



Post Conference Report

COSA Cancer Care Coordination Conference *Constructing Cancer Care Across the Continuum*

Swissotel Sydney
4th & 5th March 2014

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Information sourced from COSA Cancer Care Coordination Conference 2014 presenters*

INTRODUCTION

The Clinical Oncology Society of Australia (COSA) is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients. Since 2006, COSA has recognised cancer care coordination as a priority issue of concern to its members and has conducted workshops and national conferences to facilitate the discussion of changing issues in this field over time.

In 2010 the COSA Cancer Care Coordination Interest Group formed and an Executive Committee and working group structure implemented to progress activity in key priority areas. The Cancer Care Coordination Group of COSA continues to represent the needs of COSA members and health professionals working or interested in care coordination.

The Cancer Care Coordination Group is led by an Executive Committee, and three subcommittees; Professional Development, Communication and Networking, and Research. These teams progress priority work in cancer care coordination covering the key areas above. Project Teams are formed from the base of COSA Cancer Care Coordination Group members to drive specific projects. The work of the COSA Cancer Care Coordination Group aims to improve understanding of the contribution of cancer care coordinators improving outcomes of people with cancer in Australia.

The educational activities of this group, specifically workshops and conferences provide an important forum for discussion about evidence base underpinning care coordination intervention and to define the issues, purpose and outcomes of cancer care coordination.

A summary of key meetings supported by COSA in the field of cancer care coordination is provided below:

In **2006** COSA hosted its first Cancer Care Coordination Workshop. Participants were key stakeholders with responsibility, experience and expertise in care coordination at a national, state and territory and local level. These participants considered experiences in care coordination to date and were tasked with identifying key learnings and opportunities, and directions for future implementation of care coordination. A set of principles was developed to underpin care coordination in Australia at the patient, team and system level and directions to further coordinated care as part of multidisciplinary care were agreed upon. It highlighted the importance of achieving a patient-centred rather than disease-centred focus.

The full report (*2006 Smith D from PALM Consulting Group on behalf of Clinical Oncological Society of Australia. Care Coordination Workshop Report*), is available on the COSA website.

A follow up workshop in **2007** was held to recognise the importance of care coordination as a shared responsibility across the entire health care team and what can be achieved through the coordination of care. The workshop identified a range of outcomes and measures that could be used to show whether care coordination is being achieved at each level – patient, service (team and system) and jurisdiction/national. Participants included people with a direct responsibility for providing care coordination to cancer patients, those with a responsibility in service funding and provision, those experiencing care coordination and those with an evaluation role in cancer services. Two essential

components to care coordination were identified. These were clearly defined patient care pathways and the management of care through effective multidisciplinary teams and the participants acknowledged that such components should be in place across the whole system regardless of geography, social or cultural differences and whether care is delivered in the public or private sector.

The full report (*2008 Clinical Oncological Society of Australia. Cancer Care Coordination Workshop Report 2007*) is available on the COSA website.

The first national cancer care coordination conference, titled 'Sharing, Caring and Daring' was held in Western Australia in **2008** and hosted by the Western Australia Cancer and Palliative Care Network. This was followed by a COSA supported workshop in **2009** attended by mainly those practicing in Cancer Care Coordinator roles. The workshop titled 'Care Coordination Outcome Measures: building the evidence', explored practical outcome measures to demonstrate the impact of the Cancer Care Coordinator role and shared progress on jurisdictional activities in cancer care coordination since 2007. Five main areas were explored and these were:

- The patient journey
- The patient experience
- The multidisciplinary team
- Appropriate treatment
- Role delineation

The full report (*2009 Evans A from Alison Evans Consulting on behalf of Clinical Oncological Society of Australia, Care Coordination Outcome Measures: Building the Evidence Report*) is available on the COSA website.

The second cancer care coordination conference was held in **2010** by Queensland Health and COSA on the Gold Coast. Titled 'Relationships, Roles and Reality', the conference highlighted the progress relating to the development and implementation of Cancer Care Coordinator roles. Key messages demonstrated the need for a strategic, national approach to evaluating the positions involved in cancer care coordination and activity of these positions. Through discussions at the conference it was recommended that COSA continued to support Cancer Care Coordination Interest Group. Conference delegates agreed on the Group's main focus to support the needs of its membership through networking and information sharing activities by Cancer Care Coordinators across the country and actively promote the benefits of the role within the multidisciplinary team. Priorities for advancing cancer care coordinator practice covered at this conference were identified through the following strategies:

- Data
- Education
- Role description
- Tools
- Evaluation framework
- Strategic direction

The full report (*2010 Evans A from ZEST Health Strategies on behalf of Clinical Oncological Society of Australia, Cancer Care Coordination Conference: Relationships, Roles and Reality*) is available on the COSA website.

In **2012** COSA hosted the third national cancer care coordination conference. It was titled 'Towards New Horizons' and addressed the emerging issues and health care challenges for Cancer Care Coordinators working in an ever changing health care environment. Subspecialty areas of focus were:

- Coordinated care of the elderly
- Survivorship issues
- Indigenous health
- Adolescents and Young Adults

COSA continued to lead the way in providing a forum for discussion about the contribution of Cancer Care Coordinators to cancer control, and strategies needed to facilitate development of this role.

The full report (*2012 Clinical Oncological Society of Australia, Cancer Care Coordination Conference: Towards New Horizons*) is available via the COSA website.

In **2014**, the cancer care coordination conference 'Constructing Cancer Care Across the Continuum' explored transitions in care and change management to strengthen communication of the role and educate colleagues on other's experiences. It presented Coordinators as leaders who are well placed to bridge the gap between front line coordination of care across health settings and government, shaping the funding decisions and outcome measures for management of transitions in care. With a focus on patient and carer outcomes, the program explored how coordinators can maintain and sustain their roles by being fiscally accountable and demonstrate their presence as a necessary component across the cancer care continuum.

