



BC Cancer Agency

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An agency of the Provincial Health Services Authority

**Cancer Survivorship: creating uniform and
comprehensive supportive care programming
in Canada**

Cancer Transitions: Moving Beyond Treatment

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Overview

In Canada, there are currently close to one million people living as cancer survivors, and with further advances in prevention, screening and treatment, this number is expected to increase in the future (Canadian Cancer Statistics, 2008). The Canadian healthcare system will see a higher number of people living with survivorship issues and it is therefore critical to understand the unique needs of this growing population. The Cancer Journey Action Group (CJAG) of the Canadian Partnership Against Cancer (the Partnership) has therefore identified the development of improved approaches to cancer survivorship as a key priority. A number of national workshops and meetings have been held by the Partnership to establish clinical and research priorities in cancer survivorship (2008, 2009). Stakeholders have included members of academic research institutions, cancer agencies, community based organizations, funding and policy oriented organizations, and very importantly, cancer survivors themselves. The meetings have allowed an early alignment of research inquiry to practice and policy questions and to survivor experiences, and have optimized the use of existing knowledge and expertise by all partners.

In 2009 CJAG funded implementation and evaluation of a supportive care program in Canada called *Cancer Transitions*. *Cancer Transitions* is a program developed by the Cancer Support Community (CSC--formally The Wellness Community) and **LIVESTRONG** (Lance Armstrong Foundation) to help cancer survivors make the transition from active treatment to post treatment care. It is six-week psycho-educational program for survivors of all cancer types. It was successfully piloted at 15 locations in the United States in 2008. In partnership with the BC Cancer Agency (BCCA) and CJAG, four Canadian pilot sites delivered and evaluated the program and measured its impact on participants. The four pilot sites were: Northern Health Authority - Prince George, Hope & Cope - Montreal, Wellspring - Toronto and BCCA - Vancouver Island. Facilitators from each of the sites were trained to deliver the program by consultants from the CSC. The six-week program commenced in January 2009 and the facilitators followed the *Cancer Transitions* facilitator guide to deliver the program. The

program covers significant aspects of cancer survivorship including exercise, emotional well being, nutrition, medical management, and survivorship care planning. It provides the opportunity to practice skills that can help cancer survivors manage their life after treatment. The program is not specific to one type of cancer diagnosis, and is therefore applicable and adaptable to survivors of a variety of tumour sites. The program participants completed a workbook and received supplementary material to help them build individual survivorship care plans. The participants also completed a series of validated self reporting evaluation questionnaires at the beginning of the first and last session.

The questionnaires were used to quantitatively and qualitatively evaluate the program and changes that occurred in the participants' in physical and emotional health status and overall quality of life. Participants were asked to complete a series of five validated questionnaires at the beginning of the first session and at the end of the last session, plus three additional questionnaires at the end of the last session that evaluated the program content and process. At the end of each session the participants and facilitators also completed weekly evaluations of the program and were given space to provide qualitative feedback. Descriptive and inferential statistics were used to evaluate the program and changes that occurred during the course of participation in the program in relation to self-efficacy, physical and mental health status, and overall quality of life. The participants were also mailed three month follow up questionnaires to measure if any sustainable improvements resulted from the program. It is critical to build in mechanisms to evaluate the effectiveness of psycho educational interventions in order to be able to make service delivery recommendations. CJAG is looking to advance comprehensive and sustainable evidence based programming that can be developed and adopted on a national basis.

The pilot study results and interpretations were submitted to CJAG in May of 2009 and based on the findings funding was secured to train 40 new facilitators from hospitals, cancer agencies, and community based organizations from across Canada in the programs delivery. As a result of this project the

Cancer Transitions program is now being incorporated into models of supportive care for cancer survivors across Canada.

This report contains a description of the *Cancer Transitions* program, the sites and participants involved, comparisons of survivors' initial well being and physical health versus that at the end of the six week sessions and three month follow up, as well as survivors and facilitators overall experiences and evaluation of the program. The report also includes a description of the facilitator training and ongoing program delivery and evaluation. In depth analysis and discussion of the project and its results is planned for future publications. Individual site data and interpretation can be found in the appendices. The intention of this report is to highlight how research evidence can inform and guide clinical practice.

Cancer Transitions Partners

The national *Cancer Transitions* partnership was composed of representatives from non-profit cancer centres and community based organizations that offer support, education and guidance at all points along the cancer continuum. All the sites promote new program development supported by research and evaluation. The mandate of the group was to coordinate the delivery of evidence based survivorship supportive care programming through the delivery and evaluation of the *Cancer Transitions* program.

BCCA, Cancer Rehabilitation, Vancouver

Amanda Ward, Richard Doll, Joanne Magtoto, Cheri Van Patten and Svetlana Ristovski-Slijepcevic

The BCCA, Vancouver Centre is one of five comprehensive service cancer centres in British Columbia. The agency provides oncology consultations, chemotherapy and radiotherapy treatments, as well as a broad range of other services related to cancer control and supportive cancer care. The Vancouver Centre also has an active research centre. All stages of the pilot program study were overseen and coordinated by the BCCA. An evaluation team conducted the data analysis in order to evaluate the effectiveness of the program and its overall feasibility for delivery in Canada. The evaluation framework was based on the one used by the CSC.

Hope & Cope – Montreal

Hinda Goodman, Suzanne O'Brien and Linda Edgar

Hope & Cope is a peer based organization that provides psychosocial support for cancer patients, their families and friends. Close to 300 dedicated, specially trained volunteers, many of whom have had cancer themselves, provide patients with support, information, resources and guidance at all points along the cancer continuum. A professional staff of eight ensures effective program management and continuity. Services include a freestanding Wellness Centre with an onsite exercise room, teaching kitchen, yoga and art therapy rooms, and

other rooms for support groups and information seeking cancer patients. The Wellness Centre is designed to support survivors, as they develop and strengthen healthy life styles. In addition, hospital based volunteers offer peer counseling, support groups, practical and informational assistance. Research is an integral part of Hope & Cope's mandate to ensure that all services are evidence based, which then allows the organization to contribute new knowledge to the field of psychosocial oncology.

Wellspring – Toronto

Claire Edmonds, Holly Bradley and Ayala Beck

Founded in a welcoming coach house in 1992, Wellspring is an innovative network of centres providing high quality cancer support, education and coping skills to a growing number of individuals, family members and professional caregivers in Canada. At the core of the Wellspring network is the Centre of Innovation, which fosters new program development, research and evaluation, quality control, expansion and outreach to underserved communities. Wellspring programs are free of charge and open to individuals and caregivers who are coping with any type of cancer, at any stage. They include individual and group support, coping skills, expressive therapies, energy work and educational workshops and presentations and are housed at warm, non institutional Wellspring Centres.

Both Hope & Cope and Wellspring also offer a number of other professionally led support programs such as “The Healing Journey” and “Return to Work”.

Northern Health Authority – Prince George

Tasha Ahlstrom, James Chan and LaDonna Fehr

The Northern Health Authority currently serves the largest geographical area in British Columbia. The region is primarily rural with patients and their families facing challenges in climate and proximity to cancer services. The health authority has organized cancer services in the major centre, Prince George as well as smaller regional cancer chemotherapy services.

BCCA – Vancouver Island

Nancy Payeur and Lindsay Downie

The Vancouver Island Centre is one of five comprehensive service cancer centres of the BCCA. This centre provides oncology consultations, chemotherapy and radiotherapy treatments for people who live on Vancouver Island. Additionally, a broad range of other services related to cancer control are offered, including prevention, treatment, screening, genetic counseling and supportive care. The Vancouver Island Centre is an active research clinic contributing to knowledge generation done within the facility. The pilot study will provide information about launching a survivorship program within a tertiary care centre.

School of Population and Public Health, University of British Columbia

Knowledge Exchange Decision Support (KE-DS) Toolkit Project Group

Arminee Kazanjian, Catherine Howett and Kirsten Smilie

An integrated knowledge exchange decision support (KE-DS) toolkit to support large scale change initiatives at the health system level was created by Dr. Kazanjian through support from CJAG and the Canadian Institute of Health Research (CIHR) and was utilized by each site in a retrospectively reflect on the program implementation. The KE-DS Toolkit provides a method for recognizing and engaging stakeholders at multiple levels in addition to identifying and appraising the evidence on effectiveness, efficiency and appropriateness of the intervention. Modules to review population, economic, and social contexts are integrated as part of the model application to optimize program decision making. The information gained from the KE-DS toolkit has been submitted to CJAG in a separate report (July 2009).

Project Consultants: the CSC (formally The Wellness Community)

Mitch Golant, Julie Taylor, Ivy Ahmed, Melissa Miller and Joanne Buzaglo

The CSC is the largest non-profit provider of supportive cancer care in the USA. The organization has 24 Wellness Communities around the United States, with an additional 74 satellite and off site programs, and has collaborated with

supportive care organizations in the UK, Poland, Japan, Italy and Canada. The CSC is dedicated to providing free support, education and hope to people with cancer and their loved ones. Through participation in professionally led support groups and educational workshops, the CSC provides support, education, and hope to people with cancer and their loved ones. The CSC conducts research in order to measure and document the benefits of psychosocial support for people with cancer.

Objective

Creating uniform and comprehensive supportive care programming for cancer survivors in Canada

Long Term Supportive Care Project Objective

To identify effective supportive care interventions for cancer survivors that can be incorporated within contemporary cancer care planning and disease management strategies in Canada. These interventions will provide survivors not only with tools to cope with life after cancer treatment, but also assist them in developing long term survivorship care planning.

Cancer Transitions Pilot Study Objectives

Phase I

The purpose of the pilot study was to:

- a. Examine the feasibility (e.g. cancer survivor recruitment, adherence, and retention) of delivering the *Cancer Transitions* program in various Canadian settings and organizations
- b. Provide a preliminary examination of the impact of the program on participant quality of life, including social, emotional and physical well-being
- c. Provide recommendations regarding the effectiveness and sustainability of the program in Canada

Phase II

The purpose of Phase II was to create a sustainable Canadian *Cancer Transitions* program. The purpose of Phase II was to:

- a. Create Canadian *Cancer Transitions* participant workbook and facilitator guide
- b. Conduct facilitator training through “train the trainer” workshops for a total of forty facilitators
- c. Continue to monitor ongoing program sustainability and delivery as well as evaluation of the program and participant outcomes

Methods

The Program – Cancer Transitions: Moving Beyond Treatment

The *Cancer Transitions* program is a six session intervention targeted towards those 0 to 24 months post treatment. The program covers significant aspects of cancer survivorship including exercise, emotional well-being, nutrition, medical management, and survivorship care planning. It provides the opportunity to practice skills that can help cancer survivors manage their life after treatment. Also, the program is not specific to one type of cancer diagnosis, and is thus applicable and adaptable to survivors of a variety of tumour sites.

The course covers the following topics:

Session 1: Get Back to Wellness: Take Control of Your Survivorship

Session 2: Exercise for Wellness: Customized Exercise

Session 3: Emotional Health and Well-Being: From Patient to Survivor

Session 4: Nutrition Beyond Cancer

Session 5: Medical Management Beyond Cancer

Session 6: Life Beyond Cancer

Booster Session: Follow up and check in session

*Please refer to the facilitator guide and workbook to view each session.

Program sub messages

Exercise

Regular exercise reduces some long term side effects of cancer treatment, and increases overall physical and emotional well-being for cancer survivors. Exercise has been shown to help cancer survivors with pain, strength and endurance, sexual functioning, sleep, thinking and learning, and psychological distress such as fear, anxiety, and sadness. It is important for survivors to learn how to tailor physical activity to match their physical ability after

treatment. Even a small amount of physical activity is beneficial to cancer survivors (Doyle et al., 2006; Carlson et al., 2006).

Nutrition

Eating a healthy diet helps cancer survivors regain strength, improve recovery and well being. Nutrition for cancer survivors should focus on a plant based diet, including more than five servings of fruits and vegetables each day. Additional important nutrition tips for survivors includes eating whole grains and low fat dairy products, and reducing saturated and trans fats, red meat, salt, sugar, alcohol, pickled, and fried foods. This dietary pattern along with a healthy body weight and regular physical activity can improve overall health and vitality and attenuate some side effects of cancer treatment. In addition, in some cancer sites these lifestyle factors may be associated with a lower risk of new cancers, second primaries and play a role in the prevention and treatment of common co morbidities in cancer survivors (Duyff, 2006; Kushi et al., 2006).

Emotional Health and Well-Being

Distress is the most under reported, yet a common side effect of cancer. While initial distress in coping with diagnosis and treatment is expected, continuing distress may interfere with long term health. *Cancer Transitions* teaches program participants awareness of feelings survivors may experience after treatment, recognizing when they need support, and resources to obtain support. In the emotional health segment of the program, survivors learn mind-body activities and techniques to learn to express feelings, reduce and lower stress, and increase positive emotions, which can enhance their quality of life (Golant, 2007).

Quality of Life

As cancer patients go through treatment, they are often overwhelmed by the demands of treatment and put many other things on hold. The end of treatment may trigger different worries—“What’s next?” “What’s normal?” “How do I live as a cancer survivor?” Relationships with family, intimate partners,

friends, and co-workers may change following cancer treatment—making it even more challenging for survivors to cope. Research has shown that support groups may help reduce significant stress factors: loneliness, feeling that you have lost control, and a loss of hope. Cancer survivors may find themselves searching for meaning and inspiration in their cancer experience. Many cancer survivors remain optimistic, even when facing the challenges of their disease. One perspective for cancer survivors may be to view cancer as a second chance—an opportunity to make changes (Courneya et al., 2003; Barton-Burke, 2006).

Medical Management

One of the most important actions a cancer survivor can take is to communicate effectively with their health care team. Cancer survivors can improve communication with their health care team by keeping a health journal and preparing for physician visits by writing down any questions and concerns. One hidden medical issue for cancer survivors is pain- which often is not reported, recognized, or treated well. After cancer treatment, survivors may have heightened health risks. These health risks can be grouped into three categories: short, medium, and long term risks. Different cancer treatments may be linked with health risks to the heart, lungs, liver, eyes, joints, bones, mouth and teeth, and reproductive functions. Treatment for cancer may also raise the risk of secondary cancers. It is important that cancer survivors continue to manage any other health conditions they had before and during cancer treatment, such as diabetes or heart disease, after treatment ends (Polomano and Farrar, 2006; Stein et al., 2008).

Program Implementation Requirements

A. Ethics Approval

Each site was responsible for submitting and receiving approval from their local ethics review board to conduct the research component of the study. All relevant documentation (project protocol, consent forms etc.) were provided to each site by the BCCA project lead and research assistant.

B. Participant Recruitment

(i) Sample

Based on consultation with the CSC and the sites, a sample size of 12 to 20 post treatment survivors was agreed upon as an ideal group size. Recruitment for the program occurred via flyers, posters, newspaper articles, TV news items and other marketing efforts. Potential participants were pre screened for eligibility by phone.

Note: Due to timeline requirements and the need to wait for ethics approval, each site only had two to three weeks to market the program between late December 2008 and early January 2009.

(ii) Eligibility Criteria

Cancer survivor eligibility criteria to participate in the program:

- Adult cancer survivors, 21 years of age and older, of any cancer diagnosis
- Completed active anti cancer treatment within the past 0 to 24 months
- May be receiving hormonal or other similar adjuvant treatments
- Must have a signed release or similar approval from their physician to participate in exercise program

(iii) Consent Process

After potential participants had indicated an interest in participating in the program and had been screened for eligibility they were sent information from the program facilitator at the local site; introducing them to the program, and the evaluation study with its purpose and requirements for participation. They

received a detailed explanation of the questionnaires they would be asked to complete during the course of the program. The consent form was signed by each participant as well as a short waiver and release of liability agreement.

C. Settings for program delivery

- Provincial cancer centres
- Non-profit community cancer care centres

D. Site Requirements

1. A trained facilitator (two were trained from each site)
2. Experts to conduct set sessions (e.g. nutrition, medical management) or lead specific activities (e.g. exercise)
3. Administration (finances, marketing, recruitment)
4. Room space for program delivery

Data Collection

Evaluation Questionnaires/Measures

This was an open trial where the researchers knew the details of the intervention, and so did the participants. To test the feasibility and effectiveness of the intervention, participants completed validated self report questionnaires about the program content and their physical and psychosocial well-being at the first and last session of the program. Program feasibility was also assessed by participant recruitment, attendance and adherence.

Questionnaire Overview

A. Generalized Self-Efficacy Scale (GSE)

The GSE Scale was used to measure a broad sense of effectiveness and personal competence in dealing with a variety of demanding daily situations. The original version was developed by Matthias Jerusalem and Ralf Schwarzer in 1979, and is now available in 27 languages. This reliable tool has been shown to correlate positively with self esteem and optimism and negatively with anxiety, depression and physical symptoms. The scale has been used for a wide range of applications and although it is not specifically intended for cancer survivors it is designed to predict the ability to cope with challenges as well as adaptation after experiencing a stressful life event (Jerusalem and Schwarzer, 1992; Wegner et al., 1993).

B. Health Related Quality of Life (SF-12)

The SF-12 was used as a measure of health related quality of life. The SF-12 includes 12 items from the longer SF-36. Validation studies suggest that the shorter SF-12 derived from the Physical Health Component Scores (PCS) and Mental Health Component Scores (MCS) of the SF-36 are equivalent to the SF-36. The SF-12 includes items on physical functioning, role limitations due to physical health problems and emotional problems, bodily pain, general health

perceptions, vitality, social functioning, and general mental health (Gandek et al., 1998; Jenkinson et al., 1997).

C. Impact of Cancer (IOC)

The IOC was recently developed to measure quality of life in longer term cancer survivors. The questionnaire is comprised of 41 multiple choice items using a five point response format of: "strongly agree, agree, neutral, disagree, strongly disagree" for each item. There are 10 subscales: Health Awareness, Body Changes, Health Worries, Positive and Negative Self Evaluation, Positive and Negative Life Outlook, Social Life Interferences, Relationships, and the Meaning of Cancer (Zebrack et al., 2006). The scale is still in need of full validation; however, it was selected for use because the scale measures domains that are very relevant to the goals of the Cancer Transitions program.

D. Eating Patterns Questionnaire: Fat and Fiber Related Behaviour

The Eating Patterns Questionnaire is a self report 26 item food frequency questionnaire designed to measure food habits over the past month using a four point scale ranging from "usually or always" to "rarely or never". The questionnaire includes three areas: 1) Major food groups (represented by (a) Meat, fish and main dishes, (b) Breads, rolls, muffins and cereals, (c) Milk and cheese, and (d) Fruits, vegetables and salads), 2) Meal Patterns and 3) Food Preparation. The behaviour questionnaire is a dietary assessment instrument designed to assess habits related to food selection and intake. It was developed to assess the relevant dimensions of fat related dietary behavior and fiber related dietary behaviour. It has been shown to be a valid and reliable measure of change in dietary intake and is sensitive to modest dietary change (Shannon et al., 1997).

E. International Physical Activity Questionnaire (IPAQ)

The IPAQ questionnaire was developed for population surveillance of physical activity among adults. The questionnaire was developed and validated to provide internationally comparable data on health-related physical activity.

The questionnaire is comprised of 27 self reporting items that ask for the duration (in minutes) and frequency (in days) of low, moderate, and high levels of physical activity (Craig et al., 2003). Note: Although this tool has been used in intervention studies, it was not the original intended use of the measure. The IPAQ questionnaire was not created to measure change, just the prevalence rate of physical activity.

F. Group Experience Questionnaire

This measure is a 25 item questionnaire that contains the following dimensions: (a) Support: getting support and encouragement; making contact with someone who I could call on for help; belonging to and being accepted by the support group; and developing new friendships; (b) Disclosure: Talking about fears of death; discussing sexual concerns; expressing my true feelings (c) Existential: Owning up to maladjustment when it seems important, deepening my spiritual life, confronting difficult problems and fears; (d) Cognitive information: Getting honest feedback from others; gaining insight about myself; getting new understandings or explanations; getting direct advice, suggestions, or access to important information; and (e) Altruism: helping others.

G. Group Topics Questionnaire

This is a 30 item Likert type questionnaire that asks participants to rank how often have specific topics been discussed in the program sessions from “never” to “frequently”. Examples of group topics include financial problems, sexual concerns, and details of treatment or side effects. This questionnaire is used to provide information on the extent to which specific topical domains have been covered during the group sessions.

H. Weekly Program Evaluation Questionnaires

This is a 9 item questionnaire for the facilitator and a 12 item questionnaire for the participants. The questions asked for ranking of the session in relation to whether the information was relevant, comprehensive, organized and helpful. There are also questions at the end of each questionnaire that required written

responses as to what was most helpful about the session and how the session could be improved.

Analysis

A. Data and Record Keeping

Pre and post test participant coded questionnaires were completed at each of the four Canadian sites. The completed questionnaires were placed in an envelope that was sealed immediately and sent to the BCCA by registered mail.

The pre and post evaluation packages are being kept in a secure cabinet at the BCCA. Participants were coded with a unique code identifier. The list linking personal names and addresses to participant identifier codes was kept in secure files at each of the sites. It was not possible to use medical or background information to identify an individual who participated. No personal information that could be identified with a particular person in the evaluation will be released or published.

All of the data has been stored in a database on the BCCA institutional server, protected by a sophisticated firewall, with access limited to specific users at the discretion of the Project Director. The server is backed up daily.

B. Statistical Analysis

Pilot analysis has been completed and is included in this report. The data has been analyzed using SPSS 14.0 for Windows statistical software. The evaluation was both an impact and process evaluation. The primary outcome of the pilot was to assess program delivery feasibility in Canada. The secondary outcome was to evaluate whether participants demonstrate the ability to make improvement in a wide array of outcome indicators over the 6 week delivery period. The results are presented as descriptive and inferential statistics.

The difference between pre and post intervention data was analyzed for statistical significance. The statistical significance was determined by calculating the probability of error (p value) by the t-test ratio. The difference between the pre and post data was judged to be statistically significant when $p = 0.05$ or less. At $p = 0.05$, the difference between the pre and post data had only a 5% probability of occurring by chance alone.

The next step was to determine if the actual differences were clinically significant. Clinical significance was assessed by calculation the percent improvement. The convention is that a 25% improvement or greater represents a clinically significant difference. Firstly, the raw data scores were transformed to a 0 – 100 scale for all the measures using the following equation:

$$\text{Transformed scale} = \frac{\text{Actual raw score} - \text{Lowest possible raw score}}{\text{Possible raw score range}} \times 100$$

This transformation converts the lowest and highest possible scores to zero and one hundred respectively. Scores between these values represent the percentage of the total possible score achieved. Using the transformed data the percentage of improvement was calculated as follows:

$$\% \text{ Improvement} = \frac{\text{Post-test group mean} - \text{Pre-test group mean}}{\text{Pre-test group mean}} \times 100$$

Results: The Participants

Entire Cohort Demographics and Medical History

Sample characteristics (socio demographic and medical history) of cancer survivors (n=87) enrolled in *Cancer Transitions: Moving Beyond Treatment*

Sample characteristics		
Socio demographic characteristics		
	mean ± SD	
Age (years)	55.52 ± 9.22	
	n	%
Race/ethnicity		
White	71	81.6
Black/ African American	3	3.4
Chinese	2	2.3
Aboriginal (Inuit, Metis, NA Indian)	1	1.1
Korean	1	1.1
Latin American	1	1.1
South East Asian	1	1.1
Filipino	1	1.1
Japanese	1	1.1
Other	2	2.3
Gender		
Female	74	85.1
Male	10	11.5
Education		
Less than high school	4	4.6
Graduated from High School/GED	8	9.2
Completed Trade School	5	5.7
Some College	28	32.3
Bachelor's degree	20	23.0
Some Graduate School	6	6.9
Master's Degree	9	10.3
Ph.D., M.D., and/or J.D	4	4.6
Retired/unemployed	32	36.8
Income among employed		
<\$40,000	21	24.1
\$40,000 to \$100,000	38	43.6
≥\$100,000	16	18.4
Marital status		
Single/never married	11	12.6
Married or living as married	53	60.9
Separated/divorced	3	3.4

Widowed	5	5.7
Other	1	1.1
Medical history		
	<u>n</u>	<u>%</u>
Most recent cancer diagnosis		
Breast	43	49.4
Colon and rectal	8	9.2
Endometrial	3	3.4
Kidney	1	1.1
Leukemia	1	1.1
Lung	5	5.7
non Hodgkin's lymphoma	6	6.9
Prostate	3	3.4
Non melanoma skin	1	1.1
Thyroid	1	1.1
Other	10	11.5
Co morbid disease	52	59.8
Weight status*		
Underweight	3	3.4
Normal	30	34.5
Overweight	28	32.2
Obese	18	20.7
Cancer treatment included		
chemotherapy	60	69
Cancer treatment included radiation	51	58.6
Cancer treatment included biological		
therapy	8	9.2
Cancer treatment included Surgery	61	70.1
Cancer treatment included		
Immunotherapy	2	2.3
Cancer treatment included Bone marrow		
transplant	1	1.1

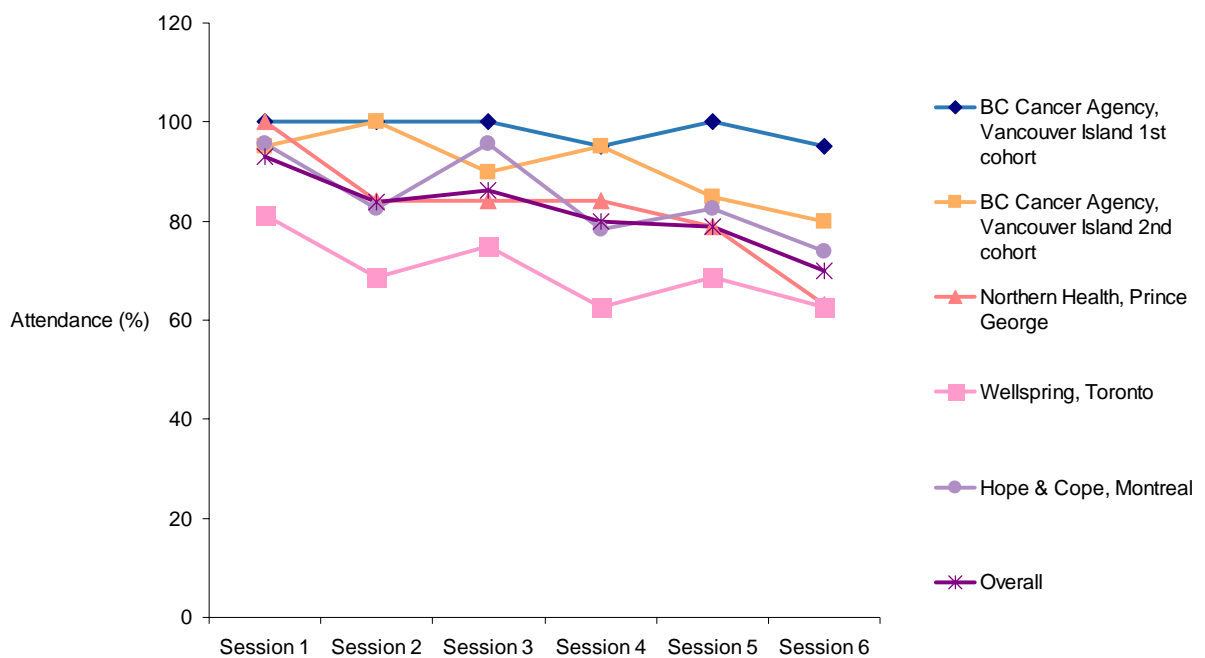
Of the 87 participants just over 70% identified as being “White” with the rest identifying as a number of racial backgrounds, the highest being Asian at 7%. The participants were mainly female (74%). The mean age was 55 years and ranged from 28 to 77years. Over 60% were married or living with a partner. Almost 45% had a college degree or higher and nearly 55% either worked part time or full time. Only one third were within the normal range for BMI. Half of the participants (49%) were survivors of breast cancer, with the remainder from a wide variety of cancer diagnoses, the highest being colorectal. Many participants had co morbid conditions.

