

## **SMICS MDT PILOT PROJECT**

**Project update: January 2010**

### ***Introduction***

The SMICS Multidisciplinary Team (MDT) Pilot Project was commenced in July 2008 as part of the larger Continuum of Care Project phases three and four. The project has been expanded to include further MDTs and has continued to enhance multidisciplinary care.

This report provides a summary of the improvements in multidisciplinary care through the continued efforts of MDT members and project staff from July to December 2009. This report should be read in conjunction with the *SMICS Continuum of Care Project: MDT Pilot Project Progress Report, August 2009<sup>1</sup>*.

### ***Project Objective***

To enhance existing MDTs and facilitate the establishment of new MDTs throughout the SMICS catchment to:

- improve multidisciplinary care and care coordination for cancer patients and their families, and
- build the capacity of health services to sustain multidisciplinary care in the future.

### ***Project Progress***

During the calendar year of 2009 the MDT Project Officers provided high level administrative support for 259 MDT meetings within the three public member health services. During the course of these meetings, MDT members discussed further investigations and treatment plans for 2216 patients with suspected or diagnosed cancer.

Health professional's recognition of the importance of and commitment to MDT treatment planning remains evident. The membership of MDTs has continued to grow over the course of the project and is reflected in meeting attendance registers. Expanded membership includes:

- nuclear medicine physician attending the Southern Health colorectal MDT
- pathologist attending the Southern Health lung MDT
- medical oncologist attending the Southern health thyroid MDT
- gastroenterology clinicians and increased surgical attendance at the Peninsula Health GI Colorectal MDT

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### Project expansion

Once MDT administration processes were established and embedded in the usual practice of participating teams, it has been possible to expand the project to include further interested MDTs. Table 1 provides a summary of the additional teams supported in each health service during the life of the project thus far, and those teams identified for involvement in the project in the coming months.

<b>Table 1</b>				
	Oct 2008 (Initial MDTs)	July 2009	Dec 2009	Preliminary scoping
Alfred Health	<ul style="list-style-type: none"> <li>• Lung</li> <li>• Genito-urinary</li> <li>• Head &amp; Neck</li> </ul>	<ul style="list-style-type: none"> <li>• Upper GI</li> </ul>	<ul style="list-style-type: none"> <li>• Breast</li> </ul>	<ul style="list-style-type: none"> <li>• Neuro</li> <li>• Colorectal</li> </ul>
Peninsula Health	<ul style="list-style-type: none"> <li>• Breast</li> <li>• Lung</li> <li>• Upper GI / Colorectal</li> </ul>			<ul style="list-style-type: none"> <li>• Genito-urinary</li> <li>• Gynae</li> <li>• Selected private MDTs</li> </ul>
Southern Health	<ul style="list-style-type: none"> <li>• Lung</li> <li>• Upper GI</li> <li>• Neurological (GBM)</li> </ul>	<ul style="list-style-type: none"> <li>• Gynae</li> <li>• Colorectal</li> </ul>	<ul style="list-style-type: none"> <li>• Neurological (Benign &amp; cerebral metastases)</li> </ul>	<ul style="list-style-type: none"> <li>• Head &amp; Neck</li> <li>• Thyroid</li> <li>• Liver</li> </ul>

### MDT minimum dataset and meeting documentation

The MDT minimum dataset developed in the early stages of the project continues to be utilised by the MDT project officers to prepare meeting documents by merging data into formatted word templates. The project officers have refined the dataset to meet the needs of MDTs which have recently been included in the project. Training and support has been provided where possible to existing administrative staff such as unit secretaries in the use of the data spreadsheets and merge functions. Additionally, at Peninsula Health an MDT database has been established in Microsoft Access format to support MDT administration.

