCP  
| FCP  |
| **10 years** History & P/E & Annual Mammogram  
| FCP  
| FCP  |

Health Sciences North / Horizon Santé-Nord
Northeast Cancer Centre
41 Ramsey Lake Road, Sudbury, Ontario P3E 5J1
(705)522-6237    (705)522-7318

TRANSITION CLINIC DISCHARGE

Patient: PATIENT LASTNAME, PATIENT FIRSTNAME, PATIENT MIDDLE INITIAL
DOB: Date of Birth
Sex: Subject's Gender
Health Card #: Health insurance number
Unit #: Unit where patient was treated
Full EHR: Electronic Health Record
NCC Number: Nine Character Code
RCP Chart #: Record Control Point Chart Number
Encounter Date: Date of encounter
Date of Service: Date of service

DIAGNOSIS:

RECOMMENDATIONS FOR COLON CANCER WELL FOLLOW-UP CARE

Patients should be encouraged to report new and persistent or worsening symptoms promptly, without waiting for a scheduled follow-up appointment.

The following are recommendations:

1. HISTORY AND PHYSICAL EXAM:

FREQUENCY:
- Every 6 months from year 1 to year 5

HISTORY:
- For CANCER RECURRENCE ask about:
  - Unexplained weight loss (e.g., >10 lbs, 4.5 kg) over 3 months
  - Vague constitutional symptoms (e.g., fatigue or nausea)
  - Dry cough
  - Abdominal pain, particularly the right upper quadrant or flank (lower area)

- For long term or LATE EFFECTS OF TREATMENT ask or assess for:
  - Emotional distress; quality of life
  - Bowel dysfunction (e.g., frequent, urgent, or loose bowel movements, gas or bloating, anal incontinence)
  - Evaluate for bowel obstruction
  - Incisional or parastomal hernia
  - Urogenital dysfunction
- For constipated patients: stool care and lifestyle adjustments
- Related to chemotherapy
  - Chemotherapy-induced peripheral neuropathy (e.g., oxaliplatin)
  - Cognitive dysfunction 'chemo brain'

2. PHYSICAL EXAMINATION:
- Abdominal exam (i.e., surgical scars, organomegaly, incisional/parastomal hernias)

PATIENT LASTNAME, PATIENT FIRSTNAME
RCP Chart #: NCC Number
Date of Service

- Respiratory exam
- CARCINOEMBRYONIC ANTIGEN (CEA) BLOOD TEST
  FREQUENCY:
  - Every 6 months from year 1 to year 5
  - Assess for rising levels
- DIAGNOSTIC IMAGING:
  FREQUENCY:
  - Every 12 months from year 1 to year 3
  - ABDOMINAL CT
  - CHEST CT
  * If local resources or patient preference precludes CT imaging, then substitute CT abdomen and chest, with ultrasound and chest x-ray respectively every 6-12 months for 3 years then annually year 4 and 5

7. COLONOSCOPY

FREQUENCY:
- At approximately ONE YEAR following surgery. The frequency of subsequent colonoscopies should be dictated by the findings of the previous one, but generally should be performed every 5 years if the findings of the previous ones are normal.

NOT RECOMMENDED:
- ROUTINE BLOOD WORK (e.g., CBC, liver function tests) aside from serum CEA, Fecal Occult Blood Test

Mosaic Auth Status
Dictator/Signature
Specialty
Copies to: Family Physician

*Transmitted-Transcribed Date/Time
**New Patient Referral Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accessible: Rapid Re-entry</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1 800 PCP non urgent advice/consult.</strong></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td><strong>X eConsult</strong></td>
<td>![Cross]</td>
</tr>
</tbody>
</table>

**PATIENT INFORMATION (Please Print)**

- **Surname**
- **Given Name(s)**
- **Date of Birth**
  - dd/mm/yy
- **Gender**
  - Male
  - Female
- **OHIN# (incl Version Code)**
- **Address**
- **City / Province**
- **Postal Code**
- **Patient’s Telephone**
- **Home**
- **Work**
- **Cell**

**Where to contact patient:**
- Home
- Hospital
- Other (specify)

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**Cancer Program will notify patient of appointment**

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**CLINICAL INFORMATION**

- The following information is required in order for this referral to be accepted and processed:
  - Final Confirming Pathology
  - Surgical Report
  - Consult and Progress Notes
  - Discharge Notes
  - History and Physical Notes
  - All Lab work Related to Diagnosis

  - *Pathology may not be required for a Radiation Oncology referral for palliative radiation. Pathology may not be required for Medical Oncology referral, at the discretion of the Medical Oncologist on call. No clinical information is required for AET review.*

**REFERRAL INFORMATION**

- **Referral to:**
  - Radiation Oncology
  - Medical Oncology
  - Surgical Oncology: Head & Neck
  - Skin
  - Gyn

- **Date of Last Surgery**
  - dd/mm/yy

- **Is Further Surgery Planned?**
  - Yes
  - No

- **Diagnosis**
  - Patient Informed of Diagnosis?
    - Yes
    - No

- **Referring Physician’s Name (Print)**
- **Physician Referral Number**
- **Referring Physician**
  - Tel:
  - Fax:

