

# Examining the multidisciplinary models of care of prostate cancer patients: phase one travel report

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This project was undertaken to examine the multidisciplinary models of care of prostate cancer patients. Specifically, the travelling fellowship was utilised to explore the provision of nursing and psychological support to prostate cancer patients at three centres of excellence in the United States of America:

1. University of California Los Angeles, Clark Urological Center, Los Angeles, California, USA
2. Walter Reed Army Medical Centre: Centre for Prostate Disease Research; Washington D.C.; USA
3. Memorial Sloan-Kettering Cancer Centre: Sidney Kimmel Centre for Prostate & Urological Cancers; New York, NY; USA.

**Acknowledgements:**

We would like to sincerely thank the Victorian Quality Council, the Statewide Quality Branch of the Department of Health, for providing us with such a wonderful opportunity. Our experiences have been fantastic and we hope that the relationships formed as part of this fellowship will enhance our work into the future.

Thank you to Paula Marsh for facilitating this experience, the Department of Urology and Royal Melbourne Hospital for supporting us in this endeavour.

Addie Wootten and Emma Birch

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## **Project summary**

### **Rationale/purpose of the project**

Cancer of the prostate (CaP) is the most common cancer diagnosis in Australia (excluding non-melanocytic skin cancer) with 13,526 new cases diagnosed in 2003 (AIHW, 2007). It is estimated that over 18,000 new CaP diagnoses will be made in 2008 Australia wide and CaP have surpassed any other form of cancer, including breast cancer. While the incidence of CaP is growing, treatment of localised disease has become very effective and many patients are reportedly living with it rather than dying from it. Whilst improvement in treatment options continues, patient care has now moved from not only the medical treatment of disease but towards a multidisciplinary approach to care, patient support and education (Hudak et al., 2008). Significant long-term issues have been identified in the CaP population including incontinence, erectile dysfunction, relationship difficulty and emotional disturbance.

Currently there is no specialised prostate cancer nursing position in the public health sector, despite the growing body of research literature indicating the significant impact of prostate cancer on patient quality of life and clinical care needs during recovery from radical treatment. There is also a lack of routine provision of psychological support to patients and their families. There is a large gap in the care provided to prostate cancer patients when compared to the care received by breast cancer patients. Therefore, there is a need to survey these models of care in order to enhance the care provided in Victorian hospitals.

The purpose of this project was to identify 'best practice' models of multidisciplinary supportive care for prostate cancer patients, travel to these centres and learn from their expertise with the aim of improving the care of prostate cancer patients in Victoria.

Nursing focus: phase one consisted of studying the various models of nursing care delivered at three internationally recognised centres of excellence to patients diagnosed with prostate cancer. It examined the framework of care with reference to best treatment options and decision making, acute clinical care, and ongoing follow up and support provided to patients to minimise consequences of treatment such as incontinence and erectile dysfunction. The project also examined evidenced based best practice guidelines for multimodal treatment of patients with prostate cancer and how best to co-ordinate this individualised treatment and communicate to all relevant parties, such as patient, GP, urologist, radiation oncologist, medical oncologist, psychologist and nurse.

Psychological focus: phase one examined the psychological, social and emotional support routinely delivered to prostate cancer patients at the identified centres of excellence. In particular, details of the structure of supportive care delivery was identified, including psychology contacts, social work contact and other emotional supports routinely provided to prostate cancer patients and their families. This phase also explored the screening tools used to assess distress/emotional support needs, and the information regularly provided to patients and families as well as the timing of the delivery of information and support.

## Top three outcomes

1. Multidisciplinary Prostate Cancer Clinic: a patient-focused approach in delivering education and support pivotal in providing information to patients to make a treatment decision that optimises cancer control and empowers patients in coping with their disease.
2. The CAISIS database: a system of patient management and documentation that enables concise and efficient record keeping. It improves patient flow and decreases missed appointments with outpatients and clinical trial scheduling.
3. Survivorship Program: a follow-up clinic that promotes wellness and education as well as surveillance post treatment for prostate cancer, kidney cancer and bladder cancer.

## Main activities undertaken

### University of California Los Angeles; Clark Urological Center – Los Angeles, California, USA

- Observation and discussion with senior medical and nursing staff as well as administration and support staff.
- Observation of the assessment of patients and running of outpatient clinic.
- Observation of the IMPACT nursing model at UCLA. This model addressed pre- and post-treatment contact with prostate cancer patients from low socioeconomic populations and their families; including the nursing and psycho/social support systems provided to both patients and their families.

