

All about multidisciplinary care

Multidisciplinary care (MDC) is considered best practice in the treatment planning and care for patients with cancer. Cancer Australia is committed to improving the uptake of multidisciplinary cancer care using lessons learnt from a number of key national projects.

MDC is an integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and collaboratively develop an individual treatment and care plan for each patient. MDC involves all relevant health professionals discussing options and making joint decisions about treatment and supportive care plans, taking into account the personal preferences of the patient.

Based on the ['Principles of multidisciplinary care'](#), Cancer Australia has developed web-based practical tools to assist health professionals and health service administrators implement MDC at the local level.



Benefits of multidisciplinary care

The benefits of adopting a multidisciplinary care (MDC) team approach include:

For patients:

- increased survival for patients managed by a MDC team
- shorter timeframes from diagnosis to treatment
- greater likelihood of receiving care in accord with clinical practice guidelines, including psychosocial support
- increased access to information
- improved satisfaction with treatment and care.

For health professionals:

- improved patient care and outcomes through the development of an agreed treatment plan
- streamlined treatment pathways and reduction in duplication of services
- improved coordination of care
- educational opportunities for health professionals
- improved mental well-being of health professionals

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“The benefits have spread into all our activities... its made a complete difference to the whole specialist network in the hospital.”





Principles of multidisciplinary care

The 'Principles of multidisciplinary care' provides a flexible definition of MDC, allowing for variation in implementation according to cancer type and the location of service provision. The principles are designed to be relevant for all cancers, across a range of health-care settings. A summary of the 'Principles of multidisciplinary care' include:

- a [team approach](#), involving core disciplines integral to the provision of good care, including general practice, with input from other specialties as required
- [communication](#) among team members regarding treatment planning
- access to the [full therapeutic range](#) for all patients, regardless of geographical remoteness or size of institution
- provision of care in accordance with [nationally agreed standards](#)
- [involvement of patients](#) in decisions about their care.

Team

Principle of care		Outcome
a	The disciplines represented by the core team should minimally include surgery, oncology (radiation and medical oncology), pathology, radiology and supportive care. The individual patient's general practitioner will be part of the team	The core team is established and known
b	In order to ensure that the patient has access to the full range of therapeutic options, the core team may be expanded or contracted to include services (may be off site), such as genetics, psychiatry, physiotherapy and nuclear medicine	Referral networks established for non-core team specialist services

Communication

Principle of care		Outcome
a	A communications framework should be established which supports and ensures interactive participation from all relevant team members at regular and dedicated case conference meetings	Communication mechanisms are established to facilitate case discussion by all team members
b	Multidisciplinary input should be considered for all patients with cancer, however, not all cases may ultimately necessitate team discussion	A local protocol is established for deciding which cases may not require team discussion





Principle of care	Outcome
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Full therapeutic range

Principle of care	Outcome
a Geographical remoteness and/or small size of the institution delivering care should not be impediments to the delivery of multidisciplinary care for patients with cancer	Systems are established for ensuring that all patients have access to all relevant services
b The members of the team should support the multidisciplinary approach to care by establishing collaborative working links	Systems are established to support collaborative working links between team members

Standards of care

Principle of care	Outcome
a All clinicians involved in the management of patients with cancer should practice in accord with guideline recommendations	Local clinician data is consistent with national benchmarks
b The treatment plan for a patient should consider individual patient circumstances and wishes	The final treatment plan is acceptable to the patient, where possible
c Discussion and decisions about treatment options should only be considered when all relevant patient results and information are available	Final reports are available to all core team members before treatment planning
d In areas where the number of new cancers is small, formal collaborative links with larger units/centres should give support and foster expertise in the smaller unit	Systems are established for the exchange of knowledge and expertise between larger and smaller caseload centres
e Maintenance of standards of best practice is supported by a number of activities which promote professional development	Systems are established for the support of professional education activities

Involvement of the patient

Principle of care	Outcome
a Patients with cancer should be encouraged to participate as members of the multidisciplinary team in treatment planning	Patients are supported to have as much input into their treatment plan as they wish





Principle of care		Outcome
b	The patient diagnosed with cancer should be fully informed of his/her treatment options as well as the benefits, risks and possible complications of treatments offered. Appropriate literature should be offered to assist his/her decision making. This information should be made available to the patient in a form that is appropriate to his/her educational level, language and culture	All patients are fully informed about all aspects of their treatment choices
c	Supportive care is an integral part of multidisciplinary care. Clinicians who treat patients with cancer should inform them of how to access appropriate support services	All clinicians involved in the management of patients with cancer ensure that patients have information about and access to support services
d	The patient with cancer should be aware of the ongoing collaboration and communication between members of the multidisciplinary team about his/her treatment	Patients with cancer feel that their care is coordinated and not fragmented

For more information:

- [View checklist for 'Principles of multidisciplinary care'](#)



The multidisciplinary care team

The multidisciplinary care (MDC) team should comprise the core disciplines integral to the provision of good care. [Team membership](#) will vary according to cancer type but should reflect both clinical and psychosocial aspects of care and the patient's general practitioner. When considering the treatment and care of Aboriginal and Torres Strait Islander patients, it is essential that the team includes an expert in providing culturally appropriate care to this population.

The general practitioner (GP) may play a number of roles in all stages of the disease process, including diagnosis, referral, treatment, coordination, and continuity of care as well as provision of information and support to the patient and his/her family.

While it may not be possible for general practitioners to attend multidisciplinary care team meetings on a regular basis, it is essential that the GP is kept informed in a timely manner about treatment decisions.

Geographical remoteness and/or small size of the institution delivering care should not be impediments to the delivery of MDC nor to access to services. Systems should be established to support collaborative working links between team members. It is important that referral links with remote services are established and can be drawn upon as required.

