# The 2010 Cancer Care Coordination Conference: Relationships, Roles, Reality

**25–26 March 2010**

Crowne Plaza Hotel, Surfers Paradise, Queensland

## CONFERENCE HIGHLIGHTS

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# INTRODUCTION

While Australian cancer treatment outcomes are statistically among the best in the world, the challenge of providing coordinated care remains. The complexity of cancer diagnosis and treatment and the broad range of settings in which care is delivered mean that care can often be disjointed, with patients missing out on much needed support and sometimes becoming 'lost' in the system. Cancer Care Coordinator positions have been established in a number of jurisdictions across Australia in an effort to streamline patient care and ensure that patients and their carers are informed and supported throughout their journey.

As the peak national body representing health professionals whose main work is cancer control, the Clinical Oncological Society of Australia (COSA) has identified cancer care coordination as a priority issue of concern to its members. Workshops conducted by COSA in 2006,[1] 2007[2,3] and 2009[4] explored and sought to define the issues, purpose and expected outcomes of cancer care coordination in Australia and worked towards practical outcome measures for evaluating and developing the Cancer Care Coordinator role.

COSA has established a Cancer Care Coordination Interest Group[5] with national representation to work through priority issues identified during these workshops with a view to developing care coordination as a formal component of multidisciplinary cancer care in Australia. The Interest Group has access to a web forum for sharing ideas, views and experiences about cancer care coordination.

In 2008, with input from the Cancer Care Coordination Interest Group Steering Committee, COSA also undertook a survey of members who self-identified as practising in Cancer Care Coordinator roles. The survey aimed to elicit information around scope of practice, work experience, referral pathways and learning and support preferences for Cancer Care Coordinators. The results highlighted the considerable variation that still exists in practice and perceived outcomes for Cancer Care Coordinator roles.

In 2008, the first national conference on cancer care coordination – *Sharing, Caring, Daring* – was held in Perth by the WA Cancer and Palliative Care Network. Queensland Health agreed to coordinate the second national conference and approached COSA to collaborate in the planning and conduct of this event.

This report provides highlights from the second national conference on cancer care coordination – *Relationships, Roles, Reality* – held on 25–26 March 2010. The conference was attended by almost 200 participants from across Australia and New Zealand (see Appendix I for a list of conference delegates). A list of the conference presentations is provided in Appendix II.

Presentations from the conference will be made available on the COSA website at http://www.cosa.org.au/Home.htm.

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[1] Clinical Oncological Society of Australia. Care Coordination workshop report, 2006. http://www.cosa.org.au/File/Reports/CCC%20workshop%20report%20-%20Palm%20Consulting%20Feb%202007%20.pdf

[2] Clinical Oncological Society of Australia. Care Coordination workshop report, 2007. http://www.cosa.org.au/File/publications/COSAcarecoordinationworkshopJAN08.pdf

[3] Evans A on behalf of the Clinical Oncological Society of Australia. Care Coordination Workshop Report. Cancer Forum 2008;32(1):49□54.

[4] Clinical Oncological Society of Australia. Cancer Care Coordination workshop report, 2009.

[5] COSA members can access information about the COSA Cancer Care Coordination Interest Group via the COSA members area http://www.cosa.org.au/MembersArea/InterestGroups/CCCoordination.htm

# SUMMARY OF RECOMMENDATIONS

The conference highlighted the considerable progress that has been made in recent years in developing and implementing Cancer Care Coordinator roles across the country. Moving forward, it was apparent that a strategic, national approach to planning, implementation and evaluation of Cancer Care Coordinator positions and activities will be essential to ensure long-term sustainability of these important roles within the multidisciplinary cancer care team.

Key recommendations arising from the conference are outlined below.