### Walter Reed Army Medical Centre: Centre for Prostate Disease Research – Washington DC, USA

- Observation of the Multidisciplinary Prostate Cancer Clinic provided a unique opportunity to participate and observe the multidisciplinary counselling and consultative service to patients newly diagnosed with prostate cancer.
- Observation of weekly department research meeting and discussion of current portfolio of clinical trials and discussion of which patients could potentially be appropriate for these trials.
- Followed Drs McLeod and Brassell in performing their clinic procedures.
- Attended the Basic Science Research Program laboratories.
- Observed the NCI/CPDR clinic which provided counselling to the advanced stage prostate cancer patients.

### Memorial Sloan Kettering Cancer Centre: Sidney Kimmel Centre for Prostate & Urological Cancers – New York, USA

- Met with Maryellen O’Sullivan, Nurse Manager of the urology Department Outpatient Centre to obtain an overview of the services provided.
- Met with Kevin Reagan, CAISIS database manager to discuss the patient information database utilised by MSKCC.
- Met with the behavioural research and psycho-social care team: Dr David Kissane, Dr Talia Zaider, Dr Andy Roth, Dr Christian Nelson to discuss psycho-social research and patient support services.

- Meet with key urologists to discuss their specialty areas of patient care: Dr Jonathan Coleman, radical prostatectomy; Dr John Mulhall, sexual rehabilitation; Dr Jaspreet Sandhu, continence.
- Meet with nurse practitioners Joe Narus, sexual medicine, and Mary Schoen, survivorship, to discuss nurse led clinics and patient follow-up.

## Major learnings

- Multidisciplinary Prostate Cancer Clinic
- Patient data registry

## Lessons for the Victorian healthcare system

### 1. Multidisciplinary Prostate Cancer Clinic

Multidisciplinary care of prostate cancer patients in the USA was a common theme across all hospitals visited. It was evident that it promoted a patient-centred approach and a collaborative environment in which to treat patients. Patient outcomes were reported to be excellent and efficiency in the system maximised.

Establishing an outpatient clinic for CaP patients to streamline their consultation process with a radiation-oncologist, urologist, psychologist and nurse to educate and inform patients about treatment options would be advised. This model has been shown to reduce patient anxiety, increase patient satisfaction with their treatment decision and improve their ability to cope with associated side effects of treatment. It also increases time efficiency and productivity of staff at no extra cost in physical facility or personnel staff. This comprehensive framework prior to treatment has the potential to decrease patient length of stay in the hospital.

### 2. Patient data registry

The centres of excellence visited in the USA routinely utilised an effective and efficient patient data registry system. This method of data collection enhanced patient care and facilitated research.

There is an absence of centralised data collection for outcome evaluation and collaboration between the major care providers in prostate cancer care across Australia is required. A centralised data collection system would enable greater understanding of how effective prostate cancer treatment is in a curative sense by surgery, radiation, brachytherapy and other modalities. The development of a systematic and objective dataset on each patient should be obtained including:

- pre-treatment PSA
- patient age
- Gleason score
- cancer stage
- biopsy patterns
- biopsy volume
- continence status
- sexual function

- quality of life
- post treatment outcome assessment by PSA, continence, sexual function, quality of life, morbidity and mortality.

This dataset would allow greater understanding of the disease and treatment process and outcomes and lead to increased consensus as to treatment of choice based on disease status.

Prostate cancer, unlike many other cancers, does not have clear guidelines available and the development of a database would inform the development of such enabling enhanced patient information and communication, increasing treatment outcomes and peace of mind for patients and their families.

## Description of the study itinerary

### The healthcare organisations:

1. University of California Los Angeles; Clark Urological Center; Los Angeles, California, USA
2. Walter Reed Army Medical Centre (WRAMC): Centre for Prostate Disease Research (CPDR); Washington D.C., USA
3. Memorial Sloan Kettering Cancer Centre: Sidney Kimmel Centre for Prostate & Urological Cancers; New York, NY, USA

### University of California Los Angeles Prostate Cancer Center; Los Angeles, California, USA

- Mrs. Glenda Hale, Chief Administrative Officer Department of Urology
- Ms. Nazy Zomorodian, Director Clinical Trials
- Ms. Marian Haskins, Clinical Team Manager and Laura Baybridge, Program Administrator IMPACT Program
- Dr. Pantuck, Associate Professor Department of Urology; Director, GU Oncology, Jonsson Comprehensive Cancer Center; Director of Translational Research, UCLA Kidney Cancer Program; Co-Director, Integrative Urology Program
- Ms. Ting Ting Yuan, Clinic Administrator
- Dr. Rettig, Chief, Division of Hematology-Oncology VA Greater Los Angeles Healthcare System, West Los Angeles; Associate Professor, David Geffen School of Medicine at UCLA
- Dr. Marks, Professor Department of Urology
- Ms. Lauren Whitted, Coordinator for the SPORE in Prostate Cancer

