Implementing GP-led follow-up care for low-risk endometrial cancer patients on completion of active treatment at Monash Health

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VICS VICTORIAN INTEGRATED CANCER SERVICES

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Contents

Authorship

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Abbreviations

Abbreviation	Meaning
SMICS	Southern Melbourne Integrated Cancer Service
GP	General Practitioner
FIGO	The International Federation of Gynaecology and Obstetrics
MDT/MDM	Multidisciplinary Team/ Multidisciplinary Team Meeting
SMR	Scanned Medical Record

Acknowledgements

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Background

Endometrial cancer is the most common gynaecological cancer in Australian women. Mostly diagnosed at an early stage, the survival rate for endometrial cancer is higher compared to other cancers resulting in an increasing number of survivors[i]. Although women diagnosed with early stage low-risk endometrial cancer have a low risk of cancer recurrence, follow-up is recommended on completion of active treatment for up to five years[ii] The purpose of follow-up and survivorship care includes early detection of recurrent disease; managing treatment related side effects and co-morbidities; managing psychosocial distress; and providing people affected by cancer with appropriate information and/or support[iii].

Traditionally follow-up care is provided by a specialist clinician in a hospital based setting[iv]. Different models of care, including GP-led follow-up, have been investigated to reduce the burden of follow-up and survivorship care in acute cancer services. Research by Cancer Australia identified shared primary care led follow-up care for women with low-risk endometrial cancer as a model that assists in providing holistic care for patients and addressing the increasing demand for specialist services[v]. In 2020, Cancer Australia published A Guide for General Practitioners to support primary care provide high quality follow-up care for women with low-risk endometrial cancer in accordance with clinical guidelines.

In September 2021, the Monash Health Gynae-Oncology Department identified a need to increase clinical capacity of its outpatient clinic to manage a growing demand for services. The clinical team proposed to implement an alternative model of GP-led follow-up care to reduce the number of low-risk patients attending the outpatient clinic for follow-up appointments, thereby increasing capacity for more urgent consultations.

The Southern Melbourne Integrated Cancer Service (SMICS) supported Monash Health to develop a procedure outlining follow-up care for women with low-risk endometrial cancer in accordance with clinical guidelines. This procedure encompassing both hospital based follow-up and subsequent discharge to GP-led follow-up care on completion of active treatment. Where clinically appropriate, women with low risk-endometrial cancer will be discharged to their nominated GP for follow-up care with rapid access to the Gynae-Oncology Department in the case of suspected recurrence.

Aims and objectives

This project aims to increase clinical capacity in the Monash Health Gynae-Oncology outpatient service by discharging low-risk endometrial cancer patients to GP-led follow-up care on completion of active treatment in accordance with clinical guidelines. To achieve this, SMICS collaborated with Monash Health to develop a:

- procedure for follow-up care of women diagnosed with low-risk endometrial cancer;
- patient information sheet about GP-led follow-up care for low-risk endometrial cancer;
- discharge letter for GPs outlining Cancer Australia guidelines for managing low-risk endometrial cancer in general practice and rapid access processes; and
- form for GPs to opt-out of providing follow-up care for low-risk patients.

Methodology

The scope of this project included planning and development the procedure for GP-led follow-up care and supporting documentation. Project stages, activities and outputs are outlined in the table below.

Stage	Activities	Outputs
1. Planning	• Review literature, existing policies, procedures and clinical guidelines. • Establish working group to oversee the project.	• Literature review and summary of clinical guidelines
2. Development	• Develop Prompt procedure and supporting documentation including a GP discharge letter and GP opt-out form in collaboration with the working group. • Develop information sheet for patients in consultation with consumers. • Develop database to track patients discharged to GP follow-up care.	• Procedure for GP-led follow-up and supporting documentation approved by the Monash Health Gynae-Oncology Multidisciplinary Team, Women's Newborn Leadership Committee and Clinical Council. • Procedure published on Prompt. • Patient resources approved by the Patient Information Team and published on Prompt. • Database for monitoring patients referred to GP-led follow-up care.
3. Implementation and monitoring*	• Implement procedure for new patients with low-risk endometrial cancer. • Disseminate information to patients and their support people as required.	• Number of low-risk endometrial cancer patients discharged to GP-led follow-up care.

