



What I'd like to do now is to welcome our final two speakers, it's a joint act. I'd like to welcome Kerry Strauch, Manager of the Border Cancer Collaboration, Upper Hume Community Health, and also Nicki Melville, also involved with the Border Cancer Care Co-ordination Project. A warm welcome for local workers please.

## Cancer support across borders—the Border Cancer Care Co-ordination Project

[Kerry Strauch](#), Manager, Border Cancer Collaboration, Upper Hume Community Health Service, [Nicki Melville](#), CEO, Bogong Regional GP Training Network

**NICKI MELVILLE:** Thank you very much, Julie, and thanks, everyone. It's quite difficult to follow such erudite speakers, but we're hoping that what you'll all take away, the 1100 delegates today, is some really practical learnings from the complexity of crossing all sorts of borders in Albury-Wodonga.

Just to contextualise it, although you're sitting in it at the moment, Albury-Wodonga are twin cities spanning the Murray River with a catchment of some 200 000 people. In reality, we are twin cities, we've got two local governments, two base hospitals, two universities, you name it. We do everything by two because the state borders stop at the river. But in reality, if you live here, and all of us who are here locally, we actually commute interstate on a daily basis. We consider that we live in Albury-Wodonga and we expect services, leisure, fun and family to be a holistic approach.

So, the real issue for us in terms of trying to collaborate for better cancer outcomes is that cancer doesn't know boundaries, cancer doesn't distinguish populations, cancer is universal. So, it's our job locally to look at the issues and to try and overcome some of the, dare I say, silliness that we were living with. Things like the fact that you couldn't as a Wodonga resident attend a lymphoedema clinic in Albury because you lived south of the border. That the two palliative care centres had different models; that we were actually living under two separate mental health acts.

Coming down to actual cancer support, the real issues are that in fact we are very, very different from metropolitan centres. We, the 1100 of us here today, know that, but I want Philip to listen to that because we do not have metropolitan teaching hospitals with salaried specialists. Our cancer specialists—and I have to say, we are absolutely blessed in Albury-Wodonga to have a fantastic team of medical, radiation oncologists and surgeons, but they are private practitioners contracting to our public sector.

Our service funding—and again, I know Chris Brook was here from DHS, which is wonderful, I'm not sure who's here from New South Wales Health, I think Jim Bishop is here—our service funding stops at the river because for our public sector, New South Wales funds New South Wales services in Albury and Victoria funds Victorian services in Wodonga.

So, we were uniquely positioned when the department, when Philip's department, released the national framework for cancer services. We were uniquely positioned to find a local solution of joining it all up across State borders, Commonwealth and State borders, the public and private health sectors and the community and acute services, and we did have really well-evaluated experience from a small Department of Human Services, a Victorian funded project, which we all love the name of, "Breast Services Enhancement Program,"—where they get the names from I'm not sure, but that really was about co-ordinating care for breast cancer patients.

And up here in Albury-Wodonga an 18 month pilot—I'm sure I'll hear the groans around the room—a pilot project, very successful, extraordinarily well-evaluated, and thanks to Kate Cuss and Jenny Black a marvellous model, but of course, 18 months later pilot finished, funding gone. We then worked together to crib another year out of the Department of Human Services in Victoria, and oh my god, their letter's going to Albury so thanks, guys, that was fantastic, then the funding finished.

We then cribbed together, the Greater Southern Area Health Service in New South Wales, Upper Hume Community Health, which I was the CEO of then, and Wodonga Regional Health Service, we all put in 30 grand from reserves to keep it going whilst we approached DOHA, and to their credit they came forward with 18 months project funding to take, as Kerry will explain now, “the best of breast” to all cancer streams.

**KERRY STRAUCH:** This is a tag team approach, folks. This is working together, which was what the Border Cancer Care Co-ordination Project was all about. It was about taking the best of breast and seeing whether all cancer tumour stream patients can benefit from the same sort of approach that was taken with breast. So, we looked at cancer care co-ordination. Did a cancer care co-ordinator need to be a nurse? All cancer care co-ordinators at that stage – and most of them were metropolitan based, certainly in Australia they were – were nurses. It was a nursing model, it was a metro-centric model; what worked in a regional and rural context?

