



## SUMMARY

# Evaluation of rehabilitation at the Health Care Centre for Cancer Survivors

Municipal measures 2007-2009



sundhedscenter  
for kræftramte



KØBENHAVNS KOMMUNE  
Sundheds- og Omsorgsforvaltningen



## Evaluation of rehabilitation at the Health Care Centre for Cancer Survivors – Summary

Summary of evaluation report on municipal rehabilitation at the Health Care Centre for Cancer Survivors, City of Copenhagen

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## Foreword

It is with joy and pride that I can declare that the City of Copenhagen is now able to document a number of effects from the municipal cancer rehabilitation that will be of benefit to the citizens. Our results emphasise that the municipalities in fact are capable of providing individualised and flexible rehabilitation programmes to citizens diagnosed with some of the most frequent cancer types in Denmark. This applies regardless of the age, gender, social status, or ethnicity of the citizen.

The Health Care Centre for Cancer Survivors has a holistic approach to rehabilitation, taking as a starting point the citizen's life status as a whole. The collaboration between the citizen with cancer and the contact person forms the basic structure of the programme and the pivotal point is the individual goals set by the citizen.

Having met citizens with cancer at the centre, I have learned that the contact person is crucial in relation to the citizens' perception of the rehabilitation programme as a coherent process. In the evaluation, the citizens have pointed out that the interaction with the contact person along with the duration of the rehabilitation programme are decisive for the way they handle everyday life during and after their cancer disease and treatment.

It is important for me to accentuate that cancer is a disease that not only affects the individual citizen, but the whole family including the spouse and children. Therefore, in collaboration with the Danish Cancer Society, the centre also offers support to relatives and to families with children where a parent is cancer-stricken.

I would like to thank the Ministry of Interior and Health, Local Government Denmark, and the Danish Cancer Society for financially supporting the evaluation report.

It is my hope that this report will serve as a source of inspiration to professionals, municipalities, and interested citizens.

Yours sincerely,

Ninna Thomsen  
Major of Health and Care





## Introduction

This pamphlet is a summary of the report “Evaluation of rehabilitation at the Health Care Centre for Cancer Survivors – Municipal measures 2007-2009”. The report describes and evaluates the municipal cancer rehabilitation as it is carried out in the City of Copenhagen. The report contains a description of the experience gained during the three years the centre has existed as well as an external evaluation of the rehabilitation programmes offered to citizens with cancer and living in the City of Copenhagen. The report can be found at the health centre’s website: [www.kraeftcenter-kbh.dk](http://www.kraeftcenter-kbh.dk)

The external evaluation shows a number of effects of the municipal cancer rehabilitation from which the citizens may benefit. This means that the municipalities are capable of providing individualised and flexible rehabilitation programmes to citizens affected by the most frequent cancer types in Denmark. This applies regardless of age, gender, social status, or ethnicity.

**The report documents that the municipalities are able to carry out the health care task of rehabilitation of citizens with cancer in an optimal way, if the following issues are ensured:**

- Sufficient degree of professionalism
- A coherent rehabilitation plan provided by cross-sectoral players within the health system
- The necessary financial support

*Persons with a chronic disease are referred to as citizens in connection with municipal activities unless the subject discussed is related to cancer, stage of disease, and cancer treatment. In these cases and when referring to hospital activities, the word patient is used.*

## What characterises municipal cancer rehabilitation?

In 2006, the Health and Care Committee of the City of Copenhagen decided that the legal responsibility in regard to the task of patient-oriented prevention and rehabilitation of citizens with chronic diseases, including cancer, should be placed with health and prevention centres and were to be defined as rehabilitation in terms of content. Since the 1 of April, 2007, hospital departments or GPs have had the possibility to refer their citizens diagnosed with cancer to the Health Care Centre for Cancer Survivors for rehabilitation. The centre prepares rehabilitation plans in accordance with the White paper's definition of the rehabilitation concept, focusing on the holistic approach:

“*Rehabilitation is a goal-oriented collaboration process taking place between a citizen, his/her relatives, and professionals over a certain period of time. The purpose is to ensure that the citizen having, or being at risk of having, seriously diminished physical, psychological, and/or social functions succeeds in obtaining independence and a meaningful life. Rehabilitation is based on the citizen's life situation as a whole and decisions taken by the citizen and comprises coordinated, coherent and, knowledge based measures.*

(From the White paper on the rehabilitation concept, Rehabilitation in Denmark)

The health care centre wants to be able to offer an evidence-based, individualised, and flexible rehabilitation plan to all cancer diagnosed citizens in Copenhagen, regardless of their cancer diagnosis, age, gender, social status, and ethnicity. The rehabilitation must be of high quality and developed on basis of a dialog between the citizens, collaborators, and employees. In general, however, there is insufficient experience with and knowledge of holistically-oriented rehabilitation for citizens with cancer. This applies in relation to the effect of life style changes as well as to evidence on effective rehabilitation programmes, intervention and measurement methods.

