

Improving cancer care for rural Australians

Report of the Clinical Oncological Society of Australia and the Medical Oncology Group of Australia

Background

The 10th National Rural Health Conference, convened by the National Rural Health Alliance, was held in Cairns in May 2009. The conference program encompassed a wide range of topics and themes, linked by a common focus on new approaches to improving health and health outcomes for Australians who live in rural and remote Australia.

Because of its significant impact on the lives of rural Australians, cancer care was the subject of a concurrent stream at the conference, supported by the Clinical Oncological Society of Australia (COSA) and the Medical Oncology Group of Australia (MOGA).

Cancer is Australia's largest disease burden, with more than 106,000 new cases and more than 39,000 cancer deaths in 2006.¹ About one-third of people affected by cancer live in rural, regional and remote areas.

It is now well established that people with cancer who live in rural areas have poorer survival rates than Australians in the major metropolitan centres.² Several factors are thought to contribute to lower survival rates including:

- rural patients' cancers are often diagnosed at a later stage, meaning they are more advanced and more difficult to successfully treat
- poorer access to specialised treatment
- relative shortage of health care providers in rural and regional areas
- higher proportion of disadvantaged groups such as Aboriginal and Torres Strait Islander peoples.³

The first national mapping of cancer services in Australian rural and regional hospitals, conducted by COSA in 2005, found marked deficiencies in clinical services in rural and regional areas of Australia. COSA's report concluded that the quality and availability of services was directly related to the lower survival rates for people in rural and regional Australia.⁴

There is a clearly identified need for action to address these inequities in order to close the gap between cancer outcomes and survival for people in rural Australia and those in metropolitan areas.

¹ AIHW (Australian Institute of Health and Welfare) & AACR (Australasian Association of Cancer Registries) 2007. Cancer in Australia: an overview, 2006. Cancer series no.37. Canberra: AIHW.

² Australian Institute of Health and Welfare and Australasian Association of Cancer Registries. Cancer survival in Australia 1992-1997: geographic categories and socioeconomic status. Cancer series no. 22. Canberra: AIHW, 2003.

³ Jong KE, Smith DP, Yu XQ, et al. Remoteness of residence and survival from cancer in New South Wales. Med J Aust 2004; 180: 618-622.

⁴ Clinical Oncological Society of Australia. Mapping rural and regional oncology services in Australia, March 2006. http://www.cosa.org.au/cosa/File/publications/Mapping_regional_oncology_services_MAR06.pdf

Improving cancer outcomes for people in rural Australia

The COSA/MOGA cancer stream at the 10th National Rural Health Conference (NRHC) provided a platform for presentations and discussion about new approaches to improving cancer care for people diagnosed with cancer who live in rural and regional areas of Australia.

Conference delegates heard about two major national initiatives that aim to substantially improve the accessibility, quality and coordination of cancer services for people in regional and rural areas:

- construction of new regional cancer centres—a model that has been advocated by COSA and other organisations, and is now a Federal Government-funded program (see page 6); and
- development of networks linking regional and metropolitan cancer services in all states and the Northern Territory (the CanNET program—see page 16).

Both approaches necessitate a significant change in thinking about health care delivery—shifting the focus from getting patients to city centres to developing ‘hubs’ of cancer care expertise in regional areas and linking and supporting services in rural centres.

Treatment for cancer is often complex, involving many disciplines and therapies. It is generally not possible for rural Australians to access the full range of care required in their local area. Confronted with multiple care providers in multiple care settings, there are many opportunities for a rural person diagnosed with cancer to become ‘lost’ in the system, experiencing fragmented, and sub-optimal, care.

This increasing complexity of cancer care necessitates better care coordination and more patient-centred approaches.

Several presentations highlighted efforts to improve rural patients’ (and caregivers’) cancer journeys, including COSA’s initiatives to improve coordination of care (page 7) and novel approaches to taking services to patients (rather than patients to services), such as:

- the use of videoconferencing to support delivery of chemotherapy in rural Queensland (page 9);
- taking skin cancer clinics to a remote Queensland population (page 15);
- the development of ‘shared care’ oncology services (a partnership between metropolitan oncologists and local nurses) in Cooma (page 13); and
- a patient-focused dietetics service for rural patients in the Tamworth area (page 18).

Delivery of safe, quality and timely cancer services to people with cancer, regardless of their location, depends on the availability of sufficient, and appropriately skilled, trained and supported, health professionals.

