

Achieving best practice cancer care

A guide for implementing multidisciplinary care

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1. Introduction

An expanding body of international and national evidence has identified multidisciplinary care as a key aspect in providing best-practice treatment and care for cancer patients. Multidisciplinary care involves a team approach to treatment planning as well as to care provision, throughout the complete patient pathway. Many people with cancer are treated by multiple health professionals within and across different health services and health sectors including public, private and community health in both metropolitan and rural regions. The nature of cancer diagnosis and treatment requires effective care coordination and communication through a multidisciplinary approach.

Multidisciplinary care aims to ensure that members of the treatment and care team can discuss all aspects of a cancer patient's physical, supportive care needs and other impacting factors. A regular meeting of all health practitioners involved in the treatment and care of a cancer patient is an essential feature of multidisciplinary care. This facilitates best-practice management and enables the most appropriate care plan to be developed. It also allows for an identified team member to convey the team recommendations to ensure the patient is able to effectively participate in forward planning. Through this process, each team member understands the plan, knows who to refer the patient to and the patient remains at the centre of all care provided by the team. It is important that both public and private sector cancer patients have access to multidisciplinary care and effective care coordination.

The Australian Better Health Initiative, which is a partnership between the states and territories and the Australian Government, aims to refocus the health system to promote good health and decrease the burden of chronic disease. Among its five priorities, the initiative aims to improve the coordination and continuity of care for people with chronic diseases, including cancer. A key aspect of this initiative is improved communication and integration between care services. This relates directly to the development of coordinated care and multidisciplinary care for cancer patients across Victoria.

2. The direction for multidisciplinary cancer care in Victoria

The Victorian Government is committed to developing and implementing multidisciplinary care for all cancer patients from diagnosis through to palliative care. The aim is to ensure a multidisciplinary team approach to prospective treatment and care planning that is aligned with best-practice and evidenced-based care.

Benefits to patients, teams and health services

An effective multidisciplinary approach can result in a number of positive outcomes for patients receiving the care, teams providing the care and health services overall. Some of the benefits are evident in the short term and others become evident over time. The **benefits to patients** include:

- improved treatment planning through consideration of full therapeutic range and thus improved outcomes (Junor et al., 1994; Sainsbury et al., 1995)
- survival benefit for cancer patients (Junor et al., 1994; Sainsbury et al., 1995; Chang et al., 2001)
- increased recruitment of patients into clinical trials (Magee et al., 2001)
- recognising the emotional needs of patients (Butow et al., 2002)
- less service duplication, improved coordination of services and development of clear lines of responsibility between members of the multidisciplinary team (Barr, 1997).

The benefits to teams and health services include:

- reduction in minor psychological morbidity of team members (Haward et al., 2003)
- learning and educational opportunities for team members
- improved team communication (Epstein, 1995; Midgley et al., 1996)
- shared decision making that is more likely to result in recommendations that align with best practice and evidenced-based care
- understanding and adherence to agreed treatment and care plan with knowledge of the investigations and results.

The purpose of the multidisciplinary care policy

The purpose of this policy is to:

- promote the development of a multidisciplinary approach in health services providing care to people with cancer
- promote linkage of multidisciplinary teams to other teams and to individual practitioners within and between the Integrated Cancer Services (ICS).

Statewide consultation and discussion with ICS has informed the development of this policy.

The consultation included:

- meetings and forums with the ICS to discuss the implementation of multidisciplinary cancer care
- the multidisciplinary forum held in August 2005, jointly organised by Cancer and Palliative Care in the Department of Human Services (Victoria) and the National Breast Cancer Centre
- the Patient Management Framework (PMF) consultation held in each ICS in 2005.

3. Cancer reforms in Victoria

The need for improved delivery of cancer services along with improved outcomes for patients and their families has been identified as a priority by both state and federal governments. It is driven by:

- an ageing population leading to an increase in cancer incidence
- the increasing complexity in the diagnosis and treatment of cancer
- the impact that cancer has on individuals, their families and the community
- the increasing cost of cancer treatment
- the shift of cancer treatment to the ambulatory care setting
- improved outcomes of current treatment regimes, resulting in increasing survival rates
- the ageing health service workforce.

