Bree Collaborative | Oncology Care Workgroup
January 7th, 2020 | 3:00 – 4:30
Foundation for Health Care Quality
705 2nd Avenue, Suite 410 | Seattle, WA 98104

MEMBERS PRESENT

Hugh Straley, MD, (Chair) Bree Collaborative Chair
Barb Jensen, RN, BSN, MBA, Director of Oncology and Palliative Care, Skagit Regional Health
Gurpreet Dhillon,* MBA, Director – Hospice, Palliative Care and PeaceHealth St. Joseph Cancer Center Service Lines, PeaceHealth
Blair Irwin,* MD, MBA, Oncology, Multicare Regional Cancer Center
Camille Puronen,* MD, Oncologist, Kaiser Permanente Washington
Laura Panattoni, PhD, Staff Scientist at Hutchinson Institute for Cancer Outcomes Research
Nancy Thompson, RN, MS, AOCNS, Director, Quality & Clinical Practice Swedish Cancer Institute

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative
Amy Etzel, Bree Collaborative
Alex Kushner, Bree Collaborative
Sasha Joseph Medical Director of Medical Oncology, MultiCare

* By phone/web conference

BREE COLLABORATIVE OVERVIEW

Hugh Straley, MD, Bree Collaborative Chair, and Ginny Weir, MPH, Bree Collaborative welcomed members to the workgroup and those present introduced themselves and gave a short summary of their background.

Ms. Weir gave a short overview of the Bree Collaborative, covering:

- Roberts Rules of Order.
- Why the Bree Collaborative was formed and how it chooses its members and workgroup topics.
- How recommendations are developed.
- The proposed plan and timeline for this workgroup.

CHARTER DISCUSSION

Dr. Straley says the goal for recommendations in Bree work is for them to create better care at a lower cost, with less administrative burden on practices. The current charter for the group is focused on the frequency with which oncology patients seek treatment through emergency departments.

- Dr. Straley reviewed the prior Oncology workgroup from the Bree collaborative:
    - Primarily focused on screening for early-stage prostate and breast cancer.
    - Also discussed Palliative Care for cancer patients.
- Dr. Straley reviewed the "Problem Statement" and "Aim" sections of the first draft of the workgroup's charter. Ms. Weir asks the group if the problem, as stated, is what we want to solve, or if we need to reframe the Charter somehow.
- The group discussed the importance of looking at data that tells us why cancer patients are going to the ED.

    - Digging into diagnosis can be overly broad; one member of the workgroup suggested looking at chief complaints instead.
- Dr. Panatonni explained the work that she has done to measure ED rates:
    - 2 projects, one to use the Community Cancer Report to reproduce the Oncology Care Model using claims data
    - 2nd project was to use claims data and EHR data to build prediction algorithms for risk stratification. Best data to use seems to be EHR data rather than claims data.
- The group discussed the scope of the workgroup: should it only focus on chemotherapy? The workgroup agreed that chemotherapy is too narrow of a focus—the group should widen its focus to oncology treatment in general.
- The group discussed what kind of time frame should be considered.
    - The current literature begins at the start of treatment and typically goes either 30 days or 6 months out. 6 month models focus on low cost interventions. However, these models have not been tested in the real world.
    - No conclusion is reached on time frame.
- The group agrees they need to be careful not create metrics that do not lead to better outcomes from patients. For example, simply reducing ED rates might mean that patients are redirected to urgent care where they get the same care they would in an ED.
    - Other group members argue that shifting care away from the ED could mean better care in cancer centers which would both prevent ED visits and improve patient health.
- Dr. Straley mentions that the cost of cancer drugs is outside the scope of the group; however, the group could potentially make recommendations regarding which drugs should be used early in treatment to prevent ED visits.

- Capitated care models are briefly discussed as they relate to work being done to avoid unnecessary ED use.

  Action Item: Kaiser has recently improved its nurse navigator program with the goal of reducing ED visits. Group members from Kaiser will look into this further for the next meeting.

  - HICOR has a project that seeks to increase contact with patients using a virtual environment or questionnaires to identify patients who need to come in for care.
    - HICOR is also researching using biometric devices that could send data to doctors to help with prevention and early treatment. The goal of either project would be to develop algorithms to predict ED visits.
    - Dr. Straley notes that the Bree wants to focus more on innovation, and this area of patient monitoring could be a fruitful area for investigation. However, Bree recommendations need to be based on evidence, and there is a paucity of data thus far.
  - Group agreed that making recommendations on appropriate cancer treatment (e.g. when is it appropriate to use chemotherapy?) would fall outside the scope of this workgroup. The group wants to focus more closely on unnecessary visits and ED admits.
  - The group discussed whether or not length of stay would be in-scope for the group.
    - Argument was made that, since our scope seems to be out-patient treatment, there is not a lot that an out-patient team can do to affect length of stay in ED. A counter-point to that was expressed that, for example, better outpatient access could help reduce time of stay in an ED and fewer complications in the ED.
    - Practically, many ED doctors also immediately redirect patients out of the ED.

    - It was agreed that it would be in-scope for the group to make recommendations about what ED doctors could do to recognize patients who might be better served outside the ED. The group wants to prevent unnecessary hospitalization *and* unnecessary ED visits.
- The group settled on the prevention of inappropriate ED use or hospitalization for patients undergoing cancer treatment.
    - In some systems there are 4 doors to be considered: urgent care, ED, hospitalization, and observation.
- Ms. Weir asked the room who is not at the table who needs to be. The group agreed that they need more members from health plans. Another recommendation was to contact Joan Altman, who is the government liaison for the Washington Health Benefit Exchange. UnitedHealthcare and Premera were also mentioned.
- The group decided to call this workgroup "Oncology," with additional language to specific the charge of the group: "Avoiding the escalation of the acuity of care in treatment for malignancy".
- The group agreed that the use of Patient Reported Outcomes data would be an important topic to continue discussing next time

Action Item: Dr. Straley asked the group to think of any evidence that would be helpful/applicable to the workgroup and to bring it to the next meeting.

GOOD OF THE ORDER

Dr. Straley thanked all for attending and adjourned the meeting.