

MDC in regional cancer centres

Working in regional cancer centres

Implementation of best practice cancer care in regional and rural locations requires a multidisciplinary focus. In regional and rural areas, meetings should be timed to allow attendance either in person or via tele-/videoconference by appropriate specialist clinicians. Non-core team members should be aware of the regular meeting day and time and should be invited in advance if their input on specific cases is required.



Telehealth

While the '[Principles of MDC](#)' remain the same irrespective of location, delivery of MDC in a rural area may require implementation of innovative strategies. Patients living in regional and rural locations should have access to a full MDC team relevant to their cancer type.

Telehealth is a strategy for delivering coordinated MDC in regional cancer centres. Telehealth facilities can be used to link health professionals across distances to ensure multidisciplinary input to the care of patients in regional and rural areas. Telehealth can also link patients with medial specialist not available in their area.

Telehealth services provide opportunities for regional cancer centres to expand the reach of their services, link health professionals across distances and facilitate networking and professional learning and development.

Factors to consider when delivering cancer care via telehealth include the need for clear communication between the health professionals involved, assurance that treatment prescribed via telehealth aligns with best practice treatment, and clearly defined roles and responsibilities of those involved in a telehealth consultation.

Multidisciplinary care teams in regional cancer centres

Considerations for assembling a MDC team in regional cancer centres:

- engage local health providers who work outside the regional cancer centres:
- involve local GPs, or ensure outcomes are reported back to GPs
- involve health professionals from both public and private services in the area
- involve Aboriginal Health Workers or health professionals with appropriate cultural competency when relevant
- document agreement of role responsibilities of MDC team members.

Case studies

- [Case study: implementing teleconferencing](#)
- [Case study: GPs and the multidisciplinary care team meeting](#)
- [Case study: involving GPs in multidisciplinary discussion of breast cancer patient](#)
- [Case study: setting up a team](#)



Case studies

Case study: implementing teleconferencing

Challenge

Availability of 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.

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.

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.

Case study: establishing a multidisciplinary meeting for head and neck cancers

Challenge

To establish a multidisciplinary care (MDC) meeting for the management of head and neck cancers in a regional cancer service. This service included two public and two private hospital campuses. Specialist clinicians, such as surgeons and oncologists, saw public and private patients in private rooms. Patients from surrounding Area Health Services were also referred to local oncology clinicians.

Solution

The head and neck MDC meeting was initiated with the available staff and initially involved specialists in head and neck surgery, medical oncology, nursing and radiation oncology. To begin with, there was limited access to other specialties such as radiology and pathology due to resource constraints. For a number of years the available specialists met fortnightly with the patient present to discuss treatment plans. Meetings were held in either medical oncology or radiation oncology rooms with administrative support provided by each practice. This group set up effective administration processes and addressed issues around patient consent to share personal information by developing consent forms

Over time additional members and organisations joined the meeting and a collaborative group with representation of clinicians (both primary care and specialist), community health organisations, regional health services and regional support services (psychology and social work) was established. The shared governance arrangements resulted in improved quality of care through the establishment of a new coordinator role as well as the inclusion of allied health in the meeting.

Outcome



The head and neck MDC meeting is now hosted by the private hospital as this is the most convenient location for the practitioners. The development of a regional cancer centre will see this service relocated into the cancer centre when built. Pathology and radiology services are also accessed. MDC meetings are now administered by the Regional Integrated Cancer Service and MDC treatment plans or decisions of the MDC teams are provided to all practitioners involved in the care of the patient.

Case study: use of technology to support access to palliative care specialists in a regional area

Challenge

To link palliative care specialists located in regional areas with primary care clinicians and specialist care clinicians to facilitate multidisciplinary care.

Solution

Involvement of palliative care specialists and other community based clinicians in MDC meetings and care planning is important for providing quality care to patients, particularly those with advanced disease. The project team explored the use of technology to provide community based clinicians with access to palliative care specialists regardless of location. A suitable unified communications platform (a service that connects people through instant messaging, video calls and online meetings) was identified, tested and implemented by the project team. This platform allows joint consultation through multiple modalities with palliative care specialist, patients, and other local service providers (community nurse/GP).

Outcome

The use of this communication technology facilitated direct access to specialist palliative care advice, and supported primary care providers to develop the initial Clinical Care Plan that is prepared with the informed consent of the patient and allows carer's to manage patients care locally when it is appropriate. This allows patients to have access to specialist input into their care without either the specialist or patient having to travel large distances. Each patient then has the Clinical Care Plan to help them and subsequent carers to provide the optimum care.

Stephen Manley



Case study: use of technology to assist with planning of treatment for colorectal and breast cancer patients in a regional area.

Challenge

To set up a MDC meeting with effective communication of patient information from regional areas across public and private sectors.

Solution

Well attended weekly MDC meetings ensure timely referrals and communication with clinicians around concurrent treatment and best supportive care. However full attendance is often difficult, as the MDC team includes a range of clinicians from both public and private health sectors and care is also provided by clinicians who are not a part of the MDC. The use of electronic records was implemented to enable access to the patient's medical records by all clinicians involved in the patient's care regardless of location. An electronic record is a computerised version of a patient's medical information. Electronic records improve accuracy, legibility and consistency of clinical notes and allow more timely access to up-to date clinical notes regardless of location. By streamlining the communication of clinical information, additional time was able to be spent discussing patient care.

Outcome

The patient's needs are the primary focus for the members of the multidisciplinary care team. The use of electronic records allowed for more effective communication between team members, including members that were unable to attend the MDC meetings, allowing the team to focus more time on patient care. The addition of this technology assisted the MDC meetings in facilitating effective communication among clinicians across both public and private health services and allowed for the efficient delivery of best practice care.



