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MEETING REPORT

Moving guidelines into action: a report from Cancer Care Ontario's event Let's Get Moving: Exercise and Rehabilitation for Cancer Patients

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ABSTRACT

The need for an improved understanding of the rehabilitation services landscape in Ontario and for promotion of Cancer Care Ontario's newly developed *Exercise for People with Cancer* guideline brought Cancer Care Ontario's Psychosocial Oncology and Survivorship Programs together to host a knowledge translation and exchange event. The primary objectives of the event were to understand recommendations from Cancer Care Ontario's new exercise guideline, to discuss key considerations and determine strategies for the implementation of the guideline recommendations, and to explore the current state and future directions of cancer rehabilitation in Ontario.

The event was attended by 124 stakeholders, including clinicians, allied health care professionals, administrators, patients, community partners, and academics representing each of the 13 regional cancer programs in Ontario. Attendees participated in two small-group activities that focused on determining the best approach for implementing the guideline recommendations into practice and discussing current barriers and the future state of cancer rehabilitation in Ontario. The activities allowed for networking and collaboration between attendees. The event provided an opportunity for the Psychosocial Oncology and Survivorship Programs to learn about the types of goals and plans that could be feasible in implementing the guideline in each region, and about ways to prioritize gaps in access to rehabilitation services and the types of implementation strategies that might be used to address the gaps. Overall, attendees were highly satisfied with the event, and the findings are being used to help inform research and practice activities with respect to guideline implementation and rehabilitation practice.

Key Words Exercise, rehabilitation services, guideline implementation, knowledge translation, knowledge exchange

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INTRODUCTION

People with cancer look to rehabilitation services for strategies to cope with impairments resulting from cancer and its treatments, including changes in physical and cognitive abilities, independence and activities of daily living, and physical activity participation levels[1]. As survival rates improve, cancer rehabilitation continues to play a critical role in optimizing health and quality of life for survivors. However, Ontario currently lacks a coordinated cancer rehabilitation system, and inpatient and outpatient services both vary widely in terms of availability, expertise, and patient access. Cancer rehabilitation has therefore been identified as a strategic area of focus in the *Ontario Cancer Plan IV: 2015–2019*[2], calling for Cancer Care Ontario's Psychosocial Oncology and Survivorship Programs to explore and identify opportunities to improve the delivery of rehabilitation services.

The need to better understand the rehabilitation services landscape in Ontario aligns with the launch of Cancer Care Ontario's newly developed guideline, *Exercise for People with Cancer*[3]. Exercise has been shown to be a safe, cost-effective means to prevent and mitigate many of the secondary complications associated with cancer treatments and to enhance quality[4] and quantity[5,6] of life for cancer survivors. Given those benefits, exercise is a key modality in cancer rehabilitation. However, in the absence of a more comprehensive implementation strategy, simple publication of guidelines does not ensure uptake[7,8].

The need to better understand the rehabilitation services landscape in Ontario and to promote the new exercise guideline within rehabilitation settings brought Cancer

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Care Ontario's Psychosocial Oncology and Survivorship Programs together to host a knowledge translation and exchange event. The event, Let's Get Moving: Exercise and Rehabilitation for Cancer Patients, was hosted in Toronto on 19 November 2015. The primary objectives of the event were to

- understand recommendations from Cancer Care Ontario's newly developed *Exercise for People with Cancer* guideline (hereafter referred to as the guideline).
- discuss key considerations and determine strategies for implementation of the guideline recommendations.
- explore the current state and future directions of cancer rehabilitation in Ontario.

EVENT SUMMARY

The event was attended by 124 stakeholders representing each of the 13 regional cancer programs in Ontario[a]. Stakeholders included clinicians (physicians, oncologists), allied health care professionals (nurses, physiotherapists, occupational therapists, exercise professionals), administrators (cancer centre program directors or managers), patient and family representatives, community partners (exercise or support program staff), academics (researchers, trainees), and Cancer Care Ontario directors and staff.

The day included a variety of presentations, breakout activities, and discussions that were presented or facilitated by a range of clinicians, allied health care providers, academics, community-members, and cancer survivors (Table I). In brief, after opening remarks and a patient story, the remainder of the morning session focused on the newly released *Exercise for People with Cancer* guideline.

