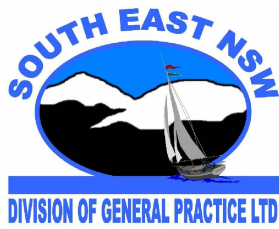


Rural Palliative Care Resource Kit



Case Study: Establishing Multidisciplinary Palliative Care Team Meetings

*The experience of a small regional health
care community introducing change in clinical
practice*

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Introduction

“Palliative care draws heavily on a broad spectrum of disciplines, knowledge, skill, experience and creative thought. Palliative care teams may include nurses, doctors, social workers, volunteers, chaplains, allied health practitioners and a multitude of other therapists. Medical science has come to new understandings about the interplay of the physical, functional, emotional, psychological, social and spiritual aspects of wellbeing and more lately has supported the development of multidisciplinary approaches.”

The South East NSW Division of General Practice (SENSWDGP) was able to commence / trial the use of multidisciplinary team (MDT) meetings as a forum for case discussion and planning with the ‘palliative care team’ as part of the Rural Palliative Care Program (RPCP).

Prior to commencing MDT meetings the PCT identified possible barriers and developed solutions to overcome these as well as exploring options to ensure that MDT meetings were sustainable post completion of the RPCP funding.

This report outlines the barriers and identifies how they were addressed. It also illustrates the model that the SENSWDGP found to be most effective. Finally it outlines the model of MDT meetings for the Eurobodalla area, and the plans to integrate Palliative Care MDT into other multidisciplinary meetings.

Setting the scene - Eurobodalla

The Eurobodalla is a coastal community of approx 36,000 people, spread over an area of 3422 sq. kilometres. It has rural, state forest, national park, residential, light industrial and commercial precincts. The three towns of Batemans Bay, Moruya and Narooma are located in the north, central and southern parts of the shire respectively. The proportion of the population^{1,5} aged over 65 years (22 percent) is almost twice the national average of 12 percent, with many being retirees from larger urban centres. It has very small numbers of culturally and linguistically diverse residents, with the largest group being indigenous persons making up of four percent of this group.

Palliative Care in the Eurobodalla is provided using the primary care model of service delivery³ utilising the local GPs, community, hospital and aged care facility staff, both ‘ageing in place’ and residential. The generalist community nurses have a broad knowledge and experience of palliative care; some members having previous experience in specialist palliative care services.

Access to tertiary level specialist palliative care support is limited to a monthly visit from a palliation consultant and a Palliative Care Clinical Nurse Consultant (CNC) funded via the Australian Government Department of Health and Ageing initiative Medical Specialist Outreach Assistance Program (MSOAP). The consultant visits one day per month and the CNC (0.8 FTE) has an area of responsibility covering all of south eastern NSW. Both these specialists are able to provide limited support. One of objectives of the RPCP was to build capacity of the primary health palliative care providers in this area, as limited access to specialist services will continue into the foreseeable future.

It was identified in a local needs assessment⁶ prior to the commencement of the RPCP that case coordination and communication between care providers was a factor affecting best practice palliative care delivery. The factors contributing to this included:

- uncertainty as to other care providers role
- time limitations for health care workers
- the complexities in communication sharing that follow when rural patients are given acute

treatment out of area, with only minimal discharge information being available to the relevant local care providers.

The literature^{2,4} indicates that MDT meetings can improve both care planning and communication. The meetings also provide clinical education opportunities, improved awareness between participants about their respective roles in patient care, improve job satisfaction and team building.⁴ It can also help to identify a case manager who can be the hub for information.

What was happening locally before the palliative care MDT meetings commenced?

Prior to the meetings' commencement in November 2005 the communication between care providers was ad-hoc. Patient case management information was usually limited to calls between care providers as needed and usually only when issues arose. In some cases various care providers were not aware of other clinicians' involvement in a patient's care. As a consequence, information sharing was variable. Patients and their carers may have been recipients of inconsistent information contributing to delays in some aspects of care.

The health care workers of the three townships in the shire had limited opportunities to meet to discuss patients. Access to allied health workers such as the Aged Care Assessment Team, Occupational Therapist, Dietitian and Pharmacist was variable.