While welcoming the government’s commitment to capital grants for regional cancer centres, conference presenters and delegates noted that the success and sustainability of regional cancer centres depends on the availability of oncology and allied health professionals and specialist services (see page 6).

The critical role of general practitioners (GPs) and community nurses in the care of regional and rural cancer patients and ensuring care coordination throughout the cancer journey was highlighted in

several conference presentations. The need to foster and support primary health care professionals was noted as being integral to the development of regional cancer centres and the CanNET networks.

Other presentations highlighted the need for effective educational resources to engage and support non-cancer specialists, such as GPs and nurses, in their increasing role in cancer care. Conference delegates heard about innovative approaches to supporting the information and training needs of rural health care providers through the Enhancing Palliation in Patients with Advanced Cancer in Rural Areas of Australia and Education Program in Cancer Care (EPICC) developed by the Medical Oncology Group of Australia (see page 12) and the National Cancer Nursing Education (EdCaN) program (page 13).

International research has highlighted the risk of burnout in cancer professionals, with potentially significant implications for patient care and for the future of the cancer workforce. A recent Australian survey of COSA members has highlighted the prevalence and predictors of burnout and associated psychosocial problems, as well as protective factors and strategies that can reduce the risk and impact of burnout (see page 10).

Reports of the COSA/MOGA cancer stream presentations follow, further explaining these novel approaches and actions to improve cancer care for people living in rural and regional areas, and highlighting key issues, findings and/or learnings.

The future of regional and rural cancer service delivery

Adam Boyce¹

¹COSA Rural and Regional Group

The establishment of regional cancer centres has been promoted by COSA and other organisations as the most cost-effective and efficient platform for efforts to reduce the disparities in cancer treatment outcomes between urban and rural Australia. This is now a Federal Government program, with a \$560 million commitment in the 2009-10 Budget to build a network of regional cancer centres.

COSA has been advocating the benefits of regional cancer centres for several years. COSA convened a workshop at its 2008 Annual Scientific Meeting which brought together clinicians, consumers and representatives of government, public and private providers to consider models of care that would best meet the needs of people affected by cancer living in non-metropolitan Australia. Participants concluded that 'Regional Cancer Centres of Excellence' were the platform from which rural and regional service delivery could be improved, by improving access to best practice diagnosis and treatment and substantially reducing the distance rural and remote patients must travel to receive multidisciplinary care.

It is recommended that the location of regional cancer centres be determined by existing infrastructure (particularly radiation services, which are capital intensive) and analysis of population density and future needs. Radiation therapy units have been established in 10 major non-metropolitan centres, with two more planned.

Regional cancer centres would contribute to ongoing capacity-building and enhancements in regional areas by building strong links between regional centres and major teaching hospitals, increasing patient and clinician access to clinical trials and research programs, improving telemedicine and upskilling local primary health care providers. They could also foster an overall culture of medical excellence in local communities through improved recruitment and retention of GPs, clinical and allied health staff, and providing a platform for diagnostic and other high tech imaging and medical services in regional Australia.

The 2009-10 Federal Government Budget provides \$560 million for capital grants to build regional cancer centres. But the success of regional cancer centres would depend on having sufficient and sustainable medical and allied health staff and the appropriate clinical and supportive care services. In "an ideal world", each RCCE would need, at a minimum:

- 2 radiation oncologists
- 2 or more medical oncologists and/or haematologists
- adequate number of radiation therapists, radiation physicists and nurses
- specialist surgical services (sufficient expertise within the centre to meet the needs of people with common cancers; but also appropriate referral pathways and care coordination to ensure patients with less common cancers are referred to major centres in a timely manner)
- specialist pharmacy services
- nurse educators for resident staff and to provide peer support for outreach and community clinics

- palliative care services—at least one FTE medical officer trained in palliative care and at least one palliative care nurse
- psychologist
- local allied health staff who are specially trained in delivery of care and services to people with cancer
- blood banking service
- care coordinators (1 per 200 new patients, to ensure patient needs are met and timely referrals made)
- appropriate out of hours emergency and assessment capacity—using the regional centre as the hub and upskilling doctors in remote areas
- appropriate accommodation services for patients and their families.

This discussion led to a priority recommendation of the National Rural Health Conference, welcoming the Federal Government’s commitment to regional cancer centres, but noting the need for the centres “to be supported by funding for adequate staffing and by effective relationships with smaller communities”.