Results: Program Attendance

Adherence and retention

	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
Site 1 Vancouver Island (1 st cohort)	100.0%	100.0%	100.0%	95.0%	100.0%	95.0%
Site 1 Vancouver Island (2 nd cohort)	95.0%	100.0%	90.0%	95.0%	85.0%	80.0%
Site 2 Northern Health	100.0%	84.2%	84.2%	84.2%	78.9%	63.2%
Site 3 Toronto	81.3%	68.8%	75.0%	62.5%	68.8%	62.5%
Site 4 Montreal	95.7%	82.6%	95.7%	78.3%	82.6%	73.9%
Overall	93.0%	83.9%	86.2%	80.0%	78.8%	70.0%

Participation of cancer survivors (n=87) participating in *Cancer Transitions*



Feasibility: Recruitment, Adherence and Retention

In total 87 participants were recruited; 32 at Site 1- Vancouver Island (1st [12] and 2nd [20] cohort), 16 at Site 2- Prince George, 16 at Site 3-Toronto and 23 at Site 4- Montreal. As mentioned in the methods the recruitment timeframe was very narrow due to ethics approval requirements (only two to three weeks between late December and early January). In the case of Site 3 (Toronto), recruitment was lower than expected and therefore they delayed their program delivery until March. The CSC (USA) recruitment ranged from 8 to 25 participants at their 15 pilot sites.

Of those who registered in the Canadian program, 93% started the program. The retention rate over the six weeks was very good, especially considering some participants had long distance travel and mid winter issues to consider. For example, one man in Northern BC had to drive 250 km round trip to attend the program each week. At the last session, the attendance was 71%, an attrition of 20% from session 1. This correlates with the adherence rates for the CSC pilots (pilot 1 attrition = 18%, pilot 2 attrition = 28%).

Results: Eating Patterns

The validated Eating Patterns Questionnaire included 26 questions and measured the effect of the intervention on participant's eating patterns primarily related to dietary fat and fibre. For the purpose of statistical analysis the questionnaire was divided into nine subscales. The number of questions included in the subscales ranged from two to seven with some questions utilized more than once.

Overall from pre to post program (six weeks) analysis there was a statistically significant improvement in the eating patterns ($p < 0.05$) and improvements in four subscales: "Modify Meat", "Substitute Lower Fat Products", "Replace with Fruits and Vegetables" and "Increase Fruits and Vegetables". In the remaining four subscales, "Replace Meats", "Avoid Fat as Flavouring", "Substitute with Higher Fibre" and "Whole Grain" results were not statistically significant but there was mean improvement except for replacing meats.

At three months follow up there was still a statistically significant improvement in the eating patterns ($p < 0.05$) compared to pre program. However, only "Replace with Fruits and Vegetables" and "Substitute with Higher Fibre" showed a statistically significant improvement at the three month follow up. Aside from "Whole Grains", all remaining subscales did show a continued mean improvement, but in some were less than that seen at the post program (six week) analysis. There may have been some regression back to pre program eating habits.

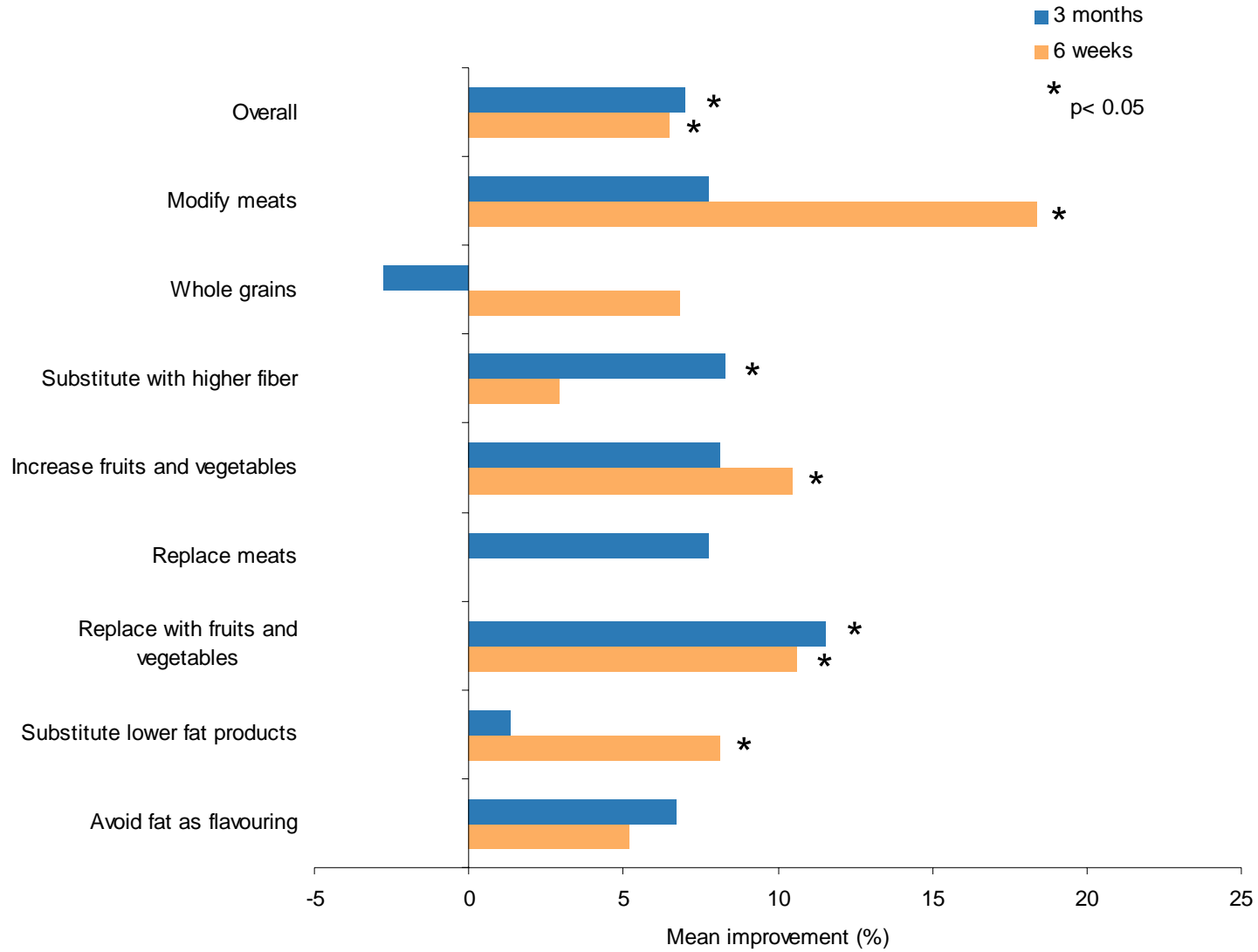
The results of this pilot study are encouraging regarding eating habits. In this and other programs, the inclusion of healthy eating information for survivors is important as there is evidence to suggest that maintaining a healthy body weight and a lower fat intake has benefits in improving quality of life, reducing the risk of cancer recurrence and potentially improving survival.

Percentage of Mean Improvement in Eating Patterns

	Post	3 month
Avoid Fat as Flavouring	5.18%	6.74%
Substitute Lower Fat Products	8.15%*	1.36%
Replace with Fruits and Vegetables	10.61%*	11.56%*
Replace Meats	0.00%	7.73%
Increase Fruits and Vegetables	10.47%*	8.11%
Substitute with Higher Fiber	2.92%	8.31%*
Whole Grains	6.85%	-2.77%
Modify Meats	18.37%*	7.76%
Overall	6.50%*	6.97%*

Note. * $p < 0.05$

Changes in Dietary Behaviours



Impact of Cancer (IOC)

The IOC covers five different subgroups: “life outlook”, “body and health”, “feelings about cancer”, “meaning of cancer”, and “activities and relationships”. The subgroups are divided into two overarching IOC outlooks, either positive or negative. The questionnaire is still undergoing validation and it has since been discovered that the positive IOC does not correlate directly with improved quality of life. The positive changes are related in more specific ways to other indexes of adjustment (Bellizzi et al., 2007). In consultation with the CSC it was decided that the positive IOC would data would not be reported. In designing interventions the greatest benefit may likely be achieved by reducing the negative effects of cancer.

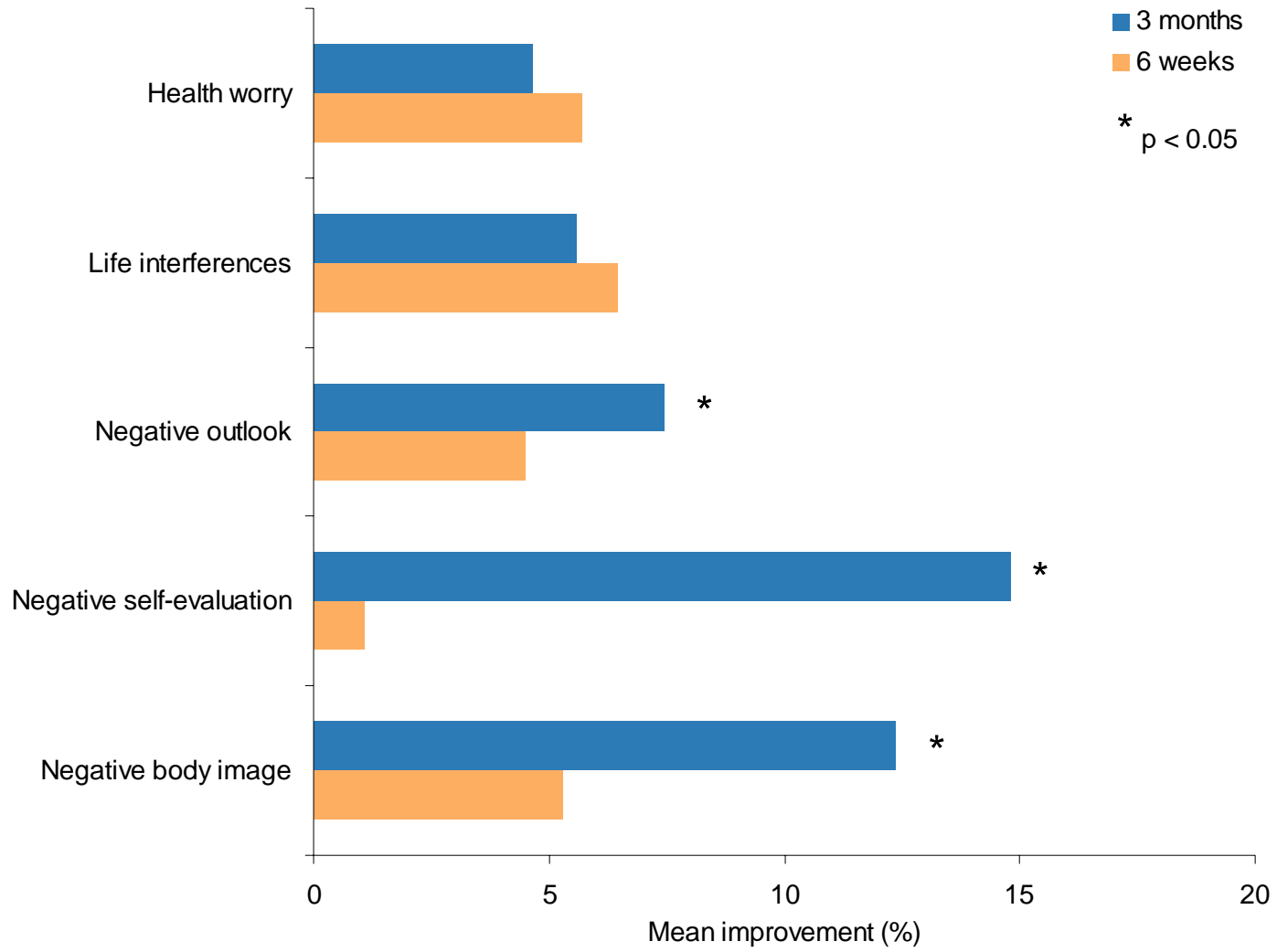
When comparing to the pre test evaluation there were trends to improvement (i.e. a reduction in the negative impact of cancer) for all the subscales. There were improvements for all subscales at both post (six weeks) and three month follow up. “Negative Body Image”, “Negative Self Evaluation”, and “Negative Outlook” were statistically significant at three months. Two subscales did not show a statistically significant trend: “life Interferences” and “Health Worry”, while not statistically significant, the trends were still showing a decrease in the negative impact of cancer after the program took place.

Percentage of Mean Improvement in the Negative Impact of Cancer

	Post	3 month
Negative Body Image	5.31%	12.35%*
Negative Self-Evaluation	1.07%	14.80%*
Negative Outlook	4.52%	7.47%*
Life Interferences	6.44%	5.59%
Health Worry	5.71%	4.66%

Note. * $p < 0.05$

Changes in the Negative Impact of Cancer



General Self-Efficacy (GSE)

The GSE Scale was used to measure a broad sense of effectiveness and personal competence in dealing with a variety of demanding daily situations. The scale has been used for a wide range of applications and although it is not specifically intended for cancer survivors, it is designed to predict the ability to cope with challenges as well as adaptation after experiencing a stressful life event.

People with a high self-efficacy set higher goals and tend to adhere to these goals for longer in comparison to those with a low self-efficacy. Actions are pre shaped in thought, and once an action has been taken, highly self efficacious people invest more effort and persist longer than those low in self-efficacy. Interestingly, when setbacks occur, they recover more quickly, cope with adversity, and remain committed to their goals. (Scholz et al., 2002).

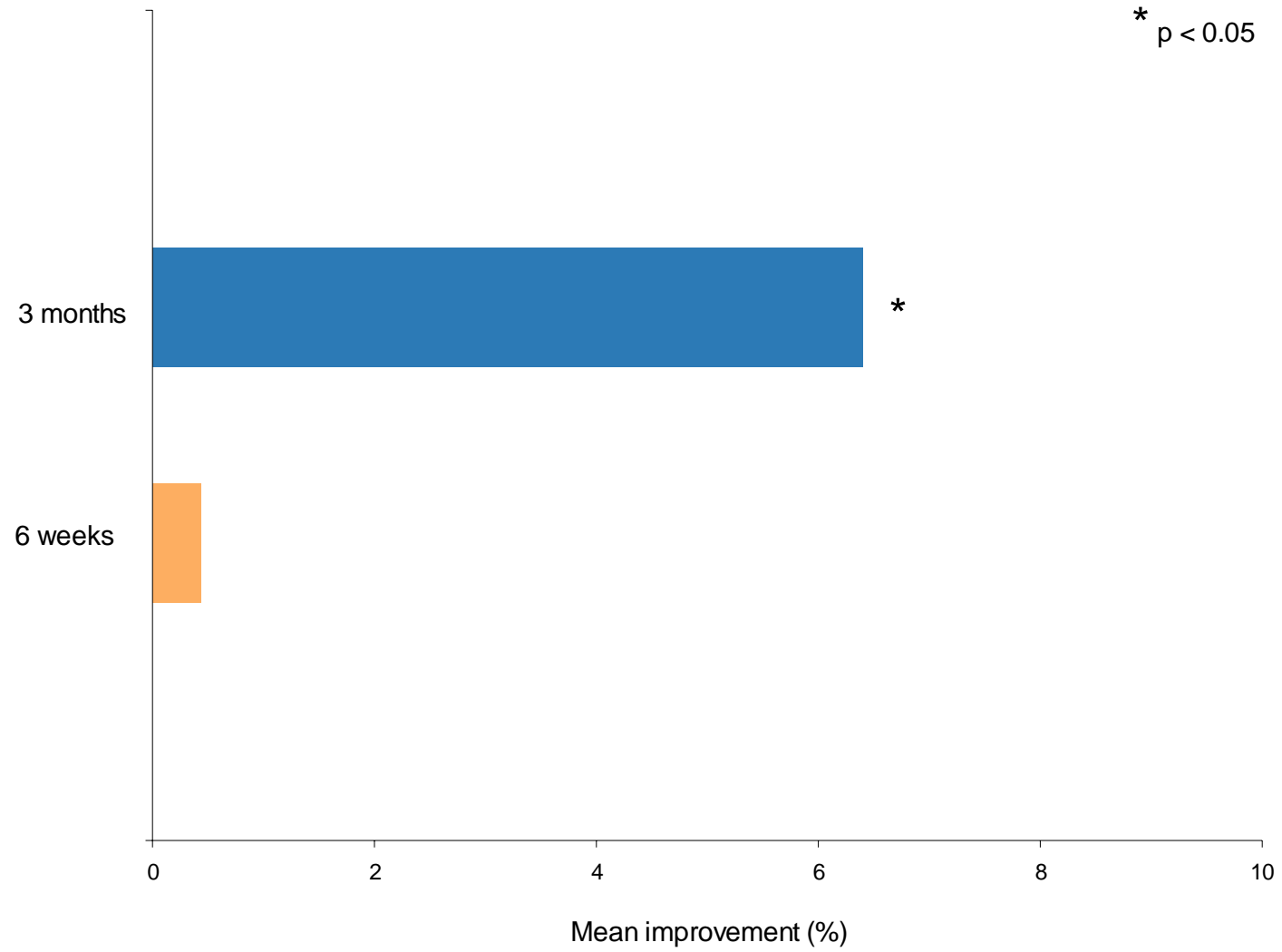
There was a very slight mean increase in GSE, but no significant improvement over the course of the program (zero to six weeks). However, there was a significant improvement ($p < 0.05$) in general self-efficacy at the three month post program. The results may indicate the program helped participants adjust and manage their survival. People who seek out programs such as Cancer Transitions are often motivated to adapt, make changes, and acquire new coping mechanisms. For example, to quote a participant from Site 4 – Montreal: *“I prefer a more pro active approach whereby I am more in control of my destiny”*.

Percentage of Mean Improvement in General Self-Efficacy

	Post	3 month
General Self Efficacy	0.44%	6.40%*

Note. * $p < 0.05$

Changes in Generalized Self-Efficacy



Health Related QOL: SF-12

The SF-12 was used as a measure of health related quality of life. It includes items on physical functioning, role limitations due to physical health problems and emotional problems, bodily pain, general health perceptions, vitality, social functioning, and general mental health.

“Physical Functioning” (see table and graph) refers to moderate activity such as moving a table, pushing a vacuum cleaner, climbing several flights of stairs, bowling or playing golf. “Physical Accomplishment” measures these daily activities in terms of a general sense of accomplishment and execution without limitations. “Social Functioning” refers to social activities such as visiting friends and relatives, and “Emotional Accomplishment” is a sense of achievement or improvement on an emotional level. “Vitality” is a measure of the participant’s general sense of the amount of energy they had available for various activities.

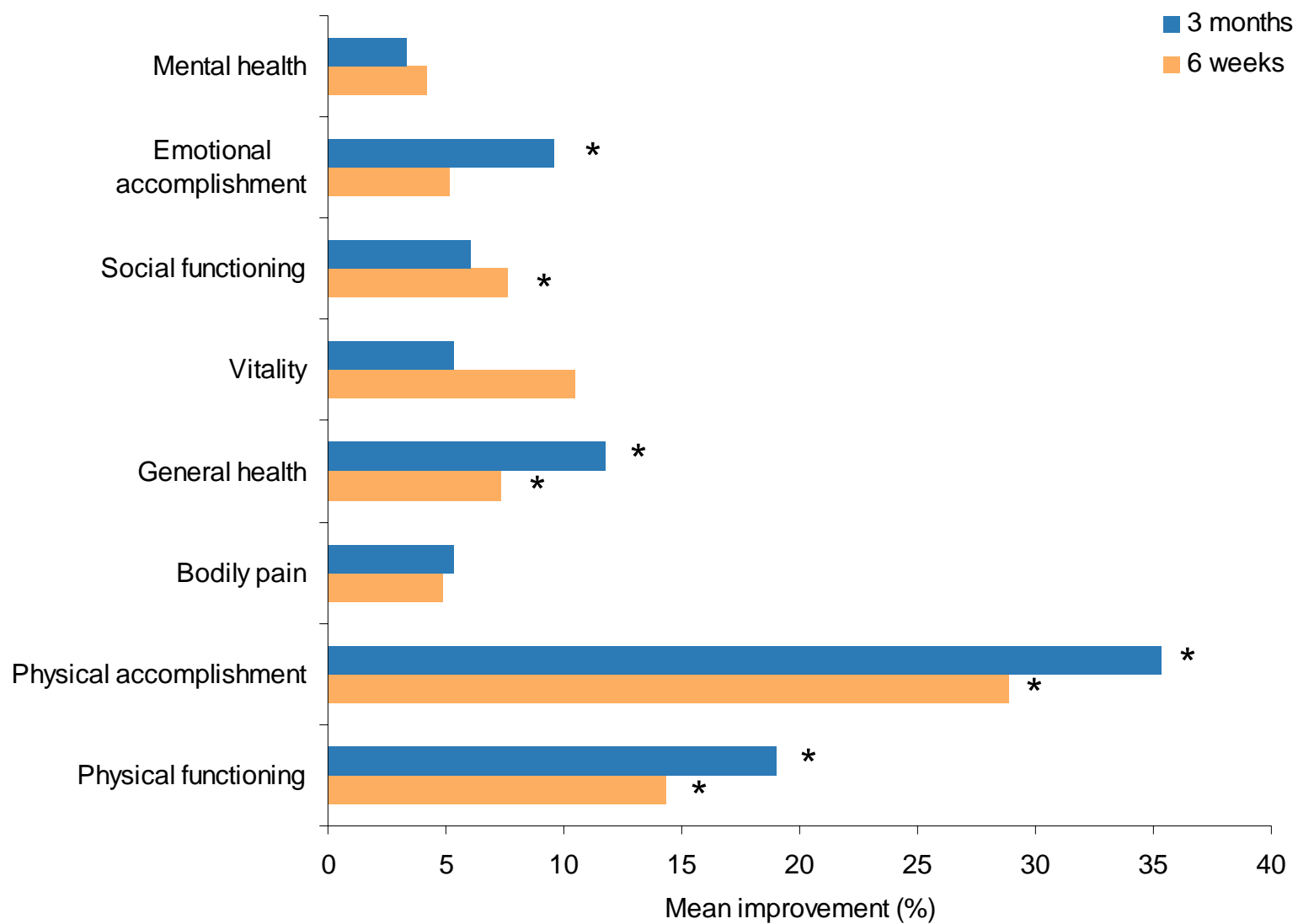
There was a significant improvement ($p < 0.05$) in many of the subscales at both the six week and the three month evaluation. Looking at the post program (six week) evaluation, “Physical Functioning” and a sense of “Physical Accomplishment”, “General Health” and “Social Functioning” were all significant. The other measures, although not significant, also showed trends that indicated improvement. The smallest improvements were seen in “Mental Health”, “Emotional Accomplishment” and “Body Pain” (a mean improvement for “Body Pain” means lack of pain). At the three month evaluation post program, “Physical Functioning” and a sense of “Physical Accomplishment”, and “General Health” remained significant and “Emotional Accomplishment” significantly improved as well.

Percentage of Mean Improvement in Health Related Quality of Life

	Post	3 months
Physical Functioning	14.37%*	18.98%*
Physical Accomplishment	28.83%*	35.34%*
Bodily Pain	4.83%	5.39%
General Health	7.38%*	11.76%*
Vitality	10.53%	5.36%
Social Functioning	7.61%*	6.10%
Emotional Accomplishment	5.13%	9.57%*
Mental Health	4.21%	3.36%

Note. * $p < 0.05$

Changes in Health Related Quality of Life



International Physical Activity Questionnaire (IPAQ)

The physical activity self report questionnaire examines the engagement in specific low, moderate, and vigorous levels of physical activity. Raw minutes of physical activity per week were analyzed pre test, post test (six weeks), and at three months (after session 6) to examine any differences physical activity.

Overall, *total minutes* of physical activity *increased* at the three month follow up, although this finding was not significant. Low levels of physical activity increased post program and three months ($p=0.05$) compared with baseline reports of physical activity. Low levels of physical activity in the IPAQ were represented as “during the last 7 days, on how many days did you walk for at least 10 minutes”. Moderate levels of physical activity, such as house and yard chores, cycling, and leisure activity with moderate physical exertion, showed a slight drop post program, but then showed an increase in activity after three months, although these findings were not significant. High levels of physical activity, such as vigorous yard and leisure physical exertion showed a small increase in activity post program and at the three month follow up, but mean minutes per week was only five minutes, and thus not statistically significant.

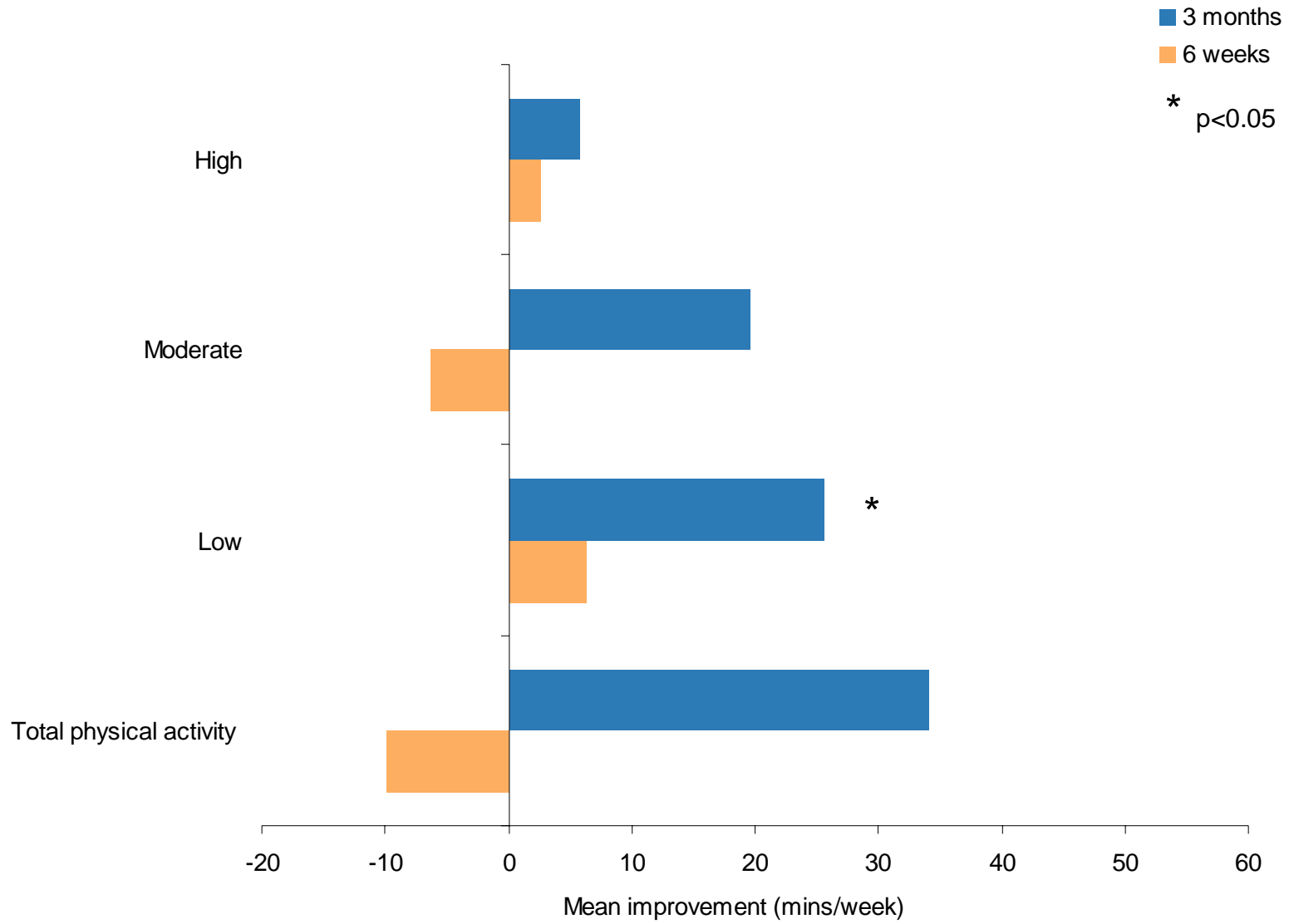
The standard deviation for the sample was quite large for all levels of physical activity. The participants varied on their activity levels, from < 1 hour to 14 hours of physical activity every week. The variability of the sample therefore did not produce a normal distribution.

