



Delaware Cancer Consortium
Quality Cancer Care/Quality of Life
January 18, 2011
Delaware Technical & Community College
Dover, DE

Attendees

Members – QCC/QOL

Attended	Christopher Frantz, MD, A.I. DuPont Hospital for Children
Did Not Attend	Wendy Gainor, Sr. Director Professional Services, Medical Society of DE
Did Not Attend	Sean Hebbel, The Wellness Community - Delaware
Did Not Attend	Eileen T. McGrath, American Cancer Society
Did Not Attend	James Monihan, MD, Allied Diagnostic Pathology Consultants, PA
Did Not Attend	Nicholas Petrelli, MD, Helen F. Graham Cancer Center
Did Not Attend	Cheryl Rogers, BayHealth Medical Center
Did Not Attend	Ola Ruark, Department of Veterans Affairs Medical Center
Did Not Attend	Ed Sobel, DO, Quality Insights of DE
Attended	Donna Stinson, BayHealth Medical Center
Did Not Attend	Janet Teixeira, Cancer Care Connection
Attended	Kathy Burt, Nanticoke Memorial Hospital
Did Not Attend	Victoria Cooke, DE Breast Cancer Coalition
Did Not Attend	Mary Lou Galantino
Did Not Attend	Theresa Gillis, MD, Christiana Care
Did Not Attend	Madeline Lambrecht, University of DE
Did Not Attend	Susan Lloyd, DE Hospice
Did Not Attend	Anna Maloney, DE Helpline
Attended	Judith Ramirez, Tunnell Cancer Center
Did Not Attend	Michelle Sobczyk, Leukemia/Lymphoma Society
Did Not Attend	Sheila Grant, Hospice & PC Network
Attended	Mary Ellen McKnight, Kaylyn Elaine Warren Foundation (Kay's Kamp)

Guests in Attendance

Rhonda Combs, Christiana Care VNA
Elaine Keegan, Hospice & PC Network (vice Sheila Grant)

Staff & Other

Committee Liaisons

Attended	Crystal English, DPH/Delaware Cancer Registry
Attended	Paul Silverman DPH

Review of Previous Meeting Minutes

Dr. Frantz called the meeting to order. The committee reviewed the minutes from the November 2010 meeting and approved them with no changes or additions.

Old & New Business

HOME BASED CHEMOTHERAPY TASK FORCE

This task force was created in late 2010 as a result of errors made in chemo therapy administered to a patient in a non-clinical setting. The task force has representation from all the cancer centers in the state, as well as a couple of the key infusion companies and home care agencies. The goal of the task force is to review the current home chemo therapy treatment delivery process to develop a new process that improves safety and accuracy and which can be deployed statewide. Handout 1(HO-1) describes the home-based chemotherapy administration process the task force developed. Key features of the new process include:

- Streamlined communication – one source of order set dispensed to the homecare agency to mix the chemo. Previously there were multiple order sets going to the home care agency and infusion provider.
- Continuous infusion is started at the cancer center where it is a controlled environment where there are two clinicians who can verify that the correct dose is being delivered to the patient.
- The home care agency will follow up with the patient in their home (e.g. if there is a pump problem they would be there for the chemo disconnect.)

The new chemo home delivery process has been approved by the respective stakeholders and implementation at a number of sites (Bayhealth, Christiana Care) has begun. The Tunnell Cancer Center is scheduled for January 24th implementation, and plans are underway to determine a final implementation date for Nanticoke.

There were two other items to be considered: pumps and order set. Specifically, is a standardized pump necessary with the new improved process (or is use of the current CAD and varied pumps sufficient), and should a single order set be used. Since many of the institutions have electronic order, single order set may not be necessary as electronic order does create a safer process.

Donna Stinson added that the task force was a very dynamic group, and inclusion of the the infusion companies brought a whole new thought process to light. This process review did reveal a gap in insurance coverage. Some patients that do not have home care option because their insurance does not cover it, they have no insurance, or they do not meet the Medicare definition of homebound. In these situations, the physician tends to get calls when the patient's machine beeps. Efforts are underway to determine whether the issue is with the physical connection to the arm or with the connection with the pump.