Rehabilitation of citizens is characterised by its variation in complexity, content, and duration. Each rehabilitation plan depends on the citizen's diagnosis, spread of disease, treatment, side and late effects, physical, psychological and social functions, financial situation, and the wishes and goals of each individual person.

The objective for rehabilitation programmes at the Health Care Centre for Cancer Survivors is for the citizen with cancer to experience an active everyday life adapted to the widest extent possible to a life with or after cancer disease and treatment. The municipal rehabilitation plan should therefore be initiated right after the citizen has been diagnosed with cancer and, based on the citizen's life situation as a whole, should continue in parallel with the treatment and/or control phase.

## Rehabilitation programmes at the Health Care Centre for Cancer Survivors

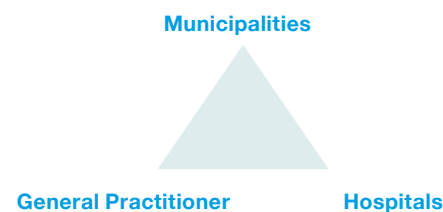
At the Health Care Centre for Cancer Survivors the rehabilitation plan is based on the citizen's life situation as a whole. The citizen participates on an equal basis in the preparation of the rehabilitation plan and, thereby, takes responsibility for the rehabilitation process. Relatives and professionals also play important roles in the process, and relatives are involved in discussions and programmes. The citizen determines the degree of involvement of her/his relatives. The rehabilitation programme is illustrated in the figure below.



Citizens can be referred by their own GP or hospital department when they have been diagnosed, and have the possibility to attend programmes at the centre during treatment and for up to 2 years after treatment has been completed. Transport to and from the centre can be arranged and an interpreter can be requested, if needed.

### COLLABORATORS

As rehabilitation is an option from the day the citizen is diagnosed with cancer, the treatment and the rehabilitation go hand in hand. It is therefore important for the citizen that the coordination between the municipal healthcare, the general practitioner, and the hospital is in place. The coherent programme should be based on a structured collaboration where the distribution of tasks and the parties' mutual respect are clearly defined.



**Rehabilitation is an effort carried out in collaboration between three parties, placing the citizen in the centre.**

In relation to the Health Care Centre for Cancer Survivors particularly two kinds of cross-sectoral collaboration call attention: The collaborations between the primary sector (municipal institutions and general practitioners) and the secondary sector (hospitals) and between the public sector (City of Copenhagen) and the private sector (the Danish Cancer Society).

Since the launch of the centre, the Danish Cancer Society has been an important partner not least because of the shared address and the formalised cooperation. From the beginning, the two parties have had focus on how they could each contribute with their special competences and how they, in collaboration, could make a broad cross-professional effort. The collaboration is undergoing continuous development and optimisation.

The collaboration with the hospitals is, among other measures, ensured by the contact persons from the health centre. On a regular basis they visit the departments referring patients to the centre. In 2009, persons from the health care centre paid 64 visits at departments of oncology and surgery, mainly at Rigshospitalet (Copenhagen University Hospital).

Below is a list of the centre's collaborators who have an influence on the citizens' rehabilitation programme:

- The Danish Cancer Society
- Rigshospitalet and Bispebjerg Hospital
- The Association of Cancer Departments in East Denmark (SKA)
- Job Centre Copenhagen, Sickness Benefit
- The Forest and Nature Agency (nature activities)
- Physical rehabilitation Copenhagen
- Prevention centres Østerbro and Nørrebro
- General Practitioners in the City of Copenhagen
- Pink Tribute (charity)

A part from the centre's collaboration with institutions and organisations, the employees participate in several formal cross-professional and cross-sectoral networks where the exchange of experience take place at meetings dedicated to knowledge sharing.

## KEY FIGURES 2007 – 2009

Until the 31 of December, 2008 the Rehabilitation Unit only accepted citizens living in the City of Copenhagen who were diagnosed with one of the three most frequent cancer diseases: Lung cancer, breast cancer, and colon and rectal cancer. In the first six months of 2009, it was made possible to refer all citizens with a cancer diagnosis to rehabilitation. An increasing number of referrals are received each year.

