

Multidisciplinary teamwork in **breast** cancer care

A perspective from the European Partnership for Action
Against Cancer (EPAAC) framework

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Introduction

Lisbon round-table, Portuguese EU Presidency (2007)

European Commission launch the European Partnership for Action Against Cancer, EPAAC (2009)

~ *Cancer care organisation matters* ~



Specific actions to be held on health services at EU level

Multidisciplinary care and cancer networks

WP7 Objective 1



To identify and assess **best cancer care practices** across European health services, promoting the exchange of experiences focusing on innovative organizational approaches, including patient's perspective

Key areas

- **Multidisciplinary care** and national / regional networks (ICO, NCOD, IPOS, EAPC, BMH, ECCO, Lombardia, ECPC)
- Standardization of treatment, symptom assessment and follow-up of palliative care (EAPC and NTNU)
- Standards of care for children with cancer (SIOPE and Polish MH)
- Complementary and Alternative Medicine (CAM): evidence and utilization in Europe (Regione Toscana)

Work Package 7 Associated partners

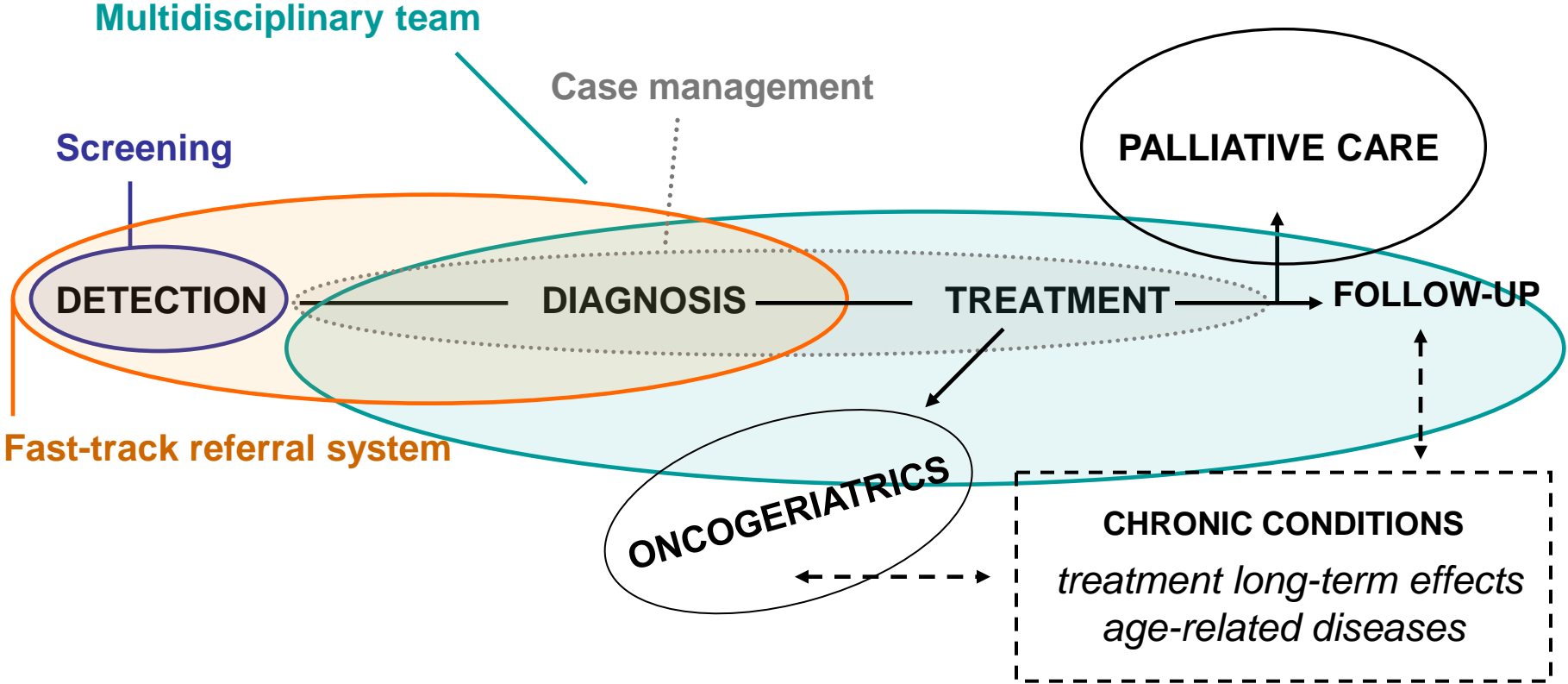
- National Coordination for Oncological Diseases, High Commissariat of Health, Ministry of Health, Portugal
- Polish Ministry of Health, PMH
- Catalan Institute of Oncology, ICO
- French National Cancer Institute, INCa
- European Health Management Association, EHMA
- European Society for Paediatric Oncology, SIOPE
- European Hospital and Healthcare Federation, HOPE
- European Society for Clinical Nutrition and Metabolism, ESPEN
- European Oncology Nursing Society, EONS
- Norwegian Directorate of Health, Norwegian University of Science and Technology, NTNU
- European School of Oncology, ESO
- Regione Toscana, Italy, RTI
- Belgium Ministry of Health, BMH
- Institute of Public Health, Ljubljana, Slovenia, IPH