An effective team approach to care ensures smooth transitions for the patient along the continuum of care. Changes to the team should be communicated to the patient and MDC team members at a time which is appropriate to all. Providing appropriate information to the patient will improve patient understanding about their disease and assist with continuity of care throughout the patient's cancer journey.

Examples of team membership

- [Treatment planning: breast cancer](#)
- [Treatment planning: lung cancer](#)
- [Case study: Setting-up a team](#)

Coordination of multidisciplinary care

The MDC team should designate an agreed point of contact. The agreed point of contact may be fulfilled by a nurse or other supportive care personnel. The team should consider who within their team can fulfil this role, if a designated person is not already in place. The role of this person will be to coordinate administrative aspects of the patient's care, which may include:

- ensuring effective communication between team members, other health professionals and the patient and caregivers
- providing information and referral to services and programs to the patient and caregivers
- providing follow-up and support for the patient and caregivers
- providing written information and resources



A lead health professional may also be designated to liaise with the patient and their caregivers, where appropriate, regarding treatment and care planning.



"The MDC meeting certainly became much more efficient once the breast care nurse came in."

Establishing a team identity

Practical examples of how to promote team identity may include

- developing a team name and agreed values that reflects the teams function
- establishing a [communications framework](#) to support the team and ensures participation from all relevant team members at regular and dedicated case conference meetings
- agreeing on the purpose of the meetings
- displaying posters identifying team members in public areas
- developing a team identifier such as a logo and letterhead (taking account of local protocols regarding the use of logos)
- providing regular team updates via email or a 'bulletin board' for team communication.

[See also - Case study: establishing a team identity](#)

A communications framework

A communications framework should be developed which encourages and supports input into case discussion from all relevant team members. The framework may vary depending on the type and size of service and should acknowledge diversity and flexibility in the way that case discussion is conducted. Seamless care involves effective and timely communication between all health professionals including the patient's GP. For example, informing the patient's GP about discussion and treatment outcomes prior to patient contact will ensure that the GP provides the patient with accurate, relevant and up-to-date information about their treatment and care.

Multidisciplinary care team meeting

Regular team meetings are an integral component of MDC. A central theme of meetings should be prospective treatment planning.

Once the team is established it may be appropriate to hold meetings outside the usual MDC treatment planning meetings to discuss specific topics of interest or for professional development. Using the meetings as an educational and information-sharing opportunity, as well as for treatment planning, can help both to encourage attendance and ensure sustained interest.



See also a recommended [Multidisciplinary care meeting – attendance register form \(DOC 40 KB\)](#).







Examples of multidisciplinary care teams

In considering the composition of the multidisciplinary care team, ensure the team includes an expert in providing culturally appropriate care for Aboriginal and Torres Strait Islander people.

Multidisciplinary care team membership for treatment planning: breast cancer

Core team members	Non-core team members
<ul style="list-style-type: none"> • Surgery • Medical oncology • Radiation oncology • Pathology • Radiology • Supportive care – oncology nurse/breast care nurse • General practice 	<ul style="list-style-type: none"> • Genetic/hereditary counselling • Physiotherapy • Psychiatry/Psychology • Nuclear medicine • Plastic surgery • Palliative care • Social work

Multidisciplinary care team membership for treatment planning: lung cancer

Core team members	Non-core team members
<ul style="list-style-type: none"> • Respiratory Medicine • Thoracic Surgery • Medical Oncology • Radiation Oncology • Pathology • Radiology • Nurse Specialist • Palliative care 	<ul style="list-style-type: none"> • Nuclear medicine • Social work • Physiotherapy • Psychiatry/Psychology • Dietetics • Occupational Therapy

Multidisciplinary care team membership: advanced disease





Allied health professionals	Clinicians
<ul style="list-style-type: none"> • Counsellor • Dietitian • Occupational therapist • Pharmacist • Physiotherapist • Psychologist • Social worker • Sexual health counsellor 	<ul style="list-style-type: none"> • General practitioner • Gynaecological oncologist • Medical oncologist • Palliative care physician • Pathologist • Physician • Psychiatrist • Radiation oncologist • Radiologist • Registrars • Surgeon • Urologist

Community health	Palliative and supportive care
<ul style="list-style-type: none"> • Community health nurse • Community palliative care team 	<ul style="list-style-type: none"> • Palliative care coordinator • Palliative care clinical nurse consultant • Pastoral care

Other health professionals	Nursing
<ul style="list-style-type: none"> • Care coordinator • Clinical trials coordinator 	<ul style="list-style-type: none"> • Research nurse • Specialist breast nurse • Specialist gynaecological nurse

Multidisciplinary care team membership: advanced breast cancer

Allied health professionals	Clinicians
<ul style="list-style-type: none"> • Counsellor • Dietitian • Occupational therapist • Pharmacist • Physiotherapist • Psychologist • Social work • Sexual health counsellor 	<ul style="list-style-type: none"> • General practitioner • Medical and radiation oncology registrars • Medical oncologist • Pathologist • Psychiatrist • Radiation oncologist • Surgeon





Allied health professionals	Clinicians
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Community health	Palliative and supportive care
<ul style="list-style-type: none"> • Community health nurse • Community palliative care team 	<ul style="list-style-type: none"> • Palliative care coordinator • Palliative care clinical nurse consultant • Palliative care physician • Pastoral care

Other health professionals	Nursing
<ul style="list-style-type: none"> • Advanced breast cancer team coordinator • Occupational therapist • Physiotherapist 	<ul style="list-style-type: none"> • Breast care nurse for advanced breast cancer • Chemotherapy nurse • Inpatient oncology nurse • Research nurse