Victoria has a significant cancer reform agenda that aims to improve the planning and delivery of treatment and support to patients so that appropriate care is provided in a timely manner as close to the patient's home as possible.

The agenda to improve the quality of cancer service delivery and patient care has been supported by:

- establishing ICS to drive change
- determining a pathway of optimal care for a range of tumour streams
(*Patient Management Frameworks*)
- developing a model for safety and quality in cancer care
(*Clinical excellence in cancer care: a model for safety and quality in Victorian cancer services*)
- identifying four key priorities areas for reform.

Integrated Cancer Services

In 2004, eight ICS were established with funding to support the development of integrated care and defined referral pathways for the populations they serve. The ICS are the platform through which improvements in cancer service delivery and patient care is being implemented.

Patient Management Frameworks

The Patient Management Frameworks (PMFs) are a guide to the optimal care management of patients in each tumour stream. They are intended to improve patient outcomes by facilitating consistent care based on evidence and best practice across the state. Multidisciplinary care is one of the key principles that support the seven identified steps of the patient journey.

Further information about the PMFs can be found at www.health.vic.gov.au/cancer

Clinical excellence in cancer care

Clinical excellence in cancer care provides a vision for how high-quality cancer services need to be delivered. It describes the key principles and practices necessary for the effective monitoring, management and improvement of cancer services across Victoria. The model incorporates six clinical dimensions that are key to improving the safety and quality of care, one of which is continuity and care coordination.

Further information about Victoria's model for safety and quality in cancer services can be found at www.health.vic.gov.au/cancer

Key priority areas for service improvement

Four key priorities for reform have been identified and are the focus of service improvement initiatives at the ICS and statewide levels:

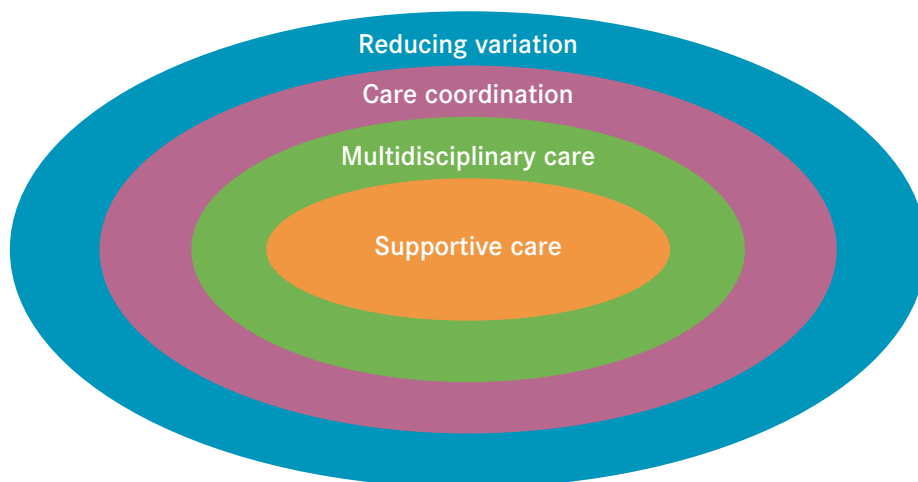
- multidisciplinary care
- care coordination across the cancer care pathway
- supportive care
- reducing unwanted variation in practice.

The four priority areas are integrally linked to each other with some initiatives impacting on more than one priority area (see Figure 1).

Multidisciplinary care is a key aspect of care coordination and further information on this area can be found at www.health.vic.gov.au/cancer. The interface between multidisciplinary care and care coordination are the processes and relationships between providers and between providers and patients.

