Multicultural Primary Care Cancer Forum

Proudly brought to you by

Cancer Institute NSW,

Hunter New England and Central Coast Primary Health Network ,

and

Hunter New England Local Health District

Thank you for joining us!

17 May 2023

Acknowledgement of Country

I acknowledge the Traditional Custodians of the lands on which we work and live, and recognise their continuing connection to land, water and community.
I pay my respects to Elders past and present.

Artwork by D.Golding 2016

Welcome

PRIMARY HEALTH NETWORK

Janice Petersen

SBS World News Presenter and Journalist

Multicultural Primary Care Cancer Forum

17 May 2023

NSW GOVERNMENT

Opening address

Professor Tracey O'Brien
NSW Chief Cancer Officer
Chief Executive Officer, Cancer Institute NSW

Multicultural Primary Care Cancer Forum

17 May 2023

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Lorin Livingstone

Executive Manager People, Operations and Engagement,

Hunter New England and Central Coast Primary Health Network

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Liz Grist

Executive Director, Nursing and

Midwifery, Hunter New England Local Health District

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Dr Lee Fong

General Practitioner, Brunker Road General Practice

Multicultural Primary Care Cancer Forum

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Culturally and Linguistically Diverse (CALD) patient experiences with GPs and service access

Ms Nyan Thit Tieu
Founder, Sisters Cancer Support Group

Multicultural Primary Care Cancer Forum

17 May 2023

SAYING AS IT IS!!!

"PERSPECTIVES ON SHARED CANCER CARE IN PRIMARY HEALTH CARE SECTOR"

by

A consumer with lived experience from a minority community group

"CANCER CARE OR CANCER JOURNEY"

- Referral for Testing and Screening
- Early detection
- Post diagnosis
- Complexity of treatments steps
- Post treatment care and survivorship
- Comorbidities
- Psychological and emotional issues
- Selfcare strategies or healthy lifestyles……..etc.

CASE STUDY 1

Background

- Been in the country for a long time
- Speaks English well
- Good formal education
- Good health literacy skills
- Can navigate the health systems
- Understands the cause & effects of Cancer
- Understands the treatment processes
- Knows how to seek for help
- Have self-care skills / healthy living skills

Diagnosis & treatments

- Breast cancer
- Early detection
- Lumpectomy, chemo, radiation, medication
- Read a lot to understand cancer
- Attended possible talks and programs to enhance my survivorship
- Changed my life-style and diet by attending cancer retreats & info sessions
- Changed my mindset with the onco-psychologist help.

CASE STUDY 2

Background

- Short time in Australia, (years in refugee camp)
- Very little English
- No formal education
- No health literacy skills
- Low or poor hygiene habits
- Cannot navigate the health system
- No understanding of cause & effects of Cancer
- No understanding of cancer treatment processes
- Don't know where to go for help
- Very little self-care skills / healthy living skills

Diagnosis & treatments

- Stomach cancer
- Misdiagnosed initially
- Operation to remove the cancer.
- No support nor understanding of how to selfcare during treatment and after treatment
- A lot of problem consuming solid food and swallowing
- Ended up with a PEG tube
- Consequently her lifestyle was changed
- Facing a lot of psychological and emotional problems

COMPARISON OF THE TWO CASE STUDIES

" NEEDS ANALYSIS "

Case Study 1 –Needs Analysis

- **Need to overcoming and break through preconceived ideas & prejudices, that leads to inequity of services**
- **Need progressive doctors and nurses who are open minded to Integrative Medicine and Life-style Medicine.**

Case Study 2 – Needs Analysis

- **Need To overcome stigma, misunderstanding & taboo in talking about cancer**
- **Need empathetic doctors and nurses who understands the nuances of different cultures**
- **Need good, knowledgeable interpreter**
- **Financial support**
- **Transport**
- **Psychological & emotional support**
- **Need a lot of day to day support from**
  - **Community nurses**
  - **Cancer support groups**
  - **Friends/relatives**

SISTERS' CANCER SUPPORT GROUP INC.

"Supporting each other on our cancer journey

You are not alone !"

Our *"**ESSENCE** of Health"* of health holistic model.

(Developed by Dr. Craig Hassad, Monash University)

- ***E*** **Education**
- **S** **Support & Stress management**
- **S** **Spirituality**
- ***E*** **Exercise**
- **N** **Nutrition**
- **C** **Connectedness**
- ***E*** **Environment**

SISTERS' CANCER SUPPORT GROUP INC.

Thank You

Best wishes and good luck to everyone in the PHC sector in

1. **C**ollaborating,
2. **C**onsulting,
3. **C**ooperating &
4. **C**o-delivering

the shared primary cancer care to the multicultural cancer patients.

Culturally and Linguistically Diverse (CALD) patient experiences with GPs and service access

Ms Nyan Thit Tieu
Founder, Sisters Cancer Support Group

Multicultural Primary Care Cancer Forum

17 May 2023

Bowel cancer prevention – diet, microbiome and screening

Dr Tom Goodsall
Gastroenterologist, John Hunter Hospital

Multicultural Primary Care Cancer Forum

17 May 2023

Cancer Institute NSW

Bowel cancer prevention: Diet, microbiome and screening

Dr Tom Goodsall

BSc MBBS(Hons) MClinEpid FRACP

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Hunter New England
Local Health District

Thank you and disclaimer

- Cancer institute NSW
- Hunter New England Multicultural health services
- Sandra Fitzgerald @ Health Pathways

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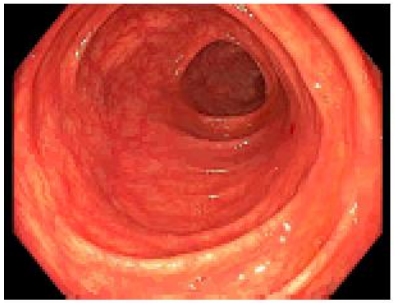
Hunter New England
Local Health District

Case study – JP 49M

- Refugee from DRC 2018, single father to two high school aged children
- Gun shot wound to sciatic nerve and forefoot amputation aged 2, features of trauma from multiple hospitalisations
- No English, speaks Lingala and Swahili
- New onset rectal bleeding and altered bowel habits, sister died from bowel cancer in late 30’s

Case study – JP 49M

- Referred to Gastro clinic Oct 2020, referral triaged as urgent
- First appointment offered Oct 2022, patient did not attend
- Next appointment Feb 2023, attended
  - Swahili interpreter available via videotelehealth
  - Consented to colonoscopy, bowel preparation instructions only available in English
  - Anaesthetic concerns
- Colonoscopy May 2023
  - Perfect prep
  - Excellent anaesthetic encounter
  - No lesions, returned to NBCSP



Challenges to bowel cancer screening and prevention in multicultural groups

- FOBT participation
- Primary care access and attendance
- Language barriers
- Cultural factors
  - Interpretation of symptoms
  - Engagement with health care
- Complex and confusing health care system
- Health literacy
- Financial
- Delays
- Advocacy
- Data

Is there a problem? NBCSP participation

- Bowel cancer is second highest cause of cancer mortality in Australia, affects 1/16 people by 85
- The National Bowel Cancer Screening Program sends out free bowel cancer tests to eligible Australians aged 50-74 every two years.
- Can be asymptomatic
- NSW participation at 40%

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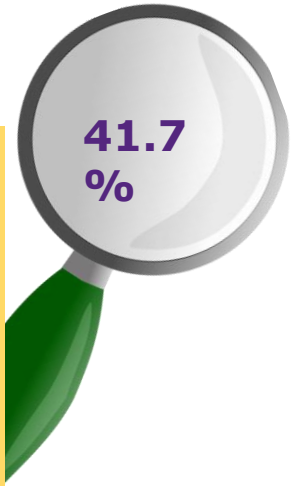
Annual bowel cancer screening participation rate by LGA for 2020 (RBCO)

Hunter New England and Central Coast PHN



Port Stephens 46.6

Walcha 45.6

Mid-Coast 46.1

Lake Macquarie 45.1

Maitland 42.6

Uralla 42.7

Newcastle 41.8

Dungog 41.4

Armidale Regional 41.0

Tamworth Regional 40.9

Inverell 40.5

Glen Innes 39.8

Cessnock 39.0

Upper Hunter Shire 38.6

Singleton 38.5

Muswellbrook 35.0

Gunnedah 34.3

Tenterfield 39.4

Gwydir 37.7

Liverpool Plains 37.7

Narrabri 31.2

Moree Plains 26.3

Is there a problem? NBCSP participation

- Australians who spoke a language other than English at home had a lower bowel screening participation rate than those who spoke English at 26-37% compared to 45-49%, respectively

- People of Culturally and Linguistically Diverse (CALD) background face barriers that limit participation in cancer screening programs.

- **These include**
  - poor health literacy
  - low general literacy
  - lack of in-language information
  - beliefs around cancer
  - low awareness of cancer screening programs
  - difficulty navigating along the care pathway

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Is there a problem? NBCSP participation

Table 5.3: Summary of performance indicators for Indigenous and non-Indigenous Australians

Indicator		Summary of performance indicators for Indigenous Australians compared with non-Indigenous Australians	Indigenous	Non-Indigenous
PI 1	Participation rate[a]	Lower participation rate	35.2%	45.5%
PI 2	Screening positivity rate	Higher screening positivity rate	10%	7%
PI 3	Diagnostic assessment rate	Lower diagnostic assessment follow-up rate	51%	62%
PI 4	Time between positive screen and diagnostic assessment	Longer median time	64 days	49 days
PI 9	Adverse events – hospital admission	Comparison not published	n.p.	n.p.
PI 10	Incidence of bowel cancer[b][c]	Similar age-standardised incidence rate	117 per 100,000	116 per 100,000
PI 11	Mortality from bowel cancer[c][d]	Higher age-standardised mortality rate	36 per 100,000	29 per 100,000

(a) Participation rates by Indigenous status were estimated using 2016 Census proportions (see Appendix F for more information).

