



**Development of tools/templates to  
strengthen the multidisciplinary team  
meeting process and facilitate  
communication with the General  
Practitioner**

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**Tumour Group: Colorectal**

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## **BACKGROUND**

Multidisciplinary care (MDC), with regular prospective multidisciplinary team (MDT) meetings at its core, is a key enabler of high quality, consistent and coordinated cancer care. Cancer patients that are managed by a multidisciplinary model of care are more likely to be recruited into clinical trials (1), a shorter journey from diagnosis to treatment (2), more likely to have evidence-based treatment (2, 3), and therefore better survival outcomes (1,2,3,4). In addition, there is increased recognition of the supportive care needs of the patient (1), improved patient satisfaction (2), and better patient access to information (2).

The Western Central Melbourne Integrated Cancer Service (WCMICS) Colorectal Tumour Group has an established history of MDT meetings. While the exact processes by which the MDT meetings operate vary across the Integrated Cancer Service (ICS), the Tumour Group has identified a number of common gaps/issues and opportunities for strengthening the existing processes. In particular the need for improved documentation at MDT meetings and internal and external communication, including with the General Practitioner (GP) and the patient, has been identified.

Documentation is an important aspect of MDT meetings. Good documentation means that all team members have access to and knowledge of the treatment plan (regardless of whether they were at the meeting), and makes it more likely to be adhered to (1). It also improves decision making transparency (3), and can assist in quality activities including clinical audit (1).

Documentation of the treatment plan also facilitates communication with the patient's GP, who should be considered a member of the multidisciplinary team (1). In one study by McAvoy (2007) (5), it was shown that in the first year after diagnosis, most cancer patients present to the GP more than 10 times, which in that study was double the number of consultations with specialists. Therefore, to ensure continuity of care, GPs should be regularly updated on the patient's treatment plan and progress.

## **AIM**

The objective of this project is to develop tools/templates to facilitate documentation of the MDT meeting outcomes and communication, including with the GP.

Key outcomes will include:

- The development of templates for documenting the treatment plan and communicating with the GP. Consideration will also be given to adaptation of the templates for patient use.
- Development of processes/systems (potentially including electronic) to facilitate communication with the GP and other members of the care team.
- Implementation (piloting) of the developed templates and processes/systems.
- Recommendations for future use.
- Strengthened Colorectal MDT processes across the WCMICS.

It is expected that the project's learnings will be transferable to other WCMICS Tumour Groups. The key benefits of this project will include improved care coordination and the strengthening of MDT processes within WCMICS Colorectal Services.

## METHODOLOGY

The project was split into 2 stages due to the need to specify in detail what would be required from an electronic solution, and the time this would take.

Stage 1 involved:

- The development of templates and agreement on the content
- Integration of the content into existing systems OR
- Implementation of paper-based templates to document the meeting and communicate with the GP

This report addresses Stage 1 only.

Stage 2 will involve:

- The development of a specification that sets out exactly what our sites require from an electronic solution, and once this is completed, the development of software to record the Treatment Plan for those sites who do not have any.

### Process

#### Identification of current practices in WCMICS sites and elsewhere

A MDT meeting Audit Tool was developed (Appendix 1) based on the DHS *Multidisciplinary Toolkit* Audit Tool (6), and this was used to gather information on current WCMICS MDT meeting processes in the Breast, Haematology, and Colorectal Tumour Groups. The clarification of MDT meeting processes across the services allowed the identification of site specific options for use of developed templates (i.e. paper-based templates, electronic, etc), and also templates already in use within the WCMICS, preventing duplication of existing processes.

In addition to this, similar projects underway across other ICS were identified to scope opportunities for collaboration and information exchange. Existing software/data systems currently being used to assist in the management of MDT meetings and communication with GPs were also identified and explored.

#### Stakeholder requirements

Interviews were held with Lead Clinicians and other key stakeholders at each site to discuss current MDT meeting practices and key areas for improvement. The interviews also aimed to identify minimum specifications for the templates, including core elements for inclusion and desired features of templates, and also opportunities to build on existing systems.

GP Liaison Officers at each organisation were also interviewed to establish what, if any, communication of the Treatment Plan to the GP currently occurs, and how this occurs, as well as to identify areas in which this can be improved. GP Liaison Officers were also questioned about the information requirements of GPs at the time of the MDT meeting.

#### Template Development

At completion of the stakeholder interviews, draft templates for documentation of MDT meeting outcomes and communication with GP were developed. These templates were circulated among the Tumour Group for feedback. They were amended to reflect the feedback and a final draft circulated via email for sign-off.

## Implementation

In conjunction with the Lead Clinician and Administrative Coordinators at each site, site-specific strategies for implementation were developed. The templates were then piloted for one month. Funding was made available to the group for equipment to support the implementation of the templates.

The development of electronic templates was out of the scope of this stage of the project. This will be addressed in Stage 2 of this project, as well as by projects funded under the WCMICS Information Strategy.

## **RESULTS & DISCUSSION**

### **Identification of current practices at WCMICS sites and elsewhere**

#### MDT Meeting Audit

The MDT meeting audit identified that most meetings are well established and are achieving many of the 'Principles of Best Practice' set out in the DHS' *Multidisciplinary Meeting Toolkit* (2). In particular, an area in which WCMICS MDT meetings are doing particularly well is communication of the treatment plan to the patient, with all patients being verbally informed of the treatment plan and given the opportunity to provide input.

However, there are some aspects of WCMICS MDT meetings that are in need of strengthening (Table 1). As noted anecdotally, documentation of the meeting and communication of the treatment plan to the GP were the most common areas needing improvement. Other areas of concern included facilities available to assist the meeting, provision of MDC information to the patient, and patient consent to discussion at the MDT meeting. More detailed results are shown in Appendix 2.

