Cancer Care Coordination Group
Webinar Q&A

Connecting cancer care using digital tools

Clinical Oncology Society of Australia

PRESENTATION FEEDBACK FROM COLETTE COLE AND HARYANA DHILLON

Did you have a process to prioritise which patients the care coordinator would see?

- During the ADAPT trial a process had been developed and integrated into the portal. All patients that scored a step 2 or more (mild anxiety/depression to very severe anxiety/depression) would get a phone call from the care coordinator to further assess what was causing the anxiety. This would then allow us to either downgrade or upgrade the screening.
- Depending on the situation we could either meet with the patient at their next appointment or directly refer them onto a more suitable person (social worker or psychologist etc.)
- With ADAPT now finished, we do conduct a new patient questionnaire for all new malignancies, we then also try to meet all new patients and assess the need to follow them.
- The ADAPT portal was designed using a stepped-care model based on the *Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients*. This was based on a series of systematic reviews and a Delphi consensus study to define the pathway and the stepped-care approach. There are 5-steps in the model and when patients' responses indicating their distress (or anxiety/depression) are at Step 2 it is flagged in the system with automatic emails directed to the roles/individuals identified to deal with the triage and referral conversations.
- The system is designed to try to avoid focusing resources on people with low levels of distress but ensuring those most in need of help are offered it, even if they don't take it up.
- What has been interesting is, so far, we are seeing the rates of anxiety and depression requiring follow-up at about the level we predicted based on previous studies of cancer populations. So services are generally finding they are not being overwhelmed with many more patients.
- A link to the *Pathway Publication* can be accessed here: http://www.pocog.org.au/content.aspx?page=adaptprogram

How can you measure KPI's if the systems don't integrate? Is this double data entry?

- Yes it was double data entry. We overcame this by copy and pasting
- This is one of the major barrier to uptake of electronic screening systems around the world. There is a need to integrate systems, this is largely a technical issue which can be overcome relatively easily with sufficient funding to provide the IT support required to do the integration. It has been done for a number of systems in different parts of the world.
- The other problem here is one of security, are the systems secure enough to meet the governance requirements of the hospital system? This problem will take significant will on the part of people within the health system and may only happen with enough pressure from consumer groups.

Does the digital interaction meet criteria for PBS funding?

- Systems like ADAPT are more likely to be considered for funding through hospital activity-based funding models or potentially through the Medicare Benefits Schedule rather than PBS. This would mean each screening interaction and the management of that response would be counted within the hospitals' activity for nursing/psychology and funded through the usual budget processes. At the moment this is not the case; there will need to be some work done to change the MBS schedule to support this approach to screening and care, but we need the cost-effectiveness evidence to support changes to the schedule. However, the online supporting interventions built into the system (e.g. iCanAdapt) are available to patients free of charge. We expect them to remain free of charge, at least for now.

What questions did the screening tool ask?

- Blacktown Hospital chose to use the Distress Thermometer and the HADS (Hospital and Anxiety Depression scale).
- The ADAPT system allows for sites to choose either the Distress Thermometer or the Edmonton Symptom Assessment Scale (ESAS), both are validated instruments used widely around the world.
- The ADAPT team are now recommending sites use the ESAS, as it provides additional detail on the symptoms the patient is experiencing which can be helpful in the triage conversation. For example, if a patient is scoring high for depression and they also have a high pain score, this information can prompt a discussion about the pain which might be driving the depression score.
- Increasingly we are recognising the need to integrate clinical pathways and have a way to prioritise management of symptoms appearing in a cluster.

How many questions form the tool that is used at Blacktown? Are resources available for accessing or implementing by other cancer care services?

- At Blacktown we no longer use the ADAPT screening tool, this is mainly due to staffing issues. The implementation of such a screening tool needs to consider staffing. At Blacktown we do not have the staffing or resources to continue a formal screening.
- We have always used a new patient screening tool to try and pre-empt any issue for patient before they present to our cancer centre.
- I'm happy to share any resources in regards to patient care also happy to speak with anyone who may have further question in regards to generic care coordination Colette.cole@health.nsw.gov.au
- We are working to try and make ADAPT sustainable and able to be integrated into systems for institutions and practices that want to use it. The tools it is based on are available for use in clinical practice.

Would the presenters be happy to share their slides, and is a webinar recording available?

- COSA members may access the webinar slides and recording via the Group's Resource page on the COSA website.