NATIONAL INSTITUTES OF HEALTH

Moderator: Everett Carpenter
March 19, 2014
1:03 p.m. CT

Female: Hi. So, if the individuals on the line can introduce themselves, just briefly state your name and your organization so we'll know who's on the call with us today please?

(Kapresa): Hi. (Kapresa), NCI.

(Ricky): Hi. This is (Ricky) ((inaudible)).

Male: ((Inaudible)).

Male: ((Inaudible)).

Female: ((Inaudible)).

Female: We're having a little trouble hearing you guys. Can you speak up a little bit please?

Bill Klein: Bill Klein, NCI.

Female: Thank you.

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Male: ((Inaudible)).

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Female: ((Inaudible)).

Female: We're having a little trouble hearing you guys. Can you speak up a little bit please?

Bill Klein: Bill Klein, NCI.

Female: Thank you.

Ingrid Nembhard: Ingrid Nembhard from Yale.

Irene Prabhu Das: Irene Prabhu Das, NCI.

Stephen Humphrey: Stephen Humphrey, Penn State.

Daren Anderson: Daren Anderson from the Community Health Center and the Weitzman Quality Institute, Middletown.

Steve Fiore: Steve Fiore from the University of Central Florida.

Heather Edwards: Heather Edwards, PCRB.

Female: Okay. That's all that's on the line. In the room with me is (Sharon Karum) from NCI.

(Helen Tanaka): (Helen Tanaka) from NCI.

Stephen Taplin: Stephen Taplin from NCI.

Female: Great.. Thank you. So, next, we're going to have Dr. Taplin to give us a brief overview of the branch.

Stephen Taplin: So, again, thank you, all, for joining us. This branch is focused on -- or this series is looking at soliciting opinions from -- we're trying to get three sectors. Certainly, all those on the phone are solicited. We're looking for input from the providers, from researchers, from government people who are involved in this area of work. And we want to identify potential research topics that might address the problems that you all face both as researchers and as

caregivers, with focuses on the research agenda of PCRB, which is about the process and about the underlying factors that affect the process of cancer care.

Male: Next slide?

Stephen Taplin: : Next slide.

Male: Yes. ((Inaudible)).

Stephen Taplin: : ((Inaudible)).

Male: ((Inaudible)).

Stephen Taplin: : Okay. We hope that we'll expose some perspectives that each of the communities that are involved in this cyber discussion hold and that we will get a better understanding of some of the conceptual and analytic problems that will help us see the situation better and study and improve the situation. We ultimately want to contribute to the development of NCI's research agenda which in our area is to improve the quality of cancer care.

So there are more presentations scheduled. And you can see them up there -- July 9th, November 5th, and July 1st. We encourage you all to join us. And if you have other people from your sector that are relevant, we certainly welcome them to join with you.

Female: Okay. So we're going to just review highlights of the case study that you received in the email prior to our call. It was a rather long and -- the email attachment, so we wanted to condense it for today's presentation. The case is around the 57-year-old ((inaudible)) female with a history of hypertension. She arrived earlier in her physician's office. She checked in late.

Stephen Taplin: : She checked in late by the nurse.

Female: Okay. All right.

Stephen Taplin: : But she arrived early, but she was checked in late.

Female: All right. And the focus of the visit is hypertension. The nurse notes the need for a mammogram on check out in her physician order.

Stephen Taplin: : Yes. They order it somehow, yes.

Female: Okay. All right.

Stephen Taplin: : They wanted to get it done.

Female: And --

Stephen Taplin: : But -- do you want me to finish it?

Female: Yes.

Stephen Taplin: : Okay. Later, an abnormal screening reported -- later -- sometime later, there's an abnormal screen reported and the physician calls the patient to leave a message. So the patient must schedule for a follow-up evaluation. Follow-up is done. And the radiologist recommends a biopsy. But the radiologist just tells the patient to schedule with the primary MD and doesn't give the result to the patient directly at that time, at the time of the study.

The radiologist does notify the MD. And, eventually, the biopsy gets performed. The woman is a busy woman. She's got business trips, time elapses. And the results are eventually given in person by the surgeon. The patient is devastated, of course. The surgeon is busy and recommends scheduling with an oncologist and a radiation therapist.

There are in this -- in this study, I think at least two groups. And I think it depends on the perspective you take which -- whether there's one team or two teams. I think from the patient's perspective, they may see that there's one healthcare team that includes the primary care docs and radiologists. But, from the radiologist's or the physician's -- the primary care physician's perspective, there may be at least two teams -- radiology team and the primary care team.

And we don't know in this -- in this -- from this summary whether or not there are -- if these are in one organization or two organizations. And I think, in general, in the United States, most often, they're in two separate organizations.

And so the issue of incentives and how they -- what inspires them to work together is, I think, important. And if you look at Stephen's paper, the issue of incentives is perhaps critical and the balance of incentives for whether they encourage cooperative work or independent work is an important consideration. So we're happy to have Stephen talking with us some more about his work to understand how incentives drive activity of groups.

Female: Next slide. Okay. So I'd like to introduce our speaker for today. It's Dr. Stephen Humphrey. And his talk will be on the micro-dynamics of teamwork. Dr. Humphrey is currently an associate professor of management in the Smeal College of Business at Pennsylvania State University. He received his doctorate in organizational behavior and human resources management from Michigan State University and his BS in Psychology from James Madison University.

Dr. Humphrey's research focuses on the structure of work, with the primary focus on teamwork and the drivers of team success. Dr. Humphrey's research has been published in the Academy of Management Journal, Journal of Applied Psychology, Journal of Personality, Organizational Behavior and Human Decision Processes, and Personnel Psychology. In addition, he has co-authored several book chapters, presented over 50 papers at professional meetings, and is a member of the Academy of Management.