**Table 1:** Summary of most common areas of concern - WCMICS Breast, Haematology, and Colorectal MDT Meetings

<b>Area of concern</b>	<b>% of sites affected (n=11)</b>
Documentation	64
GP Communication	45
Room set up	36
Facilities available	36
Provision of MDC info to patient	36
Patient consent	36
Limited room access	9
Attendance of non-medical staff	9
Attendance of medical clinicians	9

#### Documentation - current situation

Documentation of MDT meetings varied across the MDT meetings, with some meetings documenting most aspects of the meetings either electronically or on paper, and other sites not documenting anything at all. However, few sites documented all the relevant information or recorded the meeting outcomes in the patient's medical record.

Examples of current documentation include:

- Notes being taken by registrars during the meeting for their own use, but not being placed in the medical record.
- A data manager taking note of the treatment plan during the meeting, which is then entered into a Microsoft Access database, which is not openly accessible.
- A comprehensive database being established to not only document MDT meetings, but also to record other relevant clinical data. The documentation of the MDT meetings was performed by Administration staff. Data collected included patients discussed, case summary information, and the treatment plan.
- A Treatment Plan template which is filled in by hand by the Breast Care Nurse. Information record included attendance, patients discussed, referrals, and the treatment plan.

#### GP communication - current situation

Across WCMICS organisations, GPs are generally not invited to or notified in advance of their patient being discussed at MDT meetings. In the past, one organisation organised post-MDT meeting GP case conferences as part of the Breast Services Enhancement Program (BSEP), however the case conferences were discontinued due to time pressures.

Feedback from GP Liaison Officers indicated that after most MDT meetings, there is no systematic communication of MDT meeting outcomes to the GP. Generally, if there is any communication it is by a dictated letter which is posted or occasionally faxed, however these are often ad hoc and of poor quality, or do not contain information that is useful to the GP.

However, three of the eleven MDT meetings audited have instigated regular notification of meeting outcomes to the GP. One group used a one-page letter containing automatically generated information from a database used for MDT meetings. The information included pathology and a generalised treatment plan i.e.

‘Adjuvant Chemotherapy: *Recommended*’

This letter was either faxed or posted, and initial feedback from GPs was positive. The letter was also placed in the patient’s medical record and so doubled as a record of the treatment plan decided at the meeting.

Another group used a one-page template that was filled out by hand after the meeting by the Breast Care Nurse and then faxed to the GP. The information included on this template included basic surgery and pathology details, as well as recommended treatment options, psychosocial issues, and brief follow-up details.

Finally, another group had developed an extensive MDT plan to be sent to the GP at the conclusion of treatment. This four page template included information on pathology, treatment, clinical trials, psychosocial issues, lifestyle advice, and follow-up details.

#### Similar projects identified elsewhere

Other ICS were contacted via email to identify similar projects and opportunities for collaboration. Although no other ICS were currently working on similar projects, some had done previous work in this area. The Barwon South Western Regional ICS and Gippsland Regional ICS have both developed databases which they are using to document aspects of their MDT meetings. However, this

software was developed to meet the needs of regional hospitals with smaller patient numbers and dedicated MDT Meeting Coordinators, and so in its current format was not directly transferable to WCMICS sites.

It was also identified that the ACCORD (Australian Comprehensive Clinical Outcome and Research Database) project, part of BioGrid, was also developing a Colorectal MDT meeting template to record the treatment plan, and so we worked closely with them to develop a mutually acceptable template.

### **Stakeholder requirements and template development – hospitals**

Hospital stakeholders, including Lead Clinicians, Data Managers, and Breast Care Nurses, were interviewed in regards to the core inclusions and features of any templates developed.

A key issue that came out of these interviews was the questions about who would actually do the documenting of the meetings. Several clinicians noted a lack of administrative support to for MDT meeting, and suggested that if clinical staff were to take on this role, any templates developed would need to be relatively easy to fill in.

In the few sites where there was administrative or data manager support, concerns were aired around clinical information being properly interpreted. One suggestion as to how to address this was that the template could be projected while the individual was completing it to ensure it was accurate.

When asked what information should be included on the templates, hospital stakeholders identified several key items:

- Attendance
- Case summary
- Pathology results
- Imaging results
- Staging
- Supportive care issues
- Treatment plan
- Planned follow-up
- Participation in clinical trials

Three templates have been developed incorporating the feedback from hospital stakeholder interviews:

- An **Agenda** (Appendix 3) (for sites who are not yet using one)
- A **Case Summary** (Appendix 4) which can be used to be present information at the meeting, and
- A **Treatment Plan** (Appendix 5), which was developed in conjunction with the ACCORD project.

Overwhelming, hospital stakeholders were in favour of the development of an electronic system for documenting MDT meetings. Electronic systems were seen to be advantageous because data could be entered once only, it would be possible to integrate with existing systems, and the information could be viewed anywhere in the hospital rather than just where the written form was.

### **Stakeholder requirements and template development - GPs**

GP Liaison Officers were asked about the information needs of GPs in relation to MDT meetings. All GP Liaison Officers were in agreement that there is a need for

written communication from the MDT meetings that is systematic, standardised, and provides the information that they require.

GP Liaison Officers were questioned about the preferred format of written communication from the MDT meeting. Preferences were for a standardised one-page template rather than a letter format, as it was thought that this would be easier to read and would ensure that all required information would be consistently provided. The method of communication was also discussed, and the general consensus was that although encrypted email was ideal, privacy issues, software compatibility, and variable uptake of email technology by GPs meant that faxing would be the most practical method of communication in this instance.

When asked what information GPs would like included in the communication from the MDT meeting, GP Liaison Officers identified several key items:

- Procedures and Results/Staging
- Psychosocial and Supportive Care Issues/Referrals
- Treatment Plan
- Side effects of treatment
- Treatment intent, prognosis, and what the patient has been told
- Contact details for treating oncologist

These findings confer with those from a study by McConnell et al (1998) (7).

A template for communication from the MDT meeting to GPs has been developed in response to these needs, and is presented in Appendix 6.

## **Implementation**

As previously noted, although some electronic solutions have been explored, it was decided that implementation of electronic templates would be out of scope for this stage of the project. However, this will be addressed in Stage 2 of this project, as well as by projects funded under the WCMICS Information Strategy.