All report from previous COSA Cancer Care Coordination Conferences or Workshops acknowledged above can be accessed via the COSA website via the Publications > Reports and Papers page <https://www.cosa.org.au/publications/reports-and-papers.aspx>

CONFERENCE HIGHLIGHTS

The 2014 COSA Cancer Care Coordination conference “Constructing Cancer Care Across the Continuum” addressed the emerging issues and health care challenges for cancer care coordinators working in an ever-changing health care environment. The presentations highlighted a range of tools to support care coordination practice.

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

Introduction

Professor Patsy Yates and Associate Professor Sandro Porceddu

COSA President Associate Professor Sandro Porceddu welcomed delegates to the COSA Cancer Care Coordination Conference. He acknowledged the importance of the conference as a platform to bring together health professionals working in care coordination. The conference enables colleagues to discuss best practice models to assist in effective management of cancer patients and achieve optimal outcomes. As COSA President he recognised the importance of cancer care coordination and the Cancer Care Coordinator within the multidisciplinary team. He acknowledged the importance of the Interest Group to the COSA membership. In closing he thanked the delegates for their involvement and the important role they play as leaders in cancer care coordination.

Professor Patsy Yates briefly welcomed delegates, special guests and presenters to the fourth National Cancer Care Coordination Conference. She also thanked COSA for their ongoing support and the commitment shown to cancer care coordination.

Professor Yates acknowledged the introduction of the Cancer Care Coordinator role into practice nearly 10 years ago. Recommendations arising from the National Service Improvement Framework for Cancer report supported the introduction of such roles to improve the patient’s experience throughout their cancer journey. The report highlighted the need for a smooth coordinated approach to referral pathways and a strategy to address ‘how do we connect up the cancer journey?’ The establishment of a designated Cancer Care Coordinator position and a focus on coordination of cancer care provided one solution. Since this time, COSA has been involved in discussions and supported initiatives to improve cancer care coordination in Australia. The conference provided an opportunity to reflect on what the Cancer Care Coordinator role had achieved in coordinated care since its introduction. Presentations focused on principles underpinning the role, at a systems, team and individual level. Conversations were needed about where cancer care coordination roles need to go in the future to fit within an increasingly complex and changing health system.

Professor Yates welcomed Professor Jessica Corner, Dean of Health Sciences at the University of Southampton, and Chief Clinician at Macmillan Cancer Support UK as the invited international speaker for the 2014 conference. Professor Corner has an extensive background in nursing and has research interests focused on improving the care and support for people with cancer which combines academic, clinical work and research in this field. In 2005 she was seconded to Macmillan Cancer Support to work as Director of Improving Cancer Services returning to Southampton University in 2008 to become Head of the School of Health Sciences a new entity bringing together Nursing, Midwifery and Allied Health

professions into a new School. She was appointed Dean for the Faculty in 2010 and continues to support Macmillan in an advisory capacity.

She was a member of the Department of Health Cancer Reform Strategy for England, chairing the Patient Experience working group. She works closely with the Department of Health to deliver the National Cancer Survivorship Initiative, and is currently co-chair of the Department of Health Cancer Reform Strategy Patient Experience Advisory Group. She is also a member of the Higher Education Funding Council 2014 Research Excellence Framework sub-panel. Details about Professor Corner's professional experience was taken from the conference handbook.

Keynote presentations by *Professor Jessica Corner, Dean of Health Sciences, University of Southampton; and Chief Clinician, Macmillan Cancer Support UK*

How cancer is changing and how we need to respond to it

Professor Corner opened the conference by addressing the megatrends in global healthcare which are challenging current oncology practice and systems to support service models. The list of global megatrends as developed by the Harvard Business Review are:

- Ageing populations overwhelming the system
- Increasing life expectancy
- Rising costs
- Global pandemics
- Environmental challenges
- Data driven medicine – standardised protocols
- Non MDs providing care
- Payers influence treatment decisions
- Growing role of philanthropy
- Preventable diseases - big business opportunity
- Medical tourism

As a result of these global megatrends the picture of cancer care and healthcare delivery is changing and service provision needs to shift with this change. Data presented by Cancer Research UK demonstrates a worldwide increase in cancer incidence and decrease in mortality in developed countries. Through these data and the Harvard Business Review's list of megatrends in global healthcare, it is known that more people are living longer with and after cancer. As the population continues to age, the way a cancer patient interacts with healthcare services and their time spent within each phase of the cancer care continuum changes over time. Nurses and oncologists are increasingly needing to manage a patient's comorbidities including the presence of other chronic disease, and supportive care needs as well as treating the cancer diagnosis.

Professor Corner presented key concepts from the National Cancer Survivorship Initiative (NCSI) developed in the United Kingdom. The initiative outlines shifts in care and support for people living with and beyond cancer. The five shifts from the NCSI are:

1. Greater focus on recovery, health and wellbeing after cancer treatment
2. To personalised care planning based on assessment of individual risks, needs and preferences

3. Support for self-management. The approach empowers individuals to take on responsibility for their condition supported by appropriate clinical assessment, support and treatment
4. Tailored support enables early recognition of consequences of treatment and signs and symptoms of future disease
5. Measuring experience and outcomes for cancer survivors

The five survivorship phases the NCSI addresses are:

1. Information and support from point of diagnosis
2. Promoting recovery
3. Sustaining recovery
4. Managing consequences of treatment
5. Supporting people with active and advanced disease

Considering this, the NCSI listed four priorities for England, including:

1. Recovery package to support self-management
2. Redesigning follow up
 - Self-care with support
 - Shared care
 - Complex care management through multidisciplinary team
3. Physical Activity – improving outcomes through interventions to support lifestyle change
4. Patient Reported Outcome Measures and consequences of treatment

People are living longer and therefore the demand on services is changing reflecting the ageing population. Service providers must acknowledge the changing profile of cancer patients' needs and resource services accordingly. To make such decisions, services must consider a patient's use and duration of the use of a particular service to maintain cost effective service provision, resource allocation and support optimal patient outcomes. For example, there is increasing need for survivorship care as the population ages, the incidence of cancer increases and mortality decreases.

