

Supporting cancer survivors in Victoria

What have we learnt?



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Outline

- VCSP program background
- Project outputs & outcomes
- Lessons, enablers & challenges
 - Needs assessment
 - Survivorship care plans
 - Risk stratification
 - Self-management and secondary prevention
 - Evaluation
- Recommendations & Next Steps

“If you want to bring a fundamental change in people's belief and behaviour...you need to create a community around them, where those new beliefs can be practiced and expressed and nurtured.”

Malcolm Gladwell, The Tipping Point: How Little Things Can Make a Big Difference

VCSP background

Victoria's Cancer Action Plan: 'establish a state-wide program that trials patient-centred models of cancer survivorship care'

Objectives

- **Trial post-treatment shared models of care** across acute and primary care, accessing existing services/funding streams
- **Evaluate models/interventions** re: effectiveness, sustainability and transferability
- **Develop resources and recommendations**
- **Improve understanding** of the specific **needs** of groups
- **Facilitate survivor self-management** and involvement

VCSP Phase I - timeframe



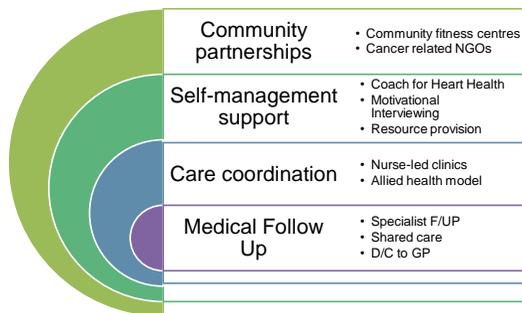
VCSP pilot projects

- **Breast cancer project**
 - (RWH, RMH, Western Health)
- **Barwon South West Survivorship Project**
 - (regional setting, mixed tumour type)
- **Melanoma project**
 - (Alfred Health, Gippsland Regional ICS)
- **Survivorship Connections AYA project**
 - (Peter Mac CC, RMH, Bendigo Health)
- **Positive change for life**
 - (Alfred Health, Leukaemia Foundation, community fitness centres)
- **Moving forward with confidence**
 - (Austin/Eastern/Nthern Health, CCV Helpline)

VCSP pilot project features

Project	Oncol f/up	Shared care	D/C to GP	Needs Ax	Care coordination	Risk stratification	Care Plan (SCP)	Self Mgt model
Breast cancer project		✓		✓	Nurse-led clinic 1 appointment	Early breast cancer	✓	
Barwon SW Survivorship project		✓	✓	✓	Nurse-led clinic 2 appointments	Specialist determined – case by case	✓	
Melanoma project			✓			Specialists determined – with criteria	Diary	
AYA project	✓			✓	Allied health-led 7 reviews	High risk cohort	✓	
Moving forward with confidence	✓			✓	Nurse-led non clinic based 4 reviews		✓	✓ MI
Positive change for life	✓				Existing late effects clinic intervention	High risk cohort	✓	✓ COACH

Models of care

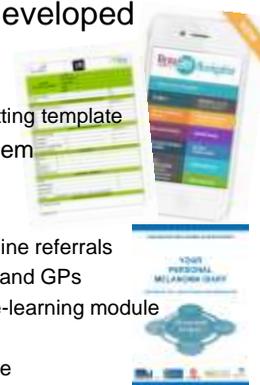


VCSP outputs and broad outcomes

- Resources developed
- Cultural shift
- Holistic needs assessment & care planning
- Positive PROMs
- Health behaviour change (some)
- Referrals to allied health and cancer NGOs
- Improved communication with GPs
- Transition to shared care/GP f/up

Resources developed

- Pilot project reports
- SCPs
 - melanoma diary, goal setting template
- Electronic reminder system
 - skin checks
- Resources
 - BreaCan Navigator & online referrals
 - Information for survivors and GPs
 - Melanoma survivorship e-learning module
 - Breast cancer pathway
 - AYA survivorship resource



Needs assessment

- Not a 'one size fits all' approach
- Tools validated for end of treatment
- Aids risk stratification & goal setting
- Informs SCP development
- Facilitate timely care coordination
- Can promote self-management
- Embed into practice (including EOT)
- Staff experienced in assessment process

