



Care coordination outcome measures: building the evidence

**36th Annual Scientific Meeting of the Clinical Oncological Society of Australia (COSA)
16 November 2007**

WORKSHOP REPORT

Prepared by Alison Evans Consulting

BACKGROUND

Cancer Care Coordinator positions have been established across many jurisdictions in Australia in response to an identified need to improve coordination and continuity of cancer care. However, there is considerable variation in the scope and implementation of these roles and an evaluation of their impact has not yet been undertaken formally.

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 and 2007 aimed to explore and define the issues, purpose and expected outcomes of cancer care coordination in Australia. The 2006 workshop led to the development of a set of principles that underpin cancer care coordination at the patient, team and system level.¹ In 2007, some progress was made towards developing a set of indicators, measures and tools to assess the effectiveness of coordinated cancer care as relevant to the patient, service and funder.² It was agreed that these outcome indicators and associated measures would form the basis for further discussion and that further validation and refinement would be required.

In 2008, COSA undertook a survey of members who self-identified as practising in Cancer Care Coordinator roles to elicit information around scope of practice, work experience, referral pathways and learning and support preferences for Cancer Care Coordinators. The survey also sought to obtain feedback on the appropriateness of the outcome indicators identified in the 2007 workshop. The purpose of the survey was to identify areas for improvement, gain insight into the professional support needs of individuals appointed to these roles, and determine the next steps in development and implementation of outcome measures relevant to cancer care coordination interventions. The results highlighted the considerable variation that still exists in practice and perceived outcomes for Cancer Care Coordinator roles.

To continue to progress this important issue, a third workshop was convened by COSA prior to the 2009 Annual Scientific meeting with a view to exploring and defining practical outcome measures that can be used to measure the impact of the Cancer Care Coordinator role.

¹ Clinical Oncological Society of Australia. Care Coordination Workshop report 2006

² Evans A on behalf of the Clinical Oncological Society of Australia. Care Coordination Workshop Report. Cancer Forum 2008;32(1):49-54.

WORKSHOP OVERVIEW

A half-day workshop was convened by COSA on 16 November, prior to the 2009 Annual Scientific Meeting. The aim of the workshop was to:

- share progress on jurisdictional activities in the area of cancer care coordination since the 2007 workshop
- define practical outcome measures for the Cancer Care Coordinator role
- consider realistic approaches to data collection in relation to measuring Cancer Care Coordinator outcomes.

The workshop program is provided at Appendix I.

The workshop was attended by 41 participants, the majority of whom were practising in Cancer Care Coordinator roles. Other participants included evaluation experts, researchers and health service administrators (see Appendix II for a list of participants).

The workshop was facilitated by Dr Alison Evans, an independent facilitator, and Professor Patsy Yates, Director of Nursing at Queensland University of Technology, who has played a lead role in the COSA cancer care coordination initiatives to date.

WORKSHOP INTRODUCTION

Professor Patsy Yates and Dr Alison Evans welcomed participants and provided an overview of the workshop aims. They emphasised that the focus of the workshop was to explore practical outcome measures that would demonstrate the impact of the Cancer Care Coordinator role rather than evaluating cancer care coordination overall, which may involve a range of other disciplines and services.

STATE-BASED ACTIVITY IN CANCER CARE COORDINATION ACTIVITIES

The workshop opened with a series of presentations providing an overview of outcome measurement activities and role development for Cancer Care Coordinators in different jurisdictions. A brief outline of the key points covered in each presentation is provided below.

Victoria: Peter MacCallum Cancer Centre

Dr Meinir Krishnasamy (Department of Nursing and Supportive Care Research, Peter MacCallum Cancer Centre)

Dr Mei Krishnasamy provided an overview of an evaluation project undertaken in 2008–2009 to map nurse coordinator roles at the Peter MacCallum Cancer Centre with a view to providing recommendations to the Nursing Executive and clinical services about the future development of the role. The mapping activity was based on four key evaluation features identified in the 2006 COSA Care Coordination Workshop Report.³

- **structure & inputs:** clarification of the components of the Cancer Nurse Coordinator role
- **process:** description of current Cancer Nurse Coordinator roles and activities
- **outcomes:** description of patient and family experiences of Cancer Nurse Coordinator involvement in their care.

