

Optimal care pathway for people living in rural and remote areas with cancer

Quick reference guide



Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

The optimal care pathways describe the standard of care that should be available to all cancer patients. The pathways support patients and carers, health systems, health professionals and services. They also encourage consistent, optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide summarises the *Optimal care pathway for people living in rural and remote areas with cancer*.

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Prevention

Effective cancer prevention strategies for people in rural and remote areas should focus on reducing risk factors and increasing access to services.

Health promotion activities include:

- healthy lifestyle choices
- immunisation
- increasing participation in screening programs
- increasing health literacy through education campaigns
- access to healthy food
- sun safety
- addressing food security concerns
- education and behaviour change, particularly emphasising recommended exercise levels, heart health and cancer prevention.

Preventive care includes access to affordable or subsidised options, including pop-up services (e.g. screening) and virtual care.

Risk factors

The risk factors for developing cancer are well established and people in rural, remote and lower socioeconomic areas have higher rates of cancer-related risk factors. It is important to consider and address these risk factors collectively.

Risk factors include:

- tobacco use (e.g. smoking)
- alcohol use
- overweight and obesity
- physical inactivity and sedentary behaviour

- dietary factors (e.g. low-fibre, processed foods)
- genetic risk factors
- infections (e.g. human papillomavirus, hepatitis B and C)
- co-existing medical conditions
- sun exposure
- environmental hazards (e.g. radiation, asbestos, chemicals).

Early detection

In comparison with metropolitan areas, people living in rural and remote areas may face extra disadvantages related to early detection, including:

- less access and availability of appointments
- less availability of screening services
- additional and longer travel to get to appointments
- lack of options and higher costs to access health care
- slower turnaround of results
- delays in follow-up.

Screening

The four population-based cancer screening programs available are the BreastScreen Australia Program, National Bowel Cancer Screening Program, National Cervical Screening Program, and National Lung Cancer Screening Program. Fewer people access these programs in rural and remote areas than in metropolitan areas.

Checklist

- ☐ Smoking status discussed and recorded, and brief smoking cessation advice offered to people who smoke
- ☐ Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- ☐ Recent weight changes discussed and the patient's weight recorded
- ☐ Physical activity recorded
- ☐ Referral to a dietitian considered
- ☐ Eligibility for national cancer screening programs (breast, bowel, cervical and lung) checked, with appropriate referrals as needed
- ☐ Referral to a physiotherapist or exercise physiologist considered
- ☐ Education on being sun smart considered

Step 1: Prevention and early detection continued

Barriers to screening for rural and remote Australians include:

- longer travel distances to screening and follow-up services
- limited availability of female providers for breast and cervical screening
- cultural concerns and distrust in healthcare systems among Aboriginal and Torres Strait Islander peoples
- lack of knowledge and awareness of cancer screening
- health literacy challenges and not appreciating the value of preventive health care.

Screening recommendations

We need to ensure that people living in rural and remote areas, especially those with a high-risk or family history of cancer,

have equitable access to screening programs.

Strategies to ensure equitable access to screening programs include:

- targeted education to the community and the health workforce
- culturally appropriate community engagement
- proactive patient navigation
- expanding mobile screening units
- integrating pre-screening and follow-up support via telehealth
- improving collaboration between local healthcare providers and tertiary centres.

Increased or high risk – refer to the cancer-specific optimal care pathway for screening recommendations.

Step 2: Presentation, initial investigations and referral

People living in rural and remote areas are more likely to have delays seeking help for symptoms than people in urban areas. This relates to lower levels of access and availability of services, attitudes and beliefs, levels of health literacy. Work responsibilities, including farming, seasonal or shift work are other important reasons why some people in rural and remote areas take longer to seek help for symptoms.

Coordinating investigations is important for people living outside major cities if these require travel. Returning for multiple visits to a centre can be burdensome, particularly for those who need to arrange accommodation, travel, childcare or work changes.

Referral options

At the referral stage, the patient's primary healthcare provider or other referring doctor should advise the patient about their options for referral, waiting periods, travel requirements, expertise, likely out-of-pocket costs and the range of services available.

- Establish the patient's preferences for where they would like to be referred. Include a discussion about public and private care, depending on whether the patient is privately insured, and about likely out-of-pocket costs.