### Documentation of MDT recommendations

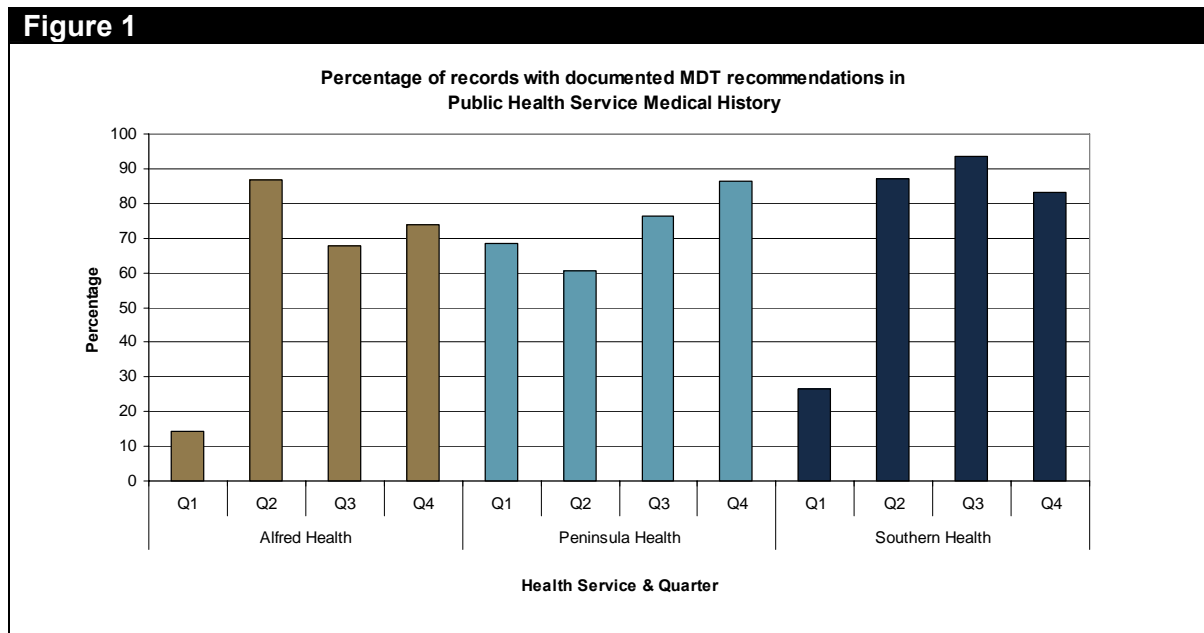
Victoria's Cancer Action Plan 2008-2011 (VCAP) outlines a medium-term vision for ongoing cancer reform that builds upon the work of the Integrated Cancer Services (ICS) that has been undertaken over the past four years. VCAP has provided additional impetus for both the ICS and cancer service providers to continue to improve the delivery of multidisciplinary care through stated measurable targets. Of particular significance to the MDT Pilot Project includes the target:

*'Increasing the number of newly diagnosed cancer patients that have a documented MDT care plan by 20 percent each year with the aim of achieving 80 percent documentation by 2012<sup>12</sup>.*

SMICS has not yet been able to contemporaneously identify the population of newly diagnosed cancer patients within its member health services. As such, within this report, it is not possible to quantify progress in the documentation rates for newly diagnosed patients alone, and thus progress against the stated VCAP target. Nonetheless considerable improvements have been seen in the rate of documentation for all patients whose case is presented at an MDT within SMICS member health services.

Figure 1 provides summary of progress made in the documentation of treatment recommendations in the medical records in the three public member health services during 2009. Participating teams in all health services have surpassed 80 percent documentation of those patients presented at MDTs. The apparent trend of declining documentation rates within Alfred Health in the second half of 2009 can be attributed to the inclusion of further MDTs in the project during this time period, where process changes to support documentation of discussions are continuing to be refined and implemented.

