





Optimal Care Pathways Lung Cancer Rapid Access Clinic CHS

ACCN Innovation Showcase May 2024

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Speaker Disclosure:
No commercial disclosures

Acknowledgements:

Dr Daniel Wang Respiratory
Physician lead clinician for the rapid
access clinic, some slides

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Cancer Nurse

Lung cancer multidisciplinary team



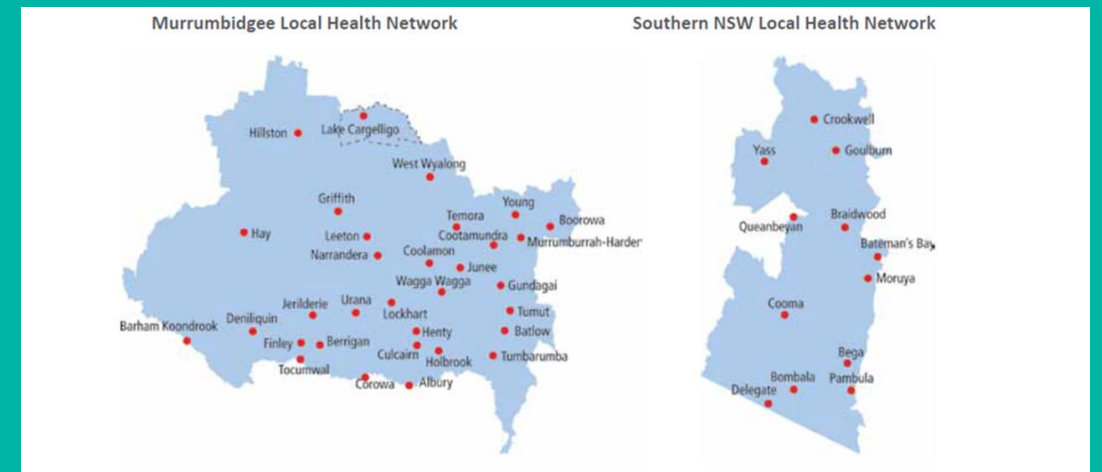
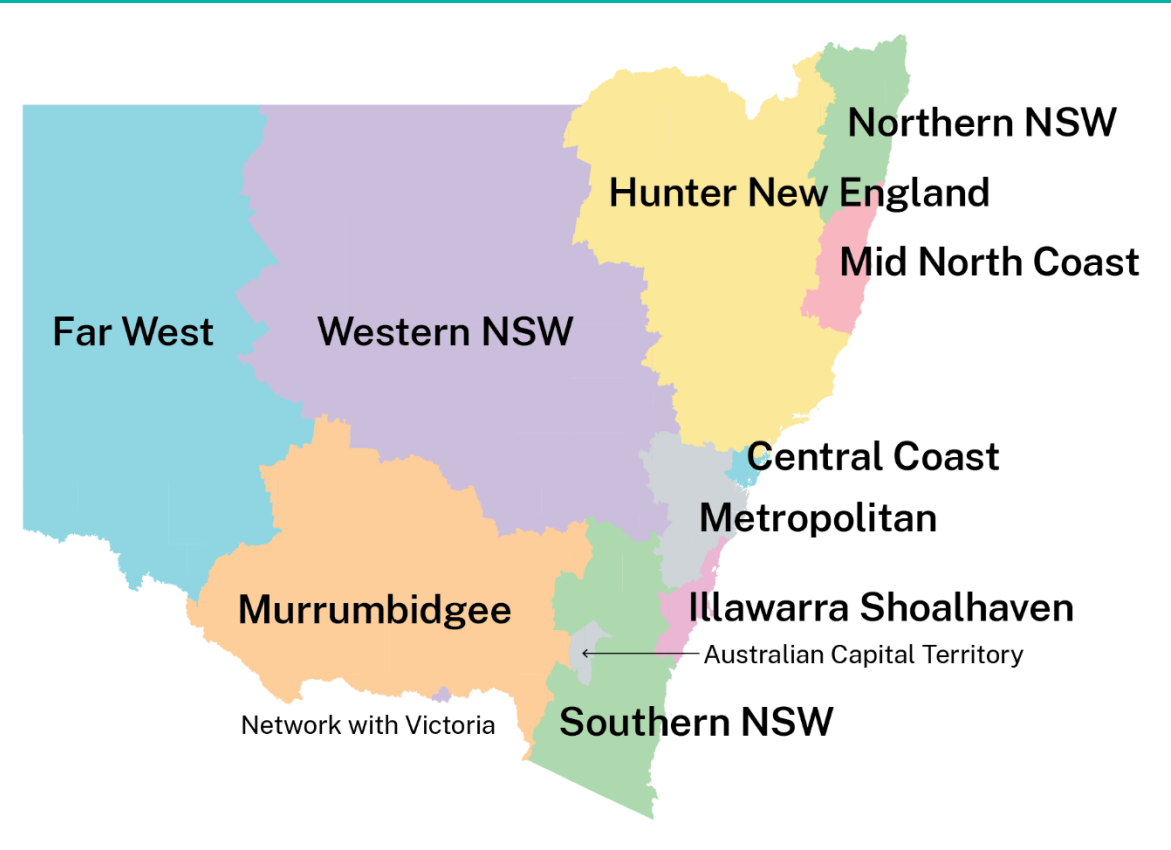
Canberra Region Cancer Centre CRCC

Located at The Canberra Hospital
Tertiary referral centre for the Canberra
Region

Also servicing South-East NSW

33% of patients from regional and rural
NSW

Outreach clinics in Bega, Moruya,
Cooma, Goulburn and close
relationships with regional teams



The Optimal Care Pathways



Optimal care pathway for people with lung cancer

Quick reference guide

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for people with lung cancer*.