(b) Includes only New South Wales, Victoria, Queensland, Western Australia and the Northern Territory.

(c) These rates were calculated using Indigenous population based on the 2016 Census and should not be compared with rates calculated using populations based on previous Censuses. See Box 3.1 for more information.

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Table 5.4: Summary of performance indicators for English speakers and those who spoke a language other than English (LOTE) at home

Indicator		Summary of performance indicators for those who spoke a language other than English at home compared with English speakers	LOTE	English
PI 1	Participation rate[(a)]	Lower participation rate	26.8–37.1%	45.2–49.0%
PI 2	Screening positivity rate	Lower screening positivity rate	6%	7%
PI 3	Diagnostic assessment rate	Lower diagnostic assessment follow-up rate	52%	63%
PI 4	Time between positive screen and diagnostic assessment	Longer median time	52 days	49 days
PI 9	Adverse events – hospital admission	Comparison not published	n.p.	n.p.
PI 10	Incidence of bowel cancer[(b)]	Comparison not available	n.a.	n.a.
PI 11	Mortality from bowel cancer[(b)]	Comparison not available	n.a.	n.a.

(a) Participation rates by language spoken at home were estimated using 2016 Census proportions (see Table A5.1 and Appendix F for more information).

(b) Data for this indicator are not available.

Notes

1. The participation indicator PI 1 is reported against the period 2019–2020 with follow-up to June 2021. The screening indicator PI 2 is reported against the period 2020. The assessment indicators PIs 3 and 4 are reported against the period 2020 with follow-up to 31 December 2021. Incidence and mortality data are not currently available for reporting by language spoken at home.
2. Indicators 3–9 rely on information being reported back to the NCSR. As NBCSP forms are not mandatory, there may be incomplete form return and incomplete data.
3. PI 5a (adenoma detection rate), PI 5b (PPV of diagnostic assessment for detecting adenoma), PI 6a (colorectal cancer detection rate), PI 6b (PPV of diagnostic assessment for detecting colorectal cancer), PI 7 (interval cancer rate) and PI 8 (cancer clinico-pathological stage distribution) are not reported due to data incompleteness or unavailability.

Sources: 2016 Census data; AIHW analysis of NCSR as at 31 December 2021 (NCSR RDE 08/01/2022).

Is there a problem?

Not enough reliable data!

The microbiome

The microbiome

- 10^{13}-10^{14} microbes covering 200m^2 of mucosa
- Microbes > 10x cells with 150x genes compared with human genome.
- 500-1000 species and > 7000 strains
- Barrier is a single epithelial layer and most microbes are pathogenic if translocated
- Microbiome impacts expression of many genes including inflammatory and anti-inflammatory proteins

Qin J, Li R, Raes J, Arumugam M, Burgdorf KS, Manichanh C, Nielsen T, Pons N, Levenez F, Yamada T, et al. A human gut microbial gene catalogue established by metagenomic sequencing. Nature 2010; 464:59-65; PMID:20203603; http://dx.doi.org/10.1038/nature08821
Maukonen J, Saarela M. Human gut microbiota: does diet matter? Proc Nutr Soc 2015; 74:23-36; PMID:25156389; http://dx.doi.org/10.1017/S0029665114000688
Plaza-Diaz J, Gomez-Llorente C, Fontana L, Gil A. Modulation of immunity and inflammatory gene expression in the gut, in inflammatory diseases of the gut and in the liver by probiotics. World J Gastroenterol 2014; 20:15632-49; PMID:25400447; http://dx.doi.org/10.3748/wjg.v20.i42.15632

Composition of the microbiome

- Dynamic
  - Gestational age and delivery method
  - Age
  - Antibiotic exposure
  - Household and environment biome
  - Diet
    - Macros
    - Emulsifiers
    - Other
  - Illness
  - Appendix
  - Host immune and genetic factors
  - Diurnal rhythm and shift work

Qin J, Li R, Raes J, Arumugam M, Burgdorf KS, Manichanh C, Nielsen T, Pons N, Levenez F, Yamada T, et al. A human gut microbial gene catalogue established by metagenomic sequencing. Nature 2010; 464:59-65; PMID:20203603; http://dx.doi.org/10.1038/nature08821
Maukonen J, Saarela M. Human gut microbiota: does diet matter? Proc Nutr Soc 2015; 74:23-36; PMID:25156389; http://dx.doi.org/10.1017/S0029665114000688
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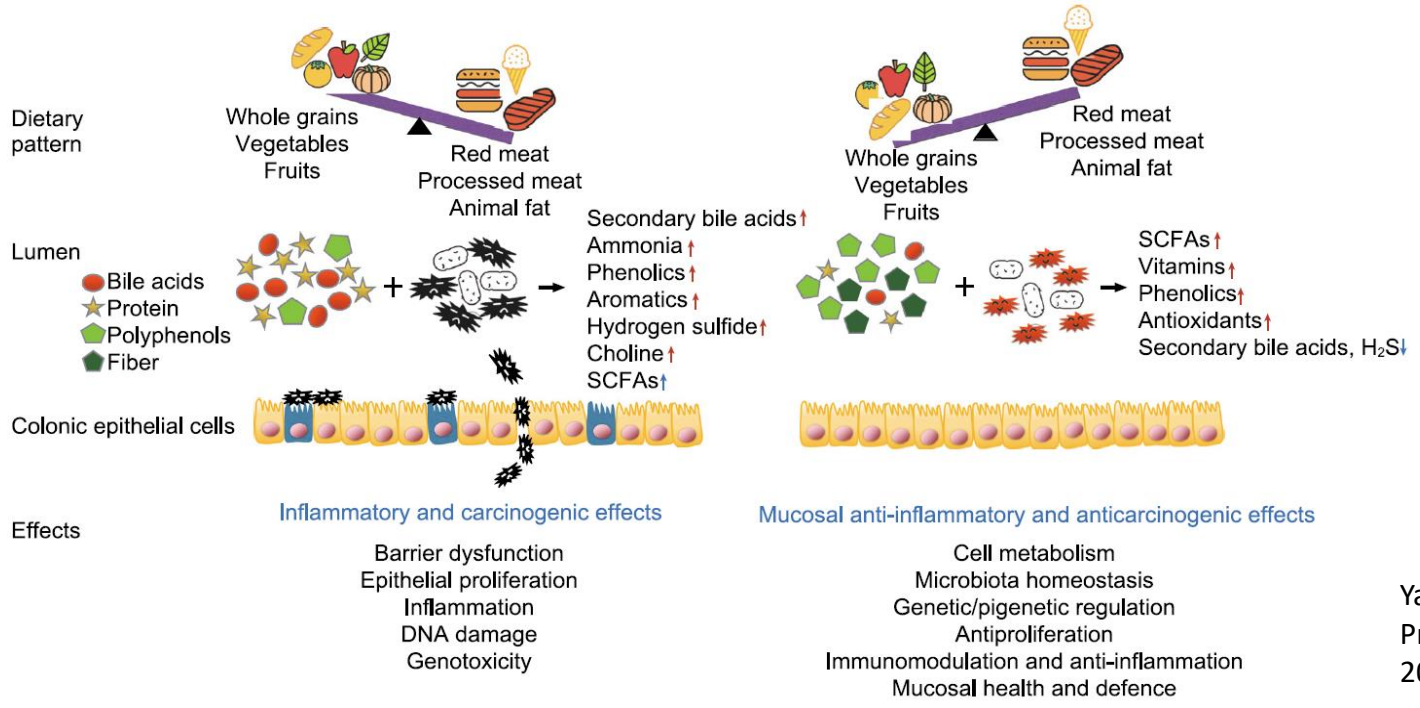
Complexity of the biome

- Soya rich diet (i.e. Japanese) improves CV health, osteoporosis, prostate Ca risk and MI/Stroke risk
- (S)-equol produced from soya isoflavone daidzein
  - Bacterial enzyme, not human
- Produced in 50-60% of Asian adults but only 25% of Western adults
- Signal for Soya diet benefit only demonstrated in Asian populations

Jackson et al. Nutr. Reviews. 2011
Setchell et al. J. Nutri. 2010

Microbiome affects bowel cancer risk

- Dietary residue (Fibre, proteins, secondary bile acids) affect the faecal microbiome and bowel cancer risk



Yang & Yu. Protein & Cell 2018.

Microbiome leads to CRC

- Increase in
  - *E. coli*
  - *Bacteroids fragilis* (Fragilysin activated NFKB cell proliferation and inflammation)
  - *Fusobacterium nucleatum* (enriched in tumours and *mets*)
  - *Providencia* (TLR interactions increasing ROS)
- Decrease in
  - *Roseburia*
  - *Fecalibacterium*

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Migrant populations and bowel cancer risk

- Lower rates of CRC amongst groups with high fibre diet
  - Decreased concentration of intestinal carcinogens due to stool bulk
  - Decreased carcinogen exposure with greater motility
  - Fermentation to Butyrate → Apoptosis and epigenetic effects inhibiting tumour growth
  - Increased *Firmicutes* species
    - Host immune response
    - Anti-inflammatory effects

Yang & Yu. Protein & Cell 2018.