Presenter

Adam Boyce is a medical oncologist and is Chair of COSA Rural and Regional Group. Having graduated from UNSW Dr Boyce completed oncology training at the Prince of Wales and Royal North Shore Hospitals. In 2003 he became the first resident medical oncologist to be based in Lismore, northern NSW. This service now provides oncology services to approximately 220 000 people. He has a keen interest in improving access to cancer services in regional areas.

The COSA Care Coordination Project—meeting the needs and measuring the outcomes

Patsy Yates¹

¹School of Nursing and Midwifery, Queensland University of Technology

Professor Yates outlined the Clinical Oncological Society of Australia's activities in recent years aimed at improving coordination of cancer care.

In November 2006 COSA convened a workshop to define care coordination and identify the key issues and problems from the perspectives of people involved in delivering cancer services and those receiving them. The outcome was a set of principles to underpin care coordination at the patient, team and system levels. [A report of the workshop was published in *Cancer Forum*, 2007; 31(3):169–172.]

A follow-up workshop in 2007 defined expected outcomes from cancer care coordination and methods for evaluating the anticipated health, economic and other benefits of care coordination. This workshop resulted in a shared understanding of coordinated care, and defined outcomes that it will achieve at patient, service and funder levels. This workshop also highlighted a need to focus attention on the specific support needs of the health professionals appointed to dedicated care coordination roles.

In 2008, COSA undertook a survey of its membership to elicit information around scope of practice, work experience, referral pathways and learning and support preferences for cancer care coordinators across metropolitan and rural settings. COSA members who self identified as being in a dedicated care coordinator role were asked to complete a web-based survey. There were 97 valid respondents (41% from regional/rural settings).

Key findings of COSA's 2008 survey of cancer care coordinators

- People in care coordinator roles are:
 - most often experienced nurses (96%); 4% other health professionals
 - new to the role (53% in the role for <2yrs)—highlighting the importance of learning and support needs.
- The survey found huge variation in the scope of practice of cancer care coordinators—some explainable due to different practice settings; some not explainable and thus needing attention.
- Most respondents said their role incorporates direct clinical care, psychosocial support and administrative functions. On average, more time is spent on activities relating to education and support of individual patients, and less time on activities that might reflect more systemic or team coordination activities. In the absence of principles and guidance, it seemed many care coordinators were confused about what they should focus their time on.
- Less than one-quarter of the sample indicated that formalised referral criteria existed for their service.
- A minority reported a formalised approach to orientation to their role (less than 37%) or ongoing clinical supervision (less than 34%).

- Respondents said clinical knowledge and communication skills were the most important areas of knowledge required for their role. Less priority was given to system knowledge or organisational skills.
- In terms of future needs, care coordinators felt that clinical updates were among the most important learning priorities, as they feel they need to have a high level of clinical knowledge.

Based on the survey findings, COSA's Care Coordination Working Group has identified several priorities, including the development of:

- evidence-based guidelines, standards and tools to minimise unnecessary variation in practice and duplication of effort
- professional and organisational supports for care coordinators, including:
 - how multidisciplinary team effectively supports and incorporates the role
 - clinical supervision for the care coordinator role
 - professional development opportunities including clinical updates, communication skills, and system coordination
 - peer networking opportunities
- valid and reliable measures of key outcomes from care coordination, with opportunities to use outcome data to drive improvements in practice
- further research to understand patient experiences and outcomes associated with various cancer care coordinator models.

Presenter

Patsy Yates has extensive clinical, education and research experience in cancer and palliative care, the past six years in a joint academic-clinical appointment with the Division of Oncology at Royal Brisbane Hospital. Patsy has an established program of research in various aspects of symptom management and supportive care, and is currently undertaking funded studies evaluating supportive interventions for people experiencing pain, breathlessness, and fatigue. Patsy is immediate past Chairperson for the Cancer Nurses' Society of Australia and member of the Board of Trustees for the International Society of Nurses in Cancer Care.

Novel ways to enhance rural patients' and clinicians' access to medical oncology services

Sabe Sabesan¹

¹Department of Medical Oncology, Townsville Cancer Centre and School of Medicine, James Cook University

Dr Sabesan described a novel approach to providing chemotherapy treatment to patients in rural and remote areas.

