Monash Health

Metastatic Breast Cancer

Nurse Practitioner

Model of Care

Report prepared by Monash Health, Nursing and Midwifery Education and Strategy Department for the Victorian Department of Health, Nursing & Midwifery Policy

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# Table of contents

Introduction .................................................................................................................. 2
Background .................................................................................................................... 2
  Metastatic breast cancer information and statistics .................................................. 2
  Treatments for MBC ................................................................................................. 2
  Supportive Care for MBC ......................................................................................... 3
  Identified Gaps in Supportive Care for MBC Patients ............................................ 3
  Reasons for these supportive care gaps include: ..................................................... 4
The Metastatic Breast Cancer Nurse Practitioner (MBCNP) Model of Care at Monash Health .......................................................................................................................... 4
  Advanced clinical nursing model of care ................................................................. 4
  Supportive care model of care ............................................................................... 4
  Patient centred (and patient advocacy) model of care ............................................ 5
  Care Co-ordination model of care ......................................................................... 5
  Multidisciplinary model of care ............................................................................. 5
  Separate model of care to existing BCN services .................................................. 6
  Community based model of care ......................................................................... 6
  Wellness model of care ......................................................................................... 6
Service parameters .................................................................................................... 7
  Client groups: ....................................................................................................... 7
  Hours of operation: .............................................................................................. 7
  Site/-settings: ....................................................................................................... 7
  Sources of referrals: .............................................................................................. 7
  Alignment with key strategy/policy directions: ..................................................... 7
Benefits of the MBCNP model of care ............................................................... 8
  Diagram 1: MBCNP Model of Care ................................................................. 9
  Figure 1: MBCNP Clinical Pathway .......................................................... 10
Governance and development within the role .................................................. 11
  Figure 2: MBCNP Governance Diagram .......................................................... 11
  Nurse Practitioner Candidate ............................................................................. 11
Glossary ..................................................................................................................... 12
References ................................................................................................................ 13
Introduction

It has been recognised by consumers both internationally and nationally that a supportive care gap exists for those patients with Metastatic Breast Cancer (MBC). In response to this Metastatic Breast Care Nursing roles have started to emerge in both the UK and Australia. At a local level this gap was also identified by a consumer member of the Southern Melbourne Integrated Cancer Service (SMICS) Breast Tumour Group. With a regional average of 31% of health service breast cancer episodes being comprised of women with stage 4 breast cancer, of whom 42% will be alive in three years it was proposed that Monash Health develop a Metastatic Breast Cancer Nurse Practitioner (MBCNP) role and Model of Care. The role requires specialised skills and knowledge to address the complex and varied supportive care needs of the MBC patient and will provide many benefits to MBC patients and their carers.

Background

Metastatic breast cancer information and statistics

Breast cancer is the most commonly diagnosed cancer in Australian women and remains the leading cause of death from cancer in women in developed countries. Early detection and improvements in adjuvant treatments are decreasing mortality rates in women diagnosed with Early Breast Cancer (EBC). However, as many as a third of these women will develop and die from MBC (Aranda et. al, 2005; Cancer Institute NSW, 2009; Cardose et. al. 2010; The Specialist Breast Nurse Project Team, 2000; Warren et.al, 2012; Watts et.al, 2011).

MBC, also commonly referred to as secondary or advanced breast cancer, is a stage IV disease that occurs when breast cancer cells spread from the first (primary) tumour in the breast through the lymphatic or blood system to other parts of the body. The most common parts of the body that breast cancer spreads to are the bones, liver, lungs and brain. MBC is now commonly being categorized as a chronic illness, with a median survival time of three years. With advancements in treatment, some women are living with their disease for as long as fifteen years (Aranda et. al. 2005; Bennet et. al. 2013; Cardose et. al, 2010; Warren et. al, 2012; Watts et.al. 2011).

In 2011-12, 956 MBC patients (6023 episodes of care) were treated in Southern Melbourne hospitals; of these 327 were treated at Monash Health (1955 episodes of care) (SMICS, 2013).

