PC3 Cyber Discussion with Dr. Ricciardi:
July 9th
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00:00:00 VERONICA CHOLLETTE: In primary care. This session is part three of a five-part series on improving the process of cancer care sponsored by the National Cancer Institute Division of Cancer Control & Population Sciences. I have a house items to address before we proceed. This webinar is being recorded as you just heard. If someone has technical difficulties, they may email pc3cyberdiscussions@icfi.com. Please mute your line to eliminate background noise when you're not speaking. If you have a question, please use the raise hand tool on the top toolbar of your screen and use the dropdown person … icon on the raise hand feature.

00:00:48 Or you may type your question in the chat function. Please include your name and organization so that we know who you are. Please note all messages in the chat function are also recorded. The purpose of the series is to engage and solicit opinions from group of researchers, healthcare providers, managers, and business people who spend a lot of time thinking about healthcare quality and how to deliver better care. Each session within our series focuses on a particular

topic that exposes challenges in various (unint.) teamwork.

00:01:20 Within the process of care branch, we are interested in developing more research on how to deliver better care as opposed to what care is actually delivered. For the purpose of the series, it's to help us identify a set of potential research topics, and we'll address how healthcare teams improve processes of care, which lead to better health outcome. We invite you to participate during the discussion period. We'd like to understand your perspective and any research questions you've identified in the background reading as well as in the case study that you received yesterday.

00:01:54 And also, we have two additional sessions in our five-part series. Our next session after today's session will be on November the 5th, and the topic of that discussion will be research priorities in cancer care teams research. And that will be delivered by Dr. Edwardo Salas from the University of Central Florida and our last presentation in our series is on July the 1st, 2015. And that topic is going to be given by Dr.

Stephen Fiore also from the University of Central Florida. And he will be speaking on team cognition, understanding the factors that drive process and performance.

00:02:31 Please share registration information with colleagues if you think they want to join our conversation on improving the process of (unint.) effective healthcare teams. We're looking forward to engaging more individuals in our conversation on identifying research priorities in (unint.) healthcare teams. And so before we begin our presentation, we want to solicit your opinion on an original case study about Mrs. Q, which we hope brings out issues and challenges with multiteams working together, patient center care, measurements of evaluation, and strategies needed for care transition to flow seamlessly between multiple providers. I'll turn it over now to Andrew Jdaydani to review highlights of the case study.

00:03:13 ANDREW JDAYDANI: Thanks, Veronica. So the case with Mrs. Q is regarding a couple whose getting ready to retire. The husband is a (unint.) surgeon and the wife is a medical assistant at an optometry office.

The wife has multiple chronic conditions and has family history, which ensures she's active in her health. Her current conditions include Stage IIA breast cancer, heartburn, and hypertension. And because she's recently retire … or she's getting ready to retire, she's transitioning to a new healthcare plan and also moving to a new primary care physician, who is undergoing a shift to an electronic healthcare (unint.) system.

00:03:56 She was able to secure the same oncologist, so that hasn't changed, and she's happy with his performance and the outcomes from him. Upon the next visit with the primary care physician, everything was going well, and she received the care that she wanted from a primary care physician and was prescribed the medication to continue with her past prescription with her previous primary care physician. When going to the primary care physician for an update, they found that one of the medications that was prescribed was … that was originally for the heartburn medication was one that negatively interacted with the Tamoxifen that was given for her Stage II prostate … Stage IIA breast cancer and was reducing its effectiveness.

00:04:52 And there was … the reason for that was a misinterpretation of the original primary care physician handwriting by the administrative assistance and the new primary care physician transition to the electronic system. So in that situation, he quickly corrected her, and now she is receiving the correct prescription for her heartburn which isn't interacting with her Tamoxifen. And that's essentially the case.

00:05:26 VERONICA CHOLLETTE: So if the phones can be unmuted, if anyone has any comment on the case relative to issue, the measurement issues of dealing with multiple things, any notices and recognition of breakdown in communication or other teamwork principles that were violated in this case that you would like to discuss.

00:05:55 STEPHEN TAPLIN: Can we hear from…

00:05:57 VERONICA CHOLLETTE: Yeah, they're on.

00:05:58 STEPHEN TAPLIN: Ingrid, you're the expert on measurement, so one of the issues here is coordination. I wondered if you had any comments

about the complexity of the coordination challenge here. So coordination between two primary care docs and an oncologist around a … what is really a pretty simple medication, Tamoxifen and something for heartburn. I know you're there Ingrid. I can see you.

00:06:31 INGRID: Sorry, I just realized I had my cell phone mute. I was talking to myself. It's always good. Actually, what struck me even … so I will comment on that, but what struck me in this case was the coordination that's necessary when you transition from electronic 'cause it seemed as though that was part of the handwriting issue that occurred and a miscommunication there was striking to me. I think in terms of coordination itself, it raised the question for me of where the burden lies. Who should be responsible for coordinating in that situation?

