

Telehealth for Supportive Survivorship Care Project VCSP Grant Type 3

FINAL REPORT
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1. Overview

'Telehealth for supportive survivorship care: Increasing access to a survivorship education, exercise and wellness program in rural and regional Victoria using telehealth' was supported by the Victorian Government in partnership with Cancer Council Victoria (CCV), the Hume Regional Integrated Cancer Service (Hume RICS) and the Grampians Integrated Cancer Service (GICS).

Aim

To develop, pilot and assess a telehealth model for the sustainable delivery of a comprehensive survivorship education, exercise and wellness program across rural and regional sites in two Victorian Integrated Cancer Services (ICS).

Outcomes

- Successful development of a sustainable and effective supportive survivorship care program that can be delivered in local health services to enable access for cancer survivors and their carers close to home.
- Delivery and evaluation of eight programs across two regions and five health services to 110 participants.
- Development of a robust, evidence based, best-practice program as a result of iterative refinements through an action research model that was informed by participant and facilitator feedback, input and evaluation data.
- Increased regional workforce capacity through the training of 41 health professionals in program delivery and the use of telehealth enabled sustainability to be embedded into the project.
- Increased level of awareness and understanding of local health professionals that was achieved through the provision of high-quality education and rehabilitation in cancer survivors.
- Strong links and improved relationships between health services, the ICS and primary care networks.
- Dedicated local health professionals whose commitment ensured the success and implementation of the model.
- Multiple referral pathways and improved internal processes at health services assisted with program recruitment.
- Establishment of regional cancer education program planning teams with the inclusion of more local rural health and community services to continually grow the program across both regions.
- Improved emotional health, wellbeing, social connections and increased local access with less travel for participants.
- Increased number of self-referrals of participants directly into allied health services after the program.
- Self-reported increased levels of physical activity and uptake of fruit and vegetables.
- Ongoing sustainability of the program underpinned by four factors:
 - Local champions who strengthened relationships between health services in each region
 - Targeted facilitator development to future-proof the program
 - Involvement of other regional health services, and
 - Using available funding models.

Learnings

1. Cross-sector project involvement and a co-design model assisted by central funding, yields innovative models of care.
2. Regional cancer survivors are interested in being involved in survivorship models of care.
3. Non-cancer, generalist health services can offer these programs with the appropriate resources and support.

Conclusion

The Telehealth for Supportive Survivorship Care Program utilising exercise and education is an effective program delivery model that improves social connections, health and wellness outcomes and overcomes geographical barriers for regional cancer survivors.

2. Executive summary

“I am healthier, exercise more, have improved my diet, know how to take better care of myself and am more mentally and emotionally positive. It makes a world of difference to get that information in your recovery. I feel very lucky to attend and get support, the whole thing was wonderful.” (Participant comment 6 months post program)

Background

The Telehealth for Supportive Survivorship Care project was innovating delivery of CCV's Wellness and Life after Cancer (WALAC) program funded by the Victorian Government. This project was delivered in partnership by CCV, Hume RICS and GICS.

In 2016, 33,037 Victorians were diagnosed with cancer. An average of 30 Victorians die from cancer every day in Victoria. Between 1986 and 2015, five-year survival increased from 48% to 68%. ¹

There is significant work being done by Australian researchers and health services to investigate the issues, difficulties and needs of post-treatment survivors, as well as the support and resources that survivors feel are needed to better assist them as they transition from the treatment to recovery phases. ²

A 2008 qualitative study of survivors, conducted by Jefford et al. ³ showed that participants reported a multitude of significant cancer impacts on everyday functioning, interpersonal relationships, self-confidence and psychological wellbeing, in addition to impacts on their physical health and vitality.

It is well established that rural and regional Victorians face additional survivorship challenges, including the distance and limited transport options required to access treatments and supports and this impacts on cancer outcomes. ⁴ It is also accepted that supporting carers is important for good cancer care, and that caring can have both physical and emotional demands for carers.

Telehealth is defined as the use of telecommunication techniques to exchange health information and provide health care and health education over a distance. ⁵ There are few examples featuring group patient education and allied health interventions using telehealth.

Aim

To provide access to a comprehensive survivorship assessment, education, exercise and wellness program for rural and regional cancer survivors and carers in the Grampians and Hume regions using telehealth.

Objectives

1. To increase access and uptake to an education, assessment rehabilitation and supportive care program for cancer patients and their carers in regional and rural locations using telehealth.
2. To design mechanisms for regional planning, promotion and delivery to reduce duplication, and link program facilitators, acute health services and primary care providers.
3. To design multiple referral pathways to the program that strengthen links between services and allow entry to the program at flexible time-points after cancer treatment.
4. To design governance and resource models for delivery of a psycho-educational intervention that translates to different contexts of supportive care.
5. To design, pilot and evaluate tools and specific facilitation models for the WALAC program, informed by the consumer experience for telehealth program delivery.

6. To innovate and enhance CCV's WALAC program with tailored assessment, practical exercise and wellness sessions for survivors and carers as part of a pilot.

Model of care

The WALAC program assists those who have finished active cancer treatment, to make the transition from clinical care to supported self-management. WALAC is facilitated by health professionals who are trained and supported by CCV. This program was innovated to develop a model of care that incorporated exercise and wellness activities, with the program delivered via telehealth.

In designing the model of care, potential participating sites were identified through the ICS and five health services were invited to participate in the project. Project governance included representation from consumers and all participating sites.

Key elements included:

- The redesign of the WALAC program to allow the delivery via telehealth of education sessions across sites, maximising regional capacity and peer support.
- Exercise rehabilitation and wellness activities developed and delivered at each site by trained facilitators and appropriate health professionals.
- Multiple referral pathways that engaged primary care and allowed cancer survivors and carers entry to the program at flexible time points after cancer treatment at locations that were convenient to them.
- A delivery model that overcame social and geographic barriers to engaging with survivorship interventions for regional and rural patients.

Evaluation

Mixed data collection methods gathered both qualitative and quantitative data from survivors and carers, health program facilitators and health services. These methods included self-reported data, focus groups and telephone surveys.

Outcomes

- Successful development of a sustainable and effective supportive survivorship care program that can be delivered in local health services to enable access for cancer survivors and their carers close to home.
- Delivery and evaluation of eight programs across two regions and five health services to 110 participants.
- Development of a robust, evidence based, best-practice program as a result of iterative refinements through an action research model that was informed by participant and facilitator feedback, input and evaluation data.
- Increased regional workforce capacity through the training of 41 health professionals in program delivery and the use of telehealth enabled sustainability to be embedded into the project.
- Increased level of awareness and understanding of local health professionals that was achieved through the provision of high-quality education and rehabilitation in cancer survivors.
- Strong links and improved relationships between health services, the ICS and primary care networks.
- Dedicated local health professionals whose commitment ensured the success and implementation of the model.
- Multiple referral pathways and improved internal processes at health services assisted with program recruitment.
- Establishment of regional cancer education program planning teams with the inclusion of more local rural health and community services to continually grow the program across both regions.
- Improved emotional health, wellbeing, social connections and increased local access with less travel for participants.
- Increased number of self-referrals of participants directly into allied health services after the program.
- Self-reported increased levels of physical activity and uptake of fruit and vegetables.

- Ongoing sustainability of the program underpinned by four factors:
 - Local champions who strengthened relationships between health services in each region
 - Targeted facilitator development to future-proof the program
 - Involvement of other regional health services, and
 - Using available funding models.

Outputs

This project provided the opportunity for CCV, GICS and Hume RICS to work in partnership to develop, innovate, trial, implement and evaluate a comprehensive exercise, education and telehealth program for cancer survivors.

Outputs included:

1. A model of care that links clinical and primary care services
2. Training and development of 41 health professionals in group facilitation, telehealth and exercise for cancer survivors.
3. The program toolkit that includes validated resources and tools
4. The online project-specific platform hosted by Hume RICS which facilitated efficient communication of program changes
5. Promotion tools and resources for program recruitment
6. Delivery of eight programs in two regions across five health services to 110 participants
7. Program evaluation activities and reports:
 - Quantitative Data Report
 - Qualitative Data Report
8. 18 project presentations to health services, general practitioner (GP) forums and conferences
9. Video library containing promotion and program videos to support delivery and recruitment
10. Headsets for project sites and ICS to support accessibility for participants

Learnings

- Cross-sector project involvement and a co-design model assisted by central funding, yields innovative models of care.
- Regional cancer survivors are interested in being involved in survivorship models of care.
- Non-cancer, generalist health services can offer these programs with the appropriate resources and support.

Recommendations

- Integration of referrals into routine care with specific time-points being identified in internal processes and the patient's treatment pathway.
- Funding to assist with on-going training and implementation in the primary and clinical care settings.
- Further engagement is required with the GPs and Primary Health Networks to increase referrals into the program at the local level.
- Evaluate the health economic impact of the program on health services.

Conclusion

The Telehealth Supportive Survivorship Care Project utilising exercise and education is an effective program delivery model that improves social connections, health and wellness outcomes and overcomes geographical barriers for cancer survivors close to home.

3. Background

Summary

This project used telehealth, and a *hub and spoke delivery model* to deliver WALAC in rural and regional Victoria, to increase access and participation in the program for cancer survivors and carers by allowing them to remain as close to home as practicable. A regional rollout was introduced and consisted of post-treatment education, assessment, rehabilitation and supportive care program across acute cancer services and primary care which built on existing models and resources.

Rationale

In 2016, 33,037 Victorians were diagnosed with cancer. An average of 30 Victorians die from cancer every day in Victoria. Between 1986 and 2015, five-year survival increased from 48% to 68%. ¹

The broad definition of cancer survivorship is acknowledged to include the full gamut of patient experiences and the concept of cancer as a chronic illness, as well as the experiences of caregivers, families and friends of a person diagnosed with cancer. ⁶

Cancer survivorship is associated with increased risk of:

- Cancer recurrence or second primaries ⁷
- Functional decline ⁸
- Co-morbid chronic conditions ⁹
- Persistent side-effects of treatment ¹⁰

Engagement with consumer groups in the Grampians and Hume ICS regions echo these challenges. Consumer perspectives of the challenges and some desirable solutions with sentiments such as those below, collected from activities of the Grampians ICS Consumer Advisory Group in 2015 have informed the development of this project.

“Many hospitals and their staff endeavour to ensure support and care is continued for patients after being discharged. However, at times some patients may feel that they have lost access to the necessary support and care they need once they are discharged leaving them and their carers struggling to cope. To ensure that all patients have adequate access to the support they need it is important that there is some overall system which can follow up with patients to make sure they have the support needed and if not to provide options for assistance from support services that may be available in the broader community – possibly through local council home and community care services or other community organisations”
- Grampians Cancer Conversations and Our Say, 2015.

“I would like to suggest that as part of all treatments that diet and exercise assistance is given. Some of this may not be taken up immediately by people but would later. I have noticed that all my medical teams are focused mainly on my cancer rather than a whole of body” - Grampians Cancer Conversations and Our Say, 2015

It is well established that rural and regional Victorians face additional survivorship challenges, including the distance and limited transport options required to access treatments and supports, impacting on cancer outcomes. It is also accepted that supporting carers is important for good cancer care, and that caring can have both physical and emotional demands for carers.

Exercise has been established by clinical research as a safe and effective intervention to counteract many of the adverse physical and psychological effects of cancer and its treatment. Emerging evidence has found that regular exercise before, during and/or following cancer treatment decreases the severity of other adverse side effects and may be associated with reduced risk of developing new cancers and comorbid conditions such as cardiovascular disease, diabetes and osteoporosis. ¹¹

Telehealth is the use of telecommunication techniques to exchange health information and provide healthcare and health education over a distance. The investment in infrastructure and models of delivery by the Victorian government has led to innovative use of telehealth to support cancer patients in regional and rural Victoria. The infrastructure investment has included the development of video conferencing facilities in regional hospitals and in the ICS. Videoconferencing allows for in-sync broadcasting from a primary site to single or multiple remote settings. ¹²

This project builds directly upon learnings from two telehealth initiatives in the regions that demonstrate that telehealth, as a model for group education and rehabilitation programs has great potential.

1. Hume RICS initiated a trial to test the feasibility and viability of telehealth as a concept by delivering CCV's 'Living with Cancer Education' program in 2015 to 15 participants between Shepparton and Seymour sites. Telehealth delivery was well received by both participants and health professionals.
2. In the GICS region, a new Cardiac Rehabilitation model was developed in 2015 in the Wimmera, Wimmera Health Care Group provided the education component of cardiac rehabilitation via telehealth and outlying health services provided the practical physical activity component. This model increased capacity for more community members to access the program close to their home. Evaluation of this program demonstrated a 217% increase in cardiac rehabilitation allied health contacts compared to contacts in the preceding 12-month period. ¹³

CCV has significant expertise in delivering information and support services designed to reduce the impact of cancer by providing reliable information and compassionate support to people living with cancer, their families and friends. These supports extend across all stages of the cancer trajectory and include two psycho-educational interventions; the 'Living with Cancer Education Program' for those undergoing cancer treatment and 'Wellness and Life After Cancer' for those who have finished active treatment and entering cancer survivorship. In 2015, health professional facilitators across 26 health organisations were supported by CCV in the delivery of 44 education programs to help reduce the impact of cancer for 561 patients, their families and carers. Participation, growth and the success of these programs has grown to the delivery of 58 programs across 30 health services to 700 participants in 2018.

Evidence-base

Psycho-educational interventions are an increasingly popular model of supportive care utilised in cancer care and community support settings. They are structured and time-limited and involve delivery of health education, enhancement of problem-solving and coping skills, stress management techniques and psychological support. Evidence shows that psycho-educational interventions are the most beneficial for cancer survivors as they provide both informational and psychological support.

A comprehensive meta-analysis of 56 interventions compared the effect of four types of interventions in breast cancer survivors – psycho-educational, cognitive-behavioural therapy, supportive and relaxation. ¹⁴ Results showed that psycho-educational interventions had positive effects on survivors. Facilitators and presenters in the small group environment that encourage peer support, are well positioned to use specific communication techniques and language which can encourage behaviour change for participants. A number of theories of health-behaviour change have highlighted the factors or processes that prompt behaviour change. ¹⁵ These processes have been identified as self-efficacy, social support, decisional processes and perceived relevance or vulnerability. The stages of readiness have also been identified as an important process to facilitating health-behaviour change.

Partnerships and participation

The Grampians Integrated Cancer Service (GICS) services a region that stretches from the South Australian border in the west to Melton in the east and from Edenhope to Hopetoun in the north. The area covers almost 50,000 square kilometres and a population nearly 220,000 people. GICS works to improve cancer care systems and services in the Grampians region.

“We act as a catalyst for and driver of change in partnership with people affected by cancer at nearly 30 community, public and private health service providers. Our vision is to improve patient experiences and outcomes by connecting cancer care and driving best practice across the Grampians region.”

Lea Marshall GICS Service Improvement Officer.

Hume Regional Integrated Cancer Service (Hume RICS) is located in Northeast Victoria and supports a wide catchment that extends from Southern NSW to the northern growth corridor of metropolitan Melbourne. Unique in its cross-border structure, HRICS is comprised of two clinical networks: Ovens Murray and Goulburn. The Hume comprises an area in excess of 40,000 square kilometres, with a population of 336,840 (including Albury in NSW).

The Hume has the second highest incidence of cancer within Victoria (Source: Victorian Cancer registry), with 9740 new cases of cancer diagnosed in 2012-16. Hume RICS provides formal partnerships between health services in the region with the aim to improve the planning and delivery of cancer care so that it is coordinated, appropriate and effective

The characteristics of each of the ICS region in terms of cancer and survival rates are detailed in Figure 1.

Figure 1. ICS region characteristics

Grampians Integrated Cancer Services (GICS)	Hume Integrated Cancer Services (Hume RICS)
Are older than the Victorian average (48% vs 45% aged 70 and over)	Are older than the Victorian average (61% vs 59% aged 65 and over)
Have later stage disease when diagnosed	Have later stage disease at diagnosis for colorectal and prostate cancer compared to the state averages.
Have lower cancer survival rates compared to the rest of the state	Have higher cancer survival rates compared to other regional ICS, but lower cancer survival rates compared to metropolitan ICS.
Have lower rates of physical activity, fruit and vegetable consumption	Have lower rates of physical activity, fruit and vegetable consumption
Have higher rates of smoking, alcohol intake, obesity	Have higher rates of smoking, alcohol intake, obesity
Have limited or no access to programs close to home to improve these factors	Have earlier stage disease at diagnosis for breast cancer compared to the state average.

Adapted from: https://www.cancervic.org.au/downloads/cec/cancer-in-vic/Cancer-in-Victoria_Statistics-and-Trends_2016.pdf

Through discussion with each of the ICS, five project sites were invited to participate in the project. At the commencement of the project, a site visit was conducted at each health service to identify facilities, discuss challenges and engage with staff and management. All five health services involved in the project have an established gym, an existing workforce of exercise specialists, oncology and allied health professionals and technology capability. Site descriptions are detailed in Figure 2.

Figure 2. ICS project sites

Grampians Integrated Cancer Services (GICS)	Hume Integrated Cancer Services (Hume RICS)
<p>Wimmera Health Care Group (WHCG) WHCG is the largest health service outside of Ballarat and is 310 km from Melbourne. It has two campuses and a wide range of acute, emergency, obstetric, surgery, dental, community and aged care services. Its new Wimmera Cancer Centre offers a day oncology unit that runs five days a week, a cancer wellness program, allied health referral and the Look Good Feel Better program.</p>	<p>Goulburn Valley Health (GVH) GVH is based in the regional city of Shepparton and is a 2-hour drive north of Melbourne. It caters for over 160,000 people in its region. GVH provides a wide range of high-quality services including mental health, cancer and wellness, community services, acute and emergency services. The oncology service offers both inpatient and outpatient treatment of oncology and haematology patients. It provides chemotherapy and supportive treatment to people affected by cancer. These services are supported by survivorship and cancer specialist nurses. Genesis care have officially announced the development of a cancer centre to open in Shepparton at the end of 2019</p>
<p>Stawell Regional Health (SRH) SRH provides a wide range of services including acute, emergency, surgery and community rehabilitation and aged care. Its day oncology service runs 3 days a week and outreach medical and radiation oncology consultations are provided. A cancer rehabilitation service, access to allied health and the Look Good Feel Better program are available to those affected by cancer.</p>	<p>Northeast Health Wangaratta (NHW) NHW provides quality health care to more than 90,000 people across North East Victoria and is 344 Kms north from Melbourne. NHW is the major referral facility for people with complex health needs from Bright, Mansfield, Beechworth, Myrtleford, Yarrawonga, Euroa and Benalla. The health services provide a telehealth service to these smaller facilities, allowing doctors at Northeast Health to provide medical advice via video link. Oncology services include chemotherapy, acute and cancer support and specialist nurses.</p>
<p>Rural Northwest Health (RNH) RNH is a public sector health service that provides a comprehensive range of acute, aged, and primary health services to the local community of about 5000 people. It does not provide cancer treatment. The Wellness Coordinators at RNH, based on the Cancer Resource Nurse model, provide supportive cancer care.</p>	

4. Methodology

Aim

To develop, pilot and assess a telehealth model for the sustainable delivery of CCV's WALAC program across rural and regional sites in two Victorian ICS.

Objectives

1. To increase access and uptake to an education, assessment rehabilitation and supportive care program for cancer patients and their carers in regional and rural locations using telehealth.
2. To design mechanisms for regional planning, promotion and delivery to reduce duplication, and link program facilitators, acute health services and primary care providers.
3. To design multiple referral pathways to the program that strengthen links between services and allow entry to the program at flexible time-points after cancer treatment.
4. To design governance and resource models for delivery of a psycho-educational intervention that translates to different contexts of supportive care.
5. To design, pilot and evaluate tools and specific facilitation models for the WALAC program, informed by the consumer experience for telehealth program delivery.
6. To innovate and enhance CCV's WALAC program with tailored assessment, practical exercise and wellness sessions for survivors and carers as part of a pilot.

