Redesigning lung cancer care in Victoria

The Lung Cancer 2019 Summit (LUNG2019 Summit) was a platform to demonstrate previous clinician-led local improvements to unwarranted variations in lung cancer care, and facilitated three small-group work sessions to plan future local action from the summit.

The Optimal Care Pathway

Dr Andreas Baich, respiratory physician, Northeast Health Wangaratta, presented on navigating the potholes of redesigning care. Work focused on what clinicians could influence that did not require a lot of additional resources, and aimed to improve time from referral to treatment. The Victorian Lung Cancer Service Redesign Program supported this work as an implementation of the optimal care pathway. Monthly multidisciplinary team meetings (MDMs) in Hume RICS meant a twofold barrier to optimal care: a four-week wait for newly diagnosed patients and mostly retrospective MDM discussions.

- Navigating the Potholes

Multidisciplinary meetings were moved to a weekly schedule. A weekly Rapid Access Clinic was formed using video link to overcome the geographic challenges staff and patients face in the region. Radiologists were asked to refer to MDM member clinicians for suspected lung malignancies. Initial data from the project indicates improvement to timeliness.

What Can We Do Better?

HRICS identified seven areas to improve through local action from the LUNG2014 Summit:

1. Patient access to lung specialists
2. Quality of lung cancer diagnosis and staging for patients with lung cancer
3. Access to and timeliness of treatment
4. Patient access to palliative care
5. Engagement with general practitioners
6. Equity of access to allied health

Victorian Lung Cancer Service Redesign Program

After the Lung Cancer 2014 Summit (LUNG2014 Summit), the Victorian Lung Cancer Service Redesign Program was created to assist hospitals in developing systems and measures targeting improvements in the timeliness of lung cancer care from stages two (referral) to four (begin treatment) of the optimal care pathway. Project implementation began March 2017, and was embedded in practice in 2018.

Summit highlights

Dr Lisa Briggs, a patient advocate with stage IV lung cancer, opened the LUNG2019 Summit with a video presentation of consumer experiences and recommendations for improvement. This can be viewed on the NEMICS website: bit.ly/2SlTnHr

Ms Melissa Arduca, Acting Assistant Director – Cancer Strategy & Development, Department of Health and Human Services, presented the summit in the context of the Victorian cancer plan 2016-2020, with a focus on equity in patient outcomes and between tumour streams. A presentation video is available: bit.ly/2U3rdXG

Associate Professor Gavin Wright, thoracic surgeon and working party co-chair, presented summit data. Data identified variations for further local investigation by clinicians with support from Integrated Cancer Services, and for clinician action on variations determined by further local investigation to be unwarranted. bit.ly/2U92Bfi

Ms Kelcie Herrmann, Acting General Manager – Rare Lung and Thoracic Cancers, Lung Foundation Australia, introduced the Foundation’s clinical and consumer survey-driven report, Making Lung Cancer a Fair Fight: A Blueprint for Reform. bit.ly/2e5imHk
Mr Andrew Barling, surgeon, Bendigo Health, spoke on the unique position of the hospital due to rebuilding. The former hospital layout had medical, radiation and surgical oncology physically distant from each other, making communication difficult. There were delays in appointments, multiple points of entry into pathways and referrals were triaged by clinicians once a week—all underscored by an underlying lack of coordination.

Complications arose with differing patient UR numbers received from Peter Mac, who provided radiography. PET scans, EBUS, and CT-guided biopsies were outsourced or difficult to obtain. With the Victorian Lung Cancer Service Redesign Program all of these factors were considered.

The new hospital opened in 2017 with collaboration rooms for MDM specialists, and a PET scanner. Administration currently assists with appointments although ultimately, a care co-ordinator is highly desired.

Dr Wasek Faisal, medical oncologist, Ballarat Health Services, discussed the hospital’s Rapid Access Lung Lesion Clinic (RALLC), which was part of the Victorian Lung Cancer Service Redesign Program. A case study had shown time from diagnosis to surgery of 70 days for a typical early stage lung cancer patient. There were multiple entry points for referrals and communication between specialist clinics was minimal.

The decision was made to bring everything under one roof with a single point of entry for referral into the RALLC. A typical early stage patient now takes 17 days from diagnosis to surgery. The clinic was a clinician initiative, with a high level of input from clinician workshops. Real-time monthly data analysis for the first six months allowed modifications to improve the initial clinic. The care co-ordinator plays a crucial communication role in patient treatment planning.

