Transforming Cancer Survivorship Care – An Australian Experience

International Conference on Cancer Nursing
Monday 5th September 2016

Amanda Piper and Nicole Kinnane
Session aims

**Learning objective 1:** Understand the Australian experience of implementing innovative survivorship programs and how this transfers to a global setting

**Learning objective 2:** Understand how to apply tools and resources to deliver survivorship care
Overview

• Examples of some of our work in the post-treatment setting:
  o Victorian Cancer Survivorship Program
  o SCP initiatives
  o CALD resource development
  o General Practice (Primary Care) engagement
  o Resources to support practice

• Survivor preferences

• Challenges & enablers

• Application to nursing practice
Health care in Australia

• Shares similarities with UK
• Contrast to UK, responsibility for health spilt: federal and state and territory governments
• No national cancer plan
• Challenges a whole system approach to post-treatment care
Cancer in Australia

Australian cancer prevalence exceeds 1 million: new estimates

Feb 2016

• 1 in 2 develop cancer by age 85
• 1 in 5 will have died by age 85
• Current follow up is neither sufficiently effective nor an efficient use of resources
• There is a need to trial novel models of care
Victoria at 6 million in 2016

1.4m Victoria’s regions

4.6m Greater Melbourne
Australian Cancer Survivorship Centre
A Richard Pratt Legacy

• Established in 2009
• Aim: to optimise health and wellbeing of cancer survivors and their carers
• Major funders are Peter MacCallum Cancer Centre, the Department of Health and Human Services (Victoria) and The Pratt Foundation
• Funding supports our small team to:
  – Improve care at Peter Mac
  – Influence survivorship care in Victoria
  – Influence survivorship care nationally
• Not clinical service
Strategic Plan 2013-16

Our vision
To optimise the health and wellbeing of cancer survivors and their carers

Our purpose
To support and enable excellent survivorship care

1. Improve survivors’ access to information and resources
2. Enable excellent survivorship care at Peter Mac
3. Increase the capability for survivorship care to be provided in the community
4. Build a sustainable program
5. Advocate for enhanced survivorship care in the broader health system
6. Develop the evidence base for survivorship care

ACSC Strategic Plan 2013-16
ACSC has supported and/or undertaken the following:

– *Victorian Cancer Survivorship Program*

– SCP initiatives

– CALD resource development

– GP engagement

– Resources to support practice
Recommendation 5: The Centers for Medicare and Medicaid Services, National Cancer Institute, Agency for Healthcare Research and Quality, the Department of Veterans Affairs, and other qualified organizations should support demonstration programs to test models of coordinated, interdisciplinary survivorship care in diverse communities and across systems of care.
Focus for 2016–2020

- Implement survivorship programs to support people in their recovery and to reduce and manage consequences of treatment to achieve better long-term quality of life:
  - rehabilitation
  - long-term follow-up for late effects of treatment – follow-up programs with children and adolescents
  - link with chronic disease management in the community for those who have persisting effects of treatment.
- Develop agreed follow-up guidelines, including shared care with general practitioners, and implement across Victoria.
- Integrate the care of other conditions with cancer treatment, particularly for the elderly.
Victorian Cancer Survivorship Program

- 2011-2014
- Government funded 6 projects
- Piloted different models of care
- Aimed to:
  - improve and evaluate new models
  - Understand and facilitate self-management
ACSC support to VCSP

- ACSC supported projects and evaluation of projects
- Develop resources
- Community of practice
  - Sharing of experiences
  - Updates on progress
  - Education
  - Discussion of issues
    - Evaluation
    - Primary care engagement
    - Needs assessment and risk stratification
    - Survivorship care plans
- ACSC concurrently implemented strategies in local context
<table>
<thead>
<tr>
<th>Project</th>
<th>Specialist f/up</th>
<th>Shared care</th>
<th>D/C to GP</th>
<th>Needs assessment</th>
<th>Care coordination</th>
<th>Risk stratification</th>
<th>SCP</th>
<th>Self Mgt model</th>
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<tbody>
<tr>
<td>Breast cancer project</td>
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<td>✓</td>
<td></td>
<td>✓</td>
<td>Nurse-led clinic 1 appt</td>
<td>Early breast cancer including DCIS</td>
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<tr>
<td>Barwon SW Survivorship Project (mixed tumour)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Nurse-led clinic 2 appts</td>
<td>Case by case-Specialists decided</td>
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<td>Melanoma project</td>
<td></td>
<td>✓</td>
<td>N.A.</td>
<td></td>
<td>Factors identified Specialists decided</td>
<td>diary</td>
<td>✓</td>
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<tr>
<td>AYA project (Adolescent/Young adult)</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Allied health-led 7 reviews</td>
<td>All considered high risk</td>
<td>✓</td>
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</tr>
<tr>
<td>Moving forward with confidence (mixed tumour)</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Nurse-led 4 reviews not clinic based</td>
<td>N.A.</td>
<td>✓</td>
<td>✓ MI</td>
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<tr>
<td>Positive change for life (haematology stem cell survivors)</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>Existing late effects clinic SCP</td>
<td>Existing late effects clinic intervention</td>
<td>✓</td>
<td>✓ COACH</td>
</tr>
</tbody>
</table>
Implementing novel models of posttreatment care for cancer survivors: Enablers, challenges and recommendations