### Walter Reed Army Medical Centre: Centre for Prostate Disease Research; Washington, D.C., USA

- Jane Hudak, Nurse; Head, patient education
- Dr McLeod, Urologist; Head, Centre for Prostate Disease Research
- Mr Mario DaRocha, Department manager
- Dr Brassell, Attending Urologist
- Ms. Mary McGarvey, Nurse
- Ms. Judi Travis, Research Nurse
- Ms. Maryellen Colston, Research Nurse
- Ms. Amina Ali, Research Scientist
- Dr. Leslie Cooper, Psychologist
- Dr. Robert Dean, Urologist, sexual medicine
- Ms. Ginger Lew-Zampieri, Physicians assistant
- Mr. Norbert Stingle, Manager
- Dr. Shiv Srivastava, scientist
- Gyorgy Petrovics, Assistant Director of basic science program
- Ms. Kimberly Peay, Nurse practitioner
- Ms. Sally Elsamanoudi, database manager

**Memorial Sloan Kettering Cancer Centre: Sidney Kimmel Centre for Prostate & Urological Cancers; New York, NY, USA**

- Maryellen O'Sullivan, Nurse Manager
- Kevin Reagan, Caisis Program Manager
- Dr. David Kissane, Director of Behavioural Research
- Dr. Talia Zaider, Attending Psychologist
- Dr. Andy Roth, Attending Psychiatrist
- Dr. Christian Nelson, Attending Psychologist
- Dr. Jonathan Coleman, Department of Surgery, Urology Service
- Dr. John Mulhall, Director, Sexual Medicine Program
- Mr. Joe Narus, Nurse Practitioner (Sexual Medicine)
- Ms. Mary Schoen, Nurse Practitioner (Survivorship)
- Mr. Richard Glassman, Clinical Social Worker
- Dr. Jaspreet Sandhu, MD, Urological Continence

## **The activities undertaken during the visit**

### **University of California (UCLA), Los Angeles, Clark Urology Center, Los Angeles, California, USA**

#### **An overview of Clark Urology Centre, UCLA**

UCLA is comprised of two main hospitals: Ronald Reagan, a level one trauma centre and Santa Monica, a community service centre with general medicine, general paediatrics and general obstetrics/gynaecology. It employs over 80,000 people with a combined bed capacity of 860 inpatient beds.

The Santa Monica division of UCLA has a urology department that is comprised of four urologist consultants with one urologist employed as a full time clinician and the remaining three urologists employed half time as clinicians and half time as researchers working on population research, clinical outcomes research and epidemiology.

The Clark Centre at the Ronald Reagan campus of UCLA is an academic urology department. UCLA follows an institute model whereby patients are managed by tumour streams rather than medical specialties which allows the urology department to stand alone rather than under the management of a division of surgery. The department consists of 28 full time urologists and eight fellows, they perform approximately 300 surgeries a month, half of which are done as outpatients (discharged at 7am). A quarter of these surgeries are radical prostatectomies and less than half of these will be robotic. Average length of stay for RRP is one day and therefore these patients stay in day recovery until discharge.

Each urologist consultant has a full time assistant who co-ordinates the patient care and the doctor's time. This helps create individualised patient support. In the outpatient clinics patients are seen by their treating surgeon and nurses perform any assessments, simple investigations at the time of their visit. All appointments and co-ordination of their care is organised by the one assistant working with that specific urologist. However, this individualised system of care delivery was noted to be more costly than providing patients with a centralised telephone contact and booking system.

The fellowships offered tend to be two years, one year clinical and one year research in the sub-specialties of public health, endo-urology, female research and uro-oncology. UCLA is considered to be in the top four for fellowship trainee programs in the USA.

The residents program at UCLA is six years which includes one year of research, to prepare them for academic careers in medicine. Residents manage the inpatient workload and attend the outpatients at Santa Monica which is more general urology.

The majority of patients seen at UCLA will have private health insurance. The urology department at UCLA aims to treat each new patient within two weeks and for robotic surgery within a month. For patients diagnosed with a cancer without insurance they can either apply for Medicaid, a form of Medicare, which is a government program.

UCLA, amongst the majority of other hospitals in the region, undertake stringent patient satisfaction research each year; the results of which are benchmarked and hospitals are ranked according to this patient feedback. This competition between hospitals appears to create an environment whereby patient satisfaction and support is highly regarded and patients will often travel to UCLA because of its reputation in this aspect of patient care.

## **Research at Clark Urology Centre, UCLA**

### ***Clinical trials:***

The Department of Urology at UCLA has an extensive clinical trial program. Each of the 28 urologists have clinical, research and teaching responsibilities and there are 30 active trials within the department; 50 per cent are kidney trials and 50 per cent prostate trials.