Treatments for MBC

Despite advancements in treatment, MBC remains an incurable disease. The main treatment goal is palliation, with the aim of maintaining/improving quality of life, and possible improvement in survival time. Many factors are taken into consideration when deciding which treatments to prescribe for MBC. These may include the single use, sequential use or combination of endocrine therapy, chemotherapy, surgery, radiotherapy and targeted therapies (Cardose et. al, 2010; Watts et.al. 2011). Some treatment modalities have been developed to be administered as oral therapies (eg: capecitabine and everolimus) or subcutaneous therapies (eg: trastuzumab and denosumab), meaning some patients now have the option of having their treatments in the ambulatory or community setting. This option significantly decreases the amount of times these patients need to come into hospital
for medical review and reduces face to face contact with health care providers (Cardose et. al, 2010; Warren et. al, 2012).

Supportive Care for MBC
Five inter-related domains of supportive care are described:
1. Physical domain: includes a wide range of physical symptoms that may be acute, relatively short-lived or ongoing, requiring continuing interventions or rehabilitation.
2. Social domain: includes a range of social and practical issues that will impact on the individual and family such as the need for emotional support, maintaining social networks, and financial concerns.
3. Psychological domain: includes a range of issues related to the person’s mental health, wellbeing and personal relationships.
4. Spiritual domain: focuses on the person’s changing sense of self and challenges to their underlying beliefs and existential concerns.
5. Information domain: transects the above domains with people needing to access information about their disease and treatment, support services and the health system overall. (Department of Health, 2013, p.9).

Women with MBC have high levels of unique, complex and unmet supportive care needs that can vary over time and differ from those with EBC (Breast Cancer Network Australia - BCNA, 2013; Watts et. al, 2011). According to Bennet et. al, 2013, p. 27), “the effect that a diagnosis of secondary breast cancer can have, cannot be underestimated as it can affect numerous areas and aspects of a patient’s life enormously, including finances, employment, supporting children and family, and lifestyle changes, in addition to the emotional burden”. Patients can also experience persistent physical symptoms from their metastatic cancer or from their treatment side effects such as pain, nausea, insomnia, depression or fatigue (BCNA, 2013; The Secondary Breast Cancer Taskforce, 2008). These needs are at their highest levels at the point of diagnosis, when treatment changes, and when disease progresses (Bennet et. al, 2013; The Secondary Breast Cancer Taskforce, 2008).

It is well documented in the literature that these patients have a greater degree of psycho-social and health information needs. Receiving news of a diagnosis or progression of their disease can be extremely distressing for patients and their families, with many reporting it being even more distressing than their original early breast cancer diagnosis (Aranda et. al, 2005; The Secondary Breast Cancer Taskforce, 2008; Watts et. al, 2011). Various studies have explored the support and information needs of women with advanced breast cancer. Their main concerns revolved around having a life-threatening condition and included:
- worries about those close to them
- living with a sense of uncertainty
- worries about loss of control
- requests for strategies for maintaining a state of wellness and quality of life (Aranda et. al, 2005; Aranda et. al, 2006; Watts et. al, 2011).

Identified Gaps in Supportive Care for MBC Patients
The literature consistently documents that women with MBC receive inadequate or inconsistent levels of support, health information and continuity of care compared to when they were first diagnosed with EBC (Aranda et. al, 2005; Bennet, et. al, 2013; Breast Cancer Care, 2012; The Secondary Breast Cancer Taskforce, 2008; Watts et. al, 2011). BCNA (2013, page 7) recently documented in their 2013 Federal Election Submission report, “many women with secondary breast cancer tell us they feel alone and not well supported”.

Reasons for these supportive care gaps include:

- unstructured and ill-defined care pathways that complicate the efforts of Breast Care Nurses (BCNs) to identify and provide care for them
- a lack of BCNs, resources, appropriate training and knowledge of metastatic disease
- the recent shift of treatment to the ambulatory setting, resulting in less time at the hospital and less face-to-face contact for assessment, support, information and referrals (BCNA, 2013; Reed et. al, 2010, The Secondary Breast Cancer Taskforce, 2008; Warren, 2012).

