

Multidisciplinary care—improving consumer outcomes

Breast Services Enhancement Program

Learning from the past—informing the future

Multidisciplinary care
–improving consumer outcomes

Breast Services Enhancement Program

Learning from the past–informing the future

© 2005 Copyright State of Victoria, Department of Human Services, September 2005. No part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*.

This work is copyright and if reproduced reference must be cited as follows: Breast Services Enhancement Program. Learning from the past—informing the future: Multidisciplinary care—improving consumer outcomes.

Published by Cancer and Palliative Care, Programs Branch, Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne, Victoria.

Also published on www.health.vic.gov.au/cancer/

Authorised by the Victorian Government, 595 Collins Street, Melbourne.

Printed by Big Print, 520 Collins Street, Melbourne.

(0170805) December 2005

Preface

Welcome to *Learning from the past—informing the future*, the learning series based on the experiences of the Victorian Breast Services Enhancement Program.

The Breast Services Enhancement Program commenced in 1999 as a key component of the Breast Disease Service Redevelopment Strategy 1999–2003¹ (BreastCare Victoria).

Since the implementation of BreastCare Victoria and the Breast Services Enhancement Program, there has been an increasing national and state focus on improving services for all people with cancer. As with breast cancer, in addition to improving discrete health outcomes such as survival and morbidity through evidence-based best practice, there is increasing emphasis on improving the experiences of people with cancer as they navigate our complex health system.²

These two aspects, improving clinical outcomes and the consumer experience, were the focus of the service redevelopment and quality improvement initiatives of the Breast Services Enhancement Program.

From 1999 to mid 2004, nine consortia of health services across Victoria joined to develop and implement the Breast Services Enhancement Program. Over sixty different initiatives of various sizes were implemented. The presence of the Breast Services Enhancement Program also enabled us to seize other unexpected opportunities to help achieve our goals.

This learning series provides examples of the many experiences of the Breast Services Enhancement Program—key learnings, critical success factors and challenges. We learned what worked well, what worked less well, what made the difference and what we could do differently next time.

The learning series addresses these topics:

- multidisciplinary care—improving consumer outcomes
- continuity and coordination of care—improving the ‘cancer journey’
- supporting sustainable change
- building partnerships with consumers for improved service delivery.

The learning series reflects the hard work of all program staff, clinicians, breast care nurses, consumers and other health and community workers, as well as members of the BreastCare Victoria Advisory Committee. We thank you all for your significant contributions, enthusiasm and commitment.

Each resource in this learning series draws on evidence from the statewide evaluation of the Breast Services Enhancement Program and on individual evaluation reports. Evidence has also been gleaned from further discussions with key stakeholders in the field.

While each resource stands alone, links are made with other documents in the series along with other useful references, resources and tools.

We hope that the experiences and learnings of the Breast Services Enhancement Program may be of assistance to you in your work, whether it is in achieving new initiatives within cancer reform or in other health care reform.

Lyn Swinburne
Chair, BreastCare Victoria Advisory Committee (1999–2004)

Acknowledgements

This learning series was written by Sheila Hirst on behalf of Cancer and Palliative Care, Victorian Department of Human Services. We thank those stakeholders who provided additional local knowledge and experiences to inform this series.

The learning series *Learning from the past—informing the future* is based on the experiences of the following nine Victorian consortia who participated in the Breast Services Enhancement Program 1999–2004.

Metropolitan consortia

Western	Royal Melbourne Hospital, Royal Women’s Hospital, Western Health and associated private providers
North Eastern	Austin Health, Northern Hospital, Peter MacCallum Cancer Centre, St Vincent’s Health
Southern	Dandenong Hospital, Monash Medical Centre.
Inner and Eastern	The Alfred, Eastern Health (Box Hill, Maroondah and Angliss Hospitals), Peter MacCallum Cancer Centre, and associated private providers

Regional consortia

Barwon–South Western Region

Grampians Region

Loddon Mallee Region

Hume Region

Gippsland Region

Contents

Preface	iii
Acknowledgements	v
Summary of learnings	ix
Evidence from the literature	ix
Learnings from the Breast Services Enhancement Program	ix
1 Introduction	1
2 Multidisciplinary care—the context	3
3 What the evidence tells us	5
3.1 Models of care	5
3.2 The principles of multidisciplinary care	7
4 Learning from the Breast Services Enhancement Program experience	11
4.1 Where we started	11
4.2 The key themes	11
5 Principles for best practice multidisciplinary review meetings	13
6 Developing and strengthening multidisciplinary review meetings	17
6.1 Starting off—successes and challenges	18
6.2 Assessing the value of multidisciplinary review meetings	24
6.3 Adding value—improving patient outcomes	25
6.4 Adding value—strengthening consumer understanding of multidisciplinary care	27
6.5 Adding value—improving team effectiveness	27
6.6 Sustainability	33
6.7 Learnings and future opportunities	33
7 The role of multidisciplinary protocols and pathways	35
7.1 Learnings and future opportunities	36
8 Measuring the quality of multidisciplinary care	37
8.1 The multidisciplinary audit tool	37
8.2 Learnings and future opportunities	39
9 Useful tools and resources	41
10 References	43
Appendix 1: National Breast Cancer Centre –The principles of multidisciplinary care*	46

You feel more confident with specialists who are prepared to participate in a team... and they question each other for different points of view.