1. COSA should continue to auspice the Cancer Care Coordination Interest Group with a strengthened and formalised committee and working party structure that will support national representation and progression of activity in priority areas.
2. A national collaborative research initiative should be undertaken, as a priority, to develop and implement a national evaluation strategy that will measure the impact of the Cancer Care Coordinator role, including a common ‘tool kit’ of data items and validated tools.
3. Activities should continue to be implemented to support networking and information sharing by Cancer Care Coordinators across the country, including an annual Cancer Care Coordination conference as well as web-based approaches to sharing resources and experiences.
4. Opportunities should be sought to actively promote the benefits of the Cancer Care Coordination role within the multidisciplinary team and more broadly to the healthcare community to increase awareness of the roles and encourage referrals.
5. An educational strategy should be developed to identify and encourage training in the core skills that underpin the cancer care coordination, regardless of who is undertaking the role.

# CONFERENCE HIGHLIGHTS

The 2010 national cancer care coordination conference provided a clear illustration of the enormous progress that has been made in the field of cancer care coordination in recent years. Presentations highlighted the range of innovative activities being undertaken across the country in an effort to standardise and streamline cancer care coordination activities and measure the impact of the role.

Key messages arising from the conference presentations and discussions are summarised below.

## Defining the Cancer Care Coordinator role

*"Cancer Care Coordinators provide a stepping stone along the patient journey."*
(Aurilea Augustine, Cancer Voices QLD)

A common theme underpinning many of the conference presentations, including plenaries by Chief Nursing Officer Rosemary Bryant and Michael Fitzpatrick from Cancer Australia, was recognition of the importance of the Cancer Care Coordinator role within the multidisciplinary cancer team. A number of presenters, including Cancer Voices Queensland representative Aurilea Augustine and Helen Gooden from Cancer Council NSW, also reflected on the value placed on the role by patients and carers.

Updates from New South Wales, Queensland, Western Australia and Victoria highlighted progress and achievements in the area of cancer care coordination at the patient, team and system levels. While it was apparent that the Cancer Care Coordinator role is still evolving, it was clear that there has been a shift in focus from questions about what the role should be to more strategic questions about how to embed the role as an accepted component of best practice.

The broad scope of practice of the Cancer Care Coordinator was also demonstrated in an interactive session in which a group of panellists used a series of case studies to describe how their role as a Cancer Care Coordinator had impacted on outcomes at the patient, team and system level. Roles described included patient navigator, educator, support provider and team coordinator. The importance of this role both in coordinating care within a comprehensive cancer care centre and in helping patients from regional and rural settings who receive care in multiple centres was highlighted.

*"We've moved on from role anguish"*
(Jacinta Elks, Sunshine Coast Health Service District, QLD)

Variation in scope of practice for Cancer Care Coordinators has been an ongoing challenge for individuals practising in these roles and for the health services in which these roles operate. Presentations from different jurisdictions highlighted the complex and multifaceted nature of the Cancer Care Coordinator role. Some of the areas of variation discussed included:

- **focus:** modality-specific vs tumour-specific approach
- **role:** nursing vs allied health background
- **integration:** across public/private and regional/metropolitan settings
- **tasks:** direct patient care vs administrative roles.

Despite this variation, discussions during the conference suggested that there is broad acceptance that skills are more important than who undertakes the role. Given the broad range of settings in which a Cancer Care Coordinator may practice, there is clearly a need for flexibility. It was suggested that further work is needed to set some parameters within which the role operates and to continue to promote the message that cancer care coordination should be the responsibility of the entire team, not solely the task of one individual. However, the broad range of discussions highlighted the fact that progress in this area is no longer being hampered significantly by questions around scope of practice, but rather that the role evolution is being seen as an accepted part of the implementation process.

## Evaluating outcomes

> *"An outcome is a change that can be attributed to something you did."*
> (Professor Kathy Eagar, University of Wollongong, NSW)

The importance of ensuring sustainability of the Cancer Care Coordinator role by demonstrating the impact of the role on patient outcomes was a key theme of the conference and a priority for future activity. Impacts were discussed at the patient, team/clinic and system/strategic level.

