



MCA Cancer Plan Revision: Treatment Workgroup

May 18, 2016 2:00 – 3:30 p.m.

Participants in person: Heather Kehn, Joe Leach,

Lara Cafruny, Stephanie Gil, Catherine Graeve, Toni Kay Mangskou, Benita Robinson, Maggie Rothstein, Rick Zera

Participants by phone: Rachel Lerner, Michelle Strangis

Location: Abbott Northwestern Hospital, Virginia Piper Building

Agenda Topic	Key Points Raised	Next Steps
Welcome and introductions	Invitation for ground rules, none identified.	N/A
Review of Cancer Plan Process and Goals	<p><u>Planning Elements</u></p> <p>1) Issue statements- objectives-strategies Objectives are the goals. Strategies are specific actions to achieve those goals.</p> <p>2) Cancer Plan MN framework: Aligning stakeholders, advancing health equity, creating policy, systems and environmental change</p>	All proposed objectives and strategies will be completed by the end of June for the steering committees review in July.
Background/ Cancer Plan MN 2011-2016	<p><u>Group Discussion</u></p> <p>Objective #17: Increase participation in cancer treatment clinical trials.</p> <ol style="list-style-type: none"> 1. Revise: Change language from “clinical trials” to “clinical research.” Keep/drop “treatment?” 2. Need to increase patient awareness of clinical trials: 	The group decided to break into groups and report back on proposed strategies and objectives.

- Soft approach: videos, infographics on registry, bio banks, clinical trials with follow-up to ensure understanding. Main concerns of patients are: does it cause harm, is it experimental, and will it help?
 - Florida and Georgia are examples we can draw from.
3. Need to educate patients and health navigators (paragraph in the listening sessions)
 4. Need to educate providers and take the responsibility of seeking out clinical trials off the patient, support provider driven approach
 5. Create a central location to find clinical trial opportunities for providers, health navigators and patients. (*Environmental Change*)

Objective #18: Connect cancer patients and caregivers with non-clinical support services.

1. Revise: what does “nonclinical support services” mean?
2. Revise Strategies: Minnesota Cancer Resources Web portal no longer exists.
3. Change to take the burden off the patient and onto the provider/clinical health system (*Systems Change*)
4. Combine with obj. 17 to create/enhance one webpage for all resources?
5. Potential partners: American Cancer Society has a connection website to add all cancer resources, [Patient Advocate Foundation](#), Leukemia/ Lymphoma Foundation, [National Cancer Institute support services web search](#)

Objective #19: Provide cancer patients with a comprehensive care summary and follow-up plan after completing treatment.

1. Revise
2. Currently a standard for CoC (Commission on Cancer) certified hospitals. The provider gives the care summary and plan to the patient and sends the information to their primary physician, given the patient can identify a primary physician.

Guiding Principle: Health Literacy is cross-cutting and doesn't need its own objective and should instead be considered within all of the objectives. As brought up in the most recent CHEN meeting; it is still important to explicitly mention in each strategy. For example, if there is a strategy about patient education it should state "plain language education" or "health literacy level inclusive education" or whatever the correct terminology might be. Same thing goes for equity; at the CHEN meeting, in preparation for those of us participating in working groups, it was mentioned that in the last plan, something similar happened with "health equity" It was not given its own objective because it really should be included within ALL objectives---but then it was not explicitly stated as such in the strategies so it got lost both in terms of expectation and accountability.

	<p>3. MN 2015 legislature passed the CARE act: providers must inform the caregivers on the patients care plan. (<i>Policy Change</i>)</p> <p>4. What does “establish health care teams to coordinate care” mean?</p> <p>Objective #15: Promote shared decision making for prostate cancer screening and treatment.</p> <ol style="list-style-type: none"> 1. Revise: Broaden scope of patient population beyond just prostate cancer; special consideration to special populations that experience cancer disparities. (note: <i>MN Cancer Facts & Figures 2015</i>) 2. Combine with Value Issue Statement? Assure shared decision making includes value of care conversation. 3. When the last plan was written, prostate screening was becoming controversial. Today, shared decision making is applicable to all cancer types. 4. Need to discuss: <ul style="list-style-type: none"> - Value: is two months of extended life worth the burden of treatment? Treatment must add value. - Genomics conversation and patient education - Financial burden - Using NCCN Evidence Blocks in clinical decisions - Partner with American Society of Clinical Oncology - Empathic decision making tool to meet the patient where they’re at. - Evaluate distress - Encouragement to get a second opinion for rare and complex cancers. - PSE: Virtual consultations/tele-health visits to increase access to care, second opinions, and continue conversations about care options, especially supportive to rural health locations. 	
<p>Emerging Issues</p>	<p>Value: Cost/Benefit, is the burden worth the outcome.</p> <ol style="list-style-type: none"> 1. Who’s going to pay for it? Patient can if they are able to, but insurance may not. <ul style="list-style-type: none"> - Quality of life, financial burden 	<p><u>Homework Groups</u> Health literacy will be woven into all objectives as a strategy.</p>

	<ul style="list-style-type: none"> - Off-label access 2. Financial toxicity: medical bankruptcy 3. Rural access, navigation system for small clinic/hospital providers to access resource to help cover the treatment/medication costs. 4. Potential collaborator and resource: Patient Advocate Foundation <p>Health/ medical Literacy – patient education is a strong need</p> <p>Patient Distress</p> <ul style="list-style-type: none"> 5. CoC accredited cancer centers are mandated to administer a distress screening for newly diagnosed cancer patients. <ul style="list-style-type: none"> Gaps: <ul style="list-style-type: none"> - Non-CoC centers are not mandated to do this. - Are there resources to address the distress identified? <p>Care navigation at the start of care/ use of Community Health Workers – Who uses this intervention? What is the benefit evidence?</p> <p>Access to care: Emergency Medical Assistance (EMA) coverage: preventative treatments are not covered for undocumented patients.</p>	<p>Objective #17 (Joe, Toni)</p> <p>Objective #18 (Heather, Catherine, Benita, Reona) - Toni has a contact for Patient Advocates)</p> <p>Objective #19 (Rachel, Joe, Stephanie)</p> <p>Objective #15 (Andres, Heather)</p> <p>Value (Rick, Rachel)</p> <p><u>Issue statement:</u> Emergency Medical Assistance (EMA) coverage (Stephanie) will be draft with policy element for review</p>
<p>Wrap-up</p>		<p>Homework due June 13. All groups will share completed objectives and strategies worksheet with the workgroup by June 13 for comment.</p> <p>Next meeting TBD (last week in June): Here we will finalize the proposed treatment objectives and strategies.</p>

Next meeting: TBD, last week in June. Heather Kehn will send out a Meeting Wizard to determine a date and time. The meeting will be in person at Abbot Northwestern with the option of participating through WebEx.