YEAR	2007	2008	2009
Number of referred citizens	273	322	691
Of this men (%)	56 (21 %)	56 (17 %)	151 (22 %)

Below is an enumeration of all services provided by the Health Care Centre for Cancer Survivors in 2009 to all newly referred citizens as well as citizens initiating rehabilitation in 2008 who have continued to use the centre in 2009:

- Assessment interviews with 691 citizens referred to the centre
- 240 citizens have participated in introduction classes to physical training run by a physiotherapist, nurse, and dietician.
- 3,200 appearances in classes dedicated to physical activities
- 470 individual physiotherapeutic sessions
- 100 individual first-time dietary advice sessions
- 65 individual follow-ups
- In 2008 and 2009, 82 citizens participated in patient education (10 classes of two hours). This is a cross-professional option headed by a nurse
- The rehabilitation unit established the social worker function on the 1 May 2009. From October – December 2009, 35 new citizens have been referred to a social worker.

## Experience gained at the health centre

It is important to the City of Copenhagen that the measures taken in relation to rehabilitation create options that add value for the citizen. The essence of the experience gained at the Rehabilitation Unit, as yet, in respect to contact persons, cross-professional programme coordination, physical activity, dietary advice, patient education as well as the broadening of the social worker function at the centre can be found in the following sections.

### THE CONTACT PERSON PROGRAMME

During the period where the citizen is attending a programme at the Health Care Centre for Cancer Survivors, she/he and the assigned contact person will be in contact, also by phone and e-mail, concerning all formal issues. Together, the citizen and the contact person prepare an action plan that is continuously evaluated throughout the citizen's rehabilitation programme and at the end of the programme. At the Health Care Centre for Cancer Survivors an action plan is defined as a written, concrete, individualised intervention plan where the pivotal point is the citizen's goals for the rehabilitation programme. The contact person works as the citizen's collaborator throughout the rehabilitation period, and at the centre this person is found to be of crucial importance to the citizen's perception of coherence of the rehabilitation programme as well as to her/his feeling of confidence.

“ My contact person called me on the phone and explained to me what the centre was all about. And then they made a plan just for me – and the person is the same, a person who knows me. And if anything came up, if I needed a psychologist or needed to talk to somebody, this was the person to call – and action was taken right away. This is the person that calls you up if you have been home, sick – then I get a phone call “ are you OK?, when will you be back?, can we help you with anything?, is there anything we can do for you?” You know, this place makes me feel that I am in safe hands.

**Statement from a woman with breast cancer**

### CROSS-PROFESSIONAL COORDINATION

When the centre opened in 2007, all employees of all professions worked from the same office resulting in daily experience sharing and coordination of each citizen's rehabilitation programme. As the centre expanded and all types of cancer were accepted for rehabilitation, two teams divided by diagnoses have been established in 2009.

Once a month, the two teams meet to discuss complex problems from selected patients. The objective is to increase the quality of each individual programme using a common professional forum.

### PHYSICAL ACTIVITY

At Health Care Centre for Cancer Survivors the training is adapted to the citizens' different levels of functionality. It is therefore possible for the citizens to begin their training at the physiotherapists' introduction course and, after that, continue in classes of different training levels. The centre is also open for free training twice a week.

Experience shows that it is of great importance that the structure of the training classes is very flexible as training must be planned taking into consideration the treatment (surgery, chemotherapy, radiation) each citizen receives or has received earlier. Therefore, the duration of the citizen's training programme and the frequency of attendance completely depend on the course of disease and treatment in combination with the psychosocial strain.

At the centre, it is found that in relation to physical training of citizens being treated for cancer, a high absence rate is to be expected because of treatment and the side effects of treatment.

“ You know, having a physiotherapist next to you makes a difference – the physiotherapist is always there when we train. Many of us, who have had surgery for colon cancer, thought that some of the exercises would make us split right down the middle. But when you say “No, I can't do it, I am afraid to do it” and things like that, well, then the physiotherapist says “Yes, of course you can, come on, you can do it” – and they are right next to you and know exactly what they are doing and know the exercises, and what we can and can't do. I just think it is absolutely fabulous

**Comment from a woman with colon cancer**

The experience at the health care centre is that the citizens through the physical training sense that the functionality of their body is intact also during the cancer treatment. Through training, the citizen recovers his/her strength and resumes confidence in the body's capacity, this leads to drive and ability to handle the everyday challenges and helps the citizens to come to terms with the consequences of disease and treatment. The citizens also see the training as a “time-out” from the disease and, furthermore, the participants use the time during and after training for networking.