In a highly engaging presentation, Professor Kathy Eagar from the *Centre for Health Service Development* at the University of Wollongong provided valuable guidance to delegates around approaches to identifying and utilising outcome measures and potential pitfalls that should be avoided. Key messages from Professor Eagar's presentation included:

- **patient and carer outcomes** rather than processes should be used as the ultimate quality measure
- a patient outcome is a **point-in-time measurement**; what is important to measure is likely to vary depending on the patient's stage of illness and values
- outcome measurement is not a 'before and after' question but a **'with and without' question** that should consider what would happen with and without a given intervention or if a different intervention were used
- outcome measurement should be **linked to the goal of the intervention**; sometimes no change or an arrest in decline can be a good outcome
- outcome measurement is not a one-off event but should be **re-assessed at intervals** based on a pre-determined protocol
- an intervention will only be sustainable at the system level if it is **sustainable at the patient and provider level**.

Professor Eagar described the key questions to be considered when developing an evaluation framework:

- **delivery:** what did you do?
- **impact:** how did you go?
- **capacity:** what has been learned?
- **sustainability:** will it keep going?
- **generalisability:** is it useful for someone else?
- **dissemination:** who did you tell?

> *"Learn to walk first...run later."*
> (Professor Kathy Eagar, University of Wollongong, NSW)

In describing how the impact of the Cancer Care Coordinator role may be evaluated, Professor Eagar:

- highlighted the difficulties in **attributing an outcome to one particular role**
- encouraged the use of **credible and validated tools**
- cautioned **against the use of patient satisfaction** as an outcome measure

- emphasised the importance of taking a **step-wise approach** – deciding what is important and how to measure it.

### Collecting data

*"It's not easy... but it is exciting."*
(Douglas Bellamy, Hunter New England Area Health Service, NSW)

A consistent approach to data collection was identified as a key step in evaluating the impact of the Cancer Care Coordinator role. A number of presenters described approaches to data collection, from state-based tools such as *Queensland Oncology Online* (QOOL) to service-level approaches to data collection such as that used in the Hunter New England Area Health Service. The value of qualitative approaches to data collection, such as the use of patient stories, was also highlighted.

While data collection was seen as important, participants were cautioned against trying to collect data relating to every aspect of their role and were encouraged to select and pilot meaningful data items in a step-wise manner.

### The power of patient stories

*"Patient stories are a powerful tool for making the patient experience visible."*
(Shoni Colquist, Queensland Cancer Control and Analysis Team, QLD)

The power of collecting and sharing patient stories within the multidisciplinary team was demonstrated graphically in a number of presentations, including an interactive session run by the QCCAT team. Shoni Colquist from the Queensland Cancer Control and Analysis Team described the 'Discovery Interview' technique[6] being used by the National Health Service in the UK as a way of generating meaningful consumer engagement.

The importance of patient feedback in driving change was also emphasised by Professor Kathy Eagar, who emphasised that health professionals are highly responsive to negative feedback from patients and carers.

Participants were introduced to new approaches to managing change based around an exploration of the patient experience rather than a solution-based approach to systems and processes. They were given the opportunity to practice using patient stories as a measure of the patient experience and to use the 'Five Whys'[7] approach to asking questions.

### Tools and strategies

*"The simplicity of this approach is its strength."*
(Marion Strong, Southern Area Cancer Service, QLD)

Presentations from a number of a number of participants highlighted the considerable work being done to address challenges, streamline processes and standardise care in the area of cancer care coordination. Participants identified the need for ongoing opportunities to share these ideas and learn from others across the country.

Some of the tools and strategies profiled included:

- a rural education roadshow to promote awareness of head and neck cancers, including symptoms, referral pathways and patient support needs (Rachel Jenkin, WA)
- adaptation of a supportive care needs assessment tool for use with Indigenous patients with cancer (Patricia Valery, QLD)

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[6] http://www.improvement.nhs.uk/discoveryinterviews/
[7] http://www.asq.org/healthcare-use/why-quality/five-whys.html

- development of a psychosocial data set within the QOOL data collection system that can be used to support Cancer Care Coordinator practice (Marion Strong, QLD)
- development of measures of cancer care coordination for use in a medical audit of colorectal cancer care (Lindy Masya, NSW)
- assessment of the use of the Palliative Care Needs Assessment Guidelines and Needs Assessment Tool for people with advanced cancer and their carers (Amy Waller, NSW)
- the use of videoconference links and a shared email folder to promote education, networking and sharing of experiences for Cancer Care Coordinators (Marion Strong, NSW)
- a combined Cancer Nurse Coordinator and allied health pre-treatment clinic for high-risk head and neck cancer patients (Luci Dall'Armi, NSW)
- a Regional Outreach and Shared Care Program between three Children's Cancer Centres in Victoria (Jane Williamson and Shanelle Scriven, VIC).