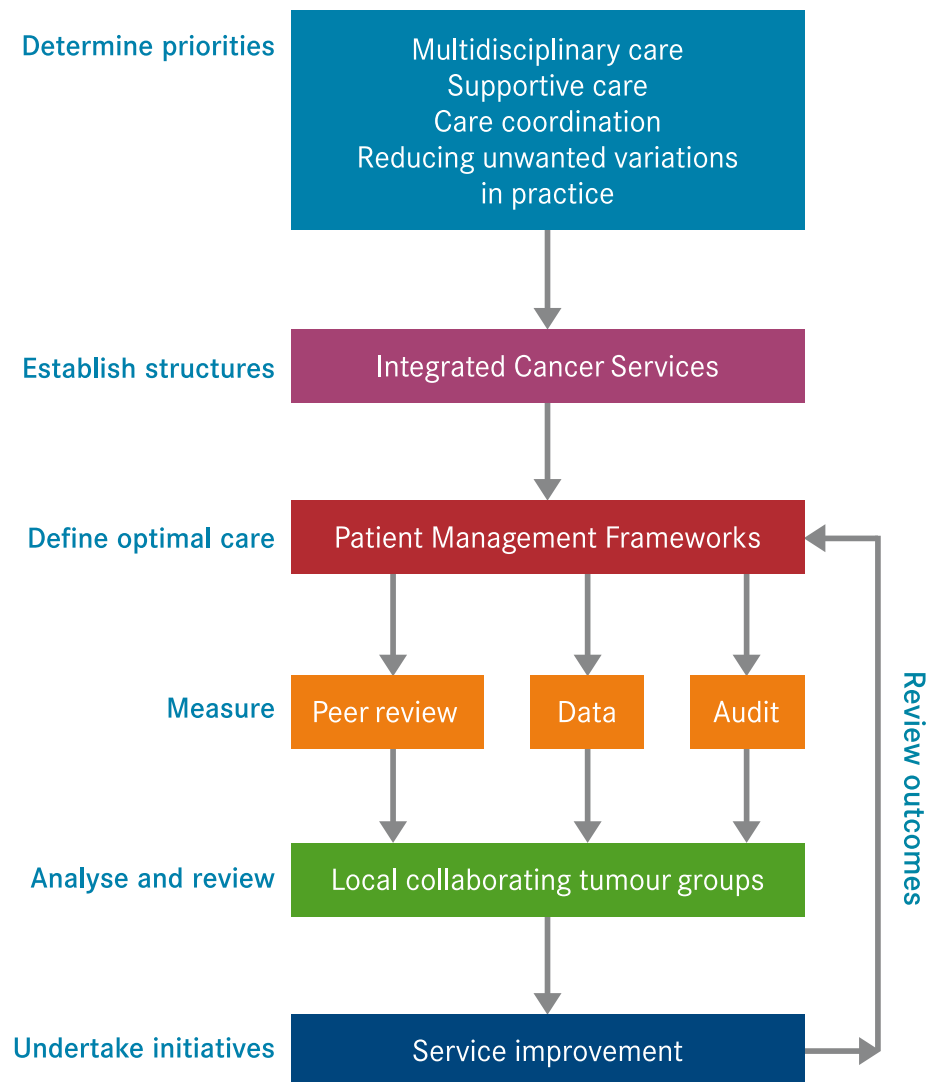
In the context of cancer, care coordination encompasses multiple aspects of cancer care delivery including multidisciplinary team meetings, supportive care assessment and providing required care, referral practices, data collection, development of common protocols, information provision and individual clinical treatment.

Figure 1: The interface between the four key priorities for reform



The relationship between the various structures and components of the cancer reforms is depicted in Figure 2.

Figure 2: Systematic approach to quality in cancer services



4. Defining multidisciplinary care

The interpretation of multidisciplinary care varies widely across the health system and is dependent on a number of factors including the patient cohort, the focus of care provided as well as workforce and resource capacity.

Multidisciplinary care can broadly be defined as:

‘...an integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient’ (National Breast Cancer Centre, 2005)

Effective multidisciplinary care maintains the patient at the centre of decision-making. Patient understanding of the multidisciplinary process and outcomes facilitates their participation in decisions about their treatment and care.

Multidisciplinary teams

The dynamic nature of multidisciplinary teams allows for flexibility in its make up and ensures team membership is reflective of the patient’s medical and supportive care needs.