### DIETARY ADVICE

Initially, the dieticians only offered guidance on an individual basis. Today, it is possible to choose from both group based sessions and individual counselling. Several citizens with complex problems use a combination of the two.

“ You know, the training here [at the health centre] is “hands-on”, so to speak. You try out the things yourself, you know, the exercises in class and you cook together with the other participants and the dietician – and you see the results. It's very motivating.

**Comment from a man with colon cancer about the training and life style changes**

An unknown number of citizens experience late effects of the disease and treatment leading to referral to a clinical dietician. Part of the registered problems requires a relevant diagnostic evaluation performed by a doctor as well as treatment in parallel with the dietary counselling. This can often be a challenge to the dieticians as they use a disproportionate amount of time to assist citizens in receiving treatment before the actual rehabilitation can be initiated.

### **PATIENT EDUCATION**

Patient education is offered in a fixed structure formed as a course of 10 two hour sessions, each class have 10-12 participants, and it is accepted that the participants cancel few sessions because of treatment, examinations, etc.

Participants express that the subjects and content of the sessions are relevant in relation to living a life with cancer. In order to create a sense of recognisability and a safe environment for the participants to share experiences and to discuss emotionally difficult subjects, it is crucial that the same nurse is present at all sessions.

### **BROADENING OF THE SOCIAL WORKER FUNCTION**

Since the 1 May 2009, the Rehabilitation Unit has had a social worker employed and this function is continuously being expanded. The core service is counselling and support. Today, the social worker can assist the citizens returning to work with counselling, guidance, and coaching. If necessary, the social worker may participate in meetings at the citizen's place of work. Furthermore, the social worker has initiated a career group focusing on the return to the labour market.

A part from this, the social worker has created a positive collaboration with Job Centre Copenhagen, Sickness Benefit. The collaboration is based on an effective procedure between the social worker at the health care centre and a contact person at the job centre.

## Evaluation of the health centre

In 2007, the health care centre received DKK 2.47 mill. from the Ministry of Interior and Health for the project: "The effect of municipal rehabilitation measures carried out by the Health Care Centre for Cancer Survivors". The project was originally designed as a classical randomised trial, but due to various reasons had to be changed into an alternative evaluation with focus on the following questions:

- What type of citizens is referred to the Health Care Centre for Cancer Survivors for rehabilitation?
- Which programmes do the citizens affected by cancer prefer to attend?
- What are the effects of the health care centre programmes according to the citizens??
- How do the health professionals at the hospitals find the cross-sectoral collaboration?

The questions are answered by an external evaluation made by the Institute for Epidemiological Cancer Research, Department for Psychosocial Cancer Research at the Danish Cancer Society. The following method has been used:

### **User Profile 2008**

A profile of 297 citizens with cancer who participated in assessment interviews at the Health Care Centre for Cancer Survivors in 2008. Data has been collected from the medical records at the centre and Landspatientregistret (LPR) (The National Patient Register) and the results concern sociodemographic factors, disease, life style, and psychological symptoms.

### **User profile, questionnaire-based survey, and activities at the centre in 2009**

A profile of 144 citizens with cancer who participated in assessment interviews over a three month period from the 17 of August to the 30 of November 2009 as well as a questionnaire-based survey among these citizens. Data has been collected from the medical records at the centre, LPR, and questionnaires containing a number of validated scales used within the area of oncology. The results concern partly the same parameters as in the user profile 2008 and partly changes in psychological goals, life quality, social network, and life style. Furthermore, the use of the activities at the centre has been summarised.

### **Focus group interviews 2007-2009**

The survey is carried out on basis of three focus group interviews and five personal interviews with users of the health care centre as well as three focus group interviews with doctors and nurses from the referring departments at Rigshospitalet and Bispebjerg Hospital. The interviews focus on the participants' experience of the effect of rehabilitation at the Health Care Centre for Cancer Survivors and the health care personnel's evaluation of the cross-sectoral collaboration.

### WHAT TYPE OF CITIZENS IS REFERRED TO THE HEALTH CARE CENTRE FOR CANCER SURVIVORS FOR REHABILITATION?

The external evaluation contains profiles of two different citizen populations with cancer referred to and having participated in an assessment interview at the Health Care Centre for Cancer Survivors (user profile 2008 and user profile 2009). The profiles show that:

- 80% of the referred citizens are women
- Average age is 55 years old
- 21% are older than 65 years in user profile 2008 and 32% are older than 65 years in user profile 2009
- About 1/3 of the citizens does not have a higher education
- About half of the citizens has a job and 77% of these citizens are on sick leave
- About 40% have a medium or severe co-morbidity
- The citizens show a pronounced decline in physical activity after their cancer diagnosis
- Half of the citizens from 2009 mentions fatigue as a daily issue. Other issues are muscle pain, sleeping problems, anxiety, and mouth problems

#### Results from the user profile 2008

The largest group of citizens is aged between 50-59 years (figure 1) and in total citizens aged between 50-69 years constitute more than half of the users at the centre (59%). About 50% live alone and the number is equally distributed between men and women.

