Cancer case management—leading all players in the team

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ABSTRACT

For the past eighteen months case management of bowel and prostate cancer patients has occurred in the Western District of Victoria with surprising results in integrated disease management including:

- full support from specialists and surgeons
- integrated disease management through distance oncology clinics
- 100% referral rates
- case manager fully funded for disease-specific conditions.

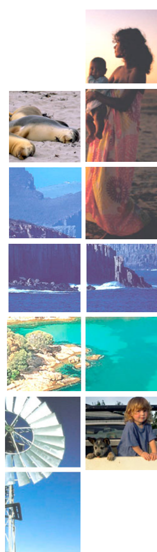
Patient focused care plans are developed and linked with surgeons and medical care from diagnosis through to home care. Disease management has developed to a nurse specialist role of care and is fully supported by all service providers.

Cancer support is a necessary process involving care from diagnosis to recovery or death. The ability to integrate all providers through one support person is not only difficult but also involved the author, employed through Western District Health Service, in providing Case management to all patients suffering from prostate and bowel related cancers.

From the time of diagnosis, the author, a registered nurse with extensive experience in intensive care, men's health and prostate and bowel cancer treatments, is referred all clients by surgeons, visiting specialists and general practitioners for education and case management. Involvement in case conferencing, postoperative management and post acute care are keys to the positive outcomes of cancer affected patients.

In this paper, the author will present the basis of the program and how this process has been forged to the benefit of the patient including::

- care plan design
- involvement of surgical specialists and general practitioners
- education packages
- management in hospital
- post-acute care
- referral and post-discharge management.



BACKGROUND

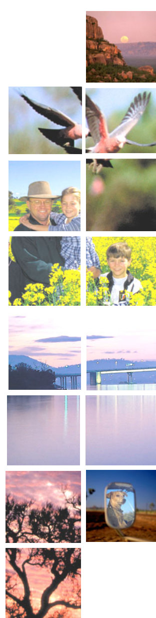
Living in a relatively remote rural community in Western Victoria unfortunately may not be all it seams with some astounding health indices that warrant further investigation. The Western District of Victoria is primarily a fine wool production area with emphasis on grazing, and these days a greater emphasis on agro-forestry. A beautiful and rich environment appears to have it all for people looking to live away from the city and bustle of metropolitan life.

Unfortunately the Western District of Victoria is an area of significant health concern as revealed by many studies in recent years. The male population is rated 52nd out of 58 in life expectancy in the recent Burden of Disease report (2001) and suffers the highest mortality rate per capita for heart disease in Victoria (ABS 1999). Its cancer rate exceeds much of the average for Victoria and it is well documented that the rural and remote male suffers in most disease areas at greater rates than their metropolitan counterparts (AIHW 1999). More recent studies have also shown that rural and remote populations suffer greater rates of certain?? cancers and have poorer access to specialised and trained support services (AIHW, 2002).

This pattern of morbidity and mortality is not a new phenomenon, yet a way of life. Western District Health Service has identified these issues and over the last two years has worked to create opportunities to meet community-driven requests for education, access and support of rural men.

HISTORY

Prior to April 2001 cancer services within the Western District amounted to purely diagnostic testing, surgical or non-surgical intervention and non-specific post acute care and support in the home. The extent to which patients and families received specific education, support and counselling on the management of specific bowel or prostate cancer was minimal and primarily directed by the relevant surgeon or specialist concerned. With the existence of Breast Case Care Managers the idea of specific education and support focusing on the care of bowel and prostate related cancers emerged. The development of specific support for bowel and prostate cancer patients was fraught with many questions, not the least of which would be the support and backing by the medical and surgical fraternity.



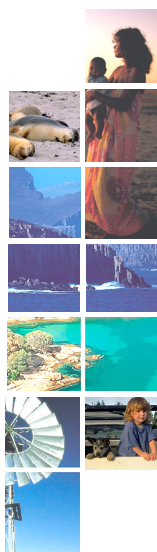
AIMS

Western District Health Service's major aims were to develop and implement case management of bowel and prostate related disease patients with full support and integration with medical, surgical and allied health services. This process was viewed initially as a difficult process considering the scope of service delivery and the number of major players in the medical and surgical merry-go-round. A case manager was found with specific skills and interest in men's health and cancer management and the task was developed.