³ Clinical Oncological Society of Australia. Care Coordination Workshop report 2006

The evaluation followed a two-phase approach involving:

- **phase I:** a literature review, self-report activities by the Cancer Nurse Coordinators and semi-structured interviews with 16 Cancer Nurse Coordinators and 3 nurse consultants
- **phase II:** electronic survey of 68 multidisciplinary team members and a telephone survey with 54 patients and 15 carers from each of the 11 clinical streams.

Key findings of the evaluation included:

- **structure:** the Cancer Nurse Coordinator role requires further definition, with the capacity to work as an advanced nursing practitioner diluted to some degree by the term 'coordinator'; it was noted that Cancer Nurse Coordinators also practice in a nursing service 'vacuum'
- **inputs:** administrative and pathway service tasks hamper the Cancer Nurse Coordinators' ability to function as expert clinical nurses and Cancer Nurse Coordinators have little control over their workload, which includes a high ambulatory load
- **outcomes:** Cancer Nurse Coordinators are valued highly by multidisciplinary team members, patients and their carers and are seen by clinical services as a central component of the model of care.

In order to build a framework for continuous evaluation of the Cancer Nurse Coordinator role, broad components of the role are being divided into meaningful and relevant data 'chunks' that will be reviewed critically to determine what information is required to demonstrate a value-add for the role. Importantly, consideration is being given to whether what will be measured is within the Cancer Nurse Coordinator's sphere of influence and whether action taken in response to findings will have a significant and tangible impact on patient care or outcomes. Once the outcome measures have been defined and agreed, approaches to data collection will be developed.

New South Wales

Ms Robyn Thomas (*Cancer Institute NSW*)

Ms Robyn Thomas provided an overview of care coordination outcome measures activity being undertaken by the Cancer Institute NSW and described related activity, including development of cancer service and multidisciplinary care performance indicators.

The Cancer Institute NSW has funded 58 Care Coordinator positions across the state as part of the Cancer Services Infrastructure Support Program, which also funds Directors of Area Cancer Services, Data Managers, lead clinicians and cancer genetics and psycho-oncology staff. The aim of this program is to improve coordination of care, multidisciplinary care, patient-centred care and clinical leadership. The program is currently under evaluation using a range of approaches including written surveys of individuals in the positions, a patient survey, as well as service- and patient-level case studies.

Evaluation indicators for cancer care coordination include:

- the extent to which stakeholders feel that care coordination has improved
- increased numbers of patients who have access to a CNC
- evidence of the provision of evidence-based information
- evidence of communication and links with the cancer care team and allied health
- increased numbers of referrals to support services
- the extent to which patients feel that having access to a CNC improved coordination of care.

In addition the evaluation is exploring the impact of the CNC positions on multidisciplinary care, with evaluation indicators that include:

- the extent to which stakeholders feel that multidisciplinary care has improved
- mechanisms for communication on behalf of patients at the multidisciplinary team meeting
- mechanisms for communication of multidisciplinary team meeting outcomes to the patient.

Ms Thomas presented preliminary results from the evaluation and described quantitative and cancer service performance indicators that are being developed as measures of the coordination, quality and delivery of health care within a service. She also described performance indicators for the multidisciplinary team that are in development. Once the full results of the CNC evaluation are available and the indicators have been defined, information technology solutions will be sought to facilitate collection of data and a pilot phase will follow.

Queensland

Ms Shoni Colquist (*Queensland Cancer Control Analysis Team*)

Ms Colquist provided an overview of activity being undertaken in Queensland by the Queensland Cancer Control Analysis Team (QCCAT) and cancer networks as part of the Commonwealth-funded CanNET initiative. The project has focused on bridging gaps in multidisciplinary care and has involved five cancer care coordination teams, each of whom identified local issues of interest for exploration:

- promotion and marketing of the cancer care coordination service
- coordinated intake screening
- timely patient information and communication to primary care
- wellness and survivorship plans
- sharing and sustainability of the cancer care coordination service.