Scope

Metropolitan Melbourne residents (69%) have higher cancer survival than that of residents in other parts of Victoria (65%) namely the Grampians region at 65% and the Hume region at 67%.¹⁶ As shown in Figure 1 both regions have lower survival rates compared to metropolitan Melbourne. The scope of this project included partnering with five rural and regional health services across the two ICS regions to deliver an education and exercise program to cancer survivors and their carers. Cancer survivors are those who had completed their primary clinical treatment and or are on maintenance or hormone therapy.

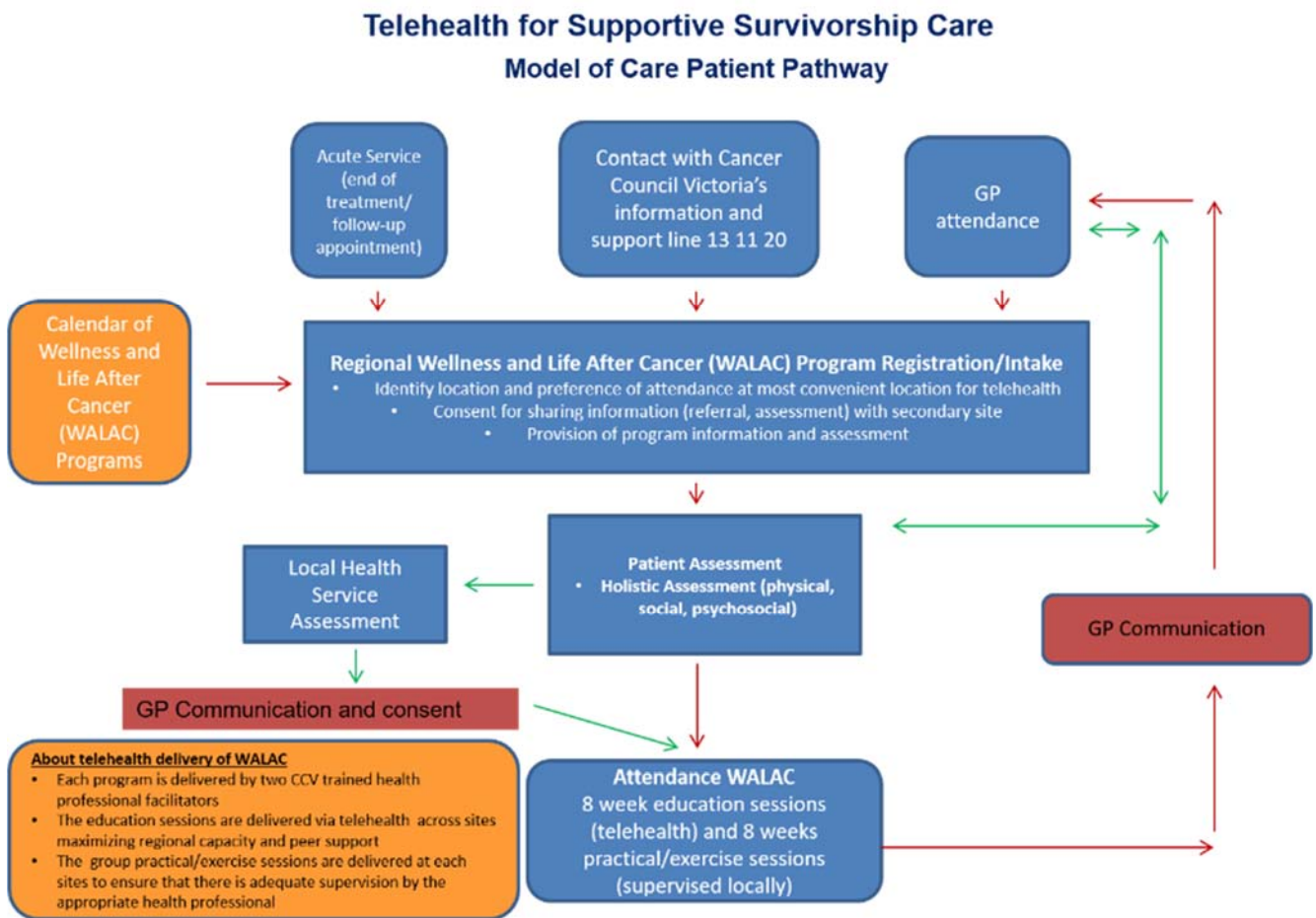
Governance

Project governance included stakeholders from both regions, health service leaders, key personnel from all project sites, representatives from the Primary Health Networks and consumer representatives. The Project Advisory Committee members reflected the experience and knowledge required to effectively guide the project. The group comprised of health representatives and Primary Health Networks from both regions. This ensured that region specific challenges and successes could be reported and discussed. The project leadership and implementation teams worked collaboratively to ensure successful delivery of the project.

Model of Care

With the background of the cardiac model in both regions and the success of the Wimmera model using telehealth, a framework and vision to be implemented in the cancer space was identified. The model of care, supported by the governance model and depicted in Figure 3, was informed by these models and the CCV WALAC program to implement a comprehensive exercise and education program for cancer survivors and carers closer to home using telehealth. This provided a structure for the key components of exercise, education and technology supported by the governance structure, stakeholder engagement and regional and local collaboration.

Figure 3. Model of care



Identifying and building on the existing workforce, resources, systems and mechanisms, supported by the development of specific tools and resources comprised the key elements of the model of care for cancer survivors and carers. Each of the tools and systems outlined below are key components of the program design and support the program’s development and delivery as shown in this model of care.

- 1. Health professionals and local networks** including Health Service management, the Primary Health Networks, GPs and Primary Care Partnerships across the regions enabled integration of the model of care into the local health services existing processes and delivery.
- 2. The WALAC Education Program** provided an evidence-based psycho-educational program which was redesigned enabling it to be delivered using telehealth over a period of eight weeks. Previously, the program delivery structure was as a one-day forum or two half day workshops. Delivery is by trained facilitators with the support of guest presenters who are experts in their field.
- 3. Existing Telehealth Infrastructure** enabled the implementation of a *hub and spoke model* allowing multiple sites to participate in the education session using video-conferencing technology in an education room. Benefits of telehealth include the need for only one presenter, a small number of participants attending and decreased need for travel by participants as the program can be accessed locally.

4. Exercise assessments and sessions are conducted by the exercise physiologist (EP) at the relevant health service. Sessions are group based with individual programs provided, supported by a home program and were supported by the education topics in the WALAC program. At completion of the exercise program, a final assessment is completed, and information provided on local networks and services available. Letters to the participant’s GP are provided both at the commencement and completion of the program.

5. Program referral and recruitment is through health professionals, GP, multi-disciplinary teams (MDMs) or by self-referral. Promotion of the program to all stakeholders and the community is ongoing and delivered through multiple avenues including GP forums, Primary Health Care events, media releases, posters and on-line promotion.

Evaluation

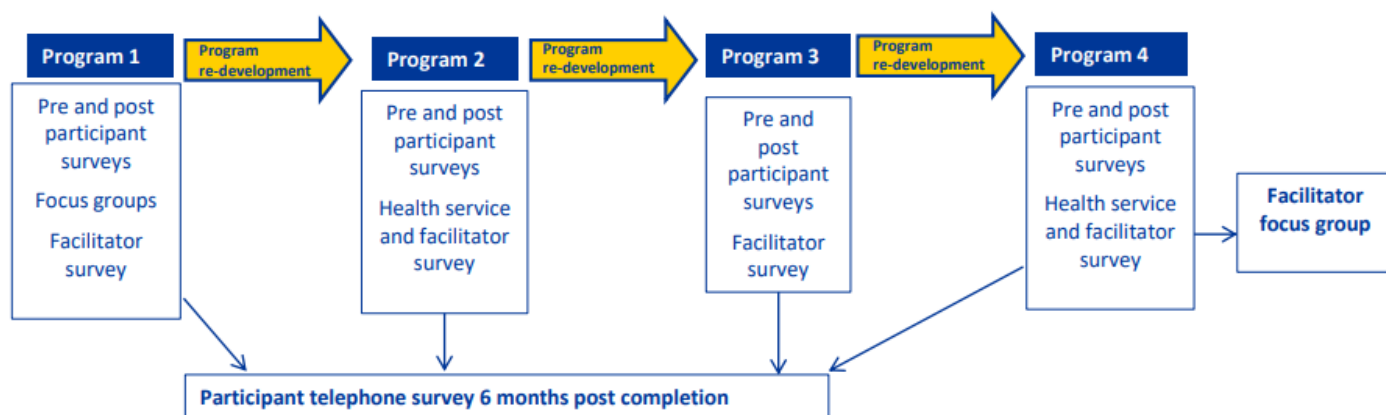
An evaluation framework was developed in alignment with the VCSP Evaluation Guidelines (Project Progress Report One). Mixed data collection methods gathered both qualitative and quantitative data from survivors and carers and program facilitators and health services. As there were two regions involved in this project, evaluation included ICS specific case comparisons.

Action research was implemented to enable continual evaluation to inform program changes and redesign throughout the project, as shown in Figure 4. This meant that changes could be made between programs, trialled and reviewed to allow a model of best practice to emerge.

The evaluation tools enabled both quantitative and qualitative data to be collected throughout the project which informed program design and development:

- Participant pre and post questionnaire
- Facilitator feedback forms
- Health service feedback forms
- Participant focus group in each region
- Facilitator focus groups at the commencement of the project and also at the conclusion
- Six-month telephone interviews of participants from both regions

Figure 4. Program evaluation map



Outputs

This project developed and implemented a model so care that links clinical and primary care together. The opportunity was provided for CCV, GICS and Hume RICS to work in partnership to develop, innovate, trial and implement a comprehensive, education and telehealth program for cancer survivors. Successful delivery of the project saw the delivery of eight programs in two regions across five health services to 110 participants.

To support this project and ensure its success, activities, events, products and resources were developed as project outputs are listed below and are discussed further in the body of this report. All are documented in the Appendix section.

1. The program toolkit that includes validated resources and tools - Appendix ONE (App.1)
 - Program manual
 - Telehealth manual
 - Exercise and physical assessment procedures manual
2. Training and development of 41 health professionals involved in program delivery - Appendix TWO (App.2)
3. Promotion tools and resources for program recruitment - Appendix THREE (App.3)
4. Program evaluation activities and reports:
 - Quantitative Data Report - Appendix FOUR (App.4)
 - Qualitative Data Report - Appendix FIVE (App.5)
5. 18 project presentations to health services, GP forums and conferences - Appendix SIX (App.6)
6. Video library containing promotion and program videos to support delivery and recruitment - Appendix SEVEN (App.7)
7. Headsets for project sites and ICS to support accessibility for participants - Appendix EIGHT (App. 8)

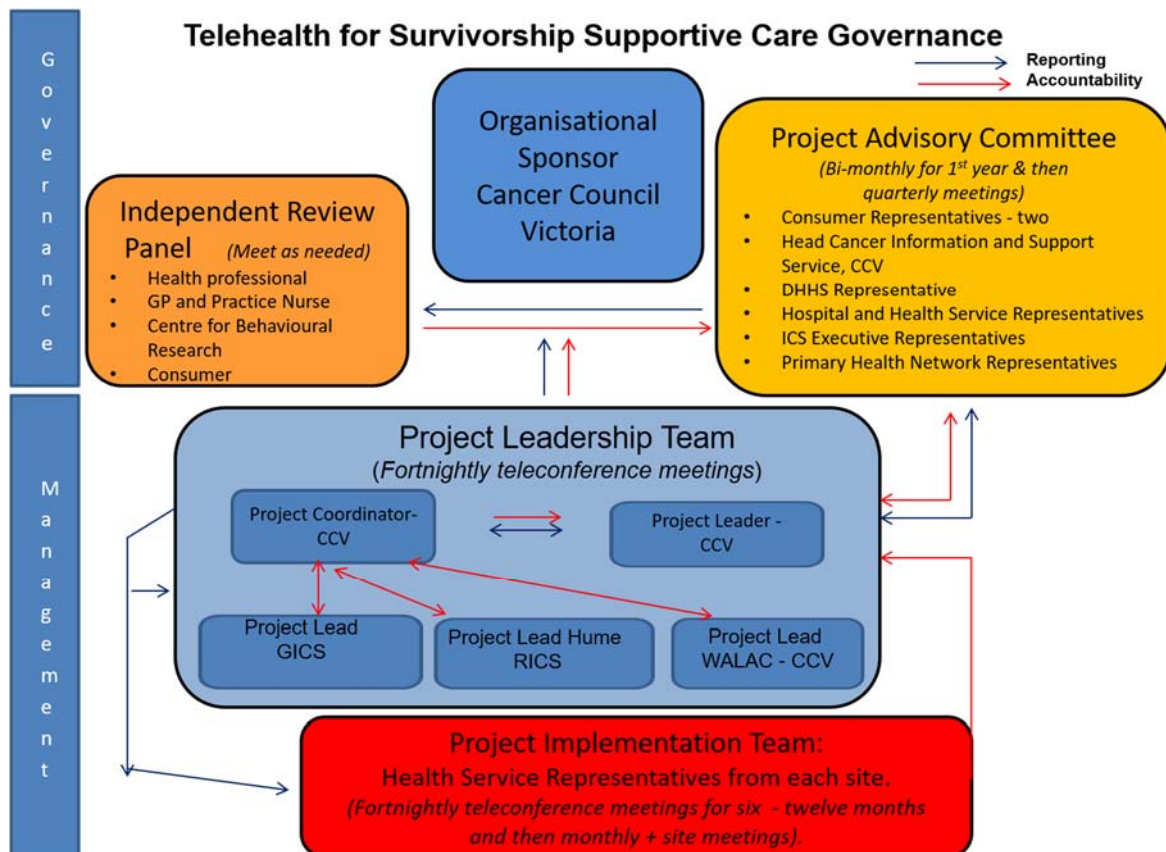
5. Evaluation Domains

5.1 Governance

Project governance included Health Service members of management, health professionals, Cancer Resource Nurses, consumer representatives, Primary Health Networks, ICS key personnel and local champions as shown in Figure 5. Implementation of a strong governance structure was supported by consistent and effective communication protocols and strategies. Inclusion of key personnel from all health services involved in all levels of the Governance structure. This enabled local challenges to be discussed and ensured that all project sites were represented. However, changes of personnel sitting on each of the committees throughout the project did cause disruption to communication flows and it is acknowledged that the amount of time required for project implementation was a burden and challenge. Online survey feedback from one of the consumer representatives indicated that:

“More guidance on the role of the consumer would have been helpful. Otherwise, it was great to be involved”.
(Consumer Representative Advisory Committee).

Figure 5. Governance structure



5.2 Model of care

The model of care has been explained previously in Methodology. One of the key strengths of a successful model of care and project was identifying local champions who became key drivers for the development and integration of the program. In the Grampians, the Wimmera Health Care Nurse Practitioner was a significant driver and in the Hume region, one of the Oncologists from GVH advocated for the program to the GPs and health services.

Working with the Primary Health Networks (PHN) in both regions enabled a GP forum to be delivered in the Grampians with 15 participants attending. A GP event, coordinated by the ICS and championed by the GVH Oncologist, was also delivered in the Hume region with 10 attending. Promoting the project with GPs was challenging and needs more work.

Identifying the workforce, resources, systems and mechanisms that existed in each of the health services was an effective approach as it enabled project elements to be built on and also embedded. This work was achieved through discussions, process mapping and determining what worked in each of the cardiac models and adapting these accordingly. This was then supported by the development of tools and resources to ensure implementation and sustainability.

5.3 Organisational development and leadership

The governance structure which was implemented informed organisational development and leadership and provided the framework for the following activities:

- Promotion of the project through the development of a video of a GP discussing survivorship, supportive care and the project to address the challenge of informing and engaging with GPs. This was provided individually to GPs through a mail out and at any events conducted.
- Delivering presentations (App.6) to multiple organisations before and during the project assisted in increasing awareness and support of the program and model of care.
- Inviting stakeholders to provide their input and feedback on different project elements of the project, including funding sources to ensure sustainability post project. Responses were then presented to the committees for consideration and discussion. This process ensured engagement and inclusion for all those involved.
- Challenges found with project leadership included change of personnel, workloads and the amount of time spent in meetings for the leadership and implementation teams. Teleconferences were fortnightly with frequent follow-ups when required.
- In the Hume region, once local health professionals became more familiar with the program model they became more engaged and identified local champions. Time was needed to implement internal processes, trial different delivery models and address technology challenges in order to find a model that best suited the region.
- The ICS governance and in-kind staff resources provided support and development of the project and troubleshooting where required. This included working with the health services to develop letters of support for ethics and presenting the project to executive, governance committees and Primary Health Networks.
- In the Hume region, there was a significant delay of ethics approval which was a challenge and delayed implementation of the project by six months.

5.3 Project Implementation and evaluation

There were five distinct phases to the project.

5.3.1 Program Framework development

The scoping and mapping stage of the project enabled stakeholder engagement to occur and provided time to identify each of the health services and local champions. This then informed the governance structure, ethics applications and the model of care development.

5.3.2 Health Professional Education

To build workforce capacity, WALAC facilitator training (App.2) was provided by CCV to 41 health professionals involved in program delivery. This included program content, facilitation skills, telehealth delivery and provided the opportunity for facilitators to connect and engage with each other and their sites as they were preparing for their first program.

Cancer and Exercise Training was also provided to 11 exercise specialist staff including the EPs and Physiotherapists by Edith Cowen University. The one-day workshop was followed up with online modules which all health professionals from both regions completed.

Telehealth professional development was provided by the Department of Education with added support for delivery if required. This was supported by several “tests” between different sites prior to the program commencing to assist with problem solving and increasing the level of confidence of staff in using the technology.

5.3.3 Program development

To guide and assist with program development, resources and tools, the Program Toolkit (App. 1) was developed, implemented, reviewed and re-designed as a best practice manual for program delivery. The toolkit was first developed at the commencement of the project and provided as both a hard copy for all project sites and online using the Hume RICS website platform. It has since been reviewed and developed into a product informed by best practice. The toolkit consists of each of the elements detailed below.

5.3.3.1 Exercise assessments and sessions

Participant assessment for program suitability was conducted by the EP at the relevant health service and a letter provided to the GP. Upon completion of the program, this process is repeated. Through the project, providing cancer and exercise training to all EP's ensured that they were well equipped to work with cancer survivors.

To ensure consistent and validated resources, a content expert Dale Ischia, Exercise Physiologist, was engaged to develop all the exercise documents. These included pre and post exercise assessment tools, program guides and a home program for participants. These documents were trialled, and feedback was provided by the EP's from all five project sites. At the end of the program, they were then finalised to include the changes and suggestions made and included in the program toolkit as the Exercise & Physical Assessment Procedures Manual (App.1. Page 20).

5.3.3.2 Education Program

The redesign of the WALAC program for the purpose of the project included a multi-stage approach. All resources were developed for the first round of programs, delivered, evaluated and reviewed and then redesigned for the final programs.

The program structure includes two topics delivered in one-hour sessions over a period of eight weeks instead of the traditional one or two day program delivery. All topics are delivered by either a guest presenter or the facilitator. Elements of the design included developing the existing topics into short twenty-minute presentations and development of participant information sheets to support the topic and to be used if the technology failed. Other supporting documents include:

- Pre and post participant questionnaires
- A flexible program schedule
- Participant resource packs

Changes to WALAC that were evaluated as strengths of the program design were:

- Decreased amount of presentation time for each topic from 30 to 20 minutes. This enabled more time for questions which needed to be built in using telehealth due to time delay and discussions across sites.