### Multidisciplinary team interactions

> *"We've gone past asking permission; we know what to do and we're doing it."*
> (Violet Platt, WA Cancer and Palliative Care)

The central role of the Cancer Care Coordinator in the multidisciplinary team was referred to regularly throughout the conference. In an interactive session, delegates were invited to consider the ability of the Cancer Care Coordinator in influencing patient outcomes through their interactions with the broader multidisciplinary team. Through this exercise, delegates were reminded of the importance of considering the patient experience and using this as a way of driving team interactions and decisions around care and support needs.

Another key theme of the conference was the multidisciplinary nature of the Cancer Care Coordinator role, with recognition that the role is not limited to individuals with a nursing background but can be undertaken by other allied health professionals. Examples were raised in which an allied health professional, such as a speech pathologist or radiologist, had taken on the care coordination role, demonstrating the potential benefits in taking a flexible approach. It should be noted that some allied health professionals should have particularly high involvement in the development and implementation of a patient's care plan, such as speech pathologists for patients with oral cancers or social workers for patients experiencing a high psycho-social burden.

Flexibility around the Cancer Care Coordinator role should also be discussed in the context of work on national care standards and professional accreditation, which are being broadly scoped as part of the federal health reform agenda. The need for flexible approaches in rural and remote oncology services will also be critical, particularly as the oncology community waits with interest for announcements on the $560 million in federal funds for capital investment in regional cancer centres – and how staffing requirements will be met.

A number of the tools presented during the conference (see *Tools and strategies* section above) also showed the potential for developing a resource base around which multidisciplinary team interactions could focus. Such resources and strategies for best practice could help underpin the role, irrespective of which member of the team is taking the lead in care coordination. Moreover, the importance of incorporating strategies into multidisciplinary team interactions and processes to ensure that patient care is coordinated was also discussed, emphasising the importance of care coordination being the responsibility of the entire team rather than one individual.

## Strategic frameworks

> *"This conference represents a real opportunity to influence the agenda."*
> (Rosemary Bryant, Chief Nursing Officer)

A number of speakers reflected on the potential for Cancer Care Coordinators to act as leaders in change management, and to influence the policy agenda. The need for a strategic framework to drive improvement was highlighted as a priority moving forward.

In considering how to take this strategic framework forward, participants were encouraged to:

- interact with and utilise the advocacy skills of consumer groups such as Cancer Voices
- build relationships with other groups providing cancer support, such as the Cancer Council Helpline
- join COSA and contribute to the national agenda by participating in ongoing Cancer Care Coordination forums and activities.

## MOVING FORWARD

In an interactive strategic planning session, facilitated by Professor Patsy Yates, Professor of Nursing, Queensland University of Technology, delegates were asked to identify key priorities for advancing Cancer Care Coordinator practice.

Small groups were asked to select one priority in a given area and to identify key steps that would be required to progress work in this area. Results from each of the groups are summarised in Table 1. While the results do not represent a consensus view on future activities, they do provide direction to inform future plans and activities at a national level.

Common priorities arising from this activity were:

- research to identify a common ‘tool kit’ of data items and validated tools to measure the impact of the Cancer Care Coordinator role
- further promotion of networking and information sharing by Cancer Care Coordinators across the country
- the need for a strategic, national approach to planning and implementation of Cancer Care Coordinator roles and activities that will ensure sustainability of the role.

