From shared motivation to joint action along the cancer journey
What will it take to optimize primary care provider engagement in care transitions?

Dominique Tremblay, RN Ph.D.
Centre de recherche Charles Le-Moyne, Longueuil, Quebec, Canada
Nursing School, Faculty of Medicine and Health Sciences, Université de Sherbrooke, Longueuil, Quebec, Canada

BACKGROUND

Real-world evidence and national cancer programs still call for greater efforts to prevent people living with and beyond cancer (PLWBC) from getting lost in transition[1-2].

Assuring integrated care increases pressure on primary care providers (PCPs) to develop collaborative approaches with cancer team members[3-4].

Collaborative governance suggests the potential to overcome boundaries of medical and professional disciplines, competing objectives within and between specialized cancer teams and other healthcare providers and the policy - clinical practice divide[5].

OBJECTIVE

This study aims to report on PCPs concerns around their role in improving transitions along the cancer journey that were identified during the course of a larger study.

METHODS

Design:	Qualitative interpretive description[6]
Approach:	Pragmatic and hypothetico-deductive
Data collection:	Focus groups (n=11) Semi-structured interviews based on collaborative governance framework
Participants:	PCPs and cancer team members (n=61)
Analysis:	Iterative thematic analysis[7]

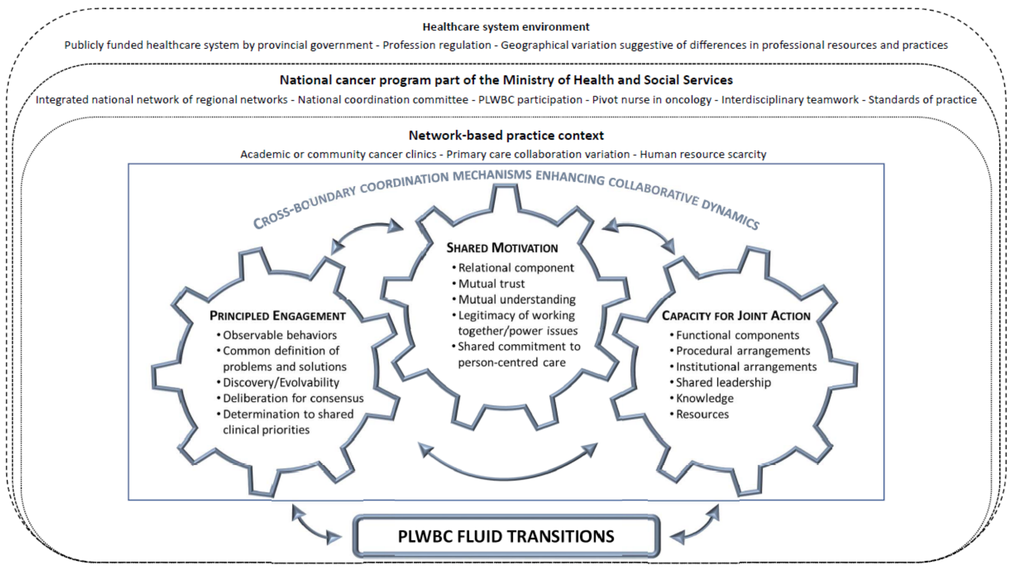


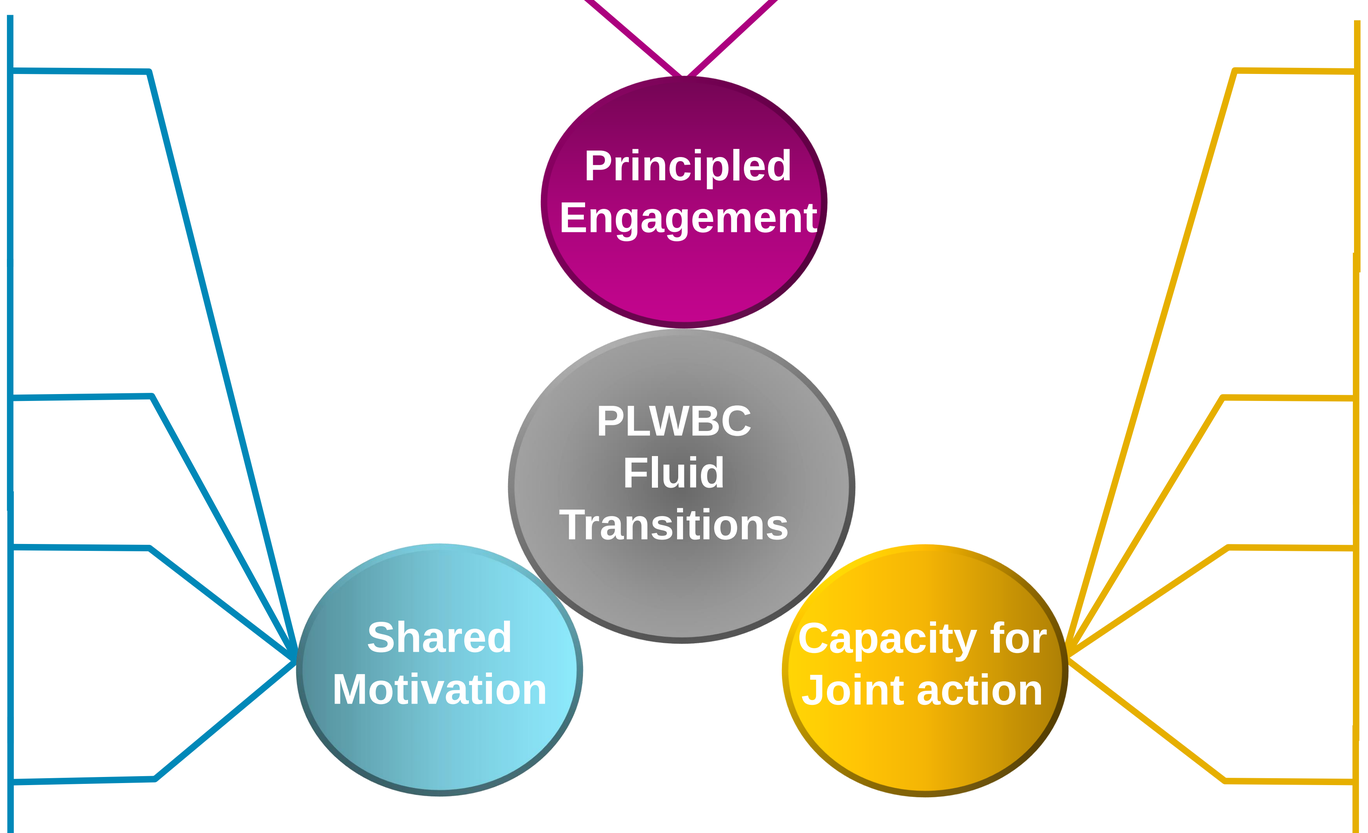
Fig. 1: Collaborative governance framework adapted to transition in PLWBC