The Metastatic Breast Cancer Nurse Practitioner (MBCNP) Model of Care at Monash Health

The Advanced Breast Cancer Pathway has a varied trajectory that starts when the patient is first diagnosed with MBC and then follows the patient through their multidisciplinary care planning and treatment phases, repeating this cycle each time there is disease progression until eventual end of life care is required (NEMICS Breast Tumour Group, 2011). Referrals to the MBCNP can be made at any time throughout the advanced breast cancer disease trajectory. The MBCNP clinical pathway (Figure 1) can be used as a framework to guide the MBCNP to identify and address the individual clinical and supportive care and information needs of those with MBC. Once these care needs are identified, relevant referrals to the hospital and local community support services and/or resources can be made as they are required. The MBCNP clinical pathway can incorporate a combination of the following models of care as described below and represented in Diagram 1:

- advanced clinical nursing
- supportive
- patient centred (and patient advocacy)
- care coordination
- multidisciplinary
- separate to existing BCN model
- community based
- wellness

Advanced clinical nursing model of care

The MBCNP will provide advanced clinical nursing care within the NP scope of practice. This will include:

- advanced assessment
- diagnostics including pathology and diagnostic imaging
- prescribing and ceasing medication
- symptom management
- support of admission to, and discharge from, inpatient services
- holistic, continuous care
- single point of contact and co-ordination for the patient and the MDT

Supportive care model of care

The main function of the MBCNP model of care is to provide supportive care to those with MBC whenever it is required throughout their advanced disease trajectory. According to Bennet et. al. (2013, p. 27), “meeting patients emotional and psychological care needs is as important as meeting their clinical needs”. As each individual’s supportive care needs are likely to change at varying points throughout their advanced disease trajectory screening should be undertaken at the following key intervals/milestones:
• diagnosis
• change in treatment
• disease progression
• times of increased stress.

The MBCNP can then tailor a care plan for each individual through these milestones and provide appropriate interventions such as:
• counselling
• reassurance
• information
• practical advice
• patient advocacy
• referrals to the hospital and/or community resources.

Having well developed communication/counselling skills and being able to spend adequate time with patients at each contact is especially important for the nurse to establish trust and rapport (Breast Cancer Care, 2012). This will enable better opportunities to assess and address their changing levels of distress whilst providing best supportive care and information when it is required.

Patient centred (and patient advocacy) model of care
When developing a new breast care nursing role, it is important to adapt and tailor the model of care to address the needs of the patients with MBC in their local settings (Bennet et. al, 2013; Paynter, et. al, 2013).

Actively involving the patient and their families/carers in decision making and care planning throughout the advanced disease trajectory is essential. Allowing adequate time to explore patient values and beliefs, and informing them of health information and options of treatment, allows patients (and their families/carers) to develop plans of care that are acceptable to them (Department of Health, 2007). The MBCNP will act as an advocate by communicating the patient’s care plan to the rest of the treatment team and facilitating the implementation of the plan.

Care Co-ordination model of care
Care of patients with MBC can be fragmented and uncoordinated as it is often undertaken by many different health professionals across multiple health services within the hospital and the community sectors (Department of Health, 2006). The MBCNP will be one point of contact for patients and their health professionals, providing updates and implementing plans of care to facilitate a more streamlined journey for the patient.

As recommended, when first developing the role, the MBCNP will spend time marketing the role and fostering partnerships and alliances with all the key service providers to assist with information sharing and continual improvement of clinical management and care processes (Department of Health, 2007; Watts et. al, 2011).