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

<p>Prevention</p> <ul style="list-style-type: none"> Stop smoking. All patients who currently smoke (or have recently quit) should be offered best practice tobacco dependence treatment, given an opt-out referral to a behavioural intervention service such as Quitline 13 78 48, and prescribed smoking cessation pharmacotherapy, if clinically appropriate. Have conversations about smoking using the Ask, Advise, Help model. Avoid exposure to second hand tobacco smoke. Prevent occupational exposure to asbestos, silica, radon, heavy metals, diesel fumes and polycyclic aromatic hydrocarbons. Take moderate to vigorous-intensity physical activity. <p>Risk factors</p> <ul style="list-style-type: none"> Lifestyle factor: <ul style="list-style-type: none"> physical inactivity Environmental factors: <ul style="list-style-type: none"> second-hand smoke occupational exposure to arsenic, polycyclic aromatic hydrocarbons, cadmium, radon, asbestos, silica, iron and steel foundry, nickel, beryllium, chromium VI, paint, diesel exhaust <ul style="list-style-type: none"> air pollution <p>Personal factors:</p> <ul style="list-style-type: none"> current or former tobacco smoking increasing age family history of lung cancer personal history of cancer chronic lung disease. <p>Indigenous Australians are approximately twice as likely to be diagnosed with and to die from lung cancer and have a lower 5-year survival compared with non-Indigenous Australians.</p> <p>Early detection</p> <p>Increased use of CT scans has led to more incidental detection of lung nodules, which should be managed according to existing guidelines.</p> <p>Screening recommendations</p> <p>There is currently no national screening program for lung cancer in Australia.</p>	<p>Checklist:</p> <ul style="list-style-type: none"> Recent weight changes discussed and weight recorded Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate Smoking status discussed and recorded and brief smoking cessation advice offered to smokers Physical activity recorded Referral to a dietitian considered Referral to a physiotherapist or exercise physiologist considered Education on being sun smart considered
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Step 2: Presentation, initial investigations and referral

<p>Signs and symptoms</p> <p>The following unexplained, persistent signs and symptoms require investigation, if lasting more than 3 weeks (earlier in patients with known risk factors or with more than one sign or symptom):</p> <ul style="list-style-type: none"> new or changed cough chest or shoulder pain 	<ul style="list-style-type: none"> shortness of breath hoarseness weight loss or loss of appetite persistent or recurrent chest infection fatigue DxI abnormal chest signs finger clubbing 	<p>Checklist:</p> <ul style="list-style-type: none"> Signs and symptoms recorded Chest x-ray for unexplained, persistent symptoms and signs
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Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

SECOND EDITION

Australian Government Cancer Australia

Cancer Council

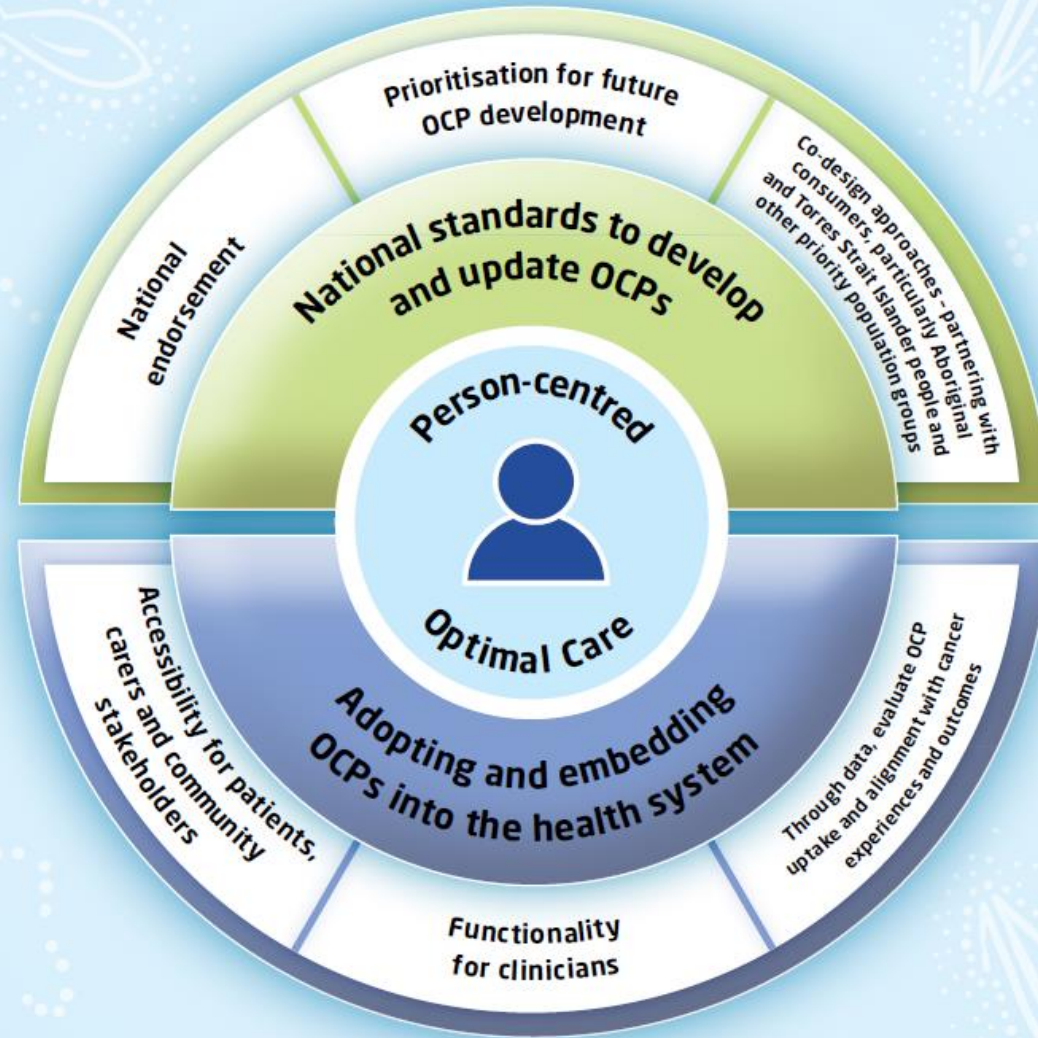
National Optimal Care Pathways Framework Summary

Vision

The integration of Optimal Care Pathways (OCPs) into clinical practice as the standard of cancer care, ensuring cultural safety and accessibility throughout the cancer journey, improving equity in cancer care and outcomes for all Australians.

Principles

- Equity
- Future-focused
- Person-centred
- Collaborative



Who is the OCP Framework For?

The National OCP Framework is intended for service planners, policy makers and OCP developers to understand the standards for OCP development and the strategies employed to enhance equitable access to care through OCPs.