Evaluation of these projects is paving the way for the future evaluation of the cancer care coordination service. Before describing the approach to evaluation, Ms Colquist provided an overview of outcome measurement. She emphasised that an outcome is the result of an action or process and that an outcome measure is not simply an administrative, statistical or research undertaking but a question of clinical effectiveness. She stressed the importance of considering outcome measures in context and the need for reliable and validated tools, measures and instruments to support data collection.

In describing the approach to defining outcome measures for cancer care coordination in Queensland, Ms Colquist reflected on the need to identify the stages or points within the patient journey where the Cancer Nurse Coordinator can add value at both the patient and service level. Using this approach, the QCCAT team has developed a draft cancer care coordination data set and online data collection tool with input from Cancer Nurse Coordinators that sits alongside the Queensland Oncology Online (QOOL) web-based cancer data management system. The data set includes information about patient demographics, clinical details, treatment, psychosocial care and cancer care coordination referral information.

A pilot of the data set and data collection tool commenced in November 2009 involving 17 cancer care coordinators at 6 sites including metropolitan and regional centres. Once established, the tool will allow electronic referral to cancer care coordinators and will support the ongoing monitoring of the cancer care coordination role. A set of outcome measures is in development, including information relating to patient flows, case mix data, multidisciplinary team involvement, review by cancer care coordinators, interventions and communication with

other health professionals. Results will inform state-wide direction and priorities for cancer care coordination in Queensland.

South Australia

Ms Sharon Reinbrecht (*Southern Adelaide Health Service*)

Ms Reinbrecht described approaches to evaluating the Cancer Care Coordinator role in South Australia. In South Australia, the current role focuses on a system-based approach and does not have clinical or case-management responsibility. There is currently one Rural Cancer Care Coordinator position, covering all age groups and tumour streams, and a Paediatric Cancer Care Coordinator position. Both roles are funded to 2010.

Initiatives to improve care coordination, including collection of information and measurement of outcomes, are being undertaken at three levels.

- **Patient:** a rural consultation process with patients and health professionals has resulted in development of recommendations to assist with regional planning. Development of referral pathways for three cancer streams (upper gastrointestinal cancers, lymphoma and adolescents and young adults with cancer) has been undertaken and two clinical pathways are nearing completion.
- **Team:** two pilot multidisciplinary team projects have been conducted, one in Mount Gambier and the second focusing on metropolitan Upper Gastrointestinal Cancer. Ongoing funding has been sourced and recruitment for pathway coordinator positions and a Rural Cancer Care Coordinator position is underway.
- **System:** a review of data relating to cancer care coordination suggests that Cancer Care Coordinator roles are not yet embedded into practice in South Australia. Regional policy development is focusing largely on chemotherapy administration. The state-wide implementation of the EdCAN framework is being explored.

Evaluation activities are assisting to inform the work of Cancer Care Coordinators with some standardisation in approaches through the use of generic tools such as a pre-chemotherapy nursing assessment tool and health service self-assessment. However, a number of barriers to evaluation remain, including system and governance issues, short-term funding for positions and a lack of meaningful data and agreed outcome measures.

Formal evaluation of a rural mentoring project and the multidisciplinary team pilots has been undertaken, although these have typically focused on process issues rather than outcomes. Further evaluation will be undertaken but will be dependent on long-term funding of the Cancer Care Coordinator positions.

Western Australia

Ms Karen Jackson (*WA Cancer and Palliative Care Network*)

Ms Karen Jackson provided an overview of the Cancer Coordination Service within the WA Cancer and Palliative Care Network. The Service has 26 nurses, including disease-specific Cancer Care Coordinators, disease-specific Clinical Nurse Specialists, a metropolitan/rural Cancer Care Coordinator, rural Cancer Care Coordinators and a rural Cancer Nurse Specialist.

