

Teaming in Cancer Care & ad hoc thoughts about joy

John V. Cox, DO
Parkland Health System
UT Southwestern

Teams?

- Cancer care is often delivered in silos – delivered by ‘groups’ of professionals – each contributing their individual expertise
- Each member of the group recognizes goals tied to their view of their role
- Yet, there are often misconceptions regarding other group members role / function
- Often leads to gaps in care, delays, lost information
- Often the primary source to drive decisions and communication is the patient / care giver

ASCO / NCI Team Project

- Call for proposals / teams
- 23 teams came together – assignments to round out teams to include clinicians, patients / advocates, and “team scientists”
- 21 teams submitted manuscripts
 - Case-based vignettes highlighting ‘team principles’ applied to problems in oncology
- Teams met at 2016 ASCO Quality meeting for full day of presentations + feedback and critique – specifically a contextual dialogue with team scientists

Teams – JOP May / Nov 2016

Vol. 12, No. 11, November 1, 2016

Health Care Delivery

Original Contribution

Special Series: NCI-ASCO Teams

Volume 12 / Issue 11 / November 2016

Journal of
Oncology
Practice

Reviewing Cancer Care Team Eff

By Stephen H. Taplin, MD, MPH, Sallie Weaver, PhD, Edu Healer M. Edwards, PhD, MPH, Suanna S. Bruinooge, and National Cancer Institute, Bethesda; Johns Hopkins University School of Quality, Baltimore; Leidos Biomedical Research, Frederick; National La of Central Florida, Orlando, FL; American Society of Clinical Oncol; See accompanying articles on pages 231 and 247

Abstract
Purpose: The management of cancer varies across its type, stage, and natural history. This necessitates involvement of a variety of individuals and groups across a number of provider types. Evidence from other fields suggests that a team-based approach helps organize and optimize tasks that involve individuals and groups, but team effectiveness has not been fully evaluated in oncology-related care.

Methods: We undertook a systematic review of literature published between 2009 and 2014 to identify studies of all teams with clear membership, a comparator group, and patient-level metrics of cancer care. When those teams included two or more people with specialty training relevant to the care of patients with cancer, we called them multidisciplinary care teams (MDTs). After reviews and exclusions, 16 studies were thoroughly evaluated: two addressing screening and diagnosis, 11 addressing

Introduction

Teams and teamwork have a long rhetorical history in medical literature because they are an intuitive solution to the information and technical burdens of medical care.¹ Teams are defined as two or more people who interact dynamically, interdependently, and adaptively to achieve a common goal.^{1,3} During the treatment phase, a cancer care team is commonly identified as a multidisciplinary care team (MDT) and typically includes clinicians with radiologic, pathologic, surgical, therapeutic radiation and/or oncologic medical and nursing knowledge.⁴ The clinicians involved in MDTs include nurses, nurse practitioners, physicians, laboratory or radiation therapy technicians, pharmacists, social workers, and other relevant staff. Other groups with specialty training that is not exclusive to oncology, such as primary care, palliative care, and hospice care also contribute to the care of people with cancer. This review addresses all teams involved in cancer care across the cancer care continuum from diagnosis through the end of life.⁵

A growing body of literature demonstrates that team-based care and efforts to optimize teamwork can reduce mortality, improve hospital management of medications, and improve outpatient management of diabetes, depression, and other medical conditions.⁶⁻⁸ The demand for teams has grown in parallel with health care reform and the public's increasing expectations for improved quality and value in health care. The

Teams and Teamwork During a Cancer Diagnosis: Interdependency Within and Between Teams

By Stephen H. Taplin, MD, MPH, Sallie Weaver, PhD, Veronica Chollette, RN, MSC, Lawrence B. Marks, MD, Andrew Jacobs, MD, Gordon Schiff, MD, Carrie T. Stricker, RN, PhD, Suanna S. Bruinooge, and Eduardo Salas, PhD