The lead author of the guideline, Dr. Roanne Segal, began by delivering a series of presentations highlighting the importance of exercise in oncology care, the rigorous process that was used to develop the guideline[9], and specifics about the guideline recommendations. After a stretch-and-nutrition break, implications for practice and key considerations for guideline implementation were discussed to set the stage for the first small-group activity. After lunch, the afternoon session focused on the current state and future directions of cancer rehabilitation in Ontario. From Dr. Eugene Chang's overview of the importance of rehabilitation in the cancer journey, to Dr. Jonathan Sussman's review of the results from a survey examining the current state of cancer rehabilitation in Ontario, to a multidisciplinary discussion panel that provided perspectives and experiences in cancer rehabilitation, attendees were provided with the information and insights necessary to complete the second small-group activity. The day concluded with an event summary and a call for attendees to continue the discussions in their regional cancer programs so that exercise and rehabilitation services for cancer survivors are optimized.

Small Group Activity 1: Exercise Guideline Goal-Setting and Action Planning

Unfortunately, without targeted dissemination activities and implementation interventions, the presence of a guideline does not guarantee the guideline's use in practice[10]. Moreover, although guideline dissemination activities such as the Let's Get Moving event and publication of the guideline on the Cancer Care Ontario Web site are important for creating awareness, dissemination alone is insufficient to change practice[11,12]. Implementation of the guideline will require both understanding and overcoming individual, organizational, and systematic barriers to guideline use[13]; targeted knowledge translation interventions are required. However, barriers are likely to differ depending on the local context and resources available at the 13 regional cancer programs in Ontario.

In consultation with the event planning committee, which comprised multidisciplinary stakeholders, a researcher with expertise in exercise behaviour change (JRT) designed an action-oriented small-group activity. The activity incorporated 2 behaviour-change techniques—goal-setting and action planning—that have been shown to be effective for changing behaviour in a number of contexts (behaviours as diverse as patient self-management to provider clinical practice) and at a number of levels (change at the individual, organizational, or systems level)[14,15].

Attendees were allocated to small groups according to the regional cancer program in which they practiced, researched, or resided. Each group was tasked with the overall objective of determining the best approach for implementing the guideline recommendations into practice by developing a goal and an action plan for their regional cancer program. Each group was given a template that guided them through two tasks, with two examples of each task being used to generate the initial discussion and idea generation[b]. Groups were asked to record their thoughts on chart paper and the provided templates, which were collected at the end of the activity. Members of the event planning committee circulated between the groups during the activity to answer questions.

Groups were asked to spend 15 minutes formulating an objective or mini-goal that would help their regional cancer program achieve the overall goal of implementing the guideline recommendations in practice. The groups were asked to formulate goals that aligned with the SMART principle[16] so that their goals would be *specific* (presented in detail rather than in generalities), *measurable* (having outcomes that can be measured in a practice setting), *attainable* (being actually achievable), *realistic* (fit to the region's current policies, practices, and resources), and *timely* (conducted within a period that aligns with other initiatives in the region).

[a] The province of Ontario is divided into 13 regional cancer programs funded through Cancer Care Ontario. Regional cancer programs are responsible for implementing provincial standards and programs for cancer care, responding to local cancer issues, coordinating care between local and regional health care providers, and working to continually improve access to care, wait times, and quality (for more information, see the Cancer Care Ontario Web site: https://www.cancercare.on.ca/ocs/rcp). In general, each regional cancer program has 1 cancer centre; an exception is the Toronto Central Regional Cancer Program, which has 2 cancer centres (Princess Margaret Hospital and the Odette Cancer Centre).

[b] The templates for the small-group activities are available from the first author upon request.

TABLE I Session details for the Let's Get Moving: Exercise and Rehabilitation for Cancer Patients event

