Guideline Resource Unit
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Supportive Care: Psychosocial and Rehabilitation Oncology

Version 1, Effective Date: February 2022

Accompanies: Supportive Care Framework Report

Cancer Care Alberta

www.ahs.ca/guru

The information outlined in this summary and accompanying framework apply to adult cancer patients. Refer to the full framework for a detailed description of the clinical questions, recommendations, development methodology, and references.

Supportive Care

Definition

Supportive Care is an overarching concept that describes all of the health care services cancer patients and their families need beyond anti-cancer medical, surgical, and radiation interventions. It is defined as the provision of the necessary services for those living with or affected by cancer to meet all of their needs (physical, emotional, social, psychological, cultural, informational, spiritual and practical).[1]

Supportive Care in Cancer Care Alberta (CCA) incorporates the following principles:

- Care is patient and family centered
- Care is evidence-informed
- Care is accessible
- Care respects diversity
- Care is integrated and interdisciplinary
- Care is provided through collaboration and pathways that include primary care and community services/agencies
- Clinical research and knowledge development is fostered in Supportive Care disciplines and programs
- Disciplines have specialized expertise in oncology care

The vision is for CCA is to provide world-class multidisciplinary supportive care services that are patient and family centered, integrated throughout the cancer care experience, and available to all Albertans with cancer. Where a supportive care intervention has therapeutic intent requiring cancer-specific clinical expertise, CCA has a responsibility to provide the service at its sites, or in collaboration with other healthcare providers through intentional service delivery partnerships and care pathways. We strive to optimize the health and quality of life of cancer patients, families and caregivers through the provision of necessary supportive care services.

The provincial Supportive Care Operational Committee provides oversight and direction of services. The Supportive Care Strategic Plan (2019-2022) identifies three key strategic priorities: 1) Building capacity for care ‘Closer to Home’, 2) Implementing innovative, sustainable, and patient-centered models of care, and 3) Increasing awareness of and access to CCA Supportive Care services. Strategic goals are achieved through partnerships and collaboration within CCA, with academic and community stakeholders. Supportive Care works in partnership with cancer support organizations such as Wellspring, to develop programs and pathways for patient care.

[1] Fitch MI. Supportive care framework. Can Oncol Nurs J. 2008 Winter;18(1):6-24.

Within Cancer Care Alberta, Albert Health Services (AHS), Supportive Care consists of the following Allied Health and Nursing disciplines and roles:

Psychosocial Oncology: Psychologists, Psychiatrists, Social Workers, Spiritual Care Practitioners, Drug Access Coordinators, Indigenous Cancer Patient Navigators, Adolescent and Young Adult (AYA) Cancer Patient Navigators, Sexual Health Consultants, and Nurse Practitioners.

Rehabilitation: Occupational Therapists, Physiatrists, Physiotherapists, Therapy Assistants, and Speech Language Pathologists or Speech Therapists.

Clinical roles are described in more detail below. In addition to clinical responsibilities, Supportive Care professionals are actively engaged in clinical education (patient and provider), training and supervision of new professionals, program development and research. Responsibilities may include practice leadership, service planning, staff development, quality improvement and evaluation, and/or research activities as identified by the needs of the service area(s).

Services and Roles

- Supportive Care CCA adopts the tiered model of Supportive Care developed by Margaret Fitch.[2] The model can be viewed from both the patient/family and provider perspective and lends understanding to the concept that all patients/families will, through their experience of living with cancer, require screening for needs, basic information and education and that this can be met through interventions by a variety of health care providers. It may also be self-directed.

- Depending on the results of screening, patient reported outcomes and clinical assessment, many patients will require additional information and support – this might be classes, guided readings, one time consults or recommendations to deal with a relatively straightforward treatment-related symptom. Further, some patients have complex needs that require highly specialized providers e.g. end of life care, complex swallowing and nutritional needs. Each discipline-specific working group examined the applicability of this model to the services provided and determined examples of the different levels of service within their discipline.

[2] Fitch MI. Supportive care framework. Can Oncol Nurs J. 2008 Winter;18(1):6-24.

