What Can Cancer Care Learn from the Chronic Condition Management Field?

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What we know:

- An invisible population on a lot of medications with a lot of complications of cancer & its treatment
- Current approaches to care not economically sustainable given rising rates of survivorship.
- Many are ‘lost in translation’ between specialist care and PHC (Hewitt et al, 2005).
- Little is known about how people affected by cancer manage to live with persistent problems once primary treatment is complete, & how they can be supported to do this.

What we know:

- Dealing with others' expectations that life should be ‘back to normal‘
- Largely regarded and treated within an acute illness framework
- Realisation that there are chronic changes associated with cancer = new challenges
- Disrupted identities into new and changed identities (Bury, 1982, Frankl)
- Supporting self-management through partnership = reverses the focus on telling patients what they ‘should do' to one where the patient is supported in addressing their own agenda.

Self-Management of Chronic Conditions

- Optimal health outcomes achieved by evidence based medical management & self-management i.e. a partnership
  - Self-management is what the patient does
  - Self-management support is what the health professional provides
- A collaborative partnership between patients & HCPs (Von Korff et al, 1997).
- Integral in re-establishing personal ownership.
- People with high self-efficacy are more likely to engage in self-management behaviours (Regan-Smith et al, 2006).

Definition of Self-Management

The Centre for Advancement in Health (1996) proposed the following definition:

"Involves [the person with the chronic disease] engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes."