Multidisciplinary care team membership: advanced ovarian cancer

Allied health professionals	Clinicians
<ul style="list-style-type: none"> • Counsellor • Dietitian • Occupational therapist • Pharmacist • Physiotherapist • Psychologist • Social worker • Sexual health counsellor 	<ul style="list-style-type: none"> • General practitioner • Gynaecological oncologist • Medical oncologist • Pathologist • Psychiatrist • Radiation oncologist • Surgeon

Community health	Palliative and supportive care
<ul style="list-style-type: none"> • Community palliative care team • Community health nurse 	<ul style="list-style-type: none"> • Palliative care consultant/nurse • Pastoral care or religious representative





Other health professionals	Nursing
<ul style="list-style-type: none">• Occupational therapist• Physiotherapist	<ul style="list-style-type: none">• Chemotherapy nurse• Gynaecological nurse specialist• Research nurse





Planning a multidisciplinary care meeting

Setting-up a new meeting

When establishing regular MDC meetings for a new team, it is important to gain consensus from all team members on:

- the team responsibilities
- meeting aims and frequencies
- local protocols for issues such as decision making, documentation processes, providing feedback about meeting outcomes, confidentiality and consent.

The planning phase may involve several meetings between team members and should be facilitated by a respected peer. Emphasise on the benefits of the multidisciplinary process will encourage participation. If possible, hold initial planning meetings at a time that is likely to be used for future treatment planning meetings to promote familiarity of timing amongst the team.

Planning meetings can be used to assess current strengths and achievements of the hospital/department as well as to identify areas for improvement or development. If a number of areas for development are identified, it may be necessary to prioritise these, with the aim of working on only one or two at one time.

[See also - Case study: Setting up a multidisciplinary care team meeting](#)

[See also - Team contact list \(DOC 34 KB\)](#)

Team leadership and coordination

Team leadership is a key aspect contributing to successful and sustainable MDC meetings. Leadership and coordination may take a number of forms:

- a 'champion' who drives initiatives and is integral in gaining and maintaining support for the meetings; this role is particularly important during the early stages of a team's formation
- a meeting chair who facilitates discussions during team meetings
- a meeting coordinator who coordinates the logistics for meetings.

These roles require energy, enthusiasm, and an ability to communicate with, and gain input from, other team members. Each role may be undertaken by one or more individuals or multiple roles may be fulfilled by one individual.

Once the roles are allocated it is important that role definition is agreed upon at the outset and that other team members are aware of which team member is responsible for which aspects of meeting organisation



and coordination. It is also important to have agreed team members to act as 'back-up' for these roles if the primary contact is not available.

“ (the champion) has strong links with all people in the team... she's one of these enthusiastic people that every team needs...”

Meeting coordinator

The meeting coordinator role is to:

- organise meetings
- identify patients for discussion during the meetings
- collate information and ensures availability of relevant information sources for presentation at meetings
- record outcomes of case conference discussions
- inform the treating clinician and/or the patient's general practitioner of the meeting outcomes

The role of the meeting coordinator can be undertaken by an administrative personnel, an oncology nurse, data manager, or registrar. At larger centres, registrars may take responsibility for coordinating meetings on an alternating basis. Regardless of who fulfils this role it is important that all team members are aware of who is undertaking the role and that a back-up is available in situations where the primary coordinator is unavailable.

Timing of meetings

Meetings should be held at the same time and place to maintain routine, avoid confusion and facilitate [sustainability of MDC](#). The duration of MDC meetings will be determined by the size of the institution and the number of cases requiring discussion. In general it will be appropriate to limit the meetings to 45–90 minutes. Any time not used for treatment planning may be used for educational purposes or discussion of other relevant issues. Meetings should be held at a time convenient for all attendees and planned to take account of attendance by off-site personnel.

Venue and resources

Generally, hospital meeting rooms can be used as venues for MDC meetings. Venues should have:

- sufficient space for all participants
- access to power points for use of projectors and light boxes
- a 'round table' format.





When setting up new meetings, consider sharing equipment with other departments or groups to minimise costs. Provision of refreshments at meetings can be important, particularly if meetings are held outside normal working hours, during breakfast or lunchtimes or towards the end of the working day.

[See also - Checklist of suggested meeting resources \(DOC 30KB\)](#)

Involving the patient's general practitioner

Communication links with the patient's GP and the MDC team are crucial and should be maintained throughout the cancer journey. The GP of patients due to be discussed at an MDC meeting should be informed of the meeting and encouraged to attend in person or via teleconference. If the GP is unable to attend, a member of the team should communicate treatment decisions to the GP in a timely manner.

[See also - Case study: involving general practitioners](#)

Involving off-site attendees

It will not always be possible for all team members to be present at one site. In regional sites, it may be appropriate to plan meetings at times when a visiting specialist is due to be present. For other sites, issues of distance may be overcome using teleconferencing or videoconferencing.

Considerations when involving off-site attendees include:

- ensure off-site attendees have access to the same information as on-site attendees including access to slides, scans and other information that will be presented at the meeting
- encourage off-site attendees to contribute to discussions
- all team members are aware of teleconference and videoconference protocols.



“We built a lot of trust across the private-public interface – before it was a barrier, and now it is an interface...”

[See also - Case study: implementing teleconferencing](#)

Deciding which patients to discuss

All patients with a newly diagnosed cancer should be discussed by the multidisciplinary team. The level of discussion may vary depending on both clinical and psychosocial factors. Some cases may only require brief discussion while others will require more detailed review and comment. There may also be a need to review



existing treatment plans for patients who have been discussed previously. Local protocols to guide the decision-making process should be agreed by the team.

