Coordination of Care with a Multidisciplinary Care Team During Treatment

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2016 NCI-ASCO Teams in Cancer Care Workshop





The Campaign to Conquer Cancer

Learning Objectives

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

- Describe the key principles of coordination of care in a multidisciplinary team setting
- Apply care coordination mechanisms in the promotion of team based care

Mr. Miller's Treatment Summary

Initial			
 Mr. Miller Dr. James Gloria Dr. Smith 	 Dr. Smith called Dr. James about Mr. Miller Medical records sent prior to second opinion Dr. James spoke with Dr. Smith about the treatment chosen by Mr. Miller 		
Salvage			
 Mr. Miller Dr. James Gloria Dr. Smith Sally 	 Mr. Miller scheduled as 'return' appointment without records Dr. James calls both Mr. Miller and Dr. Smith with recommendation Gloria arranges admission At discharge Sally coordinates care with Dr. Smith's office No documentation of hospitalization for neutropenic fever 		
 + Effective care coordination - Ineffective care coordination 			

Mr. Miller's Treatment Summary cont.

Clinical Trial		
 Mr. Miller Dr. James Mary Susan 	 Coordination between Mary, patient and multi- systems Susan starts pre-transplant evaluation and insurance approval process 	
Transplant		
 Mr. Miller Dr. James Susan Dr. Smith Sally 	 + Seen after-hours and documentation in EMR by Advance Practice Provider + Sally coordinated appointments and notified 	
	Susan of this + Packet of medical records, guidelines sent with patient for Dr. Smith and PCP	
	 Dr. James sends progress notes to Dr. Smith, radiation oncologist and PCP 	

- + Effective care coordination
- Ineffective care coordination

Key Principles of Coordination of Care

- Effective communication between members and the patient
- Promotion of strong-clinician relationship built on mutual trust and rapport
- Shared goals of care and accountability of team members to perform their respective roles
- Role clarity between team members and role identification to the patient
- Hand-off in transitions of care to promote safety and avoid fragmentation of care

***Key principles of coordination of care are not intended to be independent of each other but are interwoven and necessary for a high-quality team-based system

Application to Case

- Shared Goals and Accountability
 - Patient's goal was to pursue aggressive treatment
 - Oncologists/HCPs develop a treatment plan consistent with patient goals
- Role Clarity
 - Case managers with expertise in their respective fields emerged in leadership roles
 - Oncologists/HCPs clearly communicate their roles and responsibilities to the patient/family and to each other
 - Leadership structure resulted in comprehensive, efficient care

HCPs= Healthcare Providers

Application to Case

- Effective Communication
 - Teams utilized various methods of communication
 - Case manager overseeing each phase and serving as point of contact for ancillary services
- Hand-off
 - Safe transition in care with the internal team at the academic institution
 - Fragmentation occurred with transition between institutions
- Mutual Trust
 - All members felt connected and played a critical role in the care
 - Seamless care was provided because everyone performed their assigned job

Clinical Application

- Utilization of the coordination mechanisms are keys in developing a system of seamless care between healthcare providers regardless of their size or location
- It is important that the patient remain the constant member of the team
- The teams transitioned in and out seamlessly during the time of care in the academic healthcare center
- Disconnection occurred when there was transition from outside the immediate facility



How do we keep the water in the bucket?

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Recommendations	Improvement	Key Principles Involved
Identification of Team Members	 Specific key team members at both healthcare facilities should be identified Understanding the role of each team member is also important. Primary case manager should be a designated liaison for all correspondence and management of care. 	Shared Goals and Accountability Role Clarity Role Clarity Mutual Trust Effective Communication Hand-off Mutual Trust
Process for documentation and sharing of information between healthcare providers should established	 The patient should be instructed to call for any changes in care especially if any new treatments prescribed or hospitalizations. Providing the patient both verbal and written instruction offers a complete and duplicative review of information. The patient should be provided with an overview of reasons to call, who to call, and how to get a hold of the healthcare provider should questions arise. A small business size card could be used as an "emergency card" with important numbers and health information listed. The patient should be encouraged to keep this emergency card readily available for unexpected events. 	Shared Goals and Accountability Hand-off Effective communication Hand-off Mutual Trust Shared Goals and Accountability Effective communication Hand-off

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Implication for Research

- Research exploring the involvement of the PCP during cancer treatment is needed to define role clarity
- Research is needed to assist HCPs with information exchange across the cancer care continuum utilizing technology and valuation of handoff process
- Outcome measures to assess the impact of technology on the coordination of care mechanism must be identified

Conclusion

- It is important that the patient remains the constant member of the team
- It is important for teams to encourage open communication between each other that is efficient, accurate and precise
- Utilization of the coordination mechanisms are keys in developing a system of seamless care between healthcare providers regardless of their size or location
- Role of case management utilizing these key principles of coordination of care mechanisms enhance the the performance of a highly functioning team
- Need more research to examine the transitions in care and the methods of exchange in information