Why breast cancer is relevant in this context?

Breast cancer as a model for MDT

- 1) High incidence
- 2) Age distribution
- 3) Screening programs
- 4) Multimodality therapies
- 5) Long survivorship (i.e., chronic components)
- 6) International experiences

Systems interaction through the **breast** cancer care process: the Catalan Health Service case



Breast cancer – Main changes in organisation and delivery of services

Organisational system	Focus	Intermediate result	Potential benefit
Fast-track referral system	GP's ability in symptom identification and clear referral between levels of care	Rapid diagnosis, improved efficiency	<i>Improved clinical outcomes, reduction of patients' anxiety levels</i>
Multidisciplinary team	Decisions on diagnosis and therapeutic management planning	Consensus-based decisions	Improved clinical outcomes, better patient management
Screening	Population at risk	Early detection	Better prognosis
Case management	Pathway management and patient education and support	Responsiveness (to people's non-medical expectations), better self-care	Improved continuity and coordination of care

→ First disease in transition from disease-focused to patient oriented management

Methods

FIRST STEP: RESEARCH ON MULTIDISCIPLINARY CANCER CARE

SECOND STEP: WORKSHOP WITH EXPERTS

Systematic Review of the evidence (PubMed; 2005-2011)

→ Update of the work of Wright *et al* 1960-2005 (CCO)

+ **Environmental Scan** on the European National Cancer Plans

Systematic review of the literature

Two types of original articles included:

- 1 Impact of MD cancer patient management on outcomes (clinical, process)
- 2 Key organisational components

444 original articles (showing positive results) were included



48 articles accepted

Type 1, n=**20** *Retrospective, prospective, questionnaire, before-after*

Type 2, n=**28** *Descriptive (qualitative, case-studies)*

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Papers accepted:

- 1.- Original research - data-based papers: original data or new analyses of data on MDC.
- 2.- Program-description non data based: description of an intervention or programme without presentation of quantitative data.

Papers non accepted:

- 3.- Discussion papers or commentaries: editorials, position papers, news, letters, discussion of case reports
- 4.- Reviews (data or non-data based) of research in this area.