National Cancer Institute, Bethesda; Johns Hopkins University School of Medicine, Armstrong Institute for Patient Safety & Quality, Baltimore, MD; University of North Carolina, Chapel Hill, NC; Virginia Mason Hospital and Medical Center, Seattle, WA; Brigham and Women's Hospital, Boston, MA; Abramson Cancer Center, University of Pennsylvania, Philadelphia, PA; American Society of Clinical Oncology, Alexandria, VA; and University of Central Florida, Orlando, FL

See accompanying articles on pages 239 and 247

Abstract

This article discusses the care process among three groups (primary care, radiology, and surgery) aiding a 57-year-old woman during her screening mammography and diagnosis of breast cancer. This is the first in a series of articles exploring principles and topics relevant to teams guiding clinicians involved in cancer care. The challenges demonstrated in this case illustrate how clinicians work within and between groups to deliver

this first phase of cancer care. The case helps demonstrate the differences between *groups* and *teams*. Focusing on the patient and the overall process of care coordination can help move groups toward becoming teams who deliver better care by identifying and managing goals, roles, and interdependent care tasks. Care providers and researchers can use the case to consider their own work and essential aspects of teamwork needed to improve care, patient outcomes, and the evidence that supports each.

Introduction

Physicians, their staff, and patients struggle with a shrinking cancer care workforce and the challenge of keeping up with the growing complexity of cancer care delivery, changing guidelines, and the hope of providing evidence-based supportive care in what the Institute of Medicine (IOM) calls a "system in crisis."¹ Forty-five percent of oncologists and a slightly higher proportion of family physicians reported high levels of emotional exhaustion and depersonalization (burnout) in recent surveys,² and the problem is likely to increase. The relative supply of oncologists and primary care physicians is decreasing as the numbers of people at risk, people newly diagnosed with cancer, and long-term cancer survivors are increasing.³ The IOM suggests that teams and teamwork are a needed part of the solution to workforce shortages and the complexity of cancer care delivery (Table 1).^{1,4} To apply what we know about teams from other areas of work, this article discusses a patient's diagnosis of breast cancer and three areas of teamwork (including the patient and providers in the team): establishing explicit shared goals, clarifying roles, and managing task interdependency.

One of the challenges of cancer care is that it involves the patient and multiple care groups. Although many do not distinguish between groups and teams, we propose the distinction as a useful heuristic to guide consideration of how care providers manage work that is ultimately completed by other providers.^{5,6} Cancer care is a good example of such work when viewed from the perspective of a patient seeking help

to manage her disease with the assistance of multiple provider groups.

Groups are defined as two or more people who contribute to a common product and perform their own work relatively independently of each other. *Teams* are defined as two or more people who interact dynamically, interdependently, and adaptively to achieve a common, valued goal.^{5,7} To reduce cancer morbidity and mortality, primary care, radiology, and oncology groups and their respective staff need to share information, responsibility, and the tasks of cancer care across the cancer care continuum, from screening through end-of-life care.⁸ People seeking cancer care sometimes get lost in these processes and fail to receive needed care.^{9,10} For example, there was no documented follow-up in 17% of abnormal mammograms, 12% of abnormal Pap tests, and 41% of abnormal fecal occult blood screening tests in specific populations.¹¹⁻¹³ This lack of follow-up represents a failure in the screening process that undermines the potential benefit from screening and includes some liability risk.

We suggest that these failures may be due in part to inadequate recognition and management by providers of the multiple interdependent tasks required. *Interdependency* refers to situations in which people are mutually reliant on one another in order to complete their work and achieve their goals.^{14,15} *Teamwork* refers to the knowledge, behavioral skills, and attitudes that team members use to navigate these interdependent tasks.¹⁴ The recognition and management of distinct but interdependent roles and tasks distinguishes *teams* from *groups* (Table 2). Teams recognize and manage interdepen-

231

MAY 2015 • jop.ascopubs.org
The literature in health care and stresses that effective teamwork takes time and investment to nurture, develop, and sustain. To this end, we issue a call for participation to engage in this process. We hope this collaboration of clinicians involved in cancer care, advocates who have had cancer or been caregivers, and researchers engaged in studying teams will highlight successful models and identify areas for future research. Leaders of the initiative will invite applicants to serve on writing groups to apply principles of team-based care to specific case scenarios. The writing groups will meet in person and work by conference call and e-mail to develop a pro-