Consumer, Scott, Neil & Rodger³

Multidisciplinary care is recommended as a means of achieving best practice... 'through their combined understanding... all members of the team liaise and cooperate together and with the patient to diagnose, treat and manage the condition... to the highest possible standard of care'.

House of Representatives,
Standing Committee on Community Affairs 1995⁴

The outcome for patients with breast and other cancers is better if they are treated by a clinician who has access to the full range of treatment options in a multidisciplinary setting.

Level III evidence, NHMRC Clinical Practice Guidelines:
Management of early breast cancer⁵

I think that the multidisciplinary team is an integrated approach rather than an individual approach, so it is not just left to the surgeon or the oncologist. There is interaction between the different disciplines and I think that this gives the best outcome you can achieve for patients you know—when there is that interaction.

Pathologist, Rural Breast Services Enhancement Program⁶

Summary of learnings

Evidence from the literature

- There is strong evidence that multidisciplinary care has the potential to reduce mortality, enhance delivery of care, improve quality of life and reduce health care costs. While Australian standards of clinical care are generally good, delivery of care remains fragmented and inconsistent.
- Multidisciplinary care is a team approach to management and care, with communication at its core. This is critical at key decision making points across the pathway.
- In addition to patient outcomes, multidisciplinary care improves team effectiveness and the wellbeing of individual team members.
- Key principles of multidisciplinary care are:
 - team
 - communication
 - access to the full therapeutic range
 - standards of care
 - involvement of the woman.

Learnings from the Breast Services Enhancement Program

- Multidisciplinary review meetings with prospective case discussion or retrospective review are one important mechanism for facilitating the required multidisciplinary decision making.
- Multidisciplinary review meetings add value to both a sequential model of care and a multidisciplinary clinic model of care.
- Best practice principles for multidisciplinary review meetings based on the Breast Services Enhancement Program experience can guide future practice.
- Prospective multidisciplinary review meetings directly impact on outcomes for women with early breast cancer. At times, these changes are subtle and not readily captured in standard reporting mechanisms.
- Retrospective multidisciplinary review impacts more indirectly on women by:
 - shifting underlying clinician attitudes and knowledge
 - encouraging practice changes
 - improved referral to psychosocial support
 - increased specialisation.
- Factors influencing the establishment and sustainability of a multidisciplinary review meeting include:
 - clinical leaders willing to act as local champions
 - team commitment
 - building trust and communication
 - starting small and extending

- external triggers
- a willingness to review and improve practice
- organisational support
- embedding functions into established roles.
- Factors that influence the quality of the multidisciplinary review and patient outcomes include:
 - a clear clinical agenda
 - good chairing
 - a commitment to the team, learning and collaboration
 - good organisational support mechanisms
 - the meeting room setting.
- It is more difficult to establish multidisciplinary review meetings in low-volume services. It is recognised that good demonstrated communication systems between individual service providers may optimise multidisciplinary decision making and care coordination. The development of multidisciplinary meetings across services or tumour streams may facilitate the development of future multidisciplinary review meetings in some settings.
- Specific interventions can facilitate the integration of psychosocial issues into multidisciplinary review meetings, as part of a broader systemwide and team approach to strengthen psychosocial care into service delivery.
- Further work is needed to strengthen the development and use of multidisciplinary protocols and pathways as ‘living tools’ to facilitate service improvement.
- The use of a multidisciplinary audit tool demonstrates the capacity to develop and use objective measures to assess the performance of a multidisciplinary review meeting against established standards.

Case study 1

Jane was 41 years old with two children and 34 weeks pregnant when she came to the breast clinic with a breast mass. A core biopsy revealed a locally advanced infiltrating lobular cancer. The surgeon gave Jane her diagnosis and discussed possible surgical options. Jane's obstetrician was also contacted for pregnancy advice. Jane was very distressed.

The breast care nurse (BCN) met with Jane during this consultation. As part of her care, the BCN contacted the Cancer Connect peer support program that day, and fortunately was able to link Jane quickly with another woman who had been pregnant when diagnosed.

The surgeon told Jane that her case would be discussed at the next multidisciplinary meeting and asked her to return for further discussion.

At the multidisciplinary meeting, the surgeon presented his proposed plan. Another clinician suggested the issue of pre-surgery chemotherapy, with surgery following the baby's birth. The team discussed and agreed on the various options, which the surgeon later discussed with Jane.

Jane's obstetrician and GP were also consulted and, with their support, Jane decided to have her baby induced and then commence neo-adjuvant chemotherapy.

