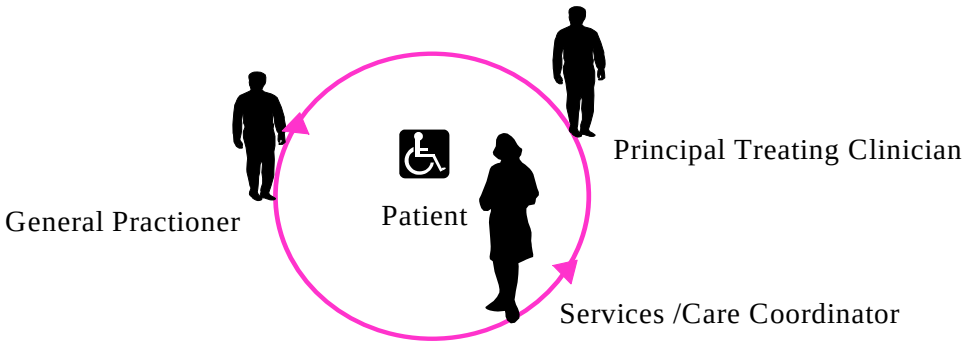
THE CANCER CARE COORDINATION SERVICE

OPERATING MODEL



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A CANCER CARE COORDINATION SERVICE

Background

In June 2002, a sub-group of the Cancer Program Executive undertook a detailed analysis of the issues confronting the SWS Cancer Service and how a Cancer Care Coordinator Service might address some of these issues. In addition to the hands on care for patients there were other organisational imperatives to be addressed.

To manage cancer services on an Area level SWS Cancer Service has developed 11 Tumour site Specific Programs. This structure has been incorporated into the NSW Clinical Framework for Optimising Cancer Care 2003-2005. The program leaders are recognised opinion leaders in their specialty. A key feature of the Tumour Programs is they provide a link across clinical services thereby reducing the fragmentation of services and providing the patients and carers with a clear pathways. Tumour Program leaders have limited time and in our experience without dedicated support the programs cannot develop. The Tumour Program leaders have indicated that 100 hours per year is the maximum reasonable time for an active clinician to dedicate to a Tumour Program.[1] This excludes attendance at MDTs. Therefore to maximise the input from the Leader there must be a close working relation ship with the Coordinator

SWS Cancer Service has considered the model of care coordination as a key building block of the organisation. We must address the fundamental principle that the leverage to improve quality and outcomes is in the resource management and system processes of the organisation. It is very difficult to try to improve services by only mitigating problems at the interface where the patient meets the service.

The root cause of patient problems need to be elicited and acted upon. This is where our model provides a direct link between identifying the problems and modifying the system to provide the solutions. The roles of care coordinators are non-clinical. We have developed the model under the Health Services Managers Award, as these positions are essentially management. In terms of professional development they are ideal as part on developing business managers for health services. This opens the recruitment up to anyone with a health background.

Over 12 months the roles for care coordinator have developed into three distinct areas.

The activities are:

60-70% Direct Patient Care

A detailed account tasks is in the operating model given below.

[1] October 2003 SWS Cancer Service Governance Workshop. In order to establish realistic governance functions and structure there needed to be a clear decision about how much time would be available for the roles. 100 hours for program leaders (resource utilisers who determine service standards and 600 hours for clinical service heads who are budget holders. (medical oncology, radiation oncology 0 who are responsible for quality.

20-30% Organisation of the weekly MDT

Reminders, minutes, recording of teams opinion, ensuring imaging and pathology are available). The NHS has a detailed specification for a generic specialist MDT as well as specific MDT specifications for: Breast, CRC, Lung, Gynaecology and Upper GI Tumour Sites. (NHS Manual of Cancer Services Standards). The NSW Standards for MDT are specified in the Clinical Service Framework for Optimising Care. With the establishment of the NSW Cancer Institute it would be expected that NSW would publish Site specific Tumour Program Standards for NSW sometime in the future.

10% Management / secretarial support for the Tumour Program business meeting.

When reliable activity data is routinely available the coordinator will be responsible for identifying patients mapped back to their tumour program. Length of stay > 10 days and frequent admissions will be managed actively through the program. The coordinator will be the responsible person for documenting the business plan for the Program. The coordinator will document and audit agreed pathways developed by the Tumour Program.