Weekly changes in minutes of Physical Activity

	Post mins/wk	3 month mins/wk
Total Physical Activity	-9.89	34.14
Low Physical Activity	6.25	25.61*
Moderate Physical Activity	-6.37	19.58
High Physical Activity	2.57	5.82

Note. * $p < 0.05$

Changes in Physical Activity



Group Experience

Experiences listed by top ten most important group experience

Group Experience											
Overall Ranking 1 to 10	Overall %	Site 1- First Program		Site 1- Second Program		Site 2		Site 3		Site 4	
		Rank	%	Rank	%	Rank	%	Rank	%	Rank	%
Getting support and encouragement 1	81	4	75	2	85	4	77	1	92	4	80
Getting direct advice, suggestions, or education 2	81	1	82	5	78	1	89	2	75	3	82
Gaining access to important information 3	80	5	70	3	84	2	80	5	69	2	86
Learning that my problems aren't unique 4	79	3	75	1	88	9	68	12	60	1	87
Getting new understandings or explanations 5	75	2	75	4	78	3	78	6	69	7	74
Developing a new attitude towards life 6	71	10	64	7	73	10	68	3	75	10	71
Learning that I am responsible for how I cope with my life 7	70	13	61	6	75	5	75	11	60	11	68
Becoming hopeful 8	69	8	66	9	69	14	64	9	64	5	77
Changing my behaviour in ways that feel satisfying 9	69	16	59	8	71	11	68	20	43	6	76
Gaining insight about myself 10	67	6	70	15	59	7	70	13	56	8	73

This measure is a 25 item questionnaire that contains questions around experience dimensions such as; getting support and encouragement, disclosing fears of recurrence and death, admitting to maladjustment, and getting honest feedback from others. The table shows the top ten experiences rated as percentages. In addition, the table provides the overall ranking by sites. The results indicate that the support, advice and information that participants received over the course of the program were rated very highly. New attitudes and insight were valued, as well as taking responsibility for coping and behavioural changes. The ranking for each of the sites in general showed consensus on the most important experiences the program provided.

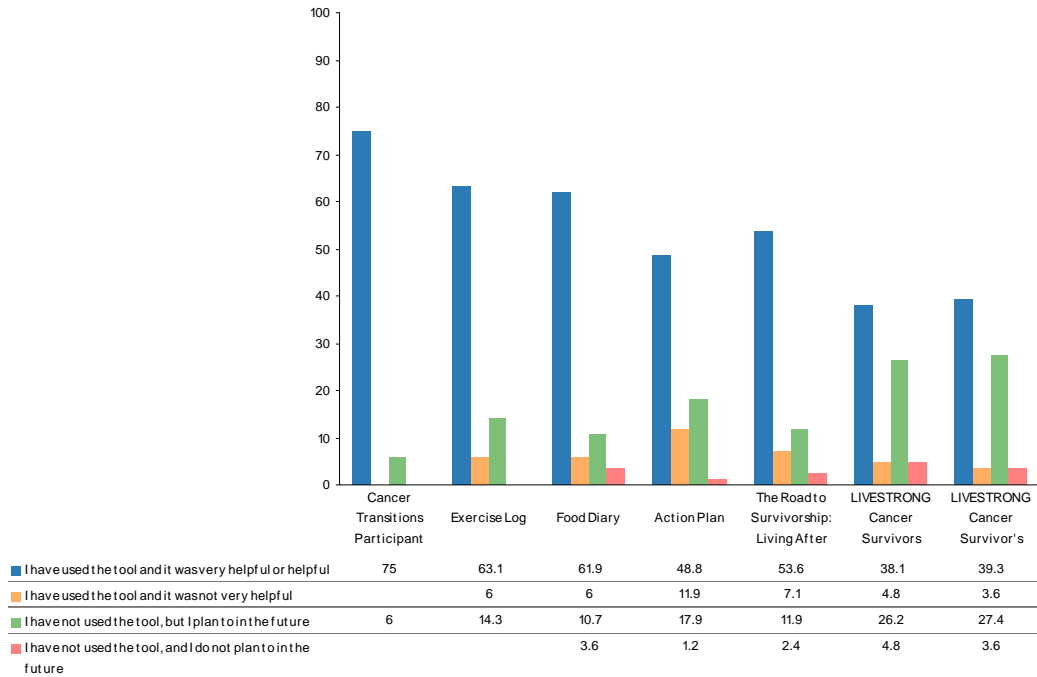
Group Topics

Top ten most frequently discussed group topics

Group Topics												
Overall Ranking 1 to 10	Overall %	Site 1- First Program		Site 1- Second Program		Site 2		Site 3		Site 4		
		Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	
1.	Thinking positively	80	3	70	5	74	1	91	2	84	2	82
2.	Access to resources for coping with cancer	78	1	80	1	81	4	77	1	84	5	73
3.	Communication with physicians and medical personnel	76	2	75	4	74	3	77	5	73	3	81
4.	Details of treatment or side effects	76	6	66	6	74	2	80	7	70	1	84
5.	Direct advice about physicians, treatments, side effects	72	4	68	3	76	9	61	8	68	4	77
6.	Recreation	71	7	64	2	79	7	70	9	68	8	69
7.	Confronting difficult problems and fears	65	5	66	7	65	15	52	6	73	7	69
8.	How you feel when others express fear, sadness, or anger	59	23	40	9	60	8	64	19	61	9	62
9.	One's accomplishments	59	8	61	18	46	5	73	14	64	10	59
10.	Encouraging each other to be more assertive	58	12	52	16	49	14	55	20	61	6	69

This measure was a 30 item questionnaire that ranked how often specific topics had been discussed in the program sessions, from “never” to “frequently”. This questionnaire was used to provide information on the extent to which specific topical domains were focused on during the group sessions. The table shows the top ten topics and rates them as a percentage. In addition, the table provides an overall ranking by site. The results indicate that overall participants felt that the topics concentrated on most frequently included thinking positively, how to access relevant resources and information, and how to communicate with medical personnel in an effective manner to gain advice and knowledge about treatments and side effects. In addition, coping, building self confidence and assertiveness also ranked very highly. The ranking for each of the sites in general showed consensus on the most frequently discussed program topics.

Program Material



Overall, the participant workbook was well received with 75% of the participants finding it very helpful or helpful. Only 6% did not use the material, but planned to do so in the future. There were no participants that said they had used the workbook and did not find it helpful, or participants that had not used and did not plan to use the workbook in the future.

The exercise log, food diary and action plan which are part of the workbook were also rated very highly. Except for the exercise log these tools were not monitored by the facilitators. The intention is that the use of these tools can continue after program completion and that they contribute to long term survivorship planning and self management. Of those who had used the tools, 6% found the exercise log not very helpful, 6% the food diary, and 12% the action plan. Between 11% and 18% had not used these tools, but planned to do so in the future. However, 4% had not used the food diary and did not plan to in the future and just over 1% had not used the action plan and did not plan to in the future.

The **LIVESTRONG** health and medical journals were also part of the workbook. They were equally used by approximately 40% of the participants, however, close to 30% of the participants planned to use the material in the future, so to some extent this lower usage may have reflected a lack of time to use the tool. Just below 5% had used the journals and did not plan to use them in the future, or had not used them and did not intend to use them in the future. There was some suggestion by both the participants and the facilitators that these journals would have been useful earlier in the cancer trajectory when they were first diagnosed with cancer.

The “*The Road to Cancer Survivorship*” supplementary material was found to be helpful by just over 50% of the participants, close to 12% had not read it but did plan to do so in the future. Under 10% had either used it and not found it very helpful, or had not used it and didn’t plan to use it in the future.

From the qualitative feedback it was noted that promotion and emphasis placed on the use of the supplementary material varied between facilitators.

Overall facilitator feedback on each session:

Repeating themes (in no particular order)

Facilitator: Session 1

Improvements needed:

- Too much information to cover (evaluation material took too long)
- Need to allow time for guidance on workbook and supplementary material/ introduce these gradually
- More time for sharing
- More time and discussion around what is meant by survivorship

Facilitator: Session 2

Improvements needed:

- Very basic – did not allow for past experience
- Include more take home examples, workout templates – not just general guidelines
- Specific modifications for survivors
- Discussion – lack of energy, loss of endurance
- Research to back benefits of exercise and cancer

Facilitator: Session 3

Improvements needed:

- More time to cover material – topics need to be adequately and respectfully addressed
- Offer more practical coping skills

Facilitator: Session 4

Improvements needed:

- Adaption for Canadian content
- More time to cover material

Facilitator: Session 5

Improvements needed:

- More depth e.g. long term/late effects
- Research evidence

Facilitator: Session 6

Improvements needed:

- Did not meet the needs of the groups
- More review/ focus on closure

Qualitative participant feedback on each session:

*Written responses from weekly questionnaires
Repeating themes (in no particular order)*

Participant feedback: Session 1

Most helpful:

- Information
- Support
- Discussion
- Sharing experiences
- Exercise
- Not alone/relate to others
- Meaning of survivorship

Improvements needed:

- More discussion
- Too much info/ rushed – more time
- Workbooks in advance

Participant feedback: Session 2

Most helpful:

- Learning new exercises
- Customizing exercises to individual need
- Discussion

Improvements needed:

- Provide more alternatives e.g. yoga, swimming
- More discussion
- More time

Participant feedback: Session 3

Most helpful:

- Sharing – realizing your recovery time/feelings are normal
- Discussion
- Exercise

Improvements needed:

- More time/discussion – make this two sessions

Participant feedback: Session 4

Most helpful:

- Daily food guidelines
- Healthy food choices and ideas
- Weekly assignments appreciated for accountability
- Exercise
- Discussion

Improvements needed:

- Resources/reading material

- Discussion time

Participant feedback: Session 5

Most helpful:

- Specific medical information and how to get it
- Discussion
- Exercise

Improvements needed:

- More time for discussion and explanation
- Health plan at diagnosis

Participant feedback: Session 6

Most helpful:

- Discussion and sharing
- Exercise

Improvements needed:

- More discussion time

Summary tables of the participant and facilitator evaluation of the weekly sessions can be found in Appendix H. Overall the data indicated that the weekly sessions were well received by both the participants and the facilitators. Reiterated in this quantitative data was the need for more discussion time. The participant weekly assignments were not always found helpful in preparing for the sessions and sometimes the facilitators found that the facilitator guide was not as supportive or as relevant as it could be.

Qualitative Facilitator Evaluation

Recurring Themes:

One on one interviews and group teleconferences

The facilitators appreciated the program because it gave them a deeper understanding of the needs of cancer survivors. The program was a good introduction to many topics that are important to survivors and the content was relevant and very helpful in addressing change and transition. It was suggested that a “Transition Model” might be helpful as a tool to teach post traumatic growth and transition.

There was a substantial amount of material to cover in many of the sessions and some of the issues were very complex and needed more time in order to provide depth. In particular, there was too much to cover in Session 3, and no time to introduce coping skills/tools. In contrast, there was not enough material in Session 6 and it was suggested that some of the material in Session 3 be added to Session 6. Session 6 would be a good time to find meaning and growth and to celebrate new strengths. Ideally, with all the sessions the facilitators needed time to raise issues, time to let the participants think, and then time for discussion as well as time to introduce coping tools where appropriate.

Exercise was an integral part of each session and generally very well received; however, it was felt that it would have been helpful to spend more time adapting exercises based on the participants’ prior experience. In addition, there was a desire to have more practical information rather than theoretical.

The facilitator guide and participant workbook provide structure, but they rely on an experienced facilitator for interpretation and instruction. It was very helpful to have facilitators who were experts in their field join the sessions, such as the nutritionist or the exercise specialist. The strength of the program is very dependent on good facilitators who know how to present the material.

The extra supplementary material and tools were useful to have symbolically and helped to contribute to a plan of action. However, it was noted that the facilitators had to be careful not to overwhelm the participants with too much material too quickly. There needed to be clear guidance on how to use the

extra material. For future revisions to the program, it would be helpful for the facilitators to review the food and exercise journals on a weekly basis to provide feedback. However, it should be noted that the facilitators had the impression the participants valued and enjoyed the process above actually using the materials.

For this program to be applied in the Canadian context, the addition of Canadian resources was recommended. For example, details regarding employment and medical insurance, both federal and provincial programs. There were contradictory feelings regarding the helpfulness of the medical records section provided in Session 5.

The facilitators were not convinced that this is the only program for cancer survivors. However, they definitely felt it was worthwhile, and they provided suggestions as to where the program needed some enhancements. It was suggested this program was a good introductory program and would be useful in conjunction with other programs.

Finally, it was beneficial to offer the program to a group of survivors from different tumour types. It added diversity and it was more about common issues they shared rather than what was different. The interest generated by the program and the wait lists of prospective participants indicates there is clearly a need for this type of survivorship program. The participants really appreciated being heard and there was a great sense of comradeship within the groups.

Quotes from participant cancer survivors.....

“It has been a great course and I’m so grateful for this opportunity. Thank you to the facilitators and also the members during the sessions”

“Our leader has been a wonderful teacher and inspiration – thank you! Also much appreciation to our exercise coach and guest speakers”

“The [exercise] instructor was very helpful at conveying options depending on the physical capabilities of the individual”

“The nutritionist was very knowledgeable and well informed”

“I realize now that it’s not just me – I’m normal”

“I’ve noticed I’ve moved forward in my wellness”

“This program was very helpful to me at this stage of the recuperation. Very valuable information. Thanks for everything”

“I will enjoy life. I will work to get stronger. I am responsible for my fitness and food choices so the better I work out and eat wisely the healthier I will be”

Site Operational Costs

Average estimate per site costs:

Human Resources approx: \$2,500

Facilitator/Leader: \$200 per session x 6 = \$1,200

Exercise Leader: \$200 x 1, \$75 x 5 = \$575

Nutrition Leader: \$200 x 1 = \$200

Medical/Nursing Leader: \$200 x 1 = \$200

Administration: \$300

Note: facilitator costs include preparation and consultation time. Administration included booking rooms, registration, material preparation and inquiries.

Material Resources approx (based on 20 participants): \$1,000+mailing

BCCA direct printing costs (CDN \$):

Participant Workbooks: \$28 each

Facilitator Guide: \$28 each

Shipping (in Canada): \$ variable

Pedometers (optional purchase): \$5 to \$10 each

(Note: the cost of the program materials can be reduced by bulk ordering)

Other site resources (e.g. marketing material): approx. \$500

Note: Room Rentals were not applicable for pilot sites but may be required for some new sites

Based on the above estimates human resources and material costs the program can be offered for approximately **\$3,500**

Study Limitations

1. Absence of a control group. In future studies, the inclusion of a control group would allow us to measure possible spontaneous improvement over time. The team is currently considering a Randomized Control Trial in Canada
2. Sample size (N = 87). For some of the questionnaires the N value should exceed 100 participants in order reach a power of analysis that gives a 95% confidence that the measured differences are significant.
3. Questionnaires. One of the questionnaires, the IOC, had not been fully validated.

Future Considerations for Ongoing Research Evaluation:

1. Except for the IOC, the questionnaires are not specifically intended for cancer survivors. It is recommended that a review of relevant measures/questionnaires is conducted in relation to the desired primary and secondary outcomes to be measured.
2. In order to see if self monitoring has an impact, evaluation of logs and journals would be useful.
3. To monitor the sustainability of the improvements observed it would be beneficial to include a six month and one year follow up.
4. Influence of site variations and external factors, for example the natural variation in facilitator delivery of the program.
5. There may have been subgroups of participants that showed more or less change, according to for example, sex, age, or cancer diagnosis. More detailed analysis of outliers may prove valuable.

Phase I Accomplishments

- Identification of four potential program sites
- Facilitator training
- Ethics application submission
- Marketing (media, newspapers, flyers, posters) and participant recruitment material development
- Site and personnel organization for program delivery
- Participant eligibility interviews
- Site and personnel organization
- Pilot Program delivery (January – May 2009)
- Pre and post evaluations and data analysis
- Preliminary progress report to CJAG (June 2009)

Phase II March 2009 – March 2010

Based on the results of the pilot program delivery and research evaluation funding was provided by the CJAG for Phase II. Phase II consisted of modifying the program materials in order to provide Canadian content and context and implementing training sessions to train more facilitators to deliver the program across Canada.

Canadian Cancer Transitions participant workbooks and facilitator guides

Cancer Transitions program materials (facilitator guide and participant workbook) were reviewed in detail by Dr. Amanda Ward and Ms. Joanne Magtoto. Recommended additions and revisions were circulated to the Steering Group for feedback and then forwarded to our consultants at Cancer Support Community.

Changes included insertion of relevant references and text for the Canadian context (e.g. Canadian Employment Laws), language changes and metric conversions. Dr. Ward and the BCCA Technology Development Office negotiated with Cancer Support Community and **LIVESTRONG** to develop a licensing agreement for the Canadian version of the Cancer Transitions program. At all times, CSC and **LIVESTRONG** have endeavored to be inclusive and cognizant of requested needs in order to make the program sustainable in Canada.

The Canadian edition of the *Cancer Transitions* materials is now available to all facilitators across Canada. The participant workbook and facilitator guide can be ordered from the BCCA by contacting Joanne Magtoto at:

Cancer Rehabilitation, 600-750 West Broadway, Vancouver, BC, V5Z 1H5,
or jmagtoto@bccancer.bc.ca.

The costs of the guide and workbook are approximately \$28/each (bulk ordering of over 100 copies reduces the cost). Shipping costs are charged in addition to the printing costs.

Cancer Transitions Facilitator Training

In order to expand delivery of the program facilitator training workshops were hosted at two locations in Eastern (Ottawa) and Western (Vancouver) Canada during the fall of 2009. Instructed by the Project Leader, Dr. Ward, from the BCCA and experienced facilitators (Dr. Golant and Mrs. Ahmed from CSC, Ms. Payeur from BCCA Vancouver Is, and Ms. Ahlstrom from BC Northern Health Authority) the objective of the workshops was to inform and train facilitators from across Canada to be able to deliver the *Cancer Transitions* program. In total, forty experienced group facilitators mainly with backgrounds in social work and clinical counseling were trained to deliver the program. They came from provincial cancer agencies, community organizations, hospitals and cancer foundations (Appendix I). All provinces were represented in the training with exception to Alberta, Newfoundland, and the Territories.

The first day started with an overview of the Cancer Transitions program (for agenda see Appendix J). After the overview there was a group exercise; the facilitators were split into six groups and were assigned a program session to review. In addition to reviewing the session material, the facilitators were also asked to identify key messages, key activities, challenges, and “local colour” for their assigned session. Then as each session was introduced to the group, the session information developed during the group exercise was presented to the larger group (Appendix K). Trainee facilitators were encouraged throughout the training to ask questions and make comments on the program structure and content. The information generated during the exercise was circulated to all the trainees after the workshops to aid with program implementation at their sites.

The second day of the workshop consisted of reviewing best practice guidelines. Best practice topics that were discussed included participant eligibility, demographics, recruitment, and marketing strategies (Appendix K). Interesting discussions also occurred around rural and remote delivery logistics and potential partnerships and collaborations for program sustainability.

Facilitators were introduced to the value of evidence based research guiding clinical practice with a presentation that highlighted the benefits of participating in the research evaluation for *Cancer Transitions*. The pilot data and interpretation for the Canadian pilots was presented by Dr. Ward, and the American Cancer Transitions program results were presented by Dr. Golant from the CSC at the East Training, and Mrs. Ahmed from the CSC at the West Training. Facilitators were asked to consider implementing the evaluation component at their organization for two reasons, firstly to provide their sites with research evidence to support the program and, secondly, to enable the research team to continue to evaluate the Cancer Transitions program and participant outcomes during Phase II. The facilitators were informed that their site evaluation would become part of a larger national study and the interpretation for their site data would be made fully available to them at the end of the study.

At the end of the training, the facilitators were asked to anonymous evaluate the facilitator training for quality of training, helpfulness of presentations, and usefulness of group exercises. The Ottawa group was emailed the evaluation form and eight were returned completed. An example of one evaluation form completed by a participant can be found in Appendix L. The Vancouver group was given the evaluation form at the meeting and fifteen were completed at the end of the meeting. Paper copies of all the evaluation will be mailed to the CJAG for their records. The program training was viewed as a great success and was very well received by all the participants. Facilitators particularly enjoyed the group exercises and the ability to collaborate amongst their colleagues and to share how they planned to initiate this program at their own organization. Several trainees suggested it would have been helpful to have the facilitator guide mailed to them prior to the training.

In total, there are now 24 sites with trained facilitators that can deliver the *Cancer Transitions* program in Canada.

**Cancer Transitions EAST Facilitator Training: Ottawa
October 22 and 23rd, 2009**



**Cancer Transitions WEST Facilitator Training: Vancouver
November 24th and 25th, 2009**



Cancer Transitions Ongoing Program Implementation

To date, 11 of the 20 sites trained have plans to deliver the program in the spring or fall of 2010 (Appendix M). One of the sites delivered the program directly after the training in November of 2009. Of the 11 sites, six have agreed to participate in the research evaluation of the program. Dr. Amanda Ward and Ms. Joanne Magtoto will continue to provide consultation to the sites; this includes assistance with research ethics, research materials, and evaluation of research evaluation questionnaires.

Canadian Cancer Transitions Program Materials Bursary

To assist with the sustainability of the Cancer Transitions program CJAG project funds were used to cover the cost of the Cancer Transitions program materials for sites that completed an application form and qualified for a Bursary (see Appendix N). Awards were based on a range of criteria were used including evidence of capacity to implement and sustain Cancer Transitions, demonstration of financial need not met by other available sources, and the number of applications submitted in relation to the total funds available. Those that applied and received the Bursary Award are listed in Appendix O. There are two Award periods: April 1st to September 30th, and October 1st to March 31st 2011. A second call for applications will be sent out September 1st 2010. As a result of bulk ordering the cost of the guide and workbook were reduced to \$22.34.

Cancer Transitions Knowledge Translation and Exchange

Based on the knowledge gained from the delivery and evaluation the following publications and presentations have been made. The sharing of lessons learned and the results of the evaluation will continue. The intention is to generate two more publications from this report.

Publications and Presentations 2009 to 2010:

1. A. Ward, R. Doll, S. Ristovski-Slijepcevic, A. Kazanjian, M. Golant (2010) Cancer Transitions: An intervention that illustrates national and international collaborations in cancer survivorship research, *Oncology Exchange*, Vol 9, No. 2, 12-14.
2. L. Fehr, T. Ahlstrom, J. Chan, M. Golant and A. Ward (2009) Cancer Transitions: Preliminary results of a cancer survivorship program in a northern rural community, Canadian Association of Psychosocial Oncology Conference, Vancouver, April 1 to 4th
3. L Fehr , T. Ahlstrom, J. Chan, M. Golant and A.Ward (2009) Cancer Transitions: Preliminary results of a cancer survivorship program in a northern rural community, National Cancer Summit, Prince George, June 11 13th
4. R. Doll, S. Ristovski-Slijepcevic, A.Ward, A. Girgis and M. Golant (2009) Cancer Survivorship: Creating national priorities through international collaborations, Multinational Association of Supportive Cancer Care, Rome, June 25 to 27th
5. J. Magtoto, A. Ward and R. Doll (2010) Cancer Transitions: Preliminary Results of a Pan-Canadian Survivorship Program, Poster presentation, BCCA Research Day, Jan 21st
5. A.Ward, R. Doll, J. Magtoto S. Ristovski-Slijepcevic, C. Van Patten, T. Ahlstrom, N Payeur H Bradley, H.Goodman, M. Golant (2010). International collaborations through Cancer Transitions: creating comprehensive and sustainable cancer survivorship programming in Canada. American Psychosocial Oncology Society, New Orleans, USA, February 18 to 21st
6. A. Ward, R. Doll, J. Magtoto, M. Golant, C. Van Patten, A. Kazanjian, S. Ristovski-Slijepcevic (2010). Cancer Transitions: Creating Comprehensive and Sustainable Cancer Survivorship Programming in Canada. International Psycho-Oncology Society (IPOS), Quebec, May 25 to 29th

7. A. Ward and J. Taylor (2010) Cancer Transitions: An international collaboration, Pre- Multinational Association of Supportive Cancer Care, Symposium Study Group Workshop, Vancouver, June 23rd

8. A.Ward (2010) Creating Comprehensive and Sustainable Supportive Care Programming for Cancer Survivors in Canada, Multinational Association of Supportive Cancer Care, Vancouver, Parallel Session XIII, Survivorship, June 24 to 26th

Phase II Accomplishments

- Development of a Canadian version of *Cancer Transitions*
- Licensing agreement with CCS and **LIVESTRONG**
- Engagement of Cancer Agencies, Hospitals and Health Authorities for program expansion
- Facilitator training workshops for forty new facilitators from across Canada
- Ongoing program implementation and delivery assistance
- Ongoing pre and post evaluations and data analysis
- Final report to CJAG (June 2010)

Next Steps

Delivery and evaluation of the Cancer Transitions program and other survivorship programs will continue and contribute to evidence based research and knowledge that can guide clinical practice. As well, different methods of program delivery will be evaluated for feasibility and benefit. In rural and remote Northern BC the use of Telehealth delivery of the program is being considered. In order to increase equal access to survivorship care throughout Canada, translation into French and other languages is planned.

Over the next year there will be ongoing knowledge translation and dissemination of the research findings. This may include publications, presentations and reports. We recognize that sharing the results of this project and the lessons learned are important for program development and knowledge exchange in survivorship research and practice.

Discussion

As cancer survival rates increase there is a greater emphasis within the health system on promoting health protective behaviours for survivors in order to minimize the risk of co morbidities and increase quality of life (Weert et al., 2008). People who develop an active coping strategy often have a better quality of life than those who take a passive approach (Rutledge and Robinson, 2009). It is important to evaluate the efficacy of interventions that motivate survivors to adopt and maintain healthy emotional and physical lifestyle practices.

The purpose of the pilot study was to examine the feasibility of delivering a psycho educational healthy living intervention, the *Cancer Transitions* program, to cancer survivors in Canada and to conduct a preliminary examination of the impact of the program on participant overall quality of life. The evaluation was constructed to be both formative and summative in that the researchers were not only looking to see if the program should be continued, but also looking at ways to improve the program based on the quantitative data and qualitative feedback.

Program feasibility was measured in a number of ways including; survivor recruitment, adherence and retention, as well as site capacity and personnel expertise in program delivery. Recruitment was very successfully, especially considering the time of year (late Dec. to early Jan.) and the narrow window of time allocated for recruitment. The marketing generated considerable interest in the program and waitlists were generated at a couple of the sites. In fact, since the original offering of the pilot study, three of the four pilot sites are in their third or fourth run of the program. The adherence and retention of participants were important elements of the feasibility; interest was maintained and participants adhered well to attending each session over the six week period. There was some attrition noted between the beginning and the end of the program, but this was acceptable when compared to the CSC *Cancer Transitions* program attendance. Certain features of the program may have contributed to the high rate of compliance and retention. For example, the program provided specialized

facilitators to deliver different components of the program. Furthermore, the program offered a flexible format to accommodate survivor's abilities, needs and interests and the program also emphasized a sense of belonging and this helped to develop a sense of cohesiveness among the group members.

Finally, with regard to feasibility, the ability of the pilot sites to offer the program based on site requirements was considered. For example, at one site, space to conduct the exercise component was a limitation. This was resolved by the second session of the program. Since the original offering of the program the two pilot sites have partnered with the YMCA to offer the program. This has been a helpful way for the survivors to transition from their treatment at the cancer centres into the community for their care. Another potential limitation was recruitment of expert facilitators, particularly to rural and remote sites. In Northern BC this was the case in terms of the exercise specialist, however, with some careful planning all expert facilitators were secured.

