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Overview of ASH Quality Improvement Activities

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American Society of Hematology

- Non-profit professional society serving clinicians and scientists around the world who are working to conquer blood diseases
- Promote research, clinical care, education, training, and advocacy in hematology
- More than 15,000 members from nearly 100 countries
- Located in Washington, DC

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Background

- Task Force co-chaired by Drs. Linda Burns and Adam Cuker recommended expansion of quality improvement efforts
- Rationale included wide-ranging impact of QI
  - Identifying and demonstrating improvement in gaps in care
  - Public accountability
  - Reimbursement
  - Maintenance of certification
- Approved 2013

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Background

- Initial emphasis on practice guideline development (foundational to other QI activities)
  - Pocket guides (paper and electronic)
  - Performance Measures
  - Clinical Decision Support/Electronic Health Record integration
  - Webinars

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STRUCTURE

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Organization

- Committee on Quality
  - Monthly conference calls, biannual meetings
- Guideline Oversight Subcommittee
- Guideline Coordination Panels and Guideline Panels
- Quality Improvement Programs Staff
- Internal Collaboration with Practice, Government Relations, Education, Training

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Guideline Development Standard Operating Procedure (SOP)

- Based on comprehensive checklist from Guidelines 2.0 article by Holger Schünemann et al (December 2013)
- Detailed description of Conflict of Interest (COI) rules
- With experience, will be revisited and modified over time
- Procedures for partnerships, endorsement, adaptation to be explored in coming year

Schünemann et al. Guidelines 2.0: systematic development of a comprehensive checklist for a successful guideline enterprise. CMAJ 2014;186(3):E123-42.

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CLINICAL PRACTICE GUIDELINES: ASH GUIDELINE DEVELOPMENT

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Prevention and Treatment of Venous Thromboembolism

- Overseen by Guideline Coordination Panel (GCP)
  - 10 Guideline Panels
  - Approximately 10 clinical questions per panel
  - Each panel will develop unique guideline publication
- Publication of first guidelines estimated late 2016, early 2017
- Online presence, maintenance planned
- Will serve as a platform for a full suite of quality projects, developed concurrently

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Additional ASH Guideline Topics

- Immune Thrombocytopenia
  - Revision of 2011 Guideline
- Myeloproliferative Neoplasms
- Other topics under exploration

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CLINICAL PRACTICE GUIDELINES: PARTNERSHIPS

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Topic	Partner
Workup of Acute Leukemia	College of American Pathologists (CAP)
Red Cell Product Requirements for Hemoglobinopathies and Myelodysplastic Syndrome	International Collaboration for Transfusion Therapies
Comprehensive Care Model for Management of Hemophilia	National Hemophilia Foundation (NHF)
Catastrophic Antiphospholipid Syndrome (CAPS)	RARE-Bestpractices
White Blood Cell Growth Factors	ASCO
Ventilation/Perfusion Imaging in Pulmonary Embolism	Society of Nuclear Medicine and Medical Imaging (SNMMI)

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QUALITY IMPROVEMENT (DISSEMINATION AND IMPLEMENTATION)

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QI Resources and Services

- Many ASH QI resources already available
- Will ramp up with new ASH guidelines

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Pocket Guides



- Popular guideline summaries developed by ASH
- 9 current guides
  - SCD: Acute
  - SCD: HU/Transfusion
  - Thrombocytopenia in Pregnancy
  - RBC Transfusion
  - von Willebrand
  - SCD: Chronic
  - ITP
  - HIT
  - Antithrombotic Management
- App

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Special Symposium on Quality

- Committee-sponsored session at ASH Annual Meeting
- Sessions are well attended, lively Q&A
- 2014: Rising Cost of Medical Care
- 2015: Promise and Pitfalls of Quality Measures and Pay-for-Performance

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Choosing Wisely

- Overseen by ASH Choosing Wisely Task Force
- ABIM Foundation activity on resource stewardship
- Professional societies list 5 tests and procedures that may be unnecessary and in some instances can cause harm
- ASH has developed 2 lists (2013 & 2014)
- Slide set available online with overview of items and their underlying evidence

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Choosing Wisely
An initiative of the ABIM Foundation

American Society of Hematology

hematology.org/choosingwisely

Ten Things Physicians and Patients Should Question

1. **Don't transfuse more than the minimum number of red blood cell (RBC) units necessary to relieve symptoms of anemia or to return a patient to a safe hemoglobin range (7 to 8 g/dL in stable, non-cardiac in-patients).**
Transfusion of the smallest effective dose of RBCs is recommended because liberal transfusion strategies do not improve outcomes when compared to restrictive strategies. Unnecessary transfusion generates costs and exposes patients to potential adverse effects without any likelihood of benefit. Clinicians are urged to avoid the routine administration of 2 units of RBCs if 1 unit is sufficient and to use appropriate weight-based dosing of RBCs in children.

