Multidisciplinary Case Conference (MDCCs) Where the Patient is Not Present

Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for National Efficient Price (NEP18)?
YES

Queensland cancer services **supports the work undertaken to include** MDCCs in the costing model to reflect their vital importance in the provision of treatment plans that ensure the best outcomes for patients.

Consumer feedback received identified the imperative of having MDCC at *critical points initial diagnosis and treatment decisions; changes in status (eg recurrence or spread) requiring decisions on new treatment regime/s including possible surgery, or radiation therapy (stereotactic or otherwise), or new chemo/targeted/immuno therapies, or clinical trials. Possibly also in cases where a patient has other serious health conditions that require intervention, but that intervention may have an impact on their path in cancer treatment.*

All cancer patients should be able to expect their cases will be reviewed by an MDCC at important treatment decision points, regardless of whether that patient is being treated for curative intent, or for recurrence, or progression, or for metastatic disease.
Queensland cancer care services are in the unique position of having established tumour specific and general cancer care multidisciplinary team meetings and would be in a position to electronically record the items identified in the KPMG report. Currently Queensland Health public cancer services record MDCC in software applications Elekta - MOSAIQ® or QCCAT - QOOL.

The digital hospitals (ieMR) implementation expansion provides the opportunity for other specialities to incorporate their MDCC within the Enterprise Scheduling Management (ESM) in combination with the ieMR's planning and documentation tools to record the suggested items. It is essential that the final requirement d) a summary of the outcomes of the MDCC is not only recorded in the patients' medical records but also communicated at a minimum to primary care providers, General Practitioner, MDCC team and patient.

As identified in the KPMG report MDCC vary in levels of complexity and proposed funding should reflect the level of expertise required to be present. The definition needs to enable multiple presentations of a patient's case as the previous intervention outcome may require further discussion to determine / modify the appropriate treatment plan. The combination of one or more speciality surgeons, radiation / medical or haematology oncologists, pathologists, radiologists, specialist nursing and allied health is required to determine the most appropriate treatment and sequence of care. This enables the patients' next steps to be tracked and monitored as determined at the MDCC and facilitates coordination of the multiple appointments across the various services.

The KPMG report identifies *MDCCs improved the quality of clinical decisions because of peer-review and group consensus of treatment options.* More than one member of the same speciality provides an alternative view of options that is beyond a peer review. The presentation at an MDT provides the best options for patients with standardisation and consistency, improving patient outcomes and facilitates coordination of care.

Given the varying complexity of MDCC's it is recommended that the classifying option that be implemented is to **add a fifth group** that would enable complexity stratification. The ability to measure MDCC's will demonstrate this vital lynch pin between specialities, services and facilities in the management of the increasing complexity of care provided between the public and private sectors. The coordination of care across geographically disparate locations reduces the financial burden of receiving care in specialist tertiary / quaternary facilities through improved coordination of care when presenting to specialist services.

Funding models being considered need to be able to accommodate the varying levels of complexity for MDCCs to be appropriately recompensed, acuity levels need to be applied, for example:

Level 1
Health Professional Lead
Relevant Allied Health (ie dietician, physiotherapist and pharmacist etc)
Nursing & Midwifery (Nurse Practitioner, Cancer Care Coordinator or Nurse Navigator)

Level 2
Medical Professional Lead – single speciality
One participant from each discipline (nursing/midwifery and relevant Allied Health)

Level 3
Medical Lead with multiple medical specialities (additional capacity to include multiple from same specialty for collaboration and peer review)
One or more participant from each discipline (as above)