- Increased range of topics which are now embedded into the program including the development of a new presentation on 'Foot Health' with the support of qualified Podiatrists and a separate GICS project.
- Redesign of the WALAC Participant booklet into individual worksheets for each topic. This was in response to feedback after the first programs were delivered to enable easier use of this resource over an eight-week period using telehealth.
- Stronger links in the presentations and material with the known benefits of exercise for cancer survivors. This enabled a more cohesive transition between the weekly exercise and education programs to occur for participants.

5.3.3.3 Telehealth delivery

Delivery of the education program using telehealth requires the use of video-conferencing facilities. In most sites, this technology was in an education or board room at the health service with participants walking to the room after the exercise session had finished. Feedback and evaluation of utilising telehealth for the delivery of the education sessions by using existing technology identified that:

- Significant training, upskilling and mentoring of facilitators to manage the technology was required and this was addressed through ongoing training and support.
- Current technology was outdated and challenging to use in some locations.
- Telehealth was challenging for all sites across each of the eight programs and required technical support on occasion.
- The opportunity for proactive solutions to be developed and implemented emerged. For example, ensuring that each site had both hard and electronic copies of all presentations and notes a day prior to the session.
- Program delivery was dependent on technology reliability which sometimes required internal IT support.
- Extra communication and processes for participants was required to ensure that they could all adequately hear the content, feel included and could ask questions.
- Comprehensive guidelines and resources were developed, implemented and reviewed and are contained into the program toolkit (App.1. Page 13). These comprise of checklists and resources to enable successful delivery using telehealth:
 - Planning documents and checklists
 - Guest presenter guidelines and suggestions
 - Information sheets for participants
 - Templates for use in the sessions

While many challenges were noted and processes implemented, overall both facilitators and participants identified that telehealth enabled the program to be run locally, reduced the need to travel and can be a successful delivery model.

5.3.3.4 Promotion Tools (App. 3)

A promotion plan was developed specifically for each region and supported by the following resources to create awareness of survivorship needs and to promote the program:

- Health Professional information sheet: outlined the project and supported presentations delivered to health services, GPs and primary care.
- GP video: provided to individual GPs across the regions to promote survivorship and the program
- Flyers, post cards, media releases and posters were developed and distributed throughout the project.
- Participant video of the benefits of the program

Each of the promotional tools and resources where possible were localised with logos and contact numbers for each of the project sites. These were supported by press releases, online advertisements and radio interviews. It was found in the Hume region that Facebook promotion was very successful with 10 direct requests for information on the programs.

5.3.4 Program delivery

Across the project, eight programs were delivered, four in each region. In the Grampians, the health services delivered a standard two-hour program over the course of eight weeks on a Thursday morning across multiple sites. The first three programs included two sites and in the third program, all three health services participated.

The programs were delivered in the clinical environment of the health service with those delivering the program including EPs, physiotherapists, the nurse practitioner, oncology nurses, social workers, allied health assistants (AHA), and resource nurses. To ensure success of the project, the project teams in each region were well supported by the ICS lead staff and other support staff including local project workers from the primary health network sector.

A significant amount of time was invested by all teams at each health service through regular meetings, mentoring each other across the project sites, co-design by all involved and providing input into program development along with participating in project evaluation.

The coordination of topics and guest presenters was shared across each of the project sites. Local health professionals were invited to present on their topic, provided with the presentation and guidelines on how to engage with participants using telehealth. Early in the program, it was realised that hard copies of their presentations and information sheets would be needed at each site prior to the day in the event of the technology not working. The focus of the final session of each program was on connecting participants to local groups, services and networks to assist them further with survivorship.

The processes for standard program implementation and delivery consists of a two hour program which includes an hour of exercise and an hour of education using telehealth over an eight week time period. In the program, the participants include cancer survivors and carers with the maximum of numbers for the exercise program capped at 10 and the minimum group number at 4. Carers could also choose to attend either both the exercise and education sessions or just the education sessions. Figure 6 outlines the eight-week schedule for all topics.

Figure 6. Eight-week exercise and education schedule

Week	One-group exercise session	One-hour education session using the telehealth hub and spoke model
1	Exercise Program	Cancer Survivorship <ul style="list-style-type: none"> • Program introduction • Cancer survivorship
2	Exercise Program	Exercise and Fatigue <ul style="list-style-type: none"> • Physical activity and exercise • Fatigue and cognitive changes
3	Exercise Program	Goal Setting
4	Exercise Program	Healthy Eating and Nutrition
5	Exercise Program	Emotions and Wellness <ul style="list-style-type: none"> • Emotions and Wellness • Exercise and emotional health
6	Exercise Program	Finances and Work
7	Exercise Program	Your GP and Your Health <ul style="list-style-type: none"> • You GP and long-term health • Your bone health
8	Exercise Program	Final Session <ul style="list-style-type: none"> • Local services & support • Celebration

In the Hume region, a tailored delivery model was explored as seen in Figure 7. The program was delivered over eight weeks with the hour exercise class weekly and the education was delivered in block time periods over the eight weeks. This was to accommodate some early challenges around room availability, workforce capacity and timetabling at the health service.

This delivery model proved challenging due to participant fatigue, lack of concentration and participants choosing not to attend the education sessions. As can be seen, the model changed over the four programs with the result being that the final program had a two-hour education block delivered fortnightly. Since the conclusion of the project, all ongoing programs now implement the standard model of two weekly exercise and education sessions.

In the Grampians region, Wimmera Health Care group as a larger health service participated in all four programs with the two smaller health services alternating depending on participant numbers.

Figure 7. Program delivery by region and site

Grampians	Program One	Program Two	Program Three	Program Four
Total No. of Participants	11	14	9	17
Wimmera Health Care Group program delivery.	✓	✓	✓	✓
Southwest Health program delivery.	✓	✗	✓	✓
Stawell Regional Health program delivery.	✗	✓	✗	✓
Education sessions	1 hr weekly x 8 wks	1 hr weekly x 8 wks	1 hr weekly x 8 wks	1 hr weekly x 8 wks
Hume	Program One	Program Two	Program Three	Program Four
Total No. of Participants	11	12	20	16
Goulburn valley Health program delivery.	✓	✓	✓	✓
Northeast Health Wangaratta program delivery.	✓	✓	✓	✓
Education sessions	2x 4 hr education blocks	2x 4 hr education blocks	3x 3 hr education blocks	4 x 2 hr education blocks

5.5.5 Evaluation

Action research was implemented to enable continual evaluation to inform program changes and redesign throughout the project. This meant that changes could be made between programs, trialled and reviewed to allow a model of best practice to emerge. The evaluation tools used enabled both quantitative and qualitative data to be collected.

5.5.5.1 Quantitative Data

The project pre and post program participation data that was collected in both regions has been analysed by data analysts with a full report and corresponding graphs in (App. 4)

The main pre and post measures of behaviour change included the number of serves of fruit per day, serves of vegetables per day, frequency of physical activity per week and duration of physical activity (minutes per week). The total physical activity (minutes per week) was calculated from the physical activity frequency and duration. The mean for the pre and post data for these measures was calculated overall and separately for Grampians and Hume.

There were 71 participants who completed a pre-program questionnaire, 84 people who completed a post program questionnaire and 48 participants who completed both. Of those who completed the pre-program questionnaire, 44%

travelled less than 10 kilometres and 31% travelled between 10 to 50 kilometres to attend the program. Three-quarters of the pre-program participants were referred by health professionals.

For all five measures of diet and physical activity, there was a statistically significant improvement from pre to post with Grampians and Hume shown as not significantly different to each other in terms of change from pre to post on these five measures. This was supported by the results of the telephone surveys where participants stated that their physical activity and healthy eating behaviours had increased.

The purpose of the project was to support the piloting and implementation of a sustainable model, and there are several limitations to the study. It was not designed to research behaviour change and so the design did not include randomisation or cross-over arms. The program was also different in the two regions and the series of programs delivered in each region evolved over time.

Measurement error was a limitation of this study. The data on fruit and vegetable serves and physical activity level were self-reported, and consequently subject to reporter bias, probably over-reporting. Also, feedback from participants in Grampians Program 2 was excluded as the wrong questionnaire was inadvertently provided. This error was corrected for programs 3 and 4.

These limitations mean that although the results are promising, they do not necessarily indicate that the program contributed to changes in behaviour. Further research comprising a robust study design addressing the identified limitations would be required to support an association between participation in the program and changes in behaviour.

5.5.5.2 Qualitative Data

This was collected through focus groups and telephone surveys. Each of these activities were timed to enable input of the focus group outcomes and comments to inform the program design and development. The three focus groups were conducted by an independent facilitator and a detailed report of each is contained in (App.5.) The key themes of each are summarised in Figure 7.

Figure 7. Focus group key themes and quotes

Program Participants	
Improvements to their psychosocial wellbeing and feeling connected	<p><i>“We could see other peoples in other communities and were, they were able to open up and share some of the things that they’ve been experiencing with the cancer treatments and, and things, and how it had emotionally affected them. ... I can relate a little bit more carefully with them now. ... it’s made my attitudes towards people a lot more sympathetic.”</i></p> <p>November 2017</p>
Increase in their knowledge of survivorship and support available locally	
Increased physical activity and healthy eating behaviours	
Access to the program close to home	
Stronger links with local health services and accessing allied health services.	
Program Facilitators	
The high level of support provided by CCV with project implementation and co-design	<p><i>“The biggest challenge was firstly being able to clearly hear and see each other’s faces through the telehealth link. The IT wasn’t really the issue, it was us, to remember what to do.”</i></p> <p>November 2017</p>
Very worthwhile program to promote overall wellness of cancer survivors	
The capacity to tailor the program for the local audience	<p><i>“As the Grampians program evolved, educational content was altered to meet attendees’ needs. The social worker added a component on emotions to the financial educational session. Foot health and complementary therapies were integrated, which were absolutely fantastic.”</i></p> <p>November 2018</p>
The benefit of using telehealth to connect with others and reduce the need to travel	
Telehealth while challenging was of great benefit to participants.	
Competing priorities, role changes and being time poor were significantly challenging	

The telephone survey (App. 5) was conducted with twenty participants from the eight programs contacted six months post their participation. From the questions asked, the following outcomes and themes emerged:

- Connecting with others was a common and significant outcome
- All have continued with and increased their level of exercise and physical activity.
- Most made some health and wellbeing changes to their lifestyle including healthier eating behaviours.
- Six mentioned that they followed up with health professional referrals after the program.
- All would recommend the program to others.
- Several were frustrated by the telehealth challenges; however, they support it as an effective model of delivery.
- The majority would not have attended if the program wasn't delivered locally.

"I would love to think the program will continue because I know the benefit, especially when it comes to balance. Being able to regain my balance was very important to me." (Participant)

5.6 Project challenges, variations and strengths

The most significant challenges for the project included workforce capacity, delivery of a complex program, staff time availability and personnel changes in the project teams. Three members of the CCV project team left with only one project team member for the last twelve months of the funding period.

Delivery of a complex program that incorporates all three elements of exercise, education and technology to be delivered four times in each region was challenging. Health services built sustainability in the model through development of internal processes to embed the program into routine care. Extra staff training and backfill were required and enabled through the ICS with small amounts of project funding.

The most significant program variation was in the Hume delivery model with the inclusion of the education blocks. For the first program the education session at one location, was delivered off-site. This impacted on the cohesion of the program and time spent travelling for both participants and staff. This was addressed for the remaining programs as an education room was able to be provided on site and in close proximity to the gym.

Some changes were made to program topics and delivery mechanisms and included:

1. Development and inclusion of the topic "Foot Health" in the education program which emerged from a separate project being delivered by GICS as a separate VCSP project.
2. Development of individual participant information sheets instead of the booklet which was originally part of the program. This provided more flexibility with the change of topics during the program and information provided.
3. Identifying that some of the program participants had hearing difficulties, so headsets are being purchased to improve accessibility of the program (App. 8.).
4. The exercise tools and resources were reviewed and updated by Dale Ischia content expert and informed by the EP's from each of the health services.
5. Development of a video library (App. 7.) of the key program topics. This will provide facilitators with a validated resource to use if topic presenters are unable to attend the program.

A strength of the project was the flexibility built into the process which enabled each of the regions and health services to tailor program elements that better reflected their health service needs, participants and community. This came about through ensuring open, honest and consistent communication occurred between CCV, the project leads and the project teams at all times. When challenges arose, communication, discussion and proactive problem solving was the key to achieving positive outcomes.

5.7 Project outcomes, achievements and outputs

5.7.1 Project outcomes and achievements

- Successful development of a sustainable and effective supportive survivorship care program that can be delivered in local health services to enable access for cancer survivors and their carers close to home.
- Delivery and evaluation of eight programs across two regions and five health services to 110 participants.
- Development of a robust, evidence based, best-practice program as a result of iterative refinements through an action research model that was informed by participant and facilitator feedback, input and evaluation data.
- Increased regional workforce capacity through the training of 41 health professionals in program delivery and the use of telehealth enabled sustainability to be embedded into the project.
- Increased level of awareness and understanding of local health professionals that was achieved through the provision of high-quality education and rehabilitation in cancer survivors.
- Strong links and improved relationships between health services, the ICS and primary care networks.
- Dedicated local health professionals whose commitment ensured the success and implementation of the model.
- Multiple referral pathways and improved internal processes at health services assisted with program recruitment.
- Establishment of regional cancer education program planning teams with the inclusion of more local rural health and community services to continually grow the program across both regions.
- Improved emotional health, wellbeing, social connections and increased local access with less travel for participants.
- Increased number of self-referrals of participants directly into allied health services after the program.
- Self-reported increased levels of physical activity and uptake of fruit and vegetables.
- Ongoing sustainability of the program underpinned by four factors:
 - Local champions who strengthened relationships between health services in each region
 - Targeted facilitator development to future-proof the program
 - Involvement of other regional health services, and
 - Using available funding models.

5.7.2 Program outputs

This project provided the opportunity for CCV, GICS and Hume RICS to work in partnership to develop, innovate, trial, implement and evaluate a comprehensive exercise, education and telehealth program for cancer survivors. Outputs include:

1. Model of care that links clinical and primary care services together:
 - Flexible patient referral pathway
2. The program toolkit which consists of validated resources and tools:
 - At the conclusion of the project this has been updated based on project learnings, feedback, input and discussion with all project facilitators to reflect best practice and will be available to guide all future programs.
3. Online platform:
 - This was provided by Hume RICS and proved to be an invaluable tool for the updating of program material as the project progressed as it was used to host all the material that was contained in the toolkit. The platform was a great enabler for version control of all material and resources.
4. Training and development:
 - Three WALAC facilitator training events were delivered by CCV with 41 health professionals attending in total.
 - Exercise and Cancer training was delivered by Edith Cowen University to 11 exercise health professionals from both regions. This included on-line modules which all trainees completed.
5. Promotion tools and resources for recruitment:

- A range of promotion tools and mechanisms were developed for health professionals and consumers and included flyers, post cards, media releases, posters and videos. These were distributed throughout the project and supported by a region-specific implementation plan
6. Delivery of eight programs across five health services
 - Four programs were delivered in each of the two regions with 110 participants attending in total.
 7. Program evaluation activities and reports:
 - Quantitative data report
 - Qualitative data report
 8. Presentations and GP forums
 - 18 presentations were delivered to create awareness of the project and engage with stakeholders, health management teams and oncology staff.
 - Two GP forums were held, one in each region.
 9. Video library
 - To support the delivery of specific topics, videos have been produced which facilitators can use in the event of not being able to access a guest presenter or telehealth not working on that day.
 10. Participant support resources – headsets:
 - Participants identified that for some of them, the guest presenter was difficult to hear over telehealth for those who had hearing difficulties. Therefore, appropriate headsets have been investigated with two being purchased to be provided to each of the project sites. There will also be two provided to GICS and HRICS to provide to other services if required (App. 8.).

5.8 Participation

Participants were included if they had completed active treatment and were deemed well enough when assessed by the EP to attend the exercise program. If they were excluded, they were then referred to either another program or put on the list for the next program depending on their health.

Participants who had completed their initial active treatment but who were on maintenance treatments such as hormone therapy, were accepted into the program as long as their health allowed. Carers who wished to participate were also accepted into both the exercise and education programs or just the education program – depending on their personal preference and need.

It is unclear as to the number of cancer survivors or carers were referred into the program compared to the number who chose to contact the health service for an assessment and participate in the program. 110 participants participated in the program and across the five services only 3 were referred elsewhere or asked to register for a later program due to health reasons.

Through an online survey, program facilitators and the ICS identified key barriers and enablers to participation of individuals into the program.

Barriers

- Lack of clinician buy in/ executive sponsorship, impacting recruitment to program
- Timing of program - for example, the program runs during business hours which means that it is not accessible to patients who have returned to work.
- In the Grampians, the lack of a system to identify patients from treating centres who are appropriate for referral (patients travel by choice, by existing referral patterns, or according to need to more specialised treatment not offered in the Wimmera)

- Primary care referrals
- Allied health or nursing in smaller health services are difficult to back fill to enable participation in training and as facilitators.
- Funding for training and involvement in the program remains challenging
- Telehealth is both a barrier and enabler. The barrier is that it is not reliable enough often enough and this creates workarounds for staff at the receiving sites while the enabler is that it increases access to programs.

Enablers

- Clinical champions engaged/referring patients to program
- Education sessions also available to families/carers providing logistical and emotional support to participants
- Program offered 'closer to home'
- Post project, ability to provide rolling 8-week program enabling patients to enter at any time, minimising wait time for patients and increased access to program
- Enthusiasm and 'can do' attitude of facilitators. Problem solving, planning and consultation amongst the group enables smooth delivery for participants
- Diversity in the project implementation group. Each member had an area of expertise that created efficiencies and rapidly resolved most issues
- Opportunities for all project participants to physically get together to discuss and resolve issues

Involvement/participation by guest presenters and other personnel

Participation and support by guest presenters were very positive across both regions, however it has been noted that access to allied health can be challenging, particularly in terms of small numbers of staff and competing priorities.

Facilitator and GICS feedback included the following points:

- Far easier to recruit guest presenters within health service(s) (i.e. Dieticians, Social Workers etc.)
- Barriers around oncology nursing staff as WALAC facilitators due to time constraints, ability to commit
- The program creates an opportunity for health service staff (as above) to demonstrate their knowledge to a larger number of participants.
- The project created an opportunity for new content development, for example, foot health that now integrates podiatrists into the program.

Barriers/enablers to program support across the organisations

For the success of the project, key stakeholder engagement and buy was integral to program support. This was achieved through different mechanisms including presentations, meetings and inclusion on project governance.

Project funding enabled trial and implementation of the project, however for program sustainability, funding can be both a barrier (lack of funding) and enabler (funding provision) to program support. Being able to offset/justify the costs against a funding pool is a common theme at present. If this cannot be demonstrated, then future support may be problematic.

Participant feedback, staff engagement and commitment were strong enablers to program support.

5.9 Expected Outcomes

Further to the project outcomes already highlighted and discussed, program facilitators identified those outcomes for both participants and their organisations that they observed.

