Bree Collaborative | Oncology Care Workgroup
April 7th, 2020 | 3:00 – 4:30
Held Remotely Due to COVID-19

MEMBERS PRESENT

Hugh Straley, MD, (Chair) Bree Collaborative Chair
Blair Irwin, MD, MBA, Oncology, Multicare Regional Cancer Center
Camille Puronen, MD, Oncologist, Kaiser Permanente Washington
Stefanie Hafermann, Regence
Sasha Joseph, MD, Medical Director of Medical Oncology, MultiCare
Nancy Thompson, RN, MS, AOCNS, Director, Quality & Clinical Practice Swedish Cancer Institute
Andra Davis, PhD, MN, BSN, Assistant Professor, Vancouver, Washington State University
Laura Panattoni, PhD, Staff Scientist, Hutchinson Institute for Cancer Outcomes Research
Sibel Blau, MD, Oncologist, Northwest Medical Specialties
Barb Jensen, RN, BSN, MBA, Director of Oncology and Palliative Care, Skagit Regional Health

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative
Amy Ellis, Director, Quality and Value Based Care, Northwest Medical Specialties
John Frownfelter, MD, FACP, Chief Medical Information Officer, Jvion

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 March 3rd Minutes
Outcome: Passed with unanimous support.

PRESENTATION: NORTHWEST MEDICAL SPECIALTIES (NWMS) JVION AI TOOL BY DR. SIBEL BLAU, AMY ELLIS, AND DR. JOHN FROWNFELTER

Sibel Blau, MD, Oncologist, Northwest Medical Specialties gave a presentation on Northwest Medical Specialties' experience with the Jvion AI tool. She was joined by Amy Ellis, Director, Quality and Value Based Care, Northwest Medical Specialties, and John Frownfelter, MD, FACP, Chief Medical Information Officer, Jvion.

- Dr. Blau gave a brief overview of Northwest Medical Specialties.
- Dr. Frownfelter took over to introduce Jvion. It is a cloud-based AI solution that targets patient outcomes. It was used to look at questions relating to patient harm: Who is at risk? Why are they at risk? What interventions can reduce risk?
- Jvion envisions their tool as an AI asset—it can be tailored to ask different questions depending on what the practice wants. Questions relating to oncology care included: 30-day mortality risk, 30-day pain risk, risk of depression in the next 6 months, risk for avoidable IP admission within 30 days, and others.
- Dr. Straley asked what the inputs to Jvion are. Dr. Frownfelter explained that Jvion purchased socioeconomic data and then pulled clinical data from the hospital (this data was updated at different rates depending on the factor being assessed).

- Amy Ellis took over to discuss the results of Jvion implementation. They saw up to 30% reduction in loss of function/ADLs; 22% increase in depression diagnoses, and 33% reduction in moderate and severe pain.
- NWMS reviews the patient dashboard in Jvion at the start of each week to assess patient needs and possible interventions. This info goes to care coordinators who can schedule patients accordingly. Information sent to providers includes a breakdown of risk factors (clinical and socioeconomic) and suggested interventions.
- Dr. Blau told the story of a patient who was identified through Jvion for risk of 30 day mortality. The patient was seen early and was, in fact, beginning to deteriorate. Early intervention helped to avoid a probable ED visit.

CHARTER DISCUSSION AND TELEHEALTH DISCUSSION

Ms. Weir transitioned to the topic of telehealth and telehealth availability given the current COVID-19 crisis.

- Stefanie Hafermann, Regence, said that Regence has experienced many more members being interested and open to telehealth amid this crisis.
- Dr. Blau added that she has been surprised at how well she has been able to care for sick patients and keep them out of the ED using telehealth.
- Two big takeaways: patients do not want to use the ED, and telehealth creates major changes to the infrastructure of providing care.
- Blair Irwin, MD, MBA, Oncology, Multicare Regional Cancer Center, commented that telehealth can be very hard for immigrant populations and those who are living in poverty. Can create disparities in access to care.
    - Dr. Straley suggested that clinics may need to provide patients with laptops and decent internet so that they can access telehealth.
    - Dr. Irwin also mentioned that telehealth services are prone to failure (through loss of internet connection or other technical glitches); the result of failure is a telephone visit which is reimbursed at a much lower rate.
    - It can be difficult to assess who is "safe" to have use telehealth.
- Ms. Weir pivoted the conversation to thinking about eventual recommendations. Are there specific areas where the group wants to push for more uniform risk stratification?
    - Ms. Hafermann offered that the group has an opportunity to create criteria that would split up the burden of outreach between health plans and hospitals.
- Laura Panattoni, PhD, Staff Scientist, Hutchinson Institute for Cancer Outcomes Research said that AI Prediction tools are trustworthy in terms of assessing who is at risk, but not at determining the exact diagnosis or reason someone is at risk—this is something that doctors are still best at.
- Ms. Weir asked the group if they know how far away the state is from the ideal of everyone having access to risk stratification technology.
    - It is still uncommon.
- Ms. Weir asked that the group think about developing a community standard for risk stratification that would function as a baseline definition to which sites could add. Such a definition could also be used by health care purchasers in developing contracts. She asked that each member draft a proposal to discuss at the next meeting.

GOOD OF THE ORDER

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