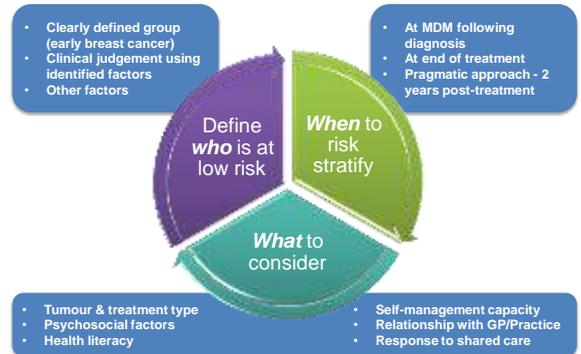
Survivorship Care Plans

- Valued communication tool for survivors and HCPs in context of wider intervention
- More likely to be used by GPs in shared care context
- Preference for paper-based SCPs (GPs, survivors-including AYAs)
- GPs value 1-page treatment summary, clear task allocation and rapid re-access process
- Time consuming - IT solutions needed

Risk stratification and shared care

- Readiness of patients & carers
- Clinical leadership / authorising context
- Stronger evidence base needed to support the pathways
- Confidence of the parties and clarity re: roles
- Use of familiar language/concepts (CDM)
- Rapid re-access processes
- Reciprocal communication (GPs & Acute)
- Engaging primary care Practice Nurses

Risk stratification and shared care



Supporting self-management and secondary prevention

- Partnerships e.g. fitness centres, NGOs, private allied health (exercise physiology/dietetics), community health & rehab
- Evidence based models
 - e.g. Coach for Heart Health
- Works well with education/motivational strategies and builds health literacy
- Engaging individuals & carers goals
- Challenges in sustaining & measuring LT impacts

Partnerships with community

- Support development of information resources and interventions (consumer-driven, self-management)
- Enable flexible provision of support over time
- Involvement in project design
- Alignment of project aims with organisational vision
- Lack of recognition of the role community can play
- Stronger referral pathways are needed
- NGOs have limited resources

Evaluation

- Common frameworks/tool selection
- Tools validated for use at end of treatment
- Sensitivity of tools e.g. health literacy
- Economic evaluation/business case/modelling
- Ethics approval delays impact recruitment
- Timeframes for demonstrating impacts
- SCPs evaluation (~ intervention context)
- Impact? Carers, CALD & ATSI, return to work

Critical enablers

- Clinical leadership ++, authorising environment & team approach
- GP/Consumer involvement
- Cancer related NGO partnerships
- Change management approaches
- Clear roles and responsibilities
- Marketing
- Communication (terminology, interdisciplinary)
- Align with chronic disease management
- Workforce & survivor education & preparation

VCSP I recommendations

- Cross sector team approaches required
- Consider IT solutions
- Prepare survivors early (at Dx / start of Rx)
- Assess needs & co-ordinate care
- Risk stratify interventions
- Processes for shared care/GP F/U
- Promote & support self-management
- Develop a tool box
- Policy, leadership, re-design, change management

WF evaluation recommendations

Domain	Recommendations
Workforce Capabilities	<ul style="list-style-type: none"> • Use workforce capability-planning framework • Conduct an audit of CS workforce • Establish expanded survivorship CoP forums
Organisational level leadership & platforms	<ul style="list-style-type: none"> • Adopt a primary care driven transformative change management approach • Create authorising environments • Frame CS within chronic disease management model
System level infrastructure	<ul style="list-style-type: none"> • Invest in multi-project comparative research design • Invest in longitudinal study of CS models of care • Explore alternate CS workforce models of care

Policy learnings

- Learn from the learnings
 - Not every experiment will succeed
 - Use the learnings to identify areas to be explored further or to extend reach/embed
 - Community of Practice approach
 - Evaluation framework
- Take longer-term view
- Strategic approach
- Aim for the tipping point

VCSP next steps

- Sustainability phase for some pilots
 - Aim to demonstrate spread of model to other sites/settings
 - Further 2 years
- Look to further development of resources and supportive policy environment
 - Consolidation/growth of resources 'toolkit'
 - Continued CoP
- Planning for a second phase of pilots

"I think [CS] has changed quite dramatically. [VCSP Pilot Project] has brought into focus an area which was certainly acknowledged prior to this project, but the project has led to everybody understanding the need for real thought about ... survivorship.

Without the project I have no doubt that things would be very much as they were and not progressed at all. I think that the influence has been enormous" (VCSP Int3)

Source: Naccarella, L. Uni of Melb (2014)

Further information

- The full *Supporting Cancer Survivors in Victoria* report will be available on DHHS website shortly
- Individual pilot project reports are available at the Australian Cancer Survivorship Centre website:



www.petermac.org/education/survivorship-education/implementing-survivorship-care#victorian-cancer-survivorship-program

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