The following was cited as aiding the task force to achieve such rapid and complete agreement:

- Quickly establishing that the cancer centers are the ones driving the orders and referrals. Once there is general agreement on that point the other providers fall in line.

- Common goal – All providers had patient safety at the forefront; the safety breach created a sense of urgency.
- Liability implications
- Delaware’s small size and provider numbers made coming to consensus quicker.

The question of whether this new process in any way changed billing by the home care and insurance companies, particularly, did they previously bill differently for starting the infusion compared to managing the whole process? For home care agencies, if the patient is a Medicare patient, billing is by visit not by method of payment. If it were a third party insurance then that would be a visit that the home care agency would not be providing and therefore would not be billing. Companies did not voice concern of potentially losing visits; the over-riding concern is safety.

Also, having all of the cancer centers presenting this as an issue to the infusion companies carried weight. There was peer pressure for them to do the right thing and the safest thing because this was an actual incident that drew people together, not a hypothetical case or speculation. It was a message to all stakeholders that this could happen to any one of us.

Dr. Frantz asked if there was any way to publish this experience on the internet in a place where the other states might be able to learn from the Delaware experience. Coombs stated believes her organization would be open to that. Sharing the Delaware experience may be beneficial to other states since incidents such as what led to the formation of the task force will become more of a problem as more drugs are delivered in the home environment. Crystal will follow up on communication options via the DCC website.

QCC Accomplishments Review for Year 3

When the Quality of Life committee merged into the Quality of Cancer Care a subcommittee formed to develop a way to merge the separate goals of the two committees into one. It was agreed that the original QOL Goal 4/Objective 4b would become QCC Goal 5 of the combined committee (Handout 2, HO-2). Per prior accomplishment review processes, tasks may be marked “done” if work on the task is either fully complete or work has begun towards accomplishing the task.

Goal 5 (formerly QOL Objective 4B) - Support continued education for physicians, hospitalists, and hospital staff (education will emphasize end-of-life, rehabilitation, vocational rehabilitation, survivorship and palliative care).

Provide CME-accredited quality-of-life training modules on site for physician practices and hospitals.

Training on YouTube - Although not CME accredited, the YouTube presentations (tubing feeding, dementia) are an accomplishment.

CME via University of WI - There was a list of palliative care CMEs from the University Wisconsin discussed during previous meetings; the QCC wants this list posted to the DCC website. Crystal will follow-up.

Pocket card guides - The committee reviewed the samples supplied by Sheila Grant and also discussed the relevance of pocket cards versus more electronic avenues of accessing information. Judith Ramirez recalled that the pocket cards had a nominal fee of \$5.00 to purchase. Sheila

Grant was to inquire about obtaining rights to post the information online. Crystal will research prior minutes to determine what the committee agreed to regarding the use of pocket cards and electronic tools/applications.

Implement quality-of-life training sessions for hospital-based staff so they can accurately articulate and disseminate information to patients and families. The ELNEC training process has been implemented and is directly related to the accomplishment of this task. The committee discussed whether this task should be marked “done”. It was asked whether tasks can be revisited after they are marked done. There was concern in losing the survivorship training aspect of this task if it is marked done. Just because it is marked done does not mean that the committee did not have to go back and continue to do that. Crystal English commented that the way the Consortium has defined “done” is that action has been taken toward the completion of the particular task; the task does not have to be fully completed. When a task is marked done, it does not mean that it can’t have action taken toward it. There are quite a few items that have been marked done, under other goals, which are on-going items; there will always be something done towards them. Dr. Frantz stated that there should be some survivorship training included with this task and perhaps the committee could come up with that for the next four year plan. It was commented that if the committee wrote this goal now it would be written in the context of survivorship as these are all elements of what survivorship education is about. Crystal added that the committee may get additional insight on this once we cover the concept mapping agenda item as it concerns a comparison of where the consortium started out in 2001 to where we are now and what the QCC may want to focus on as we plan for our goals and activities for the next 4 years.

Provide training to discharge personnel on discharge to the appropriate level of care. Dr. Frantz questioned the committee as to whether it was decided to do keep this task. Cancer care coordinators don’t usually make discharge decisions; it is usually case management. It was asked if this had anything to do with discharging the patient in an end-of-life situation. Madeline Lambrecht sat on a committee, as did a Delaware Hospice representative, and the concern at the time was that patients weren’t being appropriately discharged to end of life care. This task has to do with the whole piece of increasing the average length of stay in hospice. It did not have anything to do with discharge to re-hab or skilled nursing, occupational therapy, or vocational-rehab; it had to do strictly with end of life care.