**Figure 1**



### Patient consent to MDT discussion

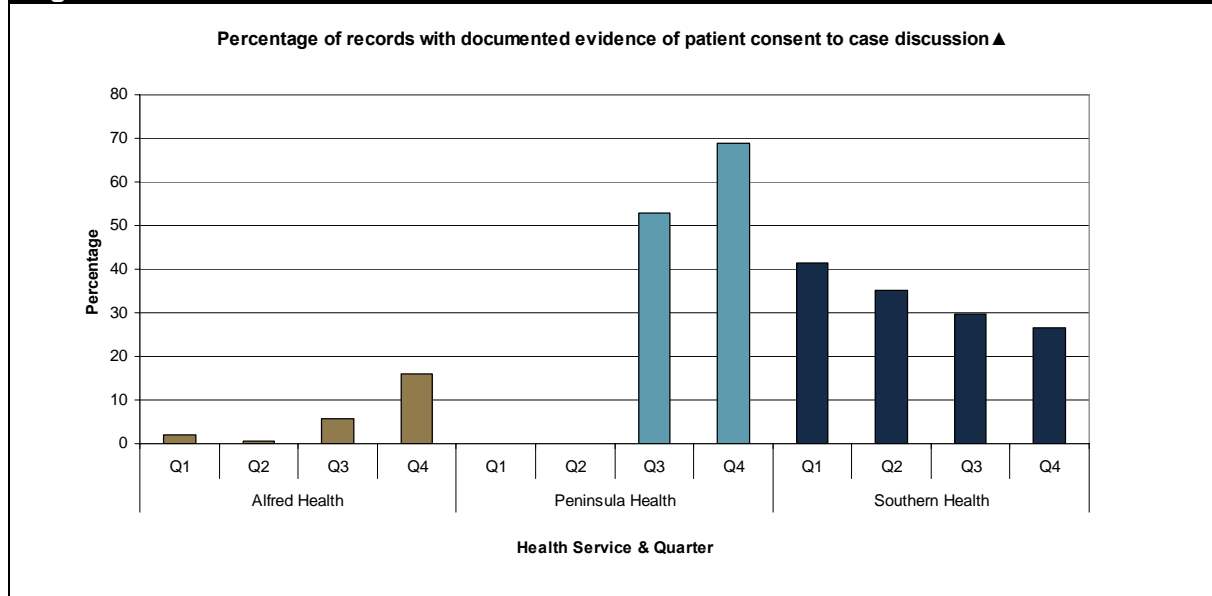
Department of Health policy specifies that patients must be informed of, and agree to their care being discussed by a multidisciplinary team<sup>3</sup>. Progress in the implementation of this policy, and other measures of multidisciplinary care, supportive care and care coordination, are tracked through the ICS audit.

Figure 2 provides a summary of progress in facilitating the documentation of patient consent to discussion within each health service over 2009. Marked improvement is noted in the documentation of consent within Peninsula Health in quarters three and four, with a documentation rate of 69% at year's end. Within Southern Health the overall number of cases discussed where consent has been documented has increased from 78 in quarter 1

A joint initiative of Alfred Health, Cabrini Health, Peninsula Health and Southern Health  
Connecting cancer care, driving best practice and improving patient outcomes

to 119 in quarter four. The apparent decline in proportion of documented consent can again be attributed to the inclusion of new Southern Health MDTs in the project in the latter part of 2009, where relationships with the MDT members are still developing and where meeting processes continue to be refined. Documentation of consent by Alfred Health MDTs has improved slowly, but requires further focus.

**Figure 2**



The MDT member survey conducted mid 2009 revealed the majority of MDT members inform their patients that their case will be discussed (47% always and 26% usually). MDT project officers also report that these survey results are commonly borne out during MDT discussions with members often indicating patients are aware of the meeting and are waiting to be informed the outcome of the discussion.

The project team however continue to encounter some resistance with regard to the documentation of patient consent to discussion of their case by an MDT. Those teams with improved rates of documenting consent to discussion continue to require frequent prompting from the project team to ensure this rate is maintained.

While the majority of clinicians have indicated they consider it important to keep patients informed of case discussions, there is considerable work yet to be done to improve and sustain the rate of documented consent. Barriers include:

- documentation of consent is considered to be less of a priority than that of clinical information and treatment recommendations
- where junior medical staff act as MDT scribes, senior medical staff leadership is required to ensure consent to discussion continues to be documented.

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### IT improvements and virtual meeting technology

Efficient MDT discussions rely on the ability of health professionals to view and review all relevant clinical information when formulating treatment recommendations. Of particular importance in determining disease type and progression are radiological and nuclear medicine investigations, and histopathology.