**Table 1: Priorities for advancing Cancer Care Coordinator practice identified through small group discussion**

| **Topic** | **Priority** | **Steps** |
|---|---|---|
| Data | Develop a minimum cancer care coordination data set to measure health outcomes | 1. Identify champions to drive the process<br>2. Undertake a literature review and identify validated tools<br>3. Undertake a national multi-site pilot study<br>4. Evaluate the results and disseminate nationally<br>5. Undertake education and promotional activities to ensure national implementation of the data set |
| Data | How do we prove that we have improved patient outcomes? | As a collaborative group:<br>1. Identify what data need to be collected to show improved outcomes linked to cancer care coordination<br>2. Identify validated tools for data collection<br>3. Develop a database into which data can be entered and from which data can be reported<br>4. Identify common research questions and work out how improvements can be made |
| Data | Patient-focused outcome measures | 1. Understand patient needs<br>2. Develop a mutually agreed and relevant set of patient-focused outcome measures |
| Data | Develop a measurable outcome measure to capture information on activity and drive business planning | 1. Categorise patients based on how much time the Cancer Care Coordinator needs to spend with them<br>2. Calculate how many hours of Cancer Care Coordinator time are needed based on patient numbers<br>3. Compare requirements with staff numbers and use to advocate for additional head count if required |
| Education | Succession planning | 1. Develop a core skill set for Cancer Care Coordinators, including communication and negotiation skills<br>2. Develop a database of Cancer Care Coordinators to support and encourage networking and sharing of information and resources |

| Topic | Priority | Steps |
|---|---|---|
| Role description | Expansion of the Cancer Care Coordinator role across Australia compared to the CNSA position statement | 1. Look at the different settings in which Cancer Care Coordinators operate (public/private, regional/metropolitan) and the different models of care to more clearly define the scope of the role<br>2. Explore commonalities and duties within the roles<br>3. Develop a national database of Cancer Care Coordinators, including states/territories not well represented at the conference |
| Role description | Establish a governing body in each state to oversee Cancer Care Coordinator needs | 1. Develop a DVD that demonstrates the role of the Cancer Care Coordinator to the broader population<br>2. Identify common themes of cancer care coordination<br>3. Collate data about the Cancer Care Coordinator role using established tools relevant to patient needs<br>4. Identify roles according to job demands<br>5. Provide assistance in publishing articles about the Cancer Care Coordination role |
| Role description | Promote the Cancer Care Coordinator role to further advance practice | 1. Utilise the media to promote awareness of the Cancer Care Coordinator role<br>2. Use letters generated by the multidisciplinary team to promote awareness of the Cancer Care Coordinator role to GPs (fax stream; develop a Cancer Care Coordinator brochure)<br>3. Undertake internal promotion within hospitals on wards and in outpatient settings and undertake in-services for staff |
| Tools | Develop strategies to encourage referral to Cancer Care Coordinators | 1. Collate evidence about current referrals and point of contact<br>2. Present data to key stakeholders to demonstrate the value-add of the Cancer Care Coordinator role in terms of patient outcomes and workload for other disciplines |
| Evaluation framework | Develop a national strategic direction and framework for evaluation of the Cancer Care Coordinator role at the patient, team and system levels | 1. Engage a professional body*<br>2. Create a national working party to explore models of practice internationally across the public and private sectors<br>3. Develop an evaluation framework/tool including national consultation with key stakeholders with different models<br>4. Gain national consensus and standardisation of the Cancer Care Coordinator role |
| Strategic direction | Develop a national strategic direction for Cancer Care Coordination | 1. Identify an umbrella organisation to take ideas forward<br>2. Identify a clinical leader from each state/territory<br>3. Identify common aims/tools/data relevant to cancer care coordination<br>4. Start to set a national agenda focused on implementation and evaluation of the role and its impacts that has equity of access as an endpoint |

*Discussed in further detail in *Professional Body* section on next page

## PROFESSIONAL BODY

Professor Yates emphasised the importance of building on existing networks and formalising approaches to taking forward priority activities in the area of cancer care coordination. With this in mind, participants were asked to consider how best to structure their professional body or group to drive the progression of activities at a national level.

