

An evaluation of the Cooma Oncology Unit pilot program

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Introduction

Greater Southern Area Health Service and the Monaro Committee for Cancer Research were successful in attracting funding from the NSW Cancer Institute's Innovation Grant Program to establish a pilot "shared care" oncology service in Cooma, NSW. The aim of the Project was to establish and evaluate a new model of oncology service delivery through partnerships between metropolitan oncologists, local rural GPs and nursing staff. The model was designed differently from other rural oncology services in that there were to be no visiting oncologists to the site. The Pilot began in order to support an identified community need, allow access to services closer to patient's homes, meet chemotherapy treatment standards and ensure optimal patient outcomes. The Pilot Program also provided an opportunity to assess sustainability from financial, resource and skilled workforce perspectives.

Project objectives

The expected objectives/achievements and advantages of the intervention model include:

- development of a Shared Care Model of service that can be implemented in other rural Areas across NSW
- increased access for rural patients to a local treatment service that assists in supporting patients throughout their cancer journey
- development of a model of service that addresses community need, allows patients to access services closer to home, meets chemotherapy administration standards and ensures optimal patient outcomes
- development of a model that is sustainable from both a financial, resource and skilled workforce perspective
- reduction in the burden of isolation from family who stay overnight for treatment (Canberra), and the financial hardship for rural patients and carers having to access services in a metropolitan or regional location
- review the hardships of travel for patients including such issues as feeling unwell from the effects of chemotherapy, family disruption and loss of work time and income
- the design, implementation and evaluation of a shared care model of service that has community input and support and will assist with future demands on oncology services
- development of a partnership arrangement of 'Shared Care' between Metropolitan Medical Oncologists and local rural GPs
- increased trained local staff accredited to administer certain oncology treatments locally.

This paper provides a summary of the outcome of a formal, qualitative evaluation of the project and makes recommendations for the future of this project based on these outcomes.

Literature supporting the initiative

This brief literature review was developed with the assistance of the report from Hardwick Consulting and Embree & McBride Consulting titled, *Literature review of models of cancer services for rural and remote communities*.¹ This review concluded that specialised cancer care for people in rural areas needs to be integrated into a formalised service system with appropriate coordination and resources that is regularly monitored to ensure quality service delivery. The report identified that the most common services in rural areas are outreach, shared care and tele-health programs. The most successful programs provide a broad specialised system in working collaboratively with local primary care providers to deliver continuity of care for the patients.

Two recent reports (Jong et al.² and Yu et al.³) demonstrated that there are clearly inequalities in cancer outcomes for people living in rural Australia. People living in the most remote areas of NSW were 35% more likely to die from their cancer within 5 years of diagnosis than people with greater access to services (Jong et al.). Risk of death was higher than the NSW average for residents of more than half of all rural Area Health Services (AHS) as compared to about one quarter of the metropolitan AHS (Yu et al.). The factors that affect these results include late tumour stage at diagnosis, limited access to treatment facilities, Indigenous communities and socioeconomic disadvantage (Healthcote and Armstrong⁴).

The Clinical Oncological Society of Australia (COSA⁵), convened the first Cancer in the Bush summit in 2001 to discuss rural oncology services. The outcomes of this summit identified eight key issues to be addressed as follows:

- transport and the need to remove inequities in the current Isolated Patient Travel and Accommodation Assistance Scheme (IPTAAS) arrangements
- improved patient support, including the provision of breast cancer nurses nationally and a cancer nurse demonstration project
- training to be nationally coordinated and funded
- workforce planning, including implementation of Australian Health Workforce Advisory Committee recommendations and development workforce planning for disciplines covering the special needs of rural areas
- networks and the development of national accreditation, commencing with chemotherapy services and trialling these standards in all disciplines; and the development of a regional cancer demonstration project
- epidemiology, in particular study comparative outcomes in survival, access, psychological support and quality of life in rural and urban Australia
- reimbursement for item numbers for rural services and tele-oncology
- issues of national priority, such as rapidly making specific cancer drugs available on the Pharmaceutical Benefits Scheme and action to be taken on the Radiation Oncology Strategic Plan and the National Cancer Control Initiative utilisation strategy.

