# Colorectal Cancer Partnered Survivorship Care Plan Pilot Project

## Nine-Month Interim Results

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## Background

In 2022, colorectal cancer (CRC) was the third most common cancer in Victoria, with 3,504 cases, accounting for 10% of all newly diagnosed cancers in both males and females. It was also the second leading cause of cancer-related death in the region, claiming 1307 lives. Thanks to advancements in early detection, the five-year survival rates for early-stage colorectal cancer are high,[1] at 98% for stage I and 92% for stage II, before dropping to 73% for stage III and 15%[1] for stage IV cancers.

The expected rise in CRC cases to between 4167 and 5757 annually by 2037 will further strain hospital outpatient services already[1] operating near total capacity. This will pose challenges in meeting the demand for[2] new referrals and timely review of existing patients. Additionally, CRC survivors often endure fatigue, gastrointestinal[3] issues and psychological challenges post-treatment, underscoring the need for regular survivor-focused[3] follow-up care. These findings highlight the need for a new care model that is person-centred and supports the overall well-being of CRC survivors, increasing accessibility and maximising the efficiency and effectiveness of the healthcare workforce

## Initiative

"An individual is considered a cancer survivor from the time of diagnosis and for the rest of their life". (Source- Definitions, Victorian Quality Cancer Survivorship Care Policy Template, December 2021).

In September 2023, Monash Health, a large health service in Victoria, developed and pilot-implemented a Colorectal Cancer (CRC) Partnered Survivorship Care Plan (PSCP). Patients who nominated English as their preferred language and were diagnosed with non-metastatic cancer, including stage I and II CRC survivors who had completed primary treatment and early-stage III survivors who had completed their primary and adjuvant treatment. The PSCP consisted of the following three components.

*Figure 1*

| *A Cancer Treatment Summary* | *A Follow-Up Care Plan* | *A Wellbeing and Healthy Lifestyle Plan* |
|---|---|---|
| *▪ Details of diagnosis and treatment (s) completed<br>• Side effects and possible late effects of treatment* | *▪ Years 1-2, three monthly reviews by a surgeon, medical oncologist or GP.<br>▪ Years 3-5, six monthly reviews by a surgeon or GP.* | *▪ Well-being goals<br>▪ Healthy lifestyle tips<br>▪ Links to reliable sources of information to empower survivors to self-manage.* |

## Aim

To improve the health and well-being of early-stage, non-metastatic CRC survivors who have completed active treatment(primary only or primary and adjuvant treatment)

## Objectives

- To support survivor-centred care by eliciting individual survivor concerns and needs to direct individual healthcare plans.
- To improve CRC survivor's knowledge about cancer diagnosis, treatment, and follow-up care.
- To provide a consistent and coordinated management plan and flow of information between providers
- To promote wellness by assisting survivors in making informed lifestyle changes and supporting them in self-managing (per their preferences).
- To improve access to care by providing patients with follow-up care closer to home

## Methods

The CRC PSCP is an evidence-based care model focused on consistent end-of-treatment processes and improved collaboration and communication with primary care providers. General practitioners (GPs) were engaged through an opt-out consent approach, with a rapid access pathway established for urgent specialist consultation. Before completing the PSCP, the survivor's unmet needs and level of distress were assessed using the validated Distress Thermometer and Problem List (DTPL).4 Qualitative and quantitative data were collected.

