

A summary of the most important opportunities for improvement identified by the lung summit participants and suggested actions for follow-up

1. Improve patient access to lung specialists

The lung optimal care pathway states that all patients with a suspected or proven lung cancer diagnosis should be referred to a specialist linked to a multidisciplinary team. To what extent this is achieved in Victoria is unclear. However, the summit participants identified this to be an important area to address.

Actions

Develop an electronic general practitioner (GP) referral system for specialist lung clinic referrals or private referrals. The concept is to have a link from a GP desktop to a “lung website” where a search could be entered for the closest 3 centres/services. A GP then selects a centre or service of choice and is transferred to a health service site to send an electronic referral to a specific physician or generic service.

Suggested measures

Times from referral to first appointment to diagnosis (requires further defining).

First steps

Present to VICS to develop a project scope and implementation plan.

Explore electronic systems of GP referral that already exist.

2. Improve quality of diagnosis and staging for lung cancer patients

The state-wide data presented at the summit suggested a geographical variation in rates of tissue diagnosis across Victoria. Delays in mutation testing turnaround times reportedly impact on timeliness of treatment. The complexity of cTNM staging guidelines contributes to variation in its interpretation and consequently staging. The quality of diagnosis and staging are crucial for achieving better outcomes for lung cancer patients. The participants identified a number of actions to improve this.

Actions

- a) Improve rate of tissue diagnosis especially for regional patients:
 - Develop a referral centre for difficult diagnosis.
- b) Decrease testing turnaround time for EGFR:
 - Circulate and inform relevant professionals and pathology departments of the Medicare rebate for EGFR testing.
 - Clinicians to request EGFR testing on pathology forms using fax – longer term pathologist directed.
- c) Promote documentation of cTNM at MDM:
 - Make a mandatory field in MDM notes/database.
 - MDMs to adopt use of decision making tools to improve the accuracy of cTNM staging.

Suggested measures

- a) Re-biopsy rate, captured at MDM as quality measure.

First steps

Prue Russel, Anatomical Pathologist at St Vincent's Hospital, volunteered to communicate with Victorian pathology providers about the change in MBS billing for EGRF testing.

Present to VICS to implement agreed strategies and include in performance audits.

3. Improve access and timeliness to treatment

The state-wide data presented at the summit suggested a geographical variation in rates of adjuvant chemotherapy for NSCLC and under utilisation of radiation therapy for the treatment of lung cancer in Victoria. The participants raised the issue of more equitable access to clinical trials as something important to address and within the sphere of influence of clinicians.

Actions

- a) Develop public reporting on waiting times for chemotherapy and radiotherapy:
- Agree standard waiting times for chemotherapy and radiotherapy for lung cancer (existing project at Peter Mac).
- b) Improve the system of referral to the clinical trials centralised system (existing website but not easy to use).

Suggested measures

- a) Percentage of services that met standard wait times versus percentage that fall outside agreed standards.
- b) Percentage of eligible new patients/percentage of eligible patients referred to clinical trials documented at MDM.

First steps

Present to VICS to develop strategies and to address the above actions.

Investigate current projects in this space and link if appropriate.

4. Better and earlier access to palliative care

The participants agreed that a lack of resources is a major impediment to accessing palliative care. It was also acknowledged that clinicians can be uncomfortable with introducing palliative care to their patients. The lung optimal care pathway states that early referral can improve quality of life and in some cases survival emphasising that referral should be based on need, not prognosis. The participants suggested forging better links between palliative care clinicians and lung MDMs and stronger advocacy to promote appropriate use of it as actions within the sphere of clinical influence.

Actions

- a) Develop reportable indicators.
- b) Ensure stage III & IV lung cancer diagnosis are listed for consideration at MDM.
- c) Advocate for change to the MBS item to reduce time allocation to be eligible to claim (currently 10 minutes - change to shorter timeframe).

Measures

The participants suggested that the existing Victorian Lung Cancer Registry quality indicator 'proportion of (new) stage IV patients who get referral to palliative within 56 days' may not be the most suitable measure to use.

First steps

Create a working party.

Investigate current projects in this space and link if appropriate.

5. Better engagement with general practitioners

On average a general practitioner encounters less than 1 case of lung cancer per year. Cancer Australia funded the development and promotion of symptom recognition and investigation for lung cancer guidelines for general practitioners. The participants acknowledged a substantial challenge in engaging general practitioners in improving early recognition of disease. However, they felt that this is still an important aspect of care to influence. The lung optimal care pathway states that lead clinician should discuss the treatment plan with the patient's general practitioner. The identified actions turned to where clinicians felt they could make some difference.

Actions

- Establishment of a central contact point at health services for managing GP referrals.
- Communication back to GPs from MDM.
- Standardisation of relevant fields to be included in GP communication (issue re how information is captured at MDM's and what fields are relevant and helpful to GPs).

Measures

Nil proposed.

Action

Present to VICS.

Link with existing groups and organisations working on similar issues, for example: Primary Health Organisations (former Medicare Locals), Cancer Council Victoria's active general practitioner group and Cancer Australia's Lung Project activities.

6. Access to Allied Health

Due to their complex care and poor prognosis, patients with a diagnosis of lung cancer have a greater need for the services of allied health clinicians. Access to allied health clinicians varies across different institutions in Victoria. It was suggested that the lung multidisciplinary membership may not fully understand the role of allied health which contributes to the underutilisation of allied health where available.

Actions:

- Linkage between health service Allied Health (AH) leadership group to compare how:
 - allied health services are utilised
 - models of care and funding accessed (Ballarat Health has done work around this)

a) Education for other health professionals on how AH can assist lung patient and team:

- to be undertaken locally
- material to be developed collaboratively
- develop information on key indicators for referral –differences between inpatient/outpatient

Measures

Increase in referrals to allied health.

First steps

Present to VICS.

Identify a working party.

7. Seek consensus on best practice model for lung MDM

The lung optimal care pathway states that all patients with suspected or proven lung cancer diagnosis should be discussed by a multidisciplinary team before the treatment begins. It was evident from the discussion on the day that many MDMs use different criteria to prioritise patients for discussion. A number of challenges to optimal functioning of an MDM were raised including a variety of meeting management softwares, efficiency and effectiveness of meetings and impediments to claiming MBS funding.

Actions

- a) Map existing practice/improvement activities nationally/state and disseminate guidelines for best practice
- b) Collaborate with development/implementation of regional MDM software to ensure specific lung issues are integrated into the solution
- c) Increase the sustainability of MDM administration through advocacy regarding MBS funding by enlisting the support of COSA, Australia Cancer Council, state governments, National Cancer Expert working groups, medical groups and individuals

Measures

Require defining.

First steps

Present to VICS to develop a project scope and implementation plan.