A consistent approach to data collection has been implemented across the service since its inception, with all nursing staff collecting data on an Excel spreadsheet about patient contacts recorded as episodes of care. One episode of care represents care or contact with a patient over a 24-hour period. Recorded data include:

- new cases
- levels of intervention (scale of 1-5 based on length of consultation)
- hospital sites

- location (metropolitan/regional)
- source of referral
- diagnosis.

An annual report provided by each care coordination service provides data on achievements and challenges and a strategic plan outlines future goals and guides service direction.

A three-phase research project is underway to evaluate roles within the care coordination service:

- **phase 1:** CNC interviews have been conducted
- **phase 2:** patient questionnaires will be administered in the near future
- **phase 3:** multidisciplinary team member questionnaires will follow.

In addition to describing planned evaluation activities, Ms Jackson provided an overview of achievements to date within the service. Highlights included hosting the inaugural Cancer Care Coordination conference in Perth in 2008 as well as a range of initiatives across different tumour streams aimed at improving coordination of care, addressing service gaps, improving awareness of issues amongst general practitioners, improving awareness and systems in rural areas and standardising processes to improve system efficiencies.

Planned initiatives include increasing the number of nurse-led clinics, further improvement of communication across the public/private and rural interfaces, conducting rural education roadshows and continuing to expand and improve the care coordination service.

APPROACHES FOR MEASURING OUTCOMES FOR CANCER CARE COORDINATION

Professor Yates provided a brief overview of the challenges in defining outcome measures for cancer care coordination. In particular she emphasised the importance of focusing not just on inputs and throughputs – but on measuring the impact of an intervention. She noted that it would be impossible to measure the impact of every aspect of cancer care coordination and that it was important to focus on meaningful measures that could be attributed to the Cancer Care Coordinator role and used to monitor the quality of care and drive service improvement.

Two presentations then provided an overview of challenges and issues identified in the implementation of initiatives to measure outcomes of cancer care coordinator activity.

The Hunter New England Experience

Mr Douglas Bellamy (*Hunter New England Area Health Service*)

Mr Douglas Bellamy provided an overview of the Cancer Care Coordinator experience in the Hunter New England area of NSW, where positions have been established to manage more complex patient journeys. This includes patients receiving multi-modality treatments, those receiving treatment that crosses service boundaries, patients from rural and remote locations and those with psychosocial and other complex issues. As an Area Cancer Care Coordinator, Mr Bellamy is tasked with providing direction and support for the service provided.

The Hunter New England Area Health Service has an information technology network that links services across the Area and provides access to Aria (a scheduling, documentation, medications and reporting tool), a Clinical Applications Portal (through which Area diagnostic, demographic and scheduling information can be accessed) and other useful applications. All Cancer Care Coordinators have access to desktop PCs.

In defining approaches to data collection, the Area Health Service has identified the different levels at which data reports are required, including government, service and coordinator levels. The types of data required and the format of the reports required varies according to the target audience. Approaches to data collection have progressed across a number of systems from a basic Excel spreadsheet to the Aria system used today.

Challenges experienced in relation to data collection and reporting have included:

- the time required to collect accurate, 'real time' data
- the need to collect not only process data but patient experience and psycho-oncology data that reflect the scope of the Cancer Care Coordinator role
- the need for clinical staff to develop the administrative skill sets required to support data collection
- lack of familiarity of clinical staff with technology and a perception that computer-focused tasks are taking staff away from their primary role in patient care and support
- concerns about how data may be used, shared or misinterpreted.

These challenges highlight the importance of developing data collection systems that are integrated with the documentation of care process so as to limit the administrative burden.

The current Aria system uses registration, ongoing care and transfer of care questionnaires that collect information relating to practical, physical, family, emotional, and spiritual domains of care. Reports can be generated to meet NSW Health reporting requirements as well as local requirements and can be generated for individual coordinators or as group reports.

Data can be used to generate reports on:

- patient numbers (new patients/ongoing care patients/discharges/total patients)
- appointments
- clinical and non-clinical communication (telephone and other telehealth)
- percentage of patients managed by Cancer Care Coordinators
- triage category (allowing research on the impact of Cancer Care Coordinators for different tumour types and stages)
- Cancer Care Coordinator activity within each of the practical, physical, family, emotional and spiritual domains of care.