The Department of Urology is developing an Institute for Urological Oncology where multidisciplinary collaboration will be fostered. This institute will bring together researchers and clinicians from urology, medical oncology, radiotherapy and basic science research. This institute aims to translate research from the bench to the bedside and hopes to drive research from the clinical perspective.

The urologists have formed their sub-specialties by disease and when a new patient comes in for their first consult, it is seen as a priority to offer them a trial. Should they not meet eligibility or decline the offer of a clinical trial, they will then receive the standard care.

Clinical trials are staffed very well and there is a team approach in conducting the clinical trials. The patient is seen by the urologist then the clinical trial director will see them and explain the trial and consent. Administration officer will co-ordinate and book their subsequent visits, technicians will take bloods, observations and have the patients complete any questionnaires, the urologist will perform any physical assessments, administration will pack and post any specimens and the clinical trial director will see the patient and complete the consent forms.

### ***SPORE:***

There are nine Specialised Program of Research Excellence (SPORE) for prostate cancer in the USA. UCLA is one of these sites and receives federal funding of \$2.5 million per year for five years for prostate cancer research. This money supports a range of research areas both at UCLA and across California.

## **The IMPACT program of Prostate Cancer Nursing, UCLA**

In 2001 Dr Mark Litwin, Urologist, commenced the IMPACT program across the state of California. This program offers prostate cancer treatment and ongoing support to men from low socio-economic backgrounds. The program has 800 providers, state wide, providing treatment to men in their own community, funded through the IMPACT program. The patients enrolled in the program have an average age of 61 and the majority have advanced disease.

The IMPACT program is a nurse-led telephone intervention. The nurse conducts an initial assessment over the telephone to screen for eligibility and any immediate problems (such as homelessness). The nurse then links the patient with a provider in their community taking into account factors such as treatment type, language, transport. The follow-up nurse management is based around a symptom management assessment (for example, pain medications, treatment they receive and its side effects, relationships at home and intimacy issues, bother with urinary, bowel symptoms and work and its influence on the family) and the nurse may link patients to social supports or any other supports required.

Once the patient has ceased active treatment, non-nurse coordinators take over the patient management role. These coordinators are bilingual and maintain the routine follow-up of patients.

These coordinators complete simple follow up phone calls following a yes/no protocol and referring back to the nurse when necessary.

There are three full-time nurses and one part-time, with a case load of approximately 140 patients. Approximately 45 of these patients at any one time will be receiving active treatment and the nurse will be actively phoning and coordinating care of treatment. The remaining patients will be followed by the non-nurse coordinator using a scripted interview.

Patients are screened for eligibility by:

- financial criteria – must have an income less than 200 per cent above the federal poverty level
- residential criteria (self report) – patients must reside in the state
- histopathology – copy of their prostate biopsy.

Patients then sign a contract for 12 months and are then screened annually as financial circumstances may change.

Outline for six monthly phone Interview:

- urinary function
- bowel function
- sexual function
- pain
- medications
- hormones and your body
- nutrition
- community resources.

IMPACT uses a sophisticated patient database where all patient information is held. Patients consent to take part in the outcomes research that is conducted as part of the program.

<b>Key areas of the nursing model of care for prostate cancer patients at UCLA</b>
<ul style="list-style-type: none"><li>▪ Each urologist directs his/her team of people (including nurses) who conduct assessments and coordinate the care for CaP patients.</li><li>▪ In the outpatients clinics, the patients are seen by their treating urologist and the nurse will perform any clinical investigations that are required before or during the consultation, such as flexible cystoscopy, urodynamics.</li><li>▪ Clinical trials are viewed as a priority to be offered to all new CaP patients. A nurse practitioner coordinates the 30 active trials within the urology department.</li><li>▪ The IMPACT program: nurses liaise by phone with men with prostate cancer and no health insurance to advise them which healthcare providers they can seek treatment from within their own community. The Impact team places focus on selecting evidence based interventions designed to improve clinical outcomes for a population of low-income men following treatment for prostate cancer.</li></ul>
<b>Key areas of the Psycho-social model of care for prostate cancer patients at UCLA</b>
<ul style="list-style-type: none"><li>▪ Patients are not routinely formally screened for psychological distress in the main</li></ul>

- Patients are routinely screened for psychological distress in the IMPACT program (men who are living on a very low income, unemployed or homeless) by the nurse or patient coordinator and referred to appropriate services in the patient's community.
- Patients are referred to the UCLA psychology services by the urologist if required.
- Patients receive high levels of individualised service and support from the treating team which could mitigate high levels of distress via the provision of this practical support.

### **Walter Reed Army Medical Centre, Centre for Prostate Disease Research (CPDR), Washington, D.C., USA**

The CPDR is a unique centre that was developed five years ago as a research centre to combine prostate screening, data collection, clinical diagnosis, education, counselling, and research in an efficient, personal, patient orientated centre.