2. **Don't test for thrombophilia in adult patients with venous thromboembolism (VTE) occurring in the setting of major transient risk factors (surgery, trauma or prolonged immobility).**
Thrombophilia testing is costly and can result in harm to patients if the duration of anticoagulation is inappropriately prolonged or if patients are incorrectly labeled as thrombophilic. Thrombophilia testing does not change the management of VTEs occurring in the setting of major transient VTE risk factors. When VTE occurs in the setting of pregnancy or hormonal therapy, or when there is a strong family history plus a major transient risk factor, the role of thrombophilia testing is complex and patients and clinicians are advised to seek guidance from an expert in VTE.

3. **Don't use inferior vena cava (IVC) filters routinely in patients with acute VTE.**
IVC filters are costly, can cause harm and do not have a strong evidentiary basis. The main indication for IVC filters is patients with acute VTE and a contraindication to anticoagulation such as active bleeding or a high risk of anticoagulant-associated bleeding. Lesser indications that may be reasonable in some cases include patients experiencing pulmonary embolism (PE) despite appropriate, therapeutic anticoagulation, or patients with massive PE and poor cardiopulmonary reserve. Retrievable filters are recommended over permanent filters with removal of the filter when the risk for PE has resolved and/or when anticoagulation can be safely resumed.

4. **Don't administer plasma or prothrombin complex concentrates for non-emergent reversal of vitamin K antagonists (i.e. outside of the setting of major bleeding, intracranial hemorrhage or anticipated emergent surgery).**
Blood products can cause serious harm to patients, are costly and are rarely indicated in the reversal of vitamin K antagonists. In non-emergent situations, elevations in the international normalized ratio are best addressed by holding the vitamin K antagonist and/or by administering vitamin K.

5. **Limit surveillance computed tomography (CT) scans in asymptomatic patients following curative-intent treatment for aggressive lymphoma.**
CT surveillance in asymptomatic patients in remission from aggressive non-Hodgkin lymphoma may be harmful through a small but cumulative risk of radiation-induced malignancy. It is also costly and has not been demonstrated to improve survival. Physicians are encouraged to carefully weigh the anticipated benefits of post-treatment CT scans against the potential harm of radiation exposure. Due to a decreasing probability of relapse with the passage of time and a lack of proven benefit, CT scans in asymptomatic patients more than 2 years beyond the completion of treatment are rarely advisable.

6. **Don't treat with an anticoagulant for more than three months in a patient with a first venous thromboembolism (VTE) occurring in the setting of a major transient risk factor.**
Anticoagulation is potentially harmful and costly. Patients with a first VTE triggered by a major, transient risk factor such as surgery, trauma or an intravascular catheter are at low risk for recurrence once the risk factor has resolved and an adequate treatment regimen with anticoagulation has been completed. Evidence-based and consensus guidelines recommend three months of anticoagulation over shorter or longer periods of anticoagulation in patients with VTE that is provoked by a major transient or reversible risk factor. By ensuring a patient receives an appropriate regimen of anticoagulation, clinicians may avoid unnecessary harm, reduce health care expenses and improve quality of life. This Choosing Wisely® recommendation is not intended to apply to VTE associated with non-major risk factors (e.g., hormonal therapy, pregnancy, travel-associated immobility, etc.), as the risk of recurrent VTE in these groups is either intermediate or poorly defined.

7. **Don't routinely transfuse patients with sickle cell disease (SCD) for chronic anemia or uncomplicated pain crisis without an appropriate clinical indication.**
Patients with SCD are especially vulnerable to potential harms from unnecessary red blood cell transfusion. In particular, they experience an increased risk of alloimmunization to minor blood group antigens and a high risk of iron overload from repeated transfusions. Patients with the most severe genotypes of SCD with baseline hemoglobin (Hb) values in the 7-10 g/dl range can usually tolerate further temporary reductions in Hb without developing symptoms of anemia. Many patients with SCD receive intravenous fluids to improve hydration when hospitalized for management of pain crisis, which may contribute to a decrease in Hb by 1-2 g/dL. Routine administration of red cells in this setting should be avoided. Moreover, there is no evidence that transfusion reduces pain due to vaso-occlusive crises. For a discussion of when transfusion is indicated in SCD, readers are referred to recent evidence-based guidelines from the National Heart, Lung, and Blood Institute (NHLBI) (see reference below).

