The Role of the Multidisciplinary Team (MDT) in the Management of IBD

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National Committee Member: IBDNA
Disclosures

- Consulting: Abbvie, Janssen, Pfizer
- Travel: Abbvie, Ferring, Janssen, Orphan, Shire, Takeda
What is a multidisciplinary team (MDT)?

The value of the MDT in the care and management of IBD

Who are the key & peripheral players in the MDT, and what are their roles?

The patient’s role within the MDT and shared decision making

Communication amongst the MDT

What happens if you don’t have an MDT > referral & access
‘Multidisciplinary care - when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one organisational umbrella or by professionals from a range of organisations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient’.

THE MULTIDISCIPLINARY TEAM

- Will generally consist of…
  - Consultant / Specialist
  - General Practitioner (GP)
  - Nursing
  - Allied Health

HOWEVER IN THE CONTEXT OF IBD…
THE MULTIDISCIPLINARY TEAM

Your GP
Psychologist or counsellor
Specialist IBD nurse
Stoma nurse
Rheumatologist
Consultant gastroenterologist
Consultant colorectal (Dukes) surgeon
Ophthalmologist
Nutrition support team
Pharmacist
Radiologist
Obstetrician
Dermatologist
Histopathologist
Dietitian
Consultant paediatrician
Evidence of the MDT approach is well documented in many settings.

Overall benefits of MDT care include:
- Improved patient health outcomes
- Enhanced client (patient) satisfaction
- More efficient use of resources
- Enhanced job satisfaction for HCPs

NSW Health, 2014
Within the MDT, clearly negotiated and defined roles contribute to the overall benefits if...

- There is trust and respect between the team members
- The skill mix of the team is optimally utilised
- There are agreed upon governance structures
- There are agreed upon systems & protocols for communication and team interaction

NSW Health, 2014
THE VALUE OF THE MDT

- In addition…
  - Shorter timeframes from diagnosis to treatment
  - Increased likelihood of receiving care in accordance with clinical practice guidelines
  - Increase patient access to information and support
  - Streamlined treatment pathways + reduction in duplication of services
  - Increased coordination of care assists patients in navigating a complex healthcare system

Department of Health (2018)
THE VALUE OF THE MDT IN CHRONIC ILLNESS (eg. IBD)

Department of Health (2012)

- Especially improved outcomes in chronic illness

- High quality chronic disease management requires ‘a longitudinal & preventative orientation manifested by well-designed, planned interactions between a practice team and a patient in which the important clinical & behavioural work of modern chronic illness care is performed predictably’

- Requires an integrated & coordinated approach by the MDT with regard to assessment, treatment, support & follow-up

- Increasing evidence that the design of the team and contributions of disciplines are primary determinates of quality of care
THE VALUE OF THE MDT IN CHRONIC ILLNESS (eg. IBD)

- Elements required for effective MDT care in chronic illness
  - Flexibility
  - Cooperative team work
  - Identified coordinator, or ‘lead’ team
  - Supported by effective communication processes
  - Are underpinned by evidence based guidelines and protocols

- ‘Integrated care’ takes this a step further…
  - Beyond just ‘sharing’ of information
  - Care that is ‘coordinated across professionals, facilities & support systems; continuous over time & between visits, tailored to the patient’s needs and preferences, based on shared responsibility between patient & caregivers for optimising health’
ULTIMATE TEAMWORK FOR OPTIMAL OUTCOMES
Standard A: High-quality clinical care
High-quality, integrated clinical care for patients should be based on a multidisciplinary team collaborating within recognised organisational structures and boundaries.

Standard B: Local delivery of care
Care for IBD patients should be delivered locally whenever possible, but with rapid access to specialised services when needed.

Standard C: Maintaining a patient-centred service
Patient-centred care should be responsive to individual needs and should offer a choice of care strategies where possible and appropriate.

Standard D: Patient education and support
IBD care should empower patients to understand their condition and its management in order to achieve the best possible quality of life.

Standard E: Data, information technology and audit
The IBD service should use data, IT and audit to support patient care effectively and to optimise clinical management.

