Guideline Resource Unit
guru@ahs.ca

Shared Care Letter for Advanced Cancer

Oncology-Family Physician

Cancer Care Alberta

www.ahs.ca/guru

[DATE]

[PATIENT INFO]

Shared Care Information Exchange

We are sharing the care of this advanced cancer patient. To foster collaborative care, we would like to provide you with the opportunity to ask any questions and individualize this patient's care plan.

Please confirm that your clinic is this patient's current medical home:

☐ Yes ☐ No (if No, please fax back to let us know)

☐ Please confirm that you are managing **non- cancer** related concerns and prescriptions:

Comments: _____

_____

_____

Do you have alternate clinic contact information the medical oncologist should use to contact you?

Do you feel comfortable in participating in the palliative approach to care for this patient? (complete the table below)

Approach to Care	Yes	No	Comments
Symptom Management: (E.g., opioids if required)			
Psychosocial: (E.g., family distress)- are Social Work and other supports available?			
Advance Care Planning- do you have a Goals of Care Form (Green Sleeve) on file? (Please fax copy if so)			

Non urgent questions you would like answered: _____

_____

_____

_____

_____

If you are reading this via Connect Care in-basket, please send this form to the oncologist via Connect Care. Otherwise, please return via the contact details below.

[MO Sig Block with CONTACT DETAILS]

[DATE]
[PATIENT INFO]

Re: Advanced Cancer Shared Care

Dear Dr._[PCP]_____,

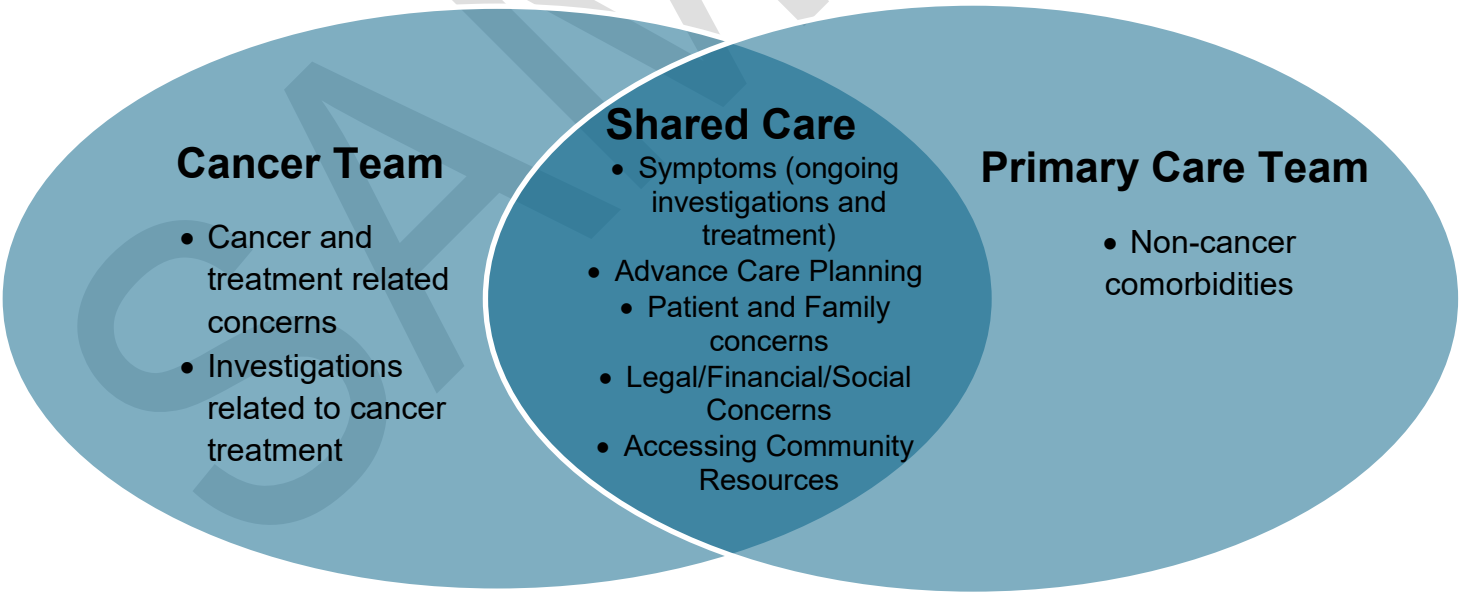
Your patient [PATIENT NAME] is in treatment at [CANCER CENTRE] for an advanced, incurable cancer. This requires **collaborative effort and a palliative approach to care:** supporting illness comprehension and coping, preventing or addressing symptoms and functional concerns, advance care planning and care coordination.

All Cancer Centre consult, progress notes, patient reported symptom trends, imaging, and lab work are available to healthcare providers in NetCare or Connect Care Provider Portal and available to patients via MyAHS Connect.