Session topic	Session details[a]
Welcome and opening remarks	*Presenters:* Dr. Robin McLeod, Dr. Jonathan Sussman, Lesley Moody ■ Highlighted the importance of collaboration as part of Cancer Care Ontario's strategy to improve access and integration within the cancer system. ■ Provided an overview of the event day and the Ontario Cancer Plan IV as a catalyst to better understand the role and implications of exercise and rehabilitation in cancer care.
Patient story	*Presenter:* Debora Prokopich Buzzi ■ Shared personal experiences and challenges of a breast cancer survivor and emphasized how maintaining an active lifestyle as a survivor can be challenging. ■ Spoke of the exercise guidance, social support, and sense of community she experienced as a participant in WE-Can, an exercise and healthy living program during and up to 5 years after active treatment. ■ Emphasized the importance of the *Exercise for People with Cancer* guideline and programs for cancer survivors to implement the guideline recommendations.
Exercise guideline: recommendations	*Presenter:* Dr. Roanne Segal ■ Shared the principles and evidence for exercise and lifestyle interventions in oncology care. ■ Discussed the rigorous guideline development process, and the guideline recommendations. ■ Encouraged guideline adoption by various members of the oncology health care team.
Stretch and nutrition break	*Facilitators:* Stefanie De Rossi, Health Works Team ■ Led attendees through a 5-minute stretch routine to break up sedentary time.
Implications and key considerations for practice	*Presenters:* Dr. Roanne Segal, Dr. Jennifer Tomasone, Dr. Michelle Nadler ■ Discussed implications of the guideline recommendations and key considerations for implementation of the guideline in practice. ■ Encouraged attendees to use a multidisciplinary approach when implementing the guideline to account for patient-, institution-, and system-level barriers.
Exercise guideline goal-setting and action planning (small-group activity 1)	*Facilitator:* Dr. Jennifer Tomasone ■ Emphasized the importance of targeted dissemination and implementation interventions to move guideline recommendations into practice. ■ Divided groups by regional cancer program and asked them to discuss a goal and to set an action plan for implementing the guideline in their region.
Lunch and networking	
Introduction and importance of rehabilitation	*Presenter:* Dr. Eugene Chang ■ Introduced the importance and growing need for cancer rehabilitation in Ontario. ■ Outlined the wide variation in both inpatient and outpatient rehabilitation provision and patient access across Ontario. ■ Discussed the challenges and opportunities in providing cancer rehabilitation, including resource limitations, lack of expertise, research and training opportunities, and collaboration between oncology and physiatry providers.
Ontario cancer plan IV and rehabilitation	*Presenter:* Dr. Jonathan Sussman ■ Provided an overview of work that has been initiated to understand the current state of cancer rehabilitation in Ontario. ■ Shared results from an online survey that identified rehabilitation programs or services currently provided to people with cancer in regional cancer programs in Ontario.
Perspectives/experience in cancer rehabilitation: barriers and gaps (discussion panel)	*Facilitators:* Dr. Jonathan Sussman, Dr. Roanne Segal ■ Explored perspectives and experiences of stakeholders from a variety of cancer rehabilitation settings. ■ Examined key barriers and gaps encountered in cancer rehabilitation, benefits and impacts of cancer rehabilitation on health outcomes, and examples of local programs that provide rehabilitation-related services. Panel members were from diverse backgrounds and included: ■ Holly Bradley, Executive Director of Wellspring's Centre of Innovation ■ Joanne MacPhail, Cancer survivor and Co-Chair of the Patient Family Advisory Council at Cancer Care Ontario ■ Renee Leahy, Physiotherapist at the Psychosocial Oncology Program, The Ottawa Hospital ■ Dr. Jennifer Jones, Director of the Cancer Rehabilitation and Survivorship Program and ELLICSR: Health, Wellness and Cancer Survivorship Centre at the Princess Margaret Cancer Centre ■ Dr. Sara McEwen, Scientist at St. John's Rehab
Stretch and nutritional break	
Current and future states of cancer rehabilitation (small-group activity 2)	*Facilitator:* Zahra Ismail ■ Identified and reviewed current barriers to cancer rehabilitation in Ontario. ■ Discussed potential improvement strategies in small multidisciplinary groups.
Summary and wrap-up	*Presenter:* Dr. Jonathan Sussman ■ Encouraged attendees to continue the momentum generated at the event in their regional cancer program.

[a] Affiliations of the presenters and facilitators (alphabetical) at the time of the meeting: Debora Prokopich Buzzi, member of Cancer Care Ontario's Patient and Family Advisory Council; Dr. Eugene Chang, Physiatrist, Toronto Rehabilitation Institute; Zahra Ismail, Manager, Psychosocial Oncology, Nursing and Patient Education, Cancer Care Ontario; Dr. Robin McLeod, Vice President, Clinical Programs and Quality Initiatives, Cancer Care Ontario; Lesley Moody, Director, Person-Centred Care, Cancer Care Ontario; Dr. Michelle Nadler, Resident, Internal Medicine, McMaster University; Stefanie De Rossi, Specialist, Survivorship, Cancer Care Ontario; Dr. Roanne Segal, Lead, Breast Disease Site and Survivorship Program, The Ottawa Hospital Cancer Centre; Dr. Jonathan Sussman, Clinical Lead, Survivorship, Cancer Care Ontario; Dr. Jennifer Tomasone, Assistant Professor, School of Kinesiology and Health Studies, Queen's University.