A Patient Experience Survey helps to close the reporting loop by identifying whether the service has been provided and also provides the patient with the opportunity to comment on the care received.

Mr Bellamy outlined a number of valuable lessons learned through the Hunter New England experience, as summarised below.

- **Work to a framework:**
 - identify what you are measuring and why
 - scope what you want and what's achievable
- **Define your data items:**
 - identify, define and document the data set
 - document this so that users have a reference

- **Engage the Coordinators who will be using the system at the beginning:**
 - identify their issues
 - ensure that they understand or are aware of the development issues
 - consult with them regularly
- **Look at what's available to you and start there:**
 - don't lament over what others have and you don't
 - try to engage the support of Area Health supported applications
 - make friends with the people that work with/manage these systems
- **Work collaboratively:**
 - work with like-minded people, share your work and build on knowledge rather than recreating it
 - accept that different groups will want to collect data for different reasons
 - identify the core data items and agree that extended items will be available as identified
- **Never assume people understand what you are talking about:**
 - many Coordinators generally have little to do with the development of key performance indicators and outcome measures
 - IT people generally don't know much about the terms Coordinators use
 - ensure that you have well-defined data items
- **Make a start – don't put it off:**
 - recognise that everyone is busy and it's easy to put evaluation work on hold
 - it's important to make a start – even a basic start – and build on that.

Mr Bellamy concluded by emphasising the importance of data collection and evaluation as a means to demonstrate the value of the Cancer Care Coordinator role and to ensure the ongoing monitoring and improvement of the patient experience.

Pilot of the COSA Care Coordination Outcome Tool

Ms Beth Ivimey (*Prince of Wales Hospital, Randwick*)

Ms Beth Ivimey gave an overview of a pilot of the COSA Care Coordination tool by Regional, Rural and Metropolitan Cancer Nurse Coordinators in the Australian Capital Territory and New South Wales. She provided feedback on views from the Cancer Nurse Coordinators about the ease of use of the resource and about the data items included within the resource. As a general comment the view was that the tool is easy to use and could be used to collect more information than it does currently.

When describing the data items collected by the tool, Ms Ivimey identified a number of data fields that should be included in order to measure outcomes from the Cancer Nurse Coordinator role. The data items identified may be relevant for others developing a similar resource:

- number of new patients as well as the ongoing caseload
- diagnosis and stage, stage of referral, person referring, and whether care is taken over by Palliative Care or a Clinical Nurse Consultant

- tumour type (important for Cancer Nurse Coordinators who have more than 1 tumour stream)
- time bar for each of the data items collected
- way of identifying whether a case was routine, complex or involved case management to reflect the time required for each case
- issues log to collect additional information, eg about the varied nature of the role, issues around increased workload due to staff absence etc
- administrative tasks undertaken
- log of clinical meetings attended other than multidisciplinary team meetings
- log of educational activities undertaken.

Ms Ivimey suggested that the availability of a tablet computer rather than a desktop computer may assist in collecting the data required.

Ms Ivimey highlighted a number of benefits of collecting data in a consistent way through the use of the tool, including the value of having comparable data for assessment and being able to collect baseline data against which the impact of interventions can be measured. In closing, Ms Ivimey provided a quote from one of the Cancer Nurse Coordinators which summarised some of the challenges of measuring outcomes for the role: *“It is a real challenge to quantify what the CNC role does in terms of numbers – so much is qualitative & I know here we are in need of doing a fresh survey of our roles. We have such a broad perspective over the whole trajectory, and yet we know that in many cases things happen in a timely way because of our interventions.”*

DEFINING OUTCOME MEASURES FOR CANCER CARE COORDINATORS

Following the presentations, participants were asked to consider potential outcome measures and associated issues relating to measuring the impact of the Cancer Care Coordinator role in five areas of cancer care:

- the patient journey
- the patient experience
- the multidisciplinary team
- appropriate treatment
- role delineation.