Information sources

Good preparation of materials and information in advance of multidisciplinary meetings is essential. The types of materials and information required at a meeting will vary according to tumour type but are likely to include:

- all relevant medical history details
- pathology reports and slides
- imaging films and scans
- results of diagnostic examinations
- blood test results
- previous treatment plans, if relevant.

The patient's medical history and diagnostic results can take the form of a 'patient summary' prepared prior to the meeting and disseminated to all team members. This task may be assigned to one of many team members, including registrars. Information about the patient's concerns, preferences and social circumstances should also be presented at the meeting, for example by the oncology nurse (or care coordinator if available) or by the treating physician. It is also appropriate to have access to relevant clinical practice guidelines and other evidence-based information at the meetings.

Collection of relevant information in advance and presentation of results is a task that can be designated, for example, to one or more surgical registrars who regularly attend the meetings. Alternatively, individual clinicians can take responsibility for bringing relevant information to the meetings regarding their own patients. Whichever system is chosen, it is important that the team agrees upon the designated responsibilities from the outset and that back-up plans are in place in case of non-attendance.

[See also - Register of information source providers \(DOC 30 KB\)](#)

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"We've seen a transition from the presentation of 'a case of breast cancer' with a lot of technical detail, to the presentation of 'a woman with breast cancer', with background details about who this woman is, what's going on in her life, what her desires might be, and how that might impact on decision-making ..."

After the meeting

It is important that systems are in place to promptly inform team members who were not able to attend the meeting about outcomes, such as the patient's general practitioner or referring clinician.



Follow-up with the general practitioner should be via letter and may also include a telephone call or a follow-up meeting with the general practitioner. It is also vital to ensure that responsibility is allocated to a specific individual to ensure that the outcomes of the meeting are conveyed to the patient's GP.

See also:

- [GP notification letter template \(DOC 28 KB\)](#)
- [Checklist for planning a MDC meeting – pre-meeting \(DOC 35 KB\)](#)



Case Studies - Planning a meeting

Case study: setting up a team

Challenge

To establish a multidisciplinary care (MDC) treatment planning meeting for the management of breast cancer in a rural/regional area consisting of one large regional centre with one public and two private hospitals, and a number of smaller rural hospitals covered by four main health services.

A number of barriers and obstacles were faced in setting up the team. The majority of stakeholders voiced concerns about the time that would be required to attend MDC meetings and the impact this may have on their clinical practice.

Clinicians were also concerned about breaches of privacy with patients being discussed in a team environment.

In the regional/rural setting, most clinicians work in both the public and private sector. Those with a significant private practice were unwilling to present patients at a meeting held in the public health service. Rural clinicians also identified the lack of oncologists at MDC meetings in rural areas and the need to have linkage to the larger regional centre.

Solution

Establishment of MDC across a large regional and rural area required face-to-face consultation with stakeholders in all sectors, discipline groups and health services. Meetings provided information about MDC and, in particular, the advantages for clinicians and patients and the opportunity to discuss issues and look at the way forward. Within the health services, the executive team was invited to planning meetings to seek support for the necessary changes.

As a result of the consultation, many clinicians recognised that the development of MDC represented best practice and subsequently met to attempt to overcome the obstacles.

Within six months the regional MDC team was meeting on a weekly basis and prospective treatment planning was established. The clinicians were initially concerned about the time commitment, but quickly recognised that most discussion took place at meetings, thus reducing the need for telephone calls and communication at other times.

To overcome clinician concern about discussing private patients in the public sector, an agreement was reached to meet at one of the private hospitals and to date the team has continued with this practice.





Team members have realised that benefit could be gained by videoconferencing to the rural areas and initial discussions have taken place to plan this strategy.

Outcome

Weekly meetings are held to prospectively plan treatment and care for women diagnosed with early, advanced and recurrent breast disease. On average, 22 health care professionals attend the meetings, but there are often 28–30 attendees. The core team consists of one or more pathologists, radiologists, surgeons, medical oncologists, and radiation oncologists, along with general practitioners, breast care nurses and social workers. One rural area has commenced videoconference linkage to the regional hospital, which is the main cancer referral centre, to ensure oncology input to treatment planning.

Case study: involving general practitioners

Challenge

Involving general practitioners in MDC.

Solution

To ensure that GPs participated in the planning phase, with a view to their participation in MDC meetings, focus groups were held at clinics in the regional area and through the Division of General Practice in two rural health services. Attendance at these meetings was impressive and though the attendees identified many obstacles to attendance at MDC meetings, they were enthusiastic about participating.

Outcome

GPs routinely attend the MDC meeting in the regional centre and on many occasions in the rural centres. The relevant Division of General Practice is notified of the name of the GPs who are to have patients discussed that week and through this mechanism, GPs are invited to the meeting. The liaison GP from the Division of General Practice attends the majority of meetings and is able to convey information about treatment planning to those GPs unable to attend the meeting.



Case study: establishing a team identity

Challenge

The need to develop an identifiable team and strengthen links between members was identified.

Solution

Diagrammatic representations of clinical management pathways were developed for each hospital site and posters summarising these pathways, including photographs of team members, were displayed in relevant waiting areas. Meetings with all clinicians from across the Collaboration were held early during the set-up phase to emphasise the benefits of a MDC approach and promote the use of the clinical management pathway. A logo was developed specifically for the Collaboration and used on letterhead distributed to all relevant facilities in the region during the implementation of strategies.

Outcome

Promotion of the team through the clinical management pathways and Collaboration logo strengthen the team identity and brought awareness to MDC for both clinicians and patients.



