



**Clinical
Oncological
Society of
Australia**

Survey of Cancer Care Coordinators within the COSA membership

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INTRODUCTION

The Clinical Oncological Society of Australia (COSA) is Australia's peak multidisciplinary society for health professionals working in cancer research, treatment, rehabilitation or palliative care. With a membership of over 1250 individuals in 22 cancer professional groups, COSA's overarching mission is to develop and maintain high-quality clinical care of cancer patients in Australia. Membership includes doctors, nurses, scientists and allied health professionals involved in clinical care of people with cancer.

The need for improvements in continuity cancer care has been identified in national cancer frameworks and cancer plans^{1,2} and coordination of care is consistently identified as a priority by consumer groups.³ COSA has undertaken a number of initiatives in this area. In November 2006, COSA convened a national workshop in which key issues associated with cancer care coordination were defined and a set of Principles developed to underpin care coordination in Australia at the patient, team and system levels.⁴ A follow-up workshop was held in 2007 to define expected outcomes from cancer care coordination, methods for evaluating those outcomes and potential benefits, including health and economic outcomes.⁵ During both workshops, the importance of Care Coordinator roles as a strategy for improving coordination of cancer care was highlighted. Cancer Care Coordinator positions have already been established across many jurisdictions. However, considerable variation exists in role delineation, scope of practice and provision of training and support for individuals practising in these roles.

In 2008, COSA undertook a survey of its membership to elicit information around scope of practice, work experience, referral pathways and learning and support preferences for Cancer Care Coordinators. The survey also sought to obtain feedback on the appropriateness of specific outcome indicators identified in the 2007 COSA Workshop. The purpose of the survey was to identify areas for improvement, gain insight into the professional support needs of individuals appointed to these roles, and determine the next steps in development and implementation of outcome measures relevant to cancer care coordination interventions.

SURVEY METHODOLOGY

The self-completed web-based survey of 29 questions was disseminated via email to the COSA membership. The survey introduction clearly indicated that the survey was to be completed by individuals who were appointed to dedicated Cancer Care Coordinator roles. Of the questions, 12 related to general demographics, profiling information and cancer care coordination work experience, 9 related to the multidisciplinary team and opinions about the appropriateness of care coordination outcome indicators, and 8 questions related to learning and professional support needs of care coordinators. Results were collated through Survey Monkey and complete responses exported into Microsoft Excel for analysis. Qualitative responses were grouped thematically and the most common themes have been reported here. Approval to conduct the survey was obtained from the Human Research Ethics Committee at Queensland University of Technology.

RESULTS

A total of 313 surveys were returned. However, over half of the respondents did not complete the full survey. We believe that this is most likely because some respondents who were not in dedicated Cancer Care Coordinators may have started to complete the survey, as their role did include significant care coordination functions. However, when progressing through the survey, those who were not in dedicated care coordinator positions would have realised that the survey questions were not relevant to them and were focused specifically on those in dedicated care coordinator positions. In these cases, it is likely that the respondents discontinued with the survey, as they would have been unable to respond to some items. To maximise the likelihood that responses analysed for this report represent the views of Cancer Care Coordinators, only those respondents who provided responses to the complete survey have been analysed. The sample for this study thus comprises 97 respondents. As there are no data available on the number of dedicated care coordinator positions in Australia, or within the COSA membership, it is not possible to report on how representative this sample would be of the population.

Survey respondents

The majority of respondents (96%) identified themselves as nurses with the remaining 4% identified as allied health/other. Over half (59%) were working in a metropolitan area and the majority (67%) were working in a public hospital or health service (Table 1).

Table 1: Demographics of survey respondents (n=97)

Demographic	Responses	
	n	%
Discipline		
<i>Nursing</i>	93	96%
<i>Allied health/other</i>	4	4%
Location		
<i>Metropolitan</i>	57	59%
<i>Regional/rural</i>	40	41%
Service type		
<i>Public hospital/service</i>	65	67%
<i>Public & private hospital/service</i>	18	19%
<i>Private hospital/service</i>	9	9%
<i>NGO/Other</i>	5	5%

Three-quarters of respondents (75%) indicated that they had been working in their identified discipline for more than 10 years; 13% for 5–10 years; and 11% for 1–5 years. In terms of specific oncology experience, 87% of respondents indicated that they had been working in cancer care for more than 5 years. However, only 20% had been working as a Cancer Care Coordinator for more than 5 years, with over half of the respondents (53%) indicating that they had been working in the role for less than 2 years. Information about the age range of participants was not collected.