Okay, Dr. Humphrey, you can take over now.

Stephen Humphrey: Well, I thank you. I appreciate Stephen and (Veronica) inviting me to this talk to work with you all. Obviously, we don't have a huge amount of time, so I want to give you sort of a taste for what I think will be valuable to this group -- though I would expect lots of follow-up. I know we have a lot of time scheduled for an actual conversation. And I hope that we do spend a good amount of time just discussing these topics more generally.

Slide please. My basic setup, what I want to talk with you here today -- and, again, it's just mostly about a taste of this information -- I want to discuss teamwork rewards, to sort of orient the conversation that I think we can have about teamwork. I want to, throughout this whole process, integrate it with the case discussion. I want to discuss the challenges of the core teams in healthcare as well as I can understand this topic area, again, I'm not a person who actually is I healthcare directly. And then I also want to end with a discussion for application for future research.

In talking with (Veronica) and Stephen before this talk, they talked about how it really matters for this what it can benefit you guys -- or what kind of benefits I can provide to you is in terms of sort of a general discussion of teamwork and incentives through the lens of an organizational behaviorist, which then I think can spur additional research. And I'm hoping that that's what I can do with this.

Slide please. In order to start this conversation, I think we need to begin by orienting to what is a team. And I think that's a very simple question, to say what is a team -- and yet one of the things that comes up by thinking through this process is that the traditional understanding of teamwork has been changing over the last several decades.

When this was begun, when this research on teamwork and group work began in social psychology 60, 70, 80 years ago, there was an assumption of organizationally embedded teams designed by organizations to accomplish a specific goal and tasks that they knew what that they were doing. They work together, complete in task, and that would be the end of this situation. This often came from funding from the military to improve combat teams, but also with a number of other contexts.

The problem is, in today's world, this is not really the definition of what teams are. What you actually see -- and this is something that when Stephen and I talked for a little bit, he seemed to reflect this notion that, in a medical community particularly, this is -- that we're going to see that teams aren't constructed this way. And so I have this definition here that "teams are an assembly of interdependent relations and activities, organizing shifting sets or subsets of participants embedded in and relevant to wider resource and institutional environments."

I've highlighted different sections. And I think, in order to walk through this, in order to understand this, which I think will inform the future conversation, I'm going to start at the bottom and work my way back to the top, if that makes sense. The first part here is that these teams are embedded in and relevant to wider resource and institutional environments.

One of the big things that was hinted at by Stephen at the beginning of this in setting up the case is that, historically, we've assumed that teams are a single organization. However, in a patient care situation, but, in fact, in most organizational contexts today, we're seeing that teams are

spread across many organizations or at least across different organizational or institutional environments.

The meaning of that is that we do not have design coming top down to create these very structured teams embedded within a single context. In the case of the case, we have a situation where these individuals may be spread across, as he said, you know, multiple medical facilities. They may be across multiple organizations. You know, Stephen said, you know, maybe it was one, maybe it was two, it could be more. And, particularly, as we start to see people who are taking control of their patient care, they actually may be across a lot of situations.

I was chatting with somebody today whose spouse was diagnosed with hyperacusis. And she actually has to work with audiologists. She has to work with psychologists. She has to work with, you know, a variety of individuals at many different organizations in order to try to diagnose the situation she's encountering. And each of them, in theory, are focused on her specific care. But, in reality, they actually have a lot of differences in terms of what their reward system is, what they're trying to accomplish, and what their interaction is with her.

The second piece, which is the red section, is that there's a shifting set or subsets of participants. And, by that, I really want to highlight the fact that teams change. What is the boundary of the team is pretty flexible. So individuals will be added as things go on. So this could be a situation for the case study that, you know, right now, I have a sense that, you know, there are some oncologists, there is a radiologist, there's a primary care physician, et cetera, but different people may be added to this process as she learns new things. Maybe we need to do after care, we need to add in somebody else, et cetera, et cetera.

We also may find that, perhaps, the radiologist is -- you know, they were able to come in and do one thing, but they can't be for any additional work. And they have to bring somebody else in for that spot or else you have, perhaps the patient would have to wait another six months before she

could actually get in with that radiologist again. So this idea that a team is a solid construct that stays the theme over time is perhaps not relevant anymore.

And the third piece is the interdependent relations and activities that are organizing. And, again, if we were to assume that this was a military organization, yes, everybody knows what they're supposed to do. If this was working on Henry Ford's assembly line, we know what your responsibilities are. But, in this situation, as we move into the real world, in today's world, we're finding that the individuals within the team are the ones who organize their relationships. They organize how they actually work together.

Now, you can't have a team if you don't have interdependence. If they're just a series of individuals, there's no team. But as they understand the relationships between each other, that's where the really critical factor is. And I think this is the question that we start to -- that we'll have to unpack as we -- have to understand incentives, is this relationship piece.

Let me just give you a sort of a simple example of that. If the radiologist and the oncologist have a history together that, for some reason, they don't like each other, you can imagine that this is going to break down the quality of the care. They may be professionals and pass all the relevant information and do everything they're supposed to be doing or they may, you know, share what they think is relevant, but not really everything, or they may share, you know, what they think is appropriate, or they may delay interacting with people.

And that's a very simple example. You can imagine though that relationships are much more complex. If I know, for example, that you are really an expert in this space, I may be able to pass on unique information that I know will be relevant to you. And that's based on our trust and our quality of our relationship and so forth.

Within any given team, you're going to have all these relationships. So a five-person team has 10 unique relationships. And that's only a five-person team. In a medical situation, you may have 10 people, 15 people that actually encounter and interact with the patient. And those relationships get really big in terms of the number of people that could be interacting with each other. So we need to understand to what extent do these relationships exist, what is the quality of those relationships, how are things being passed through those situations, passed through those relationships.