Running a multidisciplinary care meeting

Role of the Chair

Good leadership and facilitation are key factors in the success of multidisciplinary care meetings. The Chair does not have to be the same person in every meeting, as long as the leadership and facilitation roles are fulfilled. The role may be shared between several team members. The Chair should be aware of the need for strong leadership. It is important to recognise that this does not equate to dominance of clinical decision-making. Rather, the Chair's role is to facilitate participation by all members of the multidisciplinary team in clinical discussions and decision making, and to ensure that meetings are not dominated by a few clinicians.

It is the role of the Chair to:

- keep meetings to the agenda
- commence discussions
- prompt the full range of input into discussions
- summarise the discussion and invite any further input before moving to the next case
- negotiate resolution of conflict if necessary
- promote mutual professional respect among all team members.

Managing group dynamics

Mutual respect and positive group dynamics are important factors in effective MDC meetings. Participant's input into discussions should be valued and respected by the other participants. To promote positive group dynamics and understanding of team roles and role boundaries it may be beneficial to:

- clarify role perceptions and expectations of each other
- identify your own and other professionals' competencies
- explore overlapping responsibilities
- re-negotiate role assignments.

Communication skills training

Effective communication between health professionals is vital but may be challenging with an expanded team of professionals. For MDC teams to be effective, all members must communicate effectively with one another.

The way a clinician and the treatment team relate to, and communicates with, a patient can significantly benefit the patient and their family. Benefits may include improvements in psychosocial adjustment, decision-making, treatment compliance and satisfaction with care.





A range of [Communication skills training](#) modules have been developed for health professionals about how best to address issues with patients and improve communication within multidisciplinary care teams.

Treatment planning

It is important for teams to establish a process for communicating case discussion outcomes and recommendations to the patient and their GP. The treatment and care plan should be formal, in writing, and consider the full range of treatment and care options available to the patient, while taking into account the patient's preferences.

Where possible, written care plans should be made available to the patient. In addition, patients' access to a second opinion outside the initial team should be respected and facilitated.

Re-evaluating treatment and care plans should be done at critical points during the course of disease including diagnosis, change in treatment, recurrence, or at the end of active treatment. It is essential that treatment and care plans are assessed regularly because many changes will occur during the course of the patient's disease. Any changes made to the patient's treatment plan should be discussed with the patient and documented.

[See also - Generic treatment plan template](#)

A number of steps have been identified to assist the MDC team in effective decision making when developing the treatment plan:

- clarify roles and involvement by relevant MDC team members in the decision-making process
- ensure sufficient and relevant data are presented about the diagnosis through the use of a synoptic report that provides a summary of the essential diagnostic information
- consider all relevant treatment options
- consider psychosocial status and support needs
- identify responsibilities for actioning and communicating the agreed treatment plan.

Documentation

Common documentation processes that suit all team members should be established. Teams may consider using a grid where details from the meeting are filled in by all team members. Documentation can also support accreditation activities at the local level. Regular recording of attendance, frequency of meetings and decisions made, provides a record of the multidisciplinary process. Associated clinical audit processes can also assist in the collection of clinical indicator data for the purpose of quality improvement.

[See also - Checklist for running a team meeting](#)

Reviewing multidisciplinary care team process



Each MDC team should establish a process to review and audit team functionality. Team functionality refers to how members of the team work together, how the MDC meetings are set-up and sustained and how team members support each other. Reviewing functionality can include how meetings are organised, the purpose of the meeting, team membership, attendance, communication among team members, patients and caregivers, and meeting outcomes. Auditing team functionality is an ongoing process which aims to ensure that the team is working in an effective way and there is optimal team interaction.



Information about MBS items for multidisciplinary cancer care

On 1 November 2006, two Medicare Benefit Schedule items were introduced providing rebates for participation by medical practitioners in multidisciplinary treatment planning meetings for cancer patients.

Who can claim the items?

Item 871 can be claimed by a medical practitioner from any area of medical practice (defined in the item descriptor as a specialist, consultant physician or general practitioner) who is leading and coordinating a multidisciplinary case conference to develop a multidisciplinary treatment plan for a patient with cancer. The lead practitioner is responsible for ensuring that records of the meeting are kept and that the patient is informed of the outcomes from the meeting

Item 872 can be claimed by a medical practitioner from any area of medical practice (defined in the item descriptor as a specialist, consultant physician or general practitioner) who is participating in a multidisciplinary case conference to develop a multidisciplinary treatment plan for a patient with cancer.

Only **treating medical practitioners** can claim the items – that is those who have treated or provided a formal diagnosis of the patient’s cancer in the past 12 months or expect to do so within the next 12 months.

Under this definition, a ‘treating medical practitioner’ would include the pathologist or radiologist who provided a formal diagnosis of the patient’s cancer prior to the meeting, or a radiation oncologist who will prescribe radiotherapy for the patient but does not expect to have contact with the patient until some months after the meeting.

Non-treating clinicians, allied health providers and support staff are not eligible to claim the item. This includes doctors who may provide an opinion in the meeting but who are not members of the patient’s treatment team.

Under this definition, a surgeon who provides an opinion in the meeting but who will not be operating on the patient would not be eligible to claim the item.

Other relevant MBS items

Items 721 to 732: [multidisciplinary care plans](#) (medical practitioner other than specialist or consultant physician)

For more information go



to: <http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>



Frequently asked questions about MBS items 871 and 872

What meetings do the items apply to?

The items apply to discussions during a multidisciplinary team meeting held for the purpose of developing a cancer treatment plan. The items should not be billed against community or discharge case conferences. Meetings may be face-to-face or held via teleconference or videoconference.

What is the minimum number of practitioners who should be involved in the meeting?

The multidisciplinary meeting must involve at least four medical practitioners (including the lead practitioner). Participants must be from different areas of medical practice and may include general practice. Allied health practitioners must also be present.