Achievement of multidisciplinary principles

- ✓ All key team members were involved in the development of an agreed management plan and specific options to be discussed with Jane.
- ✓ There was good communication between the hospital team, the obstetrician, the GP and Jane.
- ✓ The full therapeutic range was available.
- ✓ Jane was actively involved in the decision making.

1 Introduction

Multidisciplinary care—improving consumer outcomes is the first resource in the learning series from the Victorian Breast Services Enhancement Program.

As a means of improving outcomes for cancer patients, we know that integrated multidisciplinary models of care are increasingly recognised as the cornerstone of high quality care for all Australian cancer patients and their families.² What is less well known is how best we can achieve optimal multidisciplinary care, given Australia's relatively small population, our demographic spread over a vast continent, our complex public and private health systems and significant workforce issues. One model will not fit all.

Strengthening multidisciplinary care was the major priority area for service improvement.

Through the nine consortia established through the Breast Services Enhancement Program (the Program), we faced the challenge of strengthening Victorian women's access to multidisciplinary care, regardless of where they lived—in metropolitan Melbourne, regional centres, small rural towns or more isolated communities.

In this resource, we first look at the concept of multidisciplinary care, what it meant to us in 1999 and what it means to us now. After this, we review the increasing evidence about multidisciplinary care in the literature. In Section 4 the Program experiences are introduced. Section 5 articulates the principles of best practice multidisciplinary review meetings.

The following three sections then discuss the Program experiences, which provide the evidence informing the principles, and discusses these themes:

- developing and strengthening multidisciplinary teams
- the role of multidisciplinary pathways and protocols
- measuring quality of multidisciplinary care.

At the end of each of these three sections the relevant Program learnings are articulated. All the key Program learnings along with the key learnings from the literature are also summarised below.

Section 9 identifies resources and tools which may be of assistance to others.

Throughout the text these following symbols are used:

- ★ denotes **benefits** or outcomes of service improvement
- ✓ denotes **critical success factors** of service improvement
- ◇ denotes **challenges** to service improvement

2 Multidisciplinary care—the context

When we commenced the Breast Services Enhancement Program, we knew that multidisciplinary care would make a difference to women, but were less sure about ways to optimise this within varying contexts.

Based on the evidence (see Section 3) there were clear recommendations for the benefit of multidisciplinary care in Australia.^{4, 5} Within the Breast Disease Service Redevelopment Strategy, multidisciplinary care was not well defined, but was strongly linked with the implementation of evidence-based guidelines.¹ There was little guidance on how multidisciplinary care could be best operationalised.

During the life of the Program, we grappled with what we meant by multidisciplinary care, how to work with service providers to achieve it, and we faced many questions:

- What was and who makes up a multidisciplinary team?
- What are the benefits for women and for service providers?
- How do we bring a team together within a service or across a region?
- How does multidisciplinary care make a difference to patient outcomes in different settings? For instance, in settings where clinicians treat only a small number of patients a year or in high volume centres.
- In what ways does a multidisciplinary review meeting add value to services in different settings?
- How are psychosocial and supportive care issues integrated into the multidisciplinary approach?
- Do women understand the value of a multidisciplinary case discussion?
- How do we measure success?
- What makes a group of individuals into a good multidisciplinary team?