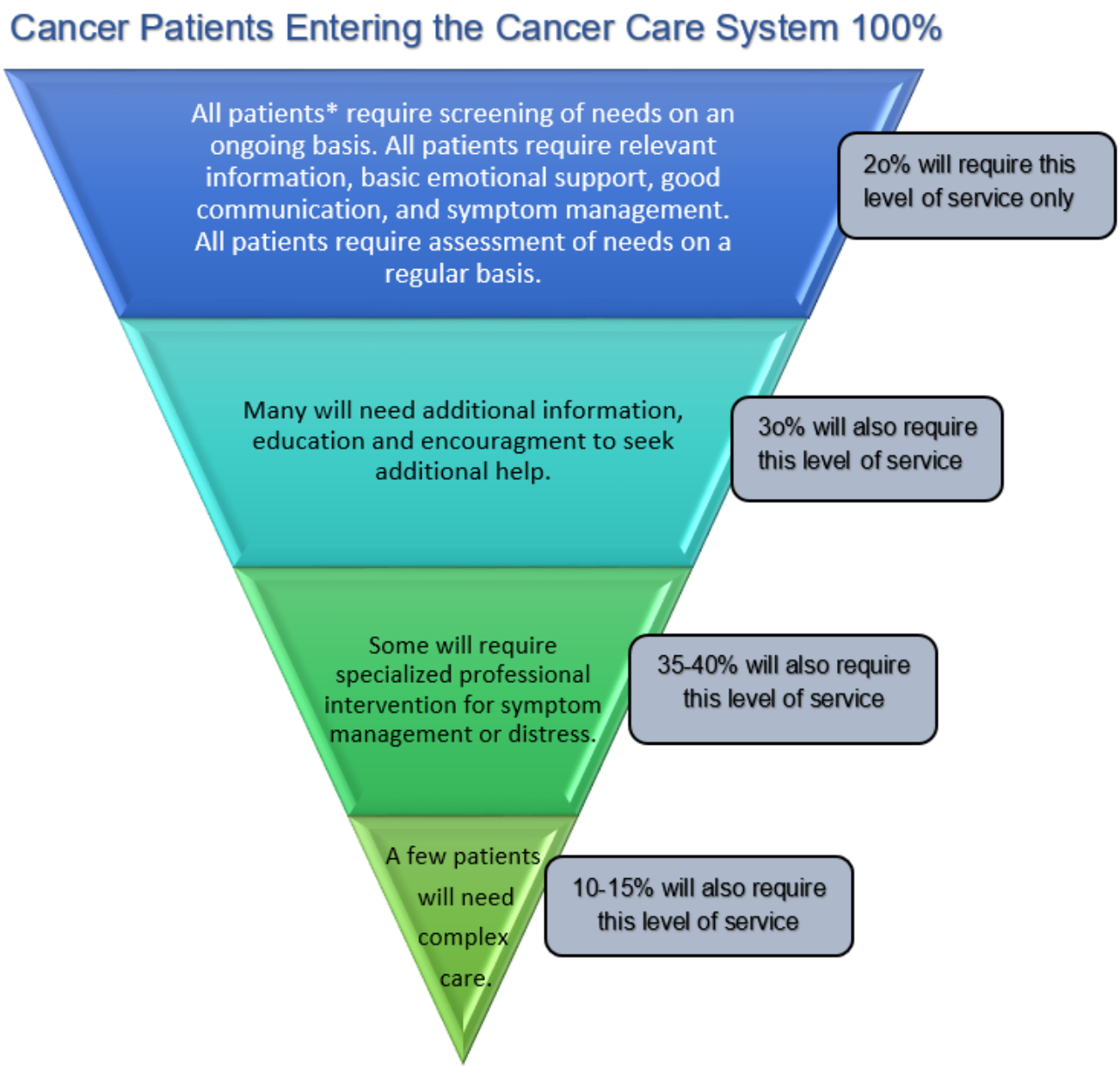

Figure 1. Supportive Care Framework (2016). Refined level of care needed for subsets of patients entering the cancer system. Adapted from Fitch, M. I. (2008).[3] Copyright 2010 by Canadian Association of Psychosocial Oncology. Reprinted with permission.

[3] Fitch MI. Supportive care framework. Can Oncol Nurs J. 2008 Winter;18(1):6-24.

