DRAFT Optimal Care Pathway

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1. Introduction

1.1 Background

A Cancer Services Framework for Victoria 2003 recommended that a tumour stream model be adopted to reduce variation in cancer care. In response, the Department of Health supported the establishment of tumour stream groups across Victoria, and in collaboration with clinicians and consumers, developed the Patient Management Frameworks to provide a clear description of the patient journey across the continuum of care.

In 2012, the Department of Health commissioned the Cancer Council Victoria to review the Frameworks to ensure they continue to support the delivery of optimal care across Victoria. The title of the Patient Management Frameworks has been changed to Optimal Care Pathway, which better reflects their intent.

1.2 Intent of the Optimal Care Pathways

The Optimal Care Pathways are a guide to support the delivery of optimal care for people with cancer. They are intended to improve patient outcomes by facilitating state-wide consistent care based on evidence and best practice. They set out the key requirements for the provision of optimal care which needs to be considered at each step of the care pathway. In contrast to clinical guidelines that guide appropriate practice and decision making, the Optimal Care Pathways provide a guide to support the patient journey to ensure patients with cancer and their families receive high quality and appropriate care and support.

1.3 Key principles of care

Underpinning the care pathways are key principles that support all seven steps. These are:

1. Patient centred care – an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships between health care providers, patients and their families.
2. Safe and quality care – enabled through appropriately trained and credentialed clinicians, hospitals and clinics that have the equipment and staffing capacity to support safe, high quality care, and the collection and evaluation of good quality treatment and outcome data.
3. Multidisciplinary care – an integrated team approach to health care in which medical, nursing and allied health care professionals consider all relevant treatment options and collaboratively develop an individual treatment plan for each patient.
4. Supportive care – encompasses all services that may be required to support people with cancer, their carers and family to meet physical, psychological, social, information and spiritual needs throughout the journey.
5. Care coordination – ensuring patient care is coordinated and integrated over time and across multiple health services and different sectors.

More detail about the underpinning principles can be found on the Victorian Department of Health’s website under Cancer Services in Victoria.
2. Steps in the care of patients with x cancer

This section outlines the steps along the care pathway and the optimal care required. Not all patients will follow every step of the pathway. This will depend on the stage of cancer at diagnosis and the patient’s decision about his or her care.

Step 1: Screening and early detection, those at higher risk, signs and symptoms and prevention

Step 1 identifies common signs and symptoms that should lead to further investigation, the types of people who may be at higher than average risk of developing cancer, recommendations for screening and early detection of cancer, as well as strategies for preventing cancer.

1.1 Screening and early detection
   • Recommendations for screening and early detection

1.2 Those at higher risk
   • Increased risk is indicated for people with:

1.3 Signs and symptoms that should lead to general/primary practitioner consultation
   • The following symptoms should be investigated, especially where there are changes in long term symptoms or new onset of symptoms:

1.4 Timeframes for genera/primary practitioner consultation
   • The following symptoms are of particular concern and require consultation as soon as possible:

1.5 Prevention
   • Recommendations for preventing cancer and healthy living

Key references
   • This will not be an exhaustive list but key references only (for example references for National Screening Guidelines or NHMRC Clinical Guidelines)

Step 2: Initial diagnosis and referral

Step 2 outlines the process of initial diagnosis and referral. Types of investigation undertaken by the primary/general practitioner will depend on patient preferences, access to diagnostic tests and access to a specialist. Decisions on investigations require discussion and agreement between the general practitioner, specialist and patient. There are a number of options. If the diagnosis can be confirmed with the initial tests, then referral to an appropriate oncologist is optimal. If the diagnosis is suspect, then referral to a specialist for further investigation may occur prior to a referral to an appropriate surgeon or oncologist.

2.1 Initial consultation with general/primary practitioner
   • Diagnostic tests to be conducted/ ordered by general/primary practitioner
   • Recommend timeframe for completion
2.2 Referral

- Guidelines/recommendations for referring to appropriate specialist, multidisciplinary team or specialist clinic
- Timeframe for referral
- Minimum content to be included in referral documentation from the general/primary practitioner
- Referral to a Care Coordinator (or other key contact as determined by the multidisciplinary team)

2.3 Staging

- Appropriate staging investigations and tools

2.4 Supportive care

**Screening and referral**
- Conduct routine supportive care screening
- Identify and manage symptoms (i.e. anxiety/depression, pain, fatigue, lymphedema)
- Explain referrals to the patient and carer; arrange as required
- Assess family and support person’s issues regarding coping and understanding