The relationship between nursing workforce and quality of care for patients undergoing treatment: listening to what patients say to help provide better care

Professor Corner described a project which aimed at identify patient experience and their interaction with services. The data for this project were collected through an annual survey of cancer patients. The aim of the survey was to identify patient experience and subsequently the quality of care being provided from pre-diagnosis to post treatment phase. Questions directly relating to the patient's interaction with a Clinical Nurse Specialist were included to provide comparative data between patient experience of those who have access to a Clinical Nurse Specialist and those who do not. Professor Corner emphasised that 'data is power' and that research enables the nursing professional to build evidence about the services they provide. This message was emphasised across the two-day conference.

Data can be used to aid strategic thinking. Frontline nurses can use data to demonstrate the impact of the cancer care coordination intervention by presenting research results and evidence with an emphasis on being solutions focused. However, this process also involves developing clinical academics to support nurse leadership. The data demonstrated an improvement in patient experience

for those patients who were supported by a designated Clinical Nurse Specialist compared to patients without a Clinical Nurse Specialist.

Professor Corner emphasised that data are key to demonstrate the value of a Cancer Care Coordinator role to service delivery decision makers. There is routinely collected data available and there must be capacity to support frontline staff to generate outcomes within their services beyond routinely collected data. The challenge is to think strategically about how this can be incorporated into standard practice.

Transitions in care: a perspective from the UK

To open Day Two of the conference, Professor Corner presented the current state of cancer care from the UK context. The presentation acknowledged the challenges associated with meeting the needs of a population with various health challenges whilst working within a complex fiscal environment. She began by acknowledging key transition points in the cancer journey:

- Seeking help
- Referral for tests/investigations
- Hand off points along the treatment journey
- End of treatment
- Aftercare
- Returning to work
- Progressive disease
- End of life

Macmillan Cancer Support UK, in partnership with the Department of Health and National Health Service, conducted a review of current practice and selected initiatives from 'Cancer Follow Up – Towards a Personalised Approach to Aftercare Services' as part of the NCSI. Professor Corner outlined the implementation of a self-management framework as a model for post treatment management of cancer patients who have received treatment with curative intent into practice at University Hospital in Southampton.

Supporting a framework for patient self-management requires a whole system change and for patients and clinicians to recognise their role in making a framework effective.

Self-management is appropriate for people in control of their long term condition and active about wanting to manage their care. To be successful a self-management framework must be supported by a system which addresses the following:

- Acknowledging that the relationship between a patient and health professional is different than clinician managed care
- Need for training for health care professionals
- Self-management education for patients
- Integrated care programmes
- The assignment of a dedicated case manager
- Patient assessment and survivorship care planning

This reflects a need for more collaboration and partnership especially when addressing integrated care programmes. Developing empowered, engaged and informed patients as well as prepared and skilled clinicians, and service redesign to tailor support and aftercare pathways for patients willing to self-manage their care.

As the number of people with cancer continues to rise self-management will become an important initiative to address scarce resources. In addition to this, the median age of the population means that a current model of palliative care may not address the needs of cancer survivors with advanced or progressed illness. Self-management may free up some resources to be directed into more complex care patients.

Dollars, Data and Sense

This session combined business and health as key considerations in cancer care service delivery. Health services within the current fiscal environment are under increased pressure to demonstrate the outcome and impact of their work. Three speakers provided varied perspectives and professional advice to assist front line health professionals who provide coordinated care to make sense of the economic and policy environment in which Cancer Care Coordinators work.

Current considerations including Activity Based Funding (ABF) and its implication for coordinated care were acknowledged. The NSW Agency for Clinical Innovation (ACI) introduced key economic concepts and terminology to delegates with practical examples of economic considerations within individual service models. The Director of Cancer Services and Cancer Network at Hunter New England Local Health outlined how managers and service funders consider which services are supported. One consideration working towards the 'Triple Aim', which multiple presenters addressed over the two days of the conference. He challenged delegates to consider the 'Triple Aim' within current models of care to support the use of scarce resources or in model re-design to provide the most health for our dollar. The Triple Aim is; improve the health of the population, enhance experience of care for patients and, control costs per capita.

The session was closed by taking delegates through a case study demonstrating the application of ABF principles. The costs and benefits for a patient who went through their cancer journey with a designated cancer care coordinator were compared to a patient who did not. Benefits were presented not only a reduction of costs on the system but also the impact on patient experience. Such outcomes include less travel time, less time away from families, earlier access to supportive care etc. Delegates were challenged to know the system they work in, how money is allocated and work those structures to influence change.

The importance and influence of data on demonstrating effectiveness continued as a key message throughout the conference. Emphasis was placed on the consideration of strategies to contain costs while working towards integrating quality care across services and jurisdictions to support a broad population and local treatment options.

Economics is your friend: The use of economic and other analyses to support the provision of health services

Liz Hay, Health Economist at the NSW Agency for Clinical Innovation

Ms Hay challenged the audience to consider 'my funding has been pulled- how do I demonstrate my worth?' She introduced basic health economics concepts and the NSW ACI frameworks as tools to aid decision making for the implementation and evaluation of a program or service. The tools assist in improving resource allocation and prioritisation. Considering the costs in healthcare supports the pursuit of a balance between improving patient outcomes and appropriate and effective resource use. A focus on patient centred care is to focus on improving patient care and outcomes independently of setting.