Slide please. So this starts out from the focus of the members of the team. And you have to -- here's a very critical question to begin with. Do I know I'm in a team? In a medical context, one may not recognize the teamwork situation. If I'm a radiologist, perhaps, I focus on my job -- and I'm doing my job, which is to provide this information for this patient. And, once I'm done with information for that patient, I move on to my next patient and then the next patient and the next patient.

So they're not seeing this as a series of interactions amongst dynamically forming teams to treat a patient, but rather dealing with a specific action, what we call sort of "task work." I have to do this specific task. I complete that task, and I move on to the next task.

If we, instead, can raise awareness that you are a member of a team, that you're actually working together to accomplish a goal -- again, this is what I said in the definition -- you have to have interdependence -- if we have some understanding that there's interdependence here, then, I may be able to define the point that I'm in a team, I may be able to do certain things such as, you know, the incentives that actually can work towards something or any of the other ideas such as team cognition and so forth that I know are going to be raised throughout the rest of this series. If we don't even know that I'm in a team, then that's the problem.

The second question is "how many teams am I in?" If I'm actually dealing with 50, 60, 70 patients, can I make sense of all this? Can I make sense of "I'm in 50 teams?" Do I know all the people? Can I pass this information, and do I know who I need to pass this information to each time?

Again, the primary responsibility of a lot of teams is information exchange and information processing. Right? In the case of diagnosing and treating cancer, you have to know is there something that we have to be concerned with. Do we have any evidence of this? What do I learn from these different things, the radiology, from the biopsy, from the surgery, from this, from that? We need to able to learn what that is and pass that information through. If I don't know who those people are that I need to pass it through, well, that's a real problem for me.

Who is the point person, the leader, the quarterback? We can use a lot of different terms on that. Who is driving the patient care? This might oftentimes be your -- it's probably going to be the patient. The patient has to coordinate all the different doctors that are involved in the actual situation. Well, it’s problematic, if you're going through a high-stress environment -- you know, being diagnosed with cancer might be something that is considered to be high stress -- you may not be able to take charge as well as you want. You may not be able to coordinate.

From Stephen's example or case study, you have the situation of a person who actually is trying to balance cancer care with actually working a full-time job, a highly demanding job with a lot of travels. How do we coordinate this? Is it this person? Is there an advocate for this person? You have to recognize who the leader is, who is actually directing the care.

And the last piece -- and this is where we sort of set up for my unique component here as well -- is "am I rewarded for this activity?"

So next slide please. When we start to focus on this idea of information exchange and information processing -- again, that's the point of what a team is -- we have to recognize where the breakdown could be. In a lot of situations, if you look -- again, I'm looking historically versus today's world -- we would just sort of treat the team as a team. What's the climate of the team? What's the team like? What's the team on average? All right?

The first time you hear somebody say, "On average, this team is like X. On average, this team, Y," that should raise some flags for you because we don't care, on average, what the team is like. What we care is, in specific, what's happening in that team. If, on average, everybody likes each other, but, as you know, we actually know that these two people don't like each other. But, on average, everybody gets along. Knowing that these two people don't like each other allows us to get insight into where the problems are. What's breaking down in the actual patient care? I mean, you need to know on average -- we don't need to know, on average, that information is being communicated correctly. We want to know, in specific, are each piece of information being communicated correctly between each relevant party. Understanding that allows us to get insight into where the benefits are and where the potential breakdowns could be.

So we need to get into that question of how much do the players or how much do the team members communicate with each other?" Is there an incentive to talk to each other? Is there an incentive to provide the relevant information and the correct information to each other? And, ultimately, what is the goal of this team? Do they see themselves as a team? Do they have a goal that they're working together at?

Next slide please. So, as I'm learning through this whole process, I've talked to Stephen and (Veronica) for a while about how this is relevant, how my stuff was relevant to the (contexts). They talked to me a bit how team cares being built into the (ACA). People are -- actually have some sort of metrics and incentives to work together. Well, that's really important. Another

question becomes "how does that affect things, you know? Or, put very generally, what are the implications of the rewards on the team member's behavior?

You guys may have read the paper that was sent on, that I (posted). I've done a couple of papers on incentives and teams. Just for sort of the high level take-away from that is the notion that, first off, we -- if you reward teams individually, teams do things individually -- which means we do high quantity of work. If we reward teams collectively, we tend to do things collectively, and we have better quality of work over time.

This is a really critical factor though in understanding the broader statement about, "If we want to do teamwork behavior, we need to reward teamwork behavior." At a really high level, that's an obvious statement from my own experience I tried to do a research study several years ago on teamwork in organizations, and I started calling up a number of organizations saying, you know, "Hey, I want to do some work with you guys. You know, I want to do some stuff on teamwork." And he said, "Awesome. Great. We love that idea. We want to do more. And this teamwork is really important."

I was, like, "Great. Wonderful. Can you talk to me a little bit about the incentives that you have for teamwork?" He said, "Well, we don't reward teamwork." "Okay, then."

Female: Stephen, I have a question.

Stephen Humphrey: Yes?

Female: Sorry. (Does ACA stand for Affordable Care Act) because... ?.

Stephen Taplin: No.

Female: No?

Stephen Humphrey: Yes.

Stephen Taplin: Affordable care organizations.

Female: Okay. Sorry.

Stephen Humphrey: Oh, I'm sorry.

Female: Sorry. ((Inaudible)).

Female: ((Inaudible)) the accountable care organization.

Stephen Taplin: I think -- I think what you're talking about, Stephen -- we just want to be sure what you -- you want to use as the words, what you meant. I think you were talking about the accountable care organizations within the (ACA), with in the (Affordablee Care Act).

