EDITORIALS

Providing Cancer Care: Individual or Team Sport?

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In this issue of the *Journal of General Internal Medicine*, Aubin and colleagues examine patient, primary care, and specialist physicians' expectations about involvement in various phases of cancer care for a cohort of Canadian lung cancer patients.¹ When PCPs were questioned about their desired roles in cancer care, most PCPs desired to be involved in all aspects of cancer care (diagnosis, treatment, and terminal phases), although fewer desired a major role in coordinating care during cancer treatment than during diagnosis or terminal phases of care. Specialists saw less of a role for PCPs in coordinating care and transmitting information during the diagnostic and treatment phases of illness, but valued PCPs involvement in emotional support and symptom relief in all phases of cancer care. When PCPs were asked specifically about their involvement in oncology care, more than half reported providing parallel care (involvement only for health problems other than cancer) or feeling left out of care entirely.

Patient participants also reported valuing highly PCPs' involvement in all aspects of cancer care. However, when the investigators assessed concordance among patients' and PCPs' expectations for involvement (among patients with a responding PCP), concordance was relatively low, suggesting that although patients value PCPs involvement, they have learned not to expect it.

Coordination of care is one of the key roles of PCPs,² and the PCPs surveyed in this study strongly supported this role in coordinating cancer care. However, a minority of cancer specialists believed that PCPs had much of a role in coordinating care related to the diagnosis or treatment of cancer, leading many PCPs to feel left out of their cancer patients' care. This discrepancy between PCPs and specialists for the diagnostic phase may simply reflect different views of the diagnostic process. PCPs are often crucial in coordinating care until a tissue diagnosis of cancer is made; once made, specialists typically take over orchestrating further diagnostic and staging procedures. This two-step process may be particularly relevant for lung cancer patients, who often require invasive diagnostic procedures performed by pulmonologists and thoracic surgeons. Even fewer specialists identified a role for PCPs in coordinating care during the treatment phase. Having a cancer specialist as the "quarterback" coordinating care among surgeons, medical oncologists, and radiation oncologists who work together closely may facilitate good communication among physicians providing cancer-directed therapies. However, not engaging the PCP during

this process may negatively impact his or her involvement in survivorship care, treatment of recurrences, or terminal illness care. Moreover, communication and coordination for such care may be particularly challenging if the providers assembled by the cancer specialist are not part of the PCP's usual referral network.

Although the importance of good care coordination is widely recognized, and it is especially critical for cancer patients receiving complex treatments from multiple specialists, this role requires substantial effort and administrative support, which remains underfunded in our current health care system. PCPs are uniquely positioned to direct patients' care, yet several changes in health care have presented challenges to this coordination role. First, PCPs have become busier with more responsibilities for each patient during each visit than time typically allows.³ Second, the shifting of care out of hospitals often means a relatively high acuity level among patients seen in the office. Third, with the emergence of hospitalists, most PCPs now spend more time in the office and less time in the inpatient setting, where they may have been more likely to interact with specialists. Finally, the average PCP must coordinate care with more than 100 specialists.⁴ Thus, the need for good coordination of care has increased, while the time available for coordinating care and the opportunities for PCPs to interact with specialists have decreased. From a specialists' perspective, the challenge is just as great. Oncologists, for example, must interact with very large numbers of primary care providers who often practice within different hospital systems that are not connected via shared medical records.

The Patient-Centered Medical Home (PCMH) offers a promising model for addressing the many challenges of delivering primary care.⁵ The PCMH uses a team-based approach to provide comprehensive primary care, facilitating partnerships between patients, their personal providers, and families. PCMH proposals typically include schemes for payment reforms that support e-mail or phone contact with patients, care coordination, and expansion of health information technology.⁵ Nevertheless, there are challenges to implementing the PCMH model, not the least of which involves the willingness and ability of all physicians involved in a patient's care (the medical "neighborhood") to participate in collaborative decision making.⁶ In 2010, the American College of Physicians released a position paper highlighting roles of Patient-Centered Medical Home Neighbors (PCMH-Ns).⁷ This statement highlighted the importance of PCMH-Ns engaging in effective bidirectional communication, coordination, and integration with PCMHs and ensuring the efficient, appropriate, and effective flow of patient and care information.⁷ The statement also noted the need for mutual acknowledgement of care relationships and clarification of each clinician's role in care. True coordination of care requires active participation from patients and "neighbors" in addition to the PCP.⁸ Yet, in our current health care system where PCPs and

specialists are often over-worked, reimbursed only for patient visits, and poorly connected via electronic records, this ideal seems far from reality.