Psychosocial Oncology

(see page 43 of Supportive Care Framework)

Definition

- Psychosocial oncology is a specialty in cancer care concerned with the understanding and treatment of the social, psychological, emotional, spiritual and functional (practical and rehabilitative) aspects of cancer, and at all stages of the disease trajectory from prevention through bereavement.
- Involves a whole-person approach to cancer care that addresses a range of human needs that can improve or optimize the best possible quality of life for individuals and their networks affected by cancer.

Roles

- Psychosocial providers are specialized in oncology and are a part of the patient's multidisciplinary cancer care team.
- Consult and collaborate with interprofessional team members, and with other medical, mental health, and community-based services/agencies in providing psychosocial care.
- Provide person-centered, evidence-informed and evidence-based therapeutic interventions to address cancer-related emotional and psychological distress, and improve coping strategies for individuals and families across the cancer trajectory.
- Support social and practical areas of need, e.g., resource counselling, drug access, connection with government agencies and other community supports.
- Facilitate referrals and coordination with community and mental health services.
- Provide supportive counselling, individual assessment and clinical interventions, couples/family counselling, support groups, programs, and educational classes.
- Services are provided in-person, and via telephone/online video (Zoom).
- For full information about Psychosocial Oncology services, resources and referral processes, patients and families may access the Psychosocial Oncology | Alberta Health Services website.

I. Resource Social Work Service

Social Worker Role

Social Workers located at tertiary and regional sites address practical and resource-based needs of patients and families; they also provide dedicated support and services to community cancer centres.

Social Workers:

- Provide a range of generalist Social Work services to cancer patients and their families, including psychosocial assessment, resource-based interventions, risk screening, supportive counselling, case management/coordination, transition planning, and advocacy.

- Address patient/family resource-based needs in relation to shelter, transportation, inadequate or low income, employment/training, etc., to enhance patient health outcomes.
- Liaise with government programs, community supports and outreach services. Advocates for clients, families and communities when necessary healthcare services are not available and accessible.
- Provide psychoeducation and supportive counselling in areas such as: grief, new medical diagnosis, adjustment to illness, caregiver support, enhanced coping abilities, end of life planning, family stress, preparation for transitions, etc.
- Facilitate advance care planning discussions and decision making with patients/families.

II. Counselling & Psychiatry Services

Within CCA, patients who are referred (or self-refer) for counselling may be seen by Social Workers, Psychologists, Spiritual Care Practitioners, or Psychiatrists. Triage to a specific provider or discipline depends on patient needs and nature of the referral, discipline/provider availability, provider specialization (e.g., tumour group), and site-specific operational factors. Information for patients and families about the CCA counselling terms of service are described in a two-page patient information flyer.

Social Worker Role

- Generalist Social Workers provide psychoeducation and supportive counselling (see above).
- Clinical Social Workers:
    - Provide advanced level bio-psychosocial assessment, psychosocial care planning, and clinical interventions from a person-in-environment perspective, to facilitate cancer patient/family engagement and enhance patient health outcomes. Provide individual, couple, family and group counselling/therapy for a range of complex and multidimensional patient and family care needs.
    - Utilize an integrated case management approach to provide advanced clinical intervention, follow-up and coordination of services.
    - Provide clinical supervision, consultation to the interprofessional team and leadership in facilitating program development/evaluation, service planning, staff development, quality improvement, and research activities.

Psychologist Role

- Psychologists provide advanced and specialized clinical psychological services (including assessment, diagnosis and/or clinical intervention) for complex patient pathologies resulting from cancer or cancer treatments.
- Conduct psychological assessment to address multiple domains and aspects of functioning (e.g. developmental, cognitive, emotional, interpersonal, and personality factors).

- Apply a customized and flexible approach to patient(s) presenting with multiple diagnoses, concurrent medical factors, multi-dimensional or complex issues to minimize risk and to effectively address and maximize treatment outcomes.
- Critically evaluate referral questions, presenting issues, and individual patient needs in the context of theory and research in psychosocial oncology and the discipline of psychology.
- Provide case consultation and develop psychosocial care plans for patients who have significant symptom severity and impact on function, including complex, higher need, and/or treatment resistant patients/populations.
- Provide training and clinical practice leadership through consultation, program development, service planning, staff development, quality improvement and evaluation, and research.
- Ensures practice aligns with and models advanced clinical practice in psychosocial oncology, that is evidence-based and in alignment with clinical guidelines and standards of practice.