00:07:20 Does the coordination fall to the previous primary care clinician to ensure that the transition occurs smoothly or to the newly selected primary physician going forward? For me, that was a question of who bears the responsibility in this relationship. I

think it's easy to identify who the parties are, but even within coordination, they're still … what I think this case raises for me is coordination along with accountability and responsibility and being clear even within the domain of teamwork who is the … I guess you've used the term quarterback in the past.

00:07:59 Who's the person who holds onto that role? And that still isn't quite clear to me even in a situation such as this.

00:08:06 STEPHEN TAPLIN: I think it's interesting question. My bed (unint.) the doc who prescribed … his name is on the wrong prescription … is the one who would be held accountable. But in a team situation, which is what this is, the person who couldn't read the handwriting … I mean, the … a question that comes up in my mind in this case is what's the culture? What's the environment in which that person who's translating their handwriting is living? So is she or he comfortable saying I can't read this writing? I'm not gonna fake it, or is she or he intimidated and pressured by the time and so just choose something on the dropdown menu of your electronic medical record

rather than raising the question: what is this? I better be sure this is right.

00:08:54 So I wonder about … yes, you could hold the doc accountable, and I think the doc is ultimately accountable. But this situation raises the question for me: what's the environment? What's the culture? Do they work together as a group, and do they create an environment in which the group can work and identify potential errors freely? Or is it an intimidating one in which what you got to do is get the next patient through, don't ask me any questions to slow me down?

00:09:20 VERONICA CHOLLETTE: There could also be issues of training. When in doubt, ask.

00:09:23 STEPHEN TAPLIN: Yeah.

00:09:24 VERONICA CHOLLETTE: And so she may not have been properly trained and informed if she had any concerns, she should ask questions, double check (unint.) or the prescription.

00:09:34 INGRID: So I think…

00:09:34 STEPHEN TAPLIN: Other comment. Go ahead.

00:09:37 INGRID: So I think … I mean, as someone who's written a lot about climate and psychology safety and so tries to get out of that sometimes when I can … but I guess I want to echo that, that I think there is always something to be said for whether or not you feel comfortable asking and whether or not you realize. And I didn't have the case attached to this, so I couldn't see what … how much ambiguity there was around the person who actually made the prescription. But I think thinking about whether you're even cognizant of it, and so that might even say, even if we … even if there … there's … one, there's a culture of whether or not you speak up but also a culture that reinforces reliability or a climate, I should say … a climate that reinforces reliability.

00:10:29 So systems that allows us to double check each other even if we don't realize that we're walking into a situation or a … making a mistake or an error. So the

climate for … safety combined with a climate for reliability within the team.

00:10:48 STEPHEN TAPLIN: Now, I think that's a good question Ingrid. I think it's a great question in this case as well because even if the handwriting had been right and that had been the right prescription, would the primary care doc have known that there's this interaction between the medication and Tamoxifen.

00:11:03 INGRID: Right.

00:11:03 STEPHEN TAPLIN: Did he know or she know that the patient was on Tamoxifen? What the connection between the oncologist, whose prescribing that Tamoxifen, and the primary care doctor … have they ever talked about? So it's possible that he could have read the writing right, put it up, and written the wrong prescription because of his ignorance…

00:11:23 INGRID: Right.

00:11:23 STEPHEN TAPLIN: Or her ignorance about the interaction, which I think is another area where I

think Rick's group in AHRQ has done a lot of work on medication errors and involvement of pharmacy in on … in teams and in healthcare in hospitals in particular.

00:11:44 VERONICA CHOLLETTE: Through TeamSTEPPS.

00:11:45 STEPHEN TAPLIN: Through TeamSTEPPS but also through research knowing that … two things, one, that culture is the most important predictor of whether or not people fix potential errors or reduce potential errors in medication. And involving a pharmacist in (unint.) is another way.

00:12:06 VERONICA CHOLLETTE: Any other comments before we go on?

00:12:09 LEANNE VALUM: Oh, hi, this is Leanne Valum (ph.) at Georgetown Lombardi Cancer Center, and I was struck by, you know, not just on the end where the assistant had misread the writing. But if the actual patient sort of medical knowledge was working against her at this point, so the … you know, her assumption that, oh, the pill looks different. This must be a generic equivalent or, you know, some sort of substitution.

You know, so her sort of knowing that and making that assumption and then not circling back, you know, with her pharmacist or with somebody else to say this … is this the med that's right? This is the one I'm supposed to be on? So she has a little bit of … you know, where a little bit of knowledge hurts you.

00:12:54 STEPHEN TAPLIN: Yeah, that's a good point. That raises the whole role of the … the role and responsibility of the patient in the situation and again, the issue of ignorance. So assuming that everybody else is right, so it must be … everybody else has got more power, so they must be right. Good point.