Dr. Frantz stated that this task could not be marked “done”. A solution suggested was to develop criteria for initiating hospice and then posting the information to various websites (e.g. DE Academy of Medicine, DE, Medical Society) and placing an advertisement in the Delaware Medical Journal. This is basically a provider decision. The message should be delivered to case managers as these people are hired by insurers to make decisions.

There is probably EOL discharge criteria already in existence. Susan Lloyd is the representative for Delaware Hospice. Perhaps a quick reference could be posted in different places with individual hospitals posting to the physician portals. Crystal will contact Sheila Grant and Susan Lloyd regarding the most current discharge to hospice criteria.

Develop and implement a report card system for institutions and practices; the credentialing program for screening may be used as a model. On many occasions the committee had talked about a report card system for other measures of quality but those things are very strictly standardized and are national measures. There was uncertainty among the committee regarding the nature of this task. Dr. Frantz recommended the committee mark this item “not feasible” due to lack of history; the committee agreed.

The YouTube presentation and DCRAC update agenda items were skipped due to time constraints.

DCC concept mapping process - In late 2010 consortium constituents engaged in a strategic planning process focused on developing the framework for Delaware's next 4-year cancer plan covering 2012-2016. A similar process was conducted in 2001 and marked the DCC's beginning. Handout 3, HO-3 summarizes the ideas generated during both concept mapping processes. The listed tasks were color coded according to importance and impact/feasibility.

Green = high importance, high impact/feasibility

Yellow = high importance, low impact/feasibility

Gray = low importance, low impact/feasibility

High Importance/High feasibility items:

Modernization of the DE Cancer Registry operations to enhance electronic reporting and increase more automated case processing.

Developing ways to support cancer patients, family, and friends on options relating to pain, mitigation and quality of life. This involves both education of these groups as well as social work/care coordination. This task can be interpreted from an informational educational perspective. Beebe uses a resource guide to raise awareness of how they can assist the patient in controlling pain, including alternative medicine interventions that patients can practice. Likewise, for the triage nurses, infusion nurses, even in radiation, learning more or understanding pain management is helpful. The HCAP (Healthy Communities Access Program) score is a good quantitative measure for this because it drills down to the cancer centers. Hospitals are held to this national program. Inpatient payment from Medicare is based on patient satisfaction and outcomes. Medicare implemented this measure and pain is a measure that is included. The measure includes the question, "Did your healthcare provider do everything they could for your pain?"

Dr. Frantz commented that AI uses Press Ganey to measure performance as it has pain questions in it. The HCAP is in addition to improvement surveying performed by various contractors such as Press Ganey. Some hospitals are expanding use of HCAP results to outpatient. Reimbursement will be attached to the HCAP measure beginning 2013.

Addressing patients' psychosocial needs (e.g. the Institute of Medicine, IOM, Standard) – In oncology, addressing the psychosocial needs of the patient can often fall to the side as providers are so driven and so focused on taking care of the patient's physical needs. The IOM standard should be looked at from an institutional level as it ties in with survivorship care, and other aspects of quality of cancer care. The committee should look at the standard to determine whether we can develop ways to approach it both in measurement and in supporting things that happen in the individual hospitals (in/outpatient) as well as in the oncology practices.

Adding to cancer survivorship care - This task involves supporting the development of survivorship care at each of our institutions, the seven hospitals that care of patients with cancer.

Developing a plan to increase Delaware residents' participation in clinical trials - The committee worked on this so perhaps some measurements are required to see if this has improved.

Supporting better management of pain while still receiving treatment as opposed to hospice only – This topic was discussed earlier in the meeting.

High Importance/Low feasibility items:

Addressing the overall financial burden placed on cancer patients including the impact of meeting daily living expenses and the lack of resources to address those needs – The financial aspect is what lowers feasibility here.