In June 2003 the NSW Clinical Framework for Optimising Care Care was published and is the first standard for Cancer Services. Care coordination is a key concept

The more highly specialised services are centralised H&N, Neuro, Gynae, Heam, They are easier to manage in many ways, with smaller numbers of treating clinicians so they are easier to identify, and fewer patients who come to one/two sites.

The more difficult cancer patients to coordinate are Lung GU, Beast, CRC and Skin. There are large numbers of clinicians treating these patients, higher numbers of patients and more than one location of treatment.

- Ψ Appointment of a coordinator will formalizes the tumor program and MDT
- Ψ They provide capacity for change and improvement
- Ψ They mitigate against system problems for individuals
- Ψ They drive quality through the Tumour Programs
- Ψ They link the coalface with the organizational structures that can address issues.
- Ψ Help us meet the standards of the CSF

To be truly effective the coordinator position must be able to influence practice. By holding this strategic role in the Tumour Program the root causes of poor quality and system inefficiencies can be addressed. Because the model covers acute and ambulatory patients across services and geographic location this role provides the glue that informs the development of the Tumour Programs, the system problems identified can be addressed form a system perspective. This is essentially incorporating quality into the fabric of servcie provision. The Terms of reference for this group are given in appendix **

1.The Strategic Importance of a Cancer Care Coordination Service

The SWS CS Goal is to:

To reduce the incidence of cancer
To increase the survival from cancer
To increase early detection of cancer
To improve the quality of life of those living with cancer

By delivering a patient-centred, comprehensive integrated cancer service to the population of South Western Sydney that is in accordance with good practice

2 CURRENT SWS CS Issues

2.1 CURRENT PATIENT /CARER ISSUES

- Education,
- Stress and concern
- Communication
- Waiting times Transport
- Appropriate support(including cost)
- Single point of contact
- Queries
- Informed Consent
- Culture and Language
- Planning
- Conflicting Advice
- Who is my Prime clinician?
- Emergency queries

2.2 SWS CANCER SERVICE – START UP INTERNAL ISSUES

- No formal Cancer Service until 2002. Previously a variety of individual providers
- No funding for Area cancer Service development
- No activity data inpatient or out patient
- No treatment and outcome data
- The Cancer Control Service is a new service with few established Policies and Procedures
- Multiple Service Providers
  - Diagnosis
  - Treatment
  - Symptom Management / Pain Management
  - Ancillary Services
  - Support Services
- Fragmented Service Delivery - -not integrated
- Poor Links between Community and Acute services
- No clear Cancer Pathways
- Little documented good practise
- Need to develop appropriate Clinical protocols and Pathways

- Need to clearly define roles and responsibilities of appropriate stakeholders
- Minimal comprehensive data on actual events e.g. Treatment, planning, Cancer pathway interactions etc
- Need to develop an appropriate agreed Model of Care
- Need to deliver patient centred care
- A significant lack of resources for the CCS and Tumour streams

2.3 SWS CANCER CONTROL SERVICE-- CURRENT EXTERNAL ISSUES

- Population 800,000
- Ethnic Groups 120+
- Cancer Incidence 2700
  Cancer Mortality 1140
  Living with Cancer 10,000+
- A sector Model - -5 Sectors., moving to an Clinical Streaming Model June 2004
- 600+ GPs *(5 Divisions of General Practice)*
- Underdeveloped Community resources (Community access block)
- Possible amalgamation of AHS

The SWS cancer service has commissioned the Health round table for report on inpatient data by facility and mapped back to tumour program. This is the first time we have been able to ascertain the size of the problem. We have also engaged an accountant to tack down expenditure.

There are many cancer patients admitted and discharged from hospital and have no contact with the cancer service.

Inpatient	$40 million
Outpatients	$40 million

3. A Cancer Care Coordination Service

The Cancer Program Executive believes that a Tumour specific Cancer Care Coordination Service would address many of the current issues faced by the SWS Cancer Service.