Stephen Humphrey: Okay.

Female: Okay. Thank you.

Stephen Humphrey: You know, I just -- I just wrote down -- when you -- when you talked to me, Stephen, was you said, "Team care built into the (ACA)," so I wrote down (ACA). So I wrote down that on the slide, too, because, hey, you know, that's -- that the words that were passed on to me. Hey, what do I know about the medical facilities or medical care? I'm limited to that. I'm sorry.

Stephen Taplin: That's fine. That's fine. That's referring to the incentive for primary care homes.

Stephen Humphrey: Okay.

Stephen Taplin: ((Inaudible)) patient centered medical homes ((inaudible)).

Stephen Humphrey: Okay. Fantastic. Thank you.

So that's where I was going, but let's just take a step back. We're in the situation that we know for sure that individuals do what they're rewarded to do. Right? It's a truism. We may do it more and more or less, but it's something that we can hold back the psychology from the last 100 years. If we're rewarded to do X behavior, we tend to do X behavior.

If we wonder why people are unethical in the organizations, it's often because we reward the production of something. Unethical behavior perhaps can increase that. And the punishment for unethical is absolutely less than the punishment for not reaching whatever it is the goal or the incentive outcome. You might get fired for these things and so forth.

The same thing happens within a teamwork context. If we focus on doing, you know, the number of patients we see, we can think about that as a normal -- normal reward thing. How many patients do we see on a daily basis? We're going to focus on getting people in and out of the office as much as we possibly can. But it will not lead to collaboration. That will not lead to more information exchange. It will not lead to better diagnoses. It will be to just more activities.

Next slide please.

What we need to be thinking about then more generally is "what are the behaviors that we're looking for within a team context?" And what I mean by that really are "what are the things that we want to see?" If we're concerned about, for example, the case analysis where the radiologist

had information and did not pass it down to the patient, and the patient may have found this really useful, may have wanted to know this stuff, rather than wait for days, weeks before they could actually see the surgeon, what do we reward it for?

If we want to reward that behavior, we want to reward the passing of information. We need to think about doing that. If we, instead, just reward teamwork, "More teamwork is good. We want you to collaborate," when we think about how do we figure out what is a good teamwork, it's not patient success or, you know, patient mortality -- it's got something, I guess, on patient satisfaction. But that's not going to get us into all these different factors. We need to be thinking about the specific behaviors that people actually care about, that we want to see.

And, in teamwork, that would be information exchange. It would be about collaborative behaviors, specific collaborative behaviors. It may be about other related things in that space, but we want to get down to that question of "what matters to us in this context for teamwork" and focus on those relationships, recognizing that those relationships may be dynamic and changing over time.

We also have to recognize this broader statement of a team -- is a team ((inaudible)), but identify that team, label that team, make people think that they're part of those teams and figure out how to actually start up the goals, put people on these teams and incentivize in that system. All right?

I think that's what I need to cover at the high level. So I think we'll turn back to Stephen for the next section.

Stephen Taplin: That's great, Stephen. That's a good introduction. And I think that the example sort of raises, for me at least, the fundamental problem that your research is addressing -- that you could conceive of the problem as the radiologist has a task to do -- and you highlighted this in your

presentation -- the radiologist has a task to do and it appears she does it for the primary care doc -- and that is "do the mammogram and find out if it's normal or abnormal."

And the primary care doc has something to do, which is refer to her screening and schedule that screening and then get -- and they do that. But is there an incentive? I think the question in this -- that I tried to raise in the example and the question I think that we face in healthcare is, "Is there actually any financial incentives for what the patient actually wants to get done?" -- which is healthcare, make sure that they get screened, if they have an abnormality, get diagnosed, if they have cancer, it gets treated.

So, within this piece, I'd be interested in your perspective on incentives, whether, within that problem, there is a problem. And is the definition of whether the tasks that are being done are, in fact, being done and conceived of as part of an interdependent activity or done and conceived of as independent activity?

Stephen Humphrey: Right. And I think, at the high level, almost all of these situations are independents. The individuals are doing their thing, they're doing their task, and there's no incentive to work together to pass information together to diagnose, to basically put the patient at the center of the process and, you know, work together on something. Rather, they're working independently towards completing their incentivized activities, at least from my understanding on the outside.

Stephen Taplin: So that, right now, you would say that this teamwork is not actually incented. What's incented is the independent tasks. And, lo and behold, that's what happens.

Stephen Humphrey: Right. And so that's why we're going to focus on higher number of patients, faster diagnoses, faster feedback, rather than quality of care over all. Quality of care requires the interaction amongst a lot of individuals who provide patient-focused outcomes. That only happens through a change in the current incentive system, at least, as I understand it as an

outsider to this, what I don't see as a theme in many of these situations. I see it as a series of interdependent actors.

I guess the metaphor I would use is the people on an elevator versus people, you know, on a tug-of-war. In a tug-of-war, we're working together to pull the other side. In an elevator, we're all travelling from up to down, but I don't think we're collaborating in any sort of meaningful way.

Stephen Taplin: There are people on the line. Daren Anderson is on the line. And he's managing the healthcare system ((inaudible)) team.

I'd be interested, Daren, whether you think that -- whether you've been able to deal with this incentive issue in constructing your system.

Daren Anderson: Yes, Stephen, I think, you know, this is really a case about care coordination and the degree to which somebody owning and taking ownership over the coordination of care as incentive because, you know, this is one simple case, you know, where there are only essentially two or three players. You know, there are patients who have four or five chronic diseases and so many different people interacting with that patient, but, ultimately, that care needs to be coordinated by one -- by one entity.

And, increasingly, I think that entity is being identified as the patient center, the medical home. And so, you know, as practices continue their progress and implementing that model, they run headlong into NCQA's certification schema which includes the coordination of care as one of its core must-pass elements.

