# Characteristics and care pathways of Indigenous Australians at the Peter MacCallum Cancer Centre: a retrospective audit

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## Project team

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# Introduction

**Gaps in research**

- From Victoria
- Outpatient treatment

**Our service**

- Specialist cancer hospital

# Methodology

- All new patients who identified as Aboriginal and/or Torres Strait Islander at registration during a five year period (2009-2013)
- Describe the demographic and clinical characteristics of the full sample
- Describe the care pathways of the final year's cohort using process mapping

# Five year cohort (n=133)

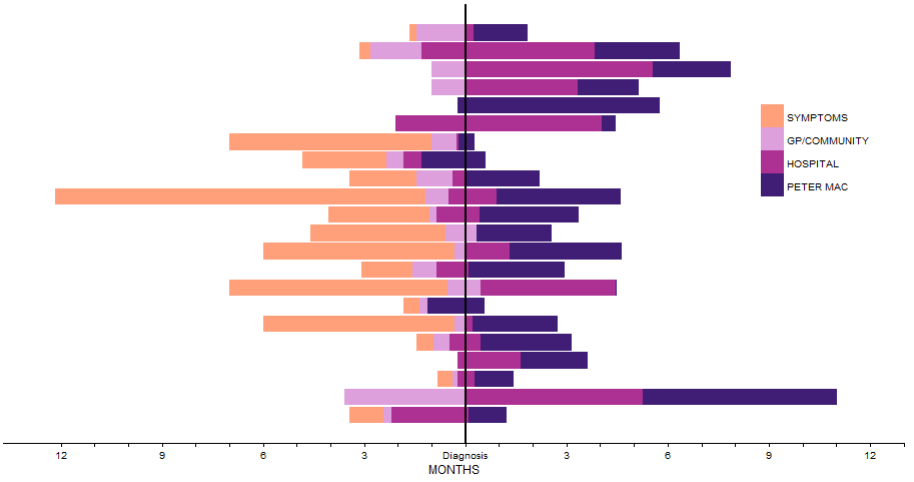
| | | | | | |
|---|---|---|---|---|---|
| **Age** | | | **Tumour Stream** | **n** | **%** |
| Mean (SD) | 55.1 (16.0) | | Gastrointestinal | 23 | 17.3 |
| Range | 6, 84 | | Lung | 23 | 17.3 |
| | | | Skin & Melanoma | 16 | 12.0 |
| **Sex** | **n** | **%** | Head & Neck | 13 | 9.8 |
| Male | 65 | 48.9 | Breast | 11 | 8.3 |
| Female | 68 | 51.1 | Urology | 10 | 7.5 |
| | | | Haematological | 7 | 5.3 |
| **Aboriginal Identification** | | | Gynaecological | 6 | 4.5 |
| Aboriginal | 111 | 83.5 | Bone & Soft tissue | 5 | 3.8 |
| Torres Strait Islander | 5 | 3.8 | Neurology | 4 | 3.0 |
| Both | 17 | 12.8 | Unknown Primary | 1 | 0.8 |
| | | | No cancer (inc. Familial Cancer Centre) | 14 | 10.5 |
| **Identified in notes** | | | | | |
| Yes | 64 | 48.1 | **Referred from** | | |
| No | 69 | 51.9 | Melbourne hospital | 49 | 36.8 |
| | | | GP | 36 | 27.1 |
| **Marital Status** | | | Rural hospital | 22 | 16.5 |
| Married/ De facto | 58 | 43.6 | Interstate hospital | 11 | 8.3 |
| Never married | 35 | 26.3 | Previous Peter Mac patient | 9 | 6.8 |
| Divorced/separated | 20 | 15.0 | Aboriginal Health Service | 4 | 3.0 |
| Widowed | 16 | 12.0 | | | |
| | | | **Reason for referral** | | |
| **Residence** | | | Radiotherapy | 59 | 44.4 |
| Rural/Regional Victoria | 58 | 43.6 | Investigations | 26 | 19.5 |
| Metropolitan Melbourne | 54 | 40.6 | Management | 28 | 21.1 |
| Interstate | 21 | 15.8 | Other | 20 | 15.1 |