Clinicians, general practitioners, trainees, nurses, allied health professionals and supportive care team members need to view themselves as a group of professionals working collaboratively throughout the patient’s cancer pathway. The team works together to develop common protocols, processes and documentation to support all team processes and patient care.

Multidisciplinary meetings

Establishing meetings for patient prospective treatment and care planning can be the first step towards embracing the broader philosophy of multidisciplinary care. Prospective treatment and care planning refers to decision making in real time, when pathology or other relevant diagnostic results are known, and prior to commencing treatment. This may take place pre and/or post surgery and prior to commencing adjuvant treatment. Meeting attendance may be in person or via technological means.

Multidisciplinary care is not confined to prospective treatment and care planning. In some instances, the disease stage or symptoms may necessitate commencing treatment prior to presentation at a multidisciplinary meeting, resulting in multidisciplinary discussion at the earliest possible time for ongoing planning. Subsequent presentation at multidisciplinary meetings may be warranted in instances where treatment plans need review.

Further information about multidisciplinary teams and meetings can be found in the multidisciplinary meeting toolkit at www.health.vic.gov.au/cancer

5. Key principles for multidisciplinary cancer care

The key principle of multidisciplinary care is that all cancer patients will have the opportunity for **prospective treatment and care planning** by a multidisciplinary team that reflects the stage of the patient's disease. The following principles guide the development and implementation of a multidisciplinary approach to cancer care:

- multidisciplinary care is centred around the patient, their family and carers, ensuring their input to the development of treatment plans that reflect the patient's medical and supportive care needs
- multidisciplinary teams comprise all core disciplines including diagnostic services, clinicians, general practitioners, allied health and supportive care health practitioners
- team membership is reflective of the individual needs of patients and the stage of the disease such as early, recurrent, advanced, palliative or any combination of these stages
- effective team communication depends on regular team member attendance at multidisciplinary meetings, communication skills, and protocols and processes that direct team conduct, communication and referrals within and beyond the team
- the availability of full therapeutic range depends the presence of or linkage to all relevant disciplines for the relevant tumour stream/s
- a focus on quality of care is maintained through the development of evidence-based protocols and processes with monitoring of activities through audit, clinical review and peer review.

An expanded list of principles is available in Appendix 1.

6. Strategic directions for multidisciplinary cancer care

The cornerstone of best practice in cancer care is prospective multidisciplinary planning of medical treatment and supportive care by a multidisciplinary team over the length of the patient's cancer journey.

Variation in how multidisciplinary care is provided between health services and tumour streams across Victoria is attributed to a range of factors including organisational culture and clinical practices, the range and nature of cancer services available within a health service, cancer patient throughput and workforce availability and capacity. Some health services have well-developed teams, meetings and clinics in many or all tumour groups, while in other settings work is required to develop teams, meetings and establish links across and between ICS.

Based on the literature and learnings from the Breast Services Enhancement Program, Victoria's strategic directions for multidisciplinary care acknowledge the need to build on the prior work of cancer services in establishing a multidisciplinary approach to cancer care and the need to build relationships between service providers across ICS and across health care sectors.

The three main strategic directions for multidisciplinary cancer care are:

- **creating and supporting effective multidisciplinary teams**
- **establishing and strengthening multidisciplinary meetings**
- **building effective team linkage across and between ICS.**

Model for multidisciplinary cancer care in Victoria

Victoria's model for multidisciplinary care incorporates the structures established to drive change (the ICS and local collaborating tumour groups) and the models that describe the requirements for optimal delivery of care that is safe, high quality and consistent with best practice.

The following list outlines the enablers and barriers that apply to the development of initiatives in one or more of the strategic directions for multidisciplinary care.