**Information provision**
- Establish patient and carer preference for receiving information at this point in time
- Tailor information to meet the preferences of patients and carers

Key references

- This will not be an exhaustive list but key references only

**Step 3: Treatment planning**

*Step 3 identifies the members of the multidisciplinary team who need to be involved in initial treatment planning. This will vary by cancer type but the general principle is that discussion and consideration of patient’s medical and supportive care needs between the multidisciplinary team will guide treatment planning.*

3.1 Members of the multidisciplinary team

- The multidisciplinary team comprises of (list in alphabetical order):
- The services that the multidisciplinary team should be linked to include: (i.e. hospital and community based support services including allied health, palliative care and psycho-oncology services)

3.2 Multidisciplinary planning

- The responsibilities of team members are:
- The optimal point in time in which MDT planning should take place is:

3.3 Clinical trials

- Participation in clinical trials should be encouraged where available and appropriate
- Include links to appropriate clinical trials databases (Cancer Trials Australia, Victorian Cancer Trials link, Australian Cancer Trials)
3.4 Supportive care

**Screening and referral**
- Review previous supportive care screening assessments and interventions
- Identify and manage symptoms (i.e. anxiety/depression, pain, lymphedema)
- Explain referrals to the patient and carer; arrange as required
- Assess family and support person’s issues regarding coping and understanding

**Information provision**
- Explain the benefits of a multidisciplinary team care approach
- Seek patient consent prior to presenting case at the appropriate MDT meeting(s)
- Establish patient preferences for making decisions regarding treatment
- Written multidisciplinary treatment plan discussed and agreed with patient and carer

3.5 Role of the general practitioner

- Involve general practitioner in multidisciplinary team and treatment planning
- Provide general practitioner with a copy of the treatment plan
- Inform general practitioner of changes to treatment plan as required

Key references
- This will not be an exhaustive list but key references only

**Step 4: Treatment**

*Step 4 outlines the treatment options available and the suitability of patients to treatment. It is also concerned with the scope of clinical practice to deliver quality and safe practice. Scope of practice reflects both the expertise and experience of the individual as well as the organisational capability for the provision of safe, high quality cancer services.*

**4A: Surgery**
- Identify patients who may benefit from surgery
- Timeframes for commencing treatment
- Common complications and side effects
- Outline training and experience required of the surgeon and other appropriate specialist(s)
- Hospital or treatment unit characteristics for provision of safe and quality care

**4B: Chemotherapy**
- Identify patients that will benefit from chemotherapy
- Timeframes for commencing treatment
- Common complications and side effects
- Outline training and experience required of the appropriate specialist(s)
- Hospital or treatment unit characteristics for provision of safe and quality care
4C: Radiotherapy
- Identify patients that will benefit from radiotherapy
- Timeframes for commencing treatment
- Common complications and side effects
- Outline training and experience required of the appropriate specialist(s)
- Hospital or treatment unit characteristics for provision of safe and quality care

4D: Hormonal therapy (if appropriate)
- Identify patients that will benefit from hormone therapy
- Timeframes for commencing treatment
- Outline training and expertise required of the appropriate specialist(s)
- Hospital or treatment unit characteristics for provision of safe and quality care

4E: Palliative care
- Conduct needs assessment to determine palliative care needs
- Refer to appropriate hospital and community based services as required
- Outline training and expertise required of appropriate specialists(s)
- Commence Advance Care Planning (if relevant)
- Hospital or treatment unit characteristics for provision of safe and quality care

4F: Complementary and alternative therapies
- Discuss impacts of complementary and alternative therapies on treatment

4.2 Supportive care

Screening and referral
- Review previous supportive care screening assessments and interventions
- Identify and manage symptoms (i.e. anxiety/depression, lymphedema)
- Explain referrals to the patient and carer; arrange as required

Information provision
- Explain intent of treatment, risks, benefits and expected outcomes
- Provide information on self-management and secondary prevention
- Provide information on the benefits of early referral to palliative care particularly for pain and symptom management
- Discuss and agree changes to the treatment plan with the patient and carer

4.3 Role of the general practitioner
- Provide general practitioner with the treatment plan including details of toxicity management
- Update general practitioner on changes to the treatment plan and/or medication

Key references
- This will not be an exhaustive list but key references only
Step 5: Follow-up, late effects and survivorship care