Groups were then asked to spend 15 minutes on the second task, which focused on generating an action plan for implementing the group's objective or mini-goal. Using the principles of action planning[14], the groups were asked to specify *who* would be responsible for accomplishing the objective, *what* specific tasks would have to be accomplished, *when* the tasks would have to be completed (or for how long), *where* the tasks would take place or the outcomes be measured, and *how* the plan would be carried out in light of potential barriers or enablers in the local context.

Table II summarizes the goals and action plans generated by the groups. Some of the common objectives and potential implementation strategies discussed by the groups were to

- increase provider awareness and knowledge of the guideline by discussing it at physician, allied health, and professional meetings.
- increase patient awareness and knowledge of the guideline by hosting "lunch and learn" sessions and patient education classes, by distributing a variety of patient education resources (for example, pamphlets, promotional videos), and by creating a patient version of the guideline.
- include exercise recommendations or prescriptions as part of treatment plans for patients, regardless of whether the prescription is given by a physician or another health provider.
- facilitate greater awareness and use of exercise programs in the region, including the creation of a database of existing programs, and generate a process for referral to those programs.

Although most of the groups were able to identify at least 1 action plan for their goal, most plans were not specific with respect to *how* the plan would be implemented; thus, further work is required to examine the context-specific barriers and facilitators to guideline implementation in each regional cancer program before knowledge translation strategies are designed. To respond to that gap in knowledge, an online questionnaire assessing barriers and resources to guideline implementation in each of the 13 regional cancer programs will be launched in 2017. Follow-up interviews or focus groups will help researchers to identify feasible knowledge translation strategies for bolstering guideline use in each regional cancer program.

Small Group Activity 2: Current and Future States of Cancer Rehabilitation

Results of Cancer Care Ontario's survey examining the current state of cancer rehabilitation identified large variability with respect to cancer rehabilitation services and patient access across the province. However, four barriers hindering the delivery of cancer rehabilitation programs or services consistently emerged:

- Funding constraints
- Limited resources for service provision (for instance, space, personnel)
- Provider knowledge gaps with respect to cancer rehabilitation
- Lack of buy-in or a clear mandate (or both) for cancer rehabilitation

Those barriers served as the foundation for the second, action-oriented group activity that was designed by the planning committee.

The overall goal of the second activity was to discuss current barriers and the future state of cancer rehabilitation in Ontario by generating an understanding of the root causes of identified barriers and by discussing potential improvement strategies. This time, attendees were divided into groups based on their role in cancer care rather than on their regional cancer program affiliation, such that each group would have a broad representation of stakeholders (for example, physician, social worker, nurse, patient and family advisor, researcher, policymaker, and so on) and, thus, varied perspectives. Each group was a provided with a template that guided them through the task, and a Cancer Care Ontario staff member facilitated and recorded the group's thoughts on chart paper that was collected at the end of the activity.

Groups were asked to select one of the four barriers identified in the "current state" survey (or an alternative barrier not listed) and to spend 20 minutes identifying the underlying reason for the barrier's existence. "The 5 Whys," a technique that is effective for uncovering the root of a problem in health care, was used to help guide the group's thinking. For the chosen barrier, group members were asked "why" the barrier exists, which might uncover an additional barrier or problem for which they were once again asked to respond "why." This iterative process was encouraged to continue until the group felt that they had reached the root cause of the problem. With a richer understanding of their particular selected barrier, the group was then asked to spend 20 minutes discussing potential strategies to improve the barrier to cancer rehabilitation.

Table III presents a complete summary of the barriers identified and the improvement strategies proposed by the eleven small groups. Two of the groups discussed the barriers of funding constraints and limited resources for services (for example, space, personnel), six groups discussed provider knowledge gaps with respect to cancer rehabilitation, and three groups discussed lack of a clear buy-in or mandate for cancer rehabilitation. No groups identified barriers that could not be classified into the barriers identified in Cancer Care Ontario's "current state" survey. The root cause of each barrier varied by group, and each group identified from 4 to 12 ideas for dealing with the barrier. Ideas for improving cancer rehabilitation that consistently emerged in the groups, regardless of the barrier discussed, included

- incorporating exercise for people with cancer and cancer rehabilitation into medical school, medical residency, and professional school curricula.
- surveying and leveraging existing exercise and cancer rehabilitation services, and having an inventory available that providers and patients can access.
- enhancing the capacity of patients for self-management with respect to accessing exercise and rehabilitation services.