And if the PCMH effectively was able to provide that, they would have beaten this case right up. They would have been tracking the referrals. They would track the abnormal results. They would track the follow-up of the patients and they would own that process. And I think establishing that

ownership and incenting that team, you know, incenting that entity to achieve these outcomes is key.

I think, you know, there are efforts nationwide to provide financial incentives for practices that identify PCMH. But they haven't -- they haven't been widespread. So in our environmentais an (FQHC), we have a patient centered medical home 3 certification but we still get reimbursed on a fee-for-service basis. And so, this type of activity is essential to our organizational dynamic and how we define themselves with the PCMH, but we don't get -- it's not aligned with any financial incentive at all.

And the second that's hard is how you measure -- what sort of metrics and measures are you able to assess to determine whether or not you are, in fact, coordinating care. I mean, we -- (Steve) and I have talked about the (30-60-90) notification within 30 days, follow-up tests within 60 days and treatment within 90 days. It's really hard to get that metric out of your electronic system. And one of our research team here ((inaudible)) had spent weeks going through charts trying to identify whether we hit (30-60-90) on our cancer follow-up because it's so challenging to get those metrics out.

(Chaplin): So that's interesting. So you're in a -- we're in a transitional situation where you're being intended to create the patient- centered medical home but not being attended to do a teamwork, that's the corollary of the patient-centered medical home.

(Daren Anderson): Yes, I mean, it's very indirect. So -- and there are, I know, in the private sector there is -- there are efforts by insurers to provide incentives for practices that gets PCMH designation but specific incentives to, you know -- and in order to achieve that you need to be able to demonstrate to the (NCQA) that you are providing, you know, coordination of care and that you are providing follow-up on abnormal results and all of that sort of thing, so indirectly that there are financial incentives increasingly being tied to this sort of activity.

In our world, in the FQHCs, that it's much less common in the -- and currently here in Connecticut we don't have any such incentive to be at PCMH or to do a specific PCMH activity. And even if we did it's really hard to measure them and that's one area that we're really focused on, is how do you measure care coordination activity in a way that you can, you know, really demonstrate that you are doing it.

I'm going -- you know, (Ingrid) is on the call with us as well. And is interested in whether or not the (CAP) survey can provide a patient assessment of the quality of care coordination in a PCMH environment as well. And we're working together in a project, looking at that.

(Chaplin): (Ingrid), do you have any comments -- so, (Steven), just to bring (Ingrid) in. She was here yesterday actually at NCI. And part of the issue of sort of outcome and metric of teamwork here that I think, that (Daren) was just alluding is coordination.

And so, I don't know, (Ingrid), if you want to talk at all or comment, or (Steven), you want to comment on whether there are metrics of coordination and how do you know that you've incented the right behavior?

Stephen Humphrey: I can talk and (Ingrid) will probably have this -- be able to ground this a lot more than me. I sort of have a reaction to what (Daren) was saying here, which is, the sort of higher level approach. I think it sounds like you're moving in the right direction but you're almost -- the concern I would have is if we incentivize the higher-level outcome, as opposed to the specific processes, this works as long as you have the right advocates in the system. You have the people who are -- whose hearts and minds are in the right place, you should be fine. The second that this starts to have a turnover -- so this is the first-generation of people who start doing these things will be likely be well off. They will advocate, they will do all the right behaviors and things will be good.

But if the information is diffused we are rewarding at a very high level. As we bring in new members into the organizations, new physicians in the process, they will not understand the nuances necessarily or the background as to why these things are, and they are going to start to see, well, if I do X behavior it comes up better on my score card.

I've talked to people, you know, again, they have these score cards, and you have these numbers of tasks, where you, you know, green, yellow, red, on terms of these kinds of activities because that's what we're going to -- you know, add all this stuff up to give you a reward based on these things and they will start to juice those different pieces to maximize their reward. This is why you really want to focus of what those things matter. And so, that's the question of, you know, can we actually measure coordination.

I don't know within this content what would be a great measure of coordination but I think you'd really want to go -- get into those specific behaviors that would encompass or at least represent coordination in patient care.

(Ingrid Nembhard): Hello, this (Ingrid). I'm going to weigh in now that I have taken myself off of mute.

So, I agree with what Stephen is saying and I think (Daren) would agree that one of the challenges that we have faced is really thinking about how do you measure coordination. And we are using the (Cap) survey and I think that that will give us -- so those who are on the line who are not familiar with the (Cap) survey. It is a survey that measures the patient's experience with care.

And what we're doing is using the coordination, using items from the coordination supplement to that. I think that will give us one way of looking at it. At least it will give us the patient's perspective. Even within that, as I think Stephen Humphrey was saying, it's more of an over-

arching approach to thinking about coordination versus perhaps looking at individual components, for example, relational coordination versus informational coordination, et cetera.

What we're doing to do to address that is in a (fast) survey, try to measure some of the specific behaviors that we think are components of teamwork so that we can begin potentially to address what Stephen was saying, if you just measure broadly this general idea of teamwork, maybe that's not so informative in terms of incentivizing people.

A question that came up for me and I'm curious whether or not Stephen has a response to this. As we're talking about incentivizing teamwork, I think there are two ways that you might do this. One way is incentivizing a group of people, right? The structure might be that we incentivize the radiologist, we incentivize the primary care physician et cetera, to work together. An alternative approach is to designate a person, for example, a nurse-care coordinator, who might be the person responsible for the teamwork, for everyone.

And I'm curious whether or not you've seen any models, or if there is any data about incentivizing a particular person to take a role versus incentivizing the person, the various persons in the team. And whether or not those two approaches, one is more effective than the other.