OBJECTIVES

The major objectives for the management of specific bowel and cancer related diseases included:

- to develop a case management process to deliver education, support and information to cancer patients and their families
- to develop a 100% effective referral process prior to surgical or non-surgical procedures from general practitioners, surgeons and specialist visiting surgeons
- to develop information packs supported by medical staff and use these in conjunction with medical advice and support
- to integrate case manager into service delivery and case management of patients
- to optimise patient care and follow-up following discharge from hospital
- to co-ordinate a total case management process for referral and support of inpatients and to continue this following discharge.



METHOD

The case management position was filled with a male who had over 14 years' experience in the intensive care field and postgraduate experience in men's health, prostate cancer education and critical care. Having these skills aided the developed relations formed between physicians, surgeons and visiting specialists. Being based in the community and acute sector of the health service also made the process of integrating care and case management more effective and supported.

The position was developed with direct contact with all major stakeholders and a full explanation of the primary aims and objectives. Colorectal surgeons were offered support to their service through patient education, support and assessments. This was gratefully accepted on the grounds that their time was important and that support through education and information would significantly enhance their service. Physicians were also offered support following diagnosis of a colorectal tumour and considering that many previous patients were counter referred to the Men's Health Education service this process was viewed as an effective and important informative process for patients and families. Prior relations were forged through men's health referrals to physicians for rural men at significant risk of cardiovascular related disease. Physicians would accept these referrals on the grounds that they were at significant risk and that the men's health educator was a clinical nurse specialist within the intensive care unit.

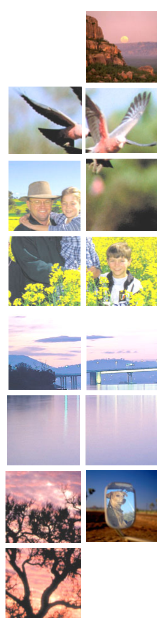
Prostate related cancer service was also addressed through a visiting Urologist who would attend once a month to the health service. Previous care of more acute patients had seen a significant relationship developed for many of the men requiring surgery. The case manager had recently completed formal study in the area of prostate related management through La Trobe University and this enhanced the process of caring for these patients. The urologist, sending a list of his prostate related patents to the case manager prior to surgery, instigated the referral of patients and this would enable all

patients to be seen and educated prior to surgery. Case management would continue throughout the hospitalisation process with care and support provided for the time of admission following the Urologist leaving the hospital. Direct contact with the urologist via phone (usually occurring on weekends) occurred with post acute care arranged, appointments, scripts and follow-up appointments being co-ordinated. This process has been developed further to incorporate referral of all prostate cancer patents within the area to the case manager for education, support and information following consultation with the urologist. The two way process has been enhanced considering the infrequent nature of the urologists visits i.e. once per month. Care and management of these patients is now a phone call away rather than a 3.5-hour road trip for a consultation.

Backup for "slip-through" referrals was also formulated through education and information sessions for all surgical staff and reinforcement of the referral process whilst working within the acute sector of the hospital. The pre-admission service was also linked with to catch any patient's pre-booked for surgery by surgeons or visiting specialists. This process has seen the referral of 100% of all colorectal patients and prostate related patients prior to surgery.

Development of education and resource packages was completed with specialist education material adapted to enhance the understanding of all patients accessed. The Cancer Council of Victoria information pamphlets were also used to formulate case management packages for all patients to have as a resource. Twenty-four hour phone service was also made available for contact and support through the case manager position. Packages are given to all patients on initial assessment and worked through on each occasion of care. Information is tailored for each patient depending on surgeon's advice and level of understanding.

Case management development and integration of all services was developed through continual attendance at whatever surgical and medical staff participated in. involvement in radiology meetings, weekly pathology sessions and surgical and medical rounds assisted in the linkage with all major stakeholders in co-ordinated care. Frequent questions and advice were sought by specialists relating to patient coping mechanism and heath status following discharge, revealing acceptance in the service provided.



