

## POSITION STATEMENT

### Coordination of Cancer Care

#### Issue

Coordination of care for people with cancer, at any stage but especially those with advanced, quality of life-limiting cancer is hard to get. This gap is distressing and destabilising for the patient, their family, carers and friends.

#### Background

CVN has heard from several members who are very concerned about the lack of coordinated treatment and care during and after their treatment “journey”. This is further exacerbated when they become seriously ill or immobilised as a result of their cancer. Once beyond the immediate services of a cancer care centre acting as “managing agent”, many cancer patients experience an unexpected and confusing journey between hospital, rehab facility, home, palliative care, ICU and back again. A characteristic of the problem is poor communications between facilities, specialists and the person’s GP and family/ carers and confusion amongst these as to where responsibility for coordination lies.

#### Present Position

Medicare provides rebatable items (GP Management Plans and Team Care Arrangements) which can be used for coordination planning. NSW Health has introduced the NSW Connecting Care Program, whose aim is to improve coordination and self management in chronic disease, including cancer. NSW Health has published an excellent Framework “*Advance Planning for Quality Care at End of Life*”. Cancer Voices has raised the issue with COSA, which holds bi-annual conferences on the topic, and with Cancer Australia. The Cancer Institute NSW held a one-day workshop (7 Feb 2014) to identify and address the problems.

GPs are expected to play a coordinating role, but once the condition requires monitoring, hospitalisation, rehabilitation or palliative care etc, the GP has trouble keeping up with events. It becomes difficult for consumers to access the required services without a coordinator who is aware of the condition, prognosis, requirements and service/ care options.

#### Recommendations

- Best practice guidelines be developed and promoted to GPs, cancer care centres, rehab centres, palliative care services and consumers
- Case conferencing be organised as soon as need for coordination can be identified
- Triggers or “flags” should be identified and circulated to care providers as functional status begins to decline
- Oncology nurses, where they exist, to be considered as ideal coordinators
- GPs to be alerted by cancer specialists when an advance care plan is needed, nominating who has responsibility to ensure coordination planning
- NSW Health to review “end of life” related services to assess gaps, with a view to ensuring resourcing (financial and workforce) for these services is adequate.

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