TABLE II Responses for small-group activity 1, exercise guideline goal-setting and action planning, by Ontario regional cancer program

Cancer program	Task 1: SMART objective/mini-goal	Task 2: Action plan/ideas for implementation
North Simcoe Muskoka	By April 2016, raise awareness of new Cancer Care Ontario guideline to Simcoe Muskoka Regional Cancer Program staff and to Royal Victoria Regional Health Centre administrators, general practitioners, and patients.	1. Perform Survey Monkey pre-/post-information sharing. 2. Information sharing through "lunch and learn," pamphlets highlighting guideline, and patient-specific pamphlets to ensure safety. 3. Present information at physician meetings, allied health meetings, and mandatory professional meetings.
South East	For May 2016 (Physiotherapy Month), physiotherapist from inpatient cancer floor will work 1 day per week in a well follow-up clinic.	At individual or group visit, 1. discuss exercise guideline. 2. prescribe exercise. 3. see 3–6 months at next visit. 4. group patients from same community. Measures: Number of patients seen; survey by telephone, post, e-mail; exercise group electronic update; see in 3–6 months.
Mississauga Halton and Central West[a]	By 30 June 2016, 5 cancer patients per week will be educated about the exercise guideline and safety, and will be referred to community programs (including Wellspring) and given a passport with a 3-month follow-up survey.	1. Prioritize exercise as part of the cancer journey. 2. Engagement and education for patients and providers using promotional materials placed in the cancer centre to promote benefits of exercise for cancer patients. 3. Passport of continuity and variety/enjoyment/mood score. 4. Use of community resources (for example, Wellspring). 5. Direct volunteer approach to patients. 6. Integration into the patient education classes.
Central	By 1 April 2016, conduct an environmental scan of the exercise programs that exist for patients with chronic diseases in the Central LHIN (and Greater Toronto Area).	1. Create a database of the exercise programs that already exist for specific chronic diseases (such as COPD, cardiac, stroke). 2. Working group will have access to the database.
Waterloo Wellington	By November 2017, each health care provider to include exercise as part of the treatment plan.	1. Education for health providers around exercise. 2. Prescription for exercise from physician. 3. Recommendation of exercise from any health care provider. 4. Compile a list of resources in the region. 5. Measure number of times exercise is included or documented (charting). 6. Make exercise part of the treatment plan and measure patient-reported outcomes (add Godin exercise questions to ESAS).
Erie St. Clair	By 2017, increase participation in RENEW (life after cancer education) program by 50%.	1. Expand to Chatham by recruiting new partners in the region. 2. Re-educate and increase awareness of health care providers through "lunch and learns" with external experts and patient story. 3. Implement patient education and self-management tools (My Cancer Journey guide book). 4. Investigate options of other expansions (for example, men's program, time and location) by forming Committee Annual Plan and Business Case.
North West	Ensure that exercise and self-management are part of the Regional Cancer Program strategic plan—currently in development—by December 2015.	1. Educate clinicians and senior leadership about Cancer Care Ontario's exercise guideline (though presentation and discussion at council meetings). 2. Promote exercise guideline or benefits of exercise and WE-Can Program to all cancer patients (ambulatory and inpatients) at diagnosis, treatment, and survivorship. 3. Referral process for WE-Can or exercise prescription (use existing WE-Can referral and Exercise Is Medicine prescription pads).
South West	By 30 June 2016, through partnership with Juravinski Cancer Centre, McMaster, and Cancer Care Ontario, conduct current state assessment (use survey tool) for *all* care providers in systems across the region to establish baseline measure to drive further improvements.	1. Assessment—"Do you play sports?"—access and evaluate, continue, modify, tailored to their life—conversation 2. Survey re. exercise—all regional partners re: current state compared with only regional cancer centre physicians. 3. Develop patient-facing materials with ideas of "what you can do" or "continue without concern" for patients at assessment, diagnosis, and treatment phases. 4. Utilize e-blasts, Survey Monkey, newsletters, etc.
Hamilton Niagara Haldimand Brant	By December 2016, implement educational objectives that 1) ask and 2) educate patients and providers alike about physical activity referrals.	1. Measure number of patients screened and referred for exercise (physician referral, take baseline information at first visit, ESAS, MyCancerIQ). 2. Create and duplicate patient version of guideline.

