Improving the efficiency of cancer care

A focus on integrated multidisciplinary care

About this focus brief

This brief is the third of a series focused on four key themes emerging from the All.Can patient survey, which aimed to obtain patients' perspectives on where they encountered inefficiency in their care, looking at the entire care continuum as well as the broader impact of cancer on their lives. The survey was open to current or former patients with any type of cancer; caregivers were also able to fill in the questionnaire on behalf of the patient, if needed. Nearly 4,000 cancer patients and caregivers responded to the survey, providing insights into which aspects of their care could be improved. The survey used the All.Can definition of inefficiency, namely resources that are not focused on what matters to patients.

This document focuses on what respondents said about integrated multidisciplinary care. For more information about the survey methodology and a full report on the survey findings, please visit https://www.all-can.org/what-we-do/research/patient-survey/

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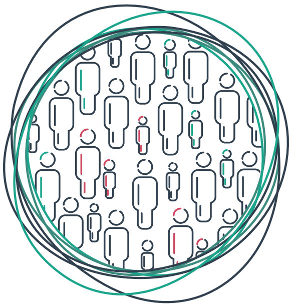

Introduction

Cancer patients have a diverse set of evolving needs throughout their treatment and care that require a variety of services from different providers.[1] High-quality cancer care should therefore be comprehensive and person-centred to meet these needs.[2-4]

Integrated care models offer a framework to achieve comprehensive cancer care. They aim to ensure that care is person-centred and tailored to meet the needs and preferences of the individual, their caregivers and family. Key features of integrated care plans include a patient needs assessment, a multidisciplinary team of healthcare professionals and a transitional cancer care plan.[1 5]

Multidisciplinary teams (MDTs) are key to achieving comprehensive cancer care. MDTs bring together healthcare professionals with different perspectives to collaborate and make evidence-based clinical decisions regarding the care and treatment for each patient.[6] A MDT typically features a central contact person who coordinates all aspects of care and provides clear communication between the care team, the patient and their family – ensuring the patient is well-informed and engaged in their own care.[3]

Many people with cancer seek complementary care or services from allied healthcare professionals, such as nutritional support, exercise, yoga, acupuncture, spiritual support and other therapies, to help meet their psychological and spiritual needs during cancer care.[7 8] Healthcare professionals in MDTs should be sensitive to these needs and able to advise on and signpost people to appropriate services in a way that augments the standard of care.

In the All.Can patient survey, integrated multidisciplinary care was identified as an area where patients experienced inefficiency. A clear opportunity to improve efficiency in cancer care from the patients' perspective is thus to make integrated multidisciplinary care a reality for all patients.

All findings in this brief are from the full report of findings: All.Can. 2019. Patient insights on cancer care: opportunities for improving efficiency. Available from: https://www.all-can.org/wp-content/uploads/2019/07/AllCan_international_patient_survey_findings.pdf

What the survey told us about integrated multidisciplinary care

Respondents felt there was sometimes a lack of coordination in their care – for example, they had no written care plan, nor a primary point of contact to whom they could ask questions.

Respondents reported a lack of communication between their primary care physician and specialists. This was particularly the case in countries with a primary-care-led model e.g. Australia, Canada and the United Kingdom.

> ‘I needed one central point of contact for everything but one place to go for everything too. I have been under the care of three different hospitals with appointments for different procedures, tests etc. at different locations – it takes a lot of energy. I had to become, in effect, a manager rather than a patient.’ Respondent from the United Kingdom

Specialist cancer nurses played an essential role in remedying these communication and coordination gaps. They were able to act as the patient’s companion and ‘navigator’ throughout all phases of care.

> ‘The cancer nurse has been very helpful and has always directed me to the appropriate specialist doctor without ever underestimating my problems. It is a real asset to have such a reliable person.’ Respondent from Belgium

Nearly a quarter of respondents (24%) felt that support from allied health professionals (dietitians, physiotherapists etc.) was not always available. Respondents wanted to know what role these different professionals or services could play in aiding their recovery.

Respondents were not always given adequate information about palliative care. Some respondents commented that palliative care was not discussed with them as an option when they themselves thought it could be helpful. Those who did have access to comprehensive palliative care services mostly reported great satisfaction with this aspect of care.

More than two thirds (69%) of respondents said they needed psychological support during or after their treatment. However, of these, 34% said it was not available. A number of respondents said they were concerned for the impact their cancer had on their families, and wanted psychological support for them as well.

> ‘Psychological support should not just be offered in the form of a brochure stating, “If you need help, you can get it here.” Many people will say they are “coping” when, in reality, they need support readily at hand.’ Respondent from Australia

How does integrated multidisciplinary care contribute to greater efficiency in cancer care?

