

Provision of chemotherapy in a rural setting

Sara Wadge, MD, FRCPC

Objectives

- Referral process
- Challenges in transition
 - CONREF
 - Patient expectations
 - RN role / training
 - Provision of follow up
- Funding of rural centres



St. Mary's Hospital

- Catchment area of about 30000
- Large retirement population
- Geographically isolated
- 5 chemotherapy certified nurses
- 3 chemotherapy trained pharmacists and their techs
- Full chemotherapy services including administration of complex regimens and infusors
- Majority of referrals from BCCA with some from LGH
- Chemo provided Tuesday-Thursday
- One prescriber presently, but not for long



Referral example.....Mr. I

- 74 year old male background history of interstitial lung disease
- Referred for palliative chemotherapy given metastatic NSCLC (LUAVPG) through CONREF
- Referral package sent to ACU and pharmacy
- Pharmacy adds to schedule / orders drugs
- Unit clerk creates chart, contacts Px, arranges lab
- RN provides education
- Orders written, triple checked
- Meds prepared, administered
- Fall out dealt with...

What works well in transition....

- CONREF
 - Minor issues with “bugs”
 - Occasional delays
- BCCA website
 - Brilliant!
 - Excellent drug monographs, protocols are clear, recommended follow up information helpful
- BCCA medical oncologists are easy to reach and very collegial
- Chemo reports from SMH are always copied to medical oncologist

What could be better...

- “Shared care”
- Delays
 - Wait times for procedures (biopsies, colonoscopies, surgery off Coast)
- Access to porta-cath services
- Drug ordering
- Funding
 - Sechelt is an example of an orphan site

Patient expectations

- The panic phone call is the rule, not the exception
- It usually occurs the day of appointment or the next day!
- There is an expectation of no wait time
- Often patients have not been able to process information and education is therefore always duplicated

RN role...

- Training well organized
- Well supported
- Presently chemo provided in a multi-purpose room (but this will change)
- One designated RN...but distractions abound
- Comfortable (?) with dealing with reactions and communication flows well

Advantages in a rural setting

- Nurses and doctors know each other extremely well
- Familiar with patients...a relationship is quickly established
- Ancillary staff (diagnostic imaging, lab, etc) bend over backwards to assist
- Community pharmacists know these patients
- Transition to palliative care if needed works well
 - Patients have involved GPs with hospital privileges
 - Palliative care coordinator superb
 - I provide palliative call services

Follow up post treatment

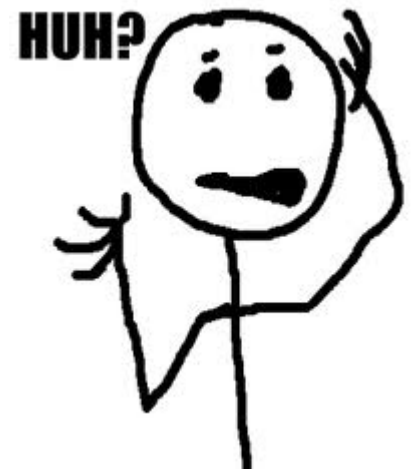
- I take ownership
- Depending on malignancy I either provide the needed follow-up (ie. adjuvant colon) or refer back to BCCA (ie. follicular lymphoma) or medical oncologist at LGH...

Chemotherapy stats

- Number of patients receiving active chemotherapy has ranged between 29-42 / month (excludes BCG, oral outpatient chemotherapy, ie tamoxifen)
- Majority of treatment of palliative intent
- Pay period April 1- November 8, 2012
 - 657 IV chemo prescriptions filled
 - 128 oral chemo prescriptions filled
 - 290 outpatient only prescriptions (tamoxifen, etc)

How is this funded?

- We receive the cost of the drug from BCCA
- \$10,000 annual stipend
- If we share services with LGH, the same patient will receive full funding there!
- If he heads up the highway to Powell River, his services will also be funded
- Fee for service model for physician



The dream....

- Abolish orphan sites by attaching funding to patient care and not site
- To increase our capacity
- Continue to foster our relationship with BCCA by focusing on communication