TABLE II Continued

Cancer program	Task 1: SMART objective/mini-goal	Task 2: Action plan/ideas for implementation
Toronto Central North[b]	By June 2016, the Sunnybrook Health Sciences Centre team (St. John's Rehabilitation, Odette Cancer Centre) will develop a patient education resource titled "Exercise Guideline for People Living with Cancer."	1. Develop written patient education materials about the guideline, available in hardcopy and online, by conducting an environmental scan, reviewing the guideline (to choose relevant information), and emphasizing how to incorporate physical activity into daily activity.
Toronto Central South[b]	By January 2016, establish an education awareness target, and leverage existing networks of services and tools.	1. Pilot site: Engaged leads and coordinators complete an environmental scan with specific criteria to understand what is already available, what is duplicated, and where we can expand or innovate. 2. Develop a provincial resource leveraging Cancer Care Ontario and relationships, as well as regional resources such as Greater Toronto Area Rehabilitation Network, Wellspring, Cardiac Care Net, YMCA, Good Life, Gilda's, Toronto Rehabilitation hospital.
Central East	By the end of 2016, all oncology patients and their caregivers will have access to the exercise guideline.	1. Broad communication leveraging regional leads and partner sites. 2. Include a 1-pager for patients (simple info) and recommendations for providers. 3. Consider for oncology: first assessment visit, primary care provider, prescription for exercise.
Champlain	By March 2016, disseminate guideline and roll out education and awareness of the exercise guideline to patients/families and health care providers.	1. Patient portal, videos, and resource list of providers. 2. "Script" (prescription) for exercise. 3. Liaise with Cancer Care Ontario to develop a 1-page document that can be given to patients or family and health care providers.
North East	By May 2016, physician exercise referral process using exercise guideline.	1. Education (screening)—physician, cancer centre team 2. Access—physiotherapy (focus on lymphedema) 3. Knowledge resources—prescription pad, simple and safety

[a] Although representing two different local health integration networks, Mississauga Halton and Central West operate as one regional cancer program.
[b] Given the presence of 2 regional cancer centres operating in distinct geographic areas in Toronto, and the large number of event attendees representing this local health integration network, stakeholders from the Toronto Central Regional Cancer Program were divided into two groups, each representing one regional cancer centre (Toronto Central North–Odette Cancer Centre, and Toronto Central South–Princess Margaret Hospital).
LHIN = local health integration network; COPD = chronic obstructive pulmonary disease; ESAS = Edmonton Symptom Assessment System.

TABLE III Summary of responses for small-group activity 2: current and future states of cancer rehabilitation

Barrier	Root causes	Ideas for improvement
Funding constraints or limited resources for service provision		
Limited resources or access	Building rehabilitation as an essential part of care from beginning; health care professionals should include it as part of thought process	1. Breaking silos (for example, some centres have resources, but need specific criteria for cancer patients to utilize those services, such as admission and discharge criteria) 2. Discharge criteria or graduated criteria based on patient needs 3. Survey of available services to identify gaps (this will also help patients identify available services) 4. Peer-to-peer support—sharing what works 5. Day-to-day, staff involved in sharing what works based on their experience 6. Use technology (for example, Ontario Telemedicine Network resources) to widen reach, handle transportation issues, and help deal with space issues 7. Sharing best practices among cancer centres (for example, the ELLICSR: Health, Wellness and Cancer Survivorship Centre kitchen online can be helpful resource, similar others too) 8. Feedback from patients and families
Funding has not been a priority both regionally and provincially for cancer rehab and exercise	Evidence is new (5–10 years; for example, cardiac rehabilitation has more evidence and longer history)	1. Raising profile of guideline 2. More education for lay people who can pass on information about programs 3. Self-management—encourage patients to do low-tech things that do not cost money 4. Leverage existing community programs and services that are safe 5. Identify champions in regions to drive work and raise profile 6. Use technology to reach the most people, including patients, providers, system—maybe Ontario Telemedicine Network

