The Science of Teamwork: Implications for Cancer Care Teams

NIH/NCI Cyber Discussion

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Outline

1. A few “**knowns**” about team effectiveness
2. A way of thinking about **interdependence**
3. 8 common **challenges** to teamwork
4. A quick look **forward**

Coordination Matters

- Meta-analysis of 130 studies -- better teamwork processes **20 to 25% more likely to succeed** (LePine et al., 2008)
  - A range of samples

Communication Matters

- Meta analysis of 72 studies (Mesmer-Magnus & DeChurch, 2009)
  - Keys: Sharing of *unique* info (not just talking) and *closed loop* communications (to ensure understanding)
- Be aware
  - People often **assume** others "know" the same things they do – they don't share unique info (Sasser et al., 2000)
    - Assigning responsibilities helps a little
  - Radiology, Primary Care, and Surgical Care may have unique information
  - In hierarchical teams, greater reluctance to speak up

Cognitions Matter

- Teams that possess a **Shared Mental Model** (SMM) perform better, particularly when coordination is required
  - Meta-analysis - 23 studies (DeChurch & Mesmer-Magnus, 2010)
- SMM about: task, goals, roles, if-then, etc.
  - What is the ultimate goal?
  - Who is responsible for scheduling a follow-up? For updating the patient?
  - What should happen if a certain type of abnormality appears?

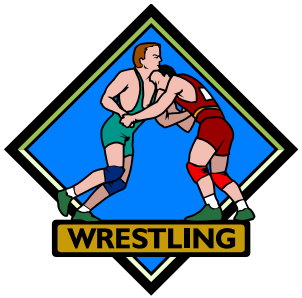
Conditions Matter

- Teams don’t operate in a vacuum
  - Same team, different environment = different results
- Resources, culture, rewards, technology all factors
  - Reward # of screenings vs rates of discussions? Reimbursement standards?
  - Is teamwork valued organizationally?

All teams are not the same

- But often treated that way
- One key difference: Degree of interdependence
  - To what extent are team members reliant on one another and **need to work together**?

How do team members view the team? How does that compare with what's required?



Low — **Medium** — **High**

Low	Medium	High
Can prep together and cheer, but perform solo; add individual scores = team score	Some members must coordinate, some of the time	Most or all members must coordinate consistently

Challenges to Effective Teamwork

Challenge	Observation	Research
Individual mindset	Not an expectation; wrestling team; Being team player less important	Collective orientation helps a team; you can be individually excellent and team player; Q: how to change expectations?
Insufficient time	Both real and perceived	Time spent debriefing boosts team performance Investment of time pays off – if interdependent
Gap in teamwork competencies	Don't know how; Not trained adequately	Team training works; Recent evidence from health care teams
Misaligned rewards	Unintended consequences	Lack of research in this area – **Research needed**
Faultlines	Subgroups can splinter – unique info	Faultlines surface under stress and hurt performance
Distance	Can jeopardize cohesion and cognitions	Some guidelines for virtual teams
Dynamic composition	Can contribute to lack of shared cognitions (e.g., roles)	Transportable skills; **Research needed**
Unclear boundaries	Challenge to shared cognitions and handoffs	Role clarity critical; Some preliminary research on "team of teams"; **Research needed**

Cancer Care Team: What if they…?

- Established **general teamwork agreements,** guidelines, rules of engagement, charters
  - Typical roles/responsibilities, what-ifs in certain scenarios, role of the patient
- **Pre-briefed** when needed
  - If unique considerations or new players
- **De-briefed periodically** (not every case)
  - Followed simple structure, not just after problem

Example debrief discussion questions (1)

- During this case, how effectively did we **update or consult with** other members of our team (e.g., from primary care, radiology, surgery, or the patient)?
  - Were there any points where we could have communicated a little sooner or more clearly? Might it have been better if you were told something or were consulted sooner?
  - If there were delays, what may have contributed to the delay?
  - In cases like this, when are we most likely to miss or be a little slow on providing an update, managing a handoff, or seeking input?
  - How do we want to handle these risk points in similar cases in the future?

Example debrief discussion questions (2)

- How did we involve the **patient** in their care?
  - Were they part of the “team”? How can we tell? What did we do or not do that conveyed that message?
  - Should this patient have been viewed as part of the team? Why/why not?
  - At what point did we engage the patient (and/or their family) in discussions about their role and preferences?
  - How do we want to involve the patient in the future? Any general guidelines or agreements we can reach?

Example debrief discussion questions (3)

- How did we **identify** that this patient needed a screening?
  - In hindsight, did we schedule it as quickly as we should have? Should we have scheduled it sooner? Why?
  - Who should be checking if it may be time for a screening or follow-up? Who can suggest it is time for a screening? Who can schedule it? What can prevent us from doing so in the most timely manner?
  - Going forward, what will we do to ensure that our patients receive timely screenings and follow up?

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- **Worth** doing this?
- What **prevents** us from doing this?
- Any of this **feasible**?
- What might **help**?