Enablers

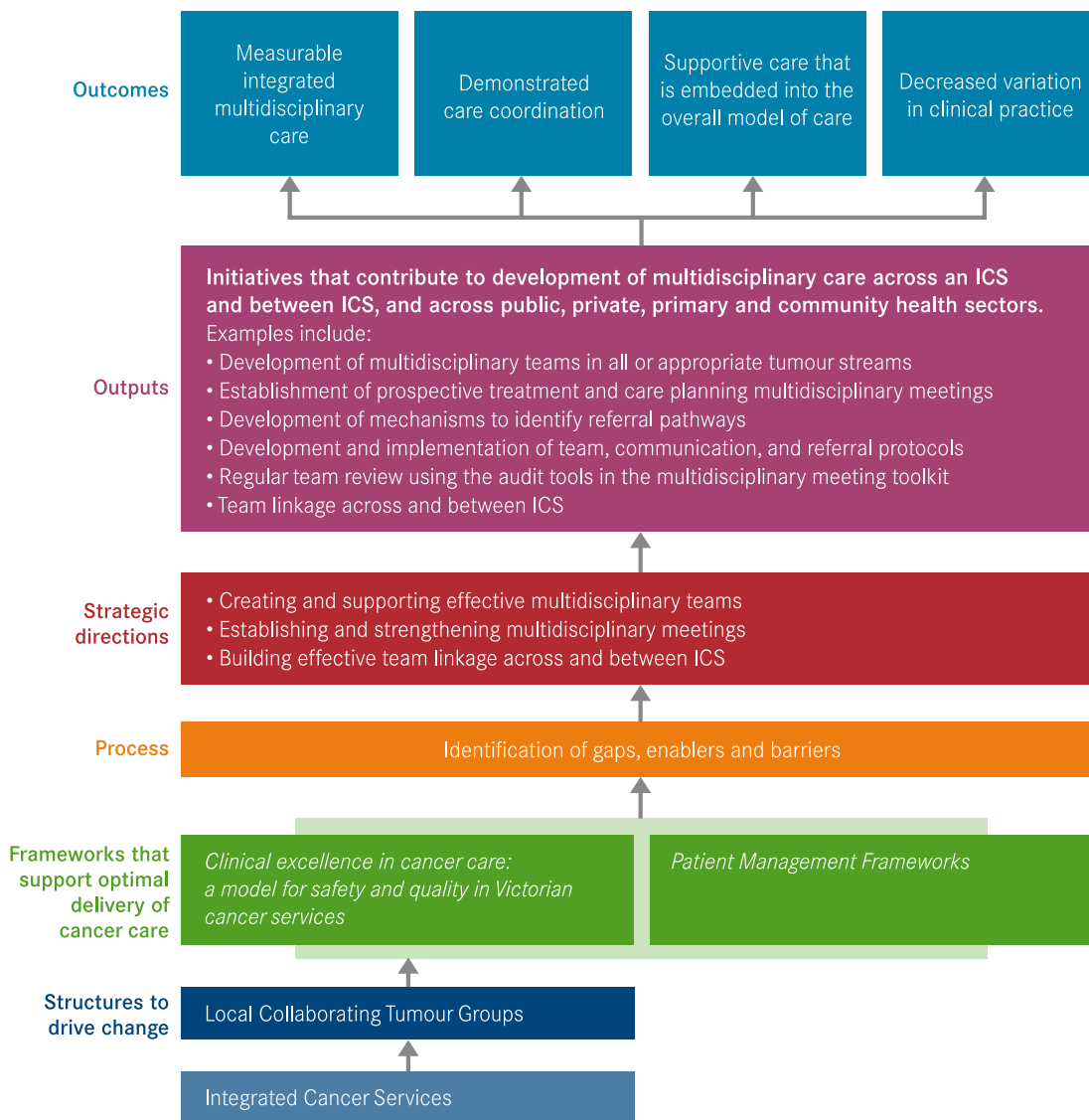
- Health service executive support for multidisciplinary activities and articulating the expectation that cancer patients will receive multidisciplinary care in health care provider contracts
- An organisational culture that supports multidisciplinary teams, meetings and other activities within health services
- A willingness to commit to multidisciplinary team development in an ongoing collaborative manner
- A flexible approach to developing multidisciplinary care in various settings that allows services to implement multidisciplinary teams according to location (metropolitan, regional or rural), the number of patients diagnosed, the team members who are local and those that need to be linked (such as via videoconference), referral patterns and other relevant factors
- An understanding within organisations and by the multidisciplinary team of the importance of prospective multidisciplinary treatment and care planning for cancer patients, to improve the quality of patient care
- A willingness and commitment by multidisciplinary team members to work collaboratively with a clear purpose and effective communication practices
- A quality improvement approach to team processes and activities.