How many people can claim the item for one patient?

Only one medical practitioner can claim item 871 for each patient discussed at the multidisciplinary case conference. There is no limit to the number of treating medical practitioners who can claim item 872 for each patient discussed.

How many patients can be claimed for at one meeting?

There is no limit to the number of patients who can be discussed during a multidisciplinary meeting. However, discussion about each patient discussed at the multidisciplinary meeting should last at least 10 minutes.

Which patients do the items apply to?

The items apply to private patients being treated in public or private hospitals or in the community who have a malignancy of a solid organ or tissue, or a systemic cancer such as a leukaemia or a lymphoma. The items do not apply to patients whose only cancer is a non-melanoma skin cancer.

How many times can a patient be billed?





In general it is expected that a patient will be discussed at no more than two case conferences each year. Therefore it is unlikely that an individual patient would be billed more than twice in one year.

What is the schedule fee?

- The schedule fee for item 871 is \$80.30 per patient
- The schedule fee for item 872 is \$37.40 per patient

How should the patient be billed?

For a patient to be billed by the lead and participating medical practitioners, the patient must understand that the meeting will take place and which practitioners will be billing them (see [Gaining patient consent](#)).

Each billing practitioner should send a separate bill to the patient unless the patient signs a Medicare form for bulk billing. Medicare forms cannot be signed until after the multidisciplinary meeting has taken place and the other requirements included in the item descriptor have been met. If the post-conference discussion is conducted with the patient by telephone, the lead practitioner or designate will need to arrange for the patient to visit the hospital and sign the form. If this is not possible due to issues of distance, it is the responsibility of the lead practitioner to make arrangements with the patient to sign the form.



Gaining patient consent for billing

It is the responsibility of each billing practitioner to ensure that the patient is informed that a charge will be incurred for the multidisciplinary meeting. This task may be delegated to one member of the team representing all billing practitioners. Regardless of who gains consent the explanation should include:

- explaining to the patient the nature of the multidisciplinary meeting and asking the patient whether he or she agrees to the meeting taking place
- informing the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers
- providing an opportunity for the patient to specify what medical and personal information he or she does not want to be conveyed to the other members of the multidisciplinary care team
- informing the patient that he or she will incur a charge for the service provided by the practitioner(s) for which a Medicare rebate will be payable
- informing the patient of any additional costs he or she will incur.

If consent is delegated to a member of the treatment team who is not a billing practitioner, and if the patient identifies information he or she does not wish to share with some or all members of the multidisciplinary team, the lead practitioner should be informed accordingly.

See also - [Keeping the patient informed](#)





Keeping the patient informed

Explaining the concept of multidisciplinary care

Explaining the concept of the 'MDC team approach' is an important part of introducing MDC to the patient. This is usually done by the lead health professional. All patients should be informed about the members of their MDC team, what and how information is shared between team members, and the treatment plan.

It is important to explain to the patient how the meetings work, the meeting structure, whether or not patient names are used in the meeting and issues relating to confidentiality.

Whilst the '[Principles of multidisciplinary care](#)' emphasise the importance of involving the patient in discussion about the treatment plan, the patient does not have to be in attendance at the treatment planning meeting itself. More important is the need to have protocols in place to ensure that patient preferences are considered in developing the plan and that the outcomes of the meeting are discussed with the patient who agrees the final treatment plan.

All patients should be provided with written information about the members of their MDC team, what and how information is shared between team members and the treatment plan. This can be achieved through the development of:

- a brochure explaining the full range of health professionals involved in the patient's care
- a map of possible care pathways
- a photo of team members or list of names
- a prompt sheet for patients to assist them in obtaining all information during consultation with other health professionals.

[See also - MDC information sheet \(DOC 33KB\)](#)

Communicating meeting outcomes with the patient

Having relevant information available to the patient not only helps the patient understand the disease, but also helps with decision-making and coping with the diagnosis. As health professionals, it is important to elicit the information needs of patients, as these may not always be forthcoming. This includes information related to the nature of the disease, cancer treatments and care options, side-effects of treatments, impact on daily life, and patients' and caregivers' psychosocial concerns.

The availability of information in different languages can improve health professionals' ability to effectively communicate with patients and their caregivers from culturally and linguistically diverse backgrounds. Information regarding the use of interpreters should be provided to patients and caregivers, if needed. If an interpreter is required, health professionals should explain that family members and friends are not



appropriate translators, as they may not understand medical terminology and may have their own reactions and issues to deal with. A professional interpreter should be used.

Consent

The patient should be informed that treatment and care planning by the MDC team is part of their care and that their case may be discussed with health professionals whom they have not yet met. Consent from patients should be obtained in-line with local protocols regarding consent for the disclosure and use of personal information in the health environment. It is important to identify the level and type of consent required; for example, who is responsible for obtaining consent and ensuring all team members are aware of consent requirements.

[See also - Checklist for communication with the patient \(DOC 35 KB\)](#)



Making multidisciplinary care work

Managing change

The success of strategies to implement or improve MDC will depend on the willingness of team members to change established processes and adopt new working practices. This process will be facilitated by ensuring that team members have an understanding of the benefits of the new processes being implemented.

It may be valuable to seek assistance from other groups who have already established regular meetings, with the aim of providing practical advice about overcoming particular barriers. Setting milestones as a team and reviewing progress at intervals will also ensure ongoing engagement in the process by team members. Ultimately the goal will be to embed the culture of MDC into everyday practice so that meetings become habitual and team decision making occurs as a matter of course.