The patient focussed key activities for 70% of the coordinators time are:

- Facilitates Patient Centred, Comprehensive, Integrated Cancer care for patients in Hospital and the Community
- A " primary point of contact" for all
- Provides organisational support to the tumour- specific Multi-disciplinary Team meeting
- Assists in the develop of individual care plans
- Liaises with and coordinates Service Providers
- Patient and Carer Education
- Patient Advocate
- Supports the business meetings for the tumour specific programs

4. The Operating Model

The Operating Model was developed as a result of a detailed analysis of the existing Cancer Service to determine Care Coordination Issues

4.1 COORDINATION ISSUES

20 issues were identified

A Service?
A Long Term Service?
Staging ?
How do we learn?
Care and Service Coordination Model ?
What is the Service "
What is the Interface with Palliative Care
Skills and Experience Requirements
(Clinical v's Community)
Operational Processes
Long Term assured funding
Evaluation
What organisational Infrastructure is required
Patient Selection Criteria
Physical Infrastructure
Service Coordinator -Position description
Service Coordinator -Skills and Experience
Training
The Key Issue – Time and Resources

* The 5 most significant issues.

- A 'Service' not a 'person'[2]
- Time and Resources
- An agreed model of coordination
- Evaluation
- Long term Funding

4.2 AN OPERATING MODEL

The Model was developed to address the identified issues. The Key features are:

- Establishing an Area Cancer Care Coordination Service that includes the individual Care Coordinators
- Ensuring that there is one person - - The Care Coordination Operations Manager, who will have the time and expertise to establish a sound Care Coordination Service that will achieve secure long term funding
- A model of Care Coordination that draws on what has been learnt elsewhere
- The concept of a Principal Treating Clinician
- A simplified Position Description for Care coordinators

[2] The Coordinator needs to part of an identifiable service, the model ere a nurse/other professional is recruited and assigned to one clinical unit is not acceptable to cancer services that are mainly ambulatory. Self-management is not a key platform for this model unlike Chronic heart and lung disease.

THE OPERATING MODEL

This Operating Model has been developed based on the following principles:

- Improve services to the patients
- Address the Existing Care Coordination Issues
- Utilise the experience and expertise of others
- Minimise complexity

THE PRINCIPLE FEATURES OF THE OPERATING MODEL ARE:

1: The Cancer Service needs a Care Coordination Service not a Care Co-ordinator

2: The Care Coordination Service must be a Long Term Service.

The Care Coordination Service cannot be yet another pilot, living year to year on inadequate funding.

The SWS CS needs to achieve secure long term funding for the service, as soon as possible

This will require:

- Evaluation
- A 3 stage approach
- Identified and prioritised funding sources
- A committed person dedicated to evaluation and securing the secure long term funding

3: The Service will require a Care Coordination Operations Manager

Based on experience, it is apparent that currently no one has the time or experience necessary to establish a successful long term securely funded Cancer Coordination Service. Especially in an environment where it may take an experienced person 6-12 months recruit a care coordinator, even if the funding is available.

If the SWS CS are to establish a successful Care coordination service with secure long term funding, there needs to be a dedicated resource to ensure this.

The service will need to appoint a Care Coordination Operations Manager, if it is to assist the SWSCS to achieve its goals.

4: A Learning Organisation

The Care Coordination Service must be provided by a learning organisation. That organisation must draw on the experience of other organisations in delivering coordinated Care. The Care Coordination Operations Manager needs to learn from organisations and people with experience in this area.

Three potential sources are:

- SWS Chronic and Complex Care Program
- Coordinated HealthCare Melbourne

Coordinated HealthCare is the only participant in both rounds 1 &2 of the Commonwealth Coordinated HealthCare trials and as such has perhaps the greatest experience in coordinated Care in Australia We have had interaction with this group and it would appear beneficial to formalise a link with the group

- SWS Palliative Care Service

5: The Care and Service Coordination Model

The Care Coordination Team

- The Team consists of

  The Patient
  The Care Coordinator
  The Principal Treating Clinician (Treatment Coordinator)
  The Patient's General Practitioner

- Care Coordinator is a non-clinician and the person providing the Coordination, Education, Advocacy, Support

- The Care Coordinator will be mobile and visit Patient, GPs and Service Providers

- Significant patient involvement

- An emphasis on Patient self management

- Care = Treatment +Other Services

- When a patient is recommended for and accepted by the Care Coordination service, the Care Coordination Service will undertake an initial patient assessment

- The subsequent Care Plan will then be developed by the relevant Clinician at that point in time and the Care coordinator

- The concept of the Primary Treating Clinician. There can only be one Primary Treating Clinician at a time but over time there may be a number of Primary Treating Clinicians. **There may be a number of treating clinicians at a point in time but there can only be one PTC. This name will appear on the front of the Care Coordination Patient record**

- The Services coordinator will organise the necessary and appropriate non-treatment Services

- There may be a number of Care Plans for a patient. The aim is to minimise the number of care plans.