- **Today’s Date**
  - dd/mm/yy

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K-systemic treatment/clinical/new patients/referral form/referral form external use REV June 2015
Safety: Surveillance Reminders

Patient Auto Reminder

Date: April 4, 2016
Jane Doe
123 Any Street
Sudbury, ON P3E 5J1
1234567890-9X

Dr H Willow
75 Bayshore Rd
Sudbury, ON P3A 2C3

Colorectal Cancer Follow-up Care Reminder

Dear Jane Doe,

Our records indicate that you have completed oncology treatment for colorectal cancer and are now in follow-up care. You are receiving this letter as a supportive reminder that you may be due for a routine follow-up care visit with your primary care provider.

Please contact your primary care provider to discuss your personalized colorectal cancer follow-up needs. Follow-up care is the best way to monitor your well-being after your cancer treatment.

Please refer to your Northeast Cancer Centre Patient Survivorship Care Plan that was provided to you at the Cancer Centre for guidance about your follow-up care. For more information, consult Cancer Care Ontario’s Colorectal Follow-up Care Patient Pathway: www.cancer.care.on.ca/patientpathway

This reminder letter, sent to you and your primary care provider, is intended for informational purposes only. This letter is not a substitute for medical advice and should not replace personalized follow-up recommendations discussed with your primary care provider.

Thank you,

Northeast Cancer Centre

If you no longer wish to receive these courtesy reminder letters, let us know at any time by contacting the Northeast Cancer Centre at 1-705-522-6237 Ext. 2777 or toll free 1-877-328-1822 Ext. 2777

Primary Care Auto Reminder

Date April 4, 2016
Dr Herman Willow
75 Bayshore Rd
Sudbury, ON P3A 2C3

Dear Dr. Willow,

Our records indicate that your patient, Jane Doe, has completed active oncology treatment for colorectal cancer and is now in follow-up care.

You are receiving this letter as a supportive reminder that your patient may now be due for routine follow-up surveillance for colorectal cancer. Follow-up care is the best way to monitor your patient’s well-being after cancer treatment, and may help find a cancer recurrence early. Your patient has also received a letter as a reminder to contact your office and discuss his/her personalized colorectal cancer follow-up needs.

The following table lists the recommended colorectal cancer follow-up tests and frequency. They are guidelines only and do not replace the personalized surveillance recommendations that have been made by the treating oncology team.

<table>
<thead>
<tr>
<th>Test</th>
<th>Recommended Intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History</td>
<td>Every 6 months for 5 years</td>
</tr>
<tr>
<td>Physical Examination</td>
<td></td>
</tr>
<tr>
<td>Carcinoembryonic Antigen (CEA) Blood test</td>
<td></td>
</tr>
<tr>
<td>Abdominal CT scan</td>
<td></td>
</tr>
<tr>
<td>Chest CT scan</td>
<td></td>
</tr>
<tr>
<td>Pelvic CT scan - for rectal cancer patients with a primary tumour in the rectum</td>
<td>Every year for 5 years</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>One year after surgery, then as recommended by the treating surgeon</td>
</tr>
<tr>
<td>Rectosigmoidoscopy</td>
<td>For rectal cancer patients who are considered at high risk of local recurrence by the treating physician, sigmoidoscopy may be considered at intervals less than 5 years</td>
</tr>
</tbody>
</table>

Please refer to the Cancer Care Ontario Colorectal Cancer Follow-Up Care Pathway, available at: https://www.cancer.care.on.ca/pathways/

If this patient is no longer under your care or have received the letter in error please notify the Northeast at 1-705-522-6237 Ext. 2777 or toll free 1-877-328-1822 Ext. 2777

Thank you,
Northeast Cancer Centre

Copy to:
Outcomes - Follow Up Location

686
16/17 Breast and colorectal patients transitioned to Primary Care

\[ \approx 1300 \]
Breast and colorectal patients eligible to transition
Balancing measure - Surveillance

Breast Cancer Survivorship Care According to Guidelines

Figure 1: Percentage of a group of patients followed for 3 years with mammogram tests in the first, second and third follow-up years, for breast cancer patients diagnosed in 2011, by Regional Cancer Centre of referral or consult.

Report Date: January 2017
Source: OCR, ALR, DAD, RACRS, DHP
Prepared by: Cancer Analytics, Analytics and Informatics, Cancer Care Ontario

Colorectal Cancer Survivorship Care According to Guidelines

Figure 2: Percentage of colorectal patients with at least one colonoscopy within 18 months of initial surgery (diagnosed 2011 to 2013), by Regional Cancer Centre of referral or consult.

Report Date: January 2017
Source: OCR, ALR, DAD, RACRS, DHP
Prepared by: Cancer Analytics, Analytics and Informatics, Cancer Care Ontario
Provincial Opportunities

• Knowledge transfer
  – Content development and maintenance
  – All stakeholders

• Measure the change
  – Plan outcome, process and balancing measures

• Align levers across system
  – Performance Indicators, Funding, Leadership Priorities.