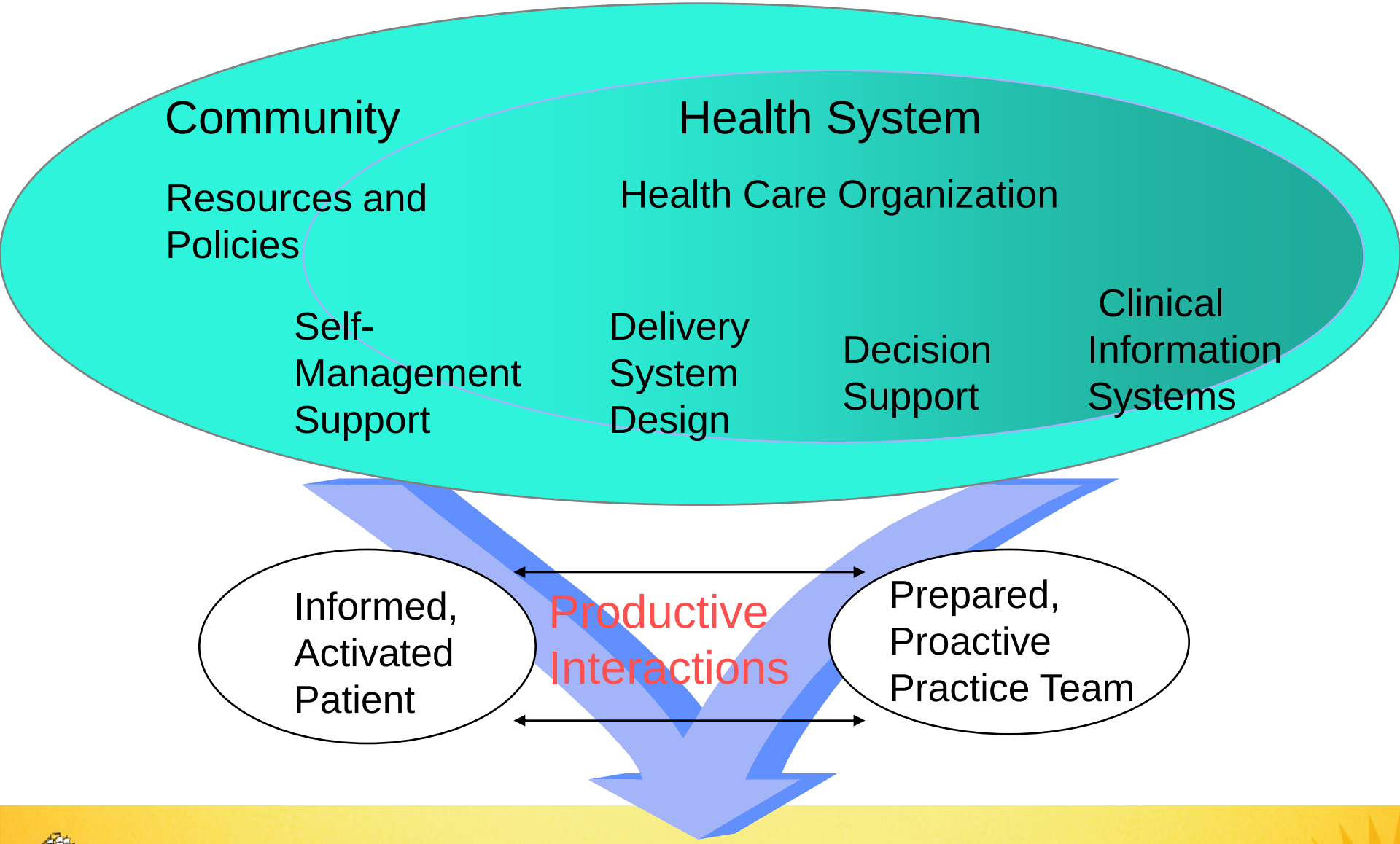
Seven Principles of Self-Management

1. Know your condition
2. Have active Involvement in decision making with the GP or health workers
3. Follow the Care plan that is agreed upon with the GP and other health professional
4. Monitor symptoms associated with the condition(s) and Respond to, manage and cope with the symptoms.

Seven Principles of Self-Management

5. Manage the physical, emotional and social Impact of the condition(s) on your life.
6. Live a healthy Lifestyle
7. Have confidence, access and the ability to use Support services

Chronic Care Model



Chronic disease management: What will it take to improve care for chronic illness?. Wagner EH. 1998;. Effective Clinical Practice 1:2-4

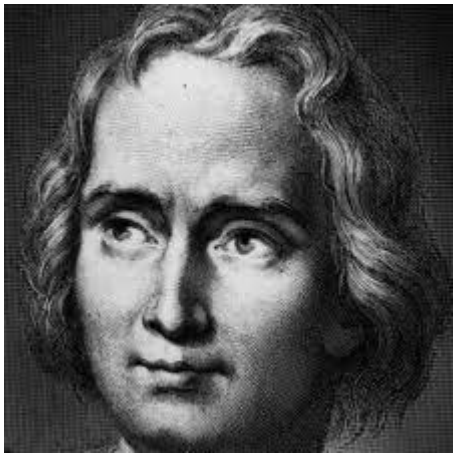
The Big ‘C’ or the little ‘cc’

Research in the RTW area prompts a number of questions:

- Is the shock of cancer diagnosis different to other chronic conditions? Why? Why not?
- Manager’s and work colleagues’ view? –expectations of the person’s return to the ‘old’ self? Assumption of care and cure within an acute perspective?
- Managers’ & colleagues’ fear and prior experience of cancer affects their workplace interactions with the cancer survivor? Unsure of boundaries and maintain distance to avoid becoming emotionally burdened?

- Why is it different for cancer compared with other chronic conditions?
- Why is this more so in Australia than in the US and UK?
- Will the shift to a CCSM view of cancer mean that an increasing number cancer survivors will eventually RTW?

(McKay, Knott & Delfabbro, in press)



Cancer Survivorship & CCSM

- Cancer as a chronic condition places new demands on patient and families to manage their own care, and it challenges old paradigms that oncology's work is done after treatment (McCorkle et al, 2011).

- Care planning should focus on evaluating patients' needs, clarifying support pathways, increasing the profile and involvement of community services and organisations, and supporting patients and families to develop effective self-management skills (Harvey et al, 2012).