So, when we did our research with cancer patients what we found was that 46 per cent of needs were actually psycho-social needs. There were only 26 per cent of needs that were clinical needs – and when I say clinical needs, it’s information about cancer diagnosis, exploring what the impact of treatment is on people’s lives, exploring through the prognosis, looking at managing the impact of treatment.

The other 17 per cent of needs related around patients actually accessing services. So we piloted two cancer care co-ordinators, one with a nursing background, one with a non-nursing background, and what we found was that both roles worked very, very well. For the nursing background cancer care co-ordinator, they obviously had the clinical knowledge, but what they needed in meeting patients’ psycho-social support needs was to be able to access social workers, to be able to access primary community care counselling services. For the social worker who was our cancer care co-ordinator, they needed to be able to access clinical information.

So what we found was that provided each cancer care co-ordinator could access the skill set that they didn’t have, the role didn’t need to be a nursing role. Now, in regional and rural areas that’s really important because you may not have the people on the ground to actually be able to provide the services. You’ve got to look at the workforce that you have and how can you best meet the need given what you can access?

We also looked at what works in a regional rural context. In Albury–Wodonga we don’t have the population base to support tumour stream specialist cancer care co-ordinators. Would a generalist role work? And what we found was, yes, it would. There were issues, issues about keeping up with knowledge, but again provided that our cancer care co-ordinators had links with the clinicians in the area we were able to support cancer patients and to meet their needs, because what we were looking at was moving beyond what had been a fairly metro-centric model which focused on the acute sector and looking at supporting patients right throughout the continuum of the cancer care journey. We wanted to catch patients just after diagnosis. We wanted to be able to support them as they went in to have their surgery, when they were discharged from the hospitals. The hospitals in Albury–Wodonga are fantastic, they provide wonderful care, but what happens to cancer patients when they move from the hospital back home, back into their communities, who supports them then? This is part of the role of cancer care co-ordinators. So, what worked in a regional context? That was what we were looking at.

We also looked at multi-disciplinary team meetings. Again, in the metro-centric model a lot of the cancer specialists were salaried doctors. They happened in the hospital, in the doctor’s time. All of our cancer specialists, as Nicki has already said – and we have a wonderful group – but they’re all private. When we have multi-disciplinary team meetings – and we support breast, gastro-intestinal, urology and general tumour stream meetings in this region – when we have those meetings the cancer specialists turn up in their own time.

So, what would make a – what would be sustainable? What were the critical success factors? What were the benefits? And how could we make it sustainable in a regional and rural environment? And what we found was there was one critical component and that was dedicated administrative and co-ordination support. Doctors and their rooms and their PAs do not have the time to collate patient information coming in, to chase up missing information, to get it to the pathologists and radiologists. It



requires dedicated administration and co-ordination to actually do that. That is a very small investment considering that cancer specialists are giving of their own time.

And it doesn't have to be a highly qualified nurse. If you look at it, if you actually do an analysis of the role, it's an administrative role, these are administrative tasks. They can be undertaken by an administrator, and that's a much more cost-effective way of doing it than to pay a nurse or to pay a registrar or to pay an intern to do it. So these were the sorts of things that we found.

We also looked at data and information, and as Nicki has said previously, New South Wales data went to Albury, stopped at the Murray River; Victorian data went to Wodonga, again stopped at the Murray River. And in Albury–Wodonga because we are a regional area, because we don't have big teaching hospitals, public service provision only accounted for approximately 50 per cent of cancer service provision. If you looked at the publicly available data through the cancer registries you were not capturing day treatment provision. You were not capturing private service provision.

And the other thing that we found was that if you used only primary ICD codes you only captured 45 per cent of service provision related to cancer services. You actually had to use secondary ICD codes to capture the rest, simply because of the way the codes were structured. So, different systems, different service data.

We also looked at communication and we've piloted the establishment of a website, providing work spaces for health professionals. And to give you an example of that, we provide a log-on work space for cancer care co-ordinators. Now, it's just taken off like wildfire through word of mouth. We now have 60 cancer care co-ordinators from Western Australia, New South Wales, the ACT, Victoria, Tasmania – and one from Canada – who log-on and share information, they share experiences, they share resources, they discuss workforce issues and service provision issues.