Standard F: Evidence-based practice and research
The IBD service should support service improvement and clinical research, and should be knowledge-based.
RESEARCH

Defining the optimal design of the inflammatory bowel disease multidisciplinary team: results from a multicentre qualitative expert-based study

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Santiago de Compostela, Gastroenterology, Santiago, Spain
CENTRE = PATIENT
INNER CIRCLE = CORE TEAM
OUTER CIRCLE = SUPPORTING TEAM

HOWEVER, MEMBERS OF THE INNER & OUTER CIRCLE CAN INTERCHANGE OVER TIME BASED ON PATIENTS’ NEEDS
Inflammatory bowel disease (IBD) is a complex condition best managed by a multidisciplinary team approach.

The IBD service should include a:

- gastroenterologist with IBD training
- colorectal surgeon with IBD training
- specialist IBD nurse
- accredited practising dietitian
- psychologist
- stomal therapist
- radiologist with an interest in IBD
- histopathologist with an interest in IBD
- pharmacist with an interest in IBD
- telephone helpline.
# Core: Gastroenterologist with IBD Training

<table>
<thead>
<tr>
<th>Role</th>
<th>What They Contribute</th>
<th>At What Part of the Patient Journey</th>
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</thead>
<tbody>
<tr>
<td>Diagnosis of disease</td>
<td>'Brains behind the operation’</td>
<td>Constant</td>
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<tr>
<td>Endoscopic monitoring</td>
<td>Highly skilled &amp; knowledgeable re: IBD</td>
<td>From diagnosis onwards</td>
</tr>
<tr>
<td>Develop treatment &amp; monitoring plan</td>
<td>Undertake thorough disease assessment</td>
<td></td>
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<tr>
<td>Prescribe therapy and adjust</td>
<td>Complex decision making about care and treatment</td>
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<tr>
<td>as necessary based on disease</td>
<td>Strive to make the patient journey as smooth as possible (WRT medical care)</td>
<td></td>
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<tr>
<td>assessment</td>
<td>alongside other MDT members</td>
<td></td>
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<tr>
<td>Request &amp; review investigations to</td>
<td>Make complex decisions about ongoing therapy</td>
<td></td>
</tr>
<tr>
<td>inform treatment decisions</td>
<td></td>
<td></td>
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<tr>
<td>Make complex decisions</td>
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<tr>
<td>ROLE</td>
<td>WHAT THEY CONTRIBUTE</td>
<td>AT WHAT PART OF THE PATIENT JOURNEY</td>
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</table>
| • Meet patients early in the disease course (& hope they don’t have to again 😊)  
• Advice on surgical management of CD, Perianal CD and UC – in the setting of the MDT meeting or clinic  
• Advise on, undertake and follow-up all surgical procedures of IBD patients within the service | • Expertise and experience in surgical management of IBD  
• Invaluable options for patients and carers to consider as an alternate to medical therapy  
• An alternate perspective on disease management  
• A patient-centred, individualised approach | • Best engaged with early in disease course – alleviate anxiety around potential ‘urgent’ need for surgery later down the track  
• At any point when surgery is considered a treatment option |
# CORE: SPECIALIST IBD NURSE (NP, CNC, CNS, RN)

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<th>WHAT THEY CONTRIBUTE</th>
<th>AT WHAT PART OF THE PATIENT JOURNEY</th>
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<tbody>
<tr>
<td>• Oversight &amp; coordination of integrated care</td>
<td>• IBD patient’s ‘right hand (wo)man’</td>
<td>• Constant</td>
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<tr>
<td>• Navigation throughout patient journey</td>
<td>• Key in the overall coordination and delivery of all aspects of IBD care</td>
<td>• From diagnosis onwards</td>
</tr>
<tr>
<td>• Monitoring of disease &amp; treatments</td>
<td>• Provide compassionate &amp; empathetic support</td>
<td></td>
</tr>
<tr>
<td>• Reference point for all MDT members, GP, patients &amp; carers,</td>
<td>• Troubleshoot: clinical, lifestyle &amp; psychosocial issues</td>
<td></td>
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<tr>
<td>• Patient advocate</td>
<td>• Facilitate access to IBD MDT care</td>
<td></td>
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<tr>
<td>• Educator – patient, carer, HCPs</td>
<td>• Strive to improve overall QoL</td>
<td></td>
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<tr>
<td>• Service delivery &amp; planning</td>
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<tr>
<td>• Proactive/early intervention</td>
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</table>
### Core: Accredited Practising Dietitian

**Role**

- Improve overall nutritional status of people living with IBD
- Undertake nutritional assessment
- Provide specific dietary advice to assist with symptom control, caloric & micronutrient requirements
- Provide advice on healthy weight loss
- Initiate & monitor complex enteral & parenteral nutritional support
- Advise on supplementation