Participants explored how outcome measures may be determined in order to measure the impact of different aspects of the Cancer Care Coordinator role as well as issues that may influence the selection and/or interpretation of these measures. A range of issues were identified that should be considered when identifying outcome measures for the Cancer Care Coordinator role. These have been grouped by theme in Table 1.

Table 1: Key issues and questions relating to definition of outcome measures for the Cancer Care Coordinator role

Theme	Key issues	Questions to assist in defining outcome measures
Scope of role	<ul style="list-style-type: none"> • The Cancer Care Coordinator role encompasses a broad range 	<ul style="list-style-type: none"> • Which aspects of the Cancer Care Coordinator role are important in terms

Theme	Key issues	Questions to assist in defining outcome measures
	<p>of tasks and outputs</p> <ul style="list-style-type: none"> The Cancer Care Coordinator role is not clearly defined or consistent within and across jurisdictions 	<p>of measuring impact?</p> <ul style="list-style-type: none"> Which points along the patient journey can/should the Cancer Care Coordinator role make the most significant impact?
Use of results	<ul style="list-style-type: none"> The data and reports required are likely to vary depending on who is going to use the data and how it will be used 	<ul style="list-style-type: none"> Why are you collecting the data? Who is interested in the results? What decisions will be made based on the results? If the results show variation, is it within your control to take action to influence or effect change?
Flexible approach	<ul style="list-style-type: none"> The Cancer Care Coordinator role varies across jurisdictions, particularly in relation to case management vs project management aspects of the role The role is evolving and may change over time 	<ul style="list-style-type: none"> How might the data collected inform the ongoing development of the Cancer Care Coordinator role? How might measures need to change as the role becomes more clearly defined or more consistent across jurisdictions?
Interpretation of results	<ul style="list-style-type: none"> Outcome measures may not solely be a reflection of Cancer Care Coordinator input Results may vary depending on who is undertaking the Cancer Care Coordinator role 	<ul style="list-style-type: none"> What effect will local context differences have on the results? What other factors may influence the outcome being measured? How might the outcomes change depending on who is undertaking the Cancer Care Coordinator role?
Sustainability	<ul style="list-style-type: none"> Cancer Care Coordinators are already time poor Data collection needs to be integrated into existing activities 	<ul style="list-style-type: none"> What data collection activities are already in place? What technology support is needed to facilitate data collection? Will data collected be compatible with other systems in use within the service?

Areas in which the Cancer Care Coordinator was considered to be able to influence outcomes included:

- streamlining the referral process to ensure that referrals happen and are appropriate
- improving the patient experience, including patient and carer satisfaction
- providing a single and consistent point of contact for the patient
- reducing duplication of service delivery during the active treatment phase.

Strategies for defining outcome measures

A number of general strategies were identified by several groups as being relevant to the definition of outcome measures, regardless of the aspect of care being evaluated, including:

- identifying the key points along the patient journey where the Cancer Care Coordinator can and should influence patient care, including those points viewed as critical by patients
- exploring impacts of the Cancer Care Coordinator role across the entire journey including diagnostic and survivorship phases
- considering outcome measures in terms of both macro and micro issues, ie identifying the issue of interest and then breaking that down into its component parts to identify what aspects the Cancer Care Coordinator influence and what can realistically be measured
- collecting process information as part of a broader evaluation framework to ensure that outcome results are meaningful, eg measurement of referral times should consider the referral centre, the content of the referral and how the referral information is communicated to the patient; measurement of number of patients seeing a Cancer Care Coordinator should consider the availability of triage systems and health professional knowledge about the role
- collecting baseline data in order to monitor change over time (including both positive and negative aspects)
- consolidating existing tools to avoid overload in terms of patient and health professional surveys
- considering the potential impact of patient, health professional and system diversity on outcomes
- considering how easy/difficult it is to collect the required information, who can collect it and what systems are required to support collection.

