Team Science and Interdisciplinary Lung Cancer Care:
Avoiding the long and winding road

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Learning Objectives

After reading and reviewing this material, the participant should be able to:

- Describe the challenges of lung cancer care delivery.
- Identify how better team coordination improves care.
- Define the lung cancer care delivery team
- Describe how team coordinating mechanisms and mutual performance monitoring can improve outcomes of lung cancer care.
- Highlight opportunities for future research
The long and winding road led me to your door…

- George Harrison
Lung cancer care is complicated!
Yes…. Complicated…!
The lung cancer care team

1. First responders: PCP, ER, hospitalists.
2. Diagnosticians: radiologists, pathologists.
4. Therapists: Medical oncologists, radiation oncologists, surgeons, palliative care specialists, nurses, etc.
5. Coordinators: navigators, schedulers and other clerical staff
Coordinating mechanisms enhance the lung cancer care team

1. Effective lung cancer care is a “team task” that requires extensive coordination among clinicians and patients to ensure patient-centered treatment.

2. Developing “coordinating mechanisms”, such as electronic systems for closed loop communication, huddles, and multidisciplinary team conferences.

3. Mutual trust may be cultivated through improved team communication and coordination.

4. Practice leaders “create the conditions” for care teams to be effective, including fostering “real” teams that have “shared mental models”.

2016 NCI-ASCO Teams in Cancer Care Workshop
Mutual Performance Monitoring

1. The likelihood of an isolated lung cancer provider considering alternative hypotheses that preclude his/her services may be relatively low.

2. The proficiency of service execution requires a lot of oversight and clear accountability.

3. Transparency in clinical decision-making, fostered by mutual performance monitoring, is an inherent quality of effective lung cancer care teams.
Priorities for Mutual Performance Monitoring in Lung Cancer Care

• Routine data collection, management, and sharing among care team members. Example measures include:
  – **Concordance rate** (between recommendations and care actually delivered care).
  – **Stage-confirmation rate**, which needs to be specifically defined within each institution/program, based on available expertise and resources.
  – Attainment of quality benchmarks in domains such as **diagnosis, staging, surgery, radiation therapy, chemotherapy, use of palliative care**, etc.
Implications for program development

1. Establish the core attributes of effective vs. ineffective lung cancer care teams, including structures and processes that are “CORE” vs. “Non-Core” for effective teams.

2. Examine whether coordinating mechanisms that work for face-to-face teams are transferrable to virtual teams, which are more common in practice.

3. Examine the incremental benefit of non-core team structures under specific clinical situations and contexts.

4. Develop and implement team-building activities that emphasize coordinating mechanisms and mutual performance monitoring.
Opportunities for future research

• Large gap in understanding how to structure and support high-functioning lung cancer care teams, particularly for teams that are not co-located.

Research priority:

• **Compare the impact** of implementing different lung cancer care team structures, coordinating mechanisms, and mutual performance monitoring on treatment concordance rates, appropriate treatment staging, and patient quality of life/ functioning.

• How important are co-location and in-person conferences to lung cancer care team effectiveness? Can alternative coordinating mechanisms improve the effectiveness of virtual lung cancer care teams?