Integrated care

Integrated care plans help to organise care processes, monitor outcomes, and promote best practice and adherence to clinical guidelines.[1]

Integrated care has been shown to enhance communication between providers, improve the quality and efficiency of care provided, reduce in-hospital complications and improve patients' care experience and outcomes.[1 4]

Other benefits include improvements in patients' awareness about their cancer treatment and side effects, including knowledge of who their key contact is during follow-up care, and greater patient involvement in managing end-of-life care.[1]

Multidisciplinary care

Effective MDTs can create better coordination of care among healthcare professionals, resulting in clear clinical decisions and improved communication with patients.[3]

MDTs may improve survival, reduce waiting times from diagnosis to treatment, improve quality of life and increase access to clinical trials.[3] They also facilitate shared decision-making between patients and their care teams through improved communication and information sharing.[3]

Complementary care and allied health professionals

Complementary care can be important for patients' wellbeing and recovery.[9] Meditation, relaxation, yoga, massage, acupuncture, music therapy and spiritual care have been shown to have a positive impact on patients' quality of life.[8]

Nutrition and exercise are also important elements of care for people with cancer. Patients with adequate nutrition have a better prognosis, respond better to chemotherapy and can tolerate higher doses of anticancer treatments.[10] Exercise can enhance treatment and care by improving physical functioning and quality of life, and reducing cancer-related fatigue.[11]

Specialist cancer nursing

Specialist cancer nurses can help ensure clear communication with patients and their families and other healthcare professionals; they can address patients' emotional, psychological, financial and social needs and offer information, advice, support and reassurance.[12 13]

Having a specialist cancer nurse has been shown to improve outcomes for patients and reduce associated costs of care. This is due to a reduction of symptoms, improved patient knowledge and self-management, improved management of chronic problems, faster care pathways, reduced rates of emergency admissions, reduced length of hospital stays and fewer follow-up appointments.[13 14]

Data suggest that the role of specialist cancer nurses may bring overall savings to healthcare systems. One report from the United Kingdom has suggested that introducing specialist cancer nurses into the cancer care pathway could save around 10% of cancer expenditure.[13]

Psychological support

Significant mental distress is common in people diagnosed with cancer and can result in difficulty processing information, barriers to treatment, poorer quality of life, and higher costs of care due to increased healthcare utilisation.[4 15-17]

The mortality rate among cancer patients with depression has been found to be 39% higher than for those who do not have depression.[16] Rates of anxiety and depression among family caregivers have been shown to be comparable or higher than those of the person for whom they provide care.[18] The effects can be far-reaching; anxiety and depression in teenage and young adult cancer survivors can inhibit their ability to gain an education or employment.[19] Psychological support interventions have shown general benefits in reducing psychiatric symptoms and somatic symptoms (such as pain), improving quality of life and wellbeing, facilitating a return to work and even improving survival.[20]

Early integration of palliative care

Early integration of palliative care combined with a discussion of the patient's goals and preferences can lead to improved symptom control and reduced distress through treatment and care delivery that matches the patient's preferences; this can lead to overall improvement in patient outcomes, quality of life and survival.[21-23]

Palliative care can provide pain relief and psychosocial support,[23] and can significantly improve patients' understanding of their prognosis over time, which may impact treatment decisions about end-of-life care and lead to less aggressive treatment.[22 24]

What are the barriers to implementation of integrated multidisciplinary care?

Limited consensus on what integrated care entails

There is limited consensus on the elements that constitute an integrated cancer care plan and, overall, there is a siloed approach to implementation. For example, care planning tends to focus on specific clinical stages of care, on treatment-specific areas of care such as surgery or chemotherapy, or on individual stages in the cancer care pathway (e.g. survivorship or palliative care only) rather than using a patient-centred view to integrate care across the entire pathway.[1] The World Health Organization has noted that there may be more than 175 different definitions of integrated care.[4] As a result, there is no clear method to develop and implement integrated care plans, or know which activities they should feature and what factors enable their uptake. Furthermore, the availability of care plans for different cancer types is inconsistent, with some cancer types more established than others.

Lack of coordination and infrastructure

Limited buy-in from providers and lack of leadership from physicians are common barriers to integrated care, along with staff turnover preventing integrated care plans from becoming embedded in workflows, inadequate information technology support and limited financial compensation.[1]

Inconsistent implementation of multidisciplinary care

Despite a multidisciplinary approach being recognised as key to improving cancer care, MDTs may not be consistently implemented due to limited funding, resource shortages or lack of personnel. For example, physicians are not always reimbursed for time spent on MDTs.[25]

Poor communication around complementary care

In Europe, it is estimated that a third of cancer patients use complementary medicine in combination with conventional treatment.[26] But people are not always supported to find complementary care services due to a communication breakdown between patients and care teams.[27] Ineffective communication about available complementary care services may actually lead to a decline in patients' use of conventional cancer treatments, as they may forego conventional treatments in favour of using complementary therapies instead, rather than in combination.[27]

Lack of psychological support

According to the International Psycho-Oncology Society (IPOS), 40–60% of cancer patients and family members experience psychological distress that could benefit from intervention, but only a minority receive psychological support and care.[28] This may be due to the fact that many cancer patients who experience psychological issues are not identified by clinicians and are therefore not referred to the needed psycho-oncology services.[20]