Patients and clinicians from rural and remote areas of Australia often lack access to specialist oncology services. Hence either patients have to travel to metropolitan centres for all or at least some of their treatment or specialists travel to rural centres for regular clinics. The problems with these current models of care are:

- long-distance travel is costly, time-consuming and often uncomfortable (eg after emetogenic chemotherapy) for patients and their families
- specialists spend valuable time travelling—perhaps 4 to 6 hours to see 5 or 6 patients, which also means being unavailable to patients at the specialist's home site
- visits are infrequent
- urgent cases need transfer to the metropolitan centre
- specialists may have to give phone advice to local doctors/nurses without seeing the patient
- local (non-specialist) doctors need frequent input from the oncologist in relation and may have to make specialist and stressful decisions
- complications are not managed by local doctors/nurses.

Hence there is a need for novel ways of delivering treatment to patients in rural areas. For the past three years medical oncologists at the Townsville Cancer Centre have conducted weekly interactive videoconference clinics with patients and their families, accompanied by a senior medical officer and oncology nurse, in Mt Isa. (Return travel time between Townsville and Mt Isa is at least 5 to 6 hours.)

More than 50 patients with all stages of cancer have been consulted, with chemotherapy given for almost all cancers. Patients needing urgent consultations are seen outside the designated clinic hours. Patients needing urgent treatment, for example patients with symptomatic small cell lung cancers, commence their chemotherapy in Mt Isa without needing to travel to Townsville.

While videoconferencing has been used effectively in other medical fields, its use in the oncology setting has been mostly for multidisciplinary team meetings. There has been limited use for patient consultation, even in the literature. This has been at least partly due to concerns about:

- lack of rapport with patients (which has not been studied in oncology)
- medico legal implications
- lack of billing for consultations (a valid concern for private specialists)
- technical difficulties
- access for patients with hearing or visual impairment.

A questionnaire-based survey of the Mt Isa patients found that all patients were satisfied with care and most patients prefer to see the specialists via interactive video-conferencing rather than travelling to Townsville. Overall 96% felt this approach saved money and time and was convenient.

The senior medical officers and nurses in Mt Isa were also satisfied with the service, reporting a high and easily accessible level of support from the oncologists. Urgent cases were able to be assessed and decisions made without needing to transfer patients.

In terms of safety (assessed by retrospective chart analysis), only four patients were admitted for complications and there were no treatment-related deaths. A cost-efficiency analysis is to be completed, but the service seems to be cost effective (particularly given the ability to consult via videoconference in urgent cases and avoid unnecessary transfers).

Future plans include:

- more studies to assess specialist-patient rapport
- completing the cost-effectiveness analysis
- extending the service to more small towns around the Townsville area
- using mobile videoconferencing to support rural doctors during ward rounds (when a patient is admitted because of complications).

Presenter

Sabe Sabesan is a consultant medical oncologist and the director of the Department of Medical Oncology at the Townsville Hospital in north Queensland and a senior lecturer at the James Cook University School of Medicine. He obtained his BMBS degree from Flinders University in 1995 and completed his fellowship in medical oncology in 2003. His main academic interests are oncology education and research into rural and Indigenous oncology. He has contributed to chapters in the Australia and New Zealand guidelines for the management of melanoma and prostate cancers and the revised ideal oncology curriculum for medical students.

Prevalence and predictors of burnout in COSA members

David Goldstein¹

¹University of NSW and Prince of Wales Hospital

Professor Goldstein reported results of a COSA survey of members to ascertain the prevalence and predictors of burnout and associated psychosocial problems.

The survey was developed in recognition of high levels of burnout among cancer care professionals, with potentially significant outcomes in terms of increased medical errors, increased turnover and absenteeism, decreased quality of patient care, and impacts on the professional and personal lives of affected professionals.

COSA members were invited to complete a 10 minute online survey to assess:

- prevalence of burnout
- prevalence of psychosocial distress
- demographic and occupational predictors of burnout
- perceived causes of professional burnout
- recommended strategies for preventing or reducing its impact on cancer care personnel.

More than 740 COSA members completed the survey (56% of members who did not opt out). Most (53%) were nurses, 20% were physicians. About one in five work in rural or remote areas.

Survey findings

Moderate to severe levels of psychiatric morbidity were identified in more than 11% of the respondents. This level of psychiatric morbidity among cancer professionals is comparable to the general population (11.6% vs 12.7%). The morbidity appears to be a direct result of the sense of burnout. Hence there is a need to identify and assist those at risk.

Self-reported levels of burnout using a single-item burnout measure were high—28% of respondents rated themselves as “definitely burning out” and almost 1 in 10 reporting that “symptoms of burnout I’m experiencing won’t go away” or “I feel completely burned out and often wonder if I can go on”.