* Implementation and monitoring of the procedure is not within the scope of this project. Phase 3 of the project will be managed by the Monash Health Gynae-Oncology Department with support from SMICS if required.

Project governance and engagement

A working group including clinicians and specialist cancer nurses from the Monash Health Gynae-Oncology Department was established to oversee the project and guide the development of the follow-up care procedure for women with low-risk endometrial cancer. The procedure was submitted to the Monash Health Gynae-Oncology Multidisciplinary Team, Women's and Newborn Leadership Committee and Clinical Council for approval.

A patient information sheet was developed as part of this project. In line with Monash Health policy, two consumers provided feedback on the information sheet before it was submitted to the Patient Information Team for approval.

Actions

- The procedure, supporting documentation and patient information sheet now available on the Monash Health Prompt system is used by clinicians to guide provision of follow-up care and to educate patients about GP follow-up care for low risk endometrial cancer.
- Initial follow-up of women with low risk-endometrial cancer be conducted at the Monash Health Gynae-Oncology clinic for the first 12 months on completion of active treatment. If clinically appropriate, women with low-risk endometrial cancer be discharged to follow-up management in primary care after their follow-up 12 month appointment in accordance with the procedure.
- If a patient does not have a GP or their nominated GP opts-out of providing follow-up care, they continue to be managed at the Monash Health Gynae-Oncology clinic.
- The Gynae-Oncology Clinical Nurse Consultant enter all patients discharged on the low-risk protocol to a register for tracking and monitoring purposes.

Recommendations

- The Gynae-Oncology Team evaluate the implementation of the procedure in 12 months-time to determine if it has been effective in reducing the number of outpatient appointments for low-risk patients, and the proportion of patients discharged to primary care who have attended follow-up appointments as per the recommended schedule.
- A survey and/or focus groups with patients and GPs be conducted to determine if the procedure is acceptable and the extent to which it is being implemented as intended.
- SMICS to consider additional tumour streams/health services that would benefit from GP-led follow-up care to reduce the number of low-risk patients attending the outpatient clinic for follow-up appointments.

Appendices

Appendix 1: Procedure (including supporting documentation, patient information)

Monash Health

Follow-up care for women with low-risk endometrial cancer **Procedure**

TARGET AUDIENCE and SETTING

This procedure applies to all clinical staff treating women with low-risk endometrial cancer at Monash Health facilities. Note students work under the direct supervision of employees and are not listed separately.

PURPOSE

This procedure outlines the process of follow-up for women with low-risk endometrial cancer following completion of active treatment. It encompasses both hospital-based follow-up and subsequent discharge to primary care for follow-up management in accordance with clinical guidelines.

DEFINITIONS (optional)

FIGO – The International Federation of Gynaecology and Obstetrics

GP – General Practitioner

STANDARD REQUIREMENTS

When undertaking any clinical interaction with a patient, staff are expected to;

- Perform routine hand hygiene. Refer to the Hand Hygiene Procedure.
- Introduce themselves to the Patient and Carer/ Family if in attendance
- Check patient identification. Refer to the Patient Identification Procedure.
- Obtain consent as per the Consent to Medical Treatment Procedure.
- Keep the patient/carer informed and involve them in decision making.
- Document interaction in the electronic medical record or health record using black pen; including date, time, signature and designation.

PROCEDURE

All patients diagnosed with FIGO stage 1A grade 1/2 endometrioid endometrial adenocarcinoma who do not require adjuvant therapy will be assessed to determine if suitable for follow-up management with primary care in accordance with best practice guidelines.

Step 1: Hospital based follow-up

Initial follow-up will be conducted at the Monash Health Gynae-Oncology Clinic including:

1. Face-to-face appointment at 4-6 weeks post-operation.

- Provide the patient with written and verbal information about the symptoms and signs which require medical attention. Document discussions and information provided in SMR.