There was broad consensus from the delegates that COSA should continue to auspice the Cancer Care Coordination Interest Group, in recognition of the multidisciplinary scope of the role and the work COSA has undertaken in the area to date. It was recognised that a link between this group and CNSA would be important given that the majority of individuals practising in Cancer Care Coordinator roles are nurses. However, the importance of not excluding other allied health disciplines who may be practising in these roles was noted.

Delegates generally agreed on the need for the Cancer Care Coordination Interest Group to have:

- national coverage, that includes state/territory representation as well as input from regional, rural and metropolitan areas and from public and private sectors
- multidisciplinary input, recognising nursing and allied health involvement in the role
- an option for state-based as well as national meetings/forums
- input from clinical and strategic management leaders
- defined terms of reference, with an agreed term for representatives (who may be appointed voluntarily or by election)
- sub-groups or working parties to work on priority questions or issues of interest
- opportunities to meet and share ideas (ideally an annual meeting)
- other forums for sharing ideas such as a website or shared email folder.

The value of participating in such a group in terms of professional development was highlighted.

## NEXT STEPS

Based on the feedback from conference delegates, it was recommended that COSA continue to auspice Cancer Care Coordination Interest Group and that steps be taken to encourage further networking and formalise the structure of this group with the major goal of progressing activity in priority areas. Professor Yates identified a series of steps to formalise the COSA Care Coordination Interest Group, ideally within the next 6 months:

- individuals who are not currently members of COSA to join and register with the Cancer Care Coordination Interest Group
- development of a document outlining the terms of reference, tenure, timeframe and tasks for the Steering Committee based on the recommendations outlined above
- release of an EOI calling for appropriate Steering Committee representation (state/territory, regional/rural/ metropolitan, public/private)
- development by the Steering Committee of a forward plan to implement activities in the priority areas identified
- agreement by the Steering Committee on a plan for the next annual Cancer Care Coordinator conference
- option for an update to provided in a breakfast session at the 2010 COSA ASM.

# APPENDIX I: CONFERENCE DELEGATES

**Mrs Judith Aldam**
Clinical Manager, Cancer Services, St Andrew's Hospital, Adelaide, **SA**

**Ms Kathleen Ansell**
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**Ms Aurilea Augustine**
Vice Chair of Cancer Voices Queensland, **QLD**

**Ms Janet Baldwin**
Clinical Nurse, St Andrew's Hospital, Adelaide, **SA**

**Mrs Dawn Bedwell**
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**Mr Douglas Bellamy**
Area Cancer Care Coordinator, Area Cancer Services, Hunter New England Health, **NSW**

**Ms Joanne Benhamu**
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**Mrs Tania Bernhardt**
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**Mrs Karen Biason**
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**Mrs Joanne Bindley**
Cancer Care Coordinator, Armidale Oncology Unit, Armidale Rural Referral Hospital, Armidale, **NSW**

**Mrs Lorraine Binnie**
Clinical Nurse, surgical/day chemotherapy, Qld Health, Malanda, **QLD**

**Ms Elizabeth Bird**
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**Mr Michael Bishop**
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**Mr Ray Bissett**
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**Ms Jhaike Braham**
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**Miss Monica Fowler**
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**Mrs Margaret Gamble**
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## APPENDIX II: CONFERENCE PRESENTATIONS