Educational qualifications

A large proportion of respondents (65%) indicated that they had some form of postgraduate qualification, ranging from a Graduate Certificate to a Masters Degree or higher. The highest qualification identified by the remaining respondents included: Bachelor's degree (21%); Undergraduate Diploma (4%); and Hospital Certificate (10%).

The majority of respondents (85%) indicated that they had undertaken formal qualifications in cancer care. Courses identified included qualifications in cancer nursing, haematology, chemotherapy, palliative care and breast care nursing. Only 26% of respondents indicated that they had undertaken further education specifically to assist with the role of Cancer Care Coordinator. Identified courses ranged from a Masters in Clinical Nursing to short courses on counseling and project management.

Orientation to the role of Cancer Care Coordinator

Individuals provided information about the orientation/training provided to assist them in undertaking the role of Cancer Care Coordinator (Table 2). Over half of the respondents (63%) indicated that no or limited orientation/training was provided when they started their role. The most common form of preparation identified was shadowing or handover from a staff member already in the role (13%). Attendance at orientation workshops was identified by 14% of respondents, with workshops organised by Cancer Institute NSW identified most frequently.

Table 2: Orientation/training for the role of Cancer Care Coordinator (n=97)

Orientation/training provided	Responses	
	n	%*
No orientation/training provided	51	53%
Training workshops/orientation sessions	14	14%
Shadowing/handover from another staff member	13	13%
Limited training provided/self-taught	10	10%
Mentoring	4	4%
Other	5	5%

**Does not total 100% due to rounding*

Clinical supervision

Overall, 34% of respondents indicated that they receive regular clinical supervision in their role. Analysis of responses from those who indicated they do receive clinical supervision indicated that there was some variation in interpretation of the question (Table 3). Overall, only 14% of respondents indicated that they have regular clinical supervision with a psychologist or social worker.

Table 3: Access to regular clinical supervision (n=97)

Form of supervision	Responses	
	n	%*
No supervision provided	64	66%
Regular sessions with psychologist/counselor/social worker	14	14%
Support from Director of Nursing/Manager	8	8%
Informal/other staff	5	5%
Other	6	6%

**Does not total 100% due to rounding*

Scope of practice

The survey explored respondents' views on the percentage of time spent in an average working week on different aspects of cancer care (Table 4). The broad spread of responses demonstrates the range of activities undertaken by individuals in these roles, and the variation in focus of the roles. Of particular note, 79% (n=77) of respondents indicated that they spend less than 25% of their time involved with direct clinical care. Despite this, more than 20% of participants identified that more than half of their time is spent on tasks including patient education about treatment and management, psychosocial assessments, and patient/family support. Less time on average was spent on activities which reflected system coordination activities, with around 70% of respondents spending less than 25% of their time on organizing links to community services, communicating with GPs and other health professionals, or coordination and participating in multidisciplinary team meetings. Around 20% of respondents indicated that they spent more than 50% performing administrative tasks. It is not possible to tell from the results what combination of answers was given by specific individuals.

Table 4: Allocation of time to different aspects of the Cancer Care Coordinator role

Aspect of role	Percentage of time spent on task					Total n
	0	1–25%	26–50%	51–75%	76–100%	
Patient education about their treatment and management	4	45	28	10	10	96
Patient psychosocial assessments	8	53	15	16	5	96
Arranging appointments for patients	7	59	18	5	5	94
Providing advice on the management of treatment side effects	4	53	21	13	6	97
Patient and/or family support/counseling	5	54	17	10	11	96
Communicating with GPs or other primary care professionals	7	66	16	5	2	96
Organising links to community-based services	10	64	13	7	2	96
Coordinating and participating in MDT meetings	13	55	15	10	3	96
Providing direct clinical care	32	45	5	7	5	94
Performing administrative tasks	2	55	20	10	10	97
Participating in service improvement activities	9	52	16	16	3	95
Educating other health professionals	6	71	12	5	1	95
Participating in research activities	29	55	8	2	1	95

Multidisciplinary team membership

The majority of respondents (90%) indicated that they participate as a member of a multidisciplinary team. Other disciplines identified by the 87 respondents as participating in multidisciplinary team meetings are listed in Table 5. The most commonly identified participants were nurses (87%) and specialist clinicians, with allied health disciplines nominated less frequently.