Collaborating on Shared Care

Your patient's care team includes: [CARE TEAM NAMES]

We will work closely with you to share care. The information shared here will help us manage this patient's symptoms and other cancer support needs together. To maintain their close relationship with you, **we have asked the patient to make a follow up appointment with you and your team to discuss and clarify elements of shared care between primary care and the cancer program**.



Please continue to manage all non-cancer related concerns. Note that co-morbid disease and its management may be impacted by cancer and its treatment (e.g., diabetes, hypertension). Adjusting

medications, simplifying and de-prescribing medication may be required. **Please inform us if there is a significant change in the patient's clinical status or location that might impact their cancer care or follow up with us.**

- **Contraception.** Ensure issues around contraception have been discussed for both female and male patients. Patients are advised to avoid becoming pregnant or fathering a child while receiving cancer treatment. There may be contraindications to the use of the contraceptive pill in some patients.
- **Smoking.** Support smoking cessation. For help patients can contact Alberta Quits 1-877-710-QUIT (7848) or *www.albertaquits.ca*. For clinical practice guideline, visit *www.ahs.ca/guru*.
- **Sun Exposure.** Chemotherapy and radiation treatment can cause skin sensitivity. Advocate for the use of sunscreen (minimum 15 SPF) and sunglasses. Advise against the use of indoor tanning beds.
- **Immunizations.** Promote annual non-live influenza vaccination, unless contraindicated (https://www.ahs.ca/assets/info/hp/cancer/if-hp-cancer-guide-supp002-vaccination.pdf). Other vaccinations as appropriate (i.e., pneumococcal, COVID-19).
- **Surveillance.** We recommend **stopping screening for other cancers** in the setting of advanced incurable cancer. Screening may be considered in a very small subgroup of patients where advanced disease is relatively indolent, or treatment is expected to result in prolonged survival.

Oncological Emergencies

Advanced cancer is associated with some of the most severe emergencies, including: **Febrile neutropenia, Spinal cord compression, Superior vena cava obstruction**. **Any fever** (over **38°C**) **while on systemic therapy** may indicate life threatening febrile neutropenia and/or other life-threatening infections. For a full description of oncological emergencies please see "Oncologic emergencies: A guide for family physicians", available through AHS's Primary Health Care Resource Centre: *https://www.ahs.ca/info/Page14872.aspx*

As part of your response to an oncological emergency during regular hours, please contact the triage line [INSERT NORTH OR SOUTH PHONE NUMBERS]. If this occurs after hours, please contact the medical or radiation oncologist on call through the switchboard of your cancer centre, as we may be able to expedite assessment. Concurrent use of the emergency room service is always available.

Symptoms

We will need to co-manage cancer-related symptoms with you. Cancer treatment side effects and complications specific to this patient are reviewed in consult letters and prior to initiation of treatment. Please contact [ONCOLOGY TEAM] with updates or questions as needed.

- For common treatment-related complications/symptoms e.g. fatigue, depression please see the Symptom Management section at *ahs.ca/guru*

- Complex symptoms may benefit from referral to specialist Palliative Care. See below

Palliative, Oncologic and Supportive Care Resources

We recommend ensuring that a strong community support system is in place as cancer progresses, to prevent crises. See the table below for a description of available services.

To find local support use:

- Referral Based Services for Advanced Cancer Care at https://www.albertahealthservices.ca/assets/info/hp/cancer/if-hp-cancer-guide-metastatic-colorectal-referral.pdf or www.ahs.ca/guru → Palliative & Supportive Care → Referral Based Services for Advanced Cancer Care

Service	Description
Oncology	Your patient may be connected to a variety of oncological providers (medical, radiation, hematologic, surgical, or gynecologic oncologist)
Integrated Home Care	In-home care and support (example: nursing services, personal care, respite services, wound care, case coordination, home care aides, equipment).
Specialized Palliative Home Care	In-home care and support. Focus on managing symptom issues, providing emotional and psychological support for clients with a progressive, life limiting illness. On call 24/7 support. Available only in Edmonton and Calgary. **Rest of province: No *separate* specialized palliative home care program, instead Integrated Home Care is provide** supported by Palliative Care Resource Nurses and Palliative Care Physician Consultants
Palliative Care Consultants (urban, rural, long term care, acute care)	Provide palliative care consultative support (in-person or phone/virtual visit) for adult clients, families, and healthcare teams to help manage complex palliative symptoms related to the client's life-threatening disease. Function.in a consultative role to better support the patient /family and attending teams e.g. family physician, oncology and homecare providers. **Consultants do not assume the role of most responsible healthcare provider.** **Rural:** If home visit is requested, the client should be admitted to **Integrated Home Care**. A joint home visit will be ideally arranged with the Case Manager.
Palliative Consult services within the Cancer centres	Patients with complex pain and symptom issues related to their cancer or cancer treatments can be referred by their oncologist for consult with the local Palliative Care team or provider at the Cancer Centre. Consultants facilitate ongoing symptom management and palliative care by patients' primary health care teams, via in-centre consult and collaboration with community and acute care providers/resources. Consult notes and recommendations will be sent to the referring oncologist and the patient's Family Physician. Patients must have symptoms caused by cancer or cancer treatment. **Consultants do not assume the role of most responsible healthcare provider.** This service is available to **current** cancer centre patients.
Emergency Medical Services: Assess Treat and Refer Program (EMS-ATR)	The EMS ATR program is for any adult patient receiving palliative or end of life care in the community (private home, supportive living site, long term care facility, and/or hospice) that may benefit from EMS involvement for urgent symptom management without transfer to hospital. Clinician (MD or homecare RN) should be present/available by phone to coordinate care with EMS. **The patient must be recognized as having high palliative care or end-of-life needs and would benefit from EMS involvement for urgent symptom management**. This is facilitated by having a C1 or C2 Goals of Care Designation order in the home and anticipating the possible need for EMS services with the home care case manager.
Community Paramedic Program	Non-emergent program for patients with chronic health concerns that prevent them from accessing available health care services. A range of medical services provided in the home. Preference of clinician present/available by phone to coordinate care.