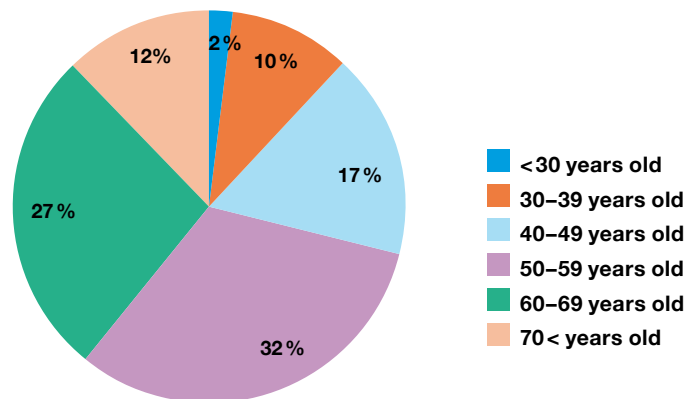


Figure 1: Age distribution among 297 users of the Health Care Centre for Cancer Survivors in 2008

The distribution of cancer diagnoses among the users of the health care centre in 2008 is shown in table 1.

Table 1: Distribution of diagnoses

CANCER DIAGNOSIS	n	%
Not informed	0	0
Colon cancer	66	22
Lung cancer	51	17
Breast cancer	178	60
Other	2	1
In total	297	100

Table 2: Time from diagnosis until the first meeting at the centre

TIME SINCE DIAGNOSIS	n	%
Not informed	24	8
0-3 months	96	32
3-6 months	71	24
6-12 months	42	14
13-24 months	26	9
> 24 months	38	13
In total	297	100

At the assessment interview, the citizens with cancer have informed their contact person of the time interval since their cancer diagnose. As shown in table 2, 32% have been diagnosed within a three months period. A little more than half of the citizens (56%) have initiated a rehabilitation programme at the health care centre within the first six months after they were diagnosed with cancer.

Data from Landspatientregistret (LPR) show up to 20 discharge diagnoses concerning all admissions since 1977 and all outpatient contacts since 1995. The Charlsons index can be used to risk score these diagnoses and to measure and manage the total disease burden (present cancer disease plus co-morbidity)

The result of the survey shows that 58% of the participants have a score of 2, signifying that these citizens have only been admitted due to their cancer disease and have no metastases. 41% have been admitted or have had an outpatient contact due to other diseases than cancer or they have cancer with known metastasis (table 3).

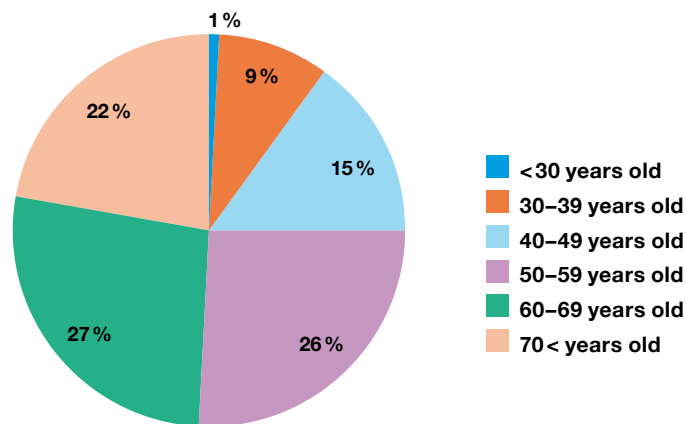
**Table 3: Charlson's index showing the user profile 2008 divided in none, medium, or severe co-morbidity**

CHARLSONS INDEX SCORE	ALL DIAGNOSES %	LUNG CANCER %	BREAST CANCER %	COLON CANCER%
Not informed	1	2	1	0
2 (No co-morbidity)	58	41	70	39
3-4 (Medium co-morbidity)	19	24	17	18
5-9 (Severe co-morbidity)	22	33	12	42
n	297	51	178	66
Average age	56 years	61 years	53 years	60 years

The diagnosis specific division of Charlson's index shows that patients with colon and lung cancer have a very high co-morbidity and, conversely, that women with breast cancer have a low occurrence of other diseases requiring admission or outpatient contact.

