



Position Statement for Cancer Care Coordinators

Preamble

People with cancer typically have a variety of complex needs that require a coordinated response from health services and health care providers. The appointment of Cancer Care Coordinators, a position focused specifically on improving the patient journey, is one strategy that can be implemented to improve the patient's experience. While the term care coordinator has been used in recent times to describe a number of roles in the health care system, this position paper is concerned with cancer care coordinator roles that incorporate the critical functions of assessment, management, and evaluation of clinical and supportive care needs throughout the cancer journey.

Consistent with the Royal College of Nursing Australia's position on the development of new roles in health care, the establishment of cancer care coordinator roles need to be based on principles including:

- clarity of role definition and role relationships,
- ongoing evaluation of the new roles,
- frameworks to support quality practice by healthcare workers,

Moreover, the development of any new roles in health care should be centered around the needs of consumers, with safety and quality being paramount considerations.

As there is growing evidence that specialist cancer nurses are essential to ensuring safety in health care and quality outcomes across a variety of health care settings, appropriately qualified and experienced cancer nurses are well placed to promote continuity of care and fill cancer care coordinator roles (Shannon, 2002). This is because the scope of practice and educational preparation of cancer nurses enhances their capacity to provide the physical, educational and psychosocial dimensions of the role (Seek & Hogel, 2007).

Cancer Nurses Society of Australia Beliefs

It is recommended by the Cancer Nurses Society of Australia (CNSA) that cancer care coordinators should:

- Hold relevant postgraduate qualifications in cancer nursing, or an equivalent;
- Have a minimum of 5 years experience in cancer nursing;
- Facilitate effective communication with peers and colleagues across health care settings;
- Be an integral part of and an active participant in a multidisciplinary team;
- Be supported in the role of care coordinator through the provision of professional development opportunities, organisational and health care team support;
- Participate in activities to facilitate continuous quality improvement of their practice;
- Contribute to ongoing research and evaluation of their role and its effectiveness in achieving optimal outcomes for individuals with cancer, their family and health services.

Rationale

A new cancer diagnosis followed by an intensive diagnostic work up and complex treatment regimens can often result in patients and their families feeling fearful, anxious and confused, as they attempt to navigate their way through the complexities of their care pathway. It is not uncommon for a person with cancer to be required to visit a number of different health care professions across many different departments and many different inpatient, ambulatory or community health care settings. Contemporary combined modality cancer treatment often involves multiple treatments over an extended period of time (Yates, 2004). These experiences place patients with cancer at risk of increased psychosocial morbidity, experiencing fragmented care and becoming lost in the health care

system (COSA, 2003; NBCC & NCCI, 2003). The need to improve the coordination of care for people with cancer has been recognised at a national and state policy level (NHPAC, 2006).

People with cancer and their carers experience a range of physical, emotional, practical, informational and spiritual needs. The complexity of these care needs requires health care responses that are carefully planned and coordinated to achieve quality outcomes for patients and to ensure that the system of care does not add to the burden and distress already experienced by people facing cancer treatment and care (Yates, 2004). A coordinated multidisciplinary approach to care has long been considered the hallmark of any effective intervention in chronic illnesses. These teams have generally included a nurse, who is very experienced in the area and who has also undertaken specialist training (Wagner, 2002).

In addition, a range of strategies at the system, organisational, team and individual health professional level have been identified as having the potential for improving the coordination of care for people experiencing cancer (Yates, 2004). The appointment of cancer care coordinators, a position focused specifically on improving the patient journey, is one strategy that can be implemented to improve the patient's experience. There is some variation in how these care coordinator roles have developed in Australia. Some care coordinator roles focus primarily on strategic improvements to cancer care within a defined region. However, in the majority of cases in Australia, care coordinator positions involve direct patient care and incorporate critical functions of assessment, management, and evaluation of clinical and supportive care needs throughout the cancer journey. This paper is concerned with the latter of these care coordinator roles.

What is Care Coordination?

Care coordination is one of a variety of terms used in contemporary health care language to describe efforts to enhance the patient's experience during illness (Yates, 2004). This term is often used synonymously with other terms such as continuum of care, case management, continuity of care and seamless care, causing considerable confusion (Haggerty, Reid et al, 2003). Central to these concepts is that the delivery of services by different providers occurs in a coherent, logical and timely fashion, consistent with the patient's medical needs and personal context (Yates, 2004). Therefore, care coordination is an integral component of continuity of care. While a range of strategies at the system, organisational, team and health professional level are required to achieve care coordination, the appointment of a dedicated care coordinator can facilitate achievement of these objectives.