Barriers

- The geographical distance between clinicians across and between ICS providing challenges to effective communication and collaborative relationships
- The ability to ensure representation by all team members especially in regional and rural areas because of lack of workforce
- Workforce and caseload issues, especially in regional and rural areas where all team members may not be represented and caseloads in many tumour streams will be low
- Lack of support for multidisciplinary teams and meetings by health service executives
- Workloads that do not allow multidisciplinary meetings and activities to take place during work hours
- Lack of available diagnostic services to represent at multidisciplinary meetings
- Lack of physical facilities for multidisciplinary meetings, such as a suitable meeting room that is consistently available, with technology infrastructure and support
- Lack of administrative support for multidisciplinary meeting organisation, documentation and data management
- Resistance to undertake multidisciplinary team audit for quality improvement purposes
- A perceived barrier to multidisciplinary meetings is the medico-legal implications of the process and its outcomes. Critical to this issue is informed patient consent and documentation of multidisciplinary team recommendations, patient decisions for treatment and the eventual care plan.

Further information regarding medico-legal issues in multidisciplinary care can be found in Appendix 3.

Figure 3: Victoria’s model for multidisciplinary care



6.1 Creating and supporting effective multidisciplinary teams

Collaboration in the planning and delivery of cancer treatment and supportive care is integral to the concept of multidisciplinary teams. Multidisciplinary teams comprise all relevant disciplines required to effectively plan treatment and care for cancer patients from diagnosis to end-of-life care. Team composition can include specialist and generalist clinicians, diagnostic services, general practitioners, allied health, nursing and supportive health care practitioners.

Developing multidisciplinary teams, meetings and associated activities is dependent on individual clinicians, teams of cancer clinicians and support at the health service (organisation) level. (Appendix 2 describes the support required from health services to develop and establish multidisciplinary care).

The following box outlines a number of initiatives that support development of multidisciplinary teams.

Initiatives to create and support an effective multidisciplinary team include:

- **comparing mapping data and information collected from ICS service mapping to the Patient Management Frameworks** to identify service gaps that could be addressed through implementing multidisciplinary teams
- **identifying team members who are required for prospective treatment and care planning** for the tumour group/s and disease stage. This team includes diagnostic clinicians, specialist and generalist cancer clinicians, general practitioners, nursing, allied health and supportive care practitioners including palliative care
- **identifying team members who are local and those that will need to be linked via technological means** to enable consideration of the full therapeutic range and patient care coordination.

6.2 Establishing and strengthening multidisciplinary meetings

An essential feature of multidisciplinary care is establishing regular multidisciplinary meetings for prospective treatment and care planning for patients in identified tumour groups.

Multidisciplinary meetings focus on determining the clinical treatment and supportive care needs for patients with early disease, recurrence, advanced disease and those requiring end-of-life care.

Patient care coordination is facilitated through effective information sharing and referral that occurs during multidisciplinary meetings. Critical to this process is effective communication between all team members.

The following box outlines a number of initiatives that support establishing and strengthening multidisciplinary meetings.

Initiatives to establish and strengthen multidisciplinary meetings include:

- **comparing mapping data and information collected from ICS service mapping to the Patient Management Frameworks** to identify service gaps that could be addressed through establishing and strengthening multidisciplinary meetings
- **providing communication training for multidisciplinary team members** to support effective communication practices and relationship building
- **developing and regular review of multidisciplinary team meeting, communication and referral protocols** (for further information on multidisciplinary audit refer to the multidisciplinary meeting toolkit www.health.vic.gov.au/cancer)
- **developing evidence-based treatment protocols** that are regularly reviewed to ensure consistency in care provision
- **establishing administrative, documentation and data entry processes** to support multidisciplinary processes, outcomes and appropriate documentation of team recommendations.