The main predictors for burnout were factors associated with emotional exhaustion:

- dissatisfaction about leave
- high levels of direct patient contact (>30 hours per week)
- perceived need for communications skills training.

The top causes of burnout nominated by the high self rating respondents were job related (excessive workload, lack of staff cover for leave, unrealistic demands) and organisational (poor hospital administration, non-responsive managers and staff shortages).

Accordingly, strategies to prevent burnout that were nominated by respondents included:

- back fill for leave
- professional development

- mentoring and peer support networks
- access to subsidised counselling
- a larger and more skilled work force.

The high burnout levels in Australian cancer professionals were similar to levels in the world literature for cancer professionals in other countries, and for other high stress occupations such as teachers and police officers.

Key points and recommendations

- Personal and organisational strategies are needed to minimise burnout.
- Screening is needed, and should focus on cancer professionals who have:
 - very high patient contact
 - neglected taking leave
 - had no communications skills training.
- Communication skills training is an effective and easily-developed strategy to address the problem.
- Optimum protective benefit is seen with a moderate amount of direct patient contact (not too much, nor too little).

Presenter

David Goldstein, Conjoint Clinical Professor UNSW, is a senior staff specialist in medical oncology at Prince of Wales Hospital in Sydney. He particularly specialises in gastrointestinal malignancies. He is Immediate Past President of the Clinical Oncology Society of Australia (COSA). He is an active clinical and translational researcher. He had been a visiting medical oncologist at Tamworth Base for a number of years and has been involved in several educational initiatives for regional health professionals about cancer treatments and an active member of the COSA regional and rural action group for enhancement of regional cancer service delivery.

Cancer education for rural health professionals: the MOGA experience

Bogda Koczwara¹

¹Medical Oncology Group of Australia

The Medical Oncology Group of Australia (MOGA) is a professional organisation, with about 400 medical oncologist members. MOGA's objectives include fostering the highest standards of care for patients with cancer in Australia.

Given the increasing complexity of cancer care and the limited number of specialists in rural settings, MOGA identified a need for effective educational resources to engage and support non-cancer specialists (eg GPs and nurses) in cancer care.

In 2006, MOGA developed and delivered a colorectal cancer care program via a series of multidisciplinary workshops in rural settings across Australia.

In 2007, MOGA led a multidisciplinary working party in development of a web-based educational module focused on the concept of "palliative oncology" (using specific cancer treatments for palliation) for GPs and health care workers in rural and remote areas of Australia.

At the end of April this year there were more than 860 users. Of the users who completed an evaluation, 75% planned to review or change their practice as a result of using the program.

Following the success of the palliative care e-learning program, similar methodology was used to analyse the needs for cancer education of non-cancer specialists and to develop a program in the area of cancer care. GPs and other non-cancer specialists expressed interest in an educational program focusing on all common cancers, their management and related clinical care. Most did not want to sub-specialise in cancer care, but to be able to access reliable information when needed and learn more when time permitted.

MOGA is now finalising the Education Program in Cancer Care (EPICC), funded by Cancer Australia. EPICC is a flexible, web-based series of modules about a range of cancer topics for public health care providers and other non-cancer specialists. It will be launched in August.

In developing these programs, MOGA has assessed and responded to user needs by:

- asking users what they want to know (but also identifying what users *need* to know)
- seeking to develop skills and attitudes, as well as knowledge
- providing practical tools and templates to support the development of 'systems' for providing cancer care
- ensuring the information is easily accessible, kept up-to-date and realistic (eg case studies reflect real life situations).

The EdCaN experience

Patsy Yates¹

¹School of Nursing and Midwifery, Queensland University of Technology

The Australian National Cancer Nursing Education Project (EdCaN) is a Cancer Australia-funded program to develop a national professional development framework and cancer educational resources for nurses.

The EdCaN program is underpinned by a patient-centred approach and rationale that every nurse (not just specialist cancer nurses) is likely to come across people with cancer.

Hence the program includes educational resources designed for nurses who have different amounts of contact with, and roles in caring for, people with cancer:

- **All** nurses, no matter where they work, need some core capabilities in their understanding of cancer control.
- **Many** nurses have some contact with people with cancer, but not necessarily day-to-day contact.
- **Some** nurses are specialist cancer nurses and thus need to have higher levels of competency.
- **Few** nurses have advanced practice skills, eg nurse practitioner level.

