HRT1311 – Improving follow-up care and wellness for cancer patients

5th and 6th Sept 2013 Melbourne

Barwon Region Survivorship Project

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Barwon Health

KEY PROBLEM:
Lack of a planned and coordinated service which identified & met the needs of survivors of cancer

Post treatment follow up

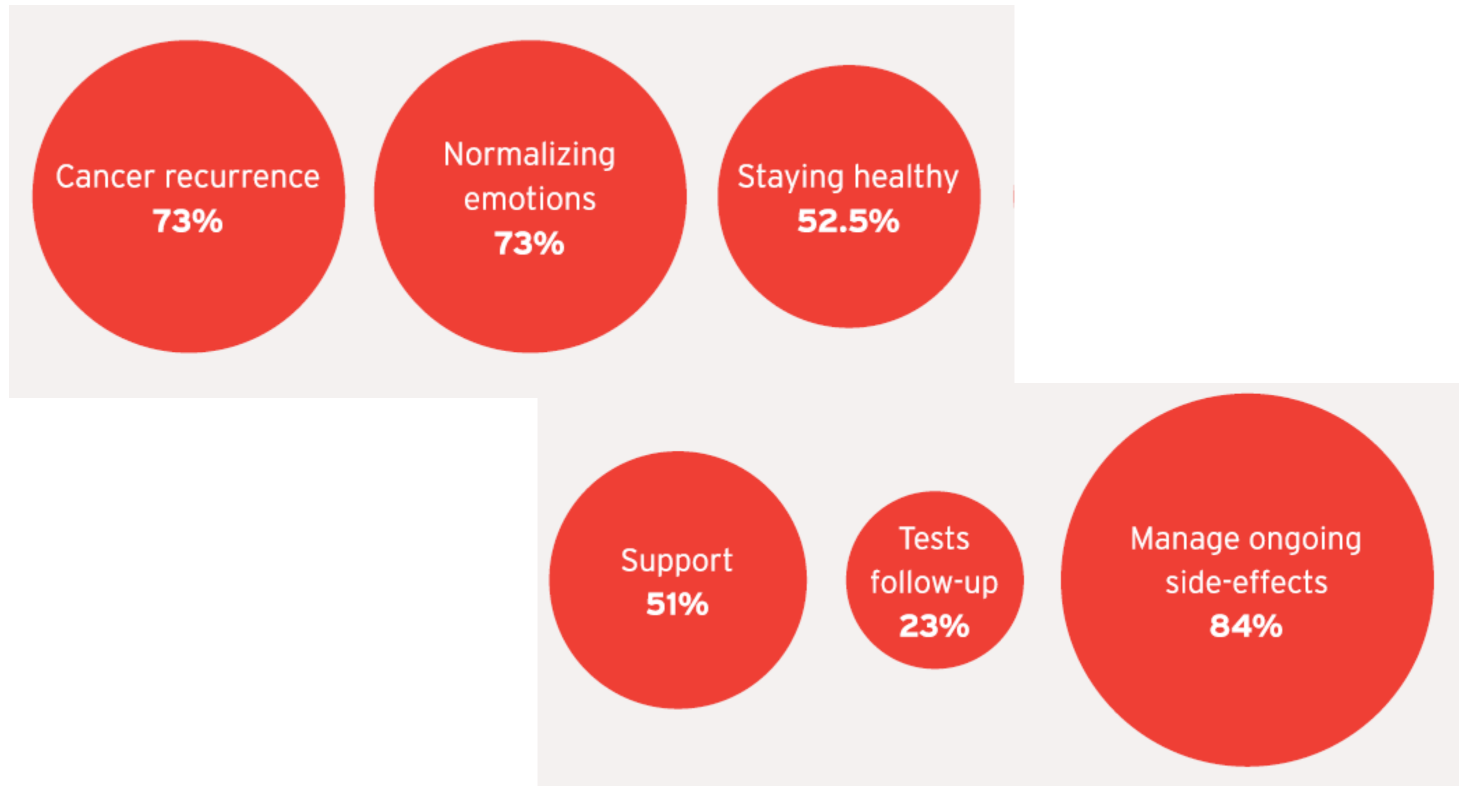
- Was largely medically or symptom focused
- Occurred within a busy treatment centre and schedule
- Time poor
- Limited focus on psychosocial, health and wellbeing needs
- No written discharge or planning documentation provided
- Limited focus on engaging patients in ongoing health outcomes
- GPs not fully aware of or engaged in patients survivorship care
- Opportunity for greater specialist to primary care pathways
- Lack of access for survivors to rehabilitation and community services