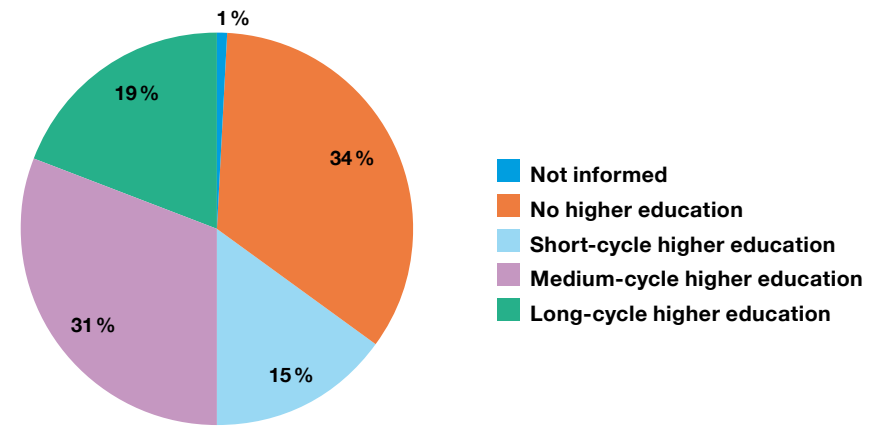
**Results from user profile 2009**

The average age is 54. The age distribution is illustrated in figure 2. A little less than half of the health care centre users live alone.



**Figure 2: Age distribution among the 144 users in 2009**

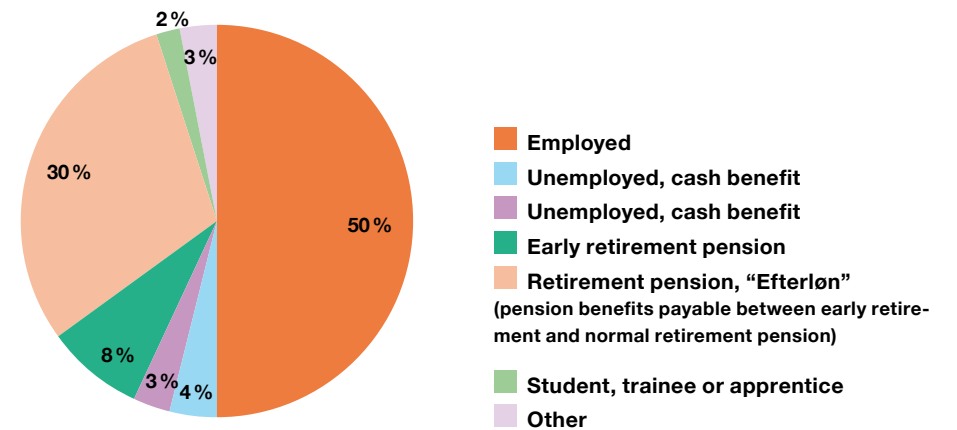
About half (49%) of the centre users have no or a short cycle higher education (figure 3).



**Figure 3: Education level among the 144 users of the centre in 2009**

Half of the 144 users (50%) were employed at the time of the diagnosis (figure 4)

**Figure 4: Employment among the 144 users of the centre in 2009**



In the user profile 2009, the distribution of cancer diagnoses shows that patients with breast cancer account for 53% of the diagnoses and therefore continues to be the largest patient group at the centre.

Figure 5 shows that 47% of the patients have reported that they have been diagnosed within a three months period, while 15% have been diagnosed more than 24 months before their contact with the health centre.

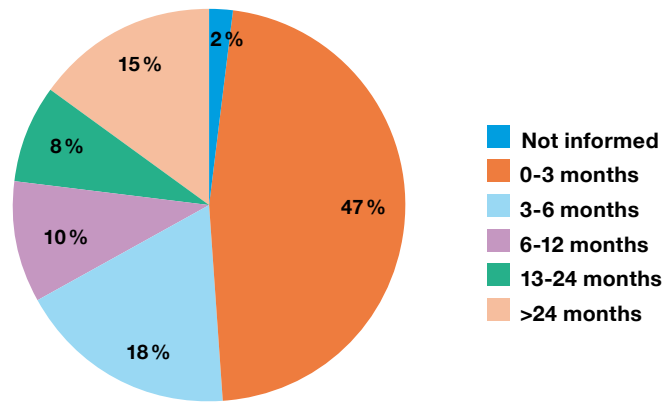


Figure 5: Time from diagnosis until the first meeting at the centre

The citizens have reported a number of symptoms (no more than five) consistent with side effects / late effects of cancer disease and treatment. Table 4 shows the seven most frequent symptoms, each reported by more than 10% of the centre users.