- Understand the patient's preferences and resources to travel through diagnosis, treatment and follow-up. Explore eligibility for patient assistance travel schemes.
- Use available information provided by the local Primary Health Network on the HealthPathways portal, available in selected states and territories only.
- Consider a referral most appropriate to the patient's diagnosis, including:
 - local infrastructure of health services and treatment options
 - the need for coordination between primary and cancer specialist care providers
 - where the patient lives and what services are locally available, including access to allied health
 - access to diagnostic investigations and cancer specialist appointments
 - availability of care coordinators to help navigate complex systems.
- Ensure clear communication pathways are established between referring primary healthcare providers and cancer specialist services, including:
 - timely transfer of clinical information
 - prompt handover of discharge summaries and treatment plans
 - clear documentation of medication regimens.

Checklist

- ☐ Signs and symptoms recorded
- ☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ☐ Effective communication with the cancer specialist team (including specialist cancer nurse coordinators where applicable) ensured, including referrals and follow-up
- ☐ Referral options discussed with the patient and/or carer including cost implications
- ☐ Patient referred to support services (such as the Cancer Council or relevant cancer-specific non-government organisations) as required

Timeframe

Timeframes for completing investigations and referrals should be informed by the relevant cancer optimal care pathways and evidence-based guidelines. While access to care can be complex, clear pathways are needed to ensure timely investigations in rural and remote Australia.

Step 2: Presentation, initial investigations and referral continued

Communication

The primary healthcare provider's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for cancer specialist appointments

- informing the patient and/or carer that they can contact Cancer Council on 13 11 20
- ensuring effective communication with the cancer specialist team, including referrals and follow-ups.

Timeframe

Visit the Cancer Council website <www.cancer.org.au/OCP> for the optimal care pathways for each cancer type.

Step 3: Diagnosis, staging and treatment planning

Diagnosis and staging

Details for cancer staging are outlined in each cancer-specific optimal care pathway.

Rural and remote patients generally experience more advanced disease stages at diagnosis, although this varies across cancer type and rurality. Contributing factors to later-stage diagnoses include:

- limited access to diagnostic services
- longer distance to treatment facilities
- longer wait times for cancer specialist consultations
- fewer diagnostic tests performed.

With extensive travel for diagnostic workup, consider whether this is appropriate for each patient. Include a discussion with the patient about the travel requirements and whether this is appropriate for them.

Travel to some specialist centres for care may be arranged through a patient assistance travel scheme <www.healthdirect.gov.au/travelling-to-your-healthcare-appointment>.

Genetic testing, molecular profiling and pharmacogenetics

Molecular testing or profiling of the tumour may determine genetic variants. Certain pathological subtypes of cancer or tumour tests (immunohistochemistry or tumour genetic tests) may suggest an underlying inherited cancer predisposition. Finding a germline mutation or an inherited gene fault will have implications for other members of the family.

Accessing genetic testing usually involves a face-to-face meeting and a formal informed consent process. This can reduce uptake, particularly for people in rural and remote areas where access to genetic counsellors can be limited.

Telephone and videoconferencing counselling sessions are increasingly used to allow access and to reduce travel time and cost.

In some states and territories, the treating team can offer 'mainstream' diagnostic genetic testing, after which referral is made to a familial cancer service if a pathogenic gene variant is identified.

Anyone diagnosed with cancer should have a detailed personal and family cancer history taken. Consult relevant guidelines <<http://www.eviq.org.au/cancer-genetics/referral-guidelines>> and refer patients to other treating centres for genomic testing as appropriate at any stage of the care pathway.

Molecular testing or profiling determines whether there are genetic variants (somatic mutations) in a person's cancer that can be targeted using specific treatments.

Pharmacogenetic testing uses a similar approach to determine genetic variants. This can lead to differences in the way certain medicines interact with the body. Pharmacogenetics can also determine the likelihood that a specific dose will be adequate and not toxic. Applying molecular and/or pharmacogenetic testing to inform treatment planning is required for many cancer types to ensure patients are prescribed the most appropriate treatment at the optimal dose.

Checklist

- ☐ Diagnosis confirmed
- ☐ Full histology obtained (remove if not relevant to cancer type)
- ☐ Performance status and comorbidities measured and recorded
- ☐ Patient discussed at an MDM and decisions provided to the patient and/or carer
- ☐ Clinical trial enrolment considered
- ☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- ☐ Patient referred to support services (such as the Cancer Council or relevant cancer-specific non-government organisations) as required
- ☐ Patient referred to relevant cancer-specific OCPs
- ☐ Treatment costs discussed with the patient and/or carer
- ☐ Advance care planning discussed with the patient and/or carer

Step 3: Diagnosis, staging and treatment planning continued

Treatment planning

Consider the following at the treatment planning stage:

- the patient's overall condition, life expectancy, personal preferences and decision-making capacity
- discussing the multidisciplinary team approach to care with the patient
- appropriate and timely referral to a multidisciplinary team meeting (MDM)
- pregnancy and fertility
- support with travel and accommodation
- teleconferencing or videoconferencing, including internet connectivity if needed.

