Guiding Cancer Control: A Path to Transformation

Advancing Team-Based, Coordinated Care Across the Life Course

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NASEM RECOMMENDATIONS

• Improve, where feasible, effective, and affordable, the availability of preventive, screening, diagnostic, and therapeutic interventions. Encourage timely palliative care, hospice care, survivorship services, and related social services according to the preferences and values of patients and their families.

• Integrate the use of social, behavioral, and other information made possible by the convergence of communication, social media, cognitive, financial, and sensor technologies as well as electronic health records, cancer registries, and insurance claims to establish large-scale interoperable data sources.
WHY
Advancing Team-Based, Coordinated Care Across the Life Course
Current State of Cancer Care

“System in Crisis”

- Increasing complexity
- Workforce shortages
- Rising cost of care
- Need for teams and teamwork

## Burnout and Career Satisfaction Among US Oncologists

### Table 3. Career Satisfaction and Burnout

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All (N = 1,117)</th>
<th>AP (n = 377)</th>
<th>PP (n = 482)</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td><strong>Burnout indices</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional exhaustion†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>22</td>
<td></td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Low score</td>
<td>433</td>
<td>40.1</td>
<td>146</td>
<td>39.0</td>
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<tr>
<td>Intermediate score</td>
<td>233</td>
<td>21.6</td>
<td>78</td>
<td>20.9</td>
</tr>
<tr>
<td>High score</td>
<td>413</td>
<td>38.3</td>
<td>150</td>
<td>40.1</td>
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<tr>
<td>Depersonalization†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Low score</td>
<td>558</td>
<td>52.3</td>
<td>191</td>
<td>51.3</td>
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<tr>
<td>Intermediate score</td>
<td>243</td>
<td>22.8</td>
<td>99</td>
<td>26.6</td>
</tr>
<tr>
<td>High score</td>
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<td>24.9</td>
<td>82</td>
<td>22.0</td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>42</td>
<td></td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>High score</td>
<td>660</td>
<td>63.0</td>
<td>225</td>
<td>61.0</td>
</tr>
<tr>
<td>Intermediate score</td>
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<td>23.8</td>
<td>89</td>
<td>24.1</td>
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<tr>
<td>Low score</td>
<td>138</td>
<td>13.2</td>
<td>55</td>
<td>14.9</td>
</tr>
<tr>
<td>Burned out‡</td>
<td>484</td>
<td>44.7</td>
<td>172</td>
<td>45.9</td>
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<tr>
<td>Career satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would become physician again</td>
<td>908</td>
<td>82.5</td>
<td>328</td>
<td>87.5</td>
</tr>
<tr>
<td>Would become oncologist again</td>
<td>877</td>
<td>80.5</td>
<td>314</td>
<td>85.1</td>
</tr>
</tbody>
</table>

Abbreviations: AP, academic practice; MBI, Maslach Burnout Inventory; PP, private practice.

†As assessed using the full MBI.
Continuum of Cancer Care

- Gaps in quality care can occur at each phase of the care continuum.
- Lack of coordination is associated with poor symptom control, medical errors, and higher costs.
Stages of Cancer Care Improvement

Cancer Care System

Clinical Knowledge

Implementation Knowledge

Delivery System Reliability

Small minority of early adopter oncology practices improving at this stage

Vast majority of oncology practices improving at this stage

Very few innovators exploring this stage

McNiff, Jacobson, JOP 2014
WHAT

Advancing Team-Based, Coordinated Care Across the Life Course
Team-Based, Care Coordination Defined

“A team is defined as two or more people who interact dynamically, interdependently, and adaptively to achieve a common goal that is shared within the context of some larger group or organization”

Reviewing Cancer Care Team Effectiveness

n=16 studies:
- 2 screening/diagnosis
- 11 treatment
- 2 palliative care
- 1 end-of-life care

Taplin SH et al., J Oncol Pract. 2015 May;11(3):239-46
Reviewing Cancer Care Team Effectiveness