Walter Reed Army Medical Centre is a hospital for military employees and retirees and to receive treatment at the hospital patients must currently be on active duty or have completed more than 20 years in the military. The hospital is funded by the department of defence and the CPDR sees approximately 8,000 patients per year.

The CPDR is affiliated with the urology department but functions independently and only treats prostate cancer patients.

#### **Multidisciplinary clinic at CPDR:**

Each Monday the multi-disciplinary prostate cancer clinic is conducted. Patients have had their biopsy performed in the outpatients/day centre and the results are rung through to them by the physician that performed this. They are then contacted by phone by a nurse who runs through the procedure of the multidisciplinary clinic on a Monday and posts out questionnaires (SHIM, IPSS, QOL). This clinic runs every Monday with approximately six newly diagnosed patients, local and advanced CaP and their partners +/- families.

The multidisciplinary clinic was designed and implemented following Lewin's (1947) force-field analysis model framework to change the clinical process for newly diagnosed CaP patients to improve both patient care and research opportunities. A nurse educator and coordinator manage a 'one-stop care' where all appointments are conducted within one day. This is convenient, time efficient and emotionally reassuring for patients and their families. It is a non-competitive team approach with the surgeon and radiation oncologist, which enhances patient and provider satisfaction, and system efficiency without substantial changes in the physical facility or personnel staff. The clinic creates a 'sense of community' for the patients and strengthens their confidence in providers as well as in suggested treatments. The providers find patients have an increasing understanding of the disease and satisfaction with their treatment choice and tend to foster a loyalty to the department allowing for more effective marketing, follow-up and research recruitment. The multidisciplinary clinic has created a professional environment with a patient-focused approach, staff are committed to operationalising the essence of quality cancer care as patients and their families are informed decision makers for their treatment.

The multidisciplinary clinic is conducted using a patient centred approach in which education and support is the main focus. The group of newly diagnosed patients assemble in the meeting room at the start of the day. The day runs from 7.30-15.00, group sessions are in a conference room

and each patient is allocated a private consulting room where the health professional comes to them for the consultation and the physical examination. Each patient will see a urologist, a radiation oncologist and a psychologist privately on the day. These individual consultations fit around a series of group education sessions on prostate cancer and sexual functioning. Across the day patients are also asked to consider taking part in the centre's research and patients will be screened for possible clinical trial involvement. Blood tests and urine samples are taken on site and questionnaires collected. While patients have lunch the team meets to discuss each patient. The fellow presents each patient and each team member presents their opinions as to the patient's suitability for each treatment and the psychologist shares insights to family dynamics and possible decision making concerns. This meeting can take 20 minutes to one hour; at the end of the meeting each clinician will go back to the patient and inform them of the outcomes of the meeting.

### **Patient education groups**

#### ***Prostate cancer overview***

Dr Jane Hudak conducts an education session outlining the details of prostate cancer including the anatomy of the prostate, the treatment options for prostate cancer and what the PSA and Gleason scores mean. This session allows patients to ask questions about prostate cancer in an interactive and relaxed environment.

### **Research**

Dr Jane Hudak and Mary McGarvey inform patients about the research that the centre is involved in. They discuss why research is being conducted and encourage patients to take part. Patients are able to ask questions about the research and discussion is often generated. This educational session often leads to many patients participating in the research. Patients are informed about the prostate cancer data registry. This database started in 1992 and has been running for 16 years and is now across six sites, one of which is a civilian hospital. The CPDR has over 23,000 patients on their database with over a total of 50,000 specimens (urine, blood and tissue). Their ongoing treatments and details are also collected and maintained; Gleason, PSA, treatment and questionnaires. Of that 50,000 specimens, 43,000 are prostate specimens, (400 slides of 12-13 blocks, six frozen cores, one lump). The database also includes any tissue from prostate procedures for example, TURP as it is designed to capture the patient from the beginning of his prostate disease. There is a high rate of consent to participate in research at this military hospital and it is thought to be because of the army mentality, 'part of the army family'.

If patients consent to take part in the prostate cancer data registry blood tests, urine samples and questionnaires are completed on the multidisciplinary day, before treatment.

#### ***Sexual health education***

Dr Robert Dean (Colonel) conducted a one hour lecture about sexual functioning and prostate cancer. He reviewed the literature around rates of emergency department (ED) associated with each treatment option, discussed PDE5 inhibitors, muse, injections, VED, and IPP. He also covered the types of ED which may occur, including anorgasmia, shorting penis, no ejaculate, urine leakage on orgasm, and peyronies. A detailed discussion around these issues prior to treatment is thought to provide patients with realistic expectations for recovery after treatment.