**What they contribute**

- Expert advice and guidance on diet & nutrition
- Support during periods of flare and remission
- Guidance on healthy weight gain & weight loss

**At what part of the patient journey**

- Upon diagnosis
- During periods of flare
- Anytime malnutrition is suspected
- Anytime when patient requests guidance on diet and nutrition
- Pre-operatively
- When planning pregnancy
Anxiety & depression are highly prevalent in people with IBD: rates reported 30 – 50%

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<tr>
<td>• Screening for psychological distress, anxiety &amp; depression&lt;br&gt; • Provision of therapy and treatment to manage psychological issues related to IBD&lt;br&gt; • Identify &amp; implement strategies for coping&lt;br&gt; • Key in improving overall patient QoL&lt;br&gt; • Assist in normalising discussion of mental health</td>
<td>• Supportive care, outside of the ‘clinical’ treating team&lt;br&gt; • A different perspective on disease management</td>
<td>• When identified by patient or clinician that psychological intervention is necessary, or would be helpful (from clinical scoring or otherwise)</td>
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# CORE: STOMAL THERAPIST

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<tbody>
<tr>
<td>• Expert advice for patients, carers &amp; HCPs on all aspects of stoma/ostomy management</td>
<td>• Vast expertise and experience in all aspects of education, stoma care and maintenance</td>
<td>• Pre &amp; post-operatively (for those requiring stoma)</td>
</tr>
<tr>
<td>• Pre and post-operative counselling for patients &amp; carers</td>
<td>• Holistic approach: clinical/physical, psychological, lifestyle considerations</td>
<td>• Constant</td>
</tr>
<tr>
<td>• Pre-op stoma siting</td>
<td></td>
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<tr>
<td>• Ongoing long-term r/v and education</td>
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<tr>
<td>• Advice on acute &amp; chronic wound management</td>
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<tr>
<td>• Advice on continence issues</td>
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<tr>
<td>• Troubleshooting on oral intake and stomal output</td>
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**ROLE**

- Expert review and reporting of imaging undertaken in IBD including, but not limited to: MRI, CT, U/S
- Reporting with consideration given to diagnosis, disease phenotype, disease location, in complex & emergency situations (eg. ASUC, abscess) and the post-operative setting

**WHAT THEY CONTRIBUTE**

- Expert clinical advice key in diagnosis, surveillance, monitoring and acute situations
- A perspective that no other member of the MDT has significant knowledge of (unless specifically trained)

**AT WHAT PART OF THE PATIENT JOURNEY**

- Variable
- During periods of both remission and relapse, dependent on individual situation and guidelines for disease monitoring
## CORE: HISTOPATHOLOGIST WITH INTEREST IN IBD

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</table>
| • Examination and reporting of endoscopic biopsy samples and resection specimens for diagnosis or differential diagnosis of CD vs. UC, non-IBD pathology, CMV etc  
• Identify dysplasia, assess disease severity & activity (acute/chronic)  
• Microscopic assessment, note: classification of remission is changing – clinical/symptomatic vs. endoscopic vs. histologic | • Expert assessment of tissue samples and reporting & discussion of same | • At any point of the patient journey when the patient has undergone endoscopy or surgery requiring biopsy or resection |
### CORE: PHARMACIST WITH INTEREST IN IBD

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<tr>
<td>• Provide education to patients and carers re: prescribed medications (PO, PR, SC, IV)</td>
<td>• Detailed knowledge of each drug, how they work, potential for interactions</td>
<td>• Constant for the duration of medical therapy</td>
</tr>
<tr>
<td>• Undertake routine medication reviews</td>
<td>• Supportive advice to patients on managing treatment regime with consideration to disease and lifestyle</td>
<td></td>
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<tr>
<td>• Monitoring for efficacy and safety, with consideration of TDM</td>
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<tr>
<td>• Assist with optimising adherence to medical therapy</td>
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<tr>
<td>• Troubleshooting re: dosing, timing, potential SEs</td>
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PERIPHERAL IBD MDT MEMBERS

● General Practitioner
  - Assist with coordinating care
  - Prescription of non-specialist medications
  - Review & implement care plan
  - Assist with coordination of blood and stool testing
  - Shared-care for IMM initiation and monitoring
  - Locally role needs to be further defined