### Peter MacCallum Cancer Centre

Peter MacCallum Cancer Centre (PMCC) uses an electronic medical record, which incorporates 'p-note' software that allows the generation of progress note templates. The PMCC Upper GI Tumour Group have been using a 'p-note' template to record their MDT meetings, and the Colorectal service indicated that they would like to use this as well.

The person in the PMCC Information Communications and Technology (ICT) Department responsible for the generation of these templates was contacted several times over a period of five months in an attempt to implement this. Towards the end of this time, WCMICS also initiated discussions with the ICT Department regarding providing funding for an electronic system to record MDT meetings. As the ICT Department are most likely going to take advantage of this funding, it was decided to abandon the implementation of the template as a 'p-note' and instead wait for the electronic system to be implemented.

As part of this project, WCMICS has funded an upgrade to the audiovisual and videoconferencing equipment in the room where this MDT meeting is held.

### Royal Melbourne Hospital

Before this project began, Royal Melbourne Hospital (RMH) did not have a formal MDT meeting. However, during this project, the Lead Clinician and Liaison Nurse at RMH established a meeting, which is functioning very well.

The colorectal surgery registrar is responsible for completing the template, which is currently being used in a paper-based format.

As part of this project, WCMICS has funded a laptop, projector, and scanner to assist with implementation.

### St Vincent's Hospital Melbourne

St Vincent's Hospital Melbourne (SVHM) have developed a comprehensive database for their Lung MDT meeting, and are currently developing a Colorectal module for this database. When this database is established, the fields agreed upon as part of this project will be incorporated.

As part of this project, WCMICS has funded a microscope pointer, wireless network, and microphones to support MDT meetings at St Vincent's.

### Western Hospital

At Western Hospital (WH), the colorectal surgery registrar was given the role of completing the template in a paper-based format. This has now been in place for over six months and an evaluation has been completed.

The results from the evaluation indicated that some minor changes needed to be made to the template, which were made by the WH Administrative Coordinator. The WH Administrative Coordinators then took the template to the Forms Committee where it was allocated a medical records number.

As part of this project, WCMICS has funded a laptop and speakers to assist with implementation.

## **CONCLUSION**

The MDT meeting audit conducted as part of this project demonstrated that previously, documentation of the outcomes of most MDT meetings, and communication of this to the GP, was ad hoc at best.

However, where implemented, the templates developed as part of this project have resulted in improved documentation and more reliable communication of the treatment plan to the GP, enhancing care coordination.

This project has also led to several future areas of work including:

- The development of an electronic solution for the management and documentation of these meetings – this is currently being addressed by the development of specifications (stage 2 of this project) and the funding of electronic solutions under the WCMICS Information Strategy.
- Allocation of medical records numbers for the templates by SVHM, PMCC, and RMH Forms Committees – the Committees have requested that templates for all Tumour Groups be submitted together – this will most likely occur in mid-2009.
- The development of Terms of Reference/Protocols for each MDT meeting.

- The need to re-audit the meetings on a regular basis to assess progress and sustainability of initiatives.

This project is now being rolled out to all other Tumour Groups as the 'Strengthening Multidisciplinary Meetings' program.

## REFERENCES

- (1) Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne, Victoria, Australia. (2007) *Achieving best practice cancer care - A guide for implementing multidisciplinary care* (2007) <http://www.health.vic.gov.au/cancer/docs/mdcare/multidisciplinarypolicy0702.pdf>
- (2) National Breast Cancer Centre. *Multidisciplinary meetings for cancer care: a guide for health service providers*. 2005 National Breast Cancer Centre, Camperdown, NSW
- (3) Ruhstaller T, Roe H, Thurlimann B, & Nicoll J J. (2006) 'The multidisciplinary meeting: An indispensable aid to communication between different specialities', *European Journal of Cancer* 42: 2459-2462
- (4) Sidhom M A, Poulsen M G. (2006) 'Multidisciplinary care in oncology: Medicolegal implications of group decisions', *Lancet Oncology* 7: 951-954
- (5) McAvoy B R. (2007) 'General practitioners and cancer control', *Medical Journal of Australia* 187(2): 115-117
- (6) Cancer & Palliative Care Unit, Victorian Government Department of Human Services, Melbourne, Victoria, Australia (2006) *Multidisciplinary meeting toolkit* [http://www.health.vic.gov.au/cancer/docs/ics/meet\\_toolkit.pdf](http://www.health.vic.gov.au/cancer/docs/ics/meet_toolkit.pdf)
- (7) McConnell D, Butow PN, & Tattersall MHN (1999). Improving the letters we write: An exploration of doctor-doctor communication in cancer care. *British Journal of Cancer* 80(3/4): 427-437

## APPENDICES

Appendix 1	MDT Meeting Audit Tool
Appendix 2	MDT Meeting Audit Results
Appendix 3	Agenda for MDT Meetings
Appendix 4	Case Summary for MDT Meetings
Appendix 5	MDT Meeting Treatment Plans
Appendix 6	GP Communication Template

## LIST OF ABBREVIATIONS

ACCORD	Australian Comprehensive Clinical Outcomes and Research Database
BSEP	Breast Services Enhancement Program
DHS	Department of Human Services

GP	General Practitioner
ICS	Integrated Cancer Service
MDC	Multidisciplinary Care
MDT	Multidisciplinary Team
PMCC	Peter MacCallum Cancer Centre
RMH	Royal Melbourne Hospital
SVHM	St Vincent's Hospital Melbourne
WCMICS	Western and Central Melbourne Integrated Cancer Service
WH	Western Hospital

## **ACKNOWLEDGEMENTS**

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Project Team: Ms Pam Crouch, St Vincent's Hospital Melbourne  
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 Ms Cathy Hammond, Western Hospital  
 Ms Joanne Peake, St Vincent's Hospital Melbourne

Suzy Kosmider from ACCORD

The Clinicians and GP Liaison Officers who were interviewed and/or provided their feedback.



