

Effect of municipality co-ordination for cancer patients

This is an excerpt from the full technical report, which is written in Norwegian.

The excerpt provides the report's main messages in English.

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Review of systematic reviews

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We would like to thank all contributors for their expertise in this project. Norwegian Knowledge Centre for the Health Services assumes final responsibility for the content of this report.

Norwegian Knowledge Centre for the Health Services
Oslo, August 2014

Executive summary (English)

Background

In Norway over 30 000 Norwegians got cancer in 2012. Prostate cancer is the most frequently occurring cancer disease and make up approximately 15% of all cancer cases in Norway. Breast, lung, and colon cancer exceed 8,500 cancer cases annually. It affects more men than women. Cancer is diagnosed in twice as many now than 50 years ago. Three out of four diagnosed are over 60 years of age. The main reason for the increase is that we live longer than in the past and hence have a growing proportion of elderly in the population. Cancer is a disease associated with age.

The number of cancer survivals has also increased significantly. In 2012, more than 224 000 men and women in Norway had cancer or lived with cancer. That is about 67 000 more than in 2001. The high numbers who survive also lead to more people living with the late effects of cancer treatment. The number of cancer survivors fully or partially disabled after cancer disease increases. Chronically ill cancer patients may lead to increasing demand for hospitals and primary care services.

The objective of cancer coordinator facilities is that users can be secured good interaction with the different parts of the services. The coordinator should help to provide the user with more continuity and stability in the follow up during and after the illness. This, in Norway, is comparable to the "case manager" which is a user-centered service in order to improve the coordination and continuity of health and care services for patients with complex needs.

In contrast to the regulatory coordination in the municipal health service for people with chronic illnesses, physical disabilities, mentally impaired, severe psychiatric disorders, substance abuse and dementia, the cancer coordinators provide specific advice and guidance to cancer patients and their relatives. Cancer coordinators can also point out the failures and deficiencies in the services, or routines, so that the person in charge of health care services in the municipality can work systematically, hence carefully plan to ensure the quality of care for patients with cancer. A cancer coordinator is employed in the municipality and has relevant education. Of the approximately 100 cancer coordinators in Norway, most are nurses with special education in cancer nursing and palliative care.

We aimed to answer the following question;

What is the effect of co-ordination management and follow-up for patients and their families on quality of life, symptoms, recurrence detection, re-hospitalization, percentage who die at home, participation in working life, satisfaction with health services, technical aid at home and patient`s involvement in decision making process?

Method

We conducted an overview of systematic reviews in accordance with the methods described in the Norwegian Knowledge Centre for the Health Services' handbook. We searched for systematic reviews in Cochrane library, Pub MED, MEDLINE, EMBASE, CINAHL, SVEMED and PsycINFO. Two authors independently assessed titles and abstracts for relevance according to the inclusion criteria. Inclusion criteria were systematic reviews (SRs) with comparisons of coordinators for cancer management versus control conditions. The quality of the included systematic reviews was assessed and we included only systematic reviews of high and moderate methodological quality. We extracted data and assessed the quality of the documentation by using Grading of Recommendations Assessment, Development and Evaluation (GRADE).

Two researchers extracted data across the systematic reviews for the outcome quality of life. Data were analyzed with Rev Man 5.1. For other outcomes we based our findings from the analysis done in the respective reviews.

Results

We identified 1 428 references. We included six systematic reviews with a total of 49 independent studies. The systematic reviews assessed the effect of different models of co-ordination of care for patients with cancer.

The results showed that coordinating interventions in the municipalities may increase the quality of life for cancer patients. There is low quality of the documentation. There was no no statistical significant difference on the effect of continuity of care to improve the function (median effect 0.00 CI -1.69, 2.65) and physical status (median 0.00 CI -0.5, 0.45). The effect of continuity of care was uncertain on psychological status (median 0.24 CI -3.04, 0.44) and users satisfaction with health services (median 6.7 CI -6.7, 11.5). The quality of the documentation is low.

Documentation on the basis of nurse-led coordination and different models for follow-up by a physician in primary care is of low quality. Nevertheless, it is possible that this can detect recurrence equal with the follow up of a specialist (14 studies).

The evidence is inconclusive whether coordinating action improves the symptoms (4 studies). It is uncertain whether coordinating action provides better patient participation and more efficient use of health care services (2 studies).

Discussion

Our main results showed that coordinating interventions in the municipalities may increase the quality of life of cancer patients, and this is in our opinion plausible.

Patients with cancer are a diverse population that may have different needs for coordination of different types of health care services. We must be cautious regarding transfer of our findings to Norwegian settings. However, the results from a wide spread of settings show reasonable similar results. There might be differences in how coordination is organized in different countries, which professions are involved and in which settings. We must also be cautious regarding models of coordination which are hospital or community based. Like coordinators in Norwegian municipalities, most of the coordination done in included studies was done by nurses.

Conclusion

Co-ordination for patients with cancer showed that coordinating interventions in the municipalities may increase the quality of life for cancer patients. The effect of the coordinators on outcome measure such as function and symptoms showed no difference. The evidence is inconclusive whether coordinating actions provide better patient satisfaction or if it affects use of health care services and patient involvement.