8. **Don't perform baseline or routine surveillance computed tomography (CT) scans in patients with asymptomatic, early-stage chronic lymphocytic leukemia (CLL).**
In patients with asymptomatic, early-stage CLL, baseline and routine surveillance CT scans do not improve survival and are not necessary to stage or prognosticate patients. CT scans expose patients to small doses of radiation, can detect incidental findings that are not clinically relevant but lead to further investigations and are costly. For asymptomatic patients with early-stage CLL, clinical staging and blood monitoring is recommended over CT scans.

9. **Don't test or treat for suspected heparin-induced thrombocytopenia (HIT) in patients with a low pre-test probability of HIT.**
In patients with suspected HIT, use the "4Ts" score to calculate the pre-test probability of HIT. This scoring system uses the timing and degree of thrombocytopenia, the presence or absence of thrombosis, and the existence of other causes of thrombocytopenia to assess the pre-test probability of HIT. HIT can be excluded by a low pre-test probability score (4T's score of 0-3) without the need for laboratory investigation. Do not discontinue heparin or start a non-heparin anticoagulant in these low-risk patients because presumptive treatment often involves an increased risk of bleeding, and because alternative anticoagulants are costly.

10. **Don't treat patients with immune thrombocytopenic purpura (ITP) in the absence of bleeding or a very low platelet count.**
Treatment for ITP should be aimed at treating and preventing bleeding episodes and improving quality of life. Unnecessary treatment exposes patients to potentially serious treatment side effects and can be costly, with little expectation of clinical benefit. The decision to treat ITP should be based on an individual patient's symptoms, bleeding risk (as determined by prior bleeding episodes and risk factors for bleeding such as use of anticoagulants, advanced age, high-risk activities, etc.), social factors (distance from the hospital/travel concerns), side effects of possible treatments, upcoming procedures, and patient preferences. In the pediatric setting, treatment is usually not indicated in the absence of mucosal bleeding regardless of platelet count. In the adult setting, treatment may be indicated in the absence of bleeding if the platelet count is very low. However, ITP treatment is rarely indicated in adult patients with platelet counts greater than 30,000/microL unless they are preparing for surgery or an invasive procedure, or have a significant additional risk factor for bleeding. In patients preparing for surgery or other invasive procedures, short-term treatment may be indicated to increase the platelet count prior to the planned intervention and during the immediate post-operative period.

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Choosing Wisely: Planned Activities

- Regular maintenance/updating of existing items
- New list of items relevant to hematologists drawn from the Choosing Wisely lists of other disciplines
  - Opportunity to draw and benefit from the QI efforts of other

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Consult a Colleague

- Initiated in 2007
- Coordinates consultation between ASH members and volunteer experts
- Response within 2 business days
- 604 requests in 2014 (increases every year)
- Includes HCT experts
- Exploring opportunities for growth

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Engagement in National Quality Enterprise

- Context: Payment, Accountability, Quality
- HHS Goal
  - 30% of Medicare fee-for-service payments tied to quality or value through alternative payment models by 2016, and 50% by 2018
- MACRA (SGR/Medicare pay reform)
  - Financial bonuses/penalties tied to measurement, funding for measure development

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Engagement in National Quality Enterprise

- Multiple National Entities
  - HHS/CMS
  - NQF
  - PCPI
  - NQMC
  - NCQA
  - Other Medical Societies

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Engagement in National Quality Enterprise

- Quality Measure Development
  - External Partnerships (e.g. with American College of Emergency Physicians)
  - Hematology PQRS Measures
    - Myelodysplastic Syndrome and Acute Leukemias
      - Baseline cytogenetic testing performed on bone marrow
      - Documentation of baseline iron stores in patients receiving erythropoietin therapy
    - Multiple Myeloma
      - Treatment with bisphosphonates
    - Chronic Lymphocytic Leukemia
      - Baseline flow cytometry
  - Development in tandem with practice guideline development
  - Some priority principles (care transitions, outcomes measurement) will not be guideline-based

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LONG TERM VISION

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Long Term Vision

- ~20 "owned" guidelines, actively maintained with additional affiliated guidelines
  - Particular focus on core hematology areas including rare disorders unique to hematology
- Robust Dissemination/Implementation plans for each guideline
  - e.g. pocket guides, quality measures, PIMs
- Emerging domains
  - e.g. Health Information Technology tools and services; Big Data/Registries
- Encourage research on quality-related ASH products and services to build evidence base for QI
- Coordination with public and private quality initiatives at all stages of the quality process

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Closing

- ASH is involved in a number of QI efforts through a variety of mechanisms (internal, partnerships)
- ASH is committed to engaging in additional and emerging QI efforts (such as this meeting)
- Collaboration and coordination of QI efforts is essential

DISCUSSION/QUESTIONS