Michael JEFFORD,1,2,3 Nicole KINNANE,1 Paula HOWELL,4 Linda NOLTE,1 Spiridoula GALETAKIS,5 Gregory BRUCE MANN,6,7 Lucio NACCARELLA,8 Julia LAI-KWON,1 Katherine SIMONS,4 Sharon AVERY,9 Kate THOMPSON,10 David ASHLEY,11,12 Martin HASKETT,13 Elise DAVIES5 and Kathryn WHITFIELD5
VCSP: Challenges

• Individual level
  – Terms: ‘Survivor’ ‘Survivorship’ vs ‘Recovery’
  – Survivor readiness

• Organisational level
  – Identify treatment completion
  – Identification those who would receive the most benefit
  – Timing to maximise benefit
  – Resources to both implement and embed
VCSP: Challenges

• **System level**
  – Inclusion criteria a constraint
  – Framework for needs assessment at **end** of treatment
  – Limited guidance for risk stratification outside low risk patients
  – Engagement with primary care
  – Reorientation from medical model to self-management
  – Evaluation focused on short-term data, diverse evaluation measures
VCSP: Key Enablers

• Individual level
  – Preparation of patients for post-treatment care model and self-management

• Organisational level
  – Clinical leadership and strong project teams
  – Awareness of outcomes of survivorship models of care

• System level
  – Workforce education and training
  – Existing relationships with primary care
  – Access and capacity of community providers
Key Recommendations

- Patient-centred care
- Multi/Interdisciplinary approach
- Health force education
- Chronic disease management framework
- Risk stratification processes
- Discharge planning to transition care
- Consider survivorship terms
- Appropriate needs assessment tools
- Improve care co-ordination
- Early messages to support self-management and healthy living
- Prepare early for share care/GP led care
- IT solutions
- Australian Cancer Survivorship Centre

Australian Cancer Survivorship Centre
A Richard Pratt Legacy
ACSC has supported and or undertaken the following:

– Victorian Cancer Survivorship Program
– *Survivorship Care Plan initiatives*
– CALD resource development
– GP engagement
– Resources to support practice
How will cancer survivors use survivorship care plans (SCPs)?
Background

- Widely endorsed
- Multi purpose communication tool

**Recommendation 2:** Patients completing primary treatment should be provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained. This “Survivorship Care Plan” should be written by the principal provider(s) who coordinated oncology treatment. This service should be reimbursed by third-party payors of health care.
Background

- Widely endorsed
- Multi-purpose communication tool

Components
- Treatment summary
- Signs of recurrence
- Late and long term effects
- Recommended follow-up plan
- Strategies to remain well

- Not standard of clinical practice in Australia
Known challenges and key enablers

Challenges
• Limited evidence
• Time to complete
• No identified personnel for preparation, delivery, update
• Remuneration

Key enablers
• Organisation commitment
• Clinical leadership
• Workforce education
• IT solutions
• Resourcing to support implementation

The Impact of Survivorship Care Planning on Patients, General Practitioners, and Hospital-Based Staff

Key learnings

• Engage stakeholders
• Communication strategy required
• Strong clinical leadership and commitment essential
• Ownership and responsibility needs clarification
• Challenges in supplying detailed SCPs
• More flexible approaches
• Risk stratification processes and needs assessment required
• Timing
• Engage primary care / general practice
Sustainable approach to delivering SCPs

Aims and methods:
• Single site survey
• Assessed survivors’ preferences
• Identify groups who did not want SCP
• Targeted people up to 12 months post treatment
• Across 10 tumour streams
  (Breast, Gynaecology, Urology, Bone and soft tissue, Haematology, Upper GI, Lower GI, Melanoma, Head & Neck, Lung)
Why do survivors want SCPs? n=207