Spiritual Health Practitioner Role (currently available for CCA North)

(see page 51 of Supportive Care Framework)

- Spiritual well-being is the experience of connection in relationship with self, others, and Other (God(s), nature, what is of significance).
- Spiritual suffering is the experience of loss of connection/disconnection in relationship with self, others, and Other (God(s), nature, what is of significance).
- Spiritual Health Practitioners are theologically and clinically trained to provide spiritual and emotional support for patients, families and staff.
- Bring personal, theological, and psychological wisdom in the assessment and support of patients navigating existential and religious questions, which often surface during transitional periods such as illness, disability, and rehabilitation.
- Offer in-depth spiritual assessment and counsel to patients in emotional, theological, religious, and/or spiritual distress, and to support varying spiritual and religious practices either directly or in consultation with or referral to spiritual/religious communities.
- Spiritual Health Practitioners provide counselling to support patients and their loved ones in their psychological, emotional, and spiritual struggles and coping.
- Compassionately support and guide patients approaching end of life, and offer anticipatory grief and short term bereavement support (for family members we have met while caring for the patient).
- Provide guidance in bioethical decision-making and informal emotional support of team members.
- Uniquely mandated within AHS to build capability for spiritual health within the interdisciplinary team.

Psychiatrist Role

- CCA Psychiatrists assist patients with cancer-related mental health concerns which may include depression, anxiety, mood changes, challenges in interpersonal relationships, addiction, and distortions of reality (e.g., hallucinations).
- May address other cancer-specific issues such as psychological response to cancer, spiritual or existential distress, fear of death or dying, psychological side effects of cancer treatments, fatigue, cognitive changes, and pain.
- Provide patient-centered psychiatric assessment and follow up using a bio-psychosocial understanding of mental health and wellbeing in relation to cancer care.
- Engage individuals and if included family members in developing collaborative goals of care
- Establish professional therapeutic relationships and provide treatment recommendations which may include information, medications, psychotherapy and/or lifestyle interventions to enhance well-being.
- Collaborate with and consult to other multidisciplinary providers within cancer care, primary care, and other AHS/community-based services.

III. Drug Access Coordination Service

Drug Access Coordinator (DAC) Role

- The DAC works with the patient and their cancer care team to address concerns about how the patient can afford their medications in a timely way.
- When a patient cannot afford the drugs, they have been prescribed, the DAC can explain the different drug funding options, help them understanding their current insurance coverage, and helps them apply for funding or additional insurance coverage.
- Communicates and liaises with drug companies to access programs that can cover or share the cost of the drug they have been prescribed.
- Assists patients to access prescription drugs, on compassionate grounds, that are not covered under the Alberta Outpatient Cancer Drug Benefit Program but are required for supportive cancer treatment and/or care.
- Ensures that resources are identified and are utilized provincially.
- The DAC participates as a member of the multidisciplinary team.

IV. Specialized Services

(see page 57 of Supportive Care Framework for definition of Nurse Navigator role in Cancer Care, and page 72 for Specialty Programs)

Sexual Health Service (OASIS: Oncology Sexuality and Intimacy Survivorship Program)

(see page 112 of Supportive Care Framework)

Cancer patients may have sexual concerns, such as: vaginal dryness, erective dysfunction, hormonal changes, anxiety or fear related to sexual activity, body image, less interest in sex, difficulty with arousal or orgasm, and relationship changes. Sexual Health Consultants provide specialized education and counselling services to individual patients and couples. Other multidisciplinary Supportive Care clinicians (e.g., nurse practitioner, psychologist) provide sexual health consultation and intervention within the OASIS program.

Sexual Health Consultant Role:

- Is a member of a regulated health profession (e.g., social work, nursing, psychology, occupational therapy).
- Develops and delivers sexual health programming specific to oncology related sexual health impairments.
- Provides oncology-related sexual health resources and services such as patient and provider education (materials and teaching).
- Provides assessment and intervention in individual, couples and group formats.
- Facilitates specialized referrals.
- Builds capacity in health care professionals working with oncology patients, to address sexual health concerns.