She introduced basic and key economic concepts to the audience including:

- *Scarcity*: this represents a basic economic issue of having unlimited wants but limited resources. As a result, economic decisions must be made to allocate resources efficiently.
- *Opportunity cost*: What is forgone to obtain something else? Opportunity cost is not always financial but there is always an opportunity cost.
- *Trade off*: this creates the opportunity cost as one thing is sacrificed to obtain another because there are not enough resources to have both choices.
- *Cost Benefit Analysis*: monetary value of performing the activity against the benefit of performing the activity
- *Cost Effectiveness Analysis*: Non-monetary value (natural health outcomes). It considers both cost of intervention and the health outcomes.

Good data supports decision making. Data collection and presentation of an evidence base addressing economic savings, and the impact on patient experience are key in demonstrating a service or position's worth. The presentation of standalone data only provides part of the picture for patient care and instead, data linkage would show the whole patient journey, how their time is spent and the services that are utilised. Demonstrating the economic impact is important however, not compromising on quality and safety management and patient outcomes is equally important to consider. Identifying the benefits of a service does not have to be monetary. This is common when focusing on patient-outcomes, as benefits such as reduced stress on patients to schedule appointments may be important.

Ms Hay acknowledged the work of the ABF taskforce in developing the NSW Health funding model to improve patient care. ABF is a tool to identify where to ask questions such as the ones below to drive effective healthcare system:

- Correct allocation of resources?
- Is the model of care correct?
- Quality care maintained?

ABF is not uncapped funding. It provides a relationship between funds allocated to the streams and the services provided. Services which are not funded on an activity basis may be eligible for block funding such as small hospitals.

Activities under ABF are expressed in one currency which is a National Weighting Activity Unit (NWAU). This enables Local Health Districts (NSW context) to understand relativities between the ABF funding streams (acute admitted; emergency department; non-admitted; sub & non-acute; mental

health admitted). NWAU is a relativity measure expressed as price of activity x NWAU = price paid for the work.

Managers, Moguls and Community

Anthony Proietto, Director of Cancer Services and Cancer Network at Hunter New England Local Health District

Dr Proietto acknowledged the increasingly complex healthcare environment consisting of multiple competing interests that have an impact on decisions about how the health dollar is allocated to maximise benefits for the population. All clinical services want a boost to resources and therefore it is becoming more important for clinicians to learn to negotiate for funding.

General challenges currently impacting the health sector are not confined to NSW or even Australia but are seen worldwide. Other presenters acknowledged the key areas of an ageing population; increasingly life expectancy; increasing costs for healthcare; and the need to develop models of service delivery to meet challenges across multiple disease. In addition to healthcare challenges, staffing challenges mainly through the up skilling of clinicians to keep up with the changing requirements of the environment and maintaining staff are crucial to delivering healthcare to a broad population.

Dr Proietto provided a profile of the extent of the challenges in providing care in NSW relating to population and cancer:

- NSW is a large geographical area however, 62% of the population is within 1.7% of land space resulting in a variety of treatment settings and major service gaps in rural and remote locations.
- Projected increase in incidence of cancer patients in NSW
- Current growth of health's share of expenditure of budget growth is unsustainable

His clinical services have multiple accountabilities including the Cancer Institute NSW, the Local Health District and Ministry of Health. Reporting, maintaining relationships and managing requests for each body is time consuming, varied and can result in duplication of work.

Some economic considerations and issues relating to cancer care and the population include:

- Key Performance Indicators to be met as set by NSW Ministry of Health with limited funding available for growth
- Meeting the fixed costs (salaries)
- Recurrent verses project funding
- Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) subsidy program to provide financial assistance to patients who need to travel long distances for specialist treatment not available locally - current funding doesn't cover the costs incurred). If transport links aren't there then people go to large cities rather than local areas.

In addition to acknowledging the challenges, Mr Proietto provided strategic suggestions to containing costs and providing the best service to patients. Breaking down silos and supporting shared care and integration of care models across facilities and jurisdictions may reduce the major service delivery gaps, provide more localised care where possible and create integrated care via health pathways.

Developing network links within and between networks would enable consideration for local area needs and resource capacity by working with Medicare Locals, General Practitioners, and the community sector. Strategic thinking must be supported to generate sustainable models of care as a means to consider how a service will compete for the limited health dollar. Consideration should be focused on how to use influence to impact of broad systems change so that coordinated care is available to the broad population.

Aligning potential models of care to the elements within the Triple Aim (improve the health of the population, enhance experience of care for patients and, control costs per capita) is beneficial when presenting the effectiveness of a health service to a manager.

The reality...

Adjunct Associate Professor Violet Platt, Director of Nursing at the Western Australian Cancer and Palliative Care Network

A/Prof Platt provided a management approach which is used to plan, budget, allocate and manage activity and financial resources to ensure delivery of safe, high quality and health services to the community. She demonstrated this by addressing the application of ABF principles to Western Australia (WA) coordinated care by nurses. ABF is attached to models of care and is any activity which is with, for or to a patient. A cost is placed on direct patient care meaning that services must be aware of what is not considered funded activity. The WA Cancer and Palliative Care Network is block funded under ABF as their services work across all public hospitals in WA.

She demonstrated the practical implications of ABF for the Cancer Care Coordinator role through a patient scenario comparing costs and benefits of the cancer journey with a Cancer Care Coordinator and without. This does not reflect non-direct patient work. The complete case study is available via the presentation on the Conference website <http://cosacc2014.org/assets/CCCC/Platt.pdf>

In summary, the comparison of the particular case study revealed the cost of a patient's treatment journey to the system through the application of ABF principles, with a Cancer Care Coordinator is \$16983, and without it is \$30706. This presents a reduced cost to the system however additional non-monetary benefits at a patient, team and system level were identified. She presented her reflections on the case as noted below.