A range of educational resources has been developed for all nurses in recognition of these different needs. Resources include defined core competencies; learning resources such as various modules, case-based learning and workshop presentations; facilitators' guides and assessment tools; and a professional development portfolio.

There is a navigation guide to enable users to work through the resources for their individual professional development, enable course providers to access them to incorporate into their courses, and enable health services to use them in continuing professional development or individual staff development programs.

The EdCaN program will be launched at the Cancer Nurses Society of Australia congress in June. It is freely accessible on cancerlearning.gov.au.

Presenter

Patsy Yates has extensive clinical, education and research experience in cancer and palliative care, the past six years in a joint academic-clinical appointment with the Division of Oncology at Royal Brisbane Hospital. Patsy has an established program of research in various aspects of symptom management and supportive care, and is currently undertaking funded studies evaluating supportive interventions for people experiencing pain, breathlessness, and fatigue. Patsy is immediate past Chairperson for the Cancer Nurses' Society of Australia and member of the Board of Trustees for the International Society of Nurses in Cancer Care.

The Cooma project—a new model of oncology service delivery through partnerships between metropolitan oncologists, local GPs and nursing staff

Bob Neumayer¹

¹Greater Southern Area Health Service

The “Cooma project” is an example of a community-driven change to cancer service. In response to an identified community need and advocacy by the local Monaro Committee for Cancer Research, the committee and the Greater Southern Area Health Service gained funding from the NSW Cancer Institute to establish a pilot “shared care” oncology service in Cooma, NSW.

The aim was to establish and evaluate a new model of delivering cancer treatment in the Cooma area (rather than patients having to travel to Canberra) through partnerships between metropolitan oncologists, local rural GPs and nursing staff.

The one year pilot began in September 2007, and has provided an average of 25 occasions of service per month.

The project was evaluated using surveys and face to face interviews to assess the success and effective implementation of the model of ‘shared care’; patient satisfaction and use of the local service; GP and nurses’ involvement and satisfaction with the program; and other measures.

Key outcomes and learnings

The Cooma ‘shared care’ model effectively met the community need, improving access to a local, quality service and thus reducing travel for patients and carers, the burden associated with travel and waiting times. Patients reported a better personal atmosphere and overall experience.

Successful delivery of the service required strong working relationships between the oncologists in Canberra and local nurses (with GPs as backup) and good communication. Strong community support and partnerships between clinicians, health staff and community health services were pivotal.

The tight timeframe for the pilot project caused a lot of stress among local health service staff, and the impact of taking two RNs from the hospital into the oncology service created pressure on other services. A key learning was the need to communicate with the whole staff about the implications of changes to clinical services.

An unexpected outcome was the lack of GP involvement in administering chemotherapy. The proposed model envisaged GPs would have a key role in providing treatment, but local GPs, while supportive, did not become involved. Instead the two nurses who were recruited to the service were appropriately trained to administer chemotherapy. They continue to provide the service, with local support, and both nurses are now completing tertiary studies in cancer care.

Sustainability of the Cooma oncology service will require an ongoing commitment to staff training and support including succession planning. As with many specialist services, the availability of growth funding could be an ongoing problem.

The model should be transferable to other settings, depending on local resources and environment.

Presenter

Bob Neumayer is the Senior Service Planner for Greater Southern Area Health Service, NSW. He supports the Area Health Service in developing its strategic planning from a broad executive level to specific site planning with area health service managers. Prior to this position, Bob was the Head of School of Community Health at Charles Sturt University.

The RFDS primary care skin cancer clinic: a pilot program for remote Australia

Stephen Margolis¹

¹Royal Flying Doctor Service (Qld Section)

The Royal Flying Doctor Service (RFDS) has a long history of delivering primary health care services to people in remote areas of Australia.

In 2006 the RFDS initiated a pilot program to ascertain whether a dedicated RFDS skin cancer clinic could improve outcomes for a remote population with a high risk and rising incidence of skin cancer.

Skin cancer is the most common cancer in Australia, and Queensland has the highest incidence of melanoma in the world. Incidence of melanoma and non-melanoma skin cancers are increasing, particularly in men over 50.

Noting the increasing use of specialist primary care skin cancer clinics in metropolitan areas, the RFDS began thinking about novel ways of providing a similar, dedicated service in an area of high need but with a very small population.

The RFDS developed a one day fly-in, fly-out primary skin cancer outreach clinic to a remote area of north-western Queensland. The population comprised about 1000 non-Indigenous adults, primarily employed in outdoor activities, and included a large group of older men.