Migrant populations and bowel cancer risk

- Bowel cancer incidence 13 times higher in African Americans than rural Africans
- Switching from a rural African plant based diet to a typical Western for 2 weeks results in
  - Shifts in microbiome with increases in *E. coli* and *Acinetobacter*
  - Decreased butyrogenesis (*Fermicutes)*
  - Increased production of secondary bile acids
  - Increased colonocyte Ki-67 index

O'Keefe SJD et al.
Nature Comm. 2015

- The reverse is true when African Americans are switch to a rural African diet for 2 weeks

Returning to Bowel Cancer Screening

NBCSP

- Full implementation since 2020
- FOBT every 2 years from 50-75
- **Standard access mail out model**
  - Send directly to eligible people using their current Medicare address
- **Alternative access model**
  - Primary health care practitioners can give directly to patients.
  - Via National Cancer Screening Register Healthcare Provider Portal
  - Practices can bulk order test kits
  - Provider training is necessary to access portal and resources

HNE Community HealthPathways

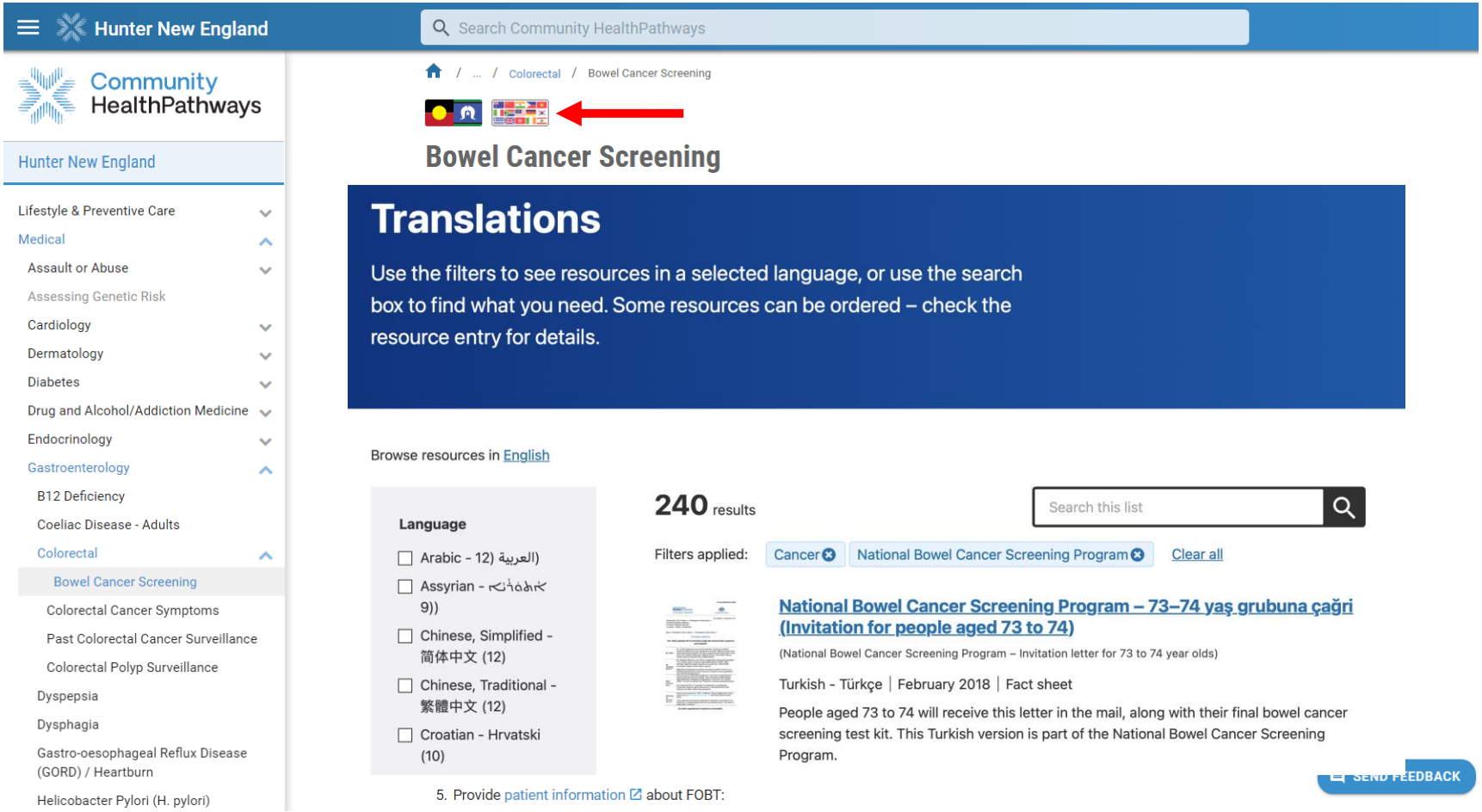
https://hne.communityhealthpathways.org/

Username: hnehealth

Password: p1thw1ys

http://patientinfo.org.au/

No password required


Hunter New England
Search Community HealthPathways
Community HealthPathways
Hunter New England
Lifestyle & Preventive Care
Medical
Assault or Abuse
Assessing Genetic Risk
Cardiology
Dermatology
Diabetes
Drug and Alcohol/Addiction Medicine
Endocrinology
Gastroenterology
B12 Deficiency
Coeliac Disease - Adults
Colorectal
Bowel Cancer Screening
Colorectal Cancer Symptoms
Past Colorectal Cancer Surveillance
Colorectal Polyp Surveillance
Dyspepsia
Dysphagia
Gastro-oesophageal Reflux Disease (GORD) / Heartburn
Helicobacter Pylori (H. pylori)
... / Colorectal / Bowel Cancer Screening
Bowel Cancer Screening
Translations
Use the filters to see resources in a selected language, or use the search box to find what you need. Some resources can be ordered – check the resource entry for details.
Browse resources in English
Language
Arabic - 12) العربية)
Assyrian - ܣܘܪܝܝܐ 9))
Chinese, Simplified - 简体中文 (12)
Chinese, Traditional - 繁體中文 (12)
Croatian - Hrvatski (10)
240 results
Search this list
Filters applied:
Cancer
National Bowel Cancer Screening Program
Clear all
National Bowel Cancer Screening Program – 73–74 yaş grubuna çağri (Invitation for people aged 73 to 74)
(National Bowel Cancer Screening Program – Invitation letter for 73 to 74 year olds)
Turkish - Türkçe | February 2018 | Fact sheet
People aged 73 to 74 will receive this letter in the mail, along with their final bowel cancer screening test kit. This Turkish version is part of the National Bowel Cancer Screening Program.
SEND FEEDBACK
5. Provide patient information about FOBT:

Management

1. If the patient's FOBT result is negative:
    - repeat screening at least once every 2 years or according to risk category assessment for patients 50 years or older, unless new symptoms develop.
    - ensure a recall is added to the patient's record.
    - discuss recommendations for reducing the risk of colorectal cancer and give patient information.

> **Recommendations for reducing the risk of colorectal cancer**
>
> Recommendations include:
>
> - completing the National Bowel Cancer Screening Program (NBCSP) at-home bowel cancer test every two years if aged 50 to 74 years
> - considering aspirin, unless contraindicated, after weighing the risks and potential benefits.
> - eating a healthy high fiber diet, including plenty of vegetables, fruit, and whole grains while minimising the intake of red meat, and barbequed, grilled, and processed meat
> - maintaining a healthy body weight
> - undertaking regular physical activity
> - avoiding or limiting alcohol intake
> - not smoking.

    - consider using the average population screening risk diagram to encourage patients to be screened for CRC with iFOBT every 2 years.
2. If the patient's FOBT result is positive:
    - request a diagnostic colonoscopy from a gastroenterologist or general surgeon, or a direct or open access colonoscopy clinic

Access

- Changes and improvement in GI access
  - Expansion of Colonoscopy Direct Access
  - Waitlist management
  - Service expansion
- Communication remains essential
  - Referrals
  - Safety netting vulnerable individuals and groups

Challenges and wicked problems

- Data collection and visibility of multicultural groups
- Funding
- Equitable access to health care
- Enhancing cultural awareness and understanding
- Healthcare in a linguistically diverse setting
- System pressures
- Health practitioner pressures
- Multicultural representation in Health Care Providers
- Identifying champions and allies

Thank you

- NCSR Healthcare portal
  - https://www.ncsr.gov.au/information-for-healthcare-providers/
- Health Pathways
  - https://hne.communityhealthpathways.org/

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Bowel cancer prevention – diet, microbiome and screening

Dr Tom Goodsall
Gastroenterologist, John Hunter Hospital

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Cancer Institute NSW

Smoking and cancer among CALD populations

Professor Christine Paul
University of Newcastle

Multicultural Primary Care Cancer Forum

17 May 2023

An intricate game: Making the right moves to address smoking and cancer among CALD populations