Individual

- Increased social connectedness between participants
- Improvements in health outcomes for participants

- Empowering consumers with self-management strategies
- Improvements to participant physical and emotional wellbeing
- Improved access to cancer survivorship closer to home
- Increased awareness of local services available and how they may be of benefit to support people with cancer to be healthy and well
- Greater access for rural and regional cancer survivors
- Positive impact on local cancer survivors

Organisational

- Increased knowledge and skills for health professionals
- Increased cancer-specific skills and knowledge for generalist and community-based nursing and allied health professionals
- Increased satisfaction for health professionals
- Closing the service gap with the program
- Improved connections with oncology department that wasn't there prior to the program and with other stakeholders
- Direct referrals from the program into allied health services, such as podiatry
- Creation of a multi-health service cancer education team that collaborates together to maximise the program
- Development of a streamlined EP assessment prior to client participation
- Commencement of the integration of foot health and podiatry into cancer care
- Increased awareness and value of survivorship and importance in cancer care for organisations, GPs and allied health professionals
- Increasing supportive care referrals to Allied Health professionals
- Embedded into standard practice

5.10 Sustainability and spread

The project has enabled the development of a comprehensive exercise and education program using telehealth which is effective and sustainable. This is supported by evaluation data, participant and facilitator feedback of value of program, the creation of relationships within the groups and participants wishing to continue the program.

The development of community maintenance based programs for referral and transition into after participants have completed the WALAC program would assist with ongoing supported self-management for cancer survivors. The Victorian Active Ageing Partnership (VAAP) is successfully developing a model in this space working with community services.

At a regional level, ensuring that the model of care is integrated into usual practice and policy are core to the program spreading and being sustainable. Smaller health services can participate depending on numbers and move in and out of the program over the course of the twelve-month schedule. To support this, the Grampians are planning an engagement strategy with other health services in terms of education/training of staff, utilising the program within each health service.

An offset of costs may impact on engagement and roll-out and ensuring that the program is established within correct health service department for remit and funding. Also developing a guide for funding for other services to consider could equip them to make an easier decision.

In the Hume region, the model of care is now based around the cardiac and pulmonary rehab programs in two Hume regional health services. This rolling 8-week program enables patients to enter at any time, minimising wait time for patients and increases access to the program.

Feedback from the governance committees regarding sustainability and spread included:

- Funding is a constant challenge
- Engagement with GPs is a challenge but important
- Ensuring workforce capacity will need to be an on-going priority
- Adapt other methodologies, for example Transition to Independent Exercise (TIE) currently in development for transition from cardiac rehab

Workforce requirements

Workforce capability/capacity requirements need to be clearly defined and articulated to health services and key stakeholders at the local level. Initially these requirements were a challenge and not identified accurately, therefore delivery of the program and recruitment process was negatively impacted. Program delivery has been completely reviewed and further scoping conducted and implemented in both regions to ensure efficiency and effectiveness which in turn assists sustainability.

Dissemination of findings

Communication of the model and dissemination of findings will be through distribution of the report, conference presentations, posters and the survivorship Community of Practice. This will be supported through facilitator, health professional and organisations networks, key events, activities and meetings.

Within each ICS area this will be through ongoing communication in multiple forms, for example newsletter, discussion with other services/clinicians, showcasing at Multi-disciplinary Team Meetings (MDM)s

Value of model and views on transferability to other services/settings

The model is currently embedded and growing in each of the ICS. Both regions with the support of CCV delivered a regional Cancer Education Program Planning workshop early in 2019. This is planned to be an annual event to facilitate regional discussions, planning, support and implementation. Robust local program planning is established to ensure successful implementation and sustainability.

In the Hume region, a rolling eight-week program has been implemented at GVH with Seymour Health joining in through telehealth at specific time points depending on number of participants. Training has been delivered to smaller regional health services with the view that they will also join in with the larger sites as their programs develop.

In the Grampians, the three project sites have established a program planning committee who continue to support program delivery. With the support of the ICS, the smaller local services have also attended facilitator training and plan to become involved. It is also planned to promote the program and model of care across the other side of the region to the relevant health services.

Funding and health professional training and time to be involved continue to be barriers for the regional roll out, however, services can see the value.

The model is flexible enough to be delivered in the community health sector with the support of allied health. Currently, many community health deliver rehabilitation programs for cardiac and chronic disease, and it has been identified that this cancer supportive survivorship care program is good fit.

6. Discussion

This project provided the opportunity to develop, pilot and assess a telehealth model for the sustainable delivery of a comprehensive survivorship education, exercise and wellness program in Victorian rural and regional health services. A new model of supportive survivorship care for cancer survivors and their carers was successfully implemented integrating exercise, education and telehealth program. This program was successfully delivered across two regions in five health services to 110 participants.

This project was informed by the experience of a local cardiac rehabilitation model, where Wimmera Health Care Group provided education via telehealth to outlying health services. Program evaluation indicated that the majority travelled less than 50 kilometres to attend, and qualitative results indicated that some participants would not have attended if it were further away from their home. While many challenges were experienced with the use of telehealth, overall both facilitators and participants identified that using telehealth enabled the program to be run locally, improved access to supportive care, and proved to be a successful delivery model.

The integration of a practical exercise component into the program was driven by the success of the cardiac model and supported by the publication of the COSA Position Statement highlighting the potential benefits of exercise for cancer survivors.¹¹ A systematic review published in 2017 indicated that exercise can be a safe and effective intervention to counteract many of the adverse physical and psychological effects of cancer and its treatment.¹⁷ Exercise may also reduce the risk of developing new cancers and comorbid conditions such as cardiovascular disease, diabetes and osteoporosis.¹⁸

Drawing on lessons learned, a new model of supportive survivorship care for cancer survivors and their carers was successfully implemented integrating exercise, education and telehealth. This program was delivered across two regions in five health services to 110 participants. Program evaluation indicated that for all five measures of diet and physical activity, there was a statistically significant improvement from pre to post program. While sample size was small for this analysis, quantitative evaluation also indicated participants found the program provided health and social benefits.

Post evaluation focus groups with facilitators indicated that they found the program promoted overall wellness of cancer survivors. The integration of EPs to improve cancer survivors' physical health was especially commended. Facilitators highlighted that regional managerial support remains vital for the program's success.

It is acknowledged that one of the most significant challenges for all those involved in the project was that of time. These were discussed in length in the facilitator focus groups. For those involved in the project leadership and implementation teams, the time needed to participate in meetings and be actively involved in the project placed additional demands. All health service staff had clinical roles and often competing priorities and so used personal time, goodwill and initiative to support the program. Teleconferences were fortnightly with frequent follow-ups required. The commitment and dedication of all those involved is to be commended.

Despite the challenges of time commitments, the positive effect of such close engagement by all partners was exemplified by the ongoing sustainability of the program at each health service. It is also important to note that recruitment was not a specific challenge for this program. The integration of the program into local pathways was effective with three-quarters of the pre-program participants referred by health professionals.

The action research model, which guided all evaluation activities, enabled continuous program development and redesign to occur. This was a strength of the project as learnings and feedback could be incorporated into new processes, mechanisms and resources which in turn were then able to also be reviewed and refined. These new processes were developed and implemented throughout the life of the project to minimise disruption and difficulties.

One significant learning was through the development of the promotion material and resources on the use of language and the program title: Wellness and Life After Cancer. This aligns with the findings of previous Victorian Cancer Survivorship projects recognising that not all people identify with the term 'survivor'.¹⁹ Significant feedback was provided on the use of the words "after cancer". Many cancer survivors discussed this with the project team and talked about that for them "after" wasn't relevant as having been diagnosed with cancer meant that it was an on-going life experience. It was also identified that the word "after" excluded many who were on maintenance or on-going treatment and would benefit greatly from the program.

6.1 Summary of key findings

1. Successful development of a sustainable and effective supportive survivorship care program that can be delivered in local health services to enable access for cancer survivors and their carers close to home.
2. Delivery and evaluation of eight programs across two regions and five health services to 110 participants.
3. Development of a robust, evidence based, best-practice program as a result of iterative refinements through an action research model that was informed by participant and facilitator feedback, input and evaluation data.
4. Increased regional workforce capacity through the training of 41 health professionals in program delivery and the use of telehealth enabled sustainability to be embedded into the project.
5. Increased level of awareness and understanding of local health professionals that was achieved through the provision of high-quality education and rehabilitation in cancer survivors.
6. Strong links and improved relationships between health services, the ICS and primary care networks.
7. Dedicated local health professionals whose commitment ensured the success and implementation of the model.
8. Multiple referral pathways and improved internal processes at health services assisted with program recruitment.
9. Establishment of regional cancer education program planning teams with the inclusion of more local rural health and community services to continually grow the program across both regions.
10. Improved emotional health, wellbeing, social connections and increased local access with less travel for participants.
11. Increased number of self-referrals of participants directly into allied health services after the program.
12. Self-reported increased levels of physical activity and uptake of fruit and vegetables.
13. Ongoing sustainability of the program underpinned by four factors:
 - Local champions who strengthened relationships between health services in each region
 - Targeted facilitator development to future-proof the program
 - Involvement of other regional health services, and
 - Using available funding models.

6.2 Recommendations

- Integration of referrals into routine care with specific time-points being identified in internal processes and the patient's treatment pathway.
- Funding to assist with on-going training and implementation in the primary and clinical care settings.
- Further engagement is required with the GPs and Primary Health Networks to increase referrals into the program at the local level.
- Evaluate the health economic impact of the program on health services.

6.3 Sustainability

To ensure sustainability:

- Ongoing commitment by leadership and sufficient funding is required
- Ensuring that the program is established within the correct health service department to support governance, funding allocation and integration of program planning.
- On-going training for the workforce
- Development of tailored promotion plans, which include multiple promotion pathways such as print and digital
- Appropriate evaluation and scoping of future programs
- Create regional referral processes if people are receiving care at specialised services

Conclusion

The Telehealth Supportive Survivorship Care Program utilising exercise and education is an effective program delivery model that improves social connections, health and wellness outcomes and overcomes geographical barriers for cancer survivors close to home.

At the project's conclusion, five health services across two regional ICS, now offer an eight-week cancer exercise and education program using telehealth. Achieving this aim has enabled people affected by cancer able to access this program closer to home. It has also broadened the involvement of nursing and allied health professionals in both specialist and generalist regional health services.

On 1st January 2019, the **Cancer Wellness and Exercise Program** was launched following the success of the project. This program is now implemented in 10 clinical, primary and community care health services with 30 programs to be delivered by the end of the year.

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8. Appendixes

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Appendix TWO – Project Workforce Training Schedule

Summary statement:

Six training events delivered to 41 health professionals from both regions.

Date	Training	Audience	Location	Attendees
2017	WALAC Facilitator Training	Health Professionals – program facilitators	CCV Melbourne	20
2017	Cancer Exercise Training	Exercise Specialists	CCV Melbourne	11
2017	Introduction to Tele-health	Health Professionals – program facilitators	CCV Melbourne	20
2017	Local Telehealth Practice	Grampians project team	Horsham and Stawell	10
2018	WALAC Facilitator Training - Hume	Allied Health Professionals – program facilitators	Wangaratta	9
2018	WALAC Facilitator Training - Grampians	Allied Health & Community Health Professionals – program facilitators	Ballarat	12

Appendix THREE – Promotion Tools

Table 1. Promotion tools and target audience

Promotion Tools	Audience	Comment
Health Professional Information Sheet	Health Professional	Developed 2017
GP Videos	Health Professional Consumers	Developed 2017
Flyer Poster and electronic screens	Consumers	Developed 2017 and 2018
DL Flyers (Bi-fold)	Consumers	Developed 2017
Media Releases	Consumers	Developed 2017
E-Newsletters	Consumers	Developed 2017
Social Media	Consumers	Developed 2017
Postcard	Consumers	Developed 2018

Table 2. Grampians promotion plan

GICS PROGRAM PILOT ONE: Promotion and Referral Resources – SRH/RNH								
Promotion Resources and tools	DL	Poster	Web CCV ICS	E-news	Media Release	Video	Program Info Sheet	Social media
Audience								
Cancer survivors Carers	x	x	x	x	x	x		x
Health Prof	x	x	x	x	x	x	x	
Distribution								
EP's - Stawell Regional Health - RNH - EGHS	x	x					x	
Cancer RNs - RNH	x	x					x	
Physios / Social Workers - Stawell Regional Health - RNH - EGHS	x	x					x	
GP's & Medical Clinics - Stawell - Ararat - Horsham - Warracknabeal	x	x				x	x	
Pharmacy - Stawell - Warracknabeal	x	x					x	
Health Services - SRH - RNH - EGHS - BHS	x	x					x	
Community Health - SRH - RNH - EGHS	x	x				x	x	
PHN - Broad promotion to GP's	x	x					x	
13 11 20 - Self-referral	x		x					
Media - Broad promotion					x			

Table 3. Hume Promotion Plan

HUME RICS PROGRAM PILOT ONE: Promotion and Referral Resources – GVH/Wangaratta								
Promotion & Referral Resources and tools	DL	Poster	Web CCV ICS	E-news	Media Release	Video	Program Info Sheet	Social media
Audience								
Cancer survivors Carers	x	x	x	x	x	x		x
Health Prof	x	x	x	x	x	x	x	
Distribution								
EP's - GVH - Wangaratta	x	x					x	
Survivorship Nurse - GVH	x	x					x	
Physios / Social Workers - GVH - Wangaratta	x	x					x	
GP's & Medical Clinics - GVH - Wangaratta	x	x				x	x	
Pharmacy - GVH - Wangaratta	x	x					x	
Health Services - GVH - Wangaratta	x	x					x	
Community Health - GVH - Wangaratta	x	x				x	x	
PHN - Broad promotion to GP's	x	x					x	
13 11 20 - Self-referral	x		x					
Media - Broad promotion					x			

Collateral examples

1. Postcard



2. Poster



3. Appointment card

Your 8-week program is booked

Day: _____

Time: _____

Contact: _____

Where: _____

Program details: _____

4. Promotional video



Table 4. Media releases

Media		
Activity	Date	Location
Hopetoun Courier	March 2018	Grampians
Wimmera Mail Times	March 2018	Grampians
Weekly Advertiser	March 2018	Grampians
Ararat Advertiser	March 2018	Grampians
Facebook paid advertising campaign – Hume targeted	March - April 18	Hume only
Border Mail article	Feb 18	Hume
Wimmera times article	Jan 18	Grampians
Facebook paid advertising campaign	Jan - Feb 18	Both
WIN TV Shepparton	Jan 18	Hume
Hopetoun Courier	Jan 18	Grampians
Wimmera Mail Times	28/09/17	Grampians
Weekly Advertiser	27/09/17	Grampians
Ararat Advertiser	27/9/17	Grampians
Healthy Aging online network news article	22/9/17	Both
WIN TV Bendigo and Ballarat	29/6/17	Both
Wimmera PCP Newsletter	20/6/17	Grampians
CCV e-news	6/6/17	Both
The Warracknabeal Herald	5/6/17	Grampians
The Hopetoun Courier	5/6/17	Grampians
The Weekly Advertiser	5/6/17	Grampians
3WM – Radio	5/6/17	Grampians
MIXX FM Radio	5/6/17	Grampians
The Wimmera Mail Times	25/5/17	Grampians
Wimmera PCP Newsletter #14	23/5/17	Grampians
Community		
Activity	Date	Location
Community services announcement – Shepparton News, Shepparton Advisor	April 18	GV Health
Horsham Relay for Life – Survivors talk	16/03/18	WHCG
Hume Leukaemia foundation mail out	18/01/2018	Hume
North Grampians Shire – What’s on	Jan 18	SRH

Appendix FOUR – Quantitative Evaluation Report

Telehealth for Supportive Survivorship Care Project

Evaluation Report, May 2019

This report was collated by Julie Bassett, Post Doctoral Research Fellow and Jamie Chamberlain, Senior Research Officer (statistician) of the Cancer Epidemiology Division.

Methods

Participants were included if they had completed active treatment and were deemed well enough by the exercise physician to attend the exercise program. If they were excluded, they were then referred to either another program or put on the list for the next program depending on their health.

Data were collected pre and post the program delivery, in two regions (Grampians and Hume).

The pre and post Likert question response distributions were tabulated and graphed. The main pre and post measures of behaviour change included the number of serves of fruit per day, serves of vegetables per day, frequency of physical activity per week and duration of physical activity (minutes per week). The total physical activity (minutes per week) was calculated from the physical activity frequency and duration.

The mean for the pre and post data for these measures was calculated overall and separately for Grampians and Hume. The confidence intervals for the pre and post means were calculated using the percentile bootstrap. The mean change was calculated, along with a 95% confidence interval. The medians and 25th and 75th percentiles were calculated pre and post and for the change.

The distributions of the data were examined and tested using a Shapiro-Wilk test for normality. Where the data were tested as non-normal, we report a Wilcoxon matched-pairs signed-rank test for the change overall and Wilcoxon rank-sum test on the change for the comparison between the two regions. Where the data tested as not having a significant departure from normality, we report a one sample t-test on the change for the overall sample and a two sample t-test on the change to compare the two regions. The one sample t-test tests whether the population mean for change is different to zero. The two sample t-test tests whether the population mean for Grampians is different to Hume. The Wilcoxon matched-pairs signed-ranks tests whether the pre and post data population mean ranks are different. The Wilcoxon rank-sum tests whether Grampians and Hume population distributions are different.

Analysis was done using Stata 14.2.

Results

There were 71 participants who completed a pre-program questionnaire, 84 people who completed a post program questionnaire and 48 participants who completed both. Of those who completed the pre-program questionnaire, 44% travelled less than 10 kilometres and 31% travelled between 10 to 50 kilometres to attend the program (Table 4c). Three-quarters of the pre-program participants were referred by health professionals (Table 4c). However, while there were some differences, the measured characteristics of those who completed both pre and post questionnaires were overall similar to the characteristics of those completing the pre questionnaire (data not shown). For participants who completed both the pre and post questionnaires (Table 4b), the mean BMI was similar on both occasions (28.8 kg/m² (pre) and 28.6 kg/m² (post)). The most common type of exercise was

walking or gym, although 44% of participants did not answer this question in the pre-program compared with 10% post program.

The results for the Likert questions are shown in Tables 1 and 2 and Figures 1 and 2.

For all five measures of diet and physical activity, there was a statistically significant improvement from pre to post (Table 3). Grampians and Hume were not significantly different to each other in terms of change from pre to post on these five measures. The physical activity duration and total physical activity were non-normally distributed with some outliers. The fruit serves data for the overall change was non-normal whereas the change data for the individual regions did not depart significantly from normal. The vegetable serves per day and physical activity frequency distributions tested as normally distributed.

Limitations

The limitations of the study design were that there was no control group and hence no rigorous comparison condition, so that any improvements could be due to regression to the mean or other reasons rather than due to the effectiveness of the program. The program was different in the two regions and the series of programs delivered in each region differed over time. This means that the results are not for just one version of the program.

Missing data was a limitation of this study. The number of people invited to participate and the number of people who consented to participate is unknown. The number of people dropping out during the program and the reasons for dropping out are unknown. Some IDs for participants were missing: 48 participants had matched pre and post data but we were unable to match up 59 records for pre and post surveys (23 pre and 36 post). There was data missing for the outcomes, with 40 participants with pre and post data for all five outcome measures. With these missing data, there are likely to be relationships between missingness on a variable and the values of that variable or other variables in the data i.e. the data are unlikely to be missing completely at random. Consequently, there will be biases to the estimates of improvement due to missing data and the direction and magnitude of these biases is unknown. We have partially addressed this issue by examining the distributions for participants with pre data compared with those who have both pre and post data.

We did not adjust or account for multiple tests or dependent tests (e.g. physical activity total is completely determined from physical activity frequency and duration), or unequal variance in the two-sample t-tests.

Measurement error was a limitation of this study. The data on fruit and vegetable serves and physical activity level were self-reported, and consequently subject to measurement error, probably over-reporting. Also, the wrong questionnaire was given to participants in Grampians program 2.

These limitations mean that although the results are promising, they do not necessarily indicate that the program contributed to changes in behaviour. Further research with more complete data collection and a control condition would be required to support an association between participation in the program and changes in behaviour.

The sample size of 48 participants matched pre and post was a limitation. This sample size gave the precision of the estimates of change shown by the confidence intervals in Table 3. A larger sample size would improve the precision of the estimates, reducing the width of the confidence intervals.