Table 5: Participants in multidisciplinary team meetings (n=87)

Discipline	Responses	
	n	%*
Nurse	76	87%
Medical oncologist	72	83%
Radiation oncologist	63	72%
Surgeon	58	67%
Social worker	55	63%
Pathologist	47	54%
Dietitian	47	54%
Radiologist	44	51%
Palliative care specialist	42	48%
Psychologist	31	36%
Occupational therapist	28	32%
Speech pathologist	22	25%
Radiation therapist	17	20%
General practitioner	10	12%
Pain management specialist	5	6%
Psychiatrist	4	5%
Geriatrician	1	1%
Other (including stomal therapist, haematologist, nuclear medicine, physiotherapist, genetic counselor, research and data managers, students, registrars, pastoral care)	21	24%

*Respondents could select more than one answer

Referral to Cancer Care Coordinators

Two-thirds of respondents (66%) indicated that a documented process for referring patients to a Cancer Care Coordinator is used routinely in their service. However, only 24% of respondents indicated that formalised referral criteria exist. The primary mechanism identified for routine referral to Cancer Care Coordinators was through the multidisciplinary meeting (63%). Other approaches included informal referral (verbal/phone/email), word of mouth, review of clinic listings by the Cancer Care Coordinator, contact with ward staff and self-referral by patients.

Supporting policies and resources

Respondents identified a broad range of policies, guidelines and resources available to support their practice as a Cancer Care Coordinator. Open-ended answers have been grouped thematically into the categories listed in Table 6. The most common resources nominated were local hospital policies (37%), Cancer Institute NSW resources (including the CI-SCaT website) (24%) and resources from other cancer organisations such as Cancer Councils and National Breast and Ovarian Cancer Centre (22%).

Table 6: Policies, guidelines and resources available to support the practice of Cancer Care Coordinators (n=97)

Resource	Responses	
	n	%*
Local/hospital policies	36	37%
Cancer Institute NSW resources (including CI-SCaT)	23	24%
Resources from cancer organisations (NBOCC, Cancer Council, Leukaemia Foundation)	21	22%
Self-directed learning (journals/websites/conferences)	18	19%
Clinical practice guidelines	16	16%
Support from other health professionals (including manager)	16	16%
Developed own resources	13	13%
State-based frameworks/resources	11	11%
CNSA resources (including Care Coordinator position statement)	11	11%
No/limited policies available	11	11%
Policies in development	8	8%
Job description	7	7%
Cancer Australia initiatives (Cancer Learning, EdCaN, CanNET)	4	4%
Other	23	24%

*Respondents could provide more than one answer

Perceived importance of patient outcomes

The survey explored respondents' views on the importance of a range of patient outcomes from a Cancer Care Coordinator perspective. Responses highlight a broad range of patient outcomes that are perceived to be extremely or moderately important, with all outcomes being identified as extremely important by at least 70% of respondents (Table 7). Outcomes most commonly identified as being extremely important from a Cancer Care Coordinator perspective were patient satisfaction with their care (96%), patients receiving appropriate treatment (93%) and improvements in patient knowledge of and access to services (91%).

Table 7: Perceived importance of patient outcomes from a Cancer Care Coordinator perspective

Outcome	Responses								Total responses
	Extremely important		Moderately important		Somewhat important		Not important		
	n	%	n	%	n	%	n	%	
Every patient is aware of their pathway of care	87	90%	5	5%	4	4%	1	1%	97
The length of time from diagnosis to treatment is appropriate	77	79%	14	14%	4	4%	2	2%	97
The patient is satisfied with their cancer care	93	96%	2	2%	1	1%	1	1%	97
The family/carer is satisfied with their cancer care	89	92%	6	6%	1	1%	1	1%	97
A clear pathway is defined for each patient and information moves with the patient through the system	85	89%	8	8%	2	2%	1	1%	96
There is an effective multidisciplinary team relevant for each cancer	70	72%	18	19%	8	8%	1	1%	97
Transfer points are well managed across networks and sectors	77	81%	14	15%	3	3%	1	1%	95
Patients are cared for by an effective multidisciplinary team	82	85%	11	11%	3	3%	1	1%	97
Patients receive appropriate treatment	89	93%	4	4%	2	2%	1	1%	96
Patients' knowledge of and access to services, especially primary care, is improved	88	91%	6	6%	2	2%	1	1%	97
Duplication of service provision is reduced	76	80%	17	18%	1	1%	1	1%	95
Reduces variation in evidence based care	73	76%	21	22%	2	2%	1	1%	96