The clinic was run concurrently with the regular primary care medical service, but focused only on skin cancer diagnosis and management. This model was used to minimise the additional costs of providing the service.

Results

A retrospective longitudinal study compared the fly-in, fly-out service with historical controls.

During the study period (just over two years) 316 people were seen at the RFDS skin cancer clinic (29% of the total non-Indigenous population), which included 39% of the 50+ year old population. Most people had only an examination; a procedure was performed in about one-third of consultations. The demographic most likely to have a lesion removed were 50+ year old men.

For 50+ year old males, there was a statistically significant (10-fold) increase in the detection and removal of lesions that were melanomas. While the absolute numbers are very small, this program could be credited with saving a few lives by detecting these melanomas within a very short period of time.

A comparison of quality indicators found that the RFDS skin cancer clinic outcomes were similar to those seen in specialised metropolitan skin cancer clinics. The fly-in, fly-out service proved to be an effective model of delivery skin cancer diagnosis and management services a remote and difficult to access location.

An article about this pilot project has been published in *Rural and Remote Health*:
http://www.rh.org.au/publishedarticles/article_print_1048.pdf

CanNET—a new service model linking regional and metropolitan cancer services into single networks

Jane Phillips¹

¹Education and Service Development Section, Cancer Australia

The Cancer Service Networks National Demonstration Program (CanNET) aims to improve access to better coordinated cancer services by linking regional and metropolitan cancer services into single networks.

The CanNET Program was established in early 2007 and the first phase will conclude at the end of June 2009. Through Cancer Australia the Australian Government has provided \$7 million to support development of networks in each of the states and the Northern Territory. Each jurisdiction is also contributing to the project. A National Support & Evaluation Service has been established to work with each of the networks and ensure their efforts complement existing work and are underpinned by consumer engagement and involvement of health care providers and to facilitate shared learnings and knowledge transfer.

Different models have evolved, given the differences in terms of population, geography, health systems and jurisdictional priorities in each region. In South Australia, the Northern Territory and Tasmania, the network encompasses the whole jurisdiction; in the other states, the network covers part of the region.

Each of the networks was required to address key elements (identified from the literature about cancer networks and feedback from consumers):

- active consumer involvement
- agreed referral pathways
- a multidisciplinary approach
- involvement of primary care and allied health
- adopted evidence-based practice
- established access to professional education and training
- integration of rural and regional cancer services into a broad mentoring and best-practice network.

Preliminary results

Dr Philips presented preliminary results of the first stage of the CanNET program, as evaluation is presently being completed. Despite having commenced from a different stage each jurisdiction has made significant progress towards the establishment of a cancer service network.

Some of the network achievements include:

Active consumer engagement

- At a minimum each CanNET has ensured consumers were actively engaged in processes and decision-making; many have taken the concept of consumer engagement much further eg identifying consumer needs; developing a consumer participation strategy

- A consumer survey has been developed and implemented in partnership with five of the jurisdictions to explore patients' experiences with and perceptions of cancer care delivery.
- Each CanNET is developing a directory of service that will identify where the initial multidisciplinary cancer assessment and treatment teams are, by tumour stream and by postcode.

Development of agreed referral pathways

- Some jurisdictions have focused on particular tumour streams (the most common, or those where there is identified need).
- In Tasmania and NT there has been preliminary work on establish referral pathways and cross-border linkages to ensure people with less common cancers can access best practice sub-specialty care.

Increased multidisciplinary care teams

- The number of multidisciplinary teams (MDTs) has increased by 18 across Australia, including:
 - 9 new teams in NSW
 - statewide MDTs in upper GI and Adolescent and Young Adult cancers in South Australia
 - general MDTs have been formed in Albany (WA), Mt Gambia (SA), Alice Springs and Darwin (NT)
 - tumour specific MDTs in Tasmania, Queensland and Victoria

Increased use of novel technology

- Trials and/or implementation of:
 - PC-based meeting technology (Vic)
 - 'Attend anywhere' PC video-meeting technology (NSW)
 - MDT data management—linked to MMX to provide summaries of MDT meetings to GPs in timely manner (WA)
 - e-health records (NT)
 - an information Hub for pathology and radiology (Tas).

Increased primary care involvement

- Strategies to increase the involvement of primary health care providers in cancer care include:
 - defining the needs of rural health care providers, particularly GPs (SA)
 - exploring the role of the GP in cancer care (QLD)
 - appointment of a GP Advisor (VIC) providing input into MDT and encouraging GP participation.