Stephen Humphrey: I'm just sort of rolling through my brain here to try to give you a better, a more concrete grounded answer. You know, if you put sort of the nurse coordinator into this role I would see that as one of two things you could call this. One would be sort of a leader. The other one is called a strategically core or critical role within the team. Either one of these things could have a suddenly different meaning but the broader statement would be that we are interested in that person who are -- in order to provide the direction, the coordination. And so, I think that's what you've just said.

(Ingrid Nembhard): Right.

Stephen Humphrey: So that gets into the question of will these people still work together? Well, having been a leader of many teams, been members of teams, I will say that if the leader is motivated but the followers are not, that alone does not produce outcomes. It might provide energy and it may -- it may incentivize to a statement. It may -- it may lead people to be a little bit more motivated to work together but I think you still get a loss of that over time. Particularly if you have to deal with 30, 40, 50 different people -- you know, that I'm (handling) these many patients. So I have these many coordinators.

Each one of these people who have to touch each one of these coordinators may say, well, I've just sort of gotten lost in the middle of this, who are you dealing with again? Why am I caring your patient versus other patients? And you may see a loss there. There is not a standard interactional process but rather, okay, I will pass it to you because you ask this time. I got your phone call -- this time, I got your phone call, the next time, the third time, the fourth time, the fifth time, maybe I'm slowing down my reaction to your call. I'm taking a message and then like the 10th or 15th person who calls me, now I'm just ducking the calls entirely.

Because I am not directly being brought into the system, rather, I am on the outside. If I am the radiologist I'm still on the outside of this process. So, yes, I think that the nurse coordinator would improve in the short run but as more and more people took on that approach and incentivized the nurse coordinator to take the directive role I think there will be diminishing returns in terms of the benefits to the patient. That's my educated guess.

(Ingrid Nembhard): I think that's -- so then it suggests that what we really need then is a nice first step and an important step. What I hear you saying is that there would still need to be a complementary sort of incentives per se that would bring everyone else into the -- into the conversation.

Stephen Humphrey: Yes, I 100 percent agree with that. The individuals, serving as a leader, I think it's critical. It's one of the things I had in my slides. But you need a point person you need to have that in some sort of way, an advocate or whatever you want to call it.

(Ingrid Nembhard): Right.

Stephen Humphrey: The individuals will still do what they are incentivized to do and if they are not incentivized to work together, over time, the motivation coming from the others is only going to -- it's going to fall apart.

Male: That's really interesting there. I think about it and potentially study -- the actual case comes from a recognized problem in care where organizations have to interface. And it's recognized widely enough that there is something called the Accountable Care Organization that is now being organized to link organizations that don't otherwise have incentives to work together. For cancer, the incentive and the metric that ties to some funding is screening rates. It's not follow-up rates. So the choice of the metric will be in. I mean, it's basically wrong. It's insufficient to actually achieve the goal of linking the two pieces.

So I think there is, again, room in light of what you are saying, Stephen, to be thinking about incentives in some very concrete ways and to eliminate where incentives work and where they are appropriate and where they are not.

Stephen Humphrey: Yes. You know, one of the old adages as well is if we can measure it, we measure it. And for things that we have data on, the greater likelihood is going to be sort of raised to importance. All of this is probably we have this from our own experiences things that are easier to grasp are the things that we put incentives on. And yet that may not be what we actually care about. It's probably a whole lot easier to tell about screening, it's harder as (Daren) was saying -- the fun in here was even just to get in terms of when are we doing a follow-up and so forth. That

may be harder to pull, while if that's harder to pull, it's harder to put incentives on it, it's harder to make that something meaningful and yet it might be the most critical factor. Again, I am speculating on that. But, you know, the accessibility of certain data raises it to an outsize importance.

Daren: So, can I ask a question. This is (Daren), if we are going to accept the need from that, we need to apply financial incentives to get the behaviors and the outcomes that we want for critical processes. How do we determine which processes, right to the level of needing an incentive, and I'm just thinking about a typical primary care practice, a typical patient or a typical day where there's probably several hundred different actions and activities that me and my team should to do to manage an asthmatic or a depressed patient or the patient with diabetes and cardiovascular disease, and every one of these has a set of clinical outcomes, of process measures, and sort of team-based activities that we're expected to engage in.

And, you know, I'm just getting dizzy thinking the number of potential incentives I would be assigning to all of these different things, any one of which could be argued is critical for that health of that individual patient. How are we going to manage the complexity of all of these different activities that need to be incentive and how should we decide what right and the level of needing of financial incentive if we accept that financial incentives are the way to go here.

(Daren Anderson): Well, that's a tough question.

Female: Well, what about the Japanese system where they pay people for being healthy? That's one way to cover all of this stuff.

(Chaplin): Maybe but if you're…

Female: If you've got all of these co-morbidities?

(Chaplin): You and all the people responsible -- if I had a breast cancer in my breast, I mean, to some extent it's not my fault, well, I still have to get it taken care of. It's like…

Female: Right, so your doctor team has to keep you healthy. I'm just trying to think through because there are so many kind of mini-systems that we have in this country in terms of some doctors are paid in a salary, which is probably more conducive for teamwork. And certainly if you are working in the same organization that's more conducive to teamwork than if you are a solo practitioner or you're in a group of maybe people working together but they are basically solo practitioners.

And then the -- I'm not exactly sure how the federally qualified healthcare centers are run. I think they're salaried, aren't they, the doctors who work there or they work pro bono?

(Chaplin): No, (Darin), they are salaried.

(Darin Anderson): Salaried. Not pro bono.