The program evaluation indicated that the program materials were very well received and appreciated. The use of the workbook, diaries, and logs helped to encourage participant accountability and investment in the program. The emphasis placed on use of supplementary material by the facilitators may have contributed to variations in uptake. The participants' rated the top program experiences as: receiving support and encouragement, advice and education, and access to important information. This was followed by learning that their problems aren't unique and gaining new understanding as they develop a new attitude towards life. The group topics that they felt they covered the most were: thinking positively, how to access resources, and communication with health care professionals. It would be interesting to determine what proportion of education versus emotional support contributed to improved outcomes. The written weekly qualitative feedback from the program evaluations from the participants and the facilitators overwhelmingly suggested the program would be improved with more group discussion time.

With the pilot study, the aim for participant evaluation was to look for improvements from pre to post analysis, and acknowledge significance when it occurred. The participant evaluations indicated that not only were there trends to improvement, but many of the subscales within each measure reached significance at the post analysis times of six weeks and three months. Actual clinical significance was assessed by calculating the percentage improvement across all the measures. The convention is that a 25% improvement or greater represents a clinically significant difference. The only subscale to reach clinical significance was “sense of physical accomplishment”, but a number of other subscales were within 5 to 20% improvement. For example, within the measure for Eating Patterns the majority of the subscales were within that range at six weeks and/or three month follow up. For the Impact of Cancer, the majority of the scales reached at least 5% improvement, with an actual reduction in the negative impact of cancer for both “body image” and “self evaluation” between 10 and 15% at the three month follow up. General Self Efficacy reached just over 6% improvement at three month follow up. For the Health Related Quality of Life measure, “physical functioning” (14%, 19%) and “physical accomplishment” (29%, 35%) showed the greatest improvements at six weeks and three months. All the other subscales showed improvement on average from 5 to 10%, with the exception of “mental health” at just below 5% improvement. The fact that the pilot study was able to generate not only significant improvements, but at times clinically significant, or close to clinically significant improvements, is very encouraging and will be used to inform the study as the evaluation continues in Phase II.

The written qualitative feedback from the participants reiterated the quantitative data. In the case of physical activity was interesting to compare the quantitative data with the qualitative. The exercise component of the program was extremely well received and in many cases there were requests for more time to be spent on exercise. Although the participants’ perception of their physical functioning reiterates this, the Physical Activity measure indicated large variability in

increased activity. The main increase in activity was at the lower level, equivalent to at least 10 minutes of walking per day.

The pilot data from the four sites is very encouraging and consideration is now being given to a more extensive randomized control trial. At the facilitator training sessions, the trainee facilitators indicated an interest in being involved in the research evaluation so that they could provide evidence based research to support the intervention at their respective locations. The results from these new sites will be added to the pilot data. All sites will receive their individual site analysis and the overall multi site evaluation.

With all interventions and evaluations the self assessment and awareness process that participants undergo because of participating in a program needs to be taken into consideration. In addition, there may be natural improvements with time as the participants move through the trajectory of survivorship. For example, there could be a steady improvement in physical and emotional accomplishments with time; however, health worry may see more irregular improvements that relate to scheduled follow up medical visits. For this reason, in future studies, a control group (wait list controls) will be incorporated to measure and understand spontaneous improvements. It is also realistic to assume that after the completion of a supervised intervention, some survivors may revert to original behaviours, or ways of thinking. It is therefore not only beneficial to consider immediate improvements (post program), but also intermediate (three to six months) and longer term health improvements (one to five yrs). This can provide insight into the enduring benefits of the program (Keats and Culos-Reed, 2008). The analysis of the three month post intervention data indicated that improvements in quality of life were continuing for the survivors. A longer follow up period (e.g. six months, one year) would be useful in providing insight into the longer term sustainability of the programs key messages. The CSC completed a six week, and a three and six month follow up of the program. They found the largest improvements as a result of the program at the three month evaluation. It would be valuable to investigate further the mechanisms of action involved in sustainability of change.

On the foundation of the pilot data, it was surmised that the results were promising and interestingly correlated almost exactly with the Cancer Support Communities pilot results. A Canadian version of the *Cancer Transitions* program was therefore developed which encompasses the context in which the program is delivered in Canada and provides relevant Canadian resources. The Canadian version will be used for all further program delivery and evaluation in Canada. The BCCA holds a licensing agreement with Cancer Support Community and **LIVESTRONG** for the Canadian version.

The issue of program sustainability needed to be considered in moving forward with program uptake and delivery on a regular basis. Therefore the CJAG funded two facilitator training workshops in the fall of 2009. A number of organizations, including health authorities, cancer agencies and foundations, were encouraged to participate in order to increase the uptake of the program at a systems level. The training was a resounding success and at this time four new sites have already delivered the program and five more intend to do so by the end of 2010. The CJAG also provided additional funding to assist with the first year of program delivery for sites that attended the training and qualified for a program material bursary. Six sites were awarded program material bursaries.

In summary, the pilot project provides preliminary evidence based research in support of the *Cancer Transitions* intervention and suggests that with the modifications for a Canadian audience it is a useful program for application in Canada. Supportive care programming for cancer survivors has become a research and health system priority at both a national and an international level, the *Cancer Transitions* program is therefore not only timely, but it engages survivors, and provides content that is applicable to improving their quality of life and adherence to positive behavioural changes.

Summary

There is a definite need for supportive care programming for cancer survivors in Canada. The *Cancer Transitions* program is aimed at improving the participant's quality of life and adherence to positive behavioural changes. The pilot study provides preliminary evidence based research in support of this intervention and suggests that *Cancer Transitions* is a useful model for application in Canada. *Cancer Transitions* is an example of how survivorship evaluation research can aid new program development and redesign based on observational studies from early adopters. The research evidence can be used to make recommendations regarding subsequent care planning and clinical policy development. As the number of these experiential studies are critically reviewed and disseminated, the findings can be used to inform similar programs, both nationally and internationally. From a research, practice and policy perspective now is the right time in Canada to invest in survivorship research.

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Appendix A

BC Cancer Agency, Vancouver Island 1st cohort Cancer Transitions: Moving Beyond Treatment

Table 1. Sample characteristics of cancer survivors (n=12) enrolled in *Cancer Transitions: Moving Beyond Treatment*

Sample characteristics		
<i>Socio demographic characteristics</i>		
	mean ± SD	
Age (years)	58.50 ± 6.749	
	n	%
Race/ethnicity		
White	10	83.3
Latin American	1	8.3
Aboriginal (Inuit, Metis, North American Indian)	1	8.3
Education		
Less than high school	-	-
Graduated from High School/GED	-	-
Completed Trade School	-	-
Some College	6	50
Bachelor's degree	4	33.3
Some Graduate School	-	-
Master's Degree	1	8.3
Ph.D., M.D., and/or J.D	1	8.3
Retired/unemployed	3	25
Income among employed		
<\$40,000		
\$40,000 to \$100,000		
≥\$100,000	2	16.7
	8	66.6
	1	8.3
Marital status		
Single/never married	2	16.7
Married or living as married	7	58.3
Separated/divorced	3	25
Widowed	-	-
Other	-	-

Medical history

	n	%
Most recent cancer diagnosis		
Breast	7	58.3
Colon and rectal	2	16.7
Endometrial	-	-
Kidney	-	-
Leukemia	1	8.3
Lung	1	8.3
non Hodgkin's lymphoma	-	-
Prostate	-	-
Non melanoma skin	1	8.3
Thyroid	-	-
Other	2	16.7
Weight status[†]		
Underweight	1	8.3
Normal	4	33.3
Overweight	5	41.7
Obese	2	16.7
Cancer treatment included chemotherapy	10	83.3
Cancer treatment included radiation	7	58.3
Cancer treatment included biological therapy	-	-
Cancer treatment included Surgery	8	66.7
Cancer treatment included Immunotherapy	-	-
Cancer treatment included Bone marrow transplant	-	-

Table 2. Participation and response rates of cancer survivors (n=12) participating in *Cancer Transitions: Moving Beyond Treatment*

Participation rate		
<i>Session</i>	<i>n</i>	<i>%</i>
1	12	100
2	12	100
3	12	100
4	11	95
5	12	100
6	11	95

**BC Cancer Agency, Vancouver Island 2nd cohort
Cancer Transitions: Moving Beyond Treatment**

Table 1. Sample characteristics of cancer survivors (n=20) enrolled in *Cancer Transitions: Moving Beyond Treatment*

Sample characteristics		
<i>Socio demographic characteristics</i>		
	mean ± SD	
Age (years)	60.00 ± 8.42	
	n	%
Race/ethnicity		
White	20	100
Black/ African American	-	-
Chinese	-	-
Other	-	-
Korean	-	-
Latin American	-	-
South East Asian	-	-
Aboriginal (Inuit, Metis, North American Indian)	-	-
Filipino	-	-
Japanese	-	-
Gender		
Female	16	80
Male	4	20
Education		
Less than high school	1	5
Graduated from High School/GED	3	15
Completed Trade School	1	5
Some College	7	35
Bachelor's degree	4	20
Some Graduate School	1	5
Master's Degree	1	5
Ph.D., M.D., and/or J.D	2	10
Retired/unemployed	14	70
Income among employed		
<\$40,000	4	20
\$40,000 to \$100,000	6	30
≥\$100,000	5	25

Marital status

Single/never married	1	5
Married or living as married	14	70
Separated/divorced	3	15
Widowed	2	10
Other	-	-

Medical history

	n	%
Most recent cancer diagnosis		
Breast	6	30
Colon and rectal	2	10
Endometrial	1	5
Kidney	-	-
Leukemia	-	-
Lung	2	10
Non Hodgkin's lymphoma	2	10
Prostate	2	10
Non melanoma skin	-	-
Thyroid	-	-
Other	5	25
Co morbid condition	13	65
Weight status[†]		
Underweight	-	-
Normal	9	45
Overweight	6	30
Obese	3	15
Cancer treatment included chemotherapy	13	65
Cancer treatment included radiation	10	50
Cancer treatment included biological therapy	3	15
Cancer treatment included Surgery	14	70
Cancer treatment included Immunotherapy	-	-
Cancer treatment included Bone Marrow transplant	-	-

Table 2. Participation and response rates of cancer survivors (n=20) participating in *Cancer Transitions: Moving Beyond Treatment*

Participation rate		
<i>Session</i>	<i>n</i>	<i>%</i>
1	19	95
2	20	100
3	18	90
4	19	95
5	17	85
6	16	80
Booster	13	65

Northern Health, Prince George
Cancer Transitions: Moving Beyond Treatment

Table 1. Sample characteristics of cancer survivors (n=16) enrolled in *Cancer Transitions: Moving Beyond Treatment*

Sample characteristics		
<i>Socio demographic characteristics</i>		
	mean ± SD	
Age (years)	57.06 ± 8.737	
	n	%
Race/ethnicity		
White	15	93.8
Black/ African American	1	6.3
Chinese	-	-
Other	-	-
Korean	-	-
Latin American	-	-
South East Asian	-	-
Aboriginal (Inuit, Metis, North American Indian)	-	-
Filipino	-	-
Japanese	-	-
Education		
Less than high school	2	12.5
Graduated from High School/GED	2	12.5
Completed Trade School	1	6.3
Some College	8	50
Bachelor's degree	1	6.3
Some Graduate School	2	12.5
Master's Degree	-	-
Ph.D., M.D., and/or J.D	-	-
Retired/unemployed	7	43.8
Income among employed		
<\$40,000	4	25
\$40,000 to \$100,000	8	50.1
≥\$100,000	3	18.8
Marital status		
Single/never married	13	81.3
Married or living as married	-	-

Separated/divorced	1	6.3
Widowed	-	-
Other		

Medical history

	n	%
Most recent cancer diagnosis		
Breast	8	50
Colon and rectal	2	12.5
Endometrial	1	6.3
Kidney	-	-
Leukemia	-	-
Lung	1	6.3
non Hodgkin's lymphoma	2	12.5
Prostate	-	-
Non melanoma skin	-	-
Thyroid	1	6.3
Other	1	6.3
Weight status^s		
Underweight	-	-
Normal	-	-
Overweight	4	25
Obese	5	31.3
	7	43.8
Cancer treatment included chemotherapy	14	87.5
Cancer treatment included radiation	8	50
Cancer treatment included biological therapy	2	12.5
Cancer treatment included Surgery	11	68.8
Cancer treatment included Immunotherapy	1	6.3
Cancer treatment included Bone marrow transplant	-	-

Table 2. Participation and response rates of cancer survivors (n=16) participating in *Cancer Transitions: Moving Beyond Treatment*

Participation rate		
<i>Session</i>	<i>n</i>	<i>%</i>
1	16	100
2	13	84.21
3	13	84.21
4	13	84.21
5	12	78.94
6	11	63.16

Wellspring, Toronto
Cancer Transitions: Moving Beyond Treatment

Table 1. Sample characteristics of cancer survivors (n=16) enrolled in *Cancer Transitions: Moving Beyond Treatment*

Sample characteristics		
<i>Socio demographic characteristics</i>		
	mean ± SD	
Age (years)	49.00 ± 9.309	
	n	%
Race/ethnicity		
White	9	56.3
Black/ African American	2	12.5
Chinese	-	-
Other	-	-
Korean	-	-
Latin American	-	-
South East Asian	1	6.3
Aboriginal (Inuit, Metis, North American Indian)	-	-
Filipino	-	-
Japanese	1	6.3
Education		
Less than high school	-	-
Graduated from High School/GED	1	6.3
Completed Trade School	1	6.3
Some College	1	6.3
Bachelor's degree	6	37.5
Some Graduate School	1	6.3
Master's Degree	2	12.5
Ph.D., M.D., and/or J.D	1	6.3
Retired/unemployed	3	18.8
Income among employed		
<\$40,000		
\$40,000 to \$100,000	4	25
≥\$100,000	7	43.8
	2	12.5
Marital status		
Single/never married	3	18.8
Married or living as married	3	18.8
Separated/divorced	5	31.3

Widowed	1	6.3
Other	1	6.3

Medical history

	n	%
Most recent cancer diagnosis		
Breast	8	50
Colon and rectal	1	6.3
Endometrial	1	6.3
Kidney	-	-
Leukemia	-	-
Lung	-	-
non Hodgkin's lymphoma	-	-
Prostate	-	-
Non melanoma skin	-	-
Thyroid	-	-
Other	6	12.5
Weight status**		
Underweight	-	-
Normal	-	-
Overweight	8	50
Obese	3	18.8
	1	6.3
Cancer treatment included chemotherapy	7	43.8
Cancer treatment included radiation	10	62.5
Cancer treatment included biological therapy	1	6.3
Cancer treatment included Surgery	11	68.8
Cancer treatment included Immunotherapy	-	-
Cancer treatment included Bone marrow transplant	-	-

Table 2. Participation and response rates of cancer survivors (n=16) participating in *Cancer Transitions: Moving Beyond Treatment*

Participation rate		
<i>Session</i>	<i>n</i>	<i>%</i>
1	13	81.25
2	11	68.75
3	12	75
4	10	62.5
5	11	68.75
6	10	62.5

Hope & Cope, Montreal
Cancer Transitions: Moving Beyond Treatment

Table 1. Sample characteristics of cancer survivors (n=23) enrolled in *Cancer Transitions: Moving Beyond Treatment*

Sample characteristics		
<i>Socio demographic characteristics</i>		
	mean ± SD	
Age (years)	52.91 ± 9.070	
	n	%
Race/ethnicity		
White	17	73.9
Black/ African American	-	-
Chinese	2	8.7
Other	2	8.7
Korean	1	4.3
Latin American	-	-
South East Asian	-	-
Aboriginal (Inuit, Metis, North American Indian)	-	-
Filipino	1	4.3
Japanese	-	-
Education		
Less than high school	1	4.3
Graduated from High School/GED	2	8.7
Completed Trade School	2	8.7
Some College	6	26.1
Bachelor's degree	5	21.7
Some Graduate School	2	8.7
Master's Degree	5	21.7
Ph.D., M.D., and/or J.D	-	-
Retired/unemployed	5	21.7
Income among employed		
<\$40,000		
\$40,000 to \$100,000	7	30.4
≥\$100,000	9	39.1
	5	21.7

Marital status

Single/never married		
Married or living as married	3	13
Separated/divorced	16	69.6
Widowed	2	8.7
Other	1	4.3
	-	-

Medical history

	n	%
Most recent cancer diagnosis		
Breast	14	60.9
Colon and rectal	1	4.3
Endometrial	-	-
Kidney	1	4.3
Leukemia	-	-
Lung	1	4.3
non Hodgkin's lymphoma	2	8.7
Prostate	1	4.3
Non melanoma skin	-	-
Thyroid	-	-
Other	3	13
Weight status^{††}		
Underweight		
Normal	2	8.7
Overweight	5	21.7
Obese	9	39.1
	5	21.7
Cancer treatment included chemotherapy	16	69.6
Cancer treatment included radiation	16	69.6
Cancer treatment included biological therapy	2	8.7
Cancer treatment included Surgery	17	73.9
Cancer treatment included Immunotherapy	1	4.3
Cancer treatment included Bone marrow transplant	1	4.3

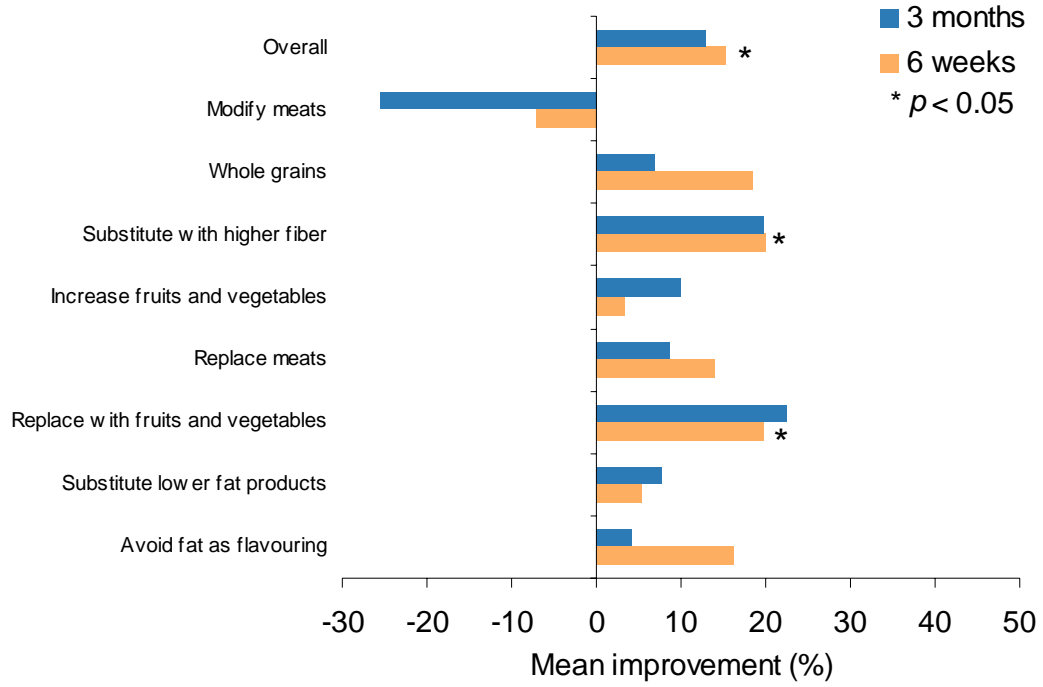
Table 2. Participation and response rates of cancer survivors (n=23) participating in *Cancer Transitions: Moving Beyond Treatment*

Participation rate		
<i>Session</i>	<i>n</i>	<i>%</i>
1	22	95.65
2	19	82.6
3	22	95.65
4	18	78.26
5	19	82.61
6	17	73.91

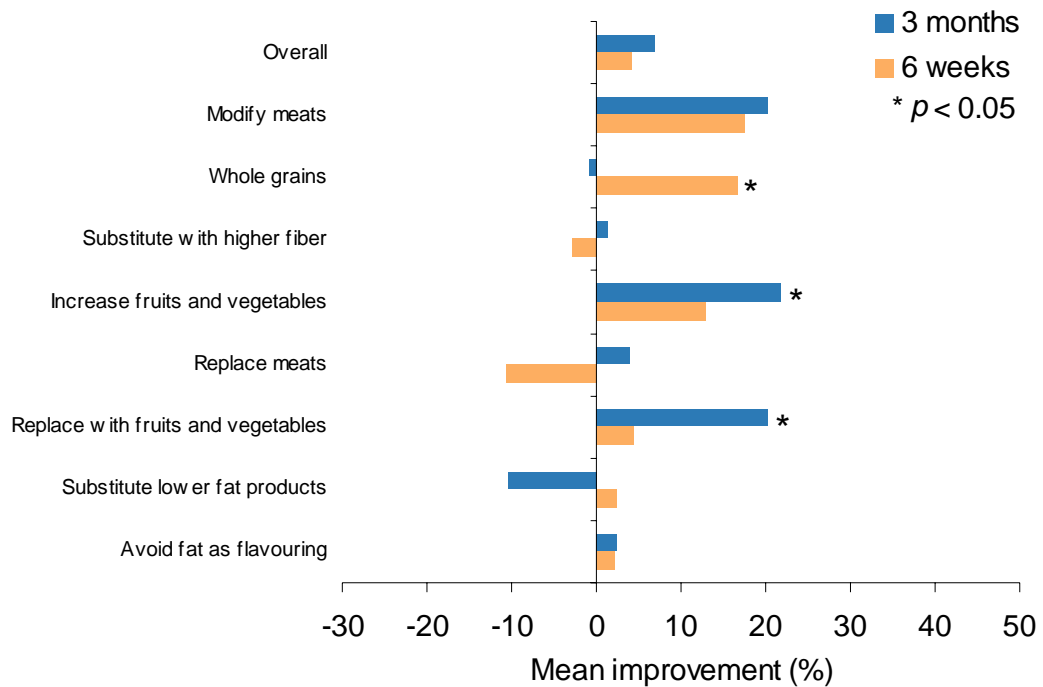
Appendix B – Eating Patterns

	Total (n=87)		BC Cancer Agency, Vancouver Island 1 st cohort		BC Cancer Agency Vancouver Island 2 nd cohort		Northern Health, Prince George		Wellspring, Toronto		Hope & Cope, Montreal	
	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth
	Avoid fat as flavouring	5.18%	6.74%	16.20%	4.32%	2.23%	2.35%	5.06%	16.87%	-3.91%	3.55%	6.62%
Substitute lower fat products	8.15%*	1.36%	5.25%	7.72%	2.43%	-10.37%	10.14%	14.19%	5.10%	-25.75%	14.51%*	8.39%
Replace with fruits and vegetables	10.61%*	11.56%*	19.81%*	22.55%	4.49%	20.33%*	9.46%	-5.77%	15.49%	16.46%	8.72%	-0.73%
Replace meats	0.00%	7.73%	13.89%	8.70%	-10.71%	4.08%	-5.88%	16.00%	-2.78%	24.14%	5.88%	-1.82%
Increase fruits and vegetables	10.47%*	8.11%	3.40%	10.08%	12.83%	21.85%*	16.67%	12.45%	6.48%	5.61%	10.48%	-5.88%
Substitute with higher fiber	2.92%	8.31%*	20.00%*	19.83%	-2.89%	1.42%	9.57%	12.50%	-15.38%	8.33%	2.61%	4.81%
Whole grains	6.85%	-2.77%	18.37%	6.83%	16.66%*	-0.79%	29.03%	6.42%	-9.47%	6.67%	-14.14%	-20.79%
Modify meats	18.37%*	7.76%	-7.14%	-25.63%	17.47%	20.24%	44.71%*	18.97%	28.84%	-24.55%	-2.48%	11.00%
Overall Eating Patterns	6.50%*	6.97%*	15.27%*	12.96%	4.14%	6.89%	13.90%	14.59%*	0.05%	5.32%	2.99%	0.51%

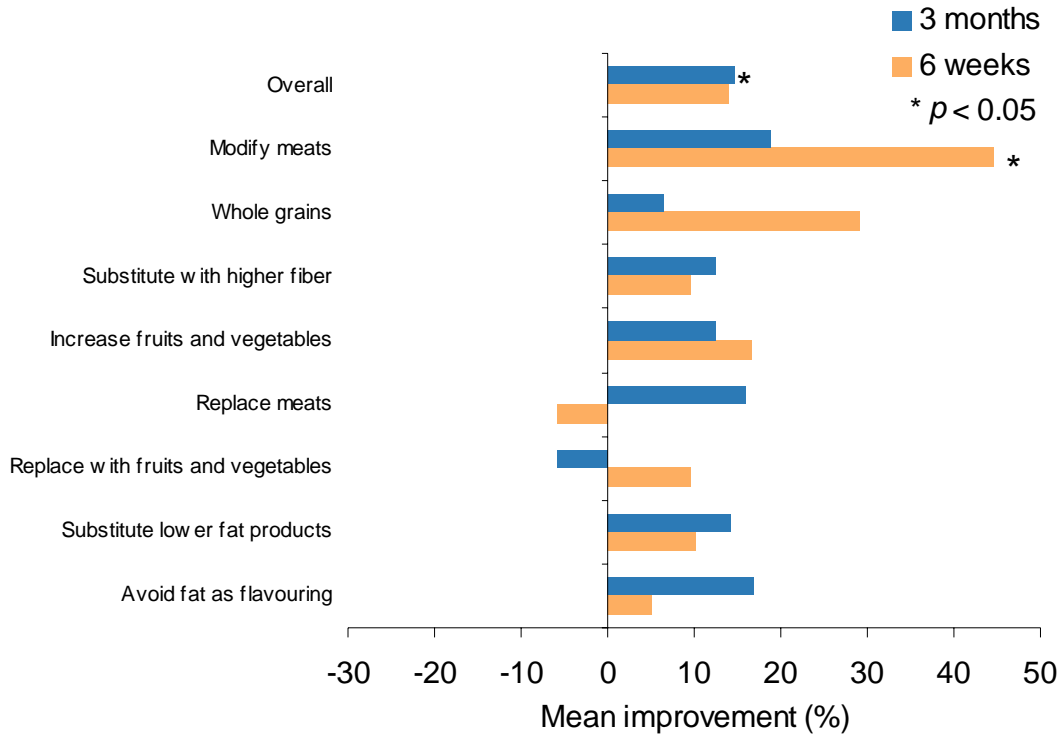
Site 1- BC Cancer Agency, Vancouver Island 1st Cohort



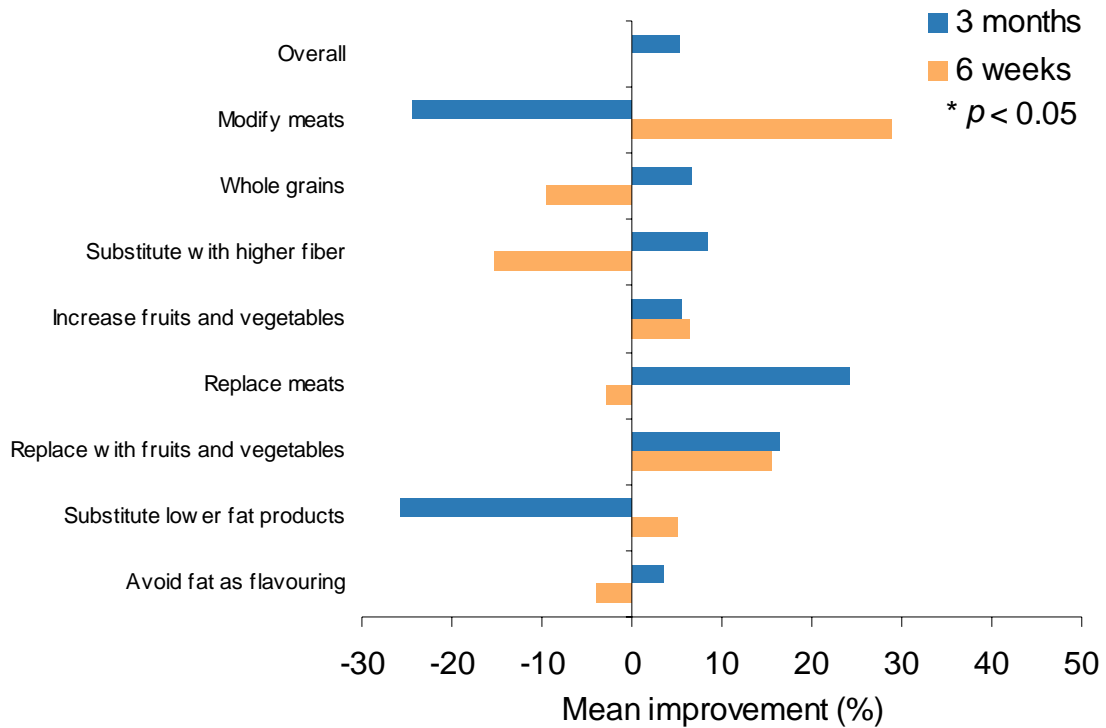
Site 1- BC Cancer Agency, Vancouver Island 2nd Cohort



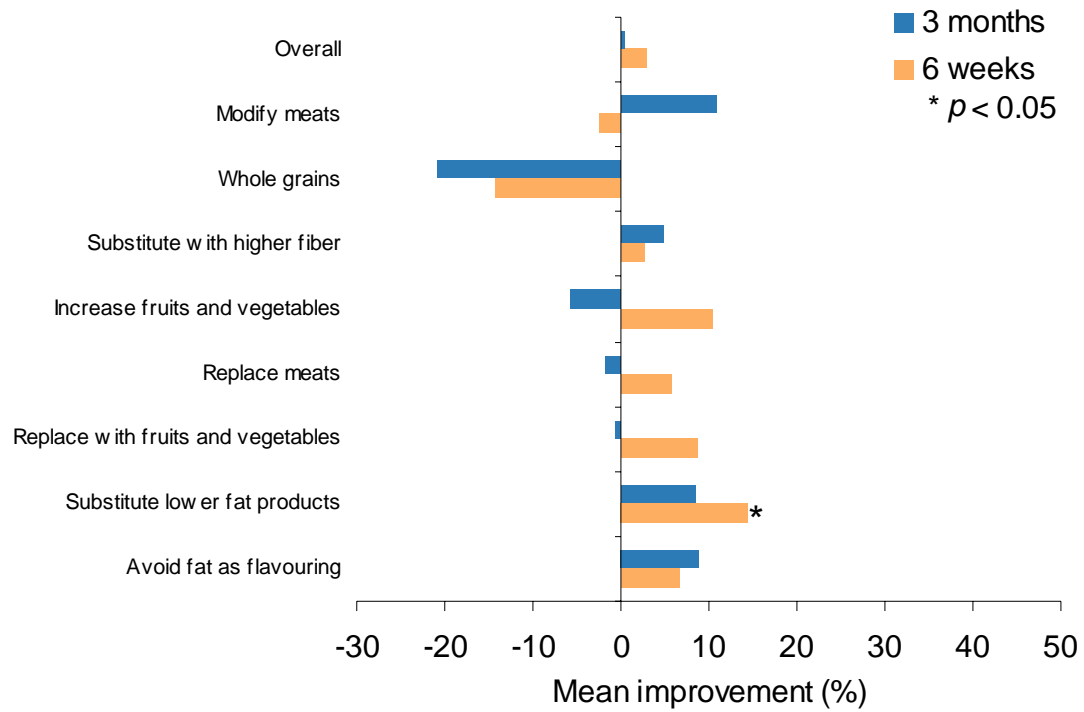
Site 2- Northern Health, Prince George



Site 3- Wellspring, Toronto



Site 4- Hope & Cope, Montreal



Individual Sites

The eating patterns data for the four geographical sites was examined for statistically significant findings ($p < 0.05$) and emerging trends ($p > 0.05$).