- Improved screening use
- Reduced time to follow-up
- MDTs improved planning of therapy
- Adherence to medication
- Pain control

Taplin SH et al., J Oncol Pract. 2015 May;11(3):239-46
Special Series: NCI-ASCO Teams

- Role of Psychological Safety in Team Communication
- A Case for Shared Leadership for Care Transitions
- Inclusion of the Patient as a Team Member
- Shared Mental Models to Improve Care Quality
- Coordinated Care as a Multiteam System Approach
HOW

Advancing Team-Based, Coordinated Care Across the Life Course
Creating the Conditions for Implementing Team Principles in Cancer Care

How do these multilevel factors influence the ability to implement team principles in cancer care?

Societal factors
- To what extent:
  - do the public’s expectation of freedom of choice in selecting individual medical providers pose challenges to team functioning?
  - do growing technological capabilities (e.g., electronic medical records) facilitate or hinder communication among providers?

Health policy:
- To what extent do federal- and state-level efforts to reform health care emphasize the value of team functioning to enhance quality of care?
- To what extent do private payer policies reward effective teams for enhancing quality of care?

Professional culture:
- Do professional standards, norms, and training:
  - identify effective team functioning as a mechanism to improve care?
  - value investing time and effort in team principles, such as setting shared goals, closed-loop communication, back-up behavior?

Community environment:
- What factors may facilitate or undermine coordination among care providers from various institutions in a community region, who are providing care to the same patient?

Organization and/or practice setting:
- To what extent do organizational policies, incentives, systems (e.g., communications systems), and resources (e.g., meeting rooms, time) hinder or facilitate team functioning?
- What practices (e.g., documentation, procedures) are in place to facilitate key team principles (e.g., establishing and revising shared goals and shared mental model), engaging in iterative team-based reflection to regulate and adapt team interactions to maximize quality of care?

Provider/team:
- To what extent have these care providers received education, training, and professional development in:
  - team characteristics and team principles?
  - approaches to implement these practices (e.g., templates to create a shared mental model)?
  - related competencies (e.g., interprofessional collaboration)?

Patient and family:
- To what extent:
  - do patient and family expectations facilitate or undermine care coordination and team functioning (e.g., do they want to hand-select providers who may not have systems for effective coordination with other providers caring for the patient)?
  - do the family and patient see themselves as, and expect that they be seen as, members of the care team?

Emphasize the need for change at multiple levels to maximize success

Improving Coordination

- care coordination approaches led to improvements in 81% of outcomes
- screening, measures of patient experience with care, and quality of end-of-life care
- Across the continuum of cancer care, patient navigation was the most frequent care coordination intervention

Review of Patient Navigation

- Patients face many challenges with the health care system (all SES groups)
- Begins at the time of diagnosis and continue throughout continuum.
- Navigation developed to reduce gaps in care, improving access and timeliness
- Commission on Cancer (CoC) standard for accreditation
- The Patient Navigation Research Program (PNRP): n= 10,521, TTD
- Cost of navigation can be offset by savings in care efficiency

Navigation Study

- Multi-institution NIH study
- Address implementation
- Address SES barriers
- Major impact on care delivery
Josiah Macy Foundation

Interprofessional education and teamwork:

“We have strong evidence that health care delivered by well-functioning teams leads to better outcomes, but we still too often educate our health professionals in silos. We need more planned and rigorous interprofessional education that links directly to ensuring optimal health for patients and communities”
Framework for Action on Interprofessional Education & Collaborative Practice

Promoting interprofessional collaboration in oncology through a teamwork skills simulation

• Interprofessional team training

• Simulated cancer care scenarios

• Paired teams of hematology-oncology nurses and fellows

• Twenty-three learners participated in two separate sessions

• Indicated skills in teamwork and communication.

SUMMARY
Advancing Team-Based, Coordinated Care Across the Life Course
Conclusions

1. Patients benefit from team-based, coordinated care
2. Patient Navigation is a promising intervention
3. Need for greater Interprofessional Education and Collaboration
4. Opportunities for future research | Implementation science
Thank you

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