Female: Salaried. Then obviously you're trying to coordinate the teams because you're even measuring. And then it seems like we've kind of got these natural experiments running. I'm thinking of (Geisinger) and some of the group and staff, group and staff health maintenance organizations that have -- we know they have more equal outcomes. We know they do a better job of screening patients. We don't know they do a better job of treating patients, but it seems like that is the sort of natural experiment in teamwork because they are working together. They are referring. They know the people in the system. And there's some evidence that some of those have better outcomes. I mean, that we've shown prior to implementing the accountable care organizations.

So, and just ((inaudible)) do we have really good hard evidence whether, you know, working together in a team in a coordinated situation, versus working in a more competitive situation which hasn't been discussed exactly explicitly, but that was in the title. You know, whether you get better outcomes from coordination. You think you would but do we have any evidence on that?

Female: To be ((inaudible)).

(Chaplin): But that's partly what's Stephen's work is, is about that. Whether…

Female: But not at ((inaudible)).

Female: Right because the (DA) does have some statistics in terms of teamwork and how to reduce mortality in the ((inaudible)) rate should have.

Female: So we do have some evidence on that.

Female: I wonder are we looking at teams and incentivizing in only one context of financial reimbursement over to the organization and should consider other contexts of incentives and rewards.

(Chaplin): Well, that's a good question, because if you looked it up -- you know, you jumped to that or you pointed out that there is a high-level incentive in this, to sort of help the patient but there is a direct incentive, which is financial. Have you studied gradations of incentives and other kinds of incentives that (Veronica) is bringing up?

Female: ((Inaudible)) financial.

Female: Right.

Stephen Humphrey: I think the important thing is that we -- I think it gets back to the earlier comments from (Daren). If I have to incentivize each behavior, particularly think of I'm going to get 10 cents for this activity today. I'm going to get, you know, a dollar fifty for that and I get lost. If I can't do the mental arithmetic behind each activity it doesn't mean anything anymore.

So parallel to that would be, within organizations that we have, a lot of people are rewarded with like what's called gain sharing. So if the organization does well, then I get a piece of that. Well, if I am a member of a 100,000 person organization how much do I think I affect that organization and therefore since I don't really know it doesn't mean anything to me. And so, giving me that reward doesn't do anything for me. But we do know that other kinds of incentives such as praise, as status, et cetera, those kinds of things do matter, in fact matter more than financial incentives to different people.

There are cross-cultural implications. So what we say in the U.S. or at least for U.S. raised people are different than what people from other cultures would value. So that's, you know, again, in terms of relational components, in terms of -- in terms of praise, in terms of respect, all those kinds of things maybe other ways to highlight this. So if we can say, hey, you're the best performer. I'm not going to use the (McDonalds) ((inaudible)) thing, let's put your face up on the wall and say, hey, you're the employee of the month. But that does -- those kinds of things do matter to the individual, more so for some individuals than others but it overall matters to people that they get respect for these kinds of activities.

(Chaplin): Can you diffuse incentives? Because we are talking about incentives for a specific task but I think was raising the issue that there are actually multiple tasks that we all do every day. So this sort of employee of the month is an incentive for multiple tasks. Have you looked at that, you

know, how incentives work when they are diffused across multiple activities versus for a specific activity?

Stephen Humphrey: I mean, you can -- you can build a broader reward in terms of this package of things, but a lot of that comes down to recognizing within there that these are what this is built from.

One of the breakdowns in a lot of situations for when they do reward teamwork and organization is they will just say, you know, teamwork, you do more teamwork or you were better at teamwork and therefore we give you a reward. It's a really vague for people and they don't know what that actually was composed of. And if they don't know what it was composed of then, yes, they are not, the individual stops because they can't understand that, you know. My project came in on time, on budget, you know, et cetera. That all works.

In this case, yes, if you can package together this set of things and these are what matter. This is what the reward is based on this set of activities, again, even cross highlighting this set of activities and they are going to be weighted. You don't want to say that, you know, you do any of these activities but don't do these other things, that's okay. Well, unless you want that you probably don't want to do these things. So we use an example, when I teach negotiation I talk about Dennis Rodman and his teamwork activities. The Chicago Bulls many years ago basically rewarded him to rebound and do nothing else. They didn't care about anything else. You show up for the game and you rebound, and you get money and you'll get extra bonuses. And that's what they wanted and that's what they got.

Other people would say you perform well, you win awards, that actually gets rewarded and that's a different way of approaching this question. Do we want to reward a behavior or set of behaviors?

Female: And I also want to come back to the question that you have 20 patients and you run 20 teams. Just a hour ago I had a conversation with somebody in the hallway talking about a patient's experience saying how can all the paid doctors not understand that they are on the patient's team, right. They say that they care about the patient's outcome. But if you're a doctor and you have 20 patients, you can't be on 20 teams. Nobody could function, keep track, coordinate with 20 different sets of teammates, right.

So this incentive idea seems to me that it has to be across paths but not around a particular patient. It's got to be that you routinely treat all patients this way or do this on time or do this in conjunction. I don't see how you could put the patient at the center of the team, practically speaking, even though that's the goal.

(Chaplin): This is their patient, (Sarah Coburn), from NCI, and that's a really interesting question. And in fact in the example and maybe both (Daren) and Stephen can comment on this. In the example it’s the radiologist who is the one who might be working on 20 different teams. A primary care doc may in fact have an incentive to take care of a group of people with a panel.

And so, maybe you could a little bit, (Daren), about what the patient-centered medical home is intended to do in terms of whether it's intended to panelized so that you -- the primary doc becomes accountable to a specific group, versus the radiologist and see if it's actually a slightly -- there are two problems within this -- within this example. One, the radiologist who may one way more than 20 patients or the primary care doctor may have one specific population they are dealing with.

(Daren Anderson): Yes, this is (Daren). I think, you know, in the medical home model primary care patients, and providers are impaneled. And you know, our model every primary care provider has approximately 800 to 1,200 patients the belong to them, that they routinely see for routine and acute needs.