Sustainability

The following factors will ensure sustainability of MDC:

- allocating dedicated funds and personnel to maintain, support and improve MDC strategies
- ensuring MDC case conference meetings are held routinely, so that meeting preparation and participation become habitual for participants
- encouraging commitment to participation in MDC case conference meetings by participants through demonstration of benefits
- enlisting a 'champion' to drive the MDC strategies, particularly in the early stages
- developing contingency plans to allow for changes in personnel and organisational structure
- support from senior health administrators for MDC.



Tools / templates

Templates to guide MDC development are available below, including practical advice for health professionals and health service administrators about how to implement MDC at the local level. Please download these sample word templates and tailor them to suit your meeting requirements.

Planning a multidisciplinary care team meeting

[Checklist for 'Principles of multidisciplinary care' \(DOC 33 KB\)](#)

[Team contact list \(DOC 34 KB\)](#)

[Checklist for suggested meeting resources \(DOC 29 KB\)](#)

[Register of information source providers \(DOC 30KB\)](#)

[Checklist for planning a Multidisciplinary care meeting \(DOC 35 KB\)](#)

Running a multidisciplinary care team meeting

[Checklist for running a team meeting \(DOC 32 KB\)](#)

[Checklist for communicating with the patient \(DOC 35KB\)](#)

[Generic treatment plan proforma \(DOC 34 KB\)](#)

[General practitioner notification \(DOC 28KB\)](#)

[Multidisciplinary care team meeting - attendance register \(DOC 40KB\)](#)

[Multidisciplinary cancer care team information sheet \(DOC 33 KB\)](#)



Multidisciplinary care case studies

Case study: setting up a multidisciplinary care team meeting

Challenge

To establish a multidisciplinary care (MDC) treatment planning meeting for the management of breast cancer in a rural/regional area consisting of one large regional centre with one public and two private hospitals, and a number of smaller rural hospitals covered by four main health services.

A number of barriers and obstacles were faced in setting up the team. The majority of stakeholders voiced concerns about the time that would be required to attend MDC meetings and the impact this may have on their clinical practice.

Clinicians were also concerned about breaches of privacy with patients being discussed in a team environment.

In the regional/rural setting, most clinicians work in both the public and private sector. Those with a significant private practice were unwilling to present patients at a meeting held in the public health service. Rural clinicians also identified the lack of oncologists at MDC meetings in rural areas and the need to have linkage to the larger regional centre.

Solution

Establishment of MDC across a large regional and rural area required face-to-face consultation with stakeholders in all sectors, discipline groups and health services. Meetings provided information about MDC and, in particular, the advantages for clinicians and patients and the opportunity to discuss issues and look at the way forward. Within the health services, the executive team was invited to planning meetings to seek support for the necessary changes.

As a result of the consultation, many clinicians recognised that the development of MDC represented best practice and subsequently met to attempt to overcome the obstacles.

Within six months the regional MDC team was meeting on a weekly basis and prospective treatment planning was established. The clinicians were initially concerned about the time commitment, but quickly recognised that most discussion took place at meetings, thus reducing the need for telephone calls and communication at other times.

To overcome clinician concern about discussing private patients in the public sector, an agreement was reached to meet at one of the private hospitals and to date the team has continued with this practice.



Team members have realised that benefit could be gained by videoconferencing to the rural areas and initial discussions have taken place to plan this strategy.

Outcome

Weekly meetings are held to prospectively plan treatment and care for women diagnosed with early, advanced and recurrent breast disease. On average, 22 health care professionals attend the meetings, but there are often 28–30 attendees. The core team consists of one or more pathologists, radiologists, surgeons, medical oncologists, and radiation oncologists, along with general practitioners, breast care nurses and social workers. One rural area has commenced videoconference linkage to the regional hospital, which is the main cancer referral centre, to ensure oncology input to treatment planning.

Case study: involving general practitioners

Challenge

Involving general practitioners in MDC.

Solution

To ensure that GPs participated in the planning phase, with a view to their participation in MDC meetings, focus groups were held at clinics in the regional area and through the Division of General Practice in two rural health services. Attendance at these meetings was impressive and though the attendees identified many obstacles to attendance at MDC meetings, they were enthusiastic about participating.

Outcome

GPs routinely attend the MDC meeting in the regional centre and on many occasions in the rural centres. The relevant Division of General Practice is notified of the name of the GPs who are to have patients discussed that week and through this mechanism, GPs are invited to the meeting. The liaison GP from the Division of General Practice attends the majority of meetings and is able to convey information about treatment planning to those GPs unable to attend the meeting.



Case study: establishing a team identity

Challenge

The need to develop an identifiable team and strengthen links between members was identified.

Solution

Diagrammatic representations of clinical management pathways were developed for each hospital site and posters summarising these pathways, including photographs of team members, were displayed in relevant waiting areas. Meetings with all clinicians from across the Collaboration were held early during the set-up phase to emphasise the benefits of a MDC approach and promote the use of the clinical management pathway. A logo was developed specifically for the Collaboration and used on letterhead distributed to all relevant facilities in the region during the implementation of strategies.

Outcome

Promotion of the team through the clinical management pathways and Collaboration logo strengthen the team identity and brought awareness to MDC for both clinicians and patients.





Case studies - Advanced disease

Case study: discussing palliative care and end-of-life issues with patients.

Challenge

The need to discuss with the patient issues associated with awareness and 'diagnosis' of a palliative state such as worsening symptoms, failure of treatments due to progressive disease or recurrent disease.

Solution

A discussion is held with the patient and palliative care team regarding timely assessment of symptom management, ability to manage illness, changing goals, wishes, and future needs. Discussions regarding EOL wishes, plans and goals are shared throughout the health care team and may be discussed at MDC meetings as planning processes. The discussions are then continued with the patients by members of the palliative care team who are known by the patient. The outcomes of conversations are shared with the entire MDC team to continue the communication process. Documentation of this plan is mandatory.