Multidisciplinary model of care
Incorporating a multidisciplinary approach is a key component of the MBCNP model of care, with the MBCNP playing a key role within the Multidisciplinary Team (MDT). It has been recommended by both the North East Melbourne Integrated Cancer Services (NEMICS) Breast Tumour Group (2011) and by The Secondary Breast Cancer Taskforce (2008) in the UK that plans of care and treatment for all MBC patients should be collaboratively discussed by a MDT. This team should include all members of the patient's clinical team, comprising of a number of specialists. Team discussions should take into account all aspects of the patient's physical and psychosocial needs, so that each patient is offered personalized
appropriate psychosocial supportive and symptom-related interventions as a routine part of their care (Cardose et. al, 2010; Department of Health, 2013; NEMICS Breast Tumour Group, 2011; The Secondary Breast Cancer Taskforce, 2008). Ideally the MDT meetings for MBC patients will be run separately to the meetings held for EBC patients, as planning the complex supportive care for MBC patients often requires more time and discussion.

The MBCNP will communicate information regarding the patient at the MDT meeting, act as an advocate and assist with implementing, co-ordinating and communicating plans of care to the people involved in the care of the patient.

The MBCNP will act as a resource for other health professionals and provide regular education and training opportunities to medical, nursing and allied health staff to ensure that best supportive care for women is coordinated, and provided in a timely and appropriate manner by all members of the MDT.

Separate model of care to existing BCN services
The role will be developed as a separate but parallel role to the existing BCN roles. If combined with an existing BCN service, there is a risk of the roles merging and the focus of care predominantly returning to supporting those newly diagnosed with breast cancer and those with EBC. Additionally:

- the supportive care needs of the two groups of patients can differ with higher complexity for those with MBC
- a different skill set and knowledge is required by the MBCNP
- different Key Performance Indicators (KPIs) need to be collected by the BCN service and the MBCNP to monitor whether the role is effectively providing better outcomes for the patients and the healthcare service.

Community based model of care
The MBCNP role model of care will be a community-based role. Support groups will be developed in local community settings inviting all patients with MBC in the region to attend, regardless of the sites at which they are receiving or have been treated. Non-hospital based settings may provide a more comfortable environment for support groups, potentially reducing anxiety levels or anticipatory symptoms that may occur when attending their place of treatment.

The MBCNP will develop close links with and work collaboratively with other dedicated health professionals in the community such as treating specialists, GPs, allied health professionals and palliative care services. There are many other community services and programs into which the BCNP can link patients, such as the Breast Cancer Foundations (BCNA, Cancer Council Victoria, and Breacan); the Living Centre, Living With Cancer, Look Good Feel Better programs; local private or public oncology rehabilitation programs; Centrelink; retreats (McDonald House, Otis Foundation); child minding services (Abracadabra).

The MBCNP will also play a key role in promoting breast cancer awareness in the community by becoming involved in activities such as BCNA's Field of Women days and Cancer Council Victoria’s Biggest Morning Tea, Daffodil Day and Pink Ribbon Day.

Wellness model of care
Conducting local support groups in the community provides a forum for the MBCNP to teach patients strategies for promoting a state of wellness. Guest speakers may be invited by the MBCNP to teach the group skills such as meditation/relaxation techniques, strategies for coping with stress, music therapy and recommendations for healthier lifestyle changes such as healthy diet, exercise and alcohol reduction recommendations.
Service parameters

Client groups:
- Newly diagnosed and existing patients with MBC at Monash Health and in the Southern Melbourne and rural regions including patients from diverse backgrounds
- Includes male and female patients
- Excludes care of children with cancer

Hours of operation:
- Monday to Friday business hours
- Approximately 30 hours per week will be required to attend breast cancer MDTs, breast oncology clinics, inpatient units, chemotherapy day units and phone triage
- An additional 5-10 hours per week will be required for the development of the role, provision of education to other health professionals, development of community wellness, support and information groups, clinical research, quality activities, data collection and the MBCNPs’ own professional development

Site/settings:
Monash Cancer Centre (MCC) Moorabbin Hospital (primarily): Outpatient Breast Oncology Clinics; Chemotherapy Day Unit (CDU); breast oncology multidisciplinary (MDT) meeting; inpatient wards and telephone support for patients at home (triage and advice)

Other Monash Health campuses – Dandenong, Clayton and Casey Hospitals: Inpatient wards; Dandenong CDU; McCullough House; Casey Palliative Care and Hospital in the Home

Community settings: Local General Practitioner (GP) clinics; community health centres; community palliative care services; support groups and community based support services.