Other linkage with prostate related co-ordination involved attending grand rounds in Melbourne where many local patients results were discussed and surgery was performed. This process also enabled exposure to future developments in the area and the enhancement of knowledge in the latest treatments and procedures. Direct patient support was also given in theatre with attendance and support during surgery. This process also aided in a better understanding of the surgery for the patient and the family post-operatively.

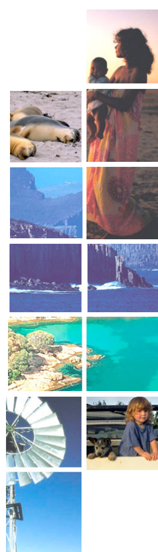
Case management of patients also extended to pathology meetings with surgeons and specialist physicians where discussion of surgery, recovery and future medical or radio-oncology services are co-ordinated.

All patients are visited prior to surgery by the case manager and followed up in hospital daily whilst an inpatient to reinforce education and support. Following discharge all patients are visited at least once with multiple visits on a needs basis. Prostate cancer patients who do not require surgery initially are visited on a needs

basis for education and support. Patients whose cancer was significantly advanced were also supported through co-ordinated care and referral to palliative care services with care and support given throughout this stage of life.

EVALUATION

The process of bowel and prostate cancer case management has been implemented since April 2001 and currently has serviced a total of 73 bowel related and 51 prostate related patients. There has been 100% referral of all patients from surgical, medical and allied health services. The process of case management is now well recognised by Western District Health Service with full funding and support for the position. The advent of the position has now seen full backing by all stakeholders for the development of a nurse practitioner position in men's health and cancer case management.



Evaluations of service provision revealed overwhelming support by patients involved of the literature and service provided by the case manager.

CONCLUSION/DISCUSSION

The development of the bowel and prostate case management process within the Western District of Victoria has been a process of integration and learning for all members of the health team. Outcomes so far include:

- 100% referral of all prostate and bowel related patients to the service
- full acceptance and endorsement by medical, surgical and visiting specialists within Western District Health Service
- full funding for the developed position of case manager
- effective integration in service delivery
- effective linkage into case management through co-ordinated team meetings and case conferencing
- endorsement of nurse practitioner status for future management of bowel and prostate cancer patients.

The process of patient case management is one that many hospitals and health care institutions must address in the future as the number of complications related to non-compliance with medications and post discharge rise. Readmission is well documented and often can be reduced with appropriate education support and information to patients and families. Surgical and medical support particularly in the rural and remote environment is limited by distance, service, and the provision of accessible health care.

Reception to the above service was overwhelmingly positive with most clients expressing gratitude to the extent to which health care and support was promoted.

In conclusion from the implementation of the case management position for the care of bowel and prostate related conditions it is evident that this process can be implemented within major or minor health care settings. The process of case management has essential keys to its development and implementation focusing on case co-ordination, effective linkage with existing services and formulation of management plans. The process for the development of disease case management should be paramount for all health services. The process is possible given effective linkage and co-ordination of services to optimise patient outcomes.

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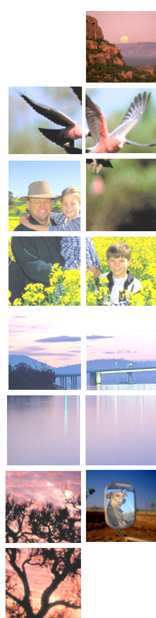

Stuart Willder is a Registered Nurse with experience and qualifications in Critical Care, Men's Health and Cancer Case Management. He currently works with Western District Health Service as a Men's Health Educator and Bowel and Prostate Cancer Case Manager. Current roles include the education and assessment of rural men through structured programs, and the case management of bowel and prostate cancer patients. Stuart works in close conjunction with GPs, physicians, surgeons and visiting specialists and co-ordinates case management of referred clients. Future directions include the development of a Men's Health Nurse Practitioner role to better service the needs of rural males. Further information relating to the cancer case management can be viewed in concurrent session C6-Cancer.