Table 1. Pre-Program Likert question responses: program expectations. Frequency distribution [N (%)]

It is important for me to find more information on/ learn about ...	Likert scale [Pre-program], N (%)					
	Total	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
Support services including local groups	56	21 (37.5)	28 (50.0)	3 (5.4)	0	4 (7.1)
How my GP can help me manage my health	56	26 (46.4)	26 (46.4)	0	0	4 (7.1)
Things I can do to remain well	59	40 (67.8)	18 (30.5)	0	0	1 (1.7)
How to develop a health and wellbeing plan	57	36 (63.2)	18 (31.6)	1 (1.8)	0	2 (3.5)
Managing the fear of cancer returning	57	28 (49.1)	19 (33.3)	1 (1.8)	2 (3.5)	7 (12.3)
Strategies for setting goals and making healthy choices	57	25 (43.9)	29 (50.9)	0	0	3 (5.3)
Importance of nutrition and exercise	59	31 (52.5)	26 (44.1)	0	0	2 (3.4)
Relaxation and managing stress/anxiety	57	34 (59.6)	18 (31.6)	2 (3.5)	0	3 (5.3)
Financial and legal support available	56	18 (32.1)	18 (32.1)	5 (8.9)	1 (1.8)	14 (25.0)
Returning to / managing work	57	14 (24.6)	17 (29.8)	1 (1.8)	2 (3.5)	23 (40.4)
Managing fatigue and side effects	58	41 (70.7)	15 (25.9)	1 (1.7)	0	1 (1.7)
Techniques to communicate with friends and family	55	22 (40.0)	20 (36.4)	4 (7.3)	1 (1.8)	8 (14.5)
Sexuality and intimacy	53	11 (20.8)	14 (26.4)	2 (3.8)	4 (7.5)	22 (41.5)
Strategies for returning to daily life	56	25 (44.6)	22 (39.3)	4 (7.1)	1 (1.8)	4 (7.1)

Figure 1: Pre-Program Likert question responses: program expectations

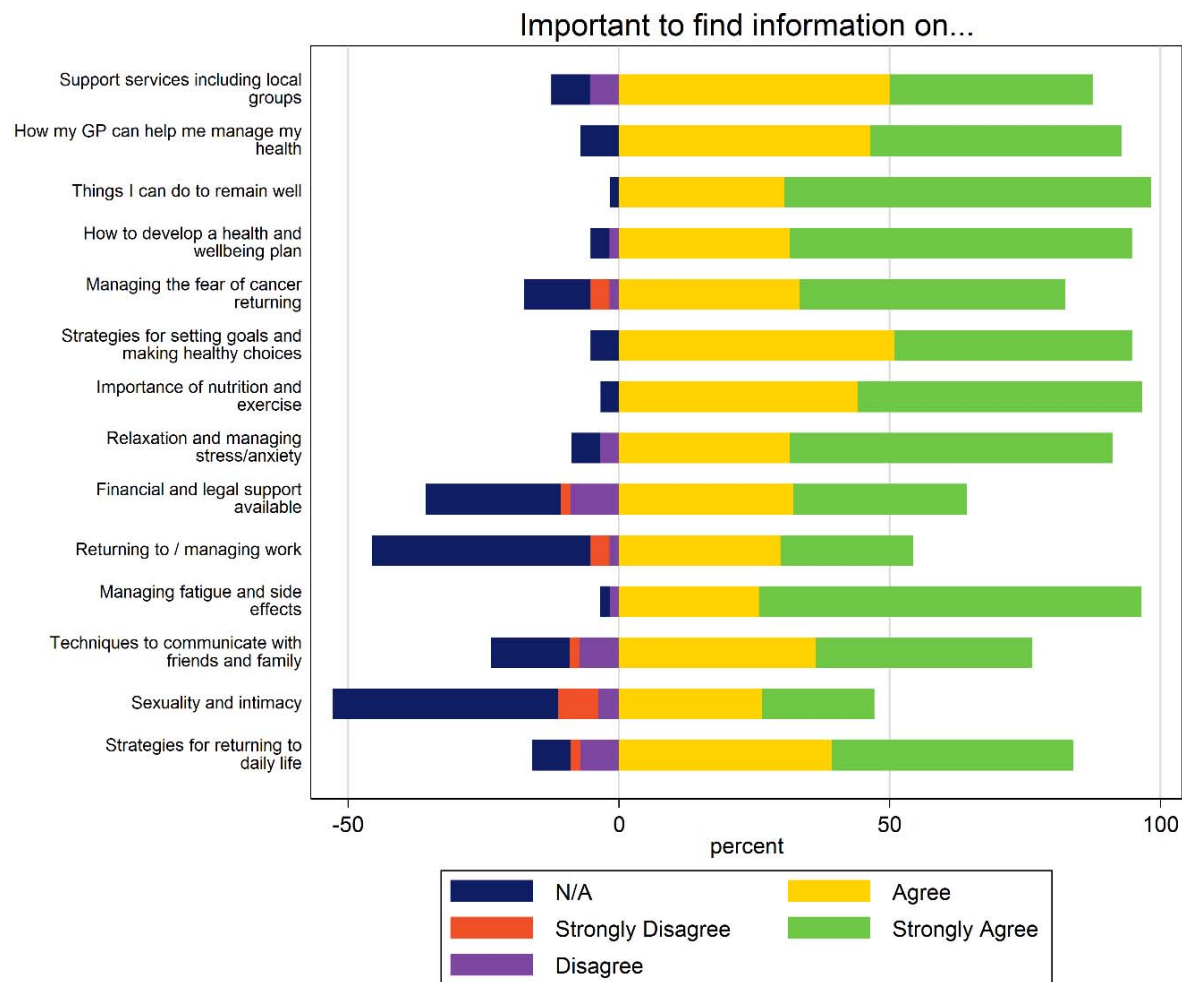


Table 2. Post-Program Likert question responses. Frequency distribution [N (%)]

	Likert scale [Post-program], N (%)							N/A
	Total	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree		
I found the information easy to understand	81	55 (67.9)	26 (32.1)	0	0	0	0	
The information is useful for me	81	43 (53.1)	34 (42.0)	4 (4.9)	0	0	0	
My key concerns or questions were covered	81	35 (43.2)	39 (48.1)	7 (8.6)	0	0	0	
The program was well run	80	63 (78.8)	16 (20.0)	1 (1.3)	0	0	0	
I felt comfortable to participate and ask key questions	82	57 (69.5)	20 (24.4)	4 (4.9)	1 (1.2)	0	0	
It was beneficial for me to be among people with similar experiences	82	60 (73.2)	20 (24.4)	2 (2.4)	0	0	0	
My knowledge of cancer survivorship has improved	82	40 (48.8)	31 (37.8)	11 (13.4)	0	0	0	
My ability to participate in exercise has improved	81	53 (65.4)	24 (29.6)	4 (4.9)	0	0	0	
My knowledge of support options available to me has improved	82	41 (50.0)	36 (43.9)	4 (4.9)	0	0	1 (1.2)	
I learnt something new at this program	79	40 (50.6)	31 (39.2)	8 (10.1)	0	0	0	
I was provided with information and strategies that I can now use	80	43 (53.8)	32 (40.0)	5 (6.3)	0	0	0	
Attending the program was worthwhile for me	77	56 (72.7)	21 (27.3)	0	0	0	0	
I will consider ringing 13 11 20 to find out more information	80	22 (27.5)	27 (33.8)	28 (35.0)	1 (1.3)	1 (1.3)	1 (1.3)	
I will recommend this program to others	82	66 (80.5)	16 (19.5)	0	0	0	0	

Figure 2: Post program evaluation Likert question responses

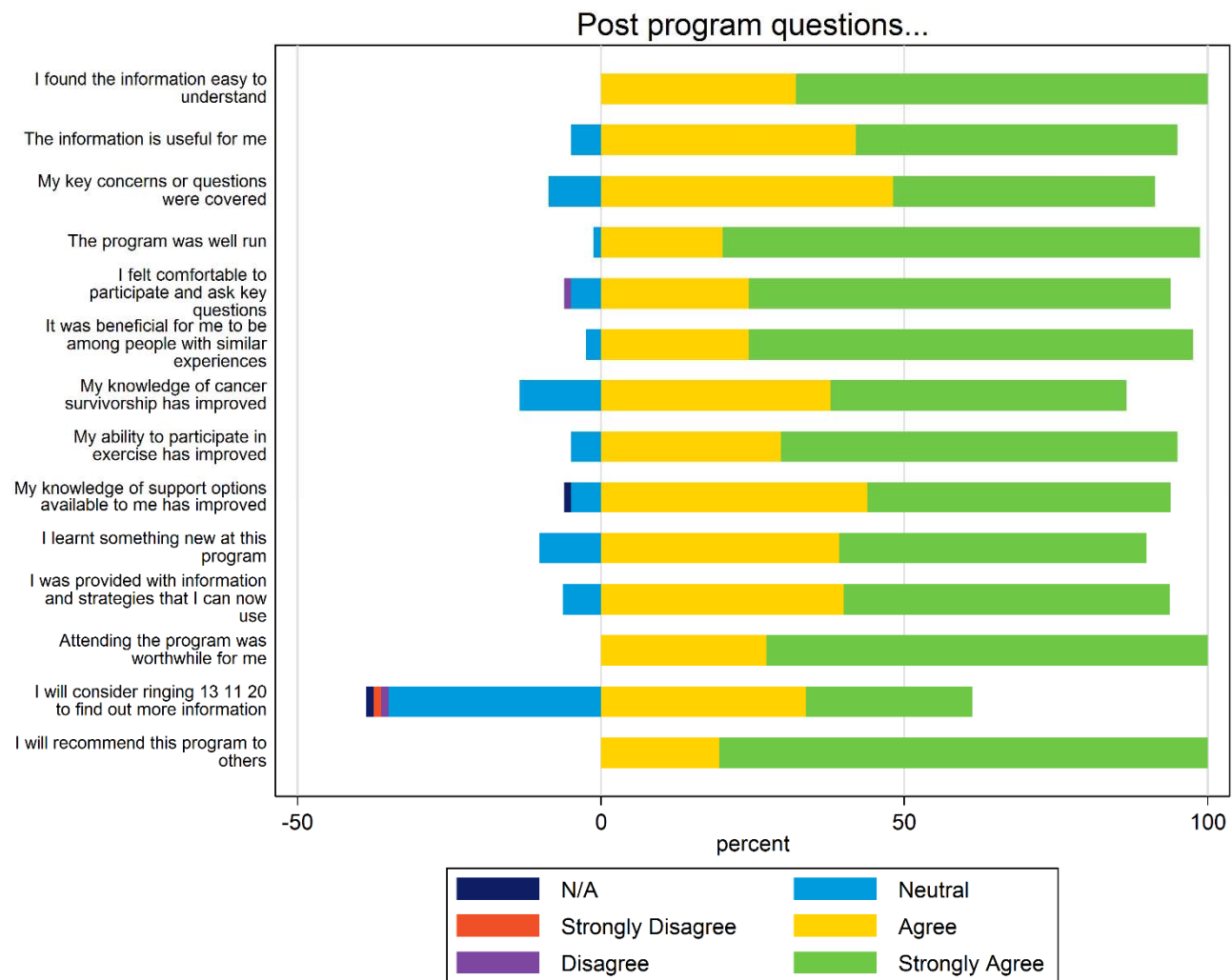


Table 3. Change in pre and post program fruit and vegetable serves and physical activity levels, overall and by region

	N	Mean				Median (25th, 75th percentiles)			P-value
		PRE	POST	Change	(95% CI)	PRE	POST	Change	
Fruit serves per day									
Overall	46	1.78	2.11	0.33	(-0.01, 0.66)	2 (1, 2)	2 (1, 3)	0 (0, 1)	0.01 ^{ac}
Grampians	22	1.82	2.05	0.23	(-0.41, 0.87)	1.5 (1, 2)	2 (1, 3)	0 (0, 1)	0.58 ^{bd}
Hume	24	1.75	2.17	0.42	(0.09, 0.74)	2 (1, 2)	2 (1.5, 3)	0 (0, 1)	
Vegetable serves									
Overall	46	2.76	3.27	0.51	(0.21, 0.82)	3 (1, 4)	3 (2, 4)	0 (0, 1)	0.001 ^{ac}
Grampians	22	2	2.73	0.73	(0.23, 1.22)	2 (1, 3)	3 (2, 3)	0 (0, 1)	0.17 ^{bd}
Hume	24	3.46	3.77	0.31	(-0.07, 0.70)	4 (2.5, 4)	4 (3, 4.8)	0 (0, 1)	
Physical activity-Frequency									
Overall	47	2.34	4.32	1.98	(1.13, 2.83)	2 (0, 4)	5 (3, 7)	1 (0, 4)	<0.001 ^{ac}
Grampians	23	1.87	4.35	2.48	(1.07, 3.89)	0 (0, 4)	5 (2, 7)	1 (0, 6)	0.25 ^{bd}
Hume	24	2.79	4.29	1.5	(0.46, 2.54)	3 (0, 4.5)	4 (3, 6.5)	1 (0, 3)	
Physical activity-Duration									
Overall	41	27.68	51.1	23.41	(0.63, 46.20)	20 (0, 30)	40 (30, 60)	20 (0, 40)	<0.001 ^{ac}
Grampians	19	15.26	61.58	46.32	(6.89, 85.74)	0 (0, 30)	40 (30, 60)	20 (0, 40)	0.21 ^{bf}
Hume	22	38.41	42.05	3.64	(-21.84, 29.12)	28 (0, 60)	40 (30, 60)	10 (-5, 30)	
Physical activity-Total									
Overall	41	98.54	266.1	167.56	(29.63, 305.49)	60 (0, 120)	150 (90, 270)	60 (0, 180)	<0.001 ^{ac}
Grampians	19	50.53	358.42	307.89	(30.34, 585.45)	0 (0, 120)	150 (90, 420)	100 (30, 300)	0.16 ^{bf}
Hume	22	140	186.36	46.36	(-49.03, 141.75)	85 (0, 300)	155 (60, 210)	60 (-55, 120)	

^a P-value for overall difference between pre and post program levels of fruit and vegetable serves and physical activity levels

^b P-value for difference between Grampians and Hume regions for the pre and post program change in levels of fruit, vegetable serves and physical activity

^c P-value from a one sample t-test on the change

^d P-value from a two sample t-test comparing regions

^e P-value from a Wilcoxon matched-pairs signed-rank test

^f P-value from a Wilcoxon rank-sum test

Table 4a. Characteristics of participants (DHHS dataset, N=74)

		N	(%)
Age group	50 or under	8	(10.8)
	51-60	13	(17.6)
	61-70	27	(36.5)
	71-80	17	(23.0)
	over 80	9	(12.2)
Sex	Female	57	(77.0)
	Male	17	(23.0)
Tumour type	Anus and anal canal - C21	1	(1.4)
	Bowel - C18-C20	14	(18.9)
	Breast - C50	27	(36.5)
	Liver and intrahepatic bile ducts - C22	1	(1.4)
	Melanoma of skin - C43	1	(1.4)
	Non-Hodgkin lymphoma - C82-C86	5	(6.8)
	Not stated	10	(13.5)
	Other and ill-defined sites - C26, C39, C76-C79	3	(4.1)
	Other and unspecified parts of mouth – C05, C06	1	(1.4)
	Ovary – C56	2	(2.7)
	Prostate - C61	5	(6.8)
	Stomach - C16	1	(1.4)
	Tongue - C01, C02	1	(1.4)
	Trachea, bronchus and lungs - C33, C34	2	(2.7)

Table 4b. Characteristics of participants (Diet & PA datasets, N=48 with matched pre/post questionnaires)

		Pre-program (N=48)		Post-Program (N=48)	
Current smoker, N (%)	No	42	(87.5)	46	(95.8)
	Yes	2	(4.2)	1	(2.1)
	Missing	4	(8.3)	1	(2.1)
Current alcohol drinker, N (%)	No	36	(75.0)	32	(66.7)
	Yes	10	(20.8)	15	(31.3)
	Missing	2	(4.2)	1	(2.1)
Type of physical activity, N (%)	Balance/Strength				
	Exercise	4	(8.3)	5	(10.4)
	Walking/Gym	19	(39.6)	29	(60.4)
	Outdoor Activities	3	(6.3)	6	(12.5)
	Sport Programs	0	(0.0)	0	(0.0)
	Allied Health Exercise	1	(2.1)	3	(6.3)
	Not answered	21	(43.8)	5	(10.4)
Weight (kg), mean (SD)		79.9	(18.6)	79.3	(18.7)
Height (cm), mean (SD)		166.6	(8.9)	166.6	(8.8)
BMI (kg/m²), mean (SD)		28.8	(6.5)	28.6	(6.5)

Table 4c. Characteristics of participants (Comment-Pre dataset, N=71)

		N	(%)
Distance travelled (km)	<10 km	31	(43.7)
	10-<50 km	22	(31.0)
	50->100 km	6	(8.5)
	>=100 km	2	(2.8)
	Not answered	10	(14.1)
Type of referral	Health Professionals	52	(73.2)
	EP/Allied Health	3	(4.2)
	Support Groups	3	(4.2)
	Social Media	4	(5.6)
	Local Media	2	(2.8)
	Self Referral	4	(5.6)
	Not answered	3	(4.2)

Appendix FIVE – Qualitative Evaluation Report

Telehealth for Supportive Survivorship Care: Increasing Access to a Survivorship Education, Exercise and Wellness Program in Rural and Regional Victoria using Telehealth.

Report 1. Grampians Participant and Health Professional Focus Group Evaluation

This report is the first of a three part evaluation of a Telehealth for Supportive Survivorship Care (TSSC) project. This 8 week program aims to provide access to a comprehensive survivorship assessment, education, exercise, and wellness program for cancer survivors and carers in the Grampians and Hume Regional Integrated Cancer Service regions. This first evaluation examines TSSC's feasibility, acceptability and usefulness for participants and health professional (HP) presenters in the Grampians. Findings are informed by 2 separate focus groups conducted with participants and HP presenters on 13/9/17 in Horsham. Groups were attended by 6 participants (3 Stawell; 3 Warracknabeal; 4 female; 6 cancer survivors; 1 was also a carer) and 5 HPs [2 nurse facilitators, one observer, 2 exercise physiologists (EPs)]. Participants were invited to discuss personal outcomes derived through participation, and views about the TSSC program's format, delivery, and accessibility. HPs discussed perspectives on delivering TSSC, Cancer Council Victoria (CCV) support, guest presenters, and perceptions about participants' experiences. Both groups also offered suggestions to CCV staff and rural TSSC organizers which are presented in two Boxes. Transcribed focus groups were inductively and thematically analysed based on grounded theory methods (Appendix 1). Following are thematic findings emergent from each focus group. To promote anonymity, all are referred to as female. P1-P6 denotes participants, F1-3 denotes facilitators/observer; EP1-2 denotes EPs.

TSSC PARTICIPANTS

Theme 1. TSSC Improved Biopsychosocial Well-being and Knowledge

Physical benefits

Participants were delighted by how involvement in TSSC improved their lives, physically, socially, emotionally, and intellectually. Physical benefits included improved exercise endurance and fatigue management, and one mentioned that a relaxation CD received in the Prevention Support folder improved sleeping and posture:

The girl came over the CD, "I want you to sit in a comfortable chair and drop your shoulders". Do you know, all my life I've been walking around like this? (Hunched shoulders upwards) ... I literally dropped my shoulders and felt better for it. (P1)

Social and empathic benefits

Participants were pleased to be in the presence of other "locals" also living with cancer face-to-face and via technology. Many nodded when one stated that she felt "part of a family" (P1) in the group. P6 felt that her bi-polar mental health condition, which flared after chemotherapy, was "understood" by the group, unlike those not living with cancer. She added, "You didn't feel like you were the only man or woman on an island." The experience was supportive, and potentially character building. P5 stated,

We could see other peoples in other communities and were, they were able to open up and share some of the things that they've been experiencing with the cancer treatments and, and things, and how it had emotionally affected them. ... I can relate a little bit more carefully with them now. ... it's made my attitudes towards people a lot more sympathetic.