00:13:20 VERONICA CHOLLETTE: Okay, let's spend a few minutes now and transition. Thank you for your comments on the case study, and there may be more after you hear Dr. Ricciardi's presentation. So I am honored to introduce our guest speaker today. It's Dr. Richard Ricciardi. He is the health scientist in the Center for Primary Care Prevention and Clinical Partnership at the Agency for Healthcare Research and Quality. Before joining AHRQ in 2010, Dr. Ricciardi served on

active duty for 30 years and had numerous positions in the Department of Defense working as a nurse practitioner, senior leader, and clinical scientist.

00:13:57 His research interest include disease prevention and health promotion, human performance and fitness and the delivery and organization of primary healthcare. And again, Dr. Ricciardi's presentation today is on team-based measures in primary care. Dr. Ricciardi, you can take it away.

00:14:25 RICHARD RICCIARDI: Thanks, Veronica. I really appreciate the opportunity to be with you all this morning or this afternoon. And I'd like to extend my welcome to all of you as well, and on behalf of AHRQ, I would like to thank Steve and Veronica for this opportunity to share with you some of our ongoing work on team-based care and specifically today on team-based care measurement. Many of the points that you have brought out in the warm-up discussion are very pertinent to some of the discussions we had both with the team, which you see on slide two that were integral, the contributors to this work on the left and also non-withstanding the great input from the

expert panel that we met with three times to inform our work and to provide us with ideas.

00:15:24 On there, you do see Edwardo Salas, who I had the opportunity to meet, so I would say buckle up your seatbelts for your next presentation. Edwardo is somebody who has a great command of this scientific body of work, and it should be an exciting presentation in November. He is considered one of the subject-matter experts on team-based science, so it's exciting that you have him to come in November. The next slide will extend out the disclosures and that this work was under contract through AHRQ, etcetera … the obligatory disclosure.

00:16:03 The next slide will have the objectives for today, which is to provide all of you and to get feedback from all of you on AHRQ's work on team-based care measurement, specifically looking at our development of a theoretically-grounded conceptual framework for measurement of team-based primary care. We were specifically looking at primary care, but we have fun extending that outside of primary care today. To conduct and environment scan, a fairly extensive

environment scan to identify and assess instruments to measure teamwork in primary care, and ultimately, to create for all of you and the public a … an available web-based, searchable atlas or inventory of instruments that we have identified that could be useful to all of you in measuring and looking at ways to evaluate different domains in team-based care.

00:16:58 And then finally, we hope to put forth some gaps in measurement of team-based care that could guide future work by both AHRQ, perhaps the NIH as well as others who are interested. In terms of the next slide, a little bit on the background of how we captured some of this information, particularly the research on teams is available and has been conducted in other sectors. I'm sure that most of you have heard of Crew Resource Management, which is part of the aviation industry looking at safety and developing strong teams.

00:17:36 In addition to that, the Department of Defense and the Warfighter community have done a lot of work on building teams around the areas of developing mutual support, situational awareness, which is sometimes

referred to as watching each other's back, leadership. What are some of the common areas around leadership? And focus on in the DoD which would be considered mission. In healthcare, we would consider that the plan of care or incorporating what the patient needs and wants are and the science which is delivered by the healthcare professionals in developing a core element of a plan of care.

00:18:13 That is seen as central to success of the team. Accumulating evidence that effective teams are associated with better outcomes has been ongoing particularly when you look at work that's being done around the patient-centered medical home. And for this case, one might consider it the patient-centered medical condominium or maybe the patient-centered medical neighborhood where we're extending out of the primary care, reaching out to the oncologist and the other subspecialist in Mrs. Q's chronic conditions.

00:18:48 There's been increasing recognition that successful primary care redesign efforts as well as all healthcare redesign efforts will require high-functioning primary care teams as evidence to that.

And then that … in NQA in their 2014 patient-centered medical home criteria, threaded throughout most of the criteria are evidence of teamwork and measurement and needs of teams and building strong teams. Again, research through both science and quality improvement efforts can help advance effective team-based primary care.

00:19:27 And there's a lot of gaps in the need for measures in the background and etcetera. You can read on that one … the other background items, but specifically, there is sort of an explosion in the educational community of interprofessional education, which is not a new topic. It's been going on for a decade. However, there seems to be some meat behind the theory now where many groups across the nation are looking at building formative training. So different groups of subspecialists, nursing, PT/OT, etcetera, working together at the formative stages to learn together and therefore work together better.

00:20:16 So it's sometimes referred to in the physiologic world as muscle memory, so those that train together, when you're out and delivering care, since you've done it

before in the formative environment, you should be able to do it more effectively and efficiently. That's a big gap right now, so that's part of the background of what we use. The next slide will provide some of the references that if you want to, you can reach out to and look out. In other to move forward on this, we had to come up with some standard definitions.