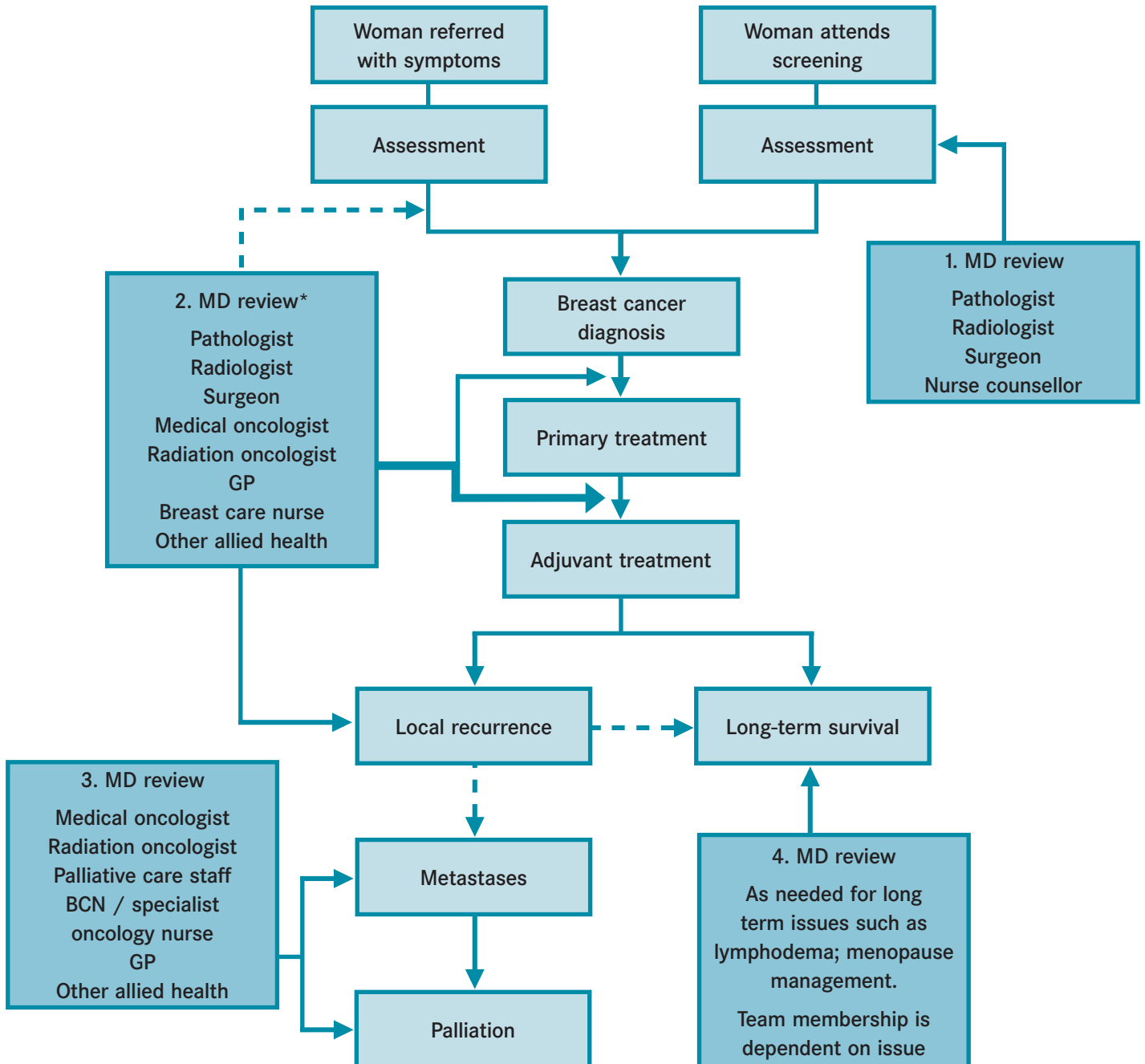
From the Program experiences, and from more recently published literature, multidisciplinary care can be seen as a concept that brings together a team approach to care, with communication at its core.

An important approach to multidisciplinary care is the establishment of multidisciplinary review processes to facilitate decision making at key points in the patient pathway^{7, 8} (See Figure 1, page 4). Depending on the context, there are different ways to achieve these decision making processes. Multidisciplinary care may be facilitated through multidisciplinary review meetings or through well-developed protocols of sequential referral and communication between service providers.

Facilitating the development of multidisciplinary review meetings was a major focus of Program initiatives. Other initiatives included the development of multidisciplinary pathways and protocols, integrating psychosocial care and measuring quality of care.

First we look at the evidence from the literature, and then consider the experiences of the Breast Services Enhancement Program in strengthening multidisciplinary care.

Figure 1: An approach to multidisciplinary care: building multidisciplinary review with different team members into key points in the care pathway for women with breast cancer



* Note: within breast care services, a key performance indicator is the provision of a multidisciplinary case discussion prior to adjuvant therapy.

3 What the evidence tells us

Key messages

- Multidisciplinary care is a team approach to the provision of care by all relevant medical and allied health professionals.
- Multidisciplinary care reduces mortality, improves quality of life, reduces health care costs, decreases fragmentation of care and improves team effectiveness and the wellbeing of individual team members.
- A multidisciplinary review meeting can strengthen a sequential model of care and a multidisciplinary clinic model of care.
- The National Breast Cancer Centre’s principles of multidisciplinary care for early breast cancer have relevance for women with advanced breast cancer and other cancers.
- The key principles are:
 - team
 - communication
 - access to all therapeutic options
 - standards of care
 - involvement of the consumer.
- The team membership, leadership, communication and work methods all influence the effectiveness of the team.
- The consumer is an essential part of the multidisciplinary team, and should be the point of focus of all care and service delivery.
- Supportive psychosocial care is an integral part of optimal multidisciplinary care.

Multidisciplinary care is described as a team approach to the provision of care by all relevant medical and allied health professionals,⁹ with specific reference to the collaborative development of an individual treatment plan for each patient.¹⁰

There is strong and increasing evidence that multidisciplinary care has the potential to reduce mortality, improve quality of life and reduce health care costs.^{5, 11, 12, 13} In particular, in overseas studies, greater clinical specialisation¹³ and higher caseloads¹² have resulted in improved access to optimal multimodality treatment.

3.1 Models of care

While there is a strong commitment to the notion of multidisciplinary care, currently there is no universally accepted model of multidisciplinary practice for cancer patients.¹⁴ Overseas multidisciplinary models do not necessarily translate readily into the Australian context.