Christine Paul

School of Medicine and Public Health, University of Newcastle

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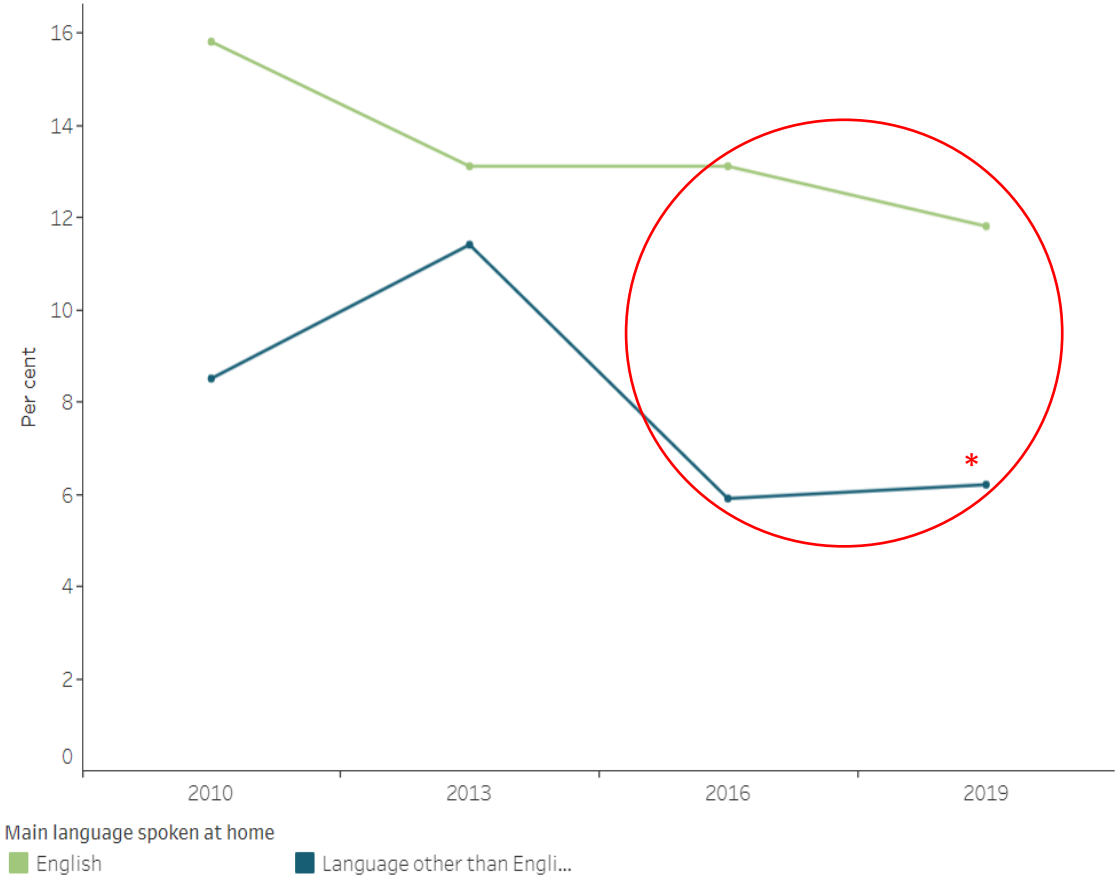
Daily Tobacco Smoking (14+)



AIHW, 2020

Tobacco Smoking Rates

Current = daily or occasional

	Never smoked*	Ex-smokers†	Current Smokers‡
All persons, 14+ years	63.1	22.8	14
Country of birth			
Australia	60.4	24.2	15.4
New Zealand & Oceania	55.7	27.6	16.6
United Kingdom	49.6	39	11.4
Europe	54.2	34.3	11.5
South East Asia	85.7	7.3	6.9
Other Asia	86.9	6.9	6.2
North Africa and the Middle East	67.7	14.8	16.9
Sub-Saharan Africa	68.1	24.3	7.7
Americas	70.3	21.0	8.7
Language spoken at home			
English	60.0	25.3	14.8
Language other than English	84.4	8.1	7.5

AIHW 2020

Sub-population differences in Australia

Women

- Higher among men than women in some groups[1]
- Higher in some women:
  - Pasifika, NZ, UK[5]
- Lower in some women:
  - E Asia and SE Asia[5]

Men

- Up to half of Vietnamese-background men[2,3]
- Up to half of Chinese-background men[2,3]
- Up to one-third Arabic speaking general practice patients[4]
- Higher in men born in Europe, North Africa, and the Middle East[5]

1. Higgs et al 2020. 2. Rissel et al 2000, 3. Jiang et al 2017 4. Girgis et al 2009 5.Weber et al 2011

Other types of tobacco products

- Waterpipe/Shisha
  - Up to 11% daily use among Arabic speakers[1,2]
- Smokeless tobacco
  - Up to 17% daily use in SE Asian communities[3]

1. Perusco et al 2007 2. Gregov et al 2011 3. Hossain et al 2014

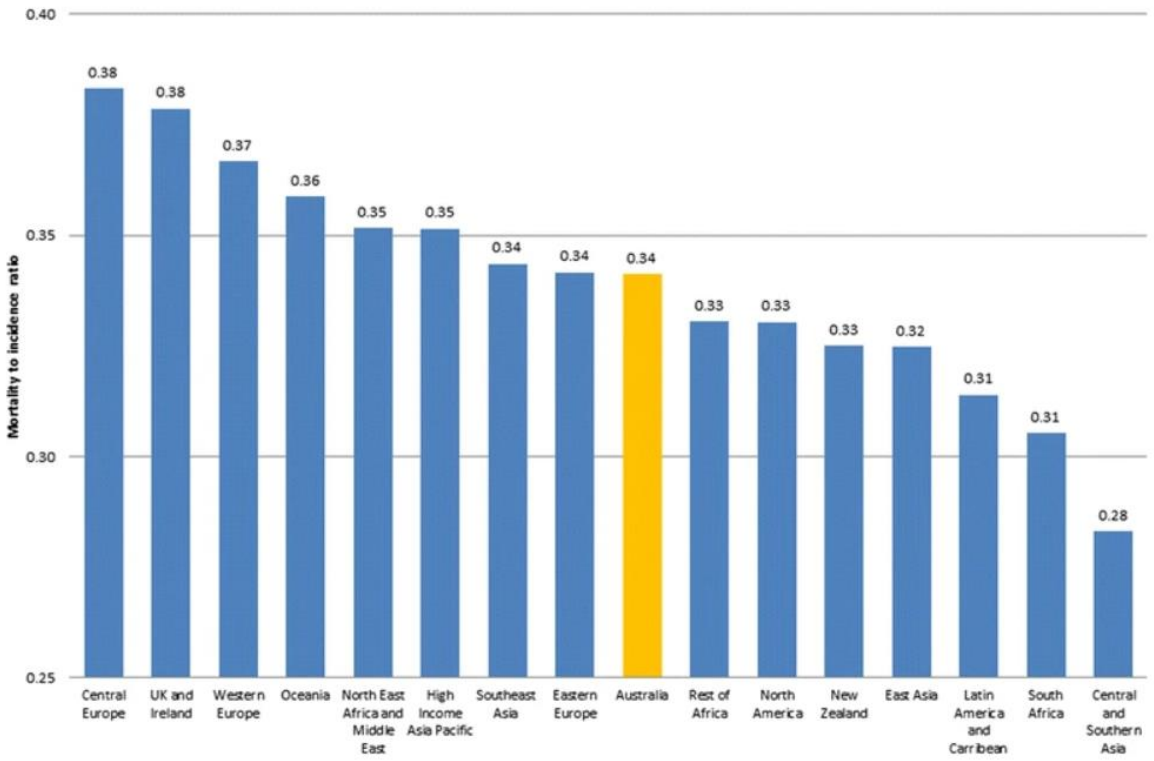
Cancer Incidence & Mortality (NSW)

- All-cancer incidence higher for NZ, Western Europe, Oceania, UK, Ireland v Aust-born [1]
- Variations in treatment and survival by country of birth in NSW for NSCLC[2]

1. Feletto et al, 2015 2. Little et al 2022

Mortality to Incidence Ratios

Need for consistent and tailored smoking cessation programs for CALD groups



Felleto and Sitas, 2015

Perceptions of tobacco use

Low perceived cancer risk

- Waterpipe/Shisha
  (oesophegeal, gastric, lung cancers[2])
- Smokeless tobacco
  (oral cancers)

- Skepticism about health risks of shisha/SLT [3]
- Health effects known but distant
- Salient negative impacts: cost, smell, breathlessness, coughing
- Current enjoyment outweighs future risks