TABLE III Continued

Barrier	Root causes	Ideas for improvement
Provider knowledge gaps with respect to cancer rehabilitation		
Lack of training of providers in community	Curriculum training—not much if any Lack of recognition and "out of scope"	1. Build capacity in the community by generating a "proper" inventory of current resources and resources to link to services or service providers 2. Private sector support ("pharmaceutical investments") 3. Training modules and programs—return to a more generalist approach, culture shift, use of technologies, online supports for patients (that is, cardiac model) 4. Research: building the evidence-base, impact
Lack of awareness and provider knowledge of cancer rehabilitation	Working in silos (that is, public, community, cancer system); system is not designed this way, no specific findings on cancer rehabilitation	1. Improve on current initiatives (do more with what we have in house—for example, media, shift in mindsets, education) 2. Making videos to play at waiting rooms or signage—by showing to teams, also educating them 3. ESAS chart audit: identify rehabilitation as an appropriate referral 4. Prompt in assessment tool for providers 5. Adapting the smoking cessation program model to cancer rehabilitation 6. Create self-management guide book
Lack of common language or knowledge	Stigma (for example, palliative care)	1. Clear understanding of survivorship and cancer rehab: psychosocial oncology needs, transition needs, where do we want to focus, cognitive behaviour therapy (motivation) 2. Policy challenges: transitions to community, who should do rehabilitation, whose responsibility is it? 3. Education and training for community providers and specialist oncologists—lack of knowledge for specific treatment for cancer patients, all professions represented in the standard of care 4. Need for understanding local resources and services 5. Learning from cardiac and stroke rehab programs—modify for cancer 6. Funding to promote programs, rounds at hospitals 7. Patient multidisciplinary cancer conferences—patients receiving tailored information from a variety of providers; patients can only do so much
Provider knowledge gaps	Oncologist not recognizing that rehabilitation is part of the care plan and need for quality of life–enhancing services, including physiotherapy Oncologists do not seek out the information Rehabilitation is not part of oncology education curriculum Kinesiologists, PTs, OTs are also not trained to support cancer patients Silo aspect of the system ("not my job") Connotation that "rehab" is not part of multidisciplinary team and care plan Disparity between regions	1. Education for residents (McGill), and get into the curriculum for oncologist, PT, OT, nursing, and general medicine 2. Build on "Rehab Week" 3. Integrated system 4. Survey of knowledge gap: doctors know exercise and rehabilitation are safe, but cannot answer follow-up questions about exercises 5. Leadership required to build it, test, and research 6. Referral networks integrated 7. Be patient: it takes time to build and evaluate program 8. Window of opportunity to use waiting spaces with education (for example, exercise bands, exercise videos) 9. Build self-efficacy with simple movements 10. What already exists (for example, cardiac college, cardiac rehab units, diabetes program) and translate or extend infrastructure already there 11. "One stop shop"—Where to hear about it? Waiting rooms and repetition hearing and seeing consistent message so that patients hear it at the right time for them 12. Speak to the decision-makers at the top; the cost is not so great 13. Peer mentors and retired professionals

- enhancing use of technology to minimize transportation and space issues (for example, perhaps through the Ontario Telemedicine Network).
- creating mechanisms for enhancing communication between patients, providers, and regional cancer centres or regional cancer programs, as well as other types of rehabilitation programs (for example, cardiac rehabilitation and smoking cessation programs) to foster the sharing of lessons learned.

Interestingly, a number of ideas for improvement identified in activity 2 mirrored the ideas for guideline

implementation discussed in activity 1, including enhancing provider awareness or education and increasing awareness and use of existing programs in each regional cancer program.

Attendee Feedback

At the end of the day, attendees provided their feedback on an event evaluation form. Overall, attendees were highly satisfied with the event and strongly agreed that the event was worth attending. They indicated that the event met the stated objectives, that the small-group activities were worthwhile, and that they planned to share with their colleagues the information learned in the sessions. As one attendee said, "My favourite part was seeing how many people are so passionate about [exercise and cancer rehabilitation]."