Participants appreciated the TSSC message that socialising was important. P5 stated that “friendships” were made in the group and P2 described improved confidence in social skills stating, “It helped me out of myself. Whereas I would shy away. ... It’s actually brought me where I can communicate and talk better”.

Emotional benefits arose from TSSC program components and its “message” of care

Most participants strongly emphasised how TSSC improved their mood and fighting spirit as a consequence of the program’s physical, social, knowledge building, and/or practical components. P4 emphasized that increased understanding that cancer did not discriminate mitigated her, “What did I do wrong?” guilt. For P4, “damage” from her doctor’s message, “We can do no more, go home and die”, was “repaired” through the program’s message that “options were available” to keep on with living. She also felt confident learning that medical marijuana would be a potential care option that would not send her “gaga”. P2 shared P4’s optimism, recalling TSSC message that, “if you’ve got good nutrition and plenty of rest, well, you have to improve.” P1 recalled improvements on the exercise bike and stated, “It makes you feel good. Because you’re achieving, and there’s incentive there, for you to get out of that rut mate. You’ve still got a life, you know”.

TSSC program’s message of care and support particularly enabled two participants to keep living with cancer. P3 stated, “I can’t speak more highly of how ... everyone that took care of me in that program”. This gave her “the strength to fight that much harder. To survive.” P1 also stated that, without TSSC and other cancer support programs, she would have committed suicide via “the ol’ hose up the exhaust pipe” because she was a “real mess” losing her partner just prior to her cancer diagnosis. The only distress arising from TSSC was that one participant said that it “hurt me so much” when another group member said that fatigue was “all in the mind”. Some were also concerned that they did not receive a relaxation and support CD given to another group, and about funding cuts threatening employment of a nurse who had helped to recruit two members to TSSC.

Theme 2. TSSC Positively Changed Lived Lives

Four participants proudly achieved personal goals established during the TSSC program. Participants applauded P1 who declared, with fist pumps, she was cooking again. P2 met her goal to have a social life, and P3 stated,

The program gave me that um, encouragement to go back to the passion with my music, which ... I was slowly giving it up and didn’t care anymore. I will be able to perform, because you know, I’ve had the encouragement to, as one of the goals, to strive to get, get back to it.

P5 was also applauded as she presented photos of her garden on her phone to demonstrate meeting her goal, “to also get my garden going again”. She added,

I’ve raked up all the stones from the fruit that had fallen down, and um, now I’ve got a couple of little turtledoves that are coming in, ... they’re dancing around under the trees.

P4 emphasised that the program assured her that, “it’s not the end of the road”, and two participants mentioned that they were continuing on with other cancer support/wellness programs. However, while P6 stated that she continued her passion for card playing, she had “lack(ed) ... incentive unfortunately” to achieve her goal of becoming more active.

Theme 3. TSSC was Mostly Well Conducted and Accessible

Compliments for the well-presented program shared with others living with cancer

Participants effusively complimented all involved in enabling their TSSC experience. The program was described as “brilliant”, “very beneficial”, “very valuable”, “lovely”, “fabulous”, “good”, and filling a gap in their support needs. All agreed that the well-balanced and ordered format, comprising exercise, coffee, then telehealth, and shared with others also living

with cancer, helped them to feel comfortable and converse freely. This format elicited “comradeship”, “mateship” (P1), and “companionship” (P3), was motivational, and “broke” the “depression side of things” (P5). P4 stated, *We’ve done our exercise, we’re having our cuppa and we’re having a something, something to munch on. We were totally at ease.*

There was also widespread agreement that confidentiality was respected. Presenters and facilitators were described as professional people who spoke honestly and not “down” to them. Participants usually had ample opportunity to question presenters, especially after meetings if they were face-to-face. Face-to-face presenters were considered to be fairly distributed across the two sites, however, P1 found the telehealth component more audible and helpful when speakers were face-to-face. All also agreed that the informative and useful workbook was the right length.

Especially valued content included information on diet, nutrition, and rest. Those not connected to the internet especially valued information components. Anticipated discomfort about needing to disclose financial aspects in the financial session was dispelled upon realization that it was just information on available support. Travel cost was not considered a problem: two explained that petrol cost burden was offset by attending to other matters in town on the days of TSSC groups.

Minor telehealth technical criticisms

Criticisms related to the telehealth component were mostly minor and included occasional start delays (causing P1 to not get a question answered), the question card not being available on occasion, and difficulties hearing (P1, P6) or seeing (P6) televised speakers. Two, however, said, that when they couldn’t see the televised presenters, they asked for the cameras to be adjusted.

Box 1. Participants’ Suggestions for CCV Staff and Rural TSSC Organizers

- Offer content refreshers to participants on occasion.
 - Facilitator or speaker should intervene when participants make inappropriate, potentially hurtful comments, e.g., the person that said fatigue was all in the mind.
 - Encourage carers to attend as they help patients/survivors. Shared survivor and carer sessions were considered a good idea. One suggested a separate carer session.
 - Consider including people with other health conditions.
 - More training for visual operators (though this improved as sessions continued).
 - Ensure all participants are offered all support resources provided.
 - Offer an integrated program of health monitoring, including TSSC, from diagnosis as the experience would have been valuable early on in the illness trajectory.
 - Consider a “hand on a stick” rather than question card (to be more observable).
 - Speakers need to state what page they are referring to when using the booklet.
 - Include alternative strategies that patients/survivors can find helpful, e.g., naturopath.
 - Keep funding cancer support nurses who refer people to the program.
 - Ongoing recruitment suggestions: through local paper, “bush telegraph” (that is, word of mouth such as through local cancer support groups); advertisements should include TSSC content, including that it can educate you on mental and physical attitudes, and that it is well worth the effort.
- Note, P5 recommended encouraging “new blood” into the groups, likely related to an ongoing support program also mentioned.

HEALTH PROFESSIONAL PRESENTERS FROM STAWELL AND WARRACKNABEAL

Theme 1: TSSC'S Beneficial Effects on Participants and Rural "Professional Connection"

Facilitators and EPs highly commended the program's valuable effects on participants' overall health and well-being and, to their surprise, emotional support. Two mentioned how one participant was more confident and "rapt" to lose 10kg through attendance at TSSC and another oncology rehabilitation program. Friendship developments amongst the group were unexpected because, "these guys were total strangers" (EP2). Two facilitators described how their group's comfort and enjoyment was evident as participants became "rowdier" across the weeks, kept returning, and were concerned when a member missed a session. EP1 stated that her group "participants catch up outside of the Health Service ... (and) formed a real friendship and a support network". F2 described a participant, who had previously lost confidence performing music, was inspired to perform again after another participant listened to her CD and gave her constructed feedback.

Individuals emphasised how the program addressed a gap whereby "holistic care" was provided "for the clients, not for the disease" (F2), and how it helped cancer survivors to continue to look after themselves when they may otherwise get "lost in the system and forgotten about" (EP2). F1 and EP1 emphasized the value of offering TSSC in a small town without an oncology service so that people have the choice of going somewhere for social interaction and emotional support following treatment. TSSC also supported the rural health professionals as they developed local "professional connection(s)" (F1) and "networking" (EP2) and learnt through client feedback. Facilitators and EPs were pleased that telehealth enabled them to flexibly link smaller groups together across broader rural areas, where it is "quite difficult" to have larger groups compared to metropolitan areas (F3). F1 described how she usually took a participant who did not have family to a cancer clinic but on one occasion was unable to. She then referred her to one of the HPs from the other telehealth group who took her. F1 doubted that the participant would have otherwise gone to the cancer clinic and indicated that this referral would not have occurred before the TSSC connection.

Theme 2. Benefits were Enabled Through CCV's Support and the Well Conducted and Scheduled Program Delivery

Invaluable, open CCV support and evidence-based resources

Facilitators and EPs emphasised how TSSC'S success was informed by CCV training and provision of good, evidence-based content and resources. People at CCV were described as "wonderful people to work with", while initial challenges related to helping CCV understand the need to tailor the program away from a "city view", to one suitable for their rural communities, were gradually resolved. This included CCV coming to understand local staff and facilities (gyms) available for programs to proceed, and agreeing to expand the "survivor" criteria to people still having cancer treatment because, as F2 outlined, "there is not much available" for people living in the country and there would be insufficient numbers to otherwise offer the program. Although CCV offer a Living with Cancer Program, F2 added that rural people, "often may not go to two programs (because of time and travel constraints), so we wanted something that would work for them". HPs also appreciated that CCV people were open to having local people present content and receiving slides from those who provided original content.

Facilitators said that the CCV 2 day preparation course was helpful, including for the regional HPs' relationship building. F1 emphasised that the good balance of face-to-face and hands-on role practice cemented their learning and confidence in running a group. EPs found the educator from Perth "very good", giving them "a few learnings" (EP2) and validating what they knew (EP1). Both agreed that it was "very valuable" to be with "people in our same field, and doing case studies" because they did not get this opportunity very often in their isolated workplaces. Both also found the online

training validated what they knew and how it was necessary to “prescribe safe exercises” and understand “contraindications” related to exercise in cancer care.

Health professionals ensured a well-conducted program tailored to rural dwellers

Facilitators and EPs were highly motivated to conduct TSSC and told their organisations that it was needed. TSSC'S success was also informed by: (a) knowledgeable, clear presenters who could handle “curly” questions and possibly deflect questions onto other members; (b) the group culture whereby it was acceptable for participants who wanted to just listen; (c) suitable time scheduling of groups; and (d) the appropriate group format. One of the facilitators was praised for her clear delivery of a telehealth education contribution and the EPs were described as “amazing” and essential to the program's success. They importantly tailored exercise programs to each individual participant who could have health issues beyond cancer diagnoses. Two hour slots across the eight weeks allowed the facilitators and EPs time to acquire a “bigger picture of (participants') health” and the “services they might need” (EP2) than if they came over shorter time frames over longer days. It also allowed participants' social interactions to evolve: “they can touch base with the new found friends or support unit” (EP1). Groups were scheduled that fitted in with participants' lives, including farming responsibilities, travel time requirements, (some travelled nearly 100km to attend) and other commitments. F1's groups fitted around “Men's Shed” meetings. The two hour format of exercise (1 hour), refreshments then education (1 hour) was effective because the exercises enabled participants to: “come together, ... (while) they still can be a little bit by themselves ... and then over the weeks that they were coming, the banter would be coming” (F1). The format also took away “the fear of exercise” as it was “fun” and “safe” (F2). Many stressed it was “very important” to connect “country people” through an activity, like talking about gym bike-riding rather than, “You're here for some counselling” (F2). Many agreed that, “They wouldn't come” (F1) if it was a cancer support group. Nonetheless, “everything else happened” (F2), i.e., participants still supported each other.

Theme C. Resourcefully Overcoming TSSC Program Challenges

Facilitators and EPs delineated a number of challenges preparing for and conducting TSSC, many of which were resourcefully addressed, e.g., through urging someone to speak louder or not rustle papers in front of the microphone, appropriate muting of the microphone, creating a cue card to remember telelink program procedures, and organising a dietician speaker to return (to one group) when people wanted further information on nutrition. F2 stated that facilitators didn't explain the workbook well enough (i.e., which pages to focus on) as they observed some participants struggle with finding the pages rather than listen to the speaker. Presenter readiness was considered to be sometimes hindered by a lack of notice and time to prepare. One group's facilitators also described challenges related to time required for scoping support resources when tailoring TSSC to local community requirements and finding appropriate presenters. All facilitators were confident, however, that by the end of pilot groups, suitable programs could continue with more confident and prepared speakers. Dominant personalities were not a concern in groups. Indeed, questions often asked by one participant were regularly deflected onto other participants and could help conversation flow. F1 also stated that participants alerted them to gaps in content and that they found out answers for them (e.g., availability of a local support group). EPs found working with 6 people at once with individualized exercise programs challenging at the start, especially EP2 who did not have an assistant, but this settled as participants became more independent with their exercise routine.

While initial “nightmare” (F3) information technology (IT) challenges between the rural sites and CCV could render facilitators nervous that the rural telelink system would falter, concerns were unfounded. The rural telelink system worked, supported by the GRA (Grampians Region) Network. Challenges related to hearing and seeing each others' faces through the telehealth link were resolved after a support person educated one of the groups on microphone positioning, the “zooming” telelink mechanism, and seating positions. Sometimes the system froze at one site, in which case immediate IT support was needed, and both sites eventually started the telelink system well before the education sessions commenced to ensure it was ready. F1 insisted, “It was not the IT the issue, it was us the issue, to remember what to do.”

The telehealth component was considered more difficult for those with hearing aids. Challenges were also mentioned regarding seeing the hand-signs indicating that participants wanted to talk. At one site this was because they blended into the background colour.

Box 2. Health Professionals' Suggestions for CCV Staff and Other Rural TSSC Organizers

- Improve telelink with CCV for ongoing telecommunication.
- Provide sufficient warning of program dates, especially for presenters; Clearly explain to presenters what is required/expected, including that resources are provided to inform their talks.
- Include a session on complementary and alternative medicines, including screening for value, safety.
- Ensure workbook is appropriate for literacy levels, with suitable font size and content spacing.
- Review pre-program questionnaire completed by participants to help tailor program content.
- Enable flexibility in content delivery informed by participant interest (not much interest on financial).
- Further education on telelink management needed, e.g., be aware of noise; zoom on speakers' faces.
- Create a step-by-step guide to ensure all procedures are followed for the telelink section.
- Only one of the online learning or face-face training segments was sufficient for EPs.
- EP assistant is needed throughout program; EPs were happy that they can now adapt the lengthy assessment; TSSC exercise component would be more effective if twice weekly.
- Need to assess participants' reading skills when determining suitability.
- Realize that assessments for TSSC may uncover it is not needed but something else could be.
- Given tiny visual screens (especially when telelink is at 3 sites), consider another hand-sign system, e.g., verbal interruption or an IT "hand-sign".
- Remember to book telelinks and meeting rooms; provide specialized hearing aid support to those with hearing impairment; ensure availability of needed staff; ensure speakers at hub site organise their handouts' availability at spoke sites.
- Ongoing recruitment suggestions: through local GPs who know patients; through local day chemotherapy unit and use previous program participants to advertise it; local radio, free newspaper.

Conclusion

Participants and HP presenters highly commended TSSC as a feasible, acceptable, and beneficial program.

Acknowledged technical glitches were considered resolvable with HP practice, IT support, and participants requesting adjustments needed. Some participants may need encouragement to do this. While participants acknowledged how TSSC addressed their physical, knowledge, and/or support needs, both participants and HPs especially highlighted the beneficial social and emotional outcomes which had improved participants' lives. HPs also acknowledged how TSSC improved professional relationships which are otherwise hindered by distance. CCV organisers were complimented for enabling TSSC and integrating HPs' suggestions into the program. In sum, focus group attendees all highly recommended that TSSC continues, to benefit others affected by cancer in rural communities, including those with diagnoses, and their informal and professional carers.

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Appendix 1. Analytic Approach and Illustration of Data Analysis

Analytic Approach

Focus group content was recorded, transcribed and comparatively analysed, informed by grounded theory methods (Corbin & Strauss, 2008) with the support of ATLAS/ti (Muhr, 2005) qualitative data management software. Transcribed data was inductively coded and comparable codes were labelled under categories. Comparable categories were then listed under more abstract themes. A narrative clarification of themes was then developed.

References

- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research 3e: Techniques and procedures for developing grounded theory*. Thousand Oaks, California: Sage.
- Muhr, T. (2005). ATLAS/ti: the knowledge workbench [CD-ROM]. Version 5.0: ATLAS.ti Scientific Software Development.

Telehealth for Supportive Survivorship Care: Increasing Access to a Survivorship Education, Exercise and Wellness Program in Rural and Regional Victoria using Telehealth.

Report 2. Hume Participant and Health Professional Focus Group Evaluation

This report is the second of a three part evaluation of a Telehealth for Supportive Survivorship Care (TSSC) project. This 8 week program aims to provide access to a comprehensive survivorship assessment, education, exercise, and wellness program for cancer survivors and carers in the Grampians and Hume Regional Integrated Cancer Service regions. This evaluation examines TSSC's feasibility, acceptability and usefulness, as perceived by Hume participants and health professional (HP) organisers. Findings are informed by one focus group conducted with participants and another conducted with HPs, held on 17/1/18 in Shepparton. Groups were attended by 4 participants (all from Shepparton; 2 female) and 8 HPs [6 organisers/facilitators (4 from Shepparton) and one exercise physiologist (EP) each from Shepparton and Wangaratta; all female]. Participants discussed personal outcomes and views about TSSC format, delivery, and accessibility. HPs discussed perspectives on delivering TSSC, Cancer Council Victoria (CCV) support, and perceptions about TSSC's value. Both groups also offered recommendations for ongoing programs which are presented in two Boxes. Transcribed focus groups were inductively and thematically analysed based on grounded theory methods (See Report 1, Appendix). Following are thematic findings emergent from participant and HP focus groups. To promote anonymity, all are referred to as female. P1-P4 denotes participants, F1-6 denotes organisers/facilitators, and EP1-2 denotes EPs.

PARTICIPANTS

Theme 1. TSSC Improved Biopsychosocial Well-being and Dietary Knowledge

Biopsychosocial benefits

Cancer was described as an "isolating" experience as many "don't know" how to talk to those who are diagnosed. Hence, face-to-face social interactions with people who had similar illness backgrounds were highly valued by participants. P3 emphasised that the program helped her to "re-enter the social sphere" after treatment. All participants experienced physical health benefits through attending the program and experiencing its "friendly faces. This included P2 who became unwell during physical exercises in the third session and needed to discontinue, and another who "ached" after the first session, needing to spend the remainder of the day in bed. Thereafter, she said:

(It) wasn't quite so hard and it just gradually improved until it was brilliant! You know, and I went home full of energy and, you know, 100 or 200% better than when I started. (P1)

P3 was very pleased to "get back on track" after cancer treatment, adding that the program helped her to "regain" physical strength, flexibility and resilience, eat healthier (increased fruit and reduced sugar intake), meet weight loss goals, and experience less fatigue. P4 achieved some improved hand movement, however, peripheral neuropathy remained a problem, especially in her feet, sometimes affecting walking and preventing her completion of prescribed exercises. Emotional wellbeing benefits were also evident, with P1 stating that, since the program, she was "not in such a hole" and had "lifted" from being "partly depressed".

Benefits could arise from the tailored weekly physical sessions and TSSC facilitators' qualities

Participants were motivated by the structured weekly sessions which, P3 and P4 said, helped them to organize the rest of their weeks. HPs managing the program were described as "friendly, helpful, considerate, compassionate people" (P4). EPs were described as "focused", "champions", and "encouraging", and their individualized, tailored programs were regarded as fundamental for participants' successful physical outcomes. "It wasn't one size fits all, it was all tailored wasn't

it," P1 said. Similarly, the organisers/facilitators were encouraging without being "pushy" and gave participants confidence. P2, however, said:

My body just could not cope The exercises were good. The physiotherapist was with us at all times. She gave us reasonable breaks between the exercises but because of my medical condition I just couldn't cope with it and I collapsed.

Nonetheless, after medical checks, P2 looked forward to participating in a future program.

Dietary information assisted P3's weight control and confirmed that P4 was eating healthily. Otherwise all who completed the program stated that memory problems hindered their recall of the educational content. P3 believed that this was due to chemotherapy effects. Therefore, P1 highlighted, it was particularly helpful to have hard copy educational materials which they could take home.