	Nursing	Physiotherapy	Psychology	Genetic Counselling	Dietetics	Palliative Care	Social Work	Admin	Other
Please list allied health team members who ROUTINELY attend meetings (include names)									

Please list any team members who attend occasionally or are invited for a specific reason and should be include on any template developed?	
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	No	Yes, identified but not documented	Yes, identified & documented	Comments
Is a lead clinician identified and documented for each patient discussed?				

	1-5 minutes	5-10 minutes	Approx 10 min	10-15 minutes	15-20 minutes	More than 20 minutes	Comments
How long (on average) is each patient discussed?							

	1-3	4-6	6-8	8-10	More than 10	Comments
How many patients (on average) are discussed per MDT meeting?						

	Less than 30 minutes	30 minutes	45 minutes	1 hour	An hour and a half	2 hours or greater	Comments
How long (on average) does the MDT meeting run?							

	At initial diagnosis but before surgery	After surgery but before other treatment	After other treatment has begun	At conclusion of treatment	At recurrence	Comments
When in the patient pathway are patients discussed at the MDT meeting?						

	Yes (please attach a copy)	No	Comments
Are there any team protocols that have been developed? (e.g. Terms of Reference, criteria for patients to be discussed)			

	Paper based	Electronic	Other	Comments
If yes, what format are they in?				

GP Communication

	Always	Almost Always	Mostly	Sometimes	Rarely	Never	Comments
Are recommendations and treatment plans communicated to the general practitioner?							

	At initial diagnosis	After treatment plan is determined but before the patient has accepted it	After treatment plan is determined and patient has accepted it	At completion of acute hospital treatment.	Comments
When does communication with the general practitioner occur?					

	Clinician who received original referral	Whole MDT	Presenting Clinician	Other (pls specify)	Comments
Who is responsible for communicating with the general practitioner?					

	In person at MDT meeting	Telephone	Letter	Fax	Email	Other (please state)	Comments
How does communication with the general practitioner occur?							

	Communication is not electronic	Software Used	Comments
If communication with the general practitioner is via electronic means, what software is used?			

	Yes (attach a copy)	No	Communication is not in writing	Comments
If communication with the general practitioner is in writing, is a template used?				

Patient Communication

	No	Yes, via pamphlet	Yes, via verbal explanation	Yes, via other (specify)	Comments
Are patients provided with information about multidisciplinary care?					

	No	Yes, verbal	Yes, written	Noted in medical record?	Comments
Is the patient's consent sought before their case is discussed?					

	Not communicated	Same day	Next appointment	Other (pls specify)	Comments
When is the outcome of the MDT meeting communicated to the patient?					

	Not communicated	Verbal Explanation	Written Treatment Plan	Written, Other	Comments
By what means is the outcome of the MDT meeting communicated to the patient?					

	Surgeon	Haematologist	Medical Onc	Nurse coordinator	Team member who patient has next appt with	Presenting clinician	Other (pls specify)	Comments
Who communicates the meeting recommendations to the patient?								

	No	Yes	Comments
Do patients provide input to their treatment plan?			

Data collection and recording of recommendations

	No	Yes, in notes	Yes, via template (pls attach)	Comments
Are the recommendations of the meeting recorded in the patient's medical record?				

	CHARM	ACCORD	Other Database (pls specify)	Comments
Are the recommendations recorded anywhere else?				

	None	Team Recommendations	Lead Clinician	Follow up arrangments	Other (pls specify)	Comments
What data is currently collected at team meetings?						

	Data is not collected	Written Notes	Electronic Notes	Written Template (pls attach)	Electronic Template (pls attach)	Other (pls specify)	Comments
How is the data collected?							

	N/A	Lead Clinician	Designated Person (pls specify)	Other (pls specify)	Comments
Who records the recommendations and data?					

Use of MDC MBS Item Numbers 871 & 872

	No	Yes	Comments
Is it identified at MDT meetings whether patients are public or private?			

	Unknown	Percentage	Comments
What percentage of patients discussed at MDT Meetings are Private Patients? (if known)			

	No	Yes (pls describe the process and attach relevant documentation)	Comments
Does your hospital currently bill for MDT meetings using the MBS Item Numbers 871 & 872?			

	No	Yes (pls specify)	Comments
Does your hospital currently bill for MDT meetings using any other item numbers?			

If your hospital bills for MDT meetings, how are the patients with current referrals identified?	
--	--

If your hospital bills for MDT meetings, how are the private patients identified?	
---	--

Other

	No	Yes (pls specify and attach)	Comments
Are there any privacy policies at your hospital that may affect the MDT project? E.g. around methods of communication with the general practitioner			

	No	Yes (pls describe)	Comments
Are there any current MDT meeting improvement projects at your hospital?			

	No	Yes (pls describe)	Comments
Are there any current projects exploring use of the MDC MBS item numbers at your hospital?			

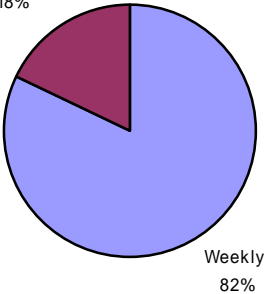
	No	Yes (pls explain)	Comments
Do you believe electronic solutions could assist the MDT process?			

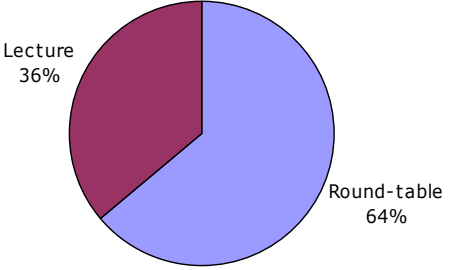
Do you have any other comments?	
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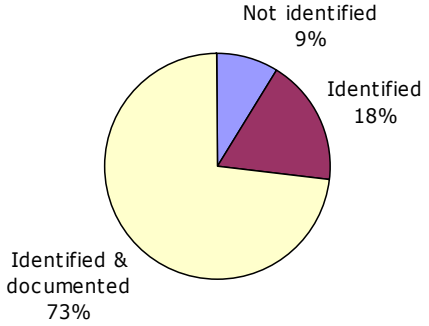
## Appendix 2 - MDT Meeting Audit Detailed Results

An audit was undertaken across all of the sites for Breast, Haematology, and Colorectal MDT meetings (11 in total).