For *patients* the additional benefits of having access to a Cancer Care Coordinator, as identified by Ms Platt meant:

- Less travel time and time away from home
- Earlier connection to community support
- Earlier social work intervention
- Earlier psycho oncology intervention
- Point of contact throughout journey for appropriate information

For the *team*, she identified that a Cancer Care Coordinator provides:

- More understanding of patient needs ahead of time
- Proactive preparation about clinical interventions

- Offer choice closer to time or with reduced travel
- Educated about services locally or in city area
- Educated about patient treatment journey
- Became part of state-wide network of cancer care delivery

For the *system*, she identified that a Cancer Care Coordinator provides:

- Streamlined appointments, proactive management of investigations and results meaning meaningful clinical activity
- More timely treatment giving increased opportunity for improved outcomes

A/Prof Platt concluded by advising health professionals involved in cancer care coordination to know where and how they add value to the system and to know how to document this within the context of their service.

Lunchtime sessions: Two optional concurrent lunchtime sessions were provided to interested delegates.

Position Paper Discussion

Professor Patsy Yates, Head, School of Nursing at Queensland University of Technology and Director of the Centre for Palliative Care Research and Education, Queensland Health.

This session was facilitated by Professor Patsy Yates to generate discussion and consensus around the direction of the position paper on the role of the cancer care coordinator. She presented the key concepts and principles on which the draft paper was developed, and acknowledged the barriers and points of debate which have arisen during its development. The purpose of the session was to seek support in the approaches to overcoming these barriers in order to produce the final document.

Q and A for New Cancer Care Coordinators

Mr Douglas Bellamy, District Cancer Clinical Nurse Coordinator at Hunter New England Local Health Network

Douglas Bellamy led a workshop aimed towards providing a back to basics approach to establishing the Coordinator role within a service. This discussion highlighted key aspects of the role including; what patients and carers expect, what the health care professionals provide, and what managers of cancer services are looking for in terms of a service which controls costs, improves experience of care and improving health of the population. He introduced tools to support the role and initiatives to develop and maintain important networks.

Concurrent oral abstract sessions

Two concurrent streams provided the opportunity for delegates to hear from their colleagues about the latest resources, research and information. The two streams each included eight presentations of 10 minutes and 5 minutes for audience questions or comments. A full list of presentation titles, their abstracts and author names and institutions are available within the program below. A cash award of

\$500 was awarded to the best presentation as judged against criteria by two judges within each session.

The two streams were:

1. **Coordinating Care**, Chaired by Julie Saunders and presentations judged by Professor Jessica Corner and Marcia Fleet.

The winner of this session was **Paula Howell**, Survivorship Project Officer at North Eastern Melbourne Integrated Cancer Service (NEMICS) presenting ***Bridging the gap: supported self-management interventions at transition from active treatment.***

2. **Coordinated Care Models**, Chaired by Pauline Tanner and presentations judged by Adjunct Associate Professor Violet Platt and Meg Rogers.

The winner of this session was **Mary Duffy**, Lung Cancer Care Coordinator, Peter MacCallum Lung Cancer Service and Chair, ANZ Lung Cancer Nurses Forum presenting ***ANZ Lung Cancer Nurses Forum (ANZ-LCNF).***

Transitions in Care

The impact of Cancer Care Coordinators: Findings from a systematic review of the evidence

Professor Patsy Yates, School of Nursing at Queensland University of Technology and Director of the Centre for Palliative Care Research and Education, Queensland Health.

Professor Yates presented the findings of a systematic review into the impact of Cancer Care Coordinators on behalf of the Review Team from the Queensland University of Technology Institute of Health and Biomedical Innovation and supported by Clinical Network, Cancer Council Victoria. The review focused on the Care Coordinator intervention and the key points where the role may have an influence.

The purpose of the review was to determine the perceived effectiveness of Cancer Care Coordinators. To do so the team examined the impact of the role on patient care, and service delivery, from the perspective of patients, clinicians and Cancer Care Coordinators. Assumptions made when conducting the review included that care coordinators are one intervention to achieve improved care coordination as care coordination is an outcome achieved by system, team, health professional and patient interventions.

She noted the limitations of the literature within the review. There were minimal studies within the Australian context as well as small sample size and bias. In addition, poorly defined outcomes and interventions associated with the role and the difficulty of attributing outcomes directly to the Cancer Care Coordinator intervention was difficult.

The narrative synthesis covered models of care coordination used; impact of care coordination through patient recorded outcomes (patient satisfaction of care), family reported outcomes, health service outcomes and staff reported outcomes. Staff which included members of the team and

associated health professionals reported the Cancer Care Coordinator role as an effective intervention. The literature review identified common enablers to integrating the Cancer Care Coordinator role into standard care. These were mainly associated with prior recognition of and support for care coordination by the organisation and staff. However, where confusion about the role is present and a lack of understanding of what a Cancer Care Coordinator contributes, its integration into standard care is not well supported.

Attributing patient outcomes and cost savings directly to the Cancer Care Coordinator intervention is a major challenge. This can present an issue when trying to demonstrate the interventions contribution to care coordination. Recommendations arising from the review recognise that further development of the functions of the Cancer Care Coordinator should focus on systems improvement and capturing outcomes data as a means to drive service improvement. Cancer care coordinator roles should also be supported by the development of strong frameworks, principles, pathways and tools.

Management of transitions – the lived experience

This session focused on managing the challenges of integrated care and smooth transitions between health care settings. Four presenters identified areas, which impact on transitions and integration of care in their role. The presentations covered what works well, what problem areas exist and what communication of care occurs and how this influences care. Four clinicians involved in various coordination functions across various settings then presented the audience with a very practical session on their experiences, challenges and strategies associated with working across geographical and service boundaries.