- Targeting need and promoting motivation to participate and maintain adherence - the most important factors to emerge in ensuring positive health outcomes (Cockle-Hearne & Faithfull, 2010).

What does follow-up care look like?

Canadian study of 330 PCPs' views on providing follow-up to cancer survivors:

- Most routine follow-up care performed by medical, radiation and/or surgical oncologists - ie. Specialist care even when well –acute care model?
- PCPs follow-up if they are given:
  - a letter,
  - guidelines,
  - expedited re-referral route if needed
  - expedited access to investigations for suspected recurrence

- 72% of physicians perceived that patients expected to receive specialist follow-up. This suggests that patient perceptions also need to shift towards CCSM support delivered in primary care settings
- Finding confirmed by other studies with physicians and patients.

(Del Guidice et al., 2009)

Cancer Survivorship CCSM Care Plans?

Grunfeld et al. (2011) evaluation of survivorship care plans (SCPs) for 408 breast cancer survivors.

Each received a discharge visit with oncologist and discharge letter sent to PCP consistent with usual care. SCP included:

- a personalised treatment summary
- a patient version of the Canadian national follow-up guidelines
- a summary table of the guideline to act as a reminder system
- a resource kit tailored to the patients' needs on available supportive resources
- Compiled in a binder and reviewed with the patient in a 30 minute education session

What needs to happen?

- Shift to SM needs to begin at point of diagnosis with a collaborative, empowering & interactive relationship between patient & HCP

- Shift in perception of clinician from expert to enabler
- Shift in perception of patients from passive recipients to active participants in their care

- Support to put knowledge into practice ie. apply it to their situation [// learning to apply to new problems as they arise, KICMRILS]
- SM is more than just knowledge acquisition

- Self-efficacy/confidence to SM [the most significant thing affected after cancer diagnosis, treatment & survivorship]

(Davies & Batehup, 2010)

Capabilities for Effective CCSM Support

Person-Centred Skills	Behaviour Change Skills	Organisational/Systems Skills
1. Health promotion approaches	9. Have knowledge of models of health behaviour change	14. Working in multidisciplinary teams / Inter-professional learning and practice
2. Assessment of health risk factors	10. Motivational Interviewing	15. Information, assessment and communication management systems
3. Communication skills	11. Collaborative problem definition	16. Organisational change techniques
4. Assessment of self management capacity (understanding strengths and barriers)	12. Goal setting and goal achievement	17. Evidence based knowledge
5. Collaborative care planning	13. Structured problem solving and action planning	18. Conducting practice based research/ quality improvement framework
6. Use of peer support		19. Awareness of community resources
7. Cultural awareness		
8. Psychosocial assessment and support skills		

But how do you put all of this together in practice?

The Flinders Program:

1. The person self-rates what they currently know and do
2. Have a conversation about it (What they do well, not so well and where barriers exist)
3. Identify the main problem (from their perspective) and a SMART goal (something they wish to achieve to address the problem)
4. Organise the issues on a SM Care Plan which is shared

