Barwon South Western Survivorship Project

A Transferable Model of Survivorship Care

Project objectives- levels

- Participant → Nurse-led Survivorship Service
- Within the Cancer Service → Tumour streams
- Cancer Service to Primary Care and Community → GPs, Practice Nurses Community Health, Allied Health, Local Gov. Services, Private Providers

Regional and rural perspective

- Participant
- Within Cancer Services
- Cancer Services to Primary Care and Community

Barwon South Western Cancer Region

Project definitions

Cancer Survivors - people who have completed active treatment, chemotherapy and/or radiotherapy and surgery, with curative intent

Project Eligibility < 2 years post treatment

Nurse Led Survivorship (Clinic)Service

- Referral- specialists and cancer team
- 2 consultations with person/family members
- Survivorship Care Plans Ref IOM 2006
  - core template tailored to 9 individual tumour streams
  - consumer friendly language
  - electronic capacity (within ARIA)
  - aligned to GP Chronic Disease Management Plans

General Practitioners

GPs prefer documents

- succinct- one page
- easy to access information
- medical language

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Non-Hodgkin lymphoma GP surveillance schedule **Date:** **Survivorship Service**

<Name:>
<DOB:>
<UR:>

Next Cancer Centre appointment and/or any review required by GP *(insert as appropriate)*
Rapid re-referral - can occur by contacting the Survivorship Nurse on Ph. 0401 011 661 or Haematology team at Andrew Love Centre on (03) 4215 2600

A guide to potential late and long term side effects of treatment	GP investigations (regularity of review recommended can be inserted)
Second Malignancy Solid tumours: especially > 10years Haematological: MDS/leukaemia, (peak 5-9 years)NHL **Cardiovascular disease** Delayed heart failure (anthracycline related) Accelerated atherosclerosis (radiation), including carotids, atherosclerosis **Pulmonary dysfunction** Acute: radiation pneumonitis Chronic: pulmonary fibrosis, bronchiectasis, chronic pleural effusions **Infertility and endocrine dysfunction** Gonad dysfunction Hypothyroidism Premature menopause **Peripheral neuropathy** **Other** Cognitive Changes cataracts Chronic fatigue sexual dysfunction Avascular necrosis (of the hip) lymphoedema Increased risk of infections – asplenism or hyposplenism	**Assessment** - Careful history and physical examination- lymphadenopathy, hepatomegaly, splenomegaly **Tests** - FBC, U&E, LFT including serum LDH, lipids, Beta 2 micro globulins - Regular ER- at least every 12 months - Urinalysis- 12 monthly **Preventative medicine** Immunisations- influenza, pneumococcal – commence 6 months post treatment Bone health, including vitamin D levels- 12 monthly Dental health checks- 12 monthly Skin examination (with a focus on irradiated field)- 12 monthly **As appropriate** Breast screen from 40, or from 25 (if > 8yrs after chest irradiation) Endocrine function Thyroid Glucose intolerance/diabetes Annual ECG if other risk factors **Psychosocial review** Healthy lifestyle- diet, reconditioning and exercise Cancer related fatigue Cancer distress and fear of cancer recurrence Carer support Return to activities of daily living and work Sexual functioning Abuse behaviour cessation Smoking Alcohol Illegal or prescription drugs
Signs & Symptoms of Recurrence	
Firm painless swollen lymph nodes Unintentional weight loss Night sweats Persistent loss of energy Generalised itching Rising LDH Blood test abnormalities New symptoms – shortness of breath, pain, bloating	

Engagement of cancer teams

Quick Tips

- Identify 'Champions' and their interests
- Work within the existing model
- Start small and promote successes
- Draft documents, present to the team and trial
- Use real case studies

Results

Participant

- Health Literacy Questionnaire-HLQ
- Health Education Impact Questionnaire- HeiQ
- Quality of Life -(AQoL-8D)

Time points- prior to, one week and 3 months post intervention

Participant program evaluation

1 week post intervention (N=84)

- 85% to **manage** ongoing symptoms and side effects
- 91% to **understand** my follow up care
- 89% to **cope** with finishing treatment
- 87% to feel in **control** of my life
- 93% to know where to **gain support**

2/3 **continued to use** survivorship care plans (at 3 months)

GP evaluation of documents

50 of 75 GPs returned feedback

Surveillance Schedule

- useful in patients ongoing care- 96%
- useful format- 98%

Survivorship Care Plan

- useful in patients ongoing care- 92%

GPs and Practice Nurses

- want to be engaged in the follow up care of survivors
- in many cases patients are already known to them

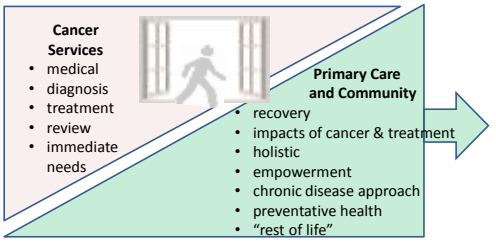
Align with Chronic Disease models

50% of participants referred -allied health, community, local services

Referrals were accepted when

- **Networking** and phone discussion
- The **language** of chronic disease and health prevention was used
- **Similarities** with their existing clients made
- **Rapid re-referral**, support and contact details offered

The language of survivorship – 'a window of opportunity'



Where to from here?

Phase 2

- Survivorship Nurse Led Service- Hume Region
- Model of shared cancer care
- Small group intervention

References

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Contact details and report

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Project Report is available on
http://www.petermac.org/education/survivorship-education/implementing-survivorship-care#victorian-cancer-survivorship-program