Theme 2. TSSC Could Positively Change Lives, but Maintaining Benefits is Questionable

Participants emphasised that TSSC's beneficial effects had remained since the program ceased 6-7 weeks earlier. One stated that, despite still being physically "slow", the program had helped her to regain flexibility, reduce stiffness and soreness, and return to gardening for the first time in three years. Participants were, however, concerned that the benefits would not be sustained. P1 and P3 discussed this:

P3: *You've done this eight week program and you sort of go out cold turkey.*

P1: *That's right there's no follow up virtually.*

P3: *Maybe a monthly check up just to, might be, of how your physical wellbeing is going.*

P1: *Yes.*

P3: *Otherwise you might have wasted that eight weeks perhaps.*

P3 added that while "separate (medical) specialists" were ensuring that her medical condition was monitored, attention to her physical wellbeing was minimal.

P4 stated that she needed HP and/or social support experienced in the group to continue. She had earlier been referred to a psychologist but found this a "waste of ... time". While P3 remembered that "allied health people" had described community groups they could join in a TSSC educational session, they had only received website contact information. She added that, however, "Once you've been isolated for a period of time (because of cancer treatment), you're less likely to get out and seek (this)". P1 agreed:

Yeah cause it was kind of out of your comfort zone to just rock up to something that you don't sort of know too much about whereas this (TSSC), because it was structured, because you knew exactly what was going to go on, it was very comfortable.

Theme 3. Telehealth was not Needed in an Otherwise Recommendable, Valuable Program

TSSC program endorsement

All participants endorsed the TSSC program and would recommend it to other cancer survivors. P2 described it as a "self-help" program. Travelling between program sites in Shepparton was not a problem. P3 stated that, "as opposed to trying to treat the cancer it's (TSSC's) trying to improve your standard of health or wellbeing". Participants felt safe and that their confidentiality was respected. Although an attending "physio" student seemed disengaged and disinterested in the group process, student involvement remained welcome because they need to learn. Attendance of P2's partner was "tremendous" for P2, did not hinder other participants, and improved P1's experience of the program. All supported

caregivers' attendance as desired. P3, however, stated that she wanted to attend alone as the illness had resulted in her spending more time with her partner.

Telehealth component not needed

Although the face-to-face exercise and dietary information received were especially praised by participants, the telehealth component from Wangaratta was considered unnecessary. Participants stated that facilitators ensured that participants' questions were answered across sites but offered no suggestions for improving the telehealth component because they did not think it was needed:

Everybody's cancer journey is different so it's very hard to tell like a package that you view that's going to answer everyone's questions ... so if you bring someone in from the Centrelink, she's describing what services are available, but if you're a certain age it might apply to you. If you're not, it's totally different. (P3)

The telehealth component could also be considered incomprehensible:

I didn't think there was any value at all in the teleconferencing. ... if I've got to listen to a TV my concentration just goes off. But if I'm talking to a person face to face I've got a better understanding of what's being said. (P2)

I didn't get anything out of the communication from Wangaratta. I found what they were saying was hard to exactly tell. ... It's easier to see the person in the room and get some of their message through facial expression. (P4)

All who completed the TSSC program agreed that a "void" remained since it finished and recommended ongoing support (see Box 1).

Box 1. Participants' Suggestions for CCV Staff and Rural TSSC Organizers

- Telehealth component is not needed; totally face-to-face program is preferred.
- Additional education components suggested: common psychological and emotional reactions to cancer diagnoses and its effects on families; pertinent local resources available.
- Face-to-face introduction to other ongoing physical wellbeing and support programs that participants can be referred to.
- An ongoing, monthly exercise and group support maintenance program (P4 would like a monthly health professional phone call to see how she is going).
- Offer TSSC 3 months after finishing cancer treatment (which one found a good time to start).

HEALTH PROFESSIONALS FROM SHEPARTON AND WANGARRATA

Theme 1. TSSC is much needed and can benefit participants' physical and social wellbeing, and health professional networking

Participants' physical and social benefits

TSSC was described as a “great” program, which improved all participants' physical wellbeing and Shepparton participants' social engagement. Observed physical improvements included that one individual met weight loss goals, and others were:

able to even walk around the block and from going from doing no activity before the program. They were now quite active and just really benefitting their body, their knees. (EP2)

The tailored, individualized exercise programs were considered vital for participants' improvements. HPs also agreed that TSSC helped cancer patients return to a “new normal” in their communities after treatment. Shepparton participants mixed well, however a Wangaratta female participant who enrolled “to mix with other people” (F1) missed anticipated social engagement because the group only included two people. F1 said, “You can't have a chitchat with a lady on a chair on the screen”.

Fatigue mitigated educational benefits

The second Wangaratta group participant was an older person, in his eighties, who fell asleep during the first education session and did not attend the second. Shepparton HPs also commented that participants could tire and “wander off” during education sessions, and that some stood up to stretch at times. Participants in both groups were described as preferring to “just listen” rather than actively engage with education components.

TSSC addressed a service gap and promoted health professional networking

HPs' line managers and organisations supported TSSC as it was considered a much needed service in their rural areas where people can “miss out” on follow-up care. All agreed that TSSC would help people diagnosed with cancer to avoid becoming “lost in the system” after treatment. Wangaratta service providers were “really excited” about the program's exercise component as they did not offer an oncology rehabilitation program and had been, “looking into ways of incorporating exercise as a normative part of cancer treatment” (F3). TSSC's exercise component was highlighted by F1 when she verbalized how she described the program to interested others:

It's a supportive care and exercise program that's designed to educate patients about the benefits of exercise ... we know that research has shown that exercise is a very helpful component to improving people's outcomes from their treatment. The education component is around helping people to live better post their cancer treatment so we hope that their fitness and their capacity to improve their quality of life is improved by being participants.

HPs also valued networking across the Shepparton and Wangaratta services and were pleased that workload managing the ongoing program would be shared. EPs said that the program enabled them to meet each other and discuss their clinical work. Learning about EPs' important role in cancer care was also appreciated. F2 said:

I didn't even realise exercise physiologists existed so it was quite an eye opener ... what an asset they are to the program, ... her wealth of knowledge and the input she's put into the patients ... I would be just wanting to congratulate her.

Theme 2. Commendable CCV preparatory training and resources received but informational, workload, and technological challenges were evident

Commendable CCV preparatory training and resources

Although one HP said that she found CCV's preparatory training "a bit daunting because we didn't realise what we were actually getting into initially" (F4), the training and information was otherwise considered "supportive", "very well done", "really good", "clever", "interesting", "clear", "engaging", "fun", and "enjoyable". HPs valued cancer "patient" presenters in the training, who explained how they cared for themselves back in the community after treatment. They also welcomed learning about, "possible scenarios you might come across and how to control different people in a group situation" (F6). F4 considered the program an expansion of another "WALAC" (Wellness and Life After Cancer) program they had already run in Shepparton, with exercises added. The CCV resource kit was commended, although there was some confusion about which presentation version to use. F5 said:

The resource kit was fabulous, it was really, really good but there were a couple of different sites to look at so there was the toolkit, there was a portal, there was a stick ... it was a bit conflicting as to which presentation we were using and you (other group) had one and we had a different one and then you saw a different one so it was all just a little bit confusing.

Preparatory training was appreciated by the EPs but they thought it could be extended (see Box 2). EP2 also added:

I've been using some of the resources and I have contacted the EP that did run the course since, just to get some more information off him. So I think it has benefitted my just normal kind of oncology patients that aren't doing the program. And just general knowledge as well.

Logistical workload and technological issues

TSSC sessions proceeded quite well in that there were no "dominant personalities", no-one appeared to have visual, hearing or literacy problems, and participant car travel across the exercise and telehealth education sites went smoothly in Shepparton. Indeed, it was agreed that car travel may have enhanced participant socialisation. One EP also avoided recruiting those with bone metastases due to their complex needs. HPs reported that the program workbooks were not used in groups as they were hard to follow and did not match content delivered by "individual presenters". The program was also adapted to:

an eight week exercise program with two education sessions rather than the exercise followed on by education because that makes it an incredibly resource intense program and there's just not the FTE¹ or funding to cover that." (F4)

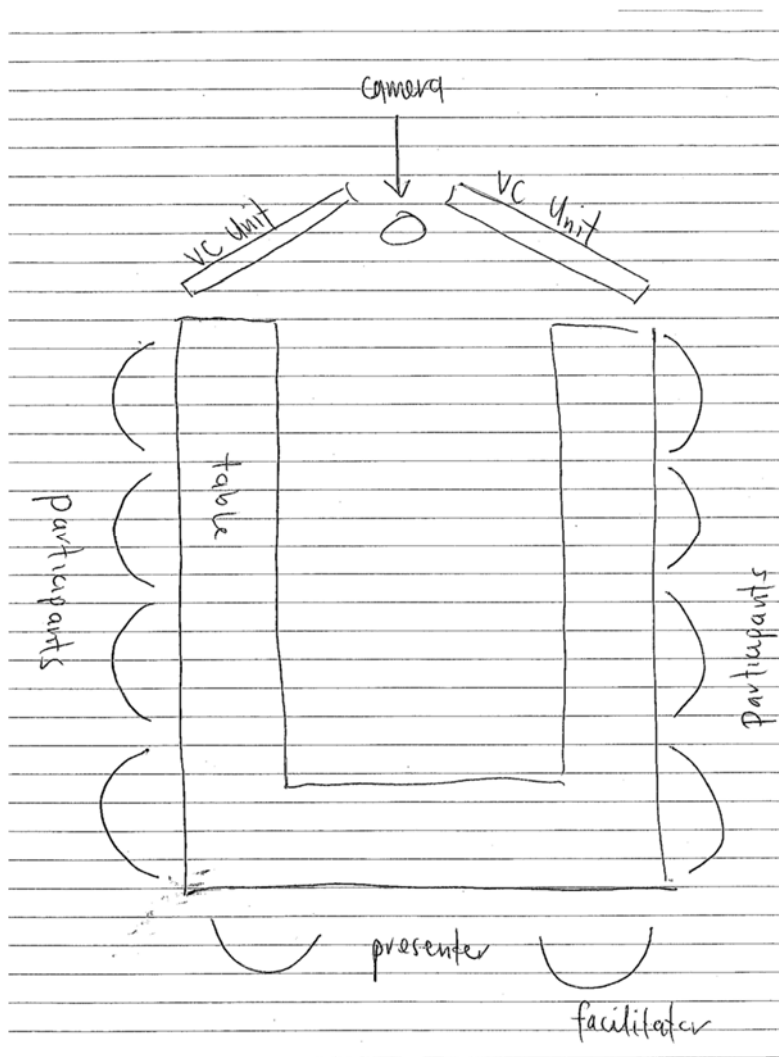
Challenges related to commencing the program were mainly experienced at Wangaratta where they felt "rushed" to sign up and commit to a program they were unclear about. F1 initially thought the program was a "one off standalone project". She would have liked a clearer "picture of what was involved", she said, to help "plan our services ahead of time and so it's not impacting on (other) patient care, which it has done over a few months because of time factors." HPs could also need to work additional, unfunded hours to organise the program. This mainly occurred amongst Wangaratta HPs who did most of the organising "ground work" (F4): one HP worked unpaid for one day a week for many weeks, and the EP gave 10 hours extra. This time commitment was unsustainable, although HPs believed that time required to manage TSSC would reduce as they became more experienced in its operation. Shepparton received more support from "Human Res"² to manage the program.

Logistical technological issues included that the Wangaratta screen system did not work so that they could only hear Shepparton input, Shepparton participants' questions could not be heard in Wangaratta and, consequently, hand signs were not used. Another unforeseen difficulty was that, after a Wangaratta presenter cancelled the day before their

¹ Presumably means "full time equivalent"

² Presumably this meant "human resources"

presentation, the replacement presenter wanted to add PowerPoint slides that could not be shared with Shepparton. Nonetheless, Shepparton HPs found that this presenter came across “okay”. Overall, HPs were confident that challenges associated with the pilot TSSC program would be addressed, and that ongoing programs would become increasingly successful, as they were “talked about” (P3) in their local communities, and supported by the new resources on a USB, recently received from CCV.



¹ Drawn by F1 during focus group discussion.

Box 2. Health Professionals' Suggestions for CCV Staff and Rural TSSC Organizers

- Weekly 2 hour physical exercise and education sessions are preferable, with flexibility for individualized needs. Participants were more vulnerable to fatigue in the long education sessions in their adapted program.
- Alter telehealth education room layout to assist people across sites seeing and hearing each other. Put camera between screens, opposite the presenter, with participants up the sides (see Appendix). Place microphone on a pedestal (away from rustling papers).
- Ensure presenters present to both screens and leave time for questions as talking through the telehealth system is not immediately heard.
- Additional TSSC site staff support is needed to conduct TSSC, including using a “human res” person within supportive care rather than a clinically based HP.
- Enable rural sites sufficient preparation time to recruit and organise TSSC, e.g., 6-8 weeks.
- Education on local community resources can be site specific (not included in the telehealth).
- More help from CCV to recruit participants would be welcome.
- Document version control on educational resources.
- Generic phone number for TSSC which people can call to find out about programs in their areas.
- Put information about TSSC in discharge packs handed out in cancer treatment settings.
- Mock presentation session would help in CCV training.
- Larger participant groups to support more discussions in TSSC education. 6-8 people is optimum for EPs.
- Revise TSSC pre-program questionnaire. It has many repeated questions. HPs did not integrate participants' statements about what they wanted from the group because the program was structured.
- TSSC is mostly needed for those who go through cancer “treatments”, not so much for surgical patients.
- EPs need regular, practical (face-to-face) professional development to keep up with fast changing research.
- EPs need an additional day's training, especially if unfamiliar with oncology, “on different types of cancer and how exercise can affect or benefit that cancer population” (EP2), to increase confidence and competence. Include more practical exercises or case studies.
- Reduce program name confusion. F1 stated, “The program has been called generically WALAC but my understanding is the WALAC is just the education component. ... I think the program could probably benefit from having a separate name, a simple name that indicates its WALAC plus exercise in a telehealth model”.

Conclusion

Participants and HPs recommended TSSC as an acceptable, feasible and beneficial program, although participants did not consider that the telehealth component was needed. Shepparton participants benefitted from social interaction and two markedly improved in physical wellbeing, however, much educational information was not well remembered. Community resource information was not considered helpful enough to enable desired connections with ongoing physical, emotional and/or social supports. Participants were thus concerned about the sustainability of derived benefits. (This report is limited by no feedback from Wangaratta participants.) HPs observed fatigue in participants during the education sessions and believed that the original TSSC 8 week schedule, of 2 hour weekly “exercise plus education” components, is preferable to their adapted 8 week schedule, of 1 hour weekly exercise, with 2 weeks additionally including a lengthy education component. HPs believed that TSSC addresses a service gap in rural areas, especially related to physical exercise, and were optimistic that the program would become widely accepted. They complimented CCV's training and resources, however emphasized that ongoing FTE assistance is needed to sustain TSSC.

Report Prepared by Dr Clare O'Callaghan, Cabrini Health. cocallaghan@cabrini.com.au 9th March, 2018

Appendix. Health professionals' recommended telehealth education room layout to assist people across sites seeing and hearing each other.³

Telehealth for Supportive Survivorship Care: Increasing Access to a Survivorship Education, Exercise and Wellness Program in Rural and Regional Victoria using Telehealth.

Report 3. Grampians and Hume Health Professional Focus Group Final Evaluation

This report is the third of a three part evaluation of the Telehealth for Supportive Survivorship Care (TSSC) project. This 8 week program aims to provide access to a comprehensive survivorship assessment, education, exercise and wellness program for cancer survivors and carers (attendees) in the Grampians and Hume Regional Integrated Cancer Service (RICS) regions. The first two evaluations examined TSSC's feasibility, acceptability and usefulness, as perceived by Grampians and Hume cancer survivor attendees and health professionals (HP). The Grampians' focus group was conducted in September 2017, and Hume evaluation in February 2018. HP organisers and facilitators were invited to attend another group on 22 November 2018 in order to:

- a) Verify whether earlier statements of findings of HP views about the TSSC project were acceptable, that is, satisfactorily represented the content of earlier focus groups
- b) Describe how the TSSC project evolved in their regions
- c) Reflect about barriers to conducting the TSSC program
- d) Enablers / recommendations to conducting successful, independently managed TSSC programs in the future

Participants in this focus group comprised 6 HPs from Grampians and 8 HPs from Hume regions. All were female. Most had attended the earlier focus groups (a minority had not). To prepare for the final focus group, HPs were requested to read the statement of findings from their region's earlier focus group (Appendix 1). A powerpoint presentation of the two statements of findings was also presented at the commencement of this focus group (Supplementary File). The audio-recorded focus group content was transcribed. Data analysis of the verification and recommendation components of the focus group was descriptive. Remaining content was inductively, cyclically and thematically analysed based on grounded theory methods (See Report 1, Appendix). To promote anonymity and indicate that responses quoted in this report reflected a variety of views, HPs were given codes when possible. The large focus group participant number sometimes prevented speaker identification. HP1-6 denotes HPs from Grampians and HP7-14 denotes HPs from Hume. Five (or 6) HPs were exercise physiologists (EPs).

Verification

Grampian HPs approved the statement of findings. S5 wanted to especially reinforce the excellent EP finding, stating, "I can't say enough how great they were" and also commended allied health assistants who supported EPs. Hume HPs approved the statement of findings except that some disagreed that TSSC was comparatively less needed for people who had undergone surgery. S14 explained: "I think surgical patients tend to drop out of their supportive care realm much more than other patients" and added, "I think we probably need to target them more".

Evolution of TSSC and Barriers to Program Success

Theme 1: TSSC's evolution reflects HP perspectives and capacity, and health service supports

TSSC Program Evolution and Health Professional Evaluation. The TSSC four program pilots were completed in both the Grampians and Hume regions, and the Grampians region conducted an additional two programs in 2018. HPs from both regions widely agreed that TSSC was an exciting development for cancer care and that they had all achieved "remarkably" to date. Many acknowledged how the COSA Position Statement on Exercise in Cancer Careⁱⁱ affirmed the program's value. 12 said, "This program's almost ahead of its time. I think we're moving into a period where exercise and its value in cancer cures is really coming to a forefront." HP5 said, "We're doing this (TSSC) because we think its core

business”, and, HP 1 said, “None of them (cancer survivors) went away and said, ‘Oh that was terrible, I’m not coming back”. CCV fortnightly support teleconferences were also “amazing”. HP11 said that CCV “encourage us in what to do and how to do it and what we needed to be doing to get ready for the next program.” HPs also felt confident that CCV would continue to support them with TSSC if needed. Comparative details about the TSSC programs’ evolution across the two regions are listed in the following categories.

Health Service Support and Sustainability. The Grampians TSSC program proceeded more smoothly than Hume’s, primarily because a “champion” project manager supported Grampians’ staff. The project manager “slid” into the role while “already ... working with GICS (Grampians Integrative Carer Service) on a couple of projects” (HP1). GICS was very supportive of TSSC. HP1 explained that GICS offer “very good buy-in whenever they want to implement something”. The program manager organised planning meetings for each TSSC eight-week program, booked rooms and managed educational resources/handouts used in the program. HP2 described how planning meetings were attended by HPs from various Grampian sites and that they decided on “who was going to present, so we were all on the same page at the same time with the same material”. She added that they learned that they needed to do this do after the first TSSC program. The Grampians’ project manager’s support would not continue into the future because, HP1 said, “We’re giving it back to the EPs as ownership rather than it just being a pilot for sustainability.” Grampians HPs expressed confidence that TSSC would independently continue and HP5 stated, that it was “fine” not having regular contact with CCV beyond the pilot. The project manager is open to helping out in the future if needed and three Grampians EPs have time “set aside” to continue supporting TSSC. S4 (an EP) said, “We’ve probably got really good managers that are happy to use our funding towards the program. We’re all passionate about it.” The Grampians EPs can also help with the education component if telelink malfunctioned at their sites.