## Research

Research is an integral part of the CPDR program and patients are actively encouraged to be participants. Each Thursday morning a research meeting is conducted in which each project is briefly summarised and the team is updated. This meeting serves as a good reminder of which studies are open to recruitment and the types of patients that might be eligible.

CPDR has a range of clinical trials open to patients and they try to engage in studies across each phase of prostate disease (localised to advanced).

The CPDR also has a separate basic science facility where lab work is conducted and prostate tissue banking occurs.

<b>Key areas of the nursing model of care for prostate cancer patients at Walter Reed Army Medical Centre, CPDR</b>
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| <ul style="list-style-type: none"><li>▪ Nurses coordinated the multidisciplinary clinic. Their role was one of patient education and support.</li><li>▪ Prostate cancer screening is managed by a nurse practitioner, includes assessing risk factors, PSA and DRE.</li><li>▪ Post treatment patients once stable are managed for PSA recurrence and possible urinary and erectile dysfunction by a nurse practitioner.</li><li>▪ Research nurses manage the 20 active clinical trials following a prostate continuum.</li></ul> |
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**Key areas of the psycho-social model of care for prostate cancer patients at Walter Reed Army Medical Centre, CPDR**

- Patients are routinely assessed by the psychologist in the multi-disciplinary clinic prior to treatment decision.
- The psychologist is involved in the multi-disciplinary team meeting to discuss each patient and their treatment options.
- Patients can be referred to the psychologist at any stage by the nurse or urologist.
- Patient education aims to reduce distress and empower patients.
- Patient education conducted in group format.
- Support groups conducted monthly for both the patients and their partners (separately).

**Memorial Sloan Kettering Cancer Centre (MSKCC), Sidney Kimmel Centre for Prostate & Urological Cancers, New York, NY, USA**

**An overview of the Kimmel Centre for Prostate and Urological Cancers, New York**

Memorial Sloan Kettering Cancer Centre is one of the foremost cancer centres worldwide. The Kimmel centre for prostate and urological cancer has been running according to a disease management model for the last ten years, a collaboration between GU and oncology. The centre is housed in a stand-alone building with both clinical and academic space. The centre has 17 urologists, each with their own subspecialties (for example, one surgeon for sexual health and one surgeon for incontinence). Each newly diagnosed prostate cancer patient will be managed by a team comprising the consultant, fellow, registrar, two nurses and a PA. Each team (one consultant) sees about 30–60 patients per outpatient clinic.

Multidisciplinary team discussions occur prior to the patient attending the clinic and there is a six week waiting list to be seen at outpatients. More than 1,500 radical prostatectomies are performed each year (773 open, 545 lap, 205 robotic) and approximately 5-7 TRUS biopsies per day. They have 17 nurses in the GU centre and four technicians.

**Patient database**

Caisis database is an open source database developed by the Urology department since 2004; [www.caisis.org](http://www.caisis.org). It is web-based and utilises very limited computer space.

This is a comprehensive patient management database that is integrated into the MSKCC clinic via both paper forms which are uploaded into the system or via the utilisation of web-based form. The information entered into CAISIS generates a report on each consultation that is then entered into the patient medical record. Currently this database has more than 120,000 patients entered into the system for MSKCC and the database is used worldwide, Westmead and the University of Sydney are using it.

The database is also utilised for clinical trial scheduling and allows scheduling of patient data collection. It also allows clinicians easy access to information about what trials the patient is involved in or eligible for. The database only provides limited query's to be run but can be linked to an access or excel database for more unique analyses.

MSKCC database staff offer free support and consultation to set up the program as well as limited help in adding features specific to the hospital.

### **Behavioural research**

MSKCC has a large behavioural research department which conducts a range of research projects in the area of prostate cancer. Headed by Dr David Kissane they are currently conducting a couple based intervention for localised prostate cancer patients as well as an intervention for advanced prostate cancer patients. Their research has shown that couple based interventions are useful for many couples dealing with prostate cancer. Feedback from participants also suggests that patients feel that they would have liked to be offered psychological therapy prior to treatment.

At MSKCC every patient is screened with the distress thermometer and a referral is generated based on the area of distress (e.g. housing or accommodation would generate a referral to social work). Patients have access to psychology, psychiatry and social work.

Psychological therapy is routinely offered to prostate cancer patients undertaking the sexual rehabilitation program overseen by Dr John Mulhall. The psychologist will meet briefly with every new patient to screen for psychological problems and to inform patients of the service.

### **Sexual Rehabilitation Program**

Under the direction of Dr John Mulhall the sexual medicine clinic is offered to all prostate cancer patients following treatment for prostate cancer. Sexual rehabilitation is seen to be an imperative part of recovery post treatment and all patients are encouraged to utilise oral medication commencing prior to surgery.