The following improvements have been made:

- the negotiation of access to diagnostic imaging investigations undertaken by MIA
- the review of IT equipment in MDT meeting venues within Southern Health
- the upgrade of equipment in the Academic Centre at Frankston Hospital
- streamlining timely referral processes at Peninsula Health through negotiating access to Pathology IP sample lists to identify positive cancer pathology
- several MDTs are completing the electronic management plans which are projected during the meeting, allowing all MDT members input into the wording of the documented recommendations.

Virtual meeting technology (VMT) continues to be used regularly by the gynae-oncology MDT based at Monash Medical Centre Moorabbin (MMCM) to link with health professionals based at Box Hill Hospital and Ballarat Hospital. The opportunity to collaborate across sites continues to be highly valued by Moorabbin based clinicians and remote participants.

VMT has been promoted widely to participating MDTs, however to date there has been only tentative interest from further MDTs in the technology. Table two provides summary of teams identified for potential use of VMT

Table 2		
Health service	Tumour stream	
Alfred Health	UGI	<ul style="list-style-type: none"> <li>• to facilitate discussions with clinicians based in Gippsland</li> </ul>
Peninsula Health	Gynae	<ul style="list-style-type: none"> <li>• registrar and pathologist to link with MMCM meeting</li> </ul>
	Lung	<ul style="list-style-type: none"> <li>• facilitate cardiothoracic surgeon and oncologist participation</li> </ul>
Southern Health	Colorectal	<ul style="list-style-type: none"> <li>• to facilitate participation of a remote hepato-biliary surgeon regarding the resection of liver metastases</li> </ul>
	Head & Neck	<ul style="list-style-type: none"> <li>• to facilitate participation of               <ul style="list-style-type: none"> <li>○ ENT surgeons at Clayton</li> <li>○ Maxillary - facial surgeons at Dandenong</li> <li>○ Radiation oncologist at East Melbourne</li> </ul> </li> </ul>

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### **GP involvement and communication of MDT recommendations**

A General Practitioner (GP) communication strategy was developed by the project team with input from the three GP Liaison units and adapted to meet the unique requirements of each health service and individual MDTs. Communication of MDT recommendations to the patients usual GP commenced with several teams in December 2009. GPs are provided with either a copy of the MDT discussion medical record form or a pro-forma letter which provides a summary of the recommendations.

Verbal feedback from MDT members indicates that the routine communication of cancer treatment recommendations to patients' own GPs as part of the project is highly valued. A survey will be distributed to GPs in tandem with the MDT correspondence during quarter 1 of 2010, in order to evaluate the usefulness of the information and to gauge GP interest in greater participation in MDT meetings via virtual meeting technology and other means.

### ***Future work***

The project team are working with the executive sponsors in each health service in order to ensure the progress achieved to date is sustained. Further detail regarding sustainability strategies for each health service will be detailed in the June 2010 report.

Additional issues which have been identified include:

- several MDTs have indicated the need for increasing the frequency of meetings to cope with the increasing number of cases being presented
- increased burden on diagnostic services (pathologists, radiologists and nuclear medicine physicians) and oncologists associated with the increased number of MDT meetings being held and the increasing number of cases being presented.
- access to meeting venues of appropriate size and with the necessary IT capability
- increased workload and equipment requirements for private pathology companies associated with providing slides for review at the meeting, or participating in the meeting

### ***Recommendations***

- That the SMICS Governance Committee and SMICS Tumour Groups note the progress in the MDT Pilot Project
- That SMICS investigates the issues regarding the development of dedicated MDT meeting venues
- That the impact of increased MDT activity on the workload of diagnostic services clinicians be discussed with health service senior management
- That the SMICS Cancer Information Analyst continues to work with Victorian Cancer Registry to contemporaneously identify newly diagnosed patients.

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<sup>1</sup> SMICS, (August 2009), Continuum of Care Project: MDT Pilot Project Progress Report

<sup>2</sup> Department of Human Services, (2008) *Victoria's Cancer Action Plan 2008-2011*, Victorian Government, Melbourne

<sup>3</sup> Department of Human Services, (2007) *Achieving best practice cancer care: A guide for implementing multidisciplinary care*, Victorian Government, Melbourne