# One year cohort (n=36)

| | | | | | |
|---|---|---|---|---|---|
| **Age** | | | **Diagnosis (n=31)** | **n** | **%** |
| Mean (SD) | 58.7 (13.4) | | At Peter Mac | 4 | 12.9 |
| Range | 24, 84 | | Prior to Peter Mac | 27 | 87.1 |
| | | | | | |
| **Sex** | **n** | **%** | **Treatment (n=31)** | | |
| Male | 15 | 41.7 | At Peter Mac | 21 | 67.7 |
| Female | 21 | 58.3 | Not at Peter Mac | 10 | 32.3 |
| | | | | | |
| **Residence** | | | | | |
| Metropolitan Melbourne | 16 | 44.4 | | | |
| Rural/Regional Victoria | 14 | 38.9 | | | |
| Interstate | 6 | 16.7 | | | |

# Process Mapping

- Visual representation of the patient journey
- Shows actual process, rather than ideal
- Aids understanding of where improvements can be made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Diagnosis
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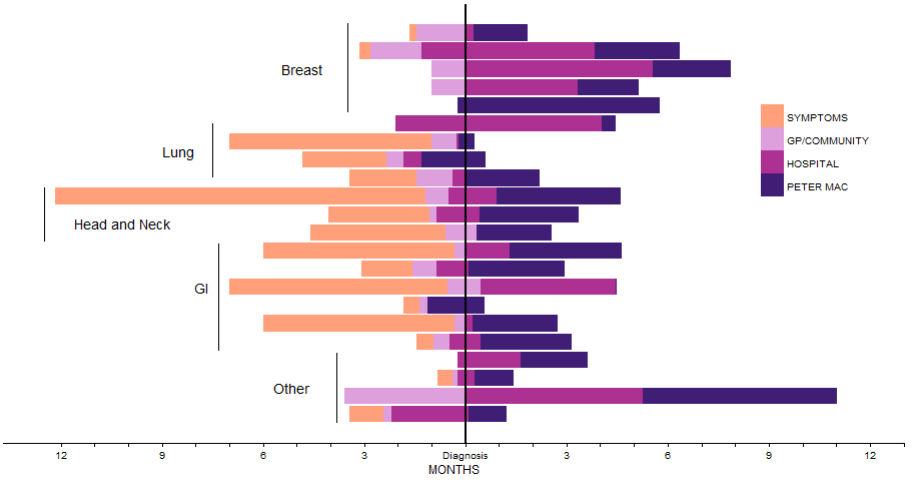
MONTHS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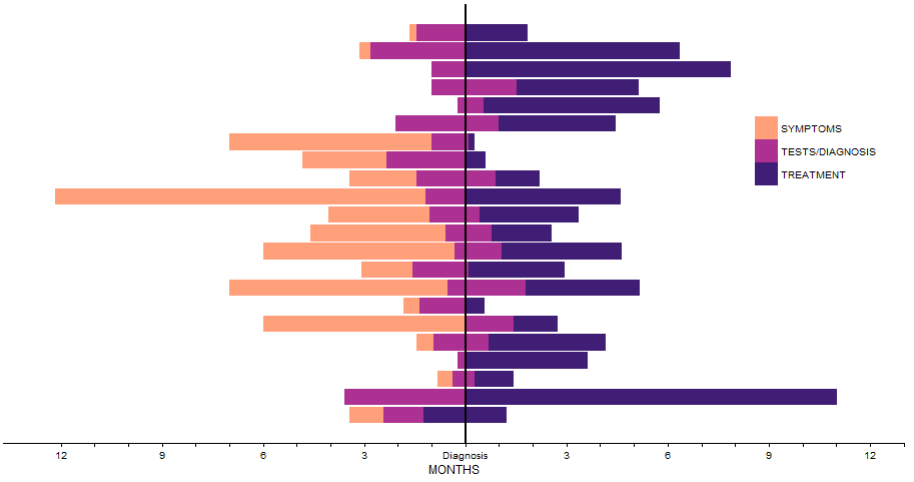
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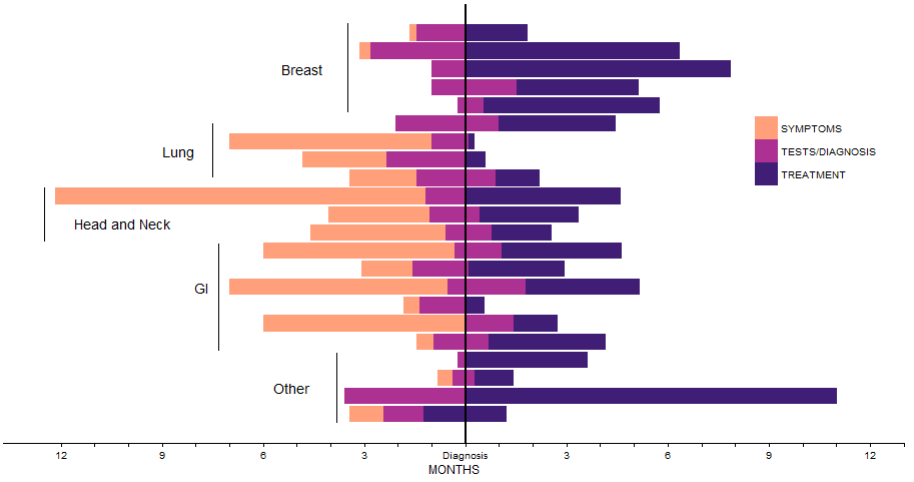
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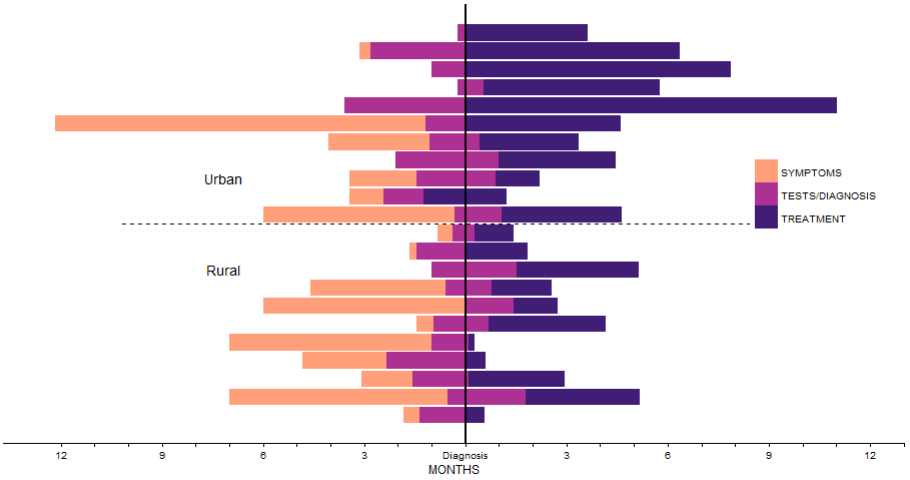
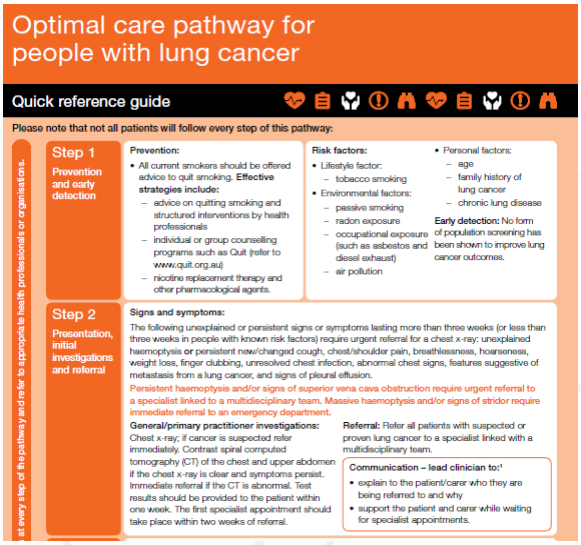