	This program does not transport patients to acute care facilities. Operates 7 days a week from 0600 to 2200 hours with no cost to the patient.
Alberta Cancer Line	A provincial central contact service that can assist nurses, physicians, or other health care professionals with information on referrals, closer to home treatment programs, contact oncologists or other specialist oncology professionals (educators, pharmacists, psychosocial), and/or assist with accessing support services within AHS Cancer Care.
Psychosocial Oncology	Services to help patients and their families cope with the emotional, psychological and social stresses that often surface as a result of cancer and its treatment. Trained professionals may include psychiatry, psychology and social work, to help patients and their families cope with the emotional, psychological and social stresses that often surface as a result of cancer and its treatment. The team is available to patients from the moment of diagnosis onward.
Rehabilitation Oncology	For further control of symptoms such as pain, fatigue, weakness and range of motion in arms and legs, management of spasticity, equipment recommendations including home equipment, and orthoses/braces. Rehabilitation may involve longitudinal exercise or observation to help determine what goals or functional level patients will have. For non-oncologic rehabilitation needs, patients may self-refer to other programs in their community. https://www.albertahealthservices.ca/cancer/Page17173.aspx
Your PCN	Your Primary Care Network may have access to counseling, social work and other allied health supports closer to home.
CCA Patient Navigation	Patient Navigators are registered nurses with specialized training in cancer care. They can explain treatment choices and test results, and assist with the physical, practical, and emotional challenges that come with a cancer diagnosis. Available at 15 community cancer centres across Alberta. Indigenous Cancer Patient Navigators and Adolescent and Young Adult Patient Navigators also available.

Other Resources for your patients and families, and you

Practical tips such as how to order out-patient paracentesis, oxygen therapy, and access Indigenous liaison support in your zone are in "**Local Tips for providers"** at *www.specialistlink.ca* or at *www.ahs.ca/GURU* under "Palliative & Supportive Care."

- **Inform Alberta-** *www.InformAlberta.ca* to search resources in your community e.g. Meals on Wheels
- **Patients and Families** Cancer Care Alberta's website "*Supportive Care and Living Well*" contains *information* and links to:
  - Cancer support groups and peer-to-peer support
  - Cancer and Work
  - Counselling and support
  - Symptom Management
  - Palliative Care
  - Grief support

Advance Care Planning (ACP)

Advance care planning brings peace of mind. It helps ensure your patient's care is consistent with their values and their clinical context, even if they lose the ability to consent or withhold consent for treatments.

- Talking about Advance Care Planning includes **ongoing discussion about personal and treatment goals** (these may change significantly over time) Patient and provider resources are at *http://www.conversationsmatter.ca*
- Please encourage your patient to create/review these three important **legal documents**:
    - **Personal Directive** (selecting an alternate medical decision maker),
    - **Enduring Power of Attorney** (selecting an alternate financial decision maker),
    - **Will.**

  More information: https://www.alberta.ca/decision-making-advance-planning.aspx
- Please review your patient's Green Sleeve to see their current **Goals of Care Designation** order (GCD). Order a new GCD if there is no preexisting order, or if the existing GCD no longer reflects the patient's values and their medical context.
- **Document your conversations** on the **ACP GCD Tracking Record**, so that the patient's values and plans will be available to other clinicians providing care to this patient. Ensure the Tracking Record is returned to the patient's Green Sleeve.
- Remind the patient to keep the **Green Sleeve** on or near the fridge at home and to take it with them to clinic or hospital visits and to upload their documents through the myAHS Connect patient portal.

For more information about ACP documents or to download Goals of Care Designation and Tracking Record documents please visit: *www.conversationsmatter.ca*

If you are on Connect Care and are reading this via Connect Care in-basket, please reply to the oncologist via Connect Care. Otherwise, please return your reply via the contact details below.

We appreciate your partnership in caring for this patient.

Sincerely,

[MO Sig Block with CONTACT DETAILS]

I have CC'd this letter to: **[REFERRING PROVIDER]** and **[OTHER]**