And so what you've got is that you are breaking down the tyranny of distance, dare I say it, and geographical boundaries, but you're also breaking down service boundaries. You've got rural cancer care co-ordinators from Western Australia who are able to access tumour stream specialists, cancer care co-ordinators in Melbourne and Sydney hospitals, and vice-versa. You've got specialists in metropolitan hospitals who are sending people back to rural centres, who are able to access people there to support the patients that they're sending back.

We looked at a local service directory where patients and clinicians could log-on to the website and find information about local support services. We looked at information about cancer events. We also considered evidence-based guidelines for managing side effects and treatment. Whilst our website was actually being developed the New South Wales Cancer Institute developed up their own protocols and so we've linked into those rather than developing our own local approach. But what we have in the website is that we've piloted a structure that is actually adaptable to other regions, all you need to do is take out the Albury–Wodonga content and put in the content that's particularly applicable to those regions.

So, looking at the outcomes of the Border Cancer Care Co-ordination Project, the key outcome – and we can't stress this enough, mind you, we're biased – but a collaborative model of care works. It works when you work together, and the key to that is local governance. And I just want to share with you our champions. Now you'll have to excuse us, we're a bit – we're not very comfortable with this technology. Nicki Melville was CEO of Upper Hume Community Health Service; Andrew Watson, CEO of Wodonga Hospital; Maryanne Warren, Manager of Albury Hospital; Jane Ayers, CEO of Mercy Hospital, Albury; Professor Stuart Snyder, CEO of Murray Valley Hospital and Albury–Wodonga Private Hospital, both private; Dr Craig Underhill, Director of Area Cancer Services and a private medical oncologist; Mr Neil Bright, surgeon; Dr Bill Walton, Chairperson of the Border Division of GPs; Dr Craig MacLeod, Murray Valley Radiation Oncology; Janet Chapman, Albury Community Health; Chris Packer, Greater Southern Area Health Services, Cancer Services Development Manager; Peter Batters, Hume Regional Integrated Services Manager; Eric Turner, Border Cancer Support Group and Client Representative; and then my role as manager.

If you look at that steering committee just very quickly you have the decision makers in the Albury–Wodonga region about cancer service provision, and what they’ve done is they’ve come together, sat around the table and they’ve shared. They have actually had the courage to move across the boundaries to say that the Murray River is not going to be a boundary. We will make our positions cross-border, we will allow our positions to service people in the region no matter what postcode they actually happen to have. So, despite the state boundaries, despite dare I say it the bureaucratic boundaries of service provision, at a local level collaboration can actually make it work.

**NICKI MELVILLE:** I don’t want to stress – as Kerry said, I want to stress so much, just to give you a concrete example of that. Before we started, and the state will remain nameless, but personnel and service providers in one state were not allowed to drive their fleet car across the river, five kilometres across the river. So it took the champions, it took the decision makers, to get through the rubbish and the red tape.

I’ll very quickly talk about the other key outcomes. What we found – and this is absolutely speaking to you, Philip, and your excellent presentation – collaboration requires resources that are recurrent. We have now got those in the border for service provision through New South Wales and Victoria for the service providers, but just what Philip said, the government should be facilitating the infrastructure that supports that crossing boundaries. We have to have management and administration to support a collaboration when you’re talking large scale service provision.

As Kerry has already touched on, the co-ordination administrative support is critical to run NBTMs, and the cancer care co-ordinator role can be a varied profession. Just to let you know, and you can read the statement yourself, because we were very keen to take to governments a well-evaluated project, this is externally reviewed and you can see Michael Barton’s comments in our report which we’ll put up at the very, very end.

I hate being a speaker who has to apologise for the complexity of slides but this one was necessary. The river running through it, this is where we’re standing now and this is very important. The blue funded positions in Victoria and New South Wales funding, and for Chris and Jim and the others present, there are about equal amounts of money, guys, you’ve done very well at putting equal amounts of money into the pot called Albury–Wodonga. We now have two cancer care co-ordinators and all those other positions permanently recurrently funded. Fantastic.