CONCLUSIONS

Let's Get Moving: Exercise and Rehabilitation for Cancer Patients presented a valuable opportunity for a group of multidisciplinary stakeholders to come together for an exploratory and action-oriented event focusing on exercise and rehabilitation for cancer patients. The small-group activities allowed for networking and collaboration between the various stakeholders that attended. The activities also provided an opportunity for the Psychosocial Oncology and Survivorship Programs at Cancer Care Ontario to learn about the types of goals and plans that might be feasible for implementing the *Exercise for People with Cancer* guideline in each region, and about ways to prioritize gaps in access to rehabilitation services and the types of implementation strategies that might address the gaps. Findings from the

TABLE III Continued

Barrier	Root causes	Ideas for improvement
Provider knowledge gaps with respect to cancer rehabilitation		
Health care professional knowledge gap	Tied into a bigger system issue of funding and overburdened health care professionals	1. Patient education and self-management tools 2. Provincial network of resources and where to refer 3. Peer support volunteers 4. Other trained volunteers for programs, referral process, psychosocial oncology, and so on 5. Promotion of services 6. Empowering patients and offering psychosocial oncology support informally 7. Continued communication between the oncologist and the patient about ongoing needs
Provider knowledge gaps	Bottom-up approach missing; everyone should ask about and promote exercise Oncologist needs to know, but needs help to "do"; no one to hand off execution of exercise	1. Knowledge translation and exchange activities; road show, ask what will it take to start 2. Sharing physiotherapy resources (inpatient and outpatient) 3. Determining what can be added to existing programs and what is available in community (partnering) 4. Opportunities to link with hospitals, health clubs, and so on across sectors to build capacity and opportunity for equitable access to exercise programs (for example, Goodlife, YMCA, American College of Sports Medicine Training—cancer centre kinesiologists or physiotherapists go to athletic clubs to provide their expertise for cancer wellness) 5. Database with what regional cancer programs are doing; Canadian Cancer Society can post on their Web site
Lack of buy-in or clear mandate for cancer rehabilitation		
Lack of buy-in or clear mandate	Education: health care professionals and patients have to be better informed	1. Build education about exercise and cancer rehabilitation into medical school or residency programs, messaging to health care professionals, Cancer Care Ontario messaging (trickle down), and look to examples or diseases that are done well (for example, cardiac rehab or chronic disease model) 2. Knowing what is the bare minimum standard for cancer rehabilitation; we should have in place as a starting point (for example, U.S. accreditation guidelines in development) 3. Goals that are achievable across the province, and building it into the accreditation process 4. Re-evaluate nomenclature: Where do rehabilitation services fall? Being very clear on nomenclature and definitions 5. Pulling rehabilitation services out of psychosocial oncology departments 6. Advocacy 7. Showing the benefits—cancer rehabilitation is multi-modal, exercise is one component

TABLE III Continued

Barrier	Root causes	Ideas for improvement
Lack of buy-in or clear mandate for cancer rehabilitation (continued)		
Ensuring rehabilitation is a standard component of care (that is, screening, postsurgical, etc.)	More people are surviving; supply and demand, playing catch up, variation or complexity of cancer Lack of trust and education about benefits of rehabilitation and understanding of rehabilitation recommendations	1. Dedicated advocates who have time and patient stories 2. Making a case re: cost versus benefits 3. Defining what exercise means 4. Defining and communicating the risks 5. Communicating recommendations to patients 6. Standardize model of care for rehabilitation that utilizes experts and can be communicated across the province, and backing the model by touching on the cost–benefit of providing rehabilitation as a standard component of cancer care
Lack of buy-in or clear mandate	Role and scope of health care professionals; limited resources, need easy and clear referral partners Tunnel vision: health care professionals see limited benefits; view from their own practice and might not see the full picture	1. Strengthening relationships of health care professionals (for example, oncologist and physiatrist)—interpersonal and site visits 2. System level: guideline development and dissemination with stakeholders together 3. Champion or lead: bring people together across multiple disciplines 4. Research data: dissemination to health care professionals and information for patients 5. Connect rehabilitation and exercise (for example, written prescription for rehabilitation and communications strategy with clear key messages with patient or family involvement; various modalities for messages, including individual targets such as use of apps) 6. Looking at methods of communication between providers (for example, e-mail messages, dissemination of guideline through channels such as Registered Nurses' Association of Ontario and other colleges) 7. Community partnerships: system, between chronic disease researchers, agencies, hospitals, and so on (for example, Cancer Care Ontario and Cardiac Care Network) 8. Economic analysis data

ESAS = Edmonton Symptom Assessment System; PT = physiotherapist; OT = occupational therapist.

group activities are being used to help inform research and practice activities with respect to guideline implementation and rehabilitation practice into the future.

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CONFLICT OF INTEREST DISCLOSURES

We have read and understood *Current Oncology*'s policy on disclosing conflicts of interest, and we declare that we have none.

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