

Original article

Interdisciplinary counseling service for renal malignancies: A patient-centered approach to raise guideline adherence

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Abstract

Objectives: Tumor boards have become an integral part of high-quality cancer care, but in general, patients are not directly involved. To overcome this weakness, we established an interdisciplinary counseling service for renal malignancies where 4 specialists talked to the patient at once. We evaluated this approach from the patients' and physicians' perspective.

Materials and methods: For 3 months, we assessed organizational and clinical data. Within a standardized telephone interview lasting for 14 ± 8 minutes, we explored the patients' view 1 week after counseling. A focus group contributed the physicians' perspective. Costs and revenues were calculated from the hospital's perspective.

Results: We included 52 consecutive patients aged 62 ± 10 years. Patients' initiative for a "second opinion" triggered 37% of all appointments. Patients had localized (52%) and systemic (48%) disease presenting with primary diagnosis (48%), relapse (27%), or under continuous therapy (25%). The treatment strategy was changed significantly in 16 of 30 (53%) patients reporting a specific external opinion. The most frequent changes in recommendation were nephron-sparing surgery instead of radical nephrectomy in 8 cases and divergent judgments on restaging causing changes in systemic treatment in 6 cases. We successfully interviewed 43 of 52 patients. Overall, patients rated the consultation as very positive and only 1 patient (2%) was dissatisfied. Patients rated the quality of interpersonal interaction as very positive and said they would recommend the consultation service to others. Disease state was not associated with ratings. Physicians expressed a very positive opinion, highlighting the patients' benefit and very constructive case discussions. Nevertheless, they report remarkable efforts concerning time investment and effective coordination of medical experts. We estimated a deficit of 39 Euro per patient given the German health care system. There might be relevant secondary positive economic effects for the hospital such as recommendations from one patient to another leading to acquisition of additional patients.

Conclusions: Patient involvement in multidisciplinary tumor boards is feasible and well regarded by patients and physicians likewise. By stimulating interdisciplinary collaboration, the interdisciplinary counseling service improves patient satisfaction and clinical decision making. The interdisciplinary counseling service corrected half of the external treatment plans for better guideline adherence. These positive effects come at the price of higher resource utilization. (www.germanctr.de, number DRKS00003279). © 2014 Elsevier Inc. All rights reserved.

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1. Introduction

Tumor boards have become an integral part of high-quality cancer care [1–4], but in general, patients are not

directly involved. Because of this lack of participation, the patients' preferences cannot be interactively assessed to determine the optimal treatment recommendation on an individual basis. Moreover, communicating the board's recommendations to the patient and family members can sometimes be harder than in direct discussions. The latter issue has gained importance owing to the continuing increase in patients' autonomy [5,6].

To overcome this lack of patient involvement, we established an interdisciplinary counseling service (ICS) for renal malignancies provided by senior physicians from urology, radiology, nephrology, and medical oncology specialties. The conception combined elements of an interdisciplinary tumor board with a conventional consultation in an outpatient setting (Fig. 1). A urology resident prepared the complete medical history based on case records beforehand and introduced it to the senior physicians. In the ICS, experts from all 4 specialties and the resident set together with the patient and explained different treatment options. The senior radiologist presented relevant imaging studies and explained them to the patient and their loved ones. After discussing emerging questions from the physicians' and the patient's side, the group worked out a treatment plan.

The aim of the study was to perform a multiperspective evaluation of this new model of care. Therefore, we evaluated the ICS from the patients' and physicians' perspective and additionally performed an economic evaluation.

2. Materials and methods

The Institutional Review Board of the University of Heidelberg approved the study protocol (Vote S-358/2011)

and registration occurred within the German Clinical Trials Register (www.germanctr.de, number DRKS00003279). We assessed the organizational, clinical, and economic data of all patients attending the ICS for a 5-month period starting from September 2011. Valid oral and written informed consent was required for inclusion in the study. Fig. 2 provides an overview of the study design.

2.1. The patients' perspective: Standardized interview

Directly before attending the ICS, patients answered a standardized questionnaire including sociodemographic characteristics. With regard to the structure of the German education system, we defined education status according to the duration of schooling as low (≤ 9 y), medium (10 y), and high (≥ 11 y). Patients provided information on their use of pain medication and completed the Patient Health Questionnaire-4, a validated measure of depression and anxiety [7]. They also rated their demand for psychological support, and we provided patients in need with suitable contact details during the follow-up interview. Therefore, a skilled psycho-oncologist (A.I.) not involved in the ICS called the patients approximately 1 week after their visit. The standardized telephone interview lasted for 14 ± 8 minutes and consisted of 4 sections: First, predefined open questions explored the patients' overall experience. Second, we asked the patients to rate different aspects concerning the ICS on a 10-point Likert scale from 0 (very low/bad) to 10 (very high/good). Third, we asked for their personal preferences when making medical decisions and categorized the answers according to a modified version of the "Control Preferences Scale" [5,6,8]. Fourth, patients had the opportunity to ask questions and make personal remarks.



Fig. 1. Setting of the ICS for renal malignancies.

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