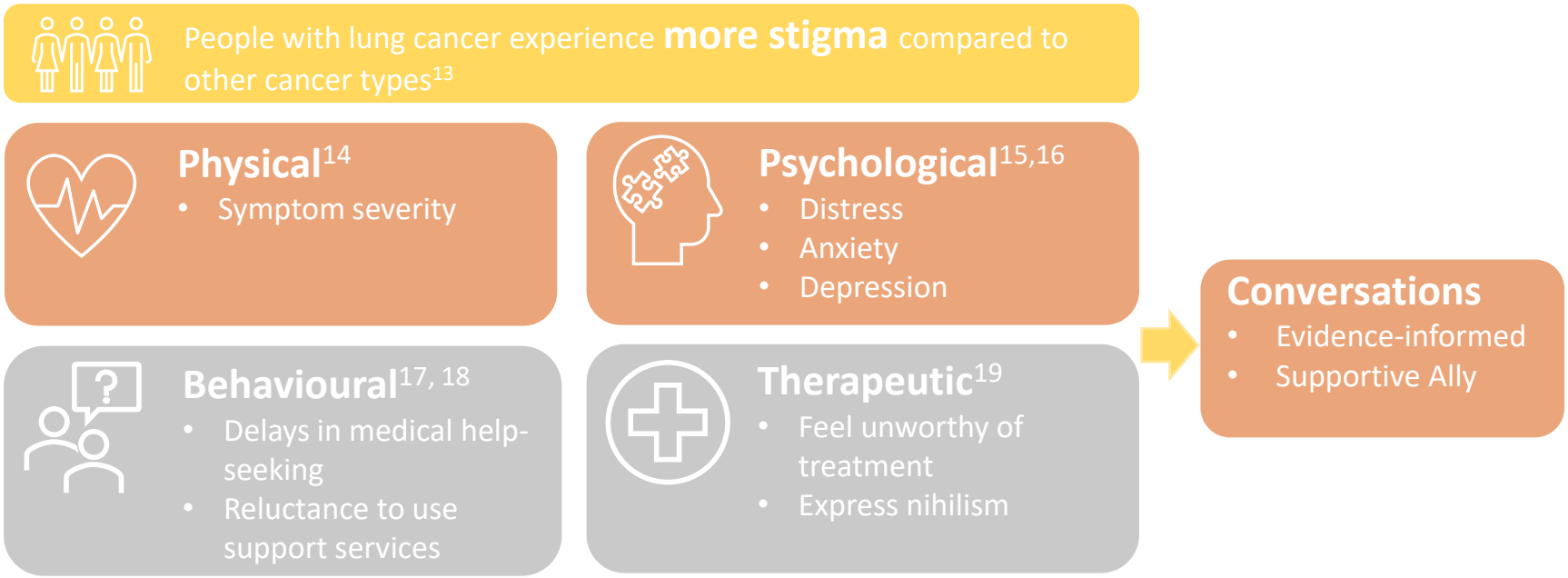
2. El Zataari et al 2015 3. Kearns et al 2015

Social context of tobacco use

- Influence of country of origin:
  - high prevalence
  - limited campaigns/ warnings
- Culture and family critical influences on continued smoking and quitting
- Cultural, social and communal practice associated with hospitality, courtesy, and generosity

NSW CALD report

Lung cancer and stigma



13. Lebel S, et al.; 2013
14. Cataldo JK and Brodsky JL; 2013
15. Chambers SK, et al.; 2012
16. Webb LA, et al.; 2019
17. Carter-Harris L, et al.; 2014
18. Devitt B, et al.; 2010
19. Chapple A, Ziebland S and McPherson A; 2004

Are CALD people who smoke given ***every*** opportunity to quit?

Effective Cessation Interventions

Intervention component	Chinese-speaking participants	Vietnamese-speaking participants	Arabic-speaking participants
Written information	✓	~	~
Education sessions	✓	~	−
Visual information	✓	?	?
Counselling	✓	~	✓
Media campaign	~	?	?
Involving a family member or friend	✓	?	?
Nicotine replacement therapy (NRT)	✓	~	?
Telephone follow-up	~	?	?
Branded merchandise	✓	−	−
Mobile messaging	✓	−	−

✓ promising evidence

~ mixed evidence or based on aggregated data for multiple CALD groups

? insufficient evidence

− no evidence

McEntee et al 2022 (Sax Inst)

Other languages

中文信息（广东话/普通话）
Information in Simplified Chinese

中文資料(粵語/普通話)
Information in Traditional Chinese

Thông tin tiếng Việt
Information in Vietnamese

معلومات باللغة العربية
Information in Arabic

NSW GOVERNMENT iCanQuit

Join iCanQuit

Quitline 137848

Sign In

Home | Stories & Experiences | tting Started | Quitting Methods | Staying Quit

Home > Quitting Methods > Information in

Quitting Method

- Willpower
- Nicotine Replacement Therapy (NRT)
- Prescribed Quit Smoking Medication
- Professional Support and Advice
- Cut Down to Quit
- Cold Turkey

Information in Simplified Chinese

Read this page in English 网页英文版

Resources

uitting-methods/professional-support-and-advice/quitline/quitline-referral

*Fields marked with an * are mandatory.*

Client/patient details

Acknowledgement *: ☐ I acknowledge that the client/patient named has been provided with information about the Quitline has provided verbal informed consent to their information being sent to the NSW Quitline.

Surname *: | Given Names *: | Postcode *:

Gender Identity:
○ Female ○ Male ○ Non-binary ○ Prefer to self-describe

Preferred phone number *: | Preferred date of first call: dd/mm/yyyy

Preferred day/s to call:
☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Preferred time/s to call:
☐ 9am to 12pm ☐ 12pm to 5pm ☐ 5pm to 8pm

Is it OK to leave a message?
○ Yes ○ No

Interpreter required? ☐ Yes If yes, specify language:

Tackling Lack of Data

CARE to QUIT

HNE Health
Multicultural Health Service

Appendix 2a. Introductory Videos for Main Study participation

Arabic 	Go to this video by clicking or typing into your web browser: https://bit.ly/MainstudyArabic Or using the QR code
Chinese (Mandarin) 	Go to this video by clicking or typing into your web browser: https://bit.ly/MainstudyChinese Or using the QR code
Vietnamese 	Go to this video by clicking or typing into your web browser: https://bit.ly/MainStudyVietnamese Or using the QR code
Greek 	Go to this video by clicking or typing into your web browser: https://bit.ly/MainStudyGreek Or using the QR code

Summary

- CALD groups have a right to informed decision making
- Diverse tobacco-use patterns for CALD populations
- Cultural ‘value’ of smoking interacts with quitting
- Effective and specific cessation support available

Smoking and cancer among CALD populations

Professor Christine Paul
University of Newcastle

Multicultural Primary Care Cancer Forum

17 May 2023

Q & A Panel

Ms Nyan Thit Tieu

Professor Christine Paul

Dr Tom Goodsall

Multicultural Primary Care Cancer Forum

17 May 2023

Multicultural Primary Care Cancer Forum

Proudly brought to you by

Cancer Institute NSW,

Hunter New England and Central Coast Primary Health Network ,

and

Hunter New England Local Health District

Thank you for joining us!

17 May 2023

HealthPathways

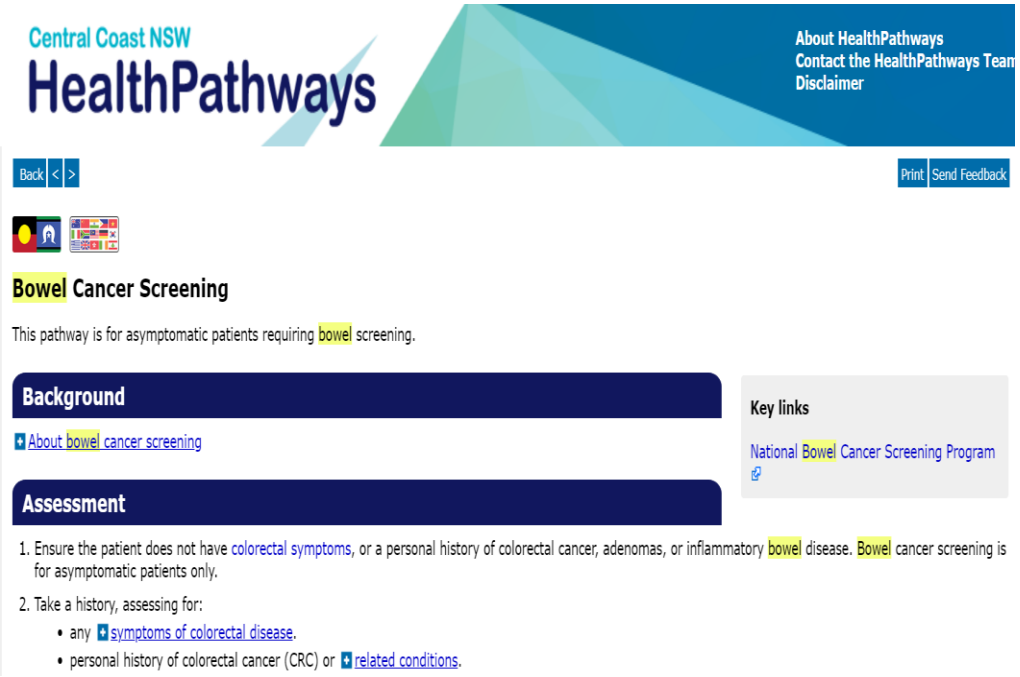
Denise Lyons
HealthPathways Clinical Editor, Hunter New England and Central Coast Primary Health Network

Multicultural Primary Care Cancer Forum

17 May 2023

Community HealthPathways – clinical pathways

Central Coast



https://centralcoast.healthpathways.org.au
Username: centralcoast
Password: 1connect

Hunter New England

https://hne.communityhealthpathways.org/
Username: hnehealth
Password: p1thw1ys

HUNTER & NEW ENGLAND
HealthPathways

- **Cancer Screening pathways**
  Bowel
  Cervical
  Breast

Optimal Cancer Care

Community HealthPathways – Referral Pages

Central Coast

Central Coast NSW HealthPathways

Back < >

Cancer Care Coordination

See also Breast Cancer Nursing.

Referral

Cancer care coordinators

1. Check providers for specific criteria.
2. Prepare the standard referral information.
3. Contact the provider.
4. Inform the patient:
   - Ensure they are aware of the referral and the reason for being referred.
   - They should advise of any change in circumstance, e.g. getting worse, as this may affect the referral.

https://centralcoast.healthpathways.org.au
Username: centralcoast
Password: 1connect

Hunter New England

Community HealthPathways – Hunter New England

Back < >

Oncology Nursing Referrals

Current and former full-time members of the Australian Defence Force may be eligible for free mental health, cancer, and pulm
needing to prove that military service caused their condition. This includes reservists who have at least one day of continuous f
liability Health Care (NLHC).