Care Coordination Teams: Influencing patient self-management to better manage their needs locally

Claudine Ford, Hunter Medicare Local

Hunter Medicare Local (Hunter ML) team delivers both the NSW Chronic Disease Management Program referred to as the Connecting Care Program, and the Closing the Gap Care Coordination and Supplementary Service Program for patients from the Aboriginal and Torres Strait Islander community. In collaboration with the patient and health service providers, the Care Coordination program seeks to develop long-term strategies for the effective management of an individual's health needs within their local community.

Managing transitions for rural cancer patients

Julie Campbell, Oncology Nurse Practitioner and Nurse Practitioner candidate at South East Regional Community Health

Julie explored the challenges of coordinating care across large geographical areas and often a number of health care providers including General Practice, and the role of the County Health SA Cancer Care Coordinator in managing these transitions between care providers.

Managing the challenges of integrated care between service boundaries

Jenny Rutherford, Gynaecology Cancer Care Coordinator at John Hunter Hospital

Jenny outlined how the Cancer Care Coordinator is able to assist with information provision at diagnosis, facilitate local referrals, local appointments and assist in improving the transition between our unit and their rural treating teams to ensure smooth transitions when care goes beyond geographical service boundaries.

Questions arising of public/private relationships to providing local care

Margaret Rankin, Nurse Manager at Radiation Oncology Victoria

Margaret presented on the development of public/private partnerships between Radiation Oncology Victoria and the Integrated Cancer Services to provide local care and the impact this has had on patient experience.

Managing Change – using your influence and power effectively

Using influence and change management for big picture influencing

Dr Tracey Tay, Clinical Lead at the NSW Agency for Clinical Innovation

Dr Tay introduced her presentation by asking delegates ‘what is your current challenge?’ Clinicians see what needs to be done and how they can support creating that change. Therefore, a model for leadership and management must have clinician input which will be successful if the organisation values clinician involvement in decision making and process change. The NSW Agency for Clinical Innovation (ACI) develops evidence based models of care to guide services across NSW. Frameworks are developed by clinical development and implementation teams with support from health economics and evaluation expert groups. All frameworks and theory acknowledged within Dr Tay’s presentation are publically available via the ACI website. These frameworks support innovative processes and resource allocation in service development with a goal to gain the most health for the dollar without compromising on patient experience or clinical outcomes.

The ACI proposes that clinicians drive the development of a model for leadership and management within a service. For this to be successful, an organisation must place value on clinical involvement within their cultural structure and education and training programs. It supports innovation and shared accountability with managers through the pursuit of common goals. Common goals are identified as meeting each point of the triple aim: improve the health of the population, enhance experience of care for patients and, control costs per capita. As much as the organisation must value clinician led development, the clinicians involved must display knowledge, skills and behaviour to add value to the development process. A clinician must have knowledge of the health system; display leadership and management characteristics, skills in quality improvement and process redesign and they should strive to create influence amongst Executive teams.

Developing a sustainable model of care involves innovative use of resources and prioritising competing needs. Dr Tay explained that a cycle of innovation is adopted to evaluate the model of care and the appropriate use of resources using the following steps: innovation; initial evaluation; adoption of decisions; optimisation of use of resources; disinvestment and evaluation

The development of a model of care can be supported by using the ACI process for Making Choices: A framework for prioritisation within ACI Clinical Network Taskforces and Institutes. It recognises that what we **want** to do is not always what we **can** do, as there is a limit to available resources. Once resources are allocated in one way they are no longer available to be spent on something else. The aim should be to buy most health with our resources and display value as patient outcome per dollar spent.

She outlined some tools to support priority setting which included:

Kingdon Multiple Streams Model can support to bring about action and set an agenda for policy formation. It functions using three streams to provoke priority setting.

1. Problem Stream: issue recognised as problem
2. Political Stream: opportunity for change created
3. Policy Stream: advice recognised as good advice

ACI Framework for Prioritisation within ACI Clinical Networks, Taskforce and Institutes provides an overview of the goals of and a process for prioritisation. Goals for undertaking a process include: reasonableness; transparency; responsiveness to feedback and accountability.

The ACI recommends the below process for identifying priority proposals:

1. Identify proposed initiatives
2. For each proposed initiative ask:
 - Clinical questions
 - Context based
 - Value based
3. Filter out any proposals that don't meet group's criteria
4. List remaining initiatives in order
5. Quantify resources available including financial and in kind resources, and clinician time
6. Identify initiatives that can be achieved within resources available for specified time period

A *driver diagram* is a tool to help think through value-based questions. It is particularly useful in helping a team determine a range of activities that are needed to achieve a specific and common goal. For complex goals the following steps are acknowledged:

- Primary drivers (high level factors)
- What things need to happen
- Shared goal
- Key drivers
- Secondary drivers (lower level factors)

Dr Tay applied a case study against the model of innovation (innovation, initial evaluation, adoption, optimisation of use, disinvestment) and showed delegates how to develop a driver diagram to identify

a common goal between clinicians and management and activities to support the primary and secondary drivers.

She summarised the key points about what a clinician needs to do to influence the healthcare system. Firstly, clinicians must demonstrate the value of their involvement. They should seek to understand the wider health system they work in and display knowledge, skills and behaviour to be successful leaders and change agents. Clinicians involved must share responsibility and accountability with their manager or Executive team to achieve the goal of improving the health of our communities, the quality of our care and controlling the costs. Ultimately, implementing and evaluating models of care seek to create sustainable healthcare system for future generations.

Communication...heard it all before?