Comprehensive Data Capture

- Improved data collection to inform OCP evaluation and drive quality improvements.

Comprehensive Cancer Care

Adherence to OCPs will be a requirement for participation in the Australian Comprehensive Cancer Network (ACCN) ensuring OCPs are embedded into clinical practice across jurisdictions and networks to deliver comprehensive cancer care.



Australian Government

Cancer Australia

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OCP Lung Cancer

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This quick reference guide provides a summary of the optimal care pathway for people with lung cancer.

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Prevention

- Stop smoking. All patients who currently smoke or have recently quit should be offered best practice tobacco dependence treatment, given an opt-out referral to a behavioural intervention service such as Quitline 13 78 48, and prescribed smoking cessation pharmacotherapy. If clinically appropriate, have conversations about smoking using the Ask, Advise, Help model.
- Avoid exposure to second-hand tobacco smoke.
- Prevent occupational exposure to asbestos, silica, radon, heavy metals, diesel fumes and polycyclic aromatic hydrocarbons.
- Take moderate to vigorous-intensity physical activity.

Risk factors

- Lifestyle factor:
 - physical inactivity
- Environmental factors:
 - second-hand smoke
 - occupational exposure to arsenic, polycyclic aromatic hydrocarbons,

Step 2: Presentation, initial investigations and referral

Signs and symptoms

- The following unexplained, persistent signs and symptoms require investigation, if lasting more than 3 weeks (earlier in patients with known risk factors or with more than one sign or symptom):
- New or changed cough
 - Chest or shoulder pain
 - Shortness of breath
 - Hoarseness
 - Weight loss or loss of appetite
 - Persistent or recurrent chest infection
 - Fatigue
 - CYT
 - Abnormal chest signs
 - Finger clubbing

Checklist

- Signs and symptoms recorded
- Chest x-ray for unexplained, persistent symptoms and signs

Step 2: Presentation, initial investigations and referral continued

- central or supraclavicular lymphadenopathy
- signs of lung cancer metastasis (e.g. brain, bone, liver or skin)
- pleural effusion
- thrombocytosis.

The following signs and symptoms require urgent referral for a chest CT scan and concurrent referral (within 2 weeks) to a specialist linked to a lung cancer multidisciplinary team.

- persistent or unexplained haemoptysis
 - signs of superior vena caval obstruction
 - high clinical suspicion of lung cancer
 - imaging findings suggesting lung cancer.
- The following signs or symptoms require immediate referral to an emergency department:
- massive haemoptysis
 - stroke.

GP investigations include:

- thorough medical history
- urgent chest x-ray for unexplained, persistent symptoms and signs lasting more than 3 weeks (earlier in patients with known risk factors or with more than one symptom or sign) – if the chest x-ray is normal and symptoms persist repeat the chest x-ray at 6 weeks

Checklist continued

- Contrast CT of the chest if there is a strong clinical suspicion of lung cancer and referral to a specialist linked to a lung cancer multidisciplinary team
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient notified of support services such as Cancer Council 13 11 20
- Referral options discussed with the patient and/or carer including cost implications

Timeline

Provide test results to the patient within 1 week of

Step 3: Diagnosis, staging and treatment

Diagnosis and staging

- Lung cancer may be diagnosed through additional imaging (they include a PET-CT scan).
- Immunohistochemistry including endobronchial ultrasound-guided biopsy
 - CT or ultrasound-guided biopsy or aspiration
 - extinction biopsy or biopsy of a metastasis
 - sputum cytology in rare cases.

Genetic testing

Familial causes are rare and testing is not usual

Treatment planning

- Staging for lung cancer involves:
- CT scans of the chest and upper abdomen (in all cases) and imaging can be MRI of the brain in some cases
 - PET-CT scans where curative treatment is being considered
 - assessment by a surgeon with thoracic lung cancer expertise in cases where curative treatment is being considered.

Step 3: Diagnosis, staging and treatment planning continued

Communication

- The lead clinician's responsibilities include:
- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
 - explaining the role of the multidisciplinary team in treatment planning and ongoing care
 - encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
 - providing appropriate information and referral to support services as required
 - communicating with the patient's GP about the diagnosis, treatment plan and recommendations from multidisciplinary meetings (MDMs).

Checklist continued

- Patient referred to support services (such as Cancer Council) as required
- Treatment costs discussed with the patient and/or carer

Timeline

Complete diagnostic tests within 2 weeks of the first specialist appointment.

Establish intent of treatment

Curative

Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure

Symptom palliation.

Surgey may be suitable for patients:

- with early-stage NSCLC who are fit for the required surgery
- requiring surgical diagnosis or palliation.

Radiation therapy may be suitable for patients with:

- early-stage I-II NSCLC who are unsuitable or unable to have surgery
- locally advanced (II), inoperable NSCLC
- limited stage I-III SCLC who are undergoing combined modality treatment with chemotherapy or who may benefit from prophylactic cranial irradiation.

All patients with NSCLC and SCLC may benefit from radiation therapy for palliative intent.

Local ablative therapies may be an alternative to curative or palliative therapy in some patients.

- with localized NSCLC who are unsuitable for surgery or radiation therapy
- with oligometastatic NSCLC who are unsuitable for surgery or radiotherapy
- undergoing multi-modality treatment in combination with radiotherapy, chemotherapy or immunotherapy.

Oligometastatic disease refers to a clinical situation where there are a limited number of metastatic tumours that could potentially be managed with curative intent.

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- Intent of treatment established
- Risks and benefits of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer
- Treatment plan provided to the patient's GP
- Referral specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Early referral to palliative care considered
- Advance care planning discussed with the patient and/or carer

Timeline

Begin treatment within 6 weeks of the initial specialist referral. Medical emergencies should follow guidelines.

Step 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- The diagnosis, including tests performed and results
- Tumour characteristics
- Treatment received (types and dates)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- follow-up schedule, including tests required and timing

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP

Checklist

- Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Most residual, local, recurrent or metastatic disease will be detected via monitoring, routine follow-up or by the patient presenting with symptoms.