Perceived influence of the role

Respondents were asked to identify the extent to which they feel their role as a Cancer Care Coordinator influences a range of patient outcomes. The results are summarised in Table 8. Outcomes most commonly identified as being influenced significantly by the Cancer Care Coordinator role were improvements in patients' knowledge and access to services (58%), awareness by patients of their pathway of care (47%) and patient satisfaction with their care (46%). Outcomes on which respondents most commonly indicated that they have less influence were the presence of an effective multidisciplinary team for each cancer (28%) and the duration from diagnosis to treatment (18%).

Table 8: Perceived influence of the Cancer Care Coordinator role on patient outcomes

Outcome	Level of influence by Cancer Care Coordinator								Total responses
	Significant		Moderate		Some		None		
	n	%	n	%	n	%	n	%	
Every patient is aware of their pathway of care	46	47%	20	21%	29	30%	5	5%	97
The length of time from diagnosis to treatment is appropriate	17	18%	32	33%	33	34%	17	18%	97
The patient is satisfied with their cancer care	45	46%	36	37%	16	16%	3	3%	97
The family/carer is satisfied with their cancer care	42	43%	35	36%	19	20%	4	4%	97
A clear pathway is defined for each patient and information moves with the patient through the system	30	31%	25	26%	33	34%	9	9%	97
There is an effective multidisciplinary team relevant for each cancer	25	26%	15	15%	30	31%	27	28%	97
Transfer points are well managed across networks and sectors	27	28%	17	18%	44	45%	10	10%	97
Patients are cared for by an effective multidisciplinary team	29	30%	27	28%	28	29%	15	15%	97
Patients receive appropriate treatment	27	28%	28	29%	36	37%	8	8%	97
Patients' knowledge of and access to services, especially primary care, is improved	56	58%	27	28%	14	14%	3	3%	97
Duplication of service provision is reduced	28	29%	40	42%	21	22%	7	7%	96
Reduces variation in evidence based care	20	21%	32	33%	35	36%	10	10%	96

Role evaluation

Only 38% of respondents indicated that a formalised evaluation of the outcomes of their role takes place in their organisation. Qualitative responses indicated that a range of approaches to evaluation are used, including annual performance review, quarterly or monthly reporting and patient feedback.

Measurement of outcomes

Almost half of the respondents (49%) indicated the availability of a tool to measure and report outcomes. Qualitative information provided by the respondents indicated that the most common tools used were databases (n=16) and patient satisfaction surveys (n=15). Other approaches included use of key performance indicators (n=8) and monthly reports (n=7). A further 7 respondents indicated that a tool is in development.

Use of care coordination evaluation data as part of a quality improvement process was reported to be happening to moderate or greater degree by around one-third of respondents (33%) (Table 9).

Table 9: Use of care coordination evaluation data as part of a quality improvement process (n=97)

Extent to which evaluation data are used for quality improvement	Responses	
	n	%
A great deal	11	11%
Moderately	20	21%
Somewhat	40	41%
Not at all	26	27%

Role satisfaction and perceived effectiveness

Overall, 29% of respondents indicated they are very satisfied and 52% indicated that they are satisfied with their current role, while 8% indicated neither satisfaction nor dissatisfaction and 11% indicated dissatisfaction with their role.

The majority of respondents indicated that, overall, they perceived their role to be extremely (38%) or moderately (50%) effective, while 12% viewed their role as somewhat effective.

Knowledge and skills required for the role of Cancer Care Coordinator

Respondents provided qualitative feedback about their views on the core areas of knowledge and skills that a Cancer Care Coordinator should possess. These have been grouped thematically in Table 10. The skills most frequently identified as being required were communication skills (51%) and knowledge of cancer (38%) and its treatments and side effects (38%).

