Living Well Beyond Cancer

Improving Care Transitions, Post Cancer Treatment in Alberta

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“We can’t do this alone. As more of our patients live longer with and after cancer, we need to find better ways to share what we know and what we are learning with Primary Care, other health care providers, and with patients and families.”

- Oncologist

There are currently over 130,000 cancer survivors receiving adjuvant treatment or who have moved into the post-treatment phase of follow-up, surveillance and monitoring. This number is expected to double in 10 years.

These patients have unique needs as they are at increased risk of re-occurrence, as well as increased risk for developing a second unrelated cancer.

Patients want trusted sources of information about their cancer, treatments and health concerns, quick access to help when they need it, and support to live as well as possible.

Supporting improved transitions between cancer specialists and primary care is central to ensuring cancer patients receive optimal follow-up care, self-management, and care coordination support.

Tumor Teams identified populations of patients who could be transitioned early, created provincial follow up guidelines for those populations, so that “End of Treatment” letters and patient resources could be created.

The objective of this work is to develop increased awareness of, and support effective uptake of targeted transition supports for well cancer patients after their cancer treatments are complete.

We would like to acknowledge the involvement of GURU, C-MORE, Provincial Patient Education, Quality and Safety, ACPLF, and the Provincial Tumor Council and Teams in this work!