Treatment

Evaluate each patient for whether referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP

Checklist

- Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Advance care planning discussed with the patient and/or carer
- Patient referred to palliative care if appropriate
- Refuse follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient referred to palliative care
- Advance care directive in place

Visit our guides to best cancer care webpage www.canceroncoguides.org.au for consumer guides. Visit our OCP webpage www.cancer.org.au/OCP/ for the optimal care pathway and instructions on how to report these guides to your GP. www.cancer.org.au/OCP/

Published in June 2021.

Canberra Hospital Guideline - Optimal Care Pathway for lung cancer

- Aim to streamline referral pathway and provision of services within Canberra Health Services
- Ensure compliance with Cancer Australia Optimal Care Pathway
- Issued in 2022

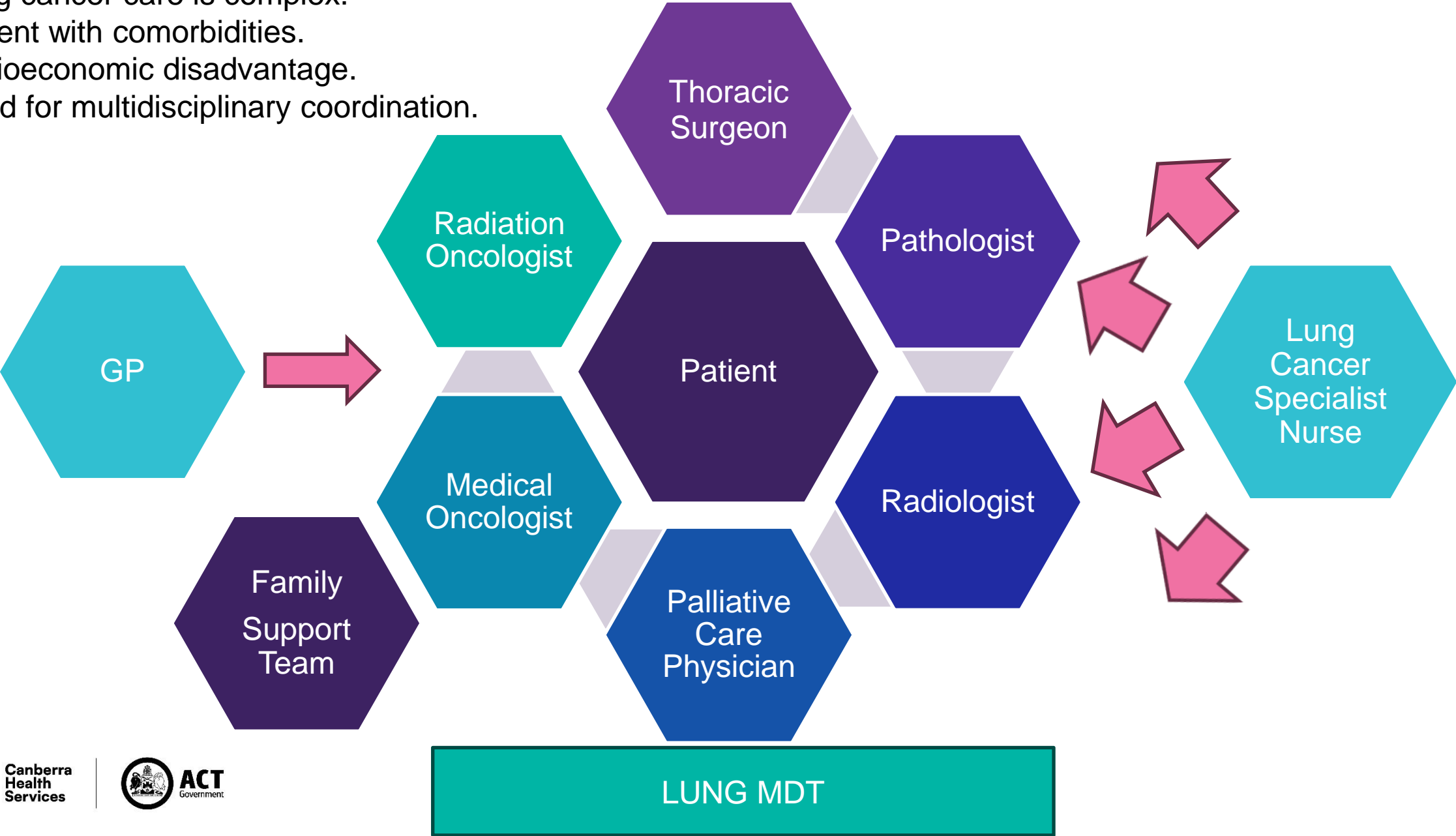


Optimal timeframes as per national guidelines are:

- - The specialist appointment must take place **within two weeks of initial referral**
- - The time from **initial referral to initial treatment must be no more than six weeks.**

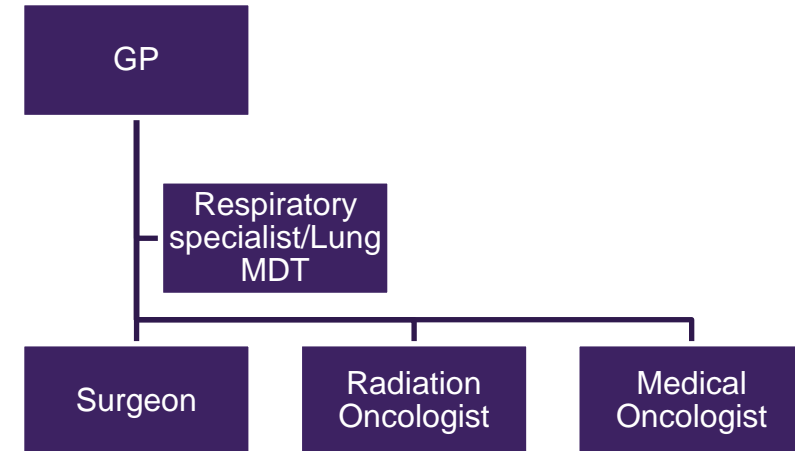
Lung cancer care

Lung cancer care is complex.
Patient with comorbidities.
Socioeconomic disadvantage.
Need for multidisciplinary coordination.



Models

- Serial referral system refer-as-you-go system.
- MDT meeting focused model allows presentation of patient cases and collaboration of lung cancer specialists for diagnostic and management decisions.
- MDT clinic-based model dedicated centralised cancer clinic space which allows a sequence of patient interactions with various lung cancer specialists at the same time.



