



Memorandum

To: Working Group

From: Richard Sullivan Clinical Director Northern Cancer Network
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Date: 3 September 2012

Re: Development and Implementation of Cancer Nurse Coordinators - Northern Region

1. Purpose

The purpose of this memorandum is to provide an over view of the funding made available through the Cancer Nurse Coordinator announcement by the Minister of Health in August 2012 and to provide a framework to support the development of a coordinated approach in the Northern region.

A Working Group is to be formed to discuss a proposed Northern region framework, and reach agreement on the basis upon which DHBs will invest in care coordination roles/activities. It will be important to also agree a means by which this investment can be measured in terms of the impact on care coordination. It is expected that the Working Group will be make recommendations to the Regional Oncology Operations Group (ROOG) whose remit is to support and assist the Regional Cancer Service in the provision of non-surgical cancer treatment services throughout the Northern Region, including Northland.¹

2. Recommendations

The Working Group is asked to:

1. Discuss the information provided and consider the proposed approach to implement the cancer nurse coordinator; and
2. Agree and make recommendations for a Northern Region approach to the implementation of the additional cancer nurse coordinators.

3. Background

As part of Budget 2012 the Government allocated funding for cancer nurse coordinators. In late August 2012 DHBs received confirmation of funding from 1 October 2012 and out years for these roles. The funding is for new clinical positions and the intention for these roles is to include coordinating patient care and helping deliver well coordinated services for patients with cancer.

¹ Regional Oncology Operations Group Terms of Reference 2006

Accompanying the funding confirmation were the Minister of Health's expectations of DHBs:

- to ensure that the health system and its processes support streamlining services and referrals between DHBs; and
- that DHBs seek to collaborate regionally when developing and implementing these roles².

These cancer nurse coordinator roles make up part of the approach in achieving the 'Faster Cancer Treatment'³ (FCT) initiative. The FCT initiative supports the joint Ministry of Health and DHB National Cancer Programme's vision for all people being able to access the best services in a timely way to improve overall cancer outcomes. The focus areas of the National Cancer Programme are:

- wait times: all people get services in a timely manner;
- access: all people have access to services that maintain good health and independence;
- quality: all people receive excellent services wherever they are; and
- financial sustainability: all services make the best use of available resources.

Funding to support the development and implementation of the cancer nurse coordinators roles is outlined in the following table. Funding has been allocated over four years to each of the Northern region DHBs and will be disbursed through a Crown funding agreement variation.

DHB	Funding over four years	Minimum FTE
Northland	\$ 606,128	1.6
Waitemata	\$ 1,554,323	4.1
Auckland	\$ 1,296,495	3.5
Counties Manukau	\$ 1,530,701	4.1

To date discussions regarding the funding and the potential scope of these roles has included the Executive Directors of Nursing (Northern region), ROOG, Northern DHBs, Cancer Control Steering Groups and other such groups. Representatives from all these groups have been invited to be part of a working group to consider a regional response to the development and implementation of these roles.

4. Care Coordination – Proposed Approach

The definition of care coordination adopted through the Northern Region Cancer Care Coordination Model is that care coordination is a comprehensive approach that seeks to achieve continuity of care and support, drawing on a variety of strategies that strive for the delivery of responsive, timely and seamless care across a person's cancer service pathway⁴.

The achievement of coordinated care is acknowledged as including a complicated range of responses across the system. These can include administrative, clinical tasks, advocacy,

² Auckland DHB funding letter to Chair Lester Levy 21 August 2012

³ The FCT will be measured by the following agreed indicators, for patients:

- referred urgently with a high suspicion of cancer receive their first cancer treatment (or other management) (best practice timeliness measure of within 62 days)
- referred urgently with a high suspicion of cancer have their first specialist assessment (best practice timeliness measure of within 14 days)
- With a confirmed diagnosis of cancer to receive their first cancer treatment (or other management) from decision-to-treat (best practice timeliness measure of within 31 days).

⁴ Northern Cancer Network – Regional Cancer Care Coordination Model August 2011 Page 7

education, socio-cultural, psychosocial, financial and service related tasks. This does not in itself preclude investment in Clinical Nurse Specialist roles, however within the Northern region any proposed approach to care coordination should align to the Northern Region Cancer Care Coordination Model and should meet expectations of a robust methodology that focuses on the whole of the cancer service pathway and not solely on a specific role/s or position/s.