Table 4: Consequences of the cancer disease and treatment

SIDE EFFECTS/ LATE EFFECTS	YES	%
Fatigue	48	33
Muscle pain	31	22
Sleeping problems	13	21
Anxiety	20	14
Mouth problems	20	14
Depression	16	11
Peripheral neuropathy	15	10

The survey shows that 29% lost weight while 19% gained weight in connection with their cancer disease. 35% of the citizens mention that they have never smoked while 24% smoke on a daily basis. A total of 9% reported that they never drank alcohol while 18% had daily alcohol consumption. Before they were diagnosed with cancer, 47% had a low physical activity level and only 10% a sedentary activity level. When

asked about their present activity level, 54% of the participants reported to have a low activity level while 32% now had a sedentary activity level corresponding to a 3-fold increase of the category. This shows that the citizens are less physically active after having been diagnosed with cancer.

**WHICH PROGRAMMES DO THE CITIZENS AFFECTED BY CANCER PREFER TO ATTEND?**

The total number of attended programmes is based on the user profile 2009 included in the external evaluation. The number of services is counted three months from any assessment interview performed in the period August-November and shows that:

- After the assessment interview, 44% of the citizens prefer a programme containing strength and cardiovascular training in classes twice a week, representing 43% of the total services provided
- In average, these citizens cancel 45% of their classes
- The patient education is the largest activity among the other group-oriented services
- Telephone consultations make up one fourth of all services

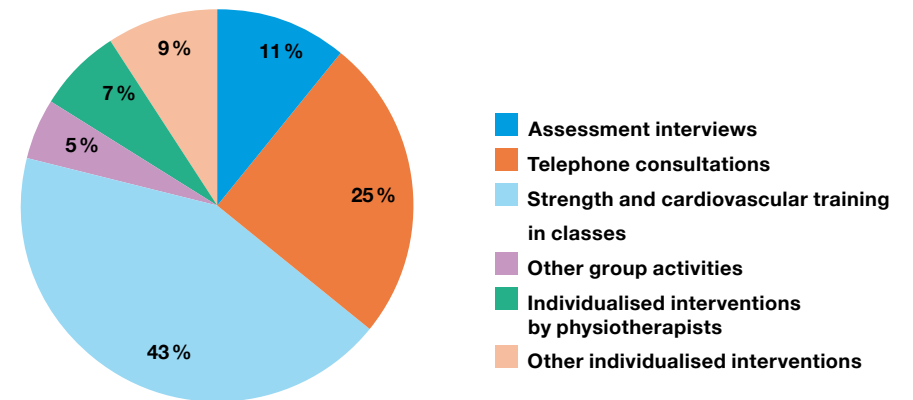


Figure 6: Distribution of the services provided to the citizens

Citizens included in the user profile 2009 have used the following services provided at the health centre:

- 24%: assessment interview and contact by telephone only
- 28%: assessment interview and attended one or more individual sessions
- 48%: assessment interview and attended one or more group sessions and one or more individual sessions

There is a large variation in the citizens' use of the services. This is partly explained by the wide span in health status at the time of referral. Some have been almost unaffected by their disease while others have had a progressive course of the disease.

## WHAT ARE THE EFFECTS OF THE HEALTH CARE CENTRE PROGRAMMES ACCORDING TO THE CITIZENS?

This question is analysed and answered partly by a questionnaire-based survey (a baseline and a three months follow-up questionnaire) and partly by using results from focus group interviews.

### Measurement of effects shows the following:

- **Citizens participating in the survey in 2009 evaluate their physical form after three months to have improved significantly since the assessment interview**
- **A cancer specific scale measuring life quality (EORTC) shows a significant improvement of role function and emotional function after three months**
- **Symptoms measured using the cancer specific life quality scale (EORTC) show that pain is reduced significantly while the incidence of fatigue and insomnia show a tendency to improve ( $p=0.06$ )**
- **A non-cancer specific life quality scale (SF-36) shows significant improvements of the physical function, of the total physical life quality, of both physical and psychological role function, and of pain from baseline until the three months follow-up.**
- **An anxiety and depression scale (HADS) shows a significant reduction of anxiety.**

It is of interest and remarkable that significant improvements can be found in a number of dimensions concerning life quality (EORTC and SF-36) and also in the anxiety dimension in HADS. The results can attribute to the measures taken by the health centre, selection (meaning that only citizens doing well complete the follow-up questionnaire), the time from baseline until follow-up, or a coincidence mainly reasoned by the several tests. The results might also represent a combination of two or more of these circumstances.