Urgent Suspected Lung Cancer Clinic: The Canberra Experience

- Fits into initial investigation / referral / staging space of OCP
- Respiratory Physician run
- Supported by Lung Cancer Specialist Nurse
- Administrative support form Division of Medicine

Suspected lung cancer clinic since 2008. Major revision of Rapid Access Clinic (RAC) in 2018.

Optimal care pathway for people with lung cancer

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Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Prevention

- Stop smoking. All patients who currently smoke (or have recently quit) should be offered best practice tobacco dependence treatment, given an opt-out referral to a behavioural intervention service such as Quitline 13 17 79, 48, and prescribed smoking cessation pharmacotherapy if clinically appropriate. Frame conversations about smoking using the Ask, Advise, Help model.
- Avoid exposure to second-hand tobacco smoke.
- Prevent occupational exposure to asbestos, silica, radon, heavy metals, diesel fumes and polycyclic aromatic hydrocarbons.
- Take moderate to vigorous-intensity physical activity.

Risk factors

- Lifestyle factors:
 - physical inactivity
- Environmental factors:
 - second-hand smoke

- cadmium, radon, asbestos, silica, iron and steel fuming, nickel, beryllium, chromium VI, paint, diesel exhaust
 - air pollution
- Personal factors:
 - current or former tobacco smoking
 - increasing age
 - family history of lung cancer
 - personal history of cancer
 - chronic lung disease.

Indigenous Australians are approximately twice as likely to be diagnosed with and die from lung cancer and have a lower 5-year survival compared with non-Indigenous Australians.

Early detection

Increased use of CT scans has led to more incidental detection of lung nodules, which should be managed according to existing guidelines.

Screening recommendations

There is currently no national screening

- Checklist
 - Recent weight changes discussed and weight recorded
 - Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
 - Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
 - Physical activity recorded
 - Referral to a dietitian considered
 - Referral to a physiotherapist or exercise physiologist considered
 - Education on being sun smart considered.

Supports administrative support

Supports clinical support

Step 2: Presentation, initial investigations and referral

Signs and symptoms
The following unexplained, persistent signs and symptoms require investigation, if lasting more than 3 weeks earlier in patients with known risk factors or with more than one sign or symptom:

- new or changed cough
- chest or shoulder pain

Checklist

- Signs and symptoms recorded
- Check x-ray for unexplained, persistent symptoms and signs

Timeframe
Begin treatment within 6 weeks of the initial referral.

SECOND EDITION Cancer Australia Council

Supports administrative support

Supports clinical support

Step 3: Diagnosis, staging and treatment planning

Communication
The lead clinician's responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication

Checklist continued

- Patient referred to support services (such as Cancer Council) as required
- Treatment costs discussed with the patient and/or carer

Timeframe
Complete diagnostic tests within 2 weeks of the first specialist appointment.

Step 4: Treatment

Establish intent of treatment

- Curative
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation

Surgery may be suitable for patients:

- with early-stage NSCLC who are fit for the required surgery
- requiring surgical diagnosis or palliation

Radiation therapy may be suitable for patients with:

- early-stage 1-4 NSCLC who are unsuitable or unwilling to have surgery
- locally advanced (III), inoperable NSCLC
- metastatic stage 4 NSCLC who are undergoing combined modality treatment with chemotherapy or who may benefit from stereotactic body radiation.

All patients with NSCLC and SCLC may benefit from radiation therapy for palliative intent.

Local ablative therapies may be an alternative to curative or palliative therapy in some patients:

- with localized NSCLC who are unsuitable for surgery or radiation therapy
- with oligometastatic NSCLC who are unsuitable for surgery or radiotherapy
- undergoing multi-modality treatment in combination with chemotherapy, chemotherapy or immunotherapy.

Oligometastatic disease refers to a clinical situation where there is a limited number of metastatic tumours that could potentially be managed with curative intent.

Refer appropriate cases to centres with expertise in the area. **Systemic therapy** may be suitable for patients with:

- advanced disease and good performance status
- NSCLC who are undergoing neoadjuvant or adjuvant therapy in conjunction with complete resection of locoregional disease
- resectable, localized NSCLC who are suitable for combined modality disease chemoradiation

Palliative care

- Early referral to palliative care can improve quality of life and in some cases survival. Referrals should be based on need, not prognosis. For more, visit the Palliative Care Australia website www.palliativecare.org.au.

Communication
The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- Intent of treatment established
- Risks and benefits of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer
- Treatment plan provided to the patient's GP
- Treating specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded and referrals to allied health services activated as required
- Early referral to palliative care considered
- Advance care planning discussed with the patient and/or carer

Timeframe
Begin treatment within 6 weeks of the initial referral. Medical emergencies should follow guidelines.

Step 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- the treatment received (types and dates) and recorded and referred early
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of those
- supportive care services provided
- a follow-up schedule, including tests required and timing

Checklist continued

- Patient referred to support services (such as Cancer Council) as required
- Treatment costs discussed with the patient and/or carer

Timeframe
Contact information for key healthcare providers who can offer support for lifestyle modification

- a process for rapid re-entry to medical services for suspected recurrence.

Communication
The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP

Checklist

- Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded, and referrals to allied health services activated as required
- Patient referred to palliative care as required
- Patient referred to advanced care planning discussed with the patient and/or carer

Step 6: Managing recurrent, residual or metastatic disease

Detection
Most residual, local, recurrent or metastatic disease will be detected via monitoring, routine follow-up or by the patient presenting with symptoms.

Treatment
Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Advance care planning
Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal preferences.

Checklist

- Risks and benefits of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer
- Treatment plan provided to the patient's GP
- Treating specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded and referrals to allied health services activated as required
- Early referral to palliative care considered
- Advance care planning discussed with the patient and/or carer

Timeframe
Begin treatment within 6 weeks of the initial referral. Medical emergencies should follow guidelines.