Copyright © 2015 by American Society of Clinical Oncology

MAY 2015 • jop.ascopubs.org

INTRODUCTION

Free National Cancer Institute–American Society of Clinical Oncology Teams in Cancer Care Project

Kosty et al.

pp. 955-958

Open URL

Citation | Full Text | PDF (768 KB)

EDITORIALS

Free Creating the Conditions for Implementing Team Principles in Cancer Care

Vogel et al.

pp. 964-969

Open URL

Citation | Full Text | PDF (806 KB)

Free Team Science in Cancer Care: Questions, an Observation, and a Caution

Salas

pp. 972-974

Open URL

Citation | Full Text | PDF (589 KB)

Free From Teams of Experts to Mindful Expert Teams and Multiteam Systems

Weaver

pp. 976-979

Open URL

Citation | Full Text | PDF (832 KB)

Free Patient Advocates Collaborate to Ensure Patients Are Members of Their Own Oncology Care Teams

Leiderman et al.

pp. 985-988

Open URL

Citation | Full Text | PDF (768 KB)

Copyright © 2015 by American Society of Clinical Oncology

MAY 2015 • jop.ascopubs.org

239



National Cancer Institute
Society of Clinical Oncology
Teams in Cancer Care Project
M.P. Kosty et al.

Endocrine Therapy in
Premenopausal Hormone
Receptor-Positive Breast
Cancer
A.J. Trossello et al.

Harbors
Press

Copyright © 2015 by American Society of Clinical Oncology

MAY 2015 • jop.ascopubs.org

247

Groups vs Teams

- Groups – two or more people who contribute to a common product / perform their own work relatively independent of one another
- Teams – two or more people who interact dynamically, interpedently and adaptively to a achieve a common valued goal
 - Interdependency – mutual reliance on one another in order to complete work / achieve goals
 - Teamwork – knowledge, behavioral skills and attributes that team members use to navigate these interdependent tasks

Distinction – the recognition and management of distinct but interdependent roles and tasks distinguishes teams / groups. Teams ‘think’ – they have cognition. They share and actively manage the relationships that are interdependent. They ‘learn’ and adapt. Groups – a loose connections between individuals with their heads down, focused on their individual tasks.

Moving from groups to teams – establish explicit goals (comprehensive goals overarching), establish roles (explicit who does what – reduces ambiguity, rework, variation, etc.) and manage interdependent work (within groups / across groups)

A “real team”

- Four basic characteristics:
 - Recognized as a team (externally and internally identified)
 - Committed to achieving team level objectives on which they have agreed
 - Work interdependently to achieve these objectives, and
 - Engage in regular reflection as a team to regulate and adapt team objectives and processes.

Team Principles to ponder

- Shared identity
- Shared team level objectives
- Shared mental models,
- Backup behaviors,
- Closed loop communication
- Teams are psychologically safe - team members having a license to speak up and engage in interpersonal risk taking to resolve conflict.
- Team effectiveness is linked to mutual trust
- Teams “think”
- Teams “practice”

Oncology Practice / Teams

- Teaming & Workforce issues on the ground
 - Quad Aim: Connection to ‘how we work together’ and quality of care delivered and the joy found in practice
 - Teaming – “Zen” – shift in attitude / self reflection for docs (all team members); team reflection to define ‘inputs’ and outputs – interdependencies recognized
- Governance
 - Critical variable to provide space for reflection and experimentation
- Promise of focus on care delivery – ‘oncology medical homes’, rethinking teams / practice
 - Growth in reports re: work / papers focused on “how we deliver care” – mission of JOP
 - Shift from FFS to global payments tied to Quality metrics = force more “teaming”?

Oncology Practice / Teams

- “Top of License” v “Compliance” v Financial
- APPs v RNs v LVNs v Clinical Pharmacists v M.D.s
- APPs
 - Expanded footprint
 - How best to incorporate in Practice?