The Hume TSSC program had a “very bumpy start” because, HP14 said, “at an integrated cancer service level we didn’t fully support the Hume region, initially unfortunately”. The main problem identified was that oncology nurses were expected to conduct and plan TSSC sessions, including recruitment of facilitators, without time allocation. The TSSC education segments were collapsed into two, 2-hour segments on weeks 4 and 8 (rather than offered one-hour a week across the eight weeks as initially intended) because managers preferred that the oncology nurses facilitated TSSC in these time slots. (One HP added that the 2 hour blocks “seemed like 4 hours”). The longer educational sessions, however, did not suit the cancer survivors as they became “extremely tired”. Recent changes in Hume Integrative Cancer Service (HICS) management, however, have resulted in greater support for TSSC and, from 2019, TSSC will proceed according to the originally intended format (one hour exercise, one hour education and refreshments weekly across 8 weeks). Hume HPs were also confident that Hume’s TSSC would successfully continue without CCV support because, HP11 stated, “We’ve got Hume RICS now”, that is, good support from Hume’s RICS. HP13 said that Hume’s future TSSC programs will run more efficiently, that local oncologists were supportive, and that they had sorted out the “logistics” adding, “We’ve got the gyms booked, we’ve got the rooms booked, we can book our ... presenters. The load is shared between facilitators, EPs”. Funding for the exercise component was securely embedded within Goulburn Valley’s rehabilitation program through activity based funding, however, sustainable oncology nurse facilitator funding remained a concern.

Telelink. Telelink was being effectively used in the Grampians to connect multiple sites for each TSSC program. In 2019 Grampians programs will include a three site connection. Telelink glitches had brought humour to group attendees, however, these had reduced since bandwidth had increased in this region. Although Hume’s “Northwest” and “Shepparton” program dates were aligned, telelink was still not being used. HP13 said, “We’ve got it there and we know we can utilise it” in the future, possibly to connect smaller service sites with Goulburn Valley Health, including Seymour, Yarrawonga, Cobram, Nathalia and Murchison. HP13 said it may also be used as a back-up if one of the site presenters cancels.

Educational Content, Resources and Workbook. As the Grampians TSSC evolved, educational content was altered to meet attendees' needs. The social worker added a component on emotions to the financial educational session. Foot health and complementary therapies were integrated, which HP1 described as "absolutely fantastic". Attendees learned the importance of seeing someone reputable for pedicures and the falsity of some mythical beliefs, e.g., apricot kernels' curative potential. "Giving them some ... factual, honest information is very important", HP5 said. Many attendees with peripheral neuropathy "did not realise that there were people out there that could help them to care for their feet" (HP6) and referrals to Grampians podiatry services had since increased. Hume HPs did not change program content because, one said, they did not think that it could be changed.

Both Grampians and Hume HPs ceased using the workbook because "it was very confusing" and not in order when session adjustments were made. HP1 also said that page flicking disturbed those at other sites. HPs in both regions offered optional resources that attendees could take home each week. Grampians HPs tailored printouts appropriate for each week, including CCV resources. HP4 observed that the slide show handouts were widely liked with some writing notes on them. Some attendees completed work-sheets while others did not. Hume HPs requested further information about Grampians' organisation of information for potential use in their sessions. They also queried Grampians' use of EPs as facilitators and involvement of the podiatrist presenter to help with their future TSSC planning.

Exercise. Two EPs reported that having allied health assistance was important, especially in early "hectic" weeks before attendees became familiar with the exercise equipment. One EP was unhappy that she did not have allied health assistance. HP3 also said that when she needed to cancel a TSSC exercise session, she encouraged attendees to attend the educational component and walk together around the local creek.

Scheduling. The two regions will use different schedules for ongoing TSSC programs. Grampians will continue according to school terms (commencing in the second week) because, HPs stated, attendees can find it difficult to attend during school holidays (e.g., grandparents may need to mind children); school terms align with seasonal cropping and harvesting; the timing is easy to remember; and the schedule aligns with available resources and HP capacities. Attendees are also welcome to attend any session missed in following TSSC programs. When this had occurred other attendees were welcoming. Goulburn Valley Health and Northwest sites will run as rolling (continuous) programs. Attendees will be able to enter at any time during the program but still attend the complete eight weeks. Hume's smaller health services will offer less programs each year. Hume HPs believed that the rolling program will enable more people to attend and offer greater convenience. When queried about whether group cohesion may diminish with an open group format one Hume HP replied that, on the contrary, it may enhance the number of connections that attendees make with each other.

Intake Procedures. Intake procedures differed across region sites. At one site an allied health worker booked physical assessments whereas Hume EPs made their own intake appointments. One stated that this helped her to build rapport with attendees and improved their comfort level. HP13 also said that work on referral management was still needed at Wangaratta.

Reviewing / following-up Attendees. Some EPs offered attendees a follow-up review and/or support following TSSC program completion. Even if attendees were continuing to exercise independently, HP6 offered reviews 2 and 4 months after program completion because, she said, attendees "get very close to us" and "often get a bit lost". HP8 does a 4 week phone review if attendees wish and they have a face-to-face review if desired. The aim remains to help attendees transition to self-management. HP4 offers some attendees ongoing private or shared exercise sessions once a week for a while and then tries to transition them to independence

Theme 2. TSSC Barriers Encompass Preparation, Fiscal, Workload, Site, Team Support and Attendee Issues

Financial Issues (Hume and Grampians). HPs from both regions emphasised that accessing money for backfill to support TSSC was a barrier to TSSC's evolution. A Grampians HP said that they were told that money would be available. Information about how to apply for it, however, was not provided and they had since been told that the money had been "reused" because no one applied for it. Lack of backfill for EP or education session cancellations during TSSC program was also a concern. There were also waiting lists for some programs and concern about whether future demand for TSSC among cancer survivors would be met.

Insufficient Preparation (Hume). Hume HPs said that they had insufficient understanding about "what we'd signed up for" related to TSSC.

Insufficient Time (Hume). Hume HPs had insufficient time to organise and conduct education components of TSSC. Hume oncology nurses were expected to come "off the floor" to manage and facilitate TSSC in their everyday work-lives. This was described as "an accident waiting to happen". Many Hume HPs used personal time to manage and deliver TSSC, including rostered days off. Hume nurses could feel overwhelmed by fitting cancer support programs into already heavy workloads. HP9 said that "it was a constant struggle. Another stated, "A week can go by without us having time to open up an email. And then when you do there's a trillion from WALAC (Wellness and Life After cancer) and you go, 'Oh, I don't even know where to start'." Another said:

At a Hume RICS level, you know, we've absorbed a lot of responsibility with this pilot project that we shouldn't have It's not sustainable for us like it's taking me away from other work, you know, like I'm here to facilitate obviously and implement but not to be a service provider.

Managerial and Multidisciplinary Team Issues (Hume). TSSC progress in Hume was also delayed because: many staff were "acting up" in more senior roles; there were prevailing communication issues related to EP placement in community health and community nursing contexts; and, as mentioned earlier, there was initial lack of support for TSSC among Hume managers. Recent managerial changes, however, rendered Hume HPs feeling more supported and optimistic about the program's future. Nonetheless, one Hume EP, who did not have any allied health assistance for her sessions, felt unsupported within her site team.

Site Issues (Hume). Some Hume HPs were concerned that Shepparton attendees were very "taxed" by needing to commute between two different sites to experience TSSC because of space issues. HP12 said, "They'd start off at the hospital at the gym and then they'd have to hop in their cars and drive down the street, find a park and then continue on to education at another site." Hume HPs were also sometimes "blocked" from accessing the CCV TSSC online information site.

Cancer Survivors' Vulnerability. Two Grampians HPs considered that burdens related to time, travel and health factors impeded some cancer survivors' attendance at the groups, including those who lived nearby. One cancer resource nurse picked up one attendee who lived three kilometres from the health service when she could not travel independently.

Enablers / Recommendations

HPs agree about most enablers and recommendations for future TSSC programs, as outlined here.

Initiating, Planning and Maintaining TSSC

- When instigating TSSC in a new region ensure that what's involved and required of HPs is clear. Training needs to include clear telehealth education. One HP said that their facilitators were initially told, "All you had to do is press the

button". EPs could do less facilitator training, but can need more cancer specific knowledge to provide individualized care. One HP said that EPs can attend regional oncology GP education to support this.

- Include information on backfill money available and on how to apply for it. Also include information on funds potentially available to sustain the program. HP5 said,

Cancer Council are excellent at providing these resources and support and stuff. They don't give us that funding for when we can do these things ... I know they can't give us the funding, but they need to say, 'But you can use this funding or this funding or this funding. This is what's being used in other places'.

- Ensure availability of a dedicated and committed HP who has available time to drive and progress TSSC programs.
- Develop an annual planning day for future programs, to update HP skills and resources, manage backfill arrangements and enable debriefing. Note, the cardiac rehabilitation HP network and training day was described as a good model for enabling a TSSC "community of practice", with upskilled HPs and consistent care delivery.
- Ensure resources are maintained, updated and accessible on the CCV portal.
- Develop a video of the GP content as it can be difficult finding GPs to facilitate.
- EPs need at least one allied health assistant to help them to run the exercise programs.
- Ensure attendee numbers fit the site's space availability and EP/ allied health assistant staffing.
- Don't expect nurses to take time off designated ward work or use unfunded time to facilitate TSSC sessions. One HP recommended broadening the scope of facilitators integrated into the program "So it's not (always) the oncology nurses struggling to get the time"
- Consider using technology to enable TSSC to support people unable to physically attend when challenged by distance or health

Educational Content

- Continue or commence: foot health, complementary therapy and sexual health education. HP8 had observed that on a Functional Assessment of Cancer Therapy: General (FACT-G)ⁱⁱⁱ questionnaire, "Pretty much every patient says that they ... don't want to answer or they don't have any kind of intimacy with their partner". Ensure that financial content was also relevant to attendees who were retired or wanting to return to work to (Some attendees said that existing content did not help).
- De-emphasise: general practitioner content (HP5 said, "Because that's very personal"); chemotherapy side-effect information (HP9 said, "That gets done to death while they're having chemo"); and wellness and recovery content (S1 said this repeats some of the EP content).

Collaboration

- Promote collaborative involvement and support among HPs (including EPs) across both the Gippsland and Hume regions where possible. Telehealth education segments could potentially be offered across the state.
- Consider an annual TSSC conference.

Running Education / Telehealth Sessions

- Provide just one relevant information package each week for attendees which matches the PowerPoint presentation to avoid confusion.

Reviewing / Following-up Attendees / Refresher Programs (Disagreement)

- HPs disagreed about whether attendees should be reviewed and/or able to attend repeated programs. H6 believes that EP reviews should be standard practice. HP5 also considered that attendees should be able to access the program again if desired as a form of support. HP10 disagreed stating that the EP funding and "wellness" model" aims to enable people to maintain independence and confidence to function in the community. She would only allow attendees to repeat TSSC if they experienced a "significant change", and added that if someone was not coping the

question needs to be, “How can we help to maintain you doing exercise in the community?” One HP also considered that a refresher program was not judiciously using health care resources.

Conclusion

Grampians and Hume HPs believe that TSSC is a very worthwhile program to promote overall wellness of cancer survivors. EPs’ work to improve cancer survivors’ physical health was especially commended. While much of the TSSC educational content and CCV resources were very helpful, HPs were also working to ensure that content was relevant and clearly understood by attendees. Regional managerial support is vital for the program’s success. Many HPs, especially in HUME, used personal time, goodwill and initiative to support TSSC. HUME nursing HPs also hoped that HUME RICs’ recent improved support for TSSC would alleviate its imposition on their work and personal lives. Grampians and HUME HPs complimented the CCV for initiating TSSC and offered recommendations for establishing TSSC programs elsewhere, including about training and information provision regarding funding support. Although telelink technology was only used to connect Grampians’ sites, all considered that the program should continue and hoped that ongoing collaborations across the regions would advance TSSC’s contribution in the future.

Report Prepared by Dr Clare O’Callaghan, Cabrini Health. cocallaghan@cabrini.com.au 1st February, 2019

Qualitative report - Telephone Survey Questionnaire

Name:

Site:

Program date: (month)

Date of interview:

1. Introduction
2. Explain your expectations of the Telehealth for Supportive Survivorship Care program prior to your participation.
3. What have been the outcomes for you as a participant since the program?
 - For example what steps have you taken to improve your health and wellness as a result of participating in the program? (Specifically in regards to physical activity/diet/lifestyle).
 - Do you currently do any physical activity regularly each week? And if so what types of exercise do you do? How often per week (days), how long for (mins)?
 - Have you changed your dietary habits as a result of participating in the Program?
How many serves* of fruit would you eat on average each day?
How many serves** of vegetables would you eat on average each day?
**A standard serve of fruit is about 1 medium apple, banana or pear*
***A standard serve of vegetables is about ½ cup cooked vegetables or ½ medium potato or 1 cup of salad*
 - Have you changed your alcohol consumption habits?
On how many days per week would you drink alcohol and how many drinks on average would you have on each of these days?
 - Do you smoke? If so have you changed your habits?
4. Have you accessed any supports or services discussed in the program since it finished? If so what have these been and how have they assisted you?
5. This pilot project used video conferencing technology (telehealth) to deliver the program. As a participant, what were benefits and/or challenges of the technology in the program for you?
6. Would you have been able to participate in the program if telehealth and the opportunity to attend closer to home were not available? What would have been the challenges for you?
7. Please describe how telehealth affected your experience of the program as a participant.
8. With regard to the information and presentations in the program (topics), how did telehealth affect your experience?
 - Can you explain if the format and content of the program was useful and appropriate?
9. With regard to the interactions with other participants and the facilitators in the program, how did telehealth affect your experience?
10. Would you recommend the Telehealth for Supportive Survivorship Care program to others as a telehealth program? Please explain your response.
 - Would you recommend this as a program without telehealth?
11. What suggestions would you make for future programs delivered using telehealth?
12. Is there anything additional you would like to add to provide feedback on the benefits and/or challenges of participating in a program using telehealth?

Appendix SIX – Project presentations

Date	Activity	Organisation / Audience
2017-03-23	Presentation	Wimmera Southern Mallee Health Alliance Meeting
2017-04-19	Presentation	Wimmera Southern Mallee Nurse Unit Managers Meeting
2017-06-08	Presentation	Wimmera Southern Mallee Chronic Disease Management Meeting
2017-07-13	Presentation	Ballarat Regional Integrated Cancer Centre (BRICC) Oncology Journal Club Meeting
2017-09-17	Presentation	Clinical Network Journal Club
2017-11-23	Presentation	Hume Region GP network meeting
2017-11-24	Presentation	Cancer in the Older Person Forum
2018-02-08	Conference Presentation	VCCC Survivorship Conference
2018-03-15	Presentation	VCSP Community Of Practice
2018-05-14	Presentation	West Vic PHN
2018-07-30	Conference Poster	CNSA National Conference
2018-08-20	Conference Poster	Western Alliance Fourth Annual Symposium
2018-09-24	Presentation	North East Health Wangaratta Oncology staff
2018-11-29	Presentation	VCSP Community Of Practice
2018-29-01	Presentation	CCV Health Professional Development Event
2019-04-17	Presentation	Stawell Regional Health Quality and Safety Committee Meeting
2019-03-	Conference Poster	COSA Survivorship Conference
2019-	Conference Presentation	VICS Conference

Appendix SEVEN – Video library

Wellness and Life after Cancer Video Library Project Plan

Background

National advances in medical oncology mean increasing numbers of patients will live with and beyond a cancer diagnosis and enter a phase now termed survivorship. This has created a need for quality information, education and material that can be easily accessed by individuals transitioning from acute clinical care through to recovery.

'Telehealth for Supportive Survivorship Care' is a project funded by the Victorian Department of Health and Human Services from 2016 – 2019 and is a collaboration between Cancer Council Victoria (CCV), and the Grampians and Hume Regional Integrated Cancer Services. The project innovates the pre-existing CCV *Wellness and Life after Cancer* (WALAC) group program, to include practical exercise and wellness sessions delivered by qualified local health professionals over eight weeks. This program enables those moving from treatment to recovery and their carers to build resilience and increase their capacity to self-manage their own health and wellbeing.

A key element the project is the utilisation of telehealth (video-conferencing), enabling one presenter to deliver the education session across multiple sites. Although this has increased capacity to access the program by removing the barrier of distance, action research learnings have identified a need for further education delivery support and materials.

Development of video resources program education topics has been proposed to support and enhance delivery where relevant health professionals are unavailable to present.

Purpose

To develop a suite of video resources to support program facilitators in ensuring program delivery is consistent and high quality.

Objectives

1. Develop video material that covers survivorship topics integral to the program. Each topic will be presented by a specialist Health Professional.
2. Increase access to high quality Cancer Wellness presentations and resources for program facilitators across Victoria. The videos will support existing material for each of the topics.

Scope

Development of a video library of themes and topics that support the Cancer Wellness program.

- Recovery and wellbeing
- Importance and benefits of exercise
- Managing fatigue
- Importance and benefits of healthy eating
- Emotional health and wellbeing
- Finances, practical support available and challenges around returning to work
- Your GP and long term health
- Complementary Therapies
- Foot health
- Cancer Council Victoria Services for cancer survivors.

Format

Q&A videos – Five topics will be presented each by a topic expert who will use a script in a Q and A format. These will become 4 – 6 minute videos and will complement a PowerPoint presentation.

Table 1. Q&A Videos

Topic	Presenter	Report Comment
Recovery, survivorship & wellbeing	Project participant Personal story - Greg Morvell	Video filming was completed on the 10 th March 2019. All edits have been completed and a master copy of each video has been provided on a USB memory stick due to the size of the files.
Healthy eating and nutrition	Amber Kelaart	
Emotional health and wellbeing	Natalie Lalor	
Life management – finances and work	Jeanne Potts	
Foot Health	Eliz O'Rourke	

Screen casting – Ten topics will be delivered by topic experts at their own computer. They will use the program power-point presentations for their delivery.

Table 2. Screen casting

Topic	Suggested presenter	Report Comment
Fatigue & survivorship	Abby Roberts Brittenie Power	Completed and a master copy of each video has been provided on a USB memory stick due to the size of the files.
Physical activity and survivorship	Abby Roberts Brittenie Power	
Complementary Therapies	Carmel O'Kane	
Healthy eating and nutrition	Amber Kelaart	Scheduled June 2019
Emotional health & wellbeing	Natalie Taylor	Scheduled June 2019
Life management - Finances & work	Jeanne Potts	Scheduled June 2019
Your GP and long-term health	Kate Graham	Scheduled June 2019
Foot Health	Chelsea Robinson	Scheduled June 2019
Your bone health	Kate Graham	Scheduled June 2019
Cancer Survivorship	Kathleen Poulton	Scheduled June 2019

Appendix EIGHT – Headset purchase and implementation plan

Some of the program participants had hearing difficulties so at times they could not understand the presenters. Recognising the likelihood of future participants experiencing similar difficulties, and in line with other programs underway in the regions, headsets are being purchased to improve program accessibility. These headsets have not been purchased at time of submitting the report due to delays in confirming the most suitable technology, however final quotes were received in time for inclusion in the final acquittal (as outlined below):

- Maggie Bridgewater, Deaf Access Officer at Horsham Rural City Council is being consulted on minimum technology requirements.
- We will be purchasing 14 headsets which will be given to the following locations:
 - 2 at each of the 5 sites involved in the project (ten total)
 - 2 at Hume RICS
 - 2 at GICS

