Care coordination—striving to make the difference in Victoria

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Cancer services and care coordination—the need for change

It is acknowledged that the cancer journey is complex and challenging. Cancer has a major impact on a person's life—physically, psychologically, emotionally, financially, spiritually and socially.

The delivery of cancer care is often complex and fragmented given that:

- most cancer treatment is multi-modal, requiring a combination of surgery, radiotherapy and chemotherapy
- patients are seen by many health professionals within and across multiple health services and across different health sectors including public, private and community health services in both metropolitan and rural regions
- communication between health care providers is often suboptimal
- there is a lack of clear referral pathways for the delivery of care.

Navigating this complex system is difficult for patients particularly while having to make huge decisions regarding treatment and care.

Cancer diagnosis and treatment: impact on individuals

Care coordination has become a major issue for consumers, carers and clinicians Australia wide and internationally. With an ageing population and associated increase in incidence of cancer, combined with the growing number of patients surviving cancer, the need to address issues related to workforce availability and cancer service capacity to deliver optimal care has become paramount.

A starting point for change

The need for cancer care coordination is acknowledged in the Victorian Government's *Fighting Cancer Policy* of November 2002, and the *Cancer Services Framework for Victoria* (2003).

The establishment of Integrated Cancer Services (ICS) in Victoria provides a structure for optimal service delivery based on specified geographic areas and defined populations.

The aim of the ICS is to promote shared planning and delivery of services and to improve communication between services, therefore better meeting the needs of people with cancer. Services include public hospitals, community-based services, general practitioners, private hospitals and psychosocial support and palliative care services.

In general, the cancer service reforms in Victoria aim to:

- ensure the delivery of integrated, high quality, evidence-based treatment, information and support for people with cancer, and
- improve the access, equity, quality and coordination of services.

The ICS are in the process of developing service improvement initiatives across tumour streams in four key areas:

- multidisciplinary care
- psychosocial and supportive care
- reducing unwanted variation in practice and
- care coordination.

What is care coordination?

The terms care coordination and continuity of care have different meanings in different contexts and are often used interchangeably by health care providers.

Continuity of care is best viewed as an outcome of care[1]—an outcome which is **experienced** by the patient as **connected and coherent**[2], logical, timely and consistent with their medical and personal needs. From the patient's perspective, this is achieved when:

- a provider knows what has happened in the past
- different providers agree on the management plan
- a provider who knows them will care for them in the future[3].

Care Coordination is an **approach** to achieving continuity of care. It is how the whole system 'talks' and how parts of the system interface with each other to streamline processes. The common elements of continuity of care are:

- the care of the individual
- care is delivered over time
- care involves crossing disciplines and organisational boundaries[3].

Continuity of care can be characterised by:

- **comprehensiveness** (provision of necessary services)
- **time** (care is delivered over a period of time)
- **relationships** (service providers have established secure and dependable relationships)
- **accessibility** (appropriate care is available when required)
- **responsiveness** (care is flexible enough to meet patient needs)[3].

If continuity of care is to be achieved, the current health system needs to be looked at from many levels (that of the system, service, team and individual). In addition to this, there are different types or approaches to continuity (informational, management and relational) that need to be considered for effective care coordination.

A workshop was recently held in Melbourne (12 July 2005) to explore approaches to, and elements of, care coordination for people with cancer. Participants included key interstate stakeholders, health care providers with expertise in care coordination and other stakeholders from each of the ICS. Oncology nurses, including some who were employed in defined coordination roles, played a key role during the workshop.

In an attempt to conceptualise the complexity of continuity of care, the Cancer and Palliative Care Unit (CPCU) of the Victorian Department of Human Services developed a matrix bringing together the three approaches to continuity of care and the four levels within the system.

A key objective of the workshop was for participants to contribute their knowledge and experience in the identification of initiatives or activities that could be implemented at each level for each of the three approaches to continuity (see table).

A key outcome of the workshop was the acknowledgment that coordination of care was the function and responsibility of the whole multidisciplinary team and service and not just the role of an individual nurse coordinator. The role of nurse coordinators however is important and could best be utilised to build the capacity of the system, service and multidisciplinary team to improve care coordination.

Conclusion

Current service delivery for cancer care needs to be challenged if it is to address the needs and care continuity of cancer patients. The increasing complexity of cancer care and limited resources for the delivery of care make it imperative that the system, services and teams consider ways in which to improve continuity of care for cancer patients. The contribution of nurses to developing and implementing initiatives to address such issues is vital in the cancer reform agenda.

References

1. Strumberg, JP. 2003. Continuity of Care: a systems based approach. *Asia Pacific Family Medicine* 2:136–142
2. Haggerty, JL et al 2003. Continuity of care: a multidisciplinary review. *British Medical Journal* 327 (7425): 1219–1221
3. Woodward CA et al 2004. What is important to continuity in home care? Perspective of key stakeholders. *Social Science and Medicine* 58 (1); 177–192

Continuity of care matrix with initiatives or activities identified to address continuity of care

	Informational Links care between one provider and another and between health care events	**Management** Services/care delivered in a complementary and timely manner	**Relational** Provides link between past, current and future care. Is achieved through one key contact (for example GP) or a core group to provide a sense of predictability and coherence
System Across and between the ICS and inclusive of primary and community care sector	• Electronic fully integrated data system • Electronic information transfer • Electronic medical record • Agreed consumer information provision by tumour stream across the patient management pathway.	• Mapping of current processes and pathways utilised within and between ICS. • Agreed models of service delivery • Partnerships • Service agreements (public/private, states, metro/rural) • Funding models • Clinical practice guidelines • Participating in clinical governance	• Standards • Advocacy
Service Throughout the health service and inclusive of all health providers/disciplines	• Enhanced documentation through medical records, letters between providers. • Discharge letters • Quality improvement	• Guidelines • Care coordination service • Accreditation/standards • CME—peak bodies • Care transition across sectors • Referral pathways/mechanisms • Multidisciplinary clinics	• Service coordinators
Team Multidisciplinary—across all disciplines involved in the care of cancer patients	• Multidisciplinary communication and documentation • Communication protocols • GP case conferencing/care planning • Quality improvement	• Multimodality (resources, MDT) • MDC (resources, MDT meetings) • Public/private interface • Agreed and shared management protocols and clear referral pathways • Implementation and audit of clinical practice guidelines • Routine psychosocial assessment and early referral	• Care planning • GP case conferencing • Communication training • Recording and disseminating information
Individual Individual patient or health care provider	• Bottom up approach—evidence and consultation—all stakeholders (change management process) • Consumer engagement all levels • Patient held record • Consumer information • Making appointments and referrals • Reinforcing information • Explaining procedures	• Team member time/focus • Consumer information • Consumer involvement in management planning • Comprehensive assessment, planning, intervention and evaluation	• Agreed key contact for patient at different phases of patient journey • Communication training • Case manager/coordinator for complex care and high need/at risk patients