Step 7: End-of-life care

Palliative care
Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication
The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- Supportive care needs assessment completed and recorded, and referrals to allied health services activated as required
- Patient referred to palliative care as required
- Advance care directive in place

Footnote:
1. Lead clinician - the clinician who is responsible for managing patient care. The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Supports administrative support

Supports clinical support

Step 2: Presentation, initial investigations and referral

Checklist continued

- Conduct CT scan if there is a strong clinical suspicion of lung cancer, persistent or unexplained haemoptysis, signs of superior vena caval obstruction or imaging findings suggest lung cancer within 2 weeks of the patient presenting with symptoms. The CT scan should be delivered with contrast unless contraindicated. Concurrently refer the patient to a specialist linked to a lung cancer multidisciplinary team (consider immediate telephone contact).
- persistent or unexplained haemoptysis
- signs of superior vena caval obstruction
- high clinical suspicion of lung cancer
- imaging findings suggesting lung cancer

The following signs and symptoms require urgent referral for a chest CT scan and concurrent referral (within 2 weeks) to a specialist linked to a lung cancer multidisciplinary team:

- massive haemoptysis
- stridor
- through medical history
- urgent chest x-ray for unexplained, persistent symptoms and signs lasting more than 3 weeks earlier in patients with known risk factors or with more than one symptom or sign
- If the chest x-ray is normal and symptoms persist repeat the chest x-ray at 8 weeks

Referral options
At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise. If there are likely to be out of pocket costs and the range of services available. This will include patients to make an informed choice of specialist and health services.

Communication
The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/or carer that they can contact Cancer Council on 13 11 00

Checklist

- Conduct CT of the chest if there is a strong clinical suspicion of lung cancer and referred to a specialist linked to a lung cancer multidisciplinary team
- Supportive care needs assessment completed and recorded, and referrals to allied health services activated as required
- Patient notified of support services such as Cancer Council 13 11 00
- Referral options discussed with the patient and/or carer including cost implications

Timeframe
Provide test results to the patient within 1 week of the referral to their GP
The first specialist referral to a lung cancer multidisciplinary team appointment should take place within 2 weeks of the initial GP referral.

Step 3: Diagnosis, staging and treatment planning

Diagnosis and staging
Lung cancer may be diagnosed through:

- additional imaging (may include a PET/CT scan)

Imaging and/or pathological confirmation of the most advanced site of disease may be required. Molecular testing and biomarker testing can inform the most appropriate treatment.

Checklist

- Diagnosis confirmed
- Staging confirmed
- Molecular testing and biomarker testing can inform the most appropriate treatment
- Performance status and an MCM and decisions provided to the patient and/or carer
- Clinical trial enrollment considered
- Supportive care needs assessment completed and recorded, and referrals to allied health services activated as required

Genetic testing
Familial causes are rare in lung cancer and testing is not usually needed.

Treatment planning
The multidisciplinary team should discuss all newly diagnosed patients with lung cancer, usually before treatment begins.

Research and clinical trials
Consider enrolment where available and appropriate. Search for a trial www.australianclinicaltrials.gov.au.

Checklist

- Genetic testing considered
- Research and clinical trials considered
- Supportive care needs assessment completed and recorded, and referrals to allied health services activated as required

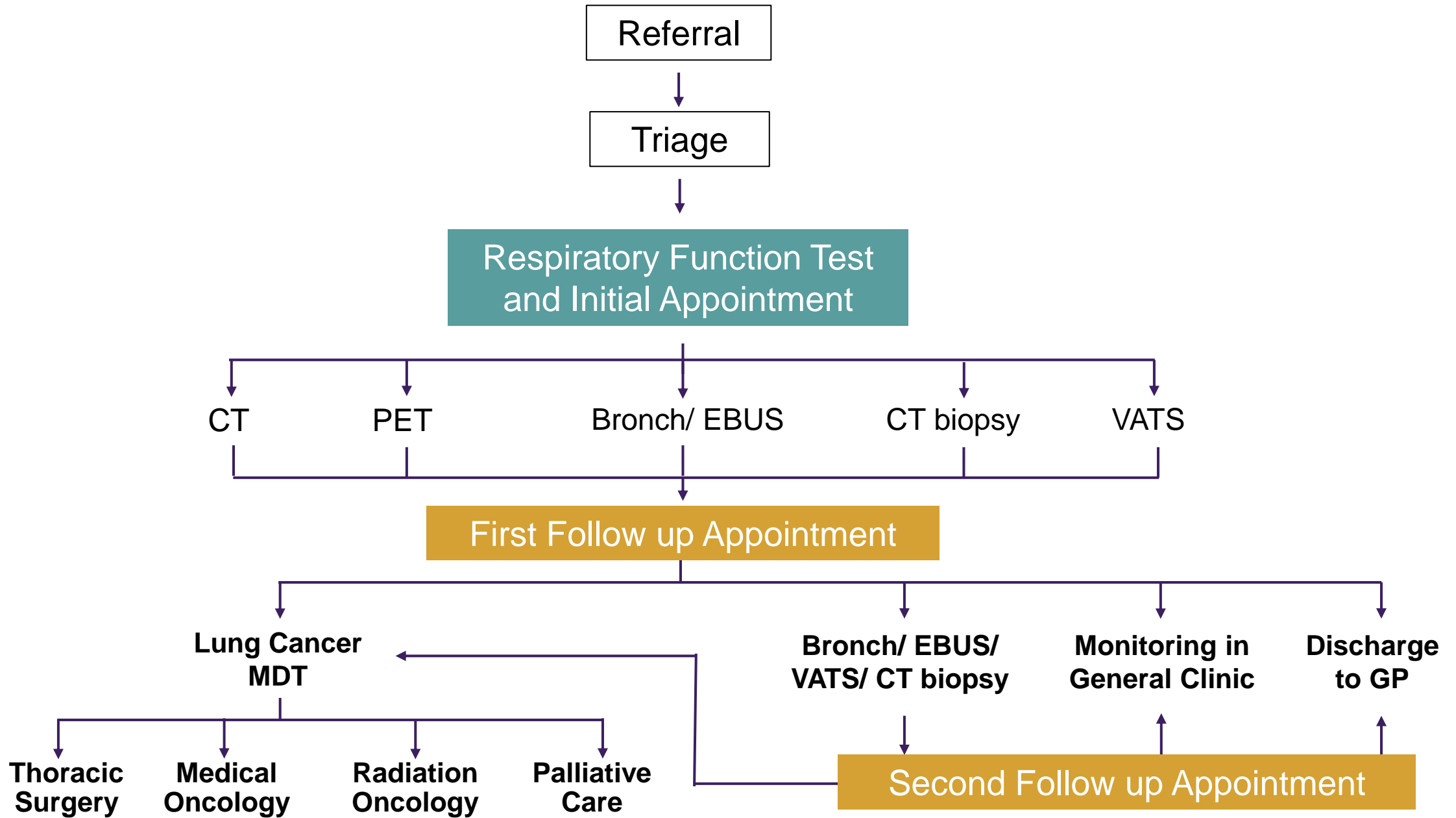
Step 5: Care after initial treatment and recovery