Adolescent and Young Adult (AYA) Oncology Program

AYA oncology is cancer care and research focused on addressing the needs of young people diagnosed with cancer between 15 and 39 years of age. From a CCA operational perspective, our AYA population is between the ages of 18 and 39. AYA cancer patients have distinct medical, psychosocial and supportive care needs compared with pediatric and adult cancer populations. This is a developmentally complex period of life, during which individuals are working to establish their own identity, develop a positive body image and sexual identity, gain independence from their parents, increase their involvement with peers, find a life partner, make decisions about higher education and careers, and possibly have their own family. A cancer diagnosis can temporarily or permanently impact these developmental goals and tasks. AYA cancer patient concerns are unique from older patients, and often include fertility, sexual health, exercise, school/work, coping, peer support, survivorship and emotional challenges.

The AYA program works to provide equitable access to specialized support services for AYAs province-wide, with the mission to enrich care and empower young adults and their supporters to live

well with and beyond cancer. The program includes medical and operational leadership, AYA cancer Patient Navigators (funded through the Alberta Cancer Foundation), multidisciplinary "champions" who advise the program and provide clinical care, and AYA clinical and epidemiological researchers. Direction and oversight are provided through the provincial AYA steering committee. For more information, please refer to the Adolescent and Young Adult (AYA) Cancer clinical practice guideline.

AYA Cancer Patient Navigator Role:

- The Adolescent and Young Adult Cancer Patient Navigator (AYA CPN) is a specialized oncology Registered Nurse (RN) who is an integral member of the multidisciplinary cancer care team.
- Facilitates timely access to information, support and cancer services for patients and families during key transition points along the cancer care continuum. This can span from first consult to treatment and follow-up, to survivorship or palliation.
- Works to identify patients' symptoms and concerns, and tailor interventions to address their physical, psychological, social, emotional, spiritual, and/or practical needs, in collaboration with the cancer care team.
- Works closely with key stakeholders (including adult and pediatric oncology specialists, other health care providers, community-based services, patient representatives and CCA) to identify gaps and develop strategies to improve access to services to better support patients and families across the cancer journey.

Indigenous Cancer Patient Navigation Service

(see page 112 of Supportive Care Framework)

Indigenous cancer patients face many intersecting barriers to completing their cancer care. Indigenous people are often diagnosed with cancer at later stage, and experience psychosocial distress, as well as socio-economic and geographic barriers to a greater extent than the general cancer population (Canadian Strategy for Cancer Control 2019-2029). Indigenous people seldom have their cultural needs met by the healthcare system, and unfortunately, most providers are not adequately trained to meet Indigenous patients' needs. In supporting Indigenous peoples with cancer, health is viewed through the four dimensions of holism – mental, physical, spiritual and emotional. Health is perceived as a connection to the community and environment in order to achieve balance and truly healthy communities.

Indigenous Cancer Patient Navigator Role:

- The Indigenous Cancer Patient Navigator (ICPN) funded by the Alberta Cancer Foundation, is a specialized oncology Registered Nurse (RN) role and an integral member of the multidisciplinary cancer care team.
- Advocates and partners for accessible, culturally appropriate, and safe health services for First Nations, Métis and Inuit peoples of Alberta.

- Supports First Nations, Inuit, and Métis patients and their families to understand their disease and treatment and navigate the complexity of the health care system.
- Supports connection between Indigenous peoples, communities, and their culture with their respective health professionals.
- Bridges access to medical and supportive care services, community supports and resources in a timely manner.
- Works in collaboration with the health care team to identify a patient's symptoms and concerns, and tailor interventions to address their physical, psychological, social, emotional, spiritual, and or practical needs.
- Builds linkages and relationships with community-based care providers, physicians and other health professionals to support cancer patients within their local environment and at a tertiary or provincial level.
- Works closely with communities and stakeholders to identify gaps and develop strategies to improve access to services to better support Indigenous cancer patients and their families.

Rehabilitation Oncology

(see pages 25, 27-35 of Supportive Care Framework)

Definition

In CCA, Rehabilitation Medicine is a health care specialty that provides therapeutic intervention to assist patients, survivors, and families in preventing or mitigating the physical and psychosocial impact of impairments and functional limitations caused by cancer or its treatment.