A strict regimen is followed whereby injection therapy is started very soon after surgery if erections are not occurring with oral medication. Patients are informed of this prior to surgery and encouraged to see this rehabilitation program as an essential component of their cancer treatment and recovery. 97 per cent of the urologists will refer their prostate cancer patients to the sexual medicine clinic after radical prostatectomy. The clinic is staffed by the urologist who sees all new patients. The nurse practitioner will then see all follow-up appointments and manages the sexual rehabilitation of the patient under the guidance of the urologist. The psychologist plays a key role in working through any psychological difficulties encountered by the patient or the couple. Issues of intimacy are common amongst couples following radical prostatectomy.

#### **Key areas of the nursing model of care for prostate cancer patients at MSKCC**

- A newly diagnosed CaP patient is managed by a physician's team; urologist, fellow, registrar, two nurses and a personal assistant. They see 30-60 outpatients in a day and are part of the multidisciplinary team discussion before the patient comes to clinic.
- There are 17 nurses in the genito-urinary centre performing procedures such as; TRUS biopsy, urodynamics, flexible cystoscopy and day patient chemotherapy.
- Nursing documentation is kept concise and efficient by utilising the CAISIS database for consultation reports that can be entered into the medical record. It improves patient flow and decreases missed appointments with outpatients and clinical trial scheduling.
- Male Sexual Health Program – supported by one nurse practitioner and available to all cancer patients at MSKCC. Penile rehabilitation post RRP is encouraged and involves approximately six individual nursing appointments in outpatients over two years.

- Survivorship Program - managed by one nurse practitioner and one secretary. Prostate cancer, kidney cancer and bladder cancer patients are referred to this clinic for ongoing follow-up, usually six months post their surgery. The nurse conducts a physical exam, orders blood work such as PSA, and any scans to monitor for cancer recurrence. The remainder of the appointment places focuses on wellness, diet and exercise. The program follows 16,000 patients and includes screening referrals to other departments within MSKCC under the NCCN guidelines.

**Key areas of the psycho-social model of care for prostate cancer patients at MSKCC**

- All new cancer patients at MSKCC are screened for distress using the distress thermometer and referrals are generated from this screening tool.
- Psychology, psychiatry and social work services are available to all prostate cancer patients on referral.
- No psycho-social support is routinely provided at the point of diagnosis unless requested. Often patients are diagnosed elsewhere and travel to MSKCC for treatment.
- Social work services are routinely provided to inpatients while receiving treatment.
- Psychology services are provided to each patient attending the sexual medicine clinic at the commencement of this treatment in the clinic setting. The psychologist attends the clinic with the medical team.
- Individual and couple therapy is available in the sexual medicine service.
- Psychiatry services are available to the sexual medicine patients on referral.
- Psychiatry services routinely staff the medical oncology prostate cancer clinic (for advanced disease) and all patients can be referred to psychiatry in the same clinic in which they receive their medical care.
- MSKCC has a large number of research projects examining the efficacy of couple and group-based interventions for men with prostate cancer, and their partners.

## **Approaches observed in overseas jurisdictions**

Multidisciplinary management of prostate cancer patients was highlighted at each institution visited. Patients were either actively encouraged to speak about treatment options with both a urologist and a radiation oncologist at their own discretion or were seen by both specialties in the same clinic. Nursing support was seen across all hospitals visited and many sites visited utilised nursing staff to actively follow-up patients post treatment.

Patient education was also highly regarded across each site visited. Patients received comprehensive reading information and urologists also confirmed that they spent time discussing issues of post treatment recovery with patients prior to treatment. Walter Reed Army Medical Centre took the issue of patient education one step further in that it held extensive pre-treatment patient education classes that all newly diagnosed prostate cancer patients were required to attend.

Research was also an important aspect of patient care at each hospital site visited. Patients were actively encouraged to take part in research and reminders were given routinely on follow-up appointments. Long-term data was stored in patient data registries at each site visited and tissue banking was also commonly used.

Patient support differed at each site depending on available resources. Each site, however, agreed that patient support from the point of diagnosis was essential. MSKCC have embedded psychological and psychiatric support into their medical clinics and it was routine for patients at this hospital to be referred to these services.

### **Evidence supporting key approaches**

Research conducted at Walter Reed Army Medical Centre suggests that the design and implementation of a multidisciplinary prostate cancer clinic can enhance quality care, patient and provider satisfaction, and system efficiency without substantial changes in the physical facility or personnel staff (Hudak et al., 2007). This research indicates that patient needs can be more adequately and effectively met by a team-based approach where all aspects of the cancer experience can be managed.

MSKCC has published reports detailing the importance of screening for psychological distress and the need to use this information in referral of the patient to appropriate services (Roth et al., 1998). They have found that patients are willing to engage in screening but that often the screening process can be undermined when referral to services does not occur.