Other factors to consider for people living in rural and remote areas include:

- geographical distance to treatment facilities
- seasonal challenges
- the nature of employment
- socioeconomic disparities
- access to supportive care services
- ensuring culturally safe care, access to interpreters and cultural practices that may influence care decisions
- psychosocial support and mental health care
- digital literacy and technology access
- caregiver support and capacity.

The multidisciplinary team should meet to discuss newly diagnosed patients before definitive treatment to recommend a treatment plan and to prepare for the post-treatment phase.

Virtual MDMs may help overcome geographical barriers and specialist shortages in rural areas. But virtual MDMs need ongoing attention to maintain team dynamics and technical infrastructure.

Lack of MDMs is a key reason for suboptimal cancer care for patients from rural and remote areas.

Research and clinical trials

Refer appropriate patients to other treating centres to take part in research, clinical trials or genomic testing at any stage of the care pathway. Be prepared to discuss the benefits and drawbacks of such trials. Any member of the multidisciplinary team can encourage cross-referral between clinical trial centres.

Search for a clinical trial <www.australiancancertrials.gov.au>.

Communication

The lead clinician's¹ responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- discussing accessibility of services, travel requirements, appropriateness of telehealth services and financial assistance that a patient may be entitled to
- providing appropriate information and referral to support services as required
- communicating with the patient's primary healthcare provider about the diagnosis, treatment plan and recommendations from MDMs.

Step 4: Treatment

Treatment decisions should respect patient preferences and logistics relating to travel, time spent away from home, competing commitments and culture. Rural and remote patients should not receive inferior treatment due to their geographical location but consider patient preferences.

Establish intent of treatment

- Curative
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation.

Checklist

- ☐ Intent of treatment established
- ☐ Risks and benefits of treatments discussed with the patient and/or carer

¹ Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4: Treatment continued

Barriers to receiving timely treatment for rural and remote patients are largely imposed by geographical locations and include:

- extended travel to access tests, surgeries, treatment and follow-up care
- potential loss of family and community support networks
- logistical complexity of organising appointments and travel arrangements
- lack of diagnostic equipment in rural and remote areas for pre-treatment testing
- healthcare workforce shortages in rural and remote areas
- limited access to multidisciplinary care teams
- financial stress associated with travel
- lack of knowledge around available support services to overcome geographical barriers.

Overcoming these barriers must be the priority of the treating team to ensure timely access to treatment. The following treatment options have extra considerations for rural and remote patients.

Surgery

Carefully consider access to postoperative care services during the treatment planning process, including their accessibility and cost.

Radiation therapy

Access to radiation therapy may be challenging for rural and remote patients. Telehealth and support with accommodation and travel can reduce barriers to access. Investigate regional radiation therapy centres <www.targetingcancer.com.au/find-a-treatment-centre>.

Systemic therapy

Tele-oncology and remote systemic therapy services have increased access to systemic treatment and should be explored as a treatment option. Despite advances, significant infrastructure and coordination challenges persist in some areas.

Where no medical oncologist is available to deliver treatment, less

complex therapies may be delivered by a cancer specialist physician, primary healthcare provider or nurse with experience and training under the direction of a multidisciplinary team. This requires a detailed treatment plan and communication with a supervising medical oncologist or haematologist. Clinical management in rural and remote settings requires careful coordination between healthcare providers and cancer specialists to manage complex side effects, which becomes particularly challenging when patients are located far from specialty centres.

Targeted therapies and immunotherapy

Rural and remote patients face greater geographical difficulties accessing immunotherapy compared with urban patients. Socioeconomic factors and insurance status particularly affect lower-income patients.

Clinical management in rural and remote settings requires careful coordination between healthcare providers and cancer specialists to manage complex side effects. This becomes particularly challenging when patients are located far from specialty centres.