AIM OF THIS INNOVATION:
To design and trial a service that addressed the needs of survivors and met service demands

- Nurse led survivorship clinic and individual care plans
- Utilise patient-centred and patient empowerment approaches
- Explored the feasibility of sustainable funding sources (MBS, ABF)
- Develop a risk stratification assessment tool
- Utilise a multidisciplinary approach/clinic
- Enhance continuity and coordination of care between acute, primary and allied health providers (Barwon Medicare Local)
- Increase professional knowledge of survivorship issues
- Develop a network of resources and services for survivors
- Evaluate outcomes and support evidence based practice

The local evidence

The PROSPECT Program was undertaken by the Cancer Council Victorian in 2009. Barwon Health was a pilot site and 198 patients completed the survey instrument. The results indicated that cancer survivors did **not** receive information about:

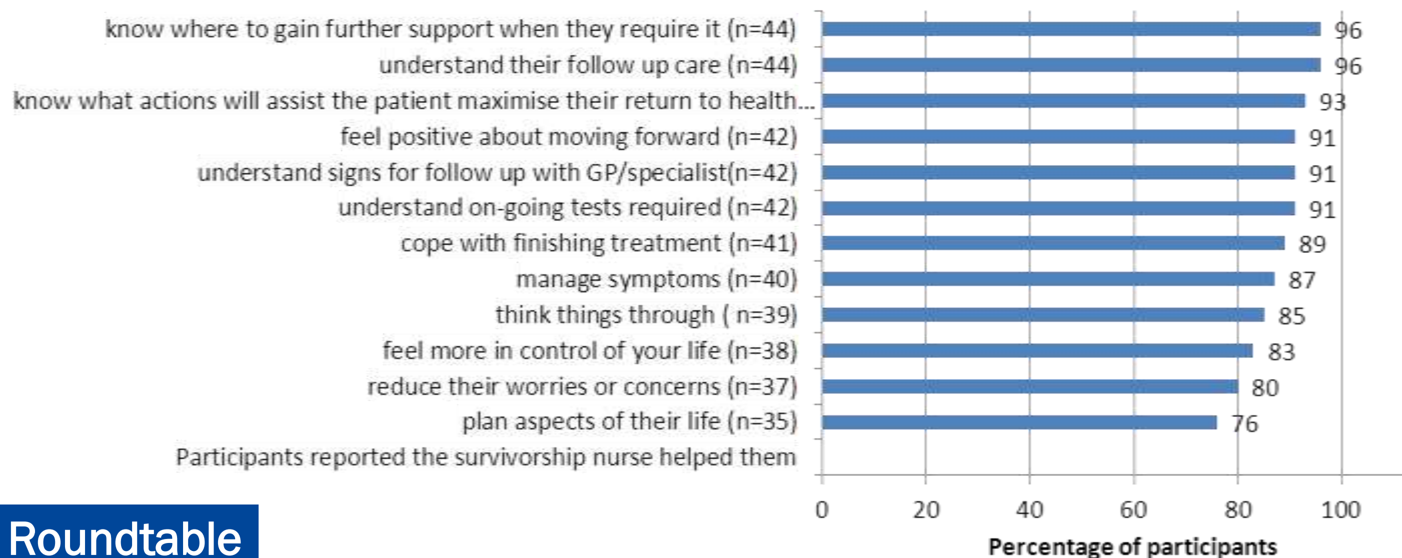


KEY CHANGES IMPLEMENTED

- Nurse led survivorship clinic run in Geelong, Hamilton and Colac(outreach)
- Written care plans tailored to 7 cancer types- ARIA
- Existing specialists letters to GPs are utilised as the basis of the communication pathway from specialist to primary care
- Primary care receive a copy of the written care plans and a one page tumour specific surveillance schedule
- Engagement of primary care nurses
- Education of GPs, primary care nurses, allied health
- Strengthened referral pathways to allied health, rehabilitation and community supports and services

OUTCOMES SO FAR

- 80 participants -survivorship clinic (included GP engagement)
- 50% of patients referred to further services
- Supported shared oncological follow up or discharge to GPs of further 15 survivors (>2 years post treatment)
- 38 of 39 GPs report care plan and surveillance schedule useful in ongoing patient care



The Health Roundtable

LESSONS LEARNT –

- 'Survivorship' experience is unique to each person dependent on cancer type, degree of disease, treatment regime, health literacy
- Standardised guidelines and processes are useful but must recognise individual differences to be successful in their application in practice
- Establish relationships and identify champions
- Most parties are supportive of addressing needs and demonstrate goodwill. Engage, Educate, Provide framework
- Access to rehabilitation and community services is vital for cancer survivors