# Optimal care pathways

Developed by Cancer Council Victoria and the Victorian Department of Health



Optimal care pathway for people with lung cancer

Quick reference guide

Please note that not all patients will follow every step of this pathway:

Step 1 Prevention and early detection

**Prevention:**

- All current smokers should be offered advice to quit smoking. **Effective strategies include:**
  - advice on quitting smoking and structured interventions by health professionals
  - individual or group counselling programs such as Quit (refer to www.quit.org.au)
  - nicotine replacement therapy and other pharmacological agents.

**Risk factors:**

- Lifestyle factor:
  - tobacco smoking
- Environmental factors:
  - passive smoking
  - radon exposure
  - occupational exposure (such as asbestos and diesel exhaust)
  - air pollution
- Personal factors:
  - age
  - family history of lung cancer
  - chronic lung disease

**Early detection:** No form of population screening has been shown to improve lung cancer outcomes.

Step 2 Presentation, initial investigations and referral

**Signs and symptoms:**

The following unexplained or persistent signs or symptoms lasting more than three weeks (or less than three weeks in people with known risk factors) require urgent referral for a chest x-ray: unexplained haemoptysis or persistent new/changed cough, chest/shoulder pain, breathlessness, hoarseness, weight loss, finger clubbing, unresolved chest infection, abnormal chest signs, features suggestive of metastasis from a lung cancer, and signs of pleural effusion.

Persistent haemoptysis and/or signs of superior vena cava obstruction require urgent referral to a specialist linked to a multidisciplinary team. Massive haemoptysis and/or signs of stridor require immediate referral to an emergency department.

**General/primary practitioner investigations:**

Chest x-ray; if cancer is suspected refer immediately. Contrast spiral computed tomography (CT) of the chest and upper abdomen if the chest x-ray is clear and symptoms persist. Immediate referral if the CT is abnormal. Test results should be provided to the patient within one week. The first specialist appointment should take place within two weeks of referral.

**Referral:** Refer all patients with suspected or proven lung cancer to a specialist linked with a multidisciplinary team.

**Communication – lead clinician to:**[1]

- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

at every step of the pathway and refer to appropriate health professionals or organisations.

From cancervic.org.au

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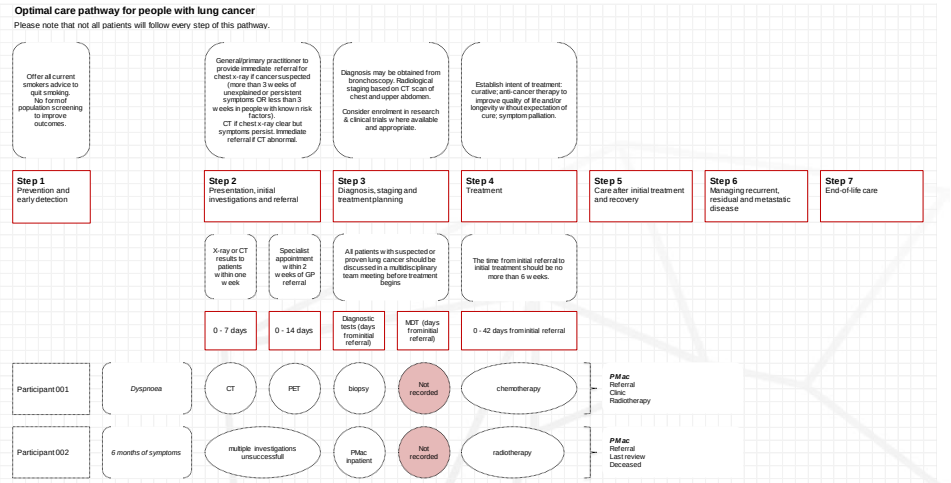


# Limitations

- Small dataset
- Hospital population
- No patient perspective
- Complex data collection

## Future directions

- Optimal care pathways
- Larger samples
- Focus on specific treatments and processes

## Questions?

## Thank you for your time