As the local Program developed, three approaches to multidisciplinary care were identified.¹⁵

Sequential models of care run the risk of poor communication between team members, and potentially reduced quality and coordination of care.

Knowledge of current best practice evidence, good referral and communication practices, and access to supportive care, are essential to optimise patient outcomes.

A multidisciplinary clinic does not necessarily provide an opportunity for full team discussion and service integration, and may not provide an optimal model of multidisciplinary care.

3.1.1 The sequential model of care

The traditional model of health care in Australia is one of sequential referral. Within cancer care, patients are referred from the general practitioner to a specialist (usually a surgeon), and then to other specialists, as required.²

Critics indicate that this ‘multimodal’ model is flawed because it depends on the knowledge of the primary specialist for appropriate and timely referral to other disciplines. However, with links to clinical specialists, good referral and communication practices, and access to supportive care networks, low-volume providers can achieve good multidisciplinary practices and evidence-based care within Australia.¹⁶

3.1.2 The multidisciplinary clinic model of care

The multidisciplinary ‘one stop’ clinic, in which all clinical specialties are present within one setting, provides the most visible evidence of the multidisciplinary team to the patient. The multidisciplinary clinic enables the patient to see all relevant specialties in one visit. Overseas, such multidisciplinary clinics are justified by the logistical advantages of high patient volume, and these have provided an opportunity to establish high standards of care with small—but demonstrable—differences in patient outcomes.¹⁷

In Australia, such multidisciplinary clinics may be viable within large-volume centres. They may significantly reduce unnecessary clinic visits and enhance continuity of care, and may go some way to providing optimal multidisciplinary care. However, in the context of a busy clinic, case discussion may be more informal and between individuals within the team, rather than with the team as a whole.^{7, 8}

This model does not necessarily reflect an integrated model of multidisciplinary care and service with the patient as the primary point of focus. Without this integration, the model of multidisciplinary care may be suboptimal.^{2, 4, 18}

3.1.3 The multidisciplinary review meeting

A multidisciplinary review meeting complements the sequential or multidisciplinary clinic model of care.

The review meeting is held with all core members of the multidisciplinary team. Optimally, prospective case discussion addresses the key clinical and psychosocial aspects of care, and results in the development of treatment recommendations to be discussed with the patient.¹⁰

The specific benefit of multidisciplinary case review was demonstrated by Chang et al¹⁹ in which the initial treatment recommendations received in a single or sequential consultation were compared with a second opinion provided by a multidisciplinary panel. For 43 per cent of women with early breast cancer, the treatment recommended by the multidisciplinary panel differed from those of individual physicians, and was more likely to be in accord with best practice.

Multidisciplinary review meetings for case discussion complement both the sequential model of care and the multidisciplinary clinic.

The multidisciplinary review facilitates better integration of care and services, and affirms the patient as the focus of care.² In a recent national study of Australian hospital breast cancer services, 30 per cent of high-volume providers did not have regular multidisciplinary meetings. Of those high-volume providers with regular meetings, 50 per cent considered all cases.¹⁰

However, the effectiveness of the review meeting in enhancing clinical decision making and service integration may depend on:

- the team membership, its leadership and communication patterns²⁰
- the team's underlying commitment to deliver integrated care.²¹

While the strengths of optimising multidisciplinary care are seen in patient benefits, the barriers appear to be more organisational, in terms of staff time and resourcing within current funding mechanisms.²

Within breast cancer, Pendlebury et al²² argue that much of the multidisciplinary care evidence comes from regions where outcomes have been historically poor, and that Australian studies indicate higher standards of care in line with the evidence. However, others^{2, 14} argue that while standards of clinical care in Australia are generally good, delivery of care often remains fragmented and inconsistent.

3.2 The principles of multidisciplinary care

Given the diversity of the Australian health care context, in 2003 the National Breast Cancer Centre established five key principles of multidisciplinary care for women with early breast cancer:

- the team
- communication
- access to the full therapeutic range
- standards of care
- involvement of the woman.⁹

These principles have the potential to be adapted and applied:

- at different points in the clinical pathway
- to other cancers
- across health systems
- to chronic illnesses.

Appendix 1 articulates each principle, the relevant elements under each principle and measurable outcomes.⁹

These multidisciplinary care principles provide an important framework to review and strengthen patients' access to multidisciplinary care. However, to move from an espoused commitment to multidisciplinary care to integrating these principles into organisational practice can be a significant challenge.²³

3.2.1 The multidisciplinary team

The specific multidisciplinary team membership depends on the point in the patient’s pathway for the case discussion (such as at diagnosis and primary treatment, post-surgery, recurrence and palliation). It will also depend on the specific cancer site. For example, the team membership for the management of people with head and neck cancers may be different from that of the breast cancer team.²

The diversity (or lack of diversity) of team membership also affects the scope of multidisciplinary case discussion. For example, in a UK study,²⁰ psychosocial issues were perceived to be less well addressed in teams that had more radiologists. Therefore it is critical for the team to have a clear and agreed purpose²⁴ and to have a membership and roles that reflect that purpose.²⁰

3.2.2 Multidisciplinary communication

A multidisciplinary meeting does **not** *per se* guarantee quality multidisciplinary care.

