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CONFERENCE ABSTRACT

"To be followed up in general practice" - developing and implementing a shared care model for prostate cancer.

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Introduction: The prevalence of PC is rising and upon completion of the initial treatment PC patients are followed-up in the hospital OPD frequently and for many years. Guidelines recommend that patients with PC in stable phase can be monitored, controlled and treated in general practice. We describe how a shared care model for patients with PC was developed and implemented in a Region in Denmark covering 1.2 mill people

Methods: (Intervention model): A shared care model was developed by a steering committee, which consisted of general practitioners, patients, urologists and nurses from all urological departments in the Region. The model included (1) a clear description patient categories suitable for transferral to shared care and how follow up should be done, (2) a fixed structure for communication with GPs and (3) systematic patient involvement. With these “hard core” elements in place each department was allowed a “soft periphery” for local adaptation of the model. _Implementation_: The “hard core” elements in the implementation process that should bring the model into the daily clinical life included: Cross-departmental learning, continuous monitoring of patients transferred to shared care and feedback. The “soft periphery” allowed for local decision on how the different elements of the shared care model should be introduced.

Results: A total of 2585 patients with PC were enrolled in the study. A total of 758 (29%) patients were elegible for transferral to their GP, and 531 patients (21%) were, in fact, transferred. The main reason that a patient could not be transferred to GP follow-up was unstable PSA and a patient wish to continue hospital follow-up. Patients transferred to shared care were followed up with a questionnaire with a response rate of 71% of which 69% stated that they felt safe “to a great extent” and 27% ” to some degree”. Only 4 % answered ”to a lesser extent/not at all”. The new model was successfully implemented in the study period in all three outpatient departments. However, change was only sustained in the departments where a bottom-up, nurse-led approach, without extra resources had been followed whereas things went back to “usual care” when a top-down project manager based approach was applied.

Conclusions: An intervention model for transferral of patient from OPD to general practice was implemented across a Region which freed the equivalent of one month appointments in the OPD. An inclusive implementation process ensured sustainability.

Lessons learned: A cross sectorial model for shared care can be successful if developed from a GP perspective and if it includes all stakeholders. The model can be implemented with little external support, but will only be sustainable if implementation is flexible and driven by clinical staff on the ground.

Limitations: It is difficult to determine which elements of the model was more important and to what extent and how the specific context influenced the finding.

Future research: More cases across different topics and in diverse context will improve generalisability of the implementation principles found in this study

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Keywords: shared care; prostate cancer; follow up; implementation

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