The results have been collated and are displayed below. Please note the percentages indicate percentage of meetings.

<p><u>Frequency of meetings</u></p> <p>Recommendation: MDT meetings should be held on a regular basis (1).</p>	 <p>A pie chart illustrating the frequency of MDT meetings. The chart is divided into two segments: a large blue segment representing 'Weekly' meetings at 82%, and a smaller maroon segment representing 'Fortnightly' meetings at 18%.</p> <table border="1"> <thead> <tr> <th>Frequency</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Weekly</td> <td>82%</td> </tr> <tr> <td>Fortnightly</td> <td>18%</td> </tr> </tbody> </table>	Frequency	Percentage	Weekly	82%	Fortnightly	18%
Frequency	Percentage						
Weekly	82%						
Fortnightly	18%						
<p><u>Length of meeting/s</u></p> <p>Recommendation: The duration of MDT meetings should depend on the number of patients requiring discussion. However, it is generally appropriate to limit the meeting to between 45-90 minutes (1).</p>	<p>Range      30 mins-3 hours Median      1 hour</p>						
<p><u>Length of discussion per patient</u></p> <p>Recommendation: The guidelines for the billing of MDT meetings using the MBS item numbers 871 &amp; 872 includes a requirement that patients must be discussed for 10 minutes or more if they are to be billed (2).</p>	<p>Range      1-10 mins Average      7 mins</p>						
<p><u>Number of patients discussed per meeting</u></p>	<p>Range      1 to &gt;10 Average      8</p>						

<p><u>Room set-up</u></p> <p>Recommendation: Venues for the MDT meetings should generally be set-up in a round-table configuration so that participants can face each other (1).</p>	 <p>Lecture 36%</p> <p>Round-table 64%</p>														
<p><u>Facilities available to the meeting</u></p> <p>Recommendation: The meeting should have access to all relevant resources. A minimum of a light box, projector, and microscope should be available (1).</p>	<table border="0"> <tr><td>Projector</td><td>91%</td></tr> <tr><td>Microscope</td><td>82%</td></tr> <tr><td>Network Computer</td><td>82%</td></tr> <tr><td>Lightbox/Elmo</td><td>73%</td></tr> <tr><td>Videoconferencing</td><td>73%</td></tr> <tr><td>Teleconferencing</td><td>64%</td></tr> <tr><td>Laptop</td><td>36%</td></tr> </table>	Projector	91%	Microscope	82%	Network Computer	82%	Lightbox/Elmo	73%	Videoconferencing	73%	Teleconferencing	64%	Laptop	36%
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<p><u>Conduct of meeting</u></p> <p>All meetings were being held face-to-face. There was no video- or teleconferencing, although these facilities were available to most sites.</p>															
<p><u>Attendance of medical clinicians</u></p> <p>Recommendation: A core group of specialists should be present at the meeting, including a radiologist, pathologist, radiation oncologist, medical oncologist, general practitioner, surgeon or other speciality where appropriate (3). In order to meet the MBS billing requirements, there must be a minimum of four different disciplines in attendance (2).</p>	<table border="0"> <tr><td>Medical Oncologist and/or Haematologist</td><td>100%</td></tr> <tr><td>Radiologist</td><td>91%</td></tr> <tr><td>Pathologist</td><td>82%</td></tr> <tr><td>Radiation Oncologist</td><td>82%</td></tr> <tr><td>Surgical Oncologist</td><td>73%</td></tr> <tr><td>Other Speciality</td><td>64%</td></tr> <tr><td>GP</td><td>0%</td></tr> </table>	Medical Oncologist and/or Haematologist	100%	Radiologist	91%	Pathologist	82%	Radiation Oncologist	82%	Surgical Oncologist	73%	Other Speciality	64%	GP	0%
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GP	0%														

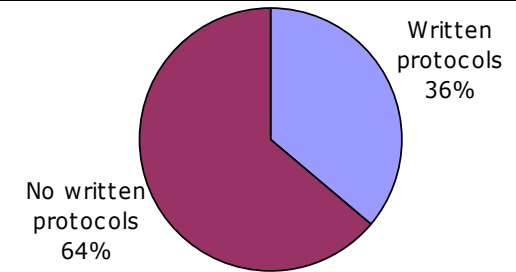
<p><u>Attendance of non-medical staff</u></p> <p>Recommendation: There should be representation from nursing, allied health, and psychosocial clinicians where appropriate (3). In order to meet the MBS billing requirements, there must at least one of these clinicians in attendance (2).</p>	<table border="0"> <tr><td>Nursing</td><td>100%</td></tr> <tr><td>Social Work</td><td>55%</td></tr> <tr><td>Admin Staff</td><td>55%</td></tr> <tr><td>Clinical Trials / Research</td><td>45%</td></tr> <tr><td>Staff</td><td>36%</td></tr> <tr><td>Other</td><td>27%</td></tr> <tr><td>Physiotherapy</td><td>27%</td></tr> <tr><td>Dietetics</td><td>18%</td></tr> <tr><td>Psychology / Mental Health</td><td>18%</td></tr> <tr><td>Genetic Counselling</td><td>0%</td></tr> <tr><td>Palliative Care</td><td></td></tr> </table>	Nursing	100%	Social Work	55%	Admin Staff	55%	Clinical Trials / Research	45%	Staff	36%	Other	27%	Physiotherapy	27%	Dietetics	18%	Psychology / Mental Health	18%	Genetic Counselling	0%	Palliative Care	
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Genetic Counselling	0%																						
Palliative Care																							
<p><u>Lead Clinician</u></p> <p>Recommendation: The lead clinician for each case should be identified (3). As MBS MDC item number 871 pertains only to lead clinician billing, to use this number the lead clinician must be identified (2), and preferably documented.</p>	 <table border="0"> <tr><td>Not identified</td><td>9%</td></tr> <tr><td>Identified</td><td>18%</td></tr> <tr><td>Identified &amp; documented</td><td>73%</td></tr> </table>	Not identified	9%	Identified	18%	Identified & documented	73%																
Not identified	9%																						
Identified	18%																						
Identified & documented	73%																						
<p><u>Stage of patient pathway that discussion occurs at</u></p> <p>Recommendation: An MDT meeting discussion should be held for all newly diagnosed and review cases within an appropriate timeframe. At a minimum, multidisciplinary discussion should occur prior to the commencement of neoadjuvant or adjuvant treatment (3)</p>	<table border="0"> <tr><td>All</td><td>55%</td></tr> <tr><td>At initial diagnosis but before surgery</td><td>91%</td></tr> <tr><td>After surgery but before other treatment</td><td>73%</td></tr> <tr><td>After other treatment has begun</td><td>64%</td></tr> <tr><td>At conclusion of treatment</td><td>55%</td></tr> <tr><td></td><td>100%</td></tr> </table>	All	55%	At initial diagnosis but before surgery	91%	After surgery but before other treatment	73%	After other treatment has begun	64%	At conclusion of treatment	55%		100%										
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After other treatment has begun	64%																						
At conclusion of treatment	55%																						
	100%																						

