Teaming in Cancer Care & ad hoc thoughts about joy

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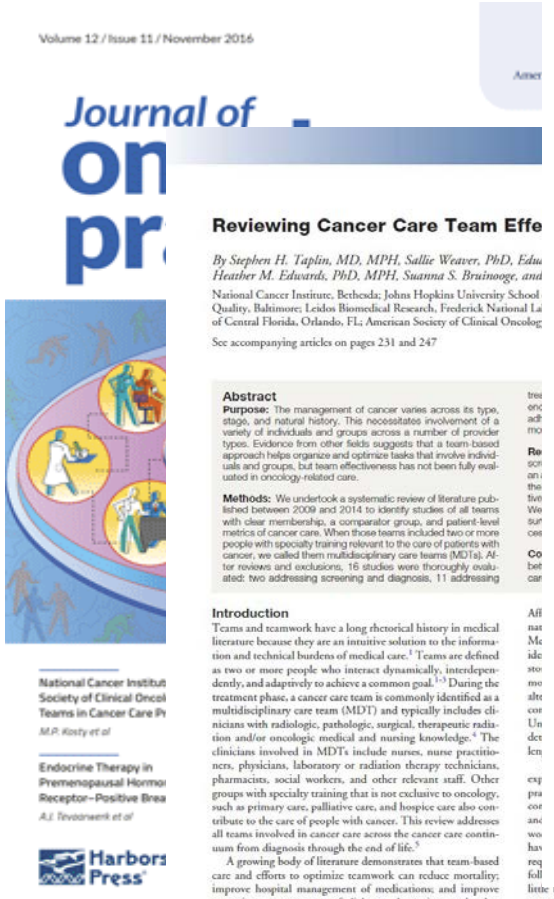
Teams?

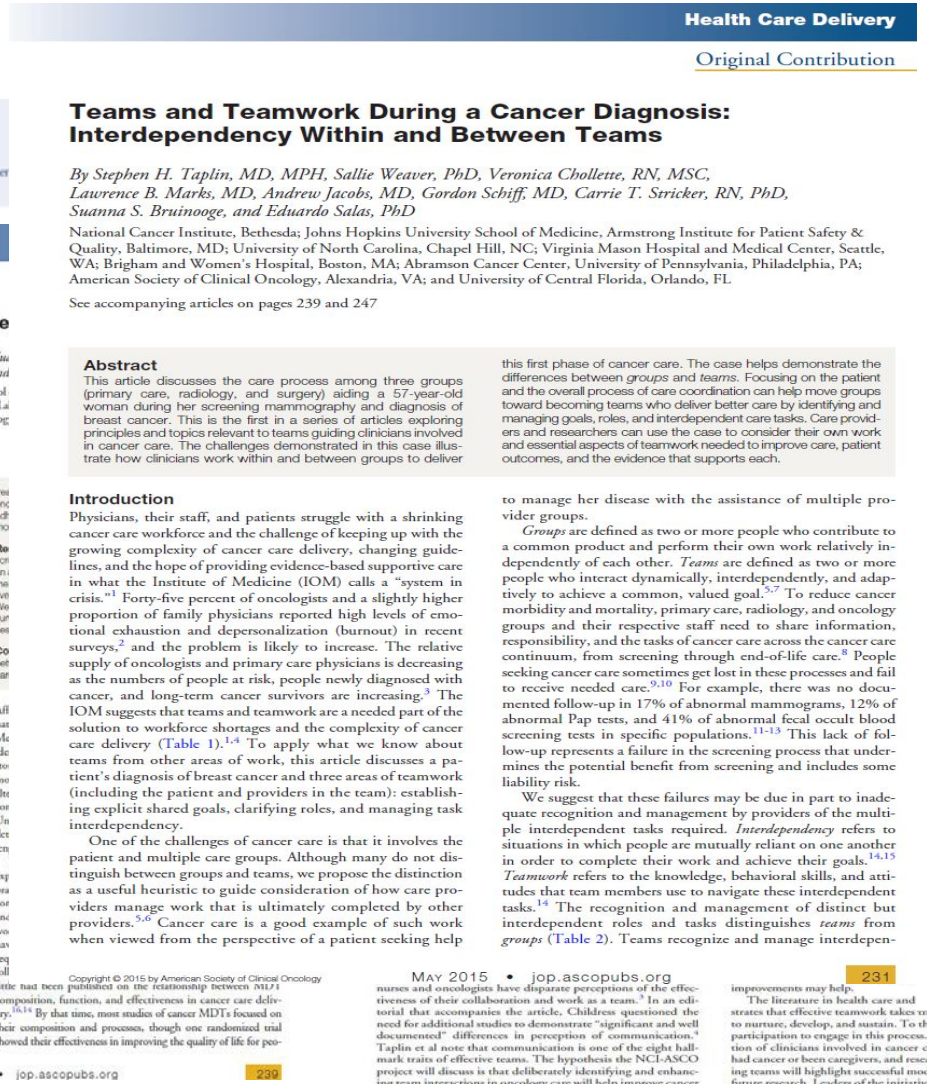
- Cancer care is often delivered in silos – delivered by ‘groups’ of professionals – each contributing their individual expertise
- Each member of the group recognizes goals tied to their view of their role
- Yet, there are often misconceptions regarding other group members role / function
- Often leads 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





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Special Series: NCI-ASCO Teams

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
Lederman et al.

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 Financi
  - APPs v RNs v LVNs v Clinical Pharmacists v M
- 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

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

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 predominately 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 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

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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?