Good team communication maximises quality clinical decision making, improves patient outcomes and reduces fragmentation and inconsistency of care. It also impacts positively on overall team effectiveness and the wellbeing of individual team members.^{20, 24}

Inadequate communication between professionals leads to confusion amongst patients about their diagnoses, management plan and prognosis²¹ and potential errors in practice.²⁵ While clinical pathways and protocols go some way in improving clinical outcomes, they do not necessarily improve inter-professional relationships and communication.²¹

Team leadership influences team communication, with a shared leadership style optimising clinical decision making. A lack of clarity or conflict about leadership or an autocratic leadership style impacts negatively on the team’s effectiveness.²⁰

The different and potentially conflicting allegiances of team members to their team or to their professional group presents health care teams with particular challenges.²⁵ Power relationships within and between professional groups jeopardises communication,²⁶ and results in team members feeling invisible or undervalued.²⁰

Given these challenges, additional training may be needed to turn a ‘team of experts into an expert team’.^{24, 28}

The multidisciplinary team, its composition, communication and working methods influences clinical decision making.¹⁹

In this way, multidisciplinary care moves beyond a ‘theatrical function’,²² about ‘being seen to be doing the right thing’, but rather, becomes integrated into ‘the way we do business around here’.

Established teams may need to review and strengthen their own communication and work practices to optimise patient (and team) outcomes.

3.2.3 Access to the full therapeutic range

As indicated, the purpose of good multidisciplinary team communication is to ensure that patients gain access to appropriate treatment, regardless of where they live in Australia. Tulloh and Goldsworthy¹⁶ have clearly demonstrated that good communication and referral networks can optimise care for women with breast cancer within a local rural community.

Telemedicine, using teleconferencing and video conferencing, has also been used successfully to facilitate multidisciplinary care. It enables formal linkages between large tertiary treatment centres with remote communities.^{29, 30, 31}

3.2.4 Standards of care

Key elements of the ‘standards of care’ principle include review of clinician practice against national benchmarks, and that standards of care are supported through professional development activities.⁹

Improved access to data is needed to measure quality cancer care in Australia.² In a recent national survey of hospital services, all high-volume breast service providers had some form of data collection, but only 40 per cent indicated any established review process.¹⁰

As part of achieving the BreastCare agenda, and to facilitate such quality improvement processes in breast cancer management, a series of draft key performance indicators (KPIs) and standards have been developed, and these are being trialled in Victorian hospitals.^{32, 33} Working with the stakeholders, these trials encourage local ownership of the processes, results and improvement processes.

3.2.5 Involvement of the consumer

In line with current trends in health care, the patient or consumer is seen as a critical partner in the multidisciplinary team, and brings their own perspectives, values and experiences to their decision making, along with the information and skills provided by the service provider.^{34, 35}

In addition to the clinical component of care, the cancer patient also requires a range of supportive care measures. While specific and detailed clinical practice guidelines have been established for the psychosocial care of adults with cancer,³⁶ they are also integrated into the clinical management guidelines, and therefore are an important component of quality multidisciplinary care.^{5, 10}

Psychosocial issues are an integral part of multidisciplinary care.

4 Learning from the Breast Services Enhancement Program experience

Since 1999, across all nine consortia, a range of approaches to enhance multidisciplinary care were developed. The experiences across Victoria provide further evidence about elements that make a difference and affirm the findings in recently published literature.

4.1 Where we started

While there was some variation in practice, the following key gaps across the nine consortia were identified:

- limited multidisciplinary review meetings
- a limited range of disciplines represented at some established meetings
- variable levels of documentation of recommended management plans
- a lack of attention to the psychosocial aspects of patient care
- a lack of clarity about consumers' understanding of multidisciplinary care
- limited systematic review of local clinical practice, and specifically, of multidisciplinary team practice.