And, you know, that patient is part of a larger team that we very clearly define. We call them pods probably because of the clinical unit in which they work. But that team is very clearly defined. It's the primary care provider and the nurse that works with that primary care provider, a medical assistant and a behavioral health provider working in that pod and that the nurse is shared between two different providers. The behavioral health provider is shared between four different providers but they are all part of a unit and a team. And I think, you know, you could ask any of them sort of what team they are on and they would be able to tell you who are the members of that team and they would understand that they have a shared ownership over a panel of patients that belong in that team as well.

Where it gets more complicated is if you extend the team out beyond the walls of a primary care center, like you mentioned to the radiologist and it maybe that we refer patients to three or four different gastroenterologists, two or three different physical therapy entities, et cetera. And then the concept gets a little bit more complicated. But I think within primary care increasingly there is an attempt to really define much more clearly the team that is responsible for the patient's outcome, and to be able to identify your outcomes for individual patients, both for the provider and aggregate for the entire team.

(Chaplin): So that's interesting. So how -- maybe (Ingrid) and I think (Sally Weaver). I don't know if she's still on. (Sally Weaver) is also a keen researcher, and could comment about the opening and Stephen could comment a little bit about the opening salvo around what exactly is a team and whether there are boundaries. So the primary care sounds like there is a team or there is at least a clear set of responsibilities and there is a set of people that might be in the pod that are responsible for those individuals.

But how do you find a team for the radiologist who is on the other side of this problem?

Stephen Humphrey: Do you want me to take that or somebody else?

(Chaplin): Go for it. Anybody who is (saying)…?

Stephen Humphrey: So, you know, one of the things that we're sort of talking about right now in terms of understanding what our team -- we're actually starting to get into this idea of the sort of the core team and sort of, you know, ((inaudible)) really calls sort of a shadow team, the people who are on the (borders) who come in and out of the context. So if we follow that through this context we have the core primary care team but we have a set of stable, perhaps, relations of people who provide value to that team.

So if you said there are three gastro -- something, that I can't pronounce ((inaudible)) but, you know, you have three radiologists, you have three of these people, you have two physical therapist, et cetera, that are normally consulted into this, they are not sort of the core members of this team. But if we have ongoing relationships we should be able to build trust, build -- you know, practices to be able to transfer information.

If we focus on the patient as a series of events -- you know, I'm not trying to dehumanize the individuals but rather say that, you know, we're going to deal with this project, this project, this project, this project, and this project, this patient A, patient B, patient C. But we have these stable relationships of people that we can bring in, that we can consult, that we can, perhaps, hopefully, build some sort of broader incentive system. Again, it doesn't have to be financial but incentives in terms of why do I want to continue to work with you, why is it a useful thing, what should it look like?

When we do all those things we may be able to benefit the patient, each individual patient coming through because we have stable or something that can -- these stable relationship with the individual -- within the broader team concept.

(Ingrid Nembhard): So let me add to that. You focus just now on the stability and I thought something that was really important that you noted earlier in your presentation was the quantity, which is similar but I think it's important, the quantity versus quality dimension of this.

With the stability part of what I think comes from having the three or four gastroenterologists that are essentially part of your network is that you are building this volume and the volume of the stability, which potentially leads of the quality of the relationship, which I think it's actually really important. And so, what I hear and what (Daren) and his troop has done is really building, as you said, certainly their stable network. But by limiting in some sense, perhaps, deliberately in limiting to three or four specialists that they use routinely is basically creating a boundary around their network. Because the alternative that, I think, a lot of healthcare organizations are contending with and that was raised in your very first slide about teams was being boundary-less and how that is presenting a challenge.

And so, the solution that we might be seeing here is that organizations are trying to create boundaries in some way or another. And so, I think that that, I mean, going back to the question of incentive that you raised I'm presuming that helps, creating the boundary helps. And I think the challenges had even incentivized in those situations where there isn't as much boundary. And maybe we're not at the stage of worrying about that, maybe the first stage is figuring out the different layers of boundaries and trying to incentivize those and then dealing with the, which you would imagine is the smaller percentage of boundary-less relationships, so to speak.

Stephen Humphrey: Yes, I agree with you basically 100 percent on what you just said. So the idea of -- you know, the more stable the relationships the greater the likelihood we have of managing routine events, right. So if I understand how to do this we're in better shape. If we had a lot of changes we may not be able to have (hand-off) as well, we might not be able to pass information as well.

But the other thing that it would recognize is that volume does not -- it might present efficiency in terms of accuracy but it doesn't tend to present the ability to manage surprise. So if we have unique cases, we've never seen something like this before. That, actually, does not work well in a high-volume context. That doesn't translate well to that. We, instead, need to find a way to (train) for a surprise and how do we handle for a surprise within this kind of context.

The stability of relationships will help in that too because we can, actually, you know, allow ourselves to be embarrassed in some respects. Hey, I don't know all of this.

(Ingrid Nembhard): Right.

Stephen Humphrey: I know that there is an assumption that we are, you know, doctors and we know everything but you don't, and in that context that you are surprised, if you have a stable relationship I trust you then we can solve the problem rather than just a fix.

(Chaplin): That's a great note to end on and I really appreciate everybody's participation and we hope that we will build ongoing relationships with you so that we incent you to join us on the subsequent calls.

Female: On July 9th. Our next presentation is on July the 9th, and our presenter will be Dr. (Rejioarty) from the (HRQ) and his topic will be (Team-Based) Measures in Primary Care. So, unfortunately, we have to give up the room that we're in right now.

So, thanks, everyone, for participating and hope to join again in July.

(Chaplin): And thank you for a rich discussion.

Female: Absolutely.

(Chaplin): So long.

Female: Bye.

END