- The Care coordinator serves as the central point of Contact

- The Care coordinator need to be aware of what services are being provided

- Services should be in accordance with the Care Plan, however it is recognised that new care plans will be necessary as the treatment / Care evolves

- Clinical Pathways are a sub-set of Cancer Pathways

Initially the Service will generate a number of Care Plans per Patient. However as experience is gained the number of Care Plane would be expected to significantly reduce

6: THE CANCER CARE CO-ORDINATION SERVICE

- Facilitates Patient Centred, Comprehensive, Integrated Cancer care for Cancer patients in Hospital and the Community, particularly those who are accepted as clients of the service
- A primary point of contact for all. Patients, Carers, Service Providers
- Assists in the develop and execution of individual care plans
- Gathers information that will assist in the development of non-clinical protocols to streamline the Cancer Pathway
- Liaises with and coordinates Service Providers
- Patient and Carer Education
- Patient Advocate

7: THE INTERFACE WITH PALLIATIVE CARE

The roles of Palliative Care Service and the SWS Cancer services coordination will gradually overlap as a disease progresses. There needs to be a clear protocol spelling out the operational interface and responsibilities between the 2 services

These protocols would initially be developed for a particular tumour stream with the Programme leader, the Care Coordination Operations Manager and a representative of Palliative Care. The intention is to minimise the variation between Tumour stream protocols.

8: SKILLS AND EXPERIENCE REQUIREMENTS (CLINICAL V'S COMMUNITY)

It is recognised that the Care Coordination Service will require access to both clinical expertise and Community skills and networks.

<u>An Option</u>

One possible way to address this is to ensure that the Care Coordination Operations Manager has a strong background in Community Services. The actual service coordinators could then have a greater tumour/ clinical focus, if necessary.

9: OPERATIONAL PROCESSES

An essential part of a successful service is the development and implementation of the necessary Operational Processes. "The devil is in the details"

The Care Coordination Operations Manager will need to develop the Operational Processes needed to deliver the agreed Model of Coordination and Services

There will need to be a Process to develop protocols, some protocols that may need to be developed would be might be

- Patient selection Criteria Screening for psycho social need
- Patient Privacy, Confidentiality and access to Personal Information (as per NSW Health Guidelines)
- Patient Involvement and Feedback

- Access to Patient Files and Records
- Principal Treating Clinician
- Patient allocation to Service Coordinators. For the 10 major cancers the allocation is by Tumour site. However the are 1/3 of all cancer that don't fall into this category. Care coordination models for rural patients will most likely not be site specific.
- Initial Discussion between Care and Service Coordinator. Currently there are two models working.
- patients are referred to care coordination by clinicians,
- new patients are identified from the booking system when they come for their first appointment with a medical or radiation oncologist
- Service coordinator safety on Home visits. Although not efficient, visiting at home is the best way to ascertain the patients' circumstances and resources to cope.
- Long Term Case Management. Do we have a discharge procedure or do patients stayed enrolled with the service for life? We may need to develop a rating system for 'active' and quiescent patients
- 24 Hour "on Call " process,
- Crisis Management, A&E Presentations
- Access to Community Resources
- Care Plan Development
- Care Coordination Review
- Care Plan Revision
- Principal Treating Clinician change
- Patient Medication Review
- Referral to Aged Care Assessment Team
- Referral to Aged Psychiatry Assessment and Treatment Team
- Use of Interpreters
- DVA Patient Entitlement
- Residential Respite
- Death or Withdrawal of Patient
- Notifications by Service Providers

10: EVALUATION AND LONG TERM ASSURED FUNDING

The two tasks of

Evaluation

Long term funding

Are intertwined and will need to be addressed by The Care Coordination Operations Manager in parallel. The best way to address the Evaluation task will be to discuss the matter with a group that has already done this

The evaluation process will facilitate the management and improvement of the service as well as serving as a basis to secure long term funding

11: ORGANISATIONAL INFRASTRUCTURE

- The Care Coordination service should be an Area service within the CS and the Care Coordination Operations Manager should report to the CS Director
- The Care Coordination service should essentially have Service Contracts with the Individual Tumour Programmes. A Tumour Leader would be taken as the client for the purposes of these contracts
- There would be a major need for Marketing and explaining the service to possible service providers both internally and externally
- There would need to be a list of affiliated Service Providers
- Training of Service providers will be necessary
- The relevant administrative processes associated with this position and service will need to be clarified and documented.