For the purposes of this position paper, a care coordinator is defined as someone who engages directly with a patient, manages the care process, including the development and communication of the care plan and ensures that all the care needed is arranged and delivered (Yates, 2004). This process includes an emphasis on education, assessment and psychosocial support for the patient within the context of a multidisciplinary team approach.

Cancer Care Coordinator Role

Varying models of the cancer care coordinator role have been established in recent years. Currently in Australia, care coordinator positions have been established in all States and the ACT. A review of these positions suggests there is significant variation in the scope of practice and functions and the qualifications and experience of persons appointed to the roles. This variation has been reflected in the different disciplinary backgrounds of those appointed as care coordinators, with registered nurses and allied health practitioners appointed to these positions. There is also significant variation in the way in which such roles are integrated within health care teams and the level of administrative and professional support provided for the positions. For example, some cancer care coordinators are institution-based while others work within a specified geographical region. Some focus on specific populations of people with cancer, such as tumour specific roles, while others have responsibilities for the more diverse group of people with cancer.

The scope of practice of care coordinators is diverse, and varies according to a range of health system, organisational, team and individual factors. Care coordinators practice within the context of a multidisciplinary team and may perform activities such as the following, in collaboration with other members of the team:

- Assessment and screening for clinical and supportive care needs and patients at risk for adverse clinical or psychosocial outcomes;
- Facilitating delivery of cancer care consistent with established evidence based guidelines;
- Ensuring prompt referral to specialist, allied health and support services;
- Facilitating continuity of care between the patient, individual health care professionals and health care teams across different settings by establishing timely communication, clear referrals pathways and acting as a liaison between family and members of the health care team;
- Providing timely and consistent education and information to patients and their families;

- Collaborating with all members of the team to facilitate the provision of physical and emotional support to patients and families;
- Promoting the active involvement of patient/family/caregiver in their care and coordination of that care;
- Assisting patients and families to navigate the health care system by coordinating appointments, streamlining investigations, explaining procedures and advocating for them when appropriate;
 - Acting as a focal point of contact for patients and family throughout their journey;
 - Developing and implementing care pathways and guidelines;
 - Contributing to service development and evaluation activities to improve the coordination of care;
 - Participating in quality improvement and clinical governance activities relevant to their role.

(Strusowski, 2006; Bicknell, 2005; Meckes, 2005; Yates, 2004; Nichols & Zaller, 1997)

The Position of the Cancer Nurses Society of Australia

It is the position of CNSA that experienced cancer nurses are well placed to play a key role in promoting continuity of care and filling care coordinator roles. This is due to the profession's focus on comprehensive, person and family-centered models of care and the central coordinating role they have in the health system (Yates, 2004). Cancer nurses have the essential knowledge regarding diagnostic work up and different cancer treatment modalities, their side effects and evidence based interventions. They are also familiar with collaborative relationships with medical and allied health colleagues and the importance of advocacy and promoting self care (Seek & Hogel, 2007). A cancer nursing background thus enhances the capacity of a care coordinator to provide the physical, educational and psychosocial dimensions of the care coordinator role (Seek & Hogel, 2007).

To ensure that care coordinators achieve the desired outcomes for people with cancer, it is the CNSA position that:

1. Cancer care coordinators require experience and qualifications that are commensurate with the advanced role functions and outcomes expected from these positions. These are:
 - relevant postgraduate qualifications in cancer nursing, or an equivalent;
 - have a minimum of 5 years experience in cancer nursing.
2. Cancer care coordinators require an appropriate level of professional support to function effectively, build sustainable roles and deliver outcomes that improve the cancer experience. This support includes:
 - dedicated time for continuing professional development and participation in quality improvement, research and professional activities;
 - clinical supervision and mentoring;
 - education programs which focus on development of the specific competencies required of care coordinators;
 - attention to succession planning within each health service in which care coordinators are employed.
3. Further research is required to examine:
 - the consumer's perspective of what good care coordination involves and how care coordinators can meet these needs;
 - how the role contributes to improved outcomes for patients;
 - models of care coordination in different settings;
 - appropriate case loads;
 - workforce planning and role evaluation;
 - cost effectiveness of the role (Yates 2007).
4. Care coordinators should be part of multi-faceted strategy for achieving improved care outcomes. Care coordinators work within the context of a multidisciplinary team, and all members of that team have a responsibility to ensure coordination of care. Care coordination is not the sole responsibility of one health professional or one member of the health care team (DHS Victoria, 2005). Health care managers and funders have a responsibility to ensure adequate resources and systems to ensure coordinated care.

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CNSA Mission

CNSA is committed to achieving and promoting excellence in cancer care through the professional contribution of nurses, through education, information, leadership, networking and professionalism.

Disclaimer

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