Dr Fran Boyle, Pam Mclean Cancer Communications Centre

Clinicians must firstly consider the message they need to communicate to a patient or the information they need to gain from the patient in order to know how best to approach the conversation. Professor Boyle acknowledged that a clinician should consider the following:

- The opening sentence and tone of discussion
- Sitting/standing position or location
- Time of day and considering how the patient might leave the conversation feeling and the impact this may have on their day and ability to recall information
- Do not be distracted by surroundings and put down anything in your hands
- Using open ended questions to gain more information and an in depth understanding, and also to express interest in all their thoughts surrounding the purpose of the conversation
- Make contact:
 - Consider head tilt and hand positions
 - Using eye contact to demonstrate the clinician's complete attention is on the patient
 - Appropriate touch can soothe and connect in ways words cant
 - Look at the wound or equivalent even if nothing of interest will be found. It acknowledges suffering and demonstrates that disfigurement is not disgusting

She acknowledged that at times, conversations will be difficult so considering how a clinician will remain empathic; empowering; effective; efficient; enduring is crucial to the ongoing clinician/ patient relationship and own mindfulness.

There are three commonly associated techniques clinicians employ when breaking bad news to a patient:

- Blunt: breaking bad news without preamble
- Forecasting: preparing recipient prior to breaking bad news
- Stalling: avoiding breaking bad news

Dr Boyle presented the findings of a study which concluded that regardless of style when receiving bad news, it takes the patient an average of 3 minutes to realise what has been said. Presenting psychological services and support groups as components of routine comprehensive care can assist in

normalising supportive care options. This strategy can assist patient as well as their family to manage emotional wellbeing.

During these conversations patients may not understand or recall all the information provided to them. Clinicians can employ techniques to ensure that patients comprehend the news they are receiving and acknowledge how much the patient has retained. Some examples include:

- Prompt sheet used with the patient can seek to cover all important information
- Ask the patient a question, provide them with information, ask them what they heard and then if they tell you anymore
- Thought stopping throughout the conversation to ask the patient to recall what was just said
- Check speed of delivery and slow down if needed
- Creating and hand writing a personalised treatment plans

Everyone has different ways of learning and responding to new information. Identifying these features in the patient can assist in delivering information and setting a plan of action. Professor Boyle outlined four common learning styles and techniques they use for problem solving which are:

An **Activist** learns through their feelings, instincts, and intuition, and their response is to leap into action. To solve a problem, Activists are interactive, chatty and spontaneous, are proactive and value relationships.

A **Pragmatist** learns through just the facts presented, and their response is to leap into action. To solve a problem, Pragmatists are matter of fact, business like and prioritise the most pressing problems and decide how to fix them. They value plans and are solutions focused.

A **Theorist** learns through just the facts presented, and they will think, plan, analyse an action in response. To solve a problem, Theorists are knowledgeable and analytical in response and require accurate details to decide on a course of action. They value standards and authority to solve a problem.

A **Reflector** learns through their feelings, instincts, intuition, and they will think, plan, analyse an action in response. To solve a problem, Reflectors are thoughtful and like to get to the bottom of things and value personal observation and understanding in considering a response.

Multidisciplinary care means that a team of clinicians need to reach agreed decisions about how to proceed in treating the cancer patient. This can be a difficult process and formal decision aids are available for making choices. The Cancer Care Coordinator is a central point of contact for the patient and negotiating with oncology practitioners about their patient's treatment options can be difficult. Communicating within the multidisciplinary team can be made easier by initially meeting other members face to face to put faces to their roles. Be an assertive advocate for patients, focus on their needs and offer assistance to clinicians in exploring the patient's options. If there is an issue which continues to arise, look for a way to change the system to avoid the same situation in the future.

Keep in constant contact with multidisciplinary team members and at the end of each conversation clarify the decision that has been made so this can then be effectively communicated to the patient and next steps clearly taken. When decisions cannot be reached easily, advanced negotiation skills are essential for determining the best course of action.

Closing Remarks

The COSA Cancer Care Coordination Executive Committee, Professor Patsy Yates, Douglas Bellamy and Violet Platt, closed the conference. They thanked presenters, delegates and COSA members in attendance for their enthusiasm, dedication and desire to improve patient outcomes in their cancer care coordination roles. The Executive acknowledged that although not all COSA Cancer Care Coordination Group members were able to attend the conference, their input remains highly valued when considering the professional development and advocacy needs of Cancer Care Coordinators nationally.

The COSA Cancer Care Coordination Conference was an opportunity for colleagues to network and engage in conversations about their experiences in coordinated care. The Executive encouraged ongoing communication and committed to establishing and utilising available platforms to support networking between colleagues. Such available communication tools include *The Coordinator* newsletter, National Contact's Database of Cancer Care Coordinators, online discussion forums via the COSA website, and regular email communication.

The Conference attracted Cancer Care Coordinators working within the private sector, and New Zealand. The Executive expressed their interest in capitalising on these new relationships and will consider how cancer care coordination colleagues working in various settings can work together and learn from each other's experiences. In addition, other groups identified ways their organisations or professional connections could provide resourcing to support future project areas. It demonstrated great opportunity and willingness for collaboration.

COSA continues to recognise the importance of the Cancer Care Coordination Group as a component of multidisciplinary cancer care. The current structure of the Group allows the Executive Committee to provide guidance to subcommittees and working groups to drive national priority activities in cancer care coordination. Delegates expressed their desire for the position paper on the role of the Cancer Care Coordinator to be completed. This was a view shared by the COSA Board and Cancer Care Coordination Executive Committee, which the Executive is committed to completing in the coming months. It will assist Cancer Care Coordinators and health professionals providing coordinated cancer care, decision makers and managers to identify and define the scope of practice of the role within a particular care setting.