Emerging therapies

Increasingly, timely decision-making in oncology to choose the right treatment at the right time depends on specialised molecular or genetic testing of the tumour tissue to see if there are changes in the cancer cells that would predict a treatment's efficacy. These tests are beyond the standard histology and immunohistochemistry tests and take time to complete. The key principle for precision medicine is prompt and clinically oriented communication and coordination with an accredited laboratory and pathologist. There may also be increased costs associated with emerging therapies. This could take longer in regional and remote areas, therefore efficient logistics, clear communication between regional and metropolitan laboratories and access to telehealth consultations is crucial.

Checklist

- ☐ Treatment plan discussed with the patient and/or carer
- ☐ Treatment plan provided to the patient's primary healthcare provider
- ☐ Treating cancer specialist has adequate qualifications, experience and expertise
- ☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ☐ Patient referred to support services (such as the Cancer Council or relevant cancer-specific non-government organisations) as required
- ☐ Early referral to palliative care considered
- ☐ Advance care planning discussed with the patient and/or carer

Timeframe

Timeframes for treatment should be informed by evidence-based guidelines (where they exist) and relevant cancer optimal care pathways (if available) while recognising avenues to support quick access to investigations. Visit the Cancer Council website <www.cancer.org.au/OCP> for the optimal care pathways for each cancer type.

Step 4: Treatment continued

Palliative care

Timely referral to palliative care can improve quality of life and referral should be based on the holistic needs of the patient and family, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Limited local palliative care services and long travel distances to cancer specialist providers can delay access to essential care. Some primary healthcare providers in rural and remote areas offer palliative support to patients. Consider exploring options for telehealth consultations and outreach services, alongside coordination with local healthcare providers to support both physical symptom management and psychosocial wellbeing. *The National palliative care standards for all health professionals and aged care services* <www.palliativecare.org.au/publication/national-palliative-care-standards-for-all-health-professionals-and-aged-care-services/> provide a framework for delivering quality primary palliative care.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate

- communicating the treatment plan to the patient's primary healthcare provider
- helping patients to find support for exercise and other allied health programs where appropriate to improve treatment outcomes.

Other needs that may arise for rural and remote Australians living with cancer include:

- support managing extended travel and accommodation needs for treatment, particularly for those needing specialised care like radiation therapy
- help coordinating care between local providers and urban treatment centres
- help accessing telehealth services to reduce travel burden for suitable appointments
- financial support for costs related to travel, accommodation and time away from work
- connection to local support networks and patient navigation services to help coordinate ongoing care needs
- support for family caregivers who may need to travel or relocate temporarily to assist with care
- access to culturally appropriate psychosocial support services that consider rural and remote values and circumstances
- help managing treatment side effects with limited local cancer specialist support
- help coordinating follow-up care and monitoring between treatments.

Step 5: Care after initial treatment and recovery

The complexity of health systems means that services, organisations and providers often work independently to support people living with and beyond cancer. This may lead to fragmented care. Rural and remote people living with and beyond cancer face multifaceted challenges that require comprehensive, personalised approaches to supportive care that address their unique geographical, social and personal circumstances. Consider the following.

Provide a treatment and follow-up summary to the patient, carer and primary healthcare provider outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided

Checklist

- ☐ Treatment and follow-up summary provided to the patient and/or carer and the patient's primary healthcare provider
- ☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as needed

Step 5: Care after initial treatment and recovery continued

- a follow-up schedule, including tests required and timing
- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Considerations for people living with and beyond cancer transitioning from active treatment to survivorship care include:

- limited access to follow-up supportive cancer care due to cancer specialist shortages and/or long travel distances
- lack of trust in local rural and remote health care services
- higher rates of cancer-related fatigue, pain and the experience of poorer psychological outcomes than those from urban areas
- lower rates of receiving comprehensive survivorship care plans including unclear post-treatment pathways
- lack of information on prognosis and recovery, referrals to support services and lifestyle advice
- the need to reiterate information at multiple timepoints in an accessible way.

The transition from initial cancer treatment to survivorship care is critical to ensuring long-term health and wellbeing. These challenges may be more pronounced in rural and remote areas and/or patients may experience extra challenges.

When transitioning from active cancer care, appropriate and timely discussions with local providers and the patient are crucial in deciding if post-acute care will take place at the treating site, the local site (if not the treating site) or as a shared care arrangement.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's primary healthcare provider.

