
Bree Collaborative | Oncology Care Workgroup

February 4th, 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

Quality & Clinical Practice Swedish Cancer
Institute

Barb Jensen,* RN, BSN, MBA, Director of
Oncology and Palliative Care, Skagit Regional
Health

Andra Davis,* PhD, MN, BSN, Assistant
Professor, Vancouver, Washington State
University

Gurpreet Dhillon,* MBA, Director – Hospice,
Palliative Care and PeaceHealth St. Joseph
Cancer Center Service Lines, PeaceHealth

Laura Panattoni,* PhD, Staff Scientist,
Hutchinson Institute for Cancer Outcomes
Research

Camille Puronen,* MD, Oncologist, Kaiser
Permanente Washington

Sibel Blau,* MD, Oncologist, Northwest Medical
Specialties

Nancy Thompson,* RN, MS, AOCNS, Director,

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative

Stefanie Hafermann,* Regence

Alex Kushner, Bree Collaborative

Karma Kreizenbeck,* Fred Hutch

Tracey Hugel,* Regence

* By phone/web conference

CHAIR REPORT & APPROVAL OF MINUTES

Hugh Straley, MD, Bree Collaborative Chair, and Ginny Weir, MPH, Bree Collaborative welcomed members to the workgroup and those present introduced themselves.

Motion: Approval of January 7th Minutes

Outcome: Passed with unanimous support.

PRESENTATION: KAISER PERMANENTE'S NURSE NAVIGATOR PROGRAM BY DR. PURONEN

Camille Puronen, MD, Oncologist, Kaiser Permanente Washington, gave a presentation on Kaiser's nurse navigator program.

- It is currently a small, multidisciplinary team composed of a medical director, service line director, registered nurses, and a complex procedural scheduler.
- 3 nurse navigators: breast/lung, head/neck, GI. Program is in multiple locations.
- Goal of navigators is to support patients while they move through the health system. Want to be able to offer individualized assistance for patients.
- Navigators do not: write prescriptions or order labs/imaging/referrals; no cross-coverage of assigned specialties. Navigators do not cover those who are referred outside of Kaiser, partially because so much of their work relies on Kaiser's Epic system.
- Dr. Puronen reviewed the flow of navigation and then explained the role of each of the three nurse navigators.
- There is not yet a significant amount of quantitative data on the results of the navigation program. Dr. Straley asked for anecdotal evidence for how nurse navigation affects emergency

department visits. Clinic nurses have reported fewer patient calls to ask questions about various pain symptoms.

- At the end of the presentation, Dr. Dhillon added that the largest impact of nurse navigation at St. Joseph has come in the form of reduced time between diagnosis and start of treatment. Dr. Straley asked that Dr. Dhillon consider presenting in the future.

CHARTER DISCUSSION & FINALIZATION

Hugh Straley, MD, Bree Collaborative Chair asked for the workgroup's opinion on the current Aim of the Charter—is it only to reduce unnecessary ED use and hospitalization in oncology care, or is it broader, as in the original Charter Draft?

- A member asked if immune checkpoint inhibitor markers should be included in the Aim section. Currently the Aim section only specifically mentions chemotherapy. This led others to comment that the Aim should be to improve appropriateness of care for cancer treatment in general.
- The group agreed that focusing on only avoidable ER utilization would be beneficial. Aim changed to “To reduce potentially avoidable emergency department visits and therefore improve patient experience and care outcomes for patients undergoing cancer treatment.”
- Andra Davis, PhD, MN, BSN, reviewed a study that she was a part of looking at 1 year's worth of visits to the ER for patients in active chemotherapy. Reason patients were coming in matched literature: pain, nausea, dehydration, and vomiting. Nearly 60% of people who came to ED came within 6 days of their last treatment.
- Question asked about the criteria for appropriateness and who gets to define what appropriate care is. Dr. Straley answers that it is within the scope of this workgroup to define this and to define how to improve appropriateness in different settings.
 - Ms. Weir also explained how implementation happens via the HCA being the first mover and then other private entities following suite.
- Question asked about which metrics will be used to measure the workgroup's success.
 - ER visits
 - Patient experience
 - Stakeholders' experience: nurses especially.
 - A number of potential surveys were mentioned.
 - Any metrics need to work for a variety of treatment settings.

Action Item: Dr. Davis to share surveys she uses with Ms. Weir and the workgroup. Dr. Straley asked that other clinicians also share any relevant metrics that they are using with the workgroup.

- Another question asked about how the group will determine which visits are avoidable.
 - A member mentions that the HEDIS definition would spell this out.
 - Cost-avoidance of ER use was also mentioned.
- In Dr. Davis' study, 60% of patients visiting the ER were sent home with no intervention.
- Laura Panattoni, PhD, mentioned CMS metrics that would be useful. She added that the group should use the “potentially preventable” CMS metrics. She also noted that within the CMS metrics, the pain, nausea, vomiting sections of the CMS are the most relevant.
 - Even under the most conservative coding, Dr. Panattoni's study found that 50% of studied ER visits were avoidable.
- Sibel Blau, MD, mentioned that her practice has found that sepsis is one of top symptoms for ED use. **She is going to share her analytic tools and data sets.**
- Dr. Straley asked the group for best practice, evidence-based interventions to avoid unnecessary ER visits.

- Dr. Blau offered that case management and nurse navigation may be the most cost effective changes to make. This was seconded by another member.
 - This raised the issue of paying for nurse navigation in a FFS system. Hospitals are incentivized to pay because it improves the time of diagnosis to time of treatment and patient experience.
- Tracey Hugel mentioned that Regence's internal care management program does outreach to chemotherapy patients.
 - She also discussed how Regence handles which nurses are chosen to be navigators.
- Gurpreet Dhillon, MBA, said that nurse care coordinators in his program have a large impact on symptom management and follow up care.
 - A member asked who manages transfers of patients between departments. Navigators are part of this process.
- Dr. Straley summarizes the group's discussion about nurse intervention: everyone who has reported has had some form of nurse-based intervention upon diagnosis for oncology care patients. This intervention can be provided in a variety of settings.
 - Are there effective treatments for those common problems (nausea, pain, etc.) and for anticipating the risk factors involved in those symptoms? Should the group think about risk stratification?
 - Dr. Panattoni mentioned that Hutchinson are running a deep learning project to see if they can predict if a patient is likely going to go to the hospital on a given day.

Action Item: The group will discuss risk stratification and risk adjustment next time. Tracey Hugel and Laura Panattoni asked to gather info about what their organizations are doing and what tools they have. Dr. Panattoni will present on her work at the next meeting.

- Ms. Weir summarized and concluded by saying that the final recommendations will probably cover risk stratification, metrics, and what intervention looks like.

GOOD OF THE ORDER

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