Professional development

- Established links between CanNET and Cancer Australia's professional development programs (Cancer Learning, EdCaN and EPICC)
- Development of two CI-SCaT modules around breast cancer care and colorectal cancer care with specific focus on primary care.

Clinical leadership

- Preliminary data indicates that those networks that had strong clinical leadership were able to make more significant progress in a short period of time (requires further investigation).

Quality assurance

- Each network is linked to existing quality assurance frameworks. Other strategies include:
 - credentialing (NT)
 - development of cancer plans (NT and Tasmania), underpinned by clinical networks
 - use of common clinical audit tools
 - use of audit to drive practice change (All).

The findings of the CanNET consumer survey will impact on the next stage of work.

Role redesign

Some jurisdictions have begun exploring different ways of using the existing cancer care workforce, such as:

- Introducing the role of Cancer Care Coordinators (TAS)
- MDT Administration Coordinators (NSW, QLD)
- Exploring new and innovative models/roles (NSW):
 - GP lead oncology review clinic
 - radiation therapist lead review clinic
 - non-nurses as cancer care coordinators.

In the 2.5 years since the CanNET program was established networks have made significant progress. CanNET has “provided the space to consider new ways of working” and to improve patients’ access to evidence based cancer care regardless of where they live.

The 2009-10 Federal Government Budget allocated a further \$15.1m to Cancer Australia to continue work aimed at improving coordination of cancer care.

Presenter

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A best-practice dietetics service model for rural patients with cancer undergoing chemotherapy

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The nutritional needs of people diagnosed with cancer are often overlooked. The incidence of malnutrition in cancer patients is estimated to be between 40% and 80%. Malnutrition can result in increase in complications, decrease in response and tolerance of treatment, lower quality of life, possibly reduced survival and higher health costs.

Ms Brown described a project to determine and test a model of a best-practice dietetic service for rural patients with cancer undergoing chemotherapy.

The study compared the best-practice protocol with usual care, as provided by the local hospital. It was implemented in an outpatient chemotherapy clinic setting in Tamworth Rural Referral Hospital in northern NSW.

A review of the literature determined that a best practice dietetics service for oncology patients should:

- have a system for the early identification of patients at risk
- have appropriate nutritional assessment
- provide appropriate interventions.

Presently most dietetics services are reactive—a patient is referred to a dietitian only when it is noted that they have lost a lot of weight, rather than enabling identification of patients at risk and action to prevent or limit weight loss.

Usual care was an ad hoc service provided on set days and times when the dietitian was available. Most referrals to the service were patients who had lost significant weight (>10 kg).

In the best practice model, the dietitian attended the outpatient clinic when patients were waiting for their chemotherapy treatment and would try to identify patients at risk of malnourishment.

A randomised controlled trial compared the pre-determined best practice service and the usual care service. Dietary intervention and advice were the same for both groups; only the way service was delivered differed.

Participants in the intervention group received more frequent (weekly or fortnightly) consultations of shorter duration (15-30 minutes) using multi-modal methods of service delivery (eg. weekly or fortnightly reviews by telephone). The 'usual care' group had longer and less frequent (monthly) consultations, which were face to face only.

Patient outcomes were measured using the Patient-generated Subjective Global Assessment (PG-SGA), Modified Constipation Assessment Scale (MCAS) and the Global Quality of Life Score (QLQ-C30).

Twenty-four patients were recruited to the study:

- 38% were classified as malnourished using the PG-SGA assessment tool
- 50% required nutrition intervention by a dietitian (PG-SGA score of 4 or greater).

While numbers were small and could not show statistical significance, the study found indicators of improved outcomes for participants in the intervention group.

The study also assessed patient satisfaction and feedback. Of the 12 respondents (from 18 study participants):

- everyone was satisfied with the service (regardless of which group they were in)
- most people said they would be prepared to travel to see a dietitian—50% of group prepared to travel 20km to see dietitian and 50% prepared to wait up to half an hour
- patients' preferred method of review was by phone or in person at the time of treatment; there was no interest in email or videoconference follow-up.

More than half of all 'best practice' service delivery was outside the 'usual service' clinic times, indicating that the usual service was insufficient to identify and meet patient needs. The patients allocated to the usual care service received fewer services in total.

The findings highlight the need to develop dietetic services in rural areas that are flexible in terms of method of delivery, days of service provision and availability of dietitians, and use appropriate screening and referral processes, to meet the needs of people with cancer.