

# How well are we doing multidisciplinary care? An audit of multidisciplinary meetings in Western and Central Melbourne

Michelle Fleming, Jenny Byrne, Prof Jeff Szer. Western and Central Melbourne Integrated Cancer Service, Melbourne, Victoria

## Background

Multidisciplinary care, with regular prospective multidisciplinary team 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), have 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).

The Western and Central Melbourne Integrated Cancer Service (WCMICS) is a collaboration of cancer services at six major metropolitan Melbourne hospitals. One of the key priorities of the WCMICS is the delivery of high quality multidisciplinary care.

Most cancer services in the hospitals that make up the WCMICS have an established history of multidisciplinary meetings (MDMs). However, the exact processes by which they operate varies, as does the maturity of the meetings. Anecdotal reports indicated that meeting processes were in need of strengthening, and so an audit of the MDMs was conducted with the aim of assessing key areas of need towards which our improvement activities should be directed, enabling tailored support to be targeted to specific MDMs.

## Methodology

### Tool Development

The audit tool was developed based on a review of the literature and the tool provided in the Victorian Department of Human Services (DHS) *Multidisciplinary Meetings Toolkit* (5). Some examples of MDM processes covered by the tool include medical and non-medical clinician attendance, meeting room facilities, criteria for inclusion of a patient on the agenda, patient communication, GP communication, and documentation of the meeting and its outcomes. The tool is available from the WCMICS website: [www.wcmics.org](http://www.wcmics.org).

### Process

The Project Officer attended each meeting and documented observations using the audit tool. The Chair of each MDM was then interviewed to confirm and/or clarify the observations, as well as to obtain information about MDM processes that were not able to be observed e.g. how the agenda was put together.

Information collected during the audit was analysed using Microsoft Excel and de-identified comparative data was then provided to each MDM Chair and members of the relevant WCMICS Tumour Groups.

### Participants

To date, 21 meetings have been audited across six Tumour Groups. Stage 1 (October 2007) included Breast, Haematology, and Colorectal MDMs, and Stage 2 (June 2008) included Upper Gastrointestinal (GI), Genitourinary, and Central Nervous System (CNS) MDMs.

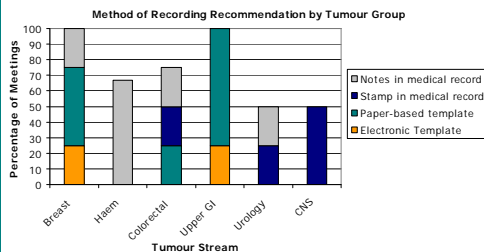
## Results

The audit identified that most of the multidisciplinary meetings are well established and are achieving many of the 'Principles of Best Practice' set out in the DHS' *Multidisciplinary Meeting Toolkit* (5). However, the audit also identified some aspects of WCMICS MDMs that need strengthening.

### Recording of Multidisciplinary Meeting Recommendations

• Meeting recommendations were recorded in 74% of the MDMs surveyed.

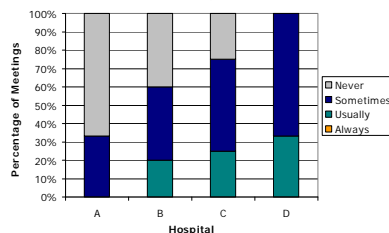
• The method in which the recommendations were recorded varied. The most common mechanisms were either by unstructured notes in the patient's medical record, or by filling in a paper-based template.



### Discussion of Supportive Care Issues at Meetings

The discussion of non-medical supportive care issues at MDMs varied across sites, however generally such discussions were uncommon.

### Supportive Care Issues Discussed During Meetings



### Attendance at MDMs by Core Team Members

Core team members that should be in attendance were defined based on the disciplines recommended in the Victorian Patient Management Frameworks (6). Percentages of meetings in which each core team member was present at is set out below:

Team Member	% of meetings present at			
	Site A	Site B	Site C	Site D
Dietician (Colorectal & Upper GI only)	50%	0%	100%	0%
Endoscopist (Upper GI only)	0%	0%	100%	0%
GP	0%	0%	0%	0%
Haematologist (Haematology only)	NA	100%	100%	100%
Medical Oncologist	100%	100%	100%	100%
Neurologist (CNS only)	NA	0%	0%	NA
Nurse	50%	83%	67%	100%
Palliative Care (Haem & CNS only)	NA	0%	0%	0%
Pathologist	100%	100%	100%	50%
Pharmacist (Haematology only)	NA	0%	100%	0%
Radiation Oncologist	100%	50%	83%	100%
Radiologist	75%	100%	100%	100%
Social Worker	25%	33%	33%	40%
Surgeon	100%	100%	100%	100%
Urologist (Genitourinary only)	100%	100%	100%	100%

- Surgeons, Medical Oncologists, Urologists, and Haematologists attended all relevant meetings.
- Non-medical disciplines (nursing, social work, pharmacy, dietetics) were less likely to attend meetings.
- GPs did not attend any WCMICS MDMs.

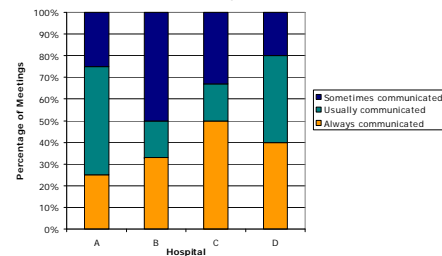
### Communication of Meeting Recommendations to the GP

The recommendations made at the multidisciplinary meeting were inconsistently communicated to the GP, with some MDMs always communicating the recommendations, whereas for others it did not often occur.

The method of communication also varied. Two meetings used a form filled out and faxed to the GP immediately after the

meeting. The majority of other meetings stated that the dictated letter sent to the GP after the patient's clinic appointment was the only method of communicating the meeting recommendations.

### Communication of the MDM Treatment Plan to the GP



## Actions

This audit has resulted in the completion of several improvement activities, including:

- The development of standardised forms to record MDM recommendations and communication of these to the GP
- Implementation of these forms in paper-based format.
- Development of written Terms of Reference for each MDM
- Funding of equipment to support MDMs, including laptops, AV equipment, and microscope accessories.

Further work is planned around electronic recording of meeting recommendations, consideration of supportive care issues in MDMs, and improving meeting attendance by core team members.

The audit will be conducted in the four remaining WCMICS Tumour Streams (Lung, Head and Neck, Skin/Melanoma, and Gynaec) in early 2009. It will also be repeated annually to assess the impact of these improvement activities.

## Conclusion

The identification of these areas of need has ensured that improvement activities conducted by the WCMICS can be appropriately targeted, enabling tailored support for specific MDMs and more efficient use of resources.

Annual repetition of the audit will also allow the measurement of changes that result from MDM improvement activities.

## References

- (1) Metropolitan Health and Aged Care Services Division (2007). *Achieving best practice cancer care - A guide for implementing multidisciplinary care*. Victorian Government Department of Human Services, Melbourne, Victoria.
- (2) National Breast Cancer Centre (2005). *Multidisciplinary meetings for cancer care: a guide for health service providers*. 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: Medical implications of group decisions', *Lancet Oncology* 7: 951-954
- (5) Cancer Coordination Unit (2006). *Multidisciplinary Meeting Toolkit*. Victorian Department of Human Services, Melbourne, Victoria
- (6) Metropolitan Health and Aged Care Services Division (2006). *Patient Management Frameworks* (various). Victorian Government Department of Human Services, Melbourne, Victoria.