| Session/title | Presenter(s) |
|---|---|
| **Opening** | |
| Opening address | Ms Rosemary Bryant, Chief Nursing and Midwifery Officer of Australia |
| Consumer perspective on coordination of care | Aurilea Augustine, Vice-Chair, Cancer Voices Queensland |
| Achievements and opportunities: the Australian experience so far | Sue Sinclair, Cancer Institute NSW<br>David Stewart, Queensland Health<br>Violet Platt, WA Cancer and Palliative Care Network<br>Mei Krishnasamy, Peter MacCallum Cancer Centre |
| **Exploring the contribution of Care Coordinators across the cancer journey** (Chair: Jacinta Elks, Southern Cluster Sunshine Coast and Wide Bay Health Service District) | |
| Interactive panel session | Panellists: Rebecca Keating (Toowoomba Base Hospital, QLD), Jo Keyser (Geraldton Regional Hospital, WA), Rebecca Blake (Ipswich Base Hospital, QLD), Colleen Stevenson (Gosford/Wyong Hospitals, NSW), Alana Fraser (Royal Brisbane Hospital, QLD) |
| **Guidelines tools and resources for Care Coordinator practice** (Chair: Douglas Bellamy, Hunter New England Area Health Service, NSW) | |
| Influencing change through the WA Model of Care | Rachel Jenkin (WA Cancer and Palliative Care Network, WA) |
| Adapting an existing supportive care needs tool to be used with Indigenous cancer patients | Patricia Vallery (Queensland Institute of Medical Research, QLD) |
| Guidelines, tools and resources for care coordination | Marion Strong (QCCAT and Southern Area Cancer Service, QLD) |
| Measures of colorectal cancer care coordination: a Delphi study | Lindy Masya (Surgical Outcomes Research Centre, NSW) |
| Systematic assessment of palliative care needs: efficacy, time and resource implications and future directions | Amy Waller (Centre for Health Research and Psycho-oncology, NSW) |
| **Abstract presentations – stream 1** (Chair: Sue Hadfield, North Queensland Cancer Service, QLD) | |
| Discovery interviews: perceptions and experiences of people affected by cancer in Queensland | Shoni Colquist (QCCAT, QLD) and Aurilea Augustine (Cancer Voices QLD) |
| 'Everybody's talking at me, I can't hear a word they're saying': the importance of the Cancer Care Coordinator's role from a patient's perspective | Helen Gooden (Cancer Council NSW) |
| What GPs think about cancer care coordination: is it good and will it work? | Letitia Burridge (University of Queensland, QLD) |
| Supporting the Cancer Care Coordinator | Marion Strong (QCCAT and Southern Area Cancer Services, QLD) |
| Feeding the data reporting beast – are we looking for reports or improvements? | Douglas Bellamy (Hunter New England Area Health Service |
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| Evaluation of the Western Australian Cancer Nurse Coordinator Role: perceptions of the coordinators (Part 1) | Leanne Monterosso (Edith Cowan University, WA) |
| **Abstract presentations – stream 2** (Chair: Mei Krishnasamy Peter MacCallum Cancer Centre, Vic) | |
| Establishment of a combined cancer nurse coordinator and allied health pre-treatment clinic for high-risk head and neck cancer patients | Luci Dell'Armi (Liverpool Head and Neck Cancer Service, NSW) |
| The Rural Cancer Nurse Coordination Team: state-wide initiatives to improve cancer care in rural and remote Western Australia | Jo Keyser (Geraldton Regional Hospital, WA) |
| The Regional Outreach and Shared Care Program – a model in practice | Jane Williamson and Shanelle Scriven (Royal Children's Hospital, VIC) |
| Head and neck cancer interdisciplinary education roadshows | Rachel Jenkin (WA Cancer and Palliative Care Network, WA) |
| Lung cancer can't wait | Rebecca Keating (Toowoomba Hospital, QLD) |
| The GCHSD cancer care coordinator – an evolving role | Gill Burton (Gold Coast Health Service District, QLD) |
| **Plenary session** (Chair: Gayle Salkield, Princess Alexandra Hospital, QLD) | |
| Cancer Australia: Cancer Care Coordination | Michael Fitzpatrick, Education and Service Delivery, Cancer Australia |
| Measuring outcomes: what care coordinators need to know | Professor Kathy Eagar, Centre for Health Services Development, University of Wollongong NSW) |
| **Care Coordinators and the multidisciplinary team: improving interactions and outcomes** | |
| Interactive workshop | Chair: Shoni Colquist (QCCAT, QLD)<br>Facilitator: Hazel Harden (QCCAT, QLD) |
| **Strategic planning workshop: setting priorities for advancing care coordinator practice** | |
| Interactive workshop | Chair: Professor Patsy Yates (Queensland University of Technology, QLD) |