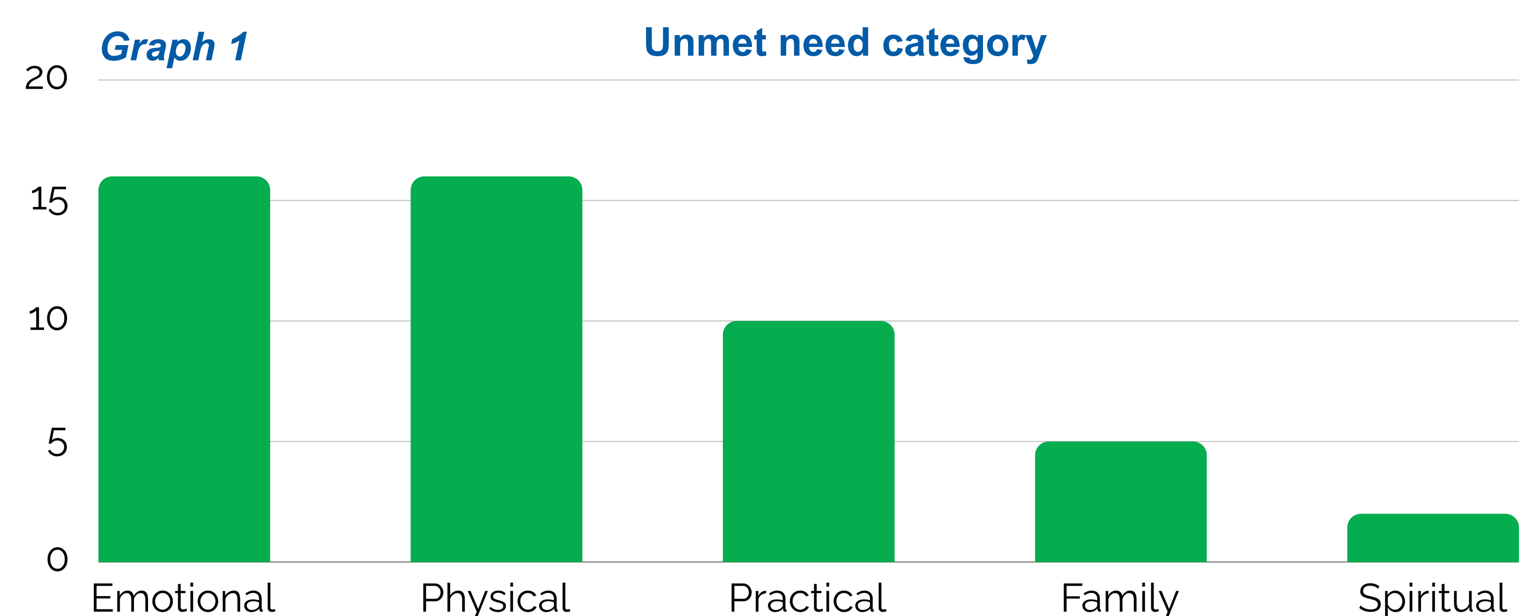
## Guiding Principles

## Results

The pilot recruited 33 CRC survivors and their GPs, putting it on track to meet its recruitment target of 52 in 12 months. The mean age of survivors was 62.45 years. Most participants were male (58%, n=19) and born in Australia (55%, n=18).

### DTPL assessment

The most frequently reported multi-response unmet needs by category were emotional and physical, each identified by 16 patients. Ten patients reported practical needs, while 5 and 2 described family and spiritual needs, respectively (Graph 1). This resulted in six referrals to Cancer Council Victoria and one to Allied Health Services.




### Prominent concerns by category

- Emotional (N=41) concerns, nervousness (34%, n=14) and worry (29%, n=12).
- Physical (N=60) symptoms, fatigue (17%, n=10) and sleep issues (13%, n=8).
- Practical (N=19) difficulties connected to work/school (26%, n=5) and decision-making (21%, n=4).
- Family (N=6) challenges, dealing with partners (33%, n=2) and children (33%,n=2).
- Spiritual (N=2) matters concerning death, dying, and the afterlife (50%, n=1), and the conflict between personal beliefs and cancer treatment (50%, n=1).

### Survey responses

Feedback from 11 participants indicated that 100% of respondents found the information in the PSCP to be highly beneficial. Most respondents strongly agreed/agreed that the PSCP was survivor-centred, addressed information needs, enhanced their knowledge and facilitated communication/coordination regarding their care (Figure 2).

***100% (N=11) strongly agreed / agreed***

**The PSCP:**
- addressed their well-being goals
- prepared them for what to expect after treatment
- provided a valuable overview of their cancer diagnosis and treatment.
- effectively summarised their cancer management information in one document.
- helped them better their health condition and the follow-up care they needed
- increased their awareness of promptly reporting any new or persistent symptoms
- Introduced them to reliable resources.

***91% (N=10) strongly agreed / agreed***

**The PSCP:**
- improved their knowledge about the late effects of treatment
- helped them know the doctors responsible for their follow-up care
- informed them about their behaviours to adopt to live a healthy lifestyle.
- facilitated communication with the other providers involved in their care
- informed their specialist and GP about the current care.

## Enablers

- Strong executive and clinical leadership support for the initiative.
- Validated tools to support reform.
- Change management and project management support for clinical teams.

## Challenges

Only 3 out of 33 participant GPs submitted the required paperwork after their patient's visit despite receiving three reminders. More work is needed to understand GP's lack of engagement.

## Conclusion

Interim results reveal that this pilot study addressed the unmet needs of CRC survivors and empowered them to take an active role in their care.

## References

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