6.3 Building effective links across and between ICS teams: integrated multidisciplinary care

Many patients receive their treatment and care in more than one health service within an ICS, in another ICS or across state borders. Care delivery across a number of health settings sometimes can lead to fragmented care, duplication of services and patient dissatisfaction with the care provided.

For many patients, particularly for those who live in rural and regional Victoria and for those with rare tumours or complex needs, there is a need to improve or form links between:

- clinician groups or teams and individual health care practitioners in small health services with multidisciplinary teams in regional and metropolitan health services
- regional health services to metropolitan centres
- metropolitan centres to other metropolitan sites.

Integrated multidisciplinary care involves linking multidisciplinary team members and teams to other teams, groups of clinicians and individual health care practitioners across all sectors including primary, community and acute, public and private and within and between ICS. Establishing these links aims to ensure that each team comprises the practitioners required for prospective treatment and care planning and to assist care coordination.

Achieving integration is a complex process and effective communication requires team members to participate in multidisciplinary discussion either in person or by technological means. Communication between teams and between health care events and health settings is a two-way interaction with information exchange occurring as patients move from one health service to another and return to their community.

A key deliverable to be met by ICS under the statewide multidisciplinary care project includes linking multidisciplinary teams across and between ICS to ensure health professionals in all sectors involved in the care of the patient participate in treatment and care planning.

The following box outlines a number of initiatives that support team linkage across and between ICS.

Initiatives to build effective links across and between ICS teams include:

- **comparing mapping data and information collected from ICS service mapping to the Patient Management Frameworks** to identify service gaps that could be addressed through linking multidisciplinary teams
- **examining referral patterns** to identify multidisciplinary team linkage needs to ensure effective care coordination
- **identifying technology requirements** to enable team member links at distant sites, to other teams within the ICS and to support metropolitan and regional ICS linkages.

Appendix 1: Key principles for multidisciplinary care

The key principle of multidisciplinary care is that all cancer patients will have the opportunity to have prospective treatment and care planning by an appropriate multidisciplinary team.

The following principles of multidisciplinary care have been developed by the National Breast Cancer Centre (2005) and adapted for use by the Victorian Integrated Cancer Services:

<p>The team</p>	<ul style="list-style-type: none"> • There is an established multidisciplinary team comprising all core disciplines including allied health and supportive care health practitioners. • The patient's general practitioner is regarded as a team member and processes to ensure effective communication with general practitioners are implemented. • Team membership will reflect the stage of disease and may change composition and focus in the case of advanced disease and palliative care. • Multidisciplinary teams develop team, referral, communication and treatment protocols. • Effective referral linkages are made to all core and non-core team members. • Referrals need to be timely and appropriate (to the relevant service/ provider as close to the patient's home as possible).
<p>Communication</p>	<ul style="list-style-type: none"> • All core disciplines regularly attend multidisciplinary meetings to provide input to diagnostic, treatment, supportive care, palliative care and end-of-life planning. • In instances where not all patients within a tumour group/s are discussed, team protocols outline those patients who will be presented at meetings. • Processes for communicating treatment and care plans to team members who are absent are developed and implemented. • Collaborative links will be formed with smaller and larger referring centres and practitioners. The result will be an integrated network of multidisciplinary teams and practitioners across and between ICS effectively working together to ensure care coordination.
<p>Full therapeutic range</p>	<ul style="list-style-type: none"> • Team membership includes all treatment modalities to enable consideration of full therapeutic range. • All patients regardless of where they live will have access to relevant treatments and services.
<p>Quality care</p>	<ul style="list-style-type: none"> • Treatment protocols and multidisciplinary team recommendations are in line with current best practice including PMFs, all dimensions of quality, clinical practice guidelines, research and where these are not available, currently accepted approaches to treatment. • Monitoring of activities through audit, clinical review and peer review is undertaken. • Professional development activities are supported and provided for all team members.