### The focus group interviews show the following:

- **The contact person is of crucial importance to the citizen's experience of continuity of the programme**
- **The health care centre personnel meet the citizens with recognition, care, and trust in the citizens' ability to act.**
- **The programme at the health care centre has played a decisive positive role in the everyday life of the citizens after the cancer diagnose**
- **Supervised physical training at the health care centre has been a motivation for life style changes and increased the sense of own ability to act.**
- **Small, accessible changes of the everyday life form the basis of the dietary counselling**
- **The citizens have been able to maintain the daily changes of their life style**

Meeting other citizens at the centre forms a central social platform for the sharing of information and an enhanced reflection in respect to the citizens own cancer disease.

“ *It is advantage that they [the physiotherapists] know so much about our disabilities that it is OK to be pushed further. Mentally, it has been so good for me to come here and be reminded that I wasn't going to break.....here there was no mercy – just get going – but you felt so safe.*

**Statement from a woman with breast cancer**

Reading the external evaluation report it can be concluded that the experience of the citizens, concerning the benefits of the programmes provided by the health care centre, is in line with the centre's objective of providing evidence-based, individualized, and flexible rehabilitation programmes to citizens with cancer.

## THE CROSS-SECTORAL COLLABORATION ACCORDING TO THE HEALTH PROFESSIONALS AT THE HOSPITALS

The qualitative, interview-based survey shows the doctors' and nurses' experiences in relation to the need for rehabilitation and the quality of the cross-sectoral collaboration:

All cancer patients have a need for rehabilitation that the health care system must take care off

The referral of patients to the health care centre is not systematised everywhere. Cancer patients come from various social backgrounds and have different needs, and the rehabilitation programme at the health care centre must take these conditions into account.

The transition from hospital to municipal programme might be eased if the health care centre personnel had a more targeted approach in relation to the inclusion of patients at the hospital departments.

A woman with breast cancer reflects on whether she was informed about the health care centre at the hospital:

“ *I got this whole bag filled with information brochures and folders about this and that, that I might have needed. I took it straight home with me and haven't opened since. I actually think I still have it. I can't really rule out the possibility that in that bag was also material about the health care centre. Well, I don't know about you, but at that time there were so many things I needed to relate to, I just couldn't go through all that material as well. What you need is a person who explains the material to you.*

## Perspectives

This evaluation calls attention to the necessity of a change of the underlying paradigm in relation to cancer treatment. It is important that both the physical treatment of the disease as well as the rehabilitation measures concentrated on maintaining the work and everyday life of the citizen are taken into consideration throughout the citizen's course of disease. It is assessed that the majority of citizens with cancer would benefit from rehabilitation intervention as early in their disease course as possible.

### **RECOMMENDATIONS FOR THE FURTHER DEVELOPMENT OF REHABILITATION PROGRAMMES**

- The contact person programme should be expanded to cover the transition from the primary sector to the secondary sector also
- When preparing a complete patient programme, a clear division between tasks carried out by the specialised department and by the municipal rehabilitation programme must be made
- The professional training of the staff at the municipal rehabilitation units is necessary and should focus in particular on the development of pedagogical competences in health
- A unified diagnostic evaluation and assessment including essential clinical, psychological, and social information about the citizen must take place
- A continuous monitoring of activities in order to provide evidence for the initiated interventions must be developed
- Particular attention should be paid to citizens with cancer living under socially difficult conditions

### **RECOMMENDATIONS FOR OTHER MUNICIPALITIES AND REGIONS**

Using the experience from this project, two key recommendations can be given to municipalities and regions wanting to be able to provide coherent rehabilitation programmes to citizens with a chronic disease:

- One total solution targeted at citizens with the most frequent chronic life style diseases requires a certain size of local population while units providing rehabilitation for citizens with cancer only, will need a larger population.
- In the rehabilitation process, the sharing of experience among citizens with cancer plays a central role, but must be carried out with the professional effort as a pivotal point, combining interventions concerning life style and psychosocial support. Relatives should be involved as a resource.

No negative effects from the use of the health care centre have been found. This is an essential observation as it must always be taken into consideration whether this type of interventions might affect the citizens in a negative way in their subjective perception of life as cancer patient.