2. Face-to-face follow-up appointment at 6 months

- Patients suitable for the low-risk protocol will be identified during Multidisciplinary Team discussions. Document recommendations in the MDT Summary in SMR.

- Inform suitable patients they may be discharged to their nominated GP for follow-up care in collaboration with Monash Health specialists in accordance with clinical guidelines. This will be confirmed at the 12 month follow-up appointment.

3. Face-to-face follow-up appointment at 12 months.

- If clinically appropriate, the patient can be discharged to follow-up management in primary care after the 12 month appointment. Reasons for continuing hospital based follow-up include, but are not limited to:
    - treatment side effect surveillance (particularly lymphedema);
    - fertility sparing treatment (i.e. no hysterectomy); and
    - medically managed patients (i.e. no surgery).

Step 2: Discharging patient to follow-up in primary care in collaboration with specialists

- Inform the patient they will be discharged to their nominated GP for follow-up in collaboration with Monash Health specialists in accordance with clinical guidelines.
- Provide the patient with the *Follow-up of Low Risk Endometrial Cancer with your General Practitioner (GP)* information sheet to explain the follow-up process (Appendix 1).
- Confirm the contact details of the nominated General Practitioner (GP). If the patient does not have a GP, confirm contact details of the preferred primary care clinic.
- Explain to the patient their nominated GP can decline to participate in the follow-up protocol. If this occurs, follow-up appointments will be conducted by a specialist at Monash Health until the patient nominates an alternative GP.
- Treating clinician completes the *Discharge letter to Primary Care* (Appendix 2) to notify the nominated GP the patient is being discharged to their care for shared follow-up.
- Gynae-Oncology Clinical Nurse Consultant (CNC) sends the signed discharge letter to be scanned into SMR.
- Gynae-Oncology CNC updates the register to track low-risk endometrial cancer patients discharged to follow-up care in primary care. Data to be collected includes patient demographics, date of discharge and expected date of first follow-up appointment.

RELATED DOCUMENTATION

Appendix 1: Follow-up of Low Risk Endometrial Cancer with your General Practitioner (GP)

Appendix 2: Discharge letter for follow-up in General Practice (example)

Appendix 3: Rapid access request to the Gynae-Oncology Department at Monash Health

Appendix 4: GP opt-out of shared follow-up protocol.

Follow-up care for women with low-risk endometrial cancer Procedure

BACKGROUND

Women diagnosed with early stage low-risk endometrial cancer are at lower risk of local, regional and distance recurrence but still require regular monitoring after treatment. Follow-up care is recommended on completion of active treatment and may be GP-led in collaboration with specialists. The purpose of follow-up includes early detection of recurrent disease; managing treatment related side effects and co-morbidities; managing psychosocial distress; and providing information and/or support.

Cancer Australia developed A Guide for General Practitioners (2020) to support GPs manage follow-up care for women treated for low-risk endometrial cancer including a suggested follow-up schedule. Women who complete active treatment at Monash Health will be followed-up in the Gynae-Oncology clinic for 12 months post diagnosis. If clinically appropriate, patients will be discharged to follow-up in primary care for 5 years in accordance with clinical practice guidelines.

Rapid access to the Gynae-Oncology Department at Monash Health is available in the event of suspected recurrence. GPs can use the Rapid Access Request if follow-up raises clinical issues requiring urgent specialist consultation or advice.

KEY STANDARDS, GUIDELINES OR LEGISLATION (optional)

- Cancer Australia: Shared follow-up and survivorship care for women with low-risk endometrial cancer: A Guide for General Practitioners 2020.
- Cancer Council Victoria and Department of Health Victoria 2021, *Optimal care pathway for women with endometrial cancer* (2nd edn, Cancer Council Victoria Melbourne).

KEYWORDS

Low-risk endometrial cancer; Shared follow-up in primary care for women with low-risk endometrial cancer.