00:20:48 And for team-based care, the IOM definition was used and the last part of it, I think, is most interesting to this discussion where there are shared goals, there are patient-shared goals across settings i.e. whether you're transitioning to a new primary care environment like in this case or whether you're coordinating here with oncology or an internist or a group that are taking care of the complex conditions to achieve coordinated and high quality care. Then we also … the next slide will demonstrate or illustrate the definition of primary care.

00:21:30 And what's important to this discussion is that it's the provision of integrated accessible healthcare. This case, we're looking at integrating the care

across different groups or across the neighborhood, if you will, of care delivery. And then of course, we … the IOM definition, the next slide will have the definition of a team that we use. The IOM definition describes the services delivered by a team but does not define what a team is or how it works nor does it describe the core properties or defining characteristics of a high-functioning primary care team.

00:22:12 Although several definitions of this exist, the one that we've depicted here is the one of the most frequently referenced definition in the organizational literature where a team is a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who seem themselves and/or are seen by others as an intact social entity embedded in one or more larger social systems, for example, business or in this case healthcare, who manage their relationships across organizational boundaries.

00:22:49 For this particular study, we … we're looking to develop a conceptual model where we reviewed over

3,200 abstracts and 45 suggested articles from our expert panel. Out of that, we identified 221 articles of which 229 instruments were readily available. 64 of those 129 instruments mapped at the item level to the conceptual framework, which we will … you'll get a … you'll get to see in two slides. 48 instruments met our inclusion criteria, and the potential relevance to measure teamwork and primary care were used on those 48 instruments.

00:23:35 In order to maintain, rigor, each of the instruments were evaluated systematically by two scientists, and if there was a disagreement, their evaluation was reconciled by another two scientists. And what we found is that most all instruments could map at least to two of the constructs. So the next slide in terms of the conceptual framework was through the literature review, and we used a fairly standard Input-Mediator-Output back to the input, so a cyclic sort of framework. The input as you'll see in the next slide on the … you can go to the next slide … on the conceptual model, the precursors or the preconditions for teams to exist.

00:24:28 And there's a long list there, and then the mediators or enablers are in the center of the circle, which is where we are continuous … continuing to focus the majority of our work on this, looking at the cognitive, effective, relational, behavioral, and leadership as the central focus for teamwork and measurement of teamwork. The output are the result of effective teamwork in primary care and looking at the triple aim as another output. So there's the four mediators or enablers in the conceptual model.

00:25:07 Moving on, what we hope will be helpful to you all, particularly in … from the discussions is more explication of the domain and the 12 domains and the four concepts. And I'm only gonna highlight some of these 'cause we don't have time to go over each of them, but in terms of … in the cognitive domain, if we look at shared explicit goals and accountability, which came up, which was a very astute observation in terms of one of the things that patients are very concerned about from our work is who is their go-to person?

00:25:48 We really preach in team-based care that there's a participatory leadership characteristic. So the leader of the care is shifting from the patient to the oncologist, to the primary care provider, which could be a physician and NP or a PA. Or in chronic care, it could be the physical therapist or the occupational therapist or for that matter, the audiologist depending on where the patient is at across their continuum of care. So the effective team, the hub of the team just like we discussed, the mission in the DoD is they actively adopt and agree upon a set of goals.

00:26:27 So the patient is the expert. They're the subject-matter expert on their care, their needs, and what they can do. The healthcare team is the expert on the science. How do we come upon an agreed set of goals and objective which are clearly articulated and which motivates them as a team and which we can put a measurement on to inform progress? So in this particular case, what was already brought up is that the patient did bear some responsibility. They identified that they pill was not the color that they were used to.

00:27:03 However, whether it was trust, whether it was assumption that the healthcare team knew what they were doing or many other possibilities, they didn't speak up. And in the culture of a healthy, high-functioning team, that patient would have spoken up and said, "Look, I'm confused by this. Please tell me what it is. Am I right? Am I wrong? If this is the correct drug, okay, I'm fine with it." The next slide in terms of the effect of relational domain, an element of trust came up here, which was mentioned in the case study.

00:27:40 And effective teams are able to act in a manner that reflects confidence in their ability and reliability of other team members. So there needs to be trust between the patient and the healthcare team and among the healthcare team interdependencies, not only the knowledge of what each person's role is, but trust that each person can perform that role in a way that is acceptable to the rest of the team. And (unint.) inter-relating, that's potentially part of what we were talking in terms of accountability earlier.

00:28:17 In the behavioral domain, which is the next slide, we get to responsibility again in terms of is the team adaptable to context and needs? Can we … do improvisation? So in this particular case, was their effective practice as this patient moved across from one care provider to the next in … you know, in looking at the new plan of care? Is their flexibility there in doing that, and how does … how is flexibility and the learning process built into the team?