Development of team protocols (e.g. TOR, criteria for discussion)

Recommendation:

Written protocols should be established to describe the organisation and content of the meeting (3).

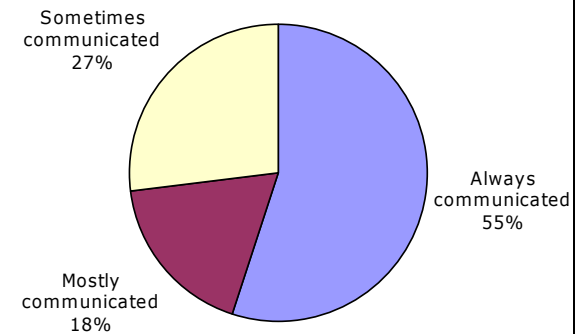
Four sites have established written protocols.



Communication of meeting outcomes to the GP

Recommendation:

The patient's GP should be informed of the meeting outcome as soon as practicable after the meeting (3).

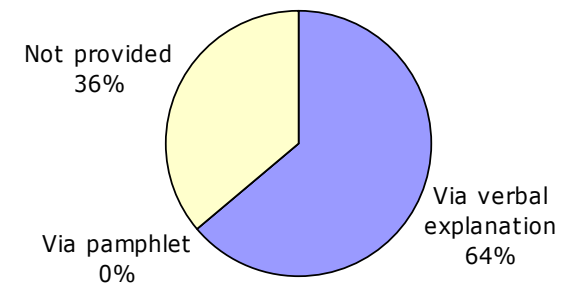


Meeting outcomes were generally communicated by letter, with 2 sites using a template for that letter.

Provision of multidisciplinary care information to the patient

Recommendation:

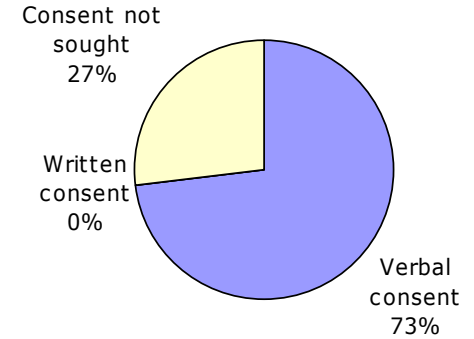
All patients should be provided with written information about multidisciplinary care (1)



Patient's consent sought before discussion

Recommendation:

The patients consent must be sought before their case is presented at the MDT meeting (3).

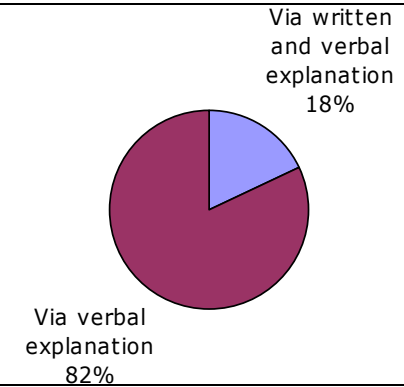


No sites noted patient consent in the medical record.

Communication of meeting outcomes to the patient

Recommendation:

The MDT meeting outcomes should be communicated with the patient (1,3) via whatever method is preferable to them (3).

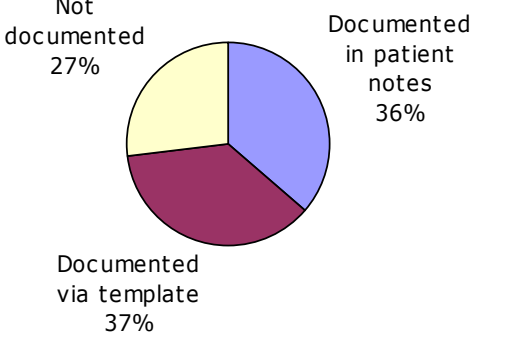
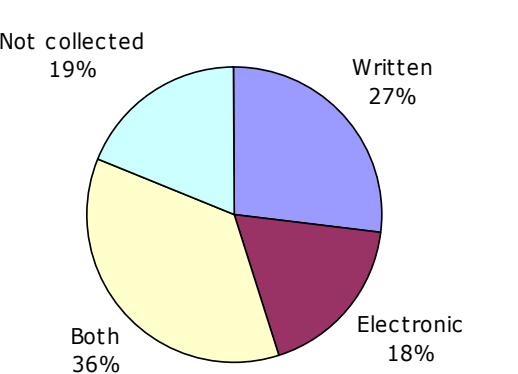


Patient input into treatment plan

Recommendation:

The patient should have the opportunity to provide input into their treatment plan (1).

All the meetings invited patient input into the treatment plan.