Mr Kane Morris, carer and consumer advocate, shared his family’s experience of lung cancer care. Kane’s wife, Cassandra Morris, was diagnosed with stage IV lung cancer. After upper thoracic spine pain, an MRI indicated nodules in the upper left lung. From this moment, time to diagnosis was two weeks. Cancer was widespread in the spine, liver and lymph nodes.

Radiation treatment planning for skeletal metastasis occurred quickly but there was a three-week diagnostic delay in tissue sampling. This was a distressing time for Cassandra, who felt that the cancer was growing but she couldn’t do anything about it. Six months after diagnosis, Cassandra experienced more symptoms, and despite two CT scans initially showing no pathology, further investigation by MRI showed cancer had spread to her brain. One year to the day from her initial diagnosis, Cassandra passed away.

Kane, who works as a project manager, has reflected that projects ‘don’t go red overnight’. Given 50% of stage 4 lung cancer patients develop cancer in the brain, he asks can cancer treatment be approached as project management, with proactive measures taken to guard against metastasis in those at risk.
Quality improvement in lung cancer care

The second panel of the summit focused on quality improvement in lung cancer care. Four panellists presented, with two interstate speakers.

Dr Allison Black, medical oncologist, Royal Hobart Hospital, presented on the Cancer Australia Lung Cancer Demonstration Project. The project reviewed patterns of care in order to implement excellent, evidence-based care for all patients.

A steering committee of all specialisations formed and the lung care co-ordinator was made full time. It was assumed the audit of practice results would be negative, but prior respiratory unit changes to referral triaging and implementation of a rapid access clinic were already working well.

Ms Barbara Page, nurse and PhD candidate, Prince Charles Hospital, Brisbane, is part of a pulmonary service improvement team operating since 1981. Its focus is increasing early diagnosis, improving referral systems, and providing timely, evidence-based treatment. Work has been undertaken on MDMs, quality and timeliness of data collection, and patient outcomes.

This focus aims to improve patient experience, including reducing regional patient access costs—of particular significance in Queensland, where patients may fly up to six hours for treatment. All regional respiratory physicians are invited to teleconference MDMs so all patients, regardless of location, can receive an MDM discussion.

Regional patients who cannot be managed by Telehealth receive a one-stop-shop service by the lung lesion diagnostic nurse, who, in collaboration with a thoracic surgeon, puts all appointments in a tracker for time management. Patients normally visit for one–three days and receive MDM discussion. MDM roles are now clearly defined to ensure all referrals are written.

Lung Foundation Australia (LFA) recently launched their survey-driven National Strategic Action Plan for Lung Conditions, containing six priority areas. Seventy percent of the feedback received from over 400 participants was consumer feedback.

In addition to the action plan, the recent Making Lung Cancer a Fair Fight: A Blueprint for Reform report shines a light on the state of play of lung cancer care in Australia, including equity of access, diagnostics, treatment, stigma and support.

The Foundation is working to map both of these key documents to political platforms, and existing government frameworks and documents. This also includes mapping to the quality improvement work of clinicians involved with Victorian Tumour Summits, in order to support and lobby for clinicians.

Patient support is available through the LFA website, lungfoundation.com.au. This is a mutual aid model, where patients talk to and support each other, and provide solutions for some patient issues.
Ms REBECCA DAVIES, patient advocate, experienced a pulmonary embolism and emergency department investigation in 2016. She was <12 weeks postpartum. CT scan showed a large mass but no diagnosis. Bronchoscopy biopsy resulted in a lung cancer diagnosis from a respiratory specialist. Rebecca had a PET scan one week before meeting the MDM team at hospital and receiving a staging of 3b.

She was told surgery was not an option, so decided to transfer hospitals. Treatment began ten days later, consisting of chemoradiotherapy and surgery. She didn’t understand the importance of her ROS1 diagnosis, which she received after her treatment began. It was only when her treatment ended that she gained clarity around what her other options may have been, even though they would have been very expensive at the time.

In 2017, Rebecca received an unrelated diagnosis of leukaemia. She is now undergoing further familial gene testing. She notes there is a lack of lung cancer gene testing available and hopes in the future there will be more.