4.2 The key themes

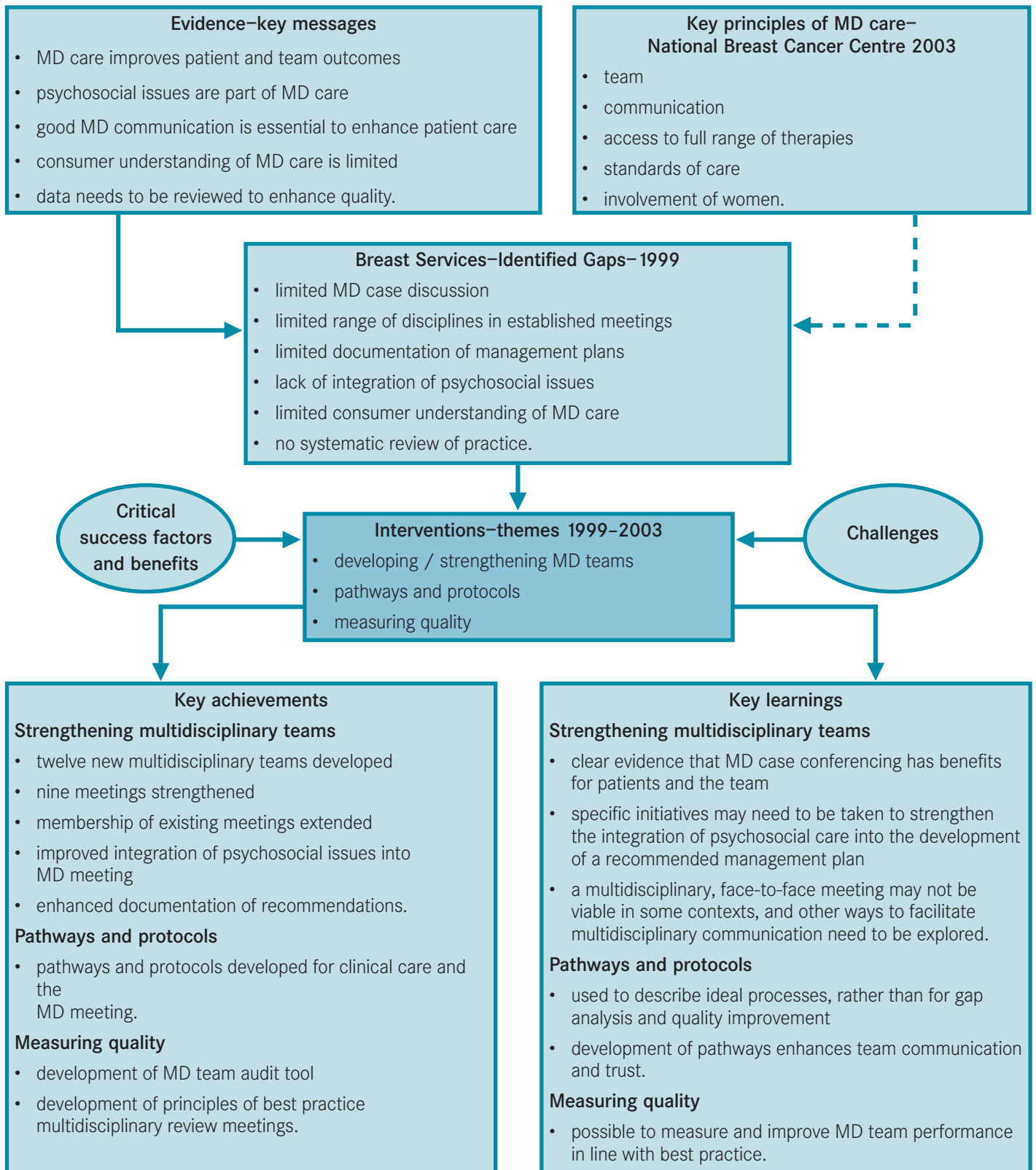
To address the identified gaps, a wide range of initiatives were developed and implemented. From this work, three key themes to strengthen multidisciplinary care emerge:

- developing and strengthening multidisciplinary review meetings
- the role of pathways and protocols
- measuring quality of multidisciplinary care.

Figure 2, below, summarises the rationale, key initiatives, achievements and key learnings.

Section 5 articulates the principles of best practice multidisciplinary review meetings. These principles emerged from the experiences of developing and evaluating 12 multidisciplinary review meetings and the strengthening of nine established meetings. Section 6 provides the more detailed evidence that informed the development of these principles. Section 7 provides a brief summary of the development of multidisciplinary protocols and pathways. Finally, Section 8 articulates mechanisms to measure multidisciplinary care.

Figure 2: Multidisciplinary care—improving consumers’ outcomes



5 Principles for best practice multidisciplinary review meetings

Drawing on the Program experiences, the definition, objectives and principles for a best practice multidisciplinary team meeting for women with early breast cancer have been established.

Against each principle, a set of standards and performance indicators as part of an audit tool have been developed that enables a review of team processes and outcomes (see Section 8.1 and Section 9).

These principles complement the National Breast Cancer Centre's Multidisciplinary Care Principles, and add specificity to multidisciplinary review meetings.