Site 1 – BC Cancer Agency, Vancouver Island 1st cohort: In Victoria there were two sequential cohorts who participated in the program. In cohort one there was a statistically significant improvement in the “Total Score” and two subscales. These findings did not remain significant at the three months follow up due to larger standard deviation scores.

Site 1 – BC Cancer Agency, Vancouver Island 2nd cohort: In contrast, in the second cohort there was only one subscale that was statistically significant at six weeks, and at three months two of the subscales had differences that were statistically significant.

Of the measures that were significant at the Vancouver Island BCCA site many were close to clinical significance (25%).

Site 2 - Northern Health, Prince George: At six weeks there was a statistically clinical significant improvement in one subscale “Modify Meat” (over 40% improvement), but this change decreased at three months, perhaps due to reversion to old habits. At three months the eating patterns “Total Score” showed a statistically significant improvement. There were mixed, non significant findings, but improvements all the same for the majority of the seven subscales.

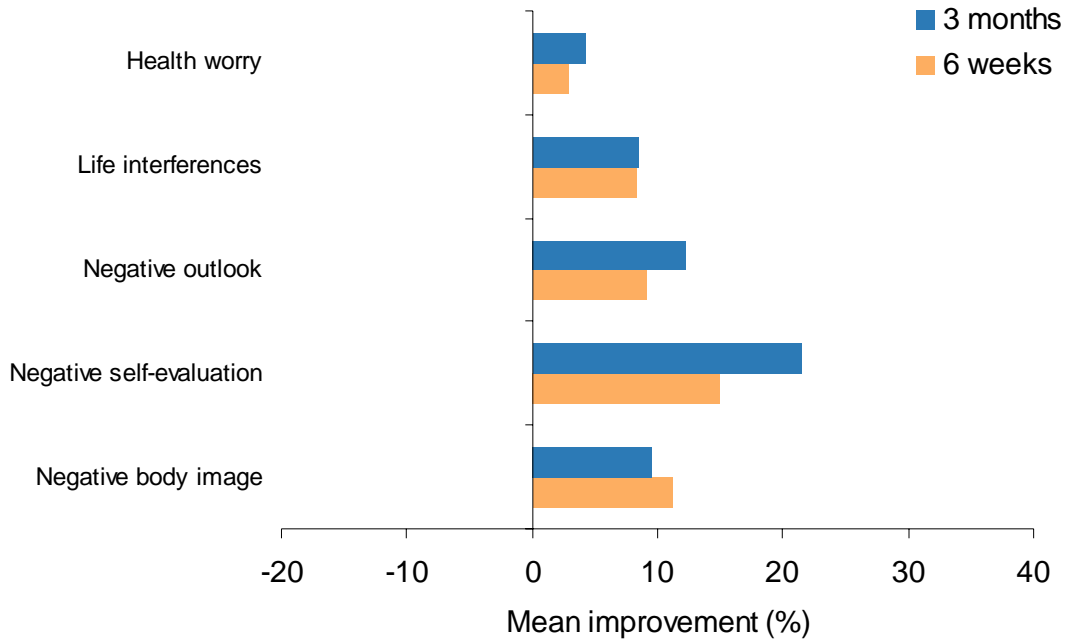
Site 3 – Wellspring, Toronto: At both the six week and three month analysis, there were no statistically significant findings in the eating patterns “Total Score” or any of the subscales. There was considerable variation in the subscale responses and a lack of improvement in a number of the subscales.

Site 4 – Hope & Cope, Montreal: There was a significant improvement in the subscale “Substitute Lower Fat Products” at six weeks, although we did not see this finding at three months. Other subscales showed a mix of results with some showing no improvements and others showing improvements, but all were below 10%.

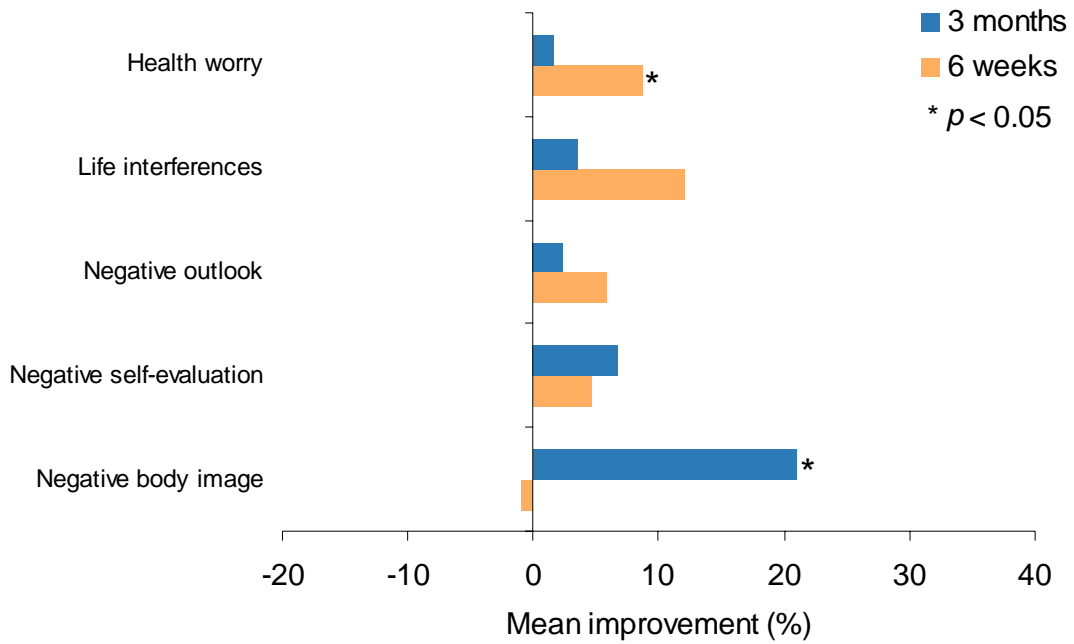
Appendix C – Impact of Cancer

	Total (n=87)		BC Cancer Agency, Vancouver Island 1 st cohort		BC Cancer Agency, Vancouver Island 2 nd cohort		Northern Health. Prince George		Wellspring, Toronto		Hope & Cope, Montreal	
	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth
Negative Body Image	5.31%	12.35%*	11.20%	9.48%	-1.03%	20.89%*	3.08%	6.41%	11.11%	2.86%	-	14.57%
Negative Self-Evaluation	1.07%	14.80%*	14.94%	21.52%	4.58%	6.80%	-15.94%	-15.15%	-4.55%	4.41%	-	29.41%*
Negative Outlook	4.52%	7.47%*	9.09%	12.26%	5.78%	2.34%	4.30%	6.25%	3.16%	3.57%	1.47%	10.56%
Life Interferences	6.44%	5.59%	8.33%	8.47%	12.04%	3.53%	-5.36%	-5.41%	5.63%	9.68%	-	7.22%
Health Worry	5.71%	4.66%	2.86%	4.30%	8.75%*	1.54%	14.77%	12.31%	-5.88%	-10.45%	-	10.63%*

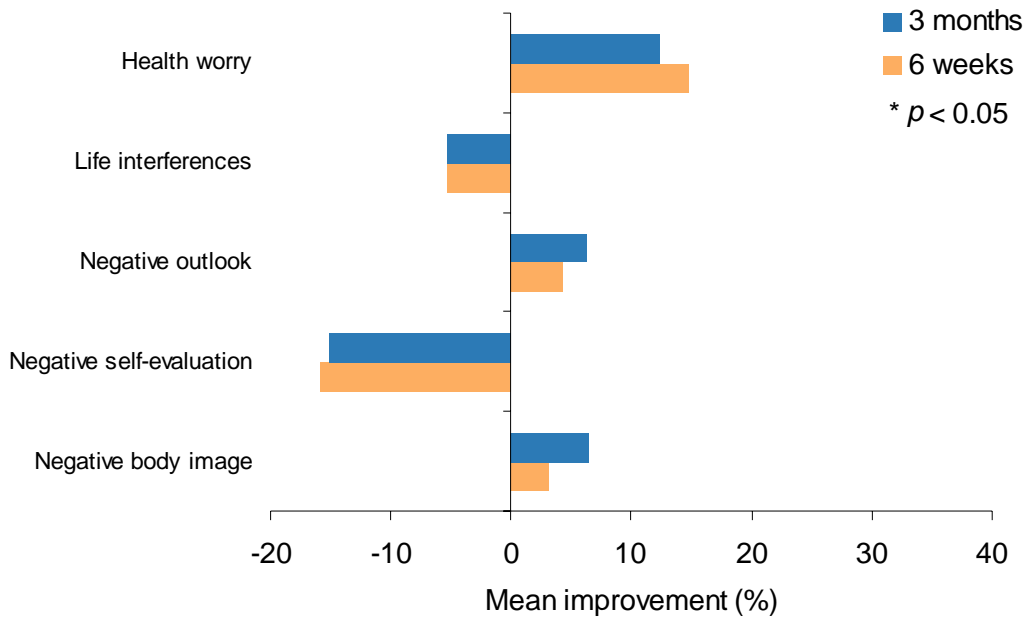
Site 1- BC Cancer Agency, Vancouver Island 1st Cohort



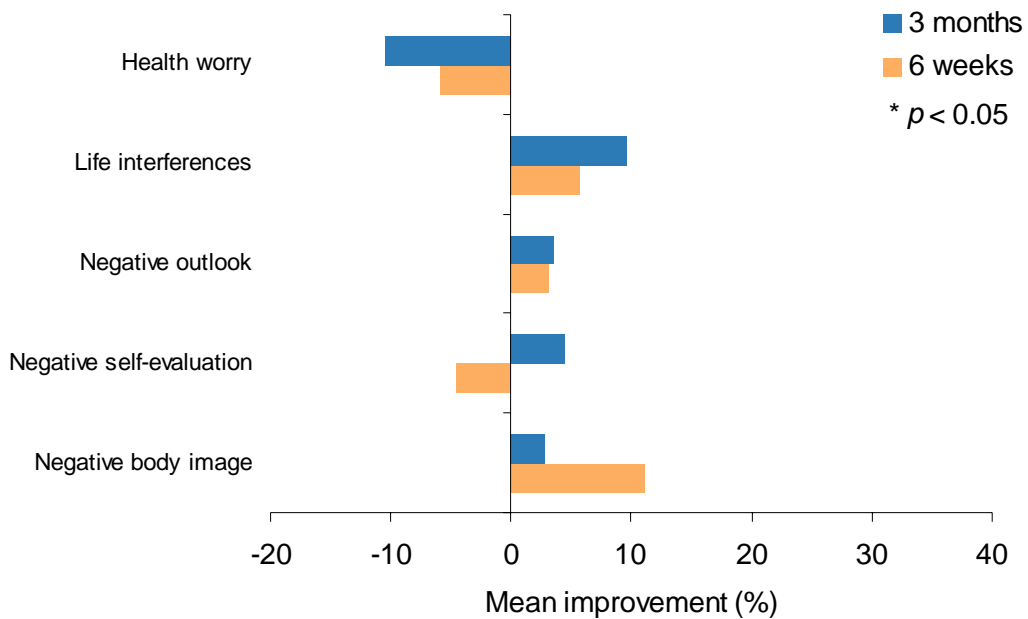
Site 1- BC Cancer Agency, Vancouver Island 2nd Cohort



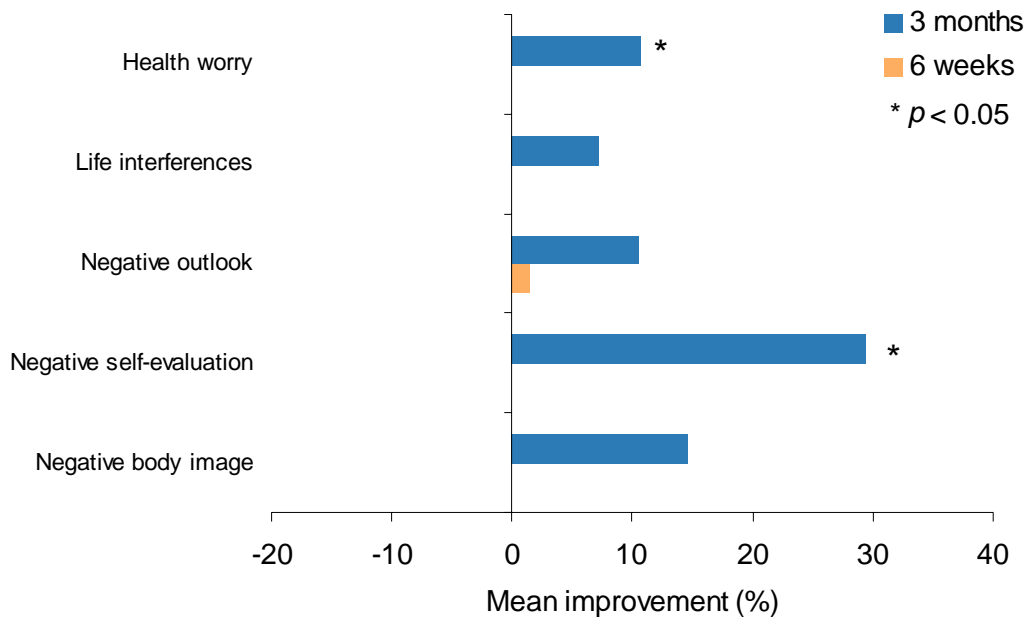
Site 2- Northern Health, Prince George



Site 3- Wellspring, Toronto



Site 4- Hope & Cope, Montreal



Individual Sites

Site 1 – BC Cancer Agency, Vancouver Island 1st cohort: there was a mean improvement trend for all five IOC measures at six weeks and three months follow up in comparison to pre test, none statistically significant. Negative self-evaluation showed an improvement of just over 20% at three months.

Site 1 – BC Cancer Agency, Vancouver Island 2nd cohort: there was a statistically significant mean improvement for health worry at six weeks and negative body image at three months. There was a general trend of mean improvement for the measures at six weeks, which continued for body image and self evaluation at three months. Negative body image showed an improvement of just over 20% at three months.

Site 2 - Northern Health, Prince George: while negative self-evaluation and life interferences worsened at six weeks and three months, there was a no statistically significant improvement in negative body image, negative outlook and health worry (with a small drop off at three months for health worry).

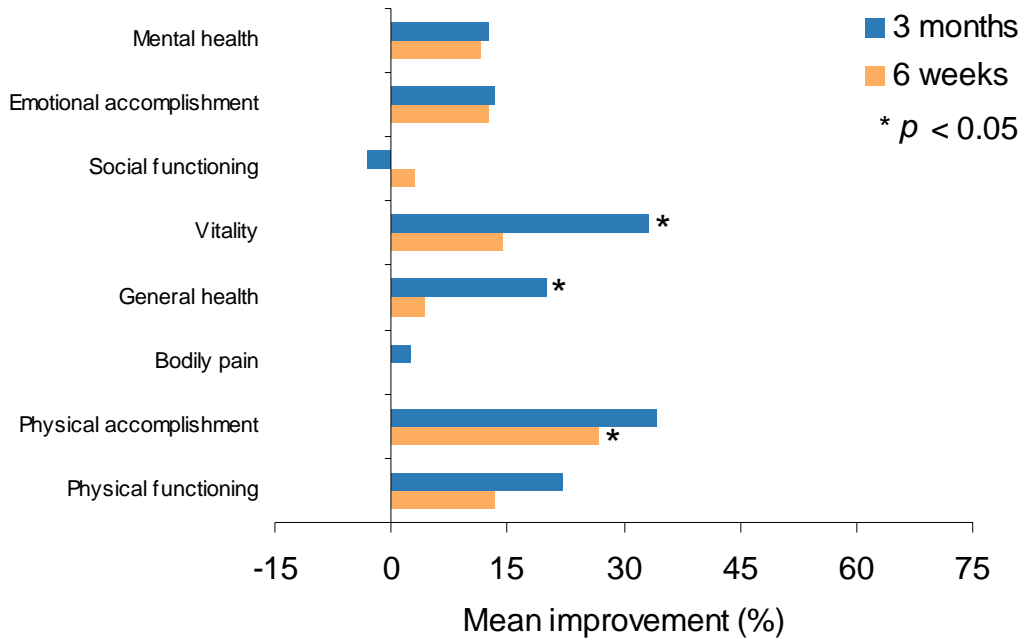
Site 3 – Wellspring, Toronto: Negative outlook and life interferences showed improvement six weeks and three months. Negative body image had improved at six weeks, but this improvement declined over time. Health worry worsened at both follow up time points and negative self-evaluation had not improved at six weeks but increased at the three month follow up. None of these findings were statistically significant.

Site 4 – Hope & Cope, Montreal: there was a general mean improvement trend at three months follow up with statistical significance for negative self-evaluation and health worry. Data was not collected for the six week time point for most of the IOC scales.

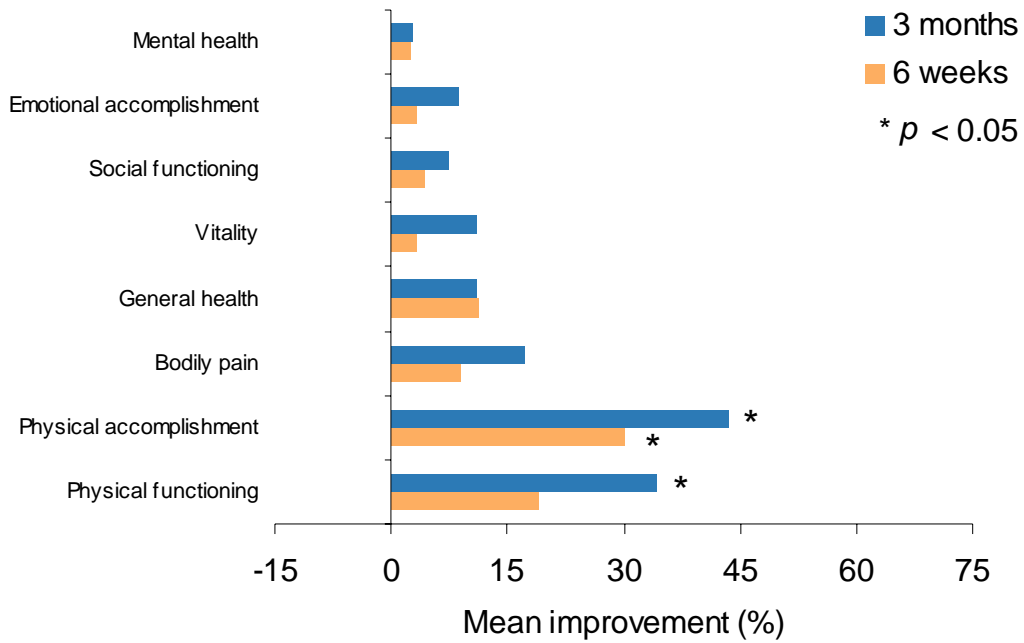
Appendix D – Health Related Quality of Life

	Total (n=87)		BC Cancer Agency, Vancouver Island 1 st cohort		BC Cancer Agency, Vancouver Island (2 nd cohort)		Northern Health, Prince George		Wellspring, Toronto		Hope & Cope, Montreal	
	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth
Physical Functioning	14.37%*	18.98%*	13.33%	22.22%	18.92%	34.37%*	66.67%*	35.71%	12.00%	6.67%	0.00%	6.12%
Physical Accomplishment	28.83%*	35.34%*	26.67%*	34.15%	30.00%*	43.64%*	48.39%*	69.57%*	48.39%	63.16%	17.76%*	17.02%*
Bodily Pain	4.83%	5.39%	0.00%	2.63%	9.09%	17.14%	-6.67%	5.88%	15.38%	17.65%	5.97%	-3.33%
General Health	7.38%*	11.76%*	4.35%	20.00%*	11.43%	11.11%	4.76%	18.75%	26.32%*	27.27%	0.00%	2.22%
Vitality	10.53%	5.36%	14.29%	33.33%*	3.23%	11.11%	46.15%*	27.27%	27.78%	0.00%	-2.00%	-13.64%
Social Functioning	7.61%*	6.10%	2.94%	-3.23%	4.26%	7.50%	21.74%	26.67%	16.00%	29.41%	4.41%	-1.64%
Emotional Accomplishment	5.13%	9.57%*	12.70%	13.33%	3.23%	8.75%	1.69%	15.00%	3.77%	22.58%	4.92%	2.65%
Mental Health	4.21%	3.36%	11.67%	12.50%	2.44%	2.82%	13.21%	15.79%*	-10.00%	-10.81%	3.60%	-1.04%

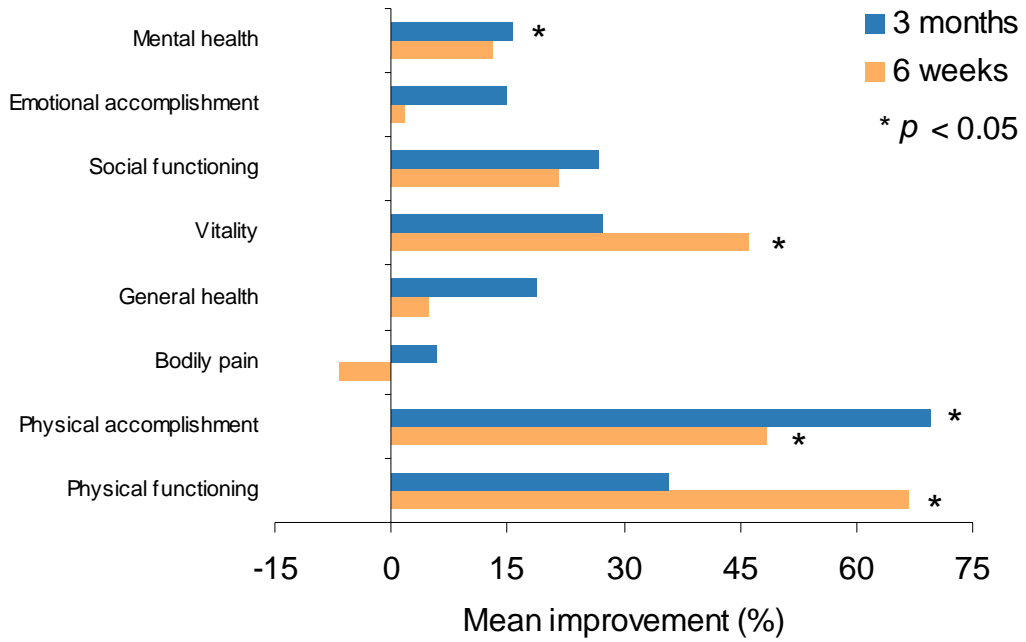
Site 1 – BC Cancer Agency, Vancouver Island 1st Cohort



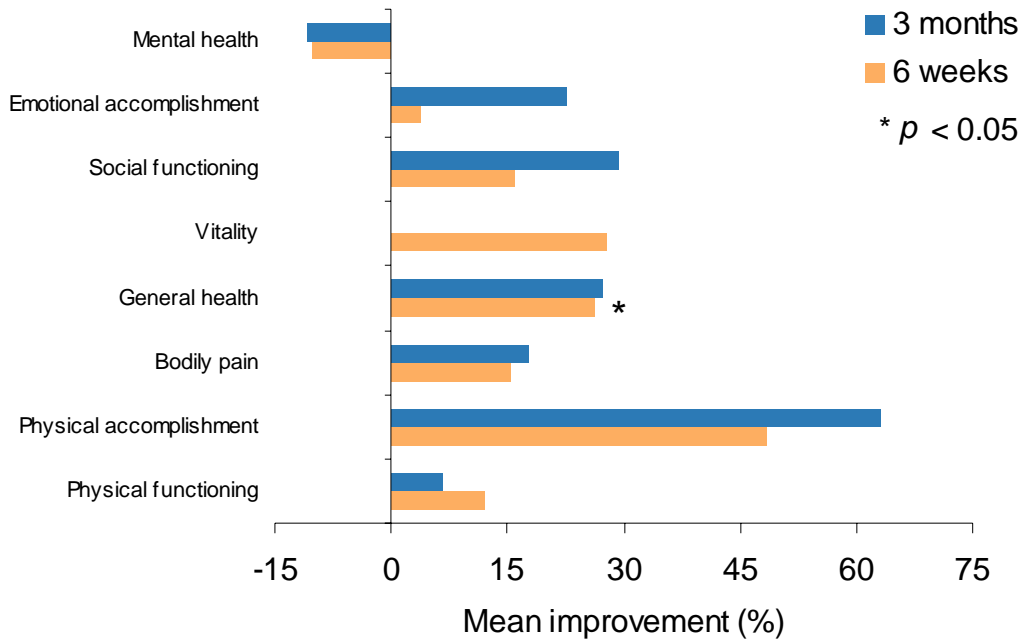
Site 1 – BC Cancer Agency, Vancouver Island 2nd Cohort



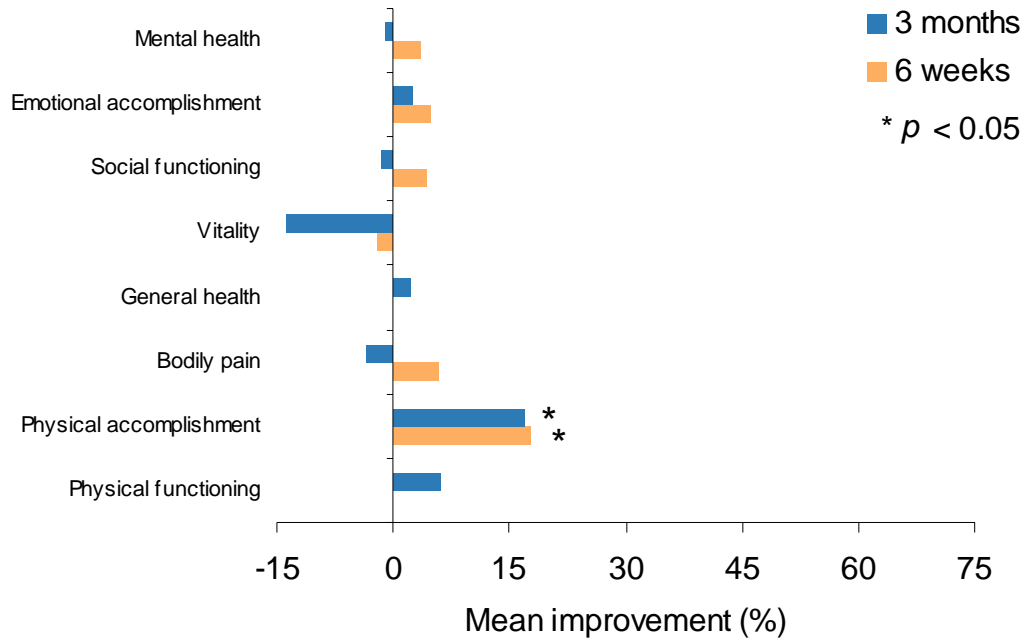
Site 2- Northern Health, Prince George



Site 3- Wellspring, Toronto



Site 4- Hope & Cope, Montreal



Individual Sites

Site 1- BC Cancer Agency, Vancouver Island 1st Cohort: There were trends to improvement for all subscales except for Body Pain (six weeks) and Social Functioning (three months). A number of the subscales reached clinical significance as well as statistical significance. The largest improvements were seen for Physical Accomplishment and Vitality.