Rehabilitation Role in Cancer Care

When a person is having limitations in everyday functioning from a health condition such as cancer, or has an injury or trauma they are recovering from, rehabilitation can help. Cancer rehabilitation (rehabilitation oncology) involves many types of healthcare specialists working together to develop a patient and family centered plan that considers the person's and their families/ support persons' preferences, strengths and goals. For full information about CCA rehabilitation services, resources and referral processes, patients and families may access the Rehabilitation Oncology | Alberta Health Services website and the online pamphlet.

I. Occupational Therapy

(see pages 25-26 of Supportive Care Framework)

- Helps manage physical, cognitive, and/or affective impairments and the dysfunction that these impairments create.
- Purposeful and meaningful activities are used to restore people's functioning and to prevent disability.

- Not only examine the physical effects of an injury or disease, but they also address the psychosocial, community and environmental factors that influence function.
- Specialize in enhancing function, participation, and comfort across the cancer trajectory.

Occupational Therapist Role in Cancer Care

- Occupational Therapy (OT) helps to solve problems that interfere with a person's ability to do things that are important to them, including everyday things like self-care, going to work/ school and leisure/ social activities.
- OT can help manage the following: fatigue and energy levels, adaptive equipment needs, changes in sensation, pain management, ability to complete/ perform daily living skills and activities, ability to complete/ perform instrumental activities of daily living, chemotherapy induced peripheral neuropathy of the hands/upper body, changes in memory/thinking/processing information, sexual health (positioning, comfort during sex), cancer-related cognitive impairment (CRCI/ brain fog), self-care, wound care prevention and management, and return to work/ school planning.
- Ideally, OTs should be an Alberta Aids to Daily Living Program Authorizer for mobility equipment, adaptive aids and compression garments.
- Cancer-related lymphedema management may be offered by OTs and Physiotherapists (PT). Most OTs and PTs receive specialized training to become Certified Lymphedema Therapists (CLTs) in order to provide combined decongestive therapy.

II. Physiatry (Physical Medicine & Rehabilitation)

(see pages 26, 32, 34 of Supportive Care Framework)

Physiatrists are medical doctors who have completed specialty training in physical medicine and rehabilitation. They assess a person's readiness for rehabilitation and other therapies, like OT and PT. Physiatrists focus their treatment on function by treating the whole person, not just one problem area.

Physiatrist Role in Cancer Care

- Physiatrists who have completed a sub-specialty in cancer rehabilitation. They are specialists in physical medicine and rehabilitation.
- Depending on the functional impairment(s) and/ or cancer-related symptoms, Physiatrists may treat their patients using the following procedures: EMG/nerve conduction studies, spasticity treatment (corticosteroid and botulinum toxin injections) and prescriptions (medications and return to work/ functional recommendations).
- Patients seen by physiatry benefit from earlier identification and treatment of rehabilitation issues potentially stemming from the cancer itself or treatment plans.
- Currently, there is one Cancer Physiatrist in the Calgary Zone. Dedicated outpatient clinic time is 0.2 full time equivalent (1 day per week).

- Consultation services provide recommendations on inpatient and outpatient rehabilitation options and the management of functional problems in hospital and on discharge (e.g. neurogenic bowel and bladder, pain, and spasticity management).

III. Physiotherapy

(see page 25 of Supportive Care Framework)

- An autonomous, client-focused health profession which incorporates a collaborative approach to goal directed care, by focusing on the musculoskeletal, neurological, cardiorespiratory and multi-systems.
- Primary care service that is anchored in movement sciences and aims to enhance or restore function of multiple body systems.
- Committed to a person-centered approach of rehabilitation that incorporates a broad range of physical and physiological therapeutic intervention.