Table 4: Best practice principles for multidisciplinary case conferencing

Component	Descriptors
Definition	<ul style="list-style-type: none"> A multidisciplinary meeting is a deliberate, regular, face-to-face (or video conference) meeting involving a range of health professionals who have expertise in the diagnosis and best practice management of all patients with breast cancer.
Purpose	<ul style="list-style-type: none"> To facilitate best practice management of all patients with breast cancer.
Objectives	<ul style="list-style-type: none"> To provide an opportunity for multidisciplinary discussions of all newly diagnosed cases of breast cancer within an appropriate timeframe to facilitate effective treatment planning. To determine (in the light of all available information and with reference to the evidence base) the most appropriate treatment plan for each individual patient. To provide an educational opportunity for team members and trainees.
Principles	
Timing	<ul style="list-style-type: none"> At a minimum, an MD meeting will occur after definitive surgery, but before adjuvant treatment begins. Ideally, an opportunity for MD case review will occur pre- and post-surgery.
Membership	<ul style="list-style-type: none"> At a minimum, the MD team meeting will comprise the surgeon, radiologist, pathologist, radiation oncologist, medical oncologist, and breast care nurse. Ideally, the treating surgeon is present.
Consent	<ul style="list-style-type: none"> After diagnosis and prior to the commencement of any treatment, the patient should be informed that the case review in the multidisciplinary team meeting is part of normal best practice care. The patient has the right to deny their consent for this to occur.

Principles	
Procedure	<ul style="list-style-type: none"> • A clinical agenda or data form will be prepared in advance and made available at all meetings. The form will include: <ul style="list-style-type: none"> - case number or patient name and unit record number name of surgeon - summary of surgery to date - grade and type of tumour - receptor status - node involvement - CerB-2 status - psychosocial status. • Equipment is available for review of pathology and radiology. • Mammogram and ultrasound films are reviewed by radiologist. • Pathology is viewed and interpreted by pathologist. • Clinical examination, radiological findings and pathology results are correlated. Low levels of correlation may indicate the need for further investigations. • Discussion about treatment and management of each case will include reference to relevant evidence bases and the opinions of team members. • Risk factors for psychosocial morbidity will be considered, where relevant to patient's ongoing care.
Recommendations	<ul style="list-style-type: none"> • As a result of discussion, recommendations about treatment options to optimise survival will be made. • Recommendations are not prescriptive. Final decisions about treatment plan will be made by the patient, in consultation with the designated member of the treatment team.
Conduct of meeting	<ul style="list-style-type: none"> • A chairperson will be appointed on a regular or rotating basis. • The chairperson will ensure all issues relevant to the patient's future management are presented, and discussion and participation by team members encouraged. • A management plan, based on the summary of the team discussion, is outlined by the chairperson at the conclusion of each case. The plan will include referrals and other recommended follow-up. • The contribution of all team members to the case discussion will be accorded appropriate professional respect.
Confidentiality	<ul style="list-style-type: none"> • The confidentiality of any information that identifies the patient will be respected.

Principles	
Communication	<ul style="list-style-type: none"> • A team member, who will describe the process of the meeting and discuss the meeting recommendations with the patient, will be identified. This discussion will occur before adjuvant treatment begins. • The patient's GP will be informed in writing of the recommended treatment plan as soon as practicable after the meeting.
Documentation	<ul style="list-style-type: none"> • Recommendations from the multidisciplinary meeting will be recorded in the patient's medical record. At a minimum, this should include the date of the meeting, and the action plan described above.
Protocols and processes	<ul style="list-style-type: none"> • Written protocols which describe how the organisation and content of the meeting will be documented.

The audit tool and associated meeting protocol based on these principles are available at www.health.vic.gov.au/cancer/

6 Developing and strengthening multidisciplinary review meetings

Key messages

- Multidisciplinary case review enhances patient outcomes (directly and indirectly) in both low- and high-volume services.
- Multidisciplinary review meetings strengthen both sequential and multidisciplinary clinic models of care.
- Factors that influence the establishment of multidisciplinary review meetings include:
 - clinical leadership willing to champion change
 - team commitment
 - building trust and communication
 - starting small and extending
 - organisational support
 - external triggers
 - a willingness to review and improve practice.
- A clear clinical agenda, good chairing, a commitment to team, learning and collaboration, the meeting venue and organisation all impact on the quality of the multidisciplinary decision making.
- Audit and other survey tools enable team members to review a range of working practices.

When the Program commenced, Program staff informally assessed that services within and across consortia were at different places on a continuum of best practice in multidisciplinary care.

Not unexpectedly or unreasonably, service providers mostly perceived their own services as offering best practice, however, this meant different things to different people.

Some service providers had little appreciation of the benefit of multidisciplinary care, with limited evidence of good sequential communication between providers.

For other service providers, in medium- to high-volume services and some working within a multidisciplinary clinic model of care, but with no established process of formal case discussion, there was a sense of ‘we know the clinical evidence’. In this instance, a multidisciplinary review meeting was seen to be redundant.

Still others with regular well-established multidisciplinary meetings also considered their services to be offering ‘best practice’.

There’s a bit of tendency to think you do it perfectly because we have been doing it for such a long time, we think how can we improve? ...but the audit tool has helped us to identify some areas where we can do better.

Clinician