Site 1 – BC Cancer Agency, Vancouver Island 2nd Cohort: There were trends to improvement for all the subscales, with the greatest and most significant improvements occurring for Physical Functioning (three months, >25%) and Physical Accomplishment (six weeks and three months, >25%). It should be noted that for the second run of the program BCCA Vancouver Island partnered with the YWCA.

Site 2- Northern Health, Prince George: Significance for Physical Functioning (six weeks), Physical Accomplishment (six weeks and three month), Vitality (six weeks), and Mental Health (three months). All other measures showed trends to improvement except for Body Pain. Physical Functioning, Physical Accomplishment and Vitality were all clinically significant (> 25%).

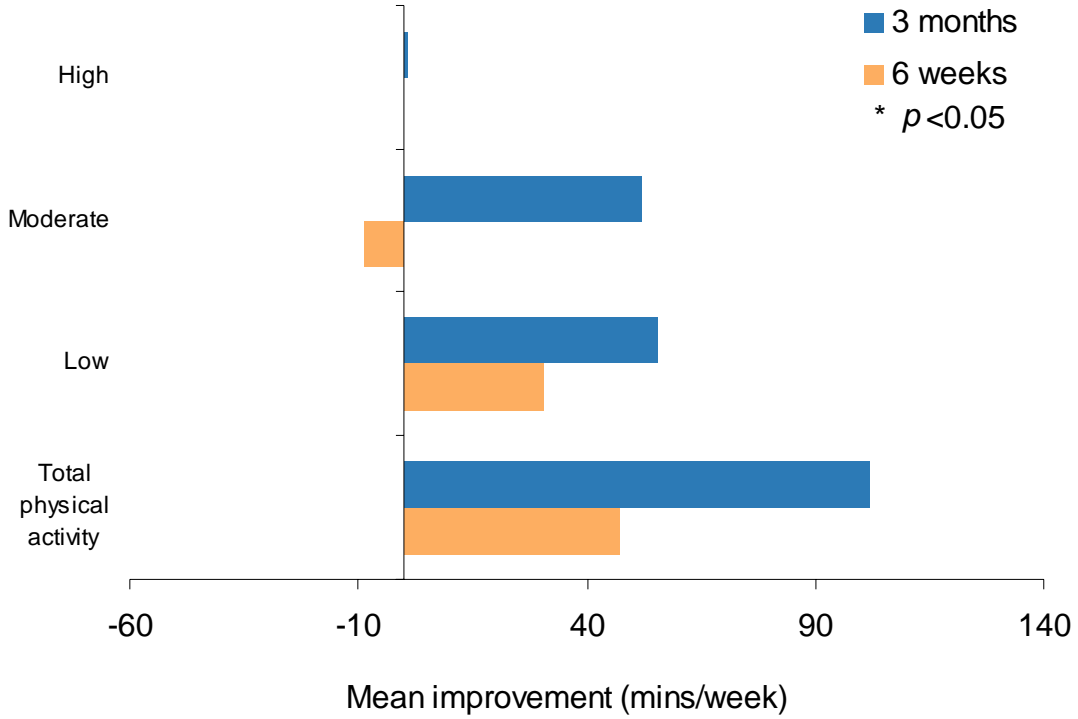
Site 3 – Wellspring, Toronto: There were trends to positive improvement for all subscales, except for Mental Health which showed a decreased. A number of the subscales reached values that were clinically significant (Physical Accomplishment, General Health, Vitality, Social Functioning) although they were not statistically significant.

Site 4 – Hope & Cope, Montreal: Significance for Physical Accomplishment. Otherwise small changes to improvement at six weeks (except for Vitality), but these generally showed a decrease at three months.

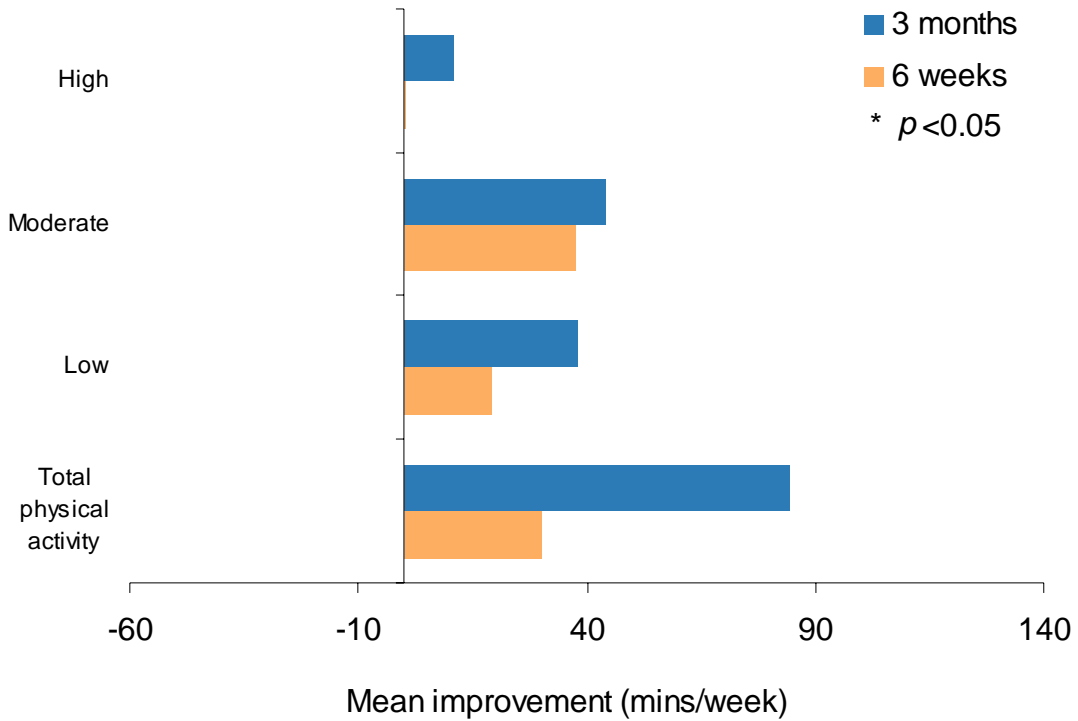
Appendix E – Physical Activity

	Total (n=87)		BC Cancer Agency, Vancouver Island 1 st cohort		BC Cancer Agency, Vancouver Island 2 nd cohort		Northern Health, Prince George		Wellspring, Toronto		Hope & Cope, Montreal	
	3		3		3		3		3		3	
	6 wk mins/wk	month mins/wk	6 wk mins/wk	month mins/wk	6 wk mins/wk	month mins/wk	6 wk mins/wk	month mins/wk	6 wk mins/wk	month mins/wk	6 wk mins/wk	month mins/wk
Total physical activity	-9.89	34.14	47.08	102.00	30.12	84.62	-24.36	-33.00	-76.00	80.50*	-35.38	-7.88
Low physical activity	6.25	25.61*	30.45	55.50	19.13	38.18	22.50	35.00	-53.00	-6.50	7.95	19.82
Moderate physical activity	-6.37	19.58	-9.00	52.00	37.56	44.17	-13.57	-25.00	-4.50	83.33*	-40.32	-13.44
High physical activity	2.57	5.82	0.00	1.00	0.40	10.83	-16.50	-3.33	-1.00	49.33	14.00	-18.25

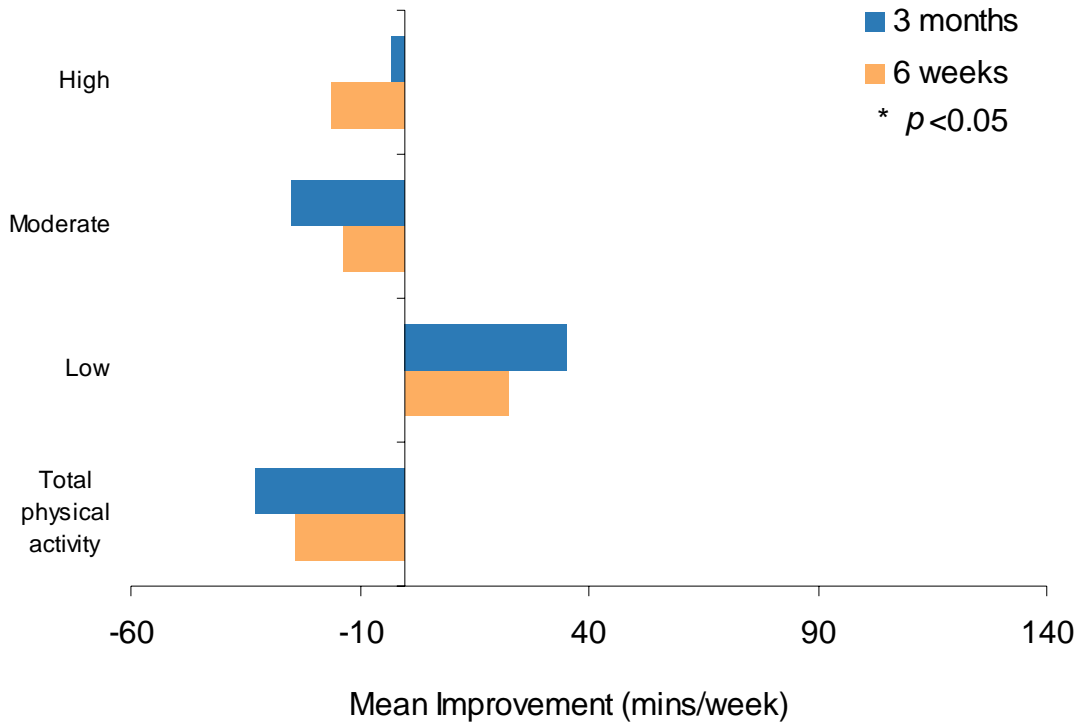
Site 1- BC Cancer Agency, Vancouver Island 1st Cohort



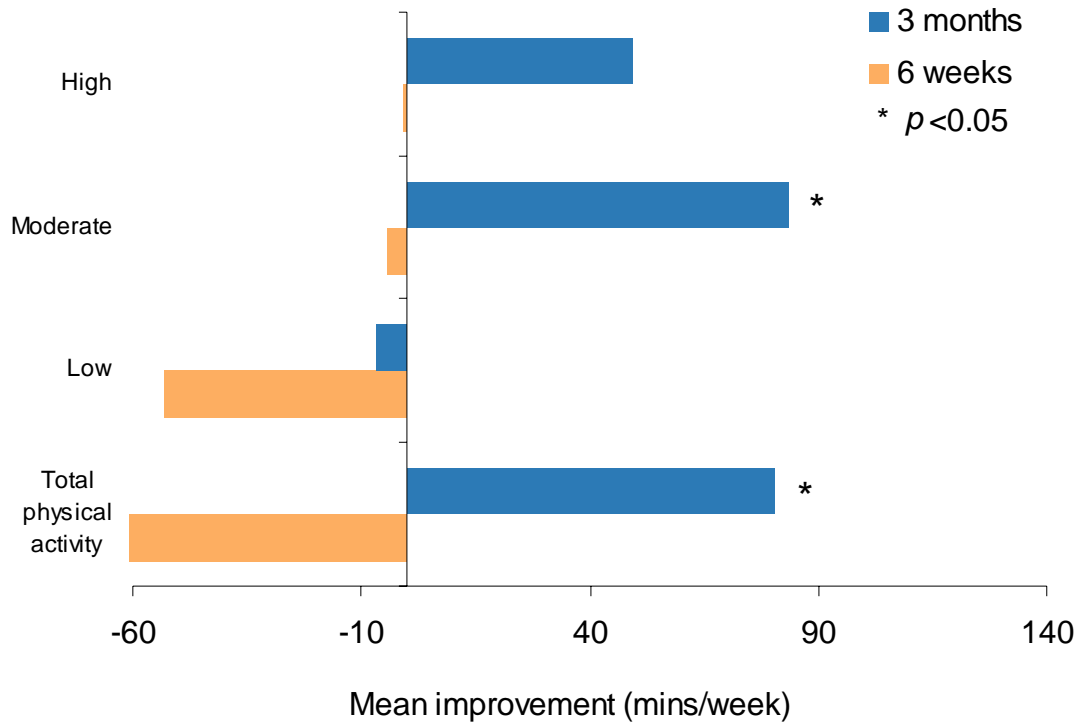
Site 1- BC Cancer Agency, Vancouver Island 2nd Cohort



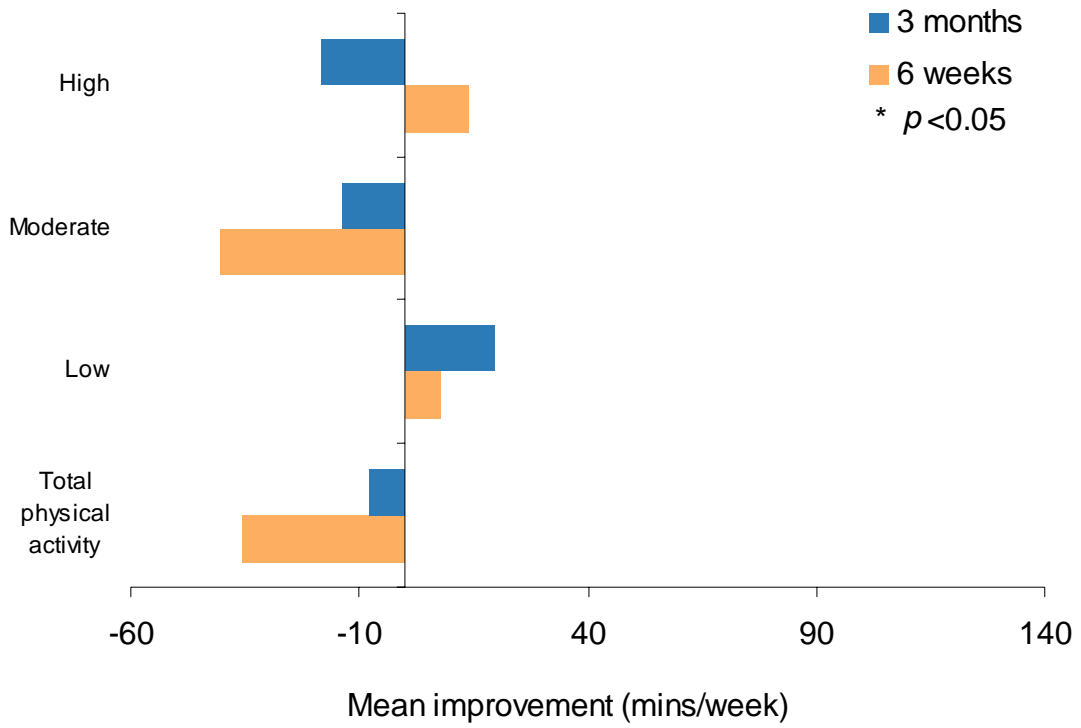
Site 2- Northern Health, Prince George



Site 3- Wellspring, Toronto



Site 4- Hope & Cope, Montreal



Individual Sites

Site 1 – BC Cancer Agency, Vancouver Island 1st cohort: Low physical activity increased after six weeks and continued three months later. Moderate activity increased from baseline at three months. High levels of physical activity were minimal. None of the changes for the Vancouver Island 1st Cohort were significant. Total physical activity showed positive trends to improvement.

Site 1 – BC Cancer Agency, Vancouver Island 2nd cohort: Overall, low, moderate, and high physical activity increased after treatment and three months post program. None of the changes for the Vancouver Island 2nd Cohort were significant. Moderate activity showed the largest increase. Total physical activity showed positive trends to improvement. It should be noted that for the second run of the program BCCA Vancouver Island partnered with the YWCA.

Site 2 - Northern Health, Prince George: Participants reported an increase in low levels of physical activity at both follow up time points. Overall, moderate, and high levels of physical activity had decreased post program and three months later, although none of the changes for the Northern Health Cohort were significant. It should be noted that the pilot was offered from January to February when weather conditions limit physical activity in northern BC

Site 3 – Wellspring, Toronto: Overall levels of physical activity had initially (six weeks) declined post program, but three months post program participants reported a significant increase in overall activity compared to initial levels before entering the Cancer Transitions program. Moderate levels of physical activity initially declined post program, but again significantly increased three months later from baseline. The largest increase was in moderate activity. The variability in the results post program to three month follow up could relate to seasonal variations in activity.

Site 4 – Hope & Cope, Montreal: Participants reported an increase in low levels of physical activity post program and three months later. Overall and moderate levels of physical activity had decreased post program and three months later. None of the changes for the Montreal cohort were significant.

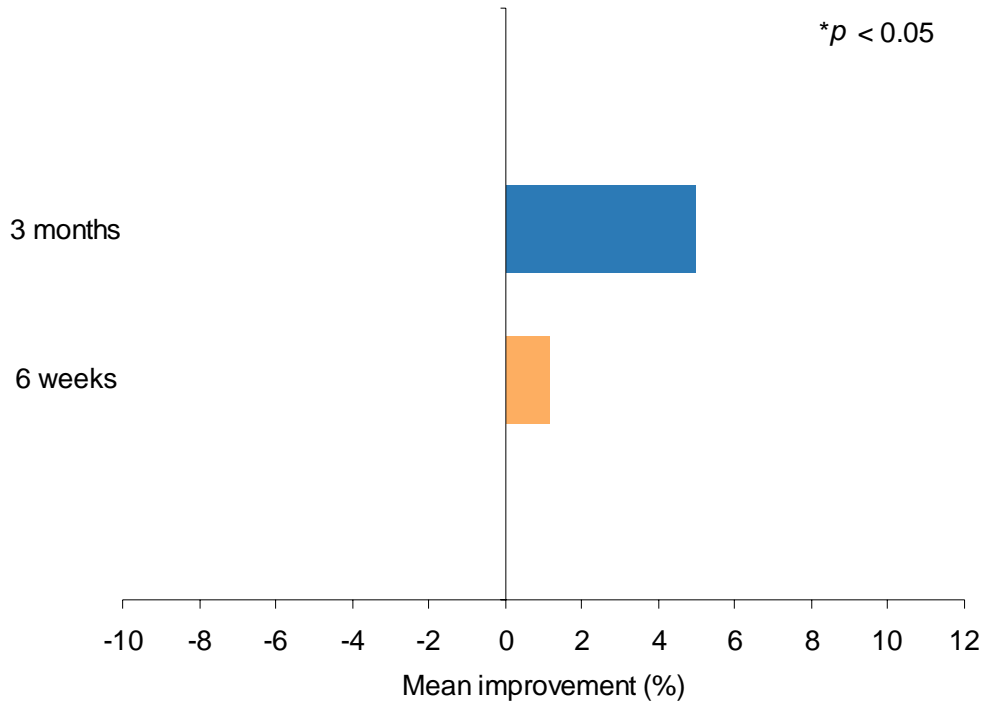
Appendix F – General Self Efficacy

Individual Sites

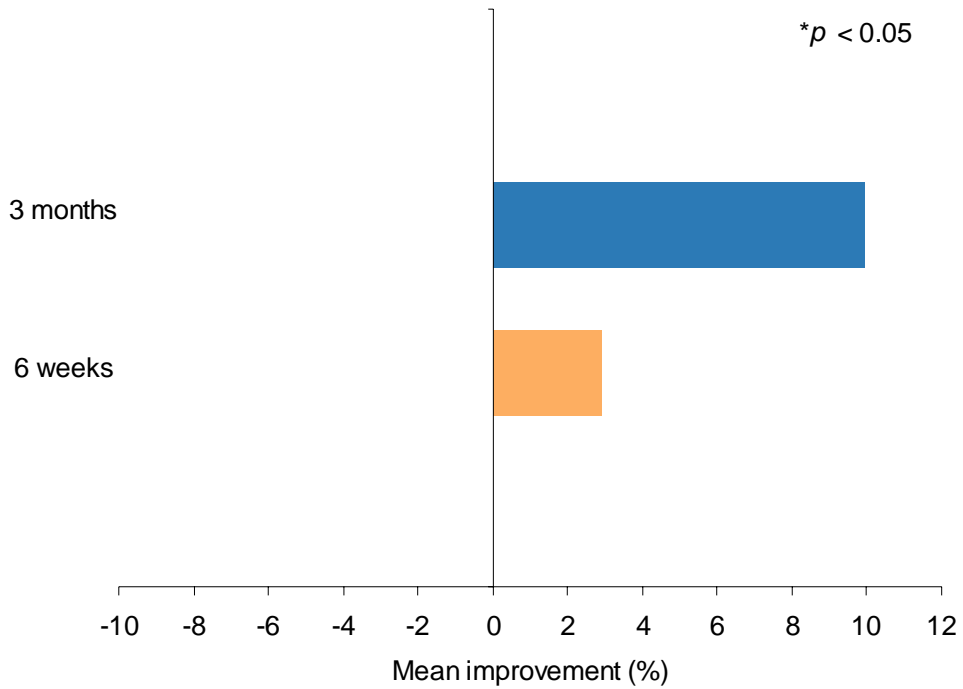
For the individual sites there were no significant changes in GSE but there were improvements for all sites at three months and for BCCA Vancouver Island and Hope & Cope at six weeks.