COSA's Regional and rural Oncology group engaged in a mapping exercise in 2006 to review rural oncology services.⁶ The results identified how rural Australians have poor access to cancer services. Their recommendations included building regional oncology centres and improved coordination of government funded travel and accommodation schemes for cancer patients and families. From these COSA recommendations, Underhill et al.⁷ and Begbie and Underhill⁸ supported the development of regional cancer centres of excellence. The centres should provide multidisciplinary care, improve educational and support services, and provide a link to more remote services.

The Cooma Oncology Unit Pilot Program was in part established to address the above issues and recommendations in providing rural oncology services to a community identified in need. The Unit was developed and established with support of the grant and using the shared care model approach.

Evaluation methodology

The evaluation project included 4 phases of face to face and/or telephone interviews. Initial interviews took place in November 2007 with members of the Advisory Committee, Oncology and support Staff, local GPs, participating Community Health Staff, and program, clinical and site Management. The purpose of these interviews was to assess initial responses of participants in regard to expectations of the project, the process of developing the unit from its inception, the effectiveness of GP and nursing training, their views on models of shared care and level of implementation, and issues on how well the unit was working to date.

Phase two involved face to face and phone interviews with patients and their carers and took place in February 2008. These interviews assessed patient satisfaction with the local service and treatments received, and the impact of the program on their lifestyles.

Phase three included face to face interviews with participating oncologists from Canberra. The intent of these interviews was to determine their views on the value of the Cooma Oncology Unit, their level of participation, communication lines with Cooma GPs and nurses, and future sustainability of the Unit.

The final phase was a second interview with all participants from the initial interviews and took place in May 2008. These interviews asked the participants similar questions from the first interview in order to compare responses and how their attitudes may have changed. In addition, updated views were gathered on the running of the oncology unit including opinions on the potential for sustainability.

Finally statistics were collected on number of patients treated, referral patterns, predominant incidents or tumour streams, type of treatments, occasions of service and outcomes of treatment.

Summary of outcomes from the evaluation

Overall, the Cooma Oncology Unit Pilot Project achieved its main objectives to develop a model of service that supports identified community need, allows patients to access services closer to home, meets chemotherapy administration standards and ensures optimal patient outcomes. The development of a shared care model was largely successful with the Cooma oncology nursing staff having close communication links with the Canberra Oncologists. The Cooma GPs remained a part of that model as backup support for emergencies and kept informed of patient treatment outcomes. Local staff were appropriately trained to administer oncology treatments from Cooma and have continued to receive ongoing local support and formal training programs. The Oncology Nurses have also enrolled, and are currently participating, in cancer care tertiary study.

The phase 1 interviews with the staff and management indicated that establishing the unit in such a short time frame created some stress and frustration amongst the Cooma staff. It needs, however, to be recognised that the implementation of the project was governed by the 12 month funding grant for the Pilot and thus restricted the time available to develop the project. A longer lead time to accommodate a more planned approach with appropriate time frames and a full change management process before the introduction of any service would have probably reduced the identified staff stress. Adding to these difficulties was a delay in recruiting oncology nursing staff and despite available funding, a designated project manager was never appointed to oversee and direct the introduction of the new service. Many of these tasks had to be undertaken by area and local site managers adding to their existing workloads.

In all interviews, there was little to no consistent definition of the 'Shared Care Model' that was being piloted for this Program. The reason for this could in part be due to the fact that it was a model to be developed and implemented according to need within the Unit. The Service operates, however, with a variety of effective communication links taking place between the GPs, Oncologists, Nursing and other Hospital Staff. The Pilot has especially evolved to a shared model approach with the Oncologists from Canberra and the Cooma Nursing staff. Local GPs provide ongoing backup support and therefore are involved in clinical management of patients but generally not the day to day operation. The Pilot has thus demonstrated that GPs are not required to be involved in the daily operation of the oncology unit, thus relieving GPs initial concern about how the Unit might have increased their workload.

