
Bree Collaborative | Oncology Care Workgroup

July 7th, 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

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

Ginny Weir, MPH, Bree Collaborative

Renee Yanke, Kaiser Permanente Washington

INTRODUCTION

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

DISCUSSION: RISK STRATIFICATION

Dr. Straley led a recap of the previous presentations including a new online tool:

www.mycarg.org/Chemo_Toxicity_Calculator. Key risk factors include age, whether a person is on multiple or a single type of chemotherapy, and other factors. The workgroup discussed:

- Whether to include a general statement that an assessment should be used, which specific factors should be included, or a specific tool.
 - Decided on language: “Some form of risk assessment needs to be made on every patient.”
 - How are a delivery site is managing the course of treatment for that person. Then are there standardized treatment protocols that are being used for common complaints.
- Everett Clinic has a very standardized process with a 7-day follow-up after infusion.
- A standardized resource could not be too complicated for low-resource clinics.
- Kaiser Pharmacist developed a nausea screening tool, e.g. did you have a lot of morning sickness when pregnant, how much alcohol did you drink, what is your nutritional status. Then depending on what screening shows they go in and adjust medication. This would mesh well with the CoSTARS tool.
- Early intervention using palliative care.
- How the recommendations will be used in contracting.
- Avoidable ER visits are a big deal for employer groups. Any group would want to have a guaranteed systematic process for assessing patients. Drug costs are very high for both plans and for employer groups who purchase health care.
- The majority of delivery sites do not have a current risk stratification protocol.
- For Kaiser, CoSTARS will be piloted in south sound for first couple months then spread it to the state. Need to show the efficacy.
- The struggle of telephone triage in general to be accurate and consistent.

- For a low-risk patient, some systems just say educate the patient and make access for further questions or need to the patient particularly by phone. Other patients who are higher risk will have proactive outreach in a week or will have a conversation each week.
- All delivery sites need to have a process to anticipate complications and a protocol for that patient to get to an RN or an MD/DO with a concern with outreach for higher-risk patients.
- OK to have a low risk patient just receive education.

Action Item: Renee Yanke to send the pharmacist-developed tool to assess nausea.

GENERAL DISCUSSION—TRIAGE PATHWAYS

Ms. Weir pivoted the group to discussing case management of oncology patients.

- Whether CoSTARs should be recommended. It is the best tool that we have found so far. This is being used and studied more in Canada.
 - Barriers to CoSTARs include documentation and people thinking they are doing this already.
 - Patient satisfaction is high.
- Calling out conditions for which there are protocols.
- Palliative care
 - Outside of CoSTARs tool.
 - Keep coming back to same central issue that we lack a validated tool to tell when someone would be a good candidate for palliative care.
 - Most oncology practices rely on nurses to make those calls.
 - For high-risk patients consider referral to palliative care.
 - Kaiser Permanente Washington is rolling out standardized pathways – takes the provider out of Epic to see first- second-line treatment and then pulls provider back into Epic with those orders. Palliative care is auto-generated for stage 4 lung cancer.
 - Advanced stage or poorly controlled symptoms may also be an indicator for specialty palliative care.
- Don't want to minimize patient education in this process.
- We want to give all the actors in our health care system a standard vocabulary when negotiating this type of care as it is often the highest cost for employer groups.

GOOD OF THE ORDER

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