General Self Efficacy	Total (n=87)		BC Cancer Agency, Vancouver Island 1 st cohort		BC Cancer Agency, Vancouver Island 2 nd cohort		Northern Health, Prince George		Wellspring, Toronto		Hope & Cope, Montreal	
	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth	6 wk	3 mth
	0.44%	6.40%*	1.15%	4.96%	2.90%	9.93%	-7.66%	5.56%	-3.06%	1.92%	4.72%	6.78%

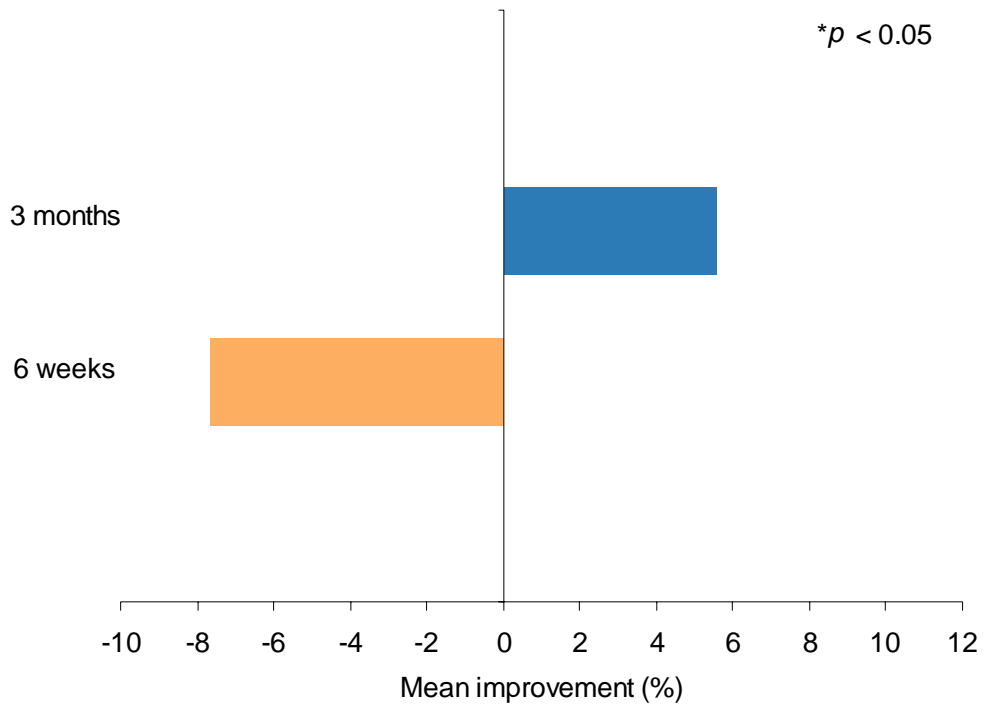
Site 1 – BC Cancer Agency, Vancouver Island 1st cohort



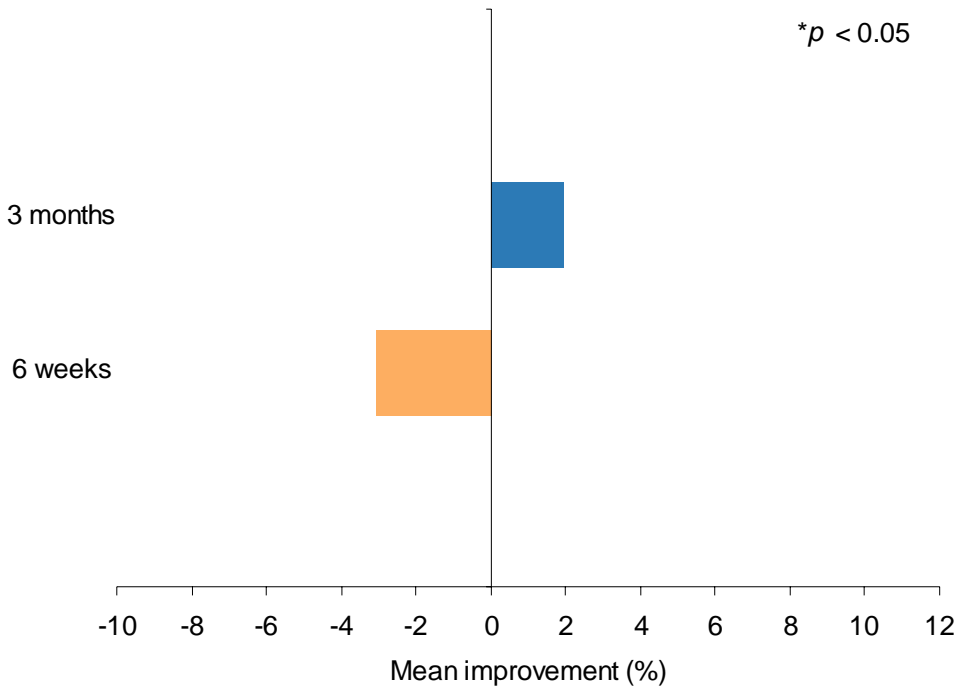
Site 1 – BC Cancer Agency, Vancouver Island 2nd cohort



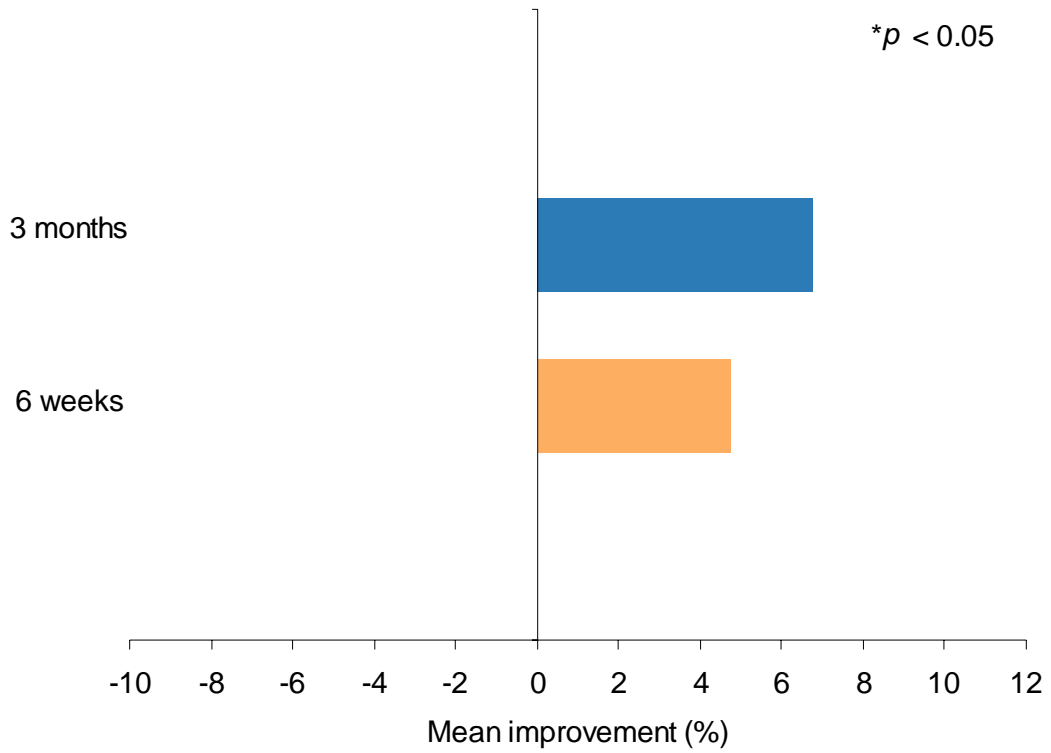
Site 2 - Northern Health, Prince George



Site 3 - Wellspring, Toronto



Site 4 – Hope & Cope, Montreal



Appendix G- Program Materials

	Cancer Transitions Participant Workbook	Exercise Log	Food Diary	Action Plan	The Road to Survivorship: Living After Cancer Treatment Brochure	LIVESTRONG Cancer Survivors Health Journal	LIVESTRONG Cancer Survivor's Medical Treatment Summary
<i>Site 1- BC Cancer Agency, Vancouver Island 1st Cohort</i>							
I have used the tool and it was very helpful or helpful	83.3	83.3	66.7	58.3	75	58.3	58.3
I have used the tool and it was not very helpful			8.3	16.7	16.7		
I have not used the tool, but I plan to in the future		8.3	8.3	8.3		16.7	16.7
I have not used the tool, and I do not plan to in the future			8.3	8.3			
<i>Site 1- BC Cancer Agency, Vancouver Island 2nd Cohort</i>							
I have used the tool and it was very helpful or helpful	85	50	70	45	65	40	45
I have used the tool and it was not very helpful		10	5	15	15	10	5
I have not used the tool, but I plan to in the future		25	5	20	5	30	30
I have not used the tool, and I do not plan to in the future			5			5	5
<i>Site 2- Northern Health, Prince George</i>							
I have used the tool and it was very helpful or helpful	56.3	68.8	68.8	50	18.8	12.5	18.8

I have used the tool and it was not very helpful		12.5				6.3	12.5
I have not used the tool, but I plan to in the future	12.5		6.3			6.3	6.3
I have not used the tool, and I do not plan to in the future				12.5		12.5	6.3

Site 3- Wellspring, Toronto

I have used the tool and it was very helpful or helpful	61.5	53.8	46.2	38.5	53.8	46.2	53.8
I have used the tool and it was not very helpful		15.4	23.1	15.4		7.7	
I have not used the tool, but I plan to in the future	7.7	15.4	15.4	30.8	23.1	30.8	23.1
I have not used the tool, and I do not plan to in the future							

Site 4- Hope & Cope, Montreal

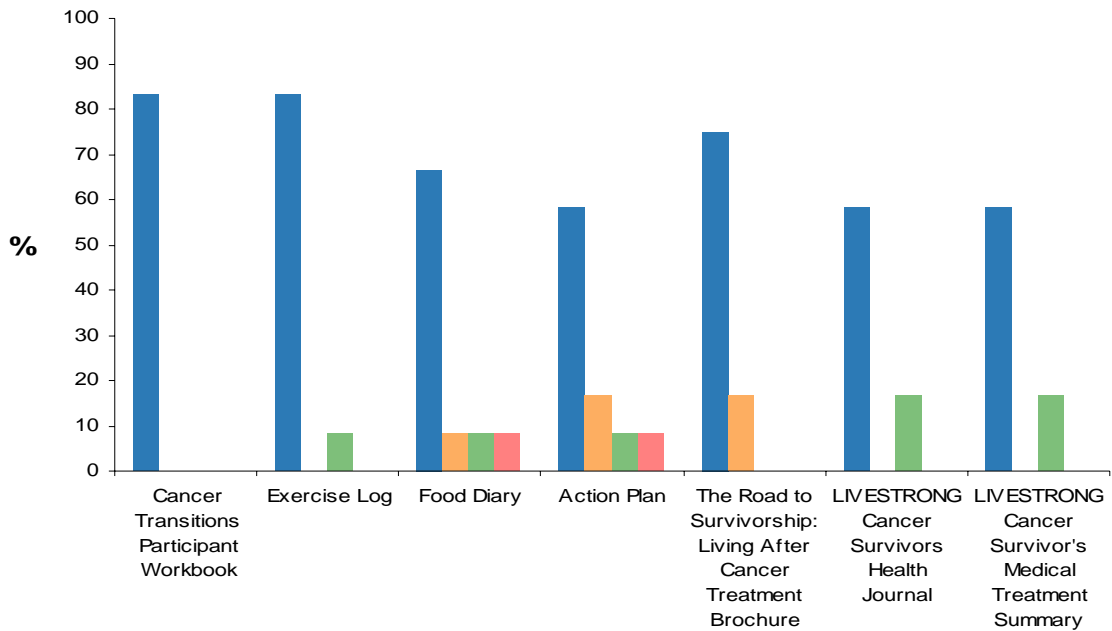
I have used the tool and it was very helpful or helpful	82.6	65.2	56.5	52.2	56.5	39.1	30.4
I have used the tool and it was not very helpful		4.3	21.7	4.3	4.3		
I have not used the tool, but I plan to in the future	8.7	17.4		21.7	26.1	39.1	47.8
I have not used the tool, and I do not plan to in the future			4.3			4.3	4.3

Note. Values may not add up to 100% due to missing responses.

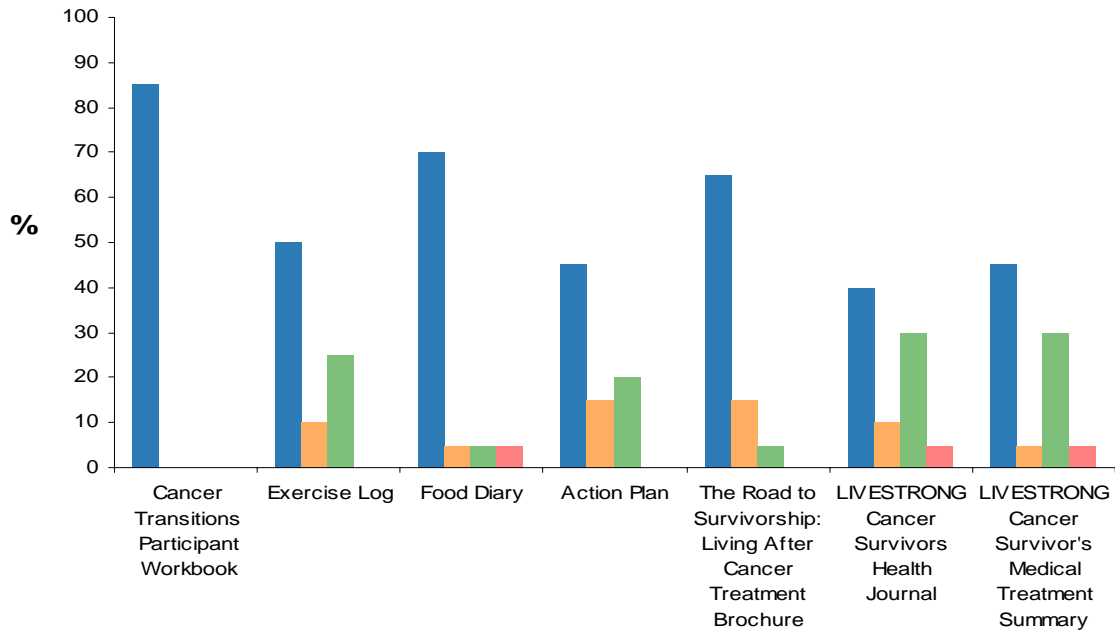
Legend

- I have used the tool and it was very helpful or helpful
- I have used the tool and it was not very helpful
- I have not used the tool, but I plan to in the future
- I have not used the tool, and I do not plan to in the future

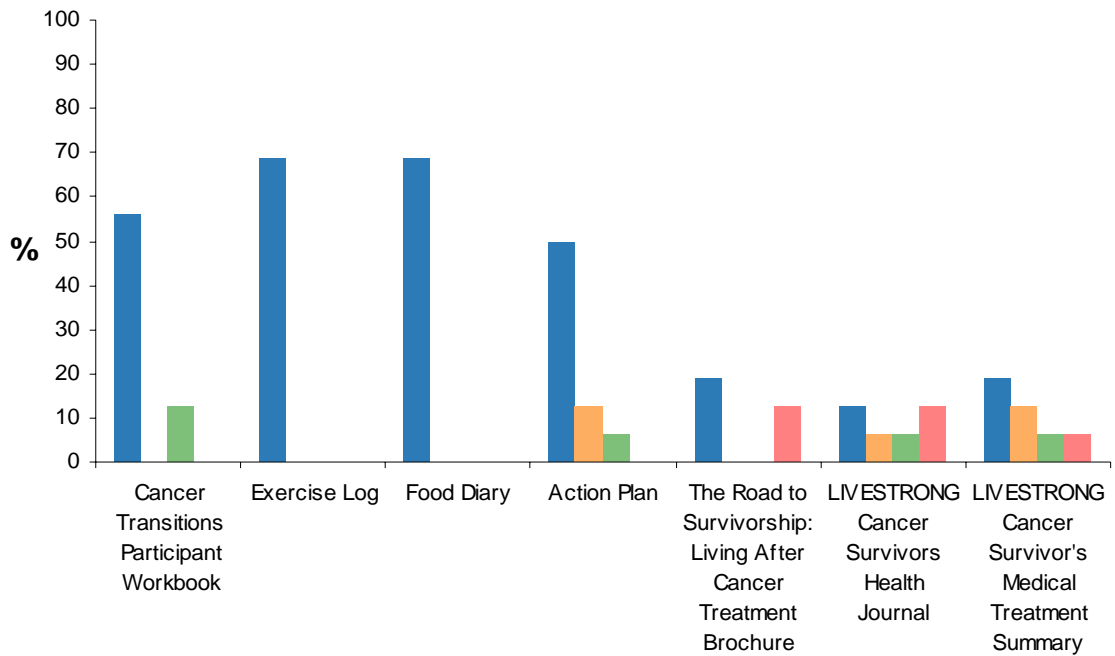
Site 1- BC Cancer Agency, Vancouver Island 1st Cohort



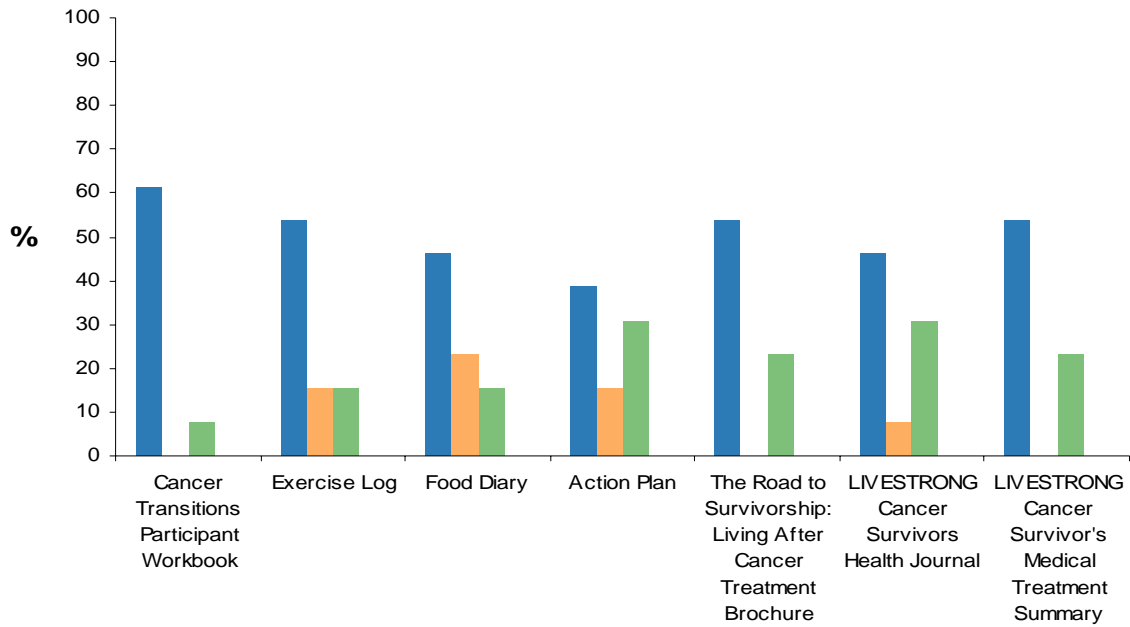
Site 1- BC Cancer Agency, Vancouver Island 2nd Cohort



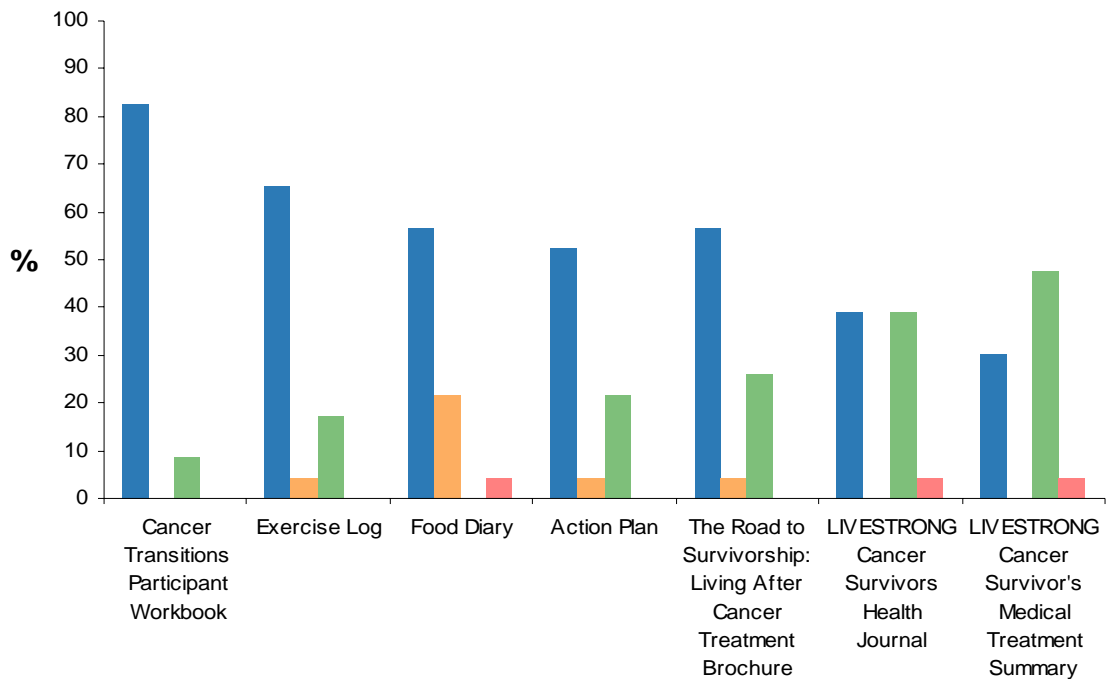
Site 2- Northern Health, Prince George



Site 3- Wellspring, Toronto



Site 4- Hope & Cope, Montreal



Appendix H

Weekly Participant Evaluation

Please rate the following statements.	Session 1 n=34				Session 2 n=40			
	Strongly Agree or agree	Neutral	Strongly Disagree or Disagree	N/A or Missing	Strongly Agree or agree	Neutral	Strongly Disagree or Disagree	N/A or Missing
The information presented in this session was clear and easy to understand.	97.0%				97.5%	2.5%		
The information provided by the presenter(s) was helpful to me.	100.0%				97.5%	2.5%		
The exercise portion of the class was helpful to me.	94.0%	6.0%			97.5%	2.5%		
The group discussion and support portion of the class was helpful to me.	91.0%	6.0%			90%	10%		
The workbook materials for this session were easy to follow and understand.	82.0%	6.0%	3.0%	3.0%	92.5%	2.5%	2.5%	2.5%
The workbook materials provided useful information for the session.	77.0%	12.0%		9.0%	90%	5%	2.5%	2.5%
The Weekly Wellness Assignments helped me prepare for this session.	30.0%	21.0%		39.0%	70%	17.5%		5%
There was adequate time for discussion and to have my questions answered.	77.0%	15.0%	6.0%		90%	5%	5%	
I will be able to use the information and tools from this session in my daily life.	97.0%				95%	2.5%		

<i>Please rate the following statements.</i>	Session 3 n=41				Session 4 n=40			
	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>
The information presented in this session was clear and easy to understand.	97.6%		2.4%		100.0%			
The information provided by the presenter(s) was helpful to me.	95.1%		2.4%		100.0%			
The exercise portion of the class was helpful to me.	95.1%	2.5%	2.5%		100.0%			
The group discussion and support portion of the class was helpful to me.	87.8%	12.2%			90.5%	2.4%	2.4%	
The workbook materials for this session were easy to follow and understand.	87.8%	7.3%	2.4%		88.1%	7.1%		
The workbook materials provided useful information for the session.	87.8%	7.3%	4.9%		86.0%	7.0%		
The Weekly Wellness Assignments helped me prepare for this session.	82.9%	12.2%	2.4%	2.4%	71.4%	19.0%	2.4%	
There was adequate time for discussion and to have my questions answered.	73.2%	14.6%	9.8%		81.0%	4.8%	9.5%	
I will be able to use the information and tools from this session in my daily life.	92.7%	2.4%	2.4%		100.0%			

<i>Please rate the following statements.</i>	Session 5 n=32				Session 6 n=43			
	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>
The information presented in this session was clear and easy to understand.	100.0%				100.0%			
The information provided by the presenter(s) was helpful to me.	96.9%	3.1%			100.0%			
The exercise portion of the class was helpful to me.	96.9%	3.1%			90.7%	4.7%		2.3%
The group discussion and support portion of the class was helpful to me.	93.8%	6.3%			90.7%	4.7%		
The workbook materials for this session were easy to follow and understand.	96.9%	3.1%			90.7%	7.0%		
The workbook materials provided useful information for the session.	87.5%	9.4%			81.4%	14.0%	2.0%	
The Weekly Wellness Assignments helped me prepare for this session.	68.8%	15.4%	3.1%	3.1%	69.8%	16.3%	4.7%	4.7%
There was adequate time for discussion and to have my questions answered.	90.6%		6.3%		88.4%	2.3%	4.7%	
I will be able to use the information and tools from this session in my daily life.	96.9%	3.1%			100.0%			

Weekly Facilitator Evaluation

Please rate the following statements.	Session 1 n=9				Session 2 n=9			
	Strongly Agree or agree	Neutral	Strongly Disagree or Disagree	N/A or Missing	Strongly Agree or agree	Neutral	Strongly Disagree or Disagree	N/A or Missing
The information included in this session was relevant to the needs of the participants.	66.7%	11.1%		22.2%	44.4%			55.6%
The information in this session was at an appropriate comprehension level for participants.	66.7%		11.1%	22.2%	22.2%	22.2%		55.6%
The Weekly Wellness Assignments were relevant and a good lead in to this session's topic.	22.2%		11.1%	66.6%	33.3%	11.1%		55.6%
The information provided was organized in a way that was easy to present.	66.7%		11.1%	22.2%	44.4%			55.6%
The facilitator notes and guidance were helpful to me.	55.5%	22.2%		22.2%	33.3%	11.1%		55.5%
The workbook materials for this session were well organized and helped in the presentation of the content.	44.4%	22.2%	11.11%	22.2%	22.2%	22.2%		55.5%
There was adequate time for discussion and to have questions answered.	44.4%		33.3%	22.2%	33.3%	11.1%	11.1%	44.4%

<i>Please rate the following statements.</i>	Session 3 n=9				Session 4 n=9			
	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>
The information included in this session was relevant to the needs of the participants.	55.5%		11.1%	33.3%	77.8%			22.2%
The information in this session was at an appropriate comprehension level for participants.	55.5%	11.1%		33.3%	77.8%			22.2%
The Weekly Wellness Assignments were relevant and a good lead in to this session's topic.	55.5%		11.1%	33.3%	55.6%		11.1%	33.3%
The information provided was organized in a way that was easy to present.	33.3%	11.1%	22.2%	33.3%	55.5%	11.1%	11.1%	22.2%
The facilitator notes and guidance were helpful to me.	44.4%	11.1%	11.1%	33.3%	66.7%		11.1%	22.2%
The workbook materials for this session were well organized and helped in the presentation of the content.	55.6%		11.1%	33.3%	55.5%	11.1%	11.1%	22.2%
There was adequate time for discussion and to have questions answered.	44.4%	22.2%		33.3%	66.7%		11.1%	22.2%

<i>Please rate the following statements.</i>	Session 5 n=9				Session 6 n=9			
	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>	<i>Strongly Agree or agree</i>	<i>Neutral</i>	<i>Strongly Disagree or Disagree</i>	<i>N/A or Missing</i>
The information included in this session was relevant to the needs of the participants.	77.8%		11.1%	11.1%	33.3%		22.2%	44.4%
The information in this session was at an appropriate comprehension level for participants.	77.8%	11.1%		11.1%	44.4%		11.1%	44.4%
The Weekly Wellness Assignments were relevant and a good lead in to this session's topic.	55.6%			44.4%	33.3%	11.1%	11.1%	44.4%
The information provided was organized in a way that was easy to present.	44.4%	11.1%		44.4%	33.3%	11.1%	11.1%	44.4%
The facilitator notes and guidance were helpful to me.	44.4%	11.1%		44.4%	44.4%		11.1%	44.4%
The workbook materials for this session were well organized and helped in the presentation of the content.	44.4%	11.1%		44.4%	44.4%		11.1%	44.4%
There was adequate time for discussion and to have questions answered.	66.7%	22.2%		11.1%	55.5%			44.4%

Appendix I

Cancer Transitions EAST Facilitator Training: Ottawa, October 22 and 23rd, 2009

Participant List



Organization/Positions	Name
<i>Ontario</i>	
Ottawa Cancer Foundation Cancer Transitions Program Manager	Eileen Lacroix
Ottawa Cancer Foundation Social Worker	Jennifer Williams
Ottawa Cancer Foundation Survivorship Program Development Manager	Tina Mattila
Colorectal Cancer Association of Canada Cancer Coach	Ann Marie Kerr
Colorectal Cancer Association of Canada Cancer Coach	Ann Robinson
Ottawa Hospital Cancer Centre Medical Lead of the Psychosocial Oncology Program	Caroline Gerin-Lajoie
Ottawa Hospital Cancer Centre Psychosocial Oncology program Oncology Social Worker	Esther Doucette
Ottawa Hospital Cancer Centre Psychosocial Oncology program Social Worker	Marion Kennedy MacQueen

Ottawa Hospital Cancer Centre Gynaecologic Advance Practice Nurse	Lynne Jolicoeur
Sudbury Regional Hospital Social Worker	Jillian Romanko
Sudbury Regional Hospital Social Worker	Traci Franklin
Princess Margaret Hospital Breast Cancer Survivorship Program Manager	Scott Secord
Princess Margaret Hospital Patient Education and Survivorship Program Manager	Janet Papadakos
Odette Cancer Centre Advanced Practice Nurse- Breast Cancer	Angela Leahey
Canadian Partnership Against Cancer Chair, CPAC CJAG; Head, Oncology Nursing and co-director, Integrated Psychosocial, Supportive and Palliative Care Program, Odette Cancer Centre	Margaret Fitch
Canadian Partnership Against Cancer Communications Manager	Shirley Connor
<i>Nova Scotia</i>	
Cape Breton Cancer Centre Social Worker	Tom McNeil
Cape Breton Cancer Centre Registered Nurse	Darlene Bates
Capital District Health Authority Medical Resource Specialist (Social Worker)	Mary Lou Robertson
Capital District Health Authority Chaplain	David Maginley
Nova Scotia Cancer Centre Radiation Oncologist	Rob Rutledge
<i>Manitoba</i>	
CancerCare Manitoba Social Worker	Irene Shapira
CancerCare Manitoba Nurse Educator	Lori Santoro
CancerCare Manitoba Psychosocial Oncology Clinician/Clinical Psychologist	Tom Hack
<i>Prince Edward Island</i>	
PEI Cancer Treatment Centre Patient Navigator	Lynn McCabe
PEI Cancer Treatment Centre Social Worker	Andrea Scott
<i>Facilitators</i>	
Cancer Support Community Senior VP Research and Training	Mitch Golant
BCCA- Vancouver Island Centre	Nancy Payeur

Regional Practice Leader, Patient and Family
Counselling

BCCA

Research Scientist

BCCA

Research Assistant

Cancer Support Community

Senior VP Research and Training

Amanda Ward

Joanne Magtoto

Mitch Golant

Cancer Transitions WEST Facilitator Training: Vancouver, November 24th and 25th, 2009
Participant List



Organization	Name
<i>British Columbia</i>	
Interior Health Authority KBRH	Diana Ferguson
KBRH Interior Health Social Worker	Jim Maniago
BCCA Clinical Counsellor	Karen Flood
BCCA Rehabilitation Counsellor	Maureen Parkinson
Mills Memorial Hospital Social Worker	Micki Smart
Interior Health Penticton Oncology Clinic Social Worker	Andrea Turner
BCCA Clinical Social Worker	Paula Myers
BCCA Clinical Researcher	Joanne Stephen
Ovarian Cancer Canada Pacific Regional Manager	Tracy Kolwich
Northern Health, St. John Hospital Registered Nurse	Mary Sommerville
BCCA Oncology Social Worker	Sandy Kwong
<i>Manitoba</i>	

CancerCare Manitoba Director, Patient and Family Support Services	Jill Taylor-Brown
CancerCare Manitoba Oncology Social Worker	Elizabeth Payne
<i>Saskatchewan</i>	
Saskatchewan Cancer Agency Clinical Oncology Social Worker	Grant Rathwell
Saskatchewan Cancer Agency	Karen Carmichael
<i>Ontario</i>	
Sunnybrook Manager Patient Education Program Sunnybrook Health Sciences Centre	Tamara Harth
<i>Quebec</i>	
Laval University and the CHUQ Professor, Researcher, and clinician psychologist	Lise Fillion
CHUQ-L'Hôtel-Dieu de Québec pivot en oncology (Oncology Pivot Nurse)	Nathalie Gravel
CHUQ-l'Hôtel-de de Québec Travailleuse sociale (Social Worker)	Geneviève Lambert
<i>Facilitators</i>	
Cancer Support Community Senior Director of Education and Outreach	Ivy Ahmed
Prince George Regional Hospital Regional Oncology Psychosocial Lead	Tasha Ahlstrom
BCCA Head, Patient and Family Counselling- Vancouver Island Centre	Nancy Payeur
BCCA Research Scientist	Amanda Ward
BCCA Research Assistant	Joanne Magtoto

Appendix J



AGENDA

Cancer Transitions Facilitator Training Workshop

Day 1: 8:00 a.m. – 4:30 p.m.