98% wanted to receive SCP

- 61% ‘A record of cancer’
- 57% ‘A reminder of things to do to look after myself’
- 55% ‘Help me understand side effects of treatment’
- 55% ‘Share with family and friends’
- 52% ‘Share the information with the GP’
Information desired

- Top 5 information elements desired n=195
  - List of symptoms to watch out for and report
  - A summary of treatment received
  - Things I can do to look after myself
  - Plan for when I should have follow up
  - Strategies to reduce worry about cancer coming back
  - A list of tests I am going to have and when
## Information elements most desired within a survivorship care plan (top 5) per cohort

<table>
<thead>
<tr>
<th>Information Elements</th>
<th>Breast</th>
<th>Gynaecology</th>
<th>Haematology</th>
<th>Head &amp; Neck</th>
<th>Lower Gastrointestinal</th>
<th>Upper Gastrointestinal</th>
<th>Melanoma</th>
<th>Bone and soft tissue</th>
<th>*Urology</th>
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<td>Summary of the treatment I received</td>
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<tr>
<td>A list of symptoms to watch out for and report</td>
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<tr>
<td>Information about side effects of treatment I received</td>
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<td>A plan for follow-up appointments</td>
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<td>Strategies for reducing worry about cancer coming back</td>
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<tr>
<td>Name and contact details of who I should call if I have concerns</td>
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<td>A list of tests I am going to have and when</td>
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<tr>
<td>Things I can do to look after myself</td>
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<td>Special instructions to follow after treatment</td>
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<td>Pain and symptom management</td>
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<td>Support group information</td>
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<tr>
<td>Coping after treatment is over</td>
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</table>
Strategies to stay well

• ‘Things I can do to look after myself,’ not specific information regarding lifestyle behaviours e.g. diet, exercise, smoking cessation, reduced alcohol consumption, exposure to UV
SCP format and delivery  n=212

- 91% preferred paper based
- Support for both brief (36%) and more detailed (42%) versions
- 55% preferred a face-to-face consultation with a health care professional
- Preference for discussion with a doctor (31%) or specialist nurse (27%)
Engagement with Primary Care

- 51% desired information ‘when to contact GP’ (n=219)
- 52% will share SCP with GP (n=207)
- 17% prefer to receive information from GP

- One page summary
- Early messages re role of primary care
- Translation of SCP to chronic disease management

Photo courtesy of Australian Primary Health Care Nurses Association (APNA)
Recommendations

**SCPs**

- Consider process to update SCPs
- More information at end of treatment
- Use existing resources: Booklets/DVDs, Factsheets, Forums
- Provide information about follow-up
- Provide early messages about role of GP during and after treatment
- Use SCP to promote co-ordinated care between HCPs
- Deliver treatment summary at end of treatment
- Consider how can be delivered within service
- Further engage survivors with healthy living discussions
Using evidence based resources

All available on our website
Wellness and life after cancer forums

- Developed in collaboration
- Group based education support transition to post-treatment
- Normalises post-treatment
- Links healthy living recommendations and community based supports
- Usually one off, can be half-day or full day
- Sustainable approach
Resources to support implementation
Next steps

- Strong support for SCPs
- Sustainable / flexible approaches
  - Trial brief care plan documents
  - Use existing resources
- Supporting clinical services to deliver at end of treatment (e.g. CDU)
ACSC has supported and/or undertaken the following:

– Victorian Cancer Survivorship Program
– SCP initiatives
– Culturally and linguistically diverse (CALD) resource development
– GP engagement
– Resources to support practice
Evidence based, consumer informed resources tailored to specific CALD groups

People from culturally and linguistically diverse (CALD) backgrounds have a poorer cancer experience when compared to dominant Anglo-English-speaking groups.
Background

Anglo-English speaking Australian groups

• The period after finishing treatment (the survivorship phase) can be distressing
• Survivors are often fearful of the cancer coming back
• Survivors can have financial, family, physical and/or emotional concerns
• Survivors are at risk of recurrence, long-term and late effects from cancer and its treatment

CALD

• Little is known if issues are the same
• Consideration of cultural differences and language important
• Cannot simply translate resources
• Identification of immigrant cancer survivorship concerns may support development of resources
Understanding the unique needs of cancer survivors from specific CALD groups

CALD 1:

“I might not have cancer if you didn’t mention it”: a qualitative study on information needed by culturally diverse cancer survivors