Better use of teams in health care could help leverage physicians' time so that they can spend more of their day interacting with patients and coordinating care with other providers and less time on administrative tasks. Yet, the field of medicine has traditionally done little to promote and enhance teamwork. Clinical teams typically operate in separate "silos," with physicians isolated from each other and from practice staff.⁹ This contrasts sharply with corporations, where team-building activities involving team members with different skills often take high priority.¹⁰ The lack of teamwork in medicine is potentiated by reimbursement that makes the office-based physician-patient interaction the focus of care delivery. Phone and electronic "visits," group visits, or behind-the-scenes coordination among providers of different specialties may be well suited to address complex patient care needs. Reorganizing care to offload tasks from physicians to others and creatively restructuring health care delivery have great potential to improve patient care and the productivity and experiences of physicians and their teams.¹¹

In oncology, the role of the PCP in a patient's care will likely vary substantially across patients and physicians and the types of care decisions being made. Some patients want substantial PCP involvement, particularly patients followed closely for other medical issues or who otherwise have a strong relationship with a PCP. Others may be less interested in such involvement. Some PCPs may be more interested than others in staying engaged with cancer patients throughout their course of illness. Some types of decisions are straightforward, and others are more complex and may benefit from a PCP's input. The key is that patients' and providers' preferences are knowable. Oncologists or their staff could provide all patients with information about the practice's standard means of communication with PCPs. They could additionally inquire about patients' preferences for involvement of PCPs in their cancer-related care. For patients preferring greater involvement, the oncology team can reach out to PCP teams and vice versa. Information systems can be improved to make communication easier, although there is also the risk that they could lead to less personal communication. Ultimately, payment changes are needed to encourage better communication among physicians.

Many changes are still needed to improve care delivery in our health care system. PCP involvement in specialized care has a

great deal to offer to patients and specialists, particularly in complex settings such as oncology. Maximizing effective communication and coordination of care that is also tailored to the wants and needs of patients, PCPs, and cancer specialists should be a key priority as PCMH practices expand. Determining the most effective use of PCMH teams and the most effective reimbursement strategies to optimize high-quality coordination of care will be important to the successful integration of neighbors into the PCMH.

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REFERENCES

1. Aubin M, Vezina L, Verreault R, Fillion L, Hudon E, Lehmann F, et al. Patient, primary care physician and specialist expectations of primary care physician involvement in cancer care. *J Gen Intern Med*. 2011; doi:10.1007/s11606-011-1777-7.
2. Starfield B. *Primary Care Concept, Evaluation, and Policy*. 1st ed. New York: Oxford University Press; 1992.
3. Ostbye T, Yarnall KS, Krause KM, Pollak KI, Gradison M, Michener JL. Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med*. 2005;3(3):209-14.
4. Pham HH, O'Malley AS, Bach PB, Saiontz-Martinez C, Schrag D. Primary care physicians' links to other physicians through Medicare patients: the scope of care coordination. *Ann Intern Med*. 2009;150(4):236-42.
5. Goodwin JS, Samet JM, Hunt WC. Determinants of survival in older cancer patients. *J Natl Cancer Inst*. 1996;88(15):1031-8.
6. Fisher ES. Building a medical neighborhood for the medical home. *N Engl J Med*. 2008;359(12):1202-5.
7. The patient-centered medical home neighbor: the interface of the patient-centered medical home with specialty/subspecialty practices. American College of Physicians. 2010. Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf accessed on Sept 23, 2011.
8. Pham HH. Good neighbors: how will the patient-centered medical home relate to the rest of the health-care delivery system? *J Gen Intern Med*. 2010;25(6):630-4.
9. Chesluk BJ, Holmboe ES. How teams work—or don't—in primary care: a field study on internal medicine practices. *Health Aff (Millwood)*. 2010;29(5):874-9.
10. Gratton L, Erickson T. Eight ways to build collaborative teams. *Harvard Business Review*. 2007;November:Accessed at <http://hbr.org/2007/11/eight-ways-to-build-collaborative-teams/ar/1> on October 11, 11.
11. Bodenheimer T. The future of primary care: transforming practice. *N Engl J Med*. 2008;359(20):2086-9.