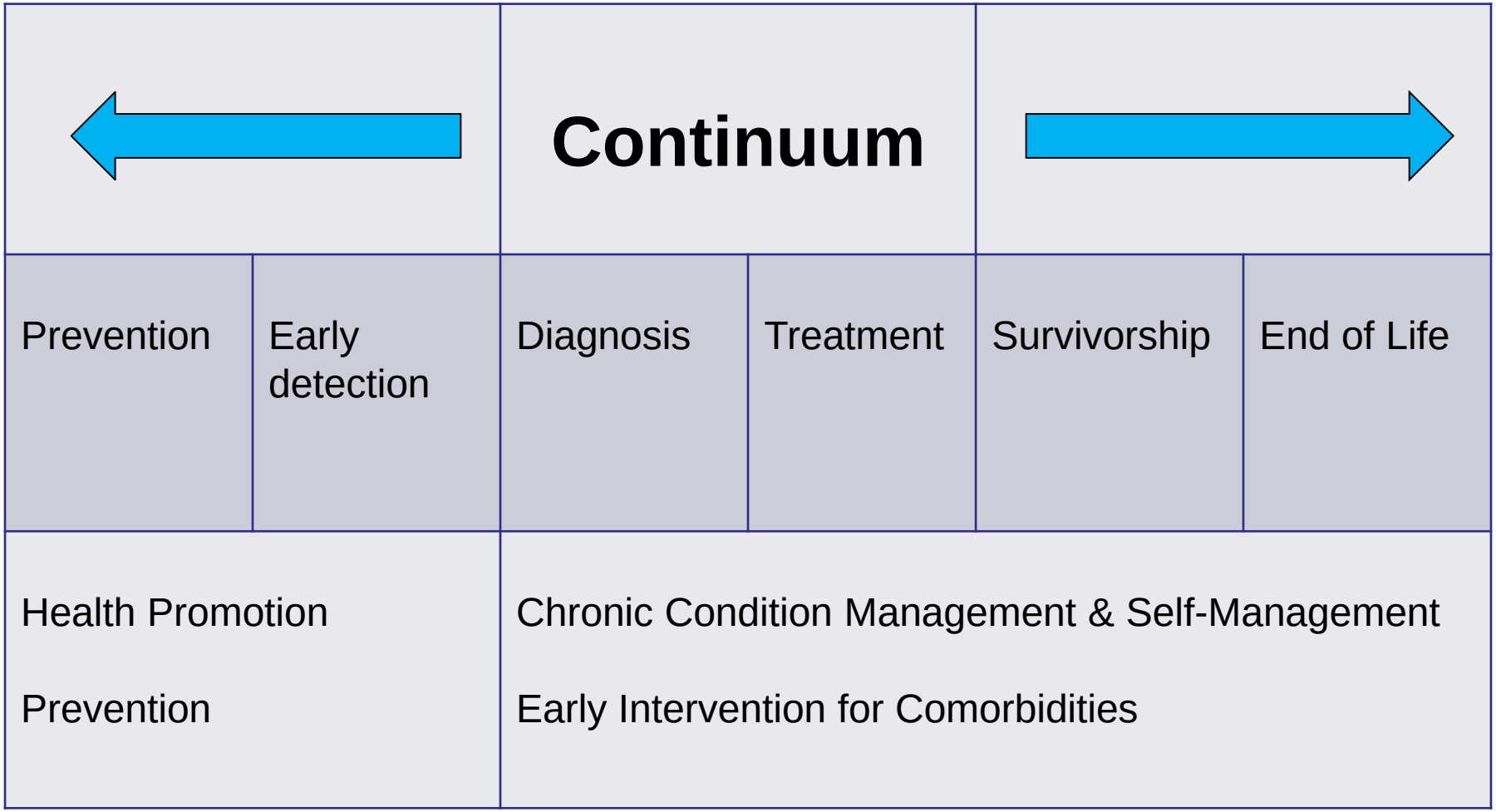
   (Issues, Aims, Steps to Get There, Who's Responsible, When to Follow-up)

http://www.flinders.edu.au/medicine/sites/fhbhru/

Feasibility & acceptability of these approaches

- Recent collaborations at Flinders University between chronic condition and cancer care researchers.

- Lifestyle interventions (diet and exercise), complementary therapies, and rehabilitation, focused on person-centred, motivational and goal-focused support.


Continuum
Prevention
Early detection
Diagnosis
Treatment
Survivorship
End of Life
Health Promotion
Prevention
Chronic Condition Management & Self-Management
Early Intervention for Comorbidities

Is ‘Survivorship’ at odds with ‘CCSM’?

- MH one of the few areas where ‘survivorship’ term is sometimes still used.
- Past examples of diseases, now treatable, that people commonly died from.
- When we stop calling it survivorship, then we will know it is truly a chronic condition.

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