00:28:54 Leadership, which we struggle on because leadership is both an input because it's necessary to develop high-functioning teams and teams to have buy-in from the leaders … but there also is a component of leadership in the enabling high-functioning team. So there's two levels of leadership that needs to be looked at and measured. So when we … the next slide will provide a highlight. When we pulled all these instruments out of the literature and we came down to the 48, what you see here is some of the specifics on the instrument. 44, no surprise. 44 were survey and 4 observational checklists.

00:29:36 You can see the settings in which the … they were deployed. One of the things that is a challenge to us, when you look at the range of the total items in the instrument, you had from 6 to 94, and you all are well knowledgeable and informed that there isn't anyone who is looking at, you know, continuity or tier or measurement of primary care that's gonna go out and use an instrument with 94 items to look and see if they're making improvements. That's just not … you know, it's not something that people are gonna do.

00:30:13 But there's the range, and the populations that these instruments were directed to, you can see the physician community being the dominant followed by nurses and other healthcare professionals. Now, interesting … I'll quickly go through these next three slides, which provides an overview of the instruments. And out of the 48 instruments, what surprised us … when you look at this slide on the y-axis is the number of instruments out of the 48. And on the x instruments the domains that they actually measured … there was a fair amount of overlap and agreement that these particular instruments … there wasn't one

particular domain that stood out, so … which was a surprise to us.

00:31:02 So 44 … for example, 44 of the 48 instruments had some element of measuring the cognitive domain, realizing that most of these instruments each map to at least two of the mediator domain. When we get to the item level, which is the next slide, you see out of the specific items, again, there was a fairly good … a number of items across all the domains with the effective relational domain having the highest number of items at 601. And then looking at the specific mediator constructs, again, it's surprising. You can see that there was a fair number with the highest number of items measuring communication.

00:31:50 No surprise there with the IOM report and much agreement at communication seems to be the root of a lot of safety efforts and needs to be improved across teams. But then shared explicit goals … we were surprised by the number of items we were actually looking at due the teams. And are they are affording the patient with shared specific goals to improve? So after, you know, that we said, okay, how are we gonna

look at and identify some of the gaps examining the extent to which instruments map the conceptual framework?

00:32:33 And to solicit structured input, we solicit structured input from the individual expert panel to inform us on what our gaps may be, and then we discuss that input with the … both internally and with the expert panel. And there was some agreement on the gaps in the next slide that we need to incorporate the patient perspective into team-based primary care assessments. Although more conceptual work is needed before instrument development occurs. So finally, like, in the discussion, we did get to the patient, and we talked about the patient responsibility.

00:33:07 But as you see, most of us didn't think there first. We originally went to, okay, was the prescribing provider responsible? Was the person who was reading the script responsible? And finally, the idea that the patient could take and is accountable for some of this. And that is also part of the measurement piece. There's very little on incorporating the patient

perspective into team-based measurement in primary care.

00:33:37 Another gap is we have to address the measurement challenges associated with aggregating at the unit level from individual clinicians, particularly when you … when we look at primary care, whether it's one and two provider practices out there. And then the … my particular challenge … because I wanted some of this work to inform practice transformation and process improvement and not only the research community, and we need to provide ways to support non-researchers who wish to use the … use these instruments or develop new instruments by researchers to provide guidance and training and how to approach, use, and interpret results.

00:34:18 So the non-research community … how does the … how do these instruments fit into a conceptual thinking of them? What are the psychometric properties and whether they can, you know, understand what those properties are? How are … is this instrument … how can it be administratively deployed? What are some of the challenges around that in an improvement process?

And finally but certainly not of the least importance is how do we interpret these instruments, many of which do not have national benchmarks?

00:34:50 So if you were to do … to deploy 'em and say, okay, let's get a baseline on how our team is doing in terms of trusting one another. You would deploy an instrument. You'd get a number. What does that number mean? What does that tell an improvement person? How is that interpreted? The researcher would perhaps have a better feel for that, but the quality improvement person may or may not. The safety person, quality improvement person may or may not have the type of skills that are necessary to make those kinds of assessments.

00:35:24 So where are we going? We hope to and we're on track to provide to you all and the public a searchable database of these 48 instruments, which we hope will help to inform and measure team-based primary care. It will be able to be searched through many key characteristics and search terms. We'll provide a summary for each instrument and it will be a resource. And we're also gonna provide a resource to support

measurement of the attributes of effective teamwork and what we hope to advance and improve team-based care both in the primary care realm but extending to that.

00:36:04 As you know that AHRQ has already published a care coordination atlas, which has some key terms and a framework to look at care coordination and is sort of a guiding light on looking at ways to measure care coordination. So this particular searchable website is due to come out in the fall. So finally, just to wrap it up, the majority of instruments that we looked at were from healthcare. So some were used from other sectors, and they were useful to inform our process of developing the conceptual model and which instruments to map to that model.