Physiotherapist Role in Cancer Care

- Physiotherapists (PTs) can help patients regain, maintain or increase strength, balance, range of motion and mobility which may have been impacted by cancer and/or cancer-related treatment and surgeries.
- PT interventions may include equipment prescription, self-management, education, exercise prescription, and modalities for pain management (e.g., acupuncture, transcutaneous electrical stimulation, therapeutic ultrasound).
- Common cancer-related conditions treated by PTs: lymphedema, cancer induced peripheral neuropathy of the feet/ lower extremity, fatigue, pain, trismus, changes in range of motion, falls/ falls risk, changes in balance, axillary web syndrome (cording).
- Ideally, PTs should be an Alberta Aids to Daily Living Program Authorizer for mobility equipment and compression garments.
- Cancer-related lymphedema management may be offered by OTs and PTs. Most OTs and PTs working in CCA receive specialized training to become Certified Lymphedema Therapists (CLTs) in order to provide combined decongestive therapy.

IV. Speech Language Pathology

(see pages 25-26 of Supportive Care Framework)

- Have clinical training and educational background in speech production, language understanding and expression, voice health and swallowing disorders.
- Expertise includes prevention, identification, evaluation, and treatment of congenital and acquired communication and swallowing disorders.

Speech Language Pathology Role in Cancer Care

- Speech Language Pathology (SLP) can help with speech production, language, voice and swallowing changes caused by cancer and cancer-related treatment.
- Assessments may include bedside swallowing assessments (observation of eating and swallowing) and instrumental assessments (e.g., fiber optic evaluation of swallowing, videofluoroscopic swallow studies, and modified barium swallow diagnostic imaging studies).
- Interventions include exercises, equipment/supplies, compensation strategies, education and counselling.
- As part of the Head and Neck Enhanced Recovery After Surgery pathway, SLP is essential healthcare provider along the inpatient and outpatient care continuum for laryngectomy patients.[4]
- If required to do voice restoration work for patients with a laryngectomy, the SLP should be approved for delegated controlled acts and have specialized training in tracheoesophageal puncture (TEP).
- If working with the Head and Neck Cancer population, SLP should be an Alberta Aids to Daily Living Program Authorizer for equipment and supplies required for patients with a laryngectomy and voice restoration.

Other Programs and Services that work closely with Supportive Care

I. Palliative Care

(see Advanced Cancer clinical practice guideline)

Definition

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[5] It includes whole person care, quality-of-life focus, and mortality acknowledgement.

There is robust evidence demonstrating that integration of palliative care with oncological care improves a variety of patient, family, and health systems outcomes. Providing palliative care earlier in the disease trajectory increases its benefits. Essential components of an early palliative approach to care are: 1) illness comprehension and coping, 2) symptoms and functional status, 3) advance care planning and patient's preferred method of decision-making, and 4) coordination of care.

[4] Hansen K, Chenoweth M, Thompson H, Strouss A. Role of the Speech-Language Pathologist (SLP) in the Head and Neck Cancer Team. Cancer Treat Res. 2018; 174:31-42.
[5] World Health Organization. Cancer Control: Knowledge into Action: WHO Guide for Effective Programmes: Module 5: Palliative Care. Geneva, 2007.

Palliative care is best delivered by an interdisciplinary team. Within CCA, Supportive Care disciplines and palliative care providers work in an integrated manner to address patient and family needs.

Roles

- Primary Level: All health care providers. Care is delivered by interdisciplinary *primary care providers* (e.g., oncology, family practice teams, urban integrated home care), which provide clinical management and care co-ordination, including assessments, interventions, referrals and triage.
- Secondary Level: Palliative Care consultants provide specialized palliative care consultation, advice, and services in an interdisciplinary team setting to primary providers, their patients and families, in various and specialized settings (home, long term care, hospice, hospital, cancer center).
- Tertiary Level: Specialized interdisciplinary palliative care teams provide care for complex cases, symptom management, or psychosocial concerns not responding to interventions.

II. Nutrition Services (Offered Through AHS Nutrition Services Portfolio)

(see pages 18-24 of Supportive Care Framework)

Definition

The Nutrition care process is a systematic, problem-solving model that dietitians use to guide critical thinking and address nutrition-related problems. It contains four distinct but interrelated and connected steps: nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation.

Dietitians

- Have in-depth scientific knowledge of food and nutrition and integrate this knowledge with their training in social sciences, education, health promotion, communication and management to help people achieve optimal health.
- Educate about food and nutrition.
- Provide nutrition counselling to promote behavior change.
- Promote nutritional and overall health, food security and food safety through the development and delivery of food and nutrition education, programs, and policies.

