Bree Collaborative | Oncology Care Workgroup
June 2nd, 2020 | 3:00 – 4:30
Held Remotely

MEMBERS PRESENT

Hugh Straley, MD, (Chair) Bree Collaborative Chair

Camille Puronen, MD, Oncologist, Kaiser Permanente Washington

Tracey Hugel, Regence (filling in for Stefanie Hafermann, DNP, BSN, RN, PHN, Regence)

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

Nancy Thompson, RN, MS, AOCNS, Director, Quality & Clinical Practice Swedish Cancer Institute

STAFF AND MEMBERS OF THE PUBLIC

Dawn Stacey, PhD, MScN, Senior Scientist, Ottowa Hospital Research Institute

Ginny Weir, MPH, Bree Collaborative

Alex Kushner, Bree Collaborative

Amy Etzel, Bree Collaborative

Renee Yanke, Kaiser Permanente Washington

Natalie Bell, Kaiser Permanente Washington

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 May 5th Minutes
> *Outcome*: Passed with unanimous support.

PRESENTATION: COSTARS BY DR. DAWN STACEY, PHD, MSCN

Dawn Stacey, PhD, MScN, Senior Scientist, Ottowa Hospital Research Institute, gave a presentation called "Quality of telephone nursing services for adults with cancer on non-emergent visits to ED"

- COSTaRS created out of a desire for evidence-based oncology symptom remote support. The project was always intended to be pan-Canadian.
- In Canada, nurses are required to use a protocol to minimize risk when providing phone services. Many oncology programs across Canada are now using COSTaRS.
- The purpose of the first study that Dr. Stacey reviewed was "To measure the quality of telephone-based nursing symptom management and impact on non-emergent ED visits.
- This was done by monitoring knowledge use (e.g. COSTaRS use) and then evaluating the appropriateness of resulting ER visits.
- Of 77 phone cases in the study (only looked at cases with ED visits not requiring hospitalization and who called telephone services within 4 weeks), 91% of cases could have been managed by an urgent care clinic; however, 43% of patients were advised to go to the ED, and 4% of calls had documentation of using practice guidelines.
- Dr. Stacey: Nurses need education on the types of face-to-face assessments that are available as alternatives to sending patients to the ED.
- When assessments are administered properly, nurses can triage better and understand who needs a face-to-face assessment.

- Dr. Stacey then reviewed a follow-up study which also assessed remote oncology support and COSTaRS use. This study reviewed recorded phone calls of nurses speaking to oncology patients.
- SMAT score (indicating the quality of symptom management), was higher when COSTaRS was used. Nurses also operated within their scope of practice more when using COSTARs on these calls, and patients were more likely to stay home with advice.
- Study found that only 33% of nurses documented using COSTaRS. There is an opportunity to explore the expectations of nurses and oncologists for telephone nursing services.
- A member asked about the perceived barriers to nurses using COSTaRS. Nurses cited lack of time to pull up COSTaRS or said that they thought they were doing a good enough job without them (this can be a problem with more experienced nurses).
- A member asked if patient outcomes were significantly different with COSTaRS use. The study did not track outcomes, but patients were more likely to stay home and out of the ED.
- Dr. Stacey emphasized that training in COSTaRS use is a key component of effectiveness. It takes judgment on the part of the nurse to identify treatment pathways: COSTaRS is not an algorithm and is meant as a tool to aid nurses' decision making.
- ROI for COSTaRS use has not been documented; ROI could be quantified through avoided ER visits.

GENERAL DISCUSSION—RISK STRATIFICATION

Ms. Weir pivoted the group to discussing risk stratification. Members were given an assessment chart between meetings with which to evaluate different risk stratification tools.
- Dr. Straley's general impression was that all five tools were used on slightly different populations.
    - Common risk factors: age, stage of cancer, type of cancer, comorbidity, cure/prolongation/palliation, poly or single chemotherapy, comorbidity index, certain lab variables, and demographics.
    - Not possible to discern which of these factors is most important.
- A member asked that the group add the commercially available algorithms to their review. Flatiron and JVION both have an algorithm (the group has already had a presentation about JVION).
- Ms. Weir: the group needs to determine how specific it is going to be in terms of risk factors it recommends looking at. And, does the group want to do a literature review?

Action Item: Dr. Stacey to send the group a list of articles about outreach from Dr. Kinta Beaver.

- Another member suggested recommending ways for practices to target their risk stratification risk factors based on what their particular population is presenting with.
- Laura Panattoni, PhD, Staff Scientist, Hutchinson Institute for Cancer Outcomes Research, said that all of the risk stratification models are too early to use. The best recommendation that the group could give would be for how clinics should proceed given the current early state of research.
    - Another member recommended creating a basic chart abstraction tool that practices could use to evaluate their specific population's risk factors.
        - However, such a tool could be a significant amount of work for a small oncology practice.

Action Item: Andra Davis, PhD, MN, BSN, Assistant Professor, Vancouver, Washington State University, to share a report that she made of a years' worth of oncology patient data as an example.

- Dr. Stacey: blood values are not necessarily useful for risk stratification because they are not up to date for many providers. Would be better to focus on factors that patients can self-report.
- Dr. Straley summarized: the group might recommend a tool that would help practices look at important risk factors for their patient population. The group could also recommend some kind of logistic regression.

GOOD OF THE ORDER

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