Because of the cancer collaboration we’ve been able to attract philanthropic, as Philip said, private funding, and Robert touched on this extensively. We have a McGrath nurse, the first one outside of metropolitan Sydney, for breast cancer full time. We have a Leukaemia Foundation position, and all the other things you can see here that are philanthropically or privately funded. And we have Commonwealth funding in research, in of course, our private practitioners, our GPs, our surgeons, our oncologists, through the Medicare scheme. And at the moment – and this is the crux – the research components also support the management of the complexity.

And really the point I want you to take from this slide is the complex nature of the beast. And just to show Robert that we were really listening, in fact one of the philanthropic things there now, the Red Cross transports patients across the border. Thank you.

**KERRY STRAUCH:** So now we’d like to share with you our vision. We have a vision for a centre of excellence in regional cancer care, and might I say that what we’ve shown you so far is an example of crossing boundaries at a local level. There is no reason why this approach can’t be duplicated in any other region in Australia. You don’t have to do what we’ve done, but if the service providers work together, work out a model that fits your area, it can be done. We have a vision for a centre of excellence in regional cancer care. Our vision is a centre that’s capable of best quality co-ordinated cancer care services. We have a vision of being able to provide comprehensive links with metropolitan centres. We have a vision of being able to link rural clinicians with our regional cancer specialists.

We have one of the best cancer specialist pools we think in regional Australia. We want to be able to link our rural clinicians, our GPs, with the regional cancer specialists. And through the centre of excellence we have the – we would have the capacity to link our rural clinicians with cancer specialists





in metropolitan centres, using technology like Telehealth. We have a vision for being able to research rural and regional issues in providing cancer services. And we have a vision of being able to optimise public and private resources available in a regional area to provide comprehensive cancer support services.

**NICKI MELVILLE:** What it's taken is agencies that can let go and can share, and we all know that that's really hard sometimes when you're funded for a project or you're funded by a state government and you've got to report that way. What it's taken is agencies and service providers who will take risks. What it's taken is people who will manage those risks. And what it will take into the future—and this is desperately what we haven't got as of June 30 this year—is the resources to allow those risks to be managed.

So we just want to conclude, and Philip said, dare I say, Philip, this is a sustainable model but government needs to see that government needs to break down those boundaries to allow such a fantastic sustainable model to carry on. Thanks.

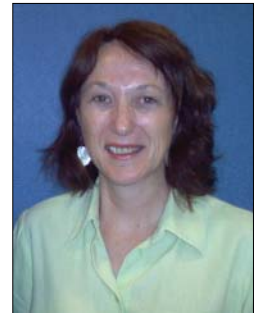
**FACILITATOR:** Ladies and gentlemen, Kerry and Nicki. I'll ask you to see them personally with questions.

## Presenters

**Kerry Strauch** is the Manager, Border Cancer Collaboration at the Upper Hume Community Health Service, a major provider of primary health and community services across the north-east of Victoria, and winner of the inaugural Victorian *Best Community Health Service in Country Victoria – 2005*.

Kerry is Manager of the Border Cancer Care Co-ordination Project, which has become Border Cancer Collaboration. Also co-ordinated the development of national practice principles, and a training program for palliative care of Indigenous Australians, and educational resources for Division 2 nurses.

Kerry has extensive experience in project management of large and small projects and in conducting stakeholder consultation at national, state and local levels. She has particular expertise in the development of resources to support individual and organisational learning in a range of sectors, including health.



**Nicola (Nicki) Melville** is the CEO of Bogong Regional GP Training Network. Previously she was CEO Upper Hume Community Health Service, a major provider of primary health and community services across the north-east of Victoria, and winner of the inaugural Victorian *Best Community Health Service in Country Victoria – 2005*.

Nicki has 12 years in the primary health field with seven of those being as the Director of the Health Promotion for the south-west region of NSW and the last six as CEO at Upper Hume.

Nicki has particular expertise in change management through primary health reform; with the determinants of health and community and service capacity building being the drivers of this reform. She also has extensive experience in population and public health theory and practice at state, national and international level.



Previous to working in health, Nicki had 10 years in industrial sector marketing with international and national experience.