00:36:49 The majority … it says some instruments but most instruments will require some adaptation to be used in primary care setting. And most instruments address multiple conceptual model constructs but with differing degrees of emphasis. No one particular measure of … measured all of the constructs within the conceptual model. So Steve and Veronica, that's where

we're at, and hopefully, that provided an overview of our work in measurement on team-based care.

00:37:25 VERONICA CHOLLETTE: Thank you very much, and thank you for integrating components of the case into discussion in terms of helping us identify where failures occurred in the four domains of your conceptual model. Are there any other comments or questions that anyone has for Dr. Ricciardi?

00:37:44 STEPHEN TAPLIN: I have one. This is Steve. I have one to start. Your definition talked about shared common goals, and I think it's a pretty rare circumstance that primary care groups actually within the primary care group sit down and say what's our goal. I would say it's even more extraordinary to think about that happening across. This case, though, raises the issue about do oncology … do the primary care teams share a common goal in the care of this patient? And have they ever sat down and talked about it.

00:38:22 So I was struck in your presentation, Rick, that that was the common theme that … or that a fundamental

definition is that there's a shared goal among the people that are being called a team. And then in the conceptualization, I didn't see it explicitly brought out, so your discussion of it, sense making including salvaging that goal. I wonder … to turn this into a question, to ask you, are you guys leading research? Is anybody looking carefully at the power and the importance of establishing that common goal?

00:39:00 RICHARD RICCIARDI: If that's directed to me, many of you already know that other work that we're doing around this involve engaging the multiple chronic condition patient. If you were to Google AHRQ in May, you'll see a … what I consider to be probably one of the best vignettes on this. We put together a very short story about a patient named May, who interestingly enough is, I think, a 57-year-old woman who has hypertension, diabetes, and how the healthcare system is fragmented and how we can come to some agreement in putting together a common care plan to include … May also had depression, which you see is bringing in the mental health component within the multiple chronic condition community.

00:39:56 So we have … we and also HHS through the MCC of Multiple Chronic Condition framework have provide a lot of work in this area and a lot of resources to include … we just funded two FOAs looking at ways to improve care to the Multiple Chronic Condition patient. And in fact, some of those are also engaging patients with cancer, which is, you know, within the framework of MCC. So I think it's critical, and that's why within the cognitive domain, we need to have shared explicit goals and accountability for those goals.

00:40:41 And what was (unint.) brought up is that that accountability and responsibility is a challenge in coming on who is that go-to person and how that go-to person flows across. But certainly, the coming together … if you watch the May video, the coming together of the oncologist, the mental health community, primary care community, the patient and their significant family that are involved in the patient's care to put forth that set of goals is critical. That's the critical link. If we don't do that, we will not be successful.

00:41:23 VERONICA CHOLLETTE: I was looking at the result item level and the mediator construct 'cause I didn't see anything here relative to organizational support for an environment that would promote (unint.) teamwork.

00:41:38 RICHARD RICCIARDI: That's in the input. If you look at the … one of the things, like I said, was leadership. Leadership must also provide the environment where that's conducive to building teams. For example, some healthcare systems … when you talk to them, when you say, okay, we want to talk about teams and particularly using TeamSTEPPS to build teams across your healthcare system, if they have no interest, it will not be successful. So when you look at the model, there is in the input section the concept of leadership and psychological safety, which was brought up, it's a huge component in building optimal teams in that particular environment.

00:42:21 The culture of that environment needs to be throughout the healthcare system not these … not just isolated teams, which perhaps could be the root of getting the leadership to buy-in. But it will not be … our work demonstrates that individual teams would have very

difficult time being successful building high-functioning teams if it's not in the culture where their leadership has buy-in particularly around psychological safety.

00:42:52 INGRID: This is Ingrid. I have two questions. I'm curious whether your expert panel or whether this was raised with them. Was there any consensus about or components of teamwork? So there are many dimensions within the conceptual model, and we found that in the work that we've done too. You were fortunate enough to have these great minds in the room to think about this, and I'm curious whether there were … there was any consensus. That's was one question, and my second question, which I think is important … you raised this idea of incorporating the patient, which also implies surveying the patient about teamwork. Have you seen any practice that give the same survey to both patients and providers?

00:43:41 RICHARD RICCIARDI: I don't know if it's the same survey, but I do know across the practice-based research community, they do have … and across the FQHCs, the Federal Qualified Health Centers … they

have huge patient engagement opportunities to have … where they have patient advisory panels. They have patient input on boards of directors, etcetera, so patients are provided opportunities for input. I don't know … I can't specifically ask on whether the surveys that are used to ask patients about the care, you know … or are the same that they use for the providers.

00:44:22 I know that the HCAHPS survey is, you know, engaging patients and asking about providers and systems and all … many other areas of it. But I do know that particularly in FQHCs and many other healthcare systems, patients are becoming a more active component of how they address success and do process improvement.