*Step 5 outlines the process for monitoring disease status (including detection of recurrent local and metastatic disease) and the management of symptoms which may arise following the initial treatment. A clear follow-up and survivorship care plan needs to be established to avoid excessive follow-up by multiple specialists.*

5.1 Follow-up and shared care

- Utilise risk stratification tool to determine risk of cancer recurrence and late effects. This will inform the level of follow-up care required (supported self-management, clinical supervised and complex care)
- Develop follow-up care plan to manage the risk of recurrence and/or late effects taking into the type of cancer, type of treatment received, and the person’s overall health, including possible cancer treatment-related problems.
- Nutritional and functional status to be monitored as part of follow-up
- Identify who will lead follow-up care and develop appropriate shared care plan

5.2 Survivorship care plan

- Utilise risk stratification tool to determine the needs of the patient
- Develop written survivorship care plan including information on diagnosis and treatment, potential late and long term effects, recommended follow-up and strategies to prevent secondary cancers and other illnesses through the adoption of healthy lifestyle behaviours.
- Identify who will lead survivorship care and develop appropriate shared care plan

5.3 Supportive care

**Screening and referral**
- Review previous supportive care screening assessments and interventions
- Identify and manage symptoms (i.e. anxiety/depression, lymphedema)
- Explain referrals to the patient and carer; arrange as required
- Assess family and support person’s issues regarding coping and understanding

**Information provision**
- Follow-up care plan to be discussed with and agreed by the patient and carer
- Survivorship care plan to be discussed with and agreed by the patient and carer
- Shared care plan to be discussed with and agreed by the patient and carer
- Educate patient and carer on identifying signs and symptoms of recurrent disease
- Educate patient and carer on living well to prevent secondary cancers

5.4 Role of the general practitioner

- Provide general practitioner with follow-up plan and survivorship care plan
- Agree on shared care plan and role of the general practitioner in follow-up care

Key references

- This will not be an exhaustive list but key references only
Step 6: Recurrence

*Step 6 covers treatment for recurrent local and metastatic disease. This is rarely curative; it is usually disease control and, in many situations, palliative. Clinical evaluation and patient decision making will determine the focus of the treatment.*

6.1 Investigative tests
- Identify which investigations should be conducted

6.2 Multidisciplinary team
- The multidisciplinary team comprises of (list in alphabetical order):
- The services that the multidisciplinary team should be linked to include: (i.e. hospital and community based support services including allied health, palliative care and psycho-oncology services)

6.3 Treatment for recurrence
- Treatment will depend on the location, extent of recurring disease and previous management.
- Treatment may include:

6.4 Supportive care

*Screening and referral*
- Review previous supportive care screening assessments and interventions
- Identify and manage symptoms (i.e. anxiety/depression, pain, lymphedema)
- Explain referrals to the patient and carer; arrange as required
- Assess family and support person’s issues regarding coping and understanding

*Information provision*
- Provide patient and carer with information regarding investigative tests and treatment options for recurrent cancers
- Discuss and agree on treatment plan for recurrent disease with patient and carer
- Discuss Advanced Care Planning and palliative care options with patient and carer

Key references
- This will not be an exhaustive list but key references only
Step 7: End of life care

Step 7 is concerned with maintaining the quality of life for the patient and continuing to support their family with care that addresses physical, psychological, social and emotional needs. Referral to palliative care should be considered early for poor prognosis cancers.

7.1 Multidisciplinary team

- The multidisciplinary team comprises of (list in alphabetical order):
- The services that the multidisciplinary team should be linked to include: (i.e. hospital and community based support services including allied health, palliative care and psycho-oncology services)
- Develop transitions plan from active treatment to community based care if appropriate

7.2 Palliative care

- Assess need for management of pain and associated cancer symptoms
- Finalise Advanced Care Planning with patients and care givers
- Arrange appropriate referrals to hospital and community based services (i.e. home aids, psychosocial support, family support, bereavement counselling and pastoral care)

7.3 Supportive care

- Screening and referral
  - Review previous supportive care screening assessments and interventions
  - Readminister screening tool as appropriate
  - Referral to supportive care services as required
  - Regularly review coping of primary support person and other family members

- Information provision
  - Provide information on pain and symptom management, palliative care services available including inpatient palliative care options and dying at home
  - Assess family and support person’s issues regarding coping and understanding

7.4 Role of general practitioner

- Discuss with GP their role in the patient’s end-of-life-care
- Ensure all necessary information on patient’s care needs has been provided to their GP

Key references

- This will not be an exhaustive list but key references only