Involvement of the patient

- Patients are informed about multidisciplinary care and the meeting process, including presentation of both clinical and supportive care information and their consent is sought prior to presentation of their case.
- The needs and views of the patient are presented as a part of the multidisciplinary discussion.
- Patients are informed about communication of the team recommendations and their role in the decision-making process.
- Patients are routinely offered information about all aspects of their treatment choices including supportive care and the recommendations of the multidisciplinary team.
- Patients and their carers are encouraged to participate in all decisions about their treatment and care.

Appendix 2: What is required to achieve multidisciplinary care?

Support from health services and health professionals

Clinicians, allied health professionals and supportive care practitioners require support from health service executives to provide multidisciplinary care for cancer patients.

Health service support for clinicians to provide multidisciplinary care

Many clinicians are committed to multidisciplinary care and attend prospective treatment and care planning meetings as well as education and team planning sessions out of normal working hours. Clinical loads need to accommodate multidisciplinary activities undertaken by all team members.

Diagnostic services are an integral component of the multidisciplinary team, with pathologists and radiologists considered core team members. Contracts or agreements signed between diagnostic services and health services need to reflect the expectation that pathologists and radiologists will attend multidisciplinary meetings to enable the team to view pathology and radiology and hear reports.

Payment to clinicians for attending multidisciplinary meetings is a contentious issue that has been partially addressed through the Medicare Benefits Schedule item number that became accessible in November 2006.

A regular meeting time and place

It is important for teams to have access to a regular venue and meeting time, so that the meeting becomes a part of the regular work undertaken.

Physical amenities

It is ideal for the team to meet in a room that comfortably accommodates all attendees in a configuration enabling visualisation of the pathology, radiology, presentations, videoconferencing equipment and team members.

Administrative support

There is considerable work in preparing an efficient and effective multidisciplinary meeting including recording and follow up after meetings. The main requirements include:

- a known person or place to whom all patients to be placed on the agenda are referred or a person who ensures that all newly diagnosed patients are listed for discussion in the relevant tumour group
- agenda preparation and distribution to all team members
- organising pathology and radiology for viewing at the meeting
- organising the equipment required at each meeting, if it is not permanently located in a room used predominantly for multidisciplinary meetings
- organising the catering for the meeting (if required)
- recording all data presented for each patient, in the medical record. Multidisciplinary meeting records/data needs to be accessible to all team members.

Technological requirements

- Data projector
- Laptop computer with CD and USB capability
- Document reader capable of reading radiology
- Projection microscope
- A suitable projection surface
- Teleconference telephone
- Videoconferencing equipment: a large enough camera to take in the multidisciplinary group, a videoconference monitor, direct linkage from the document reader and the projection microscope to the videoconference camera is essential to enable participants at distant sites to view clear images.

Technological support

When meetings are videoconferenced, information technology support is critical, as team members do not necessarily possess the skills to effectively utilise the equipment, to oversee the technological aspect of the meeting or to overcome technology difficulties or failure.

Appendix 3: Medico-legal issues

Patients need to be well informed about multidisciplinary meetings and procedures and provided with information that will enable their participation in developing their treatment and care plans.

To assist this process the following steps are recommended.

Patient consent

- Consent is sought prior to the multidisciplinary meeting from each patient to be presented.
- Informed consent consists of explanation of the multidisciplinary meeting process, meeting attendees and likely areas of discussion including clinical information, treatment and supportive care.
- Consent is recorded in the patient medical record.

The multidisciplinary team recommendations

- The recommendations made by the multidisciplinary team are evidence based and in the absence of evidence, based on accepted best practice.
- Recommendations are recorded in the patient's medical record and signed by the presenting or treating clinician. When private patients are presented at a multidisciplinary meeting, it is the responsibility of the treating clinician to record team recommendations in the patient notes and sign.
- The treating clinician or other designated team member conveys the recommendations of the multidisciplinary team to the patient, providing appropriate information to assist the patient to participate in the decision-making process.
- The patient and clinician devise the most appropriate treatment and care plan and this will be recorded in the medical record and communicated to the multidisciplinary team in accordance with team, referral and communication protocols.

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