Dietitian Role in Cancer Care

- Participate as an integral part of the multidisciplinary team to provide nutritional expertise.
- Provide screening, counselling and follow up to cancer patients.
- Assess nutritional status and the design of interventions to optimize that status.
- Translate research into practices within clinical guidelines and care pathways.

III. CCA Patient and Family Education and Information

(see page 63 of Supportive Care Framework)

Definition

CCA Patient and Family Education and Information is a structured program and approach to empower patients and families dealing with cancer with the knowledge and information they need to be full partners in their care.

Role

- Focuses on persons affected by cancer, families, and significant others from the time of diagnosis through treatment, and then on to survivorship or palliative and end of life care.
- Includes any definable activity or resource that supports the learning and behavior of persons affected by cancer.
- Evidence-informed using research, clinical expertise, patient/family values and expressed needs.

Clinical Research and Knowledge Development

Supportive Care partners with academic collaborators and CCA Cancer Research & Analytics to help develop, prioritize, and enable clinical research. We aim to preserve and build capacity for evidence literacy and practice-based research, to improve the quality and effectiveness of services. Two key examples of clinical research collaborations are highlighted below.

I. Alberta Cancer Exercise (ACE)

ACE has offered high quality, timely and tailored exercise for the survivor after a cancer diagnosis to over 2,020 Albertans. ACE was successfully implemented and evaluated between 2016-2021 by research teams at University of Alberta and University of Calgary, through grant funding (Alberta Innovates and Alberta Cancer Foundation grants), in collaboration with Supportive Care, CCA and community partners.

The ACE research program was a five-year hybrid effectiveness/implementation study to evaluate the relative benefit from an Alberta wide clinic-to-community-based cancer and exercise model of care. Research is ongoing to look at the sustainability, long-term health outcomes, health service utilization, and effectiveness of the program. It is currently running as a grant-funded free for participants 12-week exercise program designed for individuals undergoing or recovering from cancer treatment. The program consists of two supervised exercise sessions per week, for 24 sessions. The program is designed to improve participant's overall fitness over the 12 weeks. Depending on location, for a given patient, the exercise programming includes circuit training classes, group personal training, and/or supervised 1:1 tailored, flexible programming. The ACE research team is collaborating with Rehabilitation Oncology for specific cancer populations such as patients with brain tumors.

II. Integrative Oncology

In 2012, the academic Division of Psychosocial Oncology, University of Calgary launched the Integrative Oncology research program collaboratively with Supportive Care CCA. Integrative Oncology is a patient-centered, evidence-informed field of comprehensive cancer care that uses lifestyle modifications, mind-body practices, and natural products from different traditions alongside conventional cancer treatments.

Integrative Oncology uses complementary therapies including:

- Mind-body therapies (meditation, yoga, imagery, relaxation, hypnosis)
- Natural health products (herbs, vitamins, dietary supplements, cannabis)
- Energy therapies (acupuncture, Reiki, Tai Chi)
- Manipulative therapies (acupuncture, osteopathy)
- Alternative medical systems (Ayurveda, Traditional Chinese Medicine, Naturopathic Medicine).

Physical activity and nutrition counselling may also be considered complementary therapies.

While Integrative Oncology is not a distinct clinical service within CCA, Supportive Care interventions/services include selected Integrative Oncology approaches and therapies (e.g., mindfulness meditation, physical activity). Research initiatives include clinical trials of complementary therapies, and development of an Integrative Oncology clinic.

Additional Resources

Cancer Care Alberta

CCA Cancer Guidelines, Guideline Resource Unit (GURU)

Canadian Association of Psychosocial Oncology (CAPO)

International Psycho-Oncology Society (IPOS)

American Society of Clinical Oncology (ASCO)

National Comprehensive Cancer Network (NCCN)

Canadian Partnership Against Cancer: Framework for the care and support for AYAs with cancer

Lymphedema Practice Resources:

- National Lymphedema Network
- Canadian Lymphedema Framework
- International Lymphedema Framework

ASCO Endorsement of the SIO Clinical Practice Guideline: Integrative Therapies During and After Breast Cancer Treatment