The Executive thanked the Professional Development Group for developing a strong program supported by key presenters within each session. The Conference introduced topics such as shared care, activity based funding, health economics, and models of care to challenge delegates to think strategically about their roles and service delivery. Presentations from Professor Jessica Corner, national speakers and delegate discussions highlighted the importance of meaningful and uniform data collection. The presentation of key data would assist in demonstrating the benefits and outcomes associated with the Cancer Care Coordinator intervention. Delegates were supportive of a national approach to evaluation of the Cancer Care Coordinator role to address the lack of evidence supporting care coordination.

Delegates continue to recognise the importance of COSA's role in supporting the national professional group representing the interests of health care professionals working in cancer care coordination.

PROGRAM

Day One: Tuesday 4th March 2014

8:50am	Official Welcome Sandro Porceddu, COSA President
	Welcome to Country Uncle Chicka Madden, Gadigal Elder
	Official Opening Patsy Yates, Chair, COSA Cancer Care Coordination Group
9:30am	Opening Keynote Presentation Jessica Corner , <i>Dean of Health Sciences, University of Southampton and; Chief Clinician, Macmillan Cancer Support UK</i> How cancer is changing and how we need to respond to it abs#1
10:30am	Morning Tea and Poster Viewing
11am - 1pm	Dollars, Data and Sense Session Chair: Douglas Bellamy
11am	Liz Hay Economics is your friend: The use of economic and other analyses to support the provision of health services abs#2
11:30am	Anthony Proietto Managers, Moguls and Community abs#3
12pm	Sharon Lawn Collaboration and Cancer Survivorship: time to work across healthcare systems abs#4 (did not present on the day)
12:30pm	Violet Platt The reality... abs#5
1pm -2pm	Lunch Break and Poster Viewings
1:20 - 1:50pm	Lunchtime Concurrent sessions (optional)
Session One:	Patsy Yates Position Paper discussion
Session Two:	Douglas Bellamy Q and A for New Cancer Care Coordinators
2pm - 4pm	Concurrent Oral Abstract Sessions
Group One	Coordinated Care Models Session Chair: Pauline Tanner Judges: Violet Platt & Meg Rogers
2pm	Sandra Sheene Cancer Coordination Experiences from Waitemata District Health Board, New Zealand abs#6
2:15pm	Danielle Spence Cancer Care Coordinators: can we agree on what they do? Abs#7

2:30pm	Bridget Wislang A new Cancer Care Coordination Model for patients in the Grampians region
2:45pm	Esther Sadek Improving access to Cancer Care Coordinators abs#9
3pm	Lyn Brebner Constructing the Cancer Care Coordination role across regional cancer centres abs#10
3:15pm	Jenny Rutherford Cancer Care Coordinators and Telehealth – Improving care for gynaecology rural patients abs#11
3:30pm	Susan Russell Cancer patients and carer stories abs#12
3:45pm	Mary Duffy ANZ Lung Cancer Nurses Forum (ANZ-LCNF) abs#13
Group Two	Coordinating Care Session Chair: Julie Saunders Judges: Jessica Corner & Marcia Fleet
2pm	Nyree Taylor Exploring risk factors and reasons for extended length of stay in geriatric oncology inpatients abs#14
2:15pm	Aimee Stewart Producing new electronic tools for enhanced care coordination in paediatric oncology: Bottlenecks, breakthroughs and benefits abs#15
2:30pm	Paula Howell Bridging the gap: supported self-management interventions at transition from active treatment abs#16
2:45pm	Tina Griffiths Supportive Care Screening: key to providing optimal care coordination, information and support at the Olivia Newton-John Cancer & Wellness centre abs#17
3pm	Alana Fraser A process review of the multidisciplinary supportive care screening tool for ambulatory cancer patients abs#18
3:15pm	Wafa Trad A longitudinal psychosocial distress assessment in primary brain tumours: are carers and CALD groups at higher risk? abs#19
3:30pm	Douglas Bellamy What are the right questions to ask? abs#20
3:45pm	Kathryn Vidler Evaluating Radiation Therapy Care Coordination at the Royal Brisbane and Women's Hospital – how prepared are patients for radiation planning and treatment? abs#21
4pm - 4:30pm	Afternoon Tea and Poster Viewing

4:30pm	Keynote Speaker Presentation Session Chair: Violet Platt
	Jessica Corner The relationship between nursing workforce and quality of care for patients undergoing treatment: listening to what patients say to help provide better care abs#22
5:15pm 6:45pm	Networking Function

Day Two: Wednesday 5th March 2014

8:30am - 9:30am	Transitions in Care Session Chair: Douglas Bellamy
8:30am	Jessica Corner Transitions in care: a perspective from the UK abs#23
9am	Patsy Yates The impact of cancer care coordinators: Findings from a systematic review of the evidence abs#24
9:30am - 10:30am	Management of Transitions – the Lived Experience Session Chair: Violet Platt
9:30am	Claudine Ford Care Coordination Teams: Influencing patient self-management to better their needs locally abs#25
9:40am	Julie Campbell Managing transitions for rural cancer patients abs#26
9:50am	Jenny Rutherford Managing the challenges of integrated care between service boundaries abs#27
10am	Margaret Rankin Questions arising of public/private partnership to providing local care abs#28
10:10am	Discussion Panel
10:30am	Morning Tea and Poster Viewing
11am - 12pm	Managing Change – Using Your Influence and Power Effectively Session Chair: Andrea Franke
11am	Tracey Tay Using influence and change management for big picture influencing abs#29
12pm -1pm	Lunch Break and Poster Viewings
1pm - 2pm	Communication...Heard it all Before? Session Chair: Liz Zwart
	Fran Boyle, Pam McLean Cancer Communications Centre
2pm - 2:50pm	Closing Session
2pm	Where to from here? COSA Cancer Care Coordination Executive Committee
2:30pm	Presentation of Awards and Official Conference Close Jessica Corner and Patsy Yates