Original Contribution

STATE OF CANCER CARE IN AMERICA

Understanding the Role of Advanced Practice Providers in Oncology in the United States

Suanna S. Bruinooge, Todd A. Pickard, Wendy Vogel, Amy Hanley, Caroline Schenkel, Elizabeth Garrett-Mayer, Eric Tetzlaff, Margaret Rosenzweig, Heather Hylton, Shannon N. Westin, Noël Smith, Conor Lynch, Michael P. Kosty, and Stephanie F. Williams

Abstract

Purpose

Advanced practice providers (APPs, which include nurse practitioners [NPs] and physician assistants [PAs]) are integral members of oncology teams. This study aims first to identify all oncology APPs and, second, to understand personal and practice characteristics (including compensation) of those APPs.

Methods

We identified APPs who practice oncology from membership and claims data. We surveyed 3,055 APPs about their roles in clinical care.

Results

We identified at least 5,350 APPs in oncology and an additional 5,400 who might practice oncology. Survey respondents totaled 577, which provided a 19% response rate. Results focused on 540 NPs and PAs. Greater than 90% reported satisfaction with career choice. Respondents identified predominantly as white (89%) and female (94%). NPs and PAs spent the majority (80%) of time in direct patient care. The top four patient care activities were patient counseling (NPs, 94%; PAs, 98%), prescribing (NPs, 93%; PAs, 97%), treatment management (NPs, 89%; PAs, 93%), and follow-up visits (NPs, 81%; PAs, 86%). A majority of all APPs reported both independent and shared visits (65% hematology/oncology/survivorship/prevention/pediatric hematology/oncology; 85% surgical/gynecologic oncology; 78% radiation oncology). A minority of APPs reported that they conducted only shared visits. Average annual compensation was between \$113,000 and \$115,000, which is approximately \$10,000 higher than a average pay for nononcology APPs.

Conclusion

We identified 5,350 oncology APPs and conclude that number may be as high as 7,000. Survey results suggest that practices that incorporate APPs routinely rely on them for patient care. Given the increasing number of patients with and survivors of cancer, APPs are important to ensure access to quality cancer care now and in the future.

INTRODUCTION

Because the US population is aging, a shortage of hematologists/oncologists has been projected, and this shortage increases the pressure on oncology practices to

improve efficiency.¹ In addition, imbalanced geographic distribution of oncologists makes access to oncology care services challenging in many regions.² The employment of advanced practice

American Society of Clinical Oncology; American Academy of PAs, Alexandria, VA; University of Texas MD Anderson Cancer Center, Houston, TX; Ballad Health, Kingsport, TN; Fox Chase Cancer Center, Philadelphia, PA; University of Pittsburgh, Pittsburgh; Fox Chase Cancer Center, Philadelphia, PA; Memorial Sloan Kettering Cancer Center, New York, NY; Advanced Practitioner Society for Hematology and Oncology, Lawrenceville, NJ; Scripps Clinic, La Jolla, CA; and Spectrum Health Systems, Grand Rapids, MI

ASSOCIATED CONTENT

Appendix available online

DOI: <https://doi.org/10.1200/JOP.18.00181>; published online ahead of print at jop.ascopubs.org on August 22, 2018.

Oncology Practice / Teams



- Financial Components of Care
 - Defining access – persistent issue for enlarging group of patients (e.g. Dallas County)
 - Defining clinical choices –
 - patients (“financial toxicity”)
 - institutions (how to best spend limited dollars)
 - Practices (how to best align .. + issues of drug / infusion room management)
 - Effects on clinicians
 - “soul sucking” to have new science, therapy discussions limited by social determinants w/o mechanisms to address

Conclusions / Call to Action

- More reflection / data on “how we deliver care”
- Take queues from other industry – redefine teams in medicine – nuts / bolts of how we relate to one another / how we pull patients / care givers into the processes of care / “measure” teaming
- Governance to provide education / space / time / effort to build teams – reflection
- Access to care demands more clinicians working differently – definitions of collaborative / supportive roles – APPs / nursing / pharmacists / social work / navigators
- Address the soul-sucking components of lack of access vis a vis financial constraints – is health care / access to cancer care a right?