12: PATIENT SELECTION / ELIGIBILITY CRITERIA

A patient selection criteria will need to be developed at an early stage to identify and accept those people who would benefit most from this resource limited service.

It would appear that Simple (very early stage) and Complex (end stage -Palliative Care) patients are probably not appropriate at this stage

Geographic considerations will also play a part

A lack of affiliated Service providers will also set boundaries

13: PHYSICAL INFRASTRUCTURE

The Care Coordination Operations Manager and Service coordinators will require Accommodation, Mobile Phones, Cars Computers, a common location and relevant budgets if they are to function effectively

14. POSITION DESCRIPTION FOR A CARE COORDINATOR

Facilitates Patient Centred, Comprehensive, Integrated Cancer Care for patients in hospital and the community

1. Works with the Care Coordination Operations Manager and Tumour Programme Teams to develop and document guidelines, protocols and standards for the Cancer Care Coordination Service
2. Supports the Tumour Programme Team to develop and document guidelines, protocols and standards for Clinical Treatment and Multi –Disciplinary Care Teams.
3. Undertakes a comprehensive assessment of patients referred to the Cancer Care Coordination Service by a clinician
4. Provides support to the appropriate multi-disciplinary treatment team to facilitate the development of an appropriate Treatment Management Plan for a patient.
5. Develops, facilitates and manages with the Principal Treating Clinician the appropriate Coordinated Cancer Care Plan for individual patients

6. A “Primary point of contact” for all

7. Identifies stakeholders in Clinical and Care Pathways and informs them of the Cancer Care Coordination Service and the Care coordinators role in that service. Develops and maintains a list of accredited Cancer Care Coordination Service providers.

8. Liaises with and coordinates Service Providers (Primary Treating Clinician, Clinicians, Primary Care, Support Services, Ancillary Services, Carers)

9. Monitors, assesses and documents the patients and carer’s status, as well as the appropriateness of the Coordinated Cancer Care Plan. Communicates with the Primary Treating Clinician as appropriate

10. Patient and Carer education

11. A member of the relevant Tumour Programme Team and liaises with the Tumour Programme Leader as required

12. Accurate and Timely collection of Data that will assist in the development of appropriate Care Protocols and Pathways as well as the management and evaluation of the Service

Individual Knowledge and Skills for This Position:

Essential Criteria:

- A relevant health service background (social work, psychology, radiotherapy, nursing)
- Considerable experience working in health settings
- Excellent communication and problem resolution skills
- Computer literacy in Microsoft Word, Email
- Ability to work with minimal supervision
- Ability to work in a team environment
- Understanding of clinical pathways
- NSW Driver’s License

Desirable Criteria

- Knowledge of community services referral practices
- Interest in Oncology
- Experience in working with senior clinicians and GP liaison
- Experience with oncology patients and services.
- Research interest and data entry skills
- Experience in acute and community health service delivery
- Relevant postgraduate tertiary qualification

15. SKILLS AND EXPERIENCE REQUIRED FOR POSITION

The skills and experience that a Service coordinator will require will depend to a certain extent on the manner that requirement 8 is addressed

16: STAFFING

The Care Coordination Operations Manager should report to the Director of the SWSCCS and the Service Coordinators should report to that person. The service coordinators would have a dotted line to Programme Leaders

Professional accountability would be as appropriate

The Recruitment process and Performance Management of the Care Coordination Operations Manager should be handled by the Director with appropriate input from the CPE

The Recruitment process and Performance Management of the Service Coordinators should be handled by the Care Coordination Operations Manager with appropriate input from the CPE and relevant professional sources

17: TRAINING

There are two phases to implementing a care coordination model.

- startup
- Steadystate

18: FINANCING

Service Implications: In the first instance the cost of services is likely to rise. This will be due to the fact that with Care Coordination patients are no longer lost in the system and receive the services they require.

However this is not to say that the overall costs to the Health System will increase. Experiences tends to indicate that when dysfunctional parts of the Health System are reformed almost invariably the overall quality improves and the overall cost decreases. The Lack of Quality is expensive

It will be necessary to address this issue from Day 1 and establish systems to baseline the existing situation and collect data on overall costs and quality. In addition processes will need to be in place to manage costs and ensure adequate budget reallocation occurs