Day 2: 8:00 a.m. – 1:00 p.m.

Day 1		
8:00 a.m. – 8:45 a.m.	Continental Breakfast	
8:45 a.m. – 9:15 a.m.	Welcome and Group Introductions	Amanda Ward All
9:15 a.m. – 9:45 a.m.	Program Overview Cancer Transitions Cancer Support Community	Amanda Ward Mitch Golant (East) Ivy Ahmed (West)
9:45 a.m. – 10:30 a.m.	Program curriculum, process and timeline Facilitator Training Session 1	Nancy Payeur Tasha Ahlstrom
10:30 a.m. -10:45 p.m.	Break	
10:45 a.m. – 12:30 p.m.	Facilitator Training Sessions 2 and 3	Nancy Payeur Tasha Ahlstrom (West)
12:30 p.m. – 1:30 p.m.	Lunch	
1:30 p.m. – 3:15 p.m.	Facilitator Training Sessions 4 and 5	Nancy Payeur Tasha Ahlstrom (West)
3:15 p.m. – 3:30 p.m.	Break	
3:30 p.m. – 4:15 p.m.	Facilitator Training Sessions 6 and Booster	Nancy Payeur Tasha Ahlstrom (West)
4:15 p.m. – 4:30 p.m.	Closing remarks	Amanda Ward

Day 2

8:00 a.m. – 8:45 a.m.	Breakfast	
8:45 a.m. – 9:45 a.m.	Next steps: <ul style="list-style-type: none">• survivor eligibility and demographics• recruitment and marketing strategy	Nancy Payeur Tasha Ahlstrom (West)
	Best Practice Guidelines	
9:45 a.m. – 10:15 a.m.	Questions, review and reflections	All
10:15 a.m. -10:30 p.m.	Break	
10:30 a.m. – 11:30 p.m.	Cancer Transitions Evaluation	Amanda Ward
1:30 a.m. – 12:15p.m.	Discussion and questions	All
12:15 p.m. – 12:30 p.m.	Closing remarks	Amanda Ward Nancy Payeur Tasha Ahlstrom (West) Mitch Golant (East) Ivy Ahmed (West)
12:30 p.m. – 1:00 p.m.	Lunch	
1:00 p.m	Adjournment	

Appendix K

Cancer Transitions Program Curriculum

Group notes from the breakout sessions during the facilitator training

Session 1

Key Messages

Ottawa

- Patient Active Concept
- Increase sense of control
- Increase education/information
- Period of heightened learning potential
- Changing your perception
- Setting new goals, road map
- “Lost”
- What to expect in “new normal”
- Supportive program. Not therapy, but “therapeutic”

Vancouver

- Planning and follow through of small steps
- Shifting, reinforcing from past to present and future focus
- Redirecting discussion “setting context for shift knowing past history/tx could dominate”
- Patient active concept
- Dangers of passivity
- Shift to life after treatment

Key Activities

Ottawa

- Ice breaking exercise
- Introduction to facilitator, exercise consultant
- Process of setting personal goals, program provides framework
- Discussion of goals, creating goals “new normal”
- Discussion of survivorship concept
- Hand out pedometers
- Exercise

Vancouver

- Awareness of transitions- focus
- Creating context of shift taking place
- Introducing key concepts
- Overview of program
- Key practical matters- logs, pedometers

Challenges

Ottawa

- Time challenges- great deal of information/sharing to present
- Building rapport with group- sensitive to diversity/willingness to share
- Fatigue- dependent upon what point “post tx” participants are. Differences between new “acute” vs. patient post treatment
- Chemo brain
- Agenda of activities- offer varied time limits

Vancouver

- Pre screening
- Waiver
- Chronic management vs. life after cancer
- Pre existing disabilities
- Managing people’s relation of their story/introduction. Not getting bogged down in medical details
- Online- how to present exercise, dietary and medical

Local Colour

Ottawa

- Promotion of physical activity not accepted in culture/community
- Culturally sensitive- Aboriginal?

Vancouver

- Needs for different physical environment (May in Vanderhoof)
- Online- create online resources, and have local resources. Homework sharing online

Fun Stuff

Ottawa

- Ice breakers
- One positive and one negative of their cancer experience
- One accomplishment each week
- Ziploc carrying case with all materials

Vancouver

- Rekindle spirit weakened by cancer experience (want to do, but haven’t)
- Show and tell in the spirit of moving forward
- Introduction- fun goal and serious goal
- How have you set goals in the past and achieved this?
- How have you motivated yourself?

Session 2

Key Messages

Ottawa

- Develop a realistic exercise plan
- “ACE”- Alert, Calm, Energize
- Customize
- Keep moving
- Gain vs. Drain
- Deep breathing
- Establishing a support system
- Exercise is going to help you feel better

Vancouver

- Exercise as a powerful tool to help take control of physical and mental health
- Value of exercise for post treatment
- You can exercise at any point by the way you exercise will look different. Customize activities
- To maintain plan. A) Set realistic goals B) Reward yourself C) Establish a support system

Key Activities

Ottawa

- Talking to Doctor
- Diet
- Exercise log
- Pedometer

Vancouver

- Value of exercise, evidence
- Customize activities- What works for you?
- Momentum plan- workbook, realistic goals, establish support system

Challenges

Ottawa

Speaker:

- Doing it for fun
- Resources
- Free vs. paid
- Relationship with colleagues
- Timing and location

Survivor

- Motivation
- Dropping out
- Talking with Doctor
- “Medical Model”

- Varied levels of activity

Vancouver

Speaker:

- Cost, resources, location (space)
- “Imposter syndrome”

Survivor

- Fatigue
- Prior negative experience with exercise
- Awkwardness of going to a gym
- Deprivation and exercise
- Climate

Local Colour

Ottawa

- How to recruit/engagement
- How to make it standard
- Multi-cultural issues
- Culture shift/awareness “living with Cancer”
- Varying definitions of community. No sense of belonging to “community”

Vancouver

- Adapt online or pod case for rural and remote
- Already established local resources (e.g. Running room)
- Local celebrity exercising on video

Fun Stuff

Ottawa

- Make it fun- “Yes you can”
- How to keep them motivated
- Check in at the end
- Sharing, funny, joyful moments
- Fun you-tube clips on good vs. bad exercise- “leave with laughter”
- Positive messages

Vancouver

- Music and dance to “move”
- Active activities
- Knowledge of other areas
- MBSR, walking

Session 3

Key Messages

Ottawa

- Validation of distress, post treatment
- Dealing with the emotional distress- taking control, develop a plan
- When and where to get help
- Finding meaning after the cancer experience
- Relationships and communication

Vancouver

- Distress is part of the journey
- Universality of experience
- Fear of recurrence
- Moving forward, relationship with self, others, and world
- Time to acknowledge and validate without judgment process and continue while coping
- You are not alone- reminded of that
- Key messages are not black and white

Key Activities

Ottawa

- Distress thermometer- weekly
- Fear plan, strategies for anxious thoughts

Small group

- Discussion questions are great
- Didactic together

Communication in relationships

- Some kind of exercise, role playing?

Vancouver

- Experiential ways of presenting data
- Learning
- Story telling

Challenges

Ottawa

- A lot of information to cover in one session. If worried for time, tell participants information is revisited during session 6
- Co-ed group- challenges of discovering sexuality
- What is someone discovers that they have a re occurrence?
- Commitment for the duration of the group
- What is people miss a session
- Personalities that are brought to the group that are challenging
- Fatigue- session is 2.5 hours

Vancouver

- Lots of content
- Relationship based

- Practical, but needs

Local Colour

Ottawa

- Sexuality: bring in guest speaker from “Venus Envy”
- Accessibility for patients from rural communities

Vancouver

- Story telling
- Art expression
- Journal
- Knowing what processes/education
- Distress tool (Quebec)

Fun Stuff

Ottawa

- Sexuality discussion
- One positive, one negative emotion thing from your experience (pair exercise)

Vancouver

- Exercise link and emotional awareness
-

Session 4

Key Messages

Ottawa

- Advice has to be “practical” for patients, i.e. how to shop local, what should you buy, how to make your own muesli, where to get cheap blueberries, etc.
- Understand role of nutrition, rebuilding and promoting health
- “It’s your choice” and here are what make good choices. Focus on what you can do and not what you can’t do
- Positive reinforcement (key motivator) is important

Vancouver

- Variety and moderation
- Small steps
- Taking control of your diet and nutrition can make you stronger and keep you healthy
- Healthy eating may help reduce the risk of recurrence
- Minimal processed foods
- Healthy body weight
- Exercise
- Nutrient rich foods

Key Activities

Ottawa

- Make your plan- keep in mind/make some notes
- Use the people’s positive and practical changes and tips
- Have everyone complete “meal planning” plan for the next week
- How to organize meals
- How to shop for ingredients
- Review food labels and how to read them
- Measure waist circumference- link with BMI (increase motivation)

Vancouver

- Discussion with a registered dietitian on healthy eating
- Reinforcing nutrient rich foods and positive effect on health and strength
- Demonstration of serving sizes
- Quick nutrient rich meals

Challenges

Ottawa

- Getting though all of the information, a lot to cover
- Motivating patients- making the information make sense for them
- Distrust in our food system- neglect basics, turn to supplements
- Organic vs. non-organic

- Providing accurate advice re: supplements, vitamins, minerals
- Diet/weight loss- radical change in lifestyle for some
- Cultural “diet” issues
- Energy levels
- Economics- perception healthy food costs more

Vancouver

- Variance of age and ethnic groups
- Variance of education
- Mixed and new measures on what healthy nutrition is and “cures” for cancer
- More expensive to eat healthy? Debunk myth
- How to balance good nutrition with the idea that food is social and emotional
- How to empower vs. take away power

Local Colour

Ottawa

- Post nutrition session- link patients with dieticians
- Community resources
- Where to shop- lowest prices, freshest produce
- Literacy levels

Vancouver

- Partner with organizations such as Wellspring to offer health eating classes
- Creating awareness about “produce boxes”
- Local community to teach how to grow own fruits and vegetables

Fun Stuff

Ottawa

- Reading of actual food labels
- Sharing of food, snacks, recipes, food tips, food flyers
- Coupon box

Vancouver

- Focusing on demographic- finding dietician who could create/offer healthy alternatives in that particular group
- Creative recipes- quick ways to eat healthy
- Game re: “portion distortion”
- Speaker specializing in cancer and diet

Session 5

Key Messages

Ottawa

- Being an active participant in care- partnership
- Knowing what to expect (short and long term side effects)
- Building in more emphasis on smoking/alcohol (local)
- Importance of keeping track of self care activities and how to do it

Vancouver

- Communication with medical team- new symptoms
- Keeping appointments and tests-ongoing
- Ask questions
- When to seek help- what am I look for that I should not ignore?
- How to seek help- “call your doctor”

Key Activities

Ottawa

- Discussion of common side effects/normalizing it with management tips
- Work book exercise/coaching on questions to ask doctor (what's worked/what hasn't)

Vancouver

- Health diary
- Sharing fears

Challenges

Ottawa

- Comparison of different GP approaches to follow up
- Conflicting approaches to follow up/mixed messages
- High rate of people without GP, difficulty relating to material

Vancouver

- Smaller communities- set up ground rules around sharing
- Communication with medical teams- previous experience, physician style
- Patient reluctance to share
- How to portray to patients not to be number focused

Local Colour

Ottawa

- Inability to switch physicians or even obtain one
- Refusal of oncologist to treat short and long term
- Side effects for those without a GP
- PEI has excellent GP associates/nurse practitioner (strength) for guest speakers
- Space to include exercise/accessible space

- Need to speak to confidentiality- small town, seeing familiar people
- High variance/rate of age groups, disability- how do you create an exercise program that meets a range of needs?

Vancouver

- Access to physicians- strength or challenge depending on community
- Travel to appointments- telehealth- is it available?
- Facilitation- medical expertise

Fun Stuff

Ottawa

- Plug for something fun in session 6
- Infusing humour
- Skit with presenter of a “difficult GP visit” and strategies for dealing with it
- GP/presenter playing the pt and asking for a volunteer to play the doctor (how would *you* handle these questions)

Vancouver

- Meditation
 - Reflection- deep breathing/relaxation
 - Food and refreshments
 - Report on pleasant/fun
-

Session 6

Key Messages

Ottawa

- Reinforce the pro active concept and express the best benefit to them is by integrating guest speaker information and use of tools and keep on setting goals to improve their health
- Providing “hope” exercise of passing a stone around
- Organizing their medical records and plan for their ongoing care
- Facilitate new relationship building and ongoing support with each other
- Positive send off- “looking forward”

Vancouver

- Moving beyond treatment
- Next steps towards survivorship
- Managing your medical records
- Consolidate the key message from the previous sessions
- What next? Ways to keep going with what you have learned

Key Activities

Ottawa

- Importance to having copies of medical records
- Improving communication with family
- Keep exercising and good nutrition and see it as a process and progressing slowly
- Encourage to look up the additional resource
- Keep is to give hope- celebrate life
- Review Looking Forward booklet by asking two questions:
 1. What do you hope for of yourself as a cancer survivor?
 2. What are your next steps towards survivorship?
- “Transition to the transitioning”- end of program. Next steps?

Vancouver

- Summary of group sessions
- Medical records
- Physical exercise/relaxation
- Reinforce the messages from the group session i.e. discussion
- Celebration- moving forward
- Can bring out different challenges or concerns

Challenges

Ottawa

- Promoting the importance of completing medical record tools
- Session #3- lots of information, so spend time again on some aspects
- Acknowledge the moving/transitioning of end of program

Vancouver

- Client diversity, based on demographics

- Distance, transportation
- Language
- Accessing support in the community
- Accessing medical records- different specialists, hospitals,
- Cultural beliefs in regards to asking for medical records- disrespectful to Dr's?
- No specialists in community

Local Colour

Ottawa

- Geographical issues for participants attending, video conferencing would be an asset

Vancouver

- Limited resources/no specialist
- Chinese population close family relationship- whole family support needed

Fun Stuff

Ottawa

- Pot luck meal
- Handing out the certificate and say something of personal appreciation
- Send yourself a letter in six months, what would it say?
- Identify new fun things they could do
- Relaxation exercise in workbook is important
- How to let go- write down words on stones that reflect the group's needs. Can have multiple stone with the same word. Also have blank stones for participants to write their own words

Vancouver

- Appreciation fan
- Alumni connection- booster group
- Regular updates- connection board
- Awards
- Recipe book
- Goal setting for self- example: 2 things for self on note and facilitator sends goals back to participant as a reminder
- Bucket list

Key Priorities

Recruitment and Marketing

Top two:

- Partnerships: hospitals, support groups, nurses, RT, rounds
 - Hand out small flyers/business cards, “Make it easy”. Create excitement in a concise way
 - Present at cancer site rounds, reach out to doctors and nurses
- Word of mouth

Other

- Slides for hospital televisions
- Signage in hospitals
- Donated space on television guide and cable television
- Cancer registries
- Mail outs (successful, but time consuming)
- Local media
- Newspaper

Selection/group composition

- Eligibility criteria
- When do you do pre screening
- Group facilitator completes pre screening
- Red flags? Will this person benefit? Will they participate appropriately?
Always offer alternative programs that are more suitable to their needs

Partnerships/staying connected

- Staying connected for survivors
 - Cancerview- Canadian Partnership Against Cancer
www.cancerview.ca
 - Caring Voices- www.caringvoices.ca for all cancer patients. Help stay connected with all participants that have completed Cancer Transitions across Canada
- Staying connected for facilitators?
 - Caring Voices- www.caringvoices.ca private meeting for Cancer Transitions facilitators to stay connected?
 - Teleconference, group contact list?
- Partnerships with oncology team
 - CME to medical professionals to learn about Cancer Transitions

- Draw in collaborators. How do you engage without de franchising other programs within the organization? Not about competition, about collaboration and the greater good
- Bring clinicians into a forum to learn about Cancer Transitions
- Send email to all medical oncologists about survivorship (quick and short!) “Thank you for your referral, we’ve helped ___#___ survivors”
- Survivor transitions newsletter?

Rural and remote

- Facilitator on site or on line?
- Increase capacity, train the trainer
- Cultural adaptation
- How to teach exercise- DVD?
- First session meet together to personally connect
- Telehealth vs. video conferencing
- Debriefing for distressed patients?

Proposed format for rural/remote delivery

Phase 1- Gain experience with current program

Phase 2- Draw on experts

Phase 3- Implementation

- Central Coordination
- Marketing
- First day in person?/large groups?

Weekly agenda:

- Virtual check in
- Exercise live/DVD
- Didactic live/DVD
- Group process- end of evening

Appendix L

An example of the facilitator training evaluation form and a participant response to the training.

Photocopies of all the training evaluations will be mailed to the CJAG.

Please answer the following questions using the scale provided:	Excellent	Good	Fair	Poor
1. Overall, how would you rate this training?	√			
2. Overall, how would you rate the meeting and presentation materials?	√			
3. How would you rate the pre meeting logistics (i.e. preparation, accommodations and coordination)?	√			
<i>Please rate the following components:</i>				
<i>October 22nd : Day 1</i>				
4. Presentations' and focus groups usefulness in preparing you to deliver the CT program	√			
5. Your ability to deliver the CT program as a result of the training		√		
<i>October 23rd : Day 2</i>				
6. Usefulness of "next steps" and best practices discussions (marketing, recruitment, pre screening, location considerations, partnerships)		√		
7. Usefulness of research evaluation presentation		√		
<i>Please rate the Speakers for each of the criteria listed (if applicable):</i>				

Nancy Payeur, MSW (CT Training Facilitator and Program Trainer) (1) Quality of the presentations (2) Knowledge of the program (3) Effectiveness as a program trainer (4) Responsiveness to questions	√			
	√			
	√			
	√			
Mitch Golant, PhD (CT Training Facilitator and Program Research Evaluation) (1) Quality of the presentations (2) Knowledge of the program (3) Responsiveness to questions	√			
	√			
	√			
Amanda Ward, PhD (CT Training Facilitator and Program Research Evaluation) (1) Quality of the presentations (2) Knowledge of the program (3) Responsiveness to Questions	√			
	√			
	√			
	√			
<i>Please rate the training materials:</i>				
9. Quality and relevance of the CT Workbook (for participants)		√		
10. Quality and value of the Facilitator Guide		√		
11. Value of PowerPoint presentations for program delivery	√			

**Cancer Transition: Moving Beyond Treatment
Professional Training Program**

15. Do you have any questions that were not addressed or answered?

No

16. If yes, please explain below:

N/A

17. What did you find most helpful about the meeting and training?

- 1) Group work on reviewing of each session and how sharing the group's assessment aligned with the session slides afterwards.
- 2) Ability to collaborate amongst colleagues across Canada to share their experiences and how they planned on initiating this program at their own facilities.

18. What did you find least helpful?

Nothing – overall was an excellent and helpful workshop.

19. What would you change?

Perhaps would have focused on Review of the research first thing on Day two to allow for a less “rushed” effort on this and then leave the remainder of the morning for discussion on Marketing, Recruitment etc.

20. Additional comments:

Appendix M

Implementation Status and Research Evaluation Participation by Site

East Organizations				
Organization	Contact	Planning Implementation	Date	Research Evaluation
<i>Ontario</i>				
Ottawa Cancer Foundation	Jennifer Williams Tina Mattila	Yes	Nov 2009 & Sept 2010	Yes
Colorectal Cancer Association of Canada	Ann Marie Kerr Ann Robinson	Unknown		
Ottawa Hospital Cancer Centre	Caroline Gerin-Lajoie Esther Doucette Marion Kennedy MacQueen Lynne Jolicoeur (GYNO)	Unknown		
Sudbury Regional Hospital	Jillian Romanko Traci Franklin	Yes	Sept 2010	?
Princess Margaret Hospital	Scott Secord Janet Papadakos	Unknown		
Sunnybrook	Tamara Harth	Unknown		
Odette Cancer Centre	Angela Leahey	Unknown		
<i>Nova Scotia</i>				

Cape Breton Cancer Centre	Tom McNeil Darlene Bates	Yes	Apr 2010	No, will consider for next offering
Capital District Health Authority and Nova Scotia Cancer Centre	Mary Lou Robertson David Maginley Rob Rutledge	Yes	Apr 2010	Yes

Manitoba

CancerCare Manitoba	Irene Shapira Lori Santoro Tom Hack Jill Taylor-Brown	In discussion with organization		
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Quebec

CHUQ-L'Hôtel-Dieu de Québec	Lise Fillion Nathalie Gravel Geneviève Lambert	Yes	Pilot French version Sept 2010	Yes
Hope & Cope Montreal	Hinda Goodman Suzanne O'Brien	Yes	Spring & Fall 2010	

Prince Edward Island

PEI Cancer Treatment Centre	Lynn McCabe Andrea Scott	Unknown		
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New Brunswick

New Brunswick Cancer Network

Shirley Koch

Probably not this year -came to the training to observe for future implementation

West Organizations

Organization	Contact	Planning Implementation	Date	Research Evaluation
<i>British Columbia</i>				
Interior Health Authority KBRH	Diana Ferguson	Yes	Jan 2010	No
KBRH Interior Health	Jim Maniago	Yes	Jan & Sept 2010	No for January, will consider for September
BCCA- Vancouver	Karen Flood, Maureen Parkinson, Paula Myers, Joanne Stephen, Sandy Kwong	Yes	Jun 2010	Yes

Mills Memorial Hospital	Micki Smart	Unknown		
Interior Health Penticton Oncology Clinic	Andrea Turner	Unknown		
Northern Health, St. John Hospital	Mary Sommerville	Yes	Apr 2010	Yes
Northern Health, Prince George	Tasha Ahlstrom	Yes	Sept 2010	
BCCA- Vancouver Island	Nancy Payeur	Yes	Ongoing	Yes
Ovarian Cancer Canada	Tracy Kolwich	Unknown		

Saskatchewan

Saskatchewan Cancer Agency	Grant Rathwell Karen Carmichael	Yes	Mar 2010	No
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Appendix N



Application for Cancer Transitions Program Materials Bursary

Cancer Transitions: Moving Beyond Treatment is a program designed to help cancer survivors make the transition from active treatment to post treatment care. The program provides in depth information and the opportunity to practice skills that can help cancer survivors manage their life after treatment. The key areas of focus are: emotional well being, exercise, nutrition, medical management, and survivorship care planning.

The program was pilot tested in Canada in 2009 and in the fall facilitator training workshops were held in Ottawa and Vancouver. The objective of the workshops was to educate and train facilitators from across Canada in how to deliver the program. In total, forty six new facilitators were trained across Canada.

To create sustainability for the *Cancer Transitions* program, BCCA Cancer Rehabilitation has secured Canadian Partnership Against Cancer funding for *Cancer Transitions* program materials to assist organizations with program continuity.

If you are interested in applying please complete this form and provide a letter of support from your organization stating the level of commitment to program delivery and start date(s) for program implementation from April 1st 2010 to September 30th 2010

Deadline for submission: March 15th 2010

Please Note: If you have already purchased your program materials you may still be eligible for a program materials credit for future program delivery.

A second call will be sent out September 1st 2010 for the delivery period: October 1st – March 31st 2011

What criteria will be used to decide eligibility?

A range of criteria will be used including evidence of capacity to implement and sustain Cancer Transitions, demonstration of financial need not met by other available sources, and the number of applications submitted in relation to the total funds available.

Please note that only complete applications with letters of support will be considered.

All applicants will be notified in writing approximately 3 to 4 weeks after the application deadline. If successful, full or partial funding of the Cancer Transitions program materials (facilitator guide and participant workbooks only) will be provided by the BCCA Cancer Rehabilitation. Program materials will be shipped directly by BCCA Cancer Rehabilitation. Sites will be invoiced for shipping charges and any additional charges not covered by the BCCA Cancer Rehabilitation funding bursary.

Title: Dr. Mr. Mrs. Ms Miss

First Name:

Last Name:

Organization:

Job title:

Mailing/shipping Address:

City/Province: ,

Country/Postal Code: ,

Phone Number:

Email address:

Have you applied for funding elsewhere? If so, please give details, including the outcome of the application if known:

Has your organization agreed to cover the expenses incurred by Cancer Transitions?

No

Yes \$

Partial funding \$

If yes or partial funding, please specify what expenses will be covered:

Estimated site costs

Human Resources

Facilitator/Leader	\$
Exercise Leader	\$
Nutrition Leader	\$
Medical/Nursing Leader	\$
Administration	\$
Human Resources total	\$

Materials Resources

Participant workbooks (\$32/workbook)	
x estimated number Program Delivery 1	\$
x estimated number Program Delivery 2	\$

Facilitator guide (\$32/workbook)	
x estimated number Program Delivery 1	\$
x estimated number Program Delivery 2	\$
Shipping	\$
Pedometers	\$
Materials Resources total	\$
Other site resources (room rental?)	\$

Please return this form and a letter of support via email or fax to:

Joanne Magtoto
BCCA Cancer Rehabilitation
Sociobehavioural Research Centre
#600 - 750 West Broadway St.
Vancouver, B.C., V5Z 1H5
Ph# 604-877-6000 Local: 3274
Fax# 604-708-2091
Email: jmagtoto@bccancer.bc.ca
no later than March 15th 2010
Please direct questions to Dr. Amanda Ward
Email: award2@bccancer.bc.ca

Funding for program materials has been made possible by a grant from the Canadian Partnership Against Cancer www.partnershipagainstcancer.ca.

Appendix O

Cancer Transitions workbook bursary awardees

<i>Organization</i>	<i>Start date</i>	<i>Awarded</i>
Sudbury Regional Cancer Program	Sept 2010	20 participant workbooks, 2 facilitator guides
Ottawa Regional Cancer Foundation	Sept 2010	20 participant workbooks, 2 facilitator guides
BCCA, Vancouver	Jun 2010	20 participant workbooks, 2 facilitator guides
Kootney Boundary Regional Hospital	Sept 2010	24 participant workbooks
Hope & Cope	Sept 2010	50 participant workbooks, 3 facilitator guides
Northern Health	Sept 2010	24 participant workbooks, 1 facilitator guides