Outcome measures

Possible outcome measures identified through small group and plenary discussion included:

1. Time between entry, exit and transfer points in the patient journey, including referrals into and out of the service
2. Time between different treatment modalities/episodes of care
3. Availability of test results/scans to inform treatment decisions
4. Proportion of patients having treatment planned/determined by a multidisciplinary team
5. Measurement of the impact of screening for distress
6. Patient and carer satisfaction and knowledge
7. Proportion of patients seen by a Cancer Care Coordinator

Measurement tools

Possible tools or approaches to data collection included:

- 'discovery interviews'/patients telling their story (UK program)
- patient and carer surveys
- audit of activity against guidelines
- stakeholder surveys
- patterns of care studies.

NEXT STEPS

Professor Yates concluded the workshop by thanking participants for their input. She provided an update on other activities being undertaken by the COSA Care Coordination Special Interest Group, including projects focusing on:

- networking and communication
- research
- professional development.

Professor flagged the Care Coordination Conference being run by Queensland Health and COSA in March 2010 as an opportunity to discuss issues in each of these areas in more detail.

APPENDIX 1: WORKSHOP PROGRAM

Care Coordination Outcome Measures Building the Evidence

12:30pm – 5:00pm
Monday 16 November 2009
Gold Coast Convention Centre
Meeting Room 10-12
Facilitator: Dr Alison Evans

12:30 pm	Registration	
1:00 pm	Welcome and purpose	<i>Professor Patsy Yates</i>
1:05 pm	Introduction & COSA Care Coordination Outcomes Framework <i>Dr Alison Evans</i>	
1:15 pm	Overview of current outcome measurement activities	VIC - <i>Meinir Krishnasamy</i> NSW - <i>Robyn Thomas</i> QLD - <i>Shoni Colquist</i> SA - <i>Sharon Reinbrecht</i> WA - <i>Karen Jackson</i>
2:05pm	Principles for Measuring Care Coordinator Outcomes	<i>Professor Patsy Yates</i>
2:25pm	Examples of measurement tools in the field Hunter New England Area Health COSA Pilot outcome tool & feedback	<i>Douglas Bellamy</i> <i>Beth Ivimey</i>
2:45 pm	Discussion Session 1: Developing Agreement on Data Items and Measurement Tools <i>Facilitated Breakout discussion</i>	
3:45 pm	Afternoon Tea (10 mins)	
3:55 pm	Review of discussion session - <i>Feedback</i>	
4:25 pm	Recommendations <i>Facilitator</i>	
4.35 pm	Where to from here?	<i>Professor Patsy Yates</i>
	<ul style="list-style-type: none"> • COSA Special Interest Group <ul style="list-style-type: none"> - prospective activities - follow-up ?ASM 2010 	
4:45pm	CLOSE	

