
Bree Collaborative | Oncology Care Workgroup

August 4th, 2020 | 3:00 – 4:30

Held Remotely

MEMBERS PRESENT

Hugh Straley, MD, (Chair) Bree Collaborative
Chair

Amy Ellis, (for Sibel Blau, MD), Director, Quality
and Value Based Care, Northwest Medical
Specialties

Camille Puronen, MD, Oncologist, Kaiser
Permanente Washington
University

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

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

Blair Irwin, MD, MBA, Oncology, Multicare
Regional Cancer Center

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative

Alex Kushner, Bree Collaborative

Amy Etzel, Bree Collaborative

INTRODUCTION

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 July 7th Minutes

Outcome: Passed with unanimous support.

DISCUSSION: EDITS TO DRAFT RECOMMENDATIONS

Dr. Straley opened the meeting and explained that the group would be trying to finalize their recommendations (before sending them to the Bree and out for public comment).

- The recommendations are not going to advocate for a specific risk assessment tool/s; rather, they will recommend, generally, that one be used. The appendix will contain some examples of risk stratification processes that would be appropriate.
- The group moved on to reviewing the language found in the table in the “Recommendation Framework” section of the draft.
- Assessment and risk stratification:
 - Parenthetical added saying “(i.e., at least low/high)”.
 - Added “depression, distress” to the second bullet
- Patient-Centered Care:
 - Group reviewed whether asking for 24/7 access to a patient’s care team is reasonable. Group agreed that someone on the team should be accessible. Added parenthetical “(e.g., care team, nurse triage)”, also added on to the end “who has access to the patient’s medical record”.
 - The group decided to change this section from “patient-centered” to “person-centered” (moving away from paternalistic language in health care).
- Care Management:
 - “post-discharge” changed to “post-treatment” in two sub-bullets. Added a new sub-bullet reading “post-discharge outreach to those who have accessed inpatient care”.
 - The bullet on Telehealth in this section was moved up to the “Patient-Centered Care” section.

- Palliative Care: added “with need for symptom management” to first sentence here.
- The group moved on from the table and discussed the “Employers” sub-section of the “Recommendations for Stakeholders” section.
 - Added a Telehealth bullet to the Employers section: “Ensure that telehealth services are reimbursed at the same level as in-person visits, where appropriate”.
 - A member commented on endorsing the US Preventive Services Task Force by mentioning it in one of the bullets—they have had problematic recommendations in the past. Changed wording here to “Ensure that your population has access to regular, appropriate cancer screenings and other cancer prevention activities (e.g., smoking cessation, HPV vaccination).”
- Moving on to the “Health Plans” sub-section of “Recommendations for Stakeholders”:
 - The group agreed to copy much of the applicable language from the Employers sub-section—Ms. Weir to go back and update the language to make sure it is relevant to this category. Both employers and health plans need to provide similar support and resources.
- In the “Patients and Family Members” sub-section of “Recommendations for Stakeholders”:
 - The group changed second sentence of first bullet to add “for example” in front of American Cancer Society.
 - Under the bullet about discussing higher levels of care, changed wording to “conversations *can* include financial as well as medical concerns” (“can” used to be “should”—softens the recommendation).
- The group discussed whether it would be worth it to add recommendations about how to “shop” for your oncology care team.
 - It depends on the health system—some patients are going to be extremely limited in their options. However, the group decided that it is still good for patients to have that information.
 - Added a bullet, “When deciding on a care team or oncologist, ask if they offer:” and then sub-bullets reading “An online patient portal”, “24/7 access to care who has access to your medical record”, “Palliative care”.
- Ms. Weir asked the group if they feel good about this document being sent out for public comment. Are there areas that still need attention or improvement?
 - Group decided to send the document out to members of the workgroup, saying that this is the first draft and to make changes with the goal of taking it to the Bree Collaborative in September.
 - Tentatively, there will be no meeting of this workgroup in September.
 - If comments are extensive or significant, the workgroup can always meet in September (date will be held).
- Dr. Straley outlined the rest of the process for approval: taking the recs to the Bree, sending the draft out for public comment, final Bree approval, and then sending to the HCA for adoption.

GOOD OF THE ORDER

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