Checklist

- Supportive care needs assessment completed and recorded, and referrals to allied health services activated as required
- Patient referred to palliative care as required
- Advance care directive in place

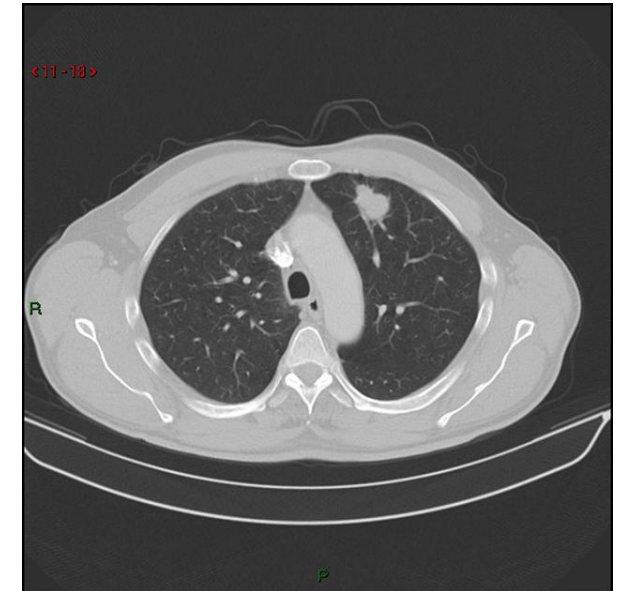
Visit our guides to best cancer care website www.cancerpatientsguides.org.au for consumer guides. Visit our OCP webpage www.cancerpatientsguides.org.au/OCP/ for the optimal care pathway and instructions on how to report these guides to your GP software.

Published in June 2021.



Referral Criteria

- Solid or semi-solid lung nodule or mass >8mm.
- Groundglass nodule \geq 6mm.
- Suspicious mediastinal mass/ lymphadenopathy.
- Enlarging pulmonary nodules on CT chest.
- Strong clinical suspicion of pulmonary malignancy.



Gaillard F, Worsley C, Yonso M, et al. Lung cancer. Reference article, Radiopaedia.org (Accessed on 20 May 2024)
<https://doi.org/10.53347/rID-1022>

Referral Triage Category

- **Cat Urgent:** Immediate intervention required – Bronch/ EBUS, CT Bx, Pleural intervention.
- **Cat 1:** Imaging to decide intervention vs monitoring.
- **Cat 2:** No immediate intervention required. For further monitoring
- **Cat Urgent:** Nodule/ mass >2cm, concerning nodule with associated lymphadenopathy, pleural effusion or invasion of chest wall/ mediastinum.
- **Cat 1:** Nodule <2cm of uncertain risk, may require either repeat CT or PET scan before decision regarding intervention vs monitoring.
- **Cat 2:** Nodule requiring repeat CT in ≥ 3 months.

*Guide not prescriptive for triaging physician

Urgent Suspected Lung Cancer Clinic: The Canberra Experience

- Reviewed 210 new patients in 2023.
- 256 referrals in 2022.
- 39% of referrals from NSW. 32% from Regional NSW.

- 1 clinic a fortnight in 2018 to now 3 clinics a fortnight.
- Supplementary clinics as required throughout the year.
- 12 physicians participating in RAC.
- 7 physicians can now perform EBUS compared to 2 in 2018.