Sources of referrals:
Referrals can be made at any time during the advanced breast cancer trajectory from: breast oncology MDT members, surgeons, medical oncologist, radiation oncologist, nurses, breast care nurses (BCN), clinical trials staff, palliative care, allied health professionals, G.Ps; self-referrals and community based support services.

Alignment with key strategy/policy directions:
The model of care aligns with National, State and organisational policies for managing chronic illness. The development of the MBCNP role can help decrease high health care expenditure and improve MBC patient outcomes by:
- providing better access to multidisciplinary and integrated specialised cancer care across the acute, primary and community settings
- promoting better health, wellbeing and quality of life
- achieving patient-centred care, self-management and empowerment
- delaying disease progression
- preventing complications of disease and hospital admissions
- facilitating direct to ward admissions and decreasing lengths of stay in hospital
- conducting nursing research/quality activities and increasing awareness of available clinical trials
Benefits of the MBCNP model of care

Benefits to the patient and their family/carers include:

- one point of contact
- early assessment and initiation of treatment and care plans
- improved symptom management
- continuity of care, including between services
- streamlined care
- multidisciplinary care and the patient’s advanced care plan are facilitated
- relationship development over time
- supportive care and information needs are met
- increased satisfaction with care
- less time in hospital
- decreased avoidable hospital admissions and Emergency Department (ED) presentations by providing expanded treatment and care options
- better communication amongst health care services
- increased awareness of, and recruitment to, available clinical trials.

Benefits to Monash Health include:

- provision of flexible, contemporary, cost effective patient management
- equitable and timely access to the appropriate health care
- integrated seamless care within and across hospital and community sectors
- evidence based practice
- mentoring and clinical leadership
- increased patient satisfaction and staff morale
- an improved cancer service
- increased efficiency and reduced duplication
- cost effectiveness – measured using KPIs
- decreased length of inpatient stay
- decreased admissions due to complications
- decreased presentations to the Emergency Department (direct ward admission is facilitated)
- decreased demand on breast cancer clinics and medical services.
The overarching model of care for the MBCNP is represented in Diagram 1.

**Diagram 1: MBCNP Model of Care**

The clinical pathway for the MBCNP model of care is represented in Figure 1.
**Figure 1: MBCNP Clinical Pathway**

**MBCNP clinical pathway**
Aims: to promote wellness, delay disease progression, prevent complications, avoid Emergency department presentations and hospital admissions, facilitate direct admissions when required, facilitate MDT care and to decrease length of stay.

**Care provided by MBCNP**

**Advanced Clinical Nursing Care:**
- Advanced assessment
- Diagnostics including pathology and diagnostic imaging
- Prescribing and ceasing medication
- Symptom management
- Supporting admission and discharge processes
- Holistic, continuous care
- Single point of contact and co-ordination for the MDT

**Care Co-ordination and patient advocacy:**
- communicate with care providers/teams when required; provide updated plans of care and updates on patient status and patient requests
- assist with implementation of MDT treatment plan / patient's advance care plans

**Support:**
- assess for psychological risk factors:
  - plans of care/ advanced care plan
  - response to diagnosis, feelings, problems, solutions, concerns on intimacy / relationships
  - family issues/needs
  - financial concerns
  - personal support networks
  - offer discussions with family/support persons
  - provide counselling/practical strategies for any issues.
- Run monthly support / wellness groups

**Information:**
- discuss (when appropriate):
  - diagnosis / prog nostic issues / treatment goals, options / practical issues
  - values, beliefs, any cultural/religious/sexuality/intimacy/financial/family issues
  - possible complications / side-effects of treatment and their prevention and management
  - relevant clinical trials available
  - family history of breast/ovarian cancer
  - plans of care / advanced care plans
  - offer discussions with family / support persons