Document Governance	
Supporting Policy	**Assessment Care Planning and Discharge (Operational)**
Executive Sponsor	A/Prof Ryan Hodges
Program, Service, Unit, Department or Committee Responsible	**Gynaecological Oncology**
Document Author	Tanya Kirk and Emma Vash
Consumer Review Yes or No	No
This Procedure has been endorsed by an EMR Subject Matter Expert (SME)	There are no Order Set or Quick Reference Guides linked

Information for patients, carers and families

Follow-up of Low Risk Endometrial Cancer with your General Practitioner (GP)

Who is this information for?

This information is for women who have completed treatment for low-risk endometrial cancer at Monash Health and are considered suitable for GP-led follow-up care.

Congratulations on reaching the end of your hospital-based follow-up. Discharge from outpatients' means that the possibility of your cancer returning is lower and we feel it is safe for you to have ongoing care with your GP. The information provided below is aimed at helping you know what worrying symptoms to report and also how often to see your GP.

How often to see your GP

We recommend you see your GP **every 6 months for the first year**, then once a year for a check-up specifically to address your endometrial cancer. This should be done for at least 10 years from when you were first diagnosed with endometrial cancer.

This check-up will generally include:

- telling your GP about how you are and any symptoms you may have (see below)
- an examination of your abdomen
- an internal pelvic examination to look in the vagina
- talking about your physical, social and emotional wellbeing.

Regular cervical screening tests (Pap smear or HPV test) and scans are not recommended as they have not been shown to improve detection of cancer recurrence.

Things to watch out for and report to your GP

If you have any of the following symptoms or feel worried, see your GP urgently as these may need to be investigated with tests or scans. It does not necessarily mean that your cancer has come back.

- Vaginal bleeding
- Lump or pain in the vagina
- New and constant pain in your abdominal or pelvic area
- Swelling of your abdomen
- New and constant cough/chest pain
- Changes in bowel habits
- Difficulty or pain when urinating
- Unexplained weight loss

Your GP will refer you back to Monash Health if your tests or scans show anything of concern. We will arrange an urgent appointment for you in this situation.

Follow-up care for women with low-risk endometrial cancer Procedure

Living well after a cancer diagnosis

A diagnosis of cancer is a life changing experience and people often have needs even after treatment has ended. We want you to feel supported once you are discharged from hospital care. Talk to your GP about any of the following common issues.

- Achieving and maintaining a healthy weight with regular exercise and diet are very important to reduce the chance of your cancer returning.
- Depression and/or anxiety can occur so please let your GP know if you feel you would benefit from support services.
- Sexuality, intimacy and how you feel about your body may be different after diagnosis and treatment of endometrial cancer. It can be difficult to talk about with your partner, friends and family. Support can be provided for you.
- If you have had early menopause due to treatment, further monitoring of your bone and heart health with your GP is very important.

For information

Gynae-oncology Clinical Nurse Consultant

Monash Health

Surgical Ward, Moorabbin

9928 8316

For interpreting services call **131 450**

Monash Health would like to acknowledge the use of Mater Health information in the preparation of this information sheet.

Last reviewed: 12/11/2021	2	Consumer Reviewed

Appendix 2: Discharge letter for follow-up in General Practice (EXAMPLE)

Dear Dr Example,

Re: *Pt name (DOB) URN*

Address

FOLLOW-UP CARE LOW RISK ENDOMETRIAL CANCER

Patient name has completed treatment for low-risk endometrial cancer at Monash Health. As the patients' nominated GP, they have been discharged to you for follow-up care in line with best practice guidelines.

Women diagnosed with early stage low-risk endometrial cancer are at lower risk of local, regional and distance recurrence but still require regular monitoring after treatment. Follow-up care is recommended on completion of active treatment and may be GP-led in collaboration with specialists. The purpose of follow-up includes early detection of recurrent disease; managing treatment related side effects and co-morbidities; managing psychosocial distress; and providing information and/or support.

Guidelines for GP-led follow-up care of low-risk endometrial cancer

The patient has been informed about symptoms they should be aware of that require review and that their follow-up care will be GP-led with rapid access to specialist support at Monash Health if required.