There are significant gaps in the availability of psycho-oncology services across Europe. For example, a 2015 survey across 27 countries in Europe found that only eight (30%) had nationally recommended psycho-oncology care guidelines, ten (37%) had budgets for psycho-oncology care, and six (22%) had official certifications for psycho-oncology care education.[29] Other barriers that have been reported include relying too much on individual judgement for psychological distress screening, and overly complex means of evaluating mental distress.[4]

Lack of consistency in specialist cancer nursing roles

There is low investment in specialist cancer nurses overall, often reflecting shortages in the general nursing workforce.[13] Estimates suggest that there are current shortages of more than 20,000 nursing vacancies in England and 1,200 in Sweden, while the United States is projected to have 1.2 million nursing vacancies overall within the next eight years.[30] Workplace stress and burnout are common, particularly when there are staff shortages and no clear definition of the role within the care team.[13] Another barrier is the lack of specialist training available for cancer nurses; availability of training varies significantly across Europe.[13] Furthermore, the specialist cancer nurse role is more developed for some cancer types than in others, creating more inconsistency.[4 13]

What can be done to improve efficiency in integrated multidisciplinary care?

By eliminating common barriers to achieving integrated multidisciplinary care, we could see dramatic improvements in cancer care for patients.

Training providers and staff on how to use integrated care plans is a crucial starting point. Appropriate training is key to enhancing buy-in for the use of integrated care plans as a tool to enhance quality of care. Having a dedicated provider team to oversee integrated care plan development and implementation is important. Appropriate IT infrastructure will enable both patients and providers to access care plans, and allow staff to align these plans with their existing workflow. Finally, national policies that promote standards for integrated care are important to establish it as the standard of care.[1]

Clinical leadership and commitment from healthcare providers and administrators is essential to make multidisciplinary care a reality. European and national policies that support these practices are needed. National cancer control plans offer a framework for the development of multidisciplinary cancer care strategies and can help to secure funding.[3]

MDTs should screen for distress in cancer patients and be able to offer appropriate support or referral to psychological support services. Psychological distress screening should be provided to all cancer patients from diagnosis onwards; it should be a routine part of cancer care that is written into care guidelines.[20]

Early integration of palliative care should be built into treatment plans early in the course of illness for advanced cancers. It should be introduced in conjunction with treatments that are intended to prolong life, such as chemotherapy or surgery.[23 31]

There is a need for formal recognition and investment in the role of specialist cancer nurses. Cancer nurses can play a variety of supportive roles throughout the cancer care pathway, and must be recognised as a core member of the MDT. Healthcare systems should develop roles for them in hospital and primary care settings, with investment in cancer-specific training.[4] Ireland, for example, has developed an oncology education programme for community nurses, and the United Kingdom has invested in more than 4,500 Macmillan cancer nurses who are working in public hospitals and the community, with specialist training courses available in pain and symptom management or psychological support.[4]

Some examples are presented as case studies below.

Case study 1. Dedicated funding for MDT roles in Belgium[32][33]

The Belgian government offers specific financing for roles such as specialist cancer nurses, psycho-oncologists, social workers and data managers to encourage a multidisciplinary approach in cancer centres. The funding to provide this extra staffing is explicitly foreseen in the Belgian national cancer plan.

MDT meetings for all cancer types have been reimbursed since 2003, and in the 2008 cancer plan they were identified as an essential step in the clinical pathway for each new cancer patient. As a result, the number of patients with cancer discussed during an MDT meeting has steadily increased since 2003, to reach 82% of patients in 2011 (compared with 50% in 2004). MDT meetings have also helped increase the frequency and quality of reporting to the Belgian Cancer Registry.

Case study 2. 'No decision about me, without me', England: legal framework for shared decision-making

Under the Health and Social Care Act 2012, the UK government has tasked the National Health Service (NHS) Commissioning Board with making shared decision-making commonplace in the NHS. The initiative, called 'no decision about me, without me', aims to give patients a say over their care and treatment by enabling more opportunity for informed choices, as a means of providing better care and improving patient outcomes.

The Department of Health and Social Care will create a 'Choice Framework' to outline where people have the legal right to make choices in their care, where they can find information and support to make these choices, and where they can go if they are not offered the choices to which they are entitled.[38]

Case study 3. Macmillan specialist cancer nurses in the United Kingdom[35]

A leading cancer charity in the United Kingdom, Macmillan Cancer Support developed a programme to fund its own nurses to help mitigate national shortages. As of October 2017, there were 4,555 Macmillan nurses across the United Kingdom – both in hospitals and community settings. These nurses are employed by the National Health Service but are funded by Macmillan for a set time (often three years). Macmillan provides support for these roles in terms of funding for education and development, and all nurses are registered with at least five years' experience including two or more years in cancer or palliative care. Others will have specialist training in pain and symptom management or psychological support.

Conclusion

Multidisciplinary and integrated care is well established as an enabler of high-quality and comprehensive cancer care. It is also a key area where respondents to the All.Can patient survey felt there were inefficiencies in their care, representing an important opportunity for improvement. Policymakers should consider these findings in future healthcare plans and investment decisions to ensure all patients benefit from integrated multidisciplinary care. Failure to act on these findings will result in higher costs of care, worse patient outcomes, and poorer quality of life and survival for people diagnosed with cancer.

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