Gray Items low importance; low impact/ feasibility

Assist hospitals with meeting additional requirements of cancer registry staff - The additional requirements possibly concern educational requirements; however, the larger concern is likely the additional reporting requirements placed on the registry staff, but with no increase in registry staff. For example, there were six ACoS reports due this year and this total does not include impromptu reporting requests that come from the state. Specifically, this item likely refers to the unfunded mandates. Regarding educational requirements, attendance at national and regional conferences is acceptable. The key is to make sure the conference content is registry focused. Regional conferences are usually less costly, but the content is often not on par with the national registry conference.

Implementing comprehensive assessment of the quality of cancer treatment in Delaware - Feasibility is a problem here. Our measures of quality don't relate to patient survival. We can assess but it cannot be comprehensive. This has been a QCC goal for the last four years in terms of eventually wanting to come up with the quality measures that have national agreement, such as the treatment of stage 3 colon cancer. Things such as this can be related to quality as well as specific pain programs or special survivorship programs. *How* those activities are staffed is a way we can measure quality without creating new ways to measure things.

Using electronic communication between provider and patients/families including reminders about medications. This task is outside of the committee's sphere of responsibility. The QCC works at a different level.

Funding the staffing of clinical trial nurses similar to cancer care coordinators at each hospital.

This activity represents another unfunded mandate. There are large dollars associated with this item; it will not happen unless other programs are cancelled. Dr. Silverman commented that more would be known about the budget once the Governor gives his state of the state address. After that the legislature must pass the budget bill which often does not occur until very late in June.

Developing holistic approaches that include combinations for mind spirit and well being.

The committee can support alternative medicine approaches. At the November 2010 meeting Lakeisha Moore, DPH trainer/educator, presented the draft agenda for a one day symposium on this topic planned for this summer.

Developing and implementing a measurable program to address the needs of caregivers, including an awareness campaign. The Wellness Community may be a good resource for assistance in explaining how their activities integrate with survivorship care. Follow-up from Sean Hebbel would be helpful. The Wellness Community has great support groups, including a 6-

part survivorship series that was delivered in Sussex County. Unfortunately, the series was not well attended.

Address childhood cancer survivorship issues relating to neuropsychological testing, insurance reimbursement for patients who are at risk for disease or treatment. Since this item concerns payers it is outside of the committee's control.

Developing outcomes that the quality committee can use to tell the story of patient navigation and its programs. There was uncertainty of what outcomes the committee could develop that would tell the story of patient navigations and its programs. The patient's story or lived experience is the outcome, so perhaps this item focuses on looking for avenues where these stories can be unfolded and shared. For example, Tunnell Cancer Center creates a "through the patient's eyes" annual calendar, focused on sharing the patient's story. The patient's experience does need to be shared but there are avenues within DPH for that. This item is outside the QCC's focus.

Considering wellcoaching grants through the DCC to assist cancer survivors in developing or addressing lifestyle changes to promote wellness and prevention. It agreed that this item would not be addressed.

In summary, Dr. Frantz reiterated that the green-labeled items really address more about where the committee should be going. Donna Stinson reiterated the concern about cancer registry work volume. It important to keep that in sight as the additional requirements on registry staff are significant. It was also asked whether the DCRAC was a better/appropriate forum for such a discussion. Dr. Frantz asked for ideas from the committee concerning the earlier discussion about unfunded mandates. Regarding structure, the DCRAC is a subcommittee of the QCC, and perhaps this concern can be shared with the DCRAC for review/consideration. Also, since the QCC's current Goal 4 is focused on registry issues, this item can be considered for inclusion in the next 4-Year Plan.

Other business /Announcements

Dr. Frantz then asked the committee for updates, introductions.

Kay's Kamp will have the "Until There's a Cure" benefit on March the 12th, 2011 at the Deerfield Golf and Tennis Club to raise money for Kay's Kamp which is Delaware's only camp for kids with cancer.

Elaine Keegan was in attendance vice Sheila Grant.

Kathy Burt is the new cancer center director for Nanticoke. She has been in this business of caring for oncology patients since 1975. She had just moved here from South Carolina where she had managed hematology and oncology services which had included liquid and solid cancers, bone marrow transplants, high dose chemo's, clinical trials, and coordinated services with the clinics, infusion clinics, radiation oncology at the Medical University of South Carolina for both in-patient and outpatient. Kathy replaces Donald Tricarico on the QCC.

Meeting adjourned.