**Referral to the MBCNP**
At any time during the advanced breast cancer trajectory pathway from any of the following:

- MDT
  - surgeon
  - oncologist
  - radiation oncologist
  - nurses
  - BCNs
  - clinical trials
  - staff
  - palliative care
  - allied health professionals

- OR
  - GP
  - self-referral
  - community-based support services

**Key principles:**
This role is independent but works to enhance the existing Breast Cancer Services and Breast Care Nurse models. This role is specifically designed to utilise the expert clinical knowledge and skills of the specialised MBCNP to provide the best care for MBC patients and to fill the supportive care gaps that currently exist.

**Advanced breast cancer trajectory**

**Diagnosis of MBC**

**MDT**

**Treatment**
- surgery
- chemotherapy
- radiotherapy
- endocrine therapy
- targeted therapy
- best supportive care

**Progressive disease**

**End of life care**
- home (+/-)
- community PC
- aged care / hospice setting
- local hospital

**Offer resources and referrals as needed:**

**Hospital based:**
- dietician
- social worker
- palliative care consultant
- physiotherapist
- psychiatrist
- clinical trials staff
- clinics (lymphoedema; pain; menopausal; plastics; familial cancer clinics)
- support groups
- other specialist nurses

**Community based:**
- Offer BCNA H&H's kit
- Living Centre/ Breacan /OF/ BCNA/ CCV relevant pamphlets and services
- GP
- PC
- psychologists / counsellors
- support groups and programs: drug co; LGFB; LWC.
- prosthesis / wig retailers
- preparation of will and funeral kits
- other local community services Centrelink; child-minding; retreats.
Governance and development within the role

The MBCNP role will report to the Operations Director, Director of Nursing, Moorabbin Hospital, operationally and professionally, and to the Head of Breast Medical Oncology clinically. The governance model is represented in the diagram below.

Figure 2: MBCNP Governance Diagram

Additional clinical and professional mentoring will be undertaken by a variety of roles including a palliative care physician and the Oncology Nurse Practitioner.

Nurse Practitioner Candidate
The role may be offered at a Nurse Practitioner Candidate (NPC) level for a maximum of 24 months whilst the incumbent is developing the required skills, knowledge and qualifications for endorsement as an NP.
## Glossary

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Authority</td>
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<td>BCI</td>
<td>Breast Cancer Institute</td>
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<td>BCN</td>
<td>Breast Care Nurse</td>
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<td>BCNA</td>
<td>Breast Cancer Network Australia</td>
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<td>CCV</td>
<td>Cancer Council Victoria</td>
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<td>CDU</td>
<td>Chemotherapy Day Unit</td>
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<td>EBC</td>
<td>Early Breast Cancer</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>H&amp;Hs</td>
<td>Hopes and Hurdles</td>
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<td>KPIs</td>
<td>Key Performance Indicators</td>
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<td>MBC</td>
<td>Metastatic breast cancer</td>
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<td>MCC</td>
<td>Monash Cancer Centre</td>
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<td>MBCNP</td>
<td>Metastatic Breast Cancer Nurse Practitioner</td>
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<td>MDT</td>
<td>Multidisciplinary team</td>
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<td>NEMICS</td>
<td>North East Melbourne Integrated Cancer Services</td>
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<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
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<td>NP</td>
<td>Nurse Practitioner</td>
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<td>NPC</td>
<td>Nurse Practitioner Candidate</td>
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<td>SMICS</td>
<td>Southern Melbourne Integrated Cancer Services</td>
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<td>UK</td>
<td>United Kingdom</td>
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References

1. Aranda, S; Schofield, P; Weih, L; Milne, D, Yates, P; and Faulkner, R. (2006). Meeting the support and information needs of women with advanced breast cancer: a randomised controlled trial. British Journal Cancer, 95 (6), 667-73