● Obstetrician
  - Close consultation with core team members during family planning, conception, pregnancy, post-pregnancy (eg. b/feeding)
  - Mode of delivery (eg. LSCS with perianal CD), timing of biologic therapy during pregnancy, risk of complications, active disease management during pregnancy
PERIPHERAL IBD MDT MEMBERS

EXTRA INTESTINAL MANIFESTATIONS (EIM)

● Rheumatologist
  • Arthritis & arthralgia reported in 40 – 70% of patients with IBD
  • Peripheral arthritis (large joints of arms & legs); axial arthritis (spondylitis, lower back & sacroiliac joints); ankylosing spondylitis (spine & SI joints, 2 – 3% of people with IBD)

● Dermatologist
  • Aphthous stomatitis (CD = 10%, UC = 4%)
  • Erythema nodosum (CD = 4 – 15%, UC = 3 – 10%)
  • Pyoderma gangrenosum (CD = 1 – 2%, UC = 5 – 12%)
  • Psoriasis (IBD = 7 – 11%)

● Ophthalmologist
  • Ocular complications reported in 4 – 10% of patients with IBD, more common in CD
  • Uveitis most common, characterised by; pain, blurred vision, sensitivity to light, redness of the eye
PERIPHERAL IBD MDT MEMBERS
EXTRA INTESTINAL MANIFESTATIONS (EIM)

INFUSION CENTRE
ENDOSCOPY
PATHOLOGY
CLINICAL TRIALS &
RESEARCH

NSW GOVERNMENT
Health
South Western Sydney
Local Health District
INPATIENT IBD MDT CARE

- Patient should be admitted under specialist GI or colorectal surgeon and be on a GE ward within 24 hours
- The IBD nurse should be notified about all IBD admissions
- A dietician should see all IBD inpatients for nutritional assessment
- Site should have rapid access to endoscopy and theatres

- Histology report should be available within 2 days of procedure
- Pharmacy support should be available for discussion of current and future therapies
- Processes and protocols between ED and the GE/CR wards should be in place for prompt commencement of agreed upon assessment, imaging and management

Australian IBD Standards (2016)
CENTRE OF THE IBD MDT: PATIENT
Shared decision making involves the integration of a patient’s values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, in order to achieve appropriate health care decisions.

It involves clinicians and patients making decisions about the patient’s management together.

In partnership with their clinician, patients are encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these.


MDT COMMUNICATION & REFERRAL

- Should occur weekly or fortnightly
- Should include all team members
- Discussion of inpatients & outpatients
- Outcomes recorded in the clinical record
- Patients: complex needs, perianal disease, those with indications for surgery, or requiring biologic therapy
- Attendance recorded & minutes kept
- Discussion of any IBD deaths, complex cases, service issues and development

Australian IBD Standards (2016)
- Patients should have access to combined medical/surgical clinics at least monthly
- There should be defined arrangement for joint discussion of patients whose clinical condition does not permit delays until next MDT
- IBD MDT meetings with the inclusion of core IBD team, radiologist & histopathologist should be regularly undertaken, minutes taken, plans & decisions documented in the patient file, and communicated in a timely manner to the patient

Australian IBD Standards (2016)
MDT COMMUNICATION & REFERRAL

- Outside of meetings, systems should be in place, whereby the outcomes of review by any member of the MDT (eg. F2F clinic or phone review) are adequately communicated to other members of the team in a timely fashion.

- It is understood that not all centres (even tertiary ones!) will have access to a full MDT, therefore referral is necessary.

- If all members of the MDT are not based in the same centre, it is important to engage with local clinicians/providers to set up referral & reporting processes.

Smaller and regional centres may not have these services, so communication and referral pathways should be established with appropriate centres. A nominated local clinician should help coordinate care.

Australian IBD Standards (2016)
FOUR TOP TIPS

1. EACH MDT MEMBER HAS DIFFERENT EXPERTISE; EACH CRITICAL AND COMPLEMENTARY TO THE OVERALL TEAM

2. THE MDT SHOULD ALWAYS PROVIDE A CONSISTENT MESSAGE TO THE PATIENT & CARERS

3. PATIENT PREFERENCES & SHARED DECISION MAKING ARE OF UTMOST IMPORTANCE

4. AS WITH ANY DISEASE/ILLNESS, EFFECTIVE COMMUNICATION IS ESSENTIAL FOR OPTIMAL PATIENT CARE
REFERENCES


THANK YOU

If you want to go fast, go alone. If you want to go far, go together.

Robin Jones Gunn