See also:

- Oncology Referrals
- Palliative Care Referrals
- Lymphoedema Management Services
- Oncology Support Services

- State-wide

- Breast cancer nurses
- Prostate cancer nurses
- Youth cancer nurses
- Other services

https://hne.communityhealthpathways.org/
Username: hnehealth
Password: p1thw1ys

Community HealthPathways

Central Coast patient info HUNTER NEW ENGLAND Hunter New England

https://www.ccpatientinfo.org.au/
No password required

http://patientinfo.org.au
No password required

HUNTER & NEW ENGLAND
HealthPathways

Information

For health professionals

Education

- Cancer Institute NSW:
  - Cancer Prevention QI Modules
  - Breast Screening QI Module

Further information

- Breast Cancer Network Australia – Mammographic Density and Screening
- BreastScreen NSW:
  - Your Role in Breast Screening
  - Screening vs Diagnostic Mammography
  - Screening Interval Guidelines
- Cancer Australia – Overdiagnosis from Mammographic Screening
- Cancer Institute NSW:
  - Breast Screening Educational Resources (includes flip chart for use with patients)
  - Information and Resources for Primary Care
  - Working with Aboriginal Communities

HealthPathways

Denise Lyons
HealthPathways Clinical Editor, Hunter New England and Central Coast Primary Health Network

Multicultural Primary Care Cancer Forum

17 May 2023

Primary Care Cancer Control Quality Improvement Toolkit

Mary Mitchelhill
Manager Business Finance, Quality and Equity
Cancer Institute NSW

Multicultural Primary Care Cancer Forum

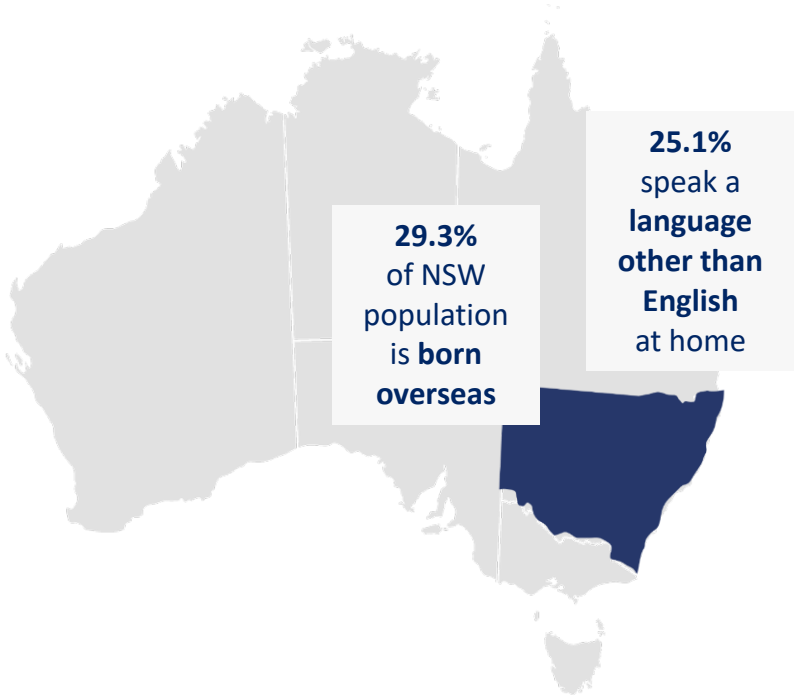
17 May 2023

Acknowledgement of Country

I acknowledge the Traditional Custodians of the lands on which we work and live, and recognise their continuing connection to land, water and community.
I pay my respects to Elders past and present.

Artwork by D.Golding 2016

NSW Multicultural Population



225
Birthplaces

307
Ancestries

146
Religions

215+
Languages

Languages used at home after English:

- Mandarin 3.4%
- Arabic 2.8%
- Cantonese 1.8%
- Vietnamese 1.5%

Top religions:

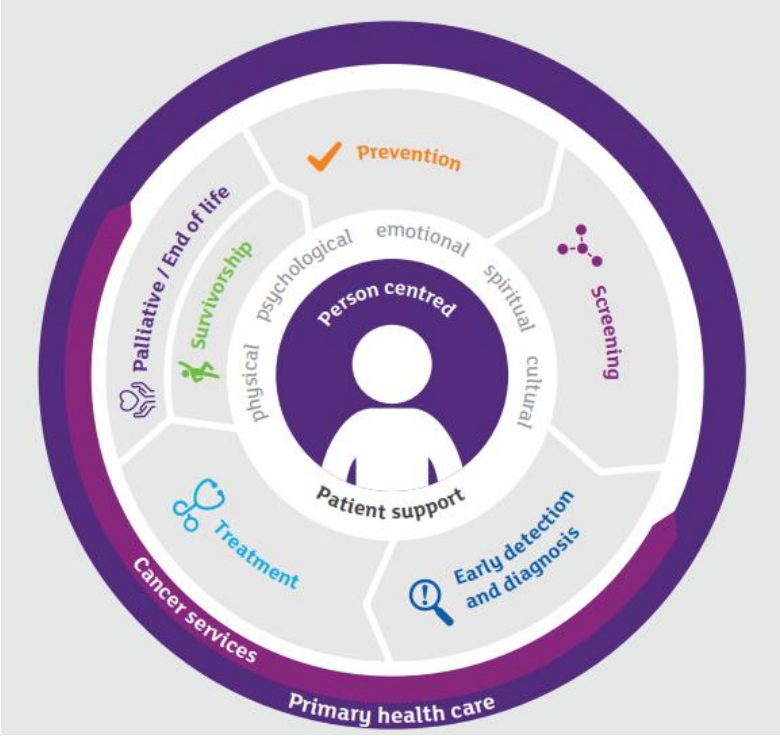
- Christianity
- Islam
- Hinduism
- Buddhism
- Judaism

Cancer Institute NSW

Provide strategic direction for cancer control in NSW

Our vision
To end cancers as we know them

Cancer control continuum



- **Person centred and integrated care** is essential to optimal cancer control outcomes.
- The primary health care sector is key to **delivering person centred care.**
- **Engagement and partnerships** across the health system strengthen and support the role of the primary health care sector in cancer control.

Smoking and CALD population groups

Key Factors:

- Family and culture important influencers in smoking behaviours and attitudes towards cessation
- Friends highly influential in encouraging smoking behaviours
- Arabic-speaking participants - smoking is shared within a family context, seen as important part of cultural life
- Among Cantonese, Vietnamese and Mandarin speaking participants
  - Young people mentioned smoking in secret and feared being found out by other family members
  - Cost of tobacco was a primary motivator for quitting
- Marriage and planning to start a family were mentioned as strong motivators for quitting

Source: Cancer Institute NSW Culturally and Linguistically Diverse Priority Populations - Formative Research for Tobacco Control Program (2018)

Multicultural communities in Hunter New England

- 61% of the women and people with cervix, aged 25-74 had a **Cervical Screening Test** in NSW.
- **Breast screening** participation rates for eligible women from culturally diverse background was 48.3%.
- People who spoke a language other than English at home had a lower **bowel screening** participation rate than those who spoke English, at 27–37%, compared to 45-49%, respectively.

General Practitioners:

- most trusted resource for patients in communities
- key role in cancer control
- can experience challenges/barriers in patient diagnosis and receiving specialist updates
- can be time poor
- recognise geographic challenges for patients accessing care

Quality improvement within your practice

- Patient outcomes
  - Reducing the risk of preventable cancers
  - Increased participation in screening and early detection of cancers
  - Increasing one- and five-year survival rates
- RACGP accreditation
- PIPQI/MBS items
- CPD hours APNA, RACGP, ACRRM
- Better management through clean data
- Motivating workplace culture

Cancer Control Quality Improvement Toolkit

An easy-to-follow roadmap for improving cancer screening rates and cancer prevention activities in your practice or health service.

cancer.nsw.gov.au/what-we-do/working-with-primary-care/primary-care-cancer-control-quality-improvement-to

Get started with the toolkit

Primary care approach

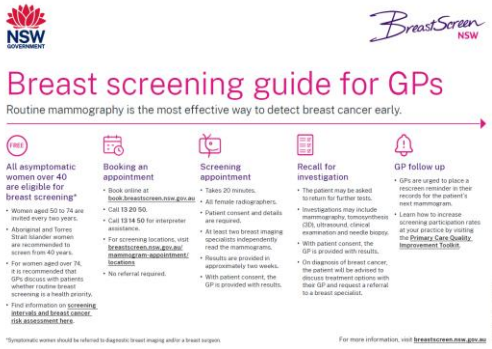
Cancer screening QI modules

Cancer prevention QI modules

Working with Aboriginal communities

Resources and tools

Cancer Institute NSW Information



A quick reference guide for General Practitioners and Practice Nurses about routine breast screening.

Flipchart supports health or community workers and educators working with multicultural communities.