The oncologists in Canberra viewed the Cooma Unit as beneficial for the patients and carers to reduce travel and financial burden. The majority of the initial referrals came from the patients requesting to be treated in Cooma. The specialists stated that some patients' treatment complexity did not always make them suitable for the Cooma unit treatment, thus being sometimes reluctant to refer. The oncologists did not identify any real benefits for their work practice and in fact, found that the program increased their paperwork load. They acknowledged, however, that it was more convenient for the patient to receive treatment locally.

One of the major goals of the pilot project was to provide a local oncology service to reduce patient/carer travel to Canberra. The oncology unit is clearly meeting these objectives. The patients felt the benefits of the unit included less waiting time for service, better personal atmosphere in the Unit than what is offered in Canberra, less travel, time and cost, and better overall experience for carers and family.

The Cooma Oncology Unit, as a rural model of oncology service, provides some valuable information for other sites considering the development of rural oncology services. This model is not a 'GP shared care' model in the full sense, but there are considerable support and communication lines between the Cooma Oncology Nurses and the Canberra Oncologists with ongoing GP support and backup. The model was developed with careful consideration to GP time limits and appropriate levels of involvement. The Cooma model also demonstrates the need to address the planning and development phases of setting up a unit carefully with appropriate support/staffing/timing so that existing staff at the site have a clear understanding of the role and function of an oncology unit and can participate in its development. There are other aspects of this unit that could assist in the development of other rural oncology units, but as with most models, each site would need to develop its own version of an effective and sustainable oncology service.

Most people interviewed believed the Unit would be sustainable if staffing issues, succession planning and a sufficient number of locally trained and up-skilled back up staff are continually being addressed. The overall numbers of clients and occasions of service will also need to be continually monitored. The treatment complexities should expand with the Oncology Nurses' increased skill levels and training, and this could likely increase patient numbers and occasions of service. A radiation oncology consultation service is now due to commence in Sept 08 and this will also increase patient numbers.

Oncology Unit treatment statistics

A total 271 Occasions of Service were provided within the Oncology Unit from September of 2007 to September 2008. The predominant tumour streams were colorectal cancer and breast cancer. These two groups accounted for 97 and 35 occasions of service. Urology and haematology accounted for 11 and 9 occasions of service. Non oncology treatments accounted for 7 occasions of service.

These numbers may be considered small but they need to be considered in the context of its first year of operation. Most rural oncology units expand service delivery over time as evidenced by the beginning of the Oncology Service in Young with fewer occasions of service at its inception to what it currently provides.

Recommendations and sustainability of the model

The Cooma Oncology Unit has demonstrated its ability to provide a quality and safe rural oncology service for its local community. It therefore could remain as a viable operational Unit if it continually addresses the sustainability issues, being:

- ongoing staffing issues including training and succession planning
- financial and staff resources
- patient numbers and Occasions of Service justifying the continuation of the service.

This pilot project and aspects of this model could be transferred to other rural sites within NSW. If the NSW Cancer Institute is interested in developing other rural models of care, the Cooma model should be carefully considered for its strengths and weaknesses and how it could be included at other rural sites.

The following recommendations are based on the overall outcomes from the evaluation project:

- support continuation of the Cooma Oncology Service into 08-09 financial year
- examine different workforce models in order to remain viable given the existing requirements for staffing and the significant cost of providing the service with relatively limited activity
- continue to monitor overall patient and occasions of service activity, complexity of treatments and staffing, resources and financial implications
- ensure that general support services (community health) are in place to reduce burden of care placed on carers and the patient
- continue to support local staff with training, up-skilling and working within the Oncology Unit
- support the growth of clinic including introduction of new support services such as radiation oncology consultation clinic
- follow up on suggestions from Oncologist interviews regarding GP involvement in reviews to further reduce patient travel
- when planning to develop other sites for rural cancer services consider how the Cooma model may be applied to provide the best possible pathways and outcomes to provide quality services

- when beginning new rural cancer services at other sites, learn from the processes that took place to develop the Cooma Oncology Service.

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Presenter

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