1 clinics per fortnight

5 NP per clinic

= roughly 125 per year

3 clinics per fortnight

5 NP per clinic

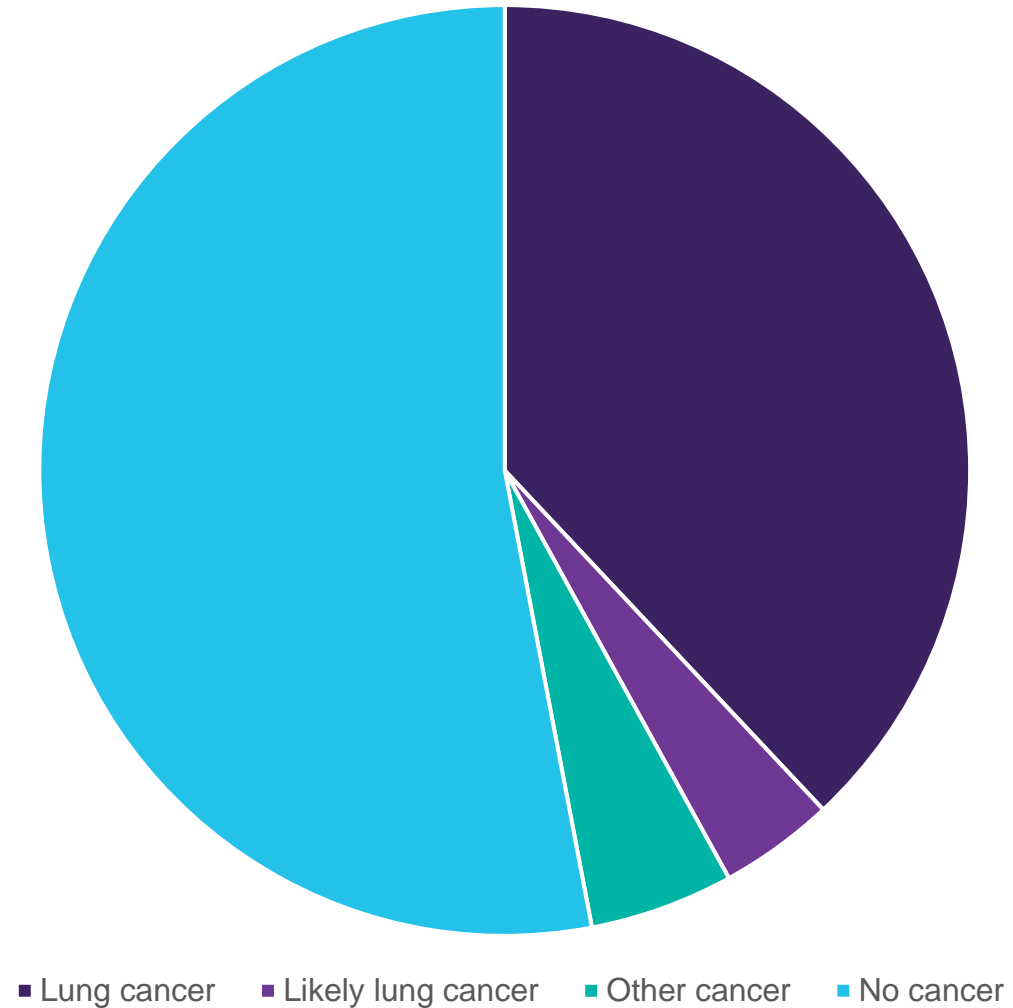
= roughly 375 possible slots per year

This number should reduce the waiting time for clinic spots.

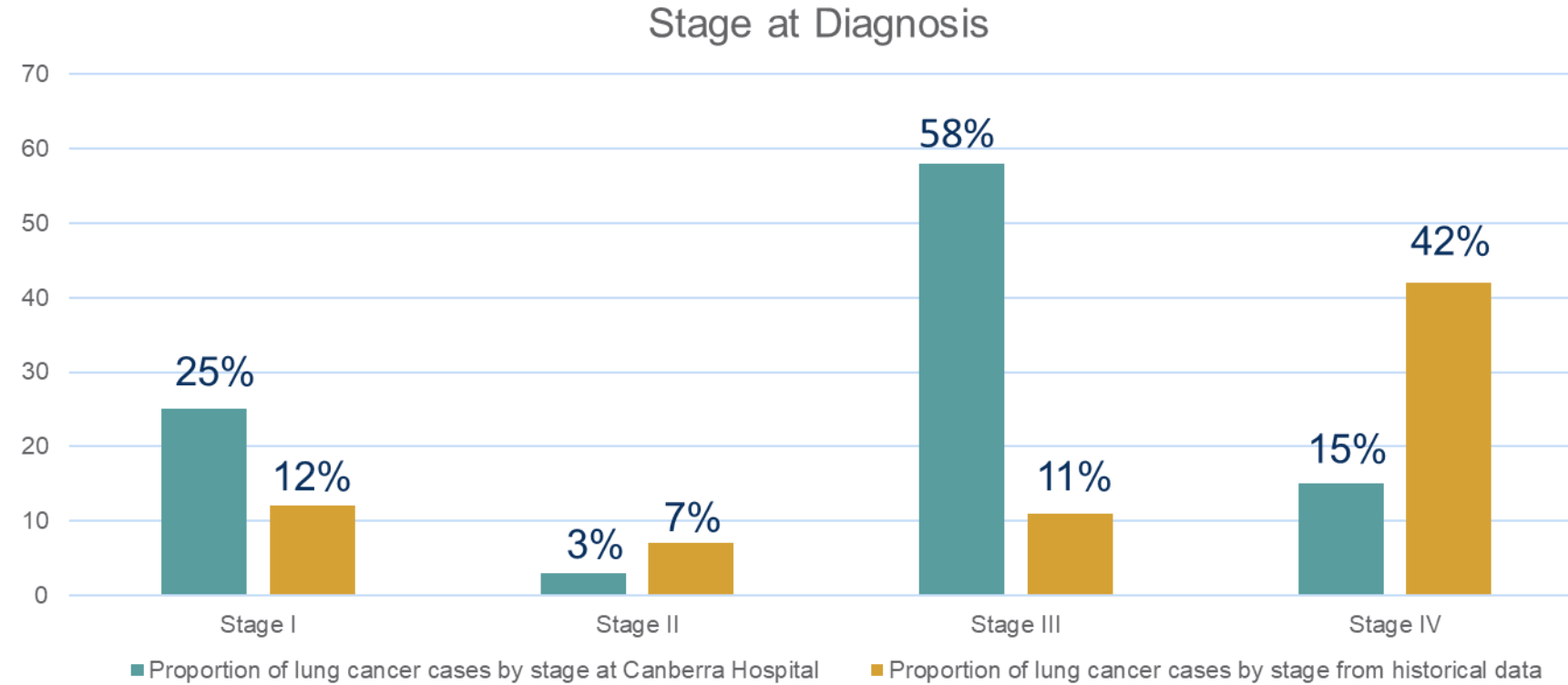
Rapid Access Clinic Audit 2023

- 38% diagnosed with lung cancer (35% NSCLC, 2% SCLC, 1% Neuroendocrine)
- 4% diagnosed with likely lung cancer (no further Ix or no tissue diagnosis because of comorbidities)
- 5% diagnosed with other cancer
- 53% did not have any cancer diagnosis (on monitoring pathway/ discharged)

Diagnoses



Lung Cancer Cases by Stage in RAC 2023



Historical data source: AIHW ACD 2014.

Issues:

- Complexity of patients
- Catering for regional patients
- Demand for service exceeds capacity
- Lung cancer specialist nurse caseload
- Dependence on system for timing into and out of clinic
- Linking back community if not having treatment in CHS

How we have changed the clinic since May 2024

- Increased capacity
 - Extra clinics
 - Additional appointments for individuals (1st and 2nd review)
- Thereafter the patient should be discussed at Lung Cancer MDT and referred to a subsequent service for treatment, have ongoing monitoring in general clinic or discharged to GP.
- Rostering changes
 - More respiratory clinicians involved
 - Changing in rostering of respiratory physicians to spread the load

Conclusions

- Optimal Care Pathways describe ideal patterns of cancer care for Australian patients
- They are important to identify areas for improvement and provide a framework for everyone to think about how we can better care of our patients from all backgrounds
- How the OCP is implemented will vary between jurisdictions
- Innovative models of care will be needed to improve achieve these outcomes
- Networks provide opportunities to further develop new ways of doing things to improve our patient's care
- Networks will provide opportunities for learning from others

ACCN Innovation Showcase May 2024

Thank you

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