A set of guiding principles and priorities have been developed below⁵ to steer the development and implementation of care coordination for the Northern region utilising the Cancer Nurse Coordinators initiative.

Proposed Principles

Each principle is intended to guide the development and implementation process and assist the DHBs in achieving the most effective implementation of the funding whilst being aware of the entire cancer service pathway. The proposed principles proposed are:

- **Commitment to MOH requirements** – Alignment of DHB implementation of the funding to meet Ministry of Health requirements for at least 13.3 FTE⁶
- **Care Coordination** as a systems approach – A component of every cancer pathway, focuses on the organising and planning of cancer care, who patients see, when they see them and how this can be made as easy as possible. Care coordination may also mean identifying who patients and whānau need to help them on the cancer pathway. To attain a successful outcome contribution is needed from across the cancer continuum (i.e. primary, secondary or tertiary care) and as such all components of the system should be recognised as critical contributors to patient outcome.
- **Health equity** – As a principle, health equity is concerned with eliminating avoidable, unfair and unjust systematic disparities in health between different groups. The concept of health equity acknowledges that different types and levels of resources may be required in order for equitable health outcomes to be achieved for different groups. Improving access to and through health services will be a key contribution towards achieving health equity.
- **Whole of system responsibility** – Achieving best health outcomes for family, whānau and health equity is a whole-of-system responsibility. Therefore, contributing to health gain and reducing ethnic inequalities is an expectation of all health activities through the whole of the health system. Particularly in this context whole of system responsibility requires the consideration of regional collaboration and solutions to attain better cancer outcomes for patients.
- **Evidence based approaches** – The evidence-based approach is a process through which scientific and other evidence is accessed and assessed for its quality, strength and relevance to local population needs. An understanding of the evidence is then used in combination with good judgement, drawing on a co-design perspectives and social justice ethic, to inform decision-making that maximises the effectiveness and efficiency of health design, quality, service delivery and practice.

Care Coordination Priorities

In discussions with stakeholders the following priorities have been identified and these are provided as an indicative list for further examination. These priorities have been captured to indicate where further work is required to support greater patient outcome which can be achieved through improved care coordination. The following are in no particular order of priority:

⁵ Informed by the guiding principles from the Northern Cancer Network – Regional Cancer Care Coordination Model August 2011 Page 12

⁶ Ministry of Health Correspondence – national funding allocation

- Access
 - Māori and Pacific navigation to and through cancer services
 - For populations with highest need
 - Regional coordination
 - Access/coordination within tumour streams e.g. lung, gynaecology
 - Transport
 - Health literacy
 - Financial
- Screening tools
 - Whanau Ora
 - Social Work Screening Tools
 - Distress Screening Tool
 - Malnutrition Universal Screening Tool
- Advocacy
 - Health literacy
 - Communication
 - Patient experience
- Whole of system responsiveness
- Psycho-social support
- Culturally appropriate services
- Service/System improvement
 - Databases
 - IT
 - Referral processes
 - Evaluation
 - Workforce development and support
 - Support/Competency
 - Peer support
 - Programme of learning
 - Including people in other roles
- Tumour streams
 - identifying those with the highest need

5. Risks

A number of risks have been identified, with mitigation aspects/factors attached, as a means to highlight potential issues. These include:

Risk	Detail	Proposed Mitigation
Different approaches across DHBs	There has been a wide scope of potential responses discussed nationally, and while all have merit, there is a possibility that this investment will not be applied in ways that impact positively or measurably to improve care coordination	Agree a regional framework to guide DHB investment.
Lack of ability to measure outcome of investment, and impact on		Agree a regional framework to measure and report outcomes.

coordination of care		
Lack of connectivity of additional Cancer Nurse Coordinators with existing roles		Agree gaps in the cancer continuum within the northern region and agree a regional framework to guide DHB implementation.
Lack of alignment of additional Cancer Nurse Coordinators with existing salary scales		Agree a regional framework to guide DHB investment.

