Facilitating the transition of cancer patients between hospital and home: cancer pathway – home

iPAAC INNOVATIVE PARTNERSHIP FOR ACTION AGAINST CANCER

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TYPE STATUS	Program in its planning phase	LAST UPDATE	December 2021	NORWAY ● NATIONAL ● MUNICIPAL Healthcare services & Cancer care

PROBLEM & OBJECTIVE

PROBLEM There is a need to identify the cancer patient`s needs for care related to cancer-caused side-effects and/or disabilities which lasts beyond the medical cancer care period, including psychological support, nutritional guidance, care and follow-up of family members. Also, interaction between different service levels is required to provide support to patients for their needs beyond the cancer treatment and palliation.

OBJECTIVE The objective of the program is to improve communication between specialized health care and primary/municipal health care services, including home-service; but also to improve the communication and logistics regarding the non-medical follow-up of cancer patients during and after cancer treatment; and to provide equal access to services by development of universal recommendations which are independent of geographical location or the socio-economic status of the patient.

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KEY COMPONENTS / STEPS

The cancer pathway – home steps to support cancer patients:

- Cancer pathway-home starts with a meeting between the patient and the health care worker (nurse, doctor etc.) at the hospital around the time of diagnosis in order to understand the patients' needs such as:
  - At the hospital, systematic identification of the patients' individual needs (beyond the cancer care follow-up), related to the life situation of the patient, and with focus on the individual , including relatives is performed.
  - The patient's needs are followed-up through communication with the primary, municipal or district health service providers including: the cancer coordinator, home care service or others, who will be responsible for the appropriate follow-up and service arrangement.
- The responsibility for patient follow-up during and after discharge from the specialized health care unit is clearly defined.

KEY CONTEXTUAL FACTORS

- Cancer treatment in Norway is the responsibility of the oncology departments within the specialized health care services. Each patient with suspicion of cancer is referred to a specific cancer pathway which ends with initiation of cancer treatment (if diagnosis is confirmed). Cancer pathway coordinators facilitate patients' access to specialized health care services.
- Legal frameworks in which the program is embedded:
  - National Cancer Strategy 2018-2022 "Living with cancer".
  - The Patient and User Rights Act § 2-5.
  - Regulations on individual plans, the Health and Care Services Act and the Specialist Health Services Act (85; 87; 111; 112).
- The Directorate of Health is responsible for drafting of the cancer pathway manuals and currently coordinates work on the cancer pathway home manual. The involved parts in the transition process of cancer patients home are cancer departments at hospitals, outpatient clinics, and GPs, the municipal or district health care services and home-care service.
- Introduction of cancer pathway – home aims to lift patients' quality of life and eliminate gaps in the services across the country without cost to the patient. This will require correct identification of patient`s needs and clear communication to the responsible unit, as well as efficient planning and allocation of resources within the municipalities.

MAIN IMPACTS / ADDED VALUE

- The main benefit for the individual cancer patient is that support is readily available to the patient during and after cancer treatment. This includes support with tackling of physical, psychological, economical and work-related challenges and help with maintaining and improving quality of life as much as possible.
- Fewer unwanted variations in patients' follow-up after a cancer diagnosis, regardless of where in the country they live.
- Consistent/ Seamless service provided across hospitals and municipalities.
- Improved interaction between the actors who have contact with the cancer patient.
- Increased security and improved logistics for patients who are transferred between the service levels.
- Patients must know who is responsible for further follow-up, and who can be contacted if necessary.

LESSONS LEARNED

- Support to cancer patients upon the transition from hospital to home requires well organized systems and good communication at both ends, in the specialized health services (hospitals) and in the municipality or district care services.
- The implementation of the Cancer pathway-home is possible within the existing infrastructure but require some accommodation.

REFERENCES & DOCUMENTATION

- Individual plan for serious illness
- Nutrition course for home-services and nursing homes

More over IPAAC Roadmap

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