RESULTS

It's important to formally coordinate links between PCPs and cancer teams. Unfortunately, we haven't even touched on stable links with cancer teams yet, despite it being on our work plan for two years (PCP manager)

The national level seeks to play a 'coach and connector' role, encouraging regional actors to talk to each other about particular issues they face, opening lines of communication (Family physician)

Directives from the Cancer Directorate are often issued without taking our realities into account, we need to see what's acceptable at a clinical level, in real life (Clinical nurse specialist, PCP)



We see what it means to work in a network, allows us to keep learning, to develop a sense of belonging that I see as a form of resilience. (...) being able to share and belong makes us more engaged in our work (Family physician)

Work on the continuum enabled PCPs and cancer team members to get to know each other's contributions and to raise trust (Oncologist)

Community of practice helps us understand transition gaps and to find solutions together (Pharmacist, Oncology)

Despite the fact that establishments in the network could have different interests, consensus appeared when discussion was brought back to the patient's needs (Social worker, Oncology)

Mobilisation went beyond top-down prescription from the Cancer Directorate. It was really carried by the co-managers and the interest of internal staff around serving the patient's best interest (Social worker, PCP)

Systematic references provide information that lead to prioritize action to facilitate transition to survivorship (Family physician)

Cancer team sends a liaison report to help us manage the patient. This enables us to follow up (Nurse, PCP)

I find myself with an oncology specialist, a nurse, a patient and a family physician. It's makes committee meetings interesting and allows the concerns of each party to be taken into consideration (PCP manager)

CONCLUSION

- Transition of care between specialized cancer and primary care teams is fragile and remains sub-optimal despite collaborative efforts.
- According to participants, better communication between care teams and the presence of referral mechanisms would make it easier to meet the needs of PLWBC.
- Results of the study offer insight into how the transition between PCPs and care teams can be supported and how these teams can complement each other while activating collaborative governance mechanisms.

ACKNOWLEDGEMENTS

IRSC CIHR Instituts de recherche en santé du Canada / Canadian Institutes of Health Research

e-mail: dominique.tremblay2@usherbrooke.ca

1.Stovall, E., Greenfield, S. and Hewitt, M. (2005). From cancer patient to cancer survivor: lost in transition. National Academies Press.
2.Ross, L. W., Townsend, J. S. and Rohan, E. A. (2022). Still Lost in Transition? Perspectives of Ongoing Cancer Survivorship Care Needs from Comprehensive Cancer Control Programs, Survivors, and Health Care Providers. Int J Environ Res Public Health, 19(5), 3037.
3.Rubin, G. et al. (2015). The expanding role of primary care in cancer control. Lancet Oncol., 16(12), 1231–1272.
4.Tremblay, D. et al. (2017). Optimizing clinical and organizational practice in cancer survivor transitions between specialized oncology and primary care teams: a realist evaluation of multiple case studies. BMC Health Serv Res., 17(1), 834.
5.Tremblay, D. et al. (2019). Collaborative governance in the Quebec Cancer Network: a realist evaluation of emerging mechanisms of institutionalization, multi-level governance, and value creation using a longitudinal multiple case study design. BMC Health Serv Res., 19(1), 752.
6.Thorne, S. (2016). Interpretive description: Qualitative research for applied practice. Routledge.
7.Braun, V. and Clarke, V. (2022). Thematic analysis : a practical guide. SAGE.