What is cancer screening brochures and factsheets

Available in 38 languages

cancer.nsw.gov.au/about-cancer/document-library/what-is-cancer-screening

Quitline Information

- Patients don’t need to be ready to quit to talk to Quitline
- Quitline advisors can help plan and prepare for quit attempts
- Bilingual advisors - Arabic, Cantonese, Mandarin or Vietnamese
- Female and male Aboriginal advisors are available
- Interpreter service available for other language groups
- Three-way calls (client-health professional-Quitline)

Quitline is open:

- **7am-10.30pm** Monday-Friday
- **9am-5pm** on weekends & public holidays

ARABIC

Quitline 1300 7848 03

توقف عن التدخين بمساعدة احترافية مجانية وباللغة العربية

CHINESE (CANTONESE AND MANDARIN)

Quitline 1300 7848 36

免費中文專業輔導協助你戒煙

VIETNAMESE

Quitline 1300 7848 65

Bỏ hút thuốc qua sự hướng dẫn chuyên nghiệp và miễn phí

Quitline 13 7848

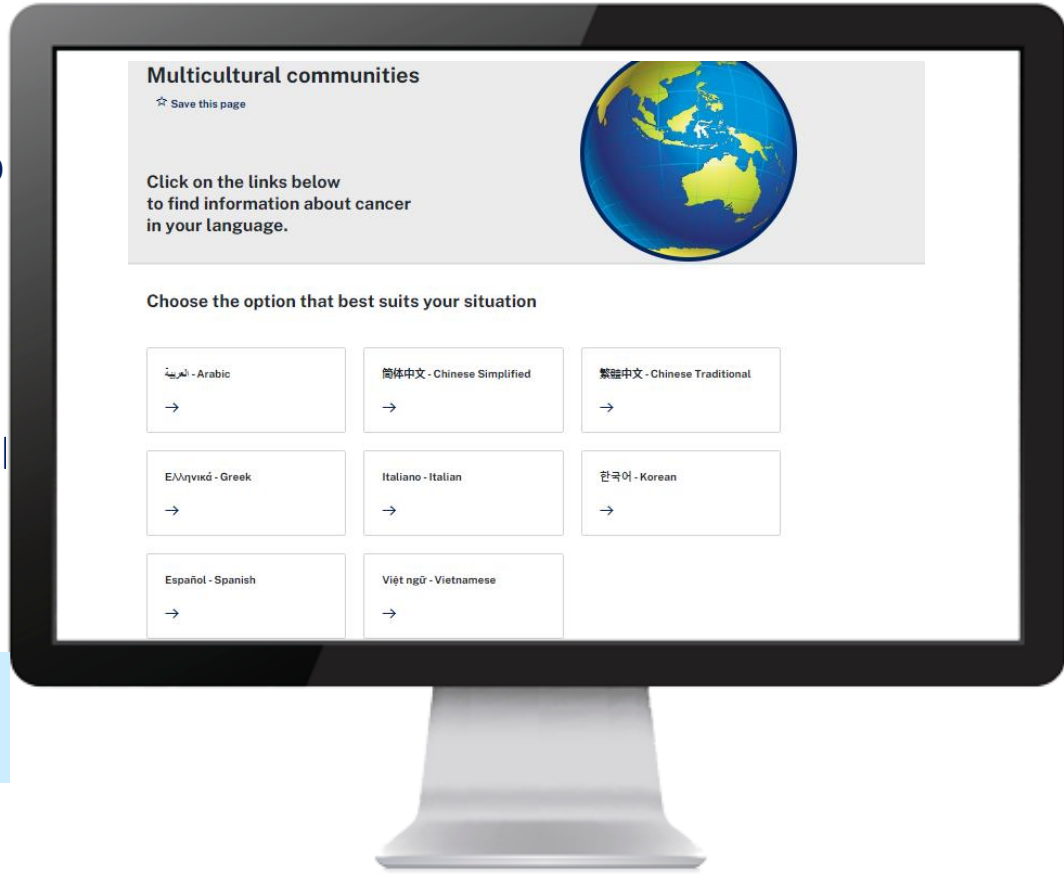
Multicultural Program Highlights

1. Refugee Cancer Screening Partnership Project

2. Multicultural Stigma Project

3. Increasing awareness of cancer clinical trials in multicultural communities

cancer.nsw.gov.au/about-cancer/types-of-cancer/general-cancer-information/communities/multicultural-communities



Primary Care Cancer Control Quality Improvement Toolkit

Mary Mitchelhill
Manager Business Finance, Quality and Equity
Cancer Institute NSW

Multicultural Primary Care Cancer Forum

17 May 2023

Supporting people and carers affected by cancer

Kimberley Williamson
Program Lead, Patient Experience Cancer Institute NSW

Multicultural Primary Care Cancer Forum

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Artwork by D.Golding 2016

Resources to support carers and people affected by cancer

- Resources available across the cancer care continuum
- Easy to access, safe, reliable and easy to understand
- Available in additional languages to support our Culturally and Linguistically Diverse communities
- Culturally safe resources for our Aboriginal communities
- Opportunity to increase awareness and usage of Cancer Institute NSW resources

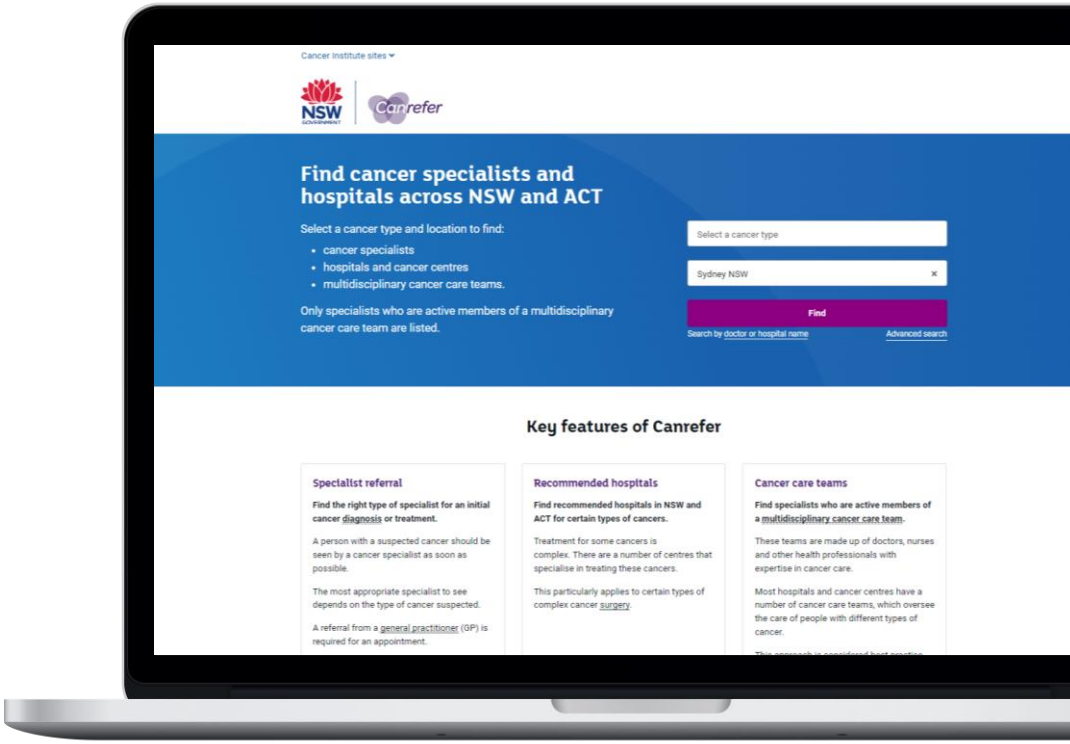
Canrefer

Free online directory for NSW & ACT listing cancer specialists, hospitals, cancer centres and multidisciplinary cancer care teams.

Key features:

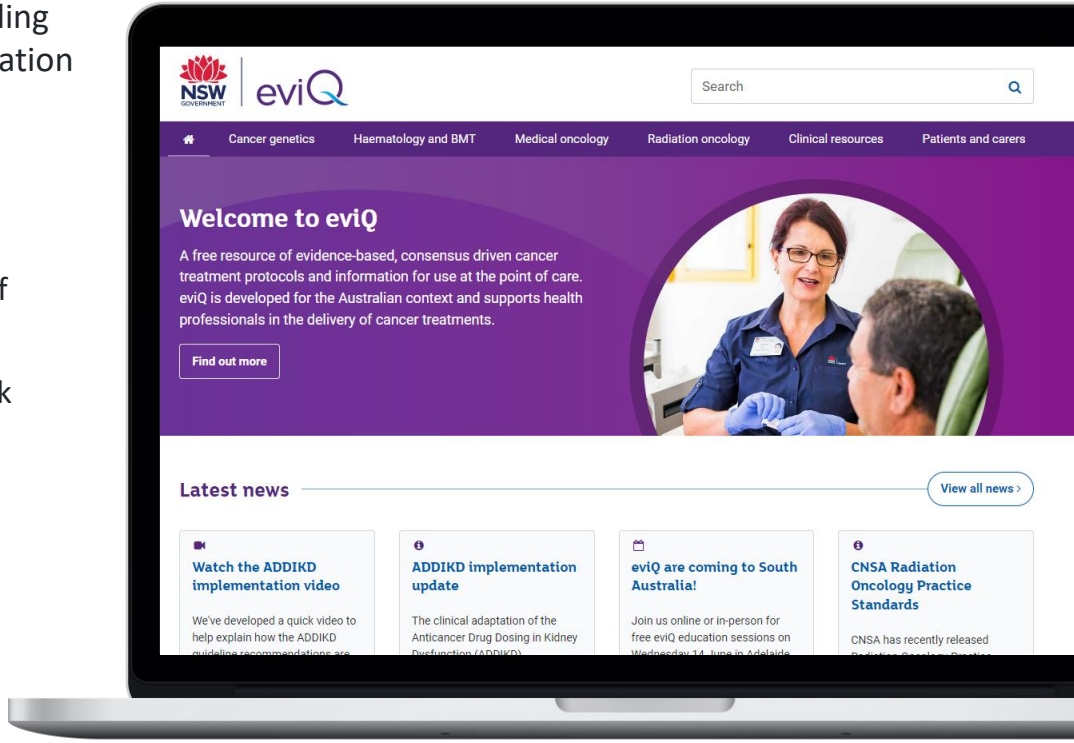
- Assist GPs with appropriate referral of patients to cancer specialists
- Aligns with optimal cancer care pathways
- Shows languages spoken by specialist (if other than English)
- Shows where Clinical Trials are available

www.canrefer.org.au



eviQ

A free online resource, developed by clinicians providing information about safe cancer treatment and information for healthcare professionals, patients and carers.