Outcome

Regular assessment and awareness of individual patient's disease and progression will lead to early and appropriate referral to the palliative care team. This will facilitate smooth transition into the palliative phase, thus allowing planning and respect of patient goals and wishes to be established.

Case study: discussing 'not for resuscitation' orders with patients

Challenge

A conversation is held with the patient at an appropriate time (individually determined by a senior clinician), to discuss 'not for resuscitation' (NFR) orders.





Solution

The initial discussion occurs at a time when the patient is not unwell or under stress (e.g. it is not appropriate when diagnosis is first given to them). It is explained to the patient that a discussion about NFR orders is best done before admission occurs. An explanation of the meaning of NFR and the processes involved with resuscitation is given. The issues relating to medical advice, appropriateness of treatment, the patient's right to choice and medical futility can be undertaken as needed. Written information will be provided to all. Admitting doctors should check the patient's 'NFR status' at each admission and ask the patient if they would like to change their status. It is suggested that their status is included in a card also recording their medications.

Outcome

The patient and their caregivers have the opportunity to be properly informed about this difficult and emotive topic. As a result, stress is reduced both for the patient and the family, as well as the doctors involved. This also avoids the distressing situation where a doctor unfamiliar with a patient, and their medical history, prognosis and other details, is required to determine the NFR status of a patient, often in the situation of the patient being acutely unwell.

Case study: initiating a palliative care referral

Challenge

Initiating a referral to palliative care.

Solution

Effective communication within the health care team to help determine appropriate and timely referral to the palliative care team is crucial. The referral is introduced to the patient and their carers by the designated care coordinator explaining the role of palliative care as one of active care that delivers specialised health care to maximise quality of life, whether that be symptom management, pain relief or spiritual, emotional, and psychological support.

Outcome



Introducing the discussion about palliative care is assessed within the MDC team on an individual basis dependent upon the patient's advancing illness and their hopes for the future.

Case study: palliative care referral for advanced breast cancer

Challenge

An advanced breast care nurse routinely assesses a patients newly diagnosed with advanced breast cancer.

Solution

An advanced breast care nurse explains to the patient the role of key team members as providers of support, information, and symptom control. Once the patient is comfortable and aware of the value of this care, the advanced breast cancer nurse may suggest, if appropriate, that a similar support role can be provided in the community, also by a specialist nurse (from the community palliative care provider).

Outcome

Patients begin to separate the supportive care role of palliative care services, distinguishing them from terminal care. Patients become more accepting of supportive care provision in the community from palliative care services.



Case Studies - regional cancer centres

Case study: implementing teleconferencing

Challenge

Lack of access to a full MDC team in a remote area. Issues that were raised included:

- How would the new technology be accepted by clinicians involved in a teleconference?
- Would this create additional work or necessitate a change in practice which would compromise the establishment of a regular meeting?
- Could a convenient time be found and would the meeting participants see the benefit, which would encourage ongoing attendance?

Solution

Telehealth was presented as a solution. A 'champion' was identified at each end of the link who was committed to the process and who would encourage colleagues to attend. The telehealth link was added to a regular team meeting so that the meeting occurred in the telehealth room as standard practice regardless of whether a link by teleconference was planned. Pathologists and radiologists joining the teleconference were provided with images in advance of the meeting so that they could evaluate them before providing comment.

Outcome

Regular meetings via teleconference.

[See also: Case study: Setting up a multidisciplinary care team](#)

Case study: general practitioners and the multidisciplinary care team

Challenge

The patient's GP initiating a MDC meeting in a rural/regional setting.





Solution

To ensure the patient's GP is involved in the MDC planning, cancer care coordinators were introduced to a rural/regional health service to provide the link between GPs and other specialists in the care team. The patient's GP works closely with the patient's care team and can initiate a care planning meeting by contacting the lead clinician. The GP is encouraged to attend the meetings in person or participate via teleconference.

Outcome

Information presented by the GP about the patient's history and psychosocial issues at the MDC planning meeting has influenced decision-making around treatment and care planning.

Case study: involving general practitioners in multidisciplinary discussion of breast cancer patients

Challenge

To Involve GPs in MDC discussion of breast cancer patients.

Solution

A representative GP from the local Division of General Practice attended the MDC meeting to represent all the patients' GPs. This representative took on the role because of an interest in the area and is therefore knowledgeable medically and in regard to the specific care available in the community. The representative GP also liaised with individual GPs before the meeting to provide any useful GP perspective on the patient's situation. After the meeting the GP's role also included feeding back the meeting recommendations to each patient's GP. This position is funded.

Outcome

Attending the meeting is one GP's regular commitment and is therefore readily achievable. Their involvement allows both input from a GP perspective, and appropriate and timely feedback to the patient's GP.





Additional information and resources

For further information please refer to the following websites.

Cancer learning

<http://www.cancerlearning.gov.au/>

Website funded by Cancer Australia for cancer health professionals providing links to resources and educational activities related to MDC.

Australia College of Rural and Remote Medicine (ACRRM)

<http://www.ehealth.acrrm.org.au/>

The site supports clinicians, administrators and rural health support teams with practical resources, timely content, and advice regarding use of TeleHealth.

Cancer Institute NSW

<http://www.cancerinstitute.org.au/>

Information about MDC initiatives for cancer health professionals in NSW.

Department of Human Services Victoria

<http://www.health.vic.gov.au/cancer/framework/multidisciplinary.htm>

Information developed by the Cancer and Palliative Care section of the Department of Human Services Victoria to support MDC teams in Victoria.