Cancer Australia has developed A Guide for General Practitioners (2020) to support GPs manage follow-up care for women treated for low-risk endometrial cancer including a suggested follow-up schedule.

Rapid access to Monash Health and clinical support

Rapid access to the Gynaecological Unit at Monash Health is available in the event of suspected recurrence. Use the attached Rapid Access Request form if follow-up raises clinical issues requiring urgent specialist consultation or advice.

If you do not agree to provide follow-up care for this patent, complete and return the attached opt-out consent form to Monash Health within 2 weeks.

If we do not hear from you, we will assume you will provide follow-up care for this patient.

For more information or advice contact the Gynae-oncology Clinical Nurse Consultant on (03) 9928 8316 or via email at gynaeonc@monashhealth.org.

Appendix 3: Rapid access request to Gynae-Oncology Department, Monash Health

RAPID ACCESS REQUEST

GP monitoring of low risk endometrial cancer

The Rapid Access Request is designed to be used by the GP and specialist when follow-up raises a clinical issue requiring urgent specialist consultation or advice.

The Rapid Access Request is not to be used as a substitute for existing referral arrangements between GPs and specialists. Additional forms can be downloaded at:
https://monashhealth.org/health-professionals/referrals/gynaecology/

FROM			
GP Name			
Practice address		Phone no.	
	State Postcode	Fax no.	
Email Address			
TO			
Specialist Name	Professor Tom Jobling	Speciality	Gynae-Oncology
Address	C/- Moorabbin Hospital / Monash Cancer Centre	Phone no.	9928 8243
	PO Box 72, East Bentleigh State VIC Postcode 3165	Fax no.	9928 8587
Email Address			
PATIENT DETAILS			
Patient Name		Date of Birth	/ /
Address		Mobile no.	
	State Postcode	Home/work no.	
Specialist Input required	☐ Urgent consultation ☐ Urgent advice		
Clinical concerns *(description of symptoms and/or test results triggering rapid access request)*			
GP's signature		Date	/ /

OUTCOME OF SPECIALIST CONSULTATION

Usually to be completed by the specialist, but may be completed by the GP at the time of phone conversation if phone advice only is received.

Outcome	Further action required ☐ Yes ☐ No If yes, further action:		
Continue follow-up care?	☐ Yes ☐ No If no, care transferred to:		
Specialist's name and signature (if appropriate)		Date	/ /
Contact option	GP to specialist ☐ Phone ☐ Letter ☐ Fax ☐ Email Specialist to GP ☐ Phone ☐ Letter ☐ Fax ☐ Email		

Fax the completed **Endometrial Cancer Rapid Access Request** form to the Monash Health Gynae-Oncology Department on **9928 8587**

Further assistance is available between 9am and 4pm Monday to Friday excluding public holidays by:

- calling: **9928 8316** (Monash Health Gynae-oncology Clinical Nurse Consultant)
- emailing: **gynaeonc@monashhealth.org**

GP-Led Follow-up Care for Low Risk Endometrial Cancer

Opt-Out Consent Form

Re: *Pt name (DOB) URN*

☐ I do **NOT** consent to provide GP-led follow-up care for this patient.

Please outline you reason(s) for opting-out of providing follow-up care (optional):

Name: _____

Signature: _____

Date: _____

Please return this form via fax: **9928 8587 or** email: gynaeonc@monashhealth.org

If you do not agree to provide follow-up care for this patent, complete and return this form to Monash Health within 2 weeks.

If we do not hear from you, we will assume you will provide follow-up care for this patient.

References

[i] Australian Institute of Health and Welfare. Cancer data in Australia. https://www.aihw.gov.au/reports/cancer/ cancer-data-in-australia/data. Accessed: May 2022

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[iv] Jeppesen MM, Mogensen O, Hansen DG, et al. How Do We Follow Up Patients With Endometrial Cancer? Curr Oncol Rep. 2019; 21:57

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