Supportive care

Other needs that may arise include:

- physical and daily living:
 - support for managing long-term treatment effects and compromised immunity
 - access to physical rehabilitation, occupational therapy, lymphoedema and exercise programs
- healthcare access:
 - transportation assistance for follow-up appointments
 - improved access to specialised survivorship care resources
 - better coordination with healthcare teams
- financial and employment support:
 - financial navigation services tailored to rural and remote circumstances
 - support for return-to-work transitions, particularly given limited rural and remote job markets and that some people are self-employed
 - assistance with disability benefits applications
- psychosocial support:
 - access to mental health services and support groups
 - encouraging patients to identify and coordinate their informal support networks
 - information about self-management strategies
 - support for managing changes in family and social relationships.

Checklist

- ☐ Patient referred to support services (such as the Cancer Council or relevant cancer-specific non-government organisations) as required
- ☐ Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Most residual or recurrent disease will be detected via routine follow-up or by the patient presenting with symptoms. If a patient's cancer has returned, the primary healthcare provider may provide care under the guidance of the treating cancer specialist team. The patient's primary healthcare provider, oncologist or care coordinator should coordinate this care. Referral back to the original team and other multidisciplinary teams is optimal, specifically to discuss further aspects of care. This may involve different therapeutic and supportive care disciplines than when initially discussed.

Due to the high reliance on primary healthcare providers in rural and remote settings, ensure they are included in MDMs about treatment planning and follow-up care to effectively support this once a person returns home.

Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences. Details for appropriate treatments and optimal timeframes are outlined in each cancer-specific optimal care pathway.

Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves. Give patients and their support network written information to take home.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and referral should be based on need, not prognosis. Where access to a palliative care physician or team is limited, explore tele-nursing to connect patients to a suitable alternative. Rural and remote patients may rely more on social networks rather than close family for hands-on care. Targeted interventions can support informal caregivers.

Communication

The lead clinician and team's responsibilities include explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's primary healthcare provider.

Other challenges and needs that may arise at this time include:

- limited access to specialist palliative care services, particularly in rural and remote areas
- transportation barriers for accessing treatment and follow-up care, often requiring long-distance travel
- need for coordinated care between local healthcare providers and urban treatment centres
- rapid turnover of primary healthcare providers in rural and remote areas, affecting continuity of care
- financial burden from travel costs and accommodation when accessing distant cancer specialist services
- challenges accessing timely symptom management support, particularly acute symptoms
- limited access to psychosocial support services and support groups in rural and remote communities
- need for enhanced communication between rural primary care providers and urban specialist teams
- greater reliance on family caregivers who may experience higher burden due to limited formal support services.

Checklist

- ☐ Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's primary healthcare provider
- ☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- ☐ Patient referred to support services (such as the Cancer Council or relevant cancer-specific non-government organisations) as required
- ☐ Advance care planning discussed with the patient and/or carer
- ☐ Patient referred to palliative care if appropriate
- ☐ Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Referrals should be made when treatment with curative intent is no longer an option, but before treatment ends. Ensure an advance care plan is in place.

Rural and remote patients face substantial geographic barriers to accessing palliative care services. Offer palliative support more broadly through symptom management if no palliative service is available.

Potential solutions to overcoming access barriers for patients include:

- developing integrated care models linking rural and remote and metropolitan services
- using telehealth for cancer specialist consultations
- strengthening partnerships between local healthcare providers and palliative care services.

In urban areas, end-of-life care is often delivered by a multidisciplinary team. But in rural and remote areas, primary healthcare providers and generalist health professionals often support this care. Share the responsibility for initiating the discussion among the treating team. End-of-life and palliative care services may be better known to the clinician providing services closest to the patient's home, highlighting the need for effective communication between treating clinicians. It's important to use culturally sensitive approaches and consider alternative language, such as 'comfort care', when discussing palliative care.

As voluntary assisted dying (VAD) is legislated by state and territory governments, it is essential to know the law and rules around this choice in the state or territory where the patient lives.

Targeted initiatives have been implemented to improve access to VAD. While progress has been made in providing end-of-life care to rural and remote cancer patients, there are still disparities in access and service availability compared with metropolitan areas.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient early
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment
- promoting patient education and agency in decision-making
- proactive communication with the patient's primary healthcare provider to inform of changes in medication regimen or of ending active treatment
- communication to inform the treatment team of a death of a patient.

Checklist

- ☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as needed
- ☐ Patient referred to support services (such as the Cancer Council or relevant cancer-specific non-government organisations) as required
- ☐ Patient referred to palliative care
- ☐ Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.