<p><u>Recording of meeting recommendations</u></p> <p>Recommendation: The recommendations from the meeting should be documented using a standardised treatment plan (1,3).</p>	 <table border="1"> <tr> <td>Not documented</td> <td>27%</td> </tr> <tr> <td>Documented in patient notes</td> <td>36%</td> </tr> <tr> <td>Documented via template</td> <td>37%</td> </tr> </table>	Not documented	27%	Documented in patient notes	36%	Documented via template	37%						
Not documented	27%												
Documented in patient notes	36%												
Documented via template	37%												
<p><u>Data recorded at meetings</u></p> <p>Recommendation: The meeting recommendations, lead clinician, attendance, and follow-up plan should be recorded as a minimum (1,3).</p>	<table border="1"> <tr> <td>Patients discussed</td> <td>45%</td> </tr> <tr> <td>Attendance</td> <td>45%</td> </tr> <tr> <td>Lead Clinician</td> <td>64%</td> </tr> <tr> <td>Treatment Plan</td> <td>64%</td> </tr> <tr> <td>Follow-up arrangements</td> <td>18%</td> </tr> <tr> <td>Referrals</td> <td>18%</td> </tr> </table>	Patients discussed	45%	Attendance	45%	Lead Clinician	64%	Treatment Plan	64%	Follow-up arrangements	18%	Referrals	18%
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<p><u>Method of data collection</u></p>	 <table border="1"> <tr> <td>Not collected</td> <td>19%</td> </tr> <tr> <td>Written</td> <td>27%</td> </tr> <tr> <td>Both</td> <td>36%</td> </tr> <tr> <td>Electronic</td> <td>18%</td> </tr> </table>	Not collected	19%	Written	27%	Both	36%	Electronic	18%				
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Written	27%												
Both	36%												
Electronic	18%												
<p><u>Other comments</u></p> <p>General comments identified a need for real time data entry, documentation of MDT meetings, GP communication, and for greater organisation support and resourcing.</p>													

## References

1. National Breast Cancer Centre. *Multidisciplinary meetings for cancer care: a guide for health service providers*. 2005 National Breast Cancer Centre, Camperdown, NSW
2. Department of Health and Ageing. *Medicare Benefits Schedule*. 2007  
<http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=NoteID&q=A.50>, Accessed 13/12/07
3. Cancer Coordination Unit. *Multidisciplinary Meeting Toolkit*. 2006 Victorian Department of Human Services, Melbourne, Victoria



## COLORECTAL MULTIDISCIPLINARY TEAM MEETING AGENDA

**Time:** <8.30am>

**Date:** <Thursday November 25, 2007>

**Location:** <Cancer Services Meeting Room, 3<sup>rd</sup> Floor, Daly Building>

**Contact:** <Dr Joe Blow x1382>

Patient Name	DOB	UR Number	Referring Clinician	Insurance Status	Investigations to be discussed (& date)	Diagnosis (if known) or Investigation Results	Reason for referral to MDT Meeting
Jane Doe	18-9-1925	869553	Mr John Smith	Public	Colonoscopy 9/11/07	Positive FOBT Multiple adenomas including 1 suspicious for malignancy	Post-op path review & management plan
Mary Poppins	6-5-1952	697561	Mr John Smith	Private	CXR 6/11/07	Grade III adenocarcinoma in 2005. Now opacity on CXR	Management plan

For any queries or additions, please contact Dr Joe Blow at [joe.blow@stvs.org](mailto:joe.blow@stvs.org) or on 9656 1382 or pager 6784.

**CASE SUMMARY - COLORECTAL MULTIDISCIPLINARY TEAM MEETING**

Patient Name:

URN:

&lt;insert logo&gt;

Age:

Place of Residence:

Referral Source:

Consultant:

**Case Summary:**

Presentation .....

Duration of Symptoms.....

 Significant Co-Morbidities Details.....**History:**Previous Benign Colorectal Disease  NO  YES - Year..... Hospital..... Pathology.....  
Treatment.....Previous Malignant Colorectal Disease  NO  YES - Year..... Hospital..... Pathology.....  
Treatment.....Family History  NO  YES - Details.....**Psychosocial/Supportive Care Issues:****Investigations** Colonoscopy Date .../.../... Results..... Biopsy Date .../.../... Results..... CT Date .../.../... Results..... CEA Date .../.../... Results..... Other Date .../.../... Results.....**Operative Procedures:**

Date .../.../... Operation..... Surgeon..... Comments.....

Date .../.../... Operation..... Surgeon..... Comments.....

Date .../.../... Operation..... Surgeon..... Comments.....

**Pathology:**

Tumour Type ..... Location..... Size .....mm

Extent of Invasion..... Grade  1  2  3  N/A Height .....mmMargins  Uncertain  Clear  Involved Lymph Nodes Involved ...../.....**Stage:** T ..... N..... M.....**Other Comments:**



Surname: \_\_\_\_\_  
 Given Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Western Health UR: \_\_\_\_\_

**Oncology Multidisciplinary Team Treatment Plan**

**Meeting Date:** \_\_\_\_\_  
**Tumour Stream:** **Colorectal**

To be completed by Registrar  <b>Diagnosis:</b> <input type="checkbox"/> Initial Diagnosis <input type="checkbox"/> Colon <input type="checkbox"/> Rectal <input type="checkbox"/> Anal	<b>Staging</b> TNM .....  Resectable Metastasis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Potentially	<input type="checkbox"/> Primary  <input type="checkbox"/> Recurrence
--	--	---

**Issues for MDT Discussion:**

<input type="checkbox"/> Neoadjuvant curative Rx	<input type="checkbox"/> Resection of primary	<input type="checkbox"/> Adjuvant curative Rx	<input type="checkbox"/> Curative surgery for metastasis	<input type="checkbox"/> Palliative Rx
--	---	---	--	--