00:44:49 INGRID: That's helpful.

00:44:52 VERONICA CHOLLETTE: (unint.) did you have your hand up?

00:45:03 MS 1: No, I don't think I did. Sorry.

00:45:05 VERONICA CHOLLETTE: Oh, okay, all right, sorry.

00:45:09 RICHARD RICCIARDI: Are there comments and questions?

00:45:13 INGRID: I'll return to my first question about any consensus about core components if … one of the things that I've encountered in surveying about teamwork is that you can ask about all of these various dimensions. And your … as you said, you cannot ask 94 questions, so you have to drill it down to essential elements. And part of that will be determined by what you want to study. But I'm curious whether or not your expert said you absolutely have to ask about these four domains or these five domains.

00:45:44 RICHARD RICCIARDI: Well, that's a great question, and I believe that there … really, there was some common consensus around the fact that there … you need to have a shared model. That's one, and I … there was agreement across that. You need to develop a culture where respectful interactions could occur so you had the psychological safety. And you also needed to have a communication ability that allows for a learning network. There needs … there seem to be agreement

that … you know, that we realize that we can always do something better.

00:46:27 And there needs to be an environment where learning takes place and people are not penalized for … you know, for … I don't want to say making mistakes, but or making mistakes. Yeah, and then you learn from that. There was consensus over that, and also, there seems to be consensus over the concept of participatory leadership, that leadership cannot be dictatorial or prescriptive, that in order to have effective teams, there needs to be an element where the leaders can change based on where the patient is across the healthcare system.

00:47:10 And that takes trust, which is another essential component of … basically, you know, everyone needs to leave their ego at the door. And trust is important element of that because some people feel conflicted about that if they give up control that if there is some potential error, that it falls back on them. And I think that in the current system where it changed to … you know, the IOM report brings up a lot of that …

you know, that many times it's the system that has let the provider down or the nurse down.

00:47:52 And that's how an error occurred. So we need to have a systems level thinking on a team, and that system could be the neighborhood. It could be the condominium, or it could be individual primary care. And that team changes. I think that's a challenge we have in measuring it. When you're looking at measurement, are you measuring the primary … the core team? Are you measuring the extended team? And it's different. There are different ways to do that.

00:48:27 That's a very good question, one that we're challenged with, and we hope over the next decade that you researchers can come up with solutions to how can we effectively and efficiently look at these domains and measure them both from a quality improvement perspective but also from a triple aim perspective.

00:48:48 STEPHEN TAPLIN: Rick, that last question, I think, is a really interesting one and a really good one and maybe a … I just … for the purposes of the discussion, an area where we might want to differ a little bit, I

think the literature talked about multiteam systems. And we're particularly at NCI interested in promoting work in that area since you guys are pretty focused on the primary care world and building that teamwork. We're trying to develop an area which complements what you're doing. And one of those areas is thinking about the system not as one big huge team but as complementary or as a multiteam system so there's a primary care team. There's an oncology team. There's a radiology team.

00:49:29 The question is, how do those teams interact? And it also gets back to, I think, the issue that you were raising earlier or I raised earlier about have they ever … have those teams ever gotten together and shared … established a common goal? And would anybody in the world see those groups as a team together, anybody besides the patient who's involved in all three of them? So I think that, to me, there's a fundamental question about whether in fact there is an uber team. There's something that … all the components … or in fact, it's better to think about this as a multiteam system.

00:50:04 And we may get more traction and have more chances of improvement if we do that. So just a comment, and I'm open to your response.

00:50:16 RICHARD RICCIARDI: Well, my response on that is I think you hit it right. My experience … for example, where I practice, if I have a patient, you know, that comes in with fatigue and they look pale, and I draw their blood and it turns out they have leukemia and I refer 'em to oncology, that patient now sees that oncologist as their primary care team. The world of oncology is very unique that it … because you have a comprehensive approach to the patient, frequently, in my experience, until that patient's cancer is stabilized, whether it's through treatments or they're in a survivor mode, they frequently see their oncology team as their team.

00:51:02 And the primary care team sort of takes a backseat. That's my personal experience and what I've read and talking to a lot of other primary care and oncology. So you're exactly right. You know, it's somewhat unique in oncology versus the cardiology team to a degree. If someone has an MI and, you know, they go

in and they get that treated or whether they have thoracic surgery provide them with a bypass and they're stabilized again and they come back to primary care, how … the concept of survivorship in oncology is one that fascinates me because those of us in primary care look a lot to the oncology community to help us to understand what we need to do when the patient is in survivorship mode.

00:51:51 So that we put these somewhat artificial, I guess, systems in place … what I'm saying in some ways it's really one team, but there are core elements to each of those teams, which are, as you said, unique. But in the overall perspective of the patient, I think we all need to somehow figure out a way to work together. I don't know if that answers your question or brings up more questions.