APPENDIX II: PARTICIPANT LIST

Name	Position	State
Douglas Bellamy	Area Cancer Care Coordinator, Calvary Mater Health Care, Newcastle	NSW
Rebecca Blake	Cancer Care Coordinator, West Moreton South Burnett, Ipswich Hospital, Ipswich	QLD
Joyce Bonello	Upper GI Cancer Care Coordinator, Prince of Wales Hospital, Randwick	NSW
Ann Bullen	Acting Cancer Care Coordinator (Hepato-biliary, Gyneacological and Upper GI), Royal Brisbane and Women's Hospital, Brisbane	QLD
Gill Burton	Southern Region Cancer Care Coordination Network	QLD
Bethany Crowe	Cancer Care Coordinator, Gold Coast Hospital	QLD
Julie Campbell	Regional Breast Care Nurse, Project Officer, CanNET SA Rural MDT Pilot, South East Regional Community Health Service, Mount Gambier	SA
Shoni Colquist	Manager Queensland Cancer Control Analysis Team, Queensland Health	QLD
Lynn Douglas	Cancer Care Coordinator, Princess Alexandra Hospital, Woolloongabba	QLD
Mary Duffy	Lung Nurse Coordinator, Lung Service PeterMacCallum Cancer Centre, Melbourne	VIC
Jacinta Elks	Cancer Care Coordinator, Southern Cluster Sunshine Coast and Wide Bay Health Service District	QLD
Cassandra Fayle	Care Coordinator, Southern Region Cancer Care Coordination Network	QLD
Marcia Fleet	Care Coordinator Establishment Officer, CNS & Colorectal Tumour Groups, Melbourne Health, Parkville	VIC
Alana Fraser	Cancer Care Coordinator, Royal Brisbane and Women's Health Service District	QLD
Sue Hausmann	Assistant Director of Nursing, Cancer Services Princess Alexandra Hospital, Woolloongabba	QLD
Beth Ivimey	Lung Cancer Nurse Coordinator, Prince of Wales Hospital, Randwick	NSW
Karen Jackson	CNC Neuro Oncology, WA Cancer & Palliative Care Network, Subiaco, Perth	WA
Meinir Krishnasamy	Deputy Director of Cancer Nursing Research, Department of Nursing and Supportive Care Research, Peter MacCallum Cancer Centre, Melbourne	VIC
Alison Love	Cancer Care Coordinator, Medical Oncology Cancer Care Services , Royal Brisbane Women's Hospital, Brisbane	QLD
Lindy Masya	Research Officer, Surgical Outcomes Research Centre (SOuRCe), Royal Prince Alfred Hospital Camperdown	NSW
Kirsten Mooney	Thoracic Cancer Nurse Coordinator, WA Cancer and Palliative Care Network, Perth	WA

Leanne Monterosso	Associate Professor Cancer Nursing, WA Centre for Cancer and Palliative Care, Faculty of Health Sciences, Curtin University of Technology, Perth	WA
Megan Nutt	Nurse Care Coordinator, Head & Neck Oncology, Capital Region Cancer Service, The Canberra Hospital, Canberra	ACT
Amanda Quenell	Cancer Care Coordinator, Southern Region Cancer Care Coordination Network	QLD
Sharon Reinbrecht	ABHI Rural Cancer Care Coordinator, Southern Adelaide Health Service	SA
Catherine Rhodes	Cancer Care Coordinator, Southern Region Cancer Care Coordination Network	QLD
Robyn Sharmon	Cancer Resource Nurse, Border/East Hume Cancer Network, Hume Regional Integrated Cancer Services	VIC
Lynne Steenhuis	CNC/Cancer Care Coordinator Cancer Care Department, Bundaberg Hospital, Sunshine Coast-Wide Bay Health Service District, Bundaberg	QLD
Marion Strong	Cancer Care Coordinator, Toowoomba Hospital, Toowoomba	QLD
Sue Taylor	Nurse Unit Manager, Cancer Care Coordinator, Cancer Services Outpatient & Referrals	QLD
Carla Thamm	Cancer Care Coordinator, Princess Alexandra Hospital, Woolloongabba	QLD
Robyn Thomas	Project Officer, Division of Cancer Services & Education, Cancer Institute NSW, Alexandria	NSW
Francina Wade	Upper GI Cancer Nurse Coordinator, Cancer Services, Royal North Shore Hospital,	NSW
Ann Wallace	Cancer Care Coordinator, Queensland Health	QLD
Jennifer Walsh	Project Manager, Surgical Outcomes Research Centre (SOuRCe), Royal Prince Alfred Hospital Missenden Road, Camperdown	NSW
Katrina West	Cancer Care Coordinator, Southern Cluster Sunshine Coast and Wide Bay Health Service District	QLD
Kate White	Professor and Director, Research Development Support Unit, School of Nursing, Sydney University	NSW
Anne Williamson	Cancer Care Coordinator, Urology, Border/East Hume Cancer Network, Hume Regional Integrated Cancer Services	VIC
Elisabeth Wilson	Nursing Service Director – Medicine, Nambour Hospital, Nambour	QLD
Patsy Yates	Director of Research, School of Nursing and Midwifery, Queensland University of Technology	QLD
Jane Young	Executive Director, Surgical Outcomes Research Centre, Royal Prince Alfred Hospital and University of Sydney	NSW