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Appendix 1 – Cancer Care Coordination Tasks⁷

The following cancer care coordination functions or tasks, as identified through the regional cancer care coordination targeted literature review, are noted below. These are taken from the perspective of patient support functions of care coordination, and internal service functions (that are required by the service, but which patients will not directly participate in).

Patient Support functions – care coordination tasks may include:	
Administrative	<ul style="list-style-type: none"> • Completion of medical and/or nursing paperwork • Coordinating appointment organisation, confirmation or rescheduling and attendance: <ul style="list-style-type: none"> ○ Reminding patients of appointments • Organising transport • Accessing support for patients who live in rural areas, for example accommodation when undergoing treatment at centres which are distant to the patients home • Assistance with work related issues, such as providing letters to employers for patients and/or their family <p>Linking patients between public and private providers, across and between cancer care health and other support providers.</p>
Clinical Tasks	<ul style="list-style-type: none"> • Coordinating care through investigation, diagnosis and treatment from multiple providers and across one or more providers • Ensuring patients are prepared for appointments • Ensuring patients and families understand their condition, treatment (including medications and therapies such as radiotherapy, chemotherapy and so on) • Monitoring adherence with treatment and either supporting/managing this or referral to other providers such as specialist or primary care services, where issues are identified • Track interventions and outcomes to ensure patients are being reviewed in accordance to protocol and have not ‘fallen through the gaps’ • Answering questions that patients and families have • Triage of patients (referral to service, of symptoms during treatment, of need for additional supports/resources) • Referral to other health providers or services • Provision or referral to other services for assistance with daily living (washing, dressing and so on)
Advocacy	<ul style="list-style-type: none"> • Advocating or coaching or ‘activating’ for patients at medical appointments: <ul style="list-style-type: none"> ○ Activation is the process of training, supporting and educating patients to increase their communication skills including developing the ability to ask questions re treatment programs • Facilitation of communication between healthcare providers and patients/family • Increasing patient’s experience of and ability to become more involved in their care. For example increasing patient’s confidence in their own, or families, abilities to manage situations

⁷ Northern Cancer Network – Regional Cancer Care Model Appendix 3

Education	<ul style="list-style-type: none"> • Providing educational resources (written, video, audio and so on) • Providing tailored cultural health education resources where indicated
Socio-cultural	<ul style="list-style-type: none"> • Ensuring social and family networks exist and are accessed where required • Assessing health literacy and supporting patients and families where required • Supporting patients and families in accessing or obtaining care for dependants (children, elderly or other family members) if this is directly affecting a patient's ability to access or uptake cancer care: investigation, diagnosis, treatment or supportive care • Assistance with housing issues • Accessing translators where required to ensure patients and families understand the condition and treatment options
Psychosocial support	<ul style="list-style-type: none"> • Emotional support provision or referral for patient and families: <ul style="list-style-type: none"> ○ Many articles noted reduction of patient fear and anxiety as a key function ○ Articles also noted 'being there' and reduction of feelings of isolation amongst navigated patients as core to the role • Spiritual support provision or referral for patient and families
Cultural support regarding beliefs and world views	<ul style="list-style-type: none"> • Provision of, or referral to, cultural support services: <ul style="list-style-type: none"> ○ Articles discussing cultural navigation services consistently noted cultural beliefs, fear and lack of trust and/or hope as key issues for the vulnerable population groups in the studies (including African American, Asian American, Pacific Island and American Indian).
Financial support	<ul style="list-style-type: none"> • Access assistance: <ul style="list-style-type: none"> ○ Knowledge of and support to complete forms for unemployment, sickness, national transportation assistance, family credits and so on • Support through the benefit system, for example at appointments with Work & Income
Internal service tasks – care coordination tasks may include:	
Service related tasks	<ul style="list-style-type: none"> • Recording interventions with patients and families • Recording meetings with other healthcare providers • Attending meetings such as multidisciplinary, care coordination, discharge from hospital and so on • Reporting (monthly, quarterly, annual and so on) • Database or spreadsheet maintenance • Building networks and relationships with other providers both internal to organisation and external • Service development, which may include: <ul style="list-style-type: none"> ○ Protocols, standards, guidelines and so on ○ Entry and exit criteria • Referral process - into the service (from other healthcare providers, self-referral and case seeking) • Service planning and development • Evaluation of service • Marketing of service • Financial management of service (where relevant)