Table 10: Core knowledge and skills identified as being required by a Cancer Care Coordinator (n=97)

Area of knowledge/skills	Responses	
	n	%
Communication skills (patient and health professionals)	49	51%
Oncology knowledge (including tumour-specific information)	37	38%
Cancer treatments and side effects	37	38%
Knowledge of the system (including how to effect/influence change)	23	24%
Disease trajectory/patient journey	19	20%
Psychosocial/supportive care (including counseling skills)	19	20%
Knowledge of resources, professional networks, and information sources	19	20%
Organisational skills (including time management, planning, flexibility)	17	18%
Education skills (patient and health professionals)	15	15%
Team work	15	15%
Ability to network	12	12%
Empathy	10	10%
Experience	10	10%
Problem solving skills	8	8%
Leadership/management	8	8%
Negotiation skills	8	8%
Clinical skills	8	8%
Advocacy skills	7	7%
Assessment	7	7%
Knowledge of when to refer	7	7%
Self-awareness and commitment to ongoing CPD	6	6%
Administrative skills (including computing, databases)	6	6%
Patient-centred approach	6	6%

Service improvement knowledge	6	6%
Research skills	5	5%
Patience	5	5%
Other (includes influencing skills, accessibility, open-mindedness, knowledge of trials, passion, evidence-based approach, meeting management, postgraduate qualifications)	33	34%

Continuing professional education

Areas identified most frequently by respondents as priorities for their continuing professional development are outlined in Table 11. By far the most common priority identified was updates on latest treatment guidelines and standards of care (83%).

Table 11: Priorities for continuing professional development

Priority area	Responses	
	n	%*
Updates on the latest treatment guidelines and standards of care	80	83%
Psychosocial care	66	68%
Survivorship	66	68%
Clinical practice improvement	61	63%
Communication skills training	60	62%
Advanced assessment and care planning skills	60	62%
Patient education	57	59%
Cancer symptom management	50	52%
Research skills	49	51%
Management of treatment side effects	47	49%
Other	15	15%

*Respondents could select more than one answer.

Respondents identified a range of preferred formats for provision of continuing professional development (Table 12). The format identified most frequently as useful was conferences/workshops (78%), while clinical attachments were identified as useful by the fewest respondents (30%).

Table 12: Preferred formats for continuing professional development

Format	Responses	
	n	%*
Conferences/workshops	76	78%
Workshops	65	67%
Web-based learning	61	63%
Mentoring	58	60%
Case conferences	52	54%
Self-directed learning materials	50	52%
Lectures	37	38%
Clinical attachments	29	30%

*Respondents could select more than one answer.

Respondents provided qualitative information about formal and informal education/training experiences that they had found useful for their role as a Cancer Care Coordinator. When grouped, the most commonly identified initiatives included:

- attendance at workshops/conferences (35%)
- other education packages (online and specific courses) (23%)
- communication skills training (21%)

- postgraduate qualifications (18%)
- peer support/mentoring (15%)
- involvement in networks/interest groups (12%).

Facilitators and enablers

Respondents identified a range of factors that they perceived have facilitated the successful implementation of their role. The most commonly identified factors have been grouped thematically in Table 13. Being part of a supportive multidisciplinary team (37%) and support from peers (24%) and the organisation (23%) were the most commonly identified factors.

Table 13: Most commonly identified factors perceived to facilitate the successful implementation of the Cancer Care Coordinator role (n=97)

Factors	Responses	
	n	%
Being part of a supportive multidisciplinary team	36	37%
Peer support	23	24%
Organisational support	22	23%
Recognition of role	16	16%
Good relationships/communication	15	15%
Strong management/leadership support	13	13%
Networking	13	13%
Adequate resources/administrative support	11	11%
Clear role delineation	10	10%

A range of potential roles for COSA in supporting Cancer Care Coordinators were identified (Table 14). The most commonly identified roles were facilitating networking and mentoring of care (87%), development of standards and guidelines for practice (85%) and advocacy for Care Coordinators (80%).

Table 14: Potential roles for COSA in supporting Cancer Care Coordinators (n=97)

Factors	Responses	
	n	%
Facilitate networking and mentoring of care	83	87%
Develop standards and guidelines for practice	81	85%
Advocate for Care Coordinators	76	80%
Provide funding to support continuing professional development	75	79%
Provide a web-based discussion site for Care Coordinators	66	70%
Undertake research on ways to improve care coordination	60	63%
Other	19	20%

DISCUSSION

The results of this survey of COSA members who self-identified as Cancer Care Coordinators provide a valuable snapshot of working practice and an indication of areas in which COSA could focus its activity to support individuals working in these roles.