Breakdown of a sample of articles

Art	T*	Origin	Tumor site	MD setting	Type of study
213	1	USA	Urologic malignancies	Tumor board	Prospective cohort study
268	2	USA	Head and neck	Tumor board	DKC**
270	2	UK	Esophageal adenocarcinoma	MDT meeting	DKC
276	1	Sweden	Colon and Rectum	MDT conference	Retrospective cohort study of county cancer registry data (1995-2004)
286	1	USA	Pancreas	TB / MD conference	Prospective cohort study
288	2	Australia	Breast	MDT meeting	DKC
307	1	UK	Colorectal liver metastases	MDT meeting	Prospective study of patients (1996-2006). Comparing patients referred to a MD specialist hepatobiliary unit (with liver surgeon) vs patients referred to local colorectal MDTs
319	2	USA	Prostate	MD cancer clinic	DKC
340	2	USA	Head and neck	Tumor board	DKC
360	2	USA	Rectum	Tumor board	DKC
370	2	UK	All	MDT meeting	DKC
374	1	Germany	Gynecological cancer	Online TB conference	Questionnaire of participants in an online national tumor conference
390	2	UK	Colorectal	MDT meeting	DKC
394	2	UK	Colorectal	MDT meeting	DKC
397	2	Australia	Breast	MDT meeting	DKC
399	1	UK	Gastro-esophageal	MDT meeting	Prospective cohort study (1997-2002)
405	1	USA	Breast	Tumor board	Retrospective review of medical records
409	2	Switz/UK	All	MDT meeting	DKC
424	1	UK	Esophageal	MDT meeting	Retrospective cohort review of patients managed by a MDT (1998-2003) or by surgeons working independently (1991-97)
426	2	UK	Gynecological cancer	MDT meeting	DKC
429	2	UK	Breast	MDT meeting	DKC
436	1	UK	Rectum	MDT meeting	Retrospective cohort study of rectal cancer patients (1999-2002). Comparing CRM+ ve rates of patients discussed at MDT meeting vs those not discussed

*Type 1: MD cancer patient management change on outcomes; type 2: key components

**Descriptive on key components

Analytical summary of the papers included on the review

Multidisciplinary cancer care: analytic vs implementation perspective

	Advantages	Problems
Analytic perspective	<ul style="list-style-type: none">- Integrative view of the process of care- Interface between MDT and other areas such as palliative care, chronic care, oncogeriatrics, etc	<ul style="list-style-type: none">- Difficult to identify specific advantages: MD care occurs simultaneously with rapid changes in treatment and use of CPG- Difficult to define MD specific model of cooperation: tumour board, one-stop diagnosis, clinical unit, MD follow-up, etc.- Interaction with related policy themes: centralization, high professional specialisation and introduction of standardized protocols- Clinical outcomes: positive but weak results
Implementation perspective	<ul style="list-style-type: none">- Specific response to the increasing complexity of cancer care- Better adherence to clinical practice guidelines- Enhanced coordination of hospital services- Increased patient access to clinical trials	<ul style="list-style-type: none">- Difficult to identify appropriate leaders- Need to focus on local adaptation once common objectives have been set up- Fragmentation of cancer care financing- Inconsistent communication between team and patient

Best-practices on multidisciplinary cancer care (1)

Basic criteria for MDT working

- Leadership and team dynamics
 - Roles: chairman (facilitator) and/or clinical coordinator, nurse case manager
 - Shared objectives (explicitly made, mutual respect)
 - Full participation (important for effective implementation of decisions)
- Administrative support
- Staff time assigned
- Specific funding from health care system

Other key requirements

- Patterns of referral within hospital/area
- Shared evaluation of the clinical outcomes

Best-practices on multidisciplinary cancer care (2)

Additional organisational criteria

- Every new cancer case (inpatient or ambulatory) under MDT guidance
- Cancer professionals associated with specific MDT (mandatory participation MTM)
- Nature of agreements: from 'recommendations' to 'binding decisions'
- Perspective on the whole process of care (key decisions made in *staging, treatment, follow-up* and *non-medical needs*)
- Coordination of follow-up (avoid duplications and focus also on general health conditions)
- Educational opportunity for physicians in training

Sample of articles: component of care focus

MDT scope (specific component focus)	Nº of studies
Treatment	6
Diagnosis and treatment	5
Diagnosis, treatment and follow-up	2
Treatment - complex cases (<i>multi-institutional</i>)	1
Staging accuracy and treatment selection	1
'Single-day' clinics/'one-stop care' (prior to TB)	2
Follow-up	1
Access to clinical trials	2

...treatment is not the only focus in literature when dealing with MDTs working.

Limitations

- Widespread policy adoption of the “multidisciplinary discourse”, but few complete experiences (published), which are restricted to specific health systems or centres (mainly in USA, UK and Australia)
- Difficult to define what “MD cancer care” is
- Quality of the evidence

Conclusions

- Logical approach to organising complex procedures and clinical decision making involving professionals with different backgrounds
- MDT setting as an answer to the increasing specialisation and degree of expertise among professionals
- Seamless process of care: need perceived by patients