Clarke O’Callaghan, Penelope Schofield, Phyllis Butow, Linda Nolte, Melanie Price, Spiri Tsintziras, Ming Sze, Thida Thein, Dorothy Yiu, Shab Mireskandari, David Goldstein, Michael Jefford

CALD 2: On the road to recovery: developing evidence based, consumer informed resources for Arabic, Italian and Vietnamese cancer survivors living in Australia
Results

• Analysis revealed issues after treatment were similar
• Common issues included fear of recurrence, changes in physical appearance, practical community assistance, financial advice, support groups, nutrition, physical activity, genetics, physical side effects, psychological support
• Participants wanted resources in their language and specific to their culture and community
• Unique challenges and needs in each of the language groups were identified
Misunderstandings about cancer

‘I saw on the TV they can extend life 10 years. I think, I've had six-and-a-half, so I have only three-and-a-half left’

Photo source:
CanRevive NSW
The concept of survivorship in different languages

‘Right word because it’s exactly true in reality’ (Vietnamese survivor)

‘It’s over, if it happens again then I’ll go through it again‘ (Greek Survivor)

‘I do not care, this name (survivor) is nothing’
( Mandarin survivor)

‘According to Chinese tradition, [survivor] implies that the survival rate is very low’ (Cantonese survivor)
Using culturally appropriate language

Sexuality and fertility:

‘………Sexuality and relationships are an important ...........It should also be discussed in a way that is culturally appropriate.’ (Arabic survivor)

Having information own language and in simple terms (health literacy):

‘its hard ( when information is only in English ) – especially when technical terms it’s hard for these to be translated by her sons.’ (Arabic survivor)
Key Learnings

Number of learnings throughout the development process:

• Awareness of how words/phrases are conceptualised by different groups
• Importance of engaging with community groups
• Budget for high costs of translation
• Robust translation processes are required
• Make resources bilingual
‘First of their kind’ Cancer Survivorship Resources CALD Communities
Next Steps

Funding for development of:

– Written resources (Filipino and Hindi – speaking) – similar process
– Low literacy resources for cancer survivors in English
– Cancer glossary (400 key cancer terms) interpreted & translated in 15 languages
– Audio resources – English, Cantonese & Mandarin
– Develop education forum for Cantonese and Mandarin speaking survivors
Stretch

Time to GET UP!
ACSC has supported and or undertaken the following:

- Victorian Cancer Survivorship Program
- SCP initiatives
- CALD resource development
- General Practice (Primary Care) engagement
- Resources to support practice
Cancer survivorship and primary care

- Continuous
- Coordinated
- Comprehensive

- Shared cancer care – transition to increased role for primary care

The expanding role of primary care in cancer control


The nature of cancer control is changing, with an increasing emphasis, fuelled by public and political demand, on prevention, early diagnosis, and patient experience during and after treatment. At the same time, primary care is increasingly promoted, by governments and health funders worldwide, as the preferred setting for most health care for reasons of increasing need, to stabilise healthcare costs, and to accommodate patient preference for care close to home. It is timely, then, to consider how this expanding role for primary care can work for cancer control, which has long been dominated by highly technical interventions centred on treatment, and in which the contribution of primary care has been largely presented as marginal. In this Commission, expert opinion from primary care and public health professionals with academic and clinical cancer experience—from epidemiologists, psychologists, policy makers, and cancer specialists—has contributed to a detailed consideration of the evidence for cancer control provided in primary care and community care settings. Ranging from primary prevention to end-of-life care, the scope for new models of care is explored, and the actions needed to effect change are outlined. The strengths of primary care—the continuous, coordinated, and comprehensive care for individuals and families—are particularly evident in prevention and diagnosis, in shared follow-up and survivorship care, and in end-of-life care. A strong theme of integration of care runs throughout, and its elements (clinical, vertical, and functional) and the tools needed for integrated working are described in detail. All of this change, as it evolves, will need to be underpinned by new research and by continuing and shared multiprofessional development.