It is well documented that people who feel supported and have their needs met are less likely to burden the healthcare system in terms of unnecessary appointments, health complaints and hospital admissions. Patients who have received education and support around their area of need will be less likely to require intensive levels of support. Hence, providing education and support in a structured and routine manner can reduce the costs associated with complex hospital admissions or ongoing health complaints.

## **Key lessons learned**

Multidisciplinary cancer management has been the best practice model of care for many years. However, the implementation of this style of patient care has not been successful in all areas of cancer care and there have been many barriers in truly implementing a holistic approach to care.

In order to implement a cohesive and effective multidisciplinary model of prostate cancer care into a public hospital facility, a number of factors need to be considered.

- Hospital and department management must be supportive of a change towards multidisciplinary management.
- Communication between each member of the treating team must be maximised and patient information must be easily accessible.
- Practical aspects must be considered:
  - consultation/treatment space must be available
  - administrative support is required for patient appointment coordination and management
  - access to interpreters.

In order to overcome any biases or prejudices in implementing a multidisciplinary model of care education must also be included in the development of the model. Healthcare providers must understand the reasons behind the model and benefits of utilising a model of multidisciplinary collaboration for both the patient and the healthcare team or system.

## **Factors that would facilitate or block introduction of these key approaches to public healthcare in Victoria**

In order to facilitate the introduction of a multidisciplinary model of care for prostate cancer patients into the Victorian public healthcare system a number of considerations must be made.

- Working relationships must be formed between departments of urology, radiation oncology and medical oncology.
- Access to staff must be available:
  - a urology nurse trained in the area of prostate cancer
  - a psychologist or other qualified counsellor with expertise in the area of oncology and relationship therapy
  - financial consideration needs to be made for payment for consultant session if travelling across hospital sites.
- Access to trained interpreters would be required to facilitate the provision of patient care, education and support to non-English speaking patients.
- Timely access to pathology and other investigations.
- Access to patient records held by other institutions – on-line patient records are highly recommended.

## **Suitability to Melbourne Health practice and the Victorian healthcare system**

Many of the learning's obtained from the centres of excellence visited as part of *Phase 1* of this travelling fellowship can be translated into our own practice at Royal Melbourne Hospital. There were many similarities between our own practice and that observed overseas. However, the main area of inefficiency in our practice was our lack of clear model of care and structured

multidisciplinary clinic. Access of patient information was also an area they excelled in and one areas of improvement for our patient management.

It was evident, however, that the resources available in the centres of excellence visited were far superior to the resources available in the public health sector in Victoria. As such it would not be possible to replicate in entirety what was witnessed in their centres. Having said that, however, we believe that excellence in patient care can be obtained without the high levels of resources witnessed overseas.

## **Improving the Victorian healthcare system**

### **Organisational impact**

A review of the way in which prostate cancer patients are supported and managed will be conducted, aiming to refine the multidisciplinary care of prostate cancer patients at Royal Melbourne Hospital. We aim to develop a comprehensive multidisciplinary patient-focused model of care with patient education and support at the focal point of care.

### **Next steps for local service improvement**

*Phase 2* will involve piloting a multidisciplinary supportive care model for prostate cancer patients at The Royal Melbourne Hospital for a period of six months. This pilot will take the form of a time series analysis of the impact of the model of care across a range of target variables. Data obtained at the pre-implementation phase of the multidisciplinary model will be compared to data obtained after the completion of the six-month pilot.

### **Next steps for promoting broader systems change**

Prostate cancer is certainly a disease commonly treated in the Victorian public healthcare sector and hence patient care and support should be relevant to each centre delivering this care. In developing a model that is efficient, effective and returning good patient outcomes, as well as not being resource intensive, this model could hold significant potential in being easily transferrable to other healthcare centres not only across Victoria but potentially Australia-wide. We aim to develop a step-by-step guide to the implementation of the multidisciplinary model of prostate cancer care so as to maximise transferability to other centres of prostate cancer care.

### **Key methods of monitoring service improvement outcomes**

As part of phase two of this project the development and implementation of the multidisciplinary model will involve review milestones across the course of the pilot period. Outcome measures will be utilised to assess patient flow, clinic efficiency, patient and health provider satisfaction. As part of the final stages of phase two an ongoing monitoring program will be developed.

### **Sharing and promoting the project**

- A presentation will be given to the Royal Melbourne Hospital Urology Department at their Multidisciplinary Unit meeting.
- *Phase 1* data will also be made available to WCMICS multidisciplinary review team for use in their audit of 'best practice' multidisciplinary care of cancer patients.
- Presentation will be given to the Victorian Urological Nursing Society (VUNS) and formally written into their annual newsletter
- An article will be provide to the Prostate Cancer Foundation of Australia.