Tailoring care to better support BREAST CANCER survivors

With the survival rate for people diagnosed with cancer continuing to increase, cancer services are shifting their focus to the support and care provided after treatment is over. A project team led by the Loddon Mallee Integrated Cancer Service established a clinic at the Bendigo Cancer Centre to provide specialist support for survivors of breast cancer and help ease their transition from the hospital into primary care.

## Background

National cancer screening programs and advancements in treatment have led to an increase in the survival rate of people diagnosed with cancer.

Cancer survivors have specific needs and concerns that are often left unmet, including physical, psychosocial, and spiritual needs. Research also shows that the time after cancer diagnosis can provide a valuable opportunity to educate and motivate patients to adopt risk-reducing behaviours.

Victorian cancer services are reviewing their models of care in response, including looking at how to transition patients from the acute hospital setting to a more sustainable, primary care setting.

As part of Victoria’s cancer service improvement network, the Loddon Mallee Integrated Cancer Service led a project team in implementing a nurse-led cancer survivorship clinic at Bendigo Health’s Bendigo Cancer Centre.

Previously, breast cancer patients at the centre who had completed treatment attended the same routine appointments as those receiving active treatment. Through the new clinic, the project team aimed to better meet the needs of these breast cancer patients by providing specialist survivorship support and a planned transition to the primary and community health system. These systems routinely manage the types of complex conditions experienced by cancer survivors, such as diabetes, mobility, and mental health conditions.

While the initial focus of the clinic was on breast cancer patients, the project aimed to create a sustainable survivorship service model that could be expanded to other cancer streams.

Bendigo Cancer Centre survivorship service

**Lead** Loddon Mallee Integrated Cancer Service

**Partners** Bendigo Health, Peter MacCallum Cancer Centre, Murray Primary Health Network, Bendigo Community Health, Echuca Regional Health

**Duration** September 2016 – December 2017

**Key outcomes**

* Saw 23 breast cancer patients at the survivorship clinic during the pilot phase
* Referred 13 patients (56 per cent) to at least one supportive care service
* Cancelled two unnecessary appointments through clinic activity, which could then be used for other patients
* Received positive feedback from patients, with 100 per cent of post-clinic survey respondents saying they were satisfied with their care
* Increased the patient survivorship information communicated to GPs, including eight mental health plan recommendations
* Developed a specially tailored 12-week exercise program for breast cancer patients at Bendigo Community Health

## Key activity

* The project used a co-design methodology. Eight consumers and 17 general practitioners were involved in the project to review and refine the service model, tools and protocols. A staff education package was also co-designed with senior medical and nursing staff.
* Three clinician education workshops were delivered to 56 attendees, including motivational interviewing training.
* The survivorship clinic was incorporated into the Bendigo Cancer Centre’s existing oncology nurse practitioner clinic.

### Survivorship clinic protocol

* Treating oncologists identified patients as candidates for the survivorship clinic.
* Patients who agreed to attend were asked to complete three screening questionnaires prior to their survivorship clinic consultation. These helped the nurse leading the clinic to target the clinic consultation and care plan to the patient’s individual circumstances and health concerns.
* During the clinic consultation, the nurse and patient worked in partnership to develop a tailored survivorship care plan, which included:
	+ identification the patient’s healthcare team
	+ diagnosis and treatment information
	+ a health and wellbeing management plan
	+ a health diary and medication record
	+ information on important symptoms or late effects of treatment
	+ health and survivorship resources, including factsheets from the Australian Cancer Survivorship Centre, Breast Cancer Network Australia, and the Cancer Council of Australia.
* The patient was given a copy of their survivorship care plan and advised to discuss the plan with their general practitioner (GP). The nurse also sent a modified copy of the plan to the patient’s GP, which provided a summary of treatments, clarified follow-up care, highlighted the late effects of treatment, and outlined concerning symptoms to look out for.
* The nurse provided referrals to other health providers as appropriate in discussion with the patient’s GP.
* The nurse would also review the patient’s future appointments with surgeons and medical oncologists and cancel any unnecessary appointments.

## Outcomes

* Twenty-three patients attended the survivorship clinic during the pilot phase.
* Thirteen patients (56 per cent) were referred to at least one supportive care service.
* The clinic cancelled two unnecessary appointments, which could then be used for other patients.
* While only four patients responded to the post-clinic survey, all were satisfied with the care they received and provided overwhelmingly positive feedback.
* During the project, 23 letters and 21 survivorship care plans were provided to GPs. This represents a significant increase in the patient survivorship information communicated to GPs; prior to the project, no care plans were provided and survivorship information was ad hoc.
* Eight recommendations were sent to GPs to establish mental health plans for breast cancer survivors. Prior to the project, no such recommendations were made.
* A specially tailored 12-week exercise program was developed at Bendigo Community Health for breast cancer patients.
* Education delivered as part of the project increased awareness within Bendigo Health of the concept of cancer survivorship and the impact on patients and carers. This included motivational interviewing training that taught staff how to:
	+ increase rapport with patients
	+ increase their engagement with treatment
	+ prepare patients for change
	+ increase patient motivation and confidence
	+ work with angry patients and those in the early stages of change.
* Annually, it is estimated the new survivorship clinic process will result in 28 patients receiving supportive care referrals each year. It is expected that these patients will have better mental and physical health as a result of their survivorship care plans, and therefore experience fewer health complications.

‘It is good to know we are not alone and we will always have someone at the hospital who cares.’

**– Patient**

‘No question was too silly.’

**– Patient**

‘All of my experiences have been extremely positive. I have always felt well informed and looked after.’

**– Patient**

## Key learnings

* The project team found that creating a new appointment type in an existing clinic – and new referral pathways to and from those appointments – was a good model for introducing a survivorship service.
* GPs responded very positively to the prospect of formalised shared care arrangements for cancer patients. They were supportive of the increased information in the survivorship care plans and the new framework that allowed them to systematically meet the needs of survivors rather than manage them in an ad-hoc manner.
* Patients indicated they would appreciate the survivorship care plan information prior to treatment, not just after treatment.
* The fact that 35 per cent of clinic participants were identified as requiring mental health plans suggests significant levels of post-treatment distress and could indicate a wider problem for cancer patients. Routine communication between acute services such as the cancer centre and GPs about the levels of post-treatment distress that could benefit from mental health plans has not yet been established.
* GPs requested education in how to manage the side effects of treatment and hormonal management, particularly medication management.
* Feedback indicated that improvements could be made to the letters sent to GPs regarding the medication, context and risk of cancer re-occurrence during the earlier stages of the cancer pathway.
* The project revealed growing interest in survivorship care amongst the medical and allied health sectors.
* The motivational interviewing training provided as part of the project was extremely popular among allied health staff.