Part 1: Introduction

Cancer control in high-income countries has long been dominated by highly technical, disease-centric interventions intended to treat or prolong life. This is changing as health policies stress an increased emphasis on quality of life and identifying emerging examples of good practice worldwide. The Commission brings together leading members of the international primary care cancer community together with cancer specialists and policy researchers. We have elected to name our Commission to highlight these

Australian Cancer Survivorship Centre
A Richard Pratt Legacy
General Practice Placement Program - pilot

- Support development of models of shared care
  - Perceptions regarding scope
  - Engagement
  - Education

Inter-professional experiential learning
GP placement program

• Design:
  – Two existing models of experiential learning/placement programs
  – General practice views and preferences

• Deliver:
  – General practice attended 10 clinical hours in cancer centre
  – Attend ambulatory care/clinic appointments
  – Focus on cancer survivorship
  – Financial stipend and reimbursement for generalists
  – Accredited for continuing professional development points

• Aims:
  – Feasible; clinically and professionally valuable; knowledge and skills transfer; identify barriers/enablers to shared care
GP placement program – Phase II

- Funded by Department of Health and Human Services, Victoria
  - Expand and improve on first pilot; test at additional hospitals
- Deliverables:
  - Toolkit
  - Video resources
Emerging program results

General practitioners and General Practice Nurses
✓ Knowledge and skills transfer
✓ Program learning outcomes met
✓ Learning outcomes met

Oncologists and Nurse specialists
✓ Program learning outcomes met
✓ Increased understanding of chronic disease management

✓ Shared enthusiasm to support shared care
✓ Clinically and professionally valuable

Learning opportunities skewed
GP Videos

• Initially for specialist audience only
• Stakeholder engagement informed an evolution
• Delivered suite of videos:
  – Consumers
  – General practice
  – Specialist
• Broader reach beyond placement program
Key messages

• Shared care
  – provides better care
  – is better because patients receive holistic, coordinated care
  – requires quality information from specialist

• Clarity around roles and responsibilities

• Patients appreciate and accept shared care

• Optimal Care Pathways (best practice care pathways) are a useful resource
Cancer Survivorship and General Practice Video

Whilst watching the video consider the role of general practice (primary care) in your setting

8 min Cancer survivorship and general practice

4 min Cancer survivorship and general practice
Evaluation

Recognising your health system may be different, having watched the video:

• General practice has an important role in survivorship care?
ACSC has supported and or undertaken the following:

- Victorian Cancer Survivorship Program
- SCP initiatives
- CALD resource development
- GP engagement
- **Resources to support practice**
  - Online education modules
  - Training program for HCPs
  - Fact sheets for HCPs
Call for additional education for healthcare professionals

Health professionals need to receive education and training to ensure proper care is provided to the growing number of cancer survivors. Although physicians and nurses are the primary providers of care, other care givers, such as rehabilitation specialists and psychosocial and mental health providers, also play an integral role in the overall cancer health care team.

Training and Education

Cancer survivorship care as a distinct phase of the cancer trajectory is a relatively new construct, and health professional schools' curricula have generally not included much content in this area. This needs to change, but a larger task is providing continuing medical education to professionals who have completed their formal training and are encountering cancer survivors in their practices.

Providers need to be apprised of the risks of cancer treatments, the probabilities of cancer recurrence and second cancers, the effectiveness of surveillance and interventions for late effects, the need to address psychosocial concerns, the benefits to patients of prevention and lifestyle changes, and the complexities of integrating survivorship concerns with care for other chronic conditions. Education and training must also stress the need for multidisciplinary approaches, integrated and coordinated care, and effective use of community-based resources.

Opportunities for Increased Training

Physicians

Cancer survivorship has yet to be well represented in undergraduate medical school curriculum and only a few schools currently offer courses or clerkships pertaining to cancer survivorship. Some medical schools have incorporated survivorship issues into their curriculum by including cancer survivors as “standardized patients” in what are referred to as “structured clinical instruction modules.”
Free online education module

- Asked cancer nurses' perceptions of their survivorship learning needs
- Preference for online education
- Engaged with survivorship experts internationally who have developed survivorship training programs and competency guidelines
- Collaborative initiative:
Flexible self-directed learning:
6 easy to use interactive learning modules

Further relevant up to date resources, readings and videos

Personal challenge – how can you improve survivorship care?