**Treatment Plan:** Tick all that apply

<b>Surgery</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Discussed post-op <input type="checkbox"/> For primary <input type="checkbox"/> For metastasis <b>Which to resect first:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Metastasis	<b>Further Investigations Required</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Tick all that are required:</i> <input type="checkbox"/> CT CAP now / ___ months <input type="checkbox"/> MRI now / ___ months <input type="checkbox"/> PET now / ___ months <input type="checkbox"/> Colonoscopy now / ___ months <input type="checkbox"/> CEA now / ___ months <input type="checkbox"/> Other _____
<b>Radiotherapy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pre-operative short course <input type="checkbox"/> Pre-operative long course <input type="checkbox"/> Post-operative <input type="checkbox"/> Palliative	
<b>Chemotherapy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clinical Trial <input type="checkbox"/> Palliative <input type="checkbox"/> Neo-adjuvant <input type="checkbox"/> Adjuvant	

**Proposed Regimen** (use codes below)

FU= 5FU	OX= Oxaliplatin	LE= Leucovorin	CE= Cetuximab
XE= Capecitabine	IR= Irinotecan	BA= Bevacizumab	OT= other

**Watch and Wait**  **Other** \_\_\_\_\_

<b>Required Referrals Medical</b>	<b>Required Referrals Allied Health</b>
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**Follow up arrangements:** \_\_\_\_\_ **Delegated to:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Registrar completing document

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Discussion Outcome:** (to be completed by treating team)

Patient Informed and Agreed with recommended Treatment Plan

Patient Informed and Agreed with Alternative Treatment Plan (as indicated below)

<b>Patient Informed by:</b> _____ <b>Signature:</b> _____ <b>Date:</b> _____	<b>Treatment Plan communicated to:</b> <b>Name:</b> ..... <b>Fax No.</b> ..... <b>Name:</b> ..... <b>Fax No.</b> .....
--	--

<insert logo>

<insert patient details/sticker>

### COLORECTAL MULTIDISCIPLINARY TEAM TREATMENT PLAN

Meeting Date:

Referring Clinician:

GP:

<b>Attendance:</b>			
<input type="checkbox"/> Surgical Oncologist	<input type="checkbox"/> Medical Oncologist	<input type="checkbox"/> Radiation Oncologist	<input type="checkbox"/> Pathologist
<input type="checkbox"/> Radiologist	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Nursing Representative	<input type="checkbox"/> Stomal Therapist
<input type="checkbox"/> Genetic Counselling	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Palliative Care Representative	<input type="checkbox"/> Dietetics
Other (please specify) .....			
<b>Diagnosis:</b>			
Location .....		Tumour Type.....	
Lymph Nodes Involved ...../.....		Distant metastases <input type="checkbox"/> No <input type="checkbox"/> Yes Location.....	
Stage T .... N.... M....		Staging based on <input type="checkbox"/> Pathology <input type="checkbox"/> Imaging <input type="checkbox"/> Other (state).....	
<b>Treatment Intent:</b>			
<input type="checkbox"/> Curative <input type="checkbox"/> Palliative			
<b>Recommended Treatment Plan:</b>			
<input type="checkbox"/> Surgery		Details.....	
<input type="checkbox"/> Chemotherapy		Details.....	
<input type="checkbox"/> Radiotherapy		Details.....	
<input type="checkbox"/> Clinical Trial		Details.....	
<input type="checkbox"/> Watch and Wait		Details.....	
<input type="checkbox"/> Other		Details.....	
<b>Follow-up Arrangements:</b>			
Action		When	Person Responsible
<b>Psychosocial/Supportive Care Issues:</b>			
.....			
.....			
Referral <input type="checkbox"/> Not required <input type="checkbox"/> Referred to: .....			
<b>Other Comments:</b>			

Meeting Recorded By: <name> <position>

**MULTIDISCIPLINARY TEAM TREATMENT PLAN**



Date:

Re: <John Smith>, DOB ...../...../.....

Dear Dr <Jane Dow>,

Your patient was discussed at the <Western Hospital> Colorectal Multidisciplinary Team Meeting on ...../...../..... Please find here a summary of the **proposed** management plan for this patient.

Procedures Performed:	
Colonoscopy <input type="checkbox"/> No <input type="checkbox"/> Yes	CT <input type="checkbox"/> No <input type="checkbox"/> Yes
Resection <input type="checkbox"/> No <input type="checkbox"/> Yes	PET <input type="checkbox"/> No <input type="checkbox"/> Yes
Stoma <input type="checkbox"/> No <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent	Other .....
Results:	
Location .....	Tumour Type.....
Lymph Nodes Involved ...../.....	Distant metastases <input type="checkbox"/> No <input type="checkbox"/> Yes Location.....
Stage T ..... N..... M.....	Staging based on <input type="checkbox"/> Pathology <input type="checkbox"/> Imaging <input type="checkbox"/> Other (state).....
Psychosocial/Supportive Care Issues:	
.....	
.....	
Referral <input type="checkbox"/> Not required <input type="checkbox"/> Referred to: .....	
Recommended Treatment:	
<input type="checkbox"/> Surgery	Details.....
<input type="checkbox"/> Chemotherapy	Details.....
<input type="checkbox"/> Radiotherapy	Details.....
<input type="checkbox"/> Clinical Trial	Details.....More info available from: <a href="http://www.actr.org.au/trialSearch.aspx">www.actr.org.au/trialSearch.aspx</a>
<input type="checkbox"/> Watch and Wait	Details.....
<input type="checkbox"/> Other	Details.....
For information on chemotherapy side-effects, please refer to <a href="http://www.treatment.cancerinstitute.org.au">www.treatment.cancerinstitute.org.au</a>	
Treatment Intent:	
<input type="checkbox"/> Curative <input type="checkbox"/> Palliative	
Other Comments:	
.....	
.....	

**Should you have any questions or concerns about this patient, please contact <name>, <title>, on 03 <xxxx xxxx> during office hours. After hours, please contact the Oncology Unit on 03 <xxxx xxxx>.**

Regards,

<Signature>

<Name & Title>

On behalf of the Colorectal Multidisciplinary Team, <Western Hospital>