Key Features:

- Specific factsheets to assist GPs in the management of patients undergoing cancer treatment
- Provides information on cancer genetics, including risk management and genetic testing guidelines
- provides resources for both clinicians and patients
- Patient resources available in many languages

www.eviq.org.au

eviQ Education

A free online resource providing rapid learnings, podcasts and videos mini quizzes about cancer care along the continuum.

www.education.eviq.org.au

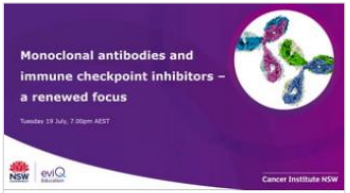
Smoking cessation

Cytokine Release Syndrome (CRS)

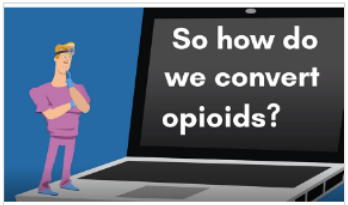
Disseminated intravascular coagulation (DIC)

Episode 5: Lessening cancer burden in multicultural communities

Melanoma: changes across the care pathway



Monoclonal antibodies and immune checkpoint inhibitors



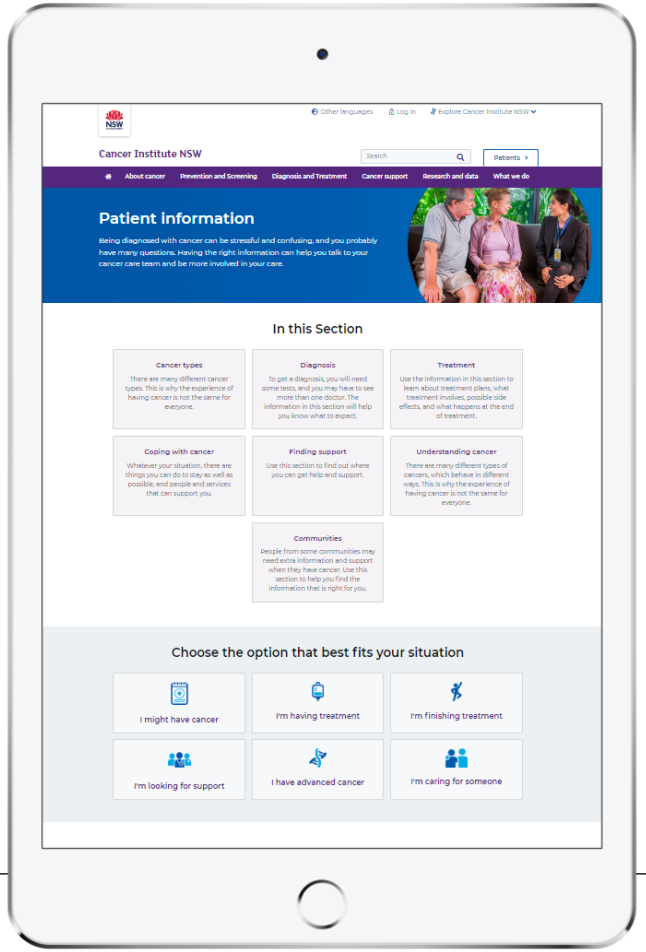
Principles of opioid conversion

Patient information

Key Features:

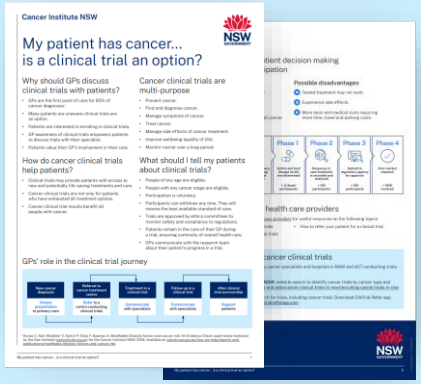
- Holistic and pragmatic information along pathway of care – links to practical advice and support bringing high quality information into one place
- Arranged as - what **do you need to know**, **what to ask or talk about** and **what happens next** including checklists and question sets to help a patient be prepared for their appointments and to know what to expect
- Information has been translated into 8 community languages (Arabic, Simplified Chinese, Traditional Chinese, Greek, Italian, Korean, Spanish and Vietnamese)
- Links to culturally safe resources for Aboriginal people

https://www.cancer.nsw.gov.au/patient-information



Cancer Clinical Trials

Information for Primary Health Care Workers



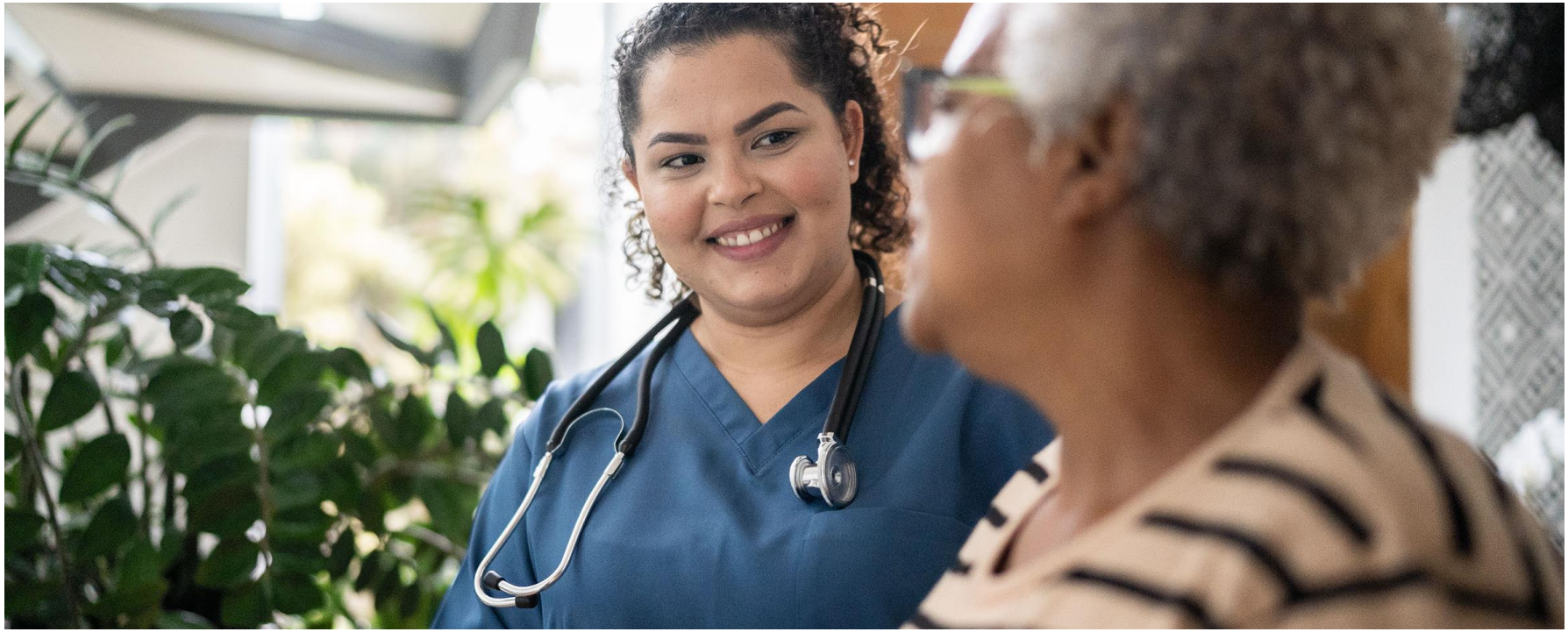
- Primary healthcare workers can play an important role in raising awareness of cancer clinical trials
- "*My patient has cancer… is a clinical trial an option*" information sheet supports GPs to better engage with patients

Raising Awareness of Cancer Clinical Trials in CALD Communities

- CALD Communities are under represented in clinical trials
- In-language resources can be provided to patients to increase awareness in clinical trials
- Available in English and 7 languages

www.cancer.nsw.gov.au/what-we-do/working-with-primary-care/clinical-trials-and-primary-care

Thankyou



Supporting people and carers affected by cancer

Kimberley Williamson
Program Lead, Patient Experience Cancer Institute NSW

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Q & A Panel

PRIMARY HEALTH NETWORK

Mary Mitchelhill

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NSW GOVERNMENT

Closing

PRIMARY HEALTH NETWORK

Janice Petersen

SBS World News Presenter and Journalist

Multicultural Primary Care Cancer Forum

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NSW GOVERNMENT

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