http://cancerlearning.gov.au/topics/survivorship
# Evaluation – response to question on satisfaction and learning preferences (n=21)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Strongly Agree (%)</th>
<th>Agree (%)</th>
<th>Neutral (%)</th>
<th>Disagree (%)</th>
<th>Strongly Disagree (%)</th>
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<tbody>
<tr>
<td>I found it easy to navigate the website.</td>
<td>9 (42.9)</td>
<td>9 (42.9)</td>
<td>3 (14.3)</td>
<td>0</td>
<td>0</td>
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<tr>
<td>The content engaged my attention.</td>
<td>7 (33.3)</td>
<td>13 (61.9)</td>
<td>1 (4.76)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I found the information applicable to me in my everyday practice.</td>
<td>8 (38.1)</td>
<td>13 (61.9)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interactive learning opportunities, such as quizzes or videos, are important to me when completing online learning.</td>
<td>9 (42.9)</td>
<td>11 (52.4)</td>
<td>1 (4.8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Links to external resources are important to me.</td>
<td>9 (42.9)</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(57.14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Downloadable fact sheets and practical tips are important to me.</td>
<td>12 (57.1)</td>
<td>9 (42.9)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accreditation for continuing professional development would be a key motivator for visiting this website.</td>
<td>5 (23.8)</td>
<td>10 (47.6)</td>
<td>5 (23.8)</td>
<td>0</td>
<td>1 (4.8)</td>
</tr>
<tr>
<td>I would recommend this site to colleagues.</td>
<td>8 (38.1)</td>
<td>10 (47.6)</td>
<td>3 (14.3)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Delivering Innovative Cancer Survivorship Care

Training program for HCPs to improve post-treatment care

Aims:

• Group based education
• Focus on implementation of survivorship care
• Asked to come prepared with a concept
• Provided with education, information and resources to support implementation
• Demand for both basic and intermediate workshops
“The importance of the patient during their survivorship as much as the medical profession”

“Resources available, chronic disease management”

“That there are all these programs and services out there that I wasn’t aware of “

Post workshop evaluation n=75

Participants nursing, allied health, organizational level attendees e.g. program managers

• 75% completed the post workshop evaluation

Of these:

• 93% were motivated and inspired to promote and implement survivorship care within their clinical setting

• 76% workshop had met their learning needs

• 88% would recommend the workshop
Resources supporting health professionals provide survivorship care

Cancer survivorship information for professionals

Follow-up of survivors of thin melanoma

Thin melanoma is defined as less than 1 mm in thickness using the Breslow method for measuring melanomas under the microscope. Follow-up of these survivors is recommended at least annually, with a full skin check to assess for any signs of recurrence or second primary cancers and for other acute effects.

Follow-up of survivors with cancer-related fatigue

Fatigue is a common experience for people who have completed cancer treatment. The effects can be short term or long term. This fact sheet explains how health professionals, particularly primary care professionals, can assist their adult patients in managing cancer-related fatigue (CRF).

Care of patients with cancer-related fatigue

Fatigue needs to be identified and managed promptly. The following recommendations are informed by international evidence-based guidelines for the assessment and treatment of CRF (4) and other emerging evidence (7). Recommendations are summarised in Table 1.

All available on our website
Nurses make a difference to the lives of people affected by cancer:
Provide leadership
Work as part of multi-disciplinary team
Promote healthcare change
Support survivor self-management
ACSC Team members
Acknowledgements

All the survivors, volunteers, community groups and staff who participated in the projects and the funders who supported the projects:

Alfred Health
Australian Primary Health Care Nurses Association
Austin Health
Australian Association of Practice Managers
Barwon Health
Barwon Medicare Local
Barwon South West Regional Integrated Cancer Service
Bendigo Health
BreaCan
Cancer Australia
Cancer Council Australia
Cancer Council Victoria
Canteen Australia
Chinese Cancer Society
Deakin University
Department of Health and Human Services
Eastern Health
Gippsland Regional Integrated Cancer Service
Great South Coast Medicare Local Health Networking Victoria
Inner North West Melbourne Medicare Local
Melanoma Patients Australia
North Eastern Melbourne Integrated Cancer Service
Northern Health
ONTrac at Peter Mac Victorian Adolescent and Young Adult Cancer Service
Peninsula General Practice Network
Peter MacCallum Cancer Centre
Psycho-oncology Cooperative Research Group
Queensland University of Technology
Royal Australian College of General Practitioners
Southern Melbourne Integrated Cancer Services
Swinburne University
The Leukaemia Foundation
The Pratt Foundation
The Royal Melbourne Hospital
The Royal Women's Hospital
The University of Melbourne
The Western Hospital
Conclusion

• ACSC has been instrumental in transforming survivorship care
• Underpinning our efforts is striving to understand survivors concerns and preferences regarding their post treatment care
• The Australian experience of implementing innovative survivorship programs can transfer to the global setting
• Our learnings and the resources are likely to be applicable internationally
For further information and links to our resources:

Amanda.Piper@petermac.org  
Nicole.Kinnane@petermac.org

www.petermac.org/cancersurvivorship

Resource sheet

On ACSC website - News and Events