00:52:23 STEPHEN TAPLIN: I think it brings up more questions, which is great, because we're research … a research institution, so that's probably what we need to do is generate questions.

00:52:31 LEANNE VALUM: Hi, this is Leanne still at Georgetown Lombardi. I'm really glad that you touched on the contrast to cardiac. Patients … 'cause I've worked with some colleagues who are young … you know, sort of young professionals like me in the field but have … so have that history of knowledge of what it took to hand off those transitions for somebody who has, you know, a pretty significant cardiac event. So you have the thoracic surgeon and the cardiac rehab piece and cardiologist and a primary care, and you know, back when all of those things were sort of new, people were actually living through MIs, which haven't been all that long ago.

00:53:15 You know, it seemed like all of those sub-disciplines had to work it out and had to figure out the handoff 'cause I think, you know, it … the handoff is where … the care transitions is where a lot of the trouble starts. It's not as clear with cancer patients transitioning to survivorship, you know. That handoff isn't as specified or delineated very well. So I think we have some … a lot to learn from potentially cardiovascular medicine in that. We don't have to

reinvent the wheel because they've already been through that as a field, so…

00:53:57 STEPHEN TAPLIN: I think that's interesting question, and there's also … there's an article coming up in the journal of oncology practice. It's a survey of patients in Israel, actually, looking at … asking them who they think … who they want involved in their care during chemotherapy. And it's interesting that within that group, they identify that they think of their oncologist as being the primary group that deliver their oncology care.

00:54:27 They definitely want their primary care doc involved, but they think their primary care doc is basically incompetent to deal with the oncology issue. So it's a very interesting set of pieces of information that I think may have relevance to what we're doing here too. And I think also raising the issue that we look forward into the issue of the workforce that there aren't enough oncologists out there to deal with people with multiple chronic conditions. And multiple chronic conditions is a good thing to watch.

00:55:02 Only 10% of cancer patients have only cancer. 90% have some other condition as well, so it's … I think it is both impractical and impossible for the oncologist to manage it all alone, to manage a patient all alone. They can manage disease all alone but they can't manage a patient all alone. So I think there's work … there's definitely work to do to figure out how to make this … how to share care and how to make this multiteam system or uber team work.

00:55:34 VERONICA CHOLLETTE: We have one last question.

00:55:35 MIHO TANAKA: Yes, I'm Miho Tanaka from PCRB and NCI. My question is about the use of the web-based atlas of team-based care instrument, because we did have … in NCI, we did have the 43 shared decision-making major, which I started up and created about two years ago. Our intention was that we wanted to put out this website (unint.) measurement and share decision-making related construct and variable. And then we wanted the researcher, investigator to come back to our (unint.) website and use it for their research and give us feedback of the usability of those instruments and constructs and variables and instrument.

00:56:30 So I was wondering that in AHRQ what are the vision for using the website, which you are about to put out? I think it's wonderful. I think it's good that possibly the investigator can go back and look at what kind of instrument and constructs and items available in the current state of team-based care. So I just wondering what your vision is and then how you want to promote and (unint.) the research community.

00:57:05 RICHARD RICCIARDI: That's a great question, and we had a vision as providing the fundamental, you know, underpinnings for future research. The government frequently, as you said, often sometimes has to take the first step in putting some sorta framework together and convene different groups because the government is very good at convening and bringing groups together to inform, perhaps, future research. So what we had hoped was that, one, this would identify baseline what some instruments are, two, what some of gaps are, and would also be a springboard for future work by academic communities, perhaps, future government FOAs as well as opportunity for other

groups that were interested in team-based care to come forward and to take interest in this.

00:58:04 So I don't know because I don't have a crystal ball. As you know, many times we do these things, and in terms of the dissemination, the implementation science, we fall short. And I'm going to try not to do that, but it's a point that I've been thinking about is that, you know, where do we go next? And those of you at NIH and other federal employees can appreciate the challenges that we as science officers have in understanding what the budget is and where we can go next in an environment of budgetary challenges.

00:58:46 So sometimes we live in the moment, but we try not to. And I hope that this … we can … in '15, garner some money from the '15 budget to move forward to advance this work in instrument development and testing. So that's a really good point, one that keeps me up at night 'cause I didn't want this work to just sit on someone's desk and collect dust. I do want the work to continue to evolve and grow.

00:59:22 VERONICA CHOLLETTE: Thank you. Well, thank you, Dr. Ricciardi for an excellent presentation. Thank you to all the participants who joined the discussion, and I hope that we all can come back together for our next topic on November the 5th, 2014 on research priorities and cancer care teams research by Dr. Edwardo Salas. (unint.) bye-bye.

00:59:43 RICHARD RICCIARDI: I'll put another plugin for Edwardo. He's awesome.

00:59:47 VERONICA CHOLLETTE: Thank you so much.

00:59:48 STEPHEN TAPLIN: Thank you, Rick.
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