The survey has a number of limitations. While respondents were drawn from metropolitan and regional settings, and from the public and private sectors, the survey was distributed to COSA members only. The results may therefore not represent the views of all individuals practising in Cancer Care Coordinator roles. Moreover, although survey instructions clearly stated the target audience for the survey as Cancer Care Coordinators, it is not possible to tell whether individuals in other roles completed the survey, or to calculate actual response rates from Care Coordinators who are COSA members. Incomplete responses were excluded from the analysis in an attempt to ensure the relevance of results. Information was not collected about the state/territory in which respondents work and given the size of the sample it was not possible to analyse responses from particular sub-groups. Further exploration of specific issues for Cancer Care Coordinators practising in rural and regional areas, in various states and territories, and in the private sector may be useful areas for further investigation. Despite these limitations, there are a number of notable findings from this survey which have important implications for efforts to improve cancer care coordination.

Survey responses indicate that the typical profile of Cancer Care Coordinators reflects a relatively experienced health professional group that is almost entirely comprised of health professionals with a nursing background. The majority of respondents had more than 10 years experience in their particular discipline and more than 5 years experience in cancer care, with the majority having postgraduate qualifications. However, most were relatively new to the role of the Cancer Care Coordinator, most likely reflecting the relatively recent introduction of these roles. The age range of respondents was not collected but may warrant further investigation as this may have implications for future workforce planning. This limited experience working with care coordinator roles reinforces the need to ensure appropriate system wide supports and coordinated continuous improvement efforts to ensure the positions realise their potential for improving cancer care.

The responses to this survey reflect significant variation in scope of practice for Cancer Care Coordinators. Survey responses illustrated the broad and varied scope of current roles, with respondents identifying a range of tasks, including direct clinical care, psychosocial support and administrative functions. Of some interest are responses indicating that Care Coordinators are likely to spend more time on average on activities relating to education and support of individual patients, and less time spent on activities that might reflect more systemic or team coordination activities.

It's not possible to tell whether this variation reflects different practice contexts and the needs of different patient populations, or other factors such as the individual preferences of the Care Coordinator or multidisciplinary team members. Given the diversity of the Australian health care system, Cancer Care Coordinator roles require flexibility in their implementation. Nevertheless, such variation does present a challenge for formalising scope of practice and managing expectations of other team members and patients about the role, and for identifying the minimum educational requirements and experience for those undertaking the role. The importance of ensuring that variation in implementation of the role does not adversely impact on outcomes for patients is highlighted by these responses.

Survey responses reinforce the need to develop standards and guidelines for Cancer Care Coordinator roles. Respondents indicated a range of resources used to support them in their roles; however, few formalised policies were identified. For example, while the multidisciplinary team provided the most common referral mechanism to the Cancer Care Coordinator, less than one-quarter of the sample indicated that formalised referral criteria existed for their service. While it may be difficult to develop policies to direct all aspects of the role, some guidelines would be useful to provide boundaries, manage expectations of patients and team members and ensure consistency in approach.

The findings also highlight other organisational and professional supports that may facilitate the effective implementation of Cancer Care Coordinator roles. Specifically, although the majority of respondents indicated satisfaction with their role, it is of some concern that a minority reported a formalised approach to orientation role or ongoing clinical supervision. Qualitative responses indicated that where orientation and supervision did occur it was often informal and initiated by the

respondent themselves. This lack of preparation and access to supervision has the potential to lead to variations in quality of practice, increased risk of stress and burnout and attrition from the role. The majority of respondents indicated that they work as part of a multidisciplinary team and that membership and support from the multidisciplinary team, from peers and from their organisation were important facilitators for the role. Formal approaches to peer support/debriefing for Cancer Care Coordinators, and development of the Care Coordinator role within the multidisciplinary team are likely to be important aspects of any future framework.

Respondents identified a broad range of areas of required knowledge for Cancer Care Coordinators and provided feedback about preferred approaches to education that will assist in ongoing development of the Care Coordinator role. Clinical knowledge and communication skills were identified as the most important areas of knowledge required for their role. Less priority was given to system knowledge or organisational skills. In terms of their individual professional development needs, respondents identified clinical updates as being amongst the most important priorities. Such responses reflect the perceived need for Cancer Care Coordinators to have some degree of clinical knowledge to perform their role. Respondents also provided useful information regarding preferred approaches for delivery of continuing professional development that will be useful in guiding development of programs in this area. Preferred methods included conferences and workshops, although web-based learning also popular.

An important objective of this survey was to obtain the opinions of Cancer Care Coordinators about the appropriateness of outcome indicators identified in the 2007 COSA Care Coordination workshop. Responses suggest that these outcomes have some face validity, with all indicators being rated by at least 70% of respondents as being extremely important. However, when asked the extent to which respondents felt they influenced these outcomes in their role as a Care Coordinator, substantial variation was noted in responses. This sample of Care Coordinators identified that they had most influence in areas including patient and family/carer satisfaction and patient's awareness of their pathway and services. However, the majority believed they had less influence on system or organisational outcomes, such as reduced variation in evidence based care, management of transfers across sectors, time from diagnosis to treatment, or the effectiveness of the multidisciplinary team.

Given the emphasis and investment placed on Cancer Care Coordinator roles in recent times, it is surprising that fewer than half of the respondents identified a formal process for evaluation of their role and use of tools to assess outcomes. Approaches to evaluation of outcomes will be important in establishing the benefits of the Care Coordinator role and identifying areas for improvement.

CONCLUSIONS AND IMPLICATIONS FOR COSA

This survey has highlighted the considerable variation that exists in practice and perceived outcomes from what is a new role in the cancer care system. It also highlights the variable organisational and professional supports that exist for Cancer Care Coordinators, and an apparent lack of systematic efforts to evaluate the implementation of the role. Such findings highlight the need for further action in areas including:

- development of evidence-based guidelines, standards and tools for practice to minimise unnecessary variation and duplication of effort
- development of professional and organisational supports for care coordinators, including:
 - multidisciplinary team support
 - clinical supervision
 - professional development opportunities in core areas including clinical updates, communication skills, and improving coordination across the system
 - peer networking opportunities
- identification and implementation of valid and reliable measures of key outcomes from care coordination that have been supported by this study, with opportunities to use outcome data to drive improvements in practice
- further research to understand the patient experience and outcomes associated with various Cancer Care Coordinator models.

As the peak body for cancer professionals in Australia, COSA has an important role in responding to these issues. To date, COSA has demonstrated leadership in this area by hosting workshops to develop agreed principles of care coordination and a framework for outcome evaluation of care coordination interventions. This survey was intended to seek feedback on the validity of the outcomes framework from the perspective of Cancer Care Coordinators, as well as to obtain data on the professional support needs of individuals practising in these roles.

The following recommendations are proposed for implementation by COSA:

Outcomes measurement

- That the COSA Care Coordinator Interest Group use the COSA outcomes evaluation framework that has been supported by this survey to:
 - identify and recommend specific tools for measuring key outcomes
 - develop accompanying guidelines for Cancer Care Coordinators to support use of the tools, and the collection and reporting of outcomes data.

Advocacy

- That COSA support an updated review of the evidence relating to Cancer Care Coordinator roles, to enable development of an evidence-based position statement relating to Care Coordinators.
- That COSA Executive develop a strategy to advocate for the ongoing development of Cancer Care Coordinator roles across all cancer settings.

Facilitating networks

- That the COSA Care Coordinator Interest Group identify a facilitator for a web-based discussion forum for Cancer Care Coordinators.
- That the COSA Care Coordinator Interest Group develop a communication strategy for its members and a promotions strategy for recruiting new members.

Professional development

- That a workshop be held for Cancer Care Coordinators prior to the 2009 COSA Annual Scientific Meeting, focusing on the professional development needs identified in this report.
- That a specific training module to prepare Cancer Care Coordinators for practice in this role, be developed in collaboration with the Cancer Learning and EdCaN project teams.

Research

- That COSA seek partners and funding to undertake further research in areas including:
 - validation of the evaluation framework and measurement tools
 - patient experience of and outcomes from various Cancer Care Coordinator models
 - innovative models for care coordination in various practice contexts.

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