Barriers to implementing MDT meetings

The main barriers identified for conducting palliative care MDT meetings were:

1. a person was needed to organise and facilitate the meeting
2. locating a suitable venue with teleconferencing facilities
3. identifying a suitable time and date to most health care workers
4. the perception of 'time wasted at another meeting!' and reluctance to attend due to workload pressures.

Overcoming these barriers

1. A person was needed to facilitate the meeting

The RPCP project officer allocated time to coordinate and provide secretariat to the meetings. The specific tasks for this role included:

- determining an agenda of patients to be discussed (Appendix 1)
- ensuring patients consented to discussion and health information sharing
- preparing patient information notes for the meeting
- disseminating the list of patients to the nominated participants at the MDT meeting several days prior to the meeting
- booking a room at the local community health centre
- disseminating the date, time and venue for the meeting
- notifying the GP that a meeting about their patient was occurring inviting them to attend via telephone or in person. Information was offered on how to claim the relevant MBS item for participation in a case conference (Appendix 2)

- minute-taking at the meeting
- disseminating notes from the meeting (Appendix 3) to the relevant health care workers.

The time required for these tasks was approximately 8 hours per meeting per month.

2. Locating a suitable venue with teleconferencing facilities

The location of the venue had to be central. Geographically, the Eurobodalla Shire is long and narrow, approx 90 kms from north to south. The health care workers found it time consuming to travel to the central site of Moruya, taking one hour as well as one hour meeting. Mental Health Services, located at the community health centre manages the teleconferencing facility.

The Moruya Community Health Centre has the advantage of being the largest of the health centres, with many of the allied health, aged care, oncology and pharmacy staff being located there. The room can accommodate approximately 15 people; however the usual attendance was between 6 and 12 persons.

3. Identifying a suitable time and date to most health care workers

As the majority of the attendees at these meeting are clinicians delivering community-based healthcare, the mornings were not considered suitable due to clinical demands. The monthly palliation physician's visit occurred on the third Tuesday of each month.

4. The perception of 'time wasted at another meeting!' and reluctance to attend due to workload pressures

As with most busy health care workers, the concept of another meeting met with initial resistance. If the clinicians were to participate in these meetings they needed reassurance that the outcomes from the meeting would have relevance and benefits for their patients as well as their own clinical practice.

This required some initial education and marketing. The features that fostered involvement included:

- the attendance of key members of the notional palliative care team including the participation each month of the visiting palliation physician, the hospital chief pharmacist and the Cancer Care clinical psychologist
- the education component of the clinical case discussion
- the opportunity to have direct conversations with other care providers who may at times be difficult to contact individually
- initially a small afternoon tea was offered, although this discontinued after about 6 months.

The initial model of palliative care MDT meetings

A monthly meeting was held at Moruya Community Health Centre facilitated by the RPCP project officer. Five to nine patients were discussed during the hour-long meeting. Those patients on the agenda included new admissions and / or current patients with complex needs or recent phase changes.

The regular or core attendees included:

- Palliation consultant
- Hospital pharmacist
- Community nurses (usually at least one from each site)
- Palliative care volunteer coordinator
- Cancer Care CNC.
- GP

Those who attended intermittently included:

- Occupational Therapist
- Aged Care Assessment Team member
- Oncology staff
- Clinical psychologist for cancer care.

After the meeting, the minutes would be typed using a template (Appendix 3) and sent via fax to the GP and other relevant health care workers. Any urgent actions were followed up as required.

On one occasion, a GP phoned in to participate in the meeting discussion of his patient. Telephone conferencing was initially used to have all community nurses included for the whole meeting, however throughout the first 12 months this decreased to a nurse joining the meeting via phone only when their patients were being discussed.

Evaluation of the existing palliative care monthly meeting

A focus group comprising of a number of participants was conducted in February 2007 to:

1. discuss perceptions of how effective the current model of meetings was for them; and
2. seek input into how the model could be improved.

Discussion comments included:

Who else would you like to see at the meetings?

Oncology staff, Occupational therapists, Aged care assessment team, Discharge planner, GPs and palliative care CNC

The role of the visiting physician in these meetings:

Vital to the quality of information transferred at the meetings.

What does your patient get out of the meetings?

Improved symptom management. Patients benefit from participants getting increased knowledge of potential treatments and care options.

What do you suggest to improve the meetings?

Pre meeting agendas could be customised so that the issues for discussion are included on the agenda listing. Minutes from the meeting to be on individual issues based rather than the set pro-forma issues. Meetings to start at 3.30pm, refreshments are nice!!!!

Do you think meetings could be improved with visual teleconferencing or is telephone conferencing adequate?

Phone conferencing is adequate however phone link is often blurry and can be inaudible if speaker is not near microphone, or paper shuffling is taking place. A telehealth facility is available at Batemans Bay but not Narooma. Currently nurses phone in a using a speaker phone function on desk phones.

Do you find that the discussions are educational?

Yes if the topic is relevant to the current patient load or a complex case. The key providers of the educational input are the palliation specialist, the pharmacist, the clinical psychologist.

What do you perceive to be the barriers now to participating in palliative care MDT meetings?

- ***Concurrent clinics***
- ***Home visits in the afternoon***
- ***Travelling is about one hours round trip on top of 60 minute meeting***
- ***Workload pressure related to clinical care and other activities such as cardiac rehab, early childhood clinics, immunisation, quality improvement committees, etc***
- ***Reduced access to cars as car pool has been downgraded in size.***
- ***Oncology staff increased afternoon chemotherapy sessions due to large workload increase***
- ***Limited numbers of ACAT, Occupational Therapist and Dieticians currently employed due to rural recruitment issues.***
- ***GPs are very heavily booked, have not indicated interest in using this forum for case discussion.***
- ***Discharge planner does not work Tuesdays, the day that current meeting is held***

Who else can facilitate the palliative care MDT meeting so it is sustainable if project officer is not available?

- *Locally based palliative Care CNS is nominal only; she is not allocated any time to focus on palliative Care issues or service delivery*
- *GSAHS Palliative Care CNC is responsible for large geographical area, would not be able to support this local meetings as she is 0.8FTE for a very large area.*
- *None of the current clinicians have time available to fulfill this role, although all have the potential capacity if time and resources were allocated.*

Focus group discussion February 2007, MDT meetings

Following this focus group discussion, a planning session was conducted between the Cancer Care Coordinator CNC (0.5 FTE) and the RPCP project officer to explore ways of responding to the feedback.

It was decided that combining the monthly palliative care MDT meeting with the fortnightly Cancer Care MDT meeting could be trialled as a way of improving the frequency of the MDT meetings. Whilst not identified by the group as a priority, greater frequency would enable improved care planning and review of clinically complex cases. Many of the patients and health care workers for both MDT are similar.

Actions needed to enable this to take place included:

- the agenda would be reformatted to focus on specific care issues
- the minutes would be modified to simplify the minute taking process
- the procedure for facilitating these meetings would be standardised so that it was the same. A policy and procedure document would be developed
- encourage greater input from Oncology service by sending the agenda the day prior, allowing them to provide updated information on their current patient's treatment plans or any pending diagnostic results
- requesting that Palliative Care CNC join the MDT meeting at least monthly either in person or via teleconference to provide clinical input
- terms of reference would be developed to ensure there was clarity about the intent and function of these meetings (Appendix 4)
- a meeting roster for the six month trial would be developed and advertised to all stakeholders
- the current MDT meeting planning and activity needs to be documented in policy and procedures format, so that second party can undertake these tasks, and to provide clarity of what needs to be done
- refreshments to be provided
- the Cancer Care CNC would facilitate the meetings and direct discussion whilst the RPCP project officer would take minutes directly onto loaded templates in laptop
- determining the agenda would be a joint effort from the RPCP officer the Cancer Care CNC. It is confirmed within 24 to 48 hours prior to the meeting
- raise awareness of teleconferencing etiquette around such issues as announcing yourself before speaking, ensuring background noise is minimized, modulating voice so it is audible in other sites.

What is happening now for Eurobodalla with MDT meetings

Since February 2007 the meetings have been conducted fortnightly. The new agenda format (Appendix 5) is preferred by the participants as it allows them to contribute to the issues pending section if there are specific concerns they wish to have discussed during the meeting. The meeting notes pro forma (Appendix 6) appears to be easier to complete and are therefore disseminated in a more timely manner.

A very positive development is that two GPs have requested to be included in a recent discussion of their patients. The key factor here is the opportunity for GPs to discuss specific clinical case issues with the palliation consultant. The waiting list for referred patients to be reviewed by the Palliation consultant is now over two months, and given the prognosis of many of these people, more immediate contact via these meetings is helping to address the symptom management issues in a timelier manner.

The meeting time was moved from 2.30pm to 3.30pm to allow clinicians more time to complete their home visits prior to the meeting. It has also facilitated the involvement of the discharge planner and dietician in more meetings. The meetings are held (normally) fortnightly on either Tuesday or Wednesday. Due to limited availability, a variety of venues have had to be used.

The Palliative Care CNC participates in the meetings more frequently now either in person or via phone

Conclusion and key messages

- The facilitator role is essential to the process of multidisciplinary team meetings.
- Time and resources need to be allocated for this function to continue.
- Consultation with the participants is essential to ensure that the MDT meeting provides them with what is relevant and helpful to their clinical practice.
- MDT meetings are a worthwhile way to improve patient case management
- Communication between healthcare providers is enhanced through a regular forum
- MDT meetings provide educational opportunities through case review
- The meeting's success is dependant upon the participation of key health care workers with expertise in palliative care and a sustained commitment from the participants.

References

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2. Palliative Care Australia (2005). *Standards for Providing Quality Palliative Care for all Australians*. Deakin, ACT: Palliative Care Australia.
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5. Crawford, G.B., Price, S.D. (2003). 'Team Working: Palliative Care as a Model of Interdisciplinary Practice' *Medical Journal of Australia*, 179 (6 suppl): s32-s34.
http://www.mja.com.au/public/issues/179_06_150903/cra10363_fm.pdf
6. *Southern Area Health Service Palliative Care Review* (2001). Hawthorn Victoria; Sach and Associates.

Appendices

- Appendix 1: Original format multidisciplinary team meeting agenda
- Appendix 2: Pre meeting fax sent to GP
- Appendix 3: Original format of minutes from multidisciplinary team meeting
- Appendix 4: Terms of reference for palliative care multidisciplinary team meetings
- Appendix 5: Modified agenda for palliative care and cancer care meeting
- Appendix 6: Modified minutes of multidisciplinary palliative care team meeting.

Appendix 1: Original format multidisciplinary team meeting agenda

Agenda of patients to be discussed at the
Palliative Care Multidisciplinary Team Meeting: 11.10.2006
2.30 - 3.30pm
Moruya Community Health Teleconference Room

Patients to be discussed:

[Name]	Narooma
[Name]	Narooma
[Name]	Moruya
[Name]	Moruya
[Name]	Moruya
[Name]	Batemans Bay Hospital
[Name]	Batemans Bay
[Name]	Batemans Bay
[Name]	Batemans Bay
[Name]	Batemans Bay

- Please use the Case Conference Guide to help formulate the planning approach for this meeting.
- If you would like a copy of your patient's meeting notes forwarded to you, please include an email address or fax number.
- All patients GPs will be posted a copy of the meeting notes about their patient.
- The next meeting will be on the 21.11. 2006, here in this conference room from 2.30pm to 3.30pm, with Dr [Name], palliation physician.

You are very welcome to attend and to suggest any patients that you think would benefit from multidisciplinary team meeting discussion. Contact [Name] on [Name] if you have any enquires.

Appendix 2: Pre meeting fax sent to GP

TO: Dr [Name]	FROM: [Name] Eurobodalla Palliative Care Support Officer
FAX NUMBER: [Name]	DATE: 13th March 2006 Number of pages including cover sheet: 1
<input type="checkbox"/> For Your Urgent Attention	

Dear Dr [Name],

On Tuesday the [date] Dr [Name], Palliation Specialist from [practice] in Sydney, will be visiting the Eurobodalla.

Your patient [Name] will be discussed at the multidisciplinary palliative care team meeting to be held from 2.30 to 3.30pm at Moruya Community Health in the tele-health room, that Dr [Name] is participating in.

I am contacting you to confirm these arrangements, and to request a copy of any relevant diagnostic and pathology reports that you feel may assist the discussion.

The reports can be faxed to the division office on [number]. All patient health information is stored securely, and written consent has been obtained for their care to be discussed at a team meeting.

If you would like to participate in the multidisciplinary team meeting, you are welcome to attend in person, or I can organise a phone link up at some stage between 2.30 and 3.30pm (usually discussion is for approximately 5 to 15 minutes per patient). Otherwise, I will forward you a copy of the team meeting notes relevant to your patient for your records.

Your involvement can contribute towards a Team Care Arrangement or Care Plan MBS item. Please contact me if you have any enquiries or concerns.

Yours sincerely

[Name]

Eurobodalla Palliative Care Support.

The information contained in this facsimile is confidential and may be subject to legal privilege, intended only for the individual to whom it is addressed. The privilege is not waived, lost or destroyed by reason of mistaken delivery or transmission of this document. If received in error, please notify the author by telephone and destroy the original.

Appendix 4: Terms of reference for palliative care multidisciplinary team meetings

TRIAL CANCER AND PALLIATIVE CARE MEETINGS 2007.

TERMS OF REFERENCE:

Aims:

- To facilitate communication between health care providers that are striving to improve patient outcomes through effective information sharing and communication and linking across related services and programs.
- To ensure information on new referrals is provided to the relevant healthcare workers.
- To foster the practice of regular and effective multidisciplinary team meetings to facilitate best practice care for the patients with both cancer and palliative care needs.
- To facilitate increased involvement of GPs in the process of communication sharing by ensuring that relevant information is sent to the GP in a timely manner.

The Services involved are:

- Cancer Care Coordinator
- Eurobodalla Palliative Care Support
- Eurobodalla Community Allied Health
- Eurobodalla Community Nursing
- Eurobodalla Oncology Service
- Eurobodalla Hospital Pharmacy
- Batemans Bay Hospital
- Moruya Hospital

Participants:

The above-mentioned groups and any interested stake holders

Date of meetings

DATE	VENUE
7th March	Laughter Room, Moruya Hospital 2pm to 3pm
20th March	MCHC Telehealth Room 3.30 to 4.30pm with Palliation physician and Palliative Care CNC
17th April	MCHC Telehealth Room 3.30 to 4.30pm with Palliative Care CNC
2nd May	MCHC Telehealth Room 2pm to 3pm
15th May	MCHC Telehealth Room 3.30 to 4.30pm with Palliation physician
30th May	Laughter Room, Moruya Hospital 2pm to 3pm
13th June	MCHC Telehealth Room 2pm to 3pm
19th June	MCHC Telehealth Room 3.30 to 4.30pm with Palliation physician
27th June	MCHC Telehealth Room 2pm to 3pm
11th July	MCHC Telehealth Room 2pm to 3pm
17th July	MCHC Telehealth Room 3.30 to 4.30pm with Palliation physician
25th July	Laughter Room, Moruya Hospital 2pm to 3pm

Procedure:

- Proposed agenda, containing the patient's name, date of birth, diagnosis, any issues for discussion, will be drafted and sent to all participants on email list
- Participants are invited to contribute to this list any details on patients or issues they wish discussed and indicate their attendance either in person or phone at meeting.
- The meeting minutes will be completed within 72 hours of meeting and sent to relevant healthcare workers for their records.

Appendix 5: Modified agenda for combined Palliative Care and Cancer Care MDT Meeting

DATE: 3.3.07

Please check this list and add any items you want discussed at tomorrows meeting, red additions are from ONCOLOGY STAFF

Name	DOB	Diagnosis	Issues	Action plan
		Ca Lung	Management of cough and dyspnoea and pain	Chemo cancelled
		Fibrosis	Dyspnoea management	
		Ca Prostate with Liver and bone mets	Reactive depression Manner of death	
		Unknown primary, Mets in lung and brain	Increasing fragility Complex home situation	
		CA Cervix and Vulva Osteoarthritis	Pain management	
		Ca Pancreas	Future care and treatment options	
		SCC abdomen	Supports for wife Oedematous legs Dietary needs	
		Melanoma 1998, Parotidectomy 2003 Lymph node clearance 2004 Craniotomy and frontal parietal lesion debulking 2007	How is he at present, what symptoms Radiotherapy last week in TCH	For chemotherapy after XRT.
		Ca Pancreas	Lives alone, needs supports???	
		NHL with reoccurrence 2007	Planning for future care ? needs community nurse support for carers	Chemotherapy